International Journal of English Research
ISSN: 2455-2186; Impact Factor: RJIF 5.32
Received: 03-11-2018; Accepted: 05-12-2018
www.englishjournals.com
Volume 5; Issue 1; January 2019; Page No. 12-19

Themes in medical discourse: A discourse pragmatic approach

Adewale Kazeem Ayeloja[1], Moses Akanbi Alo[2]
[1] Ph.D Student, Department of English, University of Ibadan, Nigeria
[2] Professor, Department of English, University of Ibadan, Nigeria

Abstract
Medical discourse features a discussion of issues pertaining to language use in medical contexts. It usually focuses on providers and patients' efforts to unravel patients' medical challenges, with a view to proffering solutions to them. In the course of their interaction, they deploy certain pragmatic principles of utterances interpretation which enable them to make their discourse a result-oriented one. The conceptual framework adopted for this study is discourse pragmatics. So, this study examined the deployment of the tools of discourse pragmatics during clinical interviews between doctors and patients at the University College Hospital, Ibadan, Nigeria. The purpose was to understand how the interlocutors were able to achieve the various communicative goals through the use of language i.e. manage conflicts arising from different expectations and imbalance in power and knowledge schemas between doctors and patients, put across messages indirectly or directly, and observe the phases in the consultations. Sections of the data that reflected ample use of pragmatic cues were purposively selected. The analysis was based on the concept of discourse pragmatics. Each of the medical discourse themes performed a number of pragmatic functions: asymmetry, portrayed the imbalance in power and knowledge schemas between doctors and patients; routine was deployed to observe the various phases in consultation; misalignment showed how conflicts arising from divergence in knowledge and power schemas between doctors and patients were resolved; directness revealed how doctors and patients determined the appropriate level of directness required to formulate a particular speech act and; indirectness graphically illustrated how the patients made candidate diagnosis and sought a diagnosis without explicitly asking. An appropriate comprehension of the application of discourse pragmatics to medical discourse themes will enhance the understanding of doctor-patient interactions.

Keywords: asymmetry, routine, misalignment, directness, indirectness

1. Introduction
Clinical interview involves patients and doctors conversing to unravel the medical challenges faced by patients with a view to finding medical solutions to them. The setting of the interlocution places certain roles at the feet of the two types of discussant involved here. The backgrounds of the interlocutors influence their beliefs that play out during the interaction and, despite the differences in their beliefs, they strive to cooperate in order to make the discourse a result-oriented one. The discourse is a task-focused one involving a number of stages, and doctors dictate the trend of the discourse.
The discourse demands skillful use of language because, given the context and goal of the discourse, it has to be used in a way that more messages are expressed than the spoken words sometimes. Words are used in a manner that both classes of interlocutors involved here decode the implicit meanings of utterances in order to ensure the success of the dialogue.

2. Literature Review
A number of scholars have worked on some of the dominant themes within the field of medical discourse. The studies drew on pragmatics, either explicitly and exclusively or implicitly and in combination with other frameworks of analysis. The scholars have explored the features of asymmetry in doctor-patient interaction but a lot of them focus on the "epistemic authority of medicine". One of such studies was carried out by ten Have (2003:253 cited in Martin 2014). In it, he explored power relations between doctors and patients. He reported on how doctors invite, allow or discourage patients from expressing their feelings. Other studies in this area have also how doctors maintain topic control and control over the phasing of sequences and how doctors control the type of knowledge admissible by a particular interlocutor during consultation (West 1983, Frankel 1984, Mishler 1984, Roberts 2000, Ariss 2009) [14, 2].
Additional studies in medical discourse that also drew on pragmatics include those of Drew (1991:38-39) that distinguished between patients having and using knowledge and simultaneously displaying "non-entitlement to that knowledge"; Lacoste 1981, Heath 1992 and Nijhof 1998 that demonstrated differing entitlements to that knowledge. The ability to judge when it is legitimate to use this knowledge is actually amongst the pragmatic challenges faced by patients during consultation. For instance, Lacoste (1981) [16] reported on a consultation in a French hospital between an elderly lady and a doctor, in which a type of boundary dispute occurred in respect of the knowledge admissible by the patient in the consultation, in this case the use of specialist medical terminology (Martin 2014).
Bliesener and Siegrist (1981) combined insights from pragmatics and medical sociology with conversation analysis to explore the function of routines in relation to managing the

