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Discourse Tact In Doctor-Patient Interactions In English: An Analysis of Diagnosis in Medical Communication in Nigeria

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ABSTRACT

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Keywords: discourse tact, doctor-patient interaction, and diagnostic interaction, medical communication

1. INTRODUCTION

Many scholars have investigated medical communication internationally, especially from the perspective of discourse and conversation analysis (Coulthard and Ashby 1976, Labov and Fanshel 1977, Coleman and Burton 1985, van Naerssen 1985, Myerscough 1992, Wodak 1997, Chimombo and Roseberry 1998 and Valero-Garces 2002). In Nigeria studies on medical communication are relatively few, exceptions being Adegbite's (1991) description of herbalist-client interactions in Yoruba as well as the description of communication needs of medical personnel by Ogunbode (1994) and Oloruntoba-Oju (1996). A study of doctor-patient interactions from the perspective of pragmatics of discourse will not only complement existing studies

on medical communication in Nigeria, but will also explicate discourse and pragmatics with data from conversations by non-native speakers of English.

van Naerssen (1985) identifies two kinds of medical communication thus: doctor-patient and doctor-other medical personnel. She claims that, impressionistically, both kinds belong to different registers, each with a range of variations within it. Eventually, she concentrates herself on the doctor-other medical personnel communication, while many other scholars have described doctor-patient interaction, including dentist-patient communication by Coleman and Burton (1985). In this paper our focus is on doctor-patient interaction in English, which we intend to analyze from the perspective of the pragmatics of discourse, for the enrichment of register studies of English. Knowledge of the pragmalinguistics and sociolinguistics of medical communication is part of the requirement of communicative competence in English by Nigeria learners of the language.

In doctor-patient interaction three parts have been generally recognized, viz. interview (or diagnosis), treatment and follow-up. Each part has its own structure and characteristic features that can be observed and analyzed either separately or as part of larger discourse. This study will be limited to the diagnostic aspect, being the most prominent aspect of the interaction that fully employs the use of conversation. A Yoruba proverb says: '*Ijo taa ba mo ohun to n se ni, aisan ti dopin*'. (Our sickness disappears the very moment we are able to diagnose our problem).

This study describes discourse tact in diagnoses in doctor-patient interactions in English in some hospitals in southwestern Nigeria. It specifically intends to analyze the contextual beliefs of the doctor and patient, the linguistic patterns exploited in the conversations and the pragmatic acts performed in them. The spoken aspect of the conversation is described while the study excludes acts of writing performed by the doctor during interactions. It is believed that the excluded area will be relevant under an analysis of prescription, medication and reports in medical records, all of which may not share the characteristics of diagnostic interaction. The findings of the study are expected to complement existing works on discourse analysis, pragmatics, register studies and medical communication in Nigeria.

2. DATA BASE OF THE STUDY

Conversations were recorded between doctors and patients in thirty hospitals in South-western Nigeria. All six states in the area—Ekiti, Lagos, Ogun, Ondo, Osun, and Oyo—were included in the study and the hospitals visited represented those owned by private, states and the federal government.

A lot of conversations between doctors and patients were surreptitiously recorded on tape. Also oral and written interviews of doctors and patients were conducted and tape-recorded. The interview questions responded to by doctors

covered issues pertaining to medical history and ethics as well as their personal experiences and opinions about medical practice. Patients and their guardians (Kamwendo 2004) were interviewed in respect of their cultural experiences about hospitals, the hospital environment and the treatment being received.

