A PRAGMATIC EXPLORATION OF DISCOURSE DEVICES IN DOCTOR-PATIENT CONSULTATIONS IN SELECTED TEACHING AND GENERAL HOSPITALS IN NIGERIA

BY

ADEWALE KAZEEM AYELOJA

MATRIC NO. 162647

B.A. English (Ife), M.A. English (Ife); MPhil English (Ibadan)

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CERTIFICATION

I certify that this work was carried out by Mr. Adewale Kazeem Ayeloja in the Department of English, University of Ibadan.

………………………………………………………..

Supervisor

Moses Akanbi Alo,

B.A.English, M.A. English (Ife), Ph.D. English (Reading)

Professor, Department of English,

University of Ibadan, Nigeria

DEDICATION

I dedicate this research to God Almighty, who, in his unlimited power, kindness, and wisdom, enabled me to begin and complete this study despite the numerous hurdles I faced prior to and during the programme. May your name be exalted eternally.

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ABSTRACT

Doctor-patient consultation is a communicative situation which enables doctors to understand patients' health challenges in order to prescribe appropriate treatments. Earlier works on doctor-patient interactions, particularly from linguistic and pragmatic perspectives, have largely examined speech acts, conversational maxims and (im)politeness, with little attention paid to the specific discourse devices and their pragmatic functions. Therefore, this study was designed to examine doctor-patient verbal interactions in selected teaching and general hospitals in Nigeria, with a view to determining the discourse devices deployed in the interactions and their pragmatic functions.

Dan Sperber and Deidre Wilson's Relevance Theory, complemented by M.A.K. Halliday's Systemic Functional Grammar, was used as the framework, while the descriptive design was adopted. Data were sourced from 200 audio tape recordings and transcriptions of doctor-patient verbal interactions in two teaching hospitals (University College Hospital Ibadan (UCH) (50), and University of Ilorin Teaching Hospital (UITH) (50)) and two general hospitals (General Hospital Abeokuta (GHA) (50), and General Hospital Kabba (GHK) (50)). The selected hospitals were chosen because they were well-patronised and were easily accessible for data collection. Data were subjected to pragmatic analysis.

Thirteen discourse devices were dominant in the interactions: circumlocution, repetition, counselling, modality, closing, direct question, indirect question, answering, phatic communion, rapport expressions, language switch, Face Threatening Act (FTA) with redress and FTA without redress. All of them were shared by the doctors and the patients across the hospitals, with the exception of FTA with redress, FTA without redress and counseling, which were doctor-specific. They performed the following pragmatic functions: phatic communion, for opening consultations; direct and indirect questions, for seeking information for diagnoses; code alternation, for explicitness, informativity and mutuality; repetition, for confirmation, emphasis and clarification; rapport expressions, for cordiality and solidarity; modality, for asymmetry of knowledge and power; counselling, for advising the patients on their health; answer, to respond to questions; closing, for ending consultations and circumlocution, for providing clues to diagnosis. Interrogatives were employed for; eliciting information. Modality was deployed for expressing views and expectations; FTA with and without redress, for correcting patients' unwholesome health practices and obtaining information for diagnosis tactfully; tact maxim, for expressing compassion and granting permission; generosity maxim, for counselling and expressing compassion; and sympathy maxim, for counselling and expressing empathy. Declaratives were employed for providing information; imperatives, for giving directives; and collocation, for connecting texts. The contributions reflected adjacency pairs in different forms, showing cooperation amongst the interactants. There were variations in the deployment of the discourse devices. The UCH and UITH doctors employed questions more than those of GHA and GHK.

The discourse devices addressed specific communication and health challenges through their pragmatic functions, thus underscoring the centrality of their knowledge to a better comprehension of diagnostic discourse in doctor-patient consultations in the Nigerian context.

Keywords: Doctor-patient consultation, Discourse devices, Circumlocution, Counselling

Word count: 456

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LIST OF ABBREVIATIONS

1) Doc. – Doctor
2) Docs. - Doctors
3) Pt. – Patient
4) Pts. - Patients
5) Pt. Rel. – Patient's relative
6) SH – Social History
7) FH –Family History
8) HPI – History of Present Illness
9) OAP – Other Active Problems
10) UCH – University College Hospital, Ibadan
11) UITH – University of Ilorin Teaching Hospital, Ilorin
12) GHA – General Hospital, Abeokuta
13) GHK – General Hospital, Kabba

CHAPTER ONE
INTRODUCTION

1.1 Background to the study

Discourse plays a critical role in diagnostic communication as it is one of the quickest ways doctors get to know about the health challenges of patients. According to Crystal (1992:25), discourse is an unbroken stretch of language longer than a sentence, thus forming an intelligible activity like a sermon, narrative, joke or argument. It performs an important function in medicine as it is one of the ways by which doctors unravel the health challenges of patients and talk about treatment management plans.

Doctors and patients dialogue during consultations to know the health challenges faced by patients for the purpose of finding appropriate medical solutions to them. In doctor-patient verbal interactions, meanings are negotiated through appropriate use of language. Given the importance of health to humans, doctors and patients should be able to communicate effectively to enable doctors diagnose and treat patients accurately in order to attain the goals of medicine. Appropriate language use is critical in establishing a positive relationship between patients and doctors, thereby initiating the restorative process, which is the medical practice's ultimate goal (Odebunmi, 2010). It also assists doctors to gather all types of information needed to make accurate diagnoses.

The primary concerns of medicine are: diagnosis, treatment and prevention of diseases (Martin (ed.) 2000:396). Active communication on the part of medical doctors and nurses is important in achieving these goals, especially in multilingual settings. 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 they, by virtue of the esteemed position they occupy, 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 practice may go down well with patients who understand English but displease those who do not. In addition, when a doctor uses a local language that a patient understands, the patient may find the discourse situation convenient. Conversely, when the doctor uses a language or slang that the patient does not understand, this may elicit negative responses from the concerned patient. Therefore, using a language or slang that a patient does not understand could cause communication breakdown, which could threaten the outcome of the consultation.

Deducible from the foregoing, doctors and patients must be able to communicate effectively to accurately diagnose patients' diseases and provide appropriate treatments. One of the obvious challenges of Western medicine is communication skill (Bean (1975), Tanner (1976) and Myerscough (1992)). 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) notes that people have realised that skillful communication is crucial to medical instruction. He further states that healthcare practitioners have not acquired requisite communication expertise. He 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.

The inadequate attention given to teaching communication skills during medical training manifests on a greater scale in Nigeria. As Oloruntoba-Oju (1996) cited in Odebunmi (2006) avers, 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, restricting medical students taking the Use of English to just a semester in the first year of

the first degree duration in universities may not be sufficient to give them adequate training in communication.

The inadequate training given to medical students in English described above suggests that the communication requirement of Nigerian medical students can be improved upon. Consequently, as Ogunbode (1991) opines, 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 through 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 may be 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 consultations with patients in hospitals.

The choice of code is critical in establishing a positive relationship between a client and a doctor, as well as in initiating the therapeutic procedure that is the interaction's ultimate purpose (Odebunmi 2010). Scholars have paid close attention to language use in clinical interactions, indicating how important it is. Heritage and Maynard (2006) identify two directions in code choice in clinical consultations in their study on doctor-patient consultations, namely: process analysis and content analysis. In the first hand, process analysis of discourse is, on the first hand, based on Bale's (1950) coding system, known as "Interaction Process Analysis," and research in the study focuses on the function link in doctor-patient meetings, with a particular focus on the patient's satisfaction level. The scope of the process analysis of discourse transcends primary health care and shows the manner doctors and patients interrelate during the visits and how patterns of communication are handled to ensure the satisfaction of both parties.

On the other hand, the content analysis 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 individual experiences, sensibilities, background orientations, and objects that constitute the medical dialogue. The content analysis model, otherwise referred to as micro-analytic approach, focuses on multilingual conversations and the languages' communicative consequences and roles (e.g.: Maynard (1989, 1991a; Peraklya 1998); Odebunmi (2005,2006); Mishler (2006, 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 language choice techniques in the negotiation process. In addition, it fails to show how discourse devices are deployed during consultation and the pragmatic roles they play in assisting doctors to make good diagnoses and enabling patients to understand them. This study will fill this gap.

1.2 Statement of the problem

In medical consultations, a great deal of research has been done. Odebunmi (2003), for example, looks at the speech characteristics of English language in hospital interactions between physicians and patients in South-West Nigeria. Other related works include: "Locutions in Medical Discourse in Southwestern Nigeria" (Odebunmi, 2006), "Effective Communication in the Medical Sciences" (Ogunbode, 1991), and "Mutual Contextual Beliefs in Doctor-patient Interaction in South-Western Nigeria" (Faleke and Alo, 2010). Similarly, Mercer O'Connor (1974) analyses the core skills in the nurse-patient relationship using a programmed text, and Adegbite (1991) studies the aspects of language use in Yoruba traditional medicine. Other works in this direction include: Ogunbode (1991), Oloruntoba-Oju (1996), Adegbite and Odebunmi (2006), Adegbite and Odebunmi (1993), West (1984), and Frankel (1984). It can be seen in the above that none of the works cited has examined the discourse devices deployed in doctor-patient consultations with their pragmatic functions in view of their potentialities to enhance understanding doctor-patient verbal discourse. Therefore, this study seeks to examine the discourse

devices and politeness maxims deployed by doctors and patients during consultations with a view to determining their pragmatic functions.

1.3 Aim and objectives

This research work investigates the discourse devices and politeness maxims doctors and patients employ during consultations and explains their pragmatic functions, using discourse analysis techniques. The objectives are:

i) to identify the discourse devices deployed in the consultations.

ii) to describe the pragmatic functions of the identified discourse devices in the context of the hospital verbal interactions.

iii) to identify the politeness maxims that are deployed in the consultations.

iv) to describe the pragmatic functions of the identified politeness maxims.

v) to explain the similarities and differences in the discourse devices used in the selected teaching and general hospitals.

1.4 Research questions

i) Which discourse devices are employed in doctor-patient consultations?

ii) What pragmatic functions do the discourse devices perform in the doctor-patient consultations?

iii) Which politeness are deployed maxims in the consultations?

iv) What pragmatic functions do the politeness maxims perform in the consultations?

v) Are there similarities and differences in the deployment of specific discourse devices between the two teaching and two general hospitals selected for this study, and how frequently are they deployed?

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 and politeness maxims deployed by the doctors and patients at the University College Hospital, Ibadan, Oyo State; and University of Ilorin Teaching Hospital, Ilorin, Kwara State, on one hand; and the General Hospital, Abeokuta, Ogun State, and General Hospital, Kabba, Kogi State, on the other, in their consultations and their pragmatic functions. It has, therefore, not studied the discourse devices deployed by other medical practitioners like: pharmacists, orthopaedists, nurses, physiotherapists, etc. during their consultations with patients.

I have restricted the choice of the subjects to doctors and patients alone to ensure detailed analyses. Secondly, the study locations have also been restricted to just four hosptals to facilitate easy data collection.

1.6 Significance of the study

Studies have revealed that many scholars 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 perspective to the studies on medical discourse as it examines the discourse devices employed in doctor-patient consultations as well as their pragmatic functions, with a view to revealing the linguistic choices doctors and patients make during the consultations.

1.7 Definition of terms

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

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

iii) **Circumlocution**: This relates to the patient's description of illness symptoms as a result of their status as non-medical specialists who lack understanding of the acceptable medical terminologies.

iv) **Code alternation**: 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, confirmation and clarification.

viii) **Modality**: this refers to the deployment of modals to pass certain messages across.

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 giving patients advice on how best to manage their health.

xi) **Rapport expressions**: This is the use of language to create social intimacy and engender free interactions between doctors and patients.

xii) **Answer**: This refers to provision information in response to questions.

xiii) **Closing**: This refers to bringing clinical interviews to an end through the use of greetings, expression of gratitude and farewell.

CHAPTER TWO

REVIEW OF RELEVANT LITERATURE AND THEORETICAL FRAMEWORK

2.1 Introduction

This section reviews the relevant literature in medical discourse with a view to knowing the extent of researches already carried out and the gaps in knowledge. In addition, it also discusses the appropriate theoretical framework for the study.

2.2 An overview of doctor-patient consultation

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

Medical discourse performs crucial functions in medicine. As types of social action, speech and writing assist in diagnosing patients' ailments and treating them. 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, analysable individually or collectively. Medical discourse can be classified into two, namely: doctor-patient and patient-other medical practitioners. Each of them belongs to dissimilar registers, with a range of varieties within it (van Naerssen, 1985). This study focuses on doctor-patient verbal interactions.

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 seven '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. The seven "commandments" are:

i) Avoid confusing generalisations with specifics.

ii) Use simple, well-known words.

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

iv.) Avoid overgeneralisation and prejudice.

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

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

vii) Avoid hurried conclusions.

An in-depth study of doctors' communication challenges would have enabled him to suggest more than seven measures to remedy nurses' communication inadequacies, and by extension, the doctors'. As things stand now, the recommended seven commandments are insufficient to tackle the problem as a widening of the scope of the study to investigating the discourse devices involved in health practitioner-patient verbal interactions would have greatly enriched the work.

Oloruntoba-Oju (1996) in the paper entitled ''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 patient could easily comprehend. 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 to not create fears which could aggravate the patients' conditions, the study did not take cognisance of the need to investigate the discourse devices deployed during doctors' consultations with patients to show how they could further enhance our understanding of medical discourse. Another problem is doctors dictating English as the language of discussion since it is the medium of instruction in medical schools in Nigeria

Odebunmi (2003) investigates the speech characteristics of English in doctor-patient consultations 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 medical interactions in Nigeria. The work is an essential addition to the existing works on medical discourse, but it does not explore issues like code change and conversational maxims in doctor-patient verbal interactions that could have greatly enriched the work in view of their potentialities to increase our understanding of medical discourse.

Faleke and Alo (2010) study the diverse ways in which interactions occur in hospitals between nurses and their clients. Their research indicates the existence of certain shared knowledge between nurse-nurses and physicians, as well as patients or patients' relations, in discourses that display specific linguistic patterns.These forms of language are accustomed and unaccustomed words used in nurse-nurse/other MPs, nurse-patient/patient's relatives interactions, respectively for the sake of concealing information that could stigmatise or psychologically affect the patients. Some of the forms include gesticulation, acronyms, body language, abbreviations, figures, etc. to communicate with patients but which the patients do not understand and see as part of the nurses' professional knowledge and ethics. This work contributes emmensely to unserstanding practitioner-patient/other discourse but would have made a greater impact if it had examined, in addition to the linguistic features, issues like speech acts to further widen the scope of the work.

Taiwo and Salami's (2010) study entitled:" Discourse Acts in Antenatal Clinic Literacy Classroom in South-Western Nigeria" examines the communicative functions of discourse acts in nurse-pregnant women discourse in antenatal classes, with the objective of

investigating how they deploy language by their selection of discourse acts and how it eases or hampers verbal interactions in the class. The study identifies three types of act, namely: primary, secondary and complementary acts. Their analysis presents a synthesis of the categories of the discourse acts Sinclair and Coulthard (1977) identified in their work. The work finds that acts have no structures, and they are mainly defined by their functions. Consideration of the non-linguistic and linguistic contexts of the expressions of the nurses and expectant mothers enables the authors to indicate the acts that the utterances realise. Much as enlightening as the work is, the failure of the authors to widen the scope of their study to focus on more discourse units greatly undermines the richness of the work.

Ayeloja's (2016) "Discourse Devices and Communicative Functions in Doctor-Patient Verbal Interactions in Two Selected Federal Hospitals in Nigeria" examines language use in doctor-patient verbal interactions with a view to unravelling the linguistic choices made by the doctors and patients during consultation and their discourse functions. The study recognises twelve (12) discourse devices and states their discourse functions to highlight how they assisted the interlocutors to make the clinical interviews a success i.e.: obtaining medical information for the purpose of prescribing appropriate treatment(s) to the health challenges of the patients and to offer appropriate clinical counsels, where necessary. The current study is, however, an expansion of the first to address the shortcomings observed in it, particularly in relation to broadening the scope and exploring an additional area of research in doctor-patient research. Specifically, this study will increase the study location from two to four and will, in addition to the discourse devices, also examine the politeness maxims.

It is clear from the above that several scholars (Oloruntoba-Oju (1996), Odebunmi (2003, 2006); Taiwo and Salami (2010); Faleke and Alo (2010)) 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 consultations and also revealing their pragmatic

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 perspective 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 power-play in doctor-patient interactions.

According to Madfes (2002, 2003), there are two types of medical discourse practice (a) the traditional practice, which is characterised by intrusion and parallel discourse in which doctors always control the floor of the conversation and display power by not responding to patients' questions, and (b) the alternative – medicine practice, which is characterised by convergence and reinforcement, in which doctors always control the floor of the conversation and display power by not responding to patients'questions.

A larger percentage of the studies on medical interactions has been carried out within the milieu of Western traditional medicine (Ainswoth-Vaunhn, 1995; Candlin and Candlin, 2003). The encounters are "ritualised" since they often go through a series of phases (Helman, 1984). A medical contact, for example, follows a six-phase sequence: 1) the beginning, 2) the complaint, 3) the examination or test, 4) the diagnosis, 5) the treatment or advice, and 6) the conclusion (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 meetings are mainly interview-like or conversational. Ferrara (1994) identifies the following distinctions in relation to seven factors when comparing psychotherapy sessions (a sort of medical interaction) with conversations: 1) Parity, 2) Reciprocity, 3) Regular Recurrence, 4) Bounded Time, 5) Restricted Topic, 6) Remuneration, and 7) Regulatory Responsibility Parity and reciprocity present more as conversational features than those of medical encounters.On the other hand, the remaining five features are more of characteristics of medical discourse than normal conversation. Several research have revealed that

questioning in medical discourse involves both power-claiming and power-sharing, but majority of them disagree that the former is more common. As a result, they call these encounters "asymmetrical interviews" (West, 1984; Hein and Wodak, 1987; Weijts, 1993; Alexias, 2008).Doctor-patient verbal 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 is carried out through language use. It is, therefore, important to investigate the discourse devices employed in such an encounter in order to understand their pragmatic functions, especially as the discourse is highly asymmetrical.

It is clear from the above that several scholars have made significant contributions to the research on medical discourse. The contributions range from register analysis, pragmatic analysis of the language of medicine to exploring means of enhancing the communication skills of nurses and doctors, etc. This research consequently seeks to complement the extant researches by examining the discourse devices and politeness maxims deployed by doctors and patients during consultations. It will also reveal their pragmatic functions, with a view to examining the linguistic choices they make to initiate consultations, control them, understand the patients' medical challenges and coclude the consultations .

2.3 Communication in medical discourse

Some forms of communication occur in the hospital setting, but the ones commonly studied are: doctor-patient consultations, doctor-nurse interactions, nurse–patient consultations and dentist-patient consultations. 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 actually take 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 and their health challenges. A combination of all these enables the physicians make accurate diagnoses. Sometimes, depending on the context of interaction with patients, doctors present their diagnoses in a clear language and at other times in an ambiguous language. It is also a common knowledge that doctors use euphemism or other literal expressions when faced with ‘’unpleasant’’ diagnoses (Odebunmi, 2003).

2.3.1 Doctor-patient consultation

Doctor-patient consultations require greater explicitness on the part of 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 jargons if they want the patients to understand them. Consequently, they use simple expressions (Odebunmi (2003, 2006); Crystal (1976)).

2.3.2 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 themselves as clearly as possible, using simple language.

2.4 Discourse

Discourse can be defined as systems of thoughts made up of dogmas and actions that methodically create the topics and the worlds they speak about, courses of action, and attitudes (Foucault 1969). Owing to its origin from the Latin Language, its meaning varies depending on the situation. In literature, it refers to a speech or piece of writing that is

usually longer than a sentence and deals formally with a specific subject. To put it in another way, discourse is an unbroken stretch of language longer than the sentence.

The classic definition of discourse is a language that is higher than a sentence or a phrase (Stubbs 1983:1). However, in spite of the multiplicity of structural approaches, a general core exists. Structural analyses concentrate on the way different units operate together but overlook the functional relationships that exist within the context of speech (Van Dijk 1985:4).

However, since this relationship between context and discourse is a feature of functional analyses, structural methods and structural analyses appear to be fundamentally different.Structurally based studies of discourse discover elements that are interrelated and which can function in a limited number of (order-directed) arrangements. Discourse is sometimes characterised as a structure that is higher than a sentence or another text unit. Many modern organisational studies of discourse consider the sentence as something that is subsumed in discourse, in line with the above description of discourse as language higher than the sentence.

Nevertheless, numerous problems stem from the dependence of definitions and analyses on the smaller units of sentence. An instantaneous setback is that units of conversation do not often en resemble sentences. Chafe (1980) submits that speech is produced in units with semantic and intonational closure – unnecessarily syntactic. He further argues that if we were to focus exclusively on speech (rather than exclusively on written language), we would more likely regard language in terms of intonation units that reflect on underlying syntactic structures (Chafe 1987, 1990). Backing for this opinion is often created by observing 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 a unit that is subsumed in discourse is theoretically problematic in other ways. Sentence is an autonomous linguistic form that is not included in some larger linguistic forms by virtue of any grammatical constructions. However, the vista that discourse is higher than the sentence - more precisely, that sentences are embedded in discourse atimes ultimately challenges the vista that sentence has

grammatical independence and closure (Bloomfield, 1933). Another consequence of the belief that discourse is higher than the sentence is the potential expectation that discourse will have a structure similar to the sentences that it is made up of . An expectation that, according to Stubbs (1983), may be unwarranted. We may consider, for instance, the sentence grammarians' deployment of the expression ''well-formed'' in relation to structures, as in Chomsky's:

''Colourless green ideas sleep furiously''

This sentence is well-formed syntactically, but it has no meaning. As a result, structure (in the sense of 'well-formedness') does not appear to apply to speech; it is utterly impossible to distinguish between constituent strings of well-formed and ill-formed discourses. According to Schiffrin (1994), the cause of this situation is our inability to define units of speech as accurately as we can identify constituents of sentences. It is observed that defining discourse as well-formed or ill-formed is not only problematic, but discourse structures are rarely the kinds of tiered structures linguists are familiar with at other stages of analysis.

Discourse study, according to Fasold (1990: 65), is the study of any aspect of language use. This viewpoint is rephrased by Brown and Yule (1983:1) as the study of conversation that is necessarily the study of language in use. As a result, it cannot be limited to describing linguistic forms without regard to the objectives or functions that those forms are intended to fulfill in human affairs.

It is apparent from the above that language cannot be studied without considering its roles and objectives in human life. Fairclough (1983:23) writes:

> "Language is a part of society; linguistic phenomena are social phenomena of a sort, and social phenomena are (in part) linguistic phenomena.".

This viewpoint expresses the belief that language and society are subsumed in each other, revealing that language cannot be examined as a separate entity.

The definition of discourse as "language in use" is in line with functionalism in general. Discourse is regarded as a system, or a socially and culturally organised style of

communication that accomplishes specific objectives. Although formal symmetries can be explored, a functionalist definition of discourse focuses discourse analysts' emphasis on how patterns of language are used for specific functions in specific circumstances rather than the structural basis of such patterns.

Functionally based approaches have a proclivity for employing a variety of analytic tools, which frequently include not only quantitative ways derived from social science approaches, but also more humanistically oriented interpretive efforts to replicate actors' own goals and intentions (Schiffrin 1994). They place more emphasis on how utterances are placed in settings than on the purely syntactic aspects of utterances as sentences. To put it in another way, functional definitions of discourse imply a connection between language and context, but studies based on this view of discourse as language in use might be overly broad, including sentence-sized units and phonological variants. They place more emphasis on utterances in settings than on the purely syntactic aspects of utterances as sentences.

Discourse is seen as a culturally and socially ordered style of speaking in functionally oriented approaches. Functional analyses focus on the way people deploy language for diverse purposes; they are normally less concerned about the way people plan what they say to serve referential meanings (to convey propositional information) and more with the envisioned cultural, expressive and social meanings , depending on the way their speeches are positioned in contexts.

In sum, it is worthwhile to note that structural definitions of discourse focus on text while functional definitions are concerned with contexts, actual analyses of discourse show that function and structure are interdependent. Saddok (1984:142) corroborates this assertion by noting that the most appropriate thing to do is to study function in relation to structural requirements and structure in relation to functional requirements 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.

2.4.1 Kinds of discourse

Traditionally, there are four dissimilar types of discourse i.e.: exposition, description, argumentation and narration. Discourse is normally assumed to include practically every kind of communication whether oral or written. There are instances where whole papers or speeches hinge on just a style; though, more often than not, the speakers, writers or authors employ more methods simultaneously. Diverse types are commonly more suitable for diverse circumstances. Each of them usually has some pretty distinctive features. In addition, the objectives may likely be different. Speakers, authors and writers usually employ the methods they consider most effective for passing their messages to their target audiences.

2.5 Discourse devices

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

2.6 Kinds of discourse devices

2.6.1 Code alternation

According to Boztope (2003), code is a language variety used during communication. It may be the dialects or varieties of the standard language or code, or the standard form. In the course of conversations, discussers deploy the particular language variety they can use proficiently. This practice is referred to as "Code choice." In monolingual circumstances, it may only involve one language; in bilingual and multilingual contexts, it may involve two or more languages. As a result of the foregoing, there are two types of codes to choose from: simple and complex. Monolinguals deploy a simple code that consists of only using the regular form of the communication language, as well as its high and low versions (Odebunmi, 2010:5). The diagrams in Figure 2.1and 2.2 illustrate this (See pages 2275 and 276).

‘’LANG: A’’ is the standard dialect while ‘’ lang: a’’ is its variety. 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 Nigeria’s South-West and North-Central geopolitical zones, 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’’).

In this work, ‘code’ refers to the above-mentioned dialects and their 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 happen in all situations because some participants sometimes have the ability to use only one code. They use just the code and the co-interlcutors are pragmatically compelled to adopt the code favoured by the other participant, even though their degree of proficiency in it is low.

The possibility of mixing or switching codes 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 enable us adapt to our environment.

The incidence of code alternation has brought about the formation of different jargons by linguists in their efforts to describe this phenomenon. "Code-mixing", "code-switching", "code alternation", and "linguistic mixing" are some of the names used (Poplack 2009; Myers-Scotton 1980; Ogunsiji 2000). The terms systematically define 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 interactions (Odebunmi, 2010:7).

Several scholars have defined code-mixing and code-switching variously. But for the purpose of this work, 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)

Odebunmi (2010) considers code-switching or code change to be functional language change and code-mixing to be non-functional language change, based on Auer's (2009) findings. He claims that the regular differentiation between the two codes has evolved into its own style of interaction, a new code with its own set of norms and regularities. Many scholars who studied code-switching agreed with Auer's observation about the function-based dimension. They serve a variety of purpose, including the development of a message, the transmission of attitudes (Tay, 1989), the formation of rapport, the symbolisation of group identity and solidarity, and the marking of a style transition (Boztope 2003). However, we must be cautious about eliminating code-mixing from the functional category because, like code-switching, code-mixing elements are utilised for calculated purposes. As a result, code-switching and code-mixing are both examples of functional language alternation.

