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Investigating the Use of Politeness Strategies of English-speaking Foreign Medical Doctors in Selected District Hospitals in Limpopo Province

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ABSTRACT

Politeness in the form of strategies and the form of address used by doctors in communicating with patients go a long way in dictating the success or otherwise of consultations. When the language of communication is a second language, various dynamics are involved. The paper investigated the use of politeness strategies by English-speaking foreign medical doctors in selected district hospitals in Limpopo Province. From a conversation analysis of recorded consultations involving nineteen (19) English-speaking foreign medical doctors, thirteen (13) nurses and thirty-five (35) patients, it was evident that the doctors engaged more in the use of positive than negative politeness. The paper concludes that the overt use of positive politeness by the doctors showed that they concentrated on convergence which may be indicative of the fact that the foreign doctors may feel an overwhelming need to please patients. It was also found that the doctors adopted English as a second language for communication but adhered to the norms of the community where they work. These have implications for the in-service-training of foreign doctors for better communication and a more holistic health care delivery to patients.

Keywords
politeness, conversation analysis, doctors, English Second Language, in-service-training, patients

Introduction

The aim of this study was to investigate the use of politeness strategies by English-speaking foreign medical doctors in selected district hospitals in Limpopo Province: Mankweng, Tshilidzini, Meclenburg District Hospitals. Mills (2002) describes politeness as a set of strategies or verbal habits which is determined as a norm by oneself or others and are socially acceptable within a given community. Foley, (1997), defined it as a battery of social skills designed to make sure everyone is affirmed in a social interaction. According to Holmes, (1995), politeness is an expression of concern for others. Blum-Kulka (1997) referred to politeness as the intentional strategic behaviour exhibited by people when they wish to save face in threatening situations. Thus, a person is judged to be polite or impolite based on the appropriateness of the behaviour towards other people in relation to the set of community-approved rules. Politeness is considered as a gift that benefits both the giver and receiver as polite people are judged more likeable by others and the interlocutor is also saved from an embarrassing situation (Holmes, 1995). Taking all the definitions into consideration, politeness is understood to be planned, appropriate, socially acceptable behaviour engaged in by interlocutors to save face during interactions and the responsibility of behaving in such a manner lies with each speaker.

Brown and Levinson (1987) building on the work of Goffman (1955) developed the politeness model which has been used in the study of various interactions and it offers a framework for the explanation of people's behaviour in face-threatening situations. The Theory, according to Blum-Kulka (1997), also offers insights into the contextual and cultural differences that may be observed in interactions.

The Politeness Theory has three main notions, namely: face, face threatening acts (FTA) and politeness strategies (Ji, 2000). Face is the public self-image a person wants to claim for himself. The face consists of two kinds of wants; negative face wants which is the desire for one's actions not to be unimpeded, and the positive face wants which is the desire to be approved of and appreciated by others (Brown & Levinson, 1987). FTA refers to actions which militate against the face while the politeness strategies are ways of negotiating these threats (Kwon & Ha, 2004). They further suggest that politeness has two main functions which are to reduce the risk of threat to the face and to show intimacy between interlocutors. Thus, the concepts of face and FTA necessitate the use of politeness strategies in interactions.

Politeness strategies are tools used to create messages based on the desire of the speaker. Brown and Levinson (1987) presented two types of politeness strategies; the positive and the negative. Positive politeness refers to strategies that take into cognizance the need to satisfy the hearer's face; communicating to the hearer that they are similar and that their wants are desirable. They also consist of familiar and joking behaviours. The negative politeness strategies, on the other hand, are used to minimize impositions that occur with FTA by paying attention to the hearer's negative face.