3. DISCOURSE TACT AND THE PRAGMATICS OF MEDICAL COMMUNICATION

Medical communication represents a series of institutional encounters that take place in the health care system. According to Heritage (1997: 164), participants in institutional encounters use a series of linguistic and interaction resources specific to the situation and in accordance with the participants' linguistic and cultural competence. Heritage (1997: 164) further identifies the characteristics of institutional interaction as follows (see also Valero-Garces 2002): (i) the participants possess some specific roles, (ii) a series of constrictions characteristic of the institutional context are important and (iii) inference marks and particular procedures associated to each institution exist. The characteristics above are complemented by the following elements: (i) assignment of the participants' roles, (ii) general structure, (iii) sequential organization (iv) lexical choice and (v) asymmetrical relationships. The observation above confirms the finding of scholars on institutional interactions as a whole. With respect to doctor-patients interaction, scholars have made observation in their studies. Adegbite (1991 and 1995) in his analysis of Yoruba interactive encounters between herbalist and clients observes that a situation of uneven power and social status between the participants leave control of strategic interaction in the hands of the herbalist who dominates turn-taking routines to his/her own advantage and sets the pace of the dialogue. Earlier, Coulthard and Ashby (1976) had observed the recurrence of doctor-initiated exchanges in diagnostic interaction between doctor and patients. According to them (Coulthard and Ashby 1976: 76) if a patent attempts to initiate, the doctor does not feel he/she has an obligation to respond. They observe that the interaction is made up of transfer exchanges, in which information passes from the responding patient to the eliciting doctor, and matching exchanges, in which the patient presents information for the doctor to confirm. The negotiation of a shared orientation between doctor and patient takes place through series (sequences) of exchanges in a sequence, until the doctor is finally able to match a medical diagnosis with the patient's problem. Chimombo and Roseberry (1998) observe that discourse participation in medical communication involves more than one speaker and listener, i.e. relations and medical personnel other than the doctor and the client participate. They conceive of medical communication as a goal-oriented process that considers participants, medium, strategies, setting and theme.

In a recent study by Valero-Garces (2002) of interactions between doctors and immigrant non-native speakers of Spanish, the researcher observes some

occurrences that indicate a modification of roles and relationships in the institution. In respect of the doctors, she (Valero-Garces 2002: 492) observes:
- exchange of roles
- petition of information not strictly medical
- higher percentage of bureaucratic negotiation and of casual inserts
- frequent explanation
- higher percentage in the use of certain speech acts, e.g. directives and commissives.

In contrast, the patients use such strategies as:
- requiring non-medical information
- mixing different levels of language
- using politeness systems in unexpected ways
- initiating conversational topics
- giving more information than requested
- repeating the same information several times
- asking for confirmation
- preference for brief answers and direct questions

It is pertinent to find out which of the features observed above are confirmed by this study and which are not.

Coming to the pragmatics of social interaction, pragmatics approaches are concerned about language in use in social context and emphasize the 'functionality' (Hymes 1991) of utterances performed in different contexts of interaction (Austin 1962, Jacobson 1960, Searle 1969, and 1976). According to Adegbija (1995: 255), pragmatic studies pay special attention to participants, their shared or mutual knowledge, what they have implied which is not overtly stated, etc. Discourse tact refers to the strategies employed by participants engaged in a discourse to give value to social interaction (Adegbija 1995). With reference to doctor-patient interaction in this paper, such strategies will be identified via the analysis of the following features:
(i) mutual contextual beliefs of participants
(ii) locution, the structure of dialogue in the interaction
(iii) illocution and perlocution of utterances
(iv) other pragmatic features pertaining to implicatures, politeness and pragmatic failure.

The social experience of participants is the main source of motivation for language use (Hymes 1962, Saville-Troike 1987). Two perspectives are available to us for describing the social context of events in this study. First is the perspective of registered studies from which Halliday (1978) has suggested three categories of field, tenor and mode. Second is the perspective of ethnography of communication from which Hymes (1962) has suggested the categories of setting, participant, ends, acts, key, instrumentatility and genre (SPEAKING). A synthesis of these perspectives is utilized as a tool for analysis

in this study. The structure of dialogue in social interaction has been described from the complementing perspective of 'structuration' and 'synchronization' (Richardson 1981, Adegbite 1995). The concept of structuration, on the one hand, is associated with the perspective of discourse analysis initiated by Sinclair and Coulthard (1975) and developed by other scholars (Burton 1980, Coulthard and Montgomery 1981, Akindele 1986). It pertains to the description of discourse as 'product' in terms of constituent structural categories such as lesson, (interaction), transaction, exchanges, moves and acts. On the other hand, synchronization derives from the description of discourse as a 'process' in which negotiations of acts of speech such as turn taking and interruptions in personal and institutional discourse are governed by social rules of speech behaviour (Sacks, Schegloff and Jefferson 1974).