The type of code-switching propounded by Auer (2009) is of prime importance to this study, and this will, where necessary, also be extended to code-mixing in the analysis. Participant-related code-switching and discourse-related code-switching are the two forms of code-switching he has identified. "The use of code-switching to structure the discussion by contributing to the interactional meaning of a given utterance" is what discourse-related code-switching is (Auer 1998: 4 cited in Odebunmi 2010). This emphasises the strategic significance of code-switching by demonstrating the establishment of a new traction in code-selection. Participant-related code-switching, on the other hand, refers to situations in bilingual conversation in which discussants just prefer one code over another without aiming for a specific goal.

As the data analysis would demonstrate later, both discourse-related code-mixing and participant-related code-mixing are relevant to physician-patient verbal interactions in hospitals in Nigeria's North-Central and South-West geopolitical zones (and the rest of Nigeria, by extemsion). In some cases, code selection during consultation is a question of choice for either party, with the potential to influence the other. In some cases, tact is required most often by medical practitioners and occasionally by patients.

Code alternation has gained so much currency among the educated and the illiterate people in the North-Central and South-West 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 hospitals is very interesting. Code alternation will therefore be examined to reveal its communicative functions and how it aided the discourses in this study.

2.6.2 Rapport expressions

'Rapport' has its origins in 'rapporteur', which is a French word. It is the use of language to create social intimacy. It means plainly to take something back and in relation to how people interact with one another. It simply means that what one sends out, the other responds with. Interlocutors may discover they have similar opinions, knowledge, or behaviour in areas such as sports, music, or politics, for example. When two people are on the same wavelength, they are identical or have a good relationship when this happens.Graham (2010) observes that rapport has three behavioural components: mutual positivity, mutual coordination and attention.

Another crucial skill that every healthcare practitioner must master is the capacity to form relationships with patients. Developing rapport with patients has a number of advantages. Doctors appreciate the opportunity to develop a close relationship with patients through the development of rapport, which also aids in the promotion of open communication between them. As a potent instrument that expert salesmen make use of, it affords them the opportunity to have more transactions almost effortlessly. According to Street (1991),

all healthcare personnels must develop the ability to establish relationships with patients and respond empathetically and adaptably to their requirements.He opines that medical practitioners adapt by assuming diverse roles depending on the patient's degree of anxiety.

Empathy, according to some researchers (McCabe 2004; Barton 2000; Sheppard 1993), facilitates open communication between medical practitioners and patients, allowing practitioners to obtain the medical data needed to make accurate diagnoses. "....the heart of the nurse-patient connection is involvement, the identification of the nurse with the patient," according to Morse et al (1992:819). This involvement is made possible via empathic responsiveness. This lends additional credence to the appropriateness of a discourse analysis approach to doctor-patient 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 relationships, and their goal is showing empathy to patients to make clinical interviews result-oriented.

There exist many techniques that ought to be beneficial in building rapport i.e.: matching your body language (i.e. gesture, posture, etc.), sustaining eye contact and matching rhythm (Stewart, 1998). As this study will later reveal, rapport can also be established through compassionate comments or advice, obtaining data on social history (SH) and family history (FH).The last set of techniques for building rapport is relevant to the analysis of our data.

2.6.3 Phatic communion

Phatic communion is employed for opening discourses. It is defined by Malinowski (1923) as a style of communication in which connections of union are formed solely through the interchange of words. " Some phatic communion researchers have supported Malinowski's (ibid) concept of phatic communion. Lyons (1968) and Silva (1980), for example, have recently emphasised how phatic utterances help discussants to build and maintain feelings of solidarity and well-being. Scholars like Hudson (1980), Cheepen (1988) and Schneider (1988) have also examined the narrative charateristics of phatic communion.

The limitations of phatic communion in transmitting referential information have also been highlighted by Leech and Turner (1974). They contend that phatic statements are meaningless since they are designed to accept and acknowledge interlocutors rather than conveying any significant information.Coupland, Coupland and Robinson (1992:210) summarise phatic communion as a term used to describe a minimalist communication practice that can take on a variety of forms. Due to its low attention value, poor informative value, low relevance, and possibly even low worthiness, phatic communion posits an alternative mode of 'genuine' or 'authentic' dialogue from which phatic discussion deviates.

Malinowski (1923) contrasts between the use of language as a tool for thinking and the use of language as a social engagement method. Malinowski's claim that "speaking was either transmitting information ('communication') or serving a social role ('phatic communion')" is supported by this dichotomy (Tracy and Naughton, 2000). A number of scholars have distinguished between the two main functions of language, such as 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 and Ylanne Mcewen (2000:179), it can be said that both Malinowski's (1923) innovative differentiation concerning code employed as a tool of thought or as a method of action and these authors' linguistic functions carry the inappropriate implication that relational talk is peripheral and incidental. Consequently, real conversation, according to Coupland (2000), is the discourse that "gets the stuff done," where "stuff" does not include "relationship stuff." It can be inferred from this philosophy that sociality is trivialised, and language for conducting business and other profit-making or institutional activities is given so much premium.

In opposition to some of the studies earlier cited, Laver (1974/1975, 1981) defends phatic utterances as exceptionally vital linguistic devices for social communication conveying important information about the discussers' social functions. 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 stage of a

dialogue – propitiatory, exploratory and initiatory. He differentiates between two basic types of phatic utterance: the ones with neutral reference i.e. speeches about the spatio-temporal setting of a dialogue, and those with personal reference i.e. speeches about either the hearer or speaker.

Furthermore, Laver (1974) analyses the use of these speeches by both American and British English speakers, and establishes definite patterns of usage. Consequently, he submits that both neutral and personal phatic utterances are deployed when discussers have a harmonious relationship. In the case of status differences between them, the interlocutor of lower status who addresses another of higher status may use self-oriented phatic utterances but not other-oriented phatic utterances, while the interlocutor of higher status who addresses another of lower status may use the other-oriented and avoid self-oriented phatic utterances.

2.6.4 Counselling

Counselling may be defined as a process that can be developmental or intervening. Counsellors concentrate on their clients' goals. Therefore, counselling comprises both change and choice. Sometimes, it is a rehearsal of action. It deals with wellness, personal growth, career, and pathological concerns (Casey, 1996: 176). Because of the special character of clinical interviews, doctors are compelled to use counselling in certain situations where assistance is needed to help patients maintain excellent health. The discourse gadget is used to motivate people and provide guidance on how to best care for their health.

2.6.5 Direct questions

Medical probes entail doctors asking patients direct questions in order to acquire information that will help them make accurate diagnoses. Direct questions are simple interrogations that are frequently preceded by WH-words. They are critical diagnostic tools for probing into patients' lives to discover the likely causes of their illnesses, obtain medical information that could reveal the true identities of their illnesses, and obtain medical data that could help doctors provide appropriate solutions to the patients' medical difficulties. Situations during consultations between doctors and patients dictate the kinds

of question that are appropriate, hence the switch between indirect and direct questions. Direct questions enable doctors to hit the nail on the head in their quest to unravel patients' medical challenges.

2.6.6 Indirect questions

Medical inquiries are characterised by the use of indirect questions by doctors to obtain information from patients in order to appropriately diagnose their conditions. Indirect questions are questions that have been concealed.They are statements but have the illocutionary force of questions. They are critical diagnostic tools used to probe into patients' lives to reveal the likely causes of their diseases, obtain medical data that can reveal the true identities of their ailments, and obtain information that can help doctors prescribe appropriate treatments for the patients' medical problems. Prevailing circumstances during consultations dictate the types of question that are appropriate, hence the alternation between indirect and direct questions. Deployment of indirect questions enables doctors to make clinical interviews less stressful to enable patients cooperate to freely release all the information needed for accurate diagnoses.

2.6.7 Answer

According to Chambers Universal Learners' Dictionary (2006), answer is a spoken or written statement made in response to a question, request, criticism or acquisition. It is a communication tool that patients utilise to send medical information to doctors so that they can diagnose their illnesses and prescribe appropriate remedies for their health challenges., and it inevitably follows the doctor's questions. Because many medical facts can only be obtained verbally from patients, the answer thus plays a significant role in diagnosis.

2.6.8 Modality

Modality is the expression of speaker's view or decision on the content and speech function of a clause. By modality is meant the aspect of meaning that lies in-between the positive and negative poles (Suhadi, 2011). In a similar vein, Saheed (2003) notes that modality forms a significant semantic category which functions at the sentence level,

arguing that it is an umbrella terminology for devices that enable utterers express fluctuating degrees of obligation to, or conviction in a proposition.

This discourse device is deployed by both doctors and patients to generate all sorts of information. It is the speaker's opinion or judgement on the content and speech function of a clause. It is broadly categorised into two: deontic and epistemic.

2.6.9 Circumlocution

Smyth (1920: 681) defines circumlocution as a tactic deployed to explain or describe the connotation of the target expression through depiction of its features: function, size, colour or shape. Put differently, it means describing something in many words whereas a concise expression exists for it. It is also known as "talking around," which occurs when people do not have the correct term to define what they are looking for. It is also a pretentious strategy for expressing ideas, views, or things in a hazy or conflicting manner. Really, when a person wants to avoid being clear about something and they do not want to say it directly, they use circumlocution. It is a regular occurrence among people learning a new language or entering a new domain. I am looking at circumlocution in the medical field since a thorough understanding of the phenomenon is critical because incorrect information can affect people's actions adversely.

When we look at the examples of circumlocution closely, we would notice that they always have the same characteristics:

a) It is used when a speaker is unable to explain a concept, using the appropriate words.

b) It is used to avoid offensive expressions in social situations.

c) It is used by politicians and lawyers.

d) It is employed in poetry or verse to create a consistent meter.

Circumlocution will be defined in this study as the explication of symptoms of diseases because of patients' lack of knowledge of specific medical nomenclature for ailments. It

will also be used in cases where patients utilise incorrect medical terminology to explain their symptoms.

2.6.10 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 ailments or hiding same as the situation demands (Thomas, 1995). Therefore, this study will investigate the deployment of this politeness principle by the doctors and its pragmatic functions. Face-threatening acts with redress (positive politeness) and face-threatening acts without redress (negative politeness) will both be examined in this study. These and others will be discussed extensively later in this chapter.

2.6.11 Closing

Medical consultations do not go on indefinitely. Therefore, they are always brought to a close after doctors have concluded the consultations, and this is usually done with a view to encouraging or permitting patients to visit the hospital again if the need for such arises. Essentially, closing is used to round off consultations.

2.6.12 Repetition

Repetition means saying a particular thing again, using the same or different words (Chambers Universal Learners' Dictionary, 2006). For practical reasons, doctors and patients alike sometimes repeat particular expressions. Their use allows physicians and patients to highlight or double-check certain medical information. The use of all of the above discourse techniques will be investigated in order to determine the specific pragmatic (speech) roles they perform, as well as their effectiveness and linguistic realisations.

2.7 Discourse approaches

Discourse analysis is an enormous and rather imprecise 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 analysing 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 can language be organised into units higher than sentence? How can language be deployed to transmit information about ourselves, social relationships and the world?

Discourse Analysis is a progressively popular aspect of study but in spite of this popularity, it is one of the areas of Linguistics that have not been adequately defined. Consequently, this has 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: Conversation Analysis (CA), Birmingham Approach (BA), Ethnography of Communication (Etcom), Speech Act Theory (SAT), Ethnomethodology, Interactional Sociolinguistics (InSoc), and Pragmatics. 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.

2.7.1 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 inquiry technique of close scrutiny of groups of people conversing in natural settings. It studies categories of verbal exchanges like telephone

exchanges, story-telling, verbal duels, greetings, and rituals in different socio-cultural settings. Goffman's (1981) work is considered relevant because of its significance in the examination of turn-taking, conversational rules, and other facets of spoken discourse. 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, Emmanuel Schegloff, Gail Jefferson and Harvey Sacks 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 study of the methodical properties and on-going achievement of daily social practices, as one of the studied communal practices in ethnomethodology. The major concern of ethnomethodology is the discovery of the manner social order is produced by members of a society.

Using the features observed in the progression of utterances, conversation analysts generalise about context – about social conduct in social life. The features identified by Jefferson, Schegloff and Sacks (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'', I 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 the foundation on which social order is built 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. Although 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 self-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, and what has just occurred during a conversation 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.

The basic premise of the Speech Act Theory is that words are not spoken in a vacuum. Rather, they are designed to carry out acts such as demanding, accusing, asserting, directing, and so on. To put it another way, every communication serves a fundamental goal, which is referred to as an illocutionary force (Austin 1962). It is concerned with the function of a given utterance: whether it attempts to change a certain condition of things or the world, attempts to persuade the hearer to do something, commits the hearer to a specific course of action, or includes the exercise of power (Adegbija 1982:54). Every

illocutionary act, whatever its purpose, is felicitous or infelicitous, happy or unhappy (Austin 1962). By this , it is meant that for an illocutionary act to be successfully performed, it must be uttered under the necessary appropriate conditions.

The Propositional Content Rule, the Preparatory Rule, the Sincerity Rule, and the Essential Rule are four subcategories of felicity requirements identified by Austin (1962). The Propositional Content of a request is that the speaker (S) expects the hearer (H) to perform a future act (A). H should be able to do A, according to the Preparatory Rules. Furthermore, both S and H must understand that H will undertake A on his own initiative in the regular run of events. S wants H to do A, according to the Sincerity Rule. The Essential Rule is that S counts the request as an attempt to persuade H to do A. (Austin 1962:66). In the following lines, he summarises the crux of such suitability conditions:

> 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.

In their argument that "intention and inference" pattern exists beneath the performance of speech actions, Bach and Harnish (1979:49) offer a fresh perspective to Austin's. They argue that actions are performed with the intention that the audience understands what is going on. The idea that deciphering verbal communication and meaning in general is essentially inferential is implicit in this argument. Mutual Contextual Beliefs are essential for such conclusion. Adegbija (1982) builds on Bach and Harnish's (1979) theory by demonstrating that speech acts cannot be fully comprehended without taking into account the entire pragmasociolinguistic (pragmatic, social, and linguistic) environment in which they arose.

The ethnomethodologists hold the view that properties of social life that appear factual, objective and transformational are actually managed accomplishments of local processes. A critical component of the ethnomethodological approach to the study of conversation, therefore, is its emphasis on the local organisation of talk as it is achieved by discussers i.e. the little step by step details by which conversation is organised, rather than the

underlying speaker intentions, interpretive schemata, social norms that offer more universal 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 solve these problems, Sacks et al (1979) propose that conversationalists address these problems through a system of rules whose methodical choices function or apply at several 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 present speaker's choice of the next speaker, second, for the next speaker's self-selection, and, third, for probable continuance by the present speaker. A structural principle that regulates dialogue is the presence of a second pair-part of an adjacency pair that is conditionally relevant on the first. In spite of its dialogical nature, this approach has not been used in the analysis of hospital interactions as far as I know. However, because of its ability to handle conversational features such as turn-taking, adjacency pairs, interruption, conversational harmony, and so on, it is a relevant approach in hospital verbal interactions.

2.7.2 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 approach of interactional sociolinguistics to the study of discourse is multidisciplinary. Anthropology, linguistics, and sociology are three disciplines that study the connection between culture, language, and society. Despite the fact that interactional sociolinguistics is founded on a variety of disciplines, there is still agreement on core concepts about language, the interaction of other and self, and context.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 refers to how language is used in certain social settings, as well as how it reflects and enhances the meaning and structure of those situations. The latter offers awareness on how people may speak the same language but then contextualise what is said differently in a manner that diverse 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 as a result of people's perception of likenesses and dissimilarities globally is greatly 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.

Saussure's "signalling mechanisms" (speech rhythm, intonation, and choice among syntactic, lexical, and phonetic options) are regarded as "contextualization cues" in Gumperz's work; aspects of language and behaviour (verbal and non-verbal signs) that relate speech to the contextual knowledge that contributes to the presuppositions required for accurate inferencing of the intended message (Schiffrin 1994:99). By and large, Gumperz's studies reveal that contextualization cues have the ability to affect the basic import of a message, though it need be stated that interlocution progresses unhindered when hearers share utterers' contextualization cues.

Two central issues, however, lie beneath Gumperz and Goffman's work, and which provide a unity to interactional sociolinguistics. They are: (i) the relations between self and other, and (ii) the context. Thus, the work of the two scholars presents a vista 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 record of characteristics of conversation expected to function as contextualization cues. Interactional sociolinguists, like speech act theorists, view speech acts as the vital elements 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 InSoc regards discourse as a social relation where language use facilitates the evolving negotiation and construction of meaning. Basically, Interactional sociolinguistics is a functional approach to the study of language. Its focus on language is counterbalanced by its attention to structure. For the interactional sociolinguist, language and context are interdependent: language provides the context, and it is contextualised in such a way that it does not function in context alone but also provides and forms 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.

Major G. (2003) used this method to demonstrate the value of Discourse Analysis (DA) in the examination of patient-nurse interactions within a sociolinguistic framework. The approach is also apposite for the study of the data on code alternation in this study because of its emphasis on how context determines the forms of language used in specific situations.

2.7.3 Conversation 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)

This method was used by Major (2003) in his effort to show the value of Discourse Analysis (DA) within a sociolinguistic framework in the analysis of patient-nurse verbal interactions. 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 deserters from a sociology they considered as based on simplistic classification.

Specifically, CA has been comprehensively enunciated by sociologists as an approach to the study of discourse, starting with Garfinkel (1967). CA is dissimilar to other branches of Sociology because instead of engaging in real examination of social order, it attempts to find out the methods by which members of a society create a sense of order. Put differently, the deployment of natural language in conversational exchanges offers direction and management of the social situations in which the dialogues occur. Therefore, CA provides explanations of how conversations realise this order. Ethnomethodological investigation of members' techniques as they are consistently deployed in creating the social world, and the social organisation of talk reveals that uncovering known as a central concern for ethnomethodology; and that knowledge is neither independent nor decontextualised.

Conversation Analysis concentrates on the specifics of genuine speech events. Analysts take notes on interactions that are not influenced in any way. They also keep track of what happens and try to duplicate what is said in ways that avoid making assumptions about what is relevant to participants or analysts. In the same vein, analysts stay away from making broad assumptions about what participants "know," preferring to focus on specific events that occur throughout the dialogue. Conversation analysts treat context ethnomethodogically.

Moreover, CA looks for distributions, forms and recurrent patterns of organisation in large corpora of talk. Conversation Analysis methods to the study of discourse study how interlocutors in a talk systematically resolve the recurrent organisational problems. Some of the problems for which solution is found are: turn-taking, repair, information receipt, opening and closing of talk, topic management, and presenting agreement and disagreement. By and large, CA offers a substantial insight into the nature of conversation when juxtaposed with conventional Discourse Analysis (Levinson, 1983).

Major G. and Holmes J. (2003) combined this approach and ethnomethodology in a research paper titled How Do Nurses Describe Health Care Procedures? Analysing 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.

2.7.4 Pragmatics

2.7.4.1 Definition and scope

Discourse Analysis requires a strong foundation in pragmatics. It is impossible to analyse any speech without at least a basic understanding of pragmatics and how it works. Defining Pragmatics and delineating its scope is as difficult as defining Text Linguistics or Discourse Analysis. One thing that is certain is that when working within the field of Pragmatics, we are dealing with meaning. But then, what is the main dissimilarity between Pragmatics and Semantics?

Simply put, if Semantics is defined as the branch of study concerned with the truth-conditional meaning of utterances, Pragmatics is concerned with all other types of meaning. However, this is a fairly broad definition comparable to that offered by Morris in 1938, which is regarded as the leading contemporary definition of the terminology. Morris' (1983) definition of pragmatics, according to Levinson, is "dealing with all the psychological, social, and biological processes that occur in the functioning of signals", which is far broader than the scope of the study usually referred to as pragmatics. According to Levinson, the scope of the term "pragmatics" has been continually narrowed, and the meanings that have eventually gained traction are those that refer to language users.

Levinson (1983) defines Pragmatics as "the study of utterance meaning," which is similar to Schiffrin's (1994:190) definition of Discourse Analysis. Alba-Juez (2009) questions if Pragmatics and Discourse Analysis are the same, but Schiffrin (1994:190) responds that "the scope of Pragmatics is very broad, and it faces definitional dilemmas similar to those faced by Discourse Analysis’’.

Pragmatics is recognised as one of the fundamental foundations and methods of Discourse Analysis in this study. As a result, Discourse Analysis is regarded as a broader study that incorporates Pragmatics ideas, while also incorporating different viewpoints. The conclusion drawn from the above is that Pragmatics is defined in a more limited way.

2.7.4.2 The Gricean cooperative principle and implicature theory

The delivering of Grice's (1967) William James Lectures was a milestone event in the construction of a systematic framework for pragmatics, according to Horn and Ward (2004:11). In Gricean Pragmatics, one of the most basic concepts is speaker meaning. Grice contrasts between speaker meaning (meaning-nn), which is unintentional, and artificial meaning (meaning-nn), which is intentional. The second intention implied in the notion of non-natural meaning is the awareness of the speaker's communicative aim on the part of the addressee. Thus, if a child says to her mother, "I like that dress," the (non-natural meaning (meaning-nn) is that she wants her mother to buy it for her (and so she wishes she recognised her disguised intention to have the dress). This type of meaning is intricately tied to another important concept in H.P. Grice's Pragmatics: conversational implicature. One of the most essential notions in Pragmatics is the concept of conversational implicature. This idea has provided language analysts with a direct explanation for the ability to imply anything other than what is actually "spoken.". Usually, the message a speaker intends to pass across is much stronger that what is directly expressed. The speaker thus exploits pragmatic principles the listener can invoke to link what is said (the verbatim content of the spoken words) to what was meant (i.e. the real message actually passed across).

Alba-Juez (2009:48) observes that conversational implicatures constitute one type of inference derivable from a statement for the purpose of working out what is “meant” from what is “said”, and they are connected to what Grice named as “Cooperative Principle” and its “Maxims”. Going by the fact that talk exchanges do not usually comprise a sequence of unrelated remarks (and if they did would appear unreasonable), the comments are typically cooperative efforts that are recognised by every participant in a mutually accepted direction. It is anticipated that speakers cooperate and follow these maxims which are reproduced below:

The cooperative principle

The cooperative principle (CP) has four maxims:

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:

Do not say what you believe to be false.

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:

Avoid obscurity of expression.

Avoid ambiguity.

Be brief (avoid unnecessary prolixity).

Be orderly.

(Grice, 1975:45-46)

Grice adds that humans occasionally break these rules, and this is where conversational implicatures come into play. In the event of a violation of any of the maxims, the listener acknowledges that the utterer is attempting to cooperate and searching for meaning at deeper levels. By doing so, he or she draws an inference, known as a "conversational implicature." The field of verbal irony is one in which conversational implicatures are fully operational. For example, if a man says after a heated dispute with a friend:

"You are indeed a good friend!"

The non-literal meaning of the phrase, as given by him, would be readily understood by his companion. He is actually breaking the Quality Maxim, because his friend should conclude, through implicature, that the man does not consider himself to be a good friend, but rather a lousy and self-centered one. According to Grice (1975:50), the listener would use the following resources to determine the presence of a conversational implicature:

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.

iv) 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 times when the message is determined by the conventional meaning of the words employed. Consider the following scenarios:

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.

As a result of the use of the connective "therefore" in (a), we come to the conclusion that lousy teaching is a result of being a dentist. Similarly, the traditional interpretation of "even" in b) leads the listener to conclude that Jane is a very slow reader. This form of inference, spurred by "hence" in a) and "even" in b), is known as "conventional implicature" by Grice. Traditional implicatures are comparable to pragmatic presuppositions in that they focus on detachable but non-cancellable components of meaning.

One of the most distinguishing characteristics of conversational implicatures over conventional implicatures is that they are cancellable, as Grice (1978:115-16) explains:

> 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.

Conversational implicatures have a "slippery" quality due to their non-conventional nature and cancellability. They are, nevertheless, an important component of both the utterer's and the listener's communicative competence. An utterer's ability to work out implicatures, among other things, makes them skilled and competent communicators. This is a critical component of the pragmatic awareness required to communicate effectively in any language.

a) A conversational exchange between Joseph and Davies, while discussing some handsome and attractive men they came across in their youth):

Joseph: Do you remember Ken?

Davies: Ooh! He was graceful, 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 graceful or gorgeous)

b) His friend is now in Germany or in India.

Implicature b- I don’t actually know that his friend is in India.

Both a) and b) elicit non-conventional conclusions, which are thus cancellable. As a result, we are dealing with conversational implicatures in both cases. However, the extension of the conditions from which the inference was formed distinguishes implicatures a and b. The inference in (a) is a conversational implicature since the listener would normally be expected to conclude the content of implicature a, i.e. Gabriel was not handsome, only in a conversational setting like that between Joseph and Davies (i.e. a talk about gorgeous men). The inference is that implicature is context-specific and would not apply in a

general situation (where no one would question Gabriel's attractiveness and would simply consider him kind). In the lack of a separate context, the conclusion formed in (b), that the speaker is unsure whether his friend is in Germany or India, is prompted. Implicature b, on the other hand, has a defaulting characteristic, and it is an instance of universalised conversational implicature. It is crucial to understand that in both cases, the utterers, not the words or propositions, are the critical factors to consider for inferring the appropriate implicatum (Alba-Juez, 2010).

2.7.5 Politeness principle

According to Georgia Greene (1989:141), politeness refers to the strategies for maintaining or changing interpersonal relations. It is defined by culture. Thus, something that is regarded as courteous in one cultural context may occasionally be pretty indecorous or basically bizarre in another. Furthermore, it is a fundamental force in communication that may be reduced to something as simple as the need to be true, relevant, clear, and instructive (Grice, 1975; Brown and Levinson, 1978; Leech, 1983). Natural languages offer diverse methods for coding politeness and, in dialogues, people decide how and the point to deploy those devices. Kaplan (1999) observes that people love to be shown due regard. He identifies the honorifics and other politeness indicators that can be used i.e.: please. Politeness pointers are closely connected to the undercurrent influence of societal relations and are regularly a critical element in determining whether those communications go well or poorly.

Brown and Levinson (1978) base their politeness model on Goffman and Grice's conceptions of "face" and "conversational logic," respectively. "Face" refers to: (i) an individual's desire to have their actions or thoughts ratified by others (positive face), and (ii) have their actions or thoughts unaffected by others (negative face). The face-saving perspective of politeness places a greater emphasis on the desires of the participants in any given communication than on the communication itself or the rules that govern the society. Face can be maintained, enhanced or lost. It is also is emotionally invested and has to be relentlessly observed in interactions (Brown and Levinson, 1987:66).

