Pragmatics of Healing Negotiation in Doctor-patient Interaction at a Nigerian University Teaching Hospital

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Abstract
The healing process entails interactions among hospital interlocutors-doctors and patients. However, in the Nigerian healthcare context, both literate and illiterate individuals often struggle with linguistic and pragmatic skills due to ignorance, linguistic multiculturalism and other factors peculiar to non-native speakers of English. This paper adopts an explanatory research design to capture and analyse authentic doctor–patient interactions in the Obstetrics and Gynaecology unit of a Nigerian University Teaching Hospital. Audio recordings were made of eleven purposively selected consultations, representing 73% of the total doctors in the unit and they were orthographically transcribed to facilitate detailed discourse analysis. From the transcriptions, three excerpts comprising sixteen purposively selected exchanges were identified as the primary data for the study. A qualitative pragmatic approach was employed, with particular attention given to identifying instances of Gricean maxim violations—namely, Quantity, Quality, Relevance, and Manner in each of the turns in the excerpts. The analyses reveal significant patterns of pragmatic behaviour in a clinical context. A recurring theme is the frequent violation of Grice's Cooperative Maxims—particularly those of Manner, Quantity, and Quality—by both doctors and patients. These violations often resulted in communication breakdowns, diagnostic ambiguities, or superficial reassurances. The study recommends that the Nigerian Healthcare communication can be improved by training doctors in pragmatic and cultural sensitivity, encouraging explicit patient expression, using clear language, addressing power imbalances, employing interpretive tools, and documenting communication challenges, especially in low-literacy and multilingual settings.
Keywords: Pragmatics, Healing negotiation, doctor- patient discourse.

Introduction
In a hospital setting, healing transcends mere medical care as it involves a negotiated dialogue between physicians and patients. In the context of a university teaching hospital, doctors—licensed experts in medicine, surgery, dentistry, or veterinary practice—do far more than diagnose and prescribe. They engage in many structured pragmatic conversations not only to elicit symptoms and explain treatment options, but also to manage expectations, reassure anxieties, and involve patients actively in decisions about their own care. In this way, "healing" encompasses both medical expertise and pragmatic negotiations, whereby shared decision-making fosters trust and promotes recovery. Patients enter this process as either inpatients—whose conditions demand continuous, on-site supervision until stabilization—or outpatients, who seek consultation, testing, or follow-up visits without overnight admission. In both roles, successful "healing negotiation" depends on physicians' clear communication,

sensitivity to each individual's background and preferences, and willingness to address misinformation. Indeed, a patient's choice of words can guide or mislead a diagnosis, underscoring the physician's responsibility to listen attentively, clarify ambiguities, and tailor explanations to each person's needs.

In linguistic terms, such exchanges between doctors and patients constitute "discourse"—stretches of spoken or written communication that flow beyond single sentences. Doctor–patient discourse encompasses both verbal and non-verbal communication. Verbal interactions involve questioning, clarifying, and summarizing, while non-verbal communication includes gestures, touch, and active listening. Odebunmi (2005) explains that medical discourse serves both transactional purposes—such as diagnosis and treatment—and interactional purposes like relationship-building, depending on the context, participants, and medical concerns. Sometimes, interactional language (e.g., greetings) may even serve transactional goals by prompting disclosures about health issues.

Conversely, the reverse may be the case particularly in situations where doctors lack adequate communicative skills, which patients often find unsatisfactory (Tanner 1976; Myerscough1992). Although diagnosis and treatment are emphasized in medical training, communication has only recently gained attention in curricula, especially in Western countries. Shachar (2001) supports this trend, noting that some American medical schools now include humanities-based electives to improve communication. This approach is recommended for adoption in developing countries to close the communication gap between health professionals and patients.

According to the Annals of Family Medicine (2023), healing is defined as a "personal experience of wholeness emerging from suffering," and physicians become true healers by recognizing, alleviating, and helping patients transcend that suffering. This requires not only clinical skill, but also nuanced communication strategies. As Viswanath (2015) notes, the era of the physician as an unquestioned authority has given way to collaborative care: patients juggle careers, families, and time constraints, and thus must partner with doctors to craft treatment plans that fit their lives.

