DISCOURSE DEVICES AND COMMUNICATIVE FUNCTIONS IN DOCTOR-PATIENT VERBAL INTERACTIONS IN TWO FEDERAL TEACHING HOSPITALS IN NIGERIA

BY

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CERTIFICATION

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DEDICATION

I dedicate this research work to Almighty God who, in his infinite power, mercy and wisdom, made it possible for me to start and complete this study, in spite of the numerous challenges encountered in the course of the programme. May your name be forever glorified.

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LIST OF ABBREVIATIONS

1) Doc. – Doctor
2) Pt. – Patient
3) Pt. Rel. – Patient's relative
4) UCH – University College Hospital
5) UITH – University of Ilorin Teaching Hospital

ABSTRACT

Discourse devices are the linguistic tools employed to address inherent problems in conversation for health purposes. Doctor-patient verbal interactions face major problems in clinical discourse due to differences in linguistic, sociolinguistic, cultural backgrounds as well as professional and communicative styles of doctors and patients. Pragmatic and sociolinguistic studies on doctor-patient verbal interactions have observed relevant socio-psychological and contextual factors, but with little attention on the deployment of discourse devices aimed at solving specific communication problems in this setting. This study, therefore, explored language use in doctor-patient interactions with a view to discovering specific discourse devices deployed to enhance diagnostic communication at the University College Hospital (UCH), Ibadan and University of Ilorin Teaching Hospital (UITH), Ilorin.

The study adopted a synthesis of Brown and Levinson's politeness and M.A.K Halliday's Systemic Functional Linguistics as framework. One hundred tape recordings of doctor-out-patient interactions were made at UCH, Ibadan and UITH, Ilorin in 2013. The two hospitals were selected because they are the leading hospitals in the study locations (South-West and North-Central geo-political zones of Nigeria). Fifty of them were purposively sampled based on their strategic content (twenty-five from each hospital). The texts were transcribed, the discourse devices there-in were identified and the data were subjected to discourse analysis.

Twelve discourse devices were dominant in the data. Doctors employed phatic communion for opening consultations; direct questions and indirect questions for diagnosis; face-threatening acts for presenting diagnosis politely; language switch for explicitness, informativity and mutuality; rapport expressions, for cordiality, solidarity and open communication; and religious belief for encouragement and solidarity. Counselling was employed to guide the patients on how best to handle their health. The patients employed answering for response to queries; closing of conversations for terminating consultations; repetition for emphasis; and circumlocution for communicating medical information. Interrogatives were employed for eliciting information ("Why did you come this morning?"). Declaratives were employed for providing information ("I have a problem with my teeth"). Language switch, realised by alternate use of English and Yoruba, was employed for clarity ("*E ti wa tele ni Monday*"), meaning: 'You came here on Monday'. Rapport expressions, realised by social questions, were deployed for cordiality ("What names do your friends call you?"). 'Sorry' is a culture-bound expression used for empathy and sympathy. Imperatives were employed for giving directives ("Buy these drugs"). Some of the observable problems exhibited the possibility of doctors upsetting patients who engaged in injurious health practices. There are insignificant differences in the frequency of occurrence of the discourse devices employed at the University College Hospital, Ibadan, and University of Ilorin Teaching Hospital, Ilorin. For instance, UCH doctors employed rapport expressions 101 times (7.2%), while those of UITH employed them 92 times (6.63%).

Discourse devices were deployed for addressing specific communication and health problems during diagnosis at the University College Hospital, Ibadan and University of Ilorin Teaching Hospital, Ilorin. Awareness of these, therefore, is important for a better understanding of diagnostic discourse in doctor-patient verbal interactions in the Nigerian context.

Keywords: Discourse devices, Communicative functions, Doctor-patient interactions, University College Hospital, Ibadan, University of Ilorin teaching hospital

Word count: 491

CHAPTER ONE

GENERAL 8INTRODUCTION

1.1 Background to the Study

Discourse plays a critical role in medical communication as a major part of diagnosis is carried out through conversations. Conversation is a cross exchange of subjects by people talking with each other for company and is essentially interactive in nature. According to Crystal (1992:25), discourse means a continuous stretch of language larger than a sentence, often constituting a coherent unit such as a sermon, argument, joke, or narrative. It plays a crucial role in medicine as it is the medium by which doctors and patients unravel the health challenges of patients and talk about treatment management plans.

The primary concerns of medicine are diagnosis, treatment and prevention of diseases (Martin (ed.) 2000:396), and effective communication on the part of medical doctors and nurses is crucial in attaining these goals, especially in a multilingual setting. It is common knowledge that the patients who seek medical attention in the hospitals to be used as samples in this study come from diverse cultural and linguistic backgrounds like the medical practitioners themselves. Therefore, since they are not all monolinguals, it should be expected that various types of codes will be used during their interactions.

During medical examination or diagnosis, the medical practitioners play host to the patients and, by virtue of the esteemed position they occupy, they could be given to the temptation of tacitly dictating English as the language of discussion, especially as the language of training in the various medical colleges in Nigeria is English Language. This act may go down well with patients who understand English while it will displease those who do not. In addition, when a doctor uses a local dialect that the patient understands, the patients may have a feeling of brotherliness. Conversely, when the doctor uses a dialect, slang or language that the patient does not understand, this may also elicit negative responses from the concerned patient. Therefore, when communication breakdown arises during doctor/nurse-patient verbal interaction, the objectives of medicine are threatened.

Therefore, it is clear from the above that both the doctors and the patients must be able to understand each other so that the medical practitioners might be able to diagnose the patients' diseases appropriately and proffer apposite medical solutions to the patients' medical challenges, thereby achieving the objectives of medical practice.

Bean (1975), Tanner (1976) and Myerscough (1992) observe that one of the obvious challenges of Western medicine is communication skill. Medical education pays less attention to acquisition of communication skills by its practitioners as it attaches greater importance to professional skills such as diagnosis, surgical procedures and treatment (Tanner, 1976). However, Myerscough (1992: 1) notes that people have realized that skillful communication is crucial to medical instruction. He further observes that healthcare practitioners have not acquired requisite communication expertise, and adds that teaching communication skills to medical students began only lately in Britain. According to him, the teaching of communication skills is not given adequate attention in the curriculum, scanty in scope and not formally assessed.

This phenomenon manifests on a greater scale in Nigeria. As Oloruntoba-Oju (1996) cited in Odebunmi (2006) observes, the communication problems of Nigerian medical practitioners pose a great challenge because the mandatory credit pass in West African Examination Council English required for admission into colleges of medicine does not test particular skills relating to the medical field but focuses on general competence in English. In addition, the medical students, like other undergraduates, take the Use of English which gives them a little training in communication, but they may not benefit much from it because of the restriction of the course to just a semester in the first year of the first degree duration in some universities.

The scenario described above suggests that the communication requirement of Nigerian medical students can be improved upon. Consequently, as Ogunbode (1991) observes, communication is never taught as a course in any medical school in Nigeria. Myerscough (1992) makes an effort to lessen the enormity of the problem by saying that doctors (medical practitioners generally) acquire communication skills via trial and error during practice. However, the views expressed above by both Ogunbode (1991) and Myerscough (1992) are objectionable because findings have shown that medical schools

across the length and breadth of Nigeria only admit students who have very good grades in all the required subjects, including the English Language. Therefore, it can be further argued that any student that can get a good grade in English in West African Examination Council examinations is no doubt a good user of the language. In addition, the various medical schools make students take several courses in communication as a result of the awareness that effective communication is central to effective diagnosis, explanation of medical procedures and compliance. What, however, still needs to be investigated are the discourse devices deployed by doctors during verbal interactions with patients in the hospital.

The appropriate choice of code plays a significant role in igniting a positive relationship between the doctor and the client, and setting in motion the therapeutic process that is the ultimate goal of the interaction (Odebunmi 2010:2). The importance of language use in medical discourse is evident in the attention paid to it by scholars. Heritage and Maynard's (2006) study on doctor-patient interactions identifies two directions in the research, i.e.: process analysis and microanalysis of discourse. The process analysis of discourse is predicated on Bale's (1950) coding system christened ''Interaction Process Analysis'', and studies in this school centre on the role relationship in the encounter between the doctor and the patient, specifically concentrating on the satisfaction level of the patient. The scope of the process analysis of discourse transcends primary health care and shows how doctors and patients interrelate in the visits and the way patterns of communications are handled to ensure the satisfaction of both parties.

On the other hand, the micro analytic model, owing its origin to Anthropology and Sociology, makes an attempt to remedy the defects of the process analytic model through the deployment of a fundamentally ethnographic and explanatory methodology, revealing the background orientations, individual experiences, sensibilities and objects that constitute the medical dialogue. Researchers in the micro-analytic conservatory concentrate on multilingual conversations and the communicative effects and roles of the languages (e.g. Maynard 1989, 1991a; Peraklya 1998; Odebunmi 2005.2006; Mishler (1984). Although, Heritage and Maynard's (2006) account appears very influential, it fails to concentrate exclusively on the dynamism of code selection or examination of

deployment of code choice strategies in the negotiation process. In addition, it fails to show how discourse devices are deployed during consultation and the communicative roles they play in assisting doctors to get good diagnoses and enabling patients to understand them. This study will fill this gap.

1.2 Statement of the Research Problem

A lot of research has been done in medical verbal interaction and some of the works in this direction are: Todd et al (1993), Roter et al (1998), and Odebunmi (2003) that examines the pragmatic features of English usage in hospital interactions amongst medical practitioners and patients in South-West Nigeria. Other related works include: Locutions in Medical Discourse in Southwestern Nigeria (Odebunmi 2006), Ogunbode (1991) that carries out a study on effective communication in the medical sciences in relation to teaching and learning in medical classes and, Faleke and Alo (2010) study mutual contextual beliefs in doctor-patient verbal interactions. Similarly, Mercer O'Connor (1974) uses a programmed text to study the fundamental skills in nurse-patient relationship while Adegbite (1991) studies the features of language use in Yoruba traditional medicine. Other works in this direction include: Ogunbode (1991), Oloruntoba-Oju (1996). Adegbite and Odebunmi (2006), West (1984), Frankel (1993). However, more researches are needed to reveal the discourse devices deployed in doctor-patient interactions as well as their communicative functions as they will greatly complement the efforts of the afore-mentioned scholars in this area. Therefore, this study seeks to examine these discourse devices deployed by doctors and patients during clinical interviews with a view to knowing their communicative functions.

1.3 Aim and Objectives

This research work investigates the discourse devices doctors and patients employ during consultations and explains their communicative functions, using discourse analysis techniques. The objectives of this study are:

(a) to explain how linguistic elements help to realize these discourse devices.

(b) to explain how politeness is achieved and the means employed.

(c) to explain how politeness maxims manifest in the interactions.

(d) to identify the differences and similarities between the actual discourse devices employed in the two locations.

(e) to explain the contextual factors that manifest in the interactions.

1.4 Research Questions

Research Question 1: Which discourse devices are employed in doctor-patient verbal interactions and what communicative functions do they perform?

Research Question 2: How and by what means is politeness achieved in the interactions?

Research Question 3: Which politeness maxims are observable in the interactions?

Research Question 4: Are there similarities and differences in the use of specific discourse devices between the two hospitals selected for this study and how frequently are they deployed?

Research Question 5: Which contextual factors manifest in the doctor-patient verbal interactions?

1.5 Scope of the Study

This study lays no claim to being an exhaustive study on hospital verbal interactions as it has only studied the discourse devices deployed by the doctors and patients at the University College Hospital, Ibadan and University of Ilorin Teaching Hospital, Ilorin in their verbal interactions and their communicative functions. It has, therefore, not studied the discourse devices deployed by other medical practitioners like: pharmacists, orthopaedists, nurses etc. during their verbal interactions with patients.

1.6 Significance of the Study

Studies have revealed that many researchers have worked on hospital verbal interactions with focuses that are different from or not totally similar to those of this study. This study, therefore, introduces another angle to medical discourse as it examines the discourse devices employed in doctors' verbal interactions with patients, with a view to revealing the linguistic choices doctors make to initiate and control the talk with patients in their efforts to understand and address the patients' medical challenges.

This research is, therefore, interested in applying the implements of Discourse Analysis (DA), using the parameters stated above, to offer an insight into the discourse devices doctors and patients employ to address communication challenges that threaten the elicitation and release of information for making accurate diagnoses in consulting rooms.

1.7 Operational Definition of Terms

i) **Discourse Devices**: These refer to the language tools employed by doctors and patients to overcome specific communication challenges during consultation. They are employed for the purposes of making the discourse effective.

ii) **Phatic Communion**: This refers to the use of greetings and empathy for starting clinical interviews.

iii) **Circumlocution**: This refers to description of symptoms of ailments as a result of the patients' status as non-medical experts, which deprives them of knowledge of the appropriate medical terminologies.

iv) **Language Switch**: This refers to alternation of codes within interactions and between interactions.

v) **Direct Question**: This refers to straightforward elicitation of information for diagnosis.

vi) **Indirect Question**: This refers to circuitous elicitation of information for the purposes of making clinical interviews less stressful.

vii) **Repetition**: By this is meant reiteration of words, ideas and sentences for the purpose of emphasis.

viii) **Religious Belief**: This refers to deployment of Biblical and Quranic teachings for enlightenment and encouragement.

ix) **Face-Threatening Acts**: These refer to the deployment of the elements of politeness for harmless presentation of diagnoses, and for correcting patients' unwholesome health practices.

x) **Counselling**: This refers to advising patients on how best to handle their health.

xi) **Rapport Expressions**: These refer to use of words that enable doctors and patients fraternize with each other.

xii) **Answering**: This refers to the supply of information in response to elicitation.

xiii) **Closing**: This refers to bringing clinical interviews to a close.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

Medical discourse is an encyclopaedic terminology for all kinds of verbal communication which occur within the confines of a hospital or any other health facilities between patients and practitioners. Good examples are the types of conversation that take place between patients and doctors or patients and nurses, physiotherapists and patients etc. during diagnosis, treatment, health check-ups and doctors ward round. Other examples include health literacy and medical classroom verbal interactions.

Medical discourse performs a crucial function in medicine. As modes of social action, writing and speech constitute medical and curative practices. Research has revealed that doctor-patient verbal interaction has three parts i.e.: diagnosis, treatment (prescription) and follow-up. Interestingly, all of them have different structures and characteristic features, analyzable individually or collectively. Medical discourse can be classified into two, namely: doctor-patient and patient-other medical practitioners. Each of them belongs to different registers, with a range of variations within it (van Naerssen, 1985). This study focuses on doctor-patient verbal interaction.

A lot of researchers have worked on doctor-patient verbal interactions worldwide by looking at medical discourse from different perspectives, using Discourse Analysis techniques. Harlen's (1977) work constitutes an effort to suggest measures by which the communication skills of nurses could be enhanced to enable them have a robust relationship with patients. He suggests ten commandments to achieve this but the study would have been a lot more beneficial if he had gone a step further to carry out an in-depth study of the doctors' communication challenges as well. This would have enabled him to suggest more than ten measures to remedy doctors and nurses' communication inadequacies. As things stand now, the recommended ten commandments are insufficient to tackle the problem as an extension of the scope of the study to investigating the discourse devices involved in practitioner-patient verbal interaction would have greatly enriched the work.

Oloruntoba-Oju (1996) in his paper titled ‘’Communication in Medicine’’ attempts to address the communication challenges faced by patients during consultation by suggesting that doctors should avoid medical jargons during consultation with patients but use words and expressions that they could easily understand. The recommendation is good but the use of medical jargons during discussions with patients is not the only communication problem bedeviling medical practice. Apart from the fact that jargons cannot be entirely avoided in medical discourse because it is sometimes necessary to hide the identities of certain ailments from patients in order not to create fears which could aggravate the patients' conditions, the study did not take cognizance of the need to investigate the discourse devices involved in doctors' discourses with patients to show how they could further enhance our understanding of medical discourse.

Odebunmi (2003) examines the pragmatic features of English usage in hospital interactions amongst medical practitioners and patients in South-Western Nigeria. His work offers a description of the features in terms of content, speech functions and forms, cooperative principles and conversational maxims etc. to give insights into the variety of English usage in hospital interactions in Nigeria. The work is an important contribution to the existing literature on medical discourse but it also fails to explore in details the discourse devices involved in doctor-patient verbal interactions in view of their potentiality to increase our understanding of medical discourse.

Faleke and Alo (2010) study the diverse ways in which interactions occurred in hospitals between nurses and their clients. Their study confirms the existence of certain mutual knowledge between nurse-nurse and medical practitioners (MPs) and patients/patients' relatives in their discourses which display certain forms of language.These forms of language are familiar and unfamiliar words used in nurse-nurse/other MPs, nurse-patient/patient's relatives interactions respectively for the sake of concealing information that could stigmatize or psychologically affect the patients. Some of the forms include acronyms, abbreviations, figures, body language, gesticulation etc. to communicate with patients but which the patients do not understand and see as part of the nurses' technical knowledge and professional ethics.

Taiwo and Salami (2010) in their paper titled: Discourse Acts in Antenatal Clinic Literacy Classroom in South-Western Nigeria examine the communicative functions of discourse acts in nurse-pregnant women discourse in antenatal classes, with the objective of investigating how they use language through their choice of discourse acts and how it facilitates or impedes communication in the class. The study identifies three types of act, namely: primary acts, secondary acts and complementary acts. Their analysis presents a synthesis of the categories of discourse acts identified in Sinclair and Coulthard (1977); Strenstrom (1994) and Olateju (1998). The work finds that acts have no structures, and they are mainly defined by their functions. Consideration of both the linguistic and non-linguistic contexts of the utterances of the nurses and expectant mothers enables the authors to indicate the acts that the utterances realize Much as enlightening as the work is, the failure of the authors to widen the scope of their study to focus on three or more of the discourse units greatly undermines the richness of the work.

It is clear from the above that several scholars have made significant contributions to medical discourse from the perspective of carrying out a register analysis, pragmatic analysis of the language of medicine or exploring means of enhancing the communication skills of nurses and doctors etc. Therefore, this study seeks to complement the existing studies by pinpointedly examining the discourse devices deployed by doctors and patients during consultation and also revealing their communicative functions, with a view to examining the linguistic choices they make to initiate the talk, control the talk and understand the patients' medical challenges.

Medical interaction has been examined from the perspectives of doctor-patient exchanges or clinical interviews. The studies employ divergent approaches i.e.: politeness theory, conversation analysis, interactional sociolinguistics, ethnomethodology, and pragmatics. A larger part of the research on medical discourse concentrates on the analysis of power-play in doctor-patient interactions. Madfes (2002, 2003) observes there are two types of medical discourse practice : a) the traditional (Western) practice, characterized by intrusion and a parallel discourse, in which the doctor always controls the floor of the conversation and often displays power by not responding to patients' inquiries, and b) the alternative – medicine practice, whose main features are reinforcement and convergence,

in which the doctors interact with their patients at a more egalitarian level, making efforts to show more understanding in their talk and body language.

A larger percentage of the studies on medical encounters has been conducted within the context of Western traditional medicine. The interactions are "ritualized" as there is a sequence of phases that normally occur in them (Helman, 1984). For instance, there is a sequence of six phases in a medical encounter: 1) Opening, 2) Complaint, 3) Examination or Test, 4) Diagnosis, 5) Treatment or Advice, and 6) Closing (Ten Have, 1989).

In spite of the ritualistic nature of medical encounters, they nonetheless exhibit characteristics of conversational discourse as they are endowed with some level of unpredictability. Some scholars have examined the question of whether medical encounters are basically conversational or interview-like. Comparing conversation with psychotherapy sessions (a type of medical interaction), Ferrara (1994) pinpoints the following differences in relation to the following seven aspects: 1) Parity, 2) Reciprocality, 3) Routine Recurrence, 4) Bounded Time, 5) Restricted Topic, 6) Remuneration, 7) Regulatory Responsibility. Parity and Reciprocality present more as conversational features than that of medical encounter. On the other hand, the remaining five features are more of characteristics of medical discourse than normal conversation. Several studies have indicated that questions in medical discourse show both power-claiming and power-sharing, although most of them argue the former predominate the latter. Thus, they describe these encounters as highly assymetrical interviews (West, 1984; Hein and Wodak, 1987; Weijts, 1993; Alexias, 2008).

Medical discourse is order-directed and goal-driven as it is conducted in such a manner as to unravel the medical challenges of patients in order to proffer appropriate solutions to them. The entire business of diagnosis and advice/treatment are carried out through language use. It is therefore important to investigate the discourse devices employed in such an encounter in order to understand the communicative functions of the strategies employed by doctors, especially as the interaction is highly assymetrical.

2.2 Communication in Medical Discourse

Some forms of communication occur in the hospital setting and the ones commonly studied are: doctor-patient interaction, doctor-nurse interaction, nurse–patient interaction and dentist-patient interaction. Odebunmi (2003:3) quoting Harlen (1977) proposes some commandments for the doctor-patient communication:

i) Avoid confusing generalizations with specifics.

ii) Use simple, well-known words.

iii) Truths and facts should be patiently and scrupulously cultivated.

iv.) Avoid overgeneralization and prejudice.

v) Pay attention to feedback signals to ensure that communication is actually taking place.

vi.) Be aware of cultural differences e.g. pay attention to age and gender specifications in communication.

vii) Avoid hurried conclusions.

During diagnosis, physicians rely heavily on referral letters, verbal interactions with patients, laboratory test reports, bodily examination etc. to obtain information about patients. A combination of all these enables the physicians get accurate diagnoses. Sometimes, they present their diagnoses in clear language and at other times in ambiguous language, depending on the context of interaction with patients. It is also a common knowledge that doctors use euphemism or o

ther literal expressions when faced with ‘’unpleasant’’ diagnoses (Odebunmi, 2003).

2.2.1 Doctor-Patient Interaction

Doctor-patient verbal interaction requires greater explicitness on the part of the doctors when explaining to patients as most patients have little or no knowledge of medical

language. This interaction even stresses the doctors more when the patients do not understand English. Here, the doctors cannot use medical jargon if they want the patients to understand them. Consequently, they use simple expressions (Odebunmi 2003, 2006); Crystal 1976).

2.2.2 Nurse-Patient Interaction

This type of communication is very similar to that of doctor-patient communication as the nurse is required to come to terms with the patient's deficiency in medical language, thereby explaining himself/herself as clearly as possible, using simple language.

2.3 Discourse: Definition

Foucault (1969) defines discourse as ''Systems of thoughts composed of ideas, attitudes, and courses of action, beliefs and practices that systematically construct the subjects and the worlds of which they speak.'' It has its roots in the Latin language. The meaning of the term differs slightly in different contexts. However, in Literature, it means writing or speech that is normally longer than sentences which deal with a certain subject formally in the form of writing or speech. Put differently, discourse is the presentation of language in its entirety while performing an intellectual inquiry in a particular area or field i.e. theological discourse or cultural discourse.

2.3.1 Discourse: Language above the Sentence

The traditional concept of discourse is that discourse is language above the sentence or above the clause (Stubbs 1983:1). However, in spite of the multiplicity of structural approaches, there is a general core: structural analyses focus on the way diverse units operate in relation to each other but disregard ''the functional relations within the context of which discourse is a part'' (Van Dijk 1985:4). But since it is exactly this connection between discourse and the context of which discourse is a part that characterizes functional analyses, it seems that the two approaches have very little similarities.

Structurally based analyses of discourse find constituents (smaller linguistic units) which have particular relationships with one another and that can occur in a restricted number of

(order-directed) arrangements. Discourse is viewed as a structure higher than the sentence or higher than another unit of text in several such approaches.

In line with the above definition of discourse as language above the sentence, many contemporary structural analyses of discourse perceive the sentence as the unit of which discourse is comprised. Yet numerous problems stem from the dependence of definitions and analyses on the smaller units of sentence. An instantaneous setback is that the units in which people speak do not always seem like sentences. Chafe (1980) submits that spoken language is produced in units with intonational and semantic closure – not necessarily syntactic closure. He further argues that if we were to concentrate exclusively on spoken language (rather than exclusively on written language), we would be more likely to regard language in terms of intonation units that reflect on underlying grammatical structures, but underlying focuses of consciousness in which information is organized (Chafe 1987, 1990). Support for this view is often found by examining the transcript of a stretch of speech and noting that the intonational breaks do not often correspond to syntactic boundaries.

The dependence on sentence as the unit of which discourse is comprised is theoretically problematic in other ways. Bloomfield (1933) defines a sentence as ‘’an independent linguistic form not included by virtue of any grammatical construction in some larger linguistic form’’. However, the view that sentence discourse is a level of structure higher than the sentence - more precisely, that discourse is a structure within which sentences are embedded, sometimes ends up challenging the opinion that sentence has grammatical autonomy and closure. One more consequence of the view that discourse is language above the sentence is the possible anticipation that discourse would exhibit a structure analogous to the sentences of which it is comprised - an anticipation which, according to Stubbs (1983), may be unnecessary. We may consider, for instance, the sentence grammarians’ use of the expression ‘’well-formed’’ as it applies to structures, as in Chomsky’s:

‘’Colourless green ideas sleep furiously’’

This sentence is syntactically well-formed but meaningless. So, structure (in the sense of ''well-formedness'') just does not appear to apply to discourse: it is simply impossible to contrast constituent strings of well-formed versus ill-formed discourse in the same way. Schiffrin (1994) asserts that one reason for this state of affair is traceable to our inability to identify units of discourse in a way as clear-cut (and mutually exclusive) as our ways for identifying constituents of sentences. More importantly, the type of structures identified by discourse analysts has not always been comprised of sentences, or indeed of language units per se; e.g. analysts have spoken of action structures and turn structures.

In the final analysis, we observe that defining discourse as well-formed or ill-formed is not only problematic, but discourse structures are rarely the kinds of hierarchical structures to which linguists are familiar at other levels of analysis.

2.3.2 Discourse: Language in Use

According to Fasold (1990: 65), ''the study of discourse is the study of any aspect of language use''. Brown and Yule (1983:1) restate this view thus:

> …the analysis of discourse is, necessarily the analysis of language in use. As such, it cannot be restricted to the description of linguistic forms independent of the purposes or functions which those forms are designed to serve in human affairs.

It is clear from the above that language cannot be analyzed without its functions and purposes in human life. Fairclough (1983:23) opines that ''language is a part of the society; linguistic phenomena are social phenomena of a sort, and social phenomena are (in part) linguistic phenomena''. This view expresses the idea that language and society partially constitute each other and reveals that language cannot be analyzed as an independent unit.

A definition of discourse as language use is consistent with functionalism in general. Discourse viewed as a system (a socially and culturally organized way of speaking), through which particular functions are realized. Although formal regularities may very well be examined, a functionalist definition of discourse leads analysts away from the structural basis of such regularities to focus, instead, on the way patterns of talk are put to use for certain purposes in particular contexts and/or strategies. Functionally based

approaches tend to draw upon a variety of methods of analysis often including not just quantitative methods drawn from social scientific approaches, but also more humanistically based interpretive efforts to replicate actors' own purposes and goals (Schiffrin 1994).They rely less on the strictly grammatical characteristics of utterances as sentences, than on the way utterances are situated in contexts. In other words, functional definitions of discourse assume an interrelationship between language and context, but analyses stemming from such a view of discourse as language use can be too inclusive: they can include sentence-sized units and phonological variants.

Functionally based approaches view discourse as a socially and culturally organized way of speaking. Functional analyses focus on how people use language to different ends: they are typically concerned less with the way people intend what they say to serve referential meanings (to convey propositional information) and more with the intended social, cultural and expressive meanings stemming from how their utterances are situated in contexts.

In sum, it is important to note that although structural definitions of discourse focus on text while functional definitions are concerned with contexts. Therefore, actual analyses of discourse reveal that structure and function are interdependent. Saddok (1984:142) corroborates this assertion by observing that the most appropriate thing to do is to examine structure in the light of functional requirement and function in the light of structural requirement as neither radical structural nor radical functional analyses are ideal. The availability of these two different perspectives – structural and functional – is partly accountable for the fabulous scope of discourse analysis.

2.3.3 Kinds of Discourse

Traditionally, there are four different kinds of discourse i.e.: exposition, narration, argumentation and description. Discourse is generally understood to include practically every kind of communication whether oral or written. There are instances where entire papers or speeches depend on just one style; though, more often than not, the speakers, writers or authors employ two or more methods simultaneously. Different types are usually better suited for different circumstances. There are usually some pretty unique

features of each. In addition, the goals tend to be different. Most of the time, speakers, authors and writers employ the method they feel is most effective at getting their points across to their target audiences.

2.4 Discourse Devices: Definition

In this study, discourse devices are the language tools that doctors and patients employ to execute clinical interviews, address communication challenges, and correct unwholesome health practices during consultation etc.Their deployment assists both the doctors and patients to ensure the talk impacts positively on the patients' health.

2.5 Types of Discourse Devices

There are a number of discourse devices commonly employed in clinical interviews, albeit unconsciously, by doctors and patients. These will be discussed in turn.

2.5.1 Language Switch (Code-Mixing and Code-Switching)

According to Boztope (2003 cited in Odebunmi (2010)), code refers to a linguistic variety used in communication. It could be the standard form, varieties or dialects of the standard language or code. During conversations, interlocutors employ whichever language variety they could adeptly use in particular circumstances. This process is termed ''code choice''. In monolingual situations, it could involve only one language, two languages or more in bilingual or multilingual settings respectively. Based on the above, therefore, two types of code selection are proposed: simple and complex. Monolinguals use the simple code by drawing only on the standard dialect of the language of communication and its varieties (high and low) (Odebunmi, 2010:5). The diagram below illustrates this.

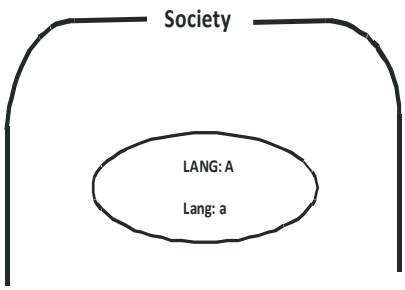

Figure 1: Simple Code Choice

‘’LANG: A’’ is standard dialect while ‘’ lang: a’’ is its varieties. Bilinguals opt for the complex code choice, and two standard dialects are involved here (A and B) - their varieties and other dialects of the standard language. In the South-West and North-Central geopolitical zones of Nigeria, Standard English Language (LANG: A) and Standard Yoruba (LANG: B) as well as their varieties are employed in communication. Additionally, dialects of Standard English (Lang: B) (e.g. Nigerian English/Pidgin English) and Standard Yoruba (Lang: B) are used (e.g. Oyo, Ife, Ijebu, Ekiti, Ilorin, Ijesha, Okun, Igbomina). Obviously, this portrays an intricate linguistic depiction, and indicates that code choice negotiation during conversations is naturally unavoidable (Odebunmi, 2010). Figure 2 illustrates this intricacy (‘’P’’ in the figure stands for ‘’Participant’’).

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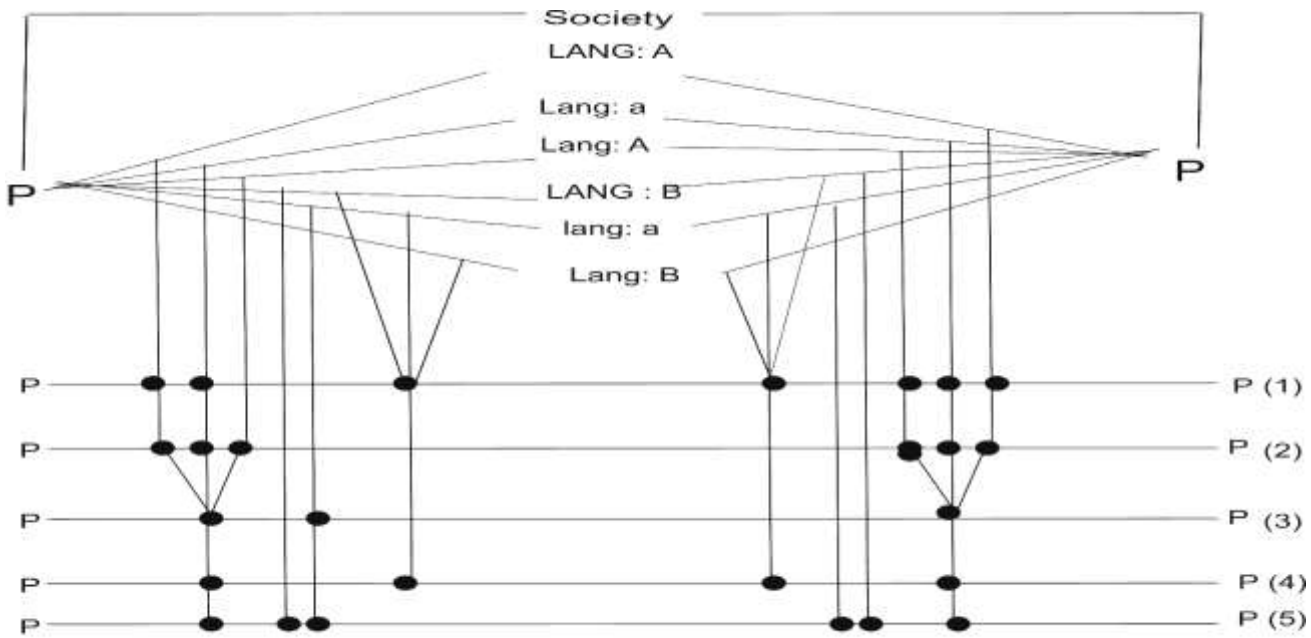

Figure 2: Complex Code Choice

(cf. Odebunmi 2010:6)

In this work, 'code' refers to the above-mentioned dialects and varieties, and ''code choice'' means language choice or the alternate use of these terminologies. In bilingual discourse, interlocutors use codes interchangeably. This, however, does not occur in all situations because, sometimes, certain participants can only use one code. They use only that code and the co-interlcutors are pragmatically compelled to adopt the code favoured by the other party even though their degree of proficiency in it is low.

The possibility of code-mixing or code-switching by interlocutors under any circumstance deemed fit attests to the dynamic nature of human communicative needs. Leung (2010: 417) corroborates this assertion by observing that managing linguistic and cultural variations is so important to humans that code alternation has gained so much acceptability and become communicatively inevitable because of its capacity to strengthen relationships and acclimatize us to our environment.

The incidence of code alternation has engendered the development of various terminologies by linguists in an attempt to capture the theoretical essence of the occurrence. Some of the said terms are: ''code-mixing'', ''code-switching'', ''code

alternation'' and ''language mixing'' (Myers-Scotton 1980, Ogunsiji 2000; 1998; Poplack 2009). These terms systematically describe the position of codes in discourses as their contextual uses allow. They also address both the sociolinguistic and linguistic relationships between the various codes interlocutors use during verbal interaction (Odebunmi, 2010:7).

Several scholars have defined code-mixing and code-switching variously. But for the purpose of this study, Auer's (2009:491) definition of the two terminologies will be adopted:

> Code-switching covers all instances of locally functional use of two languages in an interactional episode. Code-switching may occur between two turns, or turn-internally. It may be restricted to a well-defined unit or change the whole language of interaction. It may occur within a clause…. …or between clauses.
>
> (cf. Odebunmi 2010)

Drawing inferences from Auer (2009), Odebunmi (2010) views code-switching as functional language alternation and code-mixing as non-functional language alternation. He asserts that ''the frequent variation between the two 'codes' has become a mode of interaction in its own right, that is a new code with rules and regularities of its own''. Auer's observation about the function based dimension has enjoyed the patronage of many scholars who worked on code-switching. They present such functions as establishment of rapport, elaboration of a message, conveyance of attitudes (Tay 1989); symbolization of group identity and solidarity, and marking of shift in style (Boztope 2003). However, we have to exercise restraint in excluding code-mixing from the functional category because like code-switching, items in code-mixing are used for calculated purposes. This, therefore, means that both code-mixing and code-switching are functional language alternation.

Auer's type of code-switching is of prime importance to this study, and this will, where necessary, also be extended to code-mixing in the analysis. He has identified two types of code-switching: discourse-related and participant-related code-switching. Discourse-related code-switching refers to ''the use of code-switching to organize the conversation by contributing to the interactional meaning of a particular utterance'' (Auer 1998: 4

cited in Odebunmi 2010). This pinpoints the strategic importance of code-switching as it reveals the marking of a new traction in code-selection. Participant-related code-switching, on the other hand, points to circumstances in bilingual discourse where discussants merely favour a language more than another without necessarily targeting a premeditated agenda.

Both participant-related code-mixing and discourse-related code-mixing are germane to medical practitioner-patient verbal interactions in hospitals in South-West and North-Central geo-political zones of Nigeria (and the rest of Nigeria by extension) as the data analysis would reveal later. In particular circumstances, code-selection during consultation is a matter of preference by either party, which has the tendency to influence the other. However, in some other instances, tact comes into play, most times by the medical practitioner and, sometimes by the patient.

Language switch has gained so much currency among the educated and the illiterate people in South-West and North-Central geo-political zones of Nigeria as in many multilingual communities of Africa. However, the very old people have remained invincible as they are incurably habituated to the use of only one indigenous language or the other during conversation. Code-mixing and code-switching are undoubtedly fascinating phenomena, and the manifestation of their operations in Nigerian hospital is very interesting.

The subjects in this study either employed English Language and Yoruba Language intra-sententially, inters-sententially and between interactions during the clinical interviews for certain reasons. They changed codes as well for certain communicative purposes. Language switch will therefore be examined to reveal its communicative functions and how it aided the discourses.

2.5.2 Rapport Expressions

The word ‘ rapport’ originated from the French verb ‘’rapporter’’ which means literally to carry something back and in the sense of how people relate to each other. It means that what one person sends out, the other sends back. For example, they may realize they share similar beliefs, knowledge or behaviour around politics, music or sports etc. It

occurs when two people are in sync or on the same wavelength because they feel similar or relate well to each other. Rapport is theorized to include three behavioural components: mutual attention, mutual positivity and coordination (Graham, 2010).

Research has revealed that the ability to establish rapport with patients is another highly important skill every healthcare professional has to acquire. Establishing rapport with patients enables doctors to have a close relationship with patients and also helps to promote open conversation between them. It is also a potent instrument that veteran salesmen utilize, which enables them to close more deals with less effort. The ability to establish rapport with patients and respond malleably and empathetically to patients is a highly important skill every healthcare professional has to acquire. Demonstrating empathy and establishing rapport with patients enable the practitioner to have a close relationship with patients and also help to promote open conversation between them (Street 1991).

Street (1991) opines that medical practitioners adapt by assuming different roles according to the patient's degree of anxiety. Some researchers have suggested that empathy promotes open communication between medical practitioners and patients (McCabe 2004; Barton 2000; Sheppard 1993), enabling practitioners to obtain the information required for making accurate diagnoses. Morse et al (1992:819) assert "….the essence of the nurse-patient relationship is engagement, the identification of the nurse with the patient'' and add that empathetic responsiveness makes possible this engagement. This further lends credence to the appropriateness of a discourse analysis approach to medical practitioner-client verbal interactions as isolated examination of the medical practitioner's language lacks the capability of identifying evidence of comprehending or empathetic responsiveness. In addition, compassionate comments and advice are important trust-building elements in doctor-patient relationship and their goal is showing empathy to patients to make clinical interviews result-oriented.

There are a number of techniques that are supposed to be beneficial in building rapport i.e.: matching your body language (i.e. posture, gesture etc.), maintaining eye contact and matching rhythm (Stewart, 1998). As this study will later reveal, rapport can also be established through compassionate comments or advice, obtaining information on social

history (SH) and family history (FH).The last set of techniques for building rapport is relevant to the analysis of our data.

2.5.3 Phatic Communion and the Social Importance of Phatic Utterances

It is used for opening conversations. According to Malinowski (1923: 478), phatic communion is "[…] a type of speech in which ties of union are created by mere exchange of words." A number of scholars who have worked on phatic communion have re-echoed Malinowski's (ibid) definition of phatic communion. Such is the case of Lyons (1968) and and Silva (1980) who merely emphasized that phatic utterances facilitate the creation and maintenance of solidarity feeling and well-being between interlocutors. Some other scholars have also studied the narrative features of phatic communion (Hudson, 1980); (Cheepen, 1988) and (Schneider, 1988).

Leech (1974) and Turner (1974) have also underscored its weakness in transmitting referential information. They contend that the propositional content of phatic utterances is totally insignificant because they are utterances designed more to accommodate and acknowledge interlocutors than to carry an authentic message. Coupland, Coupland and Robinson conclude that:

> Phatic communion is taken to designate some sort of minimalist communicative practice, though along several possible dimensions. The 'mereness' of phatic communion […] by virtue of its low interest value, low informative value, low relevance, perhaps also its low worthiness, presupposes an alternative mode of 'true' or 'authentic' discourse from which phatic talk deviates. (1992: 210)

Malinowski (1923) draws a distinction between language used as an instrument of reflection and language used as a mode of social action. This distinction reinforces Malinowski's idea that "[…] talk was either giving information ('communication'), or doing something social ('phatic communion') (Tracy and Naughton, 2000: 71).This underlying idea is observable in the works of some authors that have differentiated between two main functions of language: representative and expressive (Buhler 1934), referential and emotive (Jackobson 1960), ideational and interpersonal (Halliday 1973), descriptive and social-expressive (Lyons 1977), or transactional and interactional (Brown

and Yule 1983). Borrowing a leaf from Coupland andYlanne Mcewen (2000:179), it can be said that both Malinowski's (1923) original differentiation between language employed as an instrument of reflection or as a mode of action and these authors' linguistic functions carry the inappropriate implication that relational talk is peripheral and incidental. Consequently, Coupland (2000: 7-8, 179) criticizes real talk as the talk that 'gets the stuff done' where 'stuff' does not include 'relational stuff. It can be deduced from this ideology that sociality is marginalized as a 'small' concern, and language for transacting business and other commercial or institutional instrumentalites is foregrounded.

In opposition to some of the studies earlier cited, Laver (1974/1975, 1981) defends phatic utterances as extremely important linguistic devices for social interaction transmitting indexical information about the interlocutors' social roles. In addition to offering suggestions, these utterances create a working consensus about some aspects of the interlocutors' social identity and have three main functions at the opening phase of a conversation – propitiatory, exploratory and initiatory. He differentiates between two basic types of phatic utterance: the ones with neutral reference i.e. utterances about the spatio-temporal setting of a conversation, and those with personal reference i.e. utterances about either the speaker or the hearer.

Furthermore, Laver (1974) analyses the use of these utterances by both British and American English speakers and establishes certain patterns of usage. Consequently, he submits that both neutral and personal phatic utterances are used when interlocutors have a solidarity relationship. He, however, states that if their relationship is not a solidarity one, the safest option is to employ a neutral phatic utterance, and in the case of status differences between them, the interlocutor of lower status that addresses another of higher status may use self-oriented phatic utterances but not other-oriented phatic utterances, and the interlocutor of higher status who addresses another of lower status may deploy other-oriented and avoid self-oriented phatic utterances.

2.5.4 Counselling

Given the special nature of clinical interview, doctors cannot but employ counselling in certain situations that call for giving pieces of advice to ensure patients have good health. This discourse device is deployed to guide patients and encourage them on how best to handle their health.

2.5.5 Direct and Indirect Questions

Medical queries involve the use of both direct and indirect questions by doctors to elicit information from patients to make accurate diagnoses. They constitute vital diagnostic instruments for probing into the patients' lives to unravel the possible causes of their ailments, obtain information that could reveal the real identity of their ailments and to also obtain information that could assist the doctors in deciding on appropriate treatment. Situations during medical consultations determine what type of question is appropriate, hence the switch between direct and indirect questions. Research has revealed that doctors deploy indirect questions to make the clinical interview appear less interrogative so that patients should find the activity less stressful and, consequently cooperate to supply all the information required to make diagnoses.

2.5.6 Answer

This is the device deployed by patients to provide the information required by doctors to make diagnoses in their attempt to solve the patents' medical challenges. This device is a natural follow-up to doctors' questioning. It occupies a central place in diagnosis as there are many medical information that are exclusively sourced verbally from patients.

2.5.7 Religious Belief

Interlocutors in discourses generally are influenced by their religious beliefs. This exactly is also the situation in medical discourse as interlocutors are mostly governed by their religious leanings. Therefore, the intelocutors in our data are influenced by two belief systems: Christianity and Islam. These religions, in a way, have some impact on their contributions as they employ them as strategies to communicate certain messages.

Expressions of religious belief are a veritable tool for persuasion and encouragement, and reseach has revealed that people use religion, just like ethnicity, to solidarise. This work, therefore, examines religious beliefs in medical domain.

2.5.8 Circumlocution

Circumlocution refers to when a particular thing is described in many words where a few words could suffice. It is also known as the act of "talking around" and occurs when people do not know the correct term to describe what they seek. It is also a rhetorical device that can be defined as an ambiguous or paradoxical way of expressing things, ideas or views. In fact, when somebody wants to stay ambiguous about anything and he does not want to say it directly, it means he is using circumlocution. This is a usual practice among learners of a new language or people entering an unfamiliar domain. In this study, we study circumlocution in the medical domain where accurate understanding in it is of prime importance since wrong information can have a large effect on people's actions.

Examining examples of circumlocution reveals that they share the following features:

a) It is used when the speaker is unable to choose the right words to express an idea.
b) It is used for social purposes to avoid the use of offensive expressions.
c) It is used in politics and law, and sometimes it becomes difficult to decide which perspective of a politician or lawyer should be supported.
d) In poetry and verse, it is used to create a regular meter.

For the sake of analysis to be undertaken in this study, the definition of circumlocution as description of symptoms of ailments as a result of patients' lack of knowledge of the specific medical names for diseases shall be adopted in this study. It will also be extended to situations where patients used wrong medical terms to describe their ailments.

2.5.9 Face-Threatening Acts (FTAs)

Face-threatening acts are employed by doctors to perform a number of communicative functions i.e.: to reveal their diagnoses to patients without worsening their health conditions, to enable patients disclose all their medcal challenges to doctors; to lessen the

effects of their diagnoses on patients in order to avoid worsening their health conditions and; to threaten the patients' face by telling them the true nature of their ailment or hiding same as the situation demands. Therefore, this study will examine the deployment of the politeness principle by the doctors and their pragmatic functions. This has been discussed extensively in the preceding section of this chapter.

2.5.10 Repetition

Certain expressions and words are sometimes repeated by doctors and patients for certain communicative purposes. Its deployment enables both the doctors and patients to draw attention to certain medical information or confirm them.

2.5.11 Closing

Clinical interviews cannot go on indefinitely. So, there is always the need to bring them to a close, and this has to be done in a way that permits or encourages another visit if there is the need for such. Principally, closing is deployed to terminate discourses.

The deployment of all the discourse devices above will be examined to reveal the specific pragmatic purposes served, the extent of their effectiveness as well as their linguistic realisations.

2.6 Discourse Approaches

Discourse analysis is a vast and somewhat vague subfield of Linguistics. It is this vastness of issues and topics that fall under the label ''discourse analysis'' that is probably responsible for the diversity of methods for analyzing discourse. Although the various methods have their origins in different disciplines (i.e. Psycholinguistics, Sociolinguistics etc), the different approaches attempt to answer some of the same questions: How do we organize language into units that are larger than sentence? How do we use language to convey information about the world, ourselves and social relationships?

Discourse Analysis is an increasingly popular area of study but in spite of this popularity, it is one of the least defined areas of Linguistics, and has thus given rise to several

descriptive approaches. By reason of the wide variety of studies that are considered to be DA, a few questions come to mind: Is there any theoretical or conceptual unity to this enquiry? Are there similarities among the approaches that override their differences? Is the purported goal of DA shared by all the approaches? What strategies does each approach adopt to accomplish such a goal?

The most relevant approaches to Discourse Analysis are: Birmingham Approach (BA), Speech Act Theory (SAT), Ethnomethodology, Interactional Sociolinguistics (InSoc), Ethnography of Communication (Etcom), Pragmatics, and Conversation Analysis (CA). Some rather new approaches have also been identified and they relate to finding solutions to particular social problems, e.g. analysis relating to gender (as in Critical Discourse Analysis), legal matters (Forensic Discourse Analysis), and qualitative analyses of lexical items (instanced in Typological Discourse Analysis, TDA).We shall now provide a discussion of the central ideas, concepts and methods of each discourse approach.

2.6.1 Ethnomethodology

The Ethnomethodological School consists of sociologists like Sacks and Garfinkel (1967), Schegloff and Jefferson (1979), Turner (1974) etc, and the approach is sociology based. This school accentuates the research method of close observation of groups of people communicating in natural settings. It examines types of speech events such as story-telling, greetings, rituals, telephone exchanges and verbal duels in different cultural and social settings. Goffman's (1981) work is considered relevant because of its significance in the study of conversational rules, turn-taking, and other aspects of spoken interaction. Conversation analysis originated from Philosophy (phenomenology) and its preoccupations were comprehensively articulated by Harold Garfinkel (1967), who owes to his credit the development of ethnomethodology. Scholars then, most notably, Harvey Sacks, Emmanuel Schegloff and Gail Jefferson applied conversation analysis primarily to the analysis of conversation. Conversation analysts apply ethnomethodological strategies to conversation but pay very little attention to linguistic categories of structure, meaning, sound and what is said. In other words, they regard conversation, the investigation of the ordered properties and on-going achievement of everyday social practices as one of the

studied social practices in ethnomethodology. The main focus of ethnomethodology is the discovery of how social order is produced by members of a society.

Using features observed in the progression of utterances, conversation analysts generalize about context – about social conduct in social life. Features identified by Sacks, Schegloff and Jefferson (1979) are:

(a) Turn-taking

(b) Next speaker selection

(c) Overlap/interruption

(d) Adjacency pairs

(e) Gaps in conversational moves

(f) Repair Mechanism

Using the extract below from Ola Rotimi's (1979:26) ''The Gods Are Not To Blame'', we provide a sample analysis:

ODEWALE: There is plague in this land, and Orunmila tells usfrom Ile-Ife that the cause of this suffering is the presence of a murderer, one who murdered King Adetusa, the king before I became king of this Land of Kutuje. Pray, tell, who is the murderer?

SECOND CHIEF: We beg of you, Old one, help us with your strange powers.

The conversation analysts' assertion that the mechanics of conversation provides a basis through which social order is constructed has been confirmed through the features manifested in the above exchange. Not only does Odewale as a plus +Higher role occupant (Berry 1987:45) initiate this plea to Baba Fakunle to ,through his divine powers, disclose the identity of the murderer of King Adetusa, which is the cause of the trouble in the Land of Kutuje, he also dominates it. Without doubt, King Odewale's utterance and his concluding question are directed at Baba Fakunle. Even though Second Chief is also involved in the effort to get the identity of the sought murderer, his (Second

Chief's) contribution, an unexpected follow-up, is not ''conditionally relevant'' on King Odewale's utterance. The desperation of the people of Kutuje to know the regicide of King Adetusa in their attempt to put an end to the suffering being experienced in the land is revealed in the Second Chief's selection as the next speaker after King Odewale. This is the kind of illumination that conversation analysis can bring on our discourse analysis of hospital verbal interactions between doctors/nurses and patients.

Schegloff (1972:51) opines that different levels of contextual information, background knowledge about the speaker, what has just occurred during an exchange of talk play a more critical role in allowing the recognition of an utterance as an action rather than a set of static mutually-known preconditions typically focused upon by speech act theorists.

One basic premise of the speech act theory is that utterances are not made in a vacuum, they are rather designed to perform actions such as stating, commanding, directing, accusing, etc. i.e. to do something. Put differently, every communication has a fundamental purpose, called an illocutionary force (Austin 1962). It concerns the function of a particular utterance: whether it tries to change a particular state of affairs or of the world, attempts to get the hearer to do something, commits the hearer to a particular course of action, or involves an exercise of authority (Adegbija 1982:54). Every illocutionary act, whatever its purpose, is felicitous or infelicitous, happy or unhappy (Austin 1962). By this it's meant that for illocutionary act to be successfully performed, it must be uttered under the necessary appropriate conditions.

Austin (1962) idemtifies four subcategories of felicity conditions, namely: the Propositional Content Rule, the Preparatory Rule, the Sincerity Rule, and the Essential Rule. The Propositional Content of a request is that there must be a future act (A), which the speaker (S) wants the hearer (H) to perform. The Preparatory Rules are that H should be able to do A.

Additionally, it must be clear to both S and H that H will do A in the normal course of events in his own accord. The Sincerity Rule is that S wants H to do A. The Essential Rule is that the request counts as an attempt by S to get H to do A (Austin 1962:66). He sums up the crux of such appropriateness conditions in the following words:

> Speaking a language is engaging in a rule-governed form of behavior…….....the semantic structure of a language may be regarded as a conventional realization of a series of underlying constitutive rules, and that speech acts are characteristically performed by uttering expressions in accordance with these sets of constitutive rules.

Bach and Harnish (1979:49) introduce a new perspective to Austin's in the contention that an ''intention and inference'' motif lies beneath the performance of speech acts. They put up the argument that acts are performed with the intention that the hearers the act being performed. Implicit in this proposal is the notion that decoding of linguistic communication and meaning in language in general is basically inferential. Such inference thrives on Mutual Contextual Beliefs. Adegbija (1982) extends Bach and Harnish's (1979) theory by showing that speech acts cannot be thoroughly understood without due regard to the total pragmatic, social and linguistic (pragmasociolinguistic) context that gave birth to them.

The ethnomethodologists hold the view that properties of social life which seem objective, factual and transformational are actually managed accomplishments or achievements of local processes. A critical component of the ethnomethodological approach to the study of conversation, therefore, is its emphasis on the local organization of talk as it is accomplished by interactants i.e. the minute step by step details by which talk is organized, rather than the underlying interpretive schemata, speaker intentions or social norms which provide more general interactional strategies, i.e. how turn transition is accomplished and how topics are changed. Determination of how turns are taken and the rules governing such turn-taking are some of the basic problems in conversation. To resolve these problems, Sacks et al (1979) propose that conversationalists address these problems through a set of rules whose ordered options operate or apply at various transition-relevance places in a current speaker's turn (places which are defined both operationally and semantically as possible completion points), and they provide, first, for the current speaker's selection of the next speaker, second, for the next speaker's self-selection, and, third, for possible continuation by the current speaker. The presence of a second pair-part of an adjacency pair that is provisionally relevant on the first is a structural principle that governs conversation. So far, and to the best of our knowledge

this approach has not been employed in the analysis of hospital interactions but its ability to handle conversational features like turn-taking, adjacency pairs, interruption, conversational harmony etc. makes it a relevant approach in hospital verbal interaction because of its dialogical nature.

