

Language, Ideology and the Construction of Illness in Selected Medical Reports from Nigerian Hospitals: A Critical Discourse Analysis

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ABSTRACT: Medical reports are foundational instruments of institutional healthcare communication that do more than record clinical observations; they actively construct illness, constitute patient identities, and enact professional authority through language. This paper analyses how post-diagnostic medical reports from Nigerian public hospitals discursively construct illness, patients, and biomedical ideology. Thirty reports were purposively sampled from three tertiary health institutions in Nigeria covering internal medicine, obstetrics and gynaecology, and general surgery. Data analysis follows Norman Fairclough's three-dimensional Critical Discourse Analysis model, supplemented by Michel Foucault's theory of discourse, knowledge, and power. The analysis identifies five thematic dimensions: the discursive construction of illness through diagnostic labelling, severity framing, and prognostic language; the construction of patient identity through agentive suppression and diagnostic substitution; the enactment of medical authority through modal constructions and certainty markers; the naturalisation of biomedical ideology; and the deployment of nominalisation, passive voice, jargon, presupposition, and euphemism as core linguistic strategies. Findings demonstrate that clinical language in Nigerian medical reports systematically marginalises patient subjectivity, naturalises institutional power, and suppresses the structural determinants of ill health. The study extends Nigerian medical discourse scholarship into written clinical documentation and has practical implications for medical education, clinical communication policy, and patient rights advocacy.

KEYWORDS: critical discourse analysis; medical discourse; illness construction; Nigerian healthcare; biomedical ideology; patient identity

1. INTRODUCTION

Language is never a neutral medium. In every institutional context, linguistic choices carry social weight, encode relationships of power, and reproduce or contest ideological assumptions. Medical discourse, as a sub-domain of institutional language, is particularly revelatory in this regard. Medical reports, discharge summaries, referral letters, and diagnostic write-ups do not merely record clinical observations; they actively construct the realities they purport to describe. When a physician writes that a patient 'was found to be' hypertensive, or that a woman 'denies' symptoms of depression, the grammatical architecture of those phrases tells us as much about institutional authority and ideological orientation as about the patient's physical condition.

The study of medical discourse has attracted sustained scholarly attention since the 1970s, with contributions from sociolinguistics, discourse analysis, and medical sociology. Mishler's (1984) foundational distinction between the 'voice of medicine' and the 'voice of the lifeworld' in clinical encounters established a productive framework for understanding how biomedical discourse systematically marginalises patient experience. The emergence of Critical Discourse Analysis (CDA) as a methodological paradigm in the 1990s, with major contributions from Norman Fairclough (1992, 1995, 2003) and Ruth Wodak (1996, 2001, 2007), provided researchers with robust tools to interrogate the ideological and social dimensions of language. Medical discourse became a productive site of application, attracting studies of clinical consultations, patient records, and health communication campaigns.

In Nigeria, research into medical discourse has gathered momentum in the twenty-first century. Scholars such as Odeunmi (2006, 2008, 2011, 2016, 2021) have contributed sustained analysis of clinical interactions in hospital settings, documenting the strategies through which Nigerian physicians enact authority, manage disclosure, and negotiate with patients. More recent work, including Odeunmi and Adeoti (2024), has extended these concerns to the management of disagreement in hospital visits. Notwithstanding these developments, written medical reports as a genre have received comparatively little scholarly scrutiny, an absence this study seeks to address.

Medical reports occupy a distinctive position within the ecosystem of healthcare communication. They are produced by credentialled professionals for professional audiences, carry legal and administrative weight, shape subsequent clinical decisions, and constitute

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enduring records of patient-institution encounters. In Nigeria, where the public health sector is characterised by severe resource constraints, institutional hierarchies that privilege specialist knowledge, and a patient population largely excluded from meaningful participation in its own care, the ideological dimensions of medical writing deserve sustained critical attention.

1.1 Statement of the Problem

Whilst the existing body of Nigerian medical discourse research has produced valuable insights into spoken clinical interaction, it has paid insufficient attention to the ideological dimensions of written medical documentation. Post-diagnostic medical reports, which constitute the textual residue of clinical encounters, remain underexplored as sites of discourse analysis. Most available studies have focused on pragmatic and conversation-analytic approaches to doctor-patient consultations, leaving the written genre of medical reports largely unexamined. This gap is especially significant given that written medical reports carry institutional authority, travel across contexts, and exert lasting influence on patient trajectories.

1.2 Aim and Objectives

This study aims to analyse the linguistic and discursive mechanisms through which illness, patient identity, and institutional ideology are constructed in post-diagnostic medical reports from Nigerian hospitals. The specific objectives are:

1. To identify the dominant linguistic features employed in selected Nigerian medical reports.
2. To examine how illness is discursively constructed through diagnostic and prognostic language.
3. To investigate the representation of patient identity and agency in medical report discourse.
4. To uncover the ideological assumptions embedded in diagnostic and treatment narratives.
5. To analyse how institutional authority and medical power are enacted through clinical language.

1.3 Research Questions

The following research questions guide this study:

- i. What linguistic features characterise post-diagnostic medical reports from Nigerian hospitals?
- ii. How is illness discursively constructed in the language of these reports?
- iii. How are patients represented, and what forms of identity and agency are available to them within this discourse?
- iv. What ideological assumptions are naturalised through the language of medical reporting?
- v. How does the language of medical reports enact institutional authority and professional power?