Austin (1962) elucidates the pragmatic theory of speech acts by identifying three types of acts: locutionary, illocutionary and perlocutionary. Locution is the actual utterances made by a speaker, which is describable in linguistic (i.e. phonological, lexical and grammatical) terms. The analysis of locution in this paper will utilize categories employed in earlier description of structural grammar (Quirk, et. al. 1972), systemic functional grammar (Halliday 1985, Bloor and Bloor 1995) and text grammar (Halliday and Hassan 1976). Illocution refers to the intention(s) of the speaker in making an utterance; such intentions are describable in terms of acts or functions of speech, e.g. elicit, inform, direct, argue, etc. (Austin 1962, Searle 1969, 1976). Perlocution refers to the effect of an utterance on the hearer, e.g. whether a listener is persuaded or not by an argument.

Speech acts may be direct or indirect. According to Yule (1996), we have a direct act when there is a direct relationship between a structure and function and an indirect act when there is an indirect relationship between a structure and function. The concept of implicature derives from the production and interpretation of indirect meaning of utterances that results from a flout or violation of certain maxims of cooperation-quantity, quality, relevance and manner (Grice 1975).

The concept of politeness and face go hand in hand. Politeness, which is observable in situations of social distance or closeness, is the means by which we show awareness of another person's face, face being technically defined as the 'public self image of a person' (Goffman 1967, Brown and Levinson 1987, Thomas 1995, Yule 1996). Scholars have suggested several maxims of politeness (Lakoff 1973, Leech 1983, Fraser 1990), especially the following maxims proposed by Leech (1983) have received wide attention: tact, generosity, approbation, modesty agreement, sympathy and Pollyanna.

The overtly antonymous concepts of pragmatic success and failure relate to understanding or misunderstanding the sense or force of an utterance. Thomas (1983) identifies two types of pragmatic failure viz. pragmalinguistic and sociopragmatic failure. The former occurs "when the pragmatic force mapped by a speaker on to a given utterance is systematically different from the force most frequently assigned to it by native speakers of the target, or when the

speech act strategies are inappropriately transferred from L1 to L2" (Thomas 1983: 99) the latter occurs when an utterance fails to conform to the social conditions placed on language in use.

4. FINDINGS OF THE STUDY

4.1 SAMPLES OF DATA

We present below samples of the data collected for reference purposes in this work.

Example 1.

Doctor x was trying to find the veins of a year old baby to make intravenous infusion. Several unsuccessful attempts were made. The doctor hissed in discouragement, and shook his hands several times in frustration.

Patients mother: (*Down cast with red-eyeballs, yet held the baby tightly to the stretcher on which the doctor was attending to her*) Doctor, what exactly is the problem with my baby?
Doctor: She has acute respiratory infection but she will be okay.
Mother: (B*roke down in tears and did not say a word*)

Example 2.

Doctor Y: Hello madam how is your health?
Patient X: Doctor I am not well at all. I have been sick for more than 3 months but the problem is that I have been loosing weight and I having persistent diarrhoea. I have taken flagyl and chloraphenicol in vain.
Doctor Y: Do you cough?
Patient X: Yes I do, but not so much.
Doctor Y: Do you have skin rash at the onset of this illness?
Patient X: Yes, but it has disappeared.
Doctor Y: Any Fever?
Patient X: No, but occasionally I feel as if I am having malaria.
Doctor Y: All right, before anything, we would have to do a series of tests on you. (*Motioning the patient to stay outside*)
Patient X: (cuts in) Will I be admitted because I want to be under medical care in the hospital? Money is not my problem.
Doctor Y: Just go outside and relax. I will send you to the laboratory first before any treatment. (*Doctor to orderly*) Take this card to the laboratory head I have written some laboratory investigations that are to be carried out on the patient including '333' screening.

Example 3.

Doctor: Madam, what is the problem?
Patient: Yes, doctor, I had a stillbirth baby late January this year. I got my menses last about four months ago. Yet I'm not pregnant.
Doctor: Okay…

Example 4.

Client's Mother: She runs temperature every now and then… she's been unconscious now for three days.
Doctor: [*after examining baby*] Yes, your daughter has cerebral malaria. The fever has got to some part of the brain. She has survival chances of 50–50. [*Mother broke down in tears.*] The disease cannot be cured, but we can try our best to control it.
Client: Oh! God will help you.

Example 5.

Patient: I hope what you are writing is not chloroquine?
Doctor: There is no problem. You'll be well.

Example 6.

Client: Doctor, he can't breathe very well.
Doctor: Yes he has acute respiratory problem.
Client: Is that why he can't breathe?
Doctor: Yes, we shall observe him for a while.

