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Face attack and patients' response strategies in a Kenyan hospital[1]

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Social power can be exercised by face attack where power differentials are sufficiently great and significant retaliation or sanctions are unlikely. Such exercise of social power is common in military contexts. It is not commonly observed in hospital settings yet some nurses in Kenya's public hospitals routinely attack the face of their patients. Using data from interactions observed in a provincial hospital, it is illustrated how nurses initiate conflict and how patients counter the face-attacking moves. The investigation shows that nurses use a high frequency of utterances that violate the dignity of patients while the latter prefer conflict avoidance strategies. Nurses generally make no attempt to mitigate the impact of most of their face-threatening utterances while patients demonstrate awareness of the need to preserve mutual face and reclaim dignity. Three strategies used by patients to reclaim dignity – namely silence, retaliatory face damage and face repair – are illustrated.

Nguvu za kijamii zinaweza kutekelezwa kwa kushambulia uso mahali kadri za nguvu ni mazito mno na ulipizaji kisasi wala vikwazo haviruhusiwi. Utekelezaji huu wa nguvu hudhihirika sana katika mazingira ya kijeshi. Hauonekani sana katika hospitali. Ingawaje, baadhi ya manesi katika hospitali za umma nchini Kenya mara kwa mara hushambulia uso ya wagonjwa wao. Huku tukitumia data ya miingiliano iliyotazamwa katika hospitali moja ya mkoa, twaonyesha jinsi manesi hubuni migogoro na vile wagonjwa hukabiliana nayo. Uchunguzi huu unaonyesha kuwa manesi hukiuka hadhi ya ubinafsi ya wagonjwa pakubwa ilhali wagonjwa huchagua mikakati ya kuepuana na migogoro. Kwa ujumla, manesi hawaonyeshi nia ya kupunguza athari za shambulio la uso katika matamshi yao ilhali wagonjwa huonyesha ufahamu wa kuhifadhi heshima na kudai tena hadhi. Mikakati mitatu ya wagonjwa ya kudai tena hadhi ikiwemo kimya, ulipizaji kisasi na urekebishaji uso inaelezwa humu.

KEYWORDS: Dignity, impoliteness, face attack, social power, retaliation, face repair

1. INTRODUCTION

> Every face-saving practice which is allowed to neutralise a particular threat opens up the possibility that the threat will be wilfully introduced for what can be safely gained by it. (Goffman 1967: 24)

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This paper is a study in the exercise of power and its consequences in interactions. It illustrates the idiosyncratic, ambiguous and socially-constructed nature of the exercise of power in a micro context where traditional and modern constructions of power interact. The context is a Kenyan hospital. The protagonists are patients and nurses. In coming to a hospital, patients are usually in a situation where they cannot cure themselves, so they place themselves in the care of the hospital and its health professionals. They are consequently in a relatively powerless position. Nurses, on the other hand, are professionals who wield social power in the form of specialist, declarative and procedural knowledge. Like many service providers, nurses are paid to provide the professional services for which they have been trained. Their exercise of their profession is however, constrained by professional codes and state policies.

The constraints placed on health professionals who practise Western medicine are many. They range from doctors taking the Hippocratic oath – and adhering to it – to being required to conform to numerous in-house regulations for health professionals in hospitals. Central to the interaction between patients and health professionals is the requirement to respect the dignity of the human person. Jacobson (2009) describes dignity as a quality of individuals and collectives that is manifested by recognition, respect and fair treatment; while the Royal College of Nursing (2008) defines dignity as the quality of being worthy of esteem or self-respect. Similarly, Meyer (2009) observes that dignity in care contexts is the kind of care which supports and promotes, and does not undermine a person's self-respect.

The concept of the dignity of the human person is enshrined in such documents as the Universal Declaration of Human Rights where it is proposed that recognition of the inherent dignity and of the equal and inalienable rights of all members of the human family is the foundation of freedom, justice and peace in the world. Dignity of the human person therefore ought to be seen as a social and ideological construct. This is clear when one notes that there have been periods of human history when it has not been presumed. Dignity, if it existed as a construct at all, has often only been accorded certain persons and not others.

As it relates to the current paper, at the policy level in Kenyan hospitals, the Kenyan government has formulated an approach that is sensitive to patients' rights. Nurses are therefore expected to treat patients with dignity and respect regardless of cultural background, age, gender, creed or socio-economic status. They are also expected to be the patients' advocate (Nursing Council of Kenya 2005). Nurses are also expected to learn the local language and appreciate the culture of the tribes in their work stations.

It is clear this does not always happen. Nurses in our study area have been reported to be verbally abusive. They shout orders to adult patients in demeaning and disrespectful ways. A majority of patients have expressed dissatisfaction with the service they receive by concluding that nurses were rude, impolite and unsympathetic (Ministry of Health 2006). For instance, older patients would expect nurses to address them with a prefatory word *jaduong'* meaning 'old man'

but nurses use their surnames instead. This is regarded as belittling and only permitted when addressing a child.

Nurses control the doctor's schedule. As gate-keepers, they determine who sees the doctor and when. This has been a cause of verbal conflict as patients express concern over discrimination. Since they are expected to be the patients' advocate, nurses have used this role to manipulate patients to cooperate with them and the perceived rebellious ones have had facts about their welfare and behaviour misrepresented to the doctor. For instance, during the doctor's ward rounds, a nurse may accuse a patient of not following instructions or being rude. The patient rarely questions or contradicts the nurse's point of view and if they do so, they may be warned of dire consequences and some privileges such as allowing their visitors in after official visiting hours may be withdrawn. Our aim in what follows is to explore these perceptions by patients by looking in detail at a set of recorded interactions and attempting to understand the sociolinguistic parameters which play a role in such interactions.