Grice's Cooperative Principle— "make your contribution as is required, at the stage at which it occurs, by the accepted purpose or direction of the talk exchange"—describes how interlocutors aim to achieve mutual understanding. Yet, in the Nigerian healthcare context, both literate and illiterate patients often struggle with conversational norms, flouting Grice's maxims of Quantity, Quality, Relevance, and Manner (Grundy 2000). While many studies of Nigerian hospital discourse have focused on inadvertent violations as communication breakdowns (Abiola et al., 2004; Adegbite, Odebunmi 2006: Wodak, 2006; Fleisher et al., 2009), few have explored the delib erate flouting of maxims as a strategic tool in healing negotiations.

This study addresses that gap by examining the types maxims flouted in doctor-patient discourses of Obstetrics and Gynaecology unit of a Nigerian Teaching Hospital; establishing why physicians in the Obstetrics and Gynaecology unit of the teaching hospital strategically flout Grice's maxims during consultations. This is done with a view to understanding how doctor-patient pragmatic choices influence the treatment of patients and the healing process on the long run.

Grice's Cooperative Principle and Its Pragmatic Relevance

Pragmatics is a branch of linguistics that investigates the ways language is tied to the contexts in which it is used. As this definition indicates, pragmatics coalesces as a distinct and coherent domain of inquiry only in relation to the study of language abstracted from its use in context, which has been the prime focus of both twentieth-century linguistics and philosophy of language (Slotta, 2021). To Slotta et al., (2021), the concept of pragmatics emerges at the convergence of two philosophical schools: American pragmatism and logical positivism.

Herbert P. Grice's Cooperative Principle, introduced in 1975, is a foundational theory in the field of pragmatics that explains how participants in conversation work collaboratively to ensure effective communication. Grice proposed that human dialogue is not random or disjointed but rather guided by a mutual, often unspoken understanding of how contributions should align with the goals of the exchange. This understanding is expressed through four conversational maxims: Quantity, Quality, Relevance, and Manner (Aynnon 2018 Reference). These maxims function as guiding principles to regulate how information is shared and interpreted during conversations.

The **Maxim of Quantity** dictates that a speaker should provide as much information as is needed—no more, no less. This principle ensures that conversations are informative without becoming overwhelming or deficient. For instance, when asked for the location of a place, a response that precisely answers the question without unnecessary detail satisfies this maxim. Violations of this principle may result in confusion or the need for follow-up questions, undermining conversational efficiency.

The **Maxim of Quality** emphasizes the importance of truthfulness in communication. Speakers are expected not to say what they believe is false or to make statements without adequate evidence. This maxim serves to build trust and credibility between interlocutors. For example, asserting something based on conjecture or rumour would violate this maxim and potentially mislead the listener. Grice noted that even in casual dialogue, participants assume that others are trying to be truthful unless there is a clear indication otherwise.

The **Maxim of Relevance** (also called Relation) requires that all contributions to a conversation remain pertinent to the subject at hand. Responses should logically follow from prior statements, contributing to a coherent and linear progression of thought. This principle helps maintain focus and direction in discourse. A relevant answer supports the flow of conversation, whereas an irrelevant one can disrupt understanding or signal conversational disengagement.

The **Maxim of Manner** relates to the clarity and orderliness of expression. It requires that speakers avoid ambiguity and obscurity, be brief where appropriate, and present their ideas in an organized fashion. This principle is particularly important in contexts where precision and clarity are essential, such as academic or professional settings. The maxim ensures that language is used in a way that is both accessible and intelligible to the listener.

While these maxims describe ideal cooperative behaviour, Grice acknowledged that they are not always strictly followed. Speakers may flout a maxim intentionally to imply something beyond the literal meaning, a phenomenon known as implicature.

For example, a speaker might give an overly vague response to subtly express disapproval or sarcasm. Such violations are not communicative failures but rather nuanced strategies used to convey layered meanings or social cues. Listeners, recognizing the underlying cooperative framework, can often infer the speaker's true intent based on context and shared understanding.