4.2 MUTUAL CONTEXTUAL BELIEFS OF DOCTORS AND PATIENTS

The hospital is an institution in which medical care is provided for sick people. Two groups of people are prominent: the medical personnel and their clients. The medical personnel include the doctor, nurse, other medical staff, paramedic, medical student, intern and administrative staff. The hospital consists of several wards and departments in which patients can be attended to or admitted into, if necessary. The personnel are distinguished from the public and from one another by the kind of training they have received for their jobs.

Doctors are specially trained to investigate and find solution to all kinds of ailments of clients. Although they specialize in different sub-fields of medicine such as paedriatics, gynaecolgy, obstetrics and gynaecolgy, orthopaedics,

surgery, etc., some doctors are assigned the role of general practitioners, to attend to patients with various kinds of complaints of ill-health in the out patient department (OPD) and casualty departments. Part of the training of medical doctors includes medical ethics, medical history and practice and medical communication with both medical personnel and patients. They are thus well prepared to understanding the diagnosis, prognosis, treatment and follow up of a sick patient.

The tenor of diagnostic interaction is consultative. The medical doctor engages a client in a conversation with a view to diagnosing the patient's problem, while in the process writes down notes on his/her observations and prescriptions (i.e. a medical report) for the treatment of the case in a medical file meant for the client. The client is either a sick person, i.e. a patient, or the parent(s) or relation(s) of a sick person. The doctor controls the interaction by dictating the pace of the turn taking (cf. Adegbite 1991). He/she can interrupt at will and use dominant acts such as directives, accusations and caution to check the client during interaction. For the successful achievement of diagnosis and medication, the client must have confidence in the medical system and such confidence is built around the personality and care of the doctor and other medical personnel.

4.3 THE STRUCTURE OF DOCTOR-PATIENTS' DIAGNOSTIC INTERACTION

The analysis of structure of doctor-patients' interaction yields a similar result to the findings of Adegbite (1995: 282). The overall content structure of the transaction can be summarized in two parts thus: (i) identifying the problem, its symptoms and sources, (Ex. 2, ll 11–15) and (ii) attempting to recommend solution(s) to the problem (Ex. 2, ll 15–19). First the interaction is dialogical and constituted by series of turn taking activities between the doctor and his/her client(s). Also, it is constituted by a transaction, which is made up of one or more exchanges and a number of moves and acts. Let us describe the exchanges, moves and acts observed in the study.

After the initial prefatory exchanges which contain initiations and replies of greetings and summons, the transaction opens with a doctor's initiation move which elicits information about the nature and symptoms of a client's illness (Ex. 2, l. 1). This elicitation may recur in consequent exchanges in the transaction in opening, bound-opening or re-opening moves (Ex. 2, ll 6, 8 and 10). Following this opening initiation is a response move supporting it by providing a reply to it (Ex. 2, ll 2, 5, 7, 9 and 11). If the reply is satisfactory, the doctor makes a follow up supporting move (Ex. 2 Ex. 3, 1–5,1–12), accepting the reply to it by going ahead to recommend prescriptions (Ex. 2, ll 12,16–19). But if the reply is unsatisfactory, the doctor either re-opens the elicitation or reacts to the reply by using pragmatic means to find out the problem, or even

reacts and elicit at the same time when necessary (Ex 4). The doctor can utilize challenging moves to condemn the action of a patient, accuse or caution the latter's excessive or wrong behaviour or calm him or her (Ex. 5 and Ex. 8). Lastly the doctor can use initiation moves to issue directives to a client when recommending solutions to the client's problem (Ex. 2 ll 16–19).

A client may however initiate a bound-opening move where she provides more information to clarify her previous reply to the doctor; and the doctor very often supports her by confirming such clarifications and assuring her that all will be well (Ex. 5, l. 2). Also, occasionally, a client may check her understanding of a doctor's suggestion in a previous move, which invites a repetition of an earlier utterance (Ex. 6, l. 2), or she may enquire information from the doctor and the doctor provides an answer to it.

4.4 ILLOCUTION AND PERLOCUTION OF UTTERANCES

4.4.1 Illocution

Diagnosis as an institutional act in medicine is expressed in the conversation mainly via the general act of representatives. Representatives are, however, represented in individual utterance moves by such acts as elicitation, confirmation, comment, information, enquiry and conclusion. From the discussion in 4.3 above, the following acts can be identified with the participants in the interaction:

(i)   doctor – elicitation (Ex. 3, l. 1) explanation (Ex. 4,l. 4) confirmation (Ex. 4,l.3) comment (Ex. 4, l.8) assurance (Ex. 5,l. 2) and criticize (Ex. 15, l.11).

