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Doctor–patient communication in rural Indonesia: a pragmatic study of directive speech acts in clinical consultations

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ABSTRACT

Background: Rural healthcare communication in Indonesia presents complex interactional challenges where institutional authority intersects with sociocultural norms of politeness and hierarchy. **Objective:** This study aims to examine how directive speech acts are produced, mitigated, and sequentially organized in rural clinical consultations. **Method:** Using a qualitative pragmatic design, 42 recorded consultations (864 directive tokens) from community health centers, private clinics, and mobile services were transcribed and analyzed through Speech Act Theory, Politeness Theory, and Conversation Analysis. **Results:** The results show that advice (44.0%) and instruction (28.7%) dominate over direct commands (8.5%), indicating preference for mitigated authority. Negative politeness strategies account for 65.3% of directives, with modal verbs and hedges as primary mitigation devices. Sequential analysis reveals that short pauses correlate with immediate acknowledgment, whereas longer pauses significantly predict repair sequences. **Implication:** This study demonstrates that medical authority in rural Indonesia is enacted through calibrated mitigation and interactional sensitivity rather than overt coercion. **Novelty:** The novelty lies in integrating illocutionary classification, face management analysis, and sequential metrics into a unified model of directive negotiation in non-Western clinical discourse.

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1. INTRODUCTION

Indonesia's healthcare system serves more than 275 million citizens, with approximately 43% of the population residing in rural areas where access to medical services remains uneven (World Health Organization; World Bank). In these rural settings, primary healthcare is largely delivered through Puskesmas, which handle millions of outpatient consultations annually. Effective doctor–patient communication is therefore not merely a linguistic concern but a public health imperative, particularly in managing chronic diseases such as hypertension and diabetes, whose prevalence in Indonesia exceeds 30% among adults (Kementerian Kesehatan Republik Indonesia). Miscommunication in clinical directives—especially regarding medication adherence and lifestyle modification—has been repeatedly linked to poor treatment outcomes and preventable complications. In rural communities where social hierarchy, local languages, and cultural norms shape interaction, the pragmatic form of medical directives becomes crucial. Understanding how directive speech acts are structured, mitigated, and responded to in such contexts is therefore both socially urgent and theoretically significant.

Existing scholarship in medical communication has extensively examined doctor–patient interaction from perspectives such as patient-centered care, shared decision-making, and institutional discourse [1], [2],

[3], [4], [5]. Studies in Western contexts have demonstrated how directives are softened through mitigation strategies to preserve patient autonomy and face [6], [7], [8], [9]. Conversation Analysis research has also documented the sequential organization of treatment recommendations and patient uptake [10], [11], [12]. However, empirical studies focusing specifically on directive speech acts in rural Southeast Asian medical contexts remain scarce. In Indonesia, previous research has largely addressed health literacy, language barriers, or general politeness strategies [2], [3], but rarely integrates Speech Act Theory, Politeness Theory, and Conversation Analysis into a unified pragmatic investigation of clinical directives. Moreover, little attention has been paid to bilingual code-switching (Indonesian–Javanese/Madurese) as a pragmatic resource in rural healthcare encounters. This gap necessitates a focused, data-driven examination of directive speech acts in authentic rural clinical consultations.

This study therefore investigates how directive speech acts are produced, mitigated, and sequentially organized in doctor–patient consultations in rural Indonesia. It addresses the following research questions: (1) What types of directive speech acts are most frequently employed by doctors and patients in rural clinical settings? (2) What politeness strategies are used to manage face and negotiate institutional authority? (3) How are directives sequentially structured and responded to within clinical interaction? By analyzing approximately 30–50 recorded consultations across Puskesmas, private clinics, and mobile health services, this study examines both linguistic form and interactional function. Particular attention is given to mitigation devices, modal expressions, repair sequences, and bilingual shifts. The objective is not only to classify directives but also to understand how power, hierarchy, and social affiliation are pragmatically enacted through everyday clinical talk.

This research advances the argument that in rural Indonesian healthcare settings, medical authority is pragmatically enacted through mitigated directives rather than overt commands, producing what may be termed "soft institutional authority." While doctors maintain epistemic and institutional dominance, they strategically employ negative politeness and affiliative code-switching to align with patients' socio-cultural expectations. The working hypothesis tested in this study is that advice and instruction forms will significantly outnumber direct commands, and that mitigation strategies will correlate with moments of potential face threat or patient resistance. By integrating Speech Act Theory, Politeness Theory, and Conversation Analysis, this study offers a multidimensional framework for examining medical directives in non-Western contexts. Its implications extend beyond linguistics, contributing to health communication research, rural healthcare policy, and culturally responsive clinical practice.

2. LITERATURE REVIEW

2.1. Directive speech act

Directive speech acts constitute a central category within pragmatic theory, referring to utterances designed to get the hearer to do something. Originally formulated by John Searle, directives include commands, requests, advice, and suggestions, distinguished by their illocutionary force and degree of authority [4], [5]. While early formulations emphasized speaker intention and conventional force [1], later pragmatic scholars have argued that directives are contextually negotiated rather than structurally fixed [2]. In institutional settings such as medical consultations, directives acquire additional layers of meaning, functioning not merely as linguistic acts but as socially embedded instruments of professional authority and therapeutic governance.