2.6.2 Interactional Sociolinguistics

> ''Language and context constitute one another: language contextualizes and is contextualized such that language does not just function in context language also forms and provides context. One particular context is social interaction. Language, culture and society are grounded in interaction: they stand in a reflexive relationship with the self, the other and the self-other relationship, and it is out of these mutually constitutive relationships that discourse is created''
>
> D. Schiffrin, Approaches to Discourse.
>
> (cf. Alba-Juez, 2010)

The interactional sociolinguistic approach to discourse analysis is multidisciplinary: it concerns the study of the relationship between language, culture and society and has its roots in Anthropology, Sociology and Linguistics. In spite of the diversity of disciplines upon which the approach is based, there is a consensus as to the basic beliefs about language, context and the interaction of self and other. There are fundamentally two branches of interactional sociolinguistics: the one by the sociologist- Erving Goffman- and that premised on the input by linguistic anthropologist - John Gumperz. The former describes how language is situated in particular circumstances of social life, and how it reflects and adds meaning and structure in those situations. The latter offers awareness on how people may speak the same language but then differently contextualize what is said in a way that different messages are created and understood. Several scholars have applied the ideas expressed by these scholars lengthily within Linguistics as evidenced in the works of Brown and Levinson (1987), Schiffrin (1987a) and Tannen (1989a).

Gumperz's work reveals that one feature of present-day metropolitan societies is their socio-cultural heterogeneity. He postulates that one consequence of such heterogeneity is that people from diverse cultural and linguistic backgrounds interact and that such

interactions can engender communicative difficulties owing to the fact that people's perception of similarities and differences globally is, to a large extent, determined by culture. In his view, these contrasts do not reflect only at the grammatical level of a language even though grammatical distinctions in people's speech constantly show them most.

In Gumperz's work, Saussure's ''signalling mechanisms'' (e.g. intonation, speech rhythm, and choice among lexical, phonetic and syntactic options) are regarded as ''contextualization cues''; ''aspects of language and behavior (verbal and non-verbal signs) that relate what is said to the contextual knowledge (including knowledge of particular activity types) that contributes to the presuppositions necessary to the accurate inferencing of what is meant'' (Schiffrin 1994:99). By and large, Gumperz's studies reveal that contextualization cues can affect the basic meaning of a message, though it need be stated that interlocution progresses unhindered when listeners share speakers' contextualization cues.

Gumperz's work (1982a) emphasizes the importance of the individual and expresses the view that a broad-spectrum theory of discourse strategies must commence by specifying the linguistic and socio-cultural knowledge that needs to be shared if conversational involvement is to be maintained, and then goes on to deal with what it is about the nature of conversational inference that makes for cultural and situational specificity of interpretation. Goffman's work also makes significant contribution to the development of interactional sociolinguistics. His focus on social interaction complements Gumperz's focus on situated inference. He adds to interactional sociolinguistics an understanding of those forms and meanings of contexts that enables us to more fully identify and appreciate the contextual presuppositions which figure in the hearers' inferences of speakers' meanings. In sum, the focus of Goffman's studies is the social organization of involvement. His work offers a description of the way diverse social occasions can create a large number of expectations for the display of involvement.

Two central issues, however, lie beneath Gumperz and Goffman's work, and which provide a unity to interactional sociolinguistics. They are: (i) the interaction between self

and other, and (ii) the context. Thus, the work of the two scholars presents a view of language as a manifestation of a social world.

As a linguistic theory that seeks to be effectively meaningful and practically applicable, its adherents have to (and do) depend on naturally occurring communication for data. In addition to using real data, the adherents of InSoc focus on transcription of characteristics of talk likely to serve as contextualization cues. Interactional sociolinguists, like speech act theorists, consider speech act as the critical unit of analysis, but unlike the latter, the former operates on the assumption that the basis for sequential occurrence between speech acts lies in the social and interactive world. (i.e. context and text) in which speech acts are produced.

Emerging from the above is that interactional sociolinguistics views discourse as a social interaction in which language use facilitates the evolving construction and negotiation of meaning. Basically a functional approach to language, its focus on language is balanced with its consideration of structure. For the interactional sociolinguist, language and context are interdependent: language contextualizes, and is contextualized, such that language not only functions in context but also forms and provides the context. The insistence of the adherents of this approach on naturally occurring conversation for data and their emphasis on context make it relevant to the analysis of our data. George Major (2003) employed this approach in his quest to demonstrate the benefit of discourse analysis within sociolinguistic framework in the analysis of nurse-patient interactions. The approach is also suitable for the analysis of the data on language switch in this study because of its emphasis on how context determines the forms of language used in specific situations.

2.6.3 Conversational Analysis

> ‘’Conversation analysts use different approaches in developing analyses; there is no one right way. This presents a challenge in teaching others to do analyses since there are many paths to the

final destination.''

A. Pomerantz and B. J. Fehr, Conversation Analysis.

(cf. Alba-Juez, 2010)

Conversation Analysis originated within Sociology as an approach to the study of social organization of everyday talk or conduct. It began with the work of Harold Garfinkel (1967, 1974) and his approach known as Ethnomethodology (which had in turn been influenced by the Phenomenology of Alfred Schutz), was then applied to conversation by Harvey Sacks, Emmanuel Schegloff and Gail Jefferson. The underlying concerns of CA were more extensively articulated by Harold Garfinkel and he has the credit for the development of ethnomethodology. Coulthard and Brazil (1992) assert that ''conversation analysts were originally fugitives from a sociology they regarded as based on simplistic classification''.

Specifically, CA offers an approach to discourse that has been extensively articulated by sociologists, starting with Harold Garfinkel, but then applied to conversation most notably by Harvey Sacks, Emmanuel Schegloff and Gail Jefferson. CA differs from other branches of Sociology because rather than engaging in actual analysis of social order, it attempts a discovery of the methods by which members of a society provides a sense of order. Put differently, the use of natural language in conversations provides order and management of the social settings in which the conversations take place. Therefore, CA provides descriptions of the way in which conversations achieve this order. Ethnomethodological investigation of members' methods as they are persistently used in the construction of the social world and the social organization of talk reveals that uncovering known as a central concern for ethnomethodology; and that knowledge is neither independent nor decontextualised.

Conversation Analysis focuses on the details of actual speech events. Analysts record conversations that occur without researcher prompting. They also produce transcriptions of events and attempt to reproduce what is said in ways that avoid presuppositions about what might be important for either participants or analysts themselves. Similarly, analysts avert making generalizations about what participants ''know''; analysts would rather

focus on specific events that occur during the conversation. Conversation analysts treat context ethnomethodogically.

Three assumptions characterize CA: interaction is structurally organized; contributions to interactions are contextually oriented; these two properties cohere in the details of interaction so that no other detail can be dismissed, a priori, accidental, or irrelevant. Moreover, CA looks for recurrent patterns, distributions, and forms of organization in large corpora of talk. Conversation Analysis approaches to discourse consider how interlocutors in a talk systematically resolve the recurrent organizational problems. Some of the problems for which solution is found are: opening and closing talk, topic management, information receipt, repair, turn-taking, and showing agreement and disagreement. By and large, CA has the most to offer in the way of substantial insight into the nature of conversation when juxtaposed with conventional Discourse Analysis (Levinson 1983) and recommends itself to the discourse-oriented linguists in view of its associated empirical methodology and extensive body of findings (Ford1993).

George et al. (2003) combined this approach and ethnomethodology in a research paper titled How Do Nurses Describe Health Care Procedures? Analyzing Nurse-Patient Interaction in a Hospital Ward in Australian Journal of Advanced Nursing Vol:4 to study the communication strategies nurses use on the ward in the description of health procedures to patients. Conversation Analysis is relevant to the analysis intended in this study in view of its emphasis on opening and closing of conversations.

2.6.4 Pragmatics

2.6.4.1 Definition and Scope

Pragmatics is an indispensable source for discourse analysis. It is not possible to analyze any discourse without having a solid basic knowledge of pragmatic phenomena and the ways in which they act and interact. To define Pragmatics and to delimit its scope is no mean task than to define Discourse Analysis or Text Linguistics. One thing that is certain is that when working within the field of Pragmatics, we are dealing with meaning. But, then, what is the difference between Semantics and Pragmatics? In a very simplified way, it could be said that if we think of Semantics as the area of study covering the truth-

conditional meaning of utterances, then Pragmatics deals with all the other kinds of meaning. However, this would be a very broad definition, similar to the one given by Morris in 1938, considered to be the first modern definition of the term. As Levinson notes, Morris' definition of Pragmatics as "dealing with all the psychological, sociological and biological phenomena which occur in the functioning of signs" (1983:108) is much wider than the scope of the work that is currently labelled as pragmatic. Levinson explains that the term Pragmatics was subject to successive narrowing of scope and the definitions which were finally influential were those making reference to the users of the language.

Many scholars have defined Pragmatics in different ways, and in these definitions, elements such as context, meaning beyond literal meaning, speech acts, deixis, understatement or implicature are presented as important components of this discipline. Levinson (1938:15) argues that "the notion of meaning not covered in semantics certainly has some cogency". Leech explains that both Semantics and Pragmatics are concerned with meaning, but the difference between them lies in two different uses of the verb to mean (1983:6):

[1] What does X mean? [2] What did you mean by X?

Semantics would deal with [1] and Pragmatics with [2]. Therefore, semantic meaning is dyadic and has to do with words or expressions in a given language regardless of particular situations, speakers or hearers, while pragmatic meaning is triadic and is defined with respect to a speaker or user of the language.

Georgia Green's definition of Pragmatics is as broad as that of Morris:

> Linguistic pragmatics as defined here is at the intersection of a number of fields within and outside of cognitive science; not only linguistics, cognitive psychology, cultural anthropology, and philosophy (logic, semantics, action theory), but also sociology (interpersonal dynamics and social convention) and rhetoric to contribute to its domain. (1989:2)

In addition, one of Levinson's (1983) definitions of Pragmatics as "the study of utterance meaning" equates it to Schiffrin's (1994:190) definition of Discourse Analysis. But,

Alba-Jues (2009) queries whether Pragmatics and Discourse Analysis are the same, and Schiffrin (1994:190) counters by saying that the scope of Pragmatics is wide and "faces definitional dilemmas similar to those faced by Discourse Analysis".

In this study, Pragmatics is viewed as one of the main sources and approaches to Discourse Analysis, therefore Discourse Analysis is considered as a broader discipline which draws from the principles of Pragmatics but other perspectives are susumed within its scope. The inference derivable from the above is that Pragmatics is considered in a narrower sense.

2.6.4.2 Gricean Cooperative Principle and the Theory of Implicature

As Horn and Ward (2004:9) note, "the landmark event in the development of a systematic framework for pragmatics was the delivery of Grice's (1967) William James Lectures". One of the basic concepts in Gricean Pragmatics is speaker meaning. Grice makes a distinction between speaker meaning, which is devoid of intentionality, and non-natural meaning (meaning-nn), which has to do with intentional communication. There is a second intention which is implicit in the definition of meaning-nn, i.e. the recognition, on the part of the addressee of the speaker's communicative intention. Thus, if a child says " I like that dress" to her mother, the meaning -nn would be that she wants her mother to buy that dress for her (and therefore she expects her mother to recognize her "hidden" intention or wish of having that dress). This type of meaning is closely connected to another of the central concepts in Gricean Pragmatics: the notion of conversational implicature, which is considered to be one of the single most important ideas in Pragmatics. This notion has provided linguistic analysts with an explicit account of how it is possible to mean more than what is actually "said". Normally, what a speaker intends to communicate is far richer than what s/he says or directly expresses, and thus, s/he exploits pragmatic principles that the hearer can invoke in order to bridge the gap between what is said (the literal content of the uttered sentence, determined by its grammatical structure) and what was meant (i.e. what was really communicated).

Alba-Juez (2009:48) observes that conversational implicatures are a kind of inference that can be derived from an utterance in order to work out the "meant" from the "said",

and they are related to what Grice called the "Cooperative Principle" and its "Maxims". Given the fact that our talk exchanges do not normally consist of a succession of disconnected remarks (and would appear irrational if they did), the remarks are characteristically cooperative efforts and each participant recognizes in them a mutually accepted direction. It is assumed that speakers cooperate and follow these maxims which are reproduced below:

A) The Cooperative Principle:

Make your contribution such as is required, at the stage at which it occurs, by the accepted purpose or direction of the talk exchange in which you are engaged.

1) The Maxim of Quantity

i. Make your contribution as informative as required (for the purposes of the exchange).
ii. Do not make your contribution more informative than is required.

2) The Maxim of Qualty

Try to make your contribution one that is true, specifically:

i. Do not say what you believe to be false.
ii. Do not say that for which you lack adequate evidence.

3) The Maxim of Relation

i. Be relevant.

4) The Maxim of Manner

Be perspicuous, and specifically:

i. Avoid obscurity of expression.
ii. Avoid ambiguity.
iii. Be brief (avoid unnecessary prolixity).

iv. Be orderly.

(Grice, 1975:45-46)

Grice explains people sometimes do flout these guidelines, and here is where conversational implicatures play their part. In the event of a violation of one of the maxims, the listener assumes that the speaker is nevertheless trying to be cooperative and looks for the meaning at some deeper level. By so doing, s/he makes an inference, namely a "conversational implicature". An area in which conversational implicatures manifest full operation is in the area of verbal irony. For instance, if, after a hot argument with a friend, a woman responds:

"You are indeed a good friend!",

The friend will readily understand the non-literal meaning of the utterance, conveyed by her proposition. She is actually violating the Quality Maxim, for her friend should reach the conclusion , by means of implicature, that the woman does not think she is a fine friend but, on the contrary , a bad and self-centred friend. According to Grice (1975:50), to work out the presence of a conversational implicature, the hearer/listener will draw on:

i) The conventional meaning of the words used, together with the identity of any that may be involved.
ii) The Cooperative Principles and its Maxims.
iii) The context, linguistic or otherwise, of the utterance.
iv) Other items of background knowledge.
v) The fact (or supposed fact) that all relevant items falling under the previous headings are available to both participants and both participants know or assume this to be the case.

However, there are cases where the conventional meaning of the words used determines what is implicated. We may examine the following examples:

a. He is a dentist and therefore he is not a good teacher.
b. John was so slow that even Jane finished the novel before him.

By using the connector "therefore" in (a), we arrive at the conclusion that the fact of teaching badly is a consequence of being a dentist. Similarly, in b), the conventional meaning of "even" makes the listener draw the inference that Jane is an extremely slow reader. This kind of inference, induced by "therefore" in a) and by "even" in b) is what Grice has called a "conventional implicature". Conventional implicatures deal with detachable but non-cancellable aspects of meaning and they are akin to pragmatic presuppositions.

One of the major features of conversational implicatures, as opposed to conventional implicatures, is that they are cancellable, a feature that Grice (1978:115-16) explains thus:

> To the form of words of the utterance of which putatively implicates that p, it is advisable to add "but not p", or" I do not mean to imply that p", and that is contextually cancellable if one can find situations in which the utterance of the form of the words would simply not carry the implicature.

The fact that all conversational implicatures are non-conventional and therefore can be cancelled gives them a somewhat "slippery" condition. However, they constitute a crucial part of both speaker and hearer communicative competence: being able to work out implicatures, among other things, makes a speaker proficient and capable of interacting successfully. This is a crucially important aspect of the pragmatic knowledge necessary to communicate efficiently in any language.

A number of scholars have debated the importance of the two main types conversational implicature, namely 1) generalized conversational implicature, and 2) particularized conversational implicature (Alba-Juez, 2009:51) The difference between the two can be illustrated thus:

a) (A conversation between Joseph and Davies, while discussing some handsome and attractive men they met in their youth):

Joseph: Remember Ken?

Davies: Ah!! He was glorious, gorgeous! What a handsome man! He was always with Gabriel, remember?

Joseph: Yes, Gabriel was a lovely person.

Implicature a) Gabriel was not attractive or handsome (or glorious or gorgeous)

b) My mother is now in Italy or in France.

Implicature b- I don't actually know that my mother is in France.

Non-conventional inferences are induced in both a) and b) and are, therefore, cancellable. Therefore, in the two instaces, we are dealing with conversational implicatures. But the distinguishing factor between implicatures a and b is the generality of the circumstances in which the inference was worked out. The inference drawn in (a) is a particularized conversational implicature for it is only in the context of a conversation like the one between Joseph and Davies (i.e. a conversation about handsome men) that the hearer will normally be expected to infer the content of implicature a, i.e. Gabriel was not handsome. That means the implicature is worked out in this particular context and would not apply to a general context (where nobody would question Gabriel's handsomeness and would just consider the fact that he was nice). On the contrary, the inference drawn in (b), that the speaker does not know for sure whether his mother is in Italy or in France, is induced in the absence of a special context. Implicature b then, has a default nature and it represents the concept of generalized conversational implicature. It is important to note that in both examples, the crucial elements to take into account for inducing the relevant implicatum are the speakers or utterances, not the propositions or sentences (Alba-Juez 2010).

2.6.5 Politeness Principle

Politeness is the practical application of good manners or etiquette. It is a culturally defined phenomenon, and therefore what is considered polite in one culture can sometimes be quite rude or simply eccentric in another cultural context. Ii is also a central force in communication, arguably as basic as the pressure to be truthful, informative,

relevant and clear (Grice, 1975; Brown and Levinson, 1978; Leech, 1983). Natural languages provide many different means for encoding politeness and, in conversation, we choose where and how to use these devices. Kaplan (1999) opines that people like to be respected and identifies honorifics and other politeness markers like: please. Politeness markers are intimately related to the power dynamics of social interactions and are often a decisive factor in whether those interactions go poorly or well.

Brown and Levinson's (1978) politeness model is founded on the notions of ''face'' offered by Goffman and "conversational logic" proposed by Grice. "Face" refers to wants of every person: (1) to be approved by others (positive face), (2) to have his/her actions or thoughts unimpeded by others (negative face). The face-saving view of politeness places emphasis on the wants of the participants in a given interaction rather than on the interaction itself or the norms operating in society. Face is ''something that is emotionally invested, and can be lost, maintained or enhanced, and must be constantly attended to in interaction'' (Brown and Levinson, 1987:66).

Brown and Levinson (1978) construct their theory of politeness on the premise that many speech acts are intrinsically threatening to face. Speech acts are threatening in that they do not support the face wants of the speaker (S) and/or those of the addressee (A). Brown and Levinson (1978: 65-67) define face-threatening acts (FTAs) according to two basic parameters: (1) Whose face is being threatened (the speaker's or the addressee's)? (2) Which type of face is being threatened (positive face or negative face). Acts that threaten an addressee's positive face include those acts in which a speaker demonstrates that he/she does not approve of or support the addressee's positive face or self-image (e.g. complaints, criticisms, accusations, mention of taboo topics, interruptions). Acts that threaten an addressee's negative face include instances in which the addressee is pressured to accept or to reject a future act of the speaker (e.g. offers, promises), or when the addressee has reason to believe that his/her goods are being coveted by the speaker. Examples of FTAs to the speaker's positive face include apologies, acceptance of a compliment, self-humiliations, and confessions. Some of the FTAs that are threatening to the speaker's face include expressing gratitude, accepting a thank-you, an apology or an offer, and making promises.

While Brown and Levinson (1978: 13) believe the notion of face to be universal, they explain that in any particular society, we would expect face to be the subject of much cultural elaboration. Their model assesses the seriousness of an FTA using the following factors: The social distance (D) of speaker (S) and hearer (h); (2) The relative power (P) of (S) and (H); and (3) The absolute ranking (R) of imposition in the particular culture. An apology is an attempt by the speaker to make up for a previous action that interfered with the addressee's face-wants (Brown and Levinson, 1978: 187). Thus, the aim of apologizing is to restore equilibrium between speaker and addressee (Leech, 1983: 125). An apology is the acknowledgement by the speaker that a violation has been committed and an admission that he/she is at least partially involved in its cause. An apology may be considered a ''post-event,'' for it signals that the event has already taken place. Apologies count as remedial work and have been traditionally regarded as hearer-supportive as they provide some benefit to the addressee at cost to the speaker (Owen, 1983). Holmes (1995) extended the question of face benefit to the speaker as well, for she claims that apologies are face-supporting acts in general.

Brown and Levinson's Politeness Model regards apologies as ''negative politeness strategies'' in that they convey respect, deference and distance rather than friendliness and involvement. Negative politeness is an avoidance-based, on-record strategy of self-effacement and restraint. Evidence of negative politeness can be seen in both the apology strategies themselves (e.g., avoiding responsibility), as well as individual linguistic and extralinguistic elements which constitute these strategies.

In performing an apology, the speaker acknowledges the addressee's face-want not to be offended. Apologizing is face-threatening for the speaker and face-saving for the addressee. In contrast with negative politeness, positive politeness is an involvement-based approach made by the speaker to ratify, understand, approve of, and admire the positive image of the addressee. Brown and Levinson (1987:75) refer to the function of positive politeness strategies as one of minimizing the potential threat of an FTA by assuring the addressee that the speaker (S) has a positive regard for him or her and wants at least some of the wants of the addressee. Holmes (1995) claims that apologies can also function as positive politeness strategies for addressee (A) since (S) supports A's need for

positive feelings and affirmation from others. Examples of an apology act functioning as positive politeness are: (1) a speaker admitting that the addressee is right to feel offended by the infraction; (2) a speaker demonstrating his commitment to remedying the situation and appeasing the addressee through an offer of repair and (3) a speaker using deference markers such as titles or forms of address (Dr. Sir, Ma'am) or formal verb forms and corresponding pronouns (T-V forms). Brown and Levinson's (1978: 74) theory assumes that negative politeness is the universally preferred approach to facework: ''It is safer to assume that H (hearer) prefers his peace self-determination more than he prefers your expression of regard, unless you are certain to the contrary.'' In agreement with other scholars (Scollon, 1981; Placencia, 1992; Nwoye, 1992), we disagree with this as a valid assumption.

Politeness involves a relationship between two participants - a speaker and hearer-, but the speakers also show politeness to a third who may or may not be present in the speech situation. The politeness principle emanated from the attempt to remedy the minuses observed in the application of the cooperative principle (CP). In the first instance, there is the argument that the cooperative principle is not functional as a large percentage of declaratives bears no information. Two, the CP has been alleged to lack universality as some of its principles are not applicable in certain linguistic communities.

Kasher (1976:201) opines that the Gricean idea that ''in all stages of any conversation, it is always possible to identify a joint purpose shared by all those in conversation'' is mistaken. He postulates that it is probable for interlcutors not to have mutual aims, and adds that every participant has the right to alter the direction as they deem fit within certain limits. Kates (1980) holds the vista that the Gricean maxims are not achievable as most speakers not only disregard this rule of cooperation but are not in any provable sense cognizant of it. Subjectively, the criticisms of the Gricean maxim merely reduce their universal applicability. They do not render them totally incompetent. Geoffrey Leech's (1983) politeness principle, even though another principle, beautifully complements the Gricean cooperative principle. This idea can be illustrated thus:

A: The classrooms, laboratories and libraries will be renovated.

B: Surely, the classrooms will be renovated.

Obviously, B's reply violates the quantity maxim. His contribution suggests only the classrooms will be renovated. By merely alluding to classrooms, however, he has reduced the politeness principle to forfend triggering offence. B's intention has therefore constrained his utterance. Irony Principle -a subcategory of the politeness phenomenon- describes a second order principle. It states thus:

> If you must cause offence, at least, at least, do so in a way which doesn't overly conflict with the PP, but allows the hearer to arrive at the offensive point of your remark indirectly, by way of implicature.
>
> (Leech 1983:82)

Another example for consideration:

Jane: David has broken your chair.

Debby: (obviously angered) Oh. Beautiful!

The implicature from B's contribution in the above conversation is polite, the meaning is impolite.

Politeness is occasionally relative to culture and people. When talking in terms of politeness in the context of Nigerian cultures, the Yoruba and Hausas operate at two extremes. While the Yoruba are reserved in their descriptions of persons, persons' deformities and phenomena, the Hausa are rather blunt. The Yoruba are essentially euphemistic in their language usage on issues thathave to do with the psycho-social and emotional aspects of co-interlocutors. Therefore, if these cultural peculiarities, conventions and associations are extended to world cultures that align with the Yoruba culture, then the politeness principle and its subcategory – irony principle - have some affiliations with euphemistic usage of language. Somehow, this confirms Leech's vista that politeness can be obtained by using indirect locution (Odebunmi, 2003.

It is salutary to also talk briefly about deference in our discussion of politeness, but it is distinct. Deference is exhibited when others are accorded respect as a result of being older, having a greater status etc., and it is incorporated into the world languages. For

instance, Yoruba is filled with honorifics that are used as markers of respect to address people with greater age or status, strangers or peers. During conversation between peers, honorifics are usually engaged by the two parties in conversation to show respect. However, it is used more in conversations between women than men. In English Language, words such as 'Sir' and 'Madam' are employed to show deference. In addition, address terms like: 'doctor', engineer', 'professor', 'pastor', 'evangelist' are used to show status differential. However, unless the norms of honorifics are violated, for instance, if someone always addressed as 'evangelist' is suddenly addressed by their first name, deference is not pragmatically relevant. Thus, deference tilts more towards sociolinguistics than pragmatics as a concept (Odebunmi 2003).

However, Dillian et al (1985), Thomas (1986), Brown and Levinson (1987), and Frazer (1990) have observed some weaknesses in Leech's approach to the politeness phenomenon. They have claimed the maxims to be inelegant. Therefore, it is salutary to adopt Thomas'(1995) reconciliation of the issues by seeing Leech's ideas as as ''a series of social-psychological constraints influencing, to a greater or lesser degree the choices made within the pragmatic parameters'' but not as maxims. Therefore, Leech's maxims will be treated as factors, even though they will still be referred to as maxims for easy reference. In order to show politeness, speakers in a speech situation observe the following maxims (Leech 1983: 132):

1) Tact maxim (in impositives and commissives): (a) Mininmize cost to other

   (b) Maximize benefit to other.

2) Generosity maxim (in impositives and commissives): (a) Minimize benefit to self (b) Maximize cost to self.

3) Approbation maxim (in expressives and assertives): (a) Mininmize dispraise of other (b) Maximize praise of other.

4) Modesty maxim (in expressives and assertives): (a) Mininmize praise of self

   (b) Maximize dispraise of self.

5) Agreement maxim (in assertives): Minimize disagreement between self and other (b) Maximize agreement between self and other.

6) Sympathy maxim (in assertives): a) Minimize apathy between self and other

(b) Maximize sympathy between self and other.

7) Polyanna Principle states that people prefer to look on the bright side of life rather than on the gloomy side of it. This is done through the deployment of euphemisms, minimizers and relexicalizations to handle offensive topics, using pleasant or unoffessive expressions.

2.6.6 Politeness Principle and Face-Threatening Acts

The politeness principle (PP) resulted from the weaknesses observed in the Cooperative Principle (CP). Politeness principle has a higher regulative value than cooperative principle (Leech 1983: 82). Politeness engenders smooth continuation of communication in a manner that cordiality is assured. He, however argues that both PP and CP have relative overriding tendencies. Sometimes, PP overrides CP, and the other way round.

Politeness can be observed in situations of social distance or closeness as the means by which we ‘’show awareness of another person’s face’’. Yule (1996:60) technically defines face as ‘’ the public self-image of a person. Odebunmi (2003) puts it differently as the emotional and social feeling of self which an individual has and expects others to recognize.

Face can be categorized. Deference or respect is the first example, and it operates in a situation of social distance e.g., the relationship between a bus driver and his conductor, or the age respect between a child and the mother. The second type of face is friendliness, camaraderie or solidarity that occurs in social closeness. This is largely found among equals. Everybody wants his/her face to be respected irrespective of the personality concerned. Thomas (1995) comments thus:

> Face, in the approach of politeness is an individual’s feeling of self-worth or self-image: this image can be damaged, maintained or enhanced through interaction with others.

Therefore, face may be positive or negative. There is positive face when a person desires respect, approval, liking and appreciation from others. On the other hand, there is negative face when a person desires to act independently without imposition by others. It is worthwhile to reiterate that everyone wants their face wants to be met. The individual is said to have his/her face saved when this happens, but when the reverse is the case, his/her face is said to be threatened. All these events are referred to as face-threatening acts (FTAs).

Face-threatening acts are illocutionary acts that are liable to damage or threaten H's positive or negative face. This sometimes results when H is insulted or when what H holds dear is disapproved of or when H's freedom is restricted. Sometimes too, might potentially cause damage to the speaker's own positive or negative face. (Odebunmi, 2003).

It is however probable to reduce the damage that S's act may cause to H's face by adopting certain strategies. To choose the suitable strategy, speaker has to assess the size of the FTA, and calculate the FTA on the basis of parameters of power (P), distance (D) and rating of imposition. The stated factors influence the strategies adopted. The strategies are: (a) performing the FTA on record without redressive action, (b) performing the FTA on record using positive politeness, (c) performing the FTA on record using negative politeness, (d) performing the FTA using off-record politeness and (e), not performing the FTA (Thomas 1995). All of them are discussed in turn below.

2.6.6.1 Performing an FTA Without Redress

This performance of the FTA is also described as bald-on-record. The FTA is performed when certain external factors constrain a person from speaking directly. Situations of emergency or when someone is working against time are some examples. Between the speaker and the hearer, S decides to make his/her request on-record if he/she reckons that the FTA is in the best interest of H. But when the power differential is great, the FTA is sometimes not mitigated, irrespective of imposition rating. In such situations, the powerful participants do use indirectness. Generally, bald-on record acts employ

imperatives which might be accompanied by mitigating devices that soften the imposition; for example, ‘’please’’, ‘’ would you?’’, ‘’could you explain why you should not be disciplined?’’ Yule (1996) opines that bald-on –record expressions go in line with speech situations which Speaker has an assumption of power over Other and which make him/her have the tendency to want to control the behaviour of Other through words.

2.6.6.2 Performing an FTA with Redress (Positive Politeness)

In discussing Brown and Levinson’s approach of face management, Thomas (1995) observes that sometimes when we speak, we may orient ourselves towards an individual’s positive face, and employ positive politeness that appeals to H’s desire to be liked and approved of. There is equality in the politeness expressed here with Leech’s (1983) principles of politeness like: ‘’seek agreement’’, ‘’avoid disagreement’’, ‘’be optimistic’’, ‘’give sympathy’’. Because these features are very positive in nature, they can tremendously save H’s face in interaction. In spite of the unsavoury preceding content of most queries, dismissal letters and warning letters written globally, it is not uncommon to see such letters end with ‘’Thank you’’. In some other cases, unpleasant situations are presented euphemistically.

2.6.6.3 Performing an FTA with Redress (Negative Politeness)

Negative politeness is achieved through the deployment of conventional politeness markers, deference markers as well as by minimizing imposition. Examples include: salutation, indirect conventionality, hedging etc. Brown and Levinson (1978) offer ten strategies for performing an FTA with redress (negative politeness) i.e: ‘’be conventionally indirect’’, ‘’hedge’’, ‘’minimize imposition’’, ‘’admit the impingement and beg forgiveness, ‘’use points of view distancing’’, ‘’ go on record as incurring a debt’’ etc. For example, in several commercial centres in Nigeria, particularly where the managers are literate, expressions like: ‘’No credit, come tomorrow’’ are common. This means that credit facilities are not available for any purchaser regardless of his/her

relationship with the management. Warning notices targeting large number of readers use negative politeness (Thomas, 1995).

2.6.6.4 Performing an FTA Using Off-Record Politeness

There are fifteen strategies for performing off-record politeness. Some examples are: ''give hints'', ''use metaphors'', '' be ambiguous or vague'' etc. (Brown and Levinson, 1978). Most of the instances of this face act type largely adopt Searle's preparatory condition. A number of practical examples can be cited from queries resulting from insubordination and dereliction of duty e.g.: "This is not the first time of such report." (Odebunmi, 2003).

2.6.6.5 Non-Performance of FTAs

Thomas (1995) observes this happens when something appears so ''potentially face-threatening that one does not say it''. Tanker (1992) explains two ways of avoiding saying anything:

(i) OOC-genuine: S does not perform a speech act, and genuinely intends to let the matter remain closed. She or he does not intend to achieve the perlocutionary effect.

(ii) OOC-strategic: S does not perform a speech act, but expects to infer his or her wish to achieve the perlocutionary effect.

Pramatics is considered apt for the analyses planned in this work because of its emphasis on face-threatening acts and politeness maxims.

2.7 Speech Acts

This is another aspect of the speech situation which is considered to be essential within pragmatic studies. The basic belief that language is used to perform actions led John Austin and John Searle to develop a theory of Speech Acts. In the famous posthumously published lectures ''How to Do Things with Words'', Austin (1962) set about

demolishing the view that truth conditions should be considered as central to language understanding. He developed a general theory of illocutionary acts, which, in turn, became a central concern of general pragmatic theory. In saying something, Austin observes, we are also doing something, and, hence, three kinds of acts are simultaneously performed:

1. Locutionary acts: the utterance of a sentence with a determinate sense and reference.
2. Illocutionary acts: the making of a statement, offer, promise, etc. in uttering a sentence by virtue of the conventional force associated with it.
3. Perlocutionary acts: the bringing about of effects on the audience by means of uttering a sentence, such effects being special to the circumstances of utterance.

(Austin 1962:101-02)

The difference between the three types of acts can be illustrated thus: (A man to his friend):

I have bought a new and costly car. Would you like to borrow it?

Here, the locutionary act would simply be the uttering of a sentence meaning that the man has a new and costly car and that he asks his friend if he wants to borrow it. The illocutionary act would in a way be the effect of the locutionary act, i.e. the function fulfilled by the locution, which in this instance is an offer. The intended perlocutionary act, however, might be for the man to impress his friend, or perhaps to show a friendly attitude. But perlocutions may be intended or unintended, so in this case an unintended perlocutionary effect could be for the interlocutor to feel offended because he interpreted that his friend was trying to belittle him by implying that he could never have or buy such a costly car.

The term speech act has come to refer exclusively to the second kind of act i.e. the illocutionary act, since this is the one that seems to present the richest developments and interpretations within pragmatic theory. In English (as in other languages), sometimes

sentences contain linguistic expressions that serve to indicate the illocutionary force of the sentence. To illustrate this, we may consider the following examples:

1) I promise I will not fight again. 2) I order you to stop shouting.

Only certain verbs (which Austin called performatives), like order or promise, have the property of allowing the speaker to do the action the verb names by using the verb in a certain way. Other verbs cannot be used in this way, and thus, for instance, saying ''I nag you to pick up your clothes'' is not nagging (Green, 1989:67). Searle's (1967) later systemization of Austin's work, in which he proposes a typology of speech acts based on felicity conditions (the social and cultural criteria that have to be met for the act to have the desired effect), became very influential. Austin and Searle's position can be formulated by saying that all utterances not only express propositions, but also perform actions. The illocutionary acts, or, more simply, the speech act, is at a privileged level within these actions. Gricean conversational maxims are relevant to our analysis, but speech act falls outside the scope of this study.

2.8 Theoretical Framework: The Hallidayan Systemic Functional Grammar

The theoretical framework adopted for this study is a blend of Pragmatics, Conversation Analysis and Interactional Sociolinguistics complemented with insights from M.A.K. Halliday's Systemic Functional Grammar. The pragmatic theory of politeness is considered suitable for the analysis of our data in view of some of its features that are relevant to the analysis intended in this work. The features include: FTA with redress, FTA without redress, FTA positive politeness, FTA negative politeness and politeness maxims.

Harold Garfinkel''s Conversation Analysis is suitable for the analysis of our data for a number of reasons. One, it was developed for the analysis of naturally occurring conversations. Two, it focuses on context. Three, it considers how interlocutors in a talk systematically resolve recurrent organizational problems i.e.: opening and closing of conversation, topic management, information receipt etc.

Interactional Sociolinguistics is suitable for our analysis in view of its ability to explicate language switch. The Systemic Functional Grammar is apt for the lexical and grammatical analysis of the interactions.

The Systemic Functional Grammar (SFG) is considered apposite for this study in view of its emphasis on semantics and contextetual relations. It is a full blown theory of grammar developed by the British linguist - Michael Halliday- in his 1965 works. SFG views language as a behaviour, matches form to function, places premium on context and examines meaning in relation to context (Halliday 1985). Meaning in relation to context occupies a prime of place in Systemic Functional Grammar.

In consonance with the above, J.R. Firth (1957) opines that meaning is the function of a linguistic item in its context of use. Buttler (1985) validates Firth's assertion by saying that although context of situation is central to SFG, it is just one kind of context in which linguistic units could function. He adds that other contexts are provided by the levels postulated to account for various types of linguistic patterning. SFG thus offers us a medium to observe, analyze and account for intra-textual lexical relations. Leech (1985) asserts that examples of such relations are: antonyms, synonyms, hyponyms etc. They all account for contextual meanings. Conversely, referential meaning can be accounted for through endophoric and exophoric references (Lyons, 1979).

Unit, structure, class and system are the four grammatical categories set up by the SFG that demonstrate how relationships between linguistic items can be consistently handled. Unit accounts for stretches that carry grammatical patterns, while structure depicts an arrangement of elements ordered in places and examines the similarities between successive events.

Deducible from the above is that linguistic units occur purposely in texts to perform certain functions. Language performs three basic functions in texts. One, the ideational function is the expression of context i.e. the expression of the speaker's view of the real world and the inner world of his own. Two, the interpersonal function establishes and maintains interpersonal relations that language serves. Three, the textual function shows

how language provides a link between itself and the features of the situation in which it is used (Halliday 1970).

Moreover, Halliday's systemic theory underlies his functional grammar that views grammar as constantly meaningful. Consequently, SFG is a theory of 'meaning as choice' (Halliday, 1985). It is premised on the vista that language plays a certain role for its users as a social group, thus endowing it with a sociolinguistic nature. Halliday (1985) consequently focuses absolutely on the functional part of grammar which is the interpretation of the grammatical patterns in terms of configuration and function. He asserts this is appropriate for the analysis of both spoken and written texts. Then, language in use and how language is used are the focus. The context of situation and context of culture by which means the meaning of the text is derived exhibit these.

Halliday (1961), therefore, explains the three different levels at which linguistic levels should be accounted for in textual analysis. These are: substance, form and context. Substance refers to the materials of language, that is, phonic (audible noise) or graphics, which are visible marks. Form is the arrangement of these audible noises and materials into meaningful events, while context accounts for the relation of the form to the non-linguistic features of the situation where language is used.

Form relates at two levels: lexical and grammatical levels. Therefore, the SFG is organized in a manner that the meaning of a linguistic event derives from a combination of its formal meaning and contextual meaning (Malmkjaer, 2002). The contextual meaning is accounted for in its relation to external factors and the formal by its operation in the network of formal relations. Situational variables and appropriate language use are accounted for at the contextual level, while linguistic features are accounted for at the formal level. Consequently, there is an interface between form and function for meaning generation in texts.

Going by the above, the Systemic Functional Grammar is considered apt for the analyses intended in this study. Accordingly, we will examine language use in doctor-patient verbal interactions from the point of view of the SFG.

CHAPTER THREE

RESEARCH METHODOLOGY

3.0 Introduction

This study is situated within Discourse Analysis. This field of Linguistics has the attention of many linguists, hence the array of approaches to it. In actual fact, new approaches have also emerged, partly to fill the hiatus created by earlier methods of analysis. Some examples of these new approaches are Typological Discourse Analysis (TDA), Forensic Discourse Analysis (FDA) and Critical Discourse Analysis (CDA). Each of them deals with a different social issue.

This section offered a description of the steps adopted in carrying out this study. It discussed the pilot study and explained its relevance to this research. It discussed how the texts for this work were collected and how the data were got from the corpus of discourse interactions. It also discussed the methods of data presentation and analysis.

3.1 Pilot Study and Findings of the Pilot Study

Prior to the conduct of this research, a pilot study (Discourse Functions of the Elements of the Discourse Units in Doctors' Verbal Interactions with Patients in Selected Federal Teaching Hospitals in Nigeria) was undertaken to test the validity and resource potential of the context of this research. It sought to: i)find out if the area of research had adequate resource and potential to warrant a full study of the discourse devices in the verbal interactions between doctors and patients and ii), investigate the possibility of accessing the data and whether the data were analyzable. Therefore, the pilot study started out to get the data and examine the discourse devices employed in doctors' verbal interactions with patients in the south-West and North-Central geo-political zones of Nigeria.

The pilot study came up with the following discoveries. The data revealed that the language resource available in the clinical interviews was rich for linguistic analysis because it offered a pool of features to explore therefrom. Concerning language use in the study with particular reference to discourse units which the pilot study sought to research into, the following were discovered:

(i) Manipulation of the elements of the discourse units enabled doctors to obtain good and adequate information to diagnose the patients.

(ii) Exchange, move and act were the only discourse units involved in the verbal interactions.

(iii) Act is the lowest on the hierarchical rank scale but yet constituted the raw material from which both exchange and move were realised.

(iv) Topic exchanges were initiated by elicitation.

(v) Moves were highly mobile and, when looked at more closely, moves earlier seen to belong to particular acts may actually be seen to belong to others.

(vi) Elicitation was used more than all the other acts as it was the major linguistic tool through which the doctors obtained information from the patients on chief concern (CC), history of present illness (HPI), family history (FH), social history (SH) and other active problems (OAP).

(vii) The successful conduct of the pilot study invigorated the zeal to embark on this research. The pilot study offered a lot of insight into the possible challenges that would have been a cog in the wheel of progress of the study, especially in relation to data collection.

3.2 The Present Research

Consequent upon the successful conduct of the pilot study and the discoveries made, the gusto for this research was ignited to investigate language use, focusing specifically on the discourse devices employed in doctor-patient verbal interactions in selected federal teaching hospitals in Nigeria. The aim was to determine the discourse devices deployed as well as how they assisted the doctors in obtaining necessary information to diagnose the patients and make the discourse generally result-oriented.

3.3 Text Collection and Methods of Collecting Texts

The texts for this study were collected at the General Out-Patients Department (GOPD) and the Dental School of the University College Hospital (UCH), Ibadan, and University of Ilorin Teaching Hospital (UITH), Ilorin.

With the full cooperation of the doctors and patients, tape-recordings of the doctors' verbal interactions with patients in the consulting rooms were done. The clinical interviews were recorded with tape recorders, and sometimes, mobile phones. The tape recorders and the mobile phones were always placed on the doctors' tables. A total number of three one audio recordings were done, and the recorded verbal interactions were subsequently transcribed and analyzed. The duration of each of the recorded transactions was determined by the length of the clinical interview. The least was 12-15 minutes, while the longest was 30-50 minutes. In addition, the researcher was, most of the time, not allowed to witness the clinical interviews.

The verbal interactions between doctors and patients were captured mainly in audio format. They were consequently played, listened to and transcribed for analysis in this study. This method was favoured as a result of the realization that the analysis and interpretation carried out in this research were better done in the written form. The reason for this is that when a spoken prose is converted to a written format, it becomes easier to see how ideas are molded into a complex, coherent and integrated whole, unlike the spoken prose that is more or less produced in transient, and can be forgotten easily. Additionally, written texts are easier to analyse as one can easily identify and pinpoint certain facts in the analysis, and the facts can then be classified or grouped under some headings that will make for easy comprehension. However, it should be understood that changing speeches to written formats does not make the spoken form inferior to the written form in any way because the spoken form, apart from being a real life production adorned with some paralinguistic features that might not have been effectively captured in the transcription, is obviously more comprehensive. It is also characterized by originality. The sampled discourse interactions in written form were subjected to linguistic analysis using relevant discourse analytic and pragmatic models.

3.4 Challenges Encountered During Data Collection at UCH, Ibadan, and UITH, Ilorin

The researcher faced some challenging situations in the course of collecting data in the two concerned hospitals. Firstly, at the University College Hospital, Ibadan, the researcher, even though armed with the ethical approval given by the Ethical Review

Committee of the infirmary, was denied the opportunity to collect data at the E.N.T. and surgery sections of the infirmary. Similarly, at the paediatric section of University of Ilorin Teaching Hospital, Ilorin, the researcher was also almost denied the researcher the opportunity to collect data there by some nurses out of unfounded fears if not for the timely intervention of a consultant surgeon who allayed their fears.

In addition, obtaining the ethical approval from the two infirmaries took almost fourteen months as result of certain bureaucratic bottlenecks. Obtaining the ethical approval from UITH, Ilorin was more tasking than that of UCH, Ibadan as the researcher spent a lot of money travelling there several times to appear before the Ethical Review Committee of the hospital, submit proposals or letters and to collect the data. Moreover, several doctors and patients talked in low tones and made most of the audio recordings to be very inaudible. In several cases too, some patients refused to allow their verbal interactions with doctors to be tape-recorded. This, therefore, made the researcher to collude with some very cooperative doctors to stealthily record the interactions by putting mobile phones or tape recorders in the record mode and putting them on the doctors' tables before the patients were called in.

3.5 Sampling Technique of Text Collection

Using the purposive sampling technique, doctors and patients were sampled in the two selected federal teaching hospitals in the South-West and North-Central geo-political zones of Nigeria. The doctors' verbal interactions with patients were tape-recorded in each of the two selected hospitals. A total number of 50 doctors, and 100 patients were used in this study. 25 doctors and 50 patients were chosen from University of Ilorin Teaching Hospital (UITH), Ilorin, while 25 doctors and 50 patients were also chosen from the University College Hospital (UCH), Ibadan, for participation in the study. In effect, we had a total of two patients to a doctor. There was a total of 100 sessions of recording of clinical interviews. However, only 50 recorded sessions of the interviews formed the data on which our analyses were based to make room for thorough analyses.

The sample from the medical profession was restricted to doctors because, one, the entire business of diagnosis and of laying treatment course for patients is an exclusive duty of

doctors. The second reason is that this sampling method would enable us carry out a detailed analysis of the interactions. Thirdly, we have also restricted the number of hospitals used in this study to two to facilitate easy data collection and to avoid making the data collection fictitious. In addition, the decision to restrict the overall sample used in the study to fifty resulted from the fact that many of the recorded interactions were inaudible as many doctors and nurses talked in very low tones.

3.6 Obtaining Ethical Approval for Text Collection for the Study

As a result of the secrecy that medical ethics demand for patients' medical conditions, ethical approval was sought and obtained from the ethical review committees of the two concerned hospitals through writing and personal visits. In each of the concerned hospitals, a proposal was submitted to seek permission for collection of data. At the university of Ilorin teaching hospital, the researcher was, in addition to submitting a proposal to seek permission for collection of data, made to personally appear before the Ethical Review Committee of the university on three different occasions to answer some questions on the submitted proposal before final the final approval was given. Some payments were also made to the Ethical Review Committees of the two infirmaries. A total sum of #5000 and #7,500 were paid to UCH, Ibadan and UITH, Ilorin, respectively as part of the conditions for obtaining ethical approval. In addition, a pamphlet containing guidelines for proposal writing was also purchased for #200 at UITH, Ilorin.

3.7 Sampled Hospitals

1) University College Hospital Ibadan, (UCH), Oyo State.

2) University of Ilorin Teaching Hospital, Ilorin, (UITH), Kwara State.

The University College Hospital, Ibadan (UCH) and University of Ilorin Teaching Hospital, Ilorin (UITH) were chosen for this study because they are the leading teaching hospitals in the location of the study. Secondly, they are the closest to the researcher for ease of data collection.

3.8 Methods of Data Collection in Texts

This section described the methods employed in collecting the data for the study. It also explained the methods of investigating each of the research questions. The data were collected to answer the research questions below.

Research Question 1: Which discourse devices are employed in doctor-patient verbal interactions and what pragmatic functions do they perform?

Method of Investigating This Research Question

Discourse devices are language tools that are used to better realize the goals of verbal interactions i.e.: language switch, phatic communion, circumlocution, rapport expressions, politeness etc. They were investigated by carefully studying our data source to determine those relevant discourse devices that enabled the interlocutors achieve their communicative goals. Efforts were also made to study the realization of the concerned discourse devices. In addition, the discourse devices employed were examined to pinpoint their communicative functions in the interactions and establish the extent of their effectiveness.

Research Question 2: How and by what means is politeness achieved in the interactions?

Method of Investigating This Research Question

An examination of the deployment of politeness was undertaken here using Brown and Levinsons' (1987) pragmatic theory of politeness to reveal how FTA with redress and FTA without redress realized politeness.

Research Question 3: Which politeness maxims are observable in the interactions?

Method of Investigating This Research Question

The politeness maxims deployed in the data were identified and discussed. In addition, efforts were made to study how the deployment of politeness maxims aided the communication.

Research Question 4: Are there similarities and differences in the use of specific discourse devices between the two hospitals selected for this study and how frequently are the discourse devices employed?

Method of Investigating This Research Question

The discourse devices employed by both the doctors and the patients in the two hospitals selected for this work were examined to pinpoint the differences and similarities observable in them. The frequency of occurrence of the discourse devices employed in the interactions was analysed by counting the number of times each of them was used and then representing them in simple percentage terms.

Research Question 5: Which contextual factors manifest in the interactions?

Method of Investigating This Research Question

A number of contextual factors manifested in the interactions. Consequently, contextual factors such as setting, religion, linguistic background and culture were examined, analyzed and discussed. The study examined the effect of the location, language choice, religious affiliation and way of life of the interlocutors on the interactions.

3.9 Methods of Data Presentation and Analysis

The data were presented and analysed using quantitative and qualitative methods. The quantitative method focused on numbers and frequency. It applied mainly to the discourse devices employed by doctors and patients in order to determine their frequency of occurrence and relevance to the study. The features were identified and their frequency of occurrence was computed in simple percentages. On the other hand, the qualitative method dealt with describing and inferring intended or perceived meaning in the texts and not just drawing statistical inferences as it applied to how the discourse devices identified elicited and got information, and performed communicative functions in the

interactions being studied. In determining the communicative effects of the discourse devices identified, this study was guided by M.A.K. Halliday's Systemic Functional Linguistic (SFL) theory, particularly the interpersonal and textual metafunctions of language and context of situation. The empirical methods adopted thus allowed for statistical information to be reflected through quantitative analysis, while it was backed up and enriched by explanations through qualitative analysis.

Our sources of data were got from audio recordings of doctor-patient verbal interactions at the University College Hospital, Ibadan and University of Ilorin Teaching Hospital, Ilorin. They were then listened to, and transcribed for analysis in this study. This was done because it was felt that the analysis to be undertaken in this study would be better done in the written form. In addition, written texts are easier to analyse as certain facts can easily be pinpointed in the analysis, and the facts can then be categorised or grouped under some headings that will make for easy comprehension.

It is, however, worthy of note that reducing the spoken texts to written form does not in any way make the written form superior to the spoken form because the spoken form, apart from being more comprehensive, is a production in real life with even some extra linguistic features that may not have been effectively captured in the transcription. Therefore, it is the established authentic source. The sampled discourse interactions, in written form, were subjected to linguistic analysis, employing Halliday's SFL theory, to determine the grammatical features of the discourse devices deployed in this study.

Given the array of approaches to discourse, we considered our data very critically and carefully decided on the approaches that were most suitable for our analyses as no particular approach seemed adequate for this study. Each methodological perspective was carefully examined and applied to specific aspects of our data. Thus, this study adopted Conversation Analysis (CA) complemented with pragmatics, particularly focusing on Brown and Levinson's theory of politeness and some other relevant approaches to study issues like: opening and closing of conversation, language switch, politeness, phatic communion, direct and indirect question, answer, counselling, repetition, circumlocution and religious belief.

3.9.1 Quantitative Data Analysis

Table 1: Frequency of Occurrence of the Discourse Devices Employed by the Doctors in UCH, Ibadan, Interactions

Discourse Devices	**Total number of Occurrences**	**Percentage**
		%
Phatic Communion	25	1.74%
Direct Questions	402	27.90%
Indirect Questions	34	2.36%
Rapport Expressions	101	7.02%
Language Switch	80	5.56%
Face-Threatening Acts	69	4.80%
Counselling	72	5.00 %
Religious Belief	14	1.00%
Answer	420	29.19%
Circumlocution	197	13.6%
Closing	25	1.74%
Total	**1439**	**100%**

Table 2: Frequency of Occurrence of the Discourse Devices Employed by the Doctors in UITH, ILORIN, Interactions

Discourse Devices	**Total number of Occurrences**	**Percentage**
		%
Phatic Communion	25	1.80%
Direct Questions	382	27.52%
Indirect Questions	28	2.02%
Rapport Expressions	92	6.63%
Language Switch	63	4.59%
Face-Threatening Acts	93	6.70%
Counselling	50	3.60%
Religious Belief	9	0.65%
Answer	414	29.80%
Repetition	8	0.60%
Circumlocution	199	14.34%
Closing	25	1.80%
Total	1388	100%

Table 3: Cummulative Frequency of Occurrence of the Discourse Devices Employed by the Doctors and Patients in all the Interactions

Discourse Devices	**Total number of Occurrences**	**Percentage**
	100	%
Phatic Communion	50	1.45%
Opening	784	22.80%
Language Switch	143	4.16%
Circumlocution	396	11.5%
Direct Questions	784	22.80%
Indirect Questions	62	1.80%
Answer	834	24.25%
Counselling	112	3.26%
Repetition	8	0.25%
Rapport Expressions	193	5.6%
Religious Belief	23	0.7%
Closing	50	1.45%
Total	**2820**	**100%**

Discourse devices are deployed to enhance effective communication and can be seen to be copiously used in the interactions under study as shown in the tables above. These devices were so well employed that they helped to manipulate language in order to effectively communicate the language users' messages and intent.