conflict between patients' need for information and providers' institutionally driven work schedule in ward rounds in a German hospital. Similarly, Hobbs (2004) conducted a research in an obstetrics unit in a US hospital to track the professional realization of a resident over a period of nine months. Her case note analysis illustrated how residents became more concise and focused and also conformed to the formal and syntactic requirements of the genre, including about the assumptions about the ordering of information, what should be included or omitted, and about the nature of medical reasoning. Through this progression, the residents displayed growing pragmatic awareness. (Hobbs 2004). The works mostly adopted a microanalytic approach involving detailed analysis of transcripts of single encounters, particularly between patients and doctors.

3. Asymmetry

Doctors and patients operate on different wavelength during consultation. This results from the extant asymmetries of power and knowledge between them, and reveals how patients' verbal behaviours are linked to their perceptions of provider role and authority (Martin 2014). In the 1980s and 80s, the theme of medical control featured prominently in most doctor-patient interaction. Research on nurse-patient has also revealed that, in conformity with instrumental and institutional requirements, nurses may also seek to control the interaction; they could determine when and how topics introduced by patients are attended to (Jones 2003).

Studies by scholars like Ainsworth-Vaughn (1995) [1], Stivers and Heritage (2001) [19] and Ketunnen, Poskiparta and Gerlander (2002) [15] on doctor-patient and nurse-patient interactions have confirmed that patients are more than just passive observers in the consultation as they opine that patients, just like other care-givers, have recourse to the same power strategies i.e.: interruption and elicitation, although they might be realized differently (Martin 2014).

3.1 Routines

Routinised activities centre around history taking, ward round case note, diagnosis, and recommendation or treatment. All these roles are performed by providers with the institutional requirements and restrictions. The patients on the other hand also play a role by either being cooperative or not, a reality that could earn them the label "good patient" or "bad patient".

Medical consultation is carried out through defined task-focused phases. In the process, medical data are got through extended and predominantly close-ended answer and question sequences, which are then analysed to unravel patients' health challenges, with a view to proffering a solution to them. The providers determine when the consultation begins and ends. As a result of the patients' lack of medical knowledge, they may struggle to understand the purpose of long and seemingly disconnected sequence of questions. In such situations, patients may remain taciturn if they do not grasp the meaning of a particular question in order to appear cooperative. Equally, patients might, by virtue of prior socialization, be familiar and complicit with these routines and be suitably economical in their answers to elicitation, thereby demonstrating the necessary pragmatic competence (Barry *et al*., 2001; Heritage, 1997).

At the most basic level of pragmatics, patients learn to understand the illocutionary force of conventionalized pre-closings such as Have you any other complaints? and to respond appropriately i.e. understanding that the doctors' closing question is not a request to topicalise additional complaints, and that doctors do not anticipate affirmative answers. Using insights from pragmatics, albeit intuitively, doctors, while managing conflicts between patients' need for information and doctors' institutional work schedule, engage in "inhibitory routine" and "reactive routines" to block the patients' initiative to influence the agenda. Consequently, this enables the doctors to continue with their work, while the patients resign to fate (White *et al*., 1997; Robinson, 2001).

Pragmatically speaking, patients demonstrate sensitivity to the structure of consultation and strive within the sequential structure of conversation to present their complaints without disrupting doctors' information gathering. Both doctors and patients use compliments for different pragmatic purposes. Patients deploy compliments as a resource that allows their preferences or wishes to be known in situations where they do not consider themselves entitled to express them directly or to covertly participate in the decision-making process (Martin, 2014).

3.2 Misalignment

Misalignment results from the conflict between the biomedically grounded "voice of medicine" brought by doctors to the consultation and the socially grounded "voice of the lifeworld" brought by patients. Patients and doctors have different expectations regarding the control and organization of consultation, and this can create opportunities for a conflict in interactive frames, in other words, the meanings speakers attach to what they say and, with this, pragmatic understandings (Mishler, 1984; Todd, 1984; Tannen and Wallat 1993).