The categorization of directives has been refined across linguistic traditions [3]. Searle's taxonomy differentiates directives based on force and felicity conditions, whereas corpus-based pragmatics highlights gradience rather than rigid classification. In clinical discourse, directives may appear as direct imperatives ("Take this medicine"), mitigated imperatives ("Please take this medicine"), or indirect forms ("You might want to take this medicine"). Scholars also distinguish between strong and weak directives, depending on coerciveness and speaker entitlement. In healthcare contexts, advice and recommendations are often preferred over explicit commands, reflecting a shift toward patient-centered interaction and shared decision-making frameworks.

2.2. Politeness strategy

Politeness theory provides a complementary lens for understanding how directives are socially managed. According to Sisay (2025), politeness strategies aim to mitigate face-threatening acts, particularly when speakers impose obligations on hearers [6]. Directives are inherently face-threatening because they constrain the hearer's autonomy (negative face). Subsequent scholarship has critiqued universalist assumptions within early politeness models [8], arguing for culturally specific interpretations of face, hierarchy, and relationality. In medical discourse, politeness does not simply soften imposition but actively negotiates power asymmetry between institutional authority and lay patients [7].

Politeness strategies in clinical directives are commonly categorized into bald-on-record, positive politeness, negative politeness, and off-record strategies [9]. Negative politeness, characterized by hedges, modal verbs, and indirectness, predominates in contemporary medical settings to preserve patient autonomy. Positive politeness strategies, such as inclusive pronouns ("Let's try this treatment"), foster solidarity. Off-record strategies may imply advice without explicit imposition. In multilingual contexts, code-switching may function as an affiliative strategy, reinforcing social proximity. Recent discourse studies demonstrate that mitigation devices correlate with sensitive topics, chronic illness management, and moments of patient hesitation, revealing the micro-politics of institutional interaction [13], [14].

2.3. Conversation analysis

Conversation Analysis offers a third analytical dimension by focusing on the sequential organization of talk-in-interaction. According to Weidner (2025), this approach examines how meaning emerges through turn-taking, adjacency pairs, and repair mechanisms [12]. Rather than treating directives as isolated utterances, Conversation Analysis situates them within unfolding sequences, such as diagnosis–recommendation–acceptance structures [10]. In medical consultations, treatment recommendations often function as "preferred actions," typically followed by minimal acknowledgment, while resistance or silence triggers elaboration and reformulation [11].

Key analytical indicators within Conversation Analysis include turn design, response preference organization, repair initiation, pause duration, and prosodic features [15]. Directives are frequently embedded in multi-turn sequences where patient uptake determines subsequent interactional trajectories. Acknowledgments such as "okay" or culturally specific equivalents signal alignment, whereas delays or clarification requests may index subtle resistance. Repair sequences reveal how doctors recalibrate directives to ensure comprehension. In bilingual settings, language shifts often occur at moments of clarification or relational alignment [15], [16]. Together, these sequential features illuminate how institutional authority is collaboratively enacted and negotiated through everyday clinical talk.

3. METHOD

The unit of analysis in this study consists of directive speech acts produced by doctors and patients during authentic clinical consultations in rural Indonesia. The corpus includes 42 recorded sessions (approximately 630 minutes) from three institutional settings: community health centers (Puskesmas), private primary clinics, and mobile health services. Each consultation lasted between 10–15 minutes and involved common cases such as respiratory infections, hypertension, and diabetes management. The dataset was transcribed verbatim, including pauses, overlaps, and code-switching (Indonesian–Javanese/Madurese). Table 1 summarizes the corpus composition. This corpus provides a comprehensive representation of directive use across institutional and linguistic variations.

Table 1. Corpus description

No	Data Type	Setting	Cases	Sessions	Duration	Language Features
1	Audio-recorded consultations	Puskesmas	ISPA, Hypertension	18	270 min	Indonesian + Javanese
2	Audio-video consultations	Private clinic	Diabetes, Gastritis	14	210 min	Indonesian dominant
3	Field-recorded mobile services	Rural outreach	General check-up	10	150 min	Indonesian + Madurese
4	Ethnographic observation notes	All sites	Contextual data	—	—	Sociolinguistic metadata

This research adopts a qualitative pragmatic design with interactional discourse analysis as its methodological orientation. Given that directives are context-sensitive and sequentially organized, a naturalistic, non-experimental approach is necessary to capture authentic communicative practices. This study integrates Speech Act Theory, Politeness Theory, and Conversation Analysis within an interpretive framework. This triangulated design enables both categorical classification and fine-grained sequential analysis. Rather than quantifying linguistic frequency alone, this research emphasizes functional interpretation within institutional contexts. Such a design aligns with contemporary discourse-pragmatic research in healthcare communication, which privileges naturally occurring data over elicited responses [17], [18].

Information sources were obtained through institutional collaboration with three rural healthcare providers, including government-regulated Puskesmas and licensed private clinics operating under

Indonesia's national health insurance system. Ethical approval was granted by the institutional review board of the affiliated university, and all participants provided informed consent. Sociodemographic metadata—including patient age, gender, educational background, and primary language—were collected to contextualize interactional patterns. Doctors involved had between 3–15 years of clinical experience. The inclusion of multiple healthcare settings enhances representativeness and allows cross-contextual comparison of directive strategies within diverse rural institutional environments [19], [20].