3.9.2 Qualitative Data Analysis

This section focused on the qualitative description of the discourse devices employed in the verbal interactions, drawing inferences from the statistical representations in the quantitative illustrations in the preceding section. The objective of this was to draw inferences to show how the identified discourse devices aided the doctors in obtaining good diagnosis through the clinical interviews under investigation. The following discourse devices were examined: indirect and direct questions, answer, phatic communion, closing, rapport expressions, language switch, circumlocution, religious belief, counselling and face-threatening acts.

Both the quantitative and qualitative methods of analysis were employed in this study. The quantitative method centred on number and frequency of occurrence of the discourse devices. It was applied mainly to the discourse devices employed during the clinical interviews so as to determine their number of occurrence and relevance to the study. The identified devices and their frequency of occurrence were counted and computed in simple percentages. Contrariwise, the qualitative method deals with drawing of inferences in relation to how the identified discourse devices aided the doctors in their diagnoses. The adoption of empirical methods consequently made room for statistical information to be revealed via quantitative analysis, and it was complemented and deepened by explanations through qualitative analysis.

Table 4: Discourse Devices, Excerpts and Functions

S/N	Discourse Devices	Excerpts	Functions
1.	Phatic Communion	What do you do?	For opening interactions
2.	Direct Questions	Why did you come this morning?	For elicitation to make diagnoses
3.	Indirect Questions	You feel it in the morning, feel it in the afternoon	For making the clinical interview appear less stressful and making the patients cooperate to release the information needed to make diagnoses.
4.	Rapport Expressions	E pele. [Sorry.] What is your name?	For promoting open communication and cordiality.
5.	Language Switch	Se e ti lo gba awon result yen?	For clarity of expressions and accommodation of patients' linguistic backgrounds.
6.	Face-Threatening Acts	You don't need to tell your wife lies.	For correcting patients.

7.	Counselling	Always use the medium one. It's the best for you.	For guiding patients aright.
8.	Religious belief	See, we have the same faith. I am also a Christian.	For persuasion and encouragement.
9.	Answer	I feel a burning sensation all over my body	For supplying the required information to make diagnoses.
10.	Circumlocution	I have body pain	For explaining ailments.
11.	Repetition	I should remove the milk teeth. Remove the milk teeth.	For emphasizing patients' medical challenges
12.	Closing	Thank you. Bye bye, Ma.	For rounding off the clinical interviews

As hinted earlier on, the employment of both the quantitative and qualitative techniques of analysis was preferred because it provided a balance for the maladroitness of either of the methods. Thus, what was inexplicable at the quantitative level was taken care of at the qualitative level.

Equally important, because the researcher understands only English and Yoruba, only the contributions of Yoruba and English languages speakers formed parts of our data. In situations where the doctors and patients conversed in Yoruba, or engaged in code-mixing or code-switching of English and Yoruba, their contributions were translated sentence by sentence into English, and the translations were square-bracketed and italicized to foreground them. Conversations conducted in English were retained.

3.10 CONCLUSION

This chapter has mapped out the strategies for investigating the discourse devices employed in doctor-patient verbal interactions in the South-West and North-Central geo-political zones of Nigeria in this work. The study identified discourse devices like: phatic communication, direct and indirect questions, answering, politeness, language switch, religious belief, counselling, circumlocution, repetition and rapport expressions. These identified discourse devices were discovered to have not only informed but some of them have also elicited appropriate information to get good diagnoses.

3.11 AN OVERVIEW OF SUBSEQUENT CHAPTERS

This study structured the subsequent chapters as follows: Chapter Four focused on the analysis and discussion of the various discourse devices deployed in the verbal interactions between doctors and patients at the University College Hospital (UCH), Ibadan, as well as their communicative functions. The analysis of these discourse devices highlighted their features and functions, especially the illuminating capacity of such devices for diagnostic purposes in the interactions. The discourse devices were also analysed grammatically.

Chapter Five featured analyses of the various discourse devices deployed by the doctors and the patients at University of Ilorin Teaching Hospital (UITH), Ilorin. The analyses revealed how they illuminated the clinical interviews.

Chapter Six presented a summary of the whole study in order to highlight the main insights gained and draw conclusions. The specific contribution this study has made to the genre of medical discourse was also spelt out here. In addition, some possible suggestions for further studies were also made.

CHAPTER FOUR

ANALYSIS AND DISCUSSION OF THE DISCOURSE DEVICES AND COMMUNICATIVE FUNCTIONS IN DOCTOR-PATIENT VERBAL INTERACTIONS AT U.C.H., IBADAN

4.0 Introduction

This chapter analysed the various discourse devices employed in the interactions and their communicative functions based on the data obtained at the University College Hospital, Ibadan. Doctor-patient verbal interaction often involves a doctor and a patient and, sometimes, a patient's relation. Therefore, the discourse devices employed by both the doctors and patients were examined here.

4.1 Research Question 1: Which discourse devices are employed in doctor-patient verbal interactions and what communicative functions do they perform?

A number of communication problems have been discovered to pose some challenges to doctor-patient verbal interactions. Consequently, this study revealed the discourse devices that doctors and patients alike employed to overcome the challenges. Discourse devices are used to realize the goals of verbal interactions. Therefore, in this study, they were realized by phatic communion, direct question, indirect question, answer, language switch, face-threatening acts, circumlocution, rapport expressions, politeness, religious belief, counselling and closing.

4.1.1 Phatic Communion: To Open Up Discourses and Show Empathy

Given the sensitive nature of clinical interviews, a bad opening potentially hinders the success of any clinical interviews. To address this problem, phatic communion was employed by the doctors in this study at the beginning of most diagnostic sessions. It was generally realized by greetings, demonstration of empathy, enquiries by doctors about patients' well-being and social life during consultations. In this study, the doctors employed phatic communion to open the interviews. The following extracts were considered:

Extract 1 (Interaction 7)

Doc.: **What do you do?**

Pt.: I am a student.

Doc.: What name do your friends call you?

Pt.: PF

Extract 2 (Interaction 18)

Doc.: Gloria **David**

Pt.: Good morning, Madam.

Extract 3 (Interaction 14)

Doc.: **How are you today?**

Pt.: I am fine.

Doc.: Do you have any complaints?

Pt.: There is no problem really. I just feel something is moving about in my body.

Extract 4 (Interaction 25)

Doc.: Sorry, Ma.

Pt.: Thank you.

Doc.: What's your name?

Pt.: Adeola Gabriel.

Doc.: What complaints do you have?

A careful look at Extract 1- 4 showed that the doctors employed phatic communion in opening the conversations with the patients during the consultations. In Extract 1 (Interaction 7), Doctor opened the conversation with the patient by using an interrogative ('What do you do?') to know the patient's vocation. In Extract 2 (Interaction 18), Doctor called the patient's name ('Gloria David') to open the conversation. In Extract 3 (Interaction 14), Doctor opened the conversation by using salutation ('How are you today?) to welcome the patient and at the same time start the interview. In Extract 4 (Interaction 25), the doctor's reading of the patient's appearance revealed that the patient was in pains. Consequently, this warranted the doctor's use of the empathetic expression ('Sorry, Ma.') to show sympathy and empathy. The deployment of the phatic communion here involving the use of salutation, non-medical questions, empathetic expression and calling of a patient's name prepared the ground for the smooth commencement of the clinical interviews. It should also be noted that there were situations where the patients opened the clinical interviews as evident in our data, and this was done mainly by employing salutation. It is clear from the discussions above that there were various strategies that the doctors employed to start their conversations with the patients. Their choices were influenced by the appearance of the patients, time of the consultation, and African culture which makes salutation mandatory at the beginning of any conversation. From the foregoing, it is clear that phatic communion was realized by greetings, interrogatives, proper nouns (names of patients) and emotive expressions to start the discourse with the patients while the patients only employed greetings or complaints (declarative).

The communicative function of the deployment of phatic communion was to open up the interactions. It was apt for starting the clinical interviews as it enabled the interlocutors to create an atmosphere conducive for a smooth commencement of the consultations. Apart from this, it made room for the interlocutors to start talking and to prepare for the actual business of diagnosis.

4.1.2 Circumlocution: Description of Symptoms of Ailments

Research has revealed that most patients are faced with the problem of not knowing the particular names of their ailments. As a result, they resort to circumlocution, which is the

description of the symptoms of the ailments suffered by the patients. It was employed mainly by the patients in the interactions. In this study, most patients tended to be circumlocutional in their talk with the doctors as they employed indirect ways of explaining their ailments. Instead of mentioning the real names of their ailments, they described the symptoms. Most of the time, this resulted from their lack of the knowledge of the appropriate medical terminologies for their medical conditions. The data were replete with examples of this phenomenon. So, the following extracts were considered:

Extract 5 (Interaction 2)

Doctor: E kaaro. [Good morning.] Kin lohun to se nyin? [What health complaints do you have?]

Patient: **Ori n fo mi. [I have a headache.]**

Doctor: Se ifunpa nyin ko ga? [Don't you have high blood pressure?]

Patient: Rara. [No].

Doctor: Awon nnkan miran wo lotun nse nyin? [Any other complaints?]

Patient: **Gbogbo ara n wo mi. [I experience general body weakness.]**

Doctor: Maa ko awon oogun kan fun nyin. [I am going to recommend some drugs for you].

Extract 6 (Interaction 7)

Doc.: So, why are you here today?

Pt.: **My teeth.**

Doc.: What's wrong with your teeth?

Pt.: **There is one at the back of another**

. Extract 7 (Interaction 10)

Doc.: Kin l'oruko nyin? [What is your name?]

Pt.: Shola Ola.

Doc.: Kin lo se nyin? [What is your complaint?]

Pt.: **Aya n ro mi gan-an, inu si tun n ta mi. [I have serious chest paint and I also feel burning sensation in my stomach]. Egbe ori kan si tun n ta mi, ese mi si tun n ku riri. [I also feel a burning sensation on a side of my head as well as cramps in my feet.]**

Doc.: Se e ti se ifunpaa nyin? [Have you done blood pressure test?]

Pt.: Rara. [No.]

The extracts above revealed that the patients mostly mentioned the symptoms of their ailments as if they were the real sicknesses they suffered from. This becomes obvious through experience as human beings that sicknesses have many manifestations. Therefore, it is not uncommon for patients that suffer from typhoid to complain about severe headache, diarrhea or body temperature, and the patients, being non-medical experts, may not know the particular ailments being suffered from. They would only know the symptoms. Therefore, all the patients' emboldened contributions in the above extracts are symptoms of certain ailments whose real names the patients did not know. However, the mention of these symptoms enabled the doctors to actually know the health challenges the patients faced. Looking specifically at Extract 5: '**Ori n fo mi.' [I have a headache.]; 'Gbogbo ara n wo mi.' [I experience general body weakness.],** the patient's emboldened contributions were manifestations of high blood pressure, and not the real sicknesses, as confirmed in the doctor's accompanying question in the same extract: 'Se ifunpa nyin ko ga?' [Don't you have high blood pressure?]. Thus, as always, when the real ailments are confronted medically, the ailments disappear. All the symptoms: headache, high body temperatures, cramps in the feet, chest pain, burning sensation in the stomach and general body weakness mentioned by the patients in the extracts above as diseases were merely symptoms of certain diseases, and not diseases themselves, but the doctors understood this.

Circumlocution served the communicative purpose of enabling the patients describe the symptoms of their health challenges as a result of their little or complete lack of knowledge of Medicine. It also afforded the doctors the opportunity of gaining insights into the patients' ailments. Grammatically, circumlocution was realized by declaratives as it was meant to provide information from which the doctors could reach diagnoses.

4.1.3 Rapport Expressions: Cordiality, Sociability and Acceptance

Unreceptive comments from doctors have been discovered to prevent patients from releasing critical information needed for accurate diagnosis. In this study, therefore, the doctors overcame this problem by employing rapport expressions. A careful study of our data revealed that rapport expressions were realized by Wh-questions, indirect questions and statements. The deployment of rapport expressions for cordiality, solidarity, acceptance, empathy and sympathy is vital as it enabled the doctors employed to fraternize with and familiarize themselves with the patients. They were also intended to promote open communication between them and the patients in order to obtain good information to enrich their diagnoses and, ultimately their prescriptions or treatment. The following extracts were considered:

Extract 8 (Interaction 3)

Doc.: In what class are you?

Pt.: JSS 111.

Doc.: Which school?

Pt. Deeper Life Secondary School, Moniya.

Doc.: What's your position in your family?

Pt. Second.

Doc.: How many children?

Pt.: Three**.**

Doc.: **Do you take sweet?**

Pt.: That was before.

Doc.: So, you don't take it again. **What about coke?**

Pt.: I take it occasionally.

Extract 9 (Interaction 14)

Doc.: Ok. **How old are you?**

Pt.: I am fifty-two.

Doc.: **You are Yoruba?**

Pt.: Yes.

Doc.: **What do you do?**

Pt.: Teaching.

Doc.: **A teacher. Primary or secondary?**

Pt.: Primary.

Doc.: **You are married?**

Pt.: Yes.

Doc.: **My record here shows you live at Akanran Road.**

Pt.: Yes.

A perusal of the extracts above revealed that the doctors ensured geniality with their patients through rapport expressions. Their deployment enabled the doctors to be friendly. In addition, they employed elicitation of information on both family history (FH) and social history (SH) to engender conviviality and open communication. In Extract 8, the doctor used a probe into the patient's family history (FH) to create some level of familiarity with the patient to enable the patient open up on all his health

challenges. Extract 9 featured a probe into the patient's social history (SH) to promote open communication as well. The rapport expressions performed the discourse function of engendering open communication between the doctors and the patients, and at the same time familiarizing the doctors with the patients. Their deployment enabled the doctors to be on the same wavelength with the patients in order to create a friendly atmosphere that could encourage the patients to release all the information needed to accurately diagnose the patients' ailments.

The rapport expressions were mostly realized by interrogatives and, sometimes, by declaratives in the interactions as they were deployed to elicit information and provide same by the doctors as the occasion demanded.

4.1.4 Language Switch: Informativity, explicitness and mutuality

Some patients' competence in just one language and doctors' inability to find second language equivalents for certain medical terms posed a challenge in the multilingual setting of this study. As a way out of this problem, and given the multilingual environment, both the patients and the doctors employed language switch. It was realized by mixing Yoruba with English and using Pidgin English within interactions and between interactions. Therefore, the various language choices made by them were analysed and discussed as this is important to examining how appropriately the codes were used and as well revealing the discourse roles they played.

Relating the above to our data on doctor-patient interaction in the South-West and North-Central Geo-Political Zones of Nigerian, we discovered that three codes, namely: Standard British English, Yoruba and Pidgin English - were used. On a number of occasions, too, there were instances of code-mixing and code switching. The following extracts were considered:

Extract 10 (Interaction 1)

Doc.: Good morning, madam.

Pt.: Good morning.

Doc.: What are your complaints?

Pt,: Some years back, I had holes in some of my teeth, may be like three or four and they were filled and since then I have not been coming except when I come for scaling and polishing but of recent I realized that when I take cold water or sweet things, I started feeling some kind of mild pain. So, I started thinking may be the teeth that were filled have started giving way again. That's my complaint.

Doc.: Is it on this particular side (right) or generally?

Pt.: On the right side.

Doc.: On the lower or upper teeth?

Pt.: Lower here and upper here.

Doc.: The fillings were done here?

Pt.: Yes.

Doc.: For how long have you felt like this? Is it a recent thing?

Pt.: Recent. About a month ago.

In the extract above, the doctor greeted the patient and enquired about the patient's health problems in standard British English, having sensed from the patient's appearance that she was educated. The patient responded in the same language, and the entire interview was conducted in it.

Extract 11 (Interaction 13)

Doc.: Sit down here.

Pt.: Ok.

Doc.: How are you today?

Pt.: Thank God. I am coping.

Doc.: Se e ti lo gba awon result yen? [Have you collected the medical test result?]

Pt.: Yes. I was around last week but I was told to come back this morning.

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

Pt.: Ok. I drink a lot.

Doc.: You have to stop it.

In the extract above, the doctor used Standard British English to open the interview, offer the patient a seat and to know the patient's health challenge. The patient responded to all the doctor's questions in the same language, but, doctor suddenly switched to Yoruba when seeking information about whether the patient had collected the results of the tests earlier recommended. Despite this, the patient still responded in Standard British English, and this forced Doctor to revert to Standard British English. Thus, the rest of the interview was conducted in Standard British English. The communicative purpose of the doctor's sudden switch from English to Yoruba was to indirectly find out whether the patient was more competent in Yoruba than English because the deployment of a language in which the patient is more competent would make room for a clear explanation of the patients' medical challenges so that the doctor should get good information to diagnose the patient appropriately.

There were also instances of code mixing in the data. Therefore, the following extracts were considered.

Extract 12 (Interaction 20)

Doc.: [looks at patient's case note.] **E ti wa ni Monday tele**. [You came here on Monday.]

Pt.: Beeni. [Yes.] Nigba ti mo wa nigbanaa, **mo complain nipa ese yii to n ro mi**, nwon wa ye ifunpaa mi wo. [I complained about the pain I feel in this leg, and my blood pressure was checked when I came then.] Nwon si so pe o ga. [They said it was high.] Nwon si fun mi ni awon oogun yii, mo si ti n loo, sugbon aya to n ro mi kodin ku. [I was given these drugs and I have been taking them, but the leg pain persists.] Mi o tun ri oorun sun loru. **Nigba ti mo so fun doctor, nwon ni ki n lo ya X-ray.** Titi di bayii, ese naa si n ro mi] In addition, I can't sleep at night. I complained about it and was asked to take an X-ray. I still feel pains in the leg up till now.]

Doc.: Result test wo leyii?

Pt.: Mi tii see tori ese naa n ro mi debii pe **mi o le gun step to wa nibi tin won ti n see**. [I have not done the test because I feel so much pain in the leg that I can't ascend the stairs that lead to the X-ray centre.]

Extract 13 (Interaction 18)

Doc.: The result of the test you brought says there are some germs in your private part. So, I will give you some drugs, and you will take them for some time and you will be okay.

Pt.: The thing is curable?

Doc.: Yes. It is curable.

Pt.: **There is one problem that is disturbing me. In my throat e be like say there is something scratching me, scratching me.[I seem to feel itching in my throat.] When I scratch e be like say my neck dey turn. [When I scratch it, my neck seems to turn.]**

In Extract 12, the doctor and the patient mixed codes at word level. They alternated the English words (Monday, complain, doctor, X-ray, result, test, step, X-ray centre) and Yoruba phrases to explain and know the medical condition of the patient and the medical tests he had done to enable the doctor get a diagnosis. The doctor engaged in code-mixing here obviously to enable the patient understand him very well, especially as some of the English words do not have Yoruba equivalents, having sensed that the patient did not understand English that much.

The communicative function of the deployment of code-switching and code-mixing by the doctors and patients in Extracts 11 and 12 above was to prevent communication breakdown as English Language cannot be entirely avoided when consulting with non-English-speaking patients given the fact that there are some English expressions used in clinical discourse that have no equivalents in Yoruba e.g.' X-ray. In addition, where they are available, they may not be able to appropriately capture the idea that the doctors or patients have in mind. Similarly, as observable in Extract 13, patients who are not very competent in English sometimes switch to Pidgin English to conceal their linguistic incompetence and communicate intelligibly.

Language switch performed the communicative function of making the discourse informative, explicit and mutual. It enabled the doctors to accommodate the linguistic backgrounds of the patients, and its deployment afforded the interlocutors the opportunity to overcome their linguistic deficiencies, thus enableing them to understand the conversations well. In Extracts 12 and 13 above, both the doctors and the patients alternated the use of English and Yoruba to make the discourses more intelligible. As can be seen in the extracts above, language switch was realized by intra-sentential and inter-sentential alternation of English, Yoruba and Pidgin English.

4.1.5 Counselling: Guidance, Enlightenment and Encouragement

Close examination of the data revealed that some patients engaged in activities that were detrimental to their health. To address this problem, the doctors deployed counselling to check the harmful health practices. Therefore, this section identified and discussed instances of deployment of counselling as a tool by the doctors to guide the patients on

how best to manage their health, and to teach them the best health practices or encourage them. The following extracts were considered:

Extract 14 (Interaction 5)

Doc.: **Next time when you are buying a toothbrush, make sure you look at the inscription on the packet because we have soft, medium and hard. Always use the medium one. It's the best for you. The soft is for children while the medium is for adult. Don't use the hard one because it damages your teeth. It scrapes off parts of your teeth.**

Pt.: Thank you.

Extract 15 (Interaction 8)

Doc.: Bring them out. Let me see them. (Looks at the drugs) **You need to pay a very good attention to your health because of the terrible conditions that may result from having untreated hypertension – diabetes, stroke etc. You are not healthy yet you could go on visit to as far as Lagos. You need to come for check-up monthly.**

Pt.: Thank you.

Doc.: We ask you to come once in a month, twelve times in a year. I do think this is too much a sacrifice for your health. Please, pay attention to your health.

Pt.: I am very grateful for your concern over my health. May God be with you.

Doc.: **Even if you want to go on pilgrimage to Mecca, you should be able to carry your doctor along as he will be able to package you well by giving you drugs that could last you till you arrive. And immediately you come back, you go see him for a check-up. That way you will be able to maintain a good health.**

Pt.: Thank you. I will be more careful next time.

The extracts above revealed the deployment of counselling for the purpose of guidance and enlightenment. In Extract 14, the doctor advised the patient to use a soft toothbrush

as the most appropriate type for his teeth, and also highlighted the damaging effect of using a hard toothbrush. At 15, the doctor taught the patient the best way to manage his hypertensive condition in order to avoid the complications (stroke and diabetes) that could result from poorly managed hypertension. She further taught the patient about how he could safely embark on a long journey and yet be adequately equipped medically for the trip.

Counselling performed the communicative function of guiding the patients aright. Its deployment also afforded the doctors the opportunity to enlighten the patients on practices that had to do with their health and to teach them how they could live a healthier life. Counselling was mainly realised by declaratives as they were deployed for the purposes of providing information and guidance.

4.1.6 Religious Belief: Guidance, Encouragement and Enlightenment

The data revealed that some patients expressed obsession with certain religious doctrines that posed a threat to their health. In a bid to arrest the situation, the doctors in this study employed their religious beliefs to enlighten the patients on the inappropriateness of some of the doctrines they observed. Therefore, the religions of the doctors were employed as a tool to perform certain pragmatic functions in the interactions through the use of Biblical and Quranic explications. The analysis here, therefore, centred on how the deployment of religious belief aided the doctors in forging solidarity with the patients, correcting them, enlightening them and also encouraging them. The following extracts were considered:

Extract 16 (Interaction 14)

Doc.: Do you feel abdomin- stomach pain?

Pt.: Yes. During Ramadan fast.

Doc.: Is it a mild stomach ache?

Pt.: No. It's always very painful.

Doc.: And you don't break the fast?

Pt.: No. Ramadan fast is a must for every true muslim.

Doc.: **Madam, as a fellow muslim, I know The Quran exempts the sick from fasting. So, it is not right to fast when you are sick, when affects your health negatively like you explained. God knows more than we do about everything concerning us, even our health. It is allowed in the Quran to provide food for those fasting if your health does not permit you to fast.**

Pt.: I didn't know this before. Thank you.

Extract 17 (Interaction 19)

Doc.: (Examines the patient's eyes) You look pale. Have you ever been diagnosed with anaemia?

Pt.: Ah. No.

Doc.: **Alright. The whiteness of the base of your eyes suggests you haven't enough blood in your system. So, I am going to recommend some blood tonic for you. Make sure you take them. Otherwise, you might be subjected to blood transfusion.**

Pt.: **I am a muslim of the Quadriyyah faith. We don't subscribe to blood transfusion.**

Doc.: **I am not saying I want to subject you to blood transfusion now. All I am saying is that if you don't take blood tonic I am recommending now, you might have to go for blood transfusion.**

Pt.: **Okay. I will take it.**

Doc.: **But let me also add this. The Quran is not opposed to medical science. Therefore, it is not against The Quran to receive blood during sickness to save the patient's life. It will not be taken through the mouth. Rather it is administered through the veins.What the Quran says is that we should not eat blood. So, you can see this is not eating blood. It is just a way of saving lives.**

Pt.: **Yes. Thank you. I can understand it better now.**

Doc.: E pele. (Gives her a prescription list) [Sorry.]

Religion as a very important tool in doctor-patient verbal interaction assists doctors in educating patients. In Extract 16, the patient suffered acute stomach ache during Ramadan Fast but, despite this, she observed it as a matter of religious obligation. She

disclosed to the doctor that she was a muslim and the doctor, being a fellow muslim,too, was able to educate her that Islam exempts the sick from fasting, with the option of providing food for those fasting. This therefore enabled the doctor to correct the erroneous belief the patient held, using Quranic teachings. It also made the patient to accept the fact that she needed to stay away from fasting since her health could not cope with it.

Similarly, in Extract 17, the patient expressed opposition to blood transfusion on religious grounds, but the doctor was able to disabuse her mind against it, stating that Islam was not opposed to the medical intervention to save lives during sickness. The doctor was able to point it out clearly to the patient that blood transfusion through veins is different from taking blood through the mouth. Consequently, the doctor was able to change the patient's view on transfusion.

The analyses above revealed that the doctors employed religious belief to perform a number of communicative functions like: guiding the patients aright in areas where they exhibited ignorance or carefree attitude in health matters. The deployment of religious belief enabled the doctors to educate the patients and to fraternize with them. Its deployment also assisted in enlightening the patients, where a certain religious practice interfered with their health, while encouraging a change in their habits of harmful fasting avoidance of blood transfusion. Here, the doctors employed their faith (Islam) to correct certain erroneous beliefs of the patients.

4.1.7 Question and Answer: Elicitation and Supply of Information for Diagnosis

In addition to laboratory tests, verbal information is also needed for rich and accurate diagnoses. This, therefore, makes question and answer inevitable in diagnostic interviews as diagnosis relies partly on elicitation and supply of information to unravel the patients' medical challenges. Thus, doctors have to seek relevant information from patients through the use of question, and the patients also have to supply them by using answer in order to assist the doctors in their investigation and treatment of the patients' medical challenges. This section, therefore, analysed and discussed how the doctors elicited

information through direct and indirect questions from patients and how the patients answered to supply them through answer.

4.1.7.1 Direct Questions with Answers

Direct questions were realized by interrogatives beginning with wh-elements while answers were realized by declaratives in the investigation of the patients' ailments. The following extracts were considered**.**

Extract 21(18 (Interaction 3)

Doc.: **How are you?**

Pt.: **I am fine.**

Doc.: **Why did you come this morning?**

Pt.: **I have problem with my teeth.**

Doc.: **What kind of problem do you have with your teeth?**

Pt.: **Two of my teeth here -Two of my teeth are shaking as if they will remove.They are removing from inside. Two of the teeth have come out but they are not of the same level. So, it gives me pains.**

Extract 19 (Interaction 9)

Doc.: **What do you do?**

Pt.: **I am processing my admission.**

Doc.: You are processing your admission. **What do you want to read?**

Pt.: **Economics.**

Direct question was one of the oral diagnostic tools employed by the doctors for investigating the patients' medical challenges. Its deployment here enabled the doctors to know how to intervene professionally in the patients' ailment. Looking carefully at the extract above, one sees how the doctors employed direct questions in each of the extracts

to obtain information on the patients' family history (FH), social history (SH) and history of present illness (HPI) for the purposes of making diagnoses. In response to the questions, the patients supplied the needed information by employing answer, thus making the discourses resulted-oriented.

The directness of the questions served the communicative purpose of tacitly informing the patients that the information being sought were crucial to the diagnosis of their ailments and eventual recovery. The questions therefore enabled the patients to actually state their health challenges. In sum, the direct questions in the interactions performed the discourse function of eliciting information to make diagnoses.

4.1.7.2 Indirect Questions with Answers

Indirect questions were realized by statements in the interaction. They have the appearance of declaratives but are fundamentally interrogative. The following extracts were considered:

Extract 20 (Interaction 5)

Doc: You feel it in the morning, feel it in the afternoon and night.

Pt. **No. I feel it once and it goes.**

Doc.: **It comes and goes.**

Pt.: Yes.

Extract 21 (Interaction 16)

Doc.: O maa n dabii pe nnkan wa nibe. [It's like something is blocking it.]

Pt.: **Beeni. [Yes.]**

A careful look at Extract 20 and 21 revealed that the main instrument in clinical interview is seeking and giving information. Evident from the doctors' contributions above is the deployment of indirect questions to obtain information on the patients' history of present illness (HPI). On the other hand, the patients' contributions supplied answers to the doctors' questions. Here, the elicitation and supply of information provided insights for the doctors into the likely causes of and the real nature of the patients' health challenges

and, consequently offered them the opportunity to intervene professionally. The doctors mostly sought information about the patients' health challenges while the patients provided them, thus revealing that both the doctors and the patients worked dependently in matters of oral diagnosis.

All the instances of the direct and indirect questions were emboldened. In Extract 18-19, there are instances of direct questions while in Extract 20 - 21, there are instances of indirect questions. The communicative import of the indirect questions was to make the interviews appear less interrogative to enable the patients who were obviously sick find the exercise less stressful and, consequently, be encouraged to cooperate in releasing all the information needed to unravel and solve their health challenges. The direct questions, on the other hand, served the discourse function of making the patients know that the particular information being sought from them were crucial to unraveling their health challenges so that the doctors should be able to treat them.

The answers naturally followed the questions as they performed the communicative function of presenting the information needed for diagnosis. Their deployment was inevitable as the discourse was purely investigative. They generated the raw materials for diagnoses. As the extracts above revealed, the answers were what the doctors needed to make diagnoses, without which it was impossible for them to gain insights into the patients' medical challenges, except the doctors were going to conduct laboratory tests on them. Question and answer are very important diagnostic tools in clinical interviews in view of the fact that there are some medical conditions that can only be investigated through (elicitation of information) question and (supply of information) answer.

Grammatically, as observable in the extracts above, direct questions were realized by interrogatives involving subject-verb inversion while indirect questions were realised by declaratives, but yet have the illocutionary force of interrogatives. Answers were realized mainly by declaratives.

4.1.8 Closing: Concluding the Discourses

After information had been obtained on chief concern (CC), history of present illness (HPI), family history (FH) and social history (SH), the interviews had to be brought to a close to enable the patients either go to procure some drugs, carry out some tests or do both. To create this opportunity, the patients used closing. It was realized by expressions of appreciation and greetings in our data. A perusal of the data revealed that various methods were employed in closing the discourses between the doctors and the patients but the most common were expressions like 'Goodbye' and 'Thank you' after the doctors' prescription of tests or drugs. Analyses and discussions of how these closing strategies were deployed in the data were attempted here.

Extract 22 (Interaction 4)

Doc.: Let us apply it for two weeks and see. How I wish I got a better instrument. I would have removed a lot of the wax to enable you start hearing well again. The eardrop costs about #800. You will apply it for two weeks. If it gets exhausted, buy another one till you have used it for two weeks.

Pt.: **Thank you, sir.**

Extract 23 (Interaction 8)

Doc.: That is alright. You should cut each of these tablets into two and then take one in the morning and one of these small ones. I have asked you to take it in the morning because it will make you urinate a lot. So, if you take it in the evening, the frequent urination will disturb your sleep and that could aggravate your already high blood pressure. So, go take the tablets now.

Pt.: Thank you.

Doc.: Please, take good care of yourself.

Pt.: **Thank you and God bless.**

Extract 24 (Interaction 15)

Doc.: Ok. Did you have sexual intercourse recently?

Pt.: Like last week.

Doc.; Alright. You will this take form to the nurses. I want us to do urinalysis. It will show if there is infection in your urine. If there is no evidence of infection in that test, then you will have to take another test. In addition, they will measure your height and weight. In fact, they should have taken all the vital signs before you came here. After that, I will take your blood pressure myself.

Pt.: **Thank you.**

The extracts above revealed that the patients mostly closed the discussions in all the extracts, but the doctors also closed the conversations sometimes. In Extract 22 (Interaction 4), the patient closed the consultation through the use of the expression 'Thank you' after receiving the final comments and prescription from the doctor. Similarly, in Extract 23, the patient ended the talk by using the expression 'Thank you and God bless' after the final instructions from the doctor. In Extract 24, the patient used 'Thank you.' to conclude the interview after the doctor had prescribed a test. The analyses above revealed that the patients closed the conversations through the deployment of the appreciative expression 'Thank you' and sometimes, with prayers 'God bless'. The deployment of the above-mentioned expressions to conclude the clinical interviews provided appropriate conclusions for the interviews.

Emerging from the above discussions is that closing performed the communicative function of bringing each of the interactions to a close. The clinical interviews could not but end at a particular time. Therefore, as can be seen in the extracts above, closing indicates the end of the interactions as signalled by the emboldened expressions above. Generally, closing was the final discourse device employed in all the clinical interviews. Grammatically, it was realized by declaratives.

4.2 Research Question 2: How and by what means is politeness achieved in the interactions?

Politeness was realized in the interactions by FTA without redress and FTA with redress (positive politeness), using frank talk, courteous expressions, reprimand, direct and indirect expressions in the data. They were used after the doctors had concluded their diagnoses. Examination of the deployment of politeness was undertaken here to reveal how the diagnoses were presented in a courteous manner and how the patients' face was threatened without redress and with redress. In addition, efforts were made to study how the deployment of the face-threatening acts and politeness maxims aided the communication.

4.2.1 Face-Threatening Acts without Redress: Checking and Correcting Unwholesome Health Practices

Face-threatening acts without redress were realized by frank talk, courteous expressions and reprimand. Here, we examined how their deployment aided the discourses. The following extracts were considered:

Extract 25 (Interaction 13)

BACKGROUND: After diagnosing Pt. with hepatitis B, Doc. counsels Pt. on the importance of getting his wife tested to know her status for appropriate medical intervention, if necessary.

Doc.: Encourage her. We can't force anyone to do any test.

Pt.: Alright. She's a cool-headed person.

Doc.: Does she know about your hepatitis status?

Pt.: Yes. I told her about it.

Doc.: Since there is nothing to hide, let her also do the test. Then if she is negative, then she can take immunization, and she will be protected for life. You understand.

Pt.: Yes.

Doc.: And if she tests positive, there is no problem.

Pt.: You mean there is a vaccine for it?

Doc.: Yes. There is a vaccine against hepatitis. Anybody that is hepatitis B negative can take a vaccine – three doses. If you come first, we give you one. Then, in a month's time, we give you another one, and then in six month time, we give you another one. Those three doses will give you a life-time immunity. So, if she's negative, let her get immunized.

Pt,: Cant I also take the vaccine?

Doc.: No. Once you are hepatitis B positive, you cannot take the injection because you already have the disease. Before one gets the disease, one can get immunized. It's like giving a little dose of this virus in the – non-infective style. I don't know how to explain it. It's like when you immunize someone against TB. It's like giving a person a little dose of that infective substance so that the body should develop immunity against it.

Pt.: That's wonderful.

Doc.: So, that when the infection comes, the army in the body will quickly stand up against it and then kill it. Let her get tested. If she is negative, she gets immunized. If she is positive, nothing to lose.

Pt.: It is clear.

Doc.: So, the only thing I will do now is to give you a form for liver function test. Do it. There is no emergency in it. So, it's not as if you must do it now. I will give you a form and then you do it and bring it.

The doctor's emboldened contribution in the extract above revealed that the doctor threatened the patient's face by not mitigating her diagnosis as she unequivocally told the patient he could not take hepatitis B vaccine once he was infected with the ailment. She went a step further to educate the patient on the category of people that could take the vaccine as well as the method of administration and how it works. The doctor talked

frankly to the patient on the impossibility of administering the vaccine on him to prove to him the incurability of hepatitis B. The purpose of this face-threatening act was not just to give the patient accurate and truthful information about his ailment as demanded by medical ethics but also to sensitize him on the dangers of not getting the wife screened for the ailment. Therefore, the doctor did not mitigate the disclosure of the diagnosis to the patient.

Extract 26 (INTERATION 16)

BACKGROUND: Doc corrects Pt. who erroneously believes she suffers from hepatitis B.

Pt.: Mo ni aarun jedojedo. I have hepatitis B]

Doc.: Kin le mo to n je jedojedo. [Do you know what is called hepatitis B?]

Pt.: Mi o mo. [I don't.]

Doc.: E o de waa beere nigbayen, uhn? [And you didn't bother to find out, unh?] Jedojedo. Iyen na n pe ni hepatitis. [That is what is called hepatitis.]

Doc.: Se nwon waa ni ke e pada wa loni ni? [Were you asked to come back today?]

Pt.: Nwon o ti e ni ki n wa loni. [I was not asked to come today.]Mo se awon test kan, mo wa ni ki n mu esii re wa. [I did some tests and decided to bring the results today].

Doc.: {Collects test result and reads it} Eleyi o ni nnkankan se pelu nnkan tee so. [This has nothing to do with what your complaint.] Nwon ni normal test leleyi [This test does not indicate any problem.]. Nibo le ti seleyii? [Where did you do this?]

The doctor's emboldened contributions in the extract above constitutes another instance of face-threatening act without redress in which the doctor slammed the patient's erroneous belief that she was hepatitis B positive. The doctor reaffirmed his claim with his third and fourth emboldened contributions in the extract, which was a true

interpretation of the test result brought by the patient. The communicative function of this FTA was not just to reprimand the patient for holding the wrong notion but also to save the patient from undue emotional stress on account of an untrue hepatitis B infection claim which could spell a disaster for her health. The doctor, therefore, threatened the patient's face with no mitigation by censuring her for not finding out the true nature of her illness and indulging in self-diagnosis. FTA without redress was realized in each of the instances by declaratives and, on some occasions, by interrogatives.

4.2.2 FTA with Redress (Positive Politeness): Correcting, Allaying Fears and Tactfully Obtaining Information for Diagnoses

FTA with redress was realized by direct and indirect talk, mitigated threats and courteous expressions in the data. This study discovered that whether as a temporary or long term act the doctors threatened patients' face or minimized the threat to their face by not talking directly about their illnesses. Sometimes, this happens during clinical interviews, following which doctors employ FTA with redress (Positive Politeness). At other times, too, for reasons best known to doctors, patients' real medical problems are hidden from them. Most of the instances of FTAs with redress (positive politeness) available in our data presented as direct expressions, indirect expressions, courteous expressions and mitigated threats. The following extracts were considered.

Extract 27 (Interaction 38)

Pt.: I sometimes tell my wife that I have eaten when I am fasting.

Doc.: You don't need to tell your wife lies.

Pt.: I tell her lies because she worries about me too much.

Doc.: The issue is that if you take your drugs appropriately, you will live a quality life, you will live longer and she too will be happy. That's what her concern is all about.[Patient's wife calls.] She is the one calling you. I'm sure she wants you to be healthy. She wants to have you around her till grey hair comes out of your head. You understand. She knows your condition – healthwise- . Now, God knows your condition, so don't isolate your physical life from your

spiritual. Both of you are together. If the doctor says ''Do not fast.'' All you have to do is – you know there are other ways of fasting. Don't deny yourself food. Do you understand?

In the extract above, the doctor employed a polite expression to correct the patient's behaviour of telling lies to the wife. The doctor felt it was wrong for the patient to falsely admit he had eaten when asked by his wife simply because he was fasting, and did not want the wife to know. Thus, the doctor employed the FTA to correct the patient and educate him on the likely benefit of complying with medical instructions fully.

Extract 28 (Interaction 15)

Doc.: How regularly do you take your drugs?

Pt.: I skip them sometimes?

Doc.: Why?

Pt.: Because I feel I am okay.

Doc.: Do you know that hypertension is not like malaria where you get treated, you get fine and you just go off it? That was why when you checked your BP two days ago, it was high.

Here, the doctor threatened the patient's face through polite expressions for violating medical prescriptions. Courteously, she drew the attention of the patient to the impropriety of skipping his drugs and the consequence of the wrong action. Grammatically, FTA with redress was realized by a combination of both declaratives and interrogatives in the interactions.

4.3 Research Question 3: Which politeness maxims are observable in the interactions?

The politeness maxims observable in the interactions are the tact maxim, the generosity maxim, the sympathy maxim and the Pollyanna principle. They were discussed in turn.

4.3.1 Tact Maxim: Compassion and Permission

Realised by interrogatives and declaratives, tact maxim was discovered to be observed in our data. The maxim states: Minimize cost to other, maximize benefit to other. Several of the doctors' utterances showed that they were compassionate on the patients as they offered them the opportunity to gain maximum advantage in the hospital visits, even though such offers meant more work for them. The following extracts were considered:

Extract 29 (Interaction 7)

Doc.: Do you have any other medical condition you go to the doctor for?

Pt.: No.

Extract 30 (Interaction 4)

Doc.: Is the pain very sharp?

Pt.: Yes.

Doc.: {Examines the ear) There is a lot of wax blocking your ear. Let me see the second one. When you pick your ear with cotton bud, does the cotton bud go in? You have difficulty hearing well because wax has blocked the whole ear. So, you will buy serumol eardrop and apply it in the ear. After applying it in one ear, you should wait for five minutes to allow it go in very well before you apply it in the second ear. You will do it for two weeks and then come back for a review. Do you understand me? When you apply the eardrop, it will soften the wax and you will see it coming out. Then, we will refer you to E.N.T. clinic where the syringing of the ear will be done for you.

Pt.: Okay, sir.

Doc.: Let us apply it for two weeks and see. **How I wish I got a better instrument. I would have removed a lot of the wax to enable you start hearing well again.** The eardrop costs about #800. You will apply it for two weeks. If it gets exhausted, buy another one till you have used it for two weeks.

Pt.: Thank you, sir.

Doc.: Bye bye.

In extracts 29 and 30, the doctors' contributions showed that they were very compassionate on the patients and wanted them to derive maximum benefits from their visit to the hospital. In Extract 29, the doctor offered the patient the opportunity to disclose other health problems he had so that he could treat them as well. Similarly, in Extract 30, the doctor's emboldened contribution suggests the doctor pitied the patient and would have assisted him by removing the wax that made it difficult for the patient to hear well, had it been the instrument for removing wax was available. Removing the wax would have meant more work for the doctor but she didn't mind. All these offers, no doubt, meant additional work for the doctors but they did not bother about them as the well being of the patients was paramount to them. Grammatically, the tact maxim was realized by interrogatives and declaratives.The tact maxim performed the discourse function of showing the patients compassion and allowing them to table all their complaints.

4.3.2 Generosity Maxim: Advice and Compassion

The generosity maxim performed the discourse function of advising the patients and showing them compassion in our data. Several times, the maxim was observed in the interactions between the doctors and the patients as the doctors' minimized benefit to themselves and also maximized cost to themselves, too. Thus, the doctors showed a great concern for the patients' health. The following interactions were considered:

Extract 31 (Interaction 5)

Doc.: Next time when you are buying a toothbrush, make sure you look at the inscription on the packet because we have soft, medium and hard. Always

use the medium one. It's the best for you. The soft is for children while the medium is for adult. Don't use the hard one because it damages your teeth. It scrapes off part of your teeth.

Pt.: Thank you.

Extract 32 (Interaction 8)

Doc.: The last time you came here was in June and this is November. Your blood pressure is always very high – 170/100. Do you take your drugs?

Pt.: Yes, I do.:

Doc.: Where are the drugs?

Pt.: They are in my bag.

Doc.: Bring them out. Let me see them.(Looks at the drugs) **You need to pay a very good attention to your health because of the terrible conditions that may result from having untreated hypertension – diabetes, stroke etc. You are not healthy yet you could go on visit to as far as Lagos. You need to come for check-up monthly.**

Pt.: Thank you.

Doc.: **We ask you to come once in a month, twelve times in a year. I do not think this is too much a sacrifice for your health. Please, pay attention to your health.**

Pt.: I am very grateful for your concern over my health. May God be with you.

Doc.: **Even if you want to go on pilgrimage to Mecca, you should be able to carry your doctor along as he will be able to package you well by giving you drugs that could last you till you arrive. And immediately you come back, you go see him for a check-up. That way you will be able to maintain a good health.**

Pt.: Thank you. I will be more careful next time.

In extracts 31 and 32 above, the doctors demonstrated great concern for the patients' health by offering them medically beneficial pieces of advice. In Extract 31, the doctor advised the patient to use the medium type of toothbrush to avoid the health risk inherent in the use of hard toothbrush. In Extract 32, the doctor advised the hypertensive patient on the importance of total adherence to medical prescriptions and instructions to avoid crises. In addition, the doctor stressed the importance of getting appropriately equipped with medicines whenever the patient was going on a long journey. Through the deployment of the generosity maxim in the doctors' contributions emboldened in the extracts above, the doctors were able to offer the patients some medically beneficial pieces of advice and, at the same time, demonstrate empathy. Grammatically, the generosity maxim was realized by declaratives and imperatives in the interactions.

4.3.3 Sympathy Maxim: Advice, Pity and Guidance

Performing the communicative function of advice, pity and guidance, the sympathy maxim was seen to be observed in several interactions between the doctors and the patients, where the doctors empathised with the patients over certain terrible health conditions. Examples of some of the utterances made to observe the maxim were found in the following extracts:

Extract 33 (Interaction 16)

Doc.: Oja kin le n ta? [What type of trade?]

Pt.: Plastic.

Doc.: Ti mo ba ni ki n gbayin ni'moran ni ti igbalode, omo meta ti to. [If I were to advise you in line with contemporary practice, three children are enough.] Olorun ti fun nyin lokunrin ati obinrin. [God has given you both sexes.] Omo beere, osi beere. ri awa alakowe nisisiyii, bi awon doctor ati nurse, ti nwon ba ti bi omo meji, elomiran gan-an eyokan, nwon maa n stop ni. [You see those of us that are educated, for example, the nurses and doctors, we stop childbearing after two issues, some even have just one]. Meta yen gan-an tito [The three are enough.] Sugbon ti e ba fee bimo sii, ko si problem.

[But if you still want to have more children, there is no problem. Iyawo meloo loko nyin ni? [How many wives does your husband have?]

Pt.: Meji. [Two.]

Doc.: Se oko nyin lo so pe omo meta o to abi awon family? [Is it your husband that complaints the children are not enough or the family?]

Pt.: Emi ni mo fee. [I am the one that want more.]

Extract 34 (Interaction 8)

Doc.: Bring them out. Let me see them.(Looks at the drugs) You need to pay a very good attention to your health because of the terrible conditions that may result from having untreated hypertension – diabetes, stroke etc. You are not healthy yet you could go on visit to as far as Lagos. You need to come for check-up monthly.

Pt.: Thank you.

Doc.: We ask you to come once in a month, twelve times in a year. I don't think this is too much a sacrifice for your health. Please, pay attention to your health.

Pt.: I am very grateful for your concern over my health. May God be with you.

Doc.: Even if you want to go on pilgrimage to Mecca, you should be able to carry your doctor along as he will be able to package you well by giving you drugs that could last you till you arrive. And immediately you come back, you go see him for a check-up. That way you will be able to maintain a good health.

Pt.: Thank you. I will be more careful next time.

In the extracts above, the doctors showed sympathy and empathy for the patients' health conditions and, therefore, counselled them on how best to handle their health in order to avoid crises. In Extract 33, the doctor pitied the patient for her low economic status and consequently advised her to forgo the desire to have more children since she had had

three issues already. The doctor employed this discourse device to save the patient from the financial agony and health challenges associated with having more children than necessary.

In Extract 34, the doctor was compassionate on the hypertensive patient and thus advised him to pay more attention to his health to avoid complications like - diabetes and stroke- that could result from untreated hypertension. He enlightened the patient on how he could go on a long journey and yet be adequately equipped medically for such a trip.

4.3.4 Pollyanna Principle - The Ethical Positivity Tendency: To open Up Talks

The Pollyanna principle was also observed in the examined verbal medical interactions. The incidence of the Pollyanna principle showed that verbal medical discourse focuses more on the positive than the negative aspect of life. This phenomenon emanated from the contextual beliefs based on medical ethics and those based on the patient-society's perspective of doctors. Medical ethics demand that doctors directly or indirectly use their professional skills to treat patients, and not to harm them either psychologically or physically. Conversely, patients too expect that doctors would meet their medical, physical and emotional desires. The Pollyanna principle has three tendencies, namely: euphemistic tendency, ethical positivity tendency and referential/hinting tendencies, but only the ethical positivity tendency was found to characterize the interactions studied.

Pollyanna principle of ethical positivity tendency echoes the ethical expectations of patients from doctors, particularly in the area of medical care, assurance, reassurance, sympathy etc. It has to do with the contextual beliefs based on the patients-society's view of the doctors. The hospital is an orthodox institution viewed by the patients and the larger society as a home of relief and cure. The patients regard the doctors as health problem solvers. Thus, they hold the doctors in very high esteem as people that can be confided in. The medical profession also recognizes this:

> Secrecy is sacred to the profession. It is essential a patient tells you Everything you for diagnosis and treatment…. in cases of unwanted pregnancy, veneral disease for instance, he or she naturally and

instinctively does not want it spread. It is not for you to tell it to anyone – not even to a husband or wife or brother or sister-inlaw.

((Mabayoje,1982:11) cited in Odebunmi 2003)

It should be noted however that some patients advertently conceal certain information from doctors for some reasons best known to them. All patients believe they would get sufficient care and kind attention from doctors. Consequently, most of them open up on their medical problems to doctors in anticipation of cooperation from doctors. The data contained instances of this phenomenon as evidenced in the extracts below:

Extract 35 (Interaction 6)

Doc.: Were you ever diagnosed with diabetes or hypertension?

Pt.: Diabetes.

Doc.: Where do you treat it and what drugs are you taking to cure it?

Pt.: The drugs I was given are in my bag.

Extract 36 (Interaction 16)

Pt.: Mi o ri nnkan osu mi mo. [I cannot menstruate again.]

Doc.: Enyin naa le le so fun wa boya o ti lo o. [You are the one that can tell us if it has stopped.]

Pt.: Enh. Mi o ri eje. [Enh. I no longer menstruate.]

Doc.: Sebi enyin ati oko nyin ti n mate latigba yen? [Do you still have sex with your husband? Ko wa mo. [It has stopped.]

Pt.: Bee ni. [Yes.]

As can be seen in the extracts above, the deployment of the ethical positivity tendency enabled the patients to freely explain their health challenges because they had the confidence that the doctors could treat them. Consequently, the doctors also reciprocated the patients' display of confidence in their professional capabilities by either recommending one type of test or another, or prescribing some drugs to treat them. It

performed the communicative function of enabling the patients to lay bare all their health challenges. Grammatically, the ethical positivity tendency was realized by declaratives and single words.

4.4 Lexical and Grammatical Devices in Doctor-Patient Interactions and Communicative Functions

4.4.1 Lexical Choices and Discourse Devices

This section considered the lexical choice and description of the discourse devices deployed in the text. This is premised on the fact that a text functions based on the frequency of occurrence of the lexical features in it, and also because such lexical features in a text often say much more about the text than is obvious. This suggests that meaning is expressed in the choice of items. Thus, our focus here was to examine the various ways in which the deliberate use of particular lexical items realized meaning in the interactions under investigation. The investigation of aspects of lexical features in the interactions reflected how the devices were used, how they contributed to the process of diagnosis and treatment, and how they enhanced meaning. This was done under the following headings:

4.4.1.1 Lexical Devices and Communicative Functions

As our data revealed, the deployment of words to achieve cohesion involved repetition of words and foregrounding of words that co-occurred. Thus, repetition was also involved in achieving cohesion in the doctor-patient discourses being examined.

4.4.1.2 Repetition of Words: Emphasis and Confirmation

Repetition is the act of saying or doing a thing repeatedly. As an instrument for achieving cohesion, it manifested prominently in reiteration of words in our data. Particular words were repeated in our data to create a necessary link within each interaction. The following extracts were considered:

Extract 37 (Interaction 1)

Doc.: How will you describe the **pain**? Is it sharp or dull?

Pt.: Aaah, It's not a sharp **pain** but dull.

Doc.: Is it continuous?

Pt.: Ehn. For some time and then stops as long as I stop that thing. Most of the time immediately after food, I normally go quickly to get some salty water to…..

Doc.: And you **feel better.**

Pt.: Yes. I **feel better.**

Extract 38 (Interaction 5)

Doc.: You can't remember it. Se you are taking one tablet **one per night?**

Pt.: Yes. **One per night**.

The emboldened expressions in each of the extracts above are instances of repetition. In each of the extracts, a certain expression was repeated in the text. Therefore, the repeated expressions created a necessary link between the two sentences in each extract to suggest cohesion and unity within the text. Additionally, the repeated expressions performed the discourse function of emphasising and confirming important points during the clinical interviews. At 37, the emboldened and repeated expressions performed the communicative function of confirming and emphasising emerging pieces of medical information, while those at 38 performed the discourse function of confirming an emerging piece of medical information.

4.4.1.3 Collocation: Connectivity of the Texts

In the doctor-patient discourse under study, lexical cohesion was also achieved through collocation. It deals with how some words appear to move very closely together in the discourses. The mention of one word brings to mind the other or other members of the group. Such words are known as collocates, and they relate as natural companions.

Therefore, they accounted for the connectivity of the text under study and provided collocative meaning. In other words, they expressed meaning within the text in relation to another.

Consequently, certain lexical items co-occurred in our data. The findings revealed that they were aptly used as they created cohesion, reinforced meaning and targeted a meaningful interpretation of the interactions. The said items were discussed under two categories: fixed and unfixed collocations.

Our data presented some examples of collocations whose meanings and structures are fixed. Examples of fixed collocation are idiomatic expressions and phrasal verbs. However, only instances of phrasal verbs were available in the data. The following instances were considered:

Extract 39 (Interaction 8)

Doc.: Bring them out. Let me see them.(Looks at the drugs) You need to pay a very good attention to your health because of the terrible conditions that may result from having untreated **hypertension – diabetes, stroke** etc. You are not healthy yet you could go on visit to as far as Lagos. You need to come for check-up monthly.

Extract 40 (Interaction 9)

Doc.: He also has itchy eyes. Do you **react to** something like smokes?

