

# Pragmatic Strategies of Diagnostic News Delivery in Nigerian Hospitals

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## Abstract

This paper sets out to study pragmatic strategies of diagnostic news delivery in Nigerian hospitals, an area that has received extremely little attention in the linguistic literature. It ultimately aims to see how these strategies are similar to or are different from those used in Western hospitals, especially as studied by Maynard (1991a, 1991b, 1991c, 1992, 2003, 2004). The hospitals sampled were stratified into teaching, state-government owned and private hospitals, and a random selection of five hospitals from each group was made. Data were collected through tape recordings, and personal observation of hospital interactions. The analysis of data was based on insights from Levinson's (1979) notion of activity type and Maynard's (1991a, 1991b, 1991c, 1992, 2003, 2004) devices of diagnostic news delivery. The findings reveal that three strategies are used to declare diagnostic news. Two of these are the main strategies identified by Maynard, namely asserting the condition and citing the evidence, but the third, mitigating the blunt news through veils and hedges, is largely peculiar to Nigerian hospitals. The paper concludes that a study of pragmatic strategies of diagnostic news delivery contributes to a better understanding of hospital interactions, and provides insights into doctors' verbal outputs in diagnostic meetings.

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## 1 Introduction

Diagnosis, defined as "the process of determining the nature of a disorder by considering the patient's signs and symptoms, medical background, and – where necessary – results of laboratory tests and X-ray examinations" (Martin 2000: 180), has received much attention in the sociological, psychological, anthropological and linguistic literature. The studies done in this regard have largely covered patients' visits to doctors and the interactions during the visits. In sociology, psychology and anthropology, seminal works, such as those conducted by ten Todd (1984), Pomerantz et al. (1987), Ten Have (1989), Cicourel (1992), etc. have addressed the structure of talk, power relations, socio-cultural constraints and professional skills involved in the diagnostic meetings of doctors and patients. In linguistics, efforts have been expended on conversation analysis, (e.g. Mishler 1984; Roberts et al. 2004); interactional sociolinguistics (e.g. Hamilton 2004); discourse analysis (e.g. Mishler 1997; Ainsworth-Vaughn 1998); and pragmatics (e.g. Maynard 1992, 2004; Odebunmi 2003).

Both in linguistics and other areas where diagnosis has been studied, little effort has been made to exclusively address the actual delivery of diagnostic messages. With the exception of Maynard (1991a, 1991b, 1991c, 1992, 2003, 2004) and Peräkylä (1998) who have specifically concentrated on diagnostic news delivery devices, many of the studies have dealt with the broad diagnostic encounters, which embody history taking, examinations, medical tests, etc. It is not sufficient to sweep the delivery (and receipt) of diagnosis along with the rest of the

diagnostic process. This is because diagnostic interactions climax at the announcement of the news, and this information determines, right from the point of disclosure, the subsequent course of the patient's life. In fact, the manner of news delivery influences subsequent encounters between the patient and medical professionals. This singular point makes the subject of diagnostic news delivery worth pursuing in the Nigerian context.

## 2 Studies on medical discourse in Nigeria

As will be shown later in greater detail, certain devices of delivering diagnostic news are available in the sociological and pragmatic literature at the international level. However, extremely little research has been carried out on the pragmatic aspects of the news delivery in Nigeria. Odeunmi (2003), among other concerns, examines diagnostic news delivery in general pragmatic terms. It does not single out the news delivery for study, but rather treats diagnosing as one of the institutional acts performed in the hospital, others being treatment and reporting; and exemplifies the act copiously from oral and written discourses by doctors and nurses in Southwestern Nigerian hospitals. Odeunmi (2006) only selects examples from oral discourses of doctors that relate to diagnosis to explain locutions that are and are not meant to be understood by patients. Other studies on medical discourse in Nigeria either concentrate on the pragmatic aspects of nurse-patient interactions (e.g. Faleke 2005) and doctor-pregnant women interactions (e.g. Salami 2006), with little value for diagnostic news delivery; or merely make treatises on medical communication (e.g. Ogunbode 1992; Alabi 1996; Oloruntoba-Oju 1996). Rare are the studies focusing exclusively on diagnostic news delivery in Nigerian hospitals. This research is therefore expected to, in addition to complementing existing studies on hospital interactions on the global scale, fill in a gap existing in the scholarship on the linguistics of medical discourse in Nigeria; and, in general, add to the research pool on medical communication in Africa, which has been observed to be slim, important as the area is:

The importance of the topic of communication between medical practitioners and their patients in Nigeria, and in any African country, cannot be over emphasized. And the topic of conversational interactions in health centres is one that is certainly of interest to students of pragmatics and linguistic anthropology... such a topic has received very very little attention in the African context (personal communication by an anonymous reviewer of *Journal of Pragmatics* 2006)

The pragmatic strategies engaged in Nigerian hospitals will, therefore, be centrally identified and glossily juxtaposed with those found in the Western literature on hospital interactions.