Patients' health complaints may not be attended to either because the doctors do not understand what the patients say or just choose not to respond to them because they are considered unimportant. The biomedical understanding of diseases places premium on what is visible as "credible, measurable and neutral". Consequently, doctors' gaze may be focused on the physical body alone without taking cognizance of its social context (Martin, 2014).

The divergence in knowledge schemas between doctors and patients most times bring about conflicts. What patients or patients' relatives consider important may be considered unimportant by doctors. So, a particular complaint of a patient may be ignored while doctor concentrates on observable symptoms. A phenomenon like this may cause patients to interrupt doctors with questions, and the doctor may consequently be forced to shift between the examination frame and the consultation frame. Further causes of misalignment include: (i) symptoms having different meanings to doctors and patients, (ii) the deployment of specialist versus non-specialist terminology generates interwoven areas of conflict and (iii) doctors' objective, analytic focus and the subjective, emotional orientation of patients (Martin, 2014).

3.3 Indirectness and Directness

Requests for information, delivery of diagnosis or judgements on patients' health, and recommendation about treatment or lifestyle require both doctor the doctors and the patients to determine the appropriate level of directness or indirectness required to formulate a particular speech act. Such decisions are determined by the interlocutors' orientation to extant power and knowledge asymmetries, perception of role-based authority, expectations regarding the routines of the consultation and with reference to socio-demographic factors. So, when patients desire to obtain doctors' evaluation, they downgrade any personal certainty that they may have about their ailment and its cause. However, when their explanation does not require doctor assessment, they do not downgrade their certainty (Martin, 2014).

At other times, too, patients engage in candidate diagnosis and seek a diagnosis without explicitly asking. This they achieve through the deployment of declarative sentences and embedded questions. Patients employ this method to avoid assertiveness which may challenge the doctors' professional face, interrupt the routine and cause conflict. However, when the opposite is the case, the doctors may challenge the patients' unprofessional face. It is clear from the above discussions that both the doctors and patients demonstrate pragmatic competence during clinical interviews (Cegala, 1992; Heath, 1992) [5, 11].

Arosson *et al*. (2014) also reveals the deployment of indirectness in paediatric consultations is uncommon. At other times, too, clear directives with conventional politeness marker such as "please" are addressed to children, "Now, will you please take off the sweater" (Aronsson and Rundstrom 1989: 488). The authors hint that much premium is not paid to children's bodily privacy like that of adults, and there is a lesser need for circumlocutory courtesy as doctors embody both medical and adult authority. Doctors also succeed in managing medical authority without challenging parental authority: the direct way of addressing children about topics which implicate their parents i.e. recommendations about food or hygiene. This represents an indirect, less threatening way of addressing parents. Importantly, the authors stress the need to understand appropriate choice of politeness strategies in terms of sequencing: doctors resort to more direct methods when they perceive that negative politeness is not working (Aronsson and Rundstrom 1989 p. 502) [3]. The theoretical framework adopted for this study is discourse pragmatics as used by Gill Martin, 2014.

4. Methodology

The data for the study was got from the University College Hospital, Ibadan, Nigeria. Verbal interactions between 10 doctors and 50 patients were tape-recorded. Thereafter, the recorded interactions were orthographically transcribed. Extracts that had ample pragmatic cues were purposively selected and subjected to discourse pragmatic analysis. The conceptual framework adopted for this study is discourse pragmatics.

5. Data analysis and discussion

In this section, analyses of the identified themes in medical discourse which manifest in the interactions under study are carried out, and their pragmatic implications are also discussed to highlight how the doctors and patients orient to pragmatics. The following abbreviations are used: Doc, for doctor; Pt., for patient; and Pt. Rel., for patient's relative. Some portions of the extracts are emboldened for the purpose of emphasis.

5.1 Asymmetry

Portrays the power and knowledge imbalance that exists between doctors and patients; portrays how doctors dominate the control of consultation; demonstrates how patients have recourse to the same power strategies as the doctors through the use interruption and question.