The positive and negative strategies as proposed by Brown and Levinson (1987) are summarised in Table 2.1

Table 2.1: Strategies for politeness

Strategies for positive politeness (Claim common ground)	**Strategies for negative politeness (Be direct)**
1. Notice, attend to interest, wants, needs, goods of the other person	Be conventionally indirect
2. Exaggerate (interest, approval, sympathy with the other person)	Questions, hedges

3. Intensify interest to other person	Be pessimistic
4. Use in-group identity markers	Minimize the imposition
5. Seek agreement	Give deference
6. Avoid disagreement	Apologize
7. Presuppose/raise/assert common ground	Impersonalize the other person
8. Joke	State the FTAs as a general rule
9. Assert or presuppose knowledge of and concern for wants of other person	Nominalize
10. Offer, promise something	Go on record as incurring a debt, or as not indebting the other person
11. Be optimistic	
12. Include both S and H in the activity	
13. Give or ask for reasons	
14. Assume or assert reciprocity	
15. Give gifts e.g. goods, sympathy, understanding, cooperation	

Table 1 (Adapted from Brown and Levinson, 1987)

The main way a speaker shows positive politeness according to Brown and Levinson (1987), is to claim a common ground with the other person. This may be achieved by making reference to similarities between the interlocutors. For example, that they have the same values and attitude or have a common background. Thus, there is the use of inclusive terms like "we" and "us" to express the notion of cooperation between the two speakers. Thirteen other examples of positive politeness were given by the authors and they focus on finding similarities between speakers or pleasing the hearer. Ten different ways by which a speaker may use negative politeness. The negative politeness focuses on saying what needs to be said directly without paying attention to the face wants of the hearer.

According to Brown and Levinson (1987), the politeness theory is a universal concept present in all cultures. The study of Kwon and Ha (2004) challenged this concept in a comparative study of Koreans and Americans politeness and concluded that while politeness is indeed universal as all cultures engage in it, overall tokens were different. This suggests that different cultures have different ways of conveying politeness even though the aim of use is the same. Each culture has its own token of politeness, hence, what is considered polite in one culture may be considered rude in another. For example, looking a person straight in the face is considered rude in many black African cultures, while failure to do so in Western cultures presents the speaker as insincere and having something to hid. When people communicate in a second language, they also need to take into account the politeness tokens of the language for effective communication. In situations where both speakers are second language users of a language, the tokens to use are not clear-cut. Summarizing the possible problems arising from the use of a second language, Allwood (1985:20) noted:

Through the difficulty of attempting to master a third culture's way of thinking and speaking that is foreign to them both, they are forced to add to the difficulties in understanding that might already exist between them because of differences between their respective background cultures. That which is said must now be interpreted not only with consideration to the background of the speaker but also with consideration to the values and norms of the third, imported culture.

In Africa, politeness may also be ensured through the use of idioms and euphemisms. Milubi (1998) argued that idioms are used to ward off feelings of embarrassment that may have otherwise prevented the patient from giving valuable information to the doctor. This presents an interesting scenario for the foreign doctor who has to consult in the English language with patients from different linguistic and cultural backgrounds. How are these idioms and euphemisms translated to convey the correct meaning to a person who does not understand the culture and health belief models behind the sayings?

Brown and Levinson (1987) argue that minor differences in interpretative strategies of speakers from the first language to the second may lead to misunderstandings in communication. However, it is not clear if second language users of a language transfer politeness strategies from the mother tongue to the L2 or use politeness strategies from the L2 when conversing with someone who is also an L2 speaker of the language.

In the doctor-patient communication, politeness strategies shed light on problems inherent in the communication process, how to avoid them, and provide a template for the training of health workers (Yin, Hsu, Kuo & Huang, 2012; Robins & Wolf 1988). As opposed to the practice in the Western world where consultation is increasingly being seen as a partnership between the doctor and the patient, the consultation style in developing and underdeveloped countries remains largely paternalistic. The doctors in the developing world are accorded a lot of respect due to the high status placed on their educational achievements. This view often leads to an asymmetric relationship in the doctor-patient communication often requiring the use of politeness when the face is threatened. Calarmita, Nugraheni, Van Dalen and Van der Vleuten (2013) note that patients often did not voice their dissatisfaction with the doctors and when they did, it was done in an indirect hesitant manner.