(ii)   client – elicitation (Ex. 2, ll. 14–15) complain/inform (Ex. 3, ll. 2–4), enquire (Ex. 6, l. 3) and appeal (Ex. 16, l.1).

The use of the directive act is ancillary. A doctor uses it to caution or calm down a patient (Ex. 8 and 11) or to prepare him/her for medication (Ex. 2, l.16–17) and by the patient to appeal for pity or seek attention (Ex. 16).

4.4.2 Perlocution

The utterances in doctor-patient diagnostic interaction have a salutary effect on the participants. The client is submissive to the dominance and control of the doctor in the interaction, hence the directives and instructions of the latter are obeyed and his/her opinions respected. Likewise, the doctor pays attention to and is guided by the information given by the client. Both the doctor and client are joined together in a collaborative search for a solution to a problem. Thus, instances of argument and disagreement between them are rare. Politeness maxims and indirect acts in communication are utilized to achieve positive

psychological effect on the patient. In the process of indirect communication, maxims of conversations are sometimes flouted and pragmatic failure may unintentionally occur. Some instances of these occurrences are discussed under 4.6–4.7 below.

4.5 LOCUTION OF UTTERANCES

4.5.1 Vocabulary

Vocabulary usage in medical communication can be described in terms of lexical occurrences, lexical collocation and lexical relationships. The lexical occurrences are as follows:

    (i)   Plain words: These are words that are found in every day speech or other registers but are used here to describe the conditions and complaints of patients, e.g., health, cough, fever, test, illness admission infection card, laboratory, etc.

    (ii)   Technical words, symbols and figures: These represent items that are unique to the field of medicine, which describe diseases, drugs and processes, e.g. chloraphenicol, diarrhoea, esophageal achalazia, malaria, DAMA, AIDS, BP, '333' screening, etc.

    (iii)   Proper names: These serve as alternatives to real names of diseases, e.g. Koch's disease, Hansen's disease, Parkinson's disease, Miss Moor's bandage, Myer's incision, etc.

    (iv)   Vocatives: Madam! Doctor! My friend!

    (v)   Deixis: Person deixis exists in the interaction in form of personal pronouns: me, you, he/she, him/her.

    (vi)   Affirmatives (yes, okay) and Negator (no)

While fixed collocation occurs in the form of technical terminologies, as observed in the names of diseases above, the patterns of non-fixed collocation are as follows:

    (i)   adjective+noun – severe headache, persistent diarrhoea, medical cure, broken limb, acute respiratory infection, neurotic disorder, cerebral malaria, survival chances, surgical operation, etc.

    (ii)   verb+ noun – lose weight, have skin rash/malaria, run temperature, check blood pressure.

    (iii)   verb + adverb – bleeding profusely, crying incessantly, trouble well well (incessantly).

Lexical relationships observed are synonymous e.g. fever/malaria, problem/disease/sickness/illness, rest/relax, treatment/cure, etc., antonyms: sick/well, non-pyrexia/pyrexia, hypertension/hypertension and hyponymy:

disease (cough, malaria, diarrhoea, skin rash), health (ill, sick, well), medicine/drug (chloraphenicol / flagyl).

4.5.2 Syntactic Pattern

The following features of syntax realize utterances in the conversation:

a. Sentence types
- (i) Minor/ elliptical or verbless clauses: Yes. Any fever? How often? All right.
- **(ii)** Major: predominantly simple (Do you cough? How is your health? I am not well at all. I have taken some antibiotics to no avail.)

b. Sentence structure
- (i) Transitivity: intensive and intransitive clause, a few extensive mono- and ditransitive clauses.
- (ii) Voice: Active
- (iii) Mood: interrogative and declarative, with or without modality.
- **(iv)** Theme: Unmarked theme; theme-Personal pronouns (I, you he she), question items (how? when? what?) Do you have?
- (v) Rheme: information about sickness and significant features of symptoms.

Here is a brief description of the grammar of sentences in a typical doctor-patient interaction from the perspective of systemic functional grammar (the grammatical terminologies are italicized).