Brown and Levinson (1978) base their concept of politeness on the idea that a number of speech acts are basically threatening. They are menacing since they do not approve of the utterer's (U) and/or listener's face desires (L). Face-threatening acts (FTAs), according to Brown and Levinson (1978: 65-67), are defined by two simple criteria: (1) Is it the speaker's or the listener's face that is in danger? (2) What face is in danger? Face-threatening acts that threaten a listener's positive face include those in which the speaker expresses disapproval of the listener's positive self-image or face (e.g.: interruptions, complaints, mention of taboo topics, criticisms, and accusations). Acts that threaten an addressee's negative face include situations in which the listener is required to accede to or reject an utterer's impending act (e.g. promises, offers), or when the listener has reason to believe that the utterer is interested in their products. Confessions, self-humiliations, apologies, and accepting a compliment are examples of FTAs to the utterer's positive face. Accepting gratitude, expressing gratitude, accepting an apology or an offer, and making promises are just a few of the FTAs that threaten the utterer's face.

While Brown and Levinson (1978: 13) think that the idea of face is a universal phenomenon, they also clarify that face is likely to be the subject of extensive cultural elaboration in every community. The following factors are used in their model to measure the seriousness of a face-threatening act: (1) the social distance (D) between the utterer (U) and the listener (L); (2) the relative power (P) of (U) and (L); and (3) the absolute ranking (R) of imposition in the given culture. An apology is an effort by the utterer to remedy a prior action that affected the hearer’s face-wants (Brown and Levinson, 1978: 187). Therefore, the purpose of apologising is to normalise relations between utterer and listener (Leech, 1983: 125). An apology is an acceptance by the utterer that the listener has been offended and an admission of being partly responsible for its cause. Because it signifies that the event has already occurred, it might also be considered a "post-event." Apologies serve as remedial labor, and they have long been thought of as hearer-friendly because they provide some benefits to the listener at the expense of the utterer (Owen, 1983). Holmes (1995) contends that apologies are often face-supporting activities, and she also extends the concept of face benefit to the utterer.

In the performance of an apology, the speaker admits that addressees do not want their face to be threatened. Apology is face-saving for the addressee and face-threatening for the speaker. Contrasting positive politeness and negative politeness, the former constitutes an involvement-based method the speaker employs to understand, admire and approve of the encouraging appearance of the listener. Brown et al (1987:75) regard the role of positive politeness strategies as that which looks for a means to reduce the likely threat of an FTA by guaranteeing the listener that the speaker (S) regards them positively and wants at least some of the wants of the listener met. Apologies can also play the role of positive politeness approaches for listener (L) since (S) supports L's desire for constructive avowal and feelings from other people (Holmes, 1985). Instances of apology acts working as positive politeness include: i) a speaker acknowledging that the listener is justified in being upset by the infraction; (ii) a speaker demonstrating responsibility for correcting the situation and pacifying the listener through an offer of repair; and (iii) a speaker using reverence indicators such as titles or forms of address (Prof., Engnr., Rev.) or official predicator forms and matching pronouns (T-V forms). Brown and Levinson's (1978:74) theory accepts that FTA without redress (negative politeness) is the commonly favoured method for facework. However, Scollon, 1981; Placencia, 1992; and Nwoye, 1992 are opposed to this view expressed by Brown and Levinson; their view is supported as a valid assumption.

Civility requires two participants - a speaker and a listener - but the interlocutors also exhibit politeness to a third party who may or may not be present at the speech event. 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) observes that Grice's idea of possible identification of a joint purpose common to participants in every stage of any dialogue is unacceptable. He claims that discussers may not have common aims. He further states that every interlocutor reserves the right to change the course of talk as they desire in certain restricted areas. Kates (1980)

expresses the opinion that the H.P. Grice's conversational maxims can not be realised because majority of speakers are not only indifferent to this norm of cooperation but are totally unaware of its existence. The disparagements of the Gricean conversational maxims only diminish their general use; they are not rendered completely incompetent. Although Geoffrey Leech's (1983) is anther principle, it is a great complement to the Gricean cooperative principle. The notion may be explained thus:

A: The dormitories, libraries and halls shall be repainted.

B: Definitely, the halls will be repainted.

The response by B apparently flouts the quantity maxim. His input submits that the halls alone will be repainted. Just by referring to halls, he has lessened the politeness to avoid causing dispeasure. B's aim has, consequently, inhibited his contribution. The Irony Principle, which is a subtype of politeness, is a second-order principle that goes like this:

> If you must cause offence, 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 instance may be considered:

Jack: Dola has torn your towel.

Denise: (apparentlly infuriated) Oh. Good!

The implicature of the contribution of B in the conversation above is polite but the connotation is not.

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 also helpful to briefly comment on deference while discussing politeness. Deference is demonstrated when other people are accorded respect because they are older or have a higher position, etc. and it is integrated into the languages of the world. For example, Yoruba have a lot of honorifics which are used as indicators of reverence to address people with higher position or higher age, peers or aliens. When peers converse, they normally use honorifics to show reverence. However, honorifics are deployed more in dialogues involving females than males. For instance, in English, expressions like: 'Sir' and 'Madam' are used to demonstrate reverence. Additionally, terminologies such as 'evangelist', 'professor', 'doctor', 'pastor' are used to indicate status differential. According to Odebunmi (2003), deference is more of a sociolinguistic matter than pragmatics. Thus, for example, if a person usually talked to as 'Evangelist' is unexpectedly addressed by their first name, then, deference is pragmatically irrelevant.

However, Dillian et al (1985), and some other scholars like: Thomas (1986), Brown et al. (1987), and Frazer (1990 detect certain flaws in Leech's method for the study of politeness; they assert the maxims are unsophisticated. Thus, it appears constructive to embrace Thomas (1995) that attempts a settlement of the arising matters by regarding Leech's opinions as a sequence of social and psychological restrictions prompting, to a lesser or greater extent, the selections made in the pragmatic yardsticks but never as maxims. Consequently, the maxims propounded by Leech are to be considered as factors, regardless of the possibility to still call them maxims for easy allusion. To demonstrate politeness during interlocution, discussers comply with the maxims below:

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

(b) Maximise benefit to other.

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

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

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

(b) Maximise dispraise of self.

5) Agreement maxim (in assertives): Minimise disagreement between self and other Maximise agreement between self and other.

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

(b) Maximise sympathy between self and other.

7) Polyanna Principle states that people choose to focus on the positive side of life instead of the other side. The Pollyanna priciple is applied by deploying minimisers, relexicalistions and euphemisms to take care of unpleasant issues, making use of agreeable or delightful expressions (Leech 1983: 132).

2.7.6 Face-threatening acts and politeness

The principle of politeness is a direct consequence of the flaws observed in the Cooperative Principle (CP). Talking of regulative value, Leecch (1983:82) states that the politeness principle is sturdier than the cooperative principle. Politeness stimulates unhindered continuance of conversation in a way friendliness is guaranteed. However, he contends that CP and PP have comparative dominant propensities. PP predominates CP atimes, and vice versa.

Politeness can be perceived in circumstances of social remoteness or intimacy as a method through which additional person's face awareness is demonstrated. Yule (1996:60) precisely describes face as a person's public self-image. Odebunmi (2003) defines it in another way as the socio-emotional feeling of self that a person possesses and anticipates other people to know.

Face is divided into classes. Deference or reverence is number one, and it functions where there is social aloofness e.g.: the affiliation between a proprietor and their worker, or the

oldness veneration between a father and his child. The second is solidarity, camaraderie or friendliness that happens in social intimacy. It exists mainly among contemporaries. Everyone desires their face to be revered, regardless of the people involved. Thomas (1995) defines face as a person's feeling of self-worth or self-image that can be maintained, damaged or enhanced through interaction with others.

Face, thus, may be negative or positive. Face is positive when someone wants approval, liking, appreciation and respect from other people. Contrariwise, face is negative when somebody desires to behave autonomously without obligation to other people. It is useful to restate that everybody desires their face wants met. One's face is saved when this happens, but one's face is threatened when the opposite is the case. All these happenings are termed face-threatening acts (FTAs).

FTAs are illocutionary activities that can detract from or intimidate H's positive or negative persona.Ocasionally, this happens when something one holds dearly is condemned, when H's independence is constrained or when H is insulted. At other times too, H may potentially damage S's negative or positive face (Odebunmi, 2003).

However, it is plausible to lessen the impairment that speaker's act might do to hearer's face, using some methods. In the attempt to pick an apposite method, S must consider the magnitude of the face-threatening act and determine the face-threatening act, taking cognisance of the factors of power (P), distance (D) and rating of imposition (R). The methods used are influenced by the supplied elements. The methods include: (a) on-record performance of the FTA without redress, (b) on-record performance of the FTA deploying positive politeness, (c) on-record performance of the FTA deploying negative politeness, (d) off-record performance of the FTA, and (e) non-performance of the FTA (Thomas 1995). All of these are discussed in the next section.

2.7.6.1 Performance of FTA without redress (Negative politeness)

Performance of FTA without redress is also called bald-on-record. The FTA is accomplished when some outside influences restrain a person from talking directly. Some of the instances include crisis situations or a situation where someone is working behind schedule. When the speaker (S) and the hearer (H) are chatting, S may choose to make

their demand on the record if they believe the FTA best serves H's interests, but when the social distance is significant, the FTA is sometimes unrestricted, regardless of imposition rating. In circumstances similar to that, the influential interlocutors use indirectness. "Would you?," please," or "could you explain why you should not be disciplined?" are examples of bald-on record behaviours that can be followed by moderating methods that reduce the imposition. Yule (1996) observes that bald-on–record remarks are consistent with interactional circumstances in which S has a sense of power over Other, allowing them to seek directing Other's behaviour with words.

2.7.6.2 Performance of FTA with redress (positive politeness)

While commenting on Brown and Levinson's face management method, Thomas (1995) proposes that when people communicate, they may change their faces to a person's affirmative face and utilise positive politeness that satisfies H's want to be liked and supported. Leech's (1983) principles of politeness suggest politeness notions like: "exhibit equality: "give sympathy", ''seek agreement'', "be optimistic" and''avoid disagreement''. Since the characteristics are highly naturally constructive, they can significantly save H's face in interactions. Despite the unpleasant constituent of majority of questions, warning and dismissal letters written worldwide, it is a usual practice to observe the letters conclude with ''Thank you''. In a number of other circumstancess, displeasing occurrences are presented euphemistically.

FTA with redress is realised through the use of deference markers, conventional politeness markers, and by curtailing imposition. Some examples are: indirect conventionality, indirect hedging, etc. Brown et al. (1978) propose ten methods for the performance of FTA with redress (negative politeness) i.e.: "admit the impingement and beg for forgiveness", ''be conventionally indirect'', ''go on record as incurring a debt'' ''hedge'', ''use points of view distancing'', ''minimise imposition'', etcetera. For instance, in numerous money-making centres across Nigeria, especially where the managerial staff members are educated, statements such as: ''No credit today, come back tomorrow'' are not uncommon. This implies that buyers are denied credit facilities regardless of their relationship with the management. Cautionary announcements aiming great number of readers employ negative politeness (Thomas, 1995).

2.7.6.3 Performance of FTA using off-record politeness

Brown and Levinson (1978) provide fifteen off-the-record politeness methods. "Be ambiguous or vague", "offer hints", "use metaphors", and so on are some examples. The majority of these types of face acts revolve around Searle's prepared condition. "Your disdain for constituted authorities is appalling," for example, can be gleaned from questions prompted by unruliness and neglect.

2.7.6.4 Non-performance of FTAs

Non-performance of FTA occurs when a situation or thing seems so possibly face-threatening that one avoids saying it (Thomas, 1995). Tanker (1992) explicates two methods of dodging saying a thing:

OOC-genuine: S does not give a speech act and really wants the situation to be resolved. She or he has no intention of creating a perlocutionary effect.

OOC-strategic: S does not give a speech act, but expects the perlocutionary consequence to be inferred from this.

Pragmatics is considered apposite for the analyses intended in this work in view of its focus on face-threatening acts and politeness maxims, and capacity to explain implicit meanings of utterances.

2.7 Possibility or otherwise of discourse pragmatics

Anne Reboul and Jacques Moeschler (1998) demonstrate how and why the discourse analysis programme could not satisfy the criteria required by a scientific approach to language. Their argument, premised on Lakatos' (1978) concept of research programme and the notion of emergent units (Searle 1994), has revealed that a discourse, unlike a sentence, is not a linguistic unit.Thus, any attempt of linguistic definition of discourse is bound to fail, as well as any restricted linguistic approach to discourse. Discourse is a non-arbitrary string of utterances, emergent 1 unit, whose properties are not the causal outcomes of its components. This non-arbitrariness of discourse yields an interesting mapping between linguistic emergent 2 units, that

is, morphemes, characterised by an arbitrary relationship between form and meaning. Nevertheless, the main theoretical issue is the following: the parallelism grounding is a linguistic theory of discourse, that is, the correspondence between sentence and grammaticality on the one hand and discourse and coherence on the other, is false. Majority of theories of discourse try to define empirically and theoretically what a discourse is from notions like coherence and markers of cohesion. It can, therefore, be deduced from *Pragmatique de discours* that coherence is not a concept that allows attributing discourse the status of an emergent 2 unit. Discourse is only an emergent 1 unit. So, the best way to build a theory of discourse is to use the principles of a theory of utterance interpretation, that is, a pragmatic approach to utterance interpretation. Central concepts of pragmatics are thus used to build a pragmatic theory of discourse as local informative intentions associated to utterances and global informative intentions associated to discourses admit that discourse coherence depends on the possible accessibility to a global informative intention as a result of a non-demonstrative process of hypotheses formation (Jacques et al, 1998). These assumptions are illustrated by showing how markers of cohesion like tenses, connectives and referential expressions function in discourse. Their proposals, which claim very few progresses have been made in the discourse analysis paradigm since its emergence in the seventies, is nowadays no more refuted by current works in discourse analysis, where discourse is now investigated in new directions, mainly in relationship to new technologies (computational linguistics, quantitative linguistics, prosody and intonation).

Nowadays, it is a fact that the domain on which their argumentation was based, that is, post-Gricean pragmatics, is not stagnant. Recent works in lexical and non-lexical pragmatics (Carson 2002, Moeschler 2009), as well as new discoveries in the development and acquisition of language, theory of mind, autism, as well as quantitative scales, negation and argumentation show that the pragmatic foundation of a theory of discourse is of current relevance. Recent advancements in the realm of post-Gricean pragmatics, according to Jacques et al (1998), allow strenghtening the assumptions of *pragmatique de discours* and show that pragmatics of discourse is not only conceivable, but also a work in progress.

2.7.1 Discourse pragmatics: A short introduction

Discourse pragmatics was borne from two statements: one, cognitive approaches of utterances never introduce external (social or discursive) hindrances on interpretation of utterance processes; two, since the advent of discourse analysis works, no universal or particular rule has been theoretically or empirically established. The first assertion lies at the heart of pragmatics, which is defined as the theory of utterance interpretation. Starting with Grice's work, pragmatics has been defined as the theory of utterance interpretation (Grice 1989). It is acknowledged that the principles that activate the interpretation of utterances are based on universal principles of human logic and communication.The cooperative principles and conversational maxims are not cultural rules that would be accurate in Western culture and vary from one culture to another. Classical counter-examples are just erroneous interpretations of conversational maxims. For instance, if a Greek on the street offers you a dishonest answer, it simply implies that the first maxim of quantity triumphs over the second maxim of quality, whereas Western Europeans favour the superiority of the quality maxims over the quantity maxims. Cultural variations are, therefore, not counter-examples of the maxims of conversation, but constraints on the hierarchy of pragmatic rules (Jacques 1991). (1) is a preference of some cultures in which it is impossible not to answer a question, whereas (2) is another preference:

Maxims of quality > maxims of quantiity

Maxims of quantity > maxims of qualiity

It is possible to show that the example given by Grice to illustrate (2) in Logic and Conversation, generally receives a different interpretation as the one Grice intended, that is, an interpretation that satisfies (1):

A: Where does C live? B: Somewhere in the South of France.

Gricean interpretation satisfying (2): B does not know precisely where C lives.

Non-Gricean interpretation satisfying (1): B knows where C lives, but is reluctant to tell A.

In the classical Gricean interpretation, B gives the strongest information, what authorises A to infer that he cannot give a more precise information and he does not know precisely where C lives. In that case, not observing the first maxim of quantity does not depend on the risk to violate the second maxim of quality, but depends on the wish to control the quantity of information necessary to draw the implicature that the hearer is invited to draw. Answers like

“No comment!” given by politicians do not mean that they do not want to say anything, but that they are reluctant to give the expected information.

The second statement, that is, the absence of particular discourse rules does not imply that discourse in organisation is not minimally limited, but it does imply that discourse rules do not play any roles in the interpretation of utterances.Let us take a classical example of an exchange:

Grock: Do you know the famous pianist Padewereski?

The pianist: Padewereski?

Grock: Yes.

The pianist: No.

Groch: Well, he even plays better than me!

(Jacques et al, 1998:219)

The above example, employed to portray subordination relation in discourse (exchange embedding in moves), is an illustratiocn of a trivial fact: some illocutionary acts create expectations of relevance. For instance, a question requires an answer, and if a question follows a question, it means that a reply to a second question is required to answer the first question.

If rules of conversation exist, they seem to be linked to questions of interpretation; utterances give rise to expectations, acts of asking require acts of saying, not acts of asking or telling (Sperber & Wilson, 1986).

If discourses are constrained by general principles guiding their interpretations, the question is whether there are no minimal general principles accounting for a fact observed by most of the approaches to discourse: well-formed discourses are coherent in the sense that utterances do not follow each other in an arbitrary way. In other words, the question is to know if principles of coherence exist, that is, principles that would play a role not only in utterances interpretation, but also in their production.

This is exactly the point where discourse pragmatics claim is the strongest because it can be demonstrated that rules of discourse are not required or adequate conditions for their coherence. In discourse pragmatics, discourse is defined as a string of non-arbitrary utterances. Indeed, single utterance discourses are seldom and atypical. For instance, anonymous letters or SMStypical one-utterance discourses:

(7) You are gonna die!

(8) Let's meet at the Linguistics Building at noon.

Secondly, discourse units are not sentences or clauses because sentences or clauses are maximal linguistic units composed by lexical and functional morphemes. Jacques et al (1998) demonstrate in *pragmatiq du discours* that discourse is not a relevant scientific unit (Searle, 1994) because it can be reduced to a string of non-arbitrary utterances, whereas utterances cannot be reduced to the combination of morphemes as sentences can. Their position is thus radical as they state the following propositions:

(i) Morphemes are not reducible to the units they are composed of because phonemes combinations do not explain their properties of higher-order units.

(i) Sentences can be described as the combination of morphemes, lexical as well as grammatical.

However, syntactic rules are not directly derived from the properties of morphemes that compose them. So, compositional semantics is closely related to syntax, and the position of morphemes in the sentences does not produce the same results from the meaning point of view.

An utterance is a combination of sentence and context. This accounts for why a great number of utterances take different meanings in different contexts because of the presence of indexical, as in (9), but also non-situational words as anaphora (10):

A. I am happy here. B. The weather is fine here.

(10)A. They are still increasing taxes. B. In Geneva, they are driving like fools.

C. The boss fired the worker because he was a convinced communist. (Moeschler, 2009)

These examples are well-known and do not demand deep comments. On the other hand, the consequence is that if the definition of utterances is projected at the level of relevant units, the conclusion is that utterances are no more linguistic units, but pragmatic ones: understanding utterances requires being able to determine the linguistic meaning and its interaction with contextual elements to access its sense. In other words, sentences can have different meanings (they can be linguistically ambiguous), but utterances do have a unique sense.

If utterances are not reducible to sentences, defined as maximal linguistic units, the utterances are the unique units at the pragmatic level being relevant scientific units. Moeschler queries if discourses are composed of strings of arbitrary utterances, would they not be relevant scientific units, that is, non-reducible to elements that compose them (utterances)? The issue is crucial because Reboul and Moeschler (1998) claim that discourse interpretation is not reducible to

interpretation of utterances. They also proffer an answer to why discourses are not candidates for relevant scientific units, that is, emergent 2 facts (Searle, 1994), and not emergent 1. The argument is double: on the one hand, in order to be emergent 2, and not emergent 1, discourses should be defined by rules that would be independent of the units they are composed of. On the other hand, the interpretation of the discourses is the result of complex hypotheses formation and confirmation processes, which are not reducible to the sum of the interpretation that compose them.

The two points are based on empirical and theoretical arguments. From an empirical point of view, a great number of discourses are coherent without the presence of linguistic markers of cohesion. Worse still, it is easy to find instances where the presence of marks of cohesion does ensure coherence of discourses. (11) is an illustration of the first case and (12) illustrates the second:

a) Ben understood that his friend's operation would be very expensive. There was always Uncle George…. He reached for the telephone directory.

Veni, vidi, vici.

Grass is green. It rained the whole summer.

12 a) Ben understood that his friend's operation would be very experience, but there was always Uncle George.

b) Veni et vidi et vici.

c) Grass is green because it rained the whole summer.

In (11a) the invited reference is that Uncle George can pay for the operation; the first two segments are in coherence relation because the second disconfirm the conclusion drawn from the first ("it will be impossible to pay for the operation"). (11a) could have been realised by (12a), that is, a more explicit version of (11a). The famous Caesar's sentence simply signals temporal order through the order of propositions, and could have been realised through a more explicit version (12b). Finally, in (11c), the reverse order triggers the causal interpretation, which is made explicit in (12c) through the connective *because*.

(13) John bought a cow. **Indeed** it is red like a squirrel. It lives in the forest and hibernates through the winter. **But** it is very cold in this part of the world (Reboul and Moeschler, 1997).

In (13), on the other hand, all marks of cohesion (connectives, anaphora) are present, but the discourse is not coherent. From the above, the conclusion that can be drawn is that no empirical

argument can support the claim that discourse would be the by-product of specific discursive rules. If that conclusion is confirmed, then the thesis that discourse is an emergent 2 is difficult to support. This is not really surprising, because only radical supporters of a constructivist approach to discourse can adopt such a claim, that is, sense is not associated to units as utterances, but is the result of an interactive construction realised in conversation?

About the nature of the content of the interpretation of discourses, Reboul and Moeschler (1997) distinguish two layers of comprehension: the local level (utterance) and the global level (discourse). Their hypothesis is Grice's theory of non-natural meaning, that is, utterances interpretation is not only commanded through the recovery of the speaker's informative intention (what he wants to communicate) but also by the recovery of his communicative intention (his intent to communicate his informative intention). The consequence is that utterance and discourse interpretation refer to a double process of informative and communicative intention. The issue of discourse interpretation can thus be formulated in the following terms thus:

Discourse interpretation is based on the speaker's global informative and communicative intentions. In other words, the hearer has to be capable, if possible at any time of the interpretive process, to determine the speaker's global informative and communicative intentions. Global intentions are determined on the basis of local informative and communicative intentions associated to utterances.

As the interpretation process is a hypothesis confirmation process, the establishment of a global informing intent (what the speaker wants to communicate in his discourse) cannot be reduced to the sum of local hypotheses.

2.7.2 Discourse pragmatics

Subjectively, discourse pragmatics and pragmatics of discourse mean the same thing. They refer to the analysis of discourse, using purely the implements of pragmatics at the level of utterance interpretation and intended message(s). In all forms of human communication, either consciously or unconsciously, we make use of the principles of utterances interpretation. This view is corroborated by Latkoff (2007:130). According to him, pragmatics links words to speakers and the context in which they speak: what they intend to achieve by speaking, the

relationship between the form they pick and the effect they desire (and get), and the assumptions speakers make about what listeners already know or need to know. It accounts for the guidelines governing language use in context. Therefore, pragmatics can show cognitive processes as well as social, professional, and cultural restrictions, such as role and power-based constraints, which influence how language is used in various types of health discourse. Despite the fact that studies on both oral and written medical discourse have, among other things, drawn on Austin (1962), Searle (1969), Brown and Levinson (1987), and Grice (1989), it is surprising how very few studies have clearly admitted employing pragmatics as a research area. This is in stark contrast to research that employs other analytic techniques, such as conversation analysis. As a study of relevant papers in the Journal of Pragmatics during the previous ten years demonstrates, it may be difficult to identify clear boundaries in research taking a pragmatic viewpoint on medical encounters.

2.7.3 Pragmatics and medical discourse

Gillian (2014) in Pragmatics of Discourse by Klaus P. et al (2014) explores the way patients and the voices of healthcare practitioners are enacted in a variety of clinical interview circumstances, and pragmatics is evaluated for its contribution to an understanding of the various complexity that characterise communication in medical settings. She examines the relationship between pragmatics and medical discourse under four main headings: field of inquiry and methodological approaches, intercultural and cross-cultural studies, taking stock and medical discourse themes.

Research in medical communication stemmed largely from disciplines like: social psychology, medical sociology, medical ethnomethodology, linguistics, medical anthropology, social psychology, and clinical linguistics. All the disciplines individually contribute to the study of the subject and issue their own set of ontological, epistemological, and methodological conventions i.e. the interaction between physicians and their clients and that amongst physicians, the social tradition of medical science, participants' fitness ideas and their place in a certain ethnic value system during a consultation. Comprehension of "the enterprise of medicine" requires a thorough understanding of medical language, both verbal and nonverbal (Charon, Greene and Adelman, 1944:955).

Majority of the research on medical encounters focus on physician-patient interactions because it is critical to have effective communication as a foundation for getting a diagnosis, planning medical intervention, counselling, and attending to the emotional repercussions of illnesses (de Haes and Bensing, 2009). In the last forty years, a considerable increased interest exists amongst discourse analysts and sociolinguists in physician-patient verbal interactions as a field of inquiry (Menz, 2011). However, the appraisal of the existing works has revealed that the borders of this area of study transcend such multi-party and dyadic consultations, and increasingly include frontstage meetings with the sick's so-called off-stage engagements (Sarangi and Roberts, 1999) comprising inter alia interactions between various healthcare practitioners in a definite formal circumstance.

2.7.4 Discourse pragmatics approach to medical discourse

Scholars using pragmatics have worked on certain medical discourse themes. These themes are: asymmetry, routines, misalignment, and directness – indirectness. Each of them is deployed to demonstrate how pragmatics contributes to communication in medical contexts, especially in relation to display of power relation, control over the phases in consultation, divergence in the expectations of providers and patients, and meaning of utterances and non-verbal cues.

2.8 Speech acts

This is another feature of the speaking situation that pragmatic studies regard to be crucial. John Austin and John Searle developed a theory of Speech Acts based on the fundamental idea that language is used to accomplish activities. Austin (1962) began deconstructing the notion that truth conditions should be considered important to language comprehension in his book "How to Do Things with Words." As a result, he devised a broad theory of illocutionary acts, which later became a focal point of general pragmatic theory. Austin observes that when we say anything, we are also doing something, and thus three types of acts are performed at the same time:

Locutionary acts: the utterance of a sentence with a determinate sense and reference.

Illocutionary acts: the making of a statement, offer, promise, etc. in uttering a sentence by virtue of the conventional force associated with it.

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?