In practice, violations of the cooperative principle occur regularly, especially in literature, film, humour, and everyday social interactions. These violations are often purposeful and serve specific rhetorical or pragmatic functions such as entertainment, politeness, persuasion, or irony. A character in a film might withhold information (violating Quantity) to build suspense or deliberately mislead (violating Quality) for dramatic effect. In real-world interactions, people may violate these principles to save face, avoid conflict, or navigate sensitive topics.

Despite such violations, the Cooperative Principle remains crucial to successful communication. It provides a conceptual framework through which speakers and listeners interpret meaning, manage expectations, and maintain mutual understanding. Communication is inherently social, requiring participants to align their contributions with the expectations of others. When these expectations are breached, interpretation becomes more complex but often more rich in meaning.

In sum, Grice's Cooperative Principle is a cornerstone of linguistic pragmatics, illuminating how implicit conversational rules facilitate understanding. While speakers may not always consciously follow its maxims, their communicative behaviours are often guided by these principles—whether to foster clarity or strategically create ambiguity. Thus, the Cooperative Principle not only enhances our grasp of everyday communication but also deepens our appreciation of the subtle interplay between language, context, and intention.

Implicature in Pragmatics

Implicature is a foundational concept in pragmatics that refers to meaning conveyed indirectly through speech, beyond what is explicitly stated. According to Archer et al. (2012), implicature is concerned with how listeners infer intended meaning from what is said, often relying on contextual cues and shared knowledge. Grundy (2008) similarly defines implicature as meaning that is suggested or implied, rather than directly expressed. For instance, the statement, *"The dress seems rumpled,"* may imply that the listener should iron it, though this action is not directly instructed. This highlights how implicature operates not through literal meanings, but through inference.

Grice, who first introduced the concept in his Cooperative Principle, posited that implicatures do not affect the truth conditions of propositions; instead, they rely on the assumption that speakers adhere to conversational norms. However, as Archer et al. (2012) note, a listener's interpretation may differ from the speaker's intended implicature. For example, when a speaker remarks, *"The weather is bad,"* they may mean that the listener should carry an umbrella, while the listener may interpret the comment as a suggestion to stay indoors or change attire. This variability underscores

that implicature is inherently inferential, and often ambiguous, depending on contextual interpretation.

Hutahaean (2020) expands on this, suggesting that implicature involves conveying more than what is said explicitly. This stems from the speaker's attempt to maintain cooperation and meaningful communication. As such, implicature is intimately connected to Grice's Cooperative Principle, where speakers rely on shared conversational norms to communicate implicit meaning effectively.

Politeness Theory in Pragmatics

Politeness, within pragmatic studies, refers to the strategic use of language to foster social harmony and avoid conflict. While the term can carry various cultural and situational connotations, pragmatic theories of politeness emphasize communicative strategies that serve to uphold interpersonal respect and cooperation (Nkirote, 2024). For instance, in formal contexts such as a dinner invitation in England, politeness might involve using expressions like *"please"* and *"thank you"* to demonstrate social decorum. However, the pragmatic understanding extends beyond etiquette to consider how speakers navigate face-threatening acts and maintain relational equilibrium.

Politeness, as described by Bacha et al. (2021), is a communicative strategy that minimizes friction in interpersonal interaction. Brown and Levinson (1987) frame politeness as a mechanism to soften threats to one's social "face"—a concept referring to a person's self-image in social interactions. Their theory presents politeness as a rational and strategic choice employed to mitigate potential threats in conversation. Other scholars offer complementary views: Arndt and Janney (1993) define politeness as interpersonal supportiveness; Nwoye, O. (1992) describes it as a linguistic device that promotes smooth communication; and Sifianou (1992) characterizes it as a set of social values that facilitate mutual expectations. Watts (2003) further juxtaposes politeness with impoliteness, suggesting that both are contextually dependent and culturally shaped.