The interaction opens with an *interrogative clause* of the *relational identifying* type (are, is) in which the doctor expresses a *value* (how? where?) of a *token* (your health). The client replies via a *declarative clause* of the *relational attributive* type (am, have been, has been) in which an *attribute* (not well, pregnant sick), is ascribed to a *carrier* (I, he, she). Alternatively, the reply is expressed via a *declarative clause* with the *relational possessive* process (have/has, am/is having got) in which a possessor (I, he, she) possesses items of illness – *possessed* (fever, malaria, cough, headache diarrhoea etc). Similar 'process' and 'participant' features to the ones above realize further diagnostic investigations in the interaction.

Occasionally, however, there may be other clauses expressing either (i) *mental process* of the *reactional/affective* type (feel[s]) in which a *senser* (I, he, she) is *affected* by a *phenomenon or condition* (hot, dizzy, like I'm having malaria); or (ii) *material process* of the action type (eat, sleep, work or can't eat/sleep/work) in which *participants* are both the *affected* and *goal* in *middle clauses*. In all of these expressions, *circumstantial* details of either *inner* or *outer* types may realize the *time duration* (3 months, for a long time); *location* (on my neck, in my mouth) and *manner* (persistently, seriously, properly, slowly) of an illness. ˙

Towards the end of the interaction, the doctor recommends treatment via *declarative clauses* of the *modalized* (shall give/send/prescribe/do) or *non-modalized* (have taken/written/ sent) type in which the material action process above (send, give, do, etc.) is performed by the doctor as an *agent/actor* (I, We) on the client as *beneficiary/recipient* and objects of medicine as *goal* (samples, drugs, etc).

4.5.3 Cohesion

The results show that cohesion is achieved mainly via *reference (exophoric and endophoric)* features and through *lexical cohesion*. The occurrences of *ellipsis* also characterize the discourse as conversation data. The features of cohesion are identified here and illustrated with items in Ex. 2.

Reference (exophoric): I, you (11 6, 8, 14, etc.) →patient; I (1.16), we (1.12) →doctor (11 2, 4, 7, 11, etc); the hospital (1.15).

Reference (linguistic): I, you madam (l.1); I (1.16) →Doctor (1.14); this illness (1.8)→sick (1.2), not well (1.2), persistent diarrhoea (1.4); skin rash (1.8)→ it (1.9).

Ellipsis: Yes, I do [cough] (1.7), [Do you have / Have you got] any fever? (1.10)

Conjunction: But (1.7) → expressing contrast.

Lexical cohesion: See 4.5.1 above on lexical collocation and relationships.

4.6 PARTICIPANTS' ORIENTATIONS TO CONVERSATION AND POLITENESS MAXIMS

4.6.1 Conversation Maxims

The maxim of quality is almost always obeyed in doctor-patient interaction because participants recognize the need for truth in the resolution of medical problems. However, other maxims of quantity, relation and manner are sometimes flouted in the course of expression of sentiments and emotional feelings and avoidance of unpleasant consequences. In Ex. 5 above the doctor flouts the relation maxim in order to assure the patient without being untruthful. The examples below respectively indicate occurrences of flouting of quality and manner maxims.

Example 7.

Doctor: Oh! Baba, good morning. Sorry, any problem?
Patient: Na wa o. Problem dey o. This body dey trouble me well, seriously, Na yesterday this thing happen.
Doctor: Don't worry, Baba. You'll be well. Where exactly is the problem?

Example 8.

Patient: [*After receiving an injection*] Doctor, thank you sir. I hope I will survive this distress.
Doctor: Just calm down, it is well. The injection given is a potent bronchi dilator.

In Ex. 7 the patient in his anxiety not only states the problem but also the time it started. It is common for patients to give less or more information than required during diagnosis. In the former situation the doctor continues to press for more information until he/she is satisfied, while in the latter situation, he/she utilizes relevant information and discards irrelevant ones. In Ex. 8 it is not clear whether the technical term used by the doctor is deliberate or not. Notice the indirect manner in which the patient answers the doctor's question in Ex. 16(1. 10) below. The patient attempts to shift responsibility for an action to someone else to avoid being blamed. Otherwise the question does not really demand the reference to a third person here.