The locutionary act here would simply be the utterance of a statement indicating that the man has purchased a brand new and expensive car and has asked his friend whether he would like to borrow it. The consequence of the locutionary act, i.e. the function supplied by the locution, which in this case is an offer, would be the illocutionary act. The mam's intended perlocutionary act, on the other hand, could be to impress his friend or to exhibit a pleasant attitude. Perlocutions can be deliberate or unintentional. So, in this situation, an unintended perlocutionary result could be that the interlocutor feels upset because he thinks his friend is mocking him by indicating that he could never afford such a pricey car.

Because the illocutionary act is the one that exhibits the most extensive developments and interpretations within the pragmatic theory, the term "speech act" currently refers exclusively to the second type of act, i.e., the illocutionary act. In English (like in other languages), sentences may contain linguistic terms that show the sentence's illocutionary power. To illustrate this, we may consider the examples below :

1) I promise I will not come late to work again.. 2) I order you to stop shouting.

Only verbs like order or promise that Austin called performatives are capable of allowing the speaker to accomplish the action that the verb names by utilising the verb in a certain way. Other verbs are denied these types of use.Therefore, for instance, it is not nagging saying ''I nag you to pick up your clothes.'' (Green, 1989:67). The systemisation of Austin's work by Searle (1967), in which he suggests a typology of speech acts based on felicity requirements (the social and cultural criteria that must be met for the act to have

the desired impact), proved immensely influential. The position of Austin and Searle might be stated as follows: "All utterances not only express propositions, but also conduct actions." Within these actions, the illocutionary acts, or, more simply, the speech act, is at a privileged level. Gricean conversational maxims are relevant to our analysis, but speech act falls outside the scope of this study.

2.9 Theoretical framework

The theoretical framework adoptedused in this study is a combination of Dan Sperber and Deider Wilson's (1986) relevance theory and Conversation Analysis, as well as M.A.K. Halliday's Systemic Functional Grammar.The only aspect of the Relevance Theory that is considered apt for this study is its ability to use context in the explication of meaning as well as its ability to study implicit meaning of utterances. The pragmatic theory of politeness is also considered suitable for the analysis of the 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 consultations.

The Systemic Functional Grammar (SFG) is considered apposite for this study in view of its emphasis on semantics and contextetual relations. SFG is a comprehensive grammar theory created by the British linguist - Michael Halliday- in his 1965 writings.. 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 purpose of a linguistic item in its environment of use. Buttler (1985) validates Firth’s assertion by saying that although context of situation is central to SFG, it is merely one type of circumstance where linguistic units can be used. He adds that other contexts are delivered by the stages hypothesised to explain numerous sorts of linguistic patterning. SFG thus offers us a medium to observe, analyse 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 a systematic organisation of elements in orderly 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 explication of the talker’s view of the actual world and the interior world of his own. Two, the interactive role 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).

Furthermore, Halliday's functional grammar, which considers grammar as always meaningful, is premised on his systemic theory. As a result, SFG is a'meaning as choice' hypothesis (Halliday, 1985). It is based on the idea that language plays a part in the activities of language users as a social group, giving it sociolinguistic characteristics. As a result, Halliday (1985) focuses solely on the practical aspect of syntax, namely the explanation of syntactic patterns in terms of configuration and function. He claims that this is applicable to both spoken and written texts. The focus then shifts to language in use and how it is employed. These are exhibited in the situational and cultural milieus from which the text's meaning is generated.

Halliday (1961), therefore, explains the three dissimilar levels at which linguistic components should be taken into account 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 to form meaningful events, while the relationship of the form to the non-linguistic aspects of the circumstance where language is utilised is accounted for by context.

Form relates at two levels: lexical and grammatical levels. Therefore, the SFG is organised in a manner that the sense of a linguistic event comes from a combination of its contextual meaning and formal meaning (Malmkjaer, 2002). The contextual meaning is accounted for in its relation to external factors and the formal meaning by operation of meaning 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, use of language in doctor-patient consultations will be examined from the viewpoint of the SFG.

CHAPTER THREE

METHODOLOGY

3.0 Introduction

This study is situated within the field of Discourse Analysis. This field of Linguistics has drawn 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 the 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 provides an outline of the procedures used to carry out the research. It discusses how the texts for this work were collected and how the data were got from the corpus of discourse interactions.

3.1 Research Design

Both the quantitative and qualitative methods of analysis were employed in this research. The following discourse devices were examined: indirect and direct questions, answer, phatic communion, closing, rapport expressions, code alternation, circumlocution, modality, counselling, and face-threatening acts.

The qualitative description of the discourse devices employed in the consultations drew inferences from the statistical representations in the quantitative illustrations in the next section. The objective of this was to draw inferences to show how the identified discourse devices aided the doctors in obtaining good medical information for diagnosis, conselling the patients and as well explaining their feelings and views through the consultations under investigation. The quantitative method applied mainly to the discourse devices and

centred on number and frequency of occurrence of the discourse devices. It was applied mainly to the discourse devices employed during the consultations so as to determine their number of occurrence and relevance to the study. The identified discourse 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 communication of both the doctors and patients in their interlocution. The adoption of empirical methods consequently made room for statistical information to be revealed through quantitative analysis, and it was complemented and deepened by explanations through qualitative analysis.

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.

3.2 Study area

This study was carried out in a teaching hospital and a general hospital in each of the South-West and North-Central geo-polital zones of Nigeria. For the South-West, the University College Hospital, Ibadan (a teaching hospital), and the General Hospital, Abeokuta were used, while the Uinversity of Ilorin Teaching Hospital, IIlorin, and General Hospital, Kabba, were used for the North-Central.

3.3 Sampling procedure

Using the purposive sampling technique, doctors and patients were sampled in the two selected teaching hospitals and two general hospitals in the North-Central and South-West Geopolitical Zones of Nigeria. The doctors' coonsultations with patients were tape-recorded in each of the four selected hospitals. A total number of twenty-five doctors, and two hundred patients were used in this study. Five doctors and twenty-five patients were chosen from each of the University of Ilorin Teaching Hospital (UITH), Ilorin; University College Hospital (UCH), Ibadan; General Hospital, Abeokuta and, General Hospital, Kabba, for participation in the study. However, only one hundred recorded sessions formed my data.

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 make possible a thorough analysis of the consultations. Thirdly, I have also restricted the number of hospitals used in this study to four 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 one hundred resulted from the fact that many of the recorded consultations were not audible. The researcher faced some challenging situations in the course of collecting data in the two concerned teaching hospitals. Firstly, at the University College Hospital, Ibadan, the researcher, despite being armed with an 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 the University of Ilorin Teaching Hospital, Ilorin, the researcher was also almost denied 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.

3.4 Sample size

A total number of one hundred patients and twenty-five doctors formed the subjects for the study. In each hospital, five doctors saw twenty-five patients, making five patients to a doctor. The sample size was used to avoid making the data fictitious so as to facilitate a detailed analysis.

3.5 Instruments

I sourced data from one hundred audio tape recordings of the doctor-patient consultations in the four hospitals chosen for this study, using a mobile phone and a tape recorder.

3.6 Producedure for data collection

Data were collected at the General Out-patient Departments of the University College Hospital Ibadan, Unilorin Teching Hospital, General Hospital Abeokuta, and General Hospital Kabba. The data were singlehandedly collected by me, using my mobile phone

and a tape recorder. As demanded by medical ethics, an ethical approval was sought and got from the Ethical Review board of each of the four hospitals used in this study. A total of 200 sessions of consultation between doctors and patients were recorded.

3.7 Data 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 the doctors and patients for the purpose of determining 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 meanings in the texts and not just drawing statistical inferences as it applied to how the discourse devices elicited and got information, and how they performed pragmatic functions in the consultations being studied. In addition, the data were carefully studied to determine the discourse devices deployed in the consultations. In determining the pragmatic effects of the discourse devices identified, this study was guided by M.A.K. Halliday's Systemic Functional Linguistics (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.

Data were got from audio tape recordings of the doctors and patients' consultations at the University College Hospital, Ibadan; University of Ilorin Teaching Hospital, Ilorin; General Hospital, Abeokuta and; General Hospital, Kabba. They were then listened to and typed out 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 pin pointed in the analysis, and the facts can then be categorised or grouped under some headings that will make for easy comprehension. The sampled consultations, 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, I considered my data very critically and carefully decided on the approaches that were most suitable for the 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 discourse pragmatics, particularly focusing on Dan Sperber and Deidre Wilson's Relevance Theory, the pragmatic theory of politeness by Brown and Levinson (1987) and some other relevant approaches to study issues like: opening and closing of conversation, code alternation, politeness, phatic communion, direct and indirect questions, answer, counselling, repetition, circumlocution and modality.

3.8 Ethical approval

Owing to the fact that medical ethics demands that patients' medical circumstances be kept private, ethical approval was sought and obtained from the Ethical Review Board of each of the hospitals involved. A proposal was submitted to each hospital to request authorisation to gather data, and it was granted.

3.9 Conclusion

This chapter maps out the strategies for investigating the discourse devices deployed in doctor-patient consultations in the North-Central and South-West geo-political zones of Nigeria in this work. The study identified and discussed discourse devices such as: phatic communion, direct and indirect questions, answering, politeness, code alternation, counselling, circumlocution, repetition, rapport expressions, modality, and closing. These discourse devices were discovered to have not only informed, but some of them have also elicited appropriate information to get appropriate diagnoses.

3.10 Limitations of the study

This study lays no claim to being an exhaustive study on hospital verbal interactions as it has only studied the consultations between doctors and patients. It has, therefore, not

studied the consultations of other medical practitioners like pharmacists, orthopaedists, nurses, physiotherapists with patients.

3.11 Sociodemographic characteristics of the subjects

200 patients and 25 doctors constituted the subjects for the study. The patients comprised 100 males and 100 females, while the doctors comprised 15 males and 10 females. Three male doctors and two female doctors participated in the research in each hospital. Each male doctor saw ten patients, while each female doctor saw ten patients in each hospital.

CHAPTER FOUR

RESULTS AND DISCUSSION

ANALYSIS AND DISCUSSION OF THE DISCOURSE DEVICES AND PRAGMATIC (SPEECH) FUNCTIONS IN DOCTOR-PATIENT CONSULTATIONS AT U.C.H., IBADAN

4.1 An overview of the section

Based on the data collected at the University College Hospital (UCH), Ibadan, the discourse devices deployed in the consultations and their speech (pragmatic) functions were examined here. The discourse devices deployed by both the patients and doctors were analysed in this section.

4.2 Research Questions One and Two: Which discourse devices are employed in doctor-patient consultations and what pragmatic functions do they perform?

A number of communication problems have been discovered to pose some challenges to doctor-patient consultations. Consequently, this study revealed the discourse devices that the doctors and patients alike employed to overcome the challenges. Discourse devices are used to realise the goals of medical consultation. Therefore, in this study, they were realised by phatic communion, direct question, indirect question, answer, code alternation, face-threatening acts (with and without redress), circumlocution, rapport expressions, politeness, counselling and closing.

4.2.1 Phatic communion for opening discourses and showing empathy

Owing to the unique nature of medical consultations, a poor start might jeopardise the success of any consultation. The doctors in this study used phatic communion at the start of most consultations in this study to initiate the consultations and ensure good communication. During consultations, doctors frequently demonstrate empathy by greeting and welcoming patients and inquiring about their well-being and social lives. Both the patients and the physicians in this study started the consultations with phatic communion. The accompanying excerpts were examined:

Extract 1 (Interaction 7)

Doc.: **Welcome.**

Pt.: Thank you, Sir.

Doc.: What is your nickname?

Pt.: FD

Extract 2 (Interaction 18)

Doc.: **Rose Bimbo!**

Pt.: Good morning, Ma.

Extract 3 (Interaction 14)

Doc.: **How do you do?**

Pt.: Fine.

Doc.: Do you have any complaints?

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

Extract 4 (Interaction 25)

Doc.: Sorry, Ma.

Pt.: Thanks.

Doc.: May I know your name?

Pt.: Adeola Gabriel.

Doc.: What complaints do you have?

A close examination of Extract 1- 4 reveals the Docs used phatic communion to begin their consultations with the patients. The deployment of phatic communion by both the doctors and patients reveals that it could not be done without in the consultations. In Extract 1 (Interaction 7), the Doc. began the consultation with the Pt. by welcoming him ('Welcome'), and also inquired about Pt.'s nick name. This is important in getting the patient talking while preparing for the diagnostic frame. Similarly, in Extract 2 (Interaction 18), Doc. started the consultation by addressing the patient by name (Rose Bimbo). In Extract 3 (Interaction 14), the doctor began the conversation by greeting the patient, using salutation ('How do you do?') while at the same time beginning the interview. The doctor looked at the patient's face in Extract 4 (Interaction 25) and discovered that the patient was in pain. Consequently, Doc. used the sympathetic expression ('Sorry, Ma.') as an ice breaker to open the conversation and to also empathise with the patient in order to create a conducive atmosphere for the commencement of the consultation. It was also intended to encourage the patient to disclose all the information required by Doc. to diagnose Pts' ailment correctly. The deployment of phatic communion in this extract, which included non-health related questions, empathetic emotions, salutation, and starting the consultation by calling the patients' names established the tone for the clinical interviews to run smoothly. Thus, phatic communion is an ice-breaker that enables doctors and patients start conversing. It is also worth noting that the Pts occasionally started the clinical interviews, as evidenced by our data. This was mostly accomplished through the use of greetings.

The doctors used a variety of ways to begin their consultations with the patients, as seen in the above extracts. A lot of things influenced their decisions i.e.: the time of the appointments, the appearance of the patients, and the culture of Africa, which requires greetings at the start of every dialogue. The aforementioned explanations clearly demonstrated that interrogatives, greetings, emotive expressions, and proper nouns (patient names) were used to begin the consultations with the patients, but the patients only used declaratives in the form of greetings, acknowledgement of greetings, and complaints.

The use of phatic communion performed the pragmatic function of opening and facilitating the consultations. The data established its appropriateness for opening the consultations since it allowed the discussants to create an environment conducive to the start of fruitful conversations. Furthermore, its use, in addition to dousing the tension generated by the patients' diseases, enabled the interlocutors to begin chatting in preparation for the diagnostic frame.

4.2.2 Circumlocution for providing clues to diagnoses of ailments

Most patients encounter the dialemma of not knowing the specific names of their health challenges. Consequently, they resort to circumlocution. Circumlocution was deployed chiefly by the patients in the consultations. It can, therefore, be seen that most of the patients appeared to be circumlocutory in explaining their health conditions. Instead of specifically naming their ailments, they merely described the symptoms. Often times, their use of circuloction arose from their ignorance of the appropriate medical names for their sicknesses. There are copious instances of this phenomenon in the consultations. The extracts below were examined:

Extract 5 (Interaction 2)

Doc.: E ku ojumo. [Good morning.] Kinni nnkan to se yin? [What complaints have you?]

Pt.: **Ori n fomi kikan kikan. [My head is aching seriously.]**

Doc.: Se eje yin ko ru? [Isn't your blood pressure high?]

Pt.: Rara. [No.]

Doc.: Kin lotun nseyin? [What other complaints do you have?]

Pt.: **Gbogbo ara nromi. [I have general body aches.]**

Doc.: Mo maa ko awon oogun kan fun yin. [I will prescribe certain drugs for you].

Extract 6 (Interaction 7)

Doc.: What brought you here to the hospital?

Pt.: **It is my teeth.**

Doc.: What's the problem with your teeth?

Pt.: **Two of my teeth are overlapping.**

Extract 7 (Interaction 10)

Doc.: Kin l'oruko yin? [What is your name, please?]

Pt.: Seyi Oba.

Doc.: Kin lo se yin? [What are your complaints?]

Pt.: **Aya n ro mi gan-an; inu si tun n ta mi. [I have serious chest paint and I also feel a burning sensation in my stomach]. Egbe ori kan situn ntami; ese mi situn nkuriri. [In addition, I can feel a burning sensation in a part of my head and cramps in my feet.]**

Doc.: Se etise ifunpa yin? [Has your blood pressure test been done?]

Pt.: Nhun hun. [No.]

The preceding extracts showed that the patients explained the symptoms of their sicknesses most of the time as if they were the real names of their ailments. As human beings, it is understood that ailments have symptoms. Consequently, it is common for typhoid patients to experience diarrhea, headaches, or a high temperature. Patients may not be aware of the specific names of the ailments they are suffering from because they

are not medical specialists. They might only be aware of the symptoms. As a result, all of the Pts' bolded comments in the excerpts above reflect the symptoms of specific health disorders which medical names the patients were unaware of. However, the doctors were able to determine the specific disorders that the patients were suffering from through the patients' statement of these symptoms. Specifically, I looked at Extract 5: ‘Ori n fo mi kikankikan.' [My head is aching seriously.]; 'Gbogbo ara nwomi.' [I feel general bodily weakness.] The doctor's subsequent question in the particular extract established that the Pt's bolded words were simply symptoms of elevated blood pressure, not the real ailment: 'Se eje yin ko ru?' [Isn’t your blood pressure high?]. When the particular illnesses are treated medically, the symptoms fade away. All the symptoms enumerated by the patients in the extract 5 - 7 as ailments, such as high body temperatures, burning sensations in the stomach, headaches, cramps in the feet, chest pain, and general body weakness, were merely symptoms of certain ailments, not the real diseases, but the doctors understood this.

The speech (pragmatic) function of circumlocution as deployed here was to provide clues to the diagnosis of the patients' diseases. The patients were able to provide clues to the diagnosis of their health dosorders by explaining the symptoms of the medical challenges they had as a result of their limited or complete lack of medical knowledge. As a result of the use of circumlocution, the doctors were able to acquire insights into the patients' health problems. Declaratives were used to create circumlocution because it was intended to present medical information from which the Docs could make diagnoses.

4.2.3 Rapport expressions for geniality, conviviality and recognition

Hostile contributions from Docs may discourage Pts from supplying important medical information required for accurate diagnoses. The physicians in this study surmounted this obstacle by using rapport expressions. A review of the data showed that positive remarks, indirect questions, elicitation of information on social history (SH) and family history (FH), and Wh-questions were used to demonstrate rapport. The use of rapport expressions for solidarity, recognition, empathy, and conviviality was critical since it allowed the physicians to connect with and get to know the patients. The rapport expressions were also intended to facilitate open discourse between Docs and Pts with the aim of collecting

useful medical information that would help the doctors make accurate diagnoses and, in the long run, prescribe appropriate treatments. The accompanyng extracts were examined:

Extract 8 (Interaction 3)

Doc.: **What is your class in secondary school?**

Pt.: I am in JSS 111.

Doc.: **What's the name of your college?**

Pt.: DLSS, Ibadan.

Doc.: In what position are you among your siblings?

Pt.: Second.

Doc.: What is the number of your siblings?

Pt.: Myself and two girls**.**

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

Pt.: No.

Doc.: So, you are averse to it. **What can you say about chewing gum?**

Pt.: Sometimes I do chew it.

Extract 9 (Interaction 14)

Doc.: **What is your age?**

Pt.: Sixty-one years.

Doc.: **Are you a Yoruba by birth?**

Pt.: Of course..

Doc.: **What is your profession?**

Pt.: Accounting..

Doc.: **In what bank?**

Pt.: Unity Bank.

Doc.: **You are married.**

Pt.: I am.

Doc.: **Your data reveal you reside at Omi tuntun.**

Pt.: That’s correct.

A careful study of the extracts above showed that the Docs achieved amiability with their patients through rapport expressions. The employment of the rapport expressions by the doctors confirmed their indispensability during the consultations, as they afforded the doctors the opportunity to be friendly. Additionally, the doctors used request for information on both social history (SH) and family history (FH) to bring about friendliness and open discourse. In Extract 8, Doc. enquired about the patient's family history (FH) for the purpose of establishing a sense of familiarity with the patient and encouraging her to open up on her medical challenges. Extract 9 involves an examination of Pt's social history (SH) in order to encourage open conversation.

The rapport expressions performed the speech function of engendering conviviality between the patients and the doctors, while also familiarising the patients with the doctors. The use of rapport expressions enabled the doctors to communicate with the patients on the same wavelength in order to create an environment that would encourage the patients to divulge all the medical information necessary to appropriately diagnose their illnesses.

In the consultations, rapport expressions were realised by interrogatives and, atimes, by declaratives since they were used to gather and provide information as the situation demanded.

4.2.4 Code alteration for explicitness; informativity and mutuality

In the multilingual setting of this study, certain patients' proficiency in one language alone and the doctors' inability to get second language equivalents for particular medical terms

created a barrier. To overcome this obstacle, the patients and doctors swapped languages. Within and across the consultations, code alternation was achieved by blending Yoruba with English and employing Pidgin English. The language choices the doctors and patients made were analysed and discussed because this is important for determining how well the languges were used and disclosing the speech (pragmatic) functions they performed.

Relating the above to our data on doctor-patient interaction in the South-West Nigeria, it was 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 extracts below were examined:

Extract 10 (Interaction 8)

Doc.: Morning, Ma.

Pt.: Nice. Meeting you.

Doc.: What health issues have you?

Pt.: A lot of my teeth developed holes a few years ago, probably three or four, but they were filled, and I haven't been back except for scaling and polishing since then. However, I just realised that whenever I drink cold water or eat sugary foods, I have mild tooth ache. So, I began to think that the teeth I filled have started giving way again. This is why I came today.

Doc.: Where in particular do you feel the pain?

Pt.: This place- right.

Doc.: On the lower or upper teeth?

Pt.: Lower here and upper here.

Doc.: Did you do the fillings here?

Pt.: Yes.

Doc.: For how long have you had this feeling? Is it a recent thing?

Pt.: About a month ago.

To start the clinical session, Doc. greeted Pt. in English and used the Standard British English to investigate the patient's dental problems after noticing from her appearance that she was educated. The patient responded using the same code because she understood the language, and the consultation was carried out entirely in the language.

Extract 11 (Interaction 13)

Doc.: Have your seat here.

Pt.: All right..

Doc.: How do you do?

Pt.: I am good. Thank God.

Doc.: **Se e tiloo gba awon test result yin? [Have you collected your medical test results?]**

Pt.: Yes. I came yesterday. However, I was asked to be here again today.

Doc.: Okay. (Collects and looks at the test result.) The result displays the three factors that were investigated. We have three kinds of antibodies and antigens that can indicate the stage of infection, whether it is very infectious or not. As a result, your test result just indicates that you are in the carrier phase. You're nothing more than a carrier. Nothing indicates that the virus is spreading. As a result, it is only in a peaceful state. The antigen in the core is negative. Envelop antigen is also negative. The envelop antigen antibody is the only one that is positive. The implication is that your body reacts to the virus. It is attempting to create a virus with a negative ability. Therefore, there is no reason for you to be afraid. You only need to take care of yourself very well. Abstain from alcohol alcohol. In addition, avoid taking unrecommended drugs.

Pt.: Ok. I take a lot of alcohol.

Doc.: You need to abstain from it.

Doc. used the Standard British English (SBE) to begin the consultation, offer the Pt. a seat, and to investigate the patient's medical issues in the Extract 11 interaction 13. The patient responded in the Standard British English to all of the doctor's questions, then Doc. unexpectedly changed to Yoruba when requesting information regarding whether the patient had collected the results of the earlier prescribed tests. However, Pt. did not change her code because she was confident she could converse well in the Standard British English. Doc. changed the code when eliciting information on Pt.'s test results because he believed that using a language in which the patient was more fluent would allow for a clearer description of the patient's health difficulties, thus allowing Doc. to obtain accurate medical information and correctly diagnose the patient's ailments. Consequently, Doc. reverted to English again, having seen the Pt.'s tacit insisistence on using English.

The data were also replete with instances of code mixing. Thus, the accompanying extracts were examined:

Extract 12 (Interaction 20)

Doc.: [Examine Pt's case note.] **E wa sibi lojo Monday**. [You were here on Monday.]

Pt.: Ehn. [Yes.] Nigba yen, **mo complain lori ese yii to nromi**, nwon si se ayewo ifunpa fun mi. [I lodged complaints about this painful leg, and my blood pressure was checked.] Nwon ni o ga. [I was told my blood pressure was elevated.] Nwon si koi awon oogun yi fun mi. Mo si ti nlo won, sugbon eseriro naa kodinku. [I have been taking the drugs I was given but the pain gives me no respite.] Mi kii tunsun lale. **Nigba ti mo complain fun doctor, nwon ni ki n lo ya X-ray wa.** Titi di isinyii ese riro naa ko dawo du ro.] In addition, I can't sleep at night. I complained to the doctor and he asked me to take an X-ray. The pain still persists.]

Doc.: Result test wo leleyii? (Which test result is this?)

Pt.: Ngo tii see nitoripe ese naa nro mi pupo. **Mi o si le gun step to wa nibi tiwon ti nse test naa**. [I haven't gone for the test because the leg gives me so much pain to the extent that it's extremely difficult for me to ascend the stairs at the entrance of the X-ray room.]

Extract 13 (Interaction 18)

Doc.: Your test result shows there are some micro-organisms in your genitals. Therefore, I will recommend some drugs for you, to be taken take for some days and you will be cured.

Pt.: Is it treatable?

Doc.: Yes. It is.

Pt.: **I have another complaint that worries me. Inside my throat, e be like say something dey scratch me, scratch me.[It's like I feel itching in my throat.] When I scratch my throat im be like say my neck dey roll. [When I scratch my throat, it's like my neck turns.]**

In Extract 12, Doc. and Pt. code-mixed at the word level. They mixed Yoruba phrases and English words (Monday, complaint, doctor, X-ray, result, test, step, X-ray room) to describe and understand Pt's health condition and the medical tests he had done to enable Doc. make a diagnosis. Doc., having established that Pt. was inept in English, used code-mixing here to make Pt. understand him well, especially since there are no Yoruba equivalents for several English medical terminologies. English Language cannot be completely avoided in a multilingual setting like that of this study when consulting with non-English-speaking patients or patients who are incompetent in English.

The speech function of code-switching and code-mixing as used in Extracts 11 and 12 above by Docs and Pts. was to avert communication breakdown. Furthermore, where there are Yoruba equivalents for some medical terminologies, they may not be able to fully capture the thoughts that Docs. or Pts. have in mind. In a similar vein, as shown in Extract 13, Pt. switched to Pidgin English to mask her linguistic shortcomings and contribute intelligibly during the consultation.

The speech function of code alternation was to make the discourse informative, explicit, understandable, and mutual. The deployment of code alternation by the Docs. showed they were able to adapt to the Pts.' linguistic backgrounds, and the interlocutors were able to overcome their linguistic shortcomings as a result of its use. Consequently, they were

able to comprehend the consultaations well. In Extracts 12 and 13 above, to make the consultations more understandable, Docs. and Pts. alternated between English and Yoruba. The code alternation was accomplished intra-sententially and inter-sententially by switching between Yoruba, English, and Pidgin English.