## 3 Corpus and Sampling

The hospitals sampled were stratified into teaching, state-government owned and private hospitals, and a random selection of five hospitals from each group was made. Thirty audio-recordings of news delivery interactions between doctors and patients (sometimes with their relatives) were made by the researcher. Where it was impossible to gain the consent of the hospital management to make recordings, notes were taken. The analysis of (our) data has been based on insights from Levinson's (1979) notion of activity type and Maynard's (1991a, 1991b, 1991c, 1992, 2003, 2004) devices of diagnostic news delivery.

## 4 Communication and language in the southwestern Nigerian hospital

English is the official language of communication in hospitals in Southwestern Nigeria. It is used exclusively where the doctor (Doc) and patient (Pt) or his/her relation (Pt: rel) can speak it. Sometimes, depending on the relationship between the parties and the goals of the encounter, they code-mix English and Yoruba, the native language of the people. But where the patient cannot speak English at all, the language he/she speaks usually, Yoruba, is selected

for communication, provided the doctor is also competent in it. Where this is not possible, or where a Nigerian language other than Yoruba is solely spoken by the patient and the doctor cannot cope with the linguistic requirements of the encounter, an interpreter is engaged to enable the doctor take proper record of the history of the patient's illness. Our data for this study however cover only situations where English alone was used in verbal exchanges in Nigerian hospitals.

Two major aspects of the Southwestern Nigerian people's culture are usually brought into hospital interactions, and the recognition of these aspects by the doctor usually smoothes the encounter. The first is the typical Yoruba person's preference for amenities and courteous utterances. Conversational interactions among the people hardly begin in a straight-to-business manner, as is largely the case in the Western cultures. Interactional exchanges such as greetings, sharing of common (current) social and political experiences, etc usually precede a typical encounter. These are believed to disalienate the participants and prepare the ground for a rewarding interaction. It is in such an environment that the Yoruba person will volunteer the information that is required in the communication.

To some extent, the expectations of the people are met in hospital meetings as doctors would ask questions about the health condition and the work of the patients, together with other relevant issues as the occasion may demand. But sometimes, doctors ask these questions as a pragmatic ploy to gain certain unvolunteered information from patients. However, as Odebunmi (2005) observes, doctors in Southwestern Nigeria generally, given the Western orientation obtained in the course of training perhaps, do not give total attention to the face wants of the people. And, as Odebunmi (2005) argues, this is the major reason why a large patronage is still obtained in traditional medicine which, being native to the culture, gives the right attention to the people's cultural needs.

## **5 Religious doxas and hospital interaction in southwestern Nigeria**

Dating back to the classical time, the term "doxa" refers to the beliefs shared by interactants in a discourse community. This sharedness occurs in many areas of life such as religion, politics, culture, etc. In the words of Amossy (2002a: 369), "the notion of doxa as common knowledge and shared opinions haunts all contemporary disciplines that put communication and social interaction at the centre of their concerns". This significance of doxic elements interacts with the view that social life, verbal communication and mutual persuasion strictly rely on a well-seated sub-structure of shared assumptions (cf. Pereluum 1998; Amossy 2002b). Invariably therefore, where subjects are new all the time to interactants and where no given background is available, communication becomes Herculean and sometimes impossible.

Doxa, at the religious level, is explored in conversational interactions in Nigerian hospitals, religion being an aspect of the people's culture. Many of the people are extremely religious whether in the Christian, Islamic or traditional sense. They recognize the supremacy of God over any physical medical efforts, and believe in spiritual elixirs, especially where doctors have pronounced the case deadly or terminal. This belief of the people is expected to be recognised and respected by doctors. Where this occurs, even when the people's faith fails them, no clash occurs with the bio-medical institution. Many times, a good number of doctors relate, in relevant situations, with patients with this cultural background in mind.

## **6 Diagnostic communication and medical discourse**

Since as far back as the medieval period, diagnosis has been considered as a final output of presentation and investigation of symptoms. "In the seventeenth century, the physician principally used verbal and visual techniques to make a diagnosis; he listened to the patient's

description of his symptoms and that of his appearance and that of his body fluids" (Reiser 1978: 22). The use of manual techniques began in the eighteenth century (Reiser 1978). Obviously, diagnosis has gone beyond this point in the modern situation as a lot of sophisticated diagnostic devices and techniques have evolved.

Diagnosis results from a patient's encounter with a doctor, the former having come to visit the latter on the ground of a dysfunction noticed in his/her body system (Hamilton 2004). An interview lasting 10–20 minutes which aims at "making a diagnosis or (more generally) an assessment, a therapy" usually ensues (Grossen/Orvig 1998: 149). According to Balint (1964: 157), diagnosis can be regarded as a study of pathological biography, as "patients consult their doctors only when they have converted the struggle with their problem into an illness". In the actual interview, power (authority) is largely disproportionately held and wielded. The interaction is controlled and structured as a therapy session by the doctor (Mondada 1998). Doctors thus assume a position of authority and superiority, which patients may or may not submit to (Leonardi/Viaro 1983).

Apart from the asymmetrical power relation between the doctor and the patient, Salazar Orvig (1998) mentions four other features of clinical interviews; namely: the therapist basing his interview on his theoretical and social knowledge of the patients' complaints; the therapist looking beyond the face content of the patients' discourse; the therapist utilizing semiotic cues and relying on the perlocutionary impacts of his/her responses; the patient carrying out operation on the therapist's interpretation of the case he/she presents.