Often in consultations, the doctor and patient have a common goal of diagnosis and treatment and make efforts to achieve this goal by using different strategies. Bagheri, Ibrahim and Habil (2012), noted that professionals use

language based on several factors which include politeness rules. However, as noted earlier, politeness tokens differ from culture to culture and this may constitute a problem during consultation in multilingual and multicultural settings. Calarmita et al (2013) noted that the doctor- patient relationship follows unspoken rules of behaviour which places emphasis on politeness and which strives to maintain a positive image.

It is not uncommon for doctors using the paternalistic method of consultation to appear rude and hurried in their interactions with patients. However, this can also be noted even when the doctor appears polite and friendly. Agledahl, Gulbrandsen, Forde and Wifstad (2011) view politeness as a cover up by the medical doctor for their lack of concern for patients' underlying existential needs. They believe that the polite and friendly demeanour of the doctors is used to ensure control of the consultation and maintain focus on medical scientific issues raised without paying attention to what the patient has to say or feel. This is plausible when one considers that some speech acts are face-threatening and people may use different strategies to minimize the threat (Brown and Levinson, 1987). Also, the need to attend to a large number of patients within a short time frame creates a conflicting situation between the wants of the doctor and those of patients. This is akin to the distinction made by Mishler, (1984:6) between the "voice of medicine" and the "voice of the life-world." With the voice of medicine, the doctor takes charge of the interaction while in the voice of the life-world, the patient is of primary importance and the doctor pays attention and gives the patient opportunity to voice concerns outside the medical issues. The voice adopted by the medical doctor will determine the type of strategies used in interaction with the patient. In a same culture consultation, it may be easy for the doctor to make a decision about the strategy to use depending on the circumstances. It may, however, be more difficult for a foreign doctor when the tokens of politeness are different.

A major token of politeness is the mode of addressing in interactions; a part of cultural awareness that indicates the level of politeness, the type of relationship that exists between the interlocutors and the attitude of the speaker towards the addressed person as well as the framework for the conversation (Trudgill, 1983; Alder, 1978; Quirk, Geenbaum, Leech & Startvik, 1985). In other words, the way a speaker addresses the hearer is very important as it occurs at the beginning of the interaction and may determine the development of the conversation.

Quirk *et al* (1985) categorised address forms into the following groups:

Names - first name, last name, full name with or without title or a nickname

Standard appellatives - family relations, titles of respect, for example, sir, ma'am, and markers of status

Occupational terms like "doctor", "nurse"

Epithets - nouns or adjective phrases expressing an evaluation either favourably or unfavourably, for example dear, honey, beautiful.

General nouns often used in more specialized senses, for example, girls, ladies.

The personal pronoun 'you'

In the doctor- patient interactions, Iragiliati (2006) opined the form of address used by medical doctors is pertinent to the success of consultations. She concluded from analysis of data that positive or negative politeness strategies are reflected through the forms of address used by both doctors and patients. The forms of address are culture based and when not used at all or used in the right context, the consultation and subsequent medication is adversely affected. This underscores the need for doctors, foreign to the culture where they practice to learn and use appropriate forms of address. Interactions in institutional settings which involve power and distance are negotiable according to Aronsson and Rundsrtom (1989), and as such some strategies which may have otherwise been viewed as negative may actually be positive. Hence, superficial rudeness may produce a feeling of solidarity when the interlocutor understands that the opposite of what is said is meant (Grainger, 2004) underscoring the fact that the interlocutors must have a shared understanding of the choice of words and circumstances.