4.2.5 Counselling for guidance, enlightenment and encouragement

A perusal of the data showed that a number of patients did things that were injurious to their well-being. As a way out, Docs. employed counselling to corect the patients' detrimental health practices, such as taking alcoholic drinks or not taking their drugs as recommended. This section highlighted how doctors used counselling as a tool to advise patients on how to effectively maintain their health, teach them healthful habits, or motivate them. The accompanying extracts were examined:

Extract 14 (Interaction 5)

Doc.: **When you're ready to purchase a new toothbrush, make sure to read the instructions on the package.There are three types: soft, medium and hard tooth brushes. Remember to always the medium type. It's the most suitable for you. Children use the soft, while adults use the medium. Avoid hard toothbrush because it damages the teeth.**

Pt.: Thank you, Sir.

Extract 15 (Interaction 8)

Doc.: **You have to pay a special attention to your well-being to avoid the unpleasant repercussions of poorly treated hypertension – stroke, etcetera. You were ill but yet went on a journey to Lagos as far as it is. You are to come to once monthly for medical check-up.**

Pt.: Thanks, Ma.

Doc.: You have been asked to come to the hospital just once every month -twelve times yearly. I am sure you don't have any objection to this. It is for your health. Kindly take good care of your health.

Pt.: I appreciate your concern for my health. Thanks a lot.

Doc.: **Even if you are going on pilgrimage, you ought to inform your doctor because he will be able to give you enough drugs that could sustain you till you arrive. Then, you go see him immediately you get back for a check-up. This is the only way you can have a good health.**

Pt.: I am grateful, Ma. I shall be extra-careful henceforth.

The use of counselling for the sake of enlightenment and guidance was indicated in the excerpts above. Its use also showed it cannot be avoided in clinical interviews as patients are known to sometimes indulge in practices that are injurious to their health. In Extract 14, the doctor advised Pt. to brush his teeth with a soft toothbrush as a result of his knowledge of the effects of using hard tooth brushes that the ptient was used to. So, she also mentioned the disadvantage of brushing with a hard tooth brush. At15, Doc. taught Pt. the best method to manage his hypertension in order to avoid the problems (diabetes and stroke) that come with untreated hypertension. She also taught Pt. how to travel securely over long distances by being adequately loaded with medications for the voyage.

Furthermore, the data disclosed that some Pts. were obsessed with certain religious doctrines that were harmful to their health. In Extract 15 (Interaction 8), Doc. used her medical expertise to teach Pt. the impropriety of skipping hospital visits and going on long journeys without adequate drug stock. From the above, it can be seen that the faiths of the Docs. and their medical expertise were used as a tool to advise the patients correctly. As a result, Docs.' faiths were used as a tool in counselling to pereform specific pragmatic functions in the consultations by deploying Biblical and Quranic explications.

Extract 16 (Interaction 14)

Doc.: Do you have stomach ache?

Pt.: Exactly. In Ramadan Fast period.

Doc.: Mild?

Pt.: No. Very painful.

Doc.: And you don’t stop the fast?

Pt.: No. It is compulsory for every truly devoted muslim.

Doc.: Madam, I am a Muslim myself. **The sick are permitted to not fast , according to the Quran. So, when you're unwell or fasting has an adverse effect on your health, as you described, it's not a good idea to fast. In all things pertaining to us, including our health, God is wiser than we are.The Quran allows those that cannot fast for health reasons to provide food for those observing the fast.**

Pt.: This is a new knowledge to me. Thank you, Sir.

Extract 17 (Interaction 19)

Doc.: You look anaemic. Ever been diagnosed with blood shortage?

Pt.: Not at all.

Doc.: **That's all right. You may be anemic based on the whiteness of the base of your eyes. As a result, I advise you to take a blood tonic. Make sure you take it. If the symptom persists, you may be subjected to blood transfusion.**

Pt.: **I belong to the Quadriyyah sect. We are averse to blood transfusion.**

Doc.: **I didn't say I wanted you to get a blood transfusion right now. All I'm saying is that if you don't take the blood tonic I'm recommending right now, you might end needing a blood transfusion.**

Pt.: **All right. I will.**

Doc.: **Let me add something else. The Quran does not condemn conventional medicine. So, in the event of a disease, being transfused with blood to save the patient's life is not against the Quran. It is injected into the veins rather than taken orally. Blood should not be consumed, according to the Quran. As you can see, this is not the same as drinking blood. It's simply a means of saving lives.**

Pt.: **Okay. Thank you, Ma. I now know better.**

Doc.: E pele. [Sorry.]

Conselling involving the use of religious belief is an important instrument in doctor-patient consultation since it aids doctors in counselling and enlightening patients. At 16, Pt. suffered severe from stomach pains during the Ramadan Fast, but she continued to observe the fast because she felt obligated to do so. She told the doctor she was a Muslim, and the doctor, who was also a Muslim, was able to tell her that Islam allows the sick to give food to those fasting in order to stay away from fasting to avoid the associated health implications. As a result, by employing Quranic insights, Doc. was able to correct the Pt's erroneous religious belief. This also helped the Pt. to accept the advice that she should not observe the Ramadan Fast because it was harmful to her health.

In a related incident, in Extract 17, the Pt. claimed religious antagonism to blood transfusion, but Doc successfully corrected his misconception, noting that Islam favours medical intervention through blood transfusion to save lives during illnesses. Doc. was successful in convincing the patient that blood transfusion through veins is not the same as blood ingestion through the mouth. As a result, Doc. was successful in changing Pt's mind concerning transfusion.

According to the findings, doctors used counselling to perform a variety of speech (pragmatic) functions, such as guiding patients in areas where they showed ignorance or a carefree attitude toward health issues. The use of counseling allowed doctors to educate and interact with the patients. Its deployment also aided in educating the patients whose religious practices were incompatible with their health by urging a change in their detrimental fasting and blood transfusion avoidance routines. The doctors used their faith (Islam) to address the patients' incorrect beliefs and practices.

The Docs' use of counselling also enabled them to educate Pts on how to live a healthy lifestyle. Declaratives were mostly used to realise counselling since it was used to provide information and guidance.

4.2.6 Answer and question for provision and elicitation of information for diagnoses

In addition to laboratory tests, verbal information is needed to augment medical data and provide correct diagnoses. As a result, question and answer sessions are unavoidable during clinical interviews because diagnosis relies on the elicitation and provision of medical information to reveal Pts' diseases to some extent. Docs must ask Pts questions in order to acquire crucial health information, which Pts must also provide in the form of answers to aid Docs in their diagnosis and treatment of Pts' diseases. This part examined how the Docs gathered medical information from the Pts through direct and indirect questions, as well as how Pts provided the necessary information through answers.

4.2.6.1 Direct questions with answers

In the Docs' diagnosis of the Pts' health concerns, direct queries and answers were realised using interrogatives, which began with wh-elements and declaratives, respectively.The extracts below were examined**.**

Extract 18 (Interaction 3)

Doc.: **How do you do?**

Pt.: **Fine.**

Doc.: **What brought you here this today?**

Pt.: **I have some dental problems.**

Doc.: **What kinds of problem do your teeth have?**

Pt.: **Two of them are threatening to come off. They are shaking. Two new teeth have sprouted in my mouth unequally. So, they pain me.**

Extract 19 (Interaction 9)

Doc.: **What are you up to?**

Pt.: **I'm awaiting admission into a tertiary institution.**

Doc.: You are awaiting admission into a university. **What is your proposed course of study?**

Pt.: **I want to study Economics.**

One of the oral diagnostic tools employed by the Docs to investigate the Pts' ailments was the direct question. Its use enabled the Docs to know how to intervene professionally in the Pts' medical challenges. A careful look at the extracts above revealed the ways the Docs deployed direct questions in every extract to elicit data on the Pts' social history (SH), family history (FH) and history of present illness (HPI) for diagnostic purposes. Cooperatively, the Pts responded by providing the required information through the use of answers, thereby resulting in result-oriented consultations.

The straightforwardness of the questions served the speech function of informing the Pts covertly that the information being sought was crucial to the diagnosis and treatment of their health challenges. The Pts were given the opportunity to explain their health problems through the questions. For example, in Extract 18, Pt. was able to explain his health challenge by answering the Docs' question: **"What brought you here today?"** In conclusion, the direct questions in the consultations served the speech (pragmatic) function of gathering data for diagnoses.

4.2.6.2 Indirect questions with answers

The direct questions, which were realised by statements in the consultations, appear to be declarative but are actually interrogative. The following extracts were examined:

Extract 20 (Interaction 5)

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

Pt.: **No. I feel it just once in a day..**

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

Pt.: Ehn..

Extract 21 (Interaction 16)

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

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

A close examination of Extracts 20 and 21 revealed that elicitation and the provision of information are two of the most common diagnostic tools used during consultations. On the one hand, the Docs' comments above demonstrated the use of indirect questions to elicit data on the patients' history of presnt illness (HPI). Pts' contributions, on the other hand, offered answers to Docs' questions. The elicitation and provision of information in Extracts 20 and 21 gave the Docs some insights into the probable causes of the Pts' ailments and, therefore, offered them the opportunity to intervene professionally. Docs commonly sought information about Pts' ailments and Pts provided them, thus showing that the Docs and Pts worked together in matters of oral diagnosis.

The direct and indirect questions were emboldened in every instance. There are instances of direct questions in Extracts 18 and 19, while Extracts 20 and 21 contain those of indirect questions. The indirect questions are interrogatives in the guise of declaratives. The pragmatic function of the indirect question was to make the consultations appear less interrogative, thus enabling the patients who were clearly ill to find them less stressful and, as a result, be exhilarated to cooperatively release every information needed to diagnose and treat their health challenges. Contrariwise, the direct questions served speech function of informing the Pts that the information they were being asked for was critical to diagnosing their ailments and enabling the Docs to intervene professionally.

The answers naturally accompanied the questions as they served the pragmatic purpose of providing diagnostic information. The consultations were strictly investigative. Thus, deploying answers was unavoidable as they provided the diagnostic "raw materials". The answers, as shown in the excerpts above, were the things the Docs required to make diagnoses. Without them, it would have been impossible for the Docs to acquire insights into the patients' health challenges, unless they subjected them to laboratory tests. Because certain illnesses are mainly diagnosed by means of oral information gathering (question) and provision of information (answer), question and answer are very significant diagnostic tools used during consultations. Direct questions were realised by interrogatives containing subject-verb inversion, while indirect questions were realisd by declaratives, as

shown in the excerpts above. Despite the declarative appearance of the indirect questions, they possess the illocutionary power of questions. All the answers were realised solely by declaratives.

Looking closely at Extract 18, 19, 20 and 21, the adjacency pairs there can be categorised in different ways. The first pair-parts are conditionally relevant on the second pair-parts. Extracts 18 and 19 presented a question-answer sequence:(Doc.: **What brought you here today?** Pt.: **I have some dental problems.),** while in Extract 20, the first and the second adjacency pairs formed observation-denial and observation-acceptance sequences, respectively (**Doc: You feel it in the morning, afternoon and evening.**
Pt.: **No. I feel it just once in a day.**). Extract 21 constitutes an observation-acceptance sequence (**Doc.: O maa n dabii pe nnkan wa nibe. [It's like something blocks it.]**Pt.: **Beeni. [Yes.]**). There is an evidence of logic in each of the adjacency pairs, thus showing cooperation amongst the participants in the consultations.

4.2.7 Closing for concluding consultations

After gathering information on the patient's history of present illness (HPI), chief concern (CC), social history (SH), and family history (FH), the consultations needed to be wrapped up so that Pts could either go get some medicines, have some testing done, or do both. The Pts deployed closing in order to get this opportunity. It was realised through greetings and expressions of gratitude all through the data. A further examination of the data revealed that several approaches were used to round off the sessions. 'Goodbye' and 'Thank you' were the most commonly used phrases by the patients after doctors had recommended tests and/or medications. The following analyses will demonstrate how these closing methods were used during the consultations.

Extract 22 (Interaction 4)

Doc.: Put drops of the eardrop in your ears for two weeks to see the extent of its effectiveness. It's painful I do haven't a good instrument to remove much of the wax to help you hear better than you do now. The eardrop is about #800. Use it for two consecutive weeks. If you use it up before the weeks end, get another bottle and continue it.

Pt.: **I am grateful, Sir.**

Extract 23 (Interaction 8)

Doc.: Good. Each of these tablets should be split in half. Take one of these small ones in the morning and one of these large ones. You must take the medications first thing in the morning because they will cause you to urinate frequently. As a result, taking it in the evening will result in frequent urination, disrupting your sleep. It's possible that this will aggravate your high blood pressure. So, you're free to leave. Take the pills as directed.

Pt.: Thank you.

Doc.: Take care.

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

Extract 24 (Interaction 15)

Doc.: Ok. Did you engage in sex lately?

Pt.: Four days ago.

Doc: All right. Take this form to the nurses for urinalysis. It will show whether your urine is infected or not. If the test shows no evidence of infection, then the test will be repeated. Your weight and height will also be measured and then we shall compare it will your weight. In fact, the vital signs should have been taken prior your admittance. After that, I shall check your blood pressure myself.

Pt.: **Thank you, Ma.**

In all the extracts, the Pts concluded the consultations majority of the time, but the Docs also did so on occasions. Following the pickup of the prescription from the Doc., Pt. ended the consultation by saying, '**I am grateful, Sir**.' in Extract 22 (Interaction 4). Similarly, after Docs' final instructions, Pt. concluded the talk with the phrase '**Thank you and God bless**' in Extract 23. After Doc.had prescribed a medical test, Pt. ended the clinical interview with '**Thank you, Ma.**' in Extract 24. According to the observations, the Pts ended the consultations with words of appreciation like: '**Thank you.**', and

occasionally with prayers, such as '**God bless.**' Ending the consultations with the expressions mentioned above provided the appropriate conclusions for them.

Closing served the pragmatic (speech) purpose of concluding the consultations. As can be seen from the analyses above, the interview sessions could not go on indefinitely. As shown in extracts 22-24, closing signified the conclusion of the consultations, as indicated by the bolded sentences above. Closing was, on the average, the last discourse device used in each consultation, and it was grammatically realised by declaratives.

4.2.8 Modality for showing asymmetry of knowledge and power, obtaining medical information, and answering doctors' questions

The findings on the pragmatic functions of modality as deployed by the doctors and patients in the data were discussed here. The analyses done here focused mainly on epistemic modality.

4.2.8.1 Pragmatic functions of deontic and epistemic modality

(i) Statement: expressing asymmetry of power and knowledge

Extract 25 (Interaction 22)

Pt.: Thank you. I appreciate your concern for my health. You are blessed.

Doc.: Even if you want to embark on a pilgrimage, you **should** tell your doctor to enable him give you enough drugs that could sustain you till you get back. Then, you see immediately you get back for a check-up. This is the only way you can have a good health.

Two modal auxiliaries (**should** and **could**) were examined in the extract above. The two of them expressed obligation and possibility, respectively. The doctor employed **should** to tell the patient that it was his duty, given his medical condition, to tell his doctor any time he was travelling so that they would be able to harm him with enough drugs that would sustain him till he returned. The doctor's medical expertise enabled him to counsel the patient on the impropriety of not having enough drugs when going on a long journey, thus indicating superior knowledge. The deployment of **should** here performed the pragmatic

function of expressing obligation as the doctor used it to tell the patient he had a duty to get enough drugs when travelling. In addition, the doctor exhibited asymmetry of power through the use of **should** as a result of his +higher-role occupant status. Its deployment thus performed the pragmatic function of showing the patient he was an authority in the discourse situation.

The deployment of **could** in the extract above (an instance of epistemic possibility conveying the lowest degree of confidence based on the doctor's knowledge on the proposition) performed the speech function of telling the patient the possibility of having enough drugs when going on long journeys to avoid health crises.

(ii) Questioning: obtaining medical data

Extract 26 (Interaction 46)

Doc.: When did the pain stop?

Pt.: About two weeks ago.

Doc.: So, how **can** you describe the pain to me? Is it sharp?

Pt.: Not all that sharp.

The modal auxiliary **can** (an instance of epistemic possibility) was used in the excerpt above by the Doc to investigate the Pt's ability to explain the actual type of pains he felt in the teeth to enable him diagnose the patient's dental challenge appropriately. In response, the patient proved his ability to do so by telling the doctor: "It is not all that sharp.'' The pragmatic function of **can** as used here is an investigation of the patient's ability to describe the pains he felt in the teeth.

(iii) Statements: expressing patients' answers to doctor's questions

Extract 27 (Interaction 53)

Pt.: I have problem with my teeth.

Doc.: What kind of problem?

Pt.: Two of my teeth are weak and **seem** to be about to fall out. They are weak. Two of my teeth have developed unevenly. As a result, they cause me discomfort.

Another instance of epistemic possibility was also found in the data. This has to do with the use of **seem** to respond to the doctor's question in the extract above, and it is anchored on prediction. It suggests a predictable tendency of two of the patient's teeth coming off probably because they were weak. It, therefore, performed the pragmatic function of expressing the patient's fear.

Extract 28 (Interaction 95)

Pt.: I feel pains in my 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?

The data also revealed another instance of epistemic uncertainty expressed through the deployment of the lexical verb **think** in the extract above. It served the pragmatic purpose of expressing the patient's uncertainty of the actual time he started feeling pains in the lower jaw.

Beyond the epistemic modality's pragmatic function of expressing possibility/impossibility or probability, it performed the pragmatic function of expressing certainty and uncertainty in the various medical contexts above. Similarly, beyond the deontic modality's pragmatic function of expressing obligation and permission, deontic modality performred the pragmatic function of counselling and command, as observable in some of the extracts above.

4.2.9 Face-threatening acts

FTA without redress (positive politeness) assisted in realising politeness in the consultations through the use of reprimand, frank talk, direct and indirect questions, and

courteous expressions. It followed diagnoses. The study of the use of politeness was carried out here to show how the face of the patients was threatened with and without redress, and how the diagnoses were presented, either courteously or discouteously. Moreover, the study revealed by what means the application of politeness generally enhanced the the success of the consultations.

4.2.9.1 Face-threatening acts without redress for correcting and checking harmful health practices

Reprimand, courteous expressions and frank talk realised face-threatening acts without redress here. The study also revealed how their deployment enhanced the consultations. The following extracts were examined:

Extract 29 (Interaction 13)

BACKGROUND: Having diagnosed Pt.'s ailment as hepatitis B, Doc. advises Pt. on the necessity of bringing the wife for test to ascertain whether she was hepatitis B positive or not so that the necessary medical steps could be taken to treat her if necessary.

Doc.: Talk to your wife. She cannot be forced to come for any medical test.

Pt.: It's okay. I shall talk to her on the need for a test to know her status.

Doc.: Does your wife know you are hepatitis B positive?

Pt.: Yes. I have told her.

Doc.: In as much as you aren't hiding anything from her, she too should be tested. After the test, if she is negative, she can be immunised, and that will protect her for life. Am I clear?

Pt.: Yes, Ma.

Doc.: On the other hand, if the test shows she is hepatitis B positive, there are no qualms.

Pt.: Are you saying there is a vaccine for hepatis B?

Doc.: Yes, of course! There is! Any patient that tests hepatitis B negative can take it. It is usually administered in three doses. During the first visit, the patient takes a dose, the second in a month's time, and then the last in six months' period. The three doses guarantee the patient a life-time immunity. So, if your wife's hepatitis B negative, she should be immunised.

Pt.: Can't it be administered on me, too?

Doc.: No. You have tested positive to the infection. So, you can't take the injection. The vaccine can only be administered before infection. This is administering some dose of this virus on the patient in a non-infective style for prophylactic reasons to assist the body develop immunity against it. It can be likened to immunizing someone against meningitis.

Pt.: Wonderful. Your explanation is very clear.

The Doc's emboldened contribution in Extract 29 (**Doc.: No. You have tested positive to the infection. So, you can't take the injection. The vaccine can only be administered before infection. This is administering some dose of this virus on the patient in a non-infective style for prophylactic reasons to assist the body develop immunity against it. It can be likened to immunising someone against meningitis.**) showed she threatened Pt.'s face by not mitigating her diagnosis because Pt. was explicitly told the hepatitis B vaccine couldn't be administered on him since he had tested positive for the ailment. She went further to enlighten Pt. on the class of people that qualify for the vaccination, the vaccine administration regime and the working of the vaccine works. Doc. spoke candidly to Pt. about the unfeasibility of giving him the hepatitis B vaccine to prove the infection's incurability. The FTA was purposefully deployed to not only give Pt. the correct information on his sickness as medical ethics demands but to also alert him on the endangerments of preventing his wife from being tested for the infection. Consequently, Doc. deliberately left the disclosure of the diagnosis to Pt unmitigated.

Extract 30 (Interaction 16)

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

Doc.: Kin le mo to n je jedojedo. [Do you know the meaning of hepatitis B?]

Pt.: Mi o mo. [I do not know it.]

Doc.: E o de waa beere nigbayen, uhn? [You should have found out the meaning, uhn?] 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 ran some tests and I have the results here].

Doc.: (Collects and reads test result) Eleyi o ni nnkankan se pelu nnkan tee so. [This is not in anyway way connected to your complaints.] Nwon ni normal test leleyi [The test does not show there is a problem.]. Nibo le ti seleyii? [Where did you do this?]

Doc.'s emboldened contributions in Extract 30: (**Doc.: Kin le mo to n je jedojedo. [Do you know the meaning of hepatitis B?]**) are additional incidences of face-threatening acts without redress where Doc. criticised Pt's wrong belief that she had hepatitis B. Through the interrogative, Doc implicitly condemned the Pt's erroneous claim of hepatitis B infection. Doc. confirmed the assertion in his third and fourth emboldened contributions in the extract in focus. The Doc's fourth emboldened contribtion in the said extract constitutes a factual explanation of the test result to Pt. This FTA performed the pragmatic function of reprimanding Pt. for having a wrong notion and at the same time protecting Pt. from undue emotional stress as a result of the false claim of the infection that could cause a catastrophe for Pt.'s health. Consequently, Doc. threatened Pt.'s face with no mitigation through a criticism of her failure to probe into the true nature of her ailments and for indulging in self-diagnosis. FTA devoid of redress (negative politeness) was realised in the extracts above by frank statements and questions.

4.2.9.2 FTA with redress (Positive politeness) for tactfully obtaining information for diagnosis, allaying fears and correcting unwholesome health practices.

FTA with redress was realised by courteous expressions, mitigated threats, direct and indirect talks in the consultations. It was revealed that the Docs. threatened Pts.' face or lessened the threat to their face through indirect talk about their ailments. This happens sometimes during consultation, after which Docs. use positive politeness. Sometimes, too, for causes known only to doctors, patients' actual ailments are not disclosed to them. Majority of the incidences of positive politeness identifiable in our data manifested as courteous statements, mitigated threats, direct expressions, and indirect statements. The following extracts were examined:

Extract 31 (Interaction 38)

Pt.: There are times I inform my wife I have taken my meal whereas I am actually fasting.

Doc.: There is no cause to lie to her.

Pt.: I deceive my wife because she is too worried about my well-being.

Doc.: This is the point. You will live a quality life if you take your drugs as recommended. You will live long and she will be glad. All she wants for you is good health and long life. [Patient receives a call from his wife.] Your wife is the one on the call. She really loves you and wants you to have a good health. Once the doctor says you should not fast, you have to comply. I believe you know there is an alternative to fasting – providing food for others. So, don't deny yourself food. Is it clear?

In the first and second contributions of Doc in Extract 31, Doc. deployed a polite statement to correct the Pt.'s conduct of lying to his wife. Doc. felt it was erroneous for Pt. to misleadingly acknowledge he had taken his meal when queried by his wife merely because did not want the wife to discover that he was fasting to seek divine intervention for his healing. Doc. used positive politeness to correct Pt. and enlighten him on the advantages of complying with medical advice fully.

Extract 32 (Interaction 15)

Doc.: Do you take your drugs regularly?

Pt.: There are times I miss them.

Doc.: But why do you do that?

Pt.: When I have the feeling that I am alright.

Doc.: I am sure you are aware that hypertension is different from malaria that you can treat completely and stop taking medications. That accounts for why your blood pressure was high when you checked it two days ago.

In the extract above, Doc. threatened Pt.'s face by means of polite expressions for flouting medical recommendations. She chivalrously proved to Pt. the offensiveness of missing his medications and the likely import of the erroneous behaviour. FTA with redress was grammatically realised by a combination of interrogatives and declaratives in the consultations.

4.2.3 Research questions Three and Four: Which politeness maxims are deployed in the consultations and what pragmatic functions do they perform?

The politeness maxims identifiable in the consultations are the Pollyanna principle,sympathy maxim, generosity maxim and tact maxim. All these were discussed in turns.

4.2.3.1 Tact maxim for compassion and permission

The tact maxim was discovered to have been observed and realised by declaratives and interrogatives in the consultations. It states: "Minimise cost to other, maximise benefit to self". Many of the Docs.' contributions revealed that they had compassion on the Pts. because they gave the Pts. the chance to derive optimal benefits from their hospital visits, in spite of the fact that the offers meant additional work for them.. The accompanying excerpts were examined:

Extract 33 (Interaction 7)

Doc.: What other health challenges do you go to hospital for?

Pt.: No other ones.

Extract 34 (Interaction 4)

Doc.: Is the pain sharp or dull?

Pt.: It is sharp.

Doc.: There is a much wax in your ear. Show me your other ear. You can't hear with all this wax blocking the whole ear. You have to buy Serumol eardrop and put drops of the drug into your ear. Apply it in the two ears and wait patiently till it has entered very well. Apply it 3-4 times daily and come back in two weeks for a review. Is it clear? The eardrop will make the wax soft and it will begin to come out. That time, you will be referred to the Ear, Nose and Throat Clinic for the syringing of the ears.

Pt.: Alright, Sir.

Doc.: Use it from till the end of two weeks and come back. **It pains me I don't have a good instrument to remove the wax to enable you start hearing well again.** The price of eardrop is about #500. You need to use it for two consecutive weeks. If it finishes, get a new bottle and continue using it till you have used it for two whole weeks.

Pt.: I am grateful, Sir.

Doc.: Bye bye.

In Extracts 32 and 33, the Docs.' words revealed that they had compassion on the Pts. and wanted them to benefit maximally from their hospital visits. At 32, the Doc.'s emboldened contribution revealed he gave the patient the chance to open up on other health challenges he suffered from so that she should treat them all. In the same vein, in Extract 33, the Doc. showed Pt. empathy and expressed the wish to remove the wax blocking the patient's ears if he had a good instrument to do it. Bringing out the wax would naturally have resulted in additional work for Doc. but she did not care. All the offers undoubtedly meant more work for the Docs. but they were not bothered because the health of the Pts. reigned

supreme in their hearts. The tact maxim was realised by declaratives and interrogatives, and it served the pragmatic purpose of showing compassion on the patients and allowing them to open up on all their health complaints.