Extract 41 (Interaction 10)

Pt.: Aya n ro mi gan-an, inu sit un n ta mi. [I have serious chest pain and I also **feel** a burning **sensation** in my stomach]. Egbe ori kan si tun n ta mi, ese mi si tun n ku riri. [I also **feel** a burning **sensation** on a side of my head as well as **cramps** in my **feet.**]

The emboldened expressions above in Extracts 39, 40 and 41 offered good instances of collocation. Those in Extracts 40 and 41 comprised a verb and a particle each, which expressed meaning in relation to each other to make the text cohesive. There was also an

instance of collocation in Extract 39 which involved words that moved together closely in the discussion of poorly treateated hypertension. A similar situation was also found in Extract 41as some words that usually go together were found there e.g.: cramp in the feet.

Our data were also replete with instances of unfixed collocation, and they were classified according to the functions they performed. They are adjective/noun, verb/adjective/noun, verb /preposition collocates etc. The examples of adjective/noun collocates observable in our data showed that certain adjectives preceded the nouns to premodify them i.e.: your age, my body, two months, occasional bleeding, married female, youngest child, malarial drug, good morning, blood pressure etc. Other examples of unfixed collocations identified include noun/noun (e.g. neck pain, chest pain, stomach ache), adverb/verb (e.g. suddenly collapsed). The first occurring word in each phrase premodified the latter.

Emerging from the discussion of word collocations above is that collocations functioned variously to account for cohesion in our data by demonstrating interconnectivity in the sense of the lexical items. Put differently, they accounted for how the interlocutors in the doctor-patient discourse employed lexical items to create collocative cohesion in it.

4.4.2 Grammatical Analysis

This section considered the grammatical analysis and description of the discourse devices in the texts. This is premised on the fact that a text functions based on the frequency of occurrence of grammatical features in it, and also because such grammatical features in a text often say much more about the text than is obvious. This suggests that meaning is expressed in the choice of items. Thus, our focus here was to examine the various ways in which the deliberate use of particular grammatical items realized meaning in the interactions under investigation. The investigation of aspects of grammatical features in the interactions showed how they reflected the devices were used, how they contributed to the process of diagnosis and treatment, and how they enhanced meaning. This was done by examining the deployment of the various forms of modal auxiliaries and imperatives.

4.4.2.1 Modal Auxiliaries: Expression of Views, Ability or inability, Opinions and Decisions

As helping verbs, modal auxiliaries were also employed in the interactions. They assisted both the doctors and patients to express their views, opinions, decisions and expectations. The following extracts were considered:

Extract 42 (Interaction 1)

Doc.: How **will** you describe the pain? Is it sharp or dull?

Extract 43a (Interaction 4)

Doc.: Let us apply it for two weeks and see. How I wish I got a better instrument. I **would** have removed a lot of the wax to enable you start hearing well again. The eardrop costs about #800. You **will** apply it for two weeks. If it gets exhausted, buy another one till you have used it for two weeks.

Extract 43b (Interaction 9)

Doc.: I **will** examine your eyes. Then, you **will** go to the nurses. You **will** read a chart so we **can** see how well your eyes can see and then, we **will** know what next to do by the time I see your – we call it visual acuity.

Extract 44 (Interaction 5)

Doc.: No problem. The X-ray is different. The X-ray - I **will** look at it. But then I need to ask you some questions and you have to like – give me the honest answers so that I **can** make my own impressions and I **will** look at the X-ray and I **can** tell you ----- do you understand. So, I'm sorry I'm going to start asking you questions afresh.

Extract 45a (Interaction 15)

Pt.: Last night, I **could** not sleep.

Extract 45b (Interaction 13)

Doc.: Continue taking them. Your blood pressure is only a little high -144 /100. I think it's a reflection of the fact that you are not taking your drug.

Pt.: I **will** start taking it again.

In Extract 42, the doctor used the modal auxiliary **will** to know the patient's experience of the dental discomfort. In Extract 43a, the doctor deployed **would** and **will** to express a past impossible medical procedure and to offer a prescription respectively. In Extract 43b, the doctor employed **will** and **can** to express his decisions and hopes. Similarly, in Extract 44, the doctor used **will** and **can** to express his decision (examining the patient's X-ray film) and to reveal his diagnosis. In Extract 45a, the patient used **could + not** to express a past inability and, at 45b, the patient employed **will** to express her decision to comply with the presciptions. A perusal of the extracts above revealed that the deployment of the modal auxiliaries enabled the doctors and patients to express their decisions, views, opinions, ability and inability in relation to the patients' health challenges.

4.4.2.2 Imperatives: Giving orders

As a sentence type, imperatives were also deployed in the interactions. Mainly employed by the doctors, they assisted them in isuing appropriate directives for the purposes of restoring or enhancing the patients' health. The following extracts were considered:

Extract 46 (Interaction 8)

Doc.: **You have to see us next week Tuesday by all means for a check-up**, and your blood pressure must have come down before then.

Extract 47 (Interaction 9)

Doc.: It's alright. **Go and do the visual acuity and we will know what to do next.**

Extract 48 (Interaction 14)

Doc.: So, when you are done, **bring the result to me.** I will be here.

Extract 49 (Interaction 22)

Doc.: Let us apply it for two weeks and see. How I wish I got a better instrument. I would haveremoved a lot of the wax to enable you start hearing well again. The eardrop costs about. #800. You will apply it for two weeks. If it gets exhausted, **buy another one till you have used it for two weeks.**

As can be seen in the extracts above, the doctors employed imperatives for various medical reasons. In Extract 46, the doctor employed the imperative "**You have to see us next week Tuesday by all means for a check-up"** to give the patient another appointment in order to review his health. In Extract 47, the imperative "**Go and do the visual acuity and we will know what to do next"** was used to request the patient to do an eye testin order to know the next line of action in the doctor's effort to treat the patient. In Extract 48, the doctor deployed the imperative "**bring the result to me**" in order to know the root cause of the patient's health challenge and; in Extract 49, the doctor empolyed the imperative "**buy another one till you have used it for two weeks.**" to guide the patient right on medication. The various imperatives enabled the doctors to enhance the patients' health.

CHAPTER FIVE

5.0 ANALYSIS AND DISCUSSION OF DISCOURSE DEVICES AND COMMUNICATIVE FUNCTIONS IN DOCTOR-PATIENT VERBAL INTERACTIONS AT UITH, ILORIN

5.1 Introduction

This chapter analysed the various discourse devices employed in the data obtained at the Unilorin Teaching Hospital, Ilorin, and their communicative functions. Doctor-patient verbal interaction often involves a doctor and a patient and, sometimes, a patient's relation. Therefore, the discourse devices employed by both the doctors and the patients in the hospital under study were examined here.

5.2 Research Question 1: Which discourse devices are employed in doctor-patient verbal interactions and what communicative functions do they perform?

Discourse devices were used to realize the goals of verbal interactions in this study. They were realized by phatic communion, direct question, indirect question, answer, language switch, circumlocution, rapport expression, politeness, religious belief, counselling and closing etc.

5.2.1 Phatic Communion: To Open up Discourses and Show Empathy

Given the sensitive nature of clinical interviews, a bad opening potentially hinders the success of clinical interviews. To solve this problem, phatic communion was employed by the doctors at the beginning of most of the diagnostic sessions. It was generally realized by greetings, demonstration of empathy, enquiries by doctors about the patients' well-being and social lives during consultations. The doctors employed it to open the interviews. The following extracts were considered:

Extract 50 (INTERACTION 29)

Doc.: **E kaasan. [Good afternoon.]**

Pt.: Yes, sir.

Doc.: Kin lo sele? [What's the problem.]

Pt.: Apa yii lo n ro mi. [I feel pains in this arm.]Mo de lo si hospital kan nibi ti nwon ti fun mi labere sugbon o si n ro mi.[I attende a hospital where I was given an injection but the pain persists.]

Extract 51 (Interaction 33)

Doc.: **Good afternoon, Ma.**

Pt.: How is your family?

Doc.: They are fine.

Pt.: Thank God.

Extract 52 (Interaction 27)

Doc.: **E pele, ma. [Sorry, Ma.]**

Pt.: E see. [Thank you.]

Extract 53 (Interaction 40)

(Doc.: **Mrs Anne Ejiofor.**

Pt.: Good afternoon, sir.

Doc.: **Afternoon, madam.** What brought you here?

Pt.Rel: My child has rashes on the buttocks and I see blood stains.

A careful look at Extract 50 - 53 showed that the doctors employed phatic communion in opening the conversations with the patients during the consultations. In Extract 50 (Interaction 29), Doctor opened the conversation with the patient by using salutation (''E kaasan'.[Good afternoon.]') to welcome the patient. In Extract 51 (Interaction 33), Doctor opened the conversation by using salutation ('Good afternoon, ma'.) to welcome the patient and at the same time start the interview. In Extract 52 (Interaction 27), the doctor's reading of the patient's appearance revealed that the patient was in pains.

Consequently, this warranted the doctor's use of the empathetic expression ('E pele, Ma.'): meaning ['Sorry, Ma.'] to show sympathy and empathy, and at the same time start the interview. In Extract 53, the doctor employed naming (**'Mrs. Anne Ejiofor.'**) in his first contribution and salutation and elicitation ('**Afternoon, madam. What brought you here?**') in his second contribution, all in the same extract before proceeding to the actual business of diagnosis. The deployment of phatic communion here involving the use of salutation, non-medical questions, empathetic expression and calling of patient's name prepared the ground for the smooth commencement of the clinical interviews. It should also be noted that there are situations where the patients opened the clinical interviews, and this was done mainly by employing salutation. It is clear from the discussions above that there are various strategies that the doctors employed to start their conversations with the patients. Their choices were influenced by the appearance of the patients, time of the consultation and African culture which makes salutation mandatory at the beginning of any conversation. Therefore, the doctors employed various elements of phatic communion i.e. greetings, interrogatives, proper nouns (names of patients) and emotive expressions to start their discourse with the patients while the patients only employed greetings.

The communicative function of the deployment of phatic communion was to open up the interactions. It was apt for starting the clinical interviews as it enabled the interlocutors to create a conducive atmosphere for a smooth commencement of the consultations. Apart from this, it made room for the interlocutors to start talking and to prepare for the actual business of diagnosis. Grammatically, phatic communion was realized in the interactions by declaratives, interrogatives and phrases.

5.2.2 Circumlocution: Description of Symptoms of Ailments

Research has revealed that most patients are faced with the problem of not knowing the particular names of their ailments. As a result, they resort to circumlocution, which is the description of the symptoms of the ailments suffered by the patients. It was employed mainly by the patients in the interactions. Most patients tended to be circumlocutional in their talk with the doctors as they employed indirect ways of explaining their ailments. Instead of mentioning the real names of their ailments, they described the symptoms.

Most of the time, this resulted from their lack of the knowledge of the appropriate medical terminologies for their medical conditions. The data are replete with examples of this phenomenon. So, the following extracts were considered:

Extract 54 (Interaction 36)

Doc.: Kin lo complain about? [What's is his complaint?]

Pt. Rel.: **Ori fifo**. **Ara re si n gbona.** [Headache. He also has high temperature.]

Doc.: Lati 'gbawo? [Since when.]

Pt. Rel.: Ijeta. [Three daya ago.]

Doc.: Pele. So, kin le ti wa lo fun? [Sorry. So, what drugs have you given her?]

Pt. Rel. Amocillin.

Doc.: Sori fifo yen po gan-an ni? [Is the headache severe?]

Pt.Rel.: **Beeni. Ti'run e ba de ti n kun, o maa n complain pe ori n fo oun. Inu tun n run-un. O de tun bi l'aaro yii. [Yes. He complains about headache when his hair is long. He has stomach pain. He also vomited this morning.]**

Doc.: Lati'jeta yen ko bi tele? Se ko ya igbe olomi? [He did not vomit since day before yesterday. Is his stool not watery?

Pt.: Rel.: Rara. Ko ya'gbe olomi.

Extract 55 (Interaction 41)

Doc.: Ewo lo gbe nyin wa? [What are your complaints?]

Pt. Rel.: Daddy, **o n yagbe sooro** , **o tun n bi** lati oru ana? [He passes **watery stool** and has also been **vomiting** since last night.]

Doc.: Kin wa a l'e n se titi di aago meji osan nisisiyii? [What have you done about it since then till 2pm now?]

Extract 56 (Interaction 44)

Doc.: Okay, sir. How are you doing today?

Pt. : **I have body pain.**

Doc.: Okay. That's what brought you.

Pt.: Yes.

Doc.: How old are you, please?

Pt.: I am fifty years.

Doc.: So, beside the body pain, no other complaint?

Pt.: **The last time I came, I complained I felt feverish** and a malaria test was done for me. I was given some drugs but I also feel pains in my body.

Doc.: For how long have you had the pain?

Pt.: It's quite a long time. It keeps coming and going.

Doc.: So, if I am getting you right, you have been have been having recurring body pain. **I will treat you for malaria. Usually, when you are treated for malaria, does the pain go?**

Pt.: Yes. Yes.

The above extracts revealed that the patients mostly mentioned the symptoms of their ailments as if they were the real sicknesses they suffered from. This becomes obvious through experience as human beings that sicknesses have many manifestations. Therefore, it is not uncommon for patients that suffer from typhoid to complain about severe headache, diarrhea or high body temperature. The patients, being non-medical experts, may not know the particular ailments being suffered from. They would only know the symptoms. Therefore, all the patients' emboldened contributions in the extracts above are symptoms of certain ailments whose real names the patients did not know. However, the mention of these symptoms enabled the doctors to actually know the health

challenges the patients had. The use of the words **watery stool** and **vomitting** in Extract 55 suggested the patient suffered from typhoid or cholera as the words are common symptoms of the indicated disease. Similarly, looking at Extract 56, the phrases **'body pain'** and **'felt feverish'** provided good clues for the doctor to know that the real health challenge the patient faced was malaria, but which the patient had described in a circumlocutory fashion. This assertion is corroborated by the doctor's second sentence '**I will treat you for malaria'** in his last contribution at 52. Similarly, in Extract 54: ('**Ori fifo**. **Ara re si n gbona'.)** [Headache. He also has high temperature]. The patient's emboldened contributions could also be manifestations of malaria as common knowledge of diseases suggests malarial attack. Thus, as always, when the real ailments are confronted medically, the ailments disappear.

Circumlocution served the communicative purpose of enabling the patients describe the symptoms of their health challenges as a result of their little or lack of knowledge of medicine. It also afforded the doctors the opportunity of gaining insights into the patients' ailments. Diarrhea, high body temperature, watery stool, chest pain and vomitting mentioned by the patients in the extracts as diseases are merely symptoms of certain diseases, and not diseases themselves but the doctors understood this. Circumlocution was realized in the interactions by declaratives.

5.2.3 Rapport Expressions: Cordiality, Solidarity, Conviviality, Empathy and Sympathy

Unreceptive comments from doctors have been discovered to prevent patients from releasing critical information needed for accurate diagnosis. To overcome this problem, the doctors employed rapport expressions. A careful study of our data revealed that rapport expressions were realized by Wh-questions, indirect questions and statements. Their deployment for cordiality, solidarity, empathy and sympathy enabled the doctors to fraternize and familiarize themselves with the patients. They were also intended to promote open communication between the doctors and the patients in order to obtain good information to enrich their diagnoses and, ultimately their prescriptions or treatment. The following extracts were considered:

Extract 56 (Interaction 37)

Doc.: **How are you?**

Pt.: Fine.

Doc.: E pele. [Sorry.] What is your name?

Pt.: E see.

Extract 57 (Interaction 27)

Doc.: **Razak Bimbo**.

Pt.: Ma.

Doc.: **E pele. Bawo lara yin? [Sorry.How do you feel?] Se alaafia ni? [Are you alright?]**

Pt.: Daadaa ni. [Fine.]

A careful look at the extracts above revealed that the doctors ensured geniality, conviviality and solidarity with their patients through the rapport expressions. Their deployment enabled the doctors to show sympathy and empathy to the patients. In addition, they employed emotive words, advice, and elicitation of information on both family history (FH) and social history (SH) to engender open communication. In Extract 56, the doctor used empathetic greeting to fraternize with and to encourage the patient to open up. In Extract 57, the doctor employed naming, empathetic comment and inquiry about the patient's well-being. The deployment of rapport expressions enabled the doctors to demonstrate empathy, sympathy and emotion to the patients. This engendered cordiality with the patients, with the medical objective of eliciting all the needed information to proffer appropriate solutions to the patients' medical challenges.

The rapport expressions performed the discourse function of engendering open communication between the doctors and the patients and familiarizing the doctors with the patients. They enabled the doctors to be on the same wavelength with the patients in order to create a friendly atmosphere that could encourage the patients to release all the

information needed for diagnosis. The doctors deployed them here in the form of enquiry into the patient's social history, empathy and sympathy. They enabled the doctors to secure the cooperation of the patients to make the discourses result-oriented. The rapport expressions were mostly realized by interrogatives and, sometimes by declaratives in the form of empathetic comments.

5.2.4 Language Switch: Informativity, explicitness and mutuality

Some patients' competence in just one language and doctors' inability to find second language equivalents for certain medical terms pose a challenge in the multilingual setting of this study. As a way out of this problem, and given the multilingual environment, both the patients and doctors employed language switch. Language switch was realized by mixing Yoruba with English and using Pidgin English within interactions and between interactions. Therefore, the various language choices made by them were identified and analysed as this is important to examining how appropriately the codes were used and as well revealing the discourse roles they played.

Relating the above to our data on doctor-patient interaction in the South-West and North-Central Geo-Political Zones of Nigerian, we discovered that three codes, namely: Standard British English, Yoruba and Pidgin English - were used. On a number of occasions, too, there were instances of code-mixing and code switching. The following exchange transpired between a doctor and a patient.

Extract 58 (Interaction 35)

Doc.: Musa Mariam.

Pt.: Afternoon, sir.

Doc.: What brought you today?

Pt.: I feel a burning sensation all over my body.

Doc.: Hun hun. You feel it all over your body.

Pt.: Yes. I also feel it inside my stomach and chest.

Doc.: When did it begin?

Pt.: About three months ago, and I have come to complaint here before.

In the above extract, the patient picked English as the language of communication by greeting the doctor in English. The doctor reciprocated by using same language to investigate the patient's chief concern (CC), and the entire interview was conducted in English as the patient was educated.

Extract 59 (Interaction 31)

Doctor: Kin l'oruko nyin? [What is your name?]

Patient: Adijatu Olamide.

Doctor: Se e ti se ifunpa? [Have you done blood pressure test?]

Patient: Beeni. [Yes.]

Doctor: Kin lo n se nyin? [What complaints do you have?]

Patient: Mo kan waa mo boya nnkankan ko se mi ni. [I only came to know whether I am medically fit now.]

In the extract above, the doctor requested for the patient's name in Yoruba. The patient answered the question, explained her chief concern (CC) and also answered other questions asked by the doctor in the same language. The entire interview was conducted in Yoruba because the doctor had sensed that the patient was not educated, and as such would not be able to speak either English or Pidgin English. This consequently informed the doctor's choice of Yoruba alone in his interaction with the patient. Its deployment thus enabled the two to understand each other clearly.

There were also instances of code mixing in the data.

Extract 60 (Interaction 34)

Pt.: So, the day before yesterday, I started using gentamycin.

Doc.: Gentamycin eardrop or injection?

Pt.: Eardrop.

Doc.: Where did you get it? Did you buy it off the counter?

Pt.: Yes

Doc.: Those two weeks when it started, what were you doing?

Pt.: Nothing.

Doc.: Mo mean pe nigba to bere, kin le se? Se laaro ni, l'osan ni abi ale? **[I mean what did you do when it started?** Did it happen in the morning or afternoon?]

Pt.: Mi o take note. Mi o kan saa mo. **[I didn't take note. I just don't know.)**

Doc.: Okay time wo le notice? [Okay. What time did you notice it?]

Pt.: Two weeks ago.

Doc.: Kin le n se lowo? [What do you for a living now?]

Pt.: I am a civil servant.

Doc.: What's your job description?

Pt.: I work where number plates and drivers' license are issued.

Doc.: Okay. Not with FRSC.

Pt.: No, I work with the Licensing Office, under Oyo State Government – Board of Internal Revenue.

Doc.: ki n de se pe ariwo po? Kii se pe e wa nibi'se nigba to bere? [Is the cause of your illness not traceable to too much noise? Were you not at work when it began?]

Pt.: Rara. All of a sudden ni mo kan riipe eti yen n yo mi lenu. [No. The ear just suddenly began to hurt.]

Doc.: Okay

Pt.: Kii se pe mi o gboran rara o. [Not that I am completely deaf.]

Doc.: Mo understand nnkan t'e n so, sugbon o maa n sele tomi ba kosi eeyan leti. Igba miran t'eeyan ba travel. [I can understand you. But it happens during travels or when water enters the ear.]

Pt.: Igba miran ti mo ba lo fo'run, o maa n se bee. O si maa si pada. Sugbon eleyi ko se bee. [It does happen when I wash my hair and I feel a respite shortly afterwards but the present one is much different.]

Doc.: No pain in your throat?

Pt.: No pain.

Doc.: Did you have sore throat around that time?

In the extract above, both the doctor and the patient engaged in code-switching as well as in code mixing both at the sentence level and word level by alternating the use of English and Yoruba Languages. This strategy was employed by both the doctor and the patient to ensure a clear understanding of their discussions and to hide their linguistic incompetence at certain levels in the concerned languages.

Extract 61 (Interaction 37)

Doc.: How are you?

Pt.: Fine.

Doc.: E pele. [Sorry.] What is your name?

Pt.: Adigun Ibrahim.

Doc.: How old are you?

Pt.: Twenty-four.

Doc.: What is your occupation?

Pt.: I am a student.

Doc.: Which school?

Pt.: Kwara State Polytecchnic.

Doc.: What level?

Pt.: ND 11.

Doc.: What course?

Pt.: Biz Admin.

Doc.: Okay. Kin lo gbe nyin wa? [What complaints actually brought you?]

Pt.: Mo n yagbe leralera. [I have diarrhoea.]

Doc.: O n wa lera nwon lera nwon gan-an. [It's very frequent.] Latigbawo lo ti bere? [When did it start?]

Pt.: O ti maa ju three weeks lo. [It should be over three months.]

Dt.: Se igbe olomi to po gan-an ni? [Is the stool very watery?]

Pt.: Teletele igbe olomi ni. Sugbon ti mo ba ti jeun bayii, mo maa yagbe gidi. [It was watery before but after eating now, my stool is no longer watery.]

Doc.: Se ara nyin maa n gbona? [Do you have high temperature?]

Pt.: Bee ni. O maa n gbona. [Yes. It is high.]

Doc.: Se inu maa n run nyin k'e to lo yagbe? [Don't you have stomach upset before going to toilet?]

Pt.: Bee ni. [Yes.]

Doc. Nigbawo le yagbe yen last? [When was the last time you went to toilet?]

Pt.: Mo yaa ni bi twelve lonii. [I went to toilet around 12pm today.]

Doc.: Kin ni e tun wa se sii? [So, what did you do about it?]

Pt.: Mo lo si hospital.[I went to to a hospital.]

Doc.: Kin ni nwon wa fun nyin? [What drugs were you given?]

Pt.: Nwon ko awon oogun kan fun mi, Zinc wa lara nwon. [I was given some drugs.and zinc was one of them.] Mo si ti lo gbogbo e tan. Njgbati mo loo tan ti mi o ri iyato, mo tun lo complain, nwon waa ni ki n lo ra ORT ati zinc again. Mo si loo, sugbon ko siyato. [I have taken all the drugs but felt no respite. So, I went to complain again and I was asked to buy zinc and O.R.T. but there was still no change.]

Similarly, in the extract above, both the doctor and the patient engaged in code switching and code-mixing at both word and sentence levels. The doctor engaged in code-mixing here obviously to enable the patient understand him very well, especially as some of the English words do not have Yoruba equivalents, having sensed that the patient did not understand English that much.

The discourse function of the deployment of code-switching and code-mixing by the doctors and patients in Extracts 59, 60 and 61 above was to prevent communication breakdown as English Language cannot be entirely avoided when consulting with non-English speaking patients, given the fact that there are some English expressions used in medical discourse that have no equivalents in Yoruba e.g.' X-ray. In addition, where they are available, they may not be able to appropriately capture the idea that the doctors or patients have in mind.

Language switch performed the discourse function of making the discourse informative, explicit and mutual. It enabled the doctors to accommodate the linguistic backgrounds of the patients. Its deployment afforded the interlocutors the opportunity to overcome their linguistic deficiencies and also enabled them to understand the conversations well. As can be seen in the extracts above, both the doctor and the patient alternated the use of English and Yoruba to make the discourses more intelligible. Grammatically, code-mixing and code-switching were realized with declaratives, imperatives and interrogatives in the interactions.

5.2.5 Counselling: Guidance and Encouragement

A close examination of the data revealed that some patients engaged in activities that were detrimental to their health. To address this problem, the doctors deployed counselling to check the harmful health practices. Therefore, this section analysed and discussed the deployment of counselling as a tool by the doctors to guide the patients on how best to manage their health, teach them the best health practices or encourage them. The following extracts were considered:

Extract 62 (Interaction 28)

Pt.: Beeni. [Yes.] Sugbon, nibii ose meloo kan sehin, mo subu lule pelu omi lori, o wa n je kehin ati egbe maa dun mi latigba yen. [But I fell down with a bucket of on my head and since then I have felt pains in my sides.]

Doc.: **Se e o l'omo lodo to le maa ban yin ponmi. [Don't you have any housemaid?] Toripe o lewu k'e maa subu, paapaa julo t'e ni ifunpa to ga. [Because it is dangerous for you to fall down.] T'eni to ni ifunpa to ga ba subu, o le ro lapa abi ese. [If a hypertensive patient falls down, he could suffer a paralysis of hand or leg.]**

Pt.: Aah.

Doc.: **So, awon nnkan inu ile ko gbodo fun po. [So, things should be well spaced in your home.]Awon stool keekekee gbodo wa lona to jin kinu ile free tori e ti dagba. [Stools should be put in corners so that you could move freely because you are now old.**

Pt.: E see. [Thank you.]

Doc.: Se e o ni omo kekere lodo ni? [Don't you have a kid livng with you?]

Pt.: Kosii. [There is none.] .

Doc.: **Okay. E maa bu omi kekere t'e legbe K'e ma baa subu mo. [Avoid carrying heavy water container to avoid falling down again.]**

Extract 63 (Interaction 30)

Doc.: So, your trade is more important than your health. Ehn? Eni to ba ti ni ito sugar tabi eje riru maa wa lori oogun titi ojo aye ni.[Anyone that is diabetic will be on medication for life.] Iru enyin t'e ni ito sugar yii gbodo maa loogun lojoojumo titi ti sugar yen fi maa loole ti a o fi sope kee ma loogun lojo meji meji, tabi ko maa lo aabo. [A diabetic like you should should take drugs every day to reduce your blood sugar level till a time we ask you to take two tablets daily or half a tablet per day.]Awa la maa soo.[We are to tell you.] E o ri bayii pe ara nyin ru. [You can see now that you look lean.] O to igbawo t'e ti loogun gbehin? [How long was the time you last took your drugs?]

Pt.: Osu merin. [Four months.]

Doc.: **E e ri nnkan. Ounje t'eyan ba de maa je, eeyan maa watch e.[One has to watch what one eats.] Gbogbo nnkan didun didun, eeyan ni lati jinna sii. Emi ni coke, sugar, saccharin – e o le jee. Malt – e o le muu. [You need to stay away from very sweet things i.e. coke, sugar, saccharin, malt etc.] Awon nnkan bii ewa, wheat, efo ati eso le le je daadaa. [You can only eat things like beans, wheat, vegetables and fruits very well.]**

Pt.: Se mo le je eso to dun? [May I eat sweet fruits?]

Doc.: **Eso to ba ti dun ju, e o le jee. [You can't eat very sweet fruits.]Pine apple to ba dun ju e o le jee.[You can't eat very sweet pine apple.] E le mu osan, e maa ya tinu e je toripe o ni roughages. [You may suck oranges and eat the flesh because it has roughages.] O dara fun ara gan-an ni. [It's very good for the body.] E le je water melon, ikan ati wheat. [You may eat water melon, garden egg and wheat.] E o waa maa je gbogbo nnkan tin won fi ewa se pata: ekuru, oole, gbegiri. [In addition, you should eat food items made with beans.] E le je ogede dudu bibo pelu efo ati eja dudu.[You may eat unripe plantain with vegetable soup and roasted mudskipper.] E le je elubo ogede naa.[You may eat plantain flour as well.] Sugbon e ni lati din jije ounje bii rice, isu, eba,fufu, eko, dodo ati amala isu ku gidigidi. [But you need to**

drastically reduce intake of food like rice, 'eba', 'fufu', 'eko' fried plantain and yam flour.] Eo maa je ida kan ninu ida merin t'e n je tele.[You are to eat a quarter of the quantity of these food items you used to eat before.] Bo ba je pe rice ni, e o bu ida kan ninu merin, e o je pelu ewa pupo. Se o ye nyin? [Do you understand me?]

Pt.: O ye mi. [I can understand you.] Se mo le je elubo lafun? [May I eat cassava flour?]

Doc.: **Rara. [No.] Elubo ogede lo dara ju.[Plantain flour is the best.] Se nwon o toju nyin fun eje riru?[Are you not being treated for high blood pressure?]**

The extracts above revealed the deployment of counselling for the purpose of guidance and enlightenment. In Extract 62, the doctor guided the hypertensive patient on how to avoid dangers which could drastically aggravate her condition by avoiding carrying heavy things and ensuring that the furniture in her house were well-spaced to allow easy passage. At 63, the doctor gave the diabetic patient instructions on the right dietary practices she should cultivate, and also stressed the importance of religious adherence to medical prescriptions. From the above, it is clear that the employment of counselling enabled the doctors to provide the patients with appropriate health information to stabilize them and, or improve their medical conditions.

Thus, counselling performed the discourse function of guiding the patients aright and encouraging them. Its deployment also afforded the doctors the opportunity to enlighten the patients on practices that had to do with their health and how they could live a healthier life. Grammatically, the instances of counselling in the interactions were realized by declaratives, imperatives and interrogatives.

5.2.6 Religious Belief: Guidance, Encouragement, Solidarity and Enlightenment

Studies have revealed that some patients express obsession with certain religious doctrines that pose a threat to their health. In a bid to arrest the situation, the doctors employed their religious belief to enlighten the patients on the inappropriateness of some of the doctrines they observed. Therefore, the religions of the doctors were employed as a

tool to perform certain pragmatic functions in the interactions through the use of Biblical and Quranic explications. The analysis here, therefore, centred on how its deployment aided the doctors in forging solidarity with the patients, correcting, enlightening and also encouraging them. The following extracts were considered:

Extract 64 (Interaction 38)

Doc.: Mr. Nzeribe, do you think it's a sin to have told me you are fasting? Tell me your faith so that I should know how to counsel you appropriately.

Pt.: You know it is not right to fast and go about telling people.

Doc.: **See, we have the same faith. I am also a Christian. When Jesus was teaching us about fasting, he said we should not let our fasting be like that of the Pharisees who will put ash on their heads and wear poor clothing, and then they would wear a long face that people might know they are fasting. You understand?**

Pt.: Yes.

Doc.: You have not done that. The reason why you have told me you are fasting is because of your drugs. Is it not? It has not even shown on your face that you are fasting. So, it is not known to others except to me. And some people say doctors are next to God, I don't know about that. But I know we are working together. God is the one that heals but doctors try to take care of patients. How can I take care of you appropriately if I don't know the current situation that you are in? Now that you have told you are fasting, it has not stopped your fasting. You have not told me so that I should hail you, saying –this is a spiritual giant. You have not told me so that I would feel condemned or that you are a good Christian. No. The purpose of telling me is that I will be able to intervene in how you will be able to comply with your drugs so that you will not compromise your faith.

Extract 65 (Interaction 34)

Doc.: Iruu family planning wo le n lo? [What type of family planning method do you adopt?]

Pt.: Mo n gba'bere ni. [I take injections.] Mo ti e fee daa duro toripe awon kan so pe ko to suna. [But I want to stop it because some people say it is unislamic.]

Doc.: **Rara. Mi o ro pe iyen je ooto. [No. I don't think that is true.] Musulumi bii yin lemi naa, iyawo mi si ngbabere ifetosomobibi. [I am a Muslim like yourself and my wife takes family planning injections.]**

Pt.: Ah. Oko mi naa so bee. [My husband said the same thing].

Doc.: **Nnkan to sa dami loju ni pe Kurani o so bee. [The only thing I am sure of is that the Quran does not contain anything like that.]**

Extract 66 (Interaction 44)

Doc.: Okay, you are not having any headache?

Pt.: Each time I fast.

Doc.: In that case, you have to stop fasting.

Pt.: I can't. We fast every week in our church.

Doc.: **Fasting is good only when it doesn't affect your health. You know I am also a Christian. We can stay away from fasting if our health cannot cope with it. The Bible allows it. You need to read your Bible more to know this.**

Pt.: Thank you. But I can't do without fast.

Doc.: You may see your pastor for further clarification on my advice. Do you eat well?

Religious belief is a very important tool in doctor-patient verbal interaction that assisted the doctors in educating and guiding the patients. In Extract 64, the patient did not tell the doctor that he was fasting because he considered it unbiblical to do so, but the doctor

later got to know in the course of the clinical interview. Consequently, she used that fact she was also a christian like the patient to advise him appropriately on fasting, using Jesus' teachings in the Bible to buttress her submissions. Therefore, being a co-religionist enabled the patient to open up to the doctor and also accepted the doctor's views concerning fasting.

In Extract 66, the patient wanted to stop taking family planning pills because someone had told her The Quran condemned the practice. However, the doctor was able to disabuse the mind of the patient as a muslim, by informing her there was no such instruction in The Quran, and adding that his wife also practised family planning. This therefore enabled the patient to know she could practise family planning and yet be a good muslim. Similarly, in Extract 66, the patient, who was also a Christian, suffered a headache anytime he fasted but yet adhered to the practice religiously. However, the doctor was able to guide him aright on what The Bible says in relation to fasting i.e. fasting is not compulsory, especially for the sick. The doctor was able to educate the patient appropriately on fasting because both shared the same faith, even though the patient still rejected the doctor's advice.

The analyses above revealed that the doctors employed religious belief to perform a number of communicative functions like guiding the patients aright in areas where they exhibited ignorance or carefree attitude in health matters. Deployment of religious belief enabled the doctors to fraternize with the patients. Its deployment also assisted in enlightening the patients where certain religious practices interfered with their health, encouraging them and educating them. Here, the doctors employed their faiths (Christianity and Islam) to correct certain erroneous beliefs of the patients. Grammatically, the various instances of religios belief expressions were realized by declaratives.

5.2.7 Repetition: Emphasis and Confirmation

Doctors may know some patients' most pressing health challenges until they are emphasized. Finding a way round this problem, the patients in this study used repetition to draw the doctors' attention to their urgent medical needs. Repetition was realized by

reiteration of same expressions or similar ideas, and it was exclusively deployed by the patients. The data revealed that certain expressions and ideas were repeated in the interactions to create a necessary link within each of the interactions and at the same time emphasize or confirm the repeated utterances. To examine this phenomenon, The following extracts were considered:

Extract 67 (Interaction 32)

Doc.: So, what do you want me to do for you?

Pt.: Remove the milk tooth.

Doc.: I should remove the milk teeth. (To pt. rel) Mummy, what do you want us to do?

Pt. Rel.: Remove the tooth now.

Extract 68 (Interaction 35)

Pt.: Afternoon, sir.

Doc.: What brought you here today?

Pt.: I feel a burning sensation all over my body.

Doc.: Hun hun. You feel it all over your body.

Pt.: Yes. I also feel it inside my stomach and chest.

Extract 69 (Interaction 34)

Pt.: Mi o ri nnkan osu mi mo. [I have stopped menstruating.]

Doc.: Enyin naa le le so fun wa boya o ti lo o. [You are the one that can tell us if it has stopped.]

Pt.: Enh. Mi o ri eje. [Enh. I no longer menstruate.]

A perusal of the extracts above revealed that the patients deployed repetition here to emphasise their medical problems and the purpose was to enable the doctors know where

actually to focus their medical intervention on. Therefore, the various instances of repetition in the data tacitly drew the doctors' attention to the patients' pressing ailments for which treatment was urgenly needed from the doctors. In Extract 67, the patient employed direct repetition of words ('**Remove the milk tooth.'; 'Remove the tooth now.')** to emphasize her health challenge. In Extract 68, the patient employed indirect repetition of the same ideas ('**I feel a burning sensation all over my body.'; 'I also feel it inside my stomach and chest**.'). Similarly, in Extract 69, the patient suggested through another instance of indirect repetition ('**Mi o ri nnkan osu mi mo. [I have stopped menstruating.]; Mi o ri eje. [I no longer menstruate.])** that she wanted a treatment that could restore her menstrual period.

Therefore, the deployment of repetition served the communicative purpose of emphasizing the patients' medical challenges and pinpointing where the doctors should focus their medical intervention on. In the extracts above, the patients made it clear to the doctors through the deployment of both direct and indirect repetition their pressing ailments for which they wanted medical attention. Grammatically, the repetitions were realized by declaratives.

5.2.8 Question and Answer: Elicitation and Supply of Information for Diagnosis

In addition to laboratory tests, verbal information is also needed for rich and accurate diagnoses. This, therefore, makes question and answer inevitable in diagnostic interviews as diagnosis relies partly on elicitation and supply of information to unravel patients' medical challenges. Thus, the doctors in this study had to seek relevant information from the patients through the use of question, and the patients also had to supply them by using answer in order to assist the doctors in their investigation and treatment of the patients' medical challenges. Inappropriate responses to doctors' queries pose a challenge to obtaining critical information needed for diagnosis. This section, therefore, analysed and discussed how the doctors in this study elicited information through direct and indirect questions from the patients and how the patients answered to supply them.

5.2.8.1 Direct Questions with Answers

The direct questions in the interactions were realized by interrogatives beginning with wh-elements while answers were realized by declaratives to investigate the patients' ailments. The following extracts were considered**:**

Extract 70 (Interaction 29)

Doc.: Kin lo sele? [What's the problem?]

Pt.: **Apa yii lo n ro mi. [I feel pains in this arm.]Mo de lo si hospital kan nibi ti nwon ti fun mi labere sugbon o si n ro mi.[I attende a hospital where I was given an injection but the pain persists.]**

Extract 71 (Interaction 32)

Doc.: What school do you attend?

Pt.: **Oritamefa Baptist….**

Doc. Whao! Oritamefa. **Are you the last born?**

Pt.: **Yes.**

Doc.: Out of how many children?

Pt.: **Four.**

Doc.: Your mum, what does she do?

Pt.: **She is a nurse.**

Doc.: Your mum is a nurse. Whao! **What of dad?**

Pt.: **A lecturer.**

Doc.: Where?

Pt.: **LAUTECH**

Extract 72 (Interaction 26)

Doc.: Were you ever diagnosed with diabetes or hypertension?

Pt.: Diabetes.

Doc.: Where do you treat it and what drugs are you taking to cure it?

Pt.: The drugs I was given are in my bag.

Doc.: Go bring them.

Pt. (Hands over the drugs to the doctor)

Doc.: So, these are the drugs you were given. Where do you treat yourself?

Pt.: Sadiku.

Doc.: When was the last time you went there for treatment?

Pt.: About two months ago.

Doc.: Then why did she change to this hospital.

Direct question was one of the oral diagnostic tools employed in the study to investigate the patients' medical challenges. Its deployment enabled the doctors to know how to intervene professionally in the patients' ailments. Looking carefully at the extracts above, one sees how the doctors employed direct questions in each of the extracts to obtain information on the patients' family history (FH), social history (SH) and history of present ailment (HPI) for the purposes of making diagnoses. In response to the questions, the patients supplied the needed information, thus making the discourses resulted-oriented.

The directness of the questions served the communicative purpose of tacitly informing the patients that the information being sought were crucial to the diagnosis of their ailments and eventual recovery. The questions, therefore, enabled the patients to actually state their health challenges. In sum, the direct question performed the discourse function of eliciting information to make diagnoses. They were grammatically realized by wh-elements.

5.2.8.2 Indirect Questions with Answers

Indirect questions were realized by statements. They have the appearance of declaratives but are fundamentally interrogative. The following extracts were considered:

Extract 73 (Interaction 32)

Doc.: Was his immunization complete?

Pt, Rel.: Yes.

Doc.: And he doesn't fall sick from time to time.

Pt. Rel.: **Not at all.**

Extract 74 (Interaction 34)

Doc.: Eje to n wa yen, eemelo loti wa ko toodi pe ko wa mo? [How many times did you bleed before it stopped?]

Pt.: A a to bii eemeje. [About seven times.]

Doc.: Ko de waa wa mo nisen. [And it has stopped now.]

Pt.: Bee ni. [Yes].

Extract 75 (Interaction 38)

Doc.: The last time you came was in April.

Pt.: Yes. April.

Doc.: **You are being treated for diabetes and hypertension according to these test results.**

Pt.: Yes. Diabetes and hypertension.

Doc.: Do you have any prescription list with you.

Pt.: Yes. I have numerous of them but I want to look for the most recent of them,

A careful look at Extract 73 - 75 revealed that the main instrument in clinical interview is seeking and giving information. Evident from the doctors' contributions above is the deployment of indirect questions to obtain information on the patients' history of present illness (HPI), social history (SH) and family history (FH). On the other hand, the patients' contributions supplied answers to the doctors' questions. The indirectness of the questions is confirmed by their interrogative status, even though couched in declarative forms, and the answer status of the accompanying responses from the patients, thus forming a question-answer sequence. Here, the elicitation and supply of information provided insights for the doctors into the likely causes of and the real nature of the patients' health challenges and, consequently, offered them the opportunity to intervene professionally. The doctors mostly sought information about the patients' health challenges while the patients provided them, thus revealing that they worked dependently in matters of oral diagnosis.

All the instances of the direct and indirect questions were emboldened. In Extract 70 – 72, there were instances of direct questions while in Extract 73 – 75, there were instances of indirect questions. The communicative function of the indirect questions was to make the interviews appear less interrogative to enable the patients who were obviously sick find the exercise less stressful and, consequently, be encouraged to cooperate in releasing all the information needed to unravel and solve their health challenges. The direct questions, on the other hand, served the discourse function of making the patients know the particular information being sought from them were crucial to unraveling their health challenges so that the doctors should be able to treat them. Unlike the direct questions, the indirect questions were realized by declaratives, but yet have the illocutionary force of question.

The answers naturally followed the questions and they performed the communicative function of presenting the information needed for diagnosis. Their deployment was inevitable as the discourse was purely investigative; they generated the raw materials for diagnosis. As the extracts above revealed, the answers were what the doctors needed to make good diagnoses, without which it was impossible for them to gain insights into the patients' medical challenges, except the doctors were going to conduct laboratory tests on

them. Question and answer are very important diagnostic tools in clinical interviews in view of the fact that there are some medical conditions that can only be investigated through questions and answers.

5.2.9 Closing: Concluding Discourses

After information had been obtained on chief concern (CC), history of present illness (HPI), family history (FH) and social history (SH), the interviews had to be brought to a close to enable the patients either go to procure some drugs, carry out some tests or do both. To create this opportunity, the patients in this study used closing. It was realized by appreciation and greeting in our data. A perusal of the data revealed that various methods were employed in closing the discourses between the doctors and the patients, but the most common are expressions like 'Goodbye' and 'Thank you' after the doctors' prescription of tests or drugs. Analyses and discussions of how these closing strategies were deployed in the data were attempted here.

Extract 76 (Interaction 42)

Doc.: Doc.: Maa fun nyin l'oogun ti e maa lo si gbogbo e. [I will recommend some drugs to take care of the complaints.] E lo ra awon oogun yii. [Buy these drugs.] Ti e ba ni complaint miran, ki e pada wa. [If you have any complaints afterwards, do come back.]

Pt.: E see. [Thanks.]

Doc.: **O dabo. [Bye bye.]**

Pt.: O dabo. [Bye bye.]

Extract 77 (Interaction 38)

Doc.: See. I am only advising you. I am not going to decide for you. May be by the time I see your result tomorrow, I am going to further advise you. Thank God I have

checked your blood pressure now, and your drug is to be taken once a day. So, take it when you are breaking in the evening. Our own God is not a wicked God. He knows everybody's condition and He will not judge you by another person's standard. He knows what is expected of everyone. He knows what you should do and He knows other people should do.

Pt.: I am very grateful.

Doc.: So, Mr Nzeribe, you don't need to feel condemned because you have told me you are fasting. So, we will see again tomorrow. It is well. (Gives him a prescription list.)

Pt.: **Bye bye, ma.**

Doc.: Bye.

Extract 78 (Interaction 42)

Doc.: O dabo. [Bye bye.]

Pt.: **O dabo. [Bye bye.]**

Extract 79 (Interaction 30)

Doc.: Bakannaa, e o maa ye abe bata nyin wo fun eso toripe to ba gun-un, o le se nyin lese. [Similarly, you should inspect the soles of your shoes to ensure there are no nails in them as they can wound you.] Atipe diabetes maa n baa won isan ese je ni debii pe ti nnkan gun eyan lese ko nii mo. [In addition, diabetes is so debilitating a disease that if you have an injury, you might not feel it.] Ni afikun, e o maa wa losoosu fun itoju ati ayewo. [Again, too, you should come monthly for examination and treatment.To ba je pe owo lani k'e waa gba, e maa wa bo je eemeji losu. [If we asked you to come to collect money, even twice monthly, you would come]. Tori naa. ilera se Pataki. [Therefore, health is important. E o maa wa losoosu.- Eemejila lodun. [You will come monthly – twelve times a year.] E o maa ra oogun nyin deede. [You should take your drugs regularly.] Toogun nyin ba ti ku merin ni e ti maa wa sibi lati waa se ayewo.[You should come here

immediately you have about four tablets left for examination.] Nigbati e ba n bo, e o nii jeun abi momi wa. [When coming, you will neither eat nor drink water.]Idi ti a ni lati se bayii ni ki sugar to wa lara nyin ti a n gbiyanju ati muwale ma baa lo soke. [We need to do this to ensure your sugar level we are trying to bring down does not go up.]

Pt.: E see. [Thank you.]

Doc.: E je ki n wo ifunpa nyin.[Let me check youe blood pressure.] E ma je eran olora yen mo.[Stop eating meat.] E maa je eja gbigbe. [Eat dried fish alone.] Ifunpa nyin dara. [Your blood pressure is alright.] [Oogun nla yen, e o maa lo meji laaro, meji lale. Oogun keekeeke yen, e maa lo eyo kan lojumo.[Take two of those big tablets in the morning and evening. Take one of the small tablets once daily.]

Pt.: E see. [Thank you.]

Doc.: O dabo. [Good bye.]

The extracts above revealed that the patients mostly closed the discussions in all the extracts, but the doctors also closed the conversations sometimes as evident in Extracts 76 (Interaction 42) and 77 (Interaction 38) through the use of the expression (O dabo. [Bye bye.]) and (‘Bye bye, Ma.’) respectively. In Extracts 78, the patient closed the interaction with ‘O dabo. [Bye bye.], while in Extract 79, the patient used the expressions: (‘E see. [Thank you.])’ to round off the interview. The deployment of the above-mentioned expressions to end the clinical interviews provided appropriate conclusions for the interviews.

Emerging from the discussion above, it is clear that closing performed the communicative function of bringing each of the interactions to a close as each of the clinical interviews could not but end at a particular time. Therefore, as can be seen in the extracts above, closing indicated the end of the interactions as signalled by the emboldened expressions above. Generally, closing is the final strategy employed in all clinical interviews as observable in all the interactions, and naturally follows prescription. Grammatically, closing was realized in the interactions by declaratives and phrases.

5.3 Research Question 2: How and by what means is politeness achieved in the interactions?

Politeness was realized in the interactions by face-threatening acts without redress and face-threatening acts with redress (positive politeness), using frank talk, courteous expressions, direct and indirect expressions in the data. They were used after the doctors had concluded their diagnoses. Examination of the deployment of politeness was undertaken here to reveal how and whether the diagnoses were presented in a courteous manner and how the patients' face was threatened without redress and with redress. In addition, efforts were made to study how the deployment of the face-threatening acts and politeness maxims aided the communication.

5.3.1 Face-Threatening Acts without Redress: Checking and Correcting Unwholesome Health Practices

Face-threatening acts without redress were realized by frank talk, courteous expressions and reprimand. Here, we examined how their deployment aided the discourses. The following extracts were considered:

Extract 80 (Interaction 38)

BACKGROUND: Doc. interviews a patient suffering from diabetes and hypertension.

Doc.: **You are being treated for diabetes and hypertension according to these test results**.

Pt.: Yes. Diabetes and hypertension.

Doc.: There is no cause for alarm. Once your sugar level is well controlled, you can do surgery.

Pt.: Nnh

Doc.: Once you take your drugs regularly there won't be any problem.

Pt.: It's the issue of the fistula that made the doctor refer me to Surgery. I even thought it was cancer but the doctor said it was not.

Doc.: Yes, it's not cancer. You see fistula results when there is reduced immunity in the body. The immune system is what fights against infection in the body, and when it becomes weak, diseases surface. It gives room to some kinds of Infection to set in. In addition, medical science has shown that if there is too much sugar in the body, immunity will be low. It weakens the armies in the system. So, they won't be able to fight diseases. Therefore, infections can have room to actually invade.

Pt.: Nnh.

Doc.: So, if your sugar is well controlled, your immunity will be okay.

Pt.: Ok.

In the above extract, the doctor threatened the patient's face by frankly telling him he suffered from diabetes and hypertension. The purpose of this FTA was not intended to frighten the patient but to let him know the true state of his health so that he might be encouraged to comply fully with medical advice and drug prescriptions. This assertion is corroborated by the doctor's emboldened second, third and fourth contributions in the extract.

Extract 81 (Interaction 35)

BACKGROUND: Doc. counsels Pt on the importance of keeping her hospital well

Doc.: Where did you lodge the complaint?

Pt.: Here. But I lost my former card.

Doc.: So, we are not responsible for the loss.

Pt.: Yes.

Doc.: But we averse to a situation where you don't take good care of things that have to do with your health. For instance, we can't see any of your past medical records, and this is not appropriate. I am sure the card did not get lost. It's just that you can't remember where you kept it. So, I advise you are careful with your card henceforth.

In the extract above, the doctor's emboldened contribution manifested another instance of FTA without redress, using frank talk to upbraid the patient for careless handling of her hospital card and at the same time charging her to keep it better because of its medical importance. It can be deduced from the foregoing that FTA without redress performed the pragmatic function of checking and correcting the patients on practices that were injurious to their health and as well revealing to them the true state of their health harmlessly.

5.3.2 Face-Threatening Acts with Redress (Positive Politeness): Correcting, Allaying Fears and Tactfully Obtaining Information for Diagnoses

FTA with redress was realized by direct and indirect talk, mitigated threats and courteous expressions in the data. This study discovered that whether as a temporary or long term act, the doctors threatened the patients' face or minimized the threat to their face by not talking directly about their illnesses. Sometimes, this happens during clinical interviews following which doctors employ FTA with redress (Positive Politeness). At other times, too, for reasons best known to doctors, patients' real medical problems are hidden from them. Most of the instances of FTAs with redress (positive politeness) available in our data presented as direct expressions, indirect expressions, courteous expressions and mitigated threats. The following extracts were considered.

Extract 82 (Interaction 38)

BACKGROUND: Doc. interviews a patient suffering from diabetes and hypertension.

Doc.: You are being treated for diabetes and hypertension according to these test results.

Pt.: Yes. Diabetes and hypertension.

Doc.: There is no cause for alarm. Once your sugar level is well controlled, you can do surgery.

Pt.: I didn't know. Thank you.

The emboldened contributions in the extract above also revealed that FTAs with redress (positive politeness) also presented as mitigated threats in our data. The doctor knew that the patient was both hypertensive and diabetic, but defused the dangers posed by the ailments to the patient's well-being by using the assurance indicative expression **"There is no cause for alarm.",** which brightened the patient's hope of possible total recovery.

Extract 83 (Interaction 29)

BACKGROUND: Doc. interviews a patient suspected to have contacted HIV/ AIDS

Doc.: A maa se ayewo HIV fun nyin. Ayewo in eje ni. [We will screen you for HIV. It's a blood test.] Ofe la maa n se e nibi. [It's free here.]Maa ko oruko ibi ti e ti maa se e fun nyin.[I will write the name of the laboratory for you.] E maa wa mu esi re wa. O le je kokoro kan lo faa, o si le ma je bee. [You will bring the result. It could have been caused by a micro-organism and it may not be so.] Ooogun ti e ma ra ni eyii. [This is the drug you will buy.]

Pt.: Se ti mo ba raa, maa tun mu wa sibi lati mo bi maa se loo? [Do I have to bring it here after purchase to know the dosage?]

Doc.: Rara. [No.] Bee se maa lo ti wa lara re.[The dosage is already stated on it.] E lo ra oogun yen nibi ti mo juwe fun nyin ki nwon le salaye bi e se maa lo fun nyin. [Go buy it in the place described so that the dosage can be explained to you.] Iyawo meloo ni e ni? [How many wives do you have?]

Pt.: Eyo kan. [One.]

Doc.: Se ko de si awon tibitibi? [Don't you have any others?]

Pt.: Rara. [No.]

In the extract above, the doctor employed both direct and indirect expressions in his quest to diagnose the patient's ailment. In the doctor's first contribution in this extract, he employed a direct expression to inform the patient about the type of test to be conducted on him: **"We will screen you for HIV"**. The doctor employed this grammatical form obviously because he wanted the patient to know that the test was very crucial to his

recovery. The doctor employed an indirect expression in his third contribution in the same extract to investigate whether the patient had many sexual partners by referring to concubines as **'others'.** The purpose was to avoid offending him so that he might give true information that would assist the doctor in making an accurate diagnosis.

Extract 84 (Interaction 30)

Doc.: (Looks at the test result) Se oogun nyin titan ni? [Have your drugs finished?]

Pt.: Tipe. [A long time ago.]

Doc.: E o de waa. 13/7 – sugar to wa lara nyin ti poju [And you didn't come to complain. 13/7 - Your blood sugar level is too high.]Mama ise wo le n se? [What's your occupation?]