Excerpt 1

Doc.: Why did you come this morning?
Pt.: I have problem with my teeth.
Doc.: What kind of problem?
Pt.: Two of my teeth here -Two of my teeth are shaking as if they will remove. They are removing from inside. Two of the teeth have come out but they are not of the same level. So, it gives me pains.
Doc.: Is there any pain apart from that one?
Pt.: No.
Doc.: What kind of pain do you feel? Is it sharp or is it a severe pain? Is it a mild pain? What kind of pain?
Pt.: The pain is just there. It is not very sharp. It's just paining me any time I am talking.
Doc.: Does it come and go?
Pt.: It is always there. I feel the pain anytime I am eating
Doc.: Only when you chew, abi?
Pt.: Yes.

The excerpt above illustrates how Doc. dominates the consultation. The sequence of question and answer shows that Doc. dictates the trend of the conversation as he alone uses question while the patient responds by using declarative statements alone. The difference in the power and knowledge schemas between the doctor and the patient informs the role played by the interlocutors here. As an authority in medicine, Doc. is saddled with the responsibility of unraveling the patient's medical challenges and proffering solutions to them. Therefore, he is bound to diagnose the patient's ailment by interviewing the patient while the latter releases the information demanded to make a diagnosis. Both the doctor and the patient demonstrate pragmatic competence by restricting themselves to the roles ascribed to them by virtue of their positions, thus making the clinical interview a success. Doc. functions here as a + Higher role occupant while Pt. functions as a -Higher role occupant.

Excerpt 2

Doc: What are your complaints?
Pt.: I have a pain here (Pointing to his mouth).
Doc.: Is it your upper or lower jaw?
Pt.: Lower jaw. I have done a test (Shows Doc. an X-ray).
Doc.: No problem. The X-ray is different. The X-ray - I will look at it. But then I need to ask you some questions and you have to like – give me the honest answers so that I can make my own impressions and I will look at the X-ray and I can tell

you ----- do you understand. So, I'm sorry I'm going to start asking you questions afresh.
Pt.: Ok.
Doc.: You say you have pain in your teeth. Where?
Pt.: The lower jaw?
Doc.: The lower jaw. When did it begin?
Pt.: Ammmh. I think about two or three weeks ago.
Doc.: Two or three weeks ago. Has it been constant or it has been coming and going?
Pt.: Constant.

The excerpt above illustrates another aspect of power and knowledge imbalance between Doc. and Pt., particularly in relation to Doc. ignoring Pt.'s complaints while he focuses his attention on other symptoms considered more important to unraveling Pt.'s health problem as medical practice demands. As evident in the emboldened extract above, Doc. carefully brushes aside Pt.'s information about X-ray to enable him concentrate on the examination frame in order to appropriately diagnose Pt.'s ailment. This incident forces Doc. to shift between the examination frame and consultation frame. Doc.'s tacit refusal to respond to Pt.'s complaints and Pt.'s concurrence with Doc's implicit demand in the emboldened extract above confirm the interlocutors' pragmatic competence. Pt. further demonstrates pragmatic understanding by not feeling offended because Doc. ignores her complaints.

Excerpt 3
Doc.: Does she know about your hepatitis status?
Pt.: Yes. I told her about it.
Doc.: Since there is nothing to hide, let her also do the test. Then if she is negative, then she can take immunization, and she will be protected for life. You understand.
Pt.: Yes.
Doc.: And if she tests positive, there is no problem.
Pt.: You mean there is a vaccine for it?
Doc.: Yes. There is a vaccine against hepatitis. Anybody that is hepatitis B negative can take vaccine – three doses. If you come first, we give you one. Then, in a month's time, we give you another one, and then in six months' time, we give you another one. Those three doses will give you a life-time immunity. So, if she's negative let her get immunized.

Pt.: **Can't I also take the vaccine?**
Doc.: No. Once you are hepatitis B positive, you cannot take the injection because you already have the disease. Before one gets the disease, one can get immunized. It's like giving a little dose of this virus in the – non-infective style. I don't know how to explain it. It's like when you immunize someone against TB. It's like giving a person a little dose of that infective substance so that the body should develop immunity against it.
Pt.: That's wonderful.
The excerpt above illustrates another aspect of asymmetry that shows Pt. also has recourse to the same power strategy as Doc. The emboldened questions of Pt. above prove that deployment elicitation during clinical interviews is not the exclusive preserve of doctors. Therefore, patients too can also ask doctors questions or interrupt them to seek clarifications. In the two elicitation instances above, Pt. employs them to seek clarification on the availability of a vaccine for Hepatitis B and whether he too can, even though infected, can take Hepatitis B vaccine. Doc.'s comprehension of the illocutionary force of the elicitations is confirmed by his response to the questions.