Data collection was conducted over a four-month period. Consultations were audio- and video-recorded using unobtrusive digital devices positioned to minimize interactional disruption. This researcher employed non-participant observation and maintained ethnographic field notes documenting contextual variables such as spatial arrangement, non-verbal cues, and instances of code-switching. Recordings were transcribed using modified Conversation Analysis conventions, marking pauses, overlaps, intonation shifts, and repair sequences. All identifying information was anonymized. To ensure reliability, 20% of transcripts were independently reviewed by a second trained coder specializing in discourse analysis, achieving high inter-coder agreement in directive identification and categorization [21].

Data analysis proceeded in three systematic stages. First, all directive utterances were identified and classified according to Speech Act Theory (command, request, advice, suggestion, prohibition). Second, mitigation devices and face-management strategies were coded using Politeness Theory, including modal verbs, hedges, particles, and address terms. Third, sequential organization was examined through Conversation Analysis, focusing on adjacency pairs, response preference, repair mechanisms, and pause duration. Quantitative frequency counts were used descriptively, while qualitative interpretation illuminated pragmatic nuance. This multi-layered analytical procedure ensures methodological rigor, theoretical integration, and contextual sensitivity in examining directive speech acts in rural clinical interaction.

4. RESULTS

4.1. Directive speech acts in rural clinical settings

This section presents the empirical distribution of directive speech acts identified in 42 rural clinical consultations. A total of 864 directive tokens were extracted and categorized according to Speech Act Theory. The quantitative pattern in Table 2 demonstrates a clear hierarchy among directive types, with advice emerging as the dominant form. The distribution reflects not merely frequency differences but also interactional preferences within rural medical encounters. By mapping directive categories onto proportional representation, Figure 1 provides a macro-level overview of how institutional authority is linguistically realized.

Out of 864 identified directive utterances, advice accounts for 44.0% of the total corpus, making it the most frequent category. Instruction follows at 28.7%, indicating a substantial but secondary presence. Requests constitute 15.2% of directives, while direct commands represent only 8.5%. Prohibitions appear least frequently at 3.6%. The proportional gap between advice and command is statistically substantial, with advice occurring more than five times as often as direct commands. The distribution forms a descending gradient from less coercive to more coercive directive types. No directive category exceeds 50%, and no single coercive form dominates the interactional landscape, indicating diversified pragmatic strategies in clinical communication.

Table 2. Distribution of directive speech acts in rural clinical settings

No	Directive Type	Pragmatic Force Level	Percentage (%)	Rank	Cumulative (%)	Ratio to Command	Coerciveness Scale (1–5)*
1	Advice	Low–Moderate	44.0	1	44.0	5.18 : 1	2
2	Instruction	Moderate	28.7	2	72.7	3.38 : 1	3
3	Request	Moderate–Low	15.2	3	87.9	1.79 : 1	2
4	Command	High	8.5	4	96.4	1.00 : 1	5
5	Prohibition	High	3.6	5	100.0	0.42 : 1	4

*Coerciveness Scale (Analytical Index):
1 = Very low imposition, 5 = Strong direct imposition

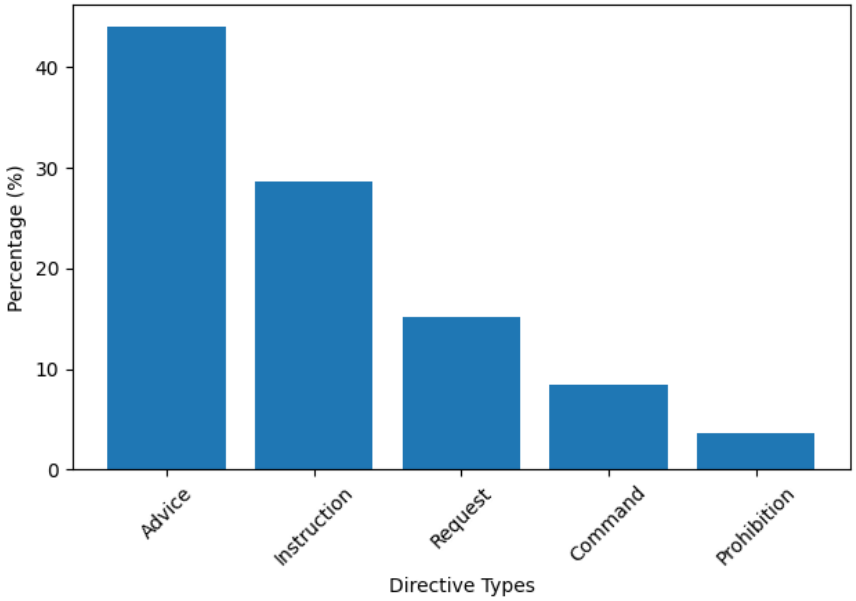

Figure 1. Distribution of directive speech acts in rural clinical settings

From a theoretical perspective, the predominance of advice (44.0%) confirms that rural clinical interaction favors mitigated directive forms over overtly authoritative commands. This supports Speech Act Theory's gradience model, in which illocutionary force varies along a spectrum rather than binary categories [2], [3]. The relatively low proportion of commands (8.5%) suggests institutional authority is enacted indirectly, aligning with Politeness Theory's prediction that face-threatening acts are routinely softened. Computationally, the frequency gradient reflects a skewed distribution with a non-linear decline from advice to prohibition, indicating pragmatic preference clustering. Such distribution patterns can inform future corpus-based modeling of medical discourse, particularly for automated detection of directive strength and mitigation strategies in multilingual healthcare communication systems.