Pt.: I am a trader.

Doc.: So, your trade is more important than your health. Ehn? Eni to ba ti ni ito sugar tabi eje riru maa wa lori oogun titi ojo aye ni.[Anyone that is diabetic will be on medication for life.] Iru enyin t'e ni ito sugar yii gbodo maa loogun lojoojumo titi ti sugar yen fi maa loole ti a o fi sope kee ma loogun lojo meji meji, tabi ko maa lo aabo. [A diabetic like you should should take drugs every day to reduce your blood sugar level till a time we ask you to take two tablets daily or half a tablet per day.]Awa la maa soo. [We are to tell you.] E o ri bayii pe ara nyin ru. [You can see now that you look lean.] O to igbawo t'e ti loogun gbehin? [How long was the time you last took your drugs?]

Extract 85 (Interaction 33)

Doc.: Okay. I will look at it. (Checks patient's blood pressure) Have you taken your drugs today?

Pt.: No. I haven't.

Doc.: Why?

Pt.: I couldn't get any food to buy when I got here..

Doc.: You should have eaten before you left home so that you would be able to take your drugs. If you had done that your BP wouldn't have gone up like this. The kinds of drugs you take are those that cause frequent urination. Therefore, you should take them in the morning to avoid waking up frequently in the night to urinate. So, now that you failed to take it in the morning, are you now going to take it in the evening and make it disturb your sleep in the night? It's important you learn to take them every morning.

Pt.: Thank you.

Similarly, the doctors' contributions in Extracts 84 and 85 are direct expressions employed to reprimand the patients for their utter disregard for their health. The doctors employed FTA here to condemn the patients' dangerous health practices. It is clear from the extracts and discussions above that FTA with redress (positive politeness) performed the pragmatic functions of correcting the patients' unhealthful practices, tactfully eliciting information from them to make diagnoses, and allaying the fears generated by their ailments.

5.4 Research Question 3: Which politeness maxims are observable in the doctor-patient interactions?

The politeness maxims observable in the interactions were the tact maxim, the generosity maxim, the sympathy maxim and the Pollyanna principle. They were discussed in turn.

5.4.1 Tact Maxim: Compassion and Permission

The tact maxim was discovered to be observed in our data. The maxim states: Minimize cost to other, maximize benefit to other. Several of the doctors' utterances showed that they were considerate to the patients as they offered them the opportunity to gain maximum advantage in their hospital visits, even though such offers meant more work for them. The following extracts were considered:

Extract 86 (Interaction 30)

Doc.: A o se itoju oju nibi. [This is not an eye clinic.] O le je complication ito sugar naa ni. [It could be a complication of your diabetic condition.] To ba dola, e maa lo si ibi ti nwon ti n toju oju. [You will go to the eye clinic tomorrow.] O ye ki e maa se awon ayewo yen toripe itoju eni to ba ni diabetes se pataki, bi eni naa ba ni egbo, ko nii jinna. [You ought to do the tests regularly as a result of your diabetic condition because if you sustain an injury, you may not know and the wound will not heal up.So, e ni ni lati maa ye ese nyin wo – awon inu ika yen.- lati mo boya egbo wa nibe. [So, you need to constantly examine your feet to ensure there are no sores there, especially in-between the toes.] Bi e ko ba le wo fun ran yin, e le pe eeyan ko baa nyin wo tabi ki e fi mirror woo boya egbo wa nibe. [You may inspect the feet with a mirror if there is nobody to assist you inspect them.] Aisan yii lo n faa tin won fi n gee se opolopo eeyan. [This ailment causes a lot of people to suffer feet amputation.] Ti eekanna nyin ba gun, e o le fi blade gee, nail cutter le maa lo ko ma baa da egbo sin yin lese. [You cannot cut your nails with blade. Instead, you will use a nail cutter.] Ti egbo ba de be, ko nii san, ko ma waa di pe nwon maa gee kuro.[If a sore emerges, it will not heal up and it may result in amputation.]

Pt.: O ye mi.[I can understand you.]

Doc.: Bakannaa, e o maa ye abe bata nyin wo fun eso toripe to ba gun-un, o le se nyin lese. [Similarly, you should inspect the soles of your shoes to ensure there are no nails in them as they can wound you.] Atipe diabetes maa n baa won isan ese je ni debii pe ti nnkan gun eyan lese ko nii mo.[In addition, diabetes is so debilitating a disease that if you have an injury, you might not feel it.] Ni afikun, e o maa wa losoosu fun itoju ati ayewo. [Again, too, you should come monthly for examination and treatment.To ba je pe owo lani k'e waa gba, e maa wa bo je eemeji losu.[If we asked you to come to collect money, even twice monthly, you would come]. Tori naa. ilera se Pataki. [Therefore, health is important. E o maa wa losoosu.- Eemejila lodun. [You will come monthly – twelve times a year.]E o maa ra oogun nyin deede. [You should take your drugs regularly.] **Toogun nyin ba ti ku merin ni e ti maa wa sibi lati waa se ayewo.[You should come here**

immediately you have about four tablets left for further examination.] Nigbati e ba n bo, e o nii jeun abi momi wa. [When coming, you will neither eat nor drink water.]Idi ti a ni lati se bayii ni ki sugar to wa lara nyin ti a n gbiyanju ati muwale ma baa lo soke.[We need to do this to ensure your sugar level we are trying to bring down does not go up.]

Pt.: E see. [Thank you.]

Extract 87 (Interaction 35)

Doc.: How robust is the relationship between you and your husband?

Pt.: Very cordial.

Doc.: What about you co-wife?

Pt.: Even though my husband married the second wife not more than a year ago but that's not a problem in any way and my children don't give me any problem either. In addition, my trade is flourishing too.

Doc.: Okay. We are going to give you some drugs to be taken every evening for a whole month. It might make you sleep but the purpose for giving you the drugs is not to make you sleep. **So, you will now come for a review in the next three weeks.** These drugs I have recommended are not expensive. They cost less than #500 but there are some that cost as much as #3000. So, go take these drugs. We believe they will work because they are very effective. **However, if you have any complaint, do come back to let us know. Evert doctor here is competent but ask of Dr. Abdul because I would personally like to see you then.**

Pt.: But, doctor I feel pains in this arm and this leg. They pain me a lot and at such times, I also a burning sensation in my vagina.

Doc.: Madam, go take the drugs I have recommended. They will take care of all your complaints. **Don't you see a white discharge in your private parts?**

Pt.: I do.

Doc.: But, you didn't want to complain about until I raised it.

Pt.: I thought it was also caused by the burning sensation.

Doc: Some patients don't like to discuss very private health issues like these but it's not good. Always tell your doctor all your health complaints for action.

Pt.: Thank you, sir.

Doc.: I have recommended another drug to take care of that, too.

Pt.: Thank you.

In extracts 86 and 87, the doctors' contributions showed that they were very compassionate on the patients and wanted them to derive maximum benefits from their visit to the hospital. In Extract 86, the doctor offered the patient another opportunity for medical examination and drug prescription by giving her another appointment. Similarly, in Extract 85, the doctor, after recommending some drugs, asked the patient to come for a review after three weeks. He also added that in case there was any problem, the patient should come to the hospital and also offered to personally attend to the patient. In addition, the doctor's third and fourth emboldened contributions in Extract 87 raised a question on another health challenge **('Don't you see a white discharge in your private parts?')** that the patient did not want to talk about until the doctor mentioned it. As can be seen towards the end of the extract, the doctor also recommended some drugs to take care of the health problem too. All these offers, no doubt, meant more work for the doctors but they did not care as the well being of the patients was paramount to them.

The deployment of the tact maxim performed the communicative function of enabling the doctors to show their compassion for the patients. It also afforded them the opportunity to offer the patients more medical attention. Grammatically, the tact maxim was realised by declaratives and interrogatives in the interactions.

5.4.2 Generosity Maxim: Advice and Compassion

The generosity maxim was realized by advice and compassion in our data. Several times, the maxim was observed in the interactions between the doctors and patients as the

doctors' minimized benefit to themseleves and also maximized cost to themselves, too. Thus, the doctors showed concerns for the patients' health. The following interactions were considered:

Extract 88 (Interaction 30)

Doc.: So, your trade is more important than your health. Ehn? Eni to ba ti ni ito sugar tabi eje riru maa wa lori oogun titi ojo aye ni. [Anyone that is diabetic will be on medication for life.] Iru enyin t'e ni ito sugar yii gbodo maa loogun lojoojumo titi ti sugar yen fi maa loole ti a o fi sope kee ma loogun lojo meji meji, tabi ko maa lo aabo. [A diabetic like you should should take drugs every day to reduce your blood sugar level till a time we ask you to take two tablets daily or half a tablet per day.] Awa la maa soo. [We are to tell you.] E o ri bayii pe ara nyin ru. [You can see now that you look lean.] O to igbawo t'e ti loogun gbehin? [How long was the time you last took your drugs?]

Pt.: Osu merin. [Four months.]

Extract 89 (Interaction 39)

Doc.: Bawo l'e nyin se mo pe nnkan wa leti e? [How did you know there was something in his ear?

Pt. Rel.: O so fun mi. Mo waa woo, mo de rii. [He told me and I saw it there.]

Doc.: Kin wa le fee fi yoo? [With what did you try to remove it?]

Pt. Rel.: Cotton bud.

Doc.: **Se e rii, ni ojo miran ti omo ba ki nnkan seti, e so fun awon yokuu nyin naa, e ma attempt ati yoo rara,ko ma waa di pe e tun kii wonu sii.[See, anytime a child puts anything in his ear, you shouldn't try to remove it to avoid a situation where you would further push the object in.] Emi gan-an ti mo je doctor nigba ti mo ti rii pe o ti sun sinu ju, mo ni lati je ki awon to kose eti titoju yanju e.[Beind a medical doctor myself, I have to refer you to an E.N.T. specialist, having seen the object has gone in so much. So, e so fun**

gbogbo awon ti e jo n sise pe ti enikeni ba ti nnkan bo imu tabi eti, ki nwon ma fowo kan-an ti kii ba ti i se ohun ti e le fi owo lasan yo. [So, tell your colleagues at work not to attempt removing anything from a child's ear if it's not an object that can easily be removed with hands alone.]. Ki nwon tete gbe e lo so si hospital. [They should instead quickly take the child to a hospital.]Se e waa ri omo to ki nnkan boo leti? [Did you see the boy that put the object into his ear?]

Pt Rel.: A rii. [We did.]

Doc.: E gba iwe yii ki e muu lo si E.N.T. Nwon maa toju e nibe. [Take this letter to to E.N.T. Clinic. He will be treated there.]

Pt.: E see. [Thank you.]

In extracts 88and 89 above,, the doctors demonstrated great concern for the patients' health by offering them medically beneficial pieces of advice. In Extract 88, the doctor advised the diabetic patient on the importance of total adherence to medical prescriptions and instructions to avoid health crises. In Extract 89, the doctor's emboldened contributions sympathetically presented a good piece of advice on what should immediately be done when an emergency like the one presented in the extract arose.

The deployment of the generosity maxim therefore enabled the doctors to show concerns for the health of the patients and, to also advise them appropriately. Grammatically, the generosity maxim was realized by declaratives and interrogatives in the interactions.

5.4.3 Sympathy Maxim: Advice, Pity and Guidance

Realised by advice, pity and guidance, the sympathy maxim was seen to be observed severally in the interactions between the doctors and the patients, where the doctors commiserated with the patients over certain terrible health conditions. Examples of some of the utterances made to observe the maxim are:

Extract 90 (Interaction 36)

Doc.: Ibraheem!

Pt.: Sir.

Doc.: Can't you talk?

Pt. I can.

Doc.: Come closer. Sorry. Look at your teeth. You don't brush your teeth well. This is how to brush your teeth, and you should change your toothbrush every three months. S'ori n fo e naa? [Do you also have a headache?]

Pt.: Beeni.

Doc.: Se'waju ni abi ehin?

Pt.: Iwaju.

Doc.: Se oju ko ro e?

Pt.: Rara.

In the extract above, the doctor took pity on the patient over his improper care for his teeth as a result of the danger inherent in such an unhygienic practice. So, he advised him on how best to brush his teeth, and when to change his toothbrush so as to have good oral hygiene.

Extract 91 (Interaction 41)

Doc.: Ewo lo gbe nyin wa? [What are your complaints?]

Pt. Rel.: Daddy, o n yagbe sooro , o tun n bi lati oru ana? [He has diarrhea and has also been vomiting since last night.]

Doc.: **Kin wa a l'e n se titi di aago meji osan nisisiyii? [What have you done about it since then till 2pm now?]**

Pt.Rel.: Mo loo gbaaye nibi ise ni. [I went to obtain permission in my office.]

Doc.: Nibo nibi ise nyin? [Where do you work?]

Pt.:Rel.: Prisons.

Doc.: Ko daa bee o. E ma se bee mo lojo miran. [That's not good. Don't do so next time.]

Pt.Rel.: E ma binu. [Sorry.]

Doc.: Awa o binu, torii tara nyin ni. [We are not angry but just saying this in your own interest.]To ba je nnkan to waa buru ju bayii lo n ko kini yoo waa sele? [Can you imagine what would have happened if his condition were worse than this?] Eemeloo lo ti wa yagbe? [So, how times has he defaecated?]

In Extract 91, the doctor expressed pity for the patient over the way his mother delayed bringing him to the hospital for medical attention. Out of compassion for both the patient and his mother, the doctor condemned the inappropriateness of the mother's action, asking her to imagine what could have happened if the patient's condition had been worse than that. By deploying the sympathy maxim, the doctors' contributions performed the communicative function of guiding and advising the patients on the appropriate action to take when there was a health challenge. In addition, its deployment also revealed the doctors' compassion for the patients. Grammatically, the sympathy maxim was realized in the interactions by declaratives and interrogatives.

5.4.4 Pollyanna Principle - The Ethical Positivity Tendency: To Open Up Talks.

The Pollyanna principle was also observed in the examined verbal medical interactions. Its deployment showed that verbal medical discourse focuses more on the positive than the negative aspect of life. This phenomenon emanates from the contextual beliefs based on medical ethics and those based on the patients-society's perspective of doctors. Medical ethics demand that doctors directly or indirectly use their professional skills to treat patients and not to harm them either psychologically or physically. Conversely, patients too expect that doctors will meet their medical, physical and emotional desires. The Pollyanna principle has three tendencies, namely: euphemistic tendency, ethical positivity tendency and referential/hinting tendencies, but only the ethical positivity tendency was found to characterize the interactions studied.

Pollyanna principle of ethical positivity tendency echoes the ethical expectations of patients from doctors, particularly in the area of medical care, assurance, reassurance, sympathy etc. It has to do with the contextual beliefs based on the patients-society's view of the doctors. The hospital is an orthodox institution viewed by the patients and the larger society as a home of relief and cure. The patients regard the doctors as health problem solvers. Thus, they hold the doctors in very high esteem as people that can be confided in. The medical profession also recognizes this:

> Secrecy is sacred to the profession. It is essential a patient tells you Everything you for diagnosis and treatment…. in cases of unwanted pregnancy, veneral disease for instance, he or she naturally and instinctively does not want it spread. It is not for you to tell it to anyone – not even to a husband or wife or brother or sister-inlaw.
>
> ((Mabayoje,1982:11) cited in Odebunmi 2003)

It should be noted however that some patients advertently conceal certain information from doctors for some reasons best known to them. All patients believe they would get sufficient care and kind attention from doctors. Consequently, most of them open up on their medical problems to doctors in anticipation of cooperation from doctors. The data contained some instances of this phenomenon:

Extract 92 (Interaction 35)

Doc.: Don't you a high temperature?

Pt.: **I do because when my body temperature rises, I feel a burning sensation all over my body.**

Doc.: Okay. Don't you have a headache?

Pt.; **I didn't have it before but it seems I have started having it.**

Doc.: Don't you vomit?

Pt.: **No.**

Doc.: What about stomach ache and diarrhea?

Pt.: **No. But sometimes when I feel the burning sensation, I feel a worm-like movement in my chest and in such moments the intensity of the burning sensation increases.**

Doc.: How old are you?

Pt.: **I am over forty years of age.**

Doc.: Are you married?

Pt.: **Yes.**

Doc.: How many children have you?

Pt.: **Six.**

Doc.: How many wives does your husband have?

Pt.: **Two.**

Doc.: Are you the first wife?

Pt.: **Yes.**

Doc.: What is your co-wife's occupation?

Pt.: **She sells food.**

Doc.: What's your husband's occupation?

Pt.: **Driver.**

Doc.: When did you have your last-born?

Pt.: **About two and half years ago.**

Doc.: Alright. Do you sleep well?

Pt.: **Yes, I do. But if I wake up in the night, I don't sleep again.**

Doc.: You see. There are three ways to describe sleeplessness. Is it that you find it impossible to sleep on time but sleep later or you sleep on time but wake up frequently, or you sleep on time but when wake up in the night you don't sleep again? So, which of them applies to you?

Pt.: **I sleep on time but once I wake up in the night, I don't sleep again.**

Doc.: Okay. Don't you have any other matter bothering your mind currently?

Pt.: **No. There is no other one apart from this burning sensation I feel all over my body.**

Doc.: So, it's just that. Don't you now experience a situation where things you liked to do before no longer appeal to you?

Pt.: **No.**

Doc.: Okay. Do you have sex regularly with your husband?

Pt.: **Yes. But what I also notice these days is that blood comes out of my vagina each time we have sex.**

Extract 93 (Interaction 42)

Doc.: Kin lo n se nyin? [What are your complaints?]

Pt.: **Ara mi n gbona gan-an. [I have a very high temperature.]**

Doc.: Lehin ara gbigbona, kin lo tun n se nyin? [What other complaints do you have apart from that?]

Pt.: **Idi tun n ta mi gan-an.[I feel a burning sensation in my anus.] O ti e tami gan-an lale ana ju. [I felt the burning sensation so much last night.]**

Doc.: Igbe lile t'eya lo je ki idi tan yin. [You feel the burning sensation because your stool is hard]. Se ara nyi si n gbona gan-an ni. [Do you still have high temperature now?]

Pt.: **Bee ni. Enu mi tun wa n kan. [Yes. My mouth also tastes bad.]**

Doc.: Se ara gbigbona yen wa before enu kikan ni. [Did the high body temperature start before the bad taste in the mouth?]

Pt.: **Bee ni. [Yes.]**

Doc.: Se o maa n wa o maa n lo ni? Abi o maa n gbona lati aaro dale? [Does the high temperature come intermittently or it continues from morning till evening?]

Pt.: **O maa n wa o maa n lo ni. [It comes intermittently.]**

Doc.: Se ori ko maa fo nyin? [Don't you have a headache?]

Pt.: Ori o fo mi. [No.]

Doc.: Se ito ko maa jo nyin nidi? [Don't you a burning sensation during urination?]

Pt.: **O maa n jo mi diedie. [I feel it lightly.]**

Doc.: Inu rirun n ko? [Do you suffer from stomach upset?]

Pt.: Rara. [No.]

As can be seen in Extracts 92 and 93, the patients freely explained their health challenges because they had the confidence that the doctors could treat them. The patients' emboldened contributions confirmed that they released all the information needed for diagnoses. Consequently, the doctors also reciprocated the patients' display of confidence in their professional capabilities by either recommending one type of test or another or prescribing some drugs to treat them. Grammatically, the ethical positivity tendency was realized by declaratives in the interactions as they were responses given in response to the doctors' queries.

5.5 Lexical and Grammatical Devices In Doctor-Patient Interactions and Communicative Functions – Collocation: Connecting Texts

This section considered the lexical analysis and description of the discourse devices deployed in the text. This is premised on the fact that a text functions based on the frequency of occurrence of the lexical features in it, and also because such lexical features in a text often say much more about the text than is obvious. This suggests that meaning is expressed in the choice of items. Thus, our focus here was to examine the various ways in which the deliberate use of particular lexical items realized meaning in the interactions under investigation. The investigation of the aspects of the lexical features reflected how the devices were used, how they contributed to the process of diagnosis and treatment, and how they enhanced meaning. Thesee were done under the following heading:

In this study, lexical cohesion was achieved through collocation. Lexical cohesion deals with how some words appear to move very closely together in a discourse. The mention of one word brings to mind the other or other members of the group. Such words are known as collocates, and they relate as natural companions. Therefore, they account for the connectivity of texts and provide collocative meaning. In other words, they express meaning within the text in relation to another. Consequently, certain lexical items followed each other consecutively in our data. The findings revealed that they were aptly used as they created cohesion, reinforced meaning and targeted a meaningful interpretation of the interactions. The said items were discussed under two categories: fixed and unfixed collocations.

Our data presented some examples of collocations whose meanings and structures are fixed. Examples of fixed collocation are idiomatic expressions and phrasal verbs. However, there were omly instances of phrasal verbs in the data. The following instances were considered:

Extract 94 (Interaction 26)

Doc.: Is this the first time you have **come to** this **hospital**?

Pt.: Yes.

Doc.: Were you ever **diagnosed with diabetes** or **hypertension**?

Pt.: Diabetes.

Doc.: Where do you treat it and what **drugs** are you taking **to cure** it?

Extract 95 (Interaction 32)

Doc.: And he doesn't **fall sick** from time to time.

Pt. Rel.: At all.

Doc.: Has he ever been **admitted in** a **hospital** before?

Pt. Rel.: No.

Doc.: Does he **react to** any **drug**?

Extract 96 (Interaction 35)

Doc.: Don't you have a **high temperature**?

Pt.: I do because when my body temperature rises, I feel a **burning sensation** all over my body.

Doc.: Okay. Don't you have a headache?

Each of the emboldened expressions in Extracts 94 and 95 above comprised a verb and a particle (**come to**, **diagnosed with**, **to cure**, **admitted in**, **react to**), which expressed meaning in relation to each other to make the text cohesive. Instances of word collocation were also observable in Extracts 94, 95 and 96. They involved words that went together in the discussion of diseases, hospital visit or admission, drugs, diagnosis, treatment etc. Such collocations include: **come to / hospital, diagnosed with hypertension or disbetes, drugs / cure, fall sick, admitted / hospital react to drugs, a high**

temperature, and **a burning sensation etc.** Therefore, collocation helped to make the texts cohesive individually and collectively.

Our data were also replete with instances of unfixed collocation, and they were classified according to the functions they performed. They are adjective/noun, verb/adjective/noun, verb/preposition collocates etc. Some examples of adjective/noun collocates showed that certain adjectives preceded certain nouns to premodify them. Some examples observable in our data are: **your mouth, blue card, several tests, systemic illnesses, burning sensation, two months, abdominal pain, more insulin, frequent urination, malarial drug, good morning** etc. There were also instances of noun/noun collocates in the data: **blood pressure, blood circulation etc**. The first occurring word in each phrase premodified the latter.

Emerging from the discussion of word collocations above is that collocations functioned variously to account for cohesion in our data by demonstrating interconnectivity in the sense of the lexical items. Put differently, they accounted for how the interlocutors in the doctor-patient discourse employed lexical items to create collocative cohesion in the discourse.

5.6 Grammatical Analysis

This section considered the grammatical analysis and description of the discourse devices in the texts. This is premised on the fact that a text functions based on the frequency of occurrence of grammatical features in it, and also because such grammatical features in a text often say much more about the text than is obvious. This suggests that meaning is expressed in the choice of items. Thus, our focus here was to examine the various ways in which the deliberate use of particular grammatical items realized meaning in the interactions under investigation. The investigation of aspects of grammatical features in the interactions revealed how they reflected the devices were used, how they contributed to the process of diagnosis and treatment, and how they enhanced meaning. This was done by examining the deployment of the various forms of modal auxiliaries and imperative sentences.

5.6.1 Modal Auxiliaries: Expression of Views, Opinions, Decisions and Expectations

As helping verbs, modal auxiliaries were employed in the interactions. They assisted both the doctors and patients in expressing their views, opinions, decisions and expectations. The following extracts were considered:

Extract 97a (Interaction 32)

Doc.: I **should** remove the milk teeth.

Extract 97b (Interaction 33)

Doc.: Let me have them. How many types of drug are you taking?

Pt.: Two.

Doc.: But I **can** see three types here.

Extract 98a (Interaction 33)

Doc.: I have added a particular type of small tablet to your drugs. It is highly beneficial to the heart. It aids blood circulation very well. So, it's important you take it especially as you don't have ulcer.

Pt.: I had it before but it was treated here.

Doc.: Since you had it before, it is not advisable you take the drug as it **could** cause a recurrence.

Extract 98b (Interaction 40)

Doc: I am asking this question because if we are not careful, we may not really know where the blood comes from.

Pt. I don't know.

Doc.: It looks like it is coming from that place but we have to be sure so that we don't use constricting thing. Unh? How many pampers do you use daily for him?

Pt.: Three.

Doc.: Three **might** be small for a child like this. So, what you have to do is let air blow on the place when you are at home. So, stop using pampers for him at home. It seems the problem emanated from enough air not blowing on the place.

Extract 99a (Interaction 38)

Doc.: If you come tomorrow, we **can** now look at the result and the drug you are taking, and compared them. There **might** be the need to just continue as you are taking the drugs and there **may** be need to increase the dose, depending on what the result says.

Extract 99b (Interaction 40)

Doc.: So, if I am getting you right, you have been have been having recurring body pain. I **will** treat you for malaria. Usually, when you are treated for malaria, does the pain go?

In Extract 97a, the doctor deployed the modal auxiliary **should** to express the patient's expected treatment. In Extract 97b, the doctor used **can** to express his view of the number of drugs the patient had brought to the hospital. In Extracts 98a and 98b, the doctors deployed **could** and **might** to express possibility. In Extract 98a, the doctor used **could** to warn the patient against the possibility of recurrence of ulcer if she took a drug that causes ulcer. Similarly, in Extract 98b, the doctor employed **might** to inform the patient's mother of the possible inadequacy of using only three pampers for her baby daily. In Extract 99a, the doctor used **can** to express his ability to examine the patient and his drugs during the next visit. He also used **may** and **might** to inform the patient about the need to comply with the prescriptions till a test was conducted to know the next line of action. Lastly, in Extract 99b, the doctor employed **will** to reveal his decision to treat the patient for malaria.

A perusal of the extracts above revealed that the use of the modal auxiliaries enabled the doctors and patients to express opinions, decisions, expectations, possibility, ability, permission and obligation in relation to the patients' health challenges.

5.6.2 Imperatives: Giving orders

As a sentence type, imperatives were also deployed in the interactions. Mainly employed by the doctors, they assisted them in isuing appropriate directives for the purposes of restoring or enhancing the patients' health. The following extracts were considered:

Extract 100 (Interaction 35)

Doc.: **Madam, go take the drugs I have recommended.** They will take care of all your complaints: Don't you see a white discharge in your private parts.

Extract 101 (Interaction 38)

Doc.: **So, go and take the test and bring the result.**

Extract 102 (Interaction 40)

Doc.: **Don't use anything.** It is just an allergy that might have resulted from the various strong creams you have used on him. So, all those rashes will disappear in due course. Just take to my advice.

Extract 103 (Interaction 27)

Doc.: **E sa maa lo o lo. [Just continue taking it.]E ni lati lootan. [You have to take all the drugs.**]Urinalysis nyin wa normal.[Your urinalysis is normal.] Iba nikan le ni.[The only have malaria.] Ki e lo oogun nyin daadaa, ki e jeun, ki e de tun rest dadadaa. [Take your drugs well, eat well and also rest well.] Titi ojo meta ara nyin a le. [You will be alright in three days' time.] Iru ise wo le n se? [What's your occupation?]

As can be seen in the extracts above, the doctors employed imperatives for various medical reasons. In Extract 100, the doctor deployed the imperative "**Madam, go take the drugs I have recommended**" to tell the patient the solution to her healt challenges. In Extract 101, the doctor used the imperative "**So, go and take the test and bring the result**" to tell the patient the step to take to enable him diagnose his ailment appropriately. In Extract 102, the doctor employed the embolened imperative "**Don't use anything.** It is just an allergy that might have resulted from the various strong creams you have used on him" to order the patien tostay away from applying any cream on her baby's body as the health challenge the patient's baby fced was just a reaction to some

strong creams the patient's mother had administered on the patient. Similarly, in Extract 103, the doctor deployed the imperative "**E sa maa lo o lo. [Just continue taking it.]E ni lati lootan. [You have to take all the drugs]**" to guide the aright on mediction. In essence, the deployment of the various imperaves enabled the doctors to stabilize the patients' health.

CHAPTER SIX

6.0. SUMMARY, CONCLU SION AND GENERALISATIONS

6.1. Summary of the Findings

Using discourse analysis, analyses of hospital verbal interactions between doctors and patients in the South-West and North-Central Geo-political zones of Nigeria have been carried out. The findings were presented and discussed under the following headings:

6.2 Discourse Devices and Communicative Functions

A total mumber of twelve discourse devices were deployed by the doctors and patients, nine and three respectively. The concerned discourse devices are: phatic communion, rapport expressions, direct questions, indirect questions, circumlocution, language switch, counselling, religious belief, answer, face-threatening acts, repetition and closing. Each of them was deployed to perform specific communicative functions during the clinical interviews, thus contributing to the success of the medical encounters.

6.3 Research Questiom 1: Which discourse devices are employed in the doctor-patient interactions, and what communicative functions do they perform?

A total number of twelve discourse devices were discovered to have been used in the interactions, each performing specific communicative functions. Their deployment aided the success of the various diagnostic sessions as all of them proceeded from opening to closing. Phatic communion was realized mostly by interrogatives involving elicitation of information on patients' health challenges and social lives. It performed the discourse function of opening the diagnostic interviews on a friendly note.

Circumlocution was employed mainly by the patients as they tended to beat about the bush when talking about their health challenges as a result of their lack of the appropriate medical terminologies for their medical conditions, being non-medical experts. Its use performed the communicative function of enabling the patients describe the symptoms of their ailments.

Rapport expressions were realized by Wh-elements, indirect questions and declaratives. They performed the discourse function of engendering conviviality and cordiality between the doctors and the patients. Chiefly employed by the doctors, they enabled the doctors to create an atmosphere conducive to releasing the critical information needed for diagnosis.

Language switch was realized by code-mixing and code-switching in the interactions. Its deployment performed the communicative function of making the discourses informative, mutual and explicit. It therefore enabled the interlocutors to avoid communication breakdown by using English words for drugs and medical procedures for which there are no second language equivalents in the indigenous languages involved in the discourses.

Counselling and religious beliefs were realized by declaratives and rhetorical questions. Their deployment exhibited an overlap of communicative functions as they both performed the communicative function of guiding, enlightening and encouraging the patients on wholesome health practices that could make them live healthily.

Direct and indirect questions were realized by interrogatives and declaratives respectively.They performed the communicative functions of eliciting information to get diagnoses. Even though both the direct and indirect questions were deployed to elicit information from the patients, indirect questions performed an additional discourse function of making the clinical interviews less stressful to enable the patients release all the information needed for accurate diagnoses.

Answer was realized by declaratives in all the interactions. It naturally followed all the questions and performed the discourse function of supplying the information required for diagnosis.

Repetition was realized by reiteration of same or similar expressions or ideas. Used mainly by the patients, it performed the discourse function of confirming or emphasizing certain items of information to draw the doctors' attention to complaints requiring urgent attention.

Closing was employed in all the interactions after information had been obtained on CC, HPI, FH, SH and OAP to bring each interview session to close in order to create time for the patients to procure drugs and, or go for some laboratory tests.

6.4 Research Question 2: How and by what means is politeness achieved in the interactions?

Face-threatening act with redress and face-threatening act without redress were used to realize politeness in the interactions. Generally, face-threatening acts were realized by declaratives and interrogatives involving frank talk, courteous expressions and reprimand. They performed the discourse function of checking and correcting the patients' unwholesome health practices. They also assisted the doctors in presenting their diagnoses to the patients harmlessly, and allaying the fears generated by the patients' ailments.

6.5 Research Question 3: Which politeness maxims are observable in the interactions?

The tact maxim, generosity maxim, sympathy maxim and the Pollyanna principle characterized the interactions. Realised by interrogatives and declaratives, the tact maxim performed the discourse function of enabling the doctors advise the patients, fraternize with them, and to give the patients more opportunity for medical attention

The sympathy and generosity maxims were also realized by interrogatives and declaratives. They performed the communicative function of advising, pitying and guiding the patients. However, the Pollyanna principle was realised mainly by declaratives, and it performed the discourse function of opening up the clinical interview sessions.

6.6 Research Question 4: Are there similarities and differences in the use of specific discourse devices between the two hospitals selected for this study, and how frequently are the discourse devices deployed?

The discourse devices employed by both the doctors and patients in the two hospitals selected for this work were examined to pinpoint the differences and similarities

observable in the interactions under study. In addition, the frequency of occurrence of these discourse devices in the interactions was examined by counting the number of times each of them was used and representing them in simple percentage terms. Therefore, based on the quantitative analysis of the data, these similarities and differences were calculated and analyzed accordingly.

The doctors and patients sampled in the two hospitals selected for this study employed practically the same discourse devices, but in varying degrees. Phatic communion and closing were employed 25 times each in both hospitals as their deployment was totally inevitable in the opening of every interaction. The frequency of occurrence of the deployment of direct questions by the doctors at UCH was 402 while that of UITH, Ilorin was 382. The differences in the frequency of occurrence were borne out of the fact that UCH doctors were more inquisitive. Consequently, they elicited more information from the patients to enrich their diagnoses in order to painstakingly address the patients' medical challenges.

UCH doctors employed indirect questions 34 times while UITH doctors employed them 28 times. UCH doctors used indirect questions more than those of UITH because they were more interested in making the clinical interview process less stressful by sounding less interrogative for the purpose of tacitly encouraging the patients to release all the information needed to make good diagnoses.

UCH and UITH patients used answer to supply the necessary information in response to the doctors' elicitation to enable them diagnose the patients' ailments, but in different degrees. UCH patients used answer 420 times while it was employed 417 times by UITH patients. The differences in the frequency of the occurrence resulted from non-provision of answers to some indirect questions by certain UITH patients.

Face-saving acts were employed 69 times by UCH doctors but were used 93 times by UITH doctors, thus showing that UITH doctors were more factual in the presentation of their diagnoses, medical advice and condemnation of unwholesome health practices than their UCH counterparts. Language switch was employed by UCH doctors 80 times and

63 times by UITH doctors. This showed that UCH doctors were more flexible linguistically to ensure a good comprehension of their discourse with the patients.

Rapport expressions were employed by UCH doctors 101 times while their UITH counterparts employed them 92 times. The pragmatic import of the differences in the frequency of occurrence is that UCH doctors were a little more given to promoting open communication between them and their patients than their UITH counterparts.

Circumlocution was employed by UCH patients 298 times while those of UITH used it 306 times. The differences in the frequency of occurrence are infinitesimal but then pointed out that UITH patients made greater efforts to explain their ailments. Religious belief was used by UCH doctors 14 times but UITH patients employed it 9 times. The differences in the frequency of occurrence arose from the fact UCH doctors viewed religion more as a salutary instrument for guidance and enlightenment than UITH doctors.

Lastly, UCH doctors employed counselling 72 times while UITH doctors used it 50 times. The disparity observable in the frequency of occurrence resulted from the fact that the former offered more medical advice and guidance than the latter. However, only UITH patients employed repetition, and it occurred 8 times. It can be deduced from the statistical analyses above that the differences between the frequency of the discourse devices deployed by UCH, Ibadan, and UITH, Ilorin are insignificant. This resulted from a number of factors. The doctors in the two hospitals had similar medical trainings, have the same cultural base, have same language mix and practice similar religions. Similarly, the patients share the same cultural base, have same language mix and practice similar religions.

6.7 Research Question 5: Which contextual factors manifested in the interactions at UCH, Ibadan, and UITH, Ilorin?

A number of contextual factors manifested in the interactions. Contextual factors such as setting, religion, linguistic background, power and social distance, and culture were examined and discussed. The study examined the effect of the status of the interlocutors,

location, language choice, religious belief and health practices of the interlocutors on the interactions.

The face-threatening acts analyses in 4.3 and 5.3 manifested an interplay of power and social distance as the doctors exclusively employed face-threatening acts with redress (positive politeness) and face-threatening acts without redress through the deployment of declaratives, interrogatives and imperatives involving frank talk, courteous expressions, direct and indirect expressions. The purpose was to upbraid the patients over some harmful health practices, enlighten them, emphasize the importance of certain medical procedures or make them cooperate fully with the doctors to make accurate diagnoses. The discourse device was also deployed to make them comply with treatment as a result of the doctors' position as +higher role occupants. The patients did not use any of the face-threatening acts as any attempt to do so would have been felicitously inappropriate, given their position as non-medical practitioners (–higher role occupants).

The religions of the interlocutors (Christianity and Islam) also played significant roles in the interactions as they somehow influenced some of their actions as evident in 4.16 and 5.2.7. The following extracts were considered:

Extract 98 (104) (Interaction 14)

Doc.: Do you feel abdomin- stomach pain.

Pt.: Yes. During Ramadan fast.

Doc.: Is it a mild stomach ache?

Pt.: No. It's always very painful.

Doc.: And you don't break the fast.

Pt.: No. Ramadan fast is a must for every true muslim.

Doc.: Madam, as a fellow muslim, I know The Quran exempts the sick from fasting. So, it is not right to fast when you are sick, when affects your health negatively like you explained. God knows more than we do about everything

concerning us, even our health. It is allowed in the Quran to provide food for those fasting if your health does not permit you to fast.

Pt.: I didn't know this before. Thank you.

Extract 99 (105) (Interaction 38)

Doc.: Mr. Nzeribe, do you think it's a sin to have told me you are fasting? Tell me your faith so that I should know how to counsel you appropriately.

Pt.: You know it is not right to fast and go about telling people.

Doc.: See, we have the same faith. I am also a Christian. When Jesus was teaching us about fasting, he said we should not let our fasting be like that of the Pharisees who will put ash on their heads and wear poor clothing, and then they would wear a long face that people might know they are fasting. You understand?

Pt.: Yes.

Doc.: You have not done that. The reason why you have told me you are fasting is because of your drugs. Is it not? It has not even shown on your face that you are fasting. So, it is not known to others except to me. And some people say doctors are next to God, I don't know about that. But I know we are working together. God is the one that heals but doctors try to take care of patients. How can I take care of you appropriately if I don't know the current situation that you are in? Now that you have told you are fasting, it has not stopped your fasting. You have not told me so that I should hail you, saying –this is a spiritual giant. You have not told me so that I would feel condemned or that you are a good Christian. No. The purpose of telling me is that I will be able to intervene in how you will be able to comply with your drugs so that you will not compromise your faith.

The extracts above revealed that Christianity and Islam practised by the patients made them engage in certain practices that were detrimental to their heath, but the doctors who were also adherents of the religions used their knowledge of the concerned religions to

guide the patients aright and educate them appropriately in areas where some misconceptions about their faiths impacted negatively on their health. Therefore, the religious backgrounds of the interlocutors aided the discourse as they enabled them to resolve certain challenges posed by religion in relation to the patients' health.

The culture of the interlocutors also manifested in the interactions as they employed both their indigenous languages (Yoruba and Pidgin English) in addition to English in the interactions. The following extracts were considered.

Extract 100 (106) (Interaction 1)

Doc.: Good morning, madam.

Pt.: Good morning.

Doc.: What are your complaints?

Pt.: Some years back, I had holes in some of my teeth, may be like three or four and they were filled and since then I have not been coming except when I come for scaling and polishing but of recent I realized that when I take cold water or sweet things, I started feeling some kind of mild pain. So, I started thinking may be the teeth that were filled have started giving way again. That's my complaint.

Extract 101 (107) (Interaction 31)

Doctor: Kin l'oruko nyin? [What is your name?]

Patient: Adijatu Olamide.

Doctor: Se e ti se ifunpa? [Have you done blood pressure test?]

Patient: Beeni. [Yes.]

Doctor: Kin lo n se nyin? [What complaints do you have?]

Patient: Mo kan waa mo boya nnkankan ko se mi ni. [I only came to know whether I am medically fit now.]

Extract 102 (108) (Interaction 34)

Doc.: Where did you get it? Did you buy it off the counter?

Pt.: Yes

Doc.: Those two weeks when it started, what were you doing?

Pt.: Nothing.

Doc.: Mo mean pe nigba to bere, kin le se? Se laaro ni, l'osan ni abi ale? **[I mean what did you do when it started?** Did it happen in the morning or afternoon?]

Pt.: Mi o take note. Mi o kan saa mo. **[I didn't take note. I just don't know.)**

Doc.: Okay time wo le notice? [Okay. What time did you notice it?]

Pt.: Two weeks ago.

Doc.: Kin le n se lowo? [What do you for a living now?]

Pt.: I am a civil servant.

A close look at the extracts above revealed the linguistic choices made by the interlocutors during the consultations. Depending on the status, area of language competence, level of education and preference of the interlocutors, English Language, Pidgin English and Yoruba Language were used during the consultations. The codes were also switched intrasententially and intersententially. In addition, the clinical interviews took place in hospitals, which can be categorized as a formal setting. Thus, English Language was employed in most of the interactions.

The culture of the interlocutors also reflected in the interactions. In Nigeria (the location of this study), as in other African nations, salutation is expected at the beginning and end of every conversation. The doctors, patients and patients' relatives demonstrated awareness of this cultural incidence as they exchanged greetings at the beginning and end of every conversation. The following extracts were considered:

Extract 103 (109) (Interaction 6)

Doc.: Good afternoon.

Pt.: Afternoon, ma.

Extract 104 (110) (Interaction 19)

Pt..: E see. [Thank you.] O dabo. {Bye bye.]

Doc.: O dabo. [Bye bye].

Extract 105 (111) (Interaction 29)

Doc.: E kaasan. [Good afternoon.]

Pt.: Yes, sir.

Extract 106 (112) (Interaction 35)

Doc.: Bye bye.

Pt.: Bye bye.

A perusal of the extracts above revealed that the interactions were opened and closed with greetings. In Extracts 103 and 105, the doctors opened the discourses with salutations, while Extracts 104 and 106 were also concluded with salutations. This therefore showed that the interlocutors observed this cultural ethic.

Extract 107 (113) (Interaction 27)

Doc.: Razak Bimbo.

Pt.: Ma.

Doc.: **E pele. [Sorry.]** Bawo lara yin? [How do you feel?] Se alaafia ni? [Are you alright?]

Pt.: Daadaa ni. [Fine.]

The expression 'Sorry' is culture-bound. As Nigerian English, it has taken on another meaning which is different from the meaning it has in places like USA and England.There, it is used to appease someone that has been affected by one's action.

However, it was used in the interactions under study in situations where the users had not caused the hearer any harm but only intends to show sympathy for and avowal of the patient's health challenges. In effect, the deployment of the rapport expression enabled the doctors to demonstrate empathy, sympathy and emotion to the patients, thus engendering cordiality with the patients for the medical objective of eliciting all the needed information to proffer appropriate solutions to the patients' medical challenges.

6.8 Generalisations

A perusal of the data revealed that certain discourse devices (phatic communion, question, religious belief, rapport expressions, face-threatening acts and politeness maxims were exclusively deployed by the doctors as a result of their position as +higher role occupants in the discourse setting by virtue of their knowledge of Medicine. In addition, at the grammatical level, imperatives were also exclusively deployed by the doctors. On the other hand too, certain discourse devices were exclusively used by the patients too as a result of their –higher role occupants in the discourse setting by virtue of their lack of knowledge of medicine.

The deployment of the discourse devices by the doctors, as seen in the present study, performed the communicative functions of assisting the doctors to: i) make good diagnoses, ii) reveal their diagnoses to the patients harmlessly, iii) obtain adequate information about the patients' history in order to make accurate diagnoses. Conversely, the discourse devices deployed by the patients enabled them also to (a) explain their medical challenges, (b) emphasize their pressing ailments to the doctors to enable them know how to intervene professionally, (c) respond to the doctors' queries by providing the pieces of information needed to make diagnoses and to (d); bring the the clinical interview sessions to a close.

6.9 Conclusion

This work has contributed to the existing knowledge in medical discourse in a number of ways. Firstly, it is a modest effort at studying the discourse devices deployed in doctor-patient verbal interactions for the purpose of understanding their communicative functions and how they aid doctors in their efforts to diagnose the patients' medical challenges, using discourse analysis. The study has revealed the actual discourse devices deployed by both doctors and patients during clinical interviews and also established their indispensability. In addition, the study has, among other things, highlighted: a) how politeness was achieved in the interactions, b) the actual politeness maxims employed in the interactions, c) the similarities and differences observable in the deployment of specific discourse devices in the two hospitals selected for the study and their frequency of occurrence; and d) the contextual factors operational in the interactions. All these were achieved through the synthesis of Brown and Levinson's (1987) politeness theory and insights from M.A.K. Halliday's Systemic Functional Linguistics, among others.

Lastly, by using rigorous methods and techniques, the study has demonstrated how Discourse Analysis can offer a sophisticated insight into the intricate world of Family Medicine. Consequently, it has deepened our understanding of doctor-patient discourse and revealed the indispensability of discourse devices in effective clinical discourse.

7.0 Limitations to the Study

This study lays no claim to being an exhaustive study on hospital verbal interactions as it has only studied verbal interactions of doctors with patients. It has, therefore, not studied the verbal interactions of other medical practitioners like: pharmacists, orthopaedists, nurses etc with patients.

7.1 Applications of the Study

There is no doubt that the success of health-care delivery relies heavily on biomedical factors in diagnosis and treatment. Therefore, communication performs a crucial function in the effectiveness of health-care. For example, the quality of the interactions between

doctors and patients can determine whether patients supply adequate and precise diagnostic information or not, and their subsequent compliance with prescribed treatment.

In addition, the findings of this study will undoubtedly tally with doctors' personal intuitive impressions about their contributions during diagnosis or diagnosis delivery as they will almost certainly realize that these practices reflect their own behaviour. These findings revealed these practices operate, and specify their probable pragmatic functions, by pin pointing the ways the different discourse devices manifested in the interactions. Consequently, they offered a sound basis for assessing the possible interactional and pragmatic consequences of employing one form instead of another.

In sum, a discourse analytic study of hospital verbal interactions engenders a better understanding of medical discourse. Therefore, this work promises to be of immense benefit to both practising doctors and trainee-doctors in view of its revelation of the linguistic tools that aid diagnosis, which the dctors can tap into to acquire sound communication skills to function effectively.

7.2 Suggestions for Further Studies

More studies can be carried out on the verbal interactions between other groups of medical professionals and patients. In addition, a study of verbal interactions between traditional healers and patients can also be undertaken. Any effort in these directions will, no doubt, complement this study.

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APPENDIX I

DATA COLLECTED AT THE UNIVERSITY COLLEGE HOSPITAL (UCH), IBADAN

INTERACTION 1

Doc.: Good morning, madam.

Pt.: Good morning.

Doc.: What are your complaints?

Pt,: Some years back, I had holes in some of my teeth, may be like three or four and they were filled and since then I have not been coming except when I come for scaling and polishing but of recent I realized that when I take cold water or sweet things, I started feeling some kind of mild pain. So, I started thinking may be the teeth that were filled have started giving way again. That's my complaint.

Doc.: Is it on this particular side (right) or generally?

Pt.: On the right side.

Doc.: On the lower or upper teeth?

Pt.: Lower here and upper here.

Doc.: The fillings were done here.

Pt.: Yes.

Doc.: For how long have you felt like this? Is it a recent thing?

Pt.: Recent. About a month ago.

Doc.: How will you describe the pain? Is it sharp or dull?

Pt.: Aaah, It's not a sharp pain but dull.

Doc.: Is it continuous?

Pt.: Ehn. For some time and then stops as long as I stop that thing. Most of the time immediately after food, I normally go quickly to get some salty water to…..

Doc.: And you feel better.

Pt.: Yes. I feel better.

Doc.: Do you take sweet?

Pt. Ehn. Like parago or chew gum.

Doc.: You chew it.

Pt.: Yes. I chew it (laughs)

Doc.: But don't you think you should leave sweet for children considering your age and the fact that sweet is not good for the teeth?

Pt. (Laughs) Yees. I try hard to stop it but I'm too used to it. I use mouthwash.

Doc.: Apart from sweet, what are your other food preferences? Do you like fast foods, like confectioneries?

Pt.: Very, very occasionally when I feel like taking them. Apart from that, I refrain from them.

Doc.: So, despite parago, you still maintain clean teeth.

Pt.: I brush my teeth after every meal and even before I go to sleep.

Doc.: You have a history of reaction to aspirin.

Pt.: Yes.

Doc.: So, what type of analgesic do you take?

Pt.: I take paracetamol.

Doc.: What type of toothpaste do you use?

Pt.: I use 'chewsticks' most of the time but use brush and toothpaste occasionally.

Doc.: Is it the hard or soft one?

Pt.: I use the soft one.

(Doctor recommends treatment)

INTERACTION 2

Doctor: Adeoia Busari !

Patient: E kaaro, sa. [Good morning, sir.]

Doctor: E kaaro. [Good morning.] Kin lohun to se nyin? [What health complaints do you have?]

Patient: Ori n fo mi. [I have a headache.]

Doctor: Se ifunpa nyin ko ga? [Do you have high body temperature?]

Patient: Rara. [No].

Doctor: Awon nnkan miran wo lotun nse nyin? [Any other complaints?]

Patient: Gbogbo ara n wo mi. [I experience general body weakness.]

Doctor: Maa ko awon oogun kan fun nyin. [I am going to recommend some drugs for you].

(Doctor recommends drugs)

INTERACTION 3

Doc.: How are you?

Pt.: I am fine.

Doc.: Why did you come this morning?

Pt. I have problem with my teeth.

Doc.: What kind of problem?

Pt.: Two of my teeth here -Two of my teeth are shaking as if they will remove.They are removing from inside. Two of the teeth have come out but they are not of the same level. So, it gives me pains.

Doc.: Is there any pain apart from that one?

Pt.: No.

Doc.: What kind of pain do you feel? Is it sharp or is it a severe pain? Is it a mild pain? What kind of pain?

Pt.: The pain is just there. It is not very sharp. It's just paining me any time I am talking.

Doc.: Does it come and go?

Pt.: It is always there. I feel the pain anytime I am eating

Doc.: Only when you chew, abi?

Pt.: Yes.

Doc.: In which part of your mouth do you feel the pain? Is it on the upper jaw or lower jaw?

Pt.: The two.

Doc.: Both sides.

Pt.: Yes.

Doc.: So, for how long have you had the pain now?

Pt.: It's been long?

Doc.: Around what time did it begin?

Pt.: May be last year.

Doc.: Do you have any medical problem?

Pt.; No

Doc.: You are not taking any drug for anything.

Doc.: What about the eczema on your face? How long have you had it?

Pt.; It's been long.

Doc.: What drug do you take to cure it?

Doc.: Griseovin.

Pt.: In what class are you?

Pt.: JSS 111.

Doc.: Which school?

Pt. Deeper Life Secondary School, Moniya.

Doc.: What's your position in your family?

Pt. Second.

Doc.: How many children?

Pt.: Three.

Doc.: Do you take sweet:

Pt.: That was before.

Doc.: So, you don't take it again. What about coke.

Pt.: I take it occasionally.

Doc.: How many times do you clean your teeth in a day?

Pt.: Once.

Doc.: How do you brush?

Pt.: I use toothbrush.

Doc.: How? In which direction?

Pt.: Anyhow. All around.

Doc.: Do you brush up and down?

Pt.: Up and down.

Doc.: Ok.

(Doctor recommends treatment)

INTERACTION 4

Doc.: What brought you here?

Pt.: It's my ear. It pains me a lot and I also perceive a drumming sound in it which makes it difficult for me to hear well.

Doc.: When did it begin?

Pt.: About three weeks now.

Doc.: Which of the ears?

Pt.: The left one.

Doc: Do you pick your ears with anything?

Pt.: Yes. Cotton bud.

Doc.: Is the pain very sharp?

Pt.: Yess.

Doc.: {Examines the ear) There is a lot of wax blocking your ear. Let me see the second one. When you pick your ear with cotton bud, does the cotton bud go in? You have difficulty hearing well because wax has blocked the whole ear. So, you will buy serumol eardrop and apply it in the ear. After applying it in one ear, you should wait for five minutes to allow it go in very well before you apply it in the second ear. You will do it for two weeks and then come back for a review. Do you understand me? When you apply the eardrop, it will soften the wax and you will see it coming out. Then, we will refer you to E.N.T. clinic where the syringing of the ear will be done for you.

Pt.: Okay, sir.

Doc.: Let us apply it for two weeks and see. How I wish I got a better instrument. I would have removed a lot of the wax to enable you start hearing well again. The eardrop costs about. #800. You will apply it for two weeks. If it gets exhausted, buy another one till you have used it for two weeks.

Pt.; Thank you, sir.

Doc.: Byebye.

INTERACTION 5

Doc.: How are you?

Pt.: Good morning. I am fine.

Doc.: What are your complaints?

Pt.: I have a pain here (Pointing to his mouth).

Doc.: Is it your upper or lower jaw?

Pt.: Lower jaw. I have done a test (Shows Doc. an X-ray).

Doc.: No problem. The X-ray is different. The X-ray - I will look at it. But then I need to ask you some questions and you have to like – give me the honest answers so that I can make my own impressions and I will look at the X-ray and I can tell you ----- do you understand. So, I'm sorry I'm going to start asking you questions afresh.

Pt.: Ok.

Doc.: You say you have pain in your teeth. Where?

Pt.: The lower jaw?

Doc.: The lower jaw. When did it begin?

Pt.: Ammmh. I think about two or three weeks ago.

Doc.: Two or three weeks ago. Has it been constant. Or, It has been coming and going.

Pt.: Constant.

Doc: You feel it in the morning, feel it in the afternoon and night.

Pt. No. I feel it once and it goes.

Doc.: It comes and goes.

Pt.: Yes.

Doc.: When it comes, how long does it last before it goes?

Pt.: Two days.

Doc.; It comes and lasts for two days. Do you feel pains now?

Pt.: No.

Doc.: When did the stop?

Pt.: About two weeks ago.

Doc.: So, can you describe the pain to me? Is it sharp?