A germane question to ask is how speakers decide on the politeness strategies to use in any given situation. Holtgraves (2002) identified two competing motives; the motive to manage face and the motive to communicate efficiently and he then reasoned that the choice of a strategy depends on the motive most important to the speaker. Brown and Levinson (1987) also thought along the same line with an additional option. They believe that speakers will weigh the options of communicating the content of the FTA, the want to be efficient and the want to ensure that the hearer's face is maintained. Hence, the speaker needs to make a decision to satisfy himself/herself or the hearer. Both authors also agree that the decision also depend on sociological variables like social distance, power, and knowledge of cultural tokens of politeness. In a multicultural and multilingual interaction, the choice is also dependent on knowledge of the hearer's cultural token of politeness as the different presentation of face in different cultures affects communication patterns (Chen & Starosta, 1998). When the communication is in a shared second language, the interlocutors need to decide the tokens of politeness to use; those of their different first languages of those of the second language.

Iragiliati (2006) noted that the use of politeness strategies that reflected the cultural values of the patients was crucial to the success of consultations. In a study of interactions between of medical doctors, seventh and eighth semester medical students and patients in Indonesia, the use of communicative codes and politeness strategies was described. It was noted that the positive face was achieved by the use of personalization and social identity markers while the negative face was achieved by using impersonal forms of address.

Methodology

Thirty-five consultations involving nineteen (19) English-speaking foreign medical doctors, thirteen (13) nurses and thirty-five (35) patients in ten government hospitals were audio-recorded. The consultations were held in four languages namely, Sepedi, Tshivenda Xitsonga and English. Silverman (2009:149) concludes that a major reason for recording conversations in research is that "we cannot rely

on our recollection of conversations." Thus, it is necessary to have a recording that can be replayed to guarantee the accuracy of the report. The use of Conversation Analysis necessitates either the visual or only audio recordings of naturally occurring interactions and transcribing same for analysis. Perakyla (1997:203) referred to them as the "raw material" of the research and adds that they can "provide for highly detailed and publicly accessible representation of social interaction." Naturally-occurring interactions between the doctor, patient and nurse were recorded based on the consent of all participants. All recorded consultations were transcribed using the Conversation analysis conventions. Those recorded in the first three languages were also translated into the English language before analysis. The translations were checked by senior language practitioners in the University.

Three categories of participants, that is, the English-speaking foreign medical doctors, nurses interpreting for them and patients were recruited for the study. Doctors who were not South Africans by birth or obtained their basic medical degrees in South Africa and do not speak any South African indigenous language fluently formed the target population from which only two doctors per hospital were included in the study. The nurses interpreting for the doctors were recruited based on their willingness to participate in the study and permission from the Head nurse. The patients were approached for consent as they entered the consulting room. If a patient agreed to participate, the recording and observation commenced.

The consultations were analysed with the aid of the Nvivo 10 qualitative software which was used to code. The principles of Conversation analysis was employed in the analysis. Continuous reflection about the data is a hallmark of qualitative analysis (Creswell, 2009). Researchers, therefore, interacted with the data by reading it several times to get familiar with it and made notes. The coding helped the researcher to identify patterns in the data. The patterns were categorized and labelled for use in the study.

Findings

In examining the politeness strategies used by English-speaking foreign medical doctors, the broad division of positive and negative politeness strategies were considered.

Positive politeness

Positive strategies are those designed to show people that they are similar, that they are liked, to show sympathy or use of humour in conversations. The observed positive strategies are discussed below.

The identified strategies are discussed below:

Reference to prior meeting outside or within the hospital

The doctor in the excerpt below realized that the patient had attended a lecture he gave in a church on high blood pressure and used this as a platform to establish a common ground for them to interact. It appeared that the doctor made references to the prior meeting anytime he needed to drive home a point. It became a safe launch pad for the issues raised in the consultation. The doctor made direct references to the lecture in lines 1,3,7,11,13 and 27.