4.6.2 Politeness Maxims

Politeness maxims are adhered to in doctor-patient's interaction for salutary purposes. The tact maxim is used in the doctor's utterances to minimize the cost of expression to a patient or patient's relation and maximize the expression of cost to the speaker, as illustrated below:

Example 9.

a. Kindly tell me your problems.
b. We're doing our best for him.
c. There are two options to this result. It could be positive; it could be negative.

On many occasions the doctor observes the generosity maxim by showing concern about a client's health, via assurance (Ex. 5, 7 and 8) and advice, e.g.:

Example 10.

a. Please, you need to rest.
b. Make sure you take care of your body

With respect to the agreement maxim the doctor on most occasions believes and assumes the truth of whatever bit of information the client provides that is relevant to a problem (Ex. 4, 1. 1 and 6, 1. 1). He/she also observes working towards the solution as a venture between them, thus requiring the full cooperation of the client in the diagnosis. Mabayoje (1982: 11) opines, "the clinical psychologist must never presume to know better than the patient what is good for him/her". Thus although the patient submits himself/herself to the doctor's control he/she still has a great role to play to determining his or her own affair. However, doctors disagree with patients who engage in self-medication and condemn their initiative to seek medication from a wrong source (see Ex. 15, ll 4–5 and 16, ll 11–12).

The sympathy maxim is largely observed in the interactions, especially in very seriously cases, e.g. Where a reproductive organ is damaged or a disease is incurable or terminal. In Ex. 11 and 12 below, sympathetic utterances are uttered to causalities of leg amputation and AIDS respectively:

Example 11.

Take it easy; you're a man.

Example 12.

Well, human being! There is a time of birth and there is a time of death. This problem you're having. I want you to take faith in God. You know we only care; it is God that heals. So, we don't know there may be a miracle somewhere.

Lastly, the doctor for psychological and therapeutic purposes uses the Polyanna principle. Doctors present cases from a positive rather than negative view through the use of avoidance strategies such hints, technical jargons and euphemisms. The examples show two ways by which a doctor reveals the results of diagnosis to a patient:

Example 13.

There are a lot of people plagued with HIV/AIDS. The fact that somebody is having it does not mean that they will die down soon. There are a lot of people that are HIV positive that live to bun corpse (sic) of people that are HIV positive.

Example 14.

Doctor 1: (*to Doctor 2*) I query CVA.
Doctor 2: Eh, CVA!
Patient: What is it, Doctor?
Doctor 1: Oh! There is no problem sir. I was telling my friend that I suspected CVA. (Smiling now) I'll put you on…

'CVA is' a professional term for 'Cerebro-Vascular Accident'. Other examples include 'Hansen's disease' for leprosy, 'oncho' for cancer, 'op' for surgical operation 'lentiviral infection' or 'government disease' (in some African countries) for HIV AIDS.

4.6.3 Face Threats

Medical ethics requires that patients be confronted with the facts of a disease. However, the expectations of indirectness in communication are carried into consultative encounters in Africa, since orthodox medicine has to twist its language to reflect the orientation and expectations of the host culture. These account for the use of avoidance strategies such as euphemism and technical jargons in medical communication. (Chimombo and Roseberry 1998). Although indirectness in medical communication sometimes occurs in the Western cultures, the phenomenon is more pronounced in African countries. The extent to which practitioners of western medicine in Africa still conform to the principle of direct communication of facts during diagnosis may partly be responsible for why some African people, despite the influence of modernization, still patronize traditional medicine, where they believe their feelings are more respected.

With respect to face threats in diagnostic interaction in Nigeria, both the doctor and client utilize either 'FTA without redress' (or 'bald on record') or 'negative politeness'. The general use of 'FTA without redress' by both participants indicates the seriousness with which they consider a diagnostic encounter. Strictly speaking, the encounter is business like and the participants have a focus, which is to probe, identify and state clearly the health problem of a patient. A doctor may use negative politeness by speaking indirectly to a patient (Ex. 15, ll 4–5) in order to condemn or express annoyance at a patient's action and may also use positive politeness to express sympathy or assurance to calm down the same patient in an interaction (Ex. 15, ll 8). In contrast, the patient uses negative politeness to show respect while requesting attention from the doctor. We shall present two conversations below and illustrate the face acts utilized in them. The face acts are labeled in bold letters –' bald on record' (B), negative politeness (N) and positive politeness (P).

Example 15.