Pt.: It is not all that sharp.

Doc.: Does the pain start on its own or something makes it start?

Pt.: It starts on its own.

Doc.: It starts on its own.

Pt.: Yes.

Doc.: Has it ever stopped you from sleeping or waking you up from sleep?

Pt.: No.

Doc.: So, it's not disturbing your sleep? You sleep well.

Pt.: Yes.

Doc.: When you have the pain, it stops at night. It has never ever woken you up from sleep. It has never stopped you from sleeping your usual time.

Pt.: No.

Doc.: Never. Ok. What and what have you taken to stop or relieve the pain?

Pt.: I was given some tablets at a hospital and I take one per night.

Doc.: Do you know the name of the drug?

Pt. No.

Doc.: You can't remember it. Se you are taking one tablet one per night?

Pt.: Yes. One per night.

Doc.: Apart from that, what else have you done?

Pt.: I went to a hospital around my home.

Doc.: Have you ever seen a general practitioner before or are you seeing one now?

Pt.: No.

Doc.: Apart from this, have ever been to any dental hospital before?

Pt.: No.

Doc.: Do you have a sickness in your body that is making you see a doctor now?

Pt.: No.

Doc.: Ok, sir. All your life, have you been seen any doctor for any ailment?

Pt.: MOP.

Doc.: When was that?

Pt.: Six years ago.

Doc.: When did you go to see a doctor then? What was the reason?

Pt..: July 2010 for convulsion.

Doc.: So, apart from the drug you were given at MOP, are you taking any other drug?

Pt.: No.

Doc.: Are you hypertensive or diabetic?

Pt.: No.

Doc.: Are you epileptic?

Pt.: No.

Doc.: You are sure.

Pt,: Yes.

Doc.: But you were having convulsion that time. What was the reason?

Pt.: I don't know.

Doc.: And that was the first time. It has stopped?

Pt.: Yes.

Doc.: Is there any drug your body doesn't tolerate?

Pt,: No.

Doc.: So, you can take any kind of drug.

Pt.: Of course

Doc.: Have you been admitted in a particular hospital recently apart from this particular one?

Pt.: No.

Doc.: Had you had an operation before?

Pt.: No.

Doc.: Not at all. How many times do you brush in a day?

Pt.: Twice - morning and night.

Doc.: Do you use toothbrush or chewstick?

Pt.: Yes.

Doc.: How do you now, brush in a day? Can you demonstrate it?

Pt.: I brush it up, down, the corners.

Doc.: Ok. So, what kind of toothbrush do you use now? Is it soft or very soft?

Pt.: Very soft brush.

Doc.: Were you told to buy soft toothbrush? Or do you know the name of the toothbrush?

Pt.: No.

Doc.: So, when you are buying a toothbrush, check the packet to ensure 'medium' is written on it.

Pt.: Ok. Thank you.

Doc.: Next time when you are buying a toothbrush, make sure you look at the inscription on the packet because we have soft, medium and hard. Always use the medium one. It's the best for you. The soft is for children while the medium is for adult. Don't use the hard one because it damages your teeth. It scrapes off part of your teeth.

Pt.: Thank you.

Doc.: You are married, I guess.

Pt.: Yes.

Doc.: What do you do for a living? What's your occupation? What's your job?

Pt.: I am retired. I retired at John Holt.

Doc.: What about your wife?

Pt.: She is a headmistress.

Doc.: Headmistress of a school. I she still in service.

Pt.: She is still in service. She works at Idi-Ikan.

Doc.: Idi-Ikan. How many children do you have?

Pt.: Four.

Doc.: But you are not yet a grandfather?

Pt.: I am.

Doc.: Whao! Do you take alcoholic drinks?

Pt.: Not all the time.

Doc.: Like how often do you take it?

Pt.: Occasionally.

Doc.: Occasionally. Do you mean like once every week, twice in a week?

Pt. Only during weekends.

Doc.: Weekends only. How many bottles do you take? One, two?

Pt.: One bottle.

Doc.: What type of beer?

Pt.: Star.

Doc.: Do you smoke?

Pt.; No, I don't.

Doc.; Do you take a lot of kolanut?

Pt. Kolanut? No.

Doc.: Do you take a lot of beverages – like bournvita, milo?

Pt.: Milo.

Doc..: Bournvita. Plenty or normally?

Pt. Plenty.

Doc.: Do you take coffee?

Pt.: Occasionally.

Doc.: What about lipton tea?

Pt.: Yes.

Doc.: Thank you

Pt.: Thank you.

INTERACTION 6

Doc.: Good afternoon.

Pt.: Afternoon, ma.

Doc. Where is your blue card?

Pt.: Here is it.

Doc.: Is this the first time you have come to this hospital?

Pt.: Yes.

Doc.: Were you ever diagnosed with diabetes or hypertension?

Pt.: Diabetes.

Doc.: Where do you treat it and what drugs are you taking to cure it?

Pt.: The drugs I was given are in my bag.

Doc.: Go bring them.

Pt. (Hands over the drugs to the doctor)

Doc.: So, these are the drugs you were given. Where do you treat yourself?

Pt.: Sadiku.

Doc.: When was the last time you went there for treatment?

Pt.: About two months ago.

Doc.: Then why did she change to this hospital.

Pt. Rel.: Because I attend this hospital.

Doc.: Doc.: So, she wants to attend the same hospital with you.

Pt. Rel.: Yes.

Doc.: There is no problem. The only thing is that we would be giving her appointment and she must be coming

Pt.: Thank you.

INTERACTION 7

Doc.: What do you do?

Pt.: I am a student.

Doc.: What name does your friend call you?

Pt.: PF

Doc.: So, why are you here today?

Pt.: My teeth.

Doc.: What's wrong with your teeth?

Pt.: There is one at the back of another teeth.

Doc.: Is it that you just don't like it.

Pt.: Yes.

Doc.: Since when did you notice this one?

Pt.: Since last year.

Doc.: Since last year?

Doc.: Do you have any medical condition you go to the doctor for?

Pt.: No. I don't fall sick.

Doc.: Any drug your body doesn't like?

Pt.: There is none.

Doc.: In what class are you?

Pt.: JSS One.

Doc.: What's the name of your school?

Pt.: Francis 'M' School.

Doc.: Frances 'M' School. Where is your school? Is it in Ibadan?

Pt.: Yes. Agbowo.

Doc.: Francis 'M' School in Agbowo. Do you take all these sugar……?

Pt.: I don't like sugar.

Doc.: But you like sweet things a lot, abi?

Pt. Sometimes.

Doc.: Like every day.

Pt.: Not every day.

Doc.: How many times do you brush in a day?

Pt.: Once.

Doc.: In the morning?

Pt.: Yes.

Doc.: So, you don't brush in the evening.

Pt.: Yes.

Doc.: What work does your mummy do?

Pt.: She is a civil servant.

Doc.: What about the father?

Pt.: Medical doctor.

(Doctor recommends treatment)

INTERACTION 8

Doc.: What is your name?

Pt.: Audu Lateef.

Doc.: What is your complaint?

Pt.: I have high blood pressue.

Doc.: When was the last time you came here?

Pt.: It's a long time ago.

Doc.: Why, sir?

Pt.; I travelled to Lagos.

Doc.: How many months did you spend there?

Pt.: Two months.

Doc. The last time you came here was in June and this is November. Your blood pressure is always very high – 170/100. Do you take your drugs?

Pt.: Yes, I do.:

Doc.: Where are the drugs?

Pt.: They are in my bag.

Doc.: Bring them out. Let me see them.(Looks at the drugs) You need to pay a very good attention to your health because of the terrible conditions that may result from having untreated hypertension – diabetes, stroke etc. You are not healthy yet you could go on visit to as far as Lagos. You need to come for check-up monthly.

Pt.: Thank you.

Doc.: We ask you to come once in a month, twelve times in a year. I do think this is too much a sacrifice for your health. Please, pay attention to your health.

Pt.: I am very grateful for your concern over my health. May God be with you.

Doc.: Even if you want to go on pilgrimage to Mecca, you should be able to carry your doctor along as he will be able to package you well by giving you drugs that could last you till you arrive. And immediately you come back, you go see him for a check-up.That way you will be able to maintain a good health.

Pt.: Thank you. I will be more careful next time.

Doc.: (Checks his blood pressure) Your blood pressure is too high.

Pt.: Ah.

Doc.: You need to reduce your salt intake. Add a lot of locust beans to your soup. It is good if you can avoid adding salt to your food.

Pt.: What about magi?

Doc.: Very little quantity. That's why I locust beans for you. It is better than maggi.

Pt.: You mean I should stop taking magi completely.

Doc.: Yes. If you must use it at all, it must be a very small quantity.

Doc.: You have to see us next week Tuesday by all means for a check-up, and your blood pressure must have come down before then.

Pt.: It will.

Doc.: That's if you take your drugs. Do you sleep well?

Pt.: I sleep well.

Doc.: That is alright. You should cut each of these tablets into two and then take one in the morning and one of these small ones. I have asked you to take it in the morning because it will make you urinate a lot. So, if you take it in the evening, the frequent urination will disturb your sleep and that could aggravate your already high blood pressure. So, go take the tablets now.

Pt.: Thank you.

Doc.: Please, take good care of yourself.

Pt.: Thank you and God bless.

INTERACTION 9

Doc.: Good morning.

Pt.: Good morning, ma.

Doc.: What do you do?

Pt.: I am processing my admission.

Doc,; You are processing your admission. What do you want to read?

Pt.: Economics.

Doc.: Economics. What's the complaint?

Pt.: I feel pains in my eyes.

Doc.: Does it tear?

Pt.: Yes.

Doc.: Does the eye itch you?

Pt.: Yes.

Doc.: It itches you. Does it turn red?

Pt.: Yes.

Doc.: Does anyone in your family have this type of condition?

Pt.: Yes. My younger brother.

Doc.: He also has itchy eyes. Do you react to something like smokes?

Pt.: Sometimes.

Doc.: Do you react to dust? Do you have skin rashes?

Pt. Yes.

Doc.: Where do you sit in class – back, in the middle or in front?

Pt.: the middle.

Doc.: And you see the board very well.

Pt.: Not very well sometimes.

Doc.: So, what have you done about the eyes?

Pt.: I use chloramphenicol eyedrop.

Doc.: And it has not changed anything.

Pt.: Yes.

Doc.: Does anybody in your family have eye problem.

Pt. Yes .My parents.

Doc.: Do they use glasses?

Pt.: Yes. My mummy uses glasses.

Doc.: So, you think your own eyes too may need glasses.

Pt.: No - no.

Doc.: You don't want glasses.

Pt.: No.

Doc.: I will examine your eyes. Then, you will go to the nurses. You will read a chart so we can see how well your eyes can see and then, we will know what next to do by the time I see your – we call it visual acuity.

Pt.: Ok.

Doc.: Have you been admitted before for any reason?

Pt.: No.

Doc.: Are you asthmatic.

Pt.: No.

Doc.: Do you have any allergies to drugs or anything?

Pt.: No.

Doc: Is there any drug that you react to?

Pt.: Yes, like chloroquine.

Doc.; What does it do?

Pt.: It itches me.

Doc.: Ok. Apart from that, have you been transfused before?

Pt.: No.

Doc.: Any surgery in the past,

Pt.: No.

Doc.: It's alright. Go and do the visual acuity and we will know what to do next.

Pt.: Thank you.

INTERACTION 10

Doc.: Kin l'oruko nyin? [What is your name?]

Pt.: Shola Ola.

Doc.: Kin lo se nyin? [What is your complaint?]

Pt.: Aya n ro mi gan-an, inu sit un n ta mi. [I have serious chest paint and I also feel burning sensation in my stomach]. Egbe ori kan si tun n ta mi, ese mi si tun n ku riri. [I also feel aburning sensation on a side of my head as well as cramps in my feet.]

Doc.: Se e ti se ifunpaa nyin? [Have you done blood pressure test?]

Pt.: Rara. [No.]

Doc.: E maa lo se awon test kan ti maa ko bayii. [You will to do some tests that I will recommend now.] E mu esii re wa nigba to ba jade. [Bring the results to me when they are out.]

INTERACTION 11

Doc.: Kin l'oruko nyin? [What is your name?]

Pt.: Shola Ola.

Doc.: Kin lo se nyin? [What is your complaint?]

Pt.: Aya n ro mi gan-an, inu sit un n ta mi. [I have serious chest paint and I also feel burning sensation in my stomach]. Egbe ori kan si tun n ta mi, ese mi si tun n ku riri. [I also feel a burning sensation on a side of my head as well as cramps in my feet.]

Doc.: Se e ti se ifunpaa nyin? [Have you done blood pressure test?]

Pt.: Rara. [No.]

Doc.: E maa lo se awon test kan ti maa ko bayii. [You will to do some tests that I will recommend now.] E mu esii re wa nigba to ba jade. [Bring the results to me when they are out.]

INTERACTION 12

Doc.: What brought you here?

Pt.: I spit too frequently.

Doc.: Are you nauseated?

Pt.: Yes.

Doc.: Do you have ulcer?

Pt.: No.

Doc.: How frequently do you urinate at night? Is it up to four, five times?

Pt.: Sometimes four or five times.

Doc.: Okay. I will recommend some tests you will do now and you will bring the results to me when they are ready.

Pt.: It's alright.

INTERACTION 13

Doc.: Sit down here.

Pt.: Ok.

Doc.: How are you today?

Pt.: Thank God. I am coping.

Doc.: Se e ti lo gba awon result yen? [Have you collected the medical test result?]

Pt.: Yes. I was around last week but I was told to come back this morning.

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

Pt. : Ok. I drink a lot.

Doc.: You have to stop it.

Pt.: You know a day to that incident I came back from South Africa and took some concoction of bitter leaf. I drank a lot of it.

Doc.: You see. The only thing is that you don't know dose you should take. We know that bitter leaf has some medicinal value but at the same time you don't know the dose that you are taking. You know that whatever you take will go through the liver and if there is a stress on the liver and you now come to add another to it, it can make the liver break down. So, watch what you take – drugs, herbal medicine – most of which do not have any specific dosage. If you can watch all these, you will be alright. So, from what I've seen now, there is no reason for you to be anxious or afraid.

Pt.; Okay.

Doc.: The other thing we can do is to carry out a liver function test. That will tell us how well the liver is doing. If there is any insult that the liver is reacting to, it will show. it will show in the liver function test and then we will know how to manage it. The colour of your eyes is not changing.

Pt.: Yes.

Doc.: And the colour of your stool has not changed too?

Pt.: Yes.

Doc.: So, the only thing we should just do is the liver function test. With all these I have seen, you have no cause to be afraid.

Pt.: Then, I also experience itching,

Doc.: Did you ever have it before?

Pt.; Yes.

Doc.: where do you feel the itching?

Pt.: In my palms.

Doc.: [Checks patient's case note] Bilateral itching on both palms.

Pt.: Yes.

Doc.: This type of itching has nothing to do with the liver. The kind of itching that the liver problem causes is on the skin. It is generalized. It is not restricted to any part. What could be causing itching on your palm could be some kind of allergies. Probably you come in contact with something that irritates your palm and then itching results. That might be an allergic thing. But if you are talking about a disease, it will affect the whole system - systemic- not just localized.

Pt.: So, with this kind of situation now, should I - since I started coming here, I have stopped having any sexual contact with my wife just to know my fate because I don't want her to catch the infection.

Doc.: Ok. The thing about hepatitis B is that it can actually be sexually transmitted the same way HIV is transmitted. In addition, if gets blood product from an infected person or if one share a sharp object with an infected person, one could have - needles, blades etc. In fact, it has been said that the virus in hepatitis B stays longer on objects than that in HIV. May be about 30 minutes, the HIV virus will have died but that of hepatitis B can stay alive for months. So, it's better to have your own clipper, blade etc.

Pt.: That's another area.

Doc.: Has your wife been tested for hepatitis B?

Pt.: No.

Doc.: Let her do a test. Let her know her own status as well. You never can tell whether she's negative or positive. You understand. Also, we have barrier methods like condom.

Pt.: You are right. We have even stopped childbearing.

Doc.: How old is your last born?

Pt.: Fourteen years.

Doc.; Does your wife use any family planning method like contraceptive?

Pt.: No, She doesn't. She has reached menopause.

Doc.: She has reached menopause.

Pt.: Yes.

Doc.: Ok. The first thing, let her do the test to know what her status is. You understand?

Pt.: Yes.

Doc.: So that you don't deny yourself unnecessarily. Let her do the test not only for hepatitis bur for HIV as well. HIV test is free. So,why not?

Pt.: Ok. I f she will want to do it.

Doc.: Encourage her. We can't force anyone to do any test.

Pt.: Alright. She's a cool-headed person.

Doc.: Does she know about your hepatitis status?

Pt.: Yes. I told her about it.

Doc.: Since there is nothing to hide, let her also do the test. Then if she is negative, then she can take immunization, and she will be protected for life. You understand.

Pt.: Yes.

Doc.: And if she tests positive, there is no problem.

Pt.: You mean there is a vaccine for it?

Doc.: Yes. There is a vaccine against hepatitis. Anybody that is hepatitis B negative can take vaccine – three doses. If you come first, we give you one. Then, in a month's time, we give you another one, and then in six month's time, we give you another one. Those three doses will give you a life-time immunity. So, if she's negative let her get immunized.

Pt,: Cant I also take the vaccine?

Doc.; No. Once you are hepatitis B positive, you cannot take the injection because you already have the disease. Before one gets the disease, one can get immunized. It's like giving a little dose of this virus in the – non-infective style. I don't know how to explain it. It's like when you immunize someone against TB. It's like giving a person a little dose of that infective substance so that the body should develop immunity against it.

Pt.: That's wonderful.

Doc.: So, that when the infection comes, the army in the body will quickly stand up against it and then kill it. Let her get tested. If she is negative, she gets immunized. If she is positive, nothing to lose.

Pt.: It is clear.

Doc.: So, the only thing I will do now is to give you a form for liver function test. Do it. There is no emergency in it. So, it's not as if you must do it now. I will give you a form and then you do it and bring it.

Pt.: Can we do it here or?

Doc.: No. You do it here. We do it in the Chemical Pathology Department. I will give you a form to do it.

Pt.; It's okay.

Doc.: NHIS covers it. For now, that's it.

Doc.: You also complained of hypertension.

Pt.: Yes.

Doc.: Let me take your blood pressure. [Doctor takes his blood pressure.]Do you take your drug regularly?

Pt.: I skip it sometimes.

Doc.: You need to take them regularly because hypertension is a silent killer. Most of the time, it doesn't show any signs. By the time it is showing symptoms, it is very severe. So, the fact that you sleep well, you have no headache does not mean you shouldn't take your drugs.

Pt.: Ok. I just stopped when I felt I was okay.

Doc.: Continue taking them. Your blood pressure is only a little high -144 /100. I think it's a reflection of the fact that you are not utaking your drug.

Pt.: I will start taking it again.

Doc.: It's very important. One tablet of moduretic a day Is not too much.

Pt. Thank you.

Doc.: What other complaint do you have?

Pt.: There is none again.

Doc.: You look younger than your age.

Pt.: Do I?

Doc.: Yes and you always come in T-shirts.

Pt.: It's my style of dressing. Thank you, doctor.

Doc.: Bye bye.

INTERACTION 14

Doc.: How are you today?

Pt.: I am fine.

Doc.: Do you have any complaints?

Pt.: There is no problem really. I just feel something is moving about in my body.

Doc.: The sensation you feel. What is it really? What is it exactly? What do you feel?

Pt.: I feel a crawling movement in my body about twice a day.

Doc.: When did it begin?

Pt.: About two months ago.

Doc.: Is that the only complaint?

Pt.: No. I also have cough.

Doc.: The last time you came you complained of cough.

Pt.: Yes. I was given some tables but it has not gone completely.

Doc.: Ok. How old are you?

Pt.: I am fifty-two.

Doc.: You are Yoruba?

Pt.: Yes.

Doc.: What do you do?

Pt.: Teaching.

Doc.: A teacher. Primary or secondary?

Pt.: Primary.

Doc.: You are married?

Pt.: Yes.

Doc.: My record here shows you live at Akanran Road.

Pt.: Yes.

Doc.: You were recently diagnosed to have elevated BP.

Pt.: Yes.

Doc.: When did you last check your BP?

Pt.: Last month.

Doc.: Before then you had never checked your BP and when you did so the last time, you were told it was elevated.

Pt.: Yes.

Doc.: Are you still seeing your period?

Pt,: No.

Doc.: How many years ago did it stop?

Pt.: Between two and three years ago.

Doc.: Do you experience occasional bleeding?

Pt.: No.

Doc.: And in your feet, you don't feel cramps?

Pt.: No.

Pt.: When I travel on long distances.

Doc.: That's after you have kept your legs in the same position for some time.

Pt.: Yes.

Pt.: Okay. So, generally, how do you feel? Do you sleeping well?

Doc.: Yes.

Pt.: And you eat well?

Pt.: Yes. I do.

Doc.: Do you feel abdomin- stomach pain.

Pt.: Yes. During Ramadan fast.

Doc.: Is it a mild stomach ache?

Pt.: No. It's always very painful.

Doc.: And you don't break the fast.

Pt.: No. Ramadan fast is a must for every true muslim.

Doc.: Madam, as a fellow muslim, I know The Quran exempts the sick from fasting. So, it is not right to fast when you are sick, when affects your health negatively like

you explained. God knows more than we do about everything concerning us, even our health. It is allowed in the Quran to provide food for those fasting if your health does not permit you to fast.

Pt.: I didn't know this before. Thank you.

Doc.: How are you going to toilet.

Pt.: I go to toilet regularly.

Doc.: How often? Everyday, once a week?

Pt.: Sometimes daily or once in two days.

Doc.: Is it hard or soft.

Pt.: Soft.

Doc.: How many children do you have?

Pt.: Three.

Doc.: How many times have you been pregnant?

Pt.: Five times.

Doc.: What happened to two of the pregnancies? Did you have any miscarriage?

Pt. The babies died shortly before birth.

Doc.: How many male and female children do you have?

Pt.: One male and two females.

Doc.: Is your firstborn a male or female?

Pt.: Male. He is a doctor too.

Doc.: So, the remaining two are females. Are they married?

Pt.: One of them is married while one is undergoing National Youth Service.

Doc.: How many children the married female have?

Pt.: One.

Doc.: Girl or boy?

Pt.: Boy.

Doc.: How old?

Pt.: Seven months.

Doc.: Is she your youngest child?

Pt.: Yes.

Doc.: Where is your husband?

Pt.: He has gone.

Doc.: At what age?

Pt.: Fifty-three.

Doc.: What happened?

Pt.: He developed anaemia and after some time, he died.

Doc.: Are your parents alive?

Pt.: No.

Doc.: At what age did they die?

Pt.: My daddy 86.My mummy 83.

Doc.: So, they grew old. Do you know whether they had hypertension, diabetes? What was the cause of their death?

Pt.: My mother suddenly collapsed and was rushed to a hospital where she died about three days later. My dad had an accident at a party and died.

Doc.: Do you have brothers and sisters?

Pt: Yes.

Doc.; How many are they?

Pt.: Seven.

Doc.: So, what's your position?

Pt.: I am the firstborn.

Doc.: What's the sex of the second born?

Pt.: A female.

Doc.: Is she married and how old is she?

Pt.: She's married and she is forty-two.

Doc.: How many children does she have?

Pt.: Three.

Doc.: Any health problem?

Pt.: None.

Doc.: Right now, who lives with you?

Pt.: One of my cousins.

Doc.: So, apart from these prescribed drugs, what other drugs are you tasking – or herbal medicines?

Pt.: I take 'efinrin' and 'ewuro'.

Doc.: What do you take them for?

Pt.: I take them after taking sugary things.Some people say they are very good.

Doc.: Do you take alcohol?

Pt.: No.

Doc.: It's alright. I'm going to examine you to check your BP but before that I want you to do a urine test. It's a basic test that the nurse will do for you to know whether there are foreign things in your urine and then we combine the result with all these to have a whole picture of what is happening.

Pt.: Yes. Yes. They will give you a bottle to do it now.

Doc.: So, when you are done, bring the result to me. I will be here.

Pt.: Thank you.

INTERACTION 15

Doc.: What's the complaint?

Pt.: Last night, I could not sleep.

Doc.: Last night you could not sleep. Everything started last night.

Doc.: That's the only thing. Pains all over your body? Do you feel feverish?

Pt.: Yes.

Doc.: Headache?

Pt.: Yes.

Doc.: So, what drugs have you taken?

Pt.: Moduretic.

Doc.: Are you hypertensive?

Pt.; Yes.

Doc.: Since when?

Pt.: That should be 2005.

Doc.: So, apart from moduretic, you don't take any other drug.

Pt. Yes.

Doc.: You are not diabetic.

Pt.: No. I don't think so.

Doc.: Any pain in your tummy?

Pt.: No.

Doc.: Any cough?

Pt.: No.

Doc.: Any chest pain?

Pt.: Yes. Sometimes when I sleep, I feel chest pain.

Doc.: Do you sometimes feel pain when you urinate?

Pt.: I do.

Doc.: When was the last time you felt pain when you urinated?

Pt.: It's been long.

Doc.: It's been long. How long?

Pt.: Last year.

Doc.: And what did you do about it?

Pt.: I went to a hospital where the doctor prescribed malarial drugs.

Doc.: Actually, what I want to know is whether during the last one week you felt pain during urination as this is very important to unravelling the cause of your body pains.

Pt.: I feel pains during urination at times.

Doc.: What's the colour of your urine?

Pt.: Yellow.

Doc.: Now, this pain that you have during urination, since when have you been having this current one?

Pt.: Yesterday.

Doc.: Do you notice any abnormal discharge during your urination?

Pt.: No.

Doc.: What's your name?

Pt.: Bakare.

Doc.: Ok. Did you have sexual intercourse recently?

Pt.: Like last week.

Doc.; Alright. You will take form to the nurses. I want us to do urinalysis. It will show if there is infection in your urine. If there evidence of infection in that test, then you will have to take another test. In addition, they will measure your height and weight. In fact, they should have taken all the vital signs before you came here. After that, I will take your blood pressure myself.

Pt.: Thank you.

INTERACTION 16

Doc.: Good afternoon.

Pt.: Good afternoong, Sir.

Doc.: What's your name?

Pt.: I am Ade Titi.

Doc.: Okay. Is this your first time?

Pt.: Yes. For about two weeks now, I have been experiencing this strange movement in my ear.

Doc.: In your ear.

Pt.: Yes. The thing is breathing. I am feeling it is breathing.

Doc.: How many days ago did it start?

Pt.: About two weeks now.

Doc.: Two weeks. Just the right one or both of them?

Pt.: I feel it inside. Most of the time, I feel like something is echoing in my ear. Sometimes, if I yearn, the thing would open, later it will come back.

Doc.: Okay.

Pt.: Then, I feel as if I used cotton wool to block it. Sometimes too, if I don't listen very well, I can't hear.

Doc.: Okay.

Pt.: So, the day before yesterday, I started using gentamycin.

Doc.: Gentamycin eardrop or injection?

Pt.: Eardrop.

Doc.: Where did you get it? Did you buy it off the counter?

Pt.: Yes

Doc.: Those two weeks when it started, what were you doing?

Pt.: Nothing.

Doc.: Mo mean pe nigba to bere, kin le se? Se laaro ni , l'osan ni abi ale? [I mean what did you do when it started? Did it happen in the morning or afternoon?]

Pt.: Mi o take note. Mo kan saa mo. [I didn't take note. I just don't know.)

Doc.: Okay time wo le notice? [Okay. What time did you notice it?

Pt.: Two weeks ago.

Doc.: Kin le n se lowo? What do you do? [What do you for a living?]

Pt.: I am a civil servant.

Doc.: What's your job description?

Pt.: I work where number plates and drivers' license are issued.

Doc.: Okay. Not with FRSC.

Pt.: No, I work with the Licensing Office, under Oyo State Government – Board of Internal Revenue.

Doc.: ki n de se pe ariwo po? Kii se pe e wa nibi'se nigba to bere? [Is the cause of your illness not traceable to too much noise? Were you not at work when it began?]

Pt.: Rara. All of a sudden ni mo kan ripe eti yen n yo mi lenu.[No, the ear just suddenly began to hurt.]

Doc.: Okay

Pt.: Kii se pe mi o gbpran rara o.[Not that I am completely deaf.]

Doc.: Mo understand nnkan t'e n so, sugbon o maa n sele tomi ba kosi eeyan leti. Igba miran t'eeyan ba travel. [I can understand you. But things like this caused by travels or when water enters the ear.]

Pt.: Igba miran ti mo ba lo fo'run, o maa n se bee. O si maa si pada. Sugbon eleyi ko se bee. [It does happen when I wash my hair and I feel a respite shortly afterwards but the present one is much different.]

Doc.: No pain in your throat?

Pt.: No pain.

Doc.: Did you have sore throat around that time?

Pt.: No.

Doc.: What about catarrh?

Pt.: No.

Doc.: Okay.

Pt.: Mo le ni catarrh ki n ma mo.[I might have catarrh without knowing it.]

Doc.: Okay.

Pt. Mo feel bii ki cloud wa lofun eeyan. Bii ki n maa try lati clear ofun mi. [I feel as if something were blocking my throat.]

Doc.: O maa n dabii pe nnkan wa nibe. [It's like something is blocking it.]

Pt.: Beeni. [Yes.]

Doc.: Se okan ki n rin nyin? [Do you have nausea?]

Pt.: O maa n se mi bii ki n po nnkan. [I always feel an urge to vomit.]

Doc.: Bii kelebe abi ounje? [Like sputum or food?]

Pt.: Ounje ti mo je gan-an ni. [Ingested food.]

Doc.: Okay. So, apart from the gentamycin eardrop, any other thing wo le ti lo seti yen? [What other drugs have you taken?]

Pt.; Nothing.

Doc.: I was asking earlier, were you having any headache with this feeling in your ear.

Pt.: No.

Doc.: E ni t'e ba yearn sometimes, o maa n dun nyin leti. [You said your ear hurt when you yearned.]

Pt.: Beeni.Tabi ti mo ba gunfe. [Yes, or when I belch.]

Doc.: Okay. Was there any time in the past ti nnkan n jade ninu eti nyin, may be when you were young? [Was there any time pus came out your ear, may be when you were young.]

Pt.: O ti pe gan-an o. [It was a long time ago.]

Doc.: Kin le wa se sii nigba yen? [What did you do to resolve the problem then?]

Pt.: Ogbomosho Hospital ni mo wa nigba yen .[I was at Ogbomosho Hospital then.] Nwon ba mi flush e.[The ear was syringed.] Idoti de jade gan-an.[A lot of wax came out.] Mo de maa n reti gan-an. [I feel itching in my ears a lot.]

Doc.: Okay. Iyen todun meloo? [How mant years ago was that?]

Pt.: Ah, I was in the secondary school that time.

Doc.: Five, ten years ago.

Pt.; Yes.

Doc.: When did you leave secondary school?

Pt.: 2009.

Doc.: 2009.

Pt.: Igba yen, mo shake eti yen gan-an, o waa ro mi. [I shook the ear and it hurt a lot.]

Doc.: Se ti e ba fi cotton bud ro eti yen, eje maa n jade? [Does blood come out when you clean your ear with cotton bud.]

Pt.: Beeni. O maa n jade.[Yes, it does come out.]

Doc.: Apart from the ear now, any other complaint?

Pt.: None.

Doc.: Igba t'e wa bere sii lo gentamycin yen, any improvement? [Did you feel any respite after using gentamycin eardrop?]

Pt.: Ko really si. Tori pe mo fe ko si. To ba si maa mo. [I still felt the blockade despite the fact that I wanted the ear to open.]

Doc.: What about food - your appetite?

Pt. Right from time, I don't eat much.

Doc.: Why?

Pt.: Mi o like ki n feel pe ikun mi tobi. [I hate to eat heavily.]

Doc.: E fee dab ii Miss Nigeria. [You want to be like Miss Nigeria.]

Pt.: Mo ma n like kikun-un mi wa normal - flat. [I always like to have a flat stomach.]

Doc.: Awon Darego lo maa n se bee. [Only the ''Daregos'' behave like this.]

Pt.: Ti mo ba ti jeun tikun mi ba ti yo, mi I feel comfortable. [I feel uncomfortable when I overeat.]

Doc.: Alright, maa wo eti yen. I will get an instrument now. [Alright, I will examine the ear with an instrument] (Goes to get an instrument.) Sometimes ohun to maa nsele nipe etii wa ati ofun wa wa connected together. [Our ears and throat are connected] Ti infection….. Iho wa to connect mejeeji po. [There is a link between the two. Iho yii lo maa n equilibrate pressure from inside and outside. [This valve equilibrates the pressure from within and without.] Either o block e completely or o je ko kere sii, the pressure will not be balance, o le je ki problem wa nibe.[When it is either completely or partially blocked, there will be an imbalance and this will result in a problem in the ear.] Se e mo bi valve se ri , ti nnkan ba wa nibi, afefe ko nii le koja. [Do you know what the valve looks like, once it is obstructed, nothing will be able to pass through it.] Ofun to dun nyin nigba kan lo fa eti to dun nyin nigba yen, tin won fi se syringing fun nyin. [The sore throat you had sometimes ago was the cause of the problem you had with your ear that led to the syringing.] E mo pe idoti maa n wa leti, t'ee ba fi cotton bud re – e mo pe ori cotton tobi- o maa n ti idoti lo sinu. So, that can cause a ear problem as you have it now. All the same I will look at it to see what the problem might be. If there is any need for further evaluation, I will refer you to the E.N.T. people. (Examines the ear and recommends some drugs)

INTERACTION 17

Doc.: Kin l'oruko nyin? [What is your name?]

Pt.: Akanni.

Doc.: Kin lo n se nyin? [What health complaints do you have?]

Pt.: Ehin nro mi.[I have backache.]

Doc.: Ohun naa le gbe wa tele. [The same complaint you had the other time.]

Pt.: Bee ni. [Yes.]

Doc.: Iru ise wo le nse? [What is your occupation?]

Pt: Mo nta moinmoin.[I sell moinmoin.]

Doc.: Elemi meloo ni? Elemi meje abi elemi meji? [How rich is it?]

Patient: ??????????????????????

Doc.: Itan ma n ro nyin naa ati orokun. [You also have pains in your thigh and knees.] Iwe ti nwon fi ko oogun fun nyin nigbati e koko wa nko? [Where is the prescription list you were given the last time?] Nigbati e lo oogun yen, bawo lo ti ri.[How did you feel after taking the drugs?]

Pt.: O fia. [I felt better.]

Doc.: O fair.[It was fair.] Se e nsun daadaa? [Do you sleep well?]

Pt.: Rara.[No.]

Doc.: E o r'oorun sun. [You don't sleep well.] S'oru le maa nse moinmoin ni? [Do you prepare moinmoin in the night?]

Pt.: Idaji ni [At dawn.]. Bi aago marun-un ni [Around 5 o'clock].

Doc.: Se kii se iyen ni ko je kee roorun sun daadaa? [Is that not responsible for your inability to sleep well.] Se e mo pe e maa fokan sii. [Don't you know your mind would be on it?] Se e mo pe e kii sun asunwora? [Don't you know you don't sleep well?]

Pt.: Lati bi ojo meedogun sehin, mi o le dana o. [Since about fifteen days ago, I have not been able to cook.]

Doc.: Ehn ehn. Mr. Daniel, abi , bawo ni? [Ehn ehn, Mr. Daniel, or.., how is it?]

Pt.: Daadaa ni.[Fine.] Bawo ni weekend? [How was the weekend?] Se e o binu pe mo wa nisisyii? [Hope you are not angered by my visit now.]

Doc.: Ara gbogbo e naa ni. [It's part of the work.] Lai ri pharmacist, awon patients o le r'oogun lo.

[Without pharmacists, patients cannot get drugs to take.]{To patient again} Moinmoin yen, se enyin nikan le nsee? [That moinmoin, are you the only one preparing it?] E o ri eeyan Kankan ran nyin lowo. [You get nobody to assist you.]

Patient: Emi nikan ni.[I prepare it all alone.]

Doc.: Lati bii ose meji bayii, e o dana. [Since about two weeks, you have not cooked.]

Pt.: Mi o dana. [I didn't cook.]

Doc.: Gbogbo awon onibara nyin to fee jeun nko? [What about your customers that want to buy and eat''moinmoin''] Bawo na se fe jeun? [How do they get ''moinmoin'' to eat?]

Pt.: Nwon a maa je nnkan mii ni. [They would look for an alternative.]

Doc.: Tori e la se gbodo toju nyin daadaa ka le ri moinmoin je.[Because of this we have to treat you very well so that we should get ‘’moinmoin’’ to eat..] Ki e lo ra awon oogun yii. [Go buy these drugs.]

Pt.: Maa de’le ki n too raa. [I will get home before I buy it.]

Doc.: E o m’owo dani. [You don’t have money on you.]

Pt.: Bee ni.[Yes.] E see. [Thank you.]

INTERACTION 18

Doc.: Gloria David

Pt.: Good morning, Madam.

Doc.: What is wrong with you?

Pt.: I brought the result of the test I did?

Doc.: The result of the test you brought says there are some germs in your private part. So, I will give you some drugs, and you will take them for some time and you will be okay.

Pt.: The thing is curable?

Doc.: Yes. It is curable.

Pt.: There is one problem that is disturbing me. In my throat e be like say there is something scratching me, scratching me.[I seem to feel itching in my throat.] When I scratch e be like say my neck dey turn. [When I scratch it, my neck seems to turn.]

Doc.: I am going to recommend some drugs to take care of that too.

Pt.: Thank you, ma.

INTERACTION 19

Doc.: Makinde Mary l’oruko nyin. [Mary Makinde is your name.]

Pt.: Bee ni. [Yes.]

Doc.: E pele. [Sorry.]

Pt.: E see. [Thank you.]

Doc.: Kini complaint t’e ni? [What are your complaints?]

Pt.: Ori n fo mi lati ana. Mi o sun tile fimo. [I have a headache since last night and I could sleep till daybreak.]

Doc.: (Looks at patient's folder) Nwon n toju nyin fun ito suga ati eje riru. [Your record says you are diabetic and hypertensive.

Pt.: Bee ni. [Yes.]

Doc.: Se e si nsise? [Do you still work?]

Pt.: Bee ni. [Yes.]

Doc.: Se otutu ko maa mu nyin? [Don't you feel feverish?]

Pt.: Rara. Ara mi kan n gbona ni. [No, I only have high body temperature.}

Doc.: Se inu ko run nyin? [Don't you have stomach upset?]

Pt.: Rara. [No.]

Doc.: Se e si loogun abi ka ko omiran fun mi. [Do your drugs still remain or do we prescribe another?]

Pt.: E ko o fun mi. [Prescribe them.]

Doc.: (Recommends drugs) Awon eleyi ikookan le o maa lo won lojumo tori sugar ko po ninu ito nyin. [You will take this once a day because the sugar content of your urine is low now.] E maa wa yoju siwa lehin osu meta ti oogun yii ba tan. Sugbon ti complaint ba wa, k'e wa. [You will come back in three months' time when these drugs are expected to have finished, but if you have any complaint before then, come to report.]

Pt.: O daa..[It's good.] Ohun naa lo je ki n wa lonii. [That's why I came today.]

Doc.: Se e o wuko? [Do you not cough?]

Pt.: Rara. [No.]

Doc.: Se e o l'ogbe inu? [don't you have ulcer?]

Pt.: Igba ti nwon ti se operation fun mi lo ti san. [I have been cured of ulcer since I was operated upon.]

Doc.: (Examines the patient's eyes) You look pale. Have you ever been diagnosed with anaemia?

Pt.: Ah. No.

Doc.: Alright. The whiteness of the base of your eyes suggests you haven't enough blood in your system. So, I am going to recommend some blood tonic for you. Make sure you take them. Otherwise, you might be subjected to blood transfusion.

Pt.: I am a muslim of the Quadriyyah faith. We don't subscribe to blood transfusion.

Doc.: I am not saying I want to subject you to blood transfusion now. All I am saying is that if you don't take blood tonic I am recommending now, you might have to go for blood transfusion.

Pt.: Okay. I will take it.

Doc.: But let me also add this. Islam is not opposed to medical science. Therefore, it is not against The Quran to receive blood during sickness to save the patient's life. It will not be taken through the mouth. Rather it is administered through the veins.What The Quran says is that we should not eat blood. So, you can see this is not eating blood. It is just a way of saving lives.

Pt.: Yes. Thank you. I can understand it better now.

Doc.: E pele. (Gives her a prescription list) [Sorry.]

Pt..: E see. [Thank you.] O dabo. {Bye bye.]

Doc.: O dabo. [Bye bye]

INTERACTION 20

Doc.: Kin loruko nyin, ma? [What is your name?]

Pt.: Ajayi Temilola.

Doc.: Se e ni kaadi nibi tele, abi? [Do you have a card here before, or?]

Pt.: Beeni. [Yes.]

Doc.: [looks at patient's case note.] E ti wa ni Monday tele. [You came here on Monday.]

Pt.: Beeni. [Yes.] Nigba ti mo wa nigbanaa, mo complain nipa ese yii to n ro mi, nwon wa ye ifunpaa mi wo. [I complained about the pain I feel in this leg, and my blood pressure was checked when I came then.] Nwon si so pe o ga. [They said it was high.] Nwon si fun mi ni awon oogun yii, mo si ti n loo, sugbon aya to n ro mi kodin ku. [I was given these drugs and I have been taking them, but the leg pain persists.] Mi o tun ri oorun sun loru. Nigba ti mo so fun doctor, nwon ni ki n lo ya X-ray. Titi di bayii ese naa si n ro mi] In addition, I can't sleep at night. I complained about it and was asked to take an X-ray. I still feel pains in the leg up till now.]

Doc.: Result test wo leyii?

Pt.: Mi tii see tori ese naa n ro debii pe mi o le gun step wa nibi tin won ti n see. [I have not done the test because I feel so much pain in the leg that can't ascend the stairs that lead to the X-ray centre.]

Doc.: Se e saa n lo awon oogun nyin? [Do you still continue taking your drugs?]

Pt.: Mo n loo mi o waa ri oorun sun naa ni. [I do take them but the problem is the inability to sleep.]

Doc.: Peluu lexotan tin won fun nyin, e o sun naa? [You mean despite taking lexotan you can't sleep.]

Pt.: Mi o sunun. [I don't sleep at all.]

Doc.: Kinni ko je ki e sun? [What disturbs your sleep?]

Pt.: Mi o moo. [Idon't know.]

Doc.: Ese to n ro nyin nko? [What about the leg paining you?]

Pt.: O si n ro mii. [It is still paining me.]

Doc.: Igba wo lo saba maa n ro nyin? [When does it normally pain you?]

Pt.: Gbogbo igba ni.[Always.] Bi mo se wa nibi bayii, o n ro mi.[It's paining me as I am here now.] O dab ii pe muscle abi pajapaja n mu mi. [It's like I have cramps.]

Doc.: Kii se joint lo ti n ro nyin? [Don't you feel the pain in the joint.]

Pt.: Nhunun. [No.] Ibi lo si isale a waa gan. [This place down.] (Pointing to her left knee.]

Doc.: Se o maa n ku riri ni abi bawo lo se maa n se nyin? [Does the leg feel numb or how do you feel.]

Pt.: Aa ku riri, a tun waa ro mi lo. [It feels numb and also pains me.]

Doc.: Ese kan yen de ni? [Is it only that leg?]

Pt.: Eleyii nikan ni. Left yii.

Doc.: Atigba wo le ti n sakiyesi iru nnkan bayen? [Since when did you begin to notice this discomfort?] Igba wo lo ti n senyin to ti bere? [When did it start?]

Pt.: O ti bere latii – ka sa so pe January. [It has begun since – let's say January.

Doc.: [Examines the drugs the patient brought along.] Se e maa n lo eleyii leekan lojumo ni? [Do you take this once daily?]

Pt.: Leekan ni.[Yes. Once daily.]

Doc,: Se e o sakiyesi pe ito nyin posii lenu ojo meta yii? [Did you not notice any increase in your urination recently?]

Pt.; Ti mo ba lo oogun yii ni mo maa n to ju. [I urinate so much only when I take this drug.]

Doc.: Se awon ayewo tin won ko fun yin e o mo boya ayewo itoo sogar wa nibe? [Do you know whether blood sugar test is among the tests recommended for you?]

Pt.: Mi o tii see.[I have not done them.]

Doc.: Emaa se eleyii nibi. [You will do this test here.] E o nilo atilo si laboratory. [You don't need to go to the laboratory.] Awon nurse maa see fun nyin nibi. [The nurses will do this for you here.

Pt.: Se ese yen si n ro nyin? [Do you still feel pains in the leg?]

Doc.: Bi mo se joko tin yin yii, o n ro mi ganan ni? [It's paining me as I sit with you here.]

Pt.: Se ko si wu? [Is it not swollen?]

Pt.: Ko wuu but riro yii ni. [It's not swollen but just the pain.] O saa n ro mi ni. [It just keeps paining me.]

Doc.: E je ki n ye ifunpa nyin wo. [Let me check your blood pressure.] (Checks patient's blood pressure.) Se e ti loogun nyin laaro yii? [Have you taken your drugs this morning?]

Pt.: Mo ti loo.

Doc.: Ifunpa nyin yii ga.[Your blood pressure is high.] Nigba wo le loo? [When did you take it?]

Pt.: Laipe nigbabti mo debii. [Shortly after I got here.]

Doc.: Se e ti ye ifunpa nyin wo laaro yii tele ni? [Have checked your blood pressure before this morning?]

Pt.: Beeni. Awon noosi lo ba mi yeewo.

Doc.: Kinni nwon so pe o je? [What was the reading?]

Pt.: 140/100.

Doc.: Ah! 140/100. Iyen ga. [Ah. That's high.] A o le je ki e lo ile bayi. [We can't allow you to go home now.] Se e ti gbo? [Have you heard me?]

Pt..; Mo ti gbo nyin.. [I have heard you.]

Doc.: Kii se pe e maa sun si hospital.{Not that you will be admitted.] E kan maa sun die nibi ni ki ifunpa nyin le wale.[You will only take some rest here to enable

your blood pressure come down]. E lo lexotan tablet miran bayii. [Take another tablet of lexotan now.]

Pt.: Eyo kan? [One tablet?]

Doc.: Beeni. [Yes.]. A o mind kee sunlo. [We don't mind if you sleep off.]

Pt.: The problem is that I just can't sleep.]

Doc.: E waa fegbelele nibi [Come rest here for some time.] Maa ban yin pana. [I will switch off the light for you.] K'Olorun je kee sun lo. [May God let you sleep off].

Pt.: Se e e si ko oogun fun ese mi. [Will you still recommend drugs for my hurting leg.?]

Doc.: Beeni, maa si ko oogun fun ese nyin sugbon ifunpa nyin lo si se Pataki si wa bayii. [Yes, I will still recommend drugs for it but our main concern now is your high blood pressure.] (Takes the patient to a resting room in the hospital.]

INTERACTION 21

Doc.: Yes, come. Please, come. (Beckons to the next patient.)

Pt.: Good morning, ma.

Doc.: Good morning. What's your complaint?

Pt.: I experience itching in my ears..

Doc.: (Examines the ears.) What drugs have you taken to stop it?

Pt.: Piriton.

Doc.: Apart from the itching, do you feel any pain there?

Pt.: No.

Doc.: Any discharge from the ear?

Pt.: No.

Doc.: Any catarrh or cold?

Pt,: No.

Doc.: How old is he?

Pt. Rel.: He will be six in August.

Doc.: So, he was born in August. We are both August visitors. We are special people.

Pt. Rel: I wanted to remove the wax but it was thick.

Doc.: Is it in the two ears?

Pt. Rel.: Yes.

Doc.: Ok. I will examine it and see what is there. (Examines the ear.)

Doc.: Since there is no pain, what I would do is give you some drugs to stop the itching. In a week's time, we will be able to see what the problem is. If there is wax in it, we will see it and we will know what to do. Actually, the E.N.T. people say there is wax in our ears because we clean our ears with cotton bud. God designed our ears in such a way that if wax accumulates in it, some air would brush it out, and then it would come out. Otherwise, one can do ear-syringing, probably once or twice a year if that mechanism is not really active. But most of the time, from infancy we clean our ears too repeatedly till that mechanism is lost. So, let him take this drug (Recommends drugs) and then come back in a week's time.

Pt. Rel.: Thank you.

Doc.; Bye bye.

INTERACTION 22

Doc. What brought you here?

Pt.: It's my ear. It pains me a lot and I also perceive a drumming sound in it which makes it difficult for me to hear well.

Doc.: When did it begin?

Pt.: About three weeks now.

Doc.: Which of the ears?

Pt.: The left one.

Doc: Do you pick your ears with anything?

Pt.: Yes. Cotton bud.

Doc.: Is the pain very sharp?

Pt.: Yess.

Doc.: {Examines the ear) There is a lot of wax blocking your ear. Let me see the second one. When you pick your ear with cotton bud, does the cotton bud go in? You have difficulty hearing well because wax has blocked the whole ear. So, you will buy serumol eardrop and apply it in the ear. After applying it in one ear, you should wait for five minutes to allow it go in very well before you apply it in the second ear. You will do it for two weeks and then come back for a review. Do you understand me? When you apply the eardrop, it will soften the wax and you will see it coming out. Then, we will refer you to E.N.T. clinic where the syringing of the ear will be done for you.

Pt.: Okay, sir.

Doc.: Let us apply it for two weeks and see. How I wish I got a better instrument. I would haveremoved a lot of the wax to enable you start hearing well again. The eardrop costs about. #800. You will apply it for two weeks. If it gets exhausted, buy another one till you have used it for two weeks.

Pt.; Thank you, sir..

Doc.: Byebye.

INTERACTION 23

Doc.: Madam, how are you? What complaints brought you here today?

Pt.: My stomach.

Doc.: What's wrong with your stomach?

Pt.: I feel pain in it and I go to toilet frequently.

Doc.: Since when:

Pt.: Two weeks ago.

Doc.: So, you said two weeks ago, you started having stomach pain and it's turning and making you go to toilet frequently.

Pt.: Yes.

Doc.: What drug did you take to restore normalcy.

Pt.; I took tetracycline and flagyl and I also feet a biting sensation sometimes probably because I have hepatitis. I still felt the bite yesterday.

Doc.: So, you also have hepatitis.

Pt.: Yes, and I also fart a lot.

Doc.: Is it still biting you now.

P:t.: No. It is no more biting me. At times when I don\t eat, I pass out gas.

Doc.: It also happens when you don't eat?

Pt.: Yes. At times in the morning when I've not eaten anything.

Doc.: So, is the farting a problem to you?

Pt.: I don't know.

Doc.: No, I am asking you. Is it a problem to you?

Pt.: I thought it's only when someone eats and I also have headache..

Doc.: Not necessarily. You are having abdominal pain. Are you passing watery stool?

Pt.: Last week.

Doc.: When?

Pt.: During the weekend.

Doc.: Has it stopped?

Pt.: It has stopped but anytime I eat, the stomach turns and I feel as if I want to go to toilet.

Doc.: Do you eventually go to toilet?

Pt.: Yes, I do go sometimes.

Doc.: When you go to toilet, what does your stool look like.?

Pt.: It's normal.

Doc.: It's not watery.

Pt.: No. It's not watery. It was as when it started but now again.

Doc.: Any temperature?

Pt.: No.

Doc.: You said you were also having headache, when did the headache start?

Pt.: Last week.

Doc.: You also said your appetite is also low.

Pt.: Yes.

Doc.: Any vomiting or feeling of wanting to vomit?

Pt.: No.

Doc.: The headaches, are they there all the time?

Pt.: I still feel it.

Doc.: Do you sleep well?

Pt.: That is when I'm placed on drugs.I don't sleep regularly.

Doc.: So, if you are not placed on drugs, you won't sleep.

Pt.: Yes.

Doc.: But the last time you came in July, you were placed on drugs.

Pt.: Yes. But I did not finish them because they were giving me stomach pains.

Doc.: So, you said you had taken flagil. How long ago did you take it?

Pt.: Since lat week. This week I have not taken it.

Doc.: Please, can you go in there? Let me examine you.

Pt.: Okay, ma.

Doc.: (Examination ends) It's okay. I will place you on some drugs until we get the result of the tests I will recommend now. (Prescribes some drugs and tests.)

Pt.: Okay, ma.

Doc.: The result should be out in the next three days at most. So, bring them when they are out.

Pt.: Thank you.

Doc.: Bye.

Pt.: Bye bye, ma.

INTERACTION 24

Doc.: E pele, ma. [Sorry, ma.]

Pt.: E see. [Thank you.]

Doc.: Se e rii, nigba ti mo beere awon ibeere yen lowo o nyin ti mo de ye nyin wo, se e mo nnkan tan'n pe ni goiter? [Through the questions I asked you and the physical examination I conducted on you, do you know what is called goiter?]

Pt.: To maa n wu sorun eeyan. [That makes the neck swell.]