The function of politeness is not uniform across cultures. While Western theories, such as those proposed by Lakoff (1973, 1975), Brown and Levinson (1978, 1987) and Leech (1983), emphasize individual agency in maintaining harmony, Eastern or non-Western perspectives often embed politeness in collectivist and hierarchical social structures. Therefore, politeness is best understood as a culturally contingent practice shaped by historical, ethnic, and societal norms.

Moreover, Fleischer et al. (2021) argue that in everyday communication, people often retain an overall impression of an interaction—whether it was polite or impolite—rather than specific utterances. This perception significantly influences social relationships and mutual understanding. Politeness, therefore, is not innate; it is learned through socialization within a particular linguistic and cultural community. It evolves as a social construct that reflects shared values and interactional norms.

Linguistic Politeness and Social Interaction

Linguistic politeness refers specifically to language-based strategies that individuals use to maintain social relationships and minimize interpersonal conflict. (Watts 2003)

points out that such politeness is interpreted pragmatically, revealing a speaker's attitude more through contextual inference than through literal semantic content. Yule (1996) similarly argues that linguistic interaction is inherently a social activity, and as such, politeness reflects broader social conventions.

Speakers often develop characteristic linguistic behaviours within their communities. For instance, if an individual is known for frequently expressing gratitude by saying *"thank you"*, their continued use of the expression helps maintain interpersonal harmony. A deviation from this expected behaviour may be interpreted as impoliteness (Watts, 2003). Thus, politeness is not merely about the use of specific words or phrases, but about fulfilling social expectations that maintain equilibrium in human relationships.

In sum, implicature and politeness are central to the pragmatic dimension of language. Implicature enables speakers to communicate efficiently and subtly, while politeness ensures that these communications are socially acceptable and maintain relational balance. Both concepts underscore the importance of context, shared norms, and cultural variation in effective human interaction.

Doctor-Patient Discourse

There are two kinds of communication in the medical context. They are: verbal communication and non-verbal communication. Non-verbal communication in the medical context can be achieved through body language, touch, feeling and active listening. Verbal communication on the other hand can be achieved through questioning, investigation, clarifying issues, paraphrasing, reflecting and summarizing. (Collins, 1983, p84). Discourse in the medical field is usually between doctors and patients, doctors and nurses; doctors and doctors; and nurses and patients.

Odebunmi (2003) opines that hospital interaction is tailored towards the transactional and interactional functions of language; it also uses speech acts which accompany these functions. The transactional function captures the business talk in the hospital such as investigating, diagnosing, giving prescription and treatment while the interactional function deals with interpersonal features such as establishing and cementing relationships, which may be casual, cordial or professional. He points out that the transactional or interactional role played by language in the hospital environment depends on the nature of the interaction. This depends on the kind of ailment being treated, the individual or interactants involved and the kind of information being sought in the encounter. He proposes that the interactional mode can be used to achieve a transactional result.

On the contrary, ordinary greetings can be used to get information about a patient's ailment. Tanner (1976) noted that lack of communication skills is one of the weaknesses of modern medicine. He contributed that medical communication plays a key role in the development of professional skills such as diagnosis and surgical procedures with the exclusion of the communicative skills needed by medical practitioners. Myerscough (1992:1) asserts that skilful communication should be learnt as a basic part of professional training. He states, however, that 144 most

patients usually complain about this aspect of doctors‟ professional competence. He opines that the teaching of communicative skills to medical students in Britain is a recent development. This is also supported by Shachar (2001) who affirms that the recently redesigned curriculum in some American medical schools includes electives in arts and literature. This latest inclusion of effective medical communication skills into medicine as a course in the developed countries should be adopted in developing countries in order to bridge communication gap between patients and health practitioners.

Methodology

The paper adopted an explanatory research design to capture and analyse authentic doctor–patient interactions within the Obstetrics and Gynaecology unit of a Nigerian University Teaching Hospital. Audio recordings were made of eleven purposively selected consultations, representing 73% of the total doctors in the unit. These recordings were orthographically transcribed to facilitate detailed discourse analysis. From the transcriptions, three excerpts comprising sixteen purposively selected conversational exchanges were identified as the primary data for the study. A qualitative pragmatic approach was employed, with particular attention given to identifying instances of Gricean maxim violations—namely, Quantity, Quality, Relevance, and Manner in each of the turns in the excerpts.