1.4 Significance of the Study

Academically, this study advances the application of CDA to written medical texts in the Nigerian context, extending existing scholarship beyond spoken clinical interaction into written institutional documentation. For medical practitioners and educators, the findings hold practical implications: understanding how clinical language encodes ideology may foster greater reflexivity about the epistemic and ethical dimensions of medical writing. For policymakers, the study provides evidence-based grounds for reconsidering documentation standards in ways that more adequately recognise patient subjectivity. For patient rights advocates, it offers discursive evidence of the ways in which institutional language can marginalise those in the care of medical institutions.

1.5 Scope and Delimitation

The study is delimited to thirty post-diagnostic medical reports collected from three publicly funded tertiary health institutions in Nigeria: a university teaching hospital, a federal medical centre, and a specialist hospital. The reports span a five-year collection window (2018-2022) and cover internal medicine, obstetrics and gynaecology, and general surgery, with ten reports per speciality. The analysis focuses on the textual and discursive dimensions of the reports as linguistic artefacts; it does not involve clinical evaluation of medical content, nor does it extend to spoken clinical interactions or patient perspectives.

2. LITERATURE REVIEW

2.1 Critical Discourse Analysis

Critical Discourse Analysis is a theoretically diverse but thematically coherent approach to the study of language in social context. Its central premise is that discourse is not merely a reflection of social reality but a constitutive element of it: language shapes as well as responds to social structures, power relations, and ideological formations. As Fairclough (2003, p. 2) observes, language is 'an irreducible part of social life, dialectically interconnected with other elements of social life'. CDA researchers are concerned not only with describing what language does but with interrogating why particular linguistic choices are made, whose interests they serve, and what social relations they reproduce or resist.

Fairclough's (1992) three-dimensional model analyses discourse at three interrelated levels: as text (the formal linguistic properties of utterances), as discursive practice (the processes of text production, distribution, and consumption), and as social practice (the broader institutional and ideological contexts within which texts are embedded). This tripartite architecture enables the analyst to

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move from micro-level textual features to macro-level social structures. It is particularly well suited to the analysis of institutional texts such as medical reports, which are produced within specific professional contexts and consumed in ways that have tangible consequences for the individuals they represent.

2.2 Medical and Institutional Discourse

Medical discourse encompasses the full range of communicative practices through which medical knowledge is produced, legitimised, and circulated. A central concern within medical discourse studies is the concept of illness narratives: the stories that patients and practitioners construct about sickness and suffering. Drawing on narrative medicine (Charon, 2006), scholars have argued that the clinical record is itself a kind of narrative, one that prioritises the biomedical account of disease over the lived experience of illness. The distinction between disease (a pathological condition) and illness (the subjective experience of that condition) is fundamental: medical reports overwhelmingly foreground disease and systematically marginalise illness, a discursive pattern with significant consequences for patient-centred care.

Institutional discourse refers to communication constrained by institutional roles, rules, and purposes. Sarangi and Roberts (1999) established that both medical talk and medical writing are profoundly shaped by the institutional contexts in which they occur, and that genre mediates between individual communicative acts and broader institutional structures. Within CDA, ideology is understood not as a set of consciously held beliefs but as a system of assumptions so deeply embedded in discourse that they appear natural and self-evident. Following Fairclough (1992, p. 87), ideologies are 'representations of aspects of the world which contribute to establishing and maintaining relations of power, domination, and exploitation'.

2.3 Review of Empirical Studies

2.3.1 International Studies

Mishler (1984) distinguished between the 'voice of medicine' and the 'voice of the lifeworld' in clinical encounters, arguing that the former systematically suppresses the latter. Although concerned primarily with spoken consultation, his framework has proven durable as a lens for written clinical discourse and remains foundational to subsequent medical discourse scholarship. Ainsworth-Vaughn (1998) examined the negotiation of power and identity in medical interviews in American private-practice settings, demonstrating both the structural advantages of the physician role and the subtle strategies through which patients occasionally resist clinical discourse. Sarangi and Roberts (1999) produced an influential edited volume on talk, work, and institutional order in clinical settings, establishing that institutional language routinely shapes how knowledge and professional identities are constituted in interaction.

Skelton and Hobbs (1999) applied corpus concordancing to primary-care consultation language, demonstrating that physicians' language reflects patterns of social power and that jargon is deployed to manage communicative dynamics. Charon (2006) argued for the clinical record as a form of narrative that positions disease as an object of biomedical knowledge whilst marginalising the patient's lived experience. Semino et al. (2018) presented a corpus-based study of illness metaphors, demonstrating that different framings of illness carry distinct ideological implications for patient agency. Wodak (2007) demonstrated that pragmatic devices such as presuppositions and indirect constructions are central mechanisms through which institutional authority is exercised and ideological assumptions naturalised. Fairclough (2003) argued that nominalisations, passive structures, and rhetorical claims to objectivity are central textual mechanisms through which institutional power is naturalised. Van Dijk (1998) argued that textual features such as lexical choices and presuppositions are the primary mechanisms through which ideological structures are realised in language. Coulthard and Johnson (2007) examined the language of medical expert reports, demonstrating that their rhetorical conventions construct professional authority and insulate expert claims against lay challenge.