2. METHODOLOGY

The data reported here were observed and recorded at the New Nyanza Provincial General Hospital in the period June – September 2007. This was part of PhD fieldwork concerned with analysing the pragmatics of politeness strategies in nurse-client interactions in selected public-health facilities in Nyanza province, Kenya. The hospital is a government facility with a daily average attendance of 600 outpatients and 200 inpatients (Ministry of Health 2006). The primary data were collected through non-participant observation. The data were recorded on audio tapes complemented with field notes. The study was approved by the hospital's Ethical Review Committee and the data-collection process was unobtrusive. Observations focused on the reception, registration, triage, customer-care desk, the Maternal Child Health section, Family Planning Clinic and the HIV/AIDS Patients' Support Centre.

3. DATA

3.1 Preliminary discussion

In this section, we present a series of illustrative interactions involving nurses and patients and provide an analysis of each interaction in the framework of Brown and Levinson's classical account of politeness (Brown and Levinson 1987). In the following section, we will present a more general account of the strategies which appear to inform the behaviours of both sets of participants: nurses and patients. Before doing so, we want to distinguish between politeness as a response to a face-threatening act, and face attack.

Face attack is not a mitigating strategy to imposing on someone and making it up to them, but is a wilful exercise of social power performed with the aim of

humiliating or coercing the hearer. We take humiliation to be a face attack on a hearer's positive face and coercion to be an attack on the hearer's negative face. For example, a playground bully in an elementary school may abuse someone he is bullying by telling them before their friends that they are stupid, ugly or weak. There may be no reason for such accusations other than to show that the bully has the social power to humiliate the hearer. Alternatively, the bully may coerce the one being bullied to crawl through a gorse hedge just to show that the bully has the power to do so.

Face attack is akin to intentional dignity violation. Jacobson (2009) argues that dignity encounters appear more likely to result in violation when an actor is in a position of vulnerability, for example, when the actor is sick, poor, weak, helpless, ashamed or confused and the other is in a position of antipathy, i.e. is prejudiced, arrogant, hostile or impatient. Violation is more common when the relationship is one of asymmetry, i.e. when the actor has more power, authority, knowledge, wealth or strength than the other. Although dignity cannot be measured, manifestations of dignity-promoting and dignity-violating acts are socially prescribed and can be monitored through the interactants' strategies of expression. As Driscoll (2007) suggests, the degree of face damage is ultimately determined by participant reactions. We assessed face damage by observing the patients' reaction to the nurses' utterances.

In assessing face attack, the addressee's reaction is a crucial indicator since, if an attack is perceived, the receiver can retaliate or attempt to repair the face damage inflicted by the attack as we will see in the discourse extracts in section 3.2 below. Out of the nurses' 590 utterances in our data set, 148, or 25 percent, constituted a face attack on the patient. We evaluated them to be face attacking because they were bluntly stated without any form of redress (cf. Brown and Levinson 1987). This figure is significant since the credo of nursing and the training curricula in Kenya expect nurses to be polite, sympathetic, and respectful to patients' values. The type and frequency of face-attack acts by nurses that threatened patients' dignity were distributed as shown in Table 1.

The face attack took various forms, including criticisms that entailed disapproval of patients' points of view and actions. Blame was uttered in situations in which the nurse faulted a patient's action. Rejection involved the nurses' distancing of patients by emphasizing their out-group status. Reprimands included castigation of patients' actions using words that conveyed annoyance. Sarcasm entailed words that contradicted the real state of affairs. Sarcasm is taken as a satirical remark uttered with some degree of scorn or contempt. It is often ironic and is intended to hurt the addressee's feelings. It also involves mocking someone by saying something good about them when the opposite is obviously true. Insults were characterized by a direct affront to the personal character of the addressee. These face-attack types constitute attempted humiliations targeting the dignity of patients.

Orders involved using imperative forms resulting in utterances that compelled patients to act, hence giving them no opportunity to opt out or negotiate with the

Table 1: Frequency and types of face-damaging speech acts by nurses towards patients*

Type of face-damaging act	Example	Frequency of occurrence
Criticism	Why do you keep disturbing us?	32
Blame	Don't you know that you must pay for drugs?	30
Rejection	I don't want to see that woman here.	26
Reprimands	The problem with you is that you don't understand.	17
Sarcasm	Why follow me in hospital as if I were your debtor?	15
Orders	Take that woman out of here now.	10
Insults	You are adults but you behave like children.	10
Warnings	If you try to be clever here, you will regret.	8
Total face-damaging utterances		148
Total utterances sampled		590

*Source: field observation data

nurse. Warnings involved uttering statements that implied some impending and usually undesirable consequences. The warnings were face damaging because the addressee was promised a bleak outlook and given no chance to justify their actions. These face-attack types are essentially coercive.

In response to face-attack acts by nurses, silence was the most frequently taken option. Silence was noted where there was no response from the patient despite a lexically explicit cue from the nurse. We adopted the description of significant silence – as conceptualized by Knapp, Enninger and Knapp-Pottoff (1987) – as the intentional non-realization of a verbal act that is conventionally expected to occur; or, abstentions from speech where, according to the rules of turn taking, a verbal utterance is normally required. Therefore, any act that defied the adjacency pair principle say, of Question-Answer was considered significant or communicative. The patients' silence would thus prompt the nurse to contribute a follow-up utterance to fill the void because the patient's silence sometimes implied defiance, apparent embarrassment and face damage for the nurse. Jaworski (1997) proposes that silence may imply withholding of communication or avoidance of threatening topics. Since a verbal utterance is required after the completion of the first pair part in normal turn taking, the ensuing silence would usually be interpreted as an intentional and meaningful reaction (Jaworski 1997).

Out of the 108 instances of silence from 120 interactions, the ratio of silence was such that only seven, or 6.5 percent, were from nurses' turns, while 101, or 93.5 percent, were noted in patients' turns. This represented an average of one occurrence of silence per interaction. This pattern reveals that patients remained silent most of the time when nurses posed face-damaging acts. Patients thus withdrew from the interaction by letting their expected turns pass while the nurse proceeded to ask a series of rhetorical questions or ignored the patient

altogether. Nurses therefore curtailed the interactions prematurely leaving patients in suspense.