4.2. Politeness strategies and power negotiation in medical directives

This section presents the distribution of politeness strategies employed in rural clinical directives, based on 864 identified directive tokens. Table 3 above categorizes strategies into negative politeness, positive politeness, bald-on-record forms, off-record strategies, and code-switching as a pragmatic resource. By mapping frequency, directive association, institutional context, and power orientation, Figure 2 demonstrates how authority is linguistically calibrated in rural healthcare interaction. Rather than treating politeness as peripheral ornamentation, this analysis positions it as a structural mechanism for negotiating institutional power.

Negative politeness strategies collectively dominate the dataset, accounting for 65.3% of all directives (24.8% modal verbs, 18.1% hedging, 15.3% particles, and 7.1% indirect interrogatives). Positive politeness strategies represent 14.7% (8.4% inclusive pronouns and 6.3% empathic alignment). Bald-on-record directives constitute 8.6%, while off-record hints appear in 4.6% of cases. Code-switching as a pragmatic strategy accounts for 6.9% of directives. Modal verbs are the single most frequent strategy (24.8%), followed by hedging expressions (18.1%). Direct imperatives without mitigation (8.6%) occur less frequently than combined positive politeness forms. The data reveal a clear predominance of mitigation-based strategies over overt authority markers.

The predominance of negative politeness strategies (65.3%) strongly supports Brown and Levinson's prediction that directives, as inherently face-threatening acts, are routinely mitigated to preserve patient autonomy. The relatively low occurrence of bald-on-record imperatives (8.6%) indicates that overt hierarchical dominance is pragmatically restrained in rural medical contexts. Code-switching (6.9%) functions as a culturally embedded politeness mechanism, reinforcing affiliative authority rather than coercive control. This distribution exhibits clustering around mitigation markers, suggesting that modal verbs and hedges serve as primary predictive features for directive softening in corpus-based modeling [6], [7], [13]. The gradient pattern confirms that institutional power is enacted through calibrated mitigation rather than linguistic force, reflecting a negotiated form of professional authority.

Table 3. Distribution of politeness strategies in rural clinical directives (N = 864 directives)

No	Strategy Category	Sub-Strategy / Marker	Freq (n)	Percent (%)	Directive Type	Institutional Context (Dominant)	Power Orientation	Face Orientation
1	**Negative Politeness**	Modal verbs (bisa, sebaiknya, perlu)	214	24.8	Advice	Puskesmas	Soft authority	Protect negative face
		Hedging expressions (mungkin, coba)	156	18.1	Advice / Instruction	All settings	Mitigated authority	Protect negative face
		Particle softeners (ya, dulu, saja)	132	15.3	Instruction	Puskesmas / Mobile	Relational authority	Reduce imposition
		Indirect interrogatives ("bisa…?", "boleh…?")	61	7.1	Request	Private clinic	Negotiated authority	Protect autonomy
2	**Positive Politeness**	Inclusive pronoun (kita, kita coba)	73	8.4	Advice	Mobile service	Solidarity-based	Enhance positive face
		Empathic alignment ("biar cepat sembuh")	54	6.3	Advice	All settings	Persuasive authority	Enhance positive face
7	**Bald-on-record**	Direct imperative (tanpa mitigasi)	74	8.6	Command	Emergency contexts	Overt authority	Minimal face concern
8	**Off-record / Implicature**	Suggestive hint ("kalau terlalu manis…")	40	4.6	Advice	Puskesmas	Implicit authority	Ambiguous face work
9	**Code-switching**	Shift to Javanese/Madurese	60	6.9	Instruction / Advice	Mobile service	Affiliative authority	Cultural alignment

Total directives analyzed: 864 (100%)