Doctor: Mr X, any problem? **[B]**
Patient: Yes, I had severe headache. I then took the initiative to do a Widal test at X (a private) clinic. Here is the … **[B]**
Doctor: (*cuts in*) I don't use it. **[B]** That is one of the ways they cheat people in this town (name omitted). **[N]** I'll ask you to go and do a reliable test. **N** Yes, blood culture at BMC. **[B]** Just to clear things. (*Practical examination of patient*). Take this to them (i.e. to the nurses)… **[B]** Go and do that tomorrow. Ask them when the result will be out. **[B]** I know you will be well before the results come out. **[P]**

Example 16.

Patient: (*Weak*) Doctor, please, help me. I'm dying! Had I known I wouldn't have gone to him o …
Doctor: Tell me what happened.
Patient: I got pregnant and because I'm not working yet and my partner too is yet to get a job so we decided to abort the pregnancy.
Doctor: How and where did you go for the termination?
Patient: I was taken to a doctor's place and he used some instruments on me to remove the pregnancy.
Doctor: After that, what did you do again?
Patient: He gave me some drugs and injections. I'm still using those drugs.
Doctor: Do you have them here? Anyway, you have made a mistake of getting pregnant at first and for you to still go for termination in a wrong place—or what is the name of the clinic or hospital the operation was carried out?
Patient: It has no name. The doctor treats people in his small apartment.
Doctor: Fake. You see, I hope the man has not punctured your womb, because with this fresh blood oozing out. (to her parents) she will definitely need blood. She's too pale and, not only that, she might ought to go surgical operation if bleeding persist.
Patient: What can I do I am in trouble. I pray God to forgive me and spare my life. Please help me.

(Only the first and last turns of the patient indicate negative politeness. All other turns in the interaction indicate 'FTA without redress'.)

4.7 PRAGMATIC FAILURE

It is observed that doctor-patient interactions thrive on the successful production and interactions thrive on the successful production and interpretation of utterances by participants. To prevent pragmatic failure, participants take pains

to seek clarifications until messages are understood. Despite this precaution, however a few instances of misinterpretation of sense in utterances are noticed. The two examples below represent in advertent miscommunication of quickly made so that no serious damage is done to the interaction. Ex. 17 below is a tape-recorded report of an incident by a medical doctor during an interview session.

Example 17.

There was the story of a Professor of orthopaedics. You know if you say, if you have a broken limb, maybe a broken arm or something, two bones are overriding and the next thing is that you may say you want to reduce that fracture. A professor strolling, I mean the mother of the kid was there, I mean the child, and the professor just instructed a young colleague, 'Oh! No problem here. Beautiful X-ray. Reduce and immobilize. The next thing the mother did was to run away because she taught reduce means reduce the length, amputation––

Example 18.

A father bought his daughter for treatment. After an examination of the patient the following interaction took place.

Doctor 1: The ultrasonic scanning revealed twelve weeks cyesis.
Doctor 2: Drama.
Father: She was ill since (sic) March 4.
Doctor: She's pregnant…

5. CONCLUSION

In this paper the discourse tactics in doctor-patient diagnostic interaction has been analyzed in terms of (i) the mutual contextual beliefs of participants; (ii) patterns of speech act (illocutionary, illocution and perlocutionary) in exchanges moves and acts in the interaction; and pragmatic features such as conversation, politeness and face maxims. The transaction involved is a consultative one in which the process of identifying a health problem is negotiated between the doctor and client.

It is observed that opening and supporting moves are predominant in the interaction, while the challenge move seldom occurs. The opening move is very often initiated by the doctor who either elicits, gives and confirms some information or gives directives to a client. In contrast, the supporting move is often made by the client who gives information at some point in the interaction. Furthermore, it is observed that the flouting of several conversation maxims apart from the quantity maxim is a consequence of participants beliefs and

attitude towards the expression, of emotions and compassion in the interaction. The utilization of politeness maxims and face acts is also a reflection of these beliefs and attitudes.

Finally, the existence of other aspects of doctor-patient interaction apart from the diagnostic aspect, e.g. prescription, recording, reporting and treatment, as well as other kinds of medical communication, e.g. doctor-doctor, doctor-nurse, nurse-nurse, etc. has also been recognized. It is claimed that each of these other aspects deserves special attention, for a better understanding of their respective characteristics and of the roles of language in medical communication in general. In other words, medical communication or the language of medicine can be regarded as either a multi-faceted register or series of registers as the case may be.

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