Anolli (2002) indicates that silence is the clue which communicates a particular emotional state to interacting partners and observers. Silence is used to underline – to increase the communicative value, both in a positive or negative sense, of content already defined by the relationship [and context]. Usually, there is no need for silence if the relationship is based on mutual reciprocity, but, in more difficult and awkward relationships, silence is often a resource. Waltzlawick, Beavin and Jackson (1967) hold that in the social and relational systems, communicative silence is not rare. It leads to inferences of intention and may express an attitude, suggest an intention, or show agreement or disagreement.

3.2 Discourse examples

The nature of face attack. Tracy (2008: 173) argues that:

> face attack is a better way to label communication acts that are seen as intentionally rude, disrespectful and insulting and that are uttered ... where the speaker is assessed by the target and at least some others as purposefully out to disrespect and insult.

Similarly, Backhaus (2009: 66) holds that 'acts that do not achieve any face saving goals and that seriously undermine one's face constitute a form of impoliteness.'

To exemplify face attack inflicted by nurses, we look at three examples below. In Extract 1, a teenage girl is in labour and requires the nurse's intervention. Her perceived young age leads the nurse to reprimand her as she enters the labour ward. In Kenya, teenage pregnancies are frowned upon by society while sex is regarded as a taboo topic and is rarely mooted in public. It is therefore undignifying to discuss sex in the presence of mother and child among other onlookers as follows:

Extract 1

a. Patient: Sister *nisaidie nakufa na maumivu.*
'Sister, help me I am dying of pain.'

b. Nurse: *Si ungemaliza shule kwanza ndiyo ushike mimba wewe msichana?*
'Why didn't you complete school before conceiving you girl?'
(Silence)

c. Nurse: *Sasa ndio utashika adabu*
'It is now that you will learn manners.'
(Silence)

Utterance 1b encodes a face attack on the patient in two ways. Firstly, it threatens the patient's positive face because she pleads for sympathy but is

rebuked by the nurse instead. Secondly, her negative face is threatened because the nurse impinges upon her personal life and prescribes the action she should have taken. Utterance 1c encodes a further castigation of the patient's action and indicates that no help is forthcoming.

In Extract 2, there is disorder on a waiting queue where some late patients bypass the punctual ones in order to be ushered in first. A punctual patient then petitions the nurse to restore order as follows:

Extract 2

a. Patient: *Watu wengine wanaruka laini.*
'Some people are jumping the queue.'

b. Nurse: *Akina nani hao?*
'Who are those?'
(Silence)

c. Nurse: *Ubaya yenu ni kuwa hamuelewi maneno.*
'The bad thing about you patients is that you don't understand.'
(Silence)

The nurses' question in 2b is an implicit warning to the patients who were reportedly distorting the order of queuing. The subsequent silence therefore portrays the patients engaging in collective self-preservation. Their failure to point out the guilty ones shows that they are not willing to jeopardize the character and dignity of their in-group members. The face attacking reprimand in 2c directly challenges the patients' capacity to understand, thereby implying that they are incorrigible. The face attack is encoded by the accusing generalization in 2c through the words 'you patients' despite being told that only 'some people' were the cause of the complaint. The patients do not counter the nurse's accusation due to its potential to polarize the in-group members. The use of the phrase 'the bad thing about you' amounts to labelling which, according to Jacobson (2009), involves tagging an actor with a descriptive term that carries a connotation of moral or social inferiority. The utterances therefore threatened the patients' dignity, hence the terminal silence evoked by them.

In interaction 3 a patient returns from the washrooms and realizes that a nurse has skipped her bed while distributing drugs. The nurse has called out a register and patients are expected to confirm their presence by responding. The patient then claims his drugs as follows:

Extract 3

a. Patient: *Dak iketo na yath e otanda na?*
'Why didn't you place medicine on my bed?'

b. Nurse: *Iluwo bang'a ei* ward *kagima an jagopi.*
'You keep following me in the ward as if I have your debt.'
(Silence)

c. Nurse: *Mano pachi ok kaka watiyo.*
'That is what you think but not how we work.'
(Silence)

Utterance 3b encodes sarcasm – i.e. it is a satirical remark uttered with some degree of scorn. It is ironic for the nurse to compare the nurse-patient relationship with that of a borrower and lender. This portrays the nurse as lacking in empathy and paints the patient as nagging. The nurse distances herself from being regarded as the patient's benefactor by declaring that she owes the patient nothing. This threatens the patient's positive face because it encodes rejection. The use of 'you' versus 'we' in 3c emphasizes the patient's out-group status while the phrase 'what you think' further diminishes the chances of the patient's contribution to the talk. In this case, the reaction of the onlookers was derisive laughter targeting the patient. This bystander reaction accentuates the loss of dignity.

The contexts in which face attack may be justified are described by Tracy (2008). She uses the context of a governance meeting where speakers express outrage about a wrong committed by the school board members in a largely uninhibited democratic setting. In such liberal contexts, it is noted that face attack may be sanctioned if people in a group judge the negative sentiments expressed by a speaker to be warranted and needing to be said. She equates such cases with reasonable hostility but notes that 'not all face attacks deserve the label of reasonable hostility hence talk that just about everybody in a social scene regards as nasty, unfair and gratuitously disrespectful does not constitute reasonable hostility' (Tracy 2008: 186). In contrast, the hospital setting appears undemocratic thereby inhibiting patients' expression. What patients can say is determined by the nurses' judgement of its relevance. Moreover, the nurses' utterances do not qualify as reasonable hostility because face attack would not be socially sanctioned against a vulnerable target such as patients.