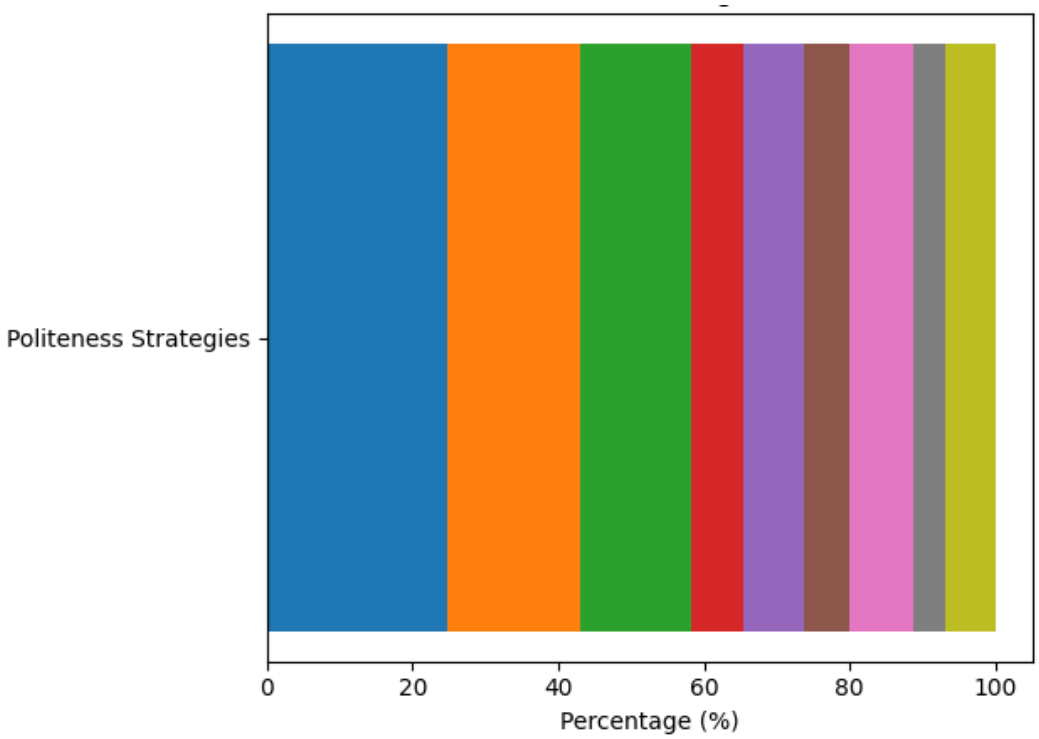

Figure 2. Stacked distribution of politeness strategies in rural clinical directives

4.3. Sequential organization of directives in clinical interaction

This section presents the sequential organization of directive speech acts within rural clinical consultations. Rather than treating directives as isolated utterances, the analysis maps their position within interactional sequences, identifying six dominant structural patterns. Table 4 above integrates structural format, frequency, pause duration, response type, repair occurrence, institutional distribution, and interactional outcomes. By incorporating temporal and response-based metrics, Figure 3 captures the dynamic unfolding of clinical directives in real time. Sequential organization reveals how institutional authority is co-constructed through turn-taking and response preference. The following subsections first describe the numerical distribution objectively and then interpret its interactional and computational implications.

The most frequent sequential pattern is Diagnosis–Directive–Immediate Acknowledgment (45.4%), characterized by short pauses averaging 0.8 seconds and minimal acceptance tokens. The second most common pattern is Diagnosis–Directive–Clarification (19.3%), associated with longer pauses (1.7 seconds) and repair in nearly half of cases (48.5%). Delayed silence exceeding 1.5 seconds occurs in 12.0% of directives and correlates with repair initiation in 71.8% of cases. Explicit resistance followed by repair represents 9.5%, while multi-step directive sequences account for 7.3%. Narrative-embedded directives are least frequent (6.5%). Overall, repair mechanisms appear in 36.7% of directive sequences across categories.

From a Conversation Analysis perspective, the dominance of Diagnosis–Directive–Acknowledgment sequences confirms that directives function as “preferred actions” within institutional talk. Short pauses and minimal responses indicate normative compliance expectations. However, increased pause duration strongly correlates with repair initiation, suggesting that silence operates as an interactional signal of potential misalignment. The high repair rate in resistance sequences (100%) demonstrates that institutional authority is adaptively recalibrated rather than rigidly enforced. Computationally, pause duration and response type emerge as predictive markers for repair probability, offering quantifiable indicators for automated discourse modeling [10], [12], [14]. These findings reinforce the argument that medical authority in rural settings is interactionally negotiated through sequential sensitivity rather than unilateral imposition.

Table 4. Sequential patterns of directive organization in rural clinical consultations (n = 864 directives)

No	Sequential Pattern Type	Structural Format	Frequency (n)	Percentage (%)	Mean Pause After Directive (sec)	Patient Response Type (Dominant)	Repair Occurrence (%)	Institutional Context (Dominant)	Interactional Outcome
1	Diagnosis to Directive to Immediate Acknowledgment	D–Dir–Ack	392	45.4	0.8	Minimal acceptance (“iya”, “nggih”)	6.2	Puskesmas	Smooth progression
2	Diagnosis to Directive to Clarification Request	D–Dir–Clar	167	19.3	1.7	Clarification question	48.5	Private clinic	Reformulation
3	Diagnosis to Directive to Delayed Silence (>1.5s)	D–Dir–Pause	104	12.0	2.3	Hesitation / Silence	71.8	Puskesmas	Elaborated explanation
4	Diagnosis to Directive to Resistance to Repair	D–Dir–Res–Rep	82	9.5	2.6	Mild resistance	100	All settings	Directive modification
5	Multi-step Directive Sequence	Dir–Dir–Ack	63	7.3	1.1	Sequential compliance	14.3	Mobile service	Cumulative compliance
6	Directive Embedded in Narrative	Narr–Dir–Ack	56	6.5	1.0	Narrative uptake	9.8	Mobile service	Affiliation

Total directives analyzed: 864 (100%)