The doctor formulates, reformulates and negotiates the problem of the patient (Apotheloz/Grossen 1995 as cited in Mondada 1998), as the patient does the narrating and states his/her experience of the illness at issue. All these are done for the therapist to be able to draw conclusions on the case being dealt with (Davis 1986; Buttny 1996; Mondada 1998); and brainstorm on the management of the problem (Silverman 1994; Mondada 1998).

The exchange of information between the doctor and the patient is not haphazard, rather it has what Goffman (1983) calls "interaction order". Roberts et al. (2004: 161) observe that the phase where the patient presents his/her complaints is usually characterized by "the description of symptoms, the context in which the symptoms occurred and the patient's stance" i.e. affective stance and epistemic stance; where the former "includes mood, attitude, feeling or disposition as well as the degree of emotional intensity", and the latter, the "degree of certainty of knowledge or commitment to truth of a proposition". In other words, the patient needs to state the symptoms noticed; these symptoms have to be tracked down to particular temporal or spatial circumstances; and the patient's emotional posture to the symptoms has to be determined.

After the doctor has collected all relevant details from the patient and has processed them appropriately, usually with supporting evidence from medical tests, he/she has to deliver the diagnosis to the patient. A few methods to do this are available largely in the sociological and pragmatic literature (cf. Maynard 1989, 1991b, 1991c, 1992, 2003, 2004; Peräkylä 1998; Beach 2002; Heath 1992; Maynard/Heritage 2005). Maynard (1991a, 1991b), for example, identifies two major devices of diagnostic news delivery; namely, citing the evidence and asserting the condition. In the words of Maynard (2004: 53):

Citing the evidence – reporting the result – is what clinicians do as a cautionary way of declaring a diagnosis, whereas asserting the condition – predicating it as an attribute of a person – is interactionally more forthright and bolder.

He observes that most clinicians prefer to use the former more predominantly than the latter. Peräkylä (1998) explains Maynard's terms better by naming his own devices, (obviously meaning the same as Maynard's) "explicating the evidence" and "plain assertions". These

terms reveal the fact that the two devices can be considered respectively in terms of indirectness and directness.

Maynard (2004) develops the two devices fully under the headings: asserting the condition as a predicate and citing the evidence as referring to tests or results. He further breaks these into six sub-devices; namely, asserting the condition baldly; citing the evidence as a predecessor account to asserting the condition; alluding to a diagnostic predicate through citing the evidence; labelling the evidence; occasioning a predicate assertion after citing the evidence and inquiring about expectations; and citing the evidence in internal medicine. These diagnostic news delivery devices identified in the sociological and pragmatic literature can be secured a place in Brown and Levinson's politeness (and face act) theory, especially face threatening acts (FTAs) without redress (bald on record), FTAs with redress positive politeness, FTAs with redress negative politeness and off-record politeness. Much of these will be explored in our analysis very shortly. It is however necessary to add that the strategies identified by Maynard (1991a, 1991b, 1991c, 1992, 2003, 2004) shall be adopted for our analysis of diagnostic interactions. Other data-peculiar devices as will be shown presently shall complement these.

Meanwhile, it is essential to say that we find Levinson's (1979) activity type model of context relevant to analyzing delivery of diagnostic news in Southwestern Nigerian hospitals. This is because, in its broad frame, the model is able to incorporate individual participants' goals, their contributions, shared assumptions, socio-contextual stretch and pragmatic constraints, all of which are required to understand doctors' announcement of diagnoses to patients in the hospitals. We discuss this pragmatic model in the next section.

## **7 Models of context and the notion of activity type**

Much of the popular inputs into the contextual approach to language studies has come from sociolinguistics. Major in this regard is Dell Hymes' ethnography of communication, which has provided avenues to consider the spatial, temporal, social and structural background to discourses. In Hymes' SPEAKING, S refers to situation i.e. a physical or abstract setting; P, participants (speakers, hearers, audience, etc); E, ends (goals of the interaction); A, act sequences (message form and content); K, Key (tone or manner of act); I, Instrumentalities (channel or mode, and form of speech); N, Norms (norms of interpretation and interaction); and G, Genre (e.g. joke, adversity, etc). Hymes' model has been patterned after his interest in describing ritualized occasions such as weddings, funerals, etc. Within this perspective, Hymes has provided an excellent framework to access context.

However, outside its inspirational base, the model is too broad-based, leading to a generalized result. This weakens the framework in a pragmatic operation. In pragmatics, a contextual framework should be capable of explaining, "why one person performs very differently from another in the same linguistic situation [...] [and] showing how one speaker successfully exploits a situation to achieve his or her goals, while the other fails dismally" (Thomas 1995: 189). Therefore, according to Thomas (ibid.), "although pragmaticists might want to use a framework such as Hymes' as a point of departure, we cannot leave it there". She recommends Levinson's (1979) notion of activity type as a way out of the trouble. This largely neglected model presents the view that what shapes the event is the individual's use of language. It also, like pragmatics in general, concerns itself with the way an individual uses language to change his/her situation, a task which Hymes' model, dealing in stereotypic samples, is incapable of performing. In actual fact, the difference between Hymes' model and that of Levinson seems to mark the distinction between sociolinguistics and pragmatics. According to Thomas (1995: 189), "The sociolinguist tries to show how features of context

systematically constrain language use. The pragmaticist tries to show how speakers use language in order to change the situation they find themselves in".