Patients' silence as an indicator of face damage. The utterances by nurses that yielded silence indicate that the patients' self image or dignity was threatened but the patients withheld their feelings in order to salvage the relationship. Eelen (2001: 21) argues that 'in facework, silence is one aspect of strategic conflict avoidance.' This implies that patients were aware of the potential for conflict in the nurses' utterances and remained silent to avoid an altercation that would strain the relationship further and disrupt service. It was an implicit recognition of the nurses' official authority by the patients and reinforced the power asymmetry between the two actors.

Holtgraves (2005) also contends that withholding one's comments is an avoidance strategy. In the Kenyan case, silence emerged as the safest avoidance strategy – i.e. the patient minimizes the chances of further face attack by withdrawing or signalling non-verbally that they have no further interest in pursuing the talk. Our data illustrates this strategy where clients steered clear

of threatening topics as in 3b, avoided influencing another's mode of operation as in 3c and avoided calling attention to another's fault as in 2b. Examples 1c, 2c and 3c were explicitly terminal since they did not seek the patients' opinion. Bruneau (2008) refers to this strategy as 'silencing' because it involves the speaker's conscious or unconscious persuasive attempts to control, restrict or prevent the verbal expressions of marginalized participants.

In 4, a nurse confirms the presence of patients in the triage section by calling out names from registration cards. In that section, patients are usually routed to various sections according to the nature of their ailment. Due to background noise, some patients cannot hear their names at the first call. This forces the nurse to repeat some names while blaming the patients for their inattention as follows:

Extract 4

a. Nurse: *Unataka nikuite mara ngapi?*
'How many times do you want me to call you?'
(Silence)

b. Nurse: *Ama masikio ni mbaya?*
'Or you have bad ears?'
(Silence)

c. Nurse: *Unadhani tunacheza hapa?*
'You think we are joking around here?'
(Silence)

d. Nurse: *Siku ingine ujaribu kunyamaza tena; ingia.*
'Next time remain silent again; go in.'
(Silence)

The utterances in 4 are intimidating because they do not demand any clear answer from the addressee. Utterance 4b is face attacking because it belittles the addressees by comparing them with the deaf. Moreover, it is insensitive because it implies that the deaf have an undesirable shortcoming. The reference to deafness therefore affects the patient's self esteem and denies them the right to non-discrimination. Utterance 4c is clearly rhetorical because the patient is invited to evaluate the degree of commitment of the nurses yet the utterance is menacingly prefaced with the accusing phrase 'you think.' Through 4d, the nurse conveys an implicit warning without mentioning the future consequences of 'remaining silent.' This leaves no room for the patient to comment. The episode in Extract 4 is therefore a monologue through which the patient withholds his feelings throughout; hence, it constitutes pragmatic failure because the patient does not contribute to the topic.

Example 5 takes place in the waiting bay of a Family Planning clinic where adult patients of mixed ages and sexes are being instructed on contraceptive options. Although public awareness of contraception has increased in Kenya,

issues of sexuality are still considered taboo and potentially embarrassing. Few non-health workers would discuss sex without inhibitions. This leads to the passivity and unresponsiveness of the patients as witnessed in 5 below:

Extract 5

a. Nurse: *Leo nataka kujua wangapi wanatumia kondom.*
'Today, I want to know how many of you use condoms.'
(Silence)

b. Nurse: *Kwa nini mnakaa kuogopa?*
'Why do you look scared?'
(Silence)

c. Nurse: *Nani mwanamme tosha atuambie?*
'Who is man enough to tell us?'
(Silence)

d. Nurse: *Wewe inaonekana unajua mambo ya ngono sana; tuambie.*
'You. . .you appear experienced in sex matters. . .tell us.'
(Silence)

In interaction 5, the nurse arouses consciousness to the sensitivity of the topic by her intimidating and explicitly face-attacking utterances. For instance, in 5b, the nurse presumes that the patients are 'scared' of discussing the topic. She attempts to assess the manhood of the audience by labelling some as 'man enough' and asking them to volunteer information in 5c. This is demeaning in a mixed-sex group that included couples. The face damage is worsened by 5d in which an individual is pinpointed and labelled a 'sex expert' yet this is a private attribute. This final instance involves two forms of dignity violation. Firstly, it entails guilt by association in which the nurse expresses a link with a practice socially considered private. Secondly, it involves intrusion whereby the nurse transgresses the patient's bodily or personal boundaries (cf. Jacobson 2009). The silences in 5 confirm the conclusion by Bruneau (2008) that many communicative silences occur not merely as a refrain from speaking, but as ways of conveying meanings that are hopelessly connotative, suggestive, secretive or taboo. They involve reactions to messages that would be difficult or undesirable to share by resorting to words (Knapp 2000). Often, such silences exist to articulate the developmental stages of a relational configuration where words would be embarrassing to one or both of the participants in the relationship (Bruneau and Ishii 1988).

Patients' retaliation to face attack. An analysis of the patients' strategies of reacting to face damage to preserve their own face revealed retaliatory face attack as an option. Miranda (2008) refers to retaliatory face damage as face counter attack. Retaliatory acts may be inferred from participant perspectives that give a clue to their orientations to meanings, interpretations and evaluation of

utterances (Driscoll 2007; Jakubowska 2008). The patients' verbalized reactions therefore pointed to the impact of the face attack and indicated the degree of acceptability of the nurses' utterances. The role of other bystanders was also crucial because in a situation such as the health-care context, there are speakers and hearers, but also, auditors and overhearers (Bell 1984). It has also been found that when observers are part of a social scene, as is the case in public encounters, face assessments also involve observer judgement (Tracy 2008).

Retaliation was observed in contexts where the nurse had performed a face attack on a patient in the hearing of other bystanders. Fourteen out of 20 of the retaliatory acts occurred where the bystanders had laughed at the nurse's attack on the patient. The derisive laughter reinforced the face damage and loss of dignity thereby rendering it a collective attack on the targeted patient. The patients' retaliatory acts were a result of their detection of verbal provocation and a perceived affront to their dignity by the nurse because, as Jacobson (2009) argues, retaliatory face attack is one of the most direct consequences of dignity violation. For instance, in Extract 6, two patients have earlier been sent to the laboratory by the nurse but fail to locate it and go back to the nurse's room without their laboratory results. Instead of redirecting them, the nurse blames them for being unobservant and likens them to blind people as in 6a.