2.3.2 African and Nigerian Studies

Adegbite and Odebunmi (2006) examined discourse tact in doctor-patient interactions in English in Nigeria, demonstrating that clinical communication draws on both standard linguistic resources and locally inflected communicative norms. Odebunmi (2008) identified three principal strategies of diagnostic news delivery in Nigerian hospitals: asserting the condition, citing the evidence, and mitigating the news through veils and hedges, with this third strategy being distinctive to Nigerian clinical contexts and absent from Western models. Odebunmi (2011) investigated nine concealment strategies, including jargonisation, veiling, mitigation, euphemisation, and doublespeak, demonstrating that concealment in Nigerian clinical contexts is a culturally patterned strategy with specific pragmatic functions.

Odebunmi (2016) examined the discursive management of accountability for poor health in post-recommendation consultations in Southwestern Nigerian hospitals, highlighting the ideological dimensions of compliance discourse. Odebunmi (2021a) investigated the negotiation of patients' therapy proposals in paternalistic and humanistic Nigerian clinical encounters, demonstrating that power-imbued strategies stifle patient voice in doctor-centred clinics. Odebunmi (2021b) analysed discursive repetitions and voices in Nigerian clinical meetings, employing Bakhtinian concepts to examine how institutional and patient voices are managed. Odebunmi and Adeoti (2024) examined the discursive management of patient disagreement with clinical recommendations, demonstrating that

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participatory and non-participatory orientations reflect and reproduce clinical power dynamics. Bamgbose (2012) demonstrated that the structural dominance of English in institutional contexts creates systematic patterns of exclusion for speakers of indigenous Nigerian languages. Adegbija (2004) argued that the monological and authoritative register of Nigerian institutional communication reflects hierarchical patterns of authority that pervade professional settings including healthcare. Odebunmi's (2006) foundational study of locutions in medical discourse in Southwestern Nigeria demonstrated that clinical communication brings standard lexical choices and local linguistic initiatives into a distinctive pragmatic union.

2.4 Research Gap

The foregoing review reveals a substantial body of scholarship on medical discourse in Nigerian and broader African contexts. However, the reviewed studies focus predominantly on spoken clinical interaction and health policy discourse. Written post-diagnostic medical reports as a distinct genre remain largely unexamined within Nigerian and African CDA scholarship. Given the institutional significance of these documents and their role in constructing enduring representations of patients and their conditions, this gap is both theoretically and practically consequential. The present study addresses this lacuna directly.

3. THEORETICAL FRAMEWORK

3.1 Fairclough's Three-Dimensional CDA Model

This study adopts Fairclough's (1992, 2003) three-dimensional model as its primary analytical framework. At the level of textual analysis, the study attends to vocabulary, modality, transitivity, nominalisation, and passive voice constructions. Nominalisation converts verbal processes into noun phrases, suppressing agency and naturalising processes as states. Passive constructions similarly suppress agency and foreground results over processes. Modality expresses degrees of certainty, necessity, and possibility through modal verbs and allied constructions. Intertextuality, the ways in which texts draw upon and respond to other texts and genres, is examined at the level of discursive practice. At the level of social practice, the analysis situates the discourse of medical reports within the broader context of Nigerian healthcare, attending to the ideological commitments of biomedicine and the institutional hierarchies that shape clinical documentation. It is at this level that the analysis becomes explicitly critical, interrogating the ways in which the discourse of medical reports reproduces and legitimises particular configurations of power and knowledge.

3.2 Foucault's Theory of Discourse and Power

Foucault's theorisation of discourse, knowledge, and power provides a complementary framework for understanding the macro-level ideological dimensions of medical reporting. Foucault (1973) introduced the concept of the medical gaze, the clinical mode of perception through which the body is constituted as an object of knowledge and surveillance. The medical gaze transforms the patient from a suffering subject into a legible body, a text to be read by the trained clinician. This transformation is accomplished not merely in the clinical encounter but in the documentation practices that record and transmit clinical findings. For Foucault (1972), discourse actively produces the objects of which it speaks: medical discourse does not simply reflect disease but constitutes it as a particular kind of object that defines the patient in terms of pathology. Foucault's (1980) concept of power/knowledge highlights the inseparability of knowledge production and the exercise of power, a dynamic that is central to understanding the double function of medical reports as simultaneously instruments of clinical knowledge and instruments of institutional authority.

4. METHODOLOGY

4.1 Research Design

This study employs a qualitative research design appropriate for research concerned with meaning, interpretation, and the social dimensions of language, all of which are central to the aims of Critical Discourse Analysis. Rather than seeking to quantify linguistic features across a large corpus, the study prioritises depth of analysis, attending to the nuanced interplay of textual features, discursive practices, and social contexts.

4.2 Data and Sampling

The data consist of thirty post-diagnostic medical reports collected from three publicly funded tertiary health institutions in Nigeria: a university teaching hospital, a federal medical centre, and a specialist hospital. The reports cover three medical specialities, with ten reports from each of internal medicine, obstetrics and gynaecology, and general surgery. The reports were produced between 2018 and 2022 and range in length from approximately 200 to 900 words. Reports were selected through purposive sampling (Patton, 2002), prioritising completeness (containing diagnosis, clinical findings, and treatment recommendations), institutional variety, and sufficient textual substance to sustain detailed discourse analysis.

4.3 Ethical Considerations

The study was conducted in accordance with ethical standards applicable to research involving human health data. Institutional approval was obtained from the ethics review boards of each participating hospital prior to data collection. All patient identifying

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information was removed before analysis and replaced with coded labels. Participating institutions are identified only by functional category rather than by name. The research was conducted with full respect for the privacy of all patients whose clinical experiences are documented in the data.