According to Levinson (1979: 368), an activity type is a

fuzzy category whose focal members are goal-defined, socially constituted, bounded, events with *constraints* on participants, setting, and so on, but above all on the kinds of allowable contributions. Paradigm examples would be teaching, a job interview, a jurat interrogation, a football game, a task in a workshop, a dinner party and so on.

There are six parts to Levinson's notion of activity type; namely, the goals of the participants (the goals of the individual rather than that of the event); allowable contributions (the limit to which contributions may be made in an interaction, given the rules of the event, and how such an allowance is manipulated in interaction); the degree to which Gricean maxims are adhered to or are suspended (for instance, considering cultural variation and activity type. The maxims are, in this study, considered in terms of how giving more or less information (quantity), being truthful (quality), being relevant (relation) and being clear (manner) influence meaning in diagnostic interactions); the degree to which interpersonal maxims are adhered to or suspended (for example, politeness maxims may or may not be observed depending on the nature and activity type); turn taking and topic control (the extent to which turn-taking rules may be exploited to achieve control of a situation or make a point); and the manipulation of pragmatic parameters (the extent to which language can be used to effect social distance, power, rights, obligations and formality of situation (Thomas 1995). On the whole, Levinson (1979) suggests that context is not just the situation in which participants find themselves and interact, but rather that context is constructed in interaction. According to Thomas (1995: 194) "the participants by their use of language, also contribute to making and changing their context".

## **8 Pragmatic strategies of diagnostic news delivery**

Maynard's (1991a, 1991b, 1991c, 1992, 2003, 2004) broadly categorized devices: asserting the condition and citing the evidence are prominently demonstrated in our data. One device that is not discussed by Maynard, but that is found in the data is mitigating the blunt news through veils and hedges. These three devices, with intervening devices such as stalling, flooding out response and perspective display sequence (Maynard 1991, 1992, 2003) are discussed in turn below.

### **8.1 Asserting the condition**

Asserting the condition occurred predominantly in hospital interactions, i.e. there were 180 instances (78.36%) of this strategy, as compared to 30 instances (13.0%) of citing the evidence, and 20 (08.7%) of mitigations. Two occasions largely necessitated this strategy, viz: when the ailment being dealt with was mild, (i.e. conditions that were not deadly or capable of attracting public scorn or abandonment e.g. leprosy) and when the patient (Pt) was seen to express deep anxieties over a condition, which may or may not be deadly.

#### **8.1.1 Dealing with mild conditions**

In the first case, the doctor (Doc), usually did not feel restrained by any ethical or emotional factor to keep from the patient or patient's relation (Pt: rel) information about illnesses and conditions such as cold, fever, fracture, etc. By the same token, no feeling of unease was noticed in the patient or relations where the latter accompanied the former to the hospital. To deliver the diagnostic news on these illnesses, Doc usually engaged FTA without redress. The interaction below exemplifies this:

### Interaction 1

- Doctor: Madam, how are you?
- Mother: Thank you sir
- Doctor: What's the problem (checked the case note, and noticed that nurses had earlier attended to the baby brought to the hospital) Oh! Your baby was very hot when you came in
- Mother: Yes sir
- Doctor: Well, no problem you've only got to be more prompt next time. She was hot to convulsion point
- Mother: Ah!

In interaction 1, Doc doxically ushered in the Pt:rel with "how are you?", to which, expecting such a gesture, she responded with an appreciation, and not the expected, "fine" which usually precedes "thank you". Doctor's asking for the complaint of the patient's mother (what's the problem) was ritualistic as it was found in almost all the encounters in exact or variant form.

Part of the procedure of medical treatment was for the nurses to first carry out preliminary medical activities on the patient before finally sending him/her to the doctor. It was in the course of this exercise that the near convulsive temperature of the baby was detected. This was announced by the doctor unmitigated: "Your baby was very hot when you came in" to which the mother responded in affirmation. The next utterance of the doctor showed a pragmatic force of reprimand, which was initiated with the preparing: "Well no problem; you have only got to be prompt next time". The actual force came with the FTA: "She was hot to convulsion point", which alarmed the mother

#### 8.1.2 Dealing with patients' anxiety

To deliver diagnosis in situations where Pt (or Pt: rel) was extremely anxious about his/her condition which may not be deadly or terminal, non-mitigations were largely engaged. To deliver the news, the presence or absence of persons other than Pts or their close associates mattered, especially where the disease was a deadly one. The following interaction may be considered:

### Interaction 2

A senior doctor and a six-month-old baby's parents were present in the doctor's consulting room. This visit was the fifth to the doctor within three days. The mother was obviously disturbed by her baby's protracted cold which was going to earn the baby hospitalization, having given her all prescribed medicines to no avail.