Extract 6

a. Nurse: *Ok uneno lab kagima un muofu?*
'You can't see the lab as if you are blind?'

b. Patient: *Wereuru gi mama no oparo ni olich.*
'Leave that woman [nurse] alone she thinks she is important.'

c. Nurse: *Ibiro neno ng'ama lich e osiptal ka.*
'It shall be known who is more important here.'

In 6b, the patient retaliates and engages in diminishment of the nurse by belittling her professional status through the phrase 'she thinks she is important.' This portrays the nurse as self-glorifying, indifferent and overzealous in exercising the power bestowed on her by her professional position. Moreover, the use of the generic term 'woman' to refer to the nurse overlooks her professional status and demotes her to the level of an ordinary female adult. Since the nurse's role as a powerful participant is no longer recognized by the patient, the former reasserts her power and privilege through 6c in order to minimize the loss of dignity occasioned by the patient's utterance in 6b. The nurse, thus, issues a warning through the phrase 'it shall be known.' This explicitly encodes a contest of power and the desire to reclaim esteem.

In interaction 7, an elderly male patient demands prompt service emphasizing the fact that he has paid the requisite fees. Instead of offering a reassurance, the nurse insists that the old man has to wait in the queue as a consequence of complaining aloud. Here the nurse explicitly victimizes the patient for voicing his right.

Extract 7

a. Nurse: *Jaduong' ang'o ma igo ne koko?*
'Old man, why are you making noise?'

b. Patient: *Asechulo pesa to ungi'ya ang'iya*
'I have paid yet you are just looking at me.'

c. Nurse: *Rit arita kaka jomoko*
'Just wait like everyone else.'

The face damage and loss of dignity in 7a is encoded by equating the patient's demand for the right of service with 'noise.' This is ironical because a quick turn-around time in health service is an indicator of courtesy (Onyango et al. 2004). It is the nurses' expression of revulsion in 7a that prompts the patient to retaliate through the rude statement in 7b. Therefore, in an ideal situation, if there is a delay that might inconvenience the patients, then an explanation ought to be proffered by the nurse but this was not forthcoming in Extract 7, hence the strained interaction. Through 7c the nurse retaliates and underlines her power and authority by concluding that the patient had no option but to wait. It would have been less face damaging to ask the patient to persevere.

In Extract 8, a male patient is undergoing dressing when he observes that his female companions are departing. He then orders the nurse to hurry up to enable him catch up with his fellows. This leads the nurse to castigate him as follows:

Extract 8

a. Nurse: *Ikasori nade in be in dhako idhi omo pi?*
'Why hurry? Are you a woman who wants to go and fetch water?'

b. Patient: *Timane, timane* nurse, *ji dhi yomba.*
'Do, do, nurse, people will leave me behind.'

a. Nurse: *We jogo odhi; ngima en mari.*
'Let them go; your health is individual.'

Utterance 8b encodes dignity violation through condescension because the patient uses the compelling word 'hurry' to order the nurse to act fast. This impinges on the nurses' freedom of action hence constitutes an attack on her negative face. It is prompted by utterance 8a in which the nurse belittles the patient by implying that his haste is driven by pending domestic chores culturally associated with women. The comparison is face damaging, since it suggests that the patient carried himself like a woman.

Retaliatory face attack invariably led to pragmatic failure because the speaker either changed to safer topics or withdrew from the interaction to avoid an altercation. Retaliation is perhaps instigated by Brown and Levinson's proposal that 'people assume each other's cooperation in maintaining face in interaction and that such cooperation is based on the mutual vulnerability of face'

(1987: 61). It is the awareness of this vulnerability that leads to the choice of strategies that maintain face and preserve dignity.

In example 9, two relatives accompany a patient who can barely talk for himself and advocate for his admission into the wards. Despite stressing the urgency of their relative's condition and the need for urgent admission, the reception nurse at the emergency section perceives their approach as rude and an altercation ensues. Significantly, the interaction proceeds entirely in English as follows:

Extract 9

a. Client: We want our patient admitted.

b. Nurse: I am not the doctor.

c. Client: So are we the doctor?

d. Nurse: Don't try to be clever here.

e. Client: This is not about who is clever or foolish.

The chain of face attacks here is initiated by a patient through the word 'want' in 9a which encodes a demand. The nurse takes this as a challenge and changes the topic by introducing an absent entity, namely 'the doctor' to the interaction. By doing this, the nurse distances herself from the patient's demand by emphasizing that it was not her duty to authorize ward admissions. Through the rhetorical question in 9c, the client retaliates by implying that they are non-professionals who require service. The clients' apparent awareness of their right to service leads the nurse to utter the intimidating 9d in which the clients are labelled as 'clever' to which the client reacts through 9e by challenging the nurse's judgement. The words 'clever' and 'foolish' in 9e imply a dispute of relative intellectual supremacy. Whereas the clients insist on getting unconditional service, the nurse emphasizes that power to determine the course of patient-care decisions resides with the institutional insiders and could not be influenced by intimidation from outsiders.

In 10, a patient has stormed a matron's office without notice to ask for extra linen. At the facility, patients are entitled to a change of bed linen every two days. When the wards are overbooked, some patients are made to share beds. When this happens, the longer staying patients ask for extra linen in order to avoid sharing with newcomers.

Extract 10

a. Nurse: *Unataka nini kwa ofisi yangu?*
'What do you want in my office?'

b. Patient: *Hii hospitali ni ya wagonjwa.*
'This hospital is for the sick.'

c. Nurse: I know that.

d. Patient: I also know what I want.

e. Nurse: You must respect my position.

f. Patient: We also hold positions where we work.