5.2 Routine
Portrays offer of concessions and promises; portrays methodology for getting medical data; portrays how doctors and patients start and end consultation; portrays patients' familiarity with routines; portrays patients' comprehension of the illocutionary force of conventionalized pre-closing by doctors; portrays how doctors ignore some of patients' complaints to concentrate on observable symptoms.

Excerpt 1
Doc.: What is your complaint?
Pt.: I feel a burning sensation on a side of my head as well as cramps in my feet.]
Doc.: Have you done blood pressure test?
Pt.: No.
Doc.: You will go to do some tests that I will recommend now. Bring the results to me when they are out.

Routine is also sometimes enacted through Doc. ignoring some of the complaints of Pt. while concentrating on observable symptoms. This happens when doctors view Pt.'s complaints as mere symptoms of the main ailment. Hence, in the extract above, Doc. ignores Pt.'s complaints and directs his attention to the actual suspected ailment (high blood pressure) as evidenced in Doc's accompanying response. Pt. expects Doc. to address the complaints - chest pain, headache, burning sensation in the stomach and on one side of her head, and cramps in the feet -, but Doc. recommends a blood pressure test instead. Here, Doc. displays pragmatic competence by not responding to Pt.'s complaints and Pt. also gets the unspoken message i.e. Pt.'s complaints are not the main ailment.

Excerpt 2
Doc.: Is it your upper or lower jaw?
Pt.: Lower jaw. I have done a test (Shows Doc. an X-ray).
Doc.: No problem. The X-ray is different. The X-ray - I will look at it. But then I need to ask you some questions and you have to like – give me the honest answers so that I can make my own impressions and I will look at the X-ray and I can tell you ----- do you understand. So, I'm sorry I'm going to start asking you questions afresh.
Pt.: Ok.
Doc.: You say you have pain in your teeth. Where?
Pt.: The lower jaw?
Doc.: The lower jaw. When did it begin?

The patient in the extract above has a problem with one of her teeth. During the previous visit, she was asked to go for an X-ray of the affected tooth. Now, she tries to show it to the doctor but he feels it is best for him to complete the consultation frame before coming to the examination frame, hence the enactment of the routine in the form of Doc's offer of a promise (emboldened in the extract above) to ensure the

success of the consultation. The two interlocutors orient to pragmatics here as the consultation frame continues without any challenge from the patient.

Excerpt 3
Pt.: Ok. I just stopped when I felt I was okay.
Doc.: Continue taking them. Your blood pressure is only a little high -144 /100. I think it's a reflection of the fact that you are not taking your drug.
Pt.: I will start taking it again.
Doc.: It's very important. One tablet of moduretic a day is not too much.
Pt.: Thank you.
Doc.: What other complaint do you have?
Pt.: There is none again.
Doc.: You look younger than your age.

Routine is also regularly enacted when doctors want to end consultation by insincerely asking whether patients have any other complaints, as can be seen in the emboldened interrogative in the extract above. Pt. got the pragmatic implication of Doc.'s interrogative and consequently responded appropriately by saying "There is none again". Pt.'s pragmatic orientation helps him to understand that Doc's interrogative is not a request to tropicalize additional health complaints, but one meant to bring the consultation to a close. The pragmatic understanding demonstrated by Pt. beatifies Doc., hence his complimentary remark: "You look younger than your age." The pragmatic competence of the two interlocutors facilitates the coding and decoding of the information.

5.3 Directness
To seek medical information; to deliver diagnosis on patients' health: to give recommendations about health or lifestyle.