- Mother: Doctor, what exactly is the problem with my baby? This cold, I'm afraid... my baby... (sobbing)
- Doctor: (Looking the woman straight in the face) she has acute respiratory infection
- Mother: (broke down in tears. Did not say a word)

Mother, in this interaction, demanded information from Doc in respect of her baby's sickness. The relapsing nature and non-improvement of the condition of the baby's condition obviously triggered off the question: what exactly [...] my baby? Her worries carried in this interrogation climaxed in the statement: "This cold [...] my baby", which was concluded with a sob. Doc, who had all along known the diagnosis but had stalled it (Maynard 2003) for the fear that the mother might go uncontrollable, had to assert the condition as an attribute of Pt. Cashing in on the cue provided by the mother's anxiety, Doc, despite the weightiness of the FTA, delivered

the news unmitigated to the mother. This is strictly in line with the medical ethics that a patient should be told what his/her condition is; in fact, "a patient should be told that he is dying" (Ashiru 1982: 117). The doctor in this interaction, himself, said, in an interview granted, that an approach such as this was appropriate to make the mother settle down with the reality as quickly as possible, and consequently brace up to co-operate in the procedure to be carried out on Pt and fully support her. By his bald on record act, Doc had directly and fully co-operatively responded to Mother's question, giving the exact amount of information needed in a clear manner for the woman to understand the condition of the baby. The directness had been preferred not only because of the anxiety read on Mother's countenance, but also because only the father and the mother were present. This was consistent with the doxa of death-potential illnesses among the people of Southwestern Nigeria. Given this sharp directness, no interpersonal maxim was observed, as Doc had the goal to make Mother take the information as it was and adjust. By the information he supplied, he exercised his authority. The mother's tears and uneasy quiet resulted from the assertion of this authority.

In another interaction, Doc had both delivered the diagnostic news and announced the prognosis of the sickness:

### **Interaction 3**

The doctor was talking to a young couple after series of tests had been conducted on their baby who had been brought to the hospital for fever. The parents had, as part of their statement of history, told the doctor that the baby convulsed shortly before she was brought to the hospital and that they had lost their first baby to such a condition.

Mother: Doctor, any problem?

Doctor: Madam, your daughter has cerebral malaria. She has survival chances of 50-50

Mother: (started crying) Oh! My God; again!

Father: Oh! God will help you (looking disturbed)

Doctor: Amen. Staff, please, bring...

In this interaction, unlike in Interaction I, requesting for the problem came from the mother, and not, the doctor. This is, in part, accounted for by the medial point where the interaction had been reported, as the initial part had been reported in the background provided on it. The mother's question was not like the object of the one asked by Doc in Interaction I where complaints had been requested. It was a subtle demand for an explanation for the baby's condition and the prognosis of the condition. Doc perfectly understood this speech act. Doc thus picked his cue from the anxiety of the mother, and opted for a bald-on-record act. In addition to this, when Doc gave the diagnosis, "Your daughter has cerebral malaria", the mother cried because she immediately connected her earlier experience with the present one, the parents having had a related experience to the one at issue. This is reflected in her utterance, "Oh my God, again!" This response suggested a cognitive link with the earlier child and the circumstance of his death. Doc had added a condition, which offered the possibility of this baby surviving the sickness this time: "She has the survival chances of 50-50". It is this hopeful avenue that brought in religion. The father's utterance: "God will help you", brought religious belief into the picture, and, of course, portrayed the tendency in Southwestern Nigeria to see God as capable of intervening in mortally-declared hopeless conditions. It is also conspicuous that the father, with the utterance, worked to tone down the mother's emotional reaction, given their mutual understanding of the infinite potentials of God. This episode is similar to that reported in Maynard (2003).

Working within the same religious background, Doc in Interaction 3 picked appropriate intake and said "amen", both as the right response to the prayer and as a pragmatic technique to empathise with the father. For Doc to ensure that the mother understood the intended message, with the right force, he gave some relevant information that matched the question asked:

Mother: Doctor, any problem?

Doctor: Madam, your daughter has cerebral malaria

In his response, Doc had asserted the condition as an attribute of Pt. But in the next statement, he provided appended information (Fisher/Groce 1990), though still preferring the bald-on-record act:

She has survival chances of 50-50

By this utterance, Doc had announced the prognosis of the disease, itself the major instigator of the introduction of religion into the discourse. Doc had, in addition, dispreferred tact, generosity and modesty maxims to be able to unleash the full weight of the bald-on-record act on the mother to achieve pragmatic effects. Announcing the diagnosis asserted the authority of Doc and altered the discourse structure of the situation: the mother wept and evoked an emotional predecessor, which only confirmed the background exploited by Doc for diagnostic news delivery; and the father only wished Doc success.

### 8.1.3 Dealing with deadly diseases

Deadly/killer diseases were also announced with Doc asserting the condition as an attribute of Pt. Generally, however, more caution and pragmatic tact were made to background the news. Usually, when such happened, Pt had largely been assured to have earlier been expecting the news or sufficiently prepared for it. The interaction below reveals this:

#### Interaction 4

Patient X was awaiting disclosure of the results of a medical test carried out on him by Doctor Y. The latter had just ordered that the laboratory attendant bring the result to his office, but had earlier, considering signs and symptoms, deeply suspected, that patient X was HIV positive.

Doctor: How do you feel after the last treatment? Sure, you should em, be better. Wrong?

Patient: Somehow; the diarrhoea came, kind of, I mean, it was not as much. Doctor, what's my, I mean result; do you think...