In 10a, the nurse portrays the patient as an unwanted trespasser. She personalizes the ward office as her private territory. This prompts the patient to utter the contemptuous dismissal in 10b to the effect that the entire hospital was meant to serve patients. This implies that the patients deserved unrestricted access to the facilities. The nurses' demarcation of spheres of influence was therefore mistaken. In 10c–f, power is seen at play as nurse and patient both emphasize their knowledge of rights and elevate their self-worth. In interaction 10, the code-switching to English by the patient illustrates a tactful power play aimed at enhancing his status and reclaiming his face and dignity in the process. The switch to English is significant because in Kenya, the language is associated with a high status and intellectual power. Through the code-switching to English, the patient could have set out to prove that he was equally worthwhile and could match or neutralize the nurses' domineering attitude. Watts (1991) defines status as an individual's position in the structure of social relationships with respect to others where such position may be determined by education, wealth, age and sex.

In the foregoing, patients faced off with nurses despite their perceived inferior status. This brings into focus the contention by Dzameshie (1995: 206) that 'within a given discourse, participants' tacit knowledge of their rights and obligations partly influences their linguistic choices'. Coppock (2005) also argues that a complaint may arise when one party does not adhere to, or respect, an interlocutor's rights and privileges.

Patients' strategies for face repair and promotion of dignity. Face repair occurred where patients overtly reclaimed their dignity by attempting to minimize the impact of face loss. It entailed giving explanations, disapproving of the nurse or justifying an action that had been criticized. Attempts to achieve face repair were motivated by the patients' desire to deflect attention from the intended face damage. These were attempts to negotiate dignity without confronting the nurses. In these cases, patients strove to prove to the bystanders that the nurses had misconstrued their intentions. These are instantiations of dignity promotion in practice. According to Jacobson (2009), dignity promotion is more likely when one actor is in a position of confidence – i.e. has a sense of self-assurance and hope and feels deserving of good things – while the other is in a position of compassion – i.e. is kind, open-minded, honest and has good intentions. This happens when the relationship between actors is one of reciprocity, rapport, empathy and trust. Face repair was characterized by conciliatory and deferential behaviour by patients as seen in the subsequent extracts.

Examples 11a–14a represent the face damaging acts by nurses while 11b–14b show the patients' reactions marked by attempts at repairing their own face while preserving the face of the nurse. In 11, a patient complains persistently to

a ward nurse over a misplaced health insurance card that is expected to have been in the custody of the nurse.

Extract 11

a. Nurse: *Kwa nini unatusumbua juu ya* card *yako?*
'Why do you disturb us about your card?'

b. Patient: *Ni kwa sababu nilidhani imepotea.*
'It is because I thought it was lost.'

Through 11a, the nurse accuses the patient of pestering her through the word 'disturb.' In order to reclaim dignity through face repair, the patient demonstrates transcendence in 11b and avoids conflict. The use of the word 'disturb' contradicts the policy of patient-centeredness. The face repair in 11 entails the desirable positive politeness strategy of avoiding disagreement. The patient expresses self blame through the phrase 'I thought' and avoids countering the accusation by the nurse. Through 11b, the patient deflects focus from the threatening topic of pestering to a neutral utterance that neither encodes direct denial of the accusation nor blames anyone over the missing card.

In 12, two orderlies assist a patient into an observation room without the nurse's permission. This happens when there is no other patient in the nurses' room and the orderlies must have concluded that it was the patient's turn to be attended to. The nurse does not welcome the move and instead emphasizes that she has not authorized the patient's entry.

Extract 12

a. Nurse: *Goluru mamano obed oko okadwa nene ka.*
'Take that woman out there; I don't want to see her here.'

b. Orderly: *Jatuo ema owacho ni wakele.*
'It is the patient who has told us to bring her in.'

Utterance 12a encodes both an order and a rejection. The face damage is however, mitigated through 12b in which the patients' orderlies shift blame to the patient by reporting that it was the patient who had ordered them to bring her in and hence it was not their fault. This exemplifies advocacy as a strategy of dignity reclamation, i.e. standing up for, or beside those who are oppressed (Jacobson 2009). This shift of focus implies that the orderlies could not be the targets of the nurse's subsequent face-damaging acts. This demonstrates the need to appreciate the cultural norms of clients. For instance, among the Luo people who were the major patrons of the health facility, the messenger is usually considered innocent and should neither be blamed nor attacked.

In interaction 13, some twenty-five victims of a road accident are undergoing first aid in an open casualty section before admission into wards. The high number of patients against only three casualty nurses meant that these patients could not be accorded private treatment. There is only one screen in the

emergency room hence first aid is conducted in the open. In the ensuing exchange, an elderly patient hesitates to undress for an injection:

Extract 13

a. Nurse: *Iluoro sandan?*
'You fear an injection?'

b. Patient: *Sandan samoro abudhone.*
'Sometimes I don't get regular injections.'

c. Nurse: *Kare gol siruaru no.*
'Then take off your pants.'

d. Patient: *We asora e katen maro kik nena*
'Let me get behind the curtain away from mother-in-law's view.'

e. Nurse: *Osiptal onge wach maro.*
'In a hospital the issue of mother-in-law does not arise.'

f. Patient: *Ooyo chanruok ema duong'*
'No, decorum is paramount.'

In 13a, the nurse attacks the patient's face by suggesting that he may be afraid of an injection. The utterance is undignifying because only children are expected to react hesitantly in fear of injections. The patient repairs face in 13b by modestly admitting that he has not had regular injections. In a further face attack in 13c the nurse directly orders the elderly patient to remove his trousers. In reaction, 13d introduces a cultural inhibition as the patient asks to be allowed to go behind the curtain lest he should be seen by his mother-in-law. Among the local Luo tribe, it is taboo for a man to encounter his mother-in-law when he is in a vulnerable state. In 13e, the nurse advocates for an understanding of modernity by downplaying the patient's personal value-laden concern while the patient portrays awareness of social decorum through 13d and f. This illustrates how the exercise of professional power can be in conflict with a patient's desire for self-determination and individual will.