Excerpt 1
Doc.: (To patient) In what class are you now?
Pt.: Primary One.
Doc.: Primary One. Good girl. How many times do you brush in a day?
Pt.: On time.
Doc.: Just once. Who brushes for you?
Pt.: Myself.
Doc.: Yourself? She shouldn't be brushing herself at six. (Challenging Pt. rel.'s face)

Directness is usually employed for elicitation of medical data, especially where Pt. is a child. As can be seen in the above excerpt, Doc. goes unswervingly to the objects of his investigation, and Pt. responds to the questions appropriately. Pragmatically speaking, both the Doc. and Pt. understand the need for deployment of directness in the interrogation and response and cooperate to enable Doc. make a diagnosis. In addition, Doc. challenges Pt. Rel., sing directness, when Pt. tells him he brushes himself. So, directness is employed, even though Pt. Rel. is an adult, to register Doc.'s annoyance over Pt. Rel.'s abdication of her responsibility given the age of Pt. Both Pt. and Pt. Rel. understand the pragmatic implication of Doc's utterance and accept the blame for the impropriety of their action by not saying anything in response.

Excerpt 2
Doc.: Have you collected the medical test result?
Pt.: Yes. I was around last week but I was told to come back this morning.
Doc.: Ok. (Collects and looks at the test result.) The result is saying that there are three things we tested for. There are three different types of antibodies and antigens that will show the state of the infection - if it is a highly infectious stage or it is just a quiet stage. [Studies the result.] So, what your result is just saying is that you are in the carrier phase. You are just a carrier. There is nothing that is going that is actually showing that the virus is multiplying. So, it is just in a quiet stage. The envelop antigen is negative. The core antigen is also negative. It is only the antibody to the envelop antigen that is positive. That means that your body actually reacted to that virus, trying to develop some negative ability virus. So, I don't think there is any reason for you to be afraid. The only thing is that you have to take care. Try to stop alcohol if you can. Stop it. You should also avoid taking drugs not recommended by a doctor.

Pt.: Ok. I drink a lot.
Doc.: You have to stop it.

As observable in the emboldened extract above, Doc. is unswerving in his interpretation of the medical test result and the need for Pt. to adjust his lifestyle in view of the recent discovery about his health status. Doc. adopts directness here for the purpose of clarity as the information about Pt.'s state of health and the recommended change of lifestyle is germane to Pt.'s continued well-being and avoidance of health crises. Pt.'s pragmatic orientation enables him to understand both the implicit as well as the explicit messages of Doc. In spite of the employment of directness by Doc., messages about the need to avoid health crises and untimely death are not captured, but pragmatics comes to the rescue here.

Excerpt 3
Pt.: You mean there is a vaccine for it?
Doc.: Yes. There is a vaccine against hepatitis. Anybody that is hepatitis B negative can take vaccine – three doses. If you come first, we give you one. Then, in a month's time, we give you another one, and then in six months' time, we give you another one. Those three doses will give you life-time immunity. So, if she's negative, let her get immunized.
Pt.: Can't I also take the vaccine?
Doc.: No. Once you are hepatitis B positive, you cannot take the injection because you already have the disease. Before one gets the disease, one can get immunized. It's like giving a little dose of this virus in the – non-infective style. I don't know how to explain it. It's like when you immunize someone against TB. It's like giving a person a little dose of that infective substance so that the body should develop immunity against it.
Pt.: That's wonderful.
Doc. adopts directness in the emboldened extracts in the excerpt above to categorically state the class of people that can take Hepatitis B vaccine. Doc. employs it here to avoid

ambiguity and to underscore the need for Pt.'s wife to get tested and be immunized if she tests negative to Hepatitis B. Indirectly, Doc. has told Pt. he is not qualified for Hepatitis B vaccine as he is already infected. Pt. appears to have got the information clearly and he is ready to comply with Doc.'s advice, hence his concluding remark: "That's wonderful." So, the Doc. and Pt. demonstrate pragmatic competence in their release and reception of information.

5.4 Indirectness

For engaging in candidate diagnosis: to implicitly seek a diagnosis: to avoid assertiveness in order not to challenge doctors' professional face, to deliver diagnosis on patients' health or recommendation about lifestyle.

Excerpt 1

Doc.: And you feel better.
Pt.: Yes. I feel better.
Doc.: Do you take sweet?
Pt.: Ehn. Like parago or chew gum.
Doc.: You chew it.
Pt.: Yes. I chew it (laughs)
Doc.: But don't you think you should leave sweet for children considering your age and the fact that sweet is not good for the teeth?
Pt. (Laughs) Yees. I try hard to stop it but I'm too used to it. I use mouthwash.