Pt.: Ti nwon maa n ni eniyan ni gege lorun - goitre.[It affects the neck.] Gland kan wan ii – eroja ara kan wa nibi orun bayii (Points to his neck), o ni bo se maa n sisee ti e. [There is a gland in the neck region and it performs a certain function.] Goitre yen lo n fa gbogbo nnkan t'e n s'alaye fun mi lati'bere.[The goiter is responsible for all your complaints so far.] Awon nnkan bii pe igbe yiya nyin tip o sii; e o ri oorun sun. [All your complaints like increased defecation and insomnia] Sugbon nigba tin won ti fun nyin ni awon oogun kan, e ti n ri oorun sun bayii. [But you have overcome that after taking some drugs.] Then, gbogbo bi e se lose weight. Tori pe o tobi, o n sise ju botiye ko sise lo. [Then, you have also lost weight because the gland is being overburdened. So, awon nnkan t'o n produce, ti gland yii n produce, o n je ki ara maa sise ju b'o ti ye lo. Iyen lo fa a ti e fi n su, ti e fi n lose weight. [The gland is forced to produce above its ability and this accounts for the weight loss.] Then, nigba ti o ti tobi, o ti press ibi ti afefe maa n gba wo'le. [The increased size of the gland has obstructed the air passage.] Oun lo je ki ohun nyin change. [It caused your voice chang.] Loro kan laarin osu meta sibi bayii, oun gan-an gan ni origin problem yii.[In a word, goiter is the real cause of the problem you have encountered in the last three months.] So, lowo bayii, nnkan t'a le se ni k'a koko se awon ayewo kann - ayewo okan nyin.[So, the only thing we can do now is to carry out some tests - ECG.] Okan nyin n sise gan-an, oun naa lo je k'o maa re nyin. [Your blood pressure is high and this is why are constantly tired.] T'o ba ti n sise bayen o maa re nyin ni [You will always be tired any time it woks this way.].Se e ti gbo. [Did you hear me?]Then, a maa se kidney test fun nyin. [Then, we will also conduct a kidney test on you.]Then, kinni orun nyin to n wu yen, a maa se test fun yen naa. Inu ayewo eje lati maa ri. [Then, we will also conduct a test on your swollen neck.[Se alaye mi ti ye nyin bayen.[Do you understand me?] So, ibeyen lati maa koko bere. [So, we will start from there.]. Nigba ti oga mi ba de laipe yii, a jo maa mo awon ayewo miran t'a tun maa se fun nyin lori nnkan t'a lero pe o n se nyin. [When my superior colleague arrives, we will jointly decide on other tests to be conducted on you to unravel the cause of you health problems.] Se e ni ibeere Kankan? [Do you have any questions.]

Pt.: Rara. Mi o ni'beere Kankan. [No, Idon't have any problem.]

Doc.: E pele. [Sorry.]

Pt.: E see.[Thank you.]

INTERACTION 25

Doc.: Sorry, ma.

Pt.: Thank you.

Doc.: What's your name?

Pt.: Adeola Gabriel.

Doc.: What complaints do you have?

Pt.: I have a sore on the left leg but I also feel pains in both legs. I also feel a burning sensation in them.

Doc.: How many times do you urinate in the night?

Pt.: Ah! About three times.

Doc.: Do you have diabetes?

Pt.: No.

Doc.: What about hypertension?

Pt.: No. I don't have it..

Doc.: You mean you have never been told you have any of them.

Pt.: Yes.

Doc.: Is this the first time you have attended this hospital?.

Pt.: Yes.

Doc.: When did this problem start?

Pt.: This is the fourth week.

Doc.: That's a month. Let me check your BP. I believe you have eaten today.

Pt.: Yes. I ate before left home.

Doc.: Stop talking. (Checks patient's BP) Your blood pressure is normal.

Pt.: Okay.

Doc: Don't you have any other complaints?

Pt.: There are no other ones apart from the ones I mentioned.

Doc.: (Recommends drugs) Make sure you eat before taking these drugs.

Pt.: I have heard you.

Doc.: Does anyone live with you?

Pt.: Yes. My children.

Doc.: That's alright. Buy these drugs and take them as recommended.

Pt:. Thanks.

Doc.: Or, were you given money to buy them here?

Pt.: No. I was only given transport money.

Doc.: Okay. Go give them the prescription to buy the drugs for you.

Pt.: Thank you.

APPENDIX II

DATA COLLECTED AT THE UNIVERSITY OF ILORIN TEACHING HOSPITAL, ILORIN

INTERACTION 26

Doc.: Good afternoon.

Pt.: Afternoon, ma.

Doc. Where is your blue card?

Pt.: Here is it.

Doc.: Is this the first time you have come to this hospital?

Pt.: Yes.

Doc.: Were you ever diagnosed with diabetes or hypertension?

Pt.: Diabetes.

Doc.: Where do you treat it and what drugs are you taking to cure it?

Pt.: The drugs I was given are in my bag.

Doc.: Go bring them.

Pt. (Hands over the drugs to the doctor)

Doc.: So, these are the drugs you were given. Where do you treat yourself?

Pt.: Sadiku.

Doc.: When was the last time you went there for treatment?

Pt.: About two months ago.

Doc.: Then why did she change to this hospital.

Pt. Rel.: Because I attend this hospital.

Doc.: Doc.: So, she wants to attend the same hospital with you.

Pt. Rel.: Yes.

Doc.: There is no problem. The only thing is that we would be giving her appointment and she must be coming.

INTERACTION 27

Doc.: Razak Bimbo.

Pt.: Ma.

Doc.: E pele . [Sorry.] Bawo lara nyin? [How do you feel?] Se alaafia ni? [Are you alright?]

Pt.: Daadaa ni.[Fine.]

Doc.: Nigbatee wa gbehin, nwon ni k'e sawon test kan.[You were asked to do some tests the last time you came.]

Pt.: Beeni.[Yes.]

Doc.: Awon da. (Collects the test results).[Where are they?] Have you been taking the drugs I recommended?

Pt.: Yes.

Doc.: (Looks at the results) E o ni ito sugar. E ti se test gbogbo e. Iba nikan ni e ni.[You are not diabetic. You only have malaria.] Se e gbo? [Did you hear me?] E de tin lo oogun lati ana -Lonart: ikan laaro, ikan lale fojo meta. [And you have been taking the drug I recommended since yesterday – Lonart: one in the morning, one in the afternoon for three days.] Se n lo pelu milk? [Are you taking it with milk?] Ojo meta le fi maa lo ati vitamofen : laaro ati ale fojo marun-un. [You will take it and vitamofen for three days:] Se e ri iyato? [Did you feel any respite?]

Pt.: Rara. Mi o tii ri changes.[No. I haven't seen any changes.]

Doc.: E sa maa lo o lo. [Just continue taking it.]E ni lati lootan. [You have to take all the drugs.]Urinalysis nyin wa normal.[Your urinalysis is normal.] Iba nikan le ni.[The only have malaria.] Ki e lo oogun nyin daadaa, ki e jeun, ki e de tun rest dadadaa. [Take your drugs well, eat well and also rest well.] Titi ojo meta ara nyin a le. [You will be alright in three days' time.] Iru ise wo le n se? [What's your occupation?]

Pt.: Civil servant ni mi.[I'm a civil servant.]

Doc.: Ok.

Pt.: So, malaria nikan ni mo ni.[So, I only have malaria.]

Doc.: Beeni.Gbogbo nnkan yoku normal. [Yes. Every other thing is normal.Ki e lo oogun nyin daadaa. [Take your drugs well.] Ki e de je fruit naa daadaa. [Eat lots fruit too.]

Pt.: E see.[Thank you.]

Doc.: k'e take care.[Take care.] Thank you very much

INTERACTION 28

Doc.: (Looks at Pt.'s test result) Mama, e pele. [Sorry, ma.] Se alaafia le wa? [Are you alright?]

Pt.: Beeni. Alaafia ni. [Yes. I am fine.]

Doc.: Ayewo ito nyin se daadaa. [Your urinalysis is good.] E je k'a wo iyoku ti ayewo inu t'e lo se. [Let's see other intestinal tests you did.] Se e ni ifunpa to ga tele ni? [Were you hypertensive before.]

Pt.: Aah. O ti e tipe lara mi.[I've had it for a long time.]

Doc.: Se e de maa n loogun nyin daadaa? [Do you take your drugs well?]

Pt. Beeni. [Yes.]

Doc.: Iru oogun wo ni?[What type of drugs are they?]

Pt.: Aldomet ati moduretic.

Doc.: Ibo ni nwon ti n toju nyin fun ifunpa to ga yen? [Where are you treated for the hypertension problem?]

Pt.: Ni General. Mo de tun maa n so fun awon counterparts mi.[At General. I also tell my colleagues in the office.

Doc.: Okay. E pele. Ayewo tinu t'e se – Ko really so pe nnkankan to bad lo titi. [Sorry. The test you did does not suggest anything that bad.] Ara awon oogun ti nwon fun nyin ku? [Do you still have some drugs left.]

Pt.: Rara.[No.]

Doc.: Okay. Se e ri iyato lehin igba tin won fun nyin loogun yen? [Did you feel any change after you were given the drugs?]

Pt.: Beeni. [Yes.] Sugbon, nibii ose meloo kan sehin, mo subu lule pelu omi lori, o wa n je kehin ati egbe maa dun mi latigba yen. [But I fell down with a bucket of on my head and since then I have felt pains in my sides.]

Doc.: Se e o l'omo lodo to le maa ban yin ponmi.[Don't you have any housemaid?] Toripe o lewu k'e maa subu, paapaa julo t'e ni ifunpa to ga. [Because it is dangerous for you to fall down.] T'eni to ni ifunpa to ga ba subu, o le ro lapa abi ese. [If a hypertensive patient falls down, he could sufer a paralysis of hand or leg.]

Pt.: Aah.

Doc.: So, awon nnkan inu ile ko gbodo fun po. [So, things should be well spaced in your home.]Awon stool keekekee gbodo wa lona to jin.[Stools should be put in corners.] Kinu ile free tori e ti dagba. [So that you could move freely because you are now old.

Pt.: E see. [Thank you.]

Doc.: Se e o ni omo kekere lodo ni? [Don't you have a kid livng with you?]

Pt.: Kosii. [There is none.] .

Doc.: Okay. E maa bu omi kekere t'e legbe K'e ma baa subu mo. E pele. [Avoid carrying heavy things to avoid falling down again.]

Pt.: Ayewo yii so pe nnkan bii aran wa ninu nyin.[This test reveals there are worms inside your stomach.] Igba wo le lo oogun aran gbehin? [When was the last time you took a worm expeller?]

Pt.: O ti pe. [It's a long time ago.] Inu mi si tun maa n daru maa waa maa so paa paa pa. [I also experience stomach upset that makes me fart.

Doc.: Okay. Maa fun nyin loogun aran nisisiyii.[I will give you a worm expeller now.]

Pt.: E see. [Thank you.]

Doc.: Maa tun fun nyin loogun ara riro.[I will also give you an analgesic.]

Pt.: E see. [Thank you.]

Doc.: Ni osu meta, a tun maa tun ayewo yen se. [We will repeat the test in three months' time.] Sugbon mo ti fun nyin loogun to maa je kara nyin ya.[But I have recommenede drugs that will make you well.]

Pt.: E see. [Thank you.]

Doc.: E pele. [Sorry.]

Pt.: O dabo. [Bye bye.]

INTERACTION 29

Doc.: E kaasan.[Good afternoon.]

Pt.: Yes, sir.

Doc.: Kin lo sele? [What's the problem.]

Pt.: Apa yii lo n ro mi. [I feel pains in this arm.]Mo de lo si hospital kan nibi ti nwon ti fun mi labere sugbon o si n ro mi.[I attende a hospital where I was given an injection but the pain persists.]

Doc.: Se e subu ni? [Did you fall down?]

Pt.: Rara. E o mo pe ise agbe ni mo n se. Nigbamiran, mo si maa n gegi. [No. I am a farmer. So, I fell trees sometimes.]

Doc.: Se o n ro nyin dehin? [Do you feel the pains in your back.]

Pt.: Beeni. [Yes.]

Doc.: Nigbawo lo bere? [When did it start?]

Pt.: Bi ose meji sehin ni.[Aboutb two weeks ago.]

Doc.: Abere meloo lo waa fun nyin? [How many injections were administered on you.]

Pt.: Merin. [Four.]

Doc.: Bawo lo se bere? [How did it start?]

Pt.: Apa n ro mi wonu eegun bakannaa ibi tun wa wu jade ni mo ba lo sodo doctor yen. [I felt an excruciating pain in my arm. So, I went to a doctor.] O si fun mi loogun sugbon o n ro mi sibe. [I was given some drugs but the pain persisted.]

Doc.: Awon oogun naa da? [Where are the drugs?]

Pt.: Mo kowon wa. [I brought them.]Riro yen ko tun wa je kin sun loru.[The pain does not allow me to sleep at night.]

Doc.: Se e ni ulcer? [Are you an ulcer patient?]

Pt.: Mo ni. [Yes.]

Doc.: A maa se ayewo HIV fun nyin. Ayewo in eje ni.[We will screen you for HIV. It's a blood test.]] ofe la maa n se e nibi. [It's free here.]Maa ko oruko ibi ti e ti maa se e fun nyin.[I will write the name of the laboratory for you.] E maa wa mu esi re wa . O le je kokoro kan lo faa, o si le ma je bee.[You will bring the result. It could have been caused by a micro-organism and it may not be so.] Ooogun ti e ma ra ni eyii.[This is the drug you will buy.]

Pt.: Se ti mo ba raa, maa tun mu wa sibi lati mo bi maa se loo? [Do I have to bring it here after purchase to know the dosage?]

Doc.: Rara.[No.] Bee se maa lo ti wa lara re.[The dosage is already stated on it.] E lo ra oogun yen nibi ti mo juwe fun nyin ki nwon le salaye bi e se maa lo fun nyin.[Go buy it in the place described so that the dosage can be explained to you.] Iyawo meloo ni e ni? [How many wives do you have?]

Pt.: Eyo kan.[One.]

Doc.: Se ko de si awon tibitibi? [Don't you have any concubine?]

Pt.: Kos ii. [There is none.]

Doc.: O daa. E lo se ayewo yen ki e si ra oogun ti mo ko yen naa. [Alright. Do those tests and buy the drugs prescribed.] Lehin naa, ki e pada wa. [Then, come back.]

Pt.: E see. [Thank you.]

INTERACTION 30

Doc.: Se e ti wa teleri? [Have you ever been here before?]

Pt.: Beeni. [Yes.]

Doc.: Ki ni nwon n toju nyin fun? [What are you being treated for?]

Pt.: Diabetes.

Doc.: Se e n loogun nyin deede? [Do you take your drugs regularly?]

Pt.: Beeni. [Yes.]

Doc.: Awon test ti won se fun nyin da? [Where are the results of the tests you have done?]

Pt.: Nwon wa ninu iwe owo nyin. [They are all inside the book in your hand.]

Doc.: (Looks at the test result) Se oogun nyin titan ni? [Have your drugs finished?]

Pt.: Tipe. [A long time ago.]

Doc.: E o de waa. 13/7 – sugar to wa lara nyin ti poju [And you didn't come to complain. 1t/7- your blood sugar level is too high.]Mama ise wo le n se? [What's your occupation?]

Pt.: I am a trader.

Doc.: So, your trade is more important than your health. Ehn? Eni to ba ti ni ito sugar tabi eje riru maa wa lori oogun titi ojo aye ni.[Anyone that is diabetic will be on

medication for life.] Iru enyin t'e ni ito sugar yii gbodo maa loogun lojoojumo titi ti sugar yen fi maa loole ti a o fi sope kee ma loogun lojo meji meji, tabi ko maa lo aabo. [A diabetic like you should should take drugs every day to reduce your blood sugar level till a time we ask you to take two tablets daily or half a tablet per day.]Awa la maa soo.[We are to tell you.] E o ri bayii pe ara nyin ru. [You can see now that you look lean.] O to igbawo t'e ti loogun gbehin? [How long was the time you last took your drugs?]

Pt.: Osu merin.[Four months.]

Doc.: E e ri nnkan.[You can see.] Ounje t'eyan ba de maa je, eeyan maa watch e.[One has to watch what he eats.] Gbogbo nnkan didun didun, eeyan ni lati jinna sii. Emi ni coke, sugar, saccharin – e o le jee. Malt – e o le muu. [You need to stay away from very sweet things i.e. coke, sugar, saccharin, malt etc.] Awon nnkan bii ewa, wheat, efo ati eso le le je daadaa. [You can only eat things like beans,wheat, vegetables and fruits very well.]

Pt.: Se mo le je eso to dun? [May I eat sweet fruits?]

Doc.: Eso to ba ti dun ju, e o le jee. [You can't eat very sweet fruits.]Pine apple to ba dun ju e o le jee.[You can't eat very sweet pine apple.] E le mu osan, e maa ya tinu e je toripe o ni roughages. [You may suck oranges and eat the flesh because it has roughages.] O dara fun ara gan-an ni. [It's very good for the body.] E le je water melon, ikan ati wheat. [You may eat water melon, garden egg and wheat.] E o waa maa je gbogbo nnkan tin won fi ewa se pata: ekuru, oole, gbegiri.[In addition, you should eat food items made with beans.] E le je ogede dudu bibo pelu efo ati eja dudu.[You may eat unripe plantain with vegetable soup and roasted mudskipper.] E le je elubo ogede naa.[You may eat plantain flour as well.] Sugbon e ni lati din jije ounje bii rice, isu, eba,fufu, eko, dodo ati amala isu ku gidigidi. [But you need to drastically reduce intake of food like rice, 'eba', 'fufu', 'eko' fried plantain and yam flour.] Eo maa je ida kan ninu ida merin t'e n je tele.[You are to eat a quareter of the quantity of these food items you used to eat before.] Bo ba je pe rice ni, e o bu ida kan ninu merion, e o je pelu ewa pupo. Se o ye nyin? [Do you understand me?]

Pt.: O ye mi. [I can understand you.] Se mo le je elubo lafun? [May I eat cassava flour?]

Doc.: Rara. [No.] Elubo ogede lo dara ju.[Plantain flour is the best.] Se nwon o toju nyin fun eje riru?[Are you not being treated for high blood pressure?]

Pt.: Beeni.[No.] Nwon se ayewo fun mi leekan, nwon de so pe o wa okay. [I was tested once and I was said to be okay.] Oju de tun maa n dun mi.[I also have eye problems.]

Doc.: A o se itoju oju nibi.[This is not an eye clinic.] O le je complication ito sugar naa ni.[It could be a complication of your diabetic condition.] To ba dola, e maa lo si ibi ti nwon ti n toju oju. [You will go to the eye clinic tomorrow.] O ye ki e maa se awon ayewo yen toripe itoju eni to ba ni diabetes se pataki, bi eni naa ba ni

egbo, ko nii jinna. [You ought to do the tests regularly as a result of your diabetic condition because if you sustain an injury, you may not know and the wound will not heal up.So, e ni ni lati maa ye ese nyin wo – awon inu ika yen.- lati mo boya egbo wa nibe. [So, you need to constantly examine your feet to ensure there are no sores there, especially in-between the toes.] Bi e ko ba le wo fun ran yin, e le pe eeyan ko baa nyin wo tabi ki e fi mirror woo boya egbo wa nibe. [You may inspect the feet with a mirror if there is nobody to assist you inspect them.] Aisan yii lo n faa tin won fi n gee se opolopo eeyan. [This ailment causes a lot of people to suffer feet amputation.] Ti eekanna nyin ba gun, e o le fi blade gee, nail cutter le maa lo ko ma baa da egbo sin yin lese. [You can not cut your nails with blade .Instead, you will use a nail cutter.] Ti egbo ba de be, ko nii san, ko ma waa di pe nwon maa gee kuro.[If a sore emerges, it will not heal up and it may result in amputation.]

Pt.: O ye mi.[I can understand you.]

Doc.: Bakannaa, e o maa ye abe bata nyin wo fun eso toripe to ba gun-un, o le se nyin lese. [Similarly, you should inspect the soles of your shoes to ensure there are no nails in them as they can wound you.] Atipe diabetes maa n baa won isan ese je ni debii pe ti nnkan gun eyan lese ko nii mo.[In addition, diabetes is so debilitating a disease that if you have an injury, you might not feel it.] Ni afikun, e o maa wa losoosu fun itoju ati ayewo. [Again, too, you should come monthly for examination and treatment.To ba je pe owo lani k'e waa gba, e maa wa bo je eemeji losu.[If we asked you to come to collect money, even twice monthly, you would come]. Tori naa. ilera se Pataki. [Therefore, health is important. E o maa wa losoosu.- Eemejila lodun. [You will come monthly – twelve times a year.]E o maa ra oogun nyin deede. [You should take your drugs regularly.] Toogun nyin ba ti ku merin ni e ti maa wa sibi lati waa se ayewo.[You should come here immediately you have about four tablets left for examination.] Nigbati e ba n bo, e o nii jeun abi momi wa. [When coming, you will neither eat nor drink water.]Idi ti a ni lati se bayii ni ki sugar to wa lara nyin ti a n gbiyanju ati muwale ma baa lo soke.[We need to do this to ensure your sugar level we are trying to bring down does not go up.]

Pt.: E see. [Thank you.]

Doc.: E je ki n wo ifunpa nyin.[Let me check youe blood pressure.] E ma je eran olora yen mo.[Stop eating meat.] E maa je eja gbigbe. [Eat dried fis. Alone.] Ifunpa nyin dara. [Your blood pressure is alright.] [Oogun nla yen, e o maa lo meji laaro, meji lale. Oogun keekeeke yen, e maa lo eyo kan lojumo.

Pt.: E see. [Thank you.]

Doc.: O dabo. [Good bye.]

INTERACTION 31

Doctor: Kin l'oruko nyin? [What is your name?]

Patient: Adijatu Olamide.

Doctor: Se e ti se ifunpa? [Have you done blood pressure test?]

Patient: Beeni. [Yes.]

Doctor: Kin lo n se nyin? [What complaints do you have?]

Patient: Mo kan waa mo boya nnkankan ko se mi ni. [I only came to know whether I am medically fit now.]

Doctor: Ayewo ifunpaa nyin dara bayii. [Your blood test reveals that your blood pressure is okay now.] Nitorinaa, a maa din oogun eje riru ti e n lo ku, e o si pada wa lose meji for ayewo miran. [So, we will have to reduce the hypertension drugs you are taking, and you will have to come back in the next two weeks again for a review.] E ko oogun t'e n lo jade. [Bring out the drugs you are taking]. E ma lo eyi ati eyi mo, sugbon e mu horo kan eyi lojoojumo. [Stop taking this and this but take a tablet of this once daily.]

Patient: E se e. [Thank you.]

(Doctor recommends drugs)

INTERACTION 32

Doc.: What brought you here today?

Pt.: My teeth.

Doc.: What's wrong with your teeth?

Pt.: My tooth has a hole.

Doc.: So, what do you want me to do for you?

Pt.: Remove the milk tooth.

Doc.: I should remove the milk teeth. (To pt. rel) Mummy, what do you want us to do?

Pt. Rel.: Remove the tooth now.

Doc.: (To pt. rel.) Since when did you notice the problem with the tooth.

Pt. Rel.: It's been long o. About six months.

Doc.: About six months. (To the patient) How old are you?

Pt.: Nine years.

Doc.: Did anyone tell you to come and remove it or you just felt you should remove it.

Pt.Rel. I thought it would come off itself bur it's becoming prolonged. So, I just decide I should bring him here for tooth extraction.

Doc.: (To pt.) Is it upper or lower teeth?

Pt.: Upper.

Doc.: (To pt. rel.) Are you treating him for any medical condition at the moment?

Pt. Rel.: No.

Doc.: (To pt. rel.) What's his genotype?

Pt. Rel.: I have not done his genotype.

Doc.: Was his immunization complete?

Pt, Rel.: Yes.

Doc.: And he doesn't fall sick from time to time.

Pt. Rel.: At all.

Doc.: Has he ever been admitted in a hospital before?

Pt. Rel.: No.

Doc.: Does he react to any drug?

Pt. Rel.: None that I know.

Doc.: (To pt.) You say you are eight years old.

Pt.: Yes.

Doc.: What school do you attend?

Pt.: Oritamefa Baptist….

Doc. Whao! Oritamefa. Are you the last born?

Pt.: Yes.

Doc.: Out of how many chikdren?

Pt.: Four.

Doc.: Your mum, what does she do?

Pt.: She is a nurse.

Doc.: Your mum is a nurse. Whao! What of dad?

Pt.: A lecturer.

Doc.: Where?

Pt.: LAUTECH

Doc.: So, how many times do you clean your mouth in a day?

Pt.: One time,

Doc.: With what?

Pt.: Brush and toothpaste.

Doc.: Who brushes for you?

Pt.: Myself but sometimes my mummy.

Doc.: You should be cleaning your mouth two times daily. What did I say?

Pt.: Two times daily.

Doc.: In the morning before breakfast and in the evening the last thing. Also make sure you use toothpastes containing fluoride.

Pt.: Ok, ma.

(Doctor recommends treatment)

INTERACTION 33

Pt.: Good afternoon, sir.

Doc.: Good afternoon, ma.

Pt.: How is your family?

Doc.: They are fine.

Pt.: Thank God.

Doc.: (Looks at patient's folder) Mama, do you take your drugs regularly?

Pt.: Yes. I do.

Doc.: Where are the drugs?

Pt.: I brought them along.

Doc.: Let me have them. How many types of drug are you taking.

Pt.: Two.

Doc.: But I can see three types here.

Pt.: I was given the third one when I complained of pains in my sides.

Doc.: Have you exhausted your drugs?

Pt.: I still have some left but they are not many.

Doc.: You have been told to always come to the hospital immediately you see the drugs you are given remains four. So, why did you come here today?

Pt.: A test was recommended for me, and I have brought the test result.

Doc.: Okay. I will look at it. (Checks patient's blood pressure) Have you taken your drugs today?

Pt.: No. I haven't.

Doc.: Why?

Pt.: I couldn't get any food to buy when I got here.

Doc.: You should have eaten before you left home so that you would be able to take your drugs. If you had done that your BP wouldn't have gone up like this. The kinds of drugs you take are those that cause frequent urination. Therefore, you should take them in the morning to avoid waking up frequently in the night to urinate in the night. So, now that you failed to take it in the morning, are now going to take it in the evening and make it disturb your sleep in the night. It's important you learn to take them every morning.

Pt.: Thank you.

Doc.: Don't you have ulcer?

Pt.: No.

Doc.: I have added a particular type of small tablet to your drugs. It is highly beneficial to the heart. It aids blood circulation very well. So, it's important you take it especially as you don't have ulcer.

Pt.: I had it before but it was treated here.

Doc.: Since you had it before, it is not advisable you take the drug as it could cause a recurrence.

Pt.: Prescribe it for me. I no longer suffer from it.

Doc.: What I am saying in essence is that if one takes it too much, it could cause ulcer again. Anyway, I have recommended it but make sure you eat very early always. So, you have an appointment again in one month's time because your BP is high.

So, if by your next appointment we check and find it has gone down considerably, we may change your appointment to once in two months or once in three months.

Pt.: Thank you, sir.

Doc.: So, make sure you take your drugs regularly. Goodbye

INTERACTION 34

Doc.: Bisi Adeoti!

PT.: E kaaro, sa.[Good morning,sir.]

Doc.: Kin lo n se nyin? [What health complaint do you have?]

Pt.: Mo ni aarun jedojedo. I have liver disease]

Doc.: Kin le mo to n je jedojedo. [Do you know what is called liver disease?]

Pt.: Mi o mo. [I don't.]

Doc.: E o de waa beere nigbayen, uhn? [And you didn't bother to find out unh?] Jedojedo. Iyen na n pe ni hepatitis. [That is what is called hepatitis.]

Doc.: Se nwon waa ni ke e pada wa loni ni? [Were you asked to come back today?]

Pt.: Nwon o ti e ni ki n wa loni. [I was not asked to come today.]Mo se awon test kan, mo wa ni ki n mu esii re wa. [I did some tests and decided to bring the results today].

Doc.: Eleyi o ni nnkankan se pelu nnkan tee so. [This has nothing to do with what your complaint.[Nwon ni normal test leleyi [This test does not indicate any problem.]. Nibo le ti seleyii? [Where did you do this?]

Pt.: Nisale nbeyen. [Down there.]

Doc.: Nnkan tan lo n se nyin eleyii ko le gbe jade.[This test is unsuitable for your health complaint.]

Pt.: Doctor yen naa lo de ni ki n lo see. [It was recommended by the doctor I saw the last time.]

Doc.: Ehn, Kin lo n se nyin gan-an nigbatee wa? [What was the health problem you the last time you came?]

Pt.: Mo maa n ri eje nigbati mo ba ni ajosepo pelu okoo mi. [I used to bleed after sexual intercourse with my husband.]

Doc.: E maa n ri eje. [Tou used to bleed]. Toko nyin ba ti nba nyin lajosepo e maa n r'eje.[You used to bleed when your husband had sex with you.]

Pt.: Bee ni.[Yes.] Sugbon latigba ti mo ti wa gbehin, ko se bee mo. [But it has stopped since the last time I came.]

Doc.: Omo meloo le ti bi bayii? [How many chikdren have you got now?]

Pt.: Meta. [Three.]

Doc.: E to omo idun meloo bayii? [How old are you now?]

Pt.: Omo ogoji odun o din meji. [I am thirty-eight years old.]

Doc.: Se'doti o maa jade loju ara nyin? [Does discharge come out of your private part?]

Pt.: Rara.{No.]

Doc.: Eje to n wa yen, eemelo loti wa ko toodi pe ko wa mo? [How many times did you bleed before it stopped?]

Pt.: A a to bii eemeje. [About seven times.]

Doc.: Ko de waa wa mo nisen. [And it has stopped now.]

Pt.: Bee ni. [Yes]/.

Doc.: Awon oogun tan ko fun nyin nigba yen gbogbo e le ti lo.[You have taken all the drugs you were given the last time]

Pt.: Bee ni.[Yes]

Doc.: Amo ko siyonu mo nisen. [But thetre is no complaimt again.]

Pt.: Bee ni.[Yes.]

Doc.: Kin lo waa de tee fi wa loni? [What then brought you to this place today?]

Pt: Mo kan ti e tun wa ni doctor.[I just decided to come,doctor.]

Doc.: A a sa ni nnkan tee fe so fun wa.[A complaint must have brought you here.] Nigbakugba ti e ba tunri eje nigbati e ba lajosepo pelu oko nyin ki e tete wa si hospital.[You should come to the hospital quickly anytime you bleed after sexual intercourse with your husband.]

Pt.: Sugbon, doctor, mo fe bimo sii [But, I want to have more children, doctor.].

Doc.: Omo meloo le ti bi, okunrin meloo, obinrin meloo? [How many children have you got now? How many boys and girls?]

Pt.: Meta. Okunrin kan, obinrin meji.[Three. Two boys, one girl.]

Doc.: Ise kin le n se? [What is your occupation?]

Pt.: Mo n ta'ja ni. [I am a trader.]

Doc.: Ise kin loko nyin n se? [What is your husband occupation?]

Pt.: A jo n ta'ja ni. [We are both traders.]

Doc.: Oja kin le n ta? [What type of trade?]

Pt.: Plastic.

Doc.: Ti mo ba ni ki n gbayin ni'moran ni ti igbalode, omo meta ti to. [If I were to advise you in line with contemporary practice, three children are enough.] Olorun ti fun nyin lokunrin ati obinrin. [God has given you both sexes.] Omo beere, osi beere. [Too many children engender poverty.] Eo mo pe enyin ti e nta'ja lowo lowo. You don't know you traders are wealthy. Se e ri awa alakowe nisisiyii, bi awon doctor ati nurse, ti nwon ba ti bi omo meji, elomiran gan-an eyokan, nwon maa n stop ni. [You see those of us that are educated, for example, the nurses and doctors, we stop childbearing after two issues,some even have just one]. Meta yen gan-an tito [The three are enough.] Sugbon ti e ba fee bimo sii, ko si problem.[But if you still want to have more children, there is no problem. Iyawo meloo loko nyin ni? [How many wives does your husband have?]

Pt.: Meji. [Two.]

Doc.: Se oko nyin lo so pe omo meta o to abi awon family? [Is it your husband that complaints the children are not enough or the family?]

Pt.: Emi ni mo fee. [I am the one that want more.]

Doc.: Iruu family planning wo le n lo? [What type of family planning method do you adopt?]

Pt.: Mo n gba'bere ni. [I take injections.] Mo ti e fee daa duro toripe awon kan so pe ko to suna. [But I want to stop it because some people say it is unislamic.]

Doc.: Rara. Mi o ro pe iyen je ooto. [No. I don't think that is true.] Musulumi bii yin lemi naa, iyawo mi si ngbabere ifetosomobibi. [I am a muslim like yourself and my wife takes family planning injections.]

Pt.: Ah. Oko mi naa so bee. [My husband said the same thing].

Doc.: Nnkan to sa dami loju ni pe Kurani o so bee. [The only thing I am sure of is that the Quran does not contain anything like that.]

Pt.: Mi o ri nnkan osu mi mo. [I have stopped menstruating.]

Doc.: Enyin naa le le so fun wa boya o ti lo o. [You are the one that can tell us if it has stopped.]

Pt.: Enh. Mi o ri eje. [Enh. I no longer menstruate.]

Doc.: Sebi enyin ati oko nyin ti n mate latigba yen? [Have you had sex with your husband? Ko wa mo. [It has stopped.]

Pt.: Bee ni. [Yes.]

Doc.: E lo ra awon oogun yii.[Buy these drugs. Awon oogun asaraloore ni.[They are multivitamins.] Ki e ki oko nyin oo. [Say me well to your husband.] Sugbon ti e ba ni complaint kankan ki e tete yoju o. [But if there is any complaint, make sure yiu come to the hospital quickly.]

Pt.: E see. Thank you.]

INTERACTION 35

Doc.: Musa Mariam.

Pt.: Afternoon,sir.

Doc.: What brought you today?

Pt.: I feel a burning sensation all over my body.

Doc.: Hun hun. You feel it all over your body.

Pt.: Yes. I also feel it inside my stomach and chest.

Doc.: When did it begin?

Pt.: About three months ago, and I have come to complaint here before.

Doc.: Okay.

Pt.: I have come to complain before.

Doc.: Where did you lodge the complaint?

Pt.: Here. But I lost my former card.

Doc.: So, we are not responsible for the loss.

Pt.: Yes.

Doc.: But we averse to a situation where you don't take good care of things that have to do with your health. For instance, we can't see any of your past medical records, and this is not appropriate. I am sure the card did not get lost. It's just that you can't remember where you kept it. So, I advise you are careful with your card henceforth. What's your occupation?

Pt.: I am a trader. I deal in fabrics.

Doc.: Where do you buy them.

Pt.: Lagos.

Doc.; And where do you sell them?

Pt.: Here in Ilorin.

Doc.: Don't you a high temperature?

Pt.: I do because when my body temperature rises, I feel the burning sensation all over my body.

Doc.: Okay. Don't you have a headache?

Pt.; I didn't have it before but it seems I have started having it.

Doc.: Don't you vomit?

Pt.: No.

Doc.: What about stomach ache and diarrhea?

Pt.: No. But sometimes when I feel the burning sensation, I feel a worm-like movement in my chest and in such moments the intensity of the burning sensation increases.

Doc.: How old are you?

Pt.: I am over forty years of age.

Doc.: Are you married?

Pt.: Yes.

Doc.: How many children have you?

Pt.: Six.

Doc.: How many wives does your husband have?

Pt.: Two.

Doc.: Are you the first wife?

Pt.: Yes.

Doc.: What is your co-wife's occupation?

Pt.: She sells food.

Doc.: What's your husband's occupation?

Pt.: Driver.

Doc.: When did you have your last-born?

Pt.: About two and half years ago.

Doc.: Alright. Do you sleep well?

Pt.: Yes, I do. But if I wake up in the night, I don't sleep again.

Doc.: You see. There are three ways to describe sleeplessness. Is it that you find it impossible to sleep on time but sleep later or you sleep on time but wake up frequently, or you sleep on time but when wake up in the night you don't sleep again? So, which of them applies to you?

Pt.: I sleep on time but once I wake up in the night, I don't sleep again.

Doc.: Okay. Don't you have any other matter bothering your mind currently?

Pt.: No. There is no other one apart from this burning sensation I feel all over my body.

Doc.: So, it's just that. Don't you now experience a situation where things you liked to do before no longer appeal to you?

Pt.: No.

Doc.: Okay. Do you have sex regularly with your husband?

Pt.: Yes. But what I also notice these days is that blood comes out of vagina each time we have sex.

Doc.: Alright. When do it, don't you find it interesting again or you find it painful?

Pt.: I don't even know how to answer that.

Doc.: Don't you have high blood pressure?

Pt.: I don't know.

Doc.: Let me check your blood pressure. (Checks patient's blood pressure). Where do you live?

Pt.: Balogun.

Doc.: Are you an indigene of Ilorin?

Pt.: Yes.

Doc.: Your blood pressure is normal. Don't you have swellings in any part of your body?

Pt.: No.

Doc.: Madam, one thing I want you to know is that our profession is what we really trained for. So, what we are going to tell you about your condition are more than

test and drugs. There are what we call body, soul and spirit. They are different but are present in the human body. One of them may be troubling the mind. It present in the form of a bodily ailment. Another may be troubling the body and present itself in the form of a mind problem. Yet, another thing is environment. So, the three work together. A problem in the environment may affect the mind. Similarly, a problem in the body or mind may affect the environment. For example, you say you have six children plus yourself and your husband, and you prepare food for all of you. Now, let us assume you are ill and the eldest child is also ill. So, the two of you won't be able to participate in the domestic chores. This means the second eldest child will now unavoidably shoulder the entire responsibility. If the situation is not well explained to him, he might feel he is being overlaboured unduly. Under this kind of situation, a lot of people in the family will be affected, and if the second–born is also not well managed, he too might be affected either in the body or mind. If he does not sweep, it will affect the environment and this can cause infection in the family. So, in relation your own condition, the burning sensation you feel is a direct consequence of some unfavourable developments in your mind. This why I asked you the number of children you have, the number of wives your husband has, your husband's occupation, how buoyant your trade is etc. All these questions we ask you may be personal i.e.; are you owing anybody or someone owing you etc? So, which of these problems applies to you?

Pt.: None. There is no problem whatsoever.

Doc.: How robust is the relationship between you and your husband?

Pt.: Very cordial.

Doc.: What about you co-wife?

Pt.: Even though my husband married the second wife not more than a year ago but that's not a problem in any way and my children don't give me any problem either. In addition, my trade is flourishing too.

Doc.: Okay. We are going to give you some drugs to be taken every evening for a whole month. It might make you sleep but the purpose for giving you the drugs is not to make you sleep. So, you will now come for a review in the next three weeks. These drugs I have recommended are not expensive. They cost less than #500 but there are some that cost as much as #3000. So, go take these drugs. We believe they will work because they are very effective. However, if you have any complaint, do come back to let us know. Evert doctor here is competent but ask of Dr. Abdul because I would personally like to see you then.

Pt.: But, doctor I feel pains in this arm and these le pain me a lot and at such times I also a burning sensation in my vagina.

Doc.: Madam, go take the drugs I have recommended. They will take care of all your complaints: Don't you see a white discharge in your private parts.

Pt.: I do.

Doc.: But, you didn't want to complain about until I raised it.

Pt.: I thought it was also caused by the burning sensation.

Doc: Some patients don't like to discuss very private health issues like these but it's not good. Always tell your doctor all your health complaints for action.

Pt.: Thank you, sir.

Doc.: I have recommended another drug to take care of that, too.

Pt.: Thank you.

Doc.: Bye bye.

INTERACTION 36

Doc.: E kaasan. [Good afternoon.]

Pt.: E kaasan. [Good afternoon.]

Doc.: Kin loruko nyin? [What's your name?]

Pt.: Lekan Ibraheem.

Doc.: Ewo lo gbe nyin wa? [What brought you here?]

Pt. Re.l.: Omo yii lo complain ori fifo nibii ijeta. O si tun ni malaria. [My child has a headache and malaria.]

Doc.: How old is he?

Pt. Rel.: Eleven years.

Doc.: In what class is he?

Pt. Rel.: Class Two.

Doc.: Boarding or day?

Pt. Rel.: Day.

Doc.: Kin lo complain about? [What's is his complaint?]

Pt. Rel.: Ori fifo. Ara re si n gbina. [Headache and high temperature.]

Doc.: Lati 'gbawo? [Since when.]

Pt. Rel.: Ijeta. [Three daya ago.]

Doc.: Pele. So, kin le ti wa lo fun? [Sorry. So, what drugs have you given her?]

Pt. Rel.? Amocillin.

Doc.: Sori fifo yen po gan-an ni? [Is the headache severe?]

Pt.Rel.: Beeni. Ti'run e ba de ti n kun, o maa n complain pe ori n fo oun. Inu tun n run-un. O de tun bi l'aaro yii. [Yes. He complains about headache when his hair is long. He has stomach pain. He also vomited this morning.]

Doc.: Lati'jeta yen ko bi tele? Se ko ya igbe olomi? [He did not vomit since day before yesterday. Is his stool not watery?

Pt.: Rel.: Rara. Ko ya'gbe olomi.

Doc.: Ibrahee!

Pt.: Sir.

Doc.: Can't you talk?

Pt. I can.

Doc.: Come closer. Sorry. Look at your teeth. You don't brush your teeth well. This is how to brush your teeth, and you should change your toothbrush every three months. S'ori n fo e naa?

Pt.: Beeni.

Doc.: Se'waju ni abi ehin?

Pt.: Iwaju.

Doc.: Se oju ko ro e?

Pt.: Rara.

Doc.: Se'ti ko ro e? [Don't your ear pain you?]

Pt.: Rara.[No.]

Doc.: Se o n wuko? Do you cough?]

Pt.: Beeni.[Yes.]

Doc.: Nigbawo lo bere? [When did it start?]

Pt.: Bii ojo melo kan sehin. [Some days ago.]

Doc.: So wuko nijeta? (Did you cough the before yesterday?]

Pt.: Beeni.[Yes.]

Doc.: Sorry. So, awon oogun wo le so pe o ti lo? [So, what drugs have you taken?]

Pt. Rel.: Folic acid, amocillin capsule ati paracetamol.

Doc.: Taalo ko oogun yii fun nyin? Abi e kan raa funraa nyin ni? (Who recommended the drugs for you? Or did you buy them without any doctor prescribing it?)

Pt. Rel.: Emi ni mo raa funraa mi. (I bought them myself).

Doc.: Se doctor leyin abi nurse? Ise wo l,eyin n se? (What is your profession?)

Pt. Rel.: Engineer ni mi..

Doc.: Iru engineer wo?

Pt. Rel.: Metal fabricator.

Doc.: E o le muu wa si hospital titi di isiyii. (So, you couldn't bring him to the hospital until now). E wa n bo nibi nisiyii nigba to fee yiwo. (You now came here when it's almost an emergency case.) Irun kikun ko nii se pelu iba, sugbon iba le se konge ori kikun. (Bushy hair does not cause malaria, but malarial attack can possibly coincide with bushy hair.) If a person with bushy hair has malaria and we cut the hair and treat him for malaria, if he is bitten by mosquitoes very well, he might malarial attack again between the next 14 to 21 days. So, it is not that bushy hair causes malaria. Do you understand me?

Pt. Rel.: Bee ni. (Yes.)

Doc.: Tori naa, ori I re t'okun ko nii se pelu iba to muu. (So, his bushy head has nothing to with this malarial attack.) Pele. (Sorry.) E ni o bi l'aaro yii. (You said he vomited this morning.)

Pt. Rel: Bee ni. (Yes.)

Doc.: Okay. Did he go to school yesterday?

Pt. Rel.: Rara .(No.)

Doc.: E l'aya gan-an 0. (You are very fearless.) Efun-un ni folic acid lasan. E o sig bee lo si hospital. (You gave him only folic acid and didn't take him to the hospital.)

Pt. Rel.: Ibi t'a n gbe jina saarin ilu. (We live far away from the city.)

Doc.: Awawi lasan niyen. (That's no excuse.) Abi e ro pe folic le wo efori ni? (So, do you think folic acid could treat the headache?) E ma se bee mo. (You shouldn't do that again.) Ko daa rara. (It's not good at all.) A maa n pe iru ohun t'e se yii ni health-seeking behavior; o si tumo si ki aisan maa se'yan, ko ma si lo si ile iwosan. (We call what you did health-seeking behaviour. It means being ill and yet refusing to go to a hospital.) S'o ye nyin? (Do you understand me?) Tori naa, e ma se bee mo. (So, don't do so next time.) Se otutu n mu e naa? (Do you feel feverish too?)

Pt. Rel.: Beeni. (Yes.)

Doc.: Se e mo genotype re? (Do you know his genotype?)

Pt. Rel.: Mi o moo. (I don't know it.)

Doc.: Kini genotype tiyin ati ti babaa re? (What is your own genotype and the father's?)

Pt. Rel.: AA

Doc.: O daa. E ra awon oogun fun-un. Ti nnkan miran ba sele, e pada waa. (Okay, buy these drugs for him. If there is still any complaint, do come back.)

Pt. Rel.: E see. (Thank you, sir).

INTERACTION 37

Doc.: How are you?

Pt.: Fine.

Doc.: E pele. [Sorry.] What is your name?

Pt.: Adigun Ibrahim.

Doc.: How old are you?

Pt.: Twenty-four.

Doc.: What is your occupation?

Pt.: I am a student.

Doc.: Which school?

Pt.: What school?

Pt.: Kwara State Polytecchnic.

Doc.: What level?

Pt.: ND 11.

Doc.: What course?

Pt.: Biz Admin.

Doc.: Okay. Kin lo gbe nyin wa? [What complaints actually brought you?]

Pt.: Mo n yagbe leralera. [I have diarrhoea.]

Doc.: O n wa lera nwon lera nwon gan-an. [It's very frequent.] Latigbawo lo ti bere? [When did it start?]

Pt.: O ti maa ju three weeks lo. [It should be over three months.]

Dt.: Se igbe olomi to po gan-an ni? [Is the stool very watery?]

Pt.: Teletele igbe olomi ni. Sugbon ti mo ba ti jeun bayii, mo maa yagbe gidi. [It was watery before but after eating now, my stool is no longer watery.]

Doc.: Se ara nyin maa n gbona? [Do you have high temperature?]

Pt.: Bee ni. O maa n gbona. [Yes. It is high.]

Doc.: Se inu maa n run nyin k'e to lo yagbe? [Don't you have stomach upset before going to toilet?]

Pt.: Bee ni. [Yes.]

Doc. Nigbawo le yagbe yen last? [When was the last time you went to toilet?]

Pt.: Mo yaa ni bi twelve lonii. [I went to toilet around 12pm today.]

Doc.: Kin ni e tun wa se sii? [So, what did you do about it?]

Pt.: Mo lo si hospital.[I went to to a hospital.]

Doc.: Kin ni nwon wa fun nyin? [What drugs were you given?]

Pt.: Nwon ko awon oogun kan fun mi, Zinc wa lara nwon. I was given some drugs.and zinc was one of them.] Mo si ti lo gbogbo e tan. Njgbati mo loo tan ti mi o ri iyato, mo tun lo complain, nwon waa ni ki n lo ra ORT ati zinc again. Mo si loo, sugbon ko siyato. [I have taken all the drugs but felt no respite. So, I went to complain again and I was asked to buy zinc and O.R.T. but there was still no change.]

Doc.: So, lati three weeks, eemeloo le yagbe yen lonii? [So, how many times hve you defaecated today?]

Pt.: Eemeta. [Three times]

Doc.: Ana n ko? [What about yesterday?]

Pt.: A a to eemefa. [It should be about six times.]

Doc.: So lomi gan-an? [Was it very watery?]

Pt.: Bee ni. [Yes.]

Doc.: Iyawo meloo le ni? [How many wives do you hve?]

Pt.: Mi o niyawo. [I have no wife.]

Doc.: Girl friend n ko? [What bout girlfriends?]

Pt.: Mi o ni.[I have none.]

Doc.: Ah ah. Kin lo de? Se nitori pe e je aafa ni? [Why? Is it because you re an Islamic cleric?]

Pt.: Rara. T'eeyan ba ni, a a so pe oun ni. Mi o nikankan. [No, I have none.]

Doc.: Unhun. Bii meloo le ti ni ri tele? [Like how many have you ever had?]

Pt.: Meji. [Two.]

Doc.: Igba wo le bawon lajosepo gbehin? [When was the last time you had sex qwith them?] E ma binu o. [Please don't feel offended.]

Pt.: O maa to two years. [It should be up to two years.]

Doc.: Okay. (Examines the patient and checks his blood pressure.) Kin le je nigba ti kinni yen bere? [What type of food did you eat before it started?]

Pt.: Bread at ewa.[Bread and beans.]

Doc.: Bread at'ewa. Se e ran ii abi e see? [Did you buy it?]

Pt.: Mo raa ni.[I bought it.]

Doc.: E raa. Okay. Se immediately t'e raa le jee abi o se die k'e too jee? [Did you eat it immediately you bought it or you left it for some time before eating it?]

Pt.: O se die.

Doc.: It's alright. Awon nnkan to n daamu nyin sometimes enteritis la maa n pe. [Your ailment is called enteritis.] Awon kokoro t'eyan ba pade nibi teeyan ba ti jeun lo saba maa n faa. [It is mostly caused by certain micro-organisms contracted through food.] Se e o maa ru pupo sa? [Don't you feel weght loss?]

Pt.: Mo ti n ru. [I am losing weight.}

Doc.: Alright.The other part to it ni, though o jinna gan-an si ati pe awon aarun keekeeke kan naa wa to maa n daamu ara to le din immunity eeyan ku. [The other part to it is, though not closely related are the minor human ailments that reduce immunity.] Fun apere bii HIV/AIDS could sometimes be partly responsible debii pe ohun to ye k'ara le take care, ko nii le take care re, sugbon, a o tii nii ronu lo ibeyen but alaye t'a koko maa se ni pe anything t'e ba fe je je, e foo daadaa and then k'e fowo nyin with soap and water. [For example, HIV/AIDS could sometimes be partly responsible to the extent that the body will not be able to function normally, but we will not rush to make hasty conclusions. The first thing is that you should ensure you wash your hand very well with soap and water before you eat.] We will give you some drugs now and see how they work. E de tun maa se test eje ati ti igbe nyin. [You will also do blood and stool test.] O maa

to ola s'otunla ki awon test result yen too ready. E maa koo wa, Then, a maa mo ohun t'atun maa se. [The test result will be ready between now and day after the next. You will bring the result, then we will know what to do next.] Is there any othet complaint? [

Pt.: Ko si. [There is none.]

Doc.: A maa fee screen nyin fun HIV/AIDS. Se e fun wa ni iyonda? [We would like to screen you for HIV/AIDS. Do you permit us?]

Pt.: O daa. [It's alright.]

Doc.: Kii se pe a so pe e ti ni HIVo. A kan fee se ayewo ni.[We haven't said you are HIV/AIDS positive but only want to screen you.]

Pt.: Ko buru. [It's alright.]

Doc.: O se Pataki ka se ayewo yii ka le mo ohun t'o n sele. Ko ma baa je pe a fi ina sori orule sun, nigba to je pe ohun t'a le se sii wa.[It is important we carry out this test to avoid creating problems, especially as there is a solution to it.]

Pt.: Okay, sir.

Doc.: So, e waa lo loogun ti mo fe ko nyin yii. Unh? [So, go buy the drugs I will recommend for you.]

Pt.: O daa. [It's alright.]

Doc.: Se e o maa muti? [Don't you drink?]

Pt.: Rara.[No.]

Doc.: Siga n ko? [What about cigarette?]

Pt.: Mi o mu siga. [I don't smoke.]

Doc.: Because ikan ninu awon oogun ti mo fee ko fun nyin yoo daamu nyin t'e ba n muti. [This is because one of the drugs I want to prescribe for you will affect you if you drink or smoke.]

Pt.: Mi kii muti. [I don't drink.]

Doc.: Se ko maa se nyin bii iba? [Don't you feel feverish?]

Pt.: O maa n se mi bee. [I feel so.]

Doc.: E loo lo awon oogum yii. Bakannaa, e se awon rest yii. [Take these drugs and do these tests.]

Pt.: E see.[Thank you.]

Doc.: E pele. [Soory.]

INTEPRACTION 38

Doc.: The last time you came was in April.

Pt.: Yes. April.

Doc.: You are being treated for diabetes and hypertension according to these test results.

Pt.: Yes. Diabetes and hypertension.

Doc.: Do you have any prescription list with you.

Pt.: Yes. I have numerous of them but I want to look for the most recent of them,

Doc.: Since you just took these tests, I mightn't be able to say anything much on your sugar control now.

Pt.: Ok. The last test read 110/127.

Doc.; So, do you have any particular complaint today?

Pt.: Yes. I had a little headache but it later stopped, and about two weeks ago, I observed I had a swollen mouth.

Doc.: Two weeks ago.

Pt.; I took some drugs a doctor gave me in Lagos, the swelling disappeared but I am scared.

Doc.: Emh, well. (Looks at the test results) Did you take any particular drug before you experienced that swelling?

Pt.: Yes. I took a drug which was not inclusive in the drugs I was given by a doctor here. So, I initially thought it was a drug reaction. In fact, I was confused. That's why I had to leave Shaki to come to Ibadan here.

Doc.: But soon after you were given that drug, the swelling disappeared.

Pt.: Yes. It did.

Doc.: I think most likely you have reacted to one drug that you took.

Pt.: But that's not the first time I had taken that drug.

Doc.: The brand you took might not be the brand you had been taking before. Did you take any pain relieving tablet around that time?

Pt.: Yes, I did. When I was having that problem, I went to the General Hospital at Shaki and I was given this drug.

Doc.: What I am trying to say is that when you discovered your mouth was swollen that time, did you have any pain in your body and did you use any pain reliever?

Pt.: No, I did not. I was just using my diabetes and hypertension drugs. But, like I'm telling you it has occurred severally.

Doc.: It has occurred several times.

Pt.: Yes. Severally.

Doc.: How far apart?

Pt.: May be one month, two months or three months.

Doc.: And the swelling is only around your mouth. Not in the throat.

Pt.: Just in the mouth. I have done several tests. I have done ECG when I was experiencing something like worm in my tummy. They are all in my file.

Doc.: Ok. But no itching?

Pt.: No.

Doc.: No pain?

Pt.: No pain.

Doc.: If you don't use any drug, does it go by itself?

Pt.: How many days?

Pt.: Like three, four days.

Doc.: Do you have any kind of allergy? Do you react to anything? May be when you come in contact with smoke or dust.

Pt.: No.

Doc.: Do you have recurrent catarrh?

Pt.: No. But I have fistula.

Doc.: Did you complain about it to any doctor.

Pt.: Yes. They said the only solution is surgery but I have to be honest to you, this my sugar level is what is making me afraid.

Doc.: There is no cause for alarm. Once your sugar level is well controlled, you can do surgery.

Pt.: Nnh

Doc.: Once you take your drugs regularly there won't be any problem.