EXCERPT 1: LTC001P1 CONSULTATION

1. *Doctor: i'm happy: (.) that you were in the church that we had a speech about high blood pressure about sugar and you are coming that you know ME because of that speech and that speech assisted you with er: how to control your: blood pressures(.) you have high blood pressure isn't that*
2. *Patient: yes*
3. *Doctor: oka:y ok i'm happy that i see some voice coming back now giving me feedback saying that it was useful for you*
4. *Patient: mm*
5. *Doctor: ok so:: now you know what is the limit for your: blood pressure=*
6. *Patient: mm*
7. *Doctor: = after that speech isn't it=*
8. *Patient: ye::s*
9. *Doctor: = so: can you tell me what is that limit*
10. *Patient: that limit was er::!-*
11. *Doctor: what is the!- should it be:: less than(.) 1 er:: 140(.) over >190<(.) you remember i gave you [i gave you some] papers huh*
12. *Patient:[you give] that paper*
13. *Doctor: you can go and check that paper again huh ? <u>your</u> blood pressure? the reason i'm explaining to you because <u>see</u> (.) your blood pressure is!- just give me a draft (.) please(.) <u>your</u> blood pressure as i explain:ned that da[y]should be less than one: [for:]::TY over 90 see*
14. *Patient: [yes] [140](0.4) mm*
15. *Doctor: we hav::: we record it like that every person has two: blood pressure*
16. *Patient: mm*
17. *Doctor: NO matter what is we don't want to go through the (days) it doesn't matter but just to know that you have two blood pressure all of us (.) and if you look here they write it like that 140 [over 90]*
18. *Patient:[over 90]*
19. *Doctor: or 140 slash 90*
20. *Patient: 90 mm*
21. *Doctor: ok S::O YOur blood pressure must be less than this (.) it means the top one mus:::tn't reach 140*
22. *Patient: ok*
23. *Doctor: and the loWER one rea[ch 9]0*
24. *Patient: [90]*
25. *Doctor: must be leSS*
26. *Patient: oh i see*
27. *Doctor: is exactly what they have written in th[at](.) paper that we distributed to the audience that day*
28. *Patient: [in that] paper*

Also, in the excerpt below, the doctor claims a common ground by saying the patient was well known to him as he had consulted with him before. The doctor names the clinic the patient usually attends, using that as a basis to claim common ground and create a rapport with the patient. The doctor's claim is supported by the patient in line 57.

EXCERPT 2: JFH002M CONSULTATION

52 Doctor: He was using Paulos Masha before
53 Nurse: [Paulos Masha]!-
54 Doctor:[I'm (sensing)] [Paulos Masha]

55 Nurse: [PAULOS MASHA] ok
56 Patient: Yes:: > ↑Paulos Masha↑ <
((they all laugh))
57 Patient: e::: Paulos Masha yaa wa e tseba
57 Patient: Yes::: he knows it Paulos Masha
58 Doctor: akere you are my friend, so I know you very well
58 Doctor: You are my friend right (.) so I know you very well

The local way of speaking and speaking the local language
Claiming common ground in conversations may be achieved by using the native dialect which according to Enfield (2006:401), is judged to be a "reliable indicator of long years of common social and cultural experience." Hence, when doctors use such words as "gonna", "wanna" and "neh" or speak the local language they are making a statement that they belong or are willing to integrate into the community they serve.
EXCERPT 3: ELM001F CONSULTATION
56. Doctor: she is ::: I think [she don't ah do] maybe she don't wanna speak

Having learnt some local language, the doctors speak directly with the patients. This strategy presents the doctor as willing to identify with the local people and temporarily removes the need for an interpreter, allowing the doctor and patient to create a rapport.

EXCERPT4: ELM002F CONSULTATION
Doctor: minjhani?
Doctor: how are you?
Patient: hi kona
Patient: I am fine
Doctor: pfukile minjhan? (hhh) okay what is the problem (hhh) today
Doctor: I am fine and you? (hhh) okay what is the problem (hhh) today

Being able to converse directly with the patient, even for a short while during the consultation introduces a personal touch to the consultation as there was no need for an interpreter when the doctor is able to speak the local language. Below, the doctor is able to give directions to the patient in the local language.