4.4 Method of Analysis

Analysis follows Fairclough's (1992, 2003) three-dimensional CDA model. Each report was subjected to systematic textual analysis, with particular attention to vocabulary selection, modality, transitivity, nominalisation, and passive voice. Patterns identified at the textual level were then interpreted in relation to the discursive practices through which the reports were produced and circulated, and subsequently situated within the broader context of Nigerian healthcare discourse and biomedical ideology. The analysis was iterative, moving repeatedly between individual textual instances and broader analytical themes. Foucault's concepts of the medical gaze and power/knowledge were employed to theorise the macro-level ideological implications of the patterns identified. Extracts are identified by speciality code and report number: IM = Internal Medicine; OG = Obstetrics and Gynaecology; GS = General Surgery.

5. ANALYSIS AND FINDINGS

5.1 The Discursive Construction of Illness

5.1.1 Diagnostic Labelling

Diagnostic labels function as the primary linguistic unit through which illness is constituted in the reports. They appear at the opening of virtually every report and recur throughout, gradually replacing biographical reference with pathological categorisation.

Extract 1 (IM/07)

'Patient A is a 47-year-old hypertensive, diabetic male who presented with features of hypertensive heart disease compounded by poorly controlled Type 2 diabetes mellitus with peripheral neuropathy.'

Two distinct diagnostic operations are performed in this single sentence. The adjectives 'hypertensive' and 'diabetic' function not merely as clinical descriptors but as nominal predicates: they transform the biographical subject into a medical identity. The patient is not a person who has hypertension; he is 'a hypertensive'. This substitution performs what Foucault (1973) describes as the constitutive function of the medical gaze, whereby the clinician's gaze actively produces the patient as a particular kind of object. The phrase 'poorly controlled' introduces an evaluative moral dimension: the patient's condition is represented not simply as a medical state but as evidence of inadequate self-management, encoding a negative assessment without any indication of the structural, financial, or social factors that may constrain diabetic self-care in the Nigerian context.

Extract 2 (IM/12)

'Patient B, a 60-year-old male, is a known case of hypertension, chronic kidney disease Stage 3, and benign prostatic hyperplasia. He presented with worsening breathlessness over three days in the setting of his established renal impairment.'

The construction 'known case of' performs a double ideological function. It positions the diagnostic categories as antecedently established professional knowledge rather than as contingent clinical interpretations, naturalising diagnosis as objective discovery rather than interpretive act. The enumeration of three concurrent conditions in a single prepositional phrase constructs the patient as an accumulation of pathologies rather than as a person with a history. As Mishler (1984) noted, the voice of medicine systematically replaces the voice of the lifeworld; here, the patient's biography is reduced entirely to a list of diagnostic codes.

5.1.2 Severity and Risk Framing

Extract 3 (OG/03)

'This is a high-risk pregnancy, complicated by severe pre-eclampsia superimposed on pre-existing hypertension and a previous uterine scar from two prior lower segment caesarean sections. The clinical picture is concerning for imminent eclampsia.'

The nominalisation 'high-risk pregnancy' converts a series of clinical judgements into a reified category that carries its own institutional weight and authorises particular clinical interventions. The passive construction 'complicated by' presents complications as properties inherent in the pregnancy rather than as observations made by a clinician. The phrase 'concerning for imminent eclampsia' modulates certainty carefully: 'concerning' hedges the prognosis whilst 'imminent' projects urgency, a rhetorical pairing that simultaneously acknowledges uncertainty and asserts the need for decisive intervention.

Extract 4 (GS/04)

'Examination findings are consistent with advanced malignancy. The tumour is of significant size and appears to have invaded the adjacent bowel wall. Prognosis is poor. Palliative intent is recommended.'

This extract condenses an extraordinarily difficult clinical situation into four sentences. 'Advanced malignancy' transforms a pathological process into a static entity. 'Significant size' deploys evaluative vocabulary to calibrate severity without specifying precise measurements, preserving the clinician's interpretive latitude. The phrase 'appears to have invaded' modulates certainty through the semi-modal 'appears'. The abrupt shift to 'Prognosis is poor', a clause with no hedging whatsoever, represents stark

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certainty assertion. The final sentence, 'Palliative intent is recommended', employs the passive voice to suppress agency: it is not stated who recommends palliative intent, nor is there any reference to patient consultation. Clinical decision-making is presented as an institutional process without a human agent.

5.1.3 Prognostic Language

Extract 5 (IM/19)

'The prognosis for meaningful functional recovery is guarded given the extent of neurological compromise. The patient is unlikely to return to his pre-morbid level of activity. Long-term institutional support may be required.'

The phrase 'guarded prognosis' is a conventionalised clinical euphemism that constructs serious uncertainty about recovery as a technical term, insulating the assessment from lay challenge. The phrase 'meaningful functional recovery' nominates a concept of health defined by functional performance rather than subjective wellbeing, reflecting the biomedical ideology of the institution. The progression from 'guarded' to 'unlikely' to 'may be required' constructs a narrative of progressive restriction that is entirely absent the patient's own perspective on his circumstances and aspirations.