Pt.: It's the issue of the fistula that made the doctor refer me to Surgery. I even thought it was cancer but the doctor said it was not.

Doc.: Yes, it's not cancer. You see fistula results when there is reduced immunity in the body. The immune system is what fights against infection in the body, and when it becomes weak, diseases surface. It gives room to some kinds of Infection to set in. In addition, medical science has shown that there is too much sugar in the body, immunity will be low. It weakens the armies in the system. So, they won't be able to fight disease. Therefore, infections can have room to actually invade.

Pt.: Nnh.

Doc.: So, if your sugar is well controlled, your immunity will be okay.

Pt.: Ok.

Doc.: Well, concerning this swelling in your mouth, I might have to further examine you and then investigate if there is any cause. Usually when things like these happen, it is either you have taken some things your body is, kind of, reacting to. Or you have been exposed to something you are reacting to. Allergy is an inherent thing in the body. Any time it comes in contact with the irritant, the body will react. Have you heard about asthma?

Pt.: Yes.

Doc.: It comes on and off. There is no cure. The only prevention is avoiding contact with what triggers it off. So, it's the same thing with someone that has allergy. You understand what I am trying to say?

Pt.: Yes.

Doc.: So, this is an allergy. It is either you are reacting to a drug or there is a systemic illness. What I mean is that there are some illnesses in your body. Diabetes can make one prone to infections. That's why I said when it is well controlled, there is no problem. You said the one you did last was 170. That was fair enough. It can be better but, to some extent, it is fair.

Pt,: It was, 98, 98, 100 but just some few months ago, it rose up to that level.

Doc: 127.

Pt.: Yes. I have been controlling it. I take my diet. I don't eat anyhow because it runs in my family. My mother is diabetic. I am the first son of my mother. So, I took it from her.

Doc.: By and large, I think what we will do is – Let's wait and see the results of that test. It should be out latest by tomorrow.

Pt.: Yes. I will come tomorrow.

Doc.: If you come tomorrow, we can now look at the result and the drug you are taking, and compared them. There might be the need to just continue as you are taking and there may be need to increase the dose, depending on what the result says. Overtime-

Pt.: The last time I came I was taking one – one but the doctor said I should take two – two. Two in the morning; two at night, and I should take this one and half.

Doc.: That means they increased the dose. You know as one grows up, the insulin that one uses comes from the pancreas, and as one grows older, normally without diseases, some of the cells within the pancreas lose their functions – normal aging process.

Pt.: That's when someone is aging.

Doc.: When someone is aging. Once you are thirty years, you don't add new cells to what you have. So, the functions of the body start reducing in some particular percentage, even though it is very little. So, it's possible that the amount of the insulin that is being produced in your body now is smaller than what was produced before and that was why they had to increase your drugs so that the pancreas could produce more insulin to meet the need of your body. You understand. But by and large, let's see the result to actually know what to do. So that we have evidence of your sugar level and compare it to the drug you are taking.

Pt.: Alright.

Doc.: So, go and take the test and bring the result.

Pt.: Thank you.

Doc.: How old are you?

Pt.: I am 46 years old.

Doc.: What do you do?

Pt.: I am a customs officer.

Doc.: Since you are coming tomorrow, I don't think I have to prescribe any drug for you now. If I do I would be giving you drugs based on the former test and that wouldn't be good enough. And since you have drugs that you can take till tomorrow, I think we should just be patient till tomorrow to recommend appropriate drugs.

Pt.: Thank you.

Doc.: Let me check your blood pressure. [Doctor checks patient's blood pressure.]

Doc.: Your BP is high. Have you stopped taking your drugs?

Pt.: I ammmmm and that's why I don't take them regularly.

Doc.: Mr. Nzeribe, do you think it's a sin to have told me you are fasting? Tell me your faith so that I can know how to counsel you appropriately.

Pt.: You know it is not right to fast and go about telling people.

Doc.: See, we have the same faith. I am also a Christian. When Jesus was teaching us about fasting, he said we should not let our fasting be like that of the Pharisees who will put ash on their heads and wear poor clothing, and then they would wear a long face that people might know they are fasting. Yaou understand.

Pt.: Yes.

Doc.: You have not done that. The reason why you have told me you are fasting is because of your drugs. Is it not? It has not even shown on your face that you are fasting. So, it is not known to others except to me. And some people say doctors are next to God, I don't know about that. But I know we are working together. God is the one that heals but doctors try to take care of patients. How can take care of you appropriately if I don't know the current situation that you are in? Now that you have told you are fasting, it has not stopped your fasting. You have not told me so that I should hail you, saying –this is a spiritual giant. You have not told me so that I would feel condemned or that you are a good Christian. No. The purpose of telling me is that I will be able to intervene in how you will be able to comply with your drugs so that you will not compromise your faith.

Pt.: I sometimes tell my wife that I have eaten when I am fasting.

Doc.: You don't need to lie to your wife lies.

Pt.: I tell her lies because she worries about me too much.

Doc.: The issue is that if you take your drugs appropriately, you will live a quality life, you will live longer and she too will be happy. That's what her concern is all about.[Patient's wife calls.] She is the one calling you. I'm sure she wants you to be healthy. She wants to have you around her till grey hair comes out of your head. You understand. She knows your condition – healthwise- . Now, God knows your condition, so don't isolate your physical life from your spiritual. Both of you are together. If the doctor says ''Do not fast.'' All you have to do is – you there are other ways of fasting. Don't deny yourself food. Do you understand?

Pt.: I am a prayer warrior.

Doc.: You know what Jesus taught us about fasting that we should not let our fasting be just about food denial. It is in Isaiah. He talked about taking care of the widow, the fatherless, giving alms.

Pt.: Yes.

Doc.: That's the kind of fasting – the one you should have spent on buying a recharge card to just chat or talk with friends, you could just give the money to the poor that don't even have food to it. It is a form of denying yourself. You understand. So, I think we should understand what fasting is all about. Most of the time, we consider fasting as only food, food denial. It goes beyond that. Your leisure time that you could have spent a watching football match, you could decide you want to use it to pray for Nigeria, for prisoners, for missionaries. It's a kind of denial. You are denying yourself the pleasure of relaxing or playing football --. Even, some of our diabetic muslim patients, some time, when we look at their sugar control we advise them: ''For this time, may be you should just stay away from fasting for the sake of your health. If you are alive to see next year, you can join the Ramadan fast next year. You understand?

Pt.: Yes.

Doc.: But if you say you must fast and you don't take your drug, and then you develop complications and then you are not alive for the next Ramadan. So, what have you gained? You understand. So, for you now, what I can still advise is that when you are breaking in the evening, use your drugs. Then, you might not be able fast every day, you might make it Monday, Wednesday, Friday. You understand.

Pt.: But it's what I am used to.

Doc.: See. I am only advising you. I am not going to decide for you. May be by the time I see your result tomorrow, I am going to further advise you. Thank God I have checked your blood pressure now, and your drug is to be taken once a day. So, take it when you are breaking in the evening. Our own God is not a wicked God. He knows everybody's condition and He will not judge you by another person's standard. He knows what is expected of everyone. He knows what you should do and He knows other people should do.

Pt.: I am very grateful.

Doc.: So, Mr Nzeribe, you don't need to feel condemned because you have told me you are fasting. So, we will see again tomorrow. It is well.

Pt.: Bye bye, ma.

Doc.: Bye.

INTERACTION 39

Doc.: Adelowo Samuel. Kin lo see? [What's wrong with him?]

Pt. Rel.: Nwon ni omokunrin kan ti pin bo leti. [A boy is said to have put a pin in his ear.]

Doc.: O ti nnkan bo o leti [He put a pin in his ear.].

Pt. Rel: Bee ni. [Yes.]

Doc.: Samuel, n gbo nwon ti nnkan bo e leti? [Samuel, is it true someone put something into your ear? Je ka woo.[Let's see.] (Examines the patient's ear) Pele.[Sorry.] Mo ti ri nnkan to wa ninu e. [I have seen what is in it. Nnkan dudu ni. [It ia a black thing.] O le ma je pin.[It might not be a pin. T'o ba je eni to dagba ju bayii lo ni, a ba yoo nibi. [If he were older than this, we would have loved to treat him here.] Torinaa, a maa fun nyin ni iwe lo si E.N.T. lati ba a yoo. [Therefore, you will be referred to the E.N.T. section for treatment.] Awon oni E.N.T. yen eti lasan ni awon n ba deal pelu. [The E.N.T. people are specialists in ear problems.

Pt.Rel: O ti ye mi. [It is clear.]

Doc.: Bawo l'e nyin se mo pe nnkan wa leti e? [How did you know there was something in his ear?

Pt. Rel.: O so fun mi. Mo waa woo, mo de rii. [He told me and I saw it there.]

Doc.: Kin wa le fee fi yoo? [With what did you try to remove it?]

Pt. Rel.: Cotton bud.

Doc.: Se e rii, ni ojo miran ti omo ba ki nnkan seti, e so fun awon yokuu nyin naa, e ma attempt ati yoo rara,ko ma waa di pe e tun kii wonu sii.[See, anytime a child puts anything in his ear, you shouldn't try to remove it to avoid a situation where you would further push the object in.] Emi gan-an ti mo je doctor nigba ti mo ti rii pe o ti sun sinu ju, mo ni lati je ki awon to kose eti titoju yanju e.[Beind a medical doctor myself, I have to refer you to an E.N.T. specialist, having seen the object has gone in so much. So, e so fun gbogbo awon ti e jo n sise pe ti enikeni ba ti nnkan bo imu tabi eti, ki nwon ma fowo kan-an ti kii ba ti i se ohun ti e le fi owo lasan yo. [So, tell your colleagues at work not to attempt removing anything from a child's ear if it's not an object that can easily be removed with hands alone.]. Ki nwon tete gbe e lo so si hospital. [They should instead quickly take the child to a hospital.]Se e waa ri omo to ki nnkan boo leti? [Did you see the boy that put the object into his ear?]

Pt Rel..: A rii. [We did.]

Doc.: E gba iwe yii ki e muu lo si E.N.T.. Nwon maa toju e nibe. [Take this letter to to E.N.T. Clinic. He will be treated there.]

Pt.: E see. [Thank you.]

Doc.: O dabo. [Bye bye.]

INTERACTION 40

Doc.: Mrs Anne Ejiofor.

Pt.: Good afternoon, sir.

Doc.: Afternoon, madam. What brought you here?

Pt.Rel: My child has rashes on the bottocks and I see blood stains.

Doc.: How long have you noticed the rash?

Pt.: A month.

Doc.: How old is he?

Pt.: Three months.

Doc.: What soap do you use to bathe him?

Pt.: Cussons.

Doc.: Do you have him in pampers always?

Pt.: Yes.

Doc.: When you use tissue paper to clean his buttocks, do you see where the blood comes from.

Pt.: No.

Doc: I am asking this question because if we are not careful, we may not really know where the blood comes from.

Pt. I don't know.

Doc.: It looks like it is coming from that place but we have to be sure so that we don't use constricting this thing. Unh? How many pampers do you use daily for him?

Pt.: Three.

Doc.: Three might be small for a child like this. So, what you have to do is let air blow on the place when you are at home. So, stop using pampers for him at home. It seems the problem emanated from enough air not blowing on the place.

Pt.: Is it the circumcision that caused it?

Doc.: No. It is excessive heat.

Pt.: Can this not become a big problem?

Doc.: No, if you prevent too much. Make sure the buttocks are always dry. Heat and moisture are a very bad combination. What kind of soap do you use for the baby?

Pt.: Cussons baby soap.

Doc.: What about hair cream?

Pt.: Mercy cream.

Doc.: Use shear butter instead. Does it itch him?

Pt.: No.

Doc.: What we call this is a kind of reaction.

Pt.: Some people even advised me tom use herb concoction.

Doc.: Don't use anything. It is just an allergy that might have resulted from the various strong creams you have used on him. So, all those rashes will disappear in due course. Just take to my advice.

Pt.: Alright.

Doc.: All of them will go. It's just baby skin reaction. You also say he coughs.

Pt.: When did the cough start?

Pt.: About three days ago.

Doc.: Alright. I will give you a drug for that. (Recommends a drug) So, give him this cough syrup.

Pt.: Thank you.

Doc.: Bye bye.

INTERACTION 41

Doc.: Akinabi Testimony.

Pt Rel..: E kaasan, sir.[Good afternoon, sir.]

Doc.: Ewo lo gbe nyin wa? [What are your complaints?]

Pt. Rel.: Daddy, o n yagbe sooro, o tun n bi lati oru ana? [He has diarrhea and has also been vomiting since last night.]

Doc.: Kin wa a l'e n se titi di aago meji osan nisisiyii? [What have you done about it since then till 2pm now?]

Pt.Rel.: Mo loo gbaaye nibi ise ni. [I went to obtain permission in my office.]

Doc.: Nibo nibi ise nyin? [Where do you work?]

Pt.:Rel.: Prisons.

Doc.: Ko daa bee o. E ma se bee mo lojo miran. [That's not good. Don't do so next time.]

Pt.Rel.: E ma binu. [Sorry.]

Doc.: Awa o binu, torii tara nyin ni. [We are not angry but just saying this in your own interest.]To ba je nnkan to waa buru ju bayii lo n ko kini yoo waa sele? [You can imagine what would have happened if his condition were worse than this.] Eemeloo lo ti wa yagbe? [So, how times has he defaecated?]

Pt. Rel.: Ko yagbe loru. [He did not run stool in the night.] O kan n bi ni.[He was only vomiting.] Aaro yii lo too bere sii yagbe. [He just began to run stool this morning.]

Doc.: Eemelo lo ti wa yagbe laaro sigbayi? [So, how many times has he defaecated between morning and now?]

Pt. Rel.: Eemefa. [Six times.]

Doc.: Okay.

Pt. Rel.: O tun ti wa n yagbe laaro yii. O de n run gan-an. [So, he has also started to run stool this morning and it smells badly.]

Doc.: O n run gan-an. [It smells badly.] Se o n jeun? [Does he eat?]

Pt. Rel.: T'o ba ti je naa lo maa bii. [He vomits immediately after eating.}

Doc.: Okay. Se o n gboyan? [Does he accept breast milk?]

Pt. Rel.: T'o ba ti gbaa naa lo maa bii. [He does but vomits it immediately afterwards.]

Doc.: Se ara re n gbona? [Does he have high temperature?]

Pt. Rel.: Rara. [No.]

Doc.: Omo meloo le ti bi? [How many children have you got?

Pt Rel.: Meta. [Three.]

Doc.: Omo odun melo ni. [How old is he?]

Pt. Rel.: Osu mejo. [Eight months.]

Doc.: (Looks at the patient's folder) Nwon ti treat omo yii ni igba meloo kan fun igbe gbuuru ati awon nnkan to fara pee. [This child has been treated here some times for diarrhea and related ailments.] Aini imototo to lokunfaa gbogbo igbe aisan to

n daa laamu. [Lack of hygiene is the cause of his sickness.] E di ori e mu, ki e si ki ese re si aarin ese nyin. [Hold him well and sandwich his between yours.] Enu re ni mo feee wo . [I want to examine his mouth.] Ofun laisan to n see wa. Tonsilitis lo n see. [It is evident in his throat he has tonsillitis.] Se ara re n gbona? [Does he have high temperature.]

Pt. Rel.: Bee ni. [Yes]

Doc: Fun ebibi t'o n bi, o maa gbabere f'ojo meji. [To take care of the vomit. He will take injections for two days.] Lehin eyii, e o maa fun ni oogun olomi ti maa fun-un nyin. [You will give him the drugs I will recommend now afterwards.] Ti e ba bere sii fun-un l'oogun olomi nisisiyii, ko nii duro lara re. [If you adminster thr drug on him now, he will still vomit it.]

Pt. Rel.: O ye mi. [I can understand you.]

Doc.: And then ti omo ba ti n yagbe, o n so fun awon obi ati ara adugbo pe imototo to wanile naa ko too. In addition, watery stool is an indication of unhygienic life style. Ki i se pe a n so pe ko too. Sugbon a n so pe a fe ko po sii. [So, what we are saying is that you need to be more hygienic.] Madam, are you listening to me?

Pt. Rel.: Yes.

Doc.: So, e ri gbogbo nnkan t'o n fowokan, a a de maa mowo naa lo s'enu.[Can you see he touches anything and takes the hand to his mouth. So, e maa fowo nyin ati ti re pelu ose ati omi nigba gbogbo. [So, wash his hands all the time with soap and water.] Uhn? Then, ti omo ba ti n yagbe, e maa fun-un ni ORT. [Then, anytime a child is running stool, he should be given ORT.]

Pt. Rel.: Se awon kokoro kan lo faa ni. [Was the sickness caused by micro-organisms?

Doc.: Bee ni. [Yes.] Ibo 'le maa n gbe e si ti e ba n lo si ibi ise? [Where do you keep him when going to work?]

Pt. Rel.: Odo aburo mi ni. [I keep her in my younger sister's place.]

Doc.: E make sure pe ibe neat daadaa.[Ensure the place is neat.]

Pt. Rel.: Yes, sir.

Doc.: (Doctor prescribes some drugs) E lo ra awon oogun yii, ki e si maa fun-un. [Buy these drugs for him.]

Pt. Rel.: Thank you.

INTERACTION 42

Doc.: Kin 'oruko nyin? [What is your name?]

Pt.: Paul Ajayi.

Doc.: Kin lo n se nyin? [What are your complaints?]

Pt.: Ara mi n gbona gan-an. [I have a very high temperature.]

Doc.: Lehin ara gbigbona , kin lo tun n se nyin? [What other complaints do you have apart from that?]

Pt.: Idi tun n ta mi gan-an.[I feel a burning sensation in my anus.] O ti e tami gan-an lale ana ju. [I felt the burning sensation so much last night.]

Doc.: Igbe lile t'eya lo je ki idi tan yin. [You feel the burning sensation because your stool is hard]. Se ara nyi si n gbona gan-an ni. [Do you still have high temperature now?]

Pt.: Bee ni. Enu mi tun wa n kan. [Yes. My mouth also tastes bad.]

Doc.: Se ara gbigbona yen wa before enu kikan ni. [Did the high body temperature start before the bad taste in the mouth?]

Pt.: Bee ni. [Yes.]

Doc.: Se o maa n wa o maa n lo ni? Abi o maa n gbona lati aaro dale? [Does the high temperature come intermittently or it continues from morning till evening?]

Pt.: O maa n wa o maa n lo ni. [It comes intermittently.]

Doc.: Se ori ko maa fo nyin? [Don't you have a headache?]

Pt.: Ori o fo mi. [No.]

Doc.: Se ito ko maa jo nyin nidi? [Don't you a burning sensation during urination?]

Pt.: O maa n jo mi diedie. [I feel it lightly.]

Doc.: Inu rirun n ko? [Do you suffer from stomach upset?]

Pt.: Rara.[No.]

Doc.: Se e o wuko? [Do you not cough?]

Pt.: Rara. [No.]

Doc.: (Checks patient's BP) E mojuto ifunpaa nyin ati iyo jije. [Pay attention to your BP and watch your salt intake.]

Pt.: Ara re naa lo je ki n wa.[That's why I came.]

Doc.: E sa a din iyo jije nyin ku. [Just make sure you reduce your salt intake.] Oogun kan wa ti a maa fun nyin. E maa maa ki i bo idi laaro ati lale. [You will be given a drug that will be inserted in your anus every morning and evening.] Se e gbo? [Do you understand me?]

Pt. Bee ni. [Yes.]

Doc.: Ki e si je ki efo maa po ninu ounje nyin ati osan. [Then, you should ensure you take lots of vegetable and orange.]

Pt.: Mo ti e n ro pe mo ni HIV ni. [I have been thinking I am probably HIV positive.]

Doc.: A le se test fun HIV ti e ba fe. [We could screen you for HIV if you so desire.] A o le so pe HIV le ni. [We can't say you are HIV positive yet] Awon apere HIV ni igbe gbuuru, iko wiwu. [Symptoms of HIV are: diarrhea, cough. Enyin le de so pe e o ri igbe ya yii. So, a ko le so pe e ni HIV. [But you say you find it hard to defaecate. So, we can't say you are HIV positive.] E je ki okan nyin bale. [Let your mind be at peace.] A maa fun nyin ni awon oogun ohun t'o n se nyin.[We will give you drugs for your health complaints.]

Pt.: Ni ale mi ki n tete ri oorun sun. [I find it difficult to sleep at night.] Ti mo ba sun ti mo ji loru, mi o nii le sun mo. [Sometimes when I wake up in the middle of the, I don't sleep again.]

Doc.: Maa fun nyin l'oogun ti e maa lo si gbogbo e. [I will recommend some drugs to take care of the complaints.] E lo ra awon oogun yii. [Buy these drugs.] Ti e ba ni complaint miran, ki e pada wa. [If you have any complaints afterwards, do come back.]

Pt.: E see. [Thanks.]

Doc.: O dabo. [Bye bye.]

Pt.: O dabo. [Bye bye.]]

INTERACTION 43

Doc.: E pele ma. Bawo lara nyin? [Sorry, ma. How are you?]

Pt.: Mo dupe lowo Olorun. [I thank God.]

Doc.: Kin lo tun se nyin bayii? [What's wrong with you again?]

Pt.: Ifunpa yii ati eti naa ni.[It's high blood pressure and this ear.]

Doc.: Se e ti se ayewo? [Have you done any test?]

Pt.: Rara. [No.]

Doc.: Gbogbo igba t'e ba ti n bo lodo wa, e ni lati s'ayewo eje.[Anytime you are coming to the hospital, you need to do blood test.]

Pt.: Ko ye mi bee.[I didn't know.]

Doc.: Mama, e maa pada wa lola toripe e ni lati se ayewo eje lati mo bi sugar ti po to ninu eje nyin. [You will have to come again tomorrow because you need to do blood sugar test to know how high your blood sugar is.]

Pt.: Ko buru. Maa wa. '[Not bad. I will come.]

Doc.: E je ki n se ifunpa fun nyin. [Let me check your BP] (Checks patient's BP)

Pt.: Uuhhun.

Doc.: A o maa reti nyin.[We will be expecting you.] O dabo. [Goodbye.]

Pt.: O dabo.[Goodbye.]

:INTERACTION 44

Doc.: Okay, sir. How are you doing today?

Pt. : I have body pain.

Doc.: Okay. That's what brought you.

Pt.: Yes.

Doc.: How old are you, please?

Pt.: I am fifty years.

Doc.: So, beside the body pain, no other complaint?

Pt.: The last time I came, I complained I felt feverish and a malaria test was done for me. I was given some drugs but I also feel pains in my body.

Doc.: For how long have you had the pain?

Pt.: It's quite a long time. It keeps coming and going.

Doc.: So, if I am getting you right, you have been have been having recurring body pain. I will treat you for malaria. Usually, when you are treated for malaria, does the pain go?

Pt.: Yes. Yes.

Doc.: It will go? This pain you are experiencing now, now long have you felt it?

Pt.: Since three months ago.

Doc.: Where exactly are you having this body pain? In what parts of the body do you feel the pain?

Pt.: Here.

Doc.: Is it your joints or generalized body pain?

Pt.: All over my body since June.

Doc.: Are telling me you have been having this body pain since June every day? Is that what you are saying?

Pt.: Sometimes, I feel it and sometimes I do not?

Doc.: So, what do you think is causing this body pain?

.Pt.: I don't know but I work in a place where I carry heavy things.

Doc.: As you explained to me just now that the nature of your job involves lifting things, don't you think the body pains you feel is connected to the kind of job you do?

Pt.: May be.

Doc.: That's what I am thinking but another thing you should also realize is that your body changes and the way your body reacts to stress also changes. So, pain is not synonymous with malaria. So, it's not that anytime you have pain, you have malaria.

Pt.: Is that?

Doc.: Yes. You can even see that you have been treating malaria yet the body pain remains. So, now there is the possibility that what you are feeling is actually a consequence of stress on your muscles. Anyway, I am going to screen you for malaria so that we can see if there is any parasite now and then we will see later if there is any other thing. But apart from this body pain you are having, are you having fever? Are you having temperature?

Pt.: No. I don't normally have any of them.

Doc.: Okay, you are not having that Any headache?

Pt.: Each time I fast.

Doc.: In that case, you have to stop fasting.

Pt.: I can't. We fast every week in our church.

Doc.: Fasting is good only when it doesn't affect your health. You know I am also a Christian.We can stay away from fasting if our health can not cope with it. The Bible allows it. You need to read your Bible more to know this.

Pt.: Thank you. But I can't do without fast.

Doc.: You may see your pastor for further clarification on my advice. Do you eat well?

Pt.: Yes.

Doc.: Okay. Do you usually feel like vomiting sometimes?

Pt.: No.

Doc.: Okay. Any stomach pain?

Pt.: Yes. Occasionally.

Doc.: Occasionally. It's not something that is disturbing you?

Pt.: It just comes and goes.

Doc.: How often does it occur?

Pt.; I felt it yesterday. I also went to toilet two times in the night.

Doc.: How many times?

Pt.: Twice.

Doc.: Twice. Is that normal for you?

Pt.: No.

Doc.: Did you notice any increase in the number of time you go to toilet?

Pt.: Yes.

Doc.: Was the stool watery?

Pt.: Yes, it was but today, it is normal

Doc.: Not watery?

Pt.: Yes. I think it's a reaction to the drug I took.

Doc.: If you take this type of drug without eating, it could actually cause some stomach discomfort. Okay. So, you are being treated for hypertension too.

Pt.: Yes.

Doc.: So, what drugs are you on actually?

Pt.: This and this.

Doc.: Where were these prescribed?

Pt.: Here.

Doc.: How regularly do you take your drugs?

Pt.: I skip them sometimes?

Doc.: Why?

Pt.: Because I feel I am okay.

Doc.: Do you know that hypertension is not like malaria where you get treated, you get fine and you just go off it. That was why when you checked your BP two days ago, it was high.

Pt.: I always go to a private hospital to check it.

Doc.: So, you usuually go to a private hospital to have it checked.

Pt.: Yes.

Doc.: That's good. When you took these drugs, did you feel any relief with the body pains?

Pt.: A little. The pain reduced.

Doc.: Anyway, I will just use this opportunity to re- emphasize the fact that with hypertension, even if you are on drug, you have to follow up the treatment so that the doctor can always check your blood pressure and find out if the drugs that you are on are actually achieving the control that is best for you. And apart from using drugs, there are other additional lifestyle activities that you can do that help in controlling the BP. I'm sure you have also been told to keep your thought at a minimal level, take lots of fruit and vegetables. You are active already because of the kind of job you do but it's also important you engage in activities that actually make your heart beat well. Yes you might be carrying heavy things but that does not necessarily mean it's the right type of exercise for you,

Pt.: My job makes me exercise a lot.

Doc.: That might not be the kind of exercise that is good for you. Just try to keep active. Basically all those activities help to lower the blood pressure.

Pt.: Alright.

Doc.: You sleep well?

Pt.: When I take the drugs I am given.

Doc.: But what hat happens without them?

Pt.: I don't sleep.

Doc.: What prevents you from sleeping?

Pt.: I just wake up in the middle of the night and don't sleep again.

Doc.: The most important thing about sleep is that one should not depend on drugs to sleep, and everyone has to learn how to develop a sleep pattern that works with him or her. You have to understand your own sleep. Has your BP been checked today?

Pt.: No.

Doc.: (Checks patient's BP) Right now, sir, your BP is 160/100. That's still not good. Have you taken your drugs today?

Pt.: Yes.

Doc.: Which ones have you taken?

Pt.: (Points to some drugs). This and this.

Doc.: Anyway, I will still leave you on that. Let me see. There was this other drug you were placed on the last time which is not part of what you have here. I mean

Pt.; I have used it up.

Doc.: Okay. So, I will recommend some tablets of that drug for you to be taken alongside these that you still have. You will come back in the next two weeks for a review but make sure you take your drugs regularly.

Pt. Thank you.

Doc.; You are welcome. (Hands over the prescription list to the patient)

Pt.: {Collects it) Thank you. Good bye.

Doc.: Goodbye.

INTERACTION 45

Doc.: E kaasan. [Good afternoon.]

Pt.: E kaasan. [Good afternoon.]

Doc.: Kin louko nyin? [What's your name?]

Pt.: Lekan Ibraheem.

Doc.: Ewo lo gbe nyin wa? [What brought you here?]

Pt. Re.l.: Omo yii lo complain ori fifo nib ii ijeat. O si tun ni malaria. [My child has a headache and malaria.]

Doc.: How old is he?

Pt. Rel.: Eleven years.

Doc.: In what class is he?

Pt. Rel.: Class Two.

Doc.: Boarding or day?

Pt. Rel.: Day.

Doc.: Kin lo complain about? [What's is his complaint?]

Pt. Rel.: Ori fifo. Ara re si n gbina. [Headache and high temperature.]

Doc.: Lati 'gbawo? [Since when.]

Pt. Rel.: Ijeta. [Three daya ago.]

Doc.: Pele. So, kin le ti wa lo fun? [Sorry. So, what drugs have you given her?]

Pt. Rel.? Amocillin.

Doc.: Sori fifo yen po gan-an ni? [Is the headache severe?]

Pt.Rel.: Beeni. Ti'run e ba de ti n kun, o maa n complain pe ori n fo oun. Inu tun n run-un. Ode tun bi l'aaro yii. [Yes. He complains about headache when his hair is long. He has stomach pain. He also vomited this morning.]

Doc.: Lati'jeta yen ko bi tele? Se ko ya igbe olomi? [He did not vomit since day before yesterday. Is his stool not watery?

Pt.: Rel.: Rara. [No,] Ko ya'gbe olomi. [He did not defaecate toda.]

Doc.: Ibrahee!

Pt.: Sir.

Doc.: Can't you talk?

Pt. I can.

Doc.: Come closer. Sorry. Look at your teeth. You don't brush your teeth well. This is how to brush your teeth, and you should change your toothbrush every three months. S'ori n fo e naa? [Do you also have a headache?]

Pt.: Beeni.

Doc.: Se'waju ni abi ehin? [Is it the front one or the back one?]

Pt.: Iwaju. [Bach.]

Doc.: Se oju ko ro e? [Don'nt you feel pains in the eyes?]

Pt.: Rara.[No.]

Doc.: Se'ti ko ro e? [Don't your ear pain you?]

Pt.: Rara.[No.]

Doc.: Se o n wuko? Do you cough?]

Pt.: Beeni.[Yes.]

Doc.: Nigbawo lo bere? [When did it start?]

Pt.: Bii ojo melo kan sehin. [Some days ago.]

Doc.: So wuko nijeta? (Did you cough the before yesterday?]

Pt.: Beeni.[Yes.]

Doc.: Sorry. So, awon oogun wo le so pe o ti lo? [So, what drugs have you taken?]

Pt. Rel.: Folic acid, amocillin capsule ati paracetamol.

Doc.: Taalo ko oogun yii fun nyin? Abi e kan raa funraa nyin ni? (Who recommended the drugs for you? Or did you buy them without any doctor prescribing it?)

Pt. Rel.: Emi ni mo raa funraa mi. (I bought them myself).

Doc.: Se doctor leyin abi nurse? Ise wo leyin n se? (What is your profession?)

Pt. Rel.: Engineer ni mi.

Doc.: Iru engineer wo?

Pt. Rel.: Metal fabricator.

Doc.: E o le muu wa si hospital titi di isiyii. (So, you couldn't bring him to the hospital until now). E wa n bo nibi nisiyii nigba to fee yiwo. (You now came here when it's almost an emergency case.) Irun kikun ko nii se pelu iba, sugbon iba le se konge ori kikun. (Bushy hair does not cause malaria, but malarial attack can possibly coincide with bushy hair.) If a person with bushy hair has malaria and we cut the hair and treat him for malaria, if he is bitten by mosquitoes very well, he might malarial attack again between the next 14 to 21 days. So, it is not that bushy hair causes malaria. Do you understand me?

Pt. Rel.: Bee ni. (Yes.)

Doc.: Tori naa, ori I re t'okun ko nii se pelu iba to muu. (So, his bushy head has nothing to with this malarial attack.) Pele. (Sorry.) E ni o bi l'aaro yii. (You said he vomited this morning.)

Pt. Rel: Bee ni. (Yes.)

Doc.: Okay. Did he go to school yesterday?

Pt. Rel.: Rara. (No.)

Doc.: E l'aya gan-an 0. (You are very fearless.) Efun-un ni folic acid lasan. E o sig bee lo si hospital. (You gave him only folic acid and didn't take him to the hospital.)

Pt. Rel.: Ibi t'a n gbe jina saarin ilu. (We live far away from the city.)

Doc.: Awawi lasan niyen. (That's no excuse.) Abi e ro pe folic le wo efori ni? (So, do you think folic acid could treat the headache?) E ma se bee mo. (You shouldn't do that again.) Ko daa rara. (It's not good at all.) A maa n pe iru ohun t'e se yii ni health-seeking behavior; o si tumo si ki aisan maa se'yan, ko ma si lo si ile iwosan. (We call what you did health-seeking behaviour. It means being ill and yet refusing to go to a hospital.) S'o ye nyin? (Do you understand me?) Tori naa, e ma se bee mo. (So, don't do so next time.) Se otutu n mu e naa? (Do you feel feverish too?)

Pt. Rel.: Beeni. (Yes.)

Doc.: Se e mo genotype re? (Do you know his genotype?)

Pt. Rel.: Mi o moo. (I don't know it.)

Doc.: Kini genotype tiyin ati ti babaa re? (What is your own genotype and the father's?)

Pt. Rel.: AA

Doc.: O daa. E ra awon oogun fun-un. Ti nnkan miran ba sele, e pada waa. (Okay, buy these drugs for him. If there is still any complaint, do come back.)

Pt. Rel.: E see. (Thank you, sir).

INTERACTION 46

Doc.: Madam, how are you? What complaints brought you here today?

Pt.: My stomach.

Doc.: What's wrong with your stomach?

Pt.: I feel pain in it and I go to toilet frequently.

Doc.: Since when:

Pt.: Two weeks ago.

Doc.: So, you said two weeks ago, you started having stomach pain and it's turning and making you go to toilet frequently.

Pt.: Yes.

Doc: What drug did you take to restore normalcy.

Pt.; I took tetracycline and flagyl and I also feet a biting sensation sometimes probably because I have hepatitis. I still felt the bite yesterday.

Doc.: So, you also have hepatitis.

Pt.: Yes, and I also fart a lot.

Doc.: Is it still biting you now.

P:t.: No. It is no more biting me. At times when I don\t eat, I pass out gas.

Doc.: It also happens when you don't eat?

Pt.: Yes. At times in the morning when I've not eaten anything.

Doc.: So, is the farting a problem to you?

Pt.: I don't know.

Doc.: No, I am asking you. Is it a problem to you?

Pt.: I thought it's only when someone eats and I also have headache..

Doc.: Not necessarily. You are having abdominal pain. Are you passing watery stool?

Pt.: Last week.

Doc.: When?

Pt.: During the weekend.

Doc.: Has it stopped?

Pt.: It has stopped but anytime I eat, the stomach turns and I feel as if I want to go to toilet.

Doc.: Do you eventually go to toilet?

Pt.: Yes, I do go sometimes.

Doc.: When you go to toilet, what does your stool look like?

Pt.: It's normal.

Doc.: It's not watery.

Pt.: No. It's not watery. It was as when it started but now again.

Doc.: Any temperature?

Pt.: No.

Doc.: You said you were also having headache, when did the headache start?

Pt.: Last week.

Doc.: You also said your appetite is also low.

Pt.: Yes.

Doc.: Any vomiting or feeling of wanting to vomit?

Pt.: No.

Doc.: The headaches, are they there all the time?

Pt.: I still feel it.

Doc.: Do you sleep well?

Pt.: That is when I'm placed on drugs.I don't sleep regularly.

Doc.: So, if you are not placed on drugs, you won't sleep.

Pt.: Yes.

Doc.: But the last time you came in July, you were placed on drugs.

Pt.: Yes. But I did not finish them because they were giving me stomach pains.

Doc.: So, you said you had taken flagil. How long ago did you take it?

Pt.: Since lat week. This week I have not taken it.

Doc.: Please, can you go in there? Let me examine you.

Pt.: Okay, ma.

Doc.: (Examination ends) It's okay. I will place you on some drugs until we get the result of the tests I will recommend now. (Prescribes some drugs and tests.)

Pt.: Okay, ma.

Doc.: The result should be out in the next three days at most. So, bring them when they are out.

Pt.: Thank you.

Doc.: Bye.

Pt.: Bye bye, ma.

INTERACTION 47

Doc.: Why is he here?

Pt. (Rel.) : They said she should come for a review.

Doc.; Who said that?

Pt. (Rel.) The last time we came, after they removed the teeth. They now said we should come back. We were asked to come the following day but I was very weak. So, I couldn't follow him.

Doc.: But what was it that she complained of?

Pt. (Rel.): The teeth that was - She was bringing out teeth. What do they call it? The former teeth - the milk teeth is not yet off for the permanent one.

Doc.: But how is it now? How is she?

Pt. (Rel): It's like the one she removed. One is in the normal position.

(Doctor calls for an instrument to examine the teeth.)

Doc.: (To patient) Can you open your mouth, please? Good girl. (Examines the teeth) So, when did you remove the teeth?

Pt. (Rel.) Two weeks ago.

Doc.: How old is she?

Pt. (Rel.).: Six.

Doc.: She is six now. Did you do all the immunization when you gave birth to her? She had all her immunization.

Pt. Rel) Yes.

Doc.: Then, Does she still take some of these refined sugar – chocolate, biscuit, sweet?

Pt. (Rel.): Sometimes.

Doc.: And I hope you have been told that those things are not good for the teeth.

Pt. (Rel.) Yes.

Doc.: (To patient) In what class are you now?

Pt.: Primary One.

Doc.: Primary One, good girl. How many times do you brush in a day?

Pt.: One time.

Doc.: Just once. Who brushes for you?

Pt.: Myself.

Doc.: Yourself? (To pt. rel.) She shouldn't be brushing herself at six.

Doc.: (To Pt. Rel.) Is she on any medication?

Pt. Rel.: Malarial drug.

Doc.: What type?

Pt. Rel.: Coartem.

Doc.: Just that. Is she allergic to any drug?

Pt. Rel.: No.

Doc.: Is she epileptic?

Pt. Rel.: No.

Doc.: Is she diabetic?

Pt. Rel.: No.

Doc.: That's alright.

(Doctor recommends drugs.)

INTERACTION 48

Doc.: Why is he here?

Pt. Rel. They said she should come for a review.

Doc.: Who said that?

Pt. Rel. The last time we came, after they removed the teeth. They now said we should come back. We were asked to come the following day but I was very weak. So, I couldn't follow him.

Doc.: But what was it that she complained of?

Pt. Rel.: The teeth that was - She was bringing out teeth. What do they call it? The former teeth – the milk teeth is not yet off for the permanent one.

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Pt. Rel) Yes.

Doc.: Then, Does she still take some of these refined sugar – chocolate, biscuit, sweet?

Pt. (Rel.): Sometimes.

Doc.: And I hope you have been told that those things are not good for the teeth.

Pt. (Rel.) Yes.

Doc.: (To patient) In what class are you now?

Pt.: Primary One.

Doc.: Primary One, good girl. How many times do you brush in a day?

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Doc.: Just once. Who brushes for you?

Pt.: Myself.

Doc.: Yourself? (To pt. rel.) She shouldn't be brushing herself at six.

Doc.: (To Pt. Rel.) Is she on any medication?

Pt. Rel.: Malarial drug.

Doc.: What type?

Pt. Rel.: Coartem.

Doc.: Just that. Is she allergic to any drug?

Pt. Rel.: No.

Doc.: Is she epileptic?

Pt. Rel.: No.

Doc.: Is she diabetic?

Pt. Rel.: No.

Doc.: That's alright.

(Doctor recommends drugs.)

INTERACTION 49

Doc.: The last time you came was in April.

Pt.: Yes. April.

Doc.: You are being treated for diabetes and hypertension according to these test results.

Pt.: Yes. Diabetic and hypertension.

Doc.: Do you have any prescription list with you.

Pt.: Yes. I have numerous of them but I want to look for the most recent of them,

Doc.: Since you just took these tests, I mightn't be able to say anything much on your sugar control now.

Pt.: Ok. The last test read 110/127.

Doc.: So, do you have any particular complaint today?

Pt.: Yes. I had a little headache but it later stopped, and about two weeks ago, I observed I had a swollen mouth.

Doc.: Two weeks ago.

Pt.; I took some drugs a doctor gave me in Lagos, the swelling disappeared but I am scared.

Doc.: Emh, well. (Looks at the test results) Did you take any particular drug before you experienced that swelling?

Pt.: Yes. I took a drug which was not inclusive in the drugs I was given by a doctor here. So, I initially thought it was a drug reaction. In fact, I was confused. That's why I had to leave Shaki to come to Ibadan here.

Doc.: But soon after you were given that drug, the swelling disappeared.

Pt.: Yes. It did.

Doc.: I think most likely you have reacted to one drug that you took.

Pt.: But that's not the first time I had taken that drug.

Doc.: The brand you took might not be the brand you had been taking before. Did you take any pain relieving tablet around that time?

Pt.: Yes, I did. When I was having that problem, I went to the General Hospital at Shaki and I was given this drug.

Doc.: What I am trying to say is that when you discovered your mouth was swollen that time, did you have any pain in your body and did you use any pain reliever?

Pt.: No, I did not. I was just using my diabetes and hypertension drugs. But, like I'm telling you it has occurred severally.

Doc.: It has occurred several times.

Pt.: Yes. Severally.

Doc.: How far apart?

Pt.: May be one month, two months or three months.

Doc.: And the swelling is only around your mouth. Not in the throat.

Pt.: Just in the mouth. I have done several tests. I have done ECG when I was experiencing something like worm in my tummy. They are all in my file.

Doc.: Ok. But no itching?

Pt.: No.

Doc.: No pain?

Pt.: No pain.

Doc.: If you don't use any drug, does it go by itself?

Pt.: How many days?

Pt.: Like three, four days.

Doc.: Do you have any kind of allergy? Do you react to anything? May be when you come in contact with smoke or dust.

Pt.: No.

Doc.: Do you have recurrent catarrh?

Pt.: No. But I have fistula.

Doc.: Did you complain about it to any doctor.

Pt.: Yes. They said the only solution is surgery but I have to be honest to you, this my sugar level is what is making me afraid.

Doc.: There is no cause for alarm. Once your sugar level is well controlled, you can do surgery.

Pt.: Nnh

Doc.: Once you use your drugs regularly there won't be any problem.

Pt.: It's the issue of the fistula that made the doctor refer me to Surgery. I even thought it was cancer but the doctor said it was not.

Doc.: Yes, it's not cancer. You see fistula results when there is reduced immunity in the body. The immune system is what fights against infection in the body, and when it becomes weak, diseases surface. It gives room to some kinds of Infection to set in. In addition, medical science has shown that there is too much sugar in the body, immunity will be low. It weakens the armies in the system. So, they won't be able to fight disease. Therefore, infections can have room to actually invade.

Pt.: Nnh.

Doc.: So, if your sugar is well controlled, your immunity will be okay.

Pt.: Ok.

Doc.: Well, concerning this swelling in your mouth, I might have to further examine you and then investigate if there is any cause. Usually when things like these happen, it is either you have taken some things your body is, kind of, reacting to. Or you have been exposed to something you are reacting to. Allergy is an inherent thing in the body. Any time it comes in contact with the irritant, the body will react. Have you heard about asthma?

Pt.: Yes.

Doc.: It comes on and off. There is no cure. The only prevention is avoiding contact with what triggers it off. So, it's the same thing with someone that has allergy. You understand what I am trying to say?

Pt.: Yes.

Doc.: So, this is an allergy. It is either you are reacting to a drug or there is a systemic illness. What I mean is that there are some illnesses in your body. Diabetes can make one prone to infections. That's why I said when it is well controlled, there is no problem. You said the one you did last was 170. That was fair enough. It can be better but, to some extent, it is fair.

Pt,: It was, 98, 98, 100 but just some few months ago, it rose up to that level.

Doc: 127.

Pt.: Yes. I have been controlling it. I take my diet. I don't eat anyhow because it runs in my family. My mother is diabetic. I am the first son of my mother. So, I took it from her.

Doc.: By and large, I think what we will do is – Let's wait and see the results of that test. It should be outlatest by tomorrow.

Pt.: Yes. I will come tomorrow.

Doc.: If you come tomorrow, we can now look at the result and the drug you are taking, and compared them. There might be the need to just continue as you are taking and there may be need to increase the dose, depending on what the result says. Overtime-

Pt.: The last time I came I was taking one – one but the doctor said I should take two – two. Two in the morning; two at night, and I should take this one and half.

Doc.: That means they increased the dose. You know as one grows up, the insulin that one uses comes from the pancreas, and as one grows older, normally without diseases, some of the cells within the pancreas lose their functions – normal aging process.

Pt.: That's when someone is aging.

Doc.: When someone is aging. Once you are thirty years, you don't add new cells to what you have. So, the functions of the body start reducing in some particular percentage, even though it is very little. So, it's possible that the amount of the insulin that is being produced in your body now is smaller than what was produced before and that was why they had to increase your drugs so that the pancreas could produce more insulin to meet the need of your body. You understand. But by and large, let's see the result to actually know what to do. So that we have evidence of your sugar level and compare it to the drug you are taking.

Pt.: Alright.

Doc.: So, go and take the test and bring the result.

Pt.: Thank you.

Doc.: How old are you?

Pt.: I am 46 years old.

Doc.: What do you do?

Pt.: I am a customs officer.

Doc.: Since you are coming tomorrow, I don't think I have to prescribe any drug for you now. If I do I would be giving you drugs based on the former test and that wouldn't be good enough. And since you have drugs that you can take till tomorrow, I think we should just be patient till tomorrow to recommend appropriate drugs.

Pt.: Thank you.

Doc.: Let me check your blood pressure.[Doctor checks patient's blood pressure.]

Doc.: Your BP is high. Have you stopped taking your drugs?

Pt.: I ammmmm and that's why I don't take them regularly.

Doc.: Mr. Nzeribe, do you think it's a sin to have told me you are fasting? Tell me your faith so that I can know how to counsel you appropriately.

Pt.: You know it is not right to fast and go about telling people.

Doc.: See, we have the same faith. I am also a Christian. When Jesus was teaching us about fasting, he said we should not let our fasting be like that of the Pharisees who will put ash on their heads and wear poor clothing, and then they would wear a long face that people might know they are fasting. Yaou understand.

Pt.: Yes.

Doc.: You have not done that. The reason why you have told me you are fasting is because of your drugs. Is it not? It has not even shown on your face that you are fasting. So, it is not known to others except to me. And some people say doctors are next to God, I don't know about that. But I know we are working together. God is the one that heals but doctors try to take care of patients. How can take care of you appropriately if I don't know the current situation that you are in? Now that you have told you are fasting, it has not stopped your fasting. You have not told me so that I should hail you, saying –this is a spiritual giant. You have not told me so that I would feel condemned or that you are a good Christian. No. The purpose of telling me is that I will be able to intervene in how you will be able to comply with your drugs so that you will not compromise your faith.

Pt.: You I sometimes tell my wife that I have eaten when I am fasting.

Doc.: You don't need to lie to your wife lies.

Pt.: I tell her lies because she worries about me too much.

Doc.: The issue is that if you take your drugs appropriately, you will live a quality life, you will live longer and she too will be happy. That's what her concern is all about.

Doc.: [Patient's wife calls.] She is the one calling you. I'm sure she wants you to be healthy. She wants to have you around her till grey hair comes out of your head. You understand. She knows your condition – healthwise- . Now, God knows your condition, so don't isolate your physical life from your spiritual. Both of you are together. If the doctor says ''Do not fast.'' All you have to do is – you there are other ways of fasting. Don't deny yourself food. Do you understand?

Pt.: I am a prayer warrior.

Doc.: You know what Jesus taught us about fasting that we should not let our fasting be just about food denial. It is in Isaiah. He talked about taking care of the widow, the fatherless, giving alms,…

Pt.: Yes.

Doc.: That's the kind of fasting – the one you should have spent on buying a recharge card to just chat or talk with friends, you could just give the money to the poor that don't even have food to it. It is a form of denying yourself. You understand. So, I think we should understand what fasting is all about. Most of the time, we consider fasting as only food, food denial. It goes beyond that. Your leisure time that you could have spent a watching football match, you could decide you want to use it to pray for Nigeria, for prisoners, for missionaries. It's a kind of denial. You are denying yourself the pleasure of relaxing or playing football --. Even, some of our diabetic muslim patients, some time, when we look at their sugar control we advise them: ''For this time, may be you should just stay away from fasting for the sake of your health. If you are alive to see next year, you can join the Ramadan fast next year. You understand?

Pt.: Yes.

Doc.: But if you say you must fast and you don't take your drug, and then you develop complications and then you are not alive for the next Ramadan. So, what have you gained? You understand. So, for you now, what I can still advise is that when you are breaking in the evening, use your drugs. Then, you might not be able fast every day, you might make it Monday, Wednesday, Friday. You understand.

Pt.: But it's what I am used to.

Doc.: See. I am only advising you. I am not going to decide for you. May be by the time I see your result tomorrow, I am going to further advise you. Thank God I have checked your blood pressure now, and your drug is to be taken once a day. So, take it when you are breaking in the evening. Our own God is not a wicked God. He knows everybody's condition and He will not judge you by another person's standard. He knows what is expected of everyone. He knows what you should do and He knows other people should do.

Pt.: I am very grateful.

Doc.: So, Mr Nzeribe, you don't need to feel condemned because you have told me you are fasting. So, we will see again tomorrow. It is well.

Pt.: Bye bye, ma.

Doc.: Bye.

INTERACTION 50

Doc.: How are you today?

Pt.: I am fine.

Doc.: Do you have any complaints?

Pt.: There is no problem really. I just feel something is moving about in my body.

Doc.: The sensation you feel. What is it really? What is it exactly? What do you feel?

Pt.: I feel a crawling movement in my body about twice a day.

Doc.: When did it begin?

Pt.: About two months ago.

Doc.: Is that the only complaint?

Pt.: No. I also have cough.

Doc.: The last time you came you complained of cough.

Pt.: Yes. I was given some tables but it has not gone completely.

Doc.: Ok. How old are you?

Pt.: I am fifty-two.

Doc.: You are Yoruba?

Pt.: Yes.

Doc.: What do you do?

Pt.: Teaching.

Doc.: A teacher. Primary or secondary?

Pt.: Primary.

Doc.: You are married?

Pt.: Yes.

Doc.: My record here shows you live at Akanran Road.

Pt.: Yes.

Doc.: You were recently diagnosed to have elevated BP.

Pt.: Yes.

Doc.: When did you last check your BP?

Pt.: Last month.

Doc.: Before then you had never checked your BP and when you did so the last time, you were told it was elevated.

Pt.: Yes.

Doc.: Are you still seeing your period?

Pt,: No.

Doc.: How many years ago did it stop?

Pt.: Between two and three years ago.

Doc.: Do you experience occasional bleeding?

Pt.: No.

Doc.: And in your feet, you don't feel cramps?

Pt.: No.

Pt.: When I travel on long distances.

Doc.: That's after you have kept your legs in the same position for some time.

Pt.: Yes.

Pt.: Okay. So, generally, how do you feel? Do you sleeping well?

Doc.: Yes.

Pt.: And you eat well?

Pt.: Yes. I do.

Doc.: Do you feel abdomin- stomach pain.

Pt.: No.

Doc.: How are you going to toilet.

Pt.: I go to toilet regularly.

Doc.: How often? Everyday, once a week?

Pt.: Sometimes daily or once in two days.

Doc.: Is it hard or soft.

Pt.: Soft.

Doc.: How many children do you have?

Pt.: Three.

Doc.: How many times have you been pregnant?

Pt.: Five times.

Doc.: What happened to two of the pregnancies? Did you have any miscarriage?

Pt. The babies died shortly before birth.

Doc.: How many male and female children do you have?

Pt.: One male and two females.

Doc.: Is your firstborn a male or female?

Pt.: Male. He is a doctor too.

Doc.: So, the remaining two are females. Are they married?

Pt.: One of them is married while one is undergoing National Youth Service.

Doc.: How many children the married female have?

Pt.: One.

Doc.: Girl or boy?

Pt.: Boy.

Doc.: How old?

Pt.: Seven months.

Doc.: Is she your youngest child?

Pt.: Yes.

Doc.: Where is your husband?

Pt.: He has gone.

Doc.: At what age?

Pt.: Fifty-three.

Doc.: What happened?

Pt.: He developed anaemia and after some time, he died.

Doc.: Are your parents alive?

Pt.: No.

Doc.: At what age did they die?

Pt.: My daddy 86.My mummy 83.

Doc.: So, they grew old. Do you know whether they had hypertension, diabetes? What was the cause of their death?

Pt.: My mother suddenly collapsed and was rushed to a hospital where she died about three days later. My dad had an accident at a party and died.

Doc.: Do you have brothers and sisters?

Pt: Yes.

Doc.; How many are they?

Pt.: Seven.

Doc.: So, what's your position?

Pt.: I am the firstborn.

Doc.: What's the sex of the second born?

Pt.: A female.

Doc.: Is she married and how old is she?

Pt.: She's married and she is forty-two.

Doc.: How many children does she have?

Pt.: Three.

Doc.: Any health problem?

Pt.: None.

Doc.: Right now, who lives with you?

Pt.: One of my cousins.

Doc.: So, apart from these prescribed drugs, what other drugs are you tasking – or herbal medicines?

Pt.: I take 'efinrin' and 'ewuro'.

Doc.: What do you take them for?

Pt.: I take them after taking sugary things.Some people say they are very good.

Doc.: Do you take alcohol?

Pt.: No.

Doc.: It's alright. I'm going to examine you to check your BP but before that I want you to do a urine test. It's a basic test that the nurse will do for you to know whether there are foreign things in your urine and then we combine the result with all these to have a whole picture of what is happening.

Pt.: Yes. Yes. They will give you a bottle to do it now.

Doc.: So, when you are done, bring the result to me. I will be here.

Pt.: Thank you.