Example 14 transpires in a Family Planning consultation room where a female patient is accompanied by her three children. In the nurse's judgement, the children are apparently closely spaced in age. This leads the nurse to criticize the mother for not planning her family and results in the face attack and repair sequences below:

Extract 14

a. Nurse: *Mama magi nyithindi tee?*
'Mother, are all these children yours?'

b. Patient: *Ee kwani ok nyalre?*
'Of course yes, is it impossible?'

c. Nurse: *Kaka tinde piny tek ni?*
'Difficult as life currently is?'

d. Patient: *Nyithindo gin gweth Nyasaye*
'Children are a gift from God.'

e. Nurse: *A a nyaka ijipanga*
'No, no you have to plan.'

f. Patient: *Be ing'eyo kaka luche gombo nyithindo?*
'Do you know how barren women desire children?'

Extract 14 also illustrates the role of culture and the parameter of dignity in determining the outcome of interactions. In 14a, c and e, the nurse advocates for a small family size. However, the choice of words constitutes face attack, i.e. words and phrases like 'all these', 'difficult life' and 'have to plan' portray the patient as uninformed and irresponsible. This violates the patients' self-esteem as a parent capable of making personal decisions independently. Consequently, through 14b, d and f, the patient attempts to reclaim dignity by justifying the desirability of many children, insisting that children are 'a blessing from God' and that 'the barren desire them.' Through the face repair, the patient implies that it is a source of satisfaction to have children regardless of their large number. She cites the wishes of the childless as a justification.

The instances of face repair presented in this section illustrate the view by Paramasivam (2007) that power co-occurs with politeness as separate but interdependent moves such that a power move is made which is then countered with a politeness move. The nurses' face damaging acts were therefore power moves whose impact was softened by the patients' face-repair politeness moves. Face repair demonstrates that there is need to avoid disrupting interactions by maintaining the social equilibrium and friendly relations (cf. Leech 1983).

Face repair further indicates the patients' awareness that positive politeness strategies were more likely to elicit cooperation (cf. Brown and Levinson 1987). By correcting the nurses' perception, a positive relationship was achieved by implicitly indicating to the nurse that the patient was not entirely opposed to their opinion but was willing to correct their perception by recognizing the nurses' views without necessarily conforming to them. This enabled productive co-construction of interactions. As a result, face repair yielded pragmatic success whereby the interactions were continued to their logical conclusion unlike in the cases of sustained face attack or terminal silence.

4. DISCUSSION

While in the above analyses we have presupposed Brown and Levinson's (1987) views of face and politeness, it emerges that most utterances by nurses observed in the interactions do not embody politeness. This is because the face attacks, being bluntly stated, are more likely to have been motivated by the nurses' desire to assert power and control their patients rather than by the need to attend to the face needs of their patients. This may deny patients their right to dignified treatment and minimize their chances of self determination.

We have illustrated that the nurses' undesirable utterances are gratuitous attacks on the patients' face apparently in exercise of social power. The question is: why should this happen when government policy, nursing-council training guidelines and ethical codes of conduct do not permit it? We suggested in the introduction that this requires an analysis of the exercise of power in terms of its idiosyncrasy, ambiguity and its socially-constructed nature. The notion of social power and how it is to be conceptualized has generated much debate. For instance, Brown and Levinson (1987) assume power to be largely static and calculable. In contrast, Harris (2001) argues that Brown and Levinson's conceptualization of power is too rigid, resulting in the power dynamics between interactants being seen as pre-existing discourse as well as being taken for granted rather than being socially constructed in discourse.

By way of defining balance of power, Wartenberg (1990) notes that a social agent 'A' has power over another social agent 'B' if, and only if,'A' strategically constrains 'B's action-environment. Similarly, Lukes (1974) says 'A' exercises power over 'B' when 'A' affects 'B' in a manner contrary to 'B's interests. These two views of power relate well to our findings because it has emerged from the data that nurses use their power to constrain patients' action-environment by issuing directives that have the potential to limit the patients' chances of raising questions or contradicting the nurses. The patients' reactions – namely silence, retaliatory attacks and face repair – indicate that the nurses' linguistic strategies for the exercise of power were contrary to the patients' interests and expectations, and hence the latter's attempts to mitigate their loss of dignity.

Weber (1947) defines power as the ability of an individual to exercise his or her will in a social action, even against the will of other actors. In relation to nurse-patient interactions, Weber's view implies that the patients in our study who engaged in face retaliation and face repair were determined to exercise their will against the nurse's stance. The strategy of retaliation therefore illustrates how patients exhibit sensitivity to the face attacks encoded in the nurses' speech. According to Giddens (1984), power is enabling as well as constraining and it is exercised as a process. It is also constituted through processes of negotiation between individuals in society as revealed by our data on face repair.

Locher (2004) proposes that power is mostly expressed through language, cannot be explained without contextualization, is relational, dynamic and contestable. She suggests that the exercise of power is often accomplished by displays of relational work and politeness in order to maintain the social equilibrium and to negotiate identities, options which are not exercised by nurses in our data. Locher and Watts (2005) argue that interactants engage in discursive struggles and propose that relational work is the work individuals invest in negotiating relationships with others. In our data, patients attempted to accomplish this by retaliating when the face attack was explicitly encoded and through face repair when the attack was mild.