EXCERPT 5. JFH001P2M CONSULTATION

103 Nurse: wa isa […]!- [o fo ba nea]
103 Nurse: Take it there!-[just give it to them]
104 Doctor: […](tše tharo neh) wa tsea [dithare] neh
104 Doctor: […](Three ok)]then you go collect [medicine]ok
105 Patient: [ka gorealo] ke sa ile go dula ntshe ka kua
105 Patient: [By saying so] I am still going to sit that side

Humour
When used appropriately during consultations, humour can help to build a cordial relationship between the doctor and patient, (Squier, 1995). The doctor, through the use of humour, reinforces the instruction that the patient was to avoid certain types of drinks.

EXCERPT6: JFH002M CONSULTATION
60 Doctor: good (.) no cold drink, no beer, no whiskey neh
Doctor: good (.) no cold drink, no beer, no whiskey ok
61 Patient: no nna ga ke dire dilo tseo
Patient: no I don't do those things
62 Doctor: ((laughs)) papa are you a pastor or are you priest
63 Interpreter: bare le moruti
Interpreter: he is saying are you a priest
64 Patient: aowa ga se nna moruti
Patient: no I am not a priest
65 Doctor: ((laughs))

However, humour must be used with care. While it can help to relax the patient and create a more conducive atmosphere for consultation, it may also reduce the seriousness that the doctor may need to attach to the information being passed to the patient.
The use of the inclusive pronoun
A cordial working relationship is important between the foreign medical doctor and the nurse interpreting. During consultations involving the use of an interpreter, the doctors often use the inclusive pronoun, "we" to refer to himself and the nurse interpreting as a team. In the excerpt below, the doctor uses the inclusive pronoun "we" when telling the patient the treatment plan and action to be taken.
EXCERPT 7: CNP002M CONSULTATION
Doctor: we will give you (.) we can give this () of er:: this anti rabies here (.) and then er:: wherever you go(.) anywhere a clinic or a hospital(.) just show them this and they will kn[ow]
Patient: [and] explain (.) so:: anywhere can i use this one
Doctor: yah sure (.) you can start [you can!-]
Patient: [i can see] the treatment has been () i don't know
Doctor: ((PS: DOCTOR'S UTTERANCES COVERED UP BY THE BACKGOUND NOICE))
Patient: you still gonna give me something
Doctor: give you some treatment
Patient: >okay<(.) so:: could any hospital ()
Doctor: we are going to put er:: (.) this(.) we are going to put hospital stamp on it and you can present it anywhere (.) at the clinic or hospital

The use of the inclusive pronoun gives the nurse a sense of belonging to the team and creates the need to contribute positively to the success of the consultation. A breakdown of communication is not considered a failure of the foreign doctor but also of the nurse who does the interpreting.

Negative politeness

The use of hedges
Hedges may be used to minimise imposition to the hearer, and convey a speaker's uncertainty. The doctor used hedges in communicating information and directives to the patients. These are used often by the doctors as an attempt to reduce the seriousness of a procedure or ailment. For example, in the excerpt below, the doctor informed the patient in line 3 that he was looking for "just" a few things and noted that the kidney was "still working well" in line 5. Also in line 8, he said the blood results were still acceptable without informing the patient what constituted an acceptable level.

EXCERPT 8: CNP001F CONSULTATION
01 Doctor: now have you got the results
02 Patient: the results yes (they're fine)
03 Doctor: (0.9) () it's jus:t (.) few things we are looking at hey
04 Patient: okay
05 Doctor: like the:: lab resulTS to see whether you: (.) your kidney is still working well
06 Doctor: it is [still working!-] it is fine
07 Patient: [it is fine] (0.3) oka:y
08 Doctor: an:d your:: blood results(.) the (hp) is still acceptable
08 Patient: okay

The excerpt below shows the doctor allaying the fear expressed by the patient in line 71 by down-playing the medical test as "just a screening"

EXCERPT 9: LTC 001P2 CONSULTATION

71. *Patient: ((laugh)) what i' m scared of is this operations i don't want to [hear about it]*
72. *Doctor: [no no no] operation it's just a screening the x-ray shows your heart is fine or not that's all we want to know okay*
73. *Patient: yes*

The use of hedges by the foreign doctors may send conflicting messages to the patients. It may appear that the doctor is not sure of what he/she is saying, that the ailment is not serious and that it was not compulsory to follow the treatment plan.