Strict practices regarding research were followed in this study to obtain information from the hospital under investigation. The researcher worked closely with the guidelines by Babcock University Research Ethical Committee (BUHREC) to obtain the needed approvals.

The following are the dimensions of pragmatic analysis of doctor–patient interaction, focusing on three core components of meaning-making:

i. **Literal Meaning**: The direct, surface-level semantic interpretation of each utterance.
ii. **Maxim Flouted**: Identification of any violations of Grice's (1975) Cooperative Principle, particularly the conversational maxims of Quantity, Quality, Relation, and Manner.
iii. **Implicature**: The inferred or implied meaning that arises when a speaker intentionally or unintentionally deviates from these maxims.

Data Analysis

Excerp1:

Exchange 1:

Doctor: I don't know if it is just my hand.
Doctor: Lump or thread?
Patient: Lump or thread.
Doctor: Like a swelling?
Patient: Like a swelling, like when I did appendix (citis) operation, those small small

lump something.
Doctor: Let me see. Down there? No problem. Leave it. It willll … Everything will dissolve.

Pragmatic Analysis of Each Turn
Exchange 1:
Patient: "There is small lump something there."

a. **Literal Meaning**: The patient attempts to report the presence of a small lump, though the location and nature are unspecified.
b. **Maxim(s) Flouted**:
    i. *Manner*: The utterance lacks syntactic clarity.
    ii. *Quantity*: Insufficient detail is provided.
c. **Implicature**: The patient likely intends to express concern and seeks the doctor's attention, despite struggling to articulate the issue clearly.

Exchange 2:
Doctor: "smaaaaaall!"

a) **Literal Meaning**: The doctor echoes the word "small," elongating it in a stylized or exaggerated manner.
b) **Maxim(s) Flouted**:
    i. *Manner*: The tone is ambiguous and potentially sarcastic.
    ii. *Relation*: The response does not further the patient's concern.
c) **Implicature**: The doctor may be trivializing or mocking the patient's complaint, thereby undermining the seriousness of the concern.

Exchange 3:
Patient: "lump something there."

a) **Literal Meaning**: A reiteration of the initial complaint, almost identical in form.
b) **Maxim(s) Flouted**:
    i. *Manner*: Repetition does not aid clarity.
    ii. *Quantity*: No additional or new information is introduced.
c) **Implicature**: The patient may feel unheard or misunderstood, and is repeating the concern in hopes of eliciting a more serious response.

Exchange 4:
Doctor: "I don't know if it is just my hand."

a) **Literal Meaning**: The doctor expresses uncertainty regarding the presence of a lump, implying it may be an illusion or tactile misperception.
b) **Maxim(s) Flouted**:
    i. *Quality*: A speculative statement is offered without investigative confirmation.
c) **Implicature**: The doctor might be attempting to deflect responsibility for a definitive diagnosis, possibly in order to downplay the complaint.

Exchange 5.
Doctor: "lump or thread?"

a) **Literal Meaning**: The doctor poses a dichotomous question, comparing the sensation to either a lump or a thread.
b) **Maxim(s) Flouted**:
    i. *Manner*: The metaphorical comparison ("thread") may be unclear or confusing to the patient.
c) **Implicature**: The doctor may be trying to simplify the diagnostic process, but risks further obscuring the issue through ambiguous analogies.

Exchange 6:
Patient: "lump or thread."

a) **Literal Meaning**: A direct repetition of the doctor's words.
b) **Maxim(s) Flouted**:
    i. *Relation*: The utterance contributes no new or clarifying information.
c) **Implicature**: The patient may not comprehend the doctor's question and echoes it either for clarification or due to confusion.

Exchange 7. Doctor: "like a swelling?"

a) **Literal Meaning**: The doctor attempts to reframe the description by offering a familiar medical term.
b) **Maxim(s) Adhered to**:
    i. The question is clear, relevant, and directly responsive.
c) **Implicature**: The doctor is attempting to assist the patient in articulating the symptom more precisely by using familiar language.