Watts (1991) proposes that the amount of power possessed by a person seems to correspond to the status of the interactants in relation to the others in the

social group. Consequently, the higher the social status, the more power one may possess and the more face one is likely to claim and maintain. The incongruence of power between nurses and patients partly explains the nurses' penchant for face attack due to the perceived vulnerability and the resultant powerlessness of their patients. Locher (2004) also argues that the exercise of power involves a latent conflict and clashes of interest. The ideal situation is that when power is exercised in a polite way, interactants show consideration for their addressee's face needs as well as protecting their own face. In her definition of relational work, Locher (2004) states that interaction plays a role in negotiating relationships because the exercise of power will more often be mitigated than exaggerated. This implies that by preferring face attack to face protection, the nurses' undesirable utterances exaggerated their exercise of power in their sphere of influence where challenge from patients is suppressed.

Social class distinctions and the attendant power also determine the level of respect and consequent degrees of politeness accorded to patients in Kenya. Upper-class individuals are habitually treated better because of their high positions. In the provincial hospital that we studied, the patients of a higher socio-economic status are handled separately in amenity wards or the private wing while ordinary patients are housed in crowded general wards. Although there is no caste system in Kenya, people are stratified according to their relative socio-economic status. Comparable studies elsewhere have concluded that in some cultures, the individual's freedom of thought and action are determined by the social status that the individual has in the group. Caste systems such as those of India and Tokugawa, Japan demonstrate this (cf. Gu 1990).

Within the framework outlined here, how are the face attacks on patients by Kenyan nurses to be understood? First the face attacks are functional in demonstrating nurses' social power in that nurses tend to exercise their power without fear of significant retaliation. They therefore, act arbitrarily in a manner that jeopardizes the envisaged cooperation in health-service provision. Secondly, patients are well aware of their having been attacked and the damage their face and dignity has suffered as demonstrated by their moves in responding to attack. The view of Ng and Bradac (1993) becomes pertinent at this point because they argue that language functions as a culturally-conventional tool for the exercise of power. They seek to reveal how and why the seemingly casual, routine use of language can recreate, enact, or otherwise subvert influence and control.

Two factors seem significant here. Firstly, nurses have a fairly high social status in Kenya by virtue of belonging to the upper-middle class. The advent of HIV/AIDS coupled with the international demand for nurses in America and Europe has occasioned a shortage of nurses in Kenya. Nurses have therefore been elevated in social status and are regarded as indispensable professionals. Secondly, nurses are the contemporary analogues of traditional healers in Kenya. In African traditional medicine, the healers are regarded as all knowing and all powerful. Their methods, prescriptions and advice are regarded as being beyond reproach. For instance, when consulting, the patient is expected to show

great humility and subservience such as by removing shoes or clothes and avoiding eye contact with the healer. The traditional interaction mainly involves one-way incantations where the healer would address supernatural beings and report their decisions to the patient who would submissively utter acceptance and compliance in a monotone. Even in contemporary Kenyan society, most Luo patients extend the use of the traditional title *ajuoga* 'healer' to all health practitioners including nurses. This traditional parameter apparently sustains the incongruence of power and the current perceptions of the invincibility of the health-service provider.

The exercise of power by nurses is however, also idiosyncratic. Attacks on patients' face can be directed in a number of ways which are not necessarily related to the current context or what the patient or nurse is attempting to achieve. This appears to be the nature of the exercise of power for its own sake. For instance, if someone has enough power and wishes to exercise it without fear of retribution, then whether they choose to humiliate or coerce may not be important.

There is also ambivalence. At the policy level, face attacks are not permitted and nurses are aware of the charter of patients' rights that guarantees polite service. The organisational context hence attempts to constrain face attack while the local context of nurse-patient interaction licenses it. This raises the question as to why more of such face attacks do not occur in hospital settings elsewhere. Presumably, it is because the power of organisational sanctions is higher than the power of individual health professionals over or against relatively-powerless patients. Just how powerless patients feel in the Kenyan context can be seen from the frequency with which silence is the response to insulting or coercive attacks on their face. It emerges that patients are not always docile and that they too feel the impact of the face attacks. They are not, however, always bound to accept it in silence. Instead, they use conflict avoidance and compliance strategies to enhance their chances of prompt service. Most of their utterances are therefore driven by the need to preserve face and promote dignity rather than the need to uphold the provisions of the patients' charter. This shows that the power imbalance between nurses and patients has not been bridged effectively by public policy and professional sanctions.

From the foregoing, it emerges that nurses are not restrained in their use of face attack on patients. Patients are, however, torn between voicing their rights on the one hand and maintaining the subservient role demanded of them by the nurses on the other. This leads patients to select mainly silence and face repair in their reactions to nurses' face-damaging utterances. Patients resort to retaliatory face attack when face damage is more manifest and reinforced by the derisive reaction of tickled bystanders.

A further factor may also be at play. Both the patients' views cited earlier and the frequency of face attack suggest that a community of practice (Eckert and McConnell-Ginet 1992; Wenger 1998) has evolved in the hospital setting where face attack is one of the licensed practices. According to Wenger (1998),

communities of practice are social and professional groups that share values, beliefs, languages and ways of doing things. As they form, they create boundaries between those who have been engaged in the practice and those who have not. These boundaries often confront newcomers or outsiders who seek entry into a community of practice. These boundaries can be experienced in a situation where one participant renders the interlocutor unable to participate effectively in a conversation. The nurses' preference for face attack has perhaps become a norm within their community of practice but is shocking to the patient who seeks help from outside that group.

5. CONCLUSION

From a theoretical perspective, we have illustrated the power-enhancing strategies of nurses who attack patients' dignity, and the detrimental effects of that exercise of power on patients as they attempt to maintain their dignity in the face of such verbal assaults. From a practical point of view, we have described a situation which is not in accord with what is considered Western best practice in hospital settings. It is clear that a community of practice has established itself where face attack is sanctioned at one social level but not at another. It would be desirable for nurses to cross the boundaries established by their community of practice and minimize blatant face attack by appreciating patients' right to respectful address and positive regard. This requires adoption of strategies that minimize verbal conflict and enhance mutual face-preserving moves, thereby stimulating sustained participation by both interacting parties.

NOTE

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