4.2.3.2 Generosity maxim for compassion and advice

In the data, generosity maxim served the pragmatic purpose of showing the patients compassion and advising them. It was frequently used in consultations as the doctors sought to minimise their own benefit while at the same time maximising their own cost, too. As a result, the doctors showed significant concern for the patients' well-being.The accompanyng extractss were examined:

Extract 34 (Interaction 5)

Doc.: When buying a new toothbrush next, ensure you read the information on the packet. Tthere are soft, medium and hard tooth brushes. Use the medium one always. It is the best type of brush for you. Children use the soft while adults use the medium. Don’t use the hard toothbrush because it destroys the teeth by scraping off parts of them.

Pt.: Thank you, Sir.

Extract 35 (Interaction 8)

Doc.: You were here in June and here again now – July. Your BP is constantly elevated – 180/100. Do you take your medications regularly?

Pt.: I do very well.

Doc.: Could you show me the drugs?

Pt.: I have them in my bag.

Doc.: You may bring them out. I would like to see them. (Doc. looks at the drugs) **You have give your health the attention it deserves to avoid the unpalatable consequences that can result from having poorly treated hypertension – stroke, etcetera. Going on**

a visit to a place as distant as Lagos in spite of your ill health is not advisable. You have to come to the hospital monthly for check-up.

Pt.: Okay.

Doc.: **You are asked to come to hospital once monthly. You are asked to come to the hospital once monthly, twelve times yearly. I believe that is not too much a sacrifice for your health. Kindly give your health utmost attention.**

Pt.: Thanks a lot. I appreciate your concern for my health.

Doc.: **Any time you want to travel, you should inform your doctor to enable him give you enough drugs that could sustain you throughout the journey. Then, you go see him for check-up immediately you get back. By so doing, having a good health is sure.**

Pt.: Thank you, Ma.

In extracts 34 and 35, the doctors showed a great worry on the patients' health by giving them good medical guidance. At 34, Doc. counselled Pt. to avoid the dental problems linked with using a hard toothbrush and advised choosing a medium-sized toothbrush instead. At 35, Doc. advised the hypertensive patient on the need to avoid health crises by adhering to medical prescriptions and instructions. Additionally, the doctor emphasised the need to get appropriately equipped with drugs any time the patient was going on a long journey. In extracts 34 and 35, by using the generosity maxim in Docs' emboldened contributions in the extracts above, the Docs were able to demonstrate empathy and to also give the patients some pieces of medically beneficial advice to enhance their health. The maxim was realiseed by declaratives and imperatives in the consultations.

4.2.3.3 Sympathy maxim for guidance, advice and pity

The deployment of the sympathy maxim performed the pragmatic function of guidance, pity and advice in the consultations involving the Docs. and Pts. as the former empathised with the latter over some terrible ailments. Some utterances made to observe the tact maxim were found in some contributions in the extracts below.

Extract 36 (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. [To advise you in agreement with contemporary practices, you have got three children, and I think they are more than enough for you.] 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. [The educated like us: nurses and doctors, have one or two children nowadays.]. 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 has your husband?]

Pt.: Meta. [Three.]

Doc.: Se oko nyin lo so pe omo meta o to abi awon family oko yin? [Who complains your children are not enough – your husband or your matrimonial family?]

Pt.: Emi ni mo fee. [It's my choice.]

Extract 37 (Interaction 8)

Doc.: You may bring them out. I would like to see them. (Doc. looks at the drugs) You have to give your health the attention it deserves to avoid the complications likely to arise from having poorly treated elevated blood pressure – stroke, diabetes, etc. It is a surprise you could travel to a place as distant as Lagos in spite of your ill health. You have to come to the hospital for a review once every month.

Pt.: Thanks, Sir.

Doc.: Once every month, you are to come to the hospital; that's twelve times yearly. I believe this is not difficult. Kindly take care of your health.

Pt.: Thanks for your concern over my health.

Doc.: Any time you want to travel, ensure you inform your doctor to enable him arm you with medications that could sustain you till you arrive. Then, you go see him for a check-up immediately yoy arrive. It's only by so doing that you could have a good health.

Pt.: Thank you. I appreciate your concern..

In extracts 36 and 37, the doctors counselled the patients on the best way to take care of their health to prevent health crises through demonstration of empathy for the patients' medical conditions. At 36, Doc. empathised with Pt. over her poor financial position and, therefore, counselled her to do away with the craving for additional children, having got three children already. Doc. deployed this discourse device to protect Pt. against the fiscal agonies and medical challenges that are associated with having too many children.

At 37, Doc. exhibited compassion for the hypertensive patient and told him to give his health the attention it deserved in order to avoid problems such as diabetes and stroke, which can occur when hypertension is not managed properly. He also taught Pt. how to prepare for a long voyage while yet having enough medications to keep him alive until he arrived.

4.2.3.4 Pollyanna principle - The ethical positivity tendency for opening up consultations

The Pollyanna principle was also observed in the data. The incidence of the Pollyanna principle revealed that medical interaction gives more attention to the positive aspect of life than the negative side. Circumstantial ideas based on medical ethics and those based on the patient-society's perception of doctors gave rise to the issue. Doctors use their expertise to treat patients, whether directly or indirectly, and not to harm them physically or psychologically.On the other hand, Pts. also expect that Docs. would attend to all their physical, emotional and medical needs. The Pollyanna principle is theorised to have three tendencies: referential or hinting tendency, ethical positivity tendency, and euphemistic

tendency. However, only the ethical positivity tendency characterised the consultations studied.

Ethical positivity tendency, one of the tendencies of Pollyanna principle, emphasises the ethical expectations of patients from doctors, especially in areas of sympathy, assurance, reassurance and medical care, etcetera. The ethical positivity tendency is concerned with the circumstantial ideas about doctors that are based on patients' and society's perceptions of them. The hospital is seen as a place of healing and relief by the patients and the general public. As a result, they hold Docs in high regard as persons they can trust with their health secrets. According to Maboyeje ((1982:11) cited in Odebunmi, 2003), the health vocation also shares this vista:

> 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.

However, it is worthy of note that some patients intentionally hold back some medical information from doctors for reasons known only by them. All patients believe they would get adequate care and compassionate attention from doctors. Therefore, majority of them disclose all their medical challengess to the doctors, expecting the doctors would reciprocate with the appropriate medical intervention. The data is replete with instances of this phenomenon as observable in the extracts below:

Extract 38 (Interaction 6)

Doc.: Did you ever test positive to hypertension or diabetes?

Pt.: Diabetes.

Doc.: In which hospital do you treat it? What medications were you given to treat it?

Pt.: The medications are in my bag.

Extract 39 (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 alone can tell us whether it has stopped or not.]

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

Doc.: Sebi enyin ati oko nyin ti n mate latigba yen? [Does your husband still have sexual intercourse with you? Ko wa mo. [It is not coming again.]

Pt.: Bee ni. [Yes.]

The ethical positivity tendency application, as seen in extracts 38 and 39, aided the patients in freely expressing their health concerns because they had so much faith in the doctors' competence to treat them. As a result, doctors responded to the patients' trust in their professional abilities by prescribing one type of treatment or another to treat them, or by ordering a test to diagnose their health problems.The deployment of the ethical positivity tendency served the pragmatic purpose of enabling the patients disclose all their medical challenges for accurate diagnoses and treatment. The ethical positivity tendency was grammatically realised by single words and declaratives.

ANALYSIS AND DISCUSSION OF DISCOURSE DEVICES AND PRAGMATIC FUNCTIONS IN DOCTOR-PATIENT CONSULTATIONS AT UITH, ILORIN

4.3 An overview of the section

Based on the data gathered at UITH, Ilorin, analyses of the numerous discourse devices used in the doctor-patient consultations as well as their pragmatic functions were carried out in this section. A doctor and a patient, and sometimes a patient's relative, are always present during medical consultations. As a result, the discourse devices used by the doctors and patients were investigated.

4.3.1 Research questions One and Two: Which discourse devices are employed in doctor-patient consultations and what pragmatic functions do they perform?

A number of communication problems have been discovered to pose some challenges to doctor-patient consultations. Consequently, this study revealed the discourse devices that doctors and patients alike employed to overcome the challenges. Discourse devices are used to realise some of the goals of medical consultation. In this study, they were realised by phatic communion, direct question, indirect question, answer, code alternation, face-threatening acts, circumlocution, rapport expressions, politeness, modality, counselling and closing.

4. 3.1.1 Phatic communion for opening consultations and showing empathy

Owing to the unique nature of medical consultations, a poor opening might jeopardise the outcome of any consultations. Docs use phatic communion at the start of most consultations to make communication successful. During consultations, phatic communion is, therefore, typically demonstrated by showing empathy, greetings, and doctors inquiring about patients' well-being. Both the doctors and the patients in this study used it to start the consultations. The accompanying excerpts were examined:

Extract 40 (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 41 (Interaction 37)

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

Pt.: How is your family?

Doc.: They are fine.

Pt.: Thank God.

Extract 42 (Interaction 27)

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

Pt.: E see. [Thank you.]

Extract 43 (Interaction 40)

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

Pt.: Good afternoon, sir.

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

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

A perusal of Extract 40 – 43 revealed that the Docs deployed phatic communion to open the consultations with the Pts. Its deployment confirmed its indispensability in clinical interviews, hence the recourse to it by both the doctors and the patients. In Extract 40 (Interaction 29), Doc. started the consultation with the Pt by using salutation (''E kaasan'. [Good afternoon.]') to welcome the patient. In Extract 41 (Interaction 33), Doc opened the conversation by using salutation ('**Good afternoon, Ma'**.) to welcome Pt and to, at the same time start the interview. In Extract 42 (Interaction 27) the Doc's study of Pt's

appearance revealed that the Pt felt excruciating pains. This, therefore, necessitated the Doc's employment of the empathetic expression: (**'E pele, Ma.**'): meaning ['Sorry, Ma.'] to empathise with the Pt, and at the same time start the interview. In Extract 43, 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 use of phatic communion in this case, which included salutation, non-medical questions, compassionate expression, and calling the patient's name, laid the groundwork for a pleasant start to the sessions. It was mostly accomplished through the use of salutation. As can be seen from the preceding conversations, Docs used a variety of techniques to begin their consultations with the Pts. The patients' outward appearance, the hour of the consultation, and African culture, which requires salutation at the start of any conversation all influenced their decisions. To begin their conversation with the Pts, the Docs used several aspects of phatic communion, such as interrogatives, greetings, proper nouns (names of Pts), and emotive phrases, but the Pts simply used greetings. By using the phatic communion, both the Docs and Pts were able to start talking while preparing for the diagnostic frame. From the above, it can be seen that the phatic communion conventional uses have been extended here to include elicitation of information on social life.

The usage of the phatic communion performed the pragmatic function of dousing the tension generated by the patients' ailments and opening the consultations. Phatic communion was appropriate for starting the consultations since it allowed the interlocutors to create an environment that allowed for a smooth start of the consultation. As an ice breaker, it also provided the space the interlocutors needed to begin conversing and to prepare for the actual diagnostic process. Declaratives, interrogatives, and phrases were used to realise phatic communion in the encounters.

4.3.1.2 Circumlocution for providing clues to diagnosis of ailments

Most patients encounter the challenge of not knowing the particular names for their sicknesses. Consequently, they resort to circumlocution. Circumlocution was employed solely by the Pts in the consultations. This study revealed that most of the patients appeared to be circumlocutory in the explanation of their sicknesses. They simply

described the symptoms rather than giving the particular names of their ailments. More often than not, circumlocution was frequently used in the consultations because of Pts' lack of knowledge of the proper medical nomenclature for their medical issues.There are copious instances of this phenomenon in the consultations. The following extracts were considered:

Extract 44 (Interaction 13)

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 45 (Interaction 18)

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 46 (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.: What is your age, please?

Pt.: 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 excerpts above revealed that majority of the time, Pts referred to their illnesses' symptoms as if they were the actual names of their illnesses. This is evident from our own experience as humans that illnesses have a wide range of symptoms. As a result, it is not uncommon for typhoid patients to complain about diarrhea, headaches, or a high temperature, among other symptoms. As non-medical specialists, the patients might not know the names of the ailments they were suffering from. They could only know the

symptoms. As a result, the emboldened contributions of Pts in the extracts above represent symptoms of diseases which true names the patients did not know. The citing of the symptoms however made it possible for the Docs to actually know the health challenges faced by the Pts. The use of the words **watery stool** and **vomitting** in Extract 45 suggested the patient suffered from typhoid or cholera as the words are common symptoms of the indicated disease. Similarly, looking at Extract 46, 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 42. Similarly, in Extract 44: ('**Ori fifo**. **Ara re si n gbona'.)** [Headache. He also has a high temperature]. The patient's emboldened contributions could also be manifestations of malaria as common knowledge of diseases suggests malarial attack. As a result, when the fundamental problems are addressed medically, the symptoms fade away.

Circumlocution served the pragmatic purpose of providing clues to the diagnosis of the Pts' ailments. The Pts facilitated this by describing the symptoms of their health challenges as a result of their limited or complete lack of medical knowledge. As a result of the use of circumlocution, Docs were able to obtain insights into the health problems of their Pts. Declaratives were used to create circumlocution, and it was intended to convey medical information so that Docs should make diagnoses.

4.3.1.3 Rapport expressions for geniality, cordiality, conviviality, and empathy

Docs' hostile comments and appearance could deter Pts from disclosing vital medical information requiired for accurate diagnoses. The doctors in this study were able to overcome this obstacle by using rapport expressions. A review of the data revealed that remarks, indirect questions, and Wh-questions were used to demonstrate rapport. The Docs were able to fraternise with and familiarise themselves with the Pts by using rapport expressions for solidarity, empathy, conviviality and cordiality. The rapport expressions were also used to encourage open dialogue between the doctors and patients in order to enable the doctors obtain useful medical information that would help them diagnose the

patients' ailments and, eventually offer effective prescriptions. The excerpts below were examined:

Extract 47 (Interaction 37)

Doc.: **How are you?**

Pt.: Fine.

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

Pt.: E see.

Extract 48 (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.]

The Docs created cordiality with their patients, using rapport expressions, as shown in the emboldened contributions in the excerpts above. The use of the rapport expressions assisted the Docs to be pleasant . In order to foster conviviality and open dialogue, the Docs used oral information gathering on both family history (FH) and social history (SH). In Extract 47, the Doc. employed empathetic greeting (**"How are you?**) to fraternise with and to encourage the Pt. to open up. In Extract 48, the doctor employed naming, empathetic comment and inquiry about the patient's well-being to realise rapport: (Doc.:**Razak Bimbo**. Pt.:Ma. Doc.: **E pele. Bawo lara yin? [Sorry.How do you feel?] Se alaafia ni? [Are you alright?]**). 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 prescribe appropriate treatments to the patients' medical challenges.

The use of rapport expressions served the speech (pragmatic) function of encouraging open conversation between the Docs and the Pts, while also familiarising the Docs with the Pts. Their use enabled the doctors to communicate with the patients on the same wavelength, allowing them to create a friendly environment in which patients would be more willing to divulge all the information needed to appropriately diagnose their illnesses. They also enabled the doctors to gain the patients' cooperation in order to make the consultations more productive.

Owing to the fact that rapport expressions were used to gather information and supply same by the Docs as the consultations warranted, they were accomplished by interrogatives and, occasionally, by declaratives in the form of empathetic comments in the consultations.

4.3.1.4 Code alternation for informativity, explicitness and mutuality

In the multilingual context of this study, certain patients' proficiency in only a code and doctors' inability to discover second language equivalents for particular medical terms created a barrier. The Pts and Docs used code alternation to address the problem. It was realised by combining Yoruba and English, as well as using Pidgin English in the interactions. The different language choices made by the Pts and Docs were analysed and debated because this is crucial for determining how well the codes were used and exposing the pragmatic purposes they served.

Relating the above to our data on doctor-patient interaction in the North-Central and South-West geo-political zones of Nigerian, it was 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 examined:

Extract 49 (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.

The extracts above and below proved that code alternation is indispensable during clinical interviews in multilingual settings like the one of this study. In the extract above, the patient picked English as the language of communication by greeting the doctor in English. The doctor reciprocated by using the same language to investigate the patient's chief concern (CC), and the entire interview was conducted in English as the patient was educated.

Extract 50 (Interaction 31)

Doctor: Kinni oruko yin? [What is your name?]

Patient: Adijatu Olamide.

Doctor: Se e ti sayewo 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.]

Doc. requested for the Pt's name in Yoruba in the extract above . The patient answered the question, explained her chief concern (CC) and also answered other questions asked by the Doc in the same language. The whole consultation 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 at all. 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. The data were also replete with instances of code mixing.

Extract 51 (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 work do you do?]

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 a sore throat around that time?

In the extract above, the contributions of both the Doc.and the Pt. revealed that they engaged in code-switching as well as in code mixing both at the sentence level and at the word level by using English and Yoruba Languages interchangeably. This strategy was employed by both the Doc and the Pt to ensure a clear understanding of their discussions and to hide their linguistic incompetence at certain levels in the concerned languages.

Extract 52 (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, both the Doc. and the Pt. in the extract above engaged in code switching and code mixing at both the word and sentence levels. The Doc. certainly employed code-mixing to help the Pt. understand him better, especially because some of the English medical words have no Yoruba equivalents, and he recognised the Pt. didn't understand English much.

The speech function of the Docs and Pts' use of code-mixing and code-switching in Extracts 50, 51, and 52 above was to avoid communication breakdown because English Language cannot be avoided entirely when consulting with non-English speaking patients because there are some English words used in medical discourse that have no equivalents in Yoruba e.g.: X-ray. Furthermore, even if they are available, they may not be able to adequately capture the idea that the doctors or patients have in mind.

The pragmatic function of code alernation was to make the consultations informative, explicit, understandable, and mutual. Its use enabled the doctors to accommodate the patients' linguistic incompetences. It also enabled the interlocutors to overcome their linguistic shortcomings. As a result, both the doctors and the patients were able to fully comprehend the conversations. Code alternation was realisedd intra-sententially and inter-sententially in the consultations by alternating English, Yoruba, and Pidgin English, employing declaratives, imperatives, and interrogatives, as shown in the extracts above.

4.3.1.5 Counselling for guidance, enlightenment and encouragement

A close examination of the data disclosed that some Pts engaged in health-harming behaviours. As a last resort, the doctors used counselling to curb the patients' unhealthy habits. This section covered examples of doctors using counselling as a powerful tool to assist Pts on how best to manage their health, teach them the best health practices, and encourage them. The accompanying extracts were examined:

Extract 53 (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 54 (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 yin fun eje riru?[Are you not being treated for high blood pressure?]**

The use of counselling for the purpose of correction and enlightenment was indicated in the emboldened contributions in the excerpts above. In Extract 53, Doc. guided the patient that had hypertension on how to avoid dangers which could adversely aggravate her health condition. He charged the patient to avoid carrying heavy things and to ensure that the furniture in her house were well-spaced to allow easy passage. Doc. gave the advice to assist the Pt. in avoiding injuries that could result from carrying heavy things or living in an apartment crowded with furnitures that make her trip. At 54, 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. All these were said to ensure the well-being of the Pt. From the above, it is clear that the employment of counselling enabled the doctors to provide the patients with the appropriate health information to stabilise them and, or improve their medical conditions.

Some Pts appeared to be obsessed with some religious doctrines that were harmful to their health. In an attempt to remedy the situation, the Docs employed counselling, using their religious beliefs and experience as medical practitioners to advise the Pts appropriately by

enlightening them on the unsuitability of some of the doctrines they observed. The employment of Biblical and Quranic explications was used as a tool to perform particular speech (pragmatic) functions in the consultations. Therefore, the focus of this study was how its use benefitted the physicians in guiding, correcting, informing, and encouraging the Pts. The following passages were examined:

Extract 55 (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 56 (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 57 (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?

Counselling is a crucial discourse device in doctor-patient verbal communication that aids physicians in properly educating and guiding patients. In Extract 64, the Pt 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 (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.**). Therefore, being a co-religionist enabled the patient to open up to the doctor and to also accept the doctor's views concerning fasting.

In Extract 56, 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 her mind as a fellow muslim, by informing her there was no such instruction in The Quran, and adding that his (Doc's) 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 57, 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, although the patient still rejected the doctor's advice. Thus, counselling served the pragmatic purpose of guiding the Pts rightly and enlightening them. Its use also enabled the doctors to educate the patients on health-related issues and how they could live healthier lives.

Here, the Docs used their faiths (Christianity and Islam) to correct certain flawed beliefs of the Pts. Grammatically, the instances of counselling in the consultations were realised by declaratives, imperatives and interrogatives.

4.3.1.6 Repetition for clarification, emphasis and confirmation

Doctors may not know some patients' most pressing health challenges until they are emphasised. 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 realised by reiteration of same expressions or similar ideas, and it was deployed by the patients and doctors, but more often 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 emphasise or confirm the repeated utterances. To examine this phenomenon, the extracts below were studied:

Extract 58 (Interaction 32)

Doc.: So, what would you like 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 59 (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 60 (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 alone can say whether it has stopped or not.]

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

A careful read-through of the extracts above revealed that the Pts 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 subtly drew the doctors' attention to the patients' pressing ailments for which treatment was urgenly needed from the doctors. In Extract 58, the patient

employed direct repetition of words (‘**Remove the milk tooth.’; ‘Remove the tooth now.’)** to emphasise her health challenge. In Extract 59, 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 60, 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 or flow.

Therefore, the deployment of repetition served the pragmatic purpose of emphasising the patients’ pressing medical challenges and pin pointing where the doctors should focus their medical intervention on. In the extracts above, the patients made clear to the doctors through the deployment of both direct and indirect repetitions their pressing ailments for which they wanted medical attention. Grammatically, the repetitions were realised by declaratives.

4.3.1.7 Answer and question and answer for provision and elicitation of information for diagnoses

Verbal information is essential to complement medical tests and augment medical information for rich and accurate diagnosis. As a result, question and answer sessions are inevitable during diagnostic interviews as diagnosis is based partly on the elicitation and provision of information. Docs have to obtain relevant information from patients by using questions, and the Pts too need to supply them through answer to aid the Docs in their diagnosis and treatment of the Pts' illnesses. This section examined how the doctors received medical information from the patients through direct and indirect questions as well as how the patients provided the necessary information through answers.

4.3.1.7.1 Direct questions with answers

In the investigation of the patients' health difficulties, direct questions were realised by interrogatives beginning with wh-elements, while replies were realised by declaratives. I looked at the accompanying extracts:

Extract 61 (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 62 (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 63 (Interaction 26)

Doc.: **Did you ever test positive to hypertension or diabetes?**

Pt.: **Diabetes.**

Doc.: **In which hospital do you treat it? What medications were you given treat it?**

Pt.: **The medications 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.**

The direct question was one of the verbal diagnostic tools used by the doctors to investigate the patients' diseases. Its use enabled the doctors to intervene professionally in their patients' medical concerns. The Docs used direct questions to acquire information on the patients' social history (SH), family history (FH), and history of present illness (HPI), as seen in the excerpts above, in order to arrive at diagnoses. In response, the Pts used answer to provide the required information, thus making the consultations successful.

The straightforwardness of the questions served the speech function of informing the Pts explicitly that the information being sought from them was critical to the diagnosis of their health challengess and eventual healing. Patients were able to express their medical problems through answers to the questions. In conclusion, straightforward questions in the consultations served the pragmatic purpose of obtaining information for diagnoses. Wh-elements were used to grammatically realise them.

4.3.1.7.2 Indirect questions with answers

During the consultations, statements were used to answer indirect questions. Indirect questions have the appearance of declaratives, yet they are basically interrogative. The accompanying extracts were examined:

Extract 64 (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 65 (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 66 (Interaction 38)

Doc.: April was the last time you came here.

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,

The main instrument doctors use during consultation is requesting and giving information, according to Extract 64–66. The use of indirect questions to collect information on the patients' social history (SH), family history (FH), and history of present illness (HPI) is evident in the doctors' contributions above. The contributions of the patients, on the other hand, provided answers to the doctors' questions.The indirectness of the questions is confirmed by their non-interrogative status, although couched in declarative forms. The answer status of the accompanying responses from the patients thus formed a question-

answer sequence. The elicitation and provision of information in this case gave the doctors insights into the potential causes and true nature of the patients' health problems, thus allowing them to intervene professionally. Docs mostly sought information about the patients' health concerns, which the patients provided. This showed that they relied on each other in matters of oral diagnosis.

The direct and indirect questions were bolded in every instance. There were instances of direct questions in Extracts 61–63, while indirect questions were seen in Extracts 64–66. The indirect questions served a pragmatic purpose of making the consultations appear less interrogative, allowing patients who were clearly ill to find the exercise less stressful, and as a result, be encouraged to cooperate in releasing all the information needed to unravel and treat all their diseases.

Direct questions served the pragmatic purpose of letting the patients realise that the information being sought from them was critical to treating their health challenges and allowing the doctors to treat them. In contrast to direct questions, indirect questions were realised by declaratives but yet carry the illocutionary power of question.

The answers naturally followed the questions as they served the pragmatic function of delivering the information needed to make diagnoses. Because the consultations were strictly investigative, their deployment was unavoidable. They supplied the diagnostic "raw materials".

The answers were what the doctors needed to make diagnoses and without them, it would have been impossible for them to gain insights into the patients' health problems, unless they conducted laboratory tests on them, as the extracts above demonstrated. In the light of the fact that some health concerns are only investigated by means of elicitation of information (question) and delivery of information (answer), question and answer are very essential diagnostic tools used during consultations.

Direct questions were realised by interrogatives containing subject-verb inversion, while indirect questions were realised by declaratives, as shown in the samples above; the

indirect questions, however, have the illocutionary power of interrogatives. Declaratives were used to realise answer.

Looking closely at Extract 61 – 66, the adjacency pairs therein can be categorised in different ways, and the first pair-parts are conditionally relevant on the second pair-parts. In Extracts 61 – 63, there are question-answer sequences. In Extract 64, the first pair-part of the contribution constitutes a question-answer sequence, while that in the second contribution constitutes an observation-acceptance sequence. In Extract 65, the first pair-part of the contribution constitutes a question-answer sequence, while the second pair-part of the contribution in the same extract constitutes an observation-acceptance sequence. Similarly, in Extract 66, the two pair-parts of the contribution there constitute observation-acceptance sequences. There is an evidence of logic in each of the adjacency pairs, thus showing cooperation amongst the doctors and patients.

4.3.1.8 Closing for concluding discourses

After gathering information on the patient's chief concern (CC), history of present illness (HPI), family history (FH), and social history (SH), the consultations needed to be wrapped up so that the patients could either go get some medicines, or do both. The patients exploited closing to create this opportunity. Expressions of gratitude and welcome were used to bring the consultations to a close in the data. A comprehensive examination of the data revealed that a variety of strategies was used to end the doctor-patient meetings, but the most used were comments like: 'Goodbye' and 'Thank you,' which were spoken by the patients after the doctors had prescribed tests or drugs. Here are some analyses of how these closure tactics were used in the data.

Extract 67 (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 68 (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 69 (Interaction 42)

Doc.: O dabo. [Bye bye.]