5.2 The Construction of Patient Identity

5.2.1 Agentive Suppression

Extract 6 (OG/09)

'Patient C was reviewed on the ward. She was found to have a uterine fundal height inconsistent with her stated gestational age. An urgent ultrasound was ordered. She was subsequently counselled regarding the possibility of intrauterine growth restriction and the implications for foetal wellbeing.'

Across these four sentences, the patient appears as grammatical subject twice, but in both instances the predicate is a passive construction: she is found, she is counselled. The agent performing these clinical acts is grammatically erased. The patient is the object of clinical observation, clinical technology, and clinical communication. The phrase 'counselled regarding the possibility' is particularly revealing: 'counselled' suggests a dialogic process, yet its passivisation removes any sense of the patient's response, reaction, or understanding. Her subjectivity is grammatically absent from an encounter ostensibly conducted in her interest.

Extract 7 (GS/02)

'The patient was consented and prepared for theatre. Intraoperative findings revealed a perforated appendix with localised peritonitis. A right hemicolectomy was performed. The patient was transferred to the intensive care unit post-operatively and was commenced on broad-spectrum intravenous antibiotics.'

The sequence 'was consented', 'was prepared', 'was transferred', 'was commenced' constructs a clinical narrative in which the patient progresses through institutional states without exercising any evident agency. The phrase 'The patient was consented' is especially ideologically significant: it reduces the ethically complex process of informed consent to a single passive verb, presenting consent as a procedural step accomplished to the patient rather than with the patient. This grammatical construction naturalises a model of clinical care in which the patient's role is compliance rather than participation.

5.2.2 Identity Reduction Through Diagnostic Substitution

Extract 8 (IM/03)

'This 38-year-old sickle cell patient was admitted for the third time this year in vaso-occlusive crisis. As with previous admissions, she presented late and was poorly compliant with her hydroxyurea regimen. The sickler requires ongoing haematological review.'

The referential shift in this extract is stark. The patient begins as 'this 38-year-old sickle cell patient' and ends as 'the sickler', a noun formed directly from the diagnostic label, absent any biographical marker. This performs what Foucault (1973) describes as a complete clinical objectification. The phrase 'poorly compliant with her hydroxyurea regimen' attributes agency to the patient only in the negative sense: her principal presence as an agent in this text is her failure to comply. The phrase 'presented late' constructs the timing of her care-seeking as a patient failing without reference to the material barriers, including costs, transportation, work obligations, and childcare, that shape patterns of healthcare access in Nigeria.

5.2.3 Attribution of Negative Agency

Extract 9 (IM/14)

'Patient D defaulted on antihypertensive medications for approximately six months prior to this admission. She denied any symptoms during this period despite documented blood pressure readings in excess of 180/110 mmHg. She failed to attend two scheduled outpatient reviews and refused a previous recommendation for cardiac monitoring.'

The verb choices in this extract constitute a discourse of patient culpability. 'Defaulted', 'denied', 'failed to attend', and 'refused' form a lexical sequence that constructs the patient as non-compliant, evasive, and obstinate. The verb 'denied' carries the dual meaning of reporting the absence of symptoms and of contesting a claim, positioning the patient's account as potentially unreliable. The phrase 'despite documented blood pressure readings' deploys the evidential marker 'documented' to authenticate the clinical record

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over and against the patient's account. The patient's subjectivity, her reasons, circumstances, and perspective, is entirely absent from a passage that constructs her as the author of her own clinical deterioration.

Extract 10 (OG/15)

'She had not attended any antenatal clinic and presented only at 36 weeks of gestation. The patient was unbooked. There was poor maternal weight gain and no documented ultrasound history.'

The term 'unbooked' carries particular ideological weight in the Nigerian obstetric context, where it functions as a diagnostic-administrative category that indexes non-compliance with institutional expectations of antenatal care. Its deployment as a predicative adjective simultaneously describes an institutional state and assigns responsibility for it to the patient. The patient's body and history are defined by absences and failures. The structural conditions that constrain antenatal attendance in Nigeria, including distance, cost, waiting times, and distrust of institutions, are not mentioned.

5.3 Medical Authority and Institutional Power

5.3.1 Modal Construction of Clinical Necessity

Extract 11 (GS/08)

'Patient E must be consented for urgent laparotomy. Anaesthetic review is mandatory prior to theatre. Pre-operative blood transfusion must be administered. A nasogastric tube is to be inserted immediately. The patient should be transferred to a monitored bed forthwith.'

The sequence of modal constructions, 'must', 'is mandatory', 'must', 'is to be', 'should', constructs a series of clinical interventions as obligations that admit no alternative. The agent of all these obligations is suppressed through passive construction, presenting clinical decisions as systemic necessities rather than as exercises of professional judgement. The patient's consent is positioned as a procedure to be performed rather than as an autonomous decision to be facilitated. The word 'mandatory' invokes the language of institutional rule. As Fairclough (1992) notes, the transformation of social processes into obligations through modal verbs is a key mechanism through which institutions naturalise power and present contingent decisions as inevitable.

5.3.2 Certainty Assertions in Diagnostic Discourse

Extract 12 (IM/22)

'Electrocardiography demonstrates left ventricular hypertrophy with strain pattern. Echocardiography confirms dilated cardiomyopathy with an ejection fraction of 28%. Chest X-ray reveals cardiomegaly with pulmonary vascular congestion. These findings are in keeping with hypertensive heart disease of advanced grade.'