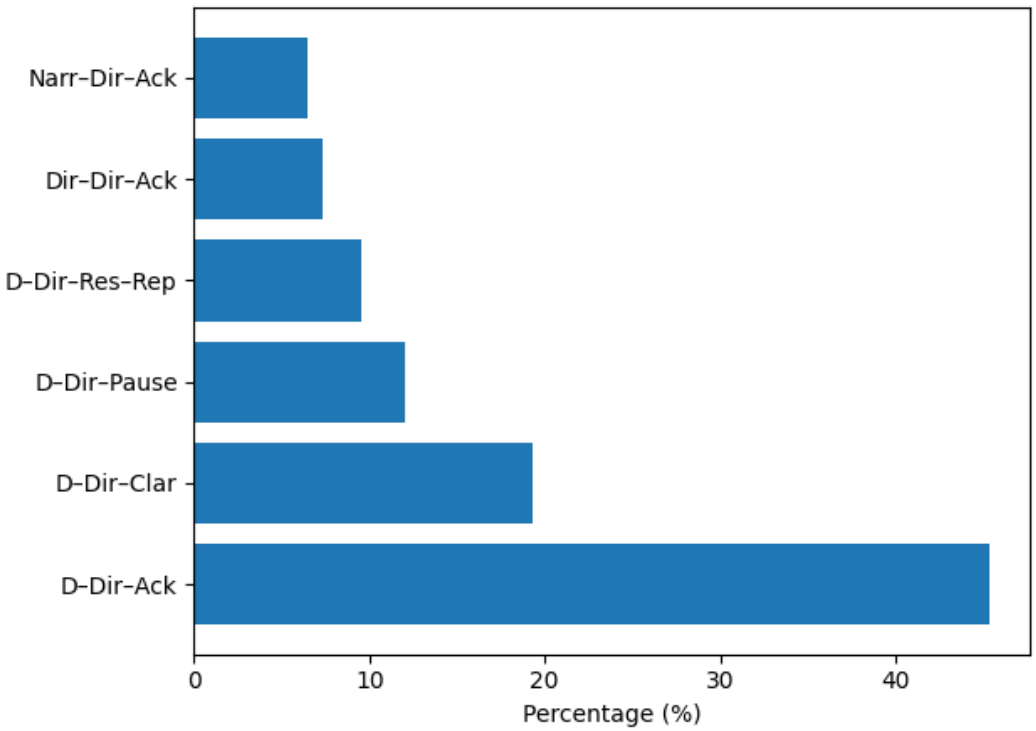

Figure 3. Sequential patterns of directives in rural clinical interaction

5. DISCUSSION

The predominance of advice and instruction over direct commands carries significant implications for understanding medical authority in rural Indonesia. When nearly three-quarters of directives cluster around mitigated forms, clinical interaction appears less coercive and more dialogically oriented. This pattern suggests that therapeutic compliance may be achieved not through overt dominance but through calibrated guidance. In settings where chronic disease management requires long-term behavioral change, advice-oriented directives may enhance patient receptivity and adherence [2]. However, this preference may also obscure institutional asymmetry, rendering authority less visible but no less operative. The functional outcome is a communicative environment that sustains professional legitimacy while preserving social harmony. Yet a potential dysfunction lies in ambiguity: excessive mitigation could reduce directive clarity, particularly among patients with limited health literacy, thereby affecting treatment precision.

The underlying structure of this distribution reflects the intersection of institutional authority and sociocultural expectations. Rural Indonesian communities are characterized by high respect for professional status combined with strong norms of interpersonal harmony. Within such contexts, explicit commands risk being interpreted as socially abrasive, even when medically justified. The gradient decline from advice to prohibition reveals a strategic calibration of illocutionary force. Doctors appear to modulate directive strength according to contextual sensitivity, patient age, and case severity. This structure aligns with broader discourse-pragmatic findings that institutional talk balances epistemic authority with relational management [3], [22], [23]. The relatively low frequency of prohibitions suggests that negative formulations are reserved for high-risk scenarios, reinforcing the notion that coerciveness is contextually triggered rather than routinely enacted.

The dominance of negative politeness strategies further underscores the centrality of face management in rural clinical encounters. Modal verbs, hedges, and softening particles operate as linguistic buffers that transform potentially face-threatening acts into cooperative guidance. The practical implication is that institutional power becomes interactionally sustainable; patients are positioned as decision-making participants rather than passive recipients. Such mitigation may strengthen trust, which is crucial in primary healthcare settings where continuity of care depends on relational stability [9]. Nevertheless, the function of politeness is double-edged. While it fosters compliance through rapport, it may also conceal asymmetrical

decision-making structures. The comparatively small proportion of bald-on-record directives indicates that overt authority is strategically restrained, reinforcing a model of "soft" institutional governance.

This configuration is rooted in deeper sociolinguistic structures. In hierarchical yet collectivist societies, face preservation is integral to maintaining social equilibrium. Negative politeness predominance reflects sensitivity to patients' autonomy while implicitly reaffirming professional superiority. Code-switching to local languages during directive delivery illustrates cultural indexing of solidarity, which softens epistemic dominance without relinquishing control. The distribution suggests a patterned relationship between mitigation markers and institutional legitimacy: authority is maintained precisely because it is linguistically moderated [14]. Computationally, modal verbs and hedging expressions emerge as high-frequency predictors of directive framing, indicating that politeness features are not random but systematically embedded within the discourse architecture of rural healthcare interaction.