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

Extract 70 (Interaction 30)

Doc.: Bakannaa, e o maa ye abe bata yin 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 patients most of the times concluded the dialogues in all the extracts, although the doctors also closed the conversations on occasions, as shown in Extracts 67 (Interaction 42) and 68 (Interaction 38) by using the expressions: (O dabo. [Bye bye.]) and ('Bye bye, Ma.'), respectively. The patient ended the interview with the expressions: 'O dabo. [Bye bye.]' and ('E see. [Thank you.]) in Extracts 69 and 70, respectively. The use of the expressions mentioned above to terminate the clinical interviews resulted in appropriate interview conclusions.

Going by the preceding discussions, it is evident that closing served the pragmatic purpose of bringing each of the encounters to a close as each of the clinical interviews had to come to an end at some point. Closing signified the end of the verbal encounters, as indicated in the emboldened statements in the extract above. Closing is, in general, the last discourse device used in all the clinical interviews, as evidenced by all the encounters, and it

naturally followed prescription. Declaratives and phrases were used to realise closing grammatically.

4.3.1.9 Modality for showing asymmetry of knowledge and power, and obtaining medical information

The findings on the pragmatic functions of modality as deployed by the doctors and patients in the data were discussed here. For the purpose of clarification, the analysis done here focused mainly on epistemic modality.

Pragmatic functions of epistemic and deontic modality

(i) Statement for expressing asymmetry of power and knowledge

Extract 71 (Interaction 30)

Pt.: Beeni. [Yes.] 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 yin 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 to inspect them.] Aisan yii lo n faa tin won fi nge ese 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 won 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.]

Two modals (**ought to** and **need to**) were examined in the extract above. Both of them expressed obligation. The doctor employed **ought to** to emphasise the importance of regular blood sugar test by Pt. because of her diabetic condition to forestall possible incurable sores that could necessitate amputation. Similarly, Doc. also employed **need to** to show Pt. she had to constantly examine her feet and toes to ensure there were no sores in them.

The doctor's medical knowledge and his +higher role status enabled him to counsel the patient on the importance of regular blood sugar test and constant examination of her feet and toes to forestall health crises that might necessitate amputation, thus indicating superior knowledge. The deployment of **ought to** here performed the pragmatic function of expressing obligation as the doctor used it to tell the patient she had a duty to check her blood sugar level and also examine her feet and toes to avoid unexpected inoperable sores. In addition, the doctor exhibited asymmetry of power through the use of **need to** as a result of his +higher role occupant status. Its deployment here thus performed the pragmatic function of showing the patient he was an authority in the discourse situation.

The deployment of **ought to** in the extract above (an instance of deontic advisability conveying the median degree of a command) served the speech purpose of counselling the patient on the importance of monitoring her blood sugar level to prevent complications. Similarly, the deployment of **need to** (an instance of deontic necessity conveying the highest degree of obligation of a command) performed the pragmatic function of commanding the patient to examine her feet and toes to avoid complications.

(ii) Questioning for obtaining medical information

Extract 72 (Interaction 48)

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.

The modal auxiliary **can** (an instance of epistemic possibility) was used in Extract 72 (Interaction 48) above by the Doc to investigate the patient's ability to open the mouth to enable him diagnose the Pt's dental challenge appropriately. In response, the patient demonstrated his ability to open his mouth by opening his mouth for examination. Beyond the discourse function of expressing epistemic possibility, **can,** by virtue of its deployment here, performed the pragmatic function of a subtle command.

(iii)Statements for expressing patients' answers to doctor's queries

Extract 73 (Interaction 38)

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-

One other instance of epistemic possibility found in the data has to do with the use of **will** in the extract above to respond to the doctor's information on the time the test result would be ready, and it is anchored on prediction. It foretells the patient's preparedness to visit the hospital the following day in continuation of her treatment. It, therefore, performed the pragmatic function of expressing the patient's preparedness to come again.

Extract 74 (Interaction 38)

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?

The data also revealed another instance of epistemic uncertainty expressed through the deployment of the lexical verb **think** in the extract above. It served the pragmatic purpose of expressing the doctor's uncertainty of the actual cause of the patient's hitherto swollen mouth.

Beyond the epistemic modality's function of expressing possibility/impossibility or probability, it performed the pragmatic function of expressing certainty and uncertainty in the various medical contexts above. Similarly, beyond the deontic modality function of expressing obligation and permission, it performed the pragmatic function of counselling and command as observable in some of the extracts above.

4.3.1.10 Face-threatening acts

Politeness was realised in the consultations by face-threatening acts without redress and face-threatening acts with redress (positive politeness) through the deployment of direct and indirect expressions, frank talk and courteous expressions. They generally accompanied the doctors' diagnoses. Here, the incidence of politeness was studied to show how and whether the diagnoses were presented courteously and how Pts.' face was threatened with redress and without redress. Moreover, efforts were made to study how the deployment of the politeness maxims and face-threatening acts enhanced the communication.

4.3.1.11 Face-threatening acts without redress (negative politeness) for correcting and checking unwholesome health practices

Negative politeness was realised by reprimand, courteous expressions and frank talk. The extent of the effectiveness of the face-threatening acts in the discourse situation was attempted here. The extracts below were examined:

Extract 75 (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, no problem will arise.

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 extract above, 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 76 (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. From the preceding, it can be established that FTA without redress served the pragmatic purpose of checking and correcting patients' habits that were harmful to their health, as well as revealing to them the true state of their health in an unobtrusive manner.

4.3.1.12 Face-threatening acts with redress (positive politeness) for tactfully obtaining information for diagnoses, allaying fears and correcting unwholesome health practices

FTA with redress was realised by courteous expressions, mitigated threats, indirect and direct talks in the consultations. The study revealed that either as a long term or temporary act, the doctors minimised the threat to their face or threatened the patients' face by talking indirectly about their ailments. This can happen during consultations, and doctors will then use FTA (positive politeness). Patients' true health issues are also withheld from them at times, for reasons best known to physicians. The majority of the FTAs with redress (positive politeness) in the data were expressed as mitigated threats, indirect expressions, courteous expressions, and direct expressions. The following extracts were investigated.

Extract 77 (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 78 (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 the true information that would assist the doctor in making an accurate diagnosis.

Extract 79 (Interaction 30)

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

Pt.: O 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 80 (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' emboldened contributions in Extracts 79 and 80 are direct expressions employed to reprimand the patients for their utter disregard for their health. The doctors employed the 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 function of correcting the patients' unhealthful practices, tactfully eliciting information from them to make diagnoses, and allaying the fears generated by their ailments.

4.3.2 Research questions Three and Four: Which politeness maxims (PMs) are deployed in the doctor-patient consultations and what pragmatic functions do they perform?

The generosity maxim, sympathy maxim, tact maxim, and Pollyanna principle were all seen as PMs in the consultations. These were covered in more detail below.

4.3.2.1 Tact maxim for compassion and permission

The tact maxim was employed in the consultations. It states:'' Minimise cost to other, maximise benefit to other". Majority of the doctors' utterances revealed that they were considerate with the patients because they gave them the chance to derive maximum benefit from their hospital visits, even though such offers meant additional work for them. The extracts below were considered:

Extract 81 (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 82 (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.

The contributions of the doctors in the samples above demonstrated that they empathised with the patients and wanted them to get the most out of their hospital trips.In Extract 81, Doc. gave the patient another chance for medical examination and drug prescription by giving her another appointment. Similarly, in Extract 88, 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 bolded comments in Extract 81 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 challenge, too. Undoubtedly, these offers translated into more drudgery for the doctors but they did not care as the health of the patients was supreme in their hearts.

The deployment of the tact maxim served the pragmatic purpose of enabling the doctors to show compassion on the patients. It also afforded them the opportunity to offer the patients more medical attention. The tact maxim was grammatically realised by interrogatives and declaratives in the consultations.

4.3.2.2 Generosity maxim for compassion and advice

The maxim was realised in the data by compassion and advice. It was noticed on multiple occasions during the consultations between the patients and the doctors that the doctors limited benefit to themselves while also maximisng cost to themselves. As a result, the doctors expressed tremendous concern for the patients' well-being. The accompanying extracts were examined:

Extract 83 (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 84 (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 Extract 83, the doctor advised the diabetic patient on the significance of strictly following medical instructions and medications in order to avoid health problems. In Extract 84, Doc.'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 use of the generosity maxim allowed the doctors to express care for the patients' health while also providing suitable advice.The generosity maxim was grammatically realised by interrogatives and declaratives in the consultations.

4.3.2.3 Sympathy maxim for advice, pity and guidance

The sympathy maxim was realised by guidance, pity and advice in the consultations several times. The doctors employed it to pity the patients on certain terrible medical conditions. A few of the utterances made to observe the maxim were examined below:

Extract 85 (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 Extract 85 (Interaction 36) , the Doc pitied Pt 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 86 (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 86, 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. The doctors' contributions performed the pragmatic function of counselling and advising the patients on the proper course of action to take when faced with a health crisis by employing the sympathy maxim.In addition, its deployment also revealed the doctors' compassion for the patients. The sympathy maxim was grammatically realised in the consultations by interrogatives and declaratives.

4.3.2.4 Pollyanna principle - The ethical positivity tendency: To open consultations

The Ethical positivity tendency, one of the elements of pollyanna principle, was also observed in the data. The incidence of the Pollyanna principle revealed that medical consultation gives greater attention to the positive aspect of life than the negative side. This phenomenon arose from the contextual ideas based on medical ethics and patient-society perceptions of doctors. Doctors must use their professional knowledge to treat patients, not to harm them physically or psychologically, according to medical ethics. On the other hand, Pts. also expect that doctors would attend to their physical, emotional and medical needs. The Pollyanna principle is theorised to have three tendencies: referential or hinting tendency, ethical positivity tendency, and euphemistic tendency. However, only the ethical positivity tendency characterised the consultations studied.

Ethical positivity tendency, one of the Pollyanna principle tendencies, emphasises the ethical expectations of patients from doctors, especially in areas of sympathy, assurance, reassurance and medical care, etcetera. The ethical positivity tendency is concerned with the doctors' contextual beliefs based on the patients' and society's perspectives because the hospital is seen as a place of healing and relief by the patients and the general public.The patients see the doctors as health providers. As a result, they hold them in high regard as persons they can trust with their health secrets.According to Maboyeje ((1982:11) cited in Odebunmi, 2003), the health vocation also shares this vista:

> 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.

However, It is worthy of note that some patients intentionally deny doctors access to some medical data for reasons known only to them. All patients feel that doctors would provide them with adequate care and empathetic attention. As a result, majority of them tell their doctors all of their medical concerns, expecting the doctors would cooperate with them. The data is replete with instances of this phenomenon as observable in the extracts below:

Extract 87 (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 has your husband?

Pt.: **Three.**

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. Does your husband have sexual intercourse with you regularly?

Pt.: **Yes. But what I also notice these days is that blood comes out of my vagina each time we have sex.**

Extract 87 (Interaction 42)

Doc.: Kinni ohun to nse yin? [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 observable in extracts 84 and 85, the patients freely explained their health challenges to the doctors as they had so much confidence in the doctors' ability to treat them. The patients' emboldened contributions confirmed that they released all the information needed for diagnoses as the patients were sure they could be entrusted with their secrets. The Docs cooperatively responded to the Pts.' confidence in their professional abilities by prescribing one type of drug or test after another or prescribing tests to diagnose the Pts.' medical problems.The ethical positivity tendency was realised syntactically by declaratives in the interactions as they were comments made in response to the doctors' questions.

4.3.3 Lexical and grammatical devices in doctor-patient consultations and pragmatic functions at UCH, Ibadan and UITH, Ilorin

4.3.3.1 Lexical choices and discourse devices

This section considered the lexical choices made and description of the discourse devices deployed in the texts. 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, the intention here is to study the diverse ways the deliberate use of particular lexical items realised meaning in the interactions under investigation. The investigation of aspects of lexical features in the consultations reflected how the discourse 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:

4.3.3.1.1 Lexical devices and pragmatic 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 consultations being examined.

4.3.3.1.2 Repetition of words for emphasis, clarification 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 accompanying extracts were examined:

Extract 88 (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 89a) (Interaction 27)

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

pragmatic function of emphasising and confirming important points during the clinical interviews. At 88, the emboldened and repeated expressions performed the pragmatic function of confirming and emphasising emerging pieces of medical information, while those at 89a performed the pragmatic function of confirming an emerging piece of medical information.

4.3.3.1.3 Collocation for connectivity of the texts

In the doctor-patient discourse under study, lexical cohesion was also achieved through collocation. It is concerned with how some words in the discourses appear to move quite close together. The utterance of one term conjures up the images of the other or other group members. 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 the 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 89b (Interaction 8)

Doc.: You may bring them out. Let me have a look. (Doc. examines the medicines) You have to pay a very good attention to your health to avoid the terrible conditions may result from having poorly treated **hypertension – stroke, diabetes,** etc. It is a big surprise you could travel to a place as distant as Lagos in spite of your ill health. You have to come once a month for check-up.

Extract 90 (Interaction 36)

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

Extract 91 (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 90, 91 and 92 offered good instances of collocation. Those in Extracts 91and 92 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 90, which involved words that moved together closely in the discussion of poorly treateated hypertension. A similar situation was also found in Extract 91 as 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.

4.3.4 Grammatical analysis

This section considers 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 the 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 realised meaning in the interactions under investigation. The investigation of aspects of grammatical features in the interactions showed how the reflected 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 auxiliary and imperatives.

4.3.4.1 Modal auxiliaries for expressing views, ability or inability, opinions and decisions

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

Extract 93 (Interaction 1)

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

Extract 94a (Interaction 34)

Doc.: Apply it for two weeks and see how your condition improves. How I wish I had a good instrument to remove most of the wax blocking your ears to enable you start hearing well again. The eardrop is about #700. You **will** apply it for two weeks. If it finishes, get another bottle till you have used it for two whole weeks.

Extract 94b (Interaction 34)

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 95 (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 96a (Interaction 45)

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

Extract 96b (Interaction 13)

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

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

In Extract 93, the doctor used the modal auxiliary **will** to know the patient's experience of the dental discomfort. In Extract 94a, the doctor deployed **would** and **will** to express a past impossible medical procedure and to offer a prescription, respectively. In Extract 94b, the doctor employed **will** and **can** to express his decisions and hopes. Similarly, in Extract 95, the doctor used **will** and **can** to express his decision (examining the patient's X-ray film) and to reveal his diagnosis. In Extract 96a, the patient used **could** + **not** to express a past inability, and at 96b, the patient employed **will** to express her decision to comply with the presciptions. A read-through of the excerpts above showed 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.

4.3.4.2 Imperatives: giving orders

As a sentence type, imperatives were also deployed in the consultations. Mainly employed by the doctors, they assisted them in issuing appropriate directives for the purpose of restoring or enhancing the patients' health. The accompanying ing extracts were studied:

Extract 97 (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 98 (Interaction 29)

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

Extract 99 (Interaction 14)

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

Extract 100 (Interaction 42)

Doc.: Put drops of the eardrop in your ears for two weeks. Wish I had a good instrument. I would have brought out much of the wax to enable you start hearing well again. The eardrop costs about. #800. Apply it for two weeks. If it finishes, **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 97, 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 98, the imperative "**Go and do the visual acuity and we will know what to do next"** was used to ask the patient to do an eye test in order to know the next line of action in the Doc's effort to treat the Pt. In Extract 99, 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 100, the doctor empolyed the imperative "**don't buy another one till you have used it for two weeks.**" to guide the patient right on the medication. The various imperatives enabled the doctors to enhance the patients' health.

ANALYSIS AND DISCUSSION OF THE DISCOURSE DEVICES AND PRAGMATIC FUNCTIONS IN DOCTOR-PATIENT CONSULTATIONS AT GENERAL HOSPITAL, ABEOKUTA

4.4 An overview of the section

Based on the data collected at the General Hospital, Ijaye, Abeokuta, this chapter examines the numerous discourse devices used in the consultations and their pragmatic functions. A doctor-patient consultation always involves a doctor and a patient, as well as the patient's relative in some cases. As a result, the discourse devices used by patients and physicians were investigated.

4.4.1 Research questions One and Two: Which discourse devices are employed in the doctor-patient consultations and what pragmatic (speech) functions do they perform?

A number of communication problems have been discovered to pose some challenges to doctor-patient consultations. Consequently, this study revealed the discourse devices that doctors and patients alike employed to overcome the challenges. Discourse devices are used to realise the goals of consultations. Therefore, in this study, they were realised by phatic communion, direct question, indirect question, answer, code alternation, face-threatening acts, circumlocution, rapport expressions, politeness, repetition, counselling and closing.

4.4.1.1 Phatic communion for opening discourses and showing empathy

Due to the sensitivity of medical consultations, a poor first impression can jeopardise the success of any clinical interview. The Docs in this study used phatic communion at the start of most of the sessions to make communication more effective. During consultations, it was frequently demonstrated by expressions of empathy, pleasantries, and questions from the doctors regarding the patients' well-being and social lives. Both the Docs and the Pts used phatic communion to begin the consultations. The accompanying extracts were studied:

Extract 101 (Interaction 52)

Doc.: **Abisola Bosun.**

Pt.: Good morning, Ma.

Doc.: What are your complaints?

Pt.: I have a cough.

Extract 102 (Interaction 69)

Doc.: **How are you?**

Pt.: I am fine.

Extract 103 (Interaction 75)

Doc.: **How is your baby doing?**

Pt. Rel.: She is fine.

Doc.: Has she completed her immunization?

Pt. Rel.: Yes.

Extract 104 (Interaction 57)

Doc.: **E kaabo. (You are welcome.)** Kin lo se yin? (What are your complaints?)

Pt.: Ese mi ni o. (My legs are the problem). O kan dede wu, o si be lojiji. (It suddenly swelled and burst.) O de tun maa n jamije. (I also feel some biting sensation in it.) Lojoojumo, kii je ki n sun. (It does not allow me to sleep every day.)

A perusal of Extract 101- 104 revealed the Docs deployed phatic communion in starting the consultations with the Pts. In Extract 101 (Interaction 52), Doc. opened the consultation by calling the Pt's name (**Abiola Bosun)**, and the patient responded by greeting: "**Good morning, Ma.**" Thereafter, the interview continued. In Extract 102 (Interaction 69), Doctor opened the conversation by using salutation: "**How are you?**" to welcome the patient and at the same time start the interview. In Extract 103 (Interaction

75), Doc.opened the conversation by deploying an interrogative: "**How is your baby doing?**", and the patient's mother responded by answering: "**She is fine.**" Then, the conversation progressed. In Extract 104 (Interaction 57), the doctor employed a welcome greeting: "**E kaabo"**. **(You are welcome.)** and an interrogative: "**Kin lo se yin**? (**What are your complaints?**)" to start off the interview, and the patient responded by explaining her medical concerns.

The use of phatic communion in this case, which included salutation, non-medical questions, and addressing the patient's by name, set the stage for a seamless start to the clinical interviews and also established its indispensability in clinical interviews. It should also be highlighted that, as seen in our data, there were instances where the patients initiated clinical interviews, primarily through the use of salutation. From the preceding discussions, it is evident that the doctors used a variety of tactics to begin their dialogues with the patients. The patients' outward appearance, the hour of the consultation, and African culture which requires salutation at the start of any talk influenced their decisions. Going by the above, it is obvious that Docs established phatic communion with Pts by using greetings, interrogatives, and proper nouns (patients' names) to begin the conversation, whereas the patients only used greetings or complaints (declarative).

The deployment of phatic communion performed the pragmatic function of dousing the tension generated by the patients' diseases and opening the consultations. As an ice breaker, it was appropriate for beginning the talks since it enabled the interlocutors to create an environment favourable to a smooth start of the interviews. Its deployment also provided space for the interlocutors to begin chatting and preparing for the diagnostic frame.

4.4.1.2 Circumlocution for providing clues to ailments' diagnoses

Most Pts encounter the challenge of not knowing the particular names of their sicknesses. Consequently, they resort to circumlocution, which was employed solely by the Pts in the consultations. This work revealed that most of the Pts appeared to be circumlocutory in telling the doctors their sicknesses. They mentioned the symptoms rather than giving the particular names of their ailments. Often times, this occurred because of their lack of

understanding of the proper medical terminologies for their ailments.There are copious instances of this phenomenon in the consultations. The following extracts were considered:

Extract 105 (Interaction 54)

Pt. Rel.: **Aya n ro o. (He feels pains in his chest.)**

Doc.: (To Pt.) Aya n ro e. (You feel pains in your chest.) Nigbawo lo bere? (When did it start?)

Pt. Rel.: Ijeta. (Three days ago.)

Doc.: Ki n se atikekere? (Not from childhood?)

Pt. Rel.: **O maa n wuko latile wa. (He coughs from childhood.)**

Doc.: Se ko po eje? (Does he not cough out blood?)

Pt.: Rara. (No.)

Doc.: Se ara re ko gbona? (Does he not have a high temperature?)

Pt. Rel.: **Ara e lo woroworo die laaro yii. (His temperature is slightly high this morning.)**

Doc.: Se o le sun kaka lai lo pillow. (Can he lie face up without using pillow?)

Pt. Rel.: **Beeni, sugbon ko sun mojumo oni.** (Yes. But he did not sleep last night.)

Doc.: Se ti o ba lo pillow se o maa n feel better? (Does he feel better when he uses a pillow?)

Pt. Rel.: Beeni (Yes.)

Doc.: **O maa se awon test kan bii ti eje, ito ati ti kelebe. (He will have to run some tests: blood test, urine test and sputum test). Esi awon ayewo yii lomma je ki a mo ohun ti ama a se. (The result of these tests will guide us on what to do.) Suga to wa ninu ito e le po. (The sugar content of his urine may be high.) E lo**

se awon test yen ki e si mu esi re wa nigbato ba jade. (Go do the tests and bring the result when it is out.)

Extract 106 (Interaction 51)

Pt.: **I feel pains in my throat.**

Doc.: You have throat discomfort. Any other complaints?

Pt.: I underwent surgery.

Doc.: You feel something is there.

Pt.: **I also have a headache.**

Doc.: Probably the cough caused the headache. When was the last time you menstruated?

Pt.: 22/23 September. Two days.

Doc.: What do you understand by mid-cycle?

Pt.: No.

Doc.: Mid-cycle is when you menstruate around 14th and before the end of the month.

Pt.: I also feel pains in the stomach.

Doc.: **Do you also feel feverish?**

Pt.: **Yes**.

Extract 107 (Interaction 56)

Doc.: What is wrong with her?

Pt.: **She has high temperature.**

Doc.: For how long has she had this?

Pt.: Five days ago.

Doc.: What time does the temperature go up?

Pt.: The high temperature starts anytime.

Doc.: **Does she cough?**

Pt.: **Yes.**

Doc.: **Does she have a headache?**

Pt.: **Yes.**

Doc.: What about catarrh?

Pt.: I don't know the meaning of catarrh.

Doc.: **She was once admitted and transfused with blood.**

Pt.: Yes. About six months ago.

Doc.: (Checking Pt.'s case note.) **Yes. She was transfused with blood. Her genotype is AS. I know AS or SS patient have malaria, their blood level goes down and we do blood transfusion for them. So, if anyone asks you her genotype, she is AS.**

Pt.: Ok.

The Pts typically reported the symptoms of their illnesses as if they were the real illnesses they were suffering from, according to the samples above. The fact that illnesses come in a variety of forms becomes clear from experience as humans. As a result, it is not uncommon for typhoid patients to give complaints about severe headaches, diarrhea, or high body temperatures, and patients who are not medical professionals may be unaware of the specific ailments theyare experiencing. They might know the symptoms alone. As a result, all of the Pts' emboldened contributions in the preceding extracts are symptoms of illnesses whose real names the patients were unaware of. However, by mentioning these symptoms, the physicians were able to gain a better understanding of the patients' health issues or suspect possible ailments.

Looking specifically at Extract 105 (Interaction 54), "**Aya n ro o. (He feels pains in his chest.); Ara e lo woroworo die laaro yii. (His temperature is slightly high this**

morning.); Beeni, sugbon ko sun mojumo oni. (**Yes. But he did not sleep last night**). The patient's emboldened contributions were mere manifestations of certain diseases not yet confirmed by the doctor, and not the particular ailments. This is established in the Doc's accompanying recommendation of sputum test, urine test and blood test for the patient to clearly unravel the patient's health challenges in the same extract. As a result, by the time the real diseases are addressed medically, the problems go away. All of the symptoms indicated by the patients as disorders in the passages above, such as headache, high body temperature, chest pain, cough, insomnia, feverish feelings, and throat discomfort were only signs of certain diseases, which the doctors recognised.

The use of circumlocution served the speech purpose of providing clues to the diagnosis of the patients' diseases. The patients were able to provide the clues by describing the symptoms of their health challenges as a result of their lack of medical training. Through the use of circumlocution, the doctors were able to obtain insights into the health problems of the patients. Declaratives were used to create circumlocution because it was intended to provide medical information from which doctors might make diagnoses.

4.4.1.3 Rapport expressions for cordiality, sociability, and conviviality

Patients may hesitate to give essential medical information needed for accurate diagnoses due to doctors' unfriendly comments. The physicians in this study were able to overcome this obstacle by using rapport expressions. A careful examination of the data revealed that statements, indirect questions, and Wh-questions were used to demonstrate rapport. The use of rapport expressions for solidarity, empathy, and cordiality was critical since it allowed doctors to become acquainted with and fraternise with their patients. The rapport expressions were also intended to encourage open conversation between the doctors and the patients in order to assist the doctors gather accurate medical information that would help them make accurate diagnoses and, eventuallyoffer appropriate prescriptions or treatments. The accompanying extracts were studied :

Extract 108 (Interaction 61)

Pt.: Beeni. (Yes.)

Doc.: Se e ti loko? (Are you married?)

Pt.: Beeni. (Yes.)

Extract 109) (Interaction 69)

Doc.: Ogunmefun Soji!

Pt.: E kaaro, ma. (Good morning, Ma.)

Doc.: How are you?

Pt.: I am fine.

The doctors achieved geniality with their patients, using rapport expressions, according to the samples above. The doctors were able to be friendly as a result of their deployment. To foster conviviality and open dialogue, the Docs used sourcing of information on both family history (FH) and social history (SH). Extract 108, in particular, included a probe into the patient's social history (Doc.: Se e ti loko? (Are you married?)) to encourage an open dialogue. The rapport expressions served the pragmatic purpose of encouraging open conversation between the doctors and patients while also familiarising the doctors with their clients.

In Extract 109, the doctor used calling Pt's name (Doc.: **Ogunmefun Soji!**) to establish some level of familiarity with the patient, thus allowing him to speak up on all his health challenges. Their use allowed the doctors to communicate with the patients on a more personal level, thus enabling them to establish a welcoming environment whereby patients would be more willing to give all the info rmation needed to effectively diagnose their diseases.

In the consultations, rapport expressions were usually realised by interrogatives but were also realised by declaratives on rare occasions, since they were used to gather information and offer it, as the circumstances dictated.