The verbs 'demonstrates', 'confirms', and 'reveals' are stative verbs of epistemic disclosure: they present diagnostic technologies as subjects that actively disclose truths about the patient's body, rather than as instruments whose outputs require clinical interpretation. The nominalisation of each investigation erases the clinical labour involved in performing and interpreting these tests, presenting them as self-executing procedures that yield unmediated knowledge. The evidential construction 'in keeping with' presents the diagnosis as a logical necessity that follows from the data rather than as an interpretive act performed by a clinician. Foucault's (1973) medical gaze is here fully textualised: the patient's body becomes a legible text whose meaning is produced by and for the clinical apparatus.

Extract 13 (GS/17)

'Histopathological examination confirms moderately differentiated adenocarcinoma of the rectum. Staging investigations are consistent with T3N1M0 disease. MDT review endorses a recommendation for neoadjuvant chemoradiation prior to definitive surgical resection.'

The verb 'confirms' performs maximum certainty assertion: histopathology does not suggest or indicate but confirms. The phrase 'MDT review endorses' presents the multidisciplinary team as an institutional collective whose deliberative process is invisible in the text. The recommendation is presented as an institutional product rather than as the outcome of a negotiation involving the patient.

5.3.3 Suppression of Patient Voice in Communication Clauses

Extract 14 (OG/06)

'The patient was extensively counselled regarding the risks of continuing the pregnancy, including maternal mortality, foetal demise, and permanent renal damage. She was informed of the option of surgical intervention. She acknowledged understanding. Her husband was present and concurred with the clinical team's recommendation.'

This extract purports to describe a communicative encounter in which the patient's informed consent is secured. Yet the patient's voice is entirely absent. She is 'counselled' (passive), 'informed' (passive), and 'acknowledged understanding', the closest she comes to active participation. The final sentence introduces the husband as a co-participant in the consent process, reflecting the patriarchal institutional norms of the Nigerian healthcare context, and presents the clinical recommendation as something to which both patient and husband respond rather than something that emerged from a joint decision-making process.

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5.4 Ideological Assumptions Embedded in Reports

5.4.1 The Naturalisation of Biomedical Authority

Extract 15 (IM/08)

'The clinical assessment is that Patient F is suffering from a hypertensive crisis secondary to non-compliance with prescribed antihypertensive therapy. Objectively, blood pressure was 230/140 mmHg on presentation. This is an emergency requiring immediate pharmacological intervention as per established hypertensive emergency protocol.'

The discourse marker 'objectively' distinguishes the numerical blood pressure reading from the preceding clinical interpretation, implicitly claiming that numerical measurement constitutes objective knowledge whilst clinical interpretation is merely subjective. The phrase 'as per established hypertensive emergency protocol' constructs the clinical decision as a technical application of validated evidence rather than as a professional judgement, presenting biomedical authority as self-evidently appropriate and foreclosing discussion of alternative frameworks.

Extract 16 (GS/13)

'Given the clinical evidence, the balance of risk strongly favours operative intervention. The patient's stated preference for conservative management is noted but is not in alignment with best clinical practice in this setting. Surgical consent is to be sought.' This extract is among the most explicitly ideological in the dataset. The phrase 'the patient's stated preference is noted' acknowledges patient preference but immediately subordinates it through the adversative conjunction 'but': the preference is 'not in alignment with best clinical practice'. The patient's preference is 'noted', a verb that records without endorsing, whilst clinical practice is 'best', an evaluative superlative that admits no equivalent. The passive 'Surgical consent is to be sought' presents the subsequent consent process as a procedural requirement rather than as a genuine renegotiation of the clinical plan in light of the patient's expressed wishes.

5.4.2 The Ideology of Individual Patient Responsibility

Extract 17 (IM/16)

'Patient G has a long-standing history of poorly controlled hypertension attributable in part to irregular medication use and inconsistent dietary compliance. He has defaulted on clinic visits on multiple occasions. This admission represents the fourth hypertension-related hospitalisation in two years, suggesting ongoing non-compliance as the primary driver of recurrent decompensation.'

The phrase 'attributable in part to irregular medication use and inconsistent dietary compliance' locates the source of poor disease control in patient behaviour. The words 'irregular' and 'inconsistent' construct the patient's conduct against an implicit standard of regularity. 'Defaulted on clinic visits' carries financial and legal overtones of obligation unmet. Most significantly, 'suggesting ongoing non-compliance as the primary driver of recurrent decompensation' deploys clinical language to formalise a causal theory that places responsibility entirely with the patient. The structural conditions within which medication adherence occurs in Nigeria are nowhere present. This pattern confirms Odebunmi's (2016) findings on the discursive management of accountability in Nigerian clinical consultations, extending that analysis from spoken to written discourse.

Extract 18 (OG/11)

'This patient had access to antenatal services but elected not to utilise them. She was aware of her hypertensive status from a previous pregnancy but did not seek review during this gestation. These are significant contributory factors to the adverse foetal outcome.'

The verb 'elected' belongs to the discourse of deliberative agency, implying that the patient made a considered selection from available alternatives. The phrase 'These are significant contributory factors to the adverse foetal outcome' frames non-attendance causally, constructing the patient as a contributor to the compromise of her baby. This construction suppresses the material reality of women's health-seeking behaviour in Nigeria, where clinic attendance is shaped by cost, distance, familial obligations, cultural norms, and distrust of institutional medicine.