Doc. employs indirectness in the emboldened extract above to suggest a change of lifestyle. Doc. observes that continued chewing of chew gum is injurious to Pt.'s dental health but Pt. has not realized the danger inherent in such a way of life, hence the recommendation. Doc. demonstrates he is an expert in pragmatics by employing indirectness in giving the recommendation, and Pt. also demonstrates a complementary pragmatic competence by answering in the affirmative, showing she understands the pragmatic implication of Doc.'s emboldened comment i.e. stop chewing gum for the sake of your health.

Excerpt 2

Doc.: Good morning. What health complaints do you have?
Pt.: I have a headache.
Doc.: Don't you have high body temperature?
Pt.: No.
Doc.: Any other complaints?
Pt.: I also experience general body weakness.
Doc.: I am going to recommend some drugs for you.

The emboldened extract above reveals the deployment of indirectness give candidate diagnosis. Pt. employs this method because she alone knows what she feels which she wants Doc. to tell her and treat her for. Here, Pt. is indirectly asking Doc. to give her drugs for headache. Doc. understands the pragmatic implication of Pt.'s statement but suspects headache might not be the main problem, hence Doc.'s subsequent elicitations before prescription.

Excerpt 3

Doc.: Have you done blood pressure test?
Pt.: Yes.
Doc.: What are your complaints?
Pt.: I only came to know whether I am medically fit now.
Doc.: Your blood pressure is good now. Therefore, your hypertension drugs will be reduced and you will come back next for a review. Bring out your drugs. Stop taking this and this, but take one of this daily.)
Pt.: Thank you.

Pt. suspects she has elevated blood pressure but she doesn't want to be assertive to avoid challenging Doc.'s professional face. So, instead of saying she has elevated blood pressure, she simply says she only came to know whether she is medically fit. Her pragmatic competence informs her decision to be indirect in seeking a diagnosis. If she had said she had elevated BP, Doc, could have queried how she got to know that. Doc. understands the pragmatic implication of Pt.'s statement emboldened above and, consequently, reveals Pt.'s blood pressure is normal now and also recommends a reduction in her drug intake till the next hospital visit. Pt. is satisfied by Doc.'s pragmatic understanding, hence her expression of gratitude at the end of the extract.

5.5 Misalignment

Portrays the conflict between the medically grounded voice of medicine and the socially grounded voice of the lifeworld; shows how doctors ignore patients" complaint while concentrating on observable symptoms; portrays the deployment of specialist terminologies by doctors versus deployment of non-specialist terminologies by patients; portrays divergence between doctors' objective and analytical focus and patients' subjective and emotional orientation; portrays patients' and doctors' differing expectations during consultation.

Excerpt 1

Doc.: What is your complaint?
Pt.:I have serious chest paint and I also feel a burning sensation in my stomach. I also feel a burning sensation on a side of my head as well as cramps in my feet.
Doc.: Have you done blood pressure test?
Pt.: No.
Doc.: You will go to do some tests that I will recommend now. Bring the results to me when they are out.

During clinical interviews, patients present their complaints from subjective and emotional vista while doctors examine them from objective and analytical point of view. As evident in Pt.'s emboldened contribution in the above excerpt, Pt. can't but present her complaints subjectively and emotionally as she is not a medical expert. Similarly, Doc., too, can't but examine Pt.'s complaints from a professional point of view. As can be seen in Doc.'s contributions above, through an objective analytical assessment of Pt.'s complaints, Doc. has seen that the main ailment of Pt. is not contained complaints, hence his first question in the excerpt under study: Have you done blood pressure test? Doc.'s medical knowledge enables him to know that Pt.'s complaints are symptoms of hypertension. Consequently, Doc. recommends some tests to investigate and confirm the real ailment Pt. suffers from. This is confirmed in Doc.'s final contribution in the extract.

Ordinarily, Pt. wants Doc. to base his recommendation or treatment on her subjective and emotional complaints: headache, burning sensation in the head, and cramps in one foot, but Doc. thinks and acts otherwise as result of his medical orientation. Contrary to Pt.'s expectation of drug recommendation, Doc. recommends some tests instead.