Doctor: (cuts in) they will bring it now. You see, there are two options to this result: it could be positive, it could be negative. If it is positive, what will you do?

Patient: Ah! Doctor, you mean, do you say I'm positive

Doctor: No, I only asked a question. In any case, let's wait, you see ours is a very delicate job. In fact, sometimes you see, people think we don't want to, em assist. Look at that woman, I mean that just left... (interrupted by the laboratory attendant who brought in the result and left immediately)

Doctor: (Carefully unsealed it, studied it and looked up, staring at the patient) Well, Mr. X, you see, you are positive

Patient: (Said nothing, but looked abstracted and depressed)

The device used in this interaction is similar to what has been called perspective display sequence (PDS) in Maynard (1991c, 1992). In a PDS, the doctor requests for the view of the

patient before announcing the diagnosis. In Interaction 4, Doc worked to activate the PDS two times, achieving little success each time. The first attempt was made with "How do you feel after the last treatment?" The opening move was elongated to almost preempt Pt: "Sure, you should be better, wrong?" flaunting his medical skills and the power of the medications given Pt at the first meeting. This had partial success as Pt merely talked about less diarrhea, but solicited the result,

Somehow; the diarrhea came, kind of, I mean it was not as much. Doctor, what's is my result; do you think...

Pt cooperated partially with Doc in his response that the diarrhea was reduced, which was the response Doc expected by the utterance: "Sure, you should be better". However, given Pt's awareness of the result of the test being available and the symptoms of his condition, he was more interested in the result than the temporary relief got from the medications taken. Hence, he decided to flout the maxim of quantity by introducing a new item:

my [...] result

and further seeking to know what it read:

Do you think?

The doctor activated the sequence again by asking another type of question: "If it is positive, what will you do?" which went farther than the earlier one. To effect the activation, doctor began by interrupting Pt with the fact obtaining with regard to the test:

they will bring it now

which referred to workers in the laboratory unit of the hospital. He went ahead to prepare Pt for the news by analysing the nature and forms of HIV/AIDS result:

You see, there are two options to this result; it could be positive, it could be negative

"You see" here sounded affirmative and appealing, which was an index for Pt's ultimate conclusion. Two sides i.e. positive and negative outcomes were presented to Pt before the actual activation of the sequence. But Pt, working with his knowledge of HIV/AIDS in conjunction with his bio-physical conditions and the tone of the doctor's utterance, rather than answering the question, interpreted the query as a signal that he might be positive. But the Doc denied this.

No, I only asked of question

He barred the patient's preemption by putting the subject temporarily on hold:

In any case, let's wait

and switched to another issue.

Doctor's "You see" served as a transition relevance place where he only turned to talking about the extent to which the medical profession was a delicate one, and the public's view of the medical institution in general. The issue of the female patient: "that woman [...] that just left" was to be a case in point, but was not concluded because the laboratory attendant brought in the result of the test in as the doctor earlier promised, interrupting the discussion. But as soon as the result was brought in, Doc took up the medical institutional authority and announced the news baldly, having sufficiently gauged the patient's possible reaction. "Well" said by the doctor was final and formal. Pt had to be addressed by his official name, (Mrs. X).

Then, Doc employed, "you see" in a different sense from the earlier two instances to mean, "it is clear/the fact is that", preceding the ultimate disclosure of the news:

You are positive

to which Pt made no verbal reaction. Pt's response was psychological all through, a direct manifestation of the tact the doctor had engaged in the interaction.

It is necessary, at this point to, briefly, consider an interaction in a Western context where assertions had been used.

### Interaction 5

- Dr N:            But uhmm (3.1) ahhh (0.3) Ricky is a retarded Chi::ld (1.0)
- Mrs L:           (Yeah)
- Dr N:           A:::nd (0.2) it's no:t Mi::ld- it's mo::derate retardation (0.2)
- Dr N:           As far as we can estimate .hhhhh We can':t give exact psychological tests::  
(.) It was tri::ed.hhh but he: (.) just wasn't cooperating enough to do i:t.  
(0.2) Hhhe:::uhhhh (0.4) was too afrai:::d or to scar:::ed or (0.1) it was  
just (0.5) too frightening a situation (.) So we can-(0.1) we can':t really  
feel we've got a completely correct (0.2) psychological: testing on him  
(1.9)
- Dr N:           But- (.) there's (0.1) significant (0.1) retardation (0.1) what we would call  
moderately retarded.hhhh Now (.) children with moderate retardation (0.4)  
are sen:t to school...

(Maynard 2004: 57)

Doc, in Interaction 5, did not mitigate the point that Pt was a retarded child. This was variously captured as: "a retarded child", "moderate retardation", "significant retardation" and "moderately retarded".

## 8.2 Cinting the evidence

As in Maynard (2004), the doctor in about 30 instances (13.0%) in our data referred to the results of tests to announce the news. This is an indirect approach when compared to the bolder asserting the condition discussed in the earlier section. This strategy shares a lot with asserting the condition as an attribute of X. Yet, they differ at the point where the doctor depends on the result for the news, by referring particularly and directly to it rather than merely using it as a basis for his/her news to the patient. We can instantiate this strategy with another HIV/AIDS case.