5.4.3 The Suppression of Social and Structural Context

Extract 19 (IM/25)

'Patient H is a 52-year-old male with a background of uncontrolled Type 2 diabetes mellitus, hypertension, and dyslipidaemia presenting with acute inferior myocardial infarction. He has been poorly compliant with his medications. He was commenced on dual antiplatelet therapy, statin, beta-blocker, and ACE inhibitor. He will require coronary angiography and likely percutaneous coronary intervention.'

The clinical management described here represents a treatment pathway derived from high-income country guidelines. Its application as a standard recommendation in a Nigerian public hospital setting involves assumptions about financial resources, institutional capacity, and follow-up infrastructure that are nowhere interrogated in the text. The patient's 'poor compliance with medications' is noted without consideration of whether the financial cost of multiple medications prescribed represents a structural

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barrier to adherence. The gap between the clinical ideal and the material realities of the patient's context is rendered invisible by the genre's commitment to the discourse of clinical objectivity and universal biomedical standards.

5.5 Linguistic Strategies in Nigerian Medical Reports

5.5.1 Nominalisation

Extract 20 (GS/06)

'Abdominal examination revealed distension and guarding. Percussion confirmed the presence of free gas. The diagnosis of perforated hollow viscus was established. A decision for operative management was reached following MDT review.'

Four nominalisations occur in four sentences: 'distension and guarding', 'the presence of free gas', 'the diagnosis of perforated hollow viscus', and 'a decision for operative management'. Each suppresses an agent and a process. The passive construction 'was reached' presents the decision as a logical outcome rather than as a professional judgement made by named individuals. The patient is entirely absent from this passage, which reads as a self-executing clinical narrative. This pattern confirms Fairclough's (1992) account of nominalisation as a principal mechanism through which contingent social processes are naturalised as stable entities.

5.5.2 Passive Constructions and Agency Suppression

Extract 21 (OG/18)

'Patient I was reviewed. She was found to be in active labour at 4 cm cervical dilatation. Foetal heart rate monitoring was commenced. Augmentation with oxytocin was initiated after four hours of observed progress. She was eventually delivered by emergency lower segment caesarean section following foetal distress. The baby was transferred to the neonatal intensive care unit. She was commenced on prophylactic antibiotics and monitored in the recovery room.'

This extract narrates the entire course of a labour and surgical delivery without once attributing an action to an identifiable agent. The patient appears as subject in several clauses, but in every instance the verb is passive. The birth of the baby, 'She was eventually delivered by emergency lower segment caesarean section', is presented as if the operative delivery were a property of the patient rather than a surgical procedure performed upon her by a clinician. The institutional processes unfold upon the patient as if she were an inert substrate through which clinical events pass, a textual enactment of the depersonalisation that Odebunmi (2011) documented in spoken Nigerian clinical encounters.

5.5.3 Technical Terminology and Jargonisation

Extract 22 (GS/15)

'Intraoperative findings included a 10 cm right ovarian teratoma with dermoid elements, bilateral hydrosalpinges, and dense adnexal adhesions consistent with chronic pelvic inflammatory disease. A right salpingo-oophorectomy and adhesiolysis were performed. The left tube was noted to be patent on chromopertubation. Uterine assessment was unremarkable.'

The extract deploys a dense repertoire of technical terminology entirely inaccessible without specialist medical training. This lexical density simultaneously conveys clinical precision and constructs a discursive boundary between the professional and the lay, immunising the clinical account against lay challenge and positioning the clinician as the sole authoritative interpreter of the clinical record. As Odebunmi (2011) observed in the context of spoken clinical discourse in Nigeria, jargonisation functions as a concealment strategy that manages the information environment of the clinical encounter in ways that reinforce asymmetric power relations. The present analysis extends this finding to written clinical documentation.

5.5.4 Presupposition

Extract 23 (IM/20)

'As per the established standard of care for this condition, the patient is to receive intravenous insulin infusion, aggressive fluid resuscitation, and continuous cardiac monitoring. This management plan represents best practice in the acute phase.'

The phrase 'as per the established standard of care' carries multiple presuppositions: that a standard of care exists, that it has been established, that it is agreed upon, and that it is applicable to this patient's situation. None of these is interrogated; they are presented as self-evident background facts. 'Represents best practice' deploys a superlative evaluative construction that presupposes a hierarchy of practices and positions this one at its apex, insulating the clinical recommendation from alternative perspectives and constituting the management plan as an uncontroversial application of objective knowledge.

5.5.5 Euphemism and Prognostic Softening

Extract 24 (IM/23)

'The prognosis for long-term survival remains guarded. The family has been sensitised to the likely trajectory of the illness. Goals of care discussion is pending. Comfort measures are to be considered in the event of further deterioration.'

This extract manages the communication of a terminal prognosis through a sequence of progressively softening euphemisms. 'Prognosis remains guarded' substitutes professional circumspection for direct statement. 'The family has been sensitised' employs a verb drawn from immunological discourse to describe the communication of a fatal prognosis, constructing an emotionally

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devastating encounter as a technical process of information transmission. 'Goals of care discussion is pending' defers to an institutional protocol that constructs a deeply human conversation as a procedural checkpoint. 'Comfort measures are to be considered' employs clinical euphemism to refer to palliative care. These strategies parallel the veiling and mitigation that Odebunmi (2008) documented in spoken Nigerian clinical discourse, suggesting that concealment practices are reproduced systematically in written clinical documentation.