Exchange 8.
Patient: "like a swelling, like when I did appendix (citis) operation those small small lump something."

a) **Literal Meaning**: The patient likens the current issue to the physical sensations experienced after an appendectomy.
b) **Maxim(s) Flouted**:
    i. *Manner*: The sentence is grammatically fragmented.
    ii. *Quantity*: The utterance remains vague and lacks specific medical descriptors.
c) **Implicature**: The patient uses a personal health history analogy to facilitate understanding, anticipating the doctor will draw parallels and infer meaning from experience.

Exchange 9.
Doctor: "Let me see. Down there? No problem. Leave it. It willll … Everything will dissolve."

a) **Literal Meaning**: The doctor acknowledges the complaint, gestures toward an unspecified location, and provides verbal reassurance.
b) **Maxim(s) Flouted**:
    i. *Quality*: Offers a confident resolution without substantiating it.
    ii. *Manner*: Informal phrasing and ambiguous references ("down there," elongated "willll") weaken clarity.
c) **Implicature**: The doctor may be attempting to reassure the patient quickly, potentially to dismiss or close the topic without further examination.

Discussion

The discussion highlights key pragmatic challenges in clinical communication, particularly the frequent violation of the Maxims of Manner and Quality by the doctor. These lapses contribute to unclear and uncooperative interactions. The patient's difficulty in expressing concerns—likely due to limited medical literacy—and the doctor's vague or dismissive responses point to a power imbalance and a lack of patient-centred care. Overall, the exchange illustrates the critical need for clear, empathetic, and cooperative communication in medical setting.

Excerpt: 2

Exchange 1

Doctor: Do you have any complaint today, hunnnnn?

Patient: No, apart from... maybe because of the way I'm lying down *sha*, my back.

Pragmatic Analysis

Doctor: "Do you have any complaint today, hunnnnn?"

a) **Literal Meaning**: The doctor inquires whether the patient has any current complaints, adding the non-standard vocalization *"hunnnnn."*
b) **Maxim(s) Flouted**:
    i. **Manner**: The prolonged *"hunnnnn"* adds ambiguity and informality to the question, potentially softening or trivializing it.
    ii. **Relation**: The added vocalization may detract from the clinical purpose of the inquiry.
c) **Implicature**:
    i. The doctor might be using a casual tone to establish rapport, reduce tension, or subtly suggest that no complaint is expected. However, it also risks undermining the seriousness of the consultation, possibly signalling a lack of full attentiveness.

Exchange 2

Patient: "No, apart from... maybe because of the way I'm lying down *sha*, my back."

a) **Literal Meaning**: The patient initially denies any complaint but hesitantly mentions discomfort in the back, possibly attributing it to their lying position. The Nigerian discourse marker *"sha"* adds a tone of softening or non-urgency.
b) **Maxim(s) Flouted**:

i. **Quantity**: The patient provides minimal detail (no description of pain intensity, duration, or history).
ii. **Manner**: The utterance is hesitant, incomplete ("apart from… maybe…"), and informal.

c) **Implicature**:
i. The patient appears reluctant to raise a complaint, possibly minimizing their concern to align with the doctor's casual tone.
ii. The use of *"sha"* downplays the issue, implying that the discomfort may not warrant medical attention. This suggests a sociopragmatic strategy for not appearing overly demanding or exaggerating one's symptoms.

Discusion

This exchange reflects the subtleties of doctor–patient pragmatics, where informality and hedging serve interpersonal and sociocultural functions. The doctor's tone, marked by the elongated *"hunnnnn,"* may be intended to foster comfort but also sets a low-expectation tone for complaint reporting. The patient, responding within this informal frame, minimizes her concern through hedging and the discourse marker *"sha"*—a linguistic softener common in Nigerian English.