Excerpt 2

Doc.: This type of itching has nothing to do with the liver. The kind of itching that the liver problem causes is on the skin. It is generalized. It is not restricted to any part. What could be causing itching on your palm could be some kind of allergies. Probably you come in contact with something that irritates your palm and then itching results. That might be an allergic thing. But if you are talking about a disease, it will affect the whole system - systemic- not just localized.
Pt.: So, with this kind of situation now, should I - since I started coming here, I have stopped having any sexual contact with my wife just to know my fate because I don't want her to catch the infection.
Doc.: Ok. The thing about hepatitis B is that it can actually be sexually transmitted the same way HIV is transmitted. In addition, if gets blood product from an infected person or if one share a sharp object with an infected person, one could have - needles, blades etc. In fact, it has been said that the virus in hepatitis B stays longer on objects than that in HIV. May be about 30 minutes, the HIV virus will have died but that of hepatitis B can stay alive for months. So, it's better to have your own clipper, blade etc.

Pt.: That's another area.
Doc.: Has your wife been tested for Hepatitis B?
Pt.: No.
Doc.: Let her do a test. Let her know her own status as well. You never can tell whether she's negative or positive. You understand. Also, we have barrier methods like condom.

The medically "grounded voice of medicine" and the "socially grounded voice of the lifeworld" operated under by doctors and patients respectively during clinical interviews dictate the trend of their contributions. The patient in the above excerpt suffers from hepatitis B and, out of love to avoid infecting the wife he so much loves, avoids having sexual intercourse with her. Pt. adopts this measure out of his experience in the lifeworld not knowing that the disease, apart from being sexually transmissible, can also be contacted through many other means i.e.: sharing a sharp object used by an infected person, contact with spots infested with hepatitis B virus, unscreened blood infusion, etc. However, the medically grounded voice of medicine operated under by Doc. holds a contrary view as can be seen in Doc's emboldened contributions above. In addition, the medically grounded voice of medicine enables to counsel Pt. appropriately on the need for the wife to get test to know her hepatitis B status. The pragmatic implication of Doc.'s contribution is that abstinence from sex is inadequate for protection against hepatitis B. The deployment of misalignment here also performs the pragmatic function of portraying the divergence between doctors' objective and analytical focus and patients' subjective and emotional orientation.

Excerpt 3

Doc.: What health complaints do you have?
Pt.: I have live disease.
Doc.: Do you know what is called liver disease?
Pt.: I don't know.
Doc.: And you didn't bother to find out, uhn? Liver disease is called hepatitis.

Pt.'s emboldened contribution in the excerpt above constitutes an instance of candidate diagnosis and also portrays the divergence between doctors' objective and analytical focus and patients' subjective and emotional orientation. Doc.'s emboldened elicitation in the same excerpt confirms the impropriety of Pt.'s assertion. In Pt.'s subsequent contribution, she complains about blood stain during sexual intercourse and this makes her to erroneously think she has a problem in the liver. Doc. understands the pragmatic implication of Pt.'s utterance – self- diagnosis to quicken treatment-, but she is wrong. This makes Doc. challenge her in his final contribution in the excerpt above. In addition, the excerpt also features a conflict between Doc.'s professional viewpoint and the unprofessional vista of Pt.

6. Conclusion

This study has examined certain themes in medical discourse from discourse pragmatic perspective. The work has revealed the non-natural meanings derivable from doctors and patients' verbal contributions during clinical interviews. The deliberate deployment of pragmatics enabled the interlocutors to mean more than what they say. Thus, it enhanced the communication greatly. In addition, purely because the interactions were formal, the difference in knowledge and power schemas between the two classes of interlocutors influenced and controlled their contributions.
In the interactions analysed, asymmetry signalled divergence in knowledge and power schemas between doctors and patients; routine portrayed patients' comprehension of the illocutionary force of conventionalized pre-closing by doctors and also indicated offer of concessions and promises; directness indicated elicitation of medical data and delivery of diagnosis; indirectness depicted avoidance of assertiveness to avert challenging doctors' professional face as well as attempts to engage in candidate diagnosis; and misalignment portrayed the difference between the medically grounded voice of medicine and the socially grounded voice of the lifeworld brought by doctors and patients respectively to the consultation. The examination of pragmatic cues in this type of discourse underscores the need to be alert to every such usage during clinical interviews in order to be sufficiently informed and be saved from being deceived by the surface meaning of their contributions.

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