6. DISCUSSION

The analysis presented across the five findings themes produces a coherent picture of how language in Nigerian medical reports functions as an instrument of biomedical ideology, institutional power, and patient depersonalisation. This section draws together the major findings and situates them within the theoretical frameworks and empirical literature that ground this study.

The most pervasive finding across the corpus is the systematic absence of the patient as a biographical subject. Across all thirty reports, the patient's voice, perspective, expressed preferences, and life circumstances are either entirely absent or marginalised to the point of invisibility. This finding resonates deeply with Mishler's (1984) foundational argument that the voice of medicine systematically suppresses the voice of the lifeworld. In the present study, however, this suppression is even more complete than in spoken consultations: the written report is produced after the clinical encounter and for a professional audience, which means there is no institutional requirement to negotiate with the patient's perspective in the way that spoken interaction sometimes necessitates. The report is the clinician's monologue about the patient, produced in the patient's absence and often circulated entirely beyond their awareness.

The findings on diagnostic labelling and identity reduction confirm and extend Foucault's (1973) account of the medical gaze. The progressive shift from biographical reference to diagnostic substitution, from patient name to 'the patient' to 'the hypertensive' to 'the sickler', tracks the clinical record's production of the patient as an institutional case rather than a biographical person. This process is not incidental to the genre but constitutive of it: the medical report is the primary textual instrument through which the medical gaze is institutionally realised and circulated.

The findings on ideological assumptions confirm Fairclough's (1992, 2003) account of the role of discourse in naturalising institutional power. The reports employ presuppositions, certainty markers, the rhetoric of objectivity, and the modal construction of clinical necessity to present biomedical authority as self-evidently legitimate and clinically determined decisions as technical necessities rather than as exercises of professional judgement within contexts of institutional hierarchy and resource constraint. The consistently moralising tone of compliance discourse, in which patients are represented as the authors of their own clinical deterioration, confirms the ideological function of individual responsibility attribution identified across the corpus. This pattern resonates with Odebunmi's (2016, 2021a) findings on the discursive management of accountability in Nigerian clinical encounters, extending that analysis from spoken to written discourse.

The findings on linguistic strategies confirm several patterns documented in existing medical discourse scholarship. The pervasiveness of nominalisation and passive voice in the corpus is consistent with Skelton and Hobbs's (1999) corpus-based findings on the grammar of clinical documentation. The institutional authority-performing function of technical terminology connects to Odebunmi's (2011) account of jargonisation as a concealment strategy in Nigerian clinical discourse. The findings on euphemism in prognostic language extend both sets of analyses by showing how softening strategies manage terminal prognosis within the register of institutional objectivity, constructing dying as a technical process rather than a human experience.

One dimension of the findings that warrants particular attention is the near-total absence of social or structural contextualisation in the corpus. In the context of a public health system characterised by severe resource constraints, high rates of catastrophic health expenditure, fragmented service provision, and deep inequalities of access, the systematic exclusion of these conditions from clinical documentation has significant ethical implications. Medical reports that attribute treatment failure to patient non-compliance without acknowledging the structural determinants of that non-compliance do not merely describe a neutral clinical reality; they participate in the reproduction of an ideological account of healthcare that naturalises institutional failures as patient failings and insulates the healthcare system from accountability for its own inadequacies.

7. CONCLUSION

This study has demonstrated that post-diagnostic medical reports from Nigerian hospitals are not neutral records of clinical observation but are discursively constructed texts that encode ideological assumptions, enact institutional power, and fashion patient identities in ways that consistently privilege biomedical authority over patient subjectivity. Through the deployment of nominalisation, passive constructions, modal certainty markers, depersonalising terminology, and technical nomenclature, these reports naturalise clinical authority, marginalise patient agency, and reproduce the ideological commitments of biomedicine in the context of Nigerian public healthcare.

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The study makes several contributions. Theoretically, it extends the application of Fairclough's CDA model and Foucault's discourse theory to a previously underexamined genre of Nigerian institutional discourse. Empirically, it provides the first sustained analysis of written post-diagnostic medical reports as a genre within Nigerian CDA scholarship, demonstrating through systematic close reading of twenty-four corpus extracts that the ideological dimensions of Nigerian clinical communication are not confined to spoken interaction but are fully reproduced, and in some respects more completely institutionalised, in written documentation. Practically, it offers evidence-based grounds for reconsidering clinical documentation practices in the interest of more equitable and patient-centred healthcare communication.

Limitations of the study include the relatively small sample drawn from three institutions; the findings cannot be generalised without qualification to the full range of Nigerian healthcare settings. Future research should extend the analysis to broader institutional contexts, a wider range of documentation genres, and larger datasets amenable to corpus-linguistic analysis. Studies triangulating textual analysis with clinician and patient interviews would complement the present study's textual focus and enrich understanding of the relationship between documentation practices and clinical culture.

For medical practitioners and educators, the findings hold clear implications: clinical training should incorporate explicit attention to the social and ethical dimensions of medical writing, including the ideological consequences of routine documentation choices. For policymakers, the study provides grounds for considering national guidelines for clinical documentation that explicitly address equity, patient dignity, and the structural determinants of health. For patient rights advocates, the discursive evidence assembled here reinforces the case for extending patients' rights to encompass meaningful access to and comprehension of their own clinical records.

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Conflict of Interest Statement

The author(s) declare no conflict of interest in connection with this manuscript.

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