Forms of Address

Forms of address play an integral part in communication and set the tone for the rest of the consultation. The form of address is usually introduced at the beginning of interaction and creates a sense of rapport (Brown, Crawford and Carter, 2006). A patient may respond negatively or positively to a doctor based on form of address. A wrong form of address is considered disrespectful and rude. In the consultations analysed, the majority of the doctors tried to use appropriate forms of address for both nurses and patients. This is an indication of convergence on the part of the doctors as they used culturally appropriate addresses.
The nurses were not at any time during the consultations addressed by their first names but by professional titles such as "Sister" or "Nurse" irrespective of their professional rankings signifying a respect for gender and professionals. The doctors used forms of address that showed a willingness to integrate culturally by using appropriate cultural address for the patient. For example, the elderly patients were often addressed as "Mama" or "Papa", according to the gender.
EXCERPT 10:JFH001F CONSULTATION
02 Doctor: What is the problem today mama
EXCERPT 11: SH002 (M1) CONSULTATION

32 Doctor: re gona PApa↓
32 Doctor: we are fine PApa↓
33 Patient: okay↓
34 Doctor: no complain Baba::
Middle aged female patients were addressed by their marital status that is "Mrs" and their male counterparts "Mr", while the younger ones were addressed by their first names or "Sesi" (Sister) or "Buti" (Brother).
EXCERPT 12: LTC001F CONSULTATION

1. *Doctor: okay:: er:::: mrs:: moDOU.*
2. *Patient: modau*
3. *Doctor moDOU*
4. *Patient: mm*

EXCERPT 13: JFH002M CONSULTATION
10 Doctor: let me ask papa what is wrong with him
11 Interpreter: bare bothata ba lena ke eng papa
11 Interpreter: he is asking what is your problem papa

EXCERPT 14: VVH001F2 CONSULTATION

1. *Doctor: SE:si WHat's wrong*
   Doctor: SI:ster WHat's wrong.

In some other cases, the doctors called the patients by their first names. These were usually middle aged or young patients who were about the doctor's age or younger.
EXCERPT 15: CNP002M1 CONSULTATION
5. Doctor: you are rodney
6. Patient: yes:
EXCERPT 16: VV002F CONSULTATION
01 Doctor: ↑es:ter
02 Nurse: ()
03 Patient: (0.4)↓le kae ma↓
03 Patient: (0.4)↓how are you ma↓
04 Nurse: re gona le kae
04 Nurse: I am fine and you

In some cases, the doctors did not use any of the forms of address discussed above but simply called "patient" and referred to her in the third person "she" as shown in the excerpt below.
EXCERPT 17: ELM001F CONSULTATION

1. *Doctor: ok are just gonna() how are you*
2. *Patient: ndi hone ndi humbela upfa haningeo*
3. *Patient: I am fine thank you how are you*
4. *Doctor: [eeeh] sister what is wrong with the patient*
5. *Nurse: vhari: vha khou vhavhudzisa uri hu khou itea mini vho dokotela*
6. *Nurse: the doctor is asking what is wrong*
7. *Patient: oh right ndi khou di dela zwezwi zwa maduvha thoho ndi yone ino ita I tshi pina pina*
8. *Patient: oh right am here for the usual, the headache is the one which troubles me*
9. *Nurse: headache and she is asking for(.)*
10. *Doctor: ok: she is taking treatment for hypertension every month and today she is complaining about the headache and then is there any other complaint.*

The doctor greeted the patient in the English language as she enters the consulting room. The patient replied in the local language indicating to the doctor that an interpreter was needed. In line 4, the doctor offered no reply to the patient's greetings but spoke to the nurse to find out what was wrong with the patient. This type of address was found in cases where the patient was young or middle aged and spoke the local language thus requiring an interpreter. This suggests that consultations were likely to become impersonal as the doctor spoke to the nurses and not the patients. It also suggests that the doctors were not favourably disposed to the use of the local language by younger patients.