## Interaction 6

A patient was waiting to be told the result of the HIV screening carried out on him in hospital X.

- Doctor: Mr. X, how are you? How have you been feeling?
- Patient: Doctor, I have not slept, even one minute. When em, I am, I think...
- Doctor: What? You think it can be positive? Oh, look; no one can say so much about life. Of course, there are a lot of people plagued with HIV/AIDS. The fact that somebody is having it does not mean that they will die. There are a lot of people that are HIV positive that live to bury the corpse [sic] of people that are not HIV positive
- Patient: Doctor, but... ah, well, I mean
- Doctor: What is it Mr. X?
- Patient: Nothing, I mean, doctor
- Doctor: Well, Mr. X, the result before me shows that em you are reactive, I mean positive
- Patient: That I... (dropped his head on doctor's table, breathing very hard and fast).
- Doctor: (left his seat, came to Mr X's side of the table and patted him at the back) Look Mr X; you can still live a normal life

Like Doc in Interaction 4, Doc here began by asking for social rather than medical information from Pt, after which he broached the subject of the meeting: "How have you been feeling?" which presupposed an earlier visit of Pt to Doc. Pt's response move and Doc's follow up move revealed a shared background upon which the two drew. Pt's "I think", in an incomplete statement hijacked by Doc, was repeated and expanded by Doc: "You think it can be positive?" The choice of "it" pointed to an exophoric precedence, the knowledge of which both interactants shared. In this context, given other lexical indexes such as "positive", "HIV/AIDS", "HIV positive" and "corpse", it can be seen that "it" was being used to refer to HIV screening, the result of which Pt was expecting. Doc, having got the result before hand and known that Pt was positive, reckoned preparing Pt for the news the best action. He thus resorted to highlighting the bio-social potentials of people living HIV/AIDS. Pt, like that in Inter 4, suspected a fishy venture, and given, perhaps his risky behaviour in the past, was not going to be completely surprised at the news. His hesitation, "Doctor, but... ah", and his eventual non-pursuit of his perspective, "nothing I mean nothing doctor" gave this out.

Doc introduced the result of the test indirectly, engaging an FTA with redress (negative politeness). While he had Pt in mind and aimed to get him to realise that the information was meant for him, he employed a generic reference and a singular 'they' construction: "The fact that somebody is having it does not mean that they will die". From "of course" to "that are not HIV positive", Doc elaborately hinted at a case of HIV infection, which Pt sought to determine by a flooding out response (Maynard 2003):

Doctor, but ...ah!, well, I mean

Now, Doc, came up with a PDS, and asked, "What's it Mr X?" which failed, as in interaction 4 to elicit the response that Doc expected. Having failed in this bid, Doc resorted to delivering the news. Before this point, he had been less assertive, had reduced distance and had relaxed formality. But right from this point, he became very assertive and authoritative. He reported the result of the HIV screening done on Pt by citing the evidence, "The result before me shows..." He reformulated the terminology, "reactive", in a clearer language for Pt to ingest the full implication of the message. In other words, using FTA without redress, he announced

the diagnosis: "I mean positive". He rounded off the encounter with the Pollyanna principle (the pragmatic principle that emphasises the good/positive rather than the bad/negative aspect of life): "you can still live a normal life", which, given the effect of the news, was to lift up the spirit of Pt.

The western experience, as reported by Maynard (2004: 59–60), can be cited briefly in comparison with the Nigerian interaction just dealt with:

### Interaction 7

- Dr B: Well (0.5) No we-we: would (0.4) we feel that (0.2) the Problem is that he ca:n't (.) yet (0.9)
- Dr B: And that he- (0.2) all our exams show that he is (,) quite retarded
- Dr B: Have- have you (0.7) h-heard this word before? And thought of it in relation to him?
- Mrs M: Retarded?...

Interaction 7 exhibits a good instance of the strategy of citing the evidence. As Maynard clearly and elaborately shows in his analysis, the statement, "all our exams show that he is retarded" demonstrates Doc's reliance on the result of tests carried out on Pt to announce the diagnosis.

## 8.3 Mitigating the blunt news

In about 20 cases (8.7%), Doc mitigated the blunt news by veiling or hedging it. This low percentage shows the relatively infrequent use of this strategy in diagnostic communication in Nigeria. Mitigations occurred where the seriousness or severity of diagnostic news was downplayed to douse the tension of the patient. Unlike assertions and citing the evidence which were also found to be used in Western hospitals, mitigations, with strategic intents, were not found in the research utilized for comparison.

### 8.3.1 Veiling the news

Veiling involved inexactitude in language use i.e. non-use of the actual or known medical term for strategic reasons. Doc veiled the diagnostic news on two grounds: one, when he/she rated that Pt was not sufficiently prepared to take the news, and felt that his/her condition would be compounded if the news was broken; two, when participants other than Pt were present. To do this, Doc usually engaged FTA with redress, aimed at Pt's positive face and the Pollyanna principle. The interaction below shows how veiling was done in transactional communication.

### Interaction 8

A patient's cousin went to meet the doctor after the latter had completed a ward round during which he attended to Mr. X.

- Cousin: Sir, Mr. X is *still* coughing. What is the *real* problem?
- Doctor: Well, he has *Koch's disease*
- Cousin: I hope there is no problem
- Doctor: No!