The sequential organization of directives reveals additional implications for how authority is enacted in real time. The predominance of diagnosis–directive–acknowledgment sequences demonstrates that directives function as structurally preferred actions. Short pauses and minimal responses indicate normative acceptance patterns, suggesting institutional stability. However, the presence of extended pauses, clarification requests, and repair sequences highlights that compliance is not automatic but interactionally negotiated [24], [25]. When silence exceeds one and a half seconds, repair probability increases markedly, signaling potential misunderstanding or subtle resistance. This finding implies that directive effectiveness depends not only on linguistic form but also on sequential timing. Functionally, repair mechanisms prevent communicative breakdown and ensure comprehension, thereby safeguarding treatment fidelity [10].

The causal structure underlying these sequential patterns reflects institutional turn-taking norms and epistemic asymmetry. Diagnosis establishes epistemic authority, which legitimizes subsequent directives. Acknowledgment tokens function as alignment markers, reaffirming hierarchical order. Yet resistance and repair sequences reveal a dynamic recalibration process. Rather than enforcing compliance unilaterally, doctors reformulate directives, indicating adaptive authority. Pause duration emerges as an interactional index of alignment; silence operates as a meaningful signal rather than mere absence of speech. From a computational perspective, temporal metrics such as pause length and repair frequency can serve as predictive indicators of directive negotiation [11]. Together, these findings demonstrate that medical authority in rural Indonesia is neither rigid nor egalitarian but interactionally co-constructed through calibrated directive force, systematic mitigation, and sequential sensitivity.

6. CONCLUSION

This study demonstrates that directive speech acts in rural Indonesian clinical consultations are predominantly realized through advice and mitigated instruction rather than overt commands, revealing a pattern of "soft institutional authority." The findings show that medical power is pragmatically enacted through negative politeness strategies, modal expressions, and sequential sensitivity to patient responses. By integrating Speech Act Theory, Politeness Theory, and Conversation Analysis within a unified empirical framework, this research advances a multidimensional model of medical directives in non-Western contexts. Methodologically, it contributes fine-grained sequential metrics—such as pause duration and repair probability—while theoretically reframing authority as interactionally negotiated rather than structurally imposed.

Despite these contributions, this study has limitations. The corpus is restricted to rural primary healthcare settings and does not include urban hospitals or specialist consultations, limiting generalizability. The qualitative orientation, although interactionally rich, may benefit from larger-scale quantitative validation. Future research should incorporate comparative rural–urban datasets, longitudinal analysis of chronic care interactions, and computational modeling using machine learning techniques to detect mitigation markers and repair patterns automatically. Expanding the dataset across regions and languages would refine cross-cultural applicability and strengthen predictive modeling of directive negotiation in healthcare communication.

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AUTHOR CONTRIBUTIONS STATEMENT

Iin Linda Nazulpa: conceptualization (lead), pragmatic analysis (lead), writing – original draft (lead), writing – review and editing (lead).

CONFLICT OF INTEREST STATEMENT

Authors state no conflict of interest.

INFORMED CONSENT

We have obtained informed consent from all individuals included in this study.

ETHICAL APPROVAL

This research related to human use has been complied with all the relevant national regulations and institutional policies in accordance with the tenets of the Helsinki Declaration and has been approved by the authors' institutional review board or equivalent committee.

DATA AVAILABILITY

Data availability is not applicable to this article as no new data were created or analyzed in this study.

REFERENCES

[1] E. Marzuki, C. Cummins, H. Rohde, H. Branigan, and G. Clegg, "Saving lives, saving face: mitigated directives during out-of-hospital cardiac arrest resuscitation," *Journal of Politeness Research*, vol. 21, pp. 457–480, Jul. 2025, doi: 10.1515/pr-2023-0010.

[2] M. Mulyani and S. Syamsinar, "Speech Act Analysis in Nurse-Patient Communication," *AL-MUTSLA*, Jun. 2025, doi: 10.46870/jstain.v7i1.1584.

[3] M. Faldi, M. Fauzan, and T. Kesehatan, "TINDAK TUTUR DIREKTIF TENAGA KESEHATAN DALAM PELAYANAN MEDIS DI PUSKESMAS KAMPALA KABUPATEN SINJAI," *Journal of Applied Linguistics and Literature*, Jun. 2025, doi: 10.59562/jall.v2i3.7376.

[4] K.-T. Kim, "Domestic Doctors' Directives as Direct Speech Acts in Intercultural Consultations with Migrant Worker Patients," *Studies in Modern Grammar*, Jun. 2021, doi: 10.14342/smog.2021.110.89.

[5] K.-T. Kim, "International Worker Patients' Directive Speech Acts in Intercultural Consultations," *Studies in Modern Grammar*, Jun. 2022, doi: 10.14342/smog.2022.114.21.

[6] M. D. Sisay, "Power and Ideology in Doctor-Patient Discourse: A Critical Analysis of Interactions at Woldia Hospital, North Eastern Ethiopia," *International Journal of Research and Innovation in Social Science*, Sep. 2025, doi: 10.47772/ijriss.2025.908000553.