Discussion

The use of the politeness strategies by the foreign doctors suggest that they were very polite in their dealings with the patients and nurses who interpreted for them. Agledahl, Gulbransen, Forde and Wifstad (2011), noted that the doctors cannot be accused of being impolite but that they may use their courteous behaviour towards patients as a cover-up for their indifference and lack of interest in the patients. This fact was also found in this study as doctors, though very polite with the patient, were not interested in discussing issues beyond the medical realm. However, in this case, the doctors may have avoided discussing non-medical issues because of their inability to understand the local languages. Hence, doctors were quite professional in their dealings with the patients. Claramita *et al* (2012) are of the opinion that doctors by virtue of their training among other factors behave in ways that underlie social distance. Hence, they maintain an air of professionalism by being polite such each participant in the interaction maintains his/her social position. Iragiliati (2006) noted that being polite is considered more important than forming a lasting relationship with patients. This, may be the case with the foreign doctors whose concentration may be on "getting the job done" as they see themselves as being in the place for a while and have no need to form lasting relationships with the patients.

A major politeness strategy used by English-speaking foreign medical doctors is claiming common ground with both patients and interpreters. This is in contrast to findings by Yin, Hsu, Kuo and Huang (2012) and Zibande and Pamukoglu (2013) who reported that doctors used mainly bald on record strategies in communicating with patients. The reason for the difference is likely to be the fact that the doctors in this study are foreign medical doctors. Using positive politeness strategies may be an attempt by the doctors to reduce uneasiness as well as create a sense of rapport with the patients during consultations as Enfield (2006) argued that communication becomes less constrained when interlocutors share a lot in common. It may, however, be argued also that overt use of these strategies by the foreign doctors is because they see themselves in a position of low power and find it necessary to identify with and please the local people. Fiscella, Boteltho, Roman-Diaz, Lue and Frankel (1997) report that foreign doctors were afraid they would be judged more strictly than other doctors if they made a mistake. Feelings like this may inform the use of the strategies. Further investigation may be required to compare the strategies used by the foreign and locally trained medical doctors.

From the use of strategies and the forms of address used by the foreign doctors show that they engaged in convergence as they tried to adapt to the language and culture of the community where they work. Jain and Krieger, (2011) note that it may be beneficial for doctors to keep their identities by maintaining their accents and pronunciations when communicating with patients. According to them, it is sometimes beneficial to maintain such as it may be a good conversation starter with curious patients.

As noted by Allwood (1985), speakers of a second language may have to adopt the norms of the language when they use it. This did not happen in this study as the doctors used the appropriate local forms of address for their patients. Elderly patients were not called by their names; rather all patients were given suitable forms of address. The doctors were aware of the cultural values of the communities where they worked and reflected this in the politeness strategies they employed. This, according to Iragiliati (2006), was crucial to the success of consultations. Hence, only the language of communication was adopted, not it norms.

It would be worthwhile to investigate the use of politeness strategies by foreign and native born doctors as well as the strategies used by patients in consultations with each group. Politeness theory proposes that the issues of power, social distance and degree of imposition will determine how polite a speaker is (Brown and Levinson, 1987). It is possible that the doctors used very polite strategies more often because they are foreigners, usually economic migrants who despite the high level of training feel powerless in a different country.

Conclusion

The article identified the politeness strategies used by English-speaking foreign medical doctors and found that they employed majorly positive strategies in communication with patients. The overt use of positive politeness to ensure convergence may be a sign of powerlessness on the part of the doctor and may result in less than holistic health care for the patients. Over convergence may lead to frustration on the part of the doctors. They should be assured that maintaining their identities is also acceptable. Politeness may determine how successful a consultation is and the need to ensure that proper strategies are employed cannot be overemphasised. It is of necessity that foreign doctors are well skilled in politeness strategies for effective communication.

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