These pragmatic choices demonstrate how both parties collaboratively shape the tone of clinical discourse, yet also how **flouting the Maxims of Quantity and Manner** can obscure potentially important medical information. For effective care, especially in culturally nuanced settings, providers should remain aware of how tone and phrasing influence patient disclosure.

Excerpt: 3

Exchange 1

Doctor: Okay! But we can actually adjust it now, *hunnnnnn*. I guess it is because of a thing. But you have started walking around.

Patient: *Haa!* Yes now, I took my bath myself today.

Pragmatic Analysis of Each Turn

1. Doctor: "Okay! But we can actually adjust it now, *hunnnnnn*. I guess it is because of a thing. But you have started walking around."

a) **Literal Meaning**: The doctor responds affirmatively, suggests an adjustment is possible (presumably in relation to an earlier-mentioned concern), speculates vaguely about the cause, and notes that the patient has begun to regain mobility.

b) **Maxim(s) Flouted**:
i. **Manner**: The phrase *"because of a thing"* is vague and lacks referential clarity; the extended *"hunnnnnn"* again adds ambiguity or casualness.
ii. **Quality**: The speculative "I guess…" lacks evidential support.
iii. **Relation**: The discourse lacks coherence; the parts are loosely connected without clear logical progression.

c) **Implicature**:
i. The doctor is likely trying to reassure the patient and minimize concern, possibly downplaying the seriousness of the issue by avoiding medical jargon.

ii. The use of informal or imprecise language may reflect an attempt to build rapport, yet risks introducing ambiguity.
iii. The final comment, "you have started walking around," serves as a marker of progress, suggesting recovery is underway and further concern is unnecessary.

Exchange 2
Patient: "*Haa!* Yes now, I took my bath myself today."

a) **Literal Meaning**: The patient confirms the doctor's observation enthusiastically, emphasizing an independent activity (bathing oneself) as a sign of improvement.
b) **Maxim(s) Flouted**:
   i. **Manner**: The exclamatory *"Haa!"* and informal phrase *"Yes now"* are expressive but not standard clinical responses.
c) **Implicature**:
   i. The patient expresses pride and satisfaction in their regained independence, signalling personal validation of recovery.
   ii. The response aligns with the doctor's optimistic tone, reinforcing mutual understanding that the patient is improving.
   iii. The expressive tone may also serve to elicit positive reinforcement or praise from the doctor.

Discussion
This exchange is marked by a collaborative use of **informal and emotionally expressive language**, which serves to maintain rapport and foster a positive interactional tone. However, the doctor's use of vague expressions such as *"because of a thing"* and *"hunnnnnn"* reflects a **flouting of the Maxims of Manner and Quality**, potentially leading to a lack of clinical clarity. Despite this, the patient responds in kind—enthusiastically and informally—reinforcing the relational bond and emphasizing personal milestones in recovery.
Overall, this interaction demonstrates how violation of maxim may not hinder healing negotiation and how **shared pragmatic strategies**, including informal expressions and minimal technical detail, can serve affective and relational goals in clinical discourse, though at the potential expense of precise communication.

Excerpt: 3
Exchange 1
Doctor: Good morning. How are you today? Do you have any complaint?
Patient: *(No verbal response; likely non-verbal nod)*
Doctor: How is your tummy?
Patient: *(No verbal response heard)*
Pragmatic Analysis
1. Doctor: "Good morning. How are you today? Do you have any complaint?"

a) **Literal Meaning**: The doctor greets the patient, inquires about general well-being, and asks if there are any medical complaints.
b) **Maxim(s) Observed**:
    i. **All maxims (Quantity, Quality, Relation, and Manner)** are observed. The doctor is polite, clear, and offers relevant, appropriately detailed questions.
c) **Implicature**:
    i. The doctor seeks to establish rapport and encourage disclosure of symptoms. The sequential questioning aims to create a comfortable space for the patient to speak.