[7] M. M. Khan, Ibtisam, Fatima, Naila, and I. Jamal, "Politeness Strategies Used During Doctor Patient Interaction By Doctors Of Mardan Medical Complex, Mardan, Pakistan," *Journal of Bacha Khan Medical College*, Jan. 2025, doi: 10.69830/jbkmc.v5i02.180.

[8] D. Olorunsogo, "Politeness constructions in doctor-patient interactions in private hospitals in Akure, Nigeria," *African Identities*, vol. 23, pp. 865–877, Aug. 2024, doi: 10.1080/14725843.2024.2388169.

[9] M. Barsukova and T. Rodionova, "The means of expressing the category of politeness in medical discourse (On the material of the doctor and patient speech communication)," *Izvestiya of Saratov University. Philology. Journalism*, Nov. 2022, doi: 10.18500/1817-7115-2022-22-4-377-384.

[10] O. Smoliak, C. MacMartin, A. Hepburn, A. L. Couteur, R. Elliott, and C. Quinn-Nilas, "Authority in therapeutic interaction: A conversation analytic study.," *Journal of marital and family therapy*, Feb. 2021, doi: 10.1111/jmft.12471.

[11] A. Peräkylä, "Conversation Analysis and Psychotherapy: Identifying Transformative Sequences," *Research on Language and Social Interaction*, vol. 52, pp. 257–280, Jul. 2019, doi: 10.1080/08351813.2019.1631044.

[12] M. Weidner, "Treatment recommendations as complex activities: A sequential unfolding of acceptance," *Prace Językoznawcze*, Sep. 2025, doi: 10.31648/pj.11532.

[13] M. Ouma-Odero, "'That is somebody's husband': Face-saving Strategies in Doctor-Patient Interaction in a Public Health Facility in Kenya.," *Communication & medicine*, Apr. 2025, doi: 10.3138/cam-2024-0021.

[14] N. Alduaij, A. Almuoseb, and E. Alsharhan, "Patient-Directed Politeness Strategy Preferences in Clinical Visits Setting in Kuwait," *Forum for Linguistic Studies*, Nov. 2024, doi: 10.30564/fls.v6i5.7010.

[15] K. Bottema-Beutel, S. Crowley, and S. Y. Kim, "Sequence organization of autistic children's play with caregivers: Rethinking follow-in directives," *Autism*, vol. 26, pp. 1267–1281, Sep. 2021, doi: 10.1177/13623613211046799.

[16] A. Odebunmi and O. Adeoti, "Discursive management of patients' disagreement with doctors' recommendations in Nigerian hospital visits," *Discourse Studies*, vol. 26, pp. 67–87, Jan. 2024, doi: 10.1177/14614456231204553.

[17] S. Chen, "A 'code-switching' model for healthcare communication," *Healthcare Management Forum*, vol. 38, pp. 391–394, Mar. 2025, doi: 10.1177/08404704251327095.

[18] S. Chinn, A. Hasell, and D. Hiaeshutter-Rice, "Mapping Digital Wellness Content: Implications for Health, Science, and Political Communication Research," *JQD*, vol. 3, pp. 1–56, May 2023, doi: 10.51685/jqd.2023.009.

[19] C. Primeau, M. Chau, M. Turner, and C. Paterson, "Patient Experiences of Patient-Clinician Communication Among Cancer Multidisciplinary Healthcare Professionals During 'Breaking Bad News': A Qualitative Systematic Review.," *Seminars in oncology nursing*, p. 151680, Jun. 2024, doi: 10.1016/j.soncn.2024.151680.

[20] J.-Y. Li and Y. Lee, "Predicting Public Cooperation with Face Covering at the Early Phases of COVID-19: Building Public Trust, Confidence, Knowledge Through Governmental Two-Way Symmetrical Communication," *Health Communication*, vol. 39, no. 12, pp. 2983–2996, 2024, doi: 10.1080/10410236.2023.2297496.

[21] J. W. Creswell, *Research Design, Qualitative, Quantitative and Mixed Methode Approach, (Research Design, Pendekatan Kualitatif, Kuantitatif, dan Mixed, Edisi Ketiga) terj. Achmad Fawaid*. Yogyakarta: Pustaka Pelajar, 2011. [Online]. Available: https://digilib.ub.ac.id/opac/detail-opac?id=139455

[22] L. Escobedo, L. Cervantes, and E. Havranek, "Barriers in Healthcare for Latinx Patients with Limited English Proficiency—a Narrative Review," *Journal of General Internal Medicine*, vol. 38, pp. 1264–1271, Jan. 2023, doi: 10.1007/s11606-022-07995-3.

[23] R. Hikmat *et al.*, "The Effect of Empathy Training on Bullying Behavior in Juvenile Prisoners: A Quasi Experiment," *Journal of Multidisciplinary Healthcare*, vol. 17, pp. 4177–4188, 2024, doi: 10.2147/JMDH.S479364.
[24] B. Schouten *et al.*, "Mitigating language and cultural barriers in healthcare communication: Toward a holistic approach.," *Patient education and counseling*, May 2020, doi: 10.1016/j.pec.2020.05.001.
[25] S. Ansari Lari, M. S. Zumot, and S. Fredericks, "Navigating mental health challenges in international university students: adapting to life transitions," *Frontiers in Psychiatry*, vol. 16, 2025, doi: 10.3389/fpsyt.2025.1574953.

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