In interaction 8, Pt had already been told that he had tuberculosis, for which he had been admitted into an isolated ward. Pt was an adult, but had not got married. On presentation, which led to the admission, he came with the woman, his cousin, but the diagnosis was

announced while she was away. So, asking the question was out of her worries about the condition of her cousin. Her worry was overtly marked by "still coughing". This was followed by the question: "What is the *real* problem". The adjective "real" interrogated the nature of the condition. Doc, acting within the provision of medical ethics to keep the secret of the patient, veiled the diagnosis by calling it another name: "Well, he has Koch's disease". In a way, he had announced the diagnosis to the cousin who did not understand the meaning of the technical term. The cousin asked a further question about the condition of Pt: "I hope there is no problem", to which Doc authoritatively indicated none. This statement did not implicate any understanding of the term "Koch's disease" and the nature of the problem. According to Odebunmi (2003), "Koch's disease" is an instance of the euphemistic tendency of the Pollyanna principle found in doctor-patient interaction in Nigeria. It should be noted in Interaction 8 that to declare the diagnosis, Doc, unlike the style in some of the earlier interactions, had kept a good distance with the cousin.

### 8.3.2 Hedging the Blunt News

Sometimes, doctors, given the circumstances in which they operated, both announced the blunt news, and simultaneously hedged the information to raise the hope of Pt. Usually the diseases concerned might not strictly have a terminal prognosis, but might be no less deadly or stigmatizing than some other terrible diseases. Doctors hedged the news by employing, in the same context, both FTA without redress and FTA with redress positive politeness. This point is clearly exemplified in the interaction that follows:

#### Interaction 9

A woman, about 50 years old, was called into a doctor's consulting room. She had a troubled look.

Patient: Good morning, doctor

Doctor: Oh, madam, you welcome. Finished the drugs?

Patient: Some left. But...

Doctor: I will add a few new ones. Then see me on... (checked the calendar on the wall for date) on 20<sup>th</sup> (writing his prescriptions)

Patient: But doctor, the sleep problem, I mean in the night, each night my sleep is bad, and this condition, I mean!

Doctor: (Said nothing but continued to write)

Patient: Doctor, please what is wrong with me. Wouldn't I die? This trouble...

Doctor: (cuts in) Madam, you have acute hypertension. It cannot be cured, but we can control it

Patient: (started crying) Doctor...

The first question posed at the patient by the doctor indicated that the doctor had earlier given her medical attention. Information was exchanged freely between Doc and Pt regarding the medication but not the condition. But, Pt. needing information on this, complained about her condition despite Doc's silence. Doc stalled information for Pt by discussing the medication alone and ignoring Pt's question centering on her condition. It was this that prompted Pt's, "please, what is wrong with me". Subsequently, Doc launched his diagnosis baldly: "You have acute hypertension". This was compounded with the explanation: "It cannot be cured", which stated the prognosis of the condition. Having said this, Doc now came with a positive side to it, using FTA with redress negative politeness: "but we can control it". This last statement is a Pollyanna expression as it gave some measure of hope to Pt. Doc's choice of the

bald on record act was in line with medical ethnics and in consistency with the needs of the occasion to make Pt know the gravity/seriousness of the condition to be able rise up appropriately to the challenges that the condition demanded. The FTA with redress aimed at Pt's positive face was meant to relieve her psychologically. No tact, generosity or modesty maxim was observed which obviously helped to show Doc's authority, establish distance and maintain the strict formality of the interaction. The table below summarises the pragmatic strategies discussed in the foregoing and their occurrences in the data.

	Distribution	Percentage
Assertions	180	78.3%
Evidence	30	13.0%
Mitigations	20	08.7%
Total	230	100%

**Table 1: Pragmatic Strategies of Diagnostic News Delivery**

## 9 Conclusion

We have shown in the foregoing that three pragmatic strategies are engaged in delivering diagnostic news in Southwestern Nigeria; namely: asserting the condition, citing the evidence and mitigating the blunt news. The news was asserted when the ailment was mild and when Pt was anxious about his/her condition; evidence was cited as an indirect way of announcing diagnostic news; and blunt news was mitigated through veils and hedges to tone down the sharpness of the news. The study has been able to show that to a large extent, there are similarities between the diagnostic news delivery strategies employed in Western hospitals as studied by Maynard and those used in Nigerian hospitals. But it has also revealed that the mitigation of diagnostic news through veils and hedges is more of the feature of news delivery in Nigerian than in the Western hospitals. The table below demonstrates this:

		Western Hospitals	Nigerian Hospitals
1.	Assertions	+	+
2.	Evidence	+	+
3.	Mitigations	?	+

**Table 2: Pragmatic Strategies of Diagnostic News Delivery in Western and Nigerian Hospitals**

We have thus far been able to show that a study of pragmatic strategies of diagnostic news delivery aids a better understanding of hospital interactions and provides insights into doctors' verbal output in diagnostic meetings. Further research can compare these strategies with those observed both in other parts of Nigeria to see how intra-national, ethno-cultural variation influences announcement of diagnosis, and those observed in other hospitals, especially in Africa, where English serves as an official language of hospital interaction.

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