Exchange 2
Patient: ***(No verbal response; likely nod)***

a) **Literal Meaning**: The patient gives no verbal response; instead, non-verbal communication (a nod) is assumed.
b) **Maxim(s) Flouted**:
    i. **Quality**: Since no explicit verbal content is available, and a nod may be ambiguous, the principle of providing a clear and truthful contribution is violated.
    ii. **Quantity & Manner (implicitly)**: Insufficient and unclear input is given, particularly in a clinical context where precise information is essential.
c) **Implicature**:
    i. The patient may be nonverbal, shy, fatigued, cognitively impaired, or unsure how to respond. The nod may imply affirmation (e.g., "I'm fine" or "No complaint"), but the ambiguity necessitates interpretive effort from the doctor.
    ii. There is also a possible power dynamic at play: the patient may not feel comfortable speaking up, relying instead on passive or minimal responses.

Exchane 3:
Doctor: "How is your tummy?"

a) **Literal Meaning**: The doctor follows up with a more specific question about abdominal well-being.
b) **Maxim(s) Observed**:
    i. **Relation**: The question is clearly related to physical health.
    ii. **Manner & Quantity**: The language is simplified and concrete—perhaps adapted for the patient's comprehension level.
c) **Implicature**:
    i. The doctor likely interprets the earlier silence or nod as inconclusive and thus narrows the focus to a specific symptom area (the abdomen), hoping to elicit a clearer response.

ii. The informal word "tummy" may be used to match the patient's perceived linguistic level or emotional state, demonstrating empathetic adjustment in communication style

Exchange 4

Patient: ***(No verbal response heard)***

a) **Literal Meaning**: The patient remains silent.

b) **Maxim(s) Flouted**:

i. **Quantity**: Provides no information in response to a direct medical question.

ii. **Manner**: Silence creates ambiguity; the doctor is left to interpret meaning without cues.

c) **Implicature**:

i. The silence could signal discomfort, inability to communicate, passive resistance, or simply that the patient does not understand the question.

ii. Alternatively, the patient may be communicating non-verbally again (e.g., a facial expression or gesture), but such signals are absent or unnoticed in the transcript.

This exchange highlights the pragmatic challenges that arise when verbal and non-verbal communication diverge in clinical settings. While the doctor maintains clarity and relevance by observing Gricean maxims and simplifying language to foster understanding, the patient's minimal or non-verbal responses—such as nodding or silence—flout the maxims of Quantity and Manner, resulting in ambiguity and interpretive burden for the doctor. These patterns suggest possible factors such as shyness, discomfort, low health literacy, or power imbalance, which may inhibit open expression. Ultimately, the interaction underscores the importance of adaptive and empathetic communication strategies that accommodate patient silence while still ensuring diagnostic clarity.

Conclusion

The analyses of the various doctor–patient interactions reveal significant patterns in pragmatic behavior within a clinical context. A recurring theme is the frequent violation of Grice's Cooperative Maxims—particularly those of **Manner**, **Quantity**, and **Quality**—by both doctors and patients. These violations often result in communication breakdowns, diagnostic ambiguities, or superficial reassurances.

Doctors tend to use informal, vague, or overly simplified language, possibly as a strategy to build rapport, reduce patient anxiety, or manage time constraints. However, such approaches often compromise clinical clarity and risk trivializing the patient's concerns. Patients, on the other hand, exhibit hesitancy, ambiguity, and reliance on local discourse markers (e.g., "sha"), suggesting discomfort, low health literacy, or sensitivity to perceived power imbalances.

Importantly, while informal language and flouting of maxims sometimes aid relational bonding and emotional comfort, they often impede precise symptom disclosure and thorough diagnosis. Communication mismatches—such as when patients respond to

vague cues with equally vague responses—highlight the need for a more structured and empathetic communication approach in medical consultations, especially in linguistically and culturally diverse settings.

Recommendations

In alignment with Shachar's (2001) observation that some American medical schools now include humanities-based electives to improve communication. This paper recommends adoption of same in developing countries to close the communication gap between health professionals and patients.

Furthermore, this study recommends that Healthcare communication can be improved by training doctors in pragmatic and cultural sensitivity, encouraging explicit patient expression, using clear language, addressing power imbalances, employing interpretive tools, and documenting communication challenges, especially in low-literacy and multilingual settings.

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