4.4.1.4 Code alternation for informativity, explicitness and mutuality

In the multilingual context of this study, certain patients' proficiency in only a code and doctors' inability to get second language equivalents for particular medical terms created a barrier. Patients and doctors used code alternation to solve this challenge, which was made more difficult by the multilingul setting. It was realised by combining Yoruba and English as well as using Pidgin English, within and across the exchanges. The different linguistic choices made were analysed and debated because this is crucial for determining how successfully the codes were employed and exposing the pragmatic purposes they served.

Relating the above to our data on doctor-patient interaction in the North-Central and South-West geo-political zones of Nigeria, it was 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 examined:

Extract 110 (Interaction 71)

Doc.: Taiwo Joseph!

Pt. Rel.: E kaasan, Sir. (Good afternoon, Sir.)

Doc.: Kin lo see? (What is wrong with him?)

Pt. Rel.: Bi ara re ti ri yii naa ni.(His skin is the problem.)

Doc.: Kin le ti waa lo? (What have you given him?)

Pt. Rel.: Lakatin powder.

Doc.: Okay. E ra ipara yii ki e maa fi paa lara. (Buy this cream and apply it on the affected parts.)

In Extract 110 (Interaction 71), the Doc greeted the Pt and inquired about her health concerns in Yoruba, assuming she was uneducated based on her appearance. The patient replied using the same code, and the interview was conducted in that language .

Extract 111 (Interaction 67)

Doc.: kinni **complaints** yin? (What is your complaint?)

Pt.: **I have swollen feet and pains in the joints. When I am walking, I feel like blood is not flowing to my legs and, at such times, I feel like I am going to fall down.**

Doc.: You feel pains here, too.

Pt.: Yes. When I first complained to a doctor about it, I was told it was arthritis. I was also told it is an old age sickness; I am just 56. I treated it then but it came back.

Doc.: Arthritis does not go like that; it is a chronic disease.

Pt.: I didn't know.

Doc.: **What is your weight?**

Pt.: **Ko poju naa,** but I have forgotten. (It's not that much.

Doc.: Does anyone have arthritis in your family?

Pt.: My mother had it, but it manifested much later in her life.

The data contained copious instances of code alternation, and this confirmed that it can not be avoided during consultations in multilingual settings like this. In the extract above, the doctor employed code-switching to open the interview by mixing Yoruba with English but the patient changed the code to English in her response to the doctor's question as evident in the Pt.'s first emboldened contribution. Both Doc. and Pt. oriented to pragmatics here by continuing to use English in the rest of the extract, except for Pt.'s spontaneous reversion to Yoruba in her second emboldened contribution in the extract in response to Doc.'s interrogative: **"What is your weight?"** The pragmatic purpose of the Pt.'s refusal to respond to the Doc.'s interrogative in English in the first part of her esponse to the Doc's question was to make the Doc. know she could speak English well.

Doc. also started the interview in Yoruba to see if the patient was more proficient in that language than in English because choosing a language in which the patient is more fluent

would allow for a clearer explanation of the patient's health concerns, thus assisting the doctor to diagnose the patient correctly. In the data, there were additional instances of code mixing. As a result, the following extracts were examined:

Extract 112 (Interaction 60)

Doc.: Igba wo le ti **treat** iba gbehin? (When was the last time you treated malaria?)

Pt.: Mo si treat e ni **last month**. (I still treated it last month.) Bi mo se joko yii, ehin a de maa romi gan-an, ori a de maa fo mi. (As I sit, I feel headache and backache.)

Doc.: Kin le lo nigbati e **treat** e ni **last month**? (What drug did you take when you treated it last month?)

Pt.: Mo lo **Cyprotab**. (I took cyprotab.)

The Doc and the Pt jumbled codes at the word level in Extract 112. They used a combination of English terms (treat, last month, cyprotab) and Yoruba phrases to describe and learn about the patient's medical condition and the drugs he was taking. This assisted the doctor to make a diagnosis and provide appropriate therapy. The doctor used code-mixing to ensure that the patient understood all he said, especially since one of the English words (cyprotab) had no Yoruba equivalent. Doc. also used code mixing in this situation, most likely to mask his deficiency in Yoruba.

The pragmatic purpose of the doctors' and patients' use of code-switching and code-mixing in Extracts 111 and 112 above was to prevent communication breakdown because English cannot be avoided entirely when consulting with non-English-speaking patients because certain English expressions used in clinical discourse have no Yoruba equivalents, such as X-ray. Furthermore, even when available, they may not be able to adequately capture the idea that the Docs or Pts have in mind.

The pragmatic function of code alternation was to make the discourses explicit, reciprocal, informative, and understandable. Its use enabled the doctors to accommodate the patients' linguistic bckgrounds; its deployment also allowed the doctors to overcome

their linguistic limitations, too. As a result, they were able to fully comprehend the consultations.

To make the discourses more understandable, the Docs and the Pts alternated the use of English and Yoruba in Extracts 110, 111, and 112. The code alternation was realised by switching between English and Yoruba intra-sententially and inter-sententially, as shown in the excerpts above.

4.4.1.5 Counselling for guidance, enlightenment and encouragement

A review of the data revealed that some patients engaged in health-harming behaviours. As a last resort, the doctors used counselling to prevent the patients from engaging in harmful health habits. This section covered examples of Docs using counselling as a powerful tool to advise patients on how to effectively maintain their health, to educate them on good health habits, or motivate them The following extracts were examined:

Extract 113 (Interaction 65)

Doc.: **Se e mo wipe ewu wa ninu ki eniyan maa fi omi gbigbona mora ko tun maa roomuu? (Do you know that it is harmful to have hot bath and also drink hot water?**)

Pt.: Rara. (No.)

Doc.: **Eyi maa nfa heart failure nigba okan ba nse ise agbara. (This causes heart failure when the heart overworks). Nitorinaa, ko dara. (So, it is not good.)**

Pt.: A ti gbo. (We have heard you.)

Extract 114 (Interaction 73)

Pt.: I was here last week and I was diagnosed with hernia.

Doc.: Are you better now with the drugs that we gave you.

Pt.: Yes.

Doc.: I believe you have been told an ailment of this nature is best treated surgically.

Pt.: Yes. But I don't want any surgery.

Doc.: Why don't you want to go for surgery?

Pt.: I am just scared of surgery.

Doc.: **There is nothing to be afraid about when we talk about surgery for minor ailments like this. What major discomfort do you feel now?**

Pt.: I suffer from constant stomach upset.

Doc.: Okay. Do you experience intermittent blockade during urination?

Pt.: Yes.

Doc.: **This recommended drug is just meant for prostrate enlargement. So, I advise you come back on time for the surgery. If it becomes an emergency issue, the doctors might say they don't have time for it again. So, take the drug as recommended and visit the hospital again in a month's time.**

Pt.: I have heard you, Ma. Thank you.

The use of counselling for the purpose of guidance and enlightenment was indicated in the excerpts above. In Extract 113, the doctor's emboldened contributions contain enlightenment and advice for the patient on the danger of taking hot water and also bathing with it. At 114, the doctor enlightened the patient on the safety of surgery and the need to not panic because of it. Doc.'s last contribution in the extract above also contains enlightenment on the drug recommended as well as a piece of advice for the patient to come back for surgery since it was the only known solution for hernia to avoid an emergency situation that could spell a doom for the patient.

According to the findings above, doctors used counselling to accomplish a variety of pragmatic functions, including advising patients where they displayed ignorance or a casual attitude toward health issues. The use of counselling allowed the doctors to educate and interact with the patients. Its deployment also aided in correcting patients whose religious practices were incompatible with their health, as well as urging a change in their

detrimental fasting and blood transfusion avoidance routines. The doctors used their faith (Islam) to address the patients' incorrect beliefs and practices.

Its deployment also provided the physicians with the opportunity to educate the patients on health-related issues and to teach them how to live a healthy life. The declaratives in the encounters were mostly used to provide information and direction, hence counselling was primarily realised by declaratives.

4.4.1.6 Answer and question for provision and elicitation of information for diagnosis

Verbal information is essential to complement laboratory tests and augment medical information for rich and accurate diagnoses. As a result, question and answer sessions are inescapable during diagnostic interviews as diagnosis is based, in part, on the elicitation and supply of information. Doctors must use questions to get relevant information from patients, and patients must respond in order to aid doctors in their investigation and treatment of the patients' problems. This section looked at how doctors obtained medical information from patients through direct and indirect questions, as well as how patients provided the necessary information through answer.

4.4.1.6.1 Direct Questions with Answers

In the investigation of the patients' health difficulties, direct questions were realised by interrogatives beginning with wh-elements, while replies were realised by declaratives. The accompanying extracts were studied .

Extract 115 (Interaction 58)

Doc.: Kinni ohun to seyin? (What is your complaint?)

Pt.: Ito mi maa n pon. (My urine is coloured.)

Doc.: Bawo lo se ri? (What does it look like?)

Pt.: O maa n dabi eje. (It looks like blood.)

Doc.: Se ko green? (Is it not green in colour?)

Pt.: Rara. (No.) Mo so fun brother mi to nsise ni UCH; Won sin i ki n lo se test. (I complained to my brother that works at UCH, Ibadan, and he asked me to go for a test.) Lehin test, won ni Schistosomiasis ni mo ni.(After the test, I was told I had schistosomiasis.

Doc.: Se won de ri schistosomiasi ninu e? (Was schistosomiasis sighted in it?)

Pt.: Beeni. (Yes.)

Extract 116 (Interaction 52)

Doc.: What are your complaints?

Pt.: I have a cough.

Doc.: Since when?

Pt.: About five days, and catarrh, too. But the cough is more than the catarrh.

Doc.: What drugs have you been taking to cure it?

Pt.: Nothing.

Doc.: Are you married?

Pt.: Yes.

Doc.: What is your age?

Pt.: 32 years.

One of the first diagnostic methods used by doctors to study the ailments of the patients was the direct question. Its use enabled the doctors to know how to intervene professionally in the patients' medical concerns. The physicians used direct questions to acquire information on the patients' social history (SH), family history (FH), history of present illness (HPI) and OAP (other active problems) in order to arrive at diagnoses, as seen in the excerpts above. In response, the patients used answer to provide the necessary information, thus making the consultations result-oriented.

The direct question served the pragmatic purpose of informing the patients that the information they were being asked for was critical to the diagnosis of their health problems and eventual healing. Patients were able to express their medical problems through answer to the questions. In conclusion, the direct questions in the consultations served the speech purpose of obtaining information for diagnoses.

4.4.1.6.2 Indirect questions with answers

During the consultations, statements were used to answer indirect questions. Indirect questions have the appearance of declaratives, yet they are basically interrogative. The accompanying extracts ere studied:

Extract 117 (Interaction 51)

Doc.: When was the last time you came to the hospital?

Pt.: This is the first time I have come.

Doc.: What is your complaint?

Pt.: I feel pains in my throat.

Doc.: **You have throat discomfort**. Any other complaints?

Pt.: I underwent surgery.

Doc.: **You feel something is there.**

Pt.: Yes.

Extract 118 (Interaction 65)

Doc.: **O o mora. (You don't dress your tummy with hot water.)**

Pt.: Beeni. (Yes.)

Doc.: O maa maa jo e lara. (You feel the hotness.)

Pt.: Beeni.

The main instrument in clinical interviews, according to Extracts 115 and 116, is eliciting and providing information. The use of indirect questions to gather information on the

patients' history of present illness (HPI) is evident from the doctors' contributions above. The contributions of the patients, on the other hand, provided answers to the questions posed by the doctors. The elicitation and supply of information in this case gave the physicians insights into the possible causes of and the true nature of the patients' medical challenges, thus enabling them to intervene professionally. The doctors primarily sought information about the patients' health problems, which the patients provided. This shows that both the doctors and the patients were reliant on each other when it came to oral diagnosis of ailments.

The direct and indirect questions were bolded in every instance. Direct questions appear in Extracts 116-117, whereas indirect questions appear in Extracts 117–118. The indirect questions' speech function was to make the interviews appear less interrogative, thereby enabling the patients who were obviously ill to find the exercise less stressful and, as a result, be encouraged to cooperate in releasing all of the information needed to unravel and solve their health concerns.The direct questions, on the other hand, performed the pragmatic (speech) function of letting the patients know that the information they were being asked for was critical to solving their health problems, thus enabling the doctors to treat them.

The answers naturally followed the questions as they served the pragmatic purpose of delivering the information needed to make diagnoses. Because the consultations were strictly investigative, their deployment was unavoidable. They supplied the diagnostic "raw materials". The answers were the things the doctors needed to make diagnoses, and without them, it was impossible for them to acquire insights into the patients' health challenges unless they conducted laboratory tests on them, as the extracts above demonstrated.

In light of the fact that some health concerns are mainly investigated through elicitation of information (question) and delivery of information (answer), question and answer are very essential diagnostic implements used during consultations. Direct questions were realised by interrogatives containing subject-verb inversion, while indirect questions were realised by declaratives, as shown in the samples above. The indirect questions, however, have the illocutionary power of interrogatives. Declaratives were used to create all the answers.

4.4.1.7 Closing for concluding the discourses

After gathering information on the patient's chief concern (CC), history of Present illness (HPI), family history (FH), and social history (SH), the consultations needed to be wrapped up so that the patients could either go get some medicines, or do both. The patients exploited closing to create this opportunity. Expressions of gratitude and welcome in the data were used to bring the consultations to a close. A comprehensive examination of the data found that a variety of strategies were used to end doctor-patient meetings, but the most used were comments like: 'Goodbye' and 'Thank you,' which were spoken by the patients after the doctors had prescribed tests or drugs. Here, I attempted to analyse how these closure tactics were used in the discourses.

Extract 120 (Interaction 57)

Doc.: So, e maa lo ra awon oogun yii. (So, you will go get these drugs.) E loo bi won ba ti ni ki e loo. (Take the drugs as directed.) E sit un maa se awon ayewo yii, e maa mu esi won wa nigbati e ba n pada bo.(You will also run these tests and bring the result along when coming for the next visit.)

Pt.: **E see. (Thank you.)**

Extract 121 (Interaction 59)

Doc.: O daa. (It is alright.) E maa se abdominal scan lati mo ohun to n sele. (You will do abdominal scan to know what is happening.) Ti e bat i gba esi re, e maa mu wa. (You will bring the result when it is out.) Eyi lo maa je ka mo ohun to n sele. (This will tell us what is actually happening.)

Pt.: **O dabo, Ma. (Byebye, Ma.)**

Extract 122 (Interaction 61)

Doc.: E maa lo si chest clinic yen. (You will go to chest clinic.) Won maa se test fun yin. (A test will be done for you there?) Won tun maa so ijo ti e maa pada wa. (You will also be told when to come back.) Ofe ni gbogbo e. (Everything is free.)

Pt.: **E see, Ma. (Thank you, Sir.)**

In all the extracts, the patients closed the dialogues most of the time, but the doctors also closed them occasionally. Following receiving the doctor's final comments and prescription, the patient concluded the consultation by saying: "Thank you" (E see.) in Extract 120 (Interaction 57). Similarly, after the doctor's final instructions, the patient in Extract 121 (Extract 59) terminated the conversation with the expression 'O dabo, Ma.' (Bye bye, Ma.). Following the doctor‘s prescription of a test, the patient said, "E see, Ma." (Thank you, Ma.) to end the interview in Extract 122. According to the findings, the patients ended the conversations with statements such as 'Thank you, Sir,' 'Bye bye, Sir,' and occasionally, with prayers such as 'God bless.' The use of the above-mentioned terms to end the clinical interviews resulted in appropriate interview conclusions.

Closing served the speech purpose of bringing each of the consultation sessions to an end, as seen in the analyses and discussions above. The conversations could not but come to an end at some point. Evidenced by the excerpts above, closing signalled the conclusion of the consultations, as indicated by the bolded expressions. In general, the last discourse device used in all the consultations was closing. Declaratives were used to realise it grammatically.

4.4.1.8 Modality for showing asymmetry of knowledge and power, obtaining medical information, and answering doctors' questions

The findings on the pragmatic functions of modality as deployed by the doctors and patients in our data were discussed here. The analysis done here focused mainly on epistemic modality.

4.4.1.8.1 Pragmatic functions of epistemic modality

(i)Statement for expressing asymmetry of power and knowledge

Extract 123 (Interaction 51)

Doc.: Don't you have diabetes?

Pt.: I don't know. My heart tends to palpitate sometimes.

Doc.: Ok. You **will have to** do some tests. The test will cost about ten thousand naira. Can you do all the tests now?

Pt.: No.

Extract 124 (Interaction 62)

Doc.: Awa o le gba scan yii toripe awon to see kii se doctor. (We cannot accept this scan because the people that did it are not doctors.) Anilati tun–un se ka le mo ohun to nsele gan-an. (We **have to** repeat it to know what is actually happening.)

Pt.: O daa. It is okay.)

Doc.: So, waa lo se scan nibeyen. (So, you will go do the scan there.) Bakannaa, a tun maa se ayewo ohun to njade loju ara e. (In addition, we will do a swab test for the discharge coming out of your private part.) Lo se awon test yii koo pada wa. (Go do these tests and come back afterwards.)

Two modals (**will have to** and **have to**) were examined in the extract above. Both of them expressed deontic necessity, conveying the highest degree of obligation of a command. The doctor employed **will have to** to emphasise the importance of a test to ascertain the actual cause of palpitation expressed by the patient. Similarly, Doc. also employed **have to** to show Pt. she had to repeat the test earlier done to enable him diagnose the patient's health challenge appropriately.

The doctor's medical knowledge and +higher role status enabled him to subtly command the patient to undergo some tests. The deployment of **will have to** and **have to** in the extracts performed the pragmatic function of expressing command to stress the inevitability of the tests in an attempt to guarantee proper treatment for the patient's medical challenges. The deployment of **will have to** and **have to** here thus performed the pragmatic function of showing the patient he was an authority in the discourse situation, in addition to giving a command.

(i) Questioning for obtaining medical data

Extract 125 (Interaction 67)

Pt.: I have pains in my stomach.

Doc.: **Can** you eat well?

Pt.: No. I have not been able to eat since yesterday.

Doc.: You will have to run a test I will recommend now. When the result is out, you bring it here.

The modal auxiliary **can** (an instance of epistemic possibility) was used in Extract 125 (Interaction 67) above by the Docto investigate the Pt's ability to eat well to enable him diagnose the patient's medical challenge appropriately. In response, the patient told the doctor she had not been able to eat since the previous day. Beyond the discourse function of expressing epistemic possibility, **can,** by virtue of its deployment here, performed the pragmatic function of a subtle command.

(ii) Statements for expressing patients' answers to doctor's queries

Extract 126 (Interaction 70)

Doc.: Iwe ayewo so pe ki e se ayewo kelebe lati ohun to fa iko ti e nwu. (This form says you are to do sputum test.) Kin lo de ti e ko fi see? (Why didn't you do it?)

Pt.: Won ni ki ntu kelebe sugbon mi o ri kelebe kankan tu rara. (I was asked to cough out some phlegm, but I **couldn't** bring out anything.)

One of the instances of epistemic impossibility found in the data has to do with the patient's use of **couldn't** in the extract above to answer the doctor's question on why he did not do the sputum test earlier recommended. The deployment of **couldn't** revealed the patient's effort to comply with medical instruction and performed the pragmatic function of expressing the patient's inability to produce the sample needed for the test.

Extract 127 (Interaction 44)

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 beneficial only if it does not harm your health. You are aware that I am also a Christian. If our health cannot handle fasting, we can refrain from doing so. It is permitted by the Bible. To understand this, you must read your Bible more.

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

The extract above offers an instance of epistemic impossibility expressed through the deployment of the modal auxiliary verb **can't** by the patient. It served the pragmatic purpose of expressing the patient's inability to abstain from fasting in spite of the negative effects it had on his health.

Beyond the epistemic modality's speech function of expressing possibility/impossibility or probability, it performed the pragmatic function of expressing certainty and uncertainty in the various medical contexts above.

4.4.1.9 Face-threatening acts

It was realised in the consultations by face-threatening acts (FTAs) with redress (positive politeness) and FTA without redress (negative politeness) through reprimand, frank talk, direct and indirect expressions, and courteous expressions in the data. The deployment of the FTAs accompanied the doctors' diagnoses. Politeness was examined here to reveal how the patients' face was threatened with redress and without redress, and how the diagnoses were presented courteously. Additionally, efforts were made to establish the extent of the effectiveness of the face-threatening acts in the consultations.

4.4.1.9.1 FTAs without redress (negative politeness) for giving diagnoses, correcting and checking unwholesome health practices

Negative politeness was realised by reprimand, courteous expressions and frank talk. The effectiveness of face-threatening acts without redress in the discourse situation was examined here. The extracts below were considered:

Extract 128a (Interaction 60)

Doc.: Iba iru wo le loo fun? (What sort of fever did you take it for?)

Pt.: Ti iba bati mumi ni mo nlo. (I take it anytime I have fever.)

Doc.: **Se cyprotab wa je oogun iba**? (Is cyprotab a malarial drug?) E lo se awon test yen. (Go do those tests). Ti e bati see, aa mo ibi to ku si. (After you have done it, we will know what to do.) Taa lo ni ki e maa lo gbogbo oogun bayii. (Who recommended these drugs for you?)

Pt.: Ohun naa lo je ki n wa, maa le mo ohun to n sele. (That's why I came so that I might know what is happening.)

Doc.: E lo se awon test yen. (Go do those tests.)

Pt.: E see. (Thanks.)

Extract 128b (Interaction 53)

Pt. Rel.: This is the letter we were given.

Doc.: **The test result says he is HIV positive.**

Pt. Rel.: Hmnnn

Doc.: Is that why you came?

Pt. Rel.: Yes.

Doc.: Does he have any other complaints?

Pt. Rel.: I only came to know what I can do about it.

Doc.: **OK. We need to confirm that he is truly HIV positive. So, you will take this test prescription to the laboratory over there.**

Pt. Rel.: Yes, Ma.

Doc.: So, bring back the result when it is out.

Doc.'s foregrounded contribution at 128a showed that the Doc. threatened the Pt.'s face by politely condemning the patient's habit of taking cyprotab (an antibiotic) any time she had malaria instead of an anti-malarial drug and also recommended some medical tests to know the root cause of the Pt's medical challenge. The purpose of the FTA was not only to inform the patient it was wrong to take antibiotics instead of antimalarial drugs but to also let him know that self-medication is dangerous. This, therefore, accounts for why the doctor recommended some medical tests for him to know the particular ailment he suffered from. Thus, the doctor did not lessen the condemnation of the patient's self-medication practice.

The speech function of the FTA with redress was not to only reprimand the patient for attempting self-medication erroneously but to also teach him to steer clear of practices that could cause a catastrophe for his health. Therefore, the doctor threatened the Pt's face without mitigation by criticising him for not going to a hospital to get appropriate medical attention instead of indulging in self-diagnosis and self-medication.

In Extract 128b, Doc. did not mitigate the diagnosis as she told the patients the test result claimed the patient was HIV-positive. The doctor was very direct in the release of the diagnosis. The pragmatic function of the face-threatening act (negative politeness) here was to enable the patient know the severity of his condition so that he should take his treatment serious. Face-threatening act without redress (negative politeness) was realised across the consutations by interrogatives and declaratives.

4.4.1.9.2 FTA with redress (Positive politeness) for tactfully obtaining information for diagnosis, allaying fears and correcting unwholesome health practice.

FTA with redress was realised by courteous expressions, mitigated threats, direct and indirect talks throughout the consultations. This study discovered that the doctors threatened or minimised the threat to the Pts' faces by speaking indirectly about their ailments, either as a one-time or long-term behaviour. This happens occasionally during consultations, following which doctors use FTA (Positive Politeness). Patients' true health issues are sometimes withheld from them, too, for reasons best known to physicians. In our data, majority of the FTAs with redress (positive politeness) appeared as mitigated threats, courteous expressions, indirect expressions, and direct expressions.The following extracts were examined.

Extract 135 (Interaction 64)

Pt.: **Beeni, osu kesan odun ni mo see. (Yes, I did it in the ninth month.) Nnkankan o se mi mo. (Nothing is wrong with me again.) Mo kan ni ki n wa gboogun ni. (I only came to collect drugs.)**

Doc.: **A o kan le fun yin loogun laisepe a se test fun yin. (We can't just give you drugs without test.)**

Pt.: Ah. Mi o mo. (I didn't know.)

Doc.: **E wa laaro ola lati se test yii. (Come tomorrow morning for the test.) A o le fun yin ni oogun Kankan bayii, sugbon e le maa lo eyi ti e ni lo. (We can't give you any drugs, but you can continue taking the ones you have.)**

Pt.: E see.

In Extract 135, the doctor deployed a polite (courteous) expression to correct the Pt's habit of requesting for drugs without diagnosis. The doctor felt it was wrong for the patient to have such a mind-set because diagnosis must come before drug prescription. Obviously, the patient employed this method to quicken her treatment. The doctor, therefore, deployed the FTA to guide the patient rightly and enlighten her on the inappropriateness of asking for drug prescription before diagnosis.

Extract 136 (Interaction 65)

Doc.: **Se e mo wipe ewu wa ninu ki eniyan maa fi omi gbigbona mora ko tun maa roomuu? (Do you know that it is harmful to have hot bath and also drink hot water?)**

Pt.: Rara. (No.)

Doc.: **Eyi maa nfa heart failure nigba okan ba nse ise agbara. (This causes heart failure when the heart overworks). Nitorinaa, ko dara. (So, it is not good.)**

Pt.: A ti gbo. (We have heard you.)

Doc.: So, e maa lo se awon test yii. (So, you go do nthiese medical tests.) E de tun lo gba awon oogun yii. (You will also go collect these drugs.) Ti esi awon test yen bati jade, e mu wa. (Bring the test result when it is out.)

In Extract 136, Doc. threatened Pt.'s face for engaging in unwholesome health practices (drinking hot water and bathing with same) by using polite expressions. Courteously, the doctor drew the patient's attention to the impropriety of having a warmth bath and also drinking it, as well as the likely repercussion of the erroneous action (heart failure). In the consultations, the FTA with redress was grammatically realised by using a mix of interrogatives and declaratives. The deployment of the various face-threatening acts performed the pragmatic function of checking and correcting the patients' unwholesome health practices.

4.4.2 Research questions Three and Four: Which politeness maxims (PMs) are deployed in the consultations and what pragmatic functions do they perform?

The sympathy maxim, generosity maxim, tact maxim, and Pollyanna principle are among the politeness maxims (PMs) observable in the consultations.These were discussed in turn in the extracts below.

4.4.2.1 Tact maxim for permission and compassion

Realised by interrogatives and declaratives, tact maxim was deployed in the cnsultations. "Minimise cost to other, maximise benefit to other," it says. The majority of the Docs'

contributions demonstrated that they cared deeply about the patients. This accounts for why they gave them the opportunity to derive maximum benefits from their hospital visits, in spite of the fact that such visits meant additional work for the Docs. The extracts below were studied:

Extract 137 (Interaction 52)

Doc.: What is your age?

Pt.: 32 years.

Doc.: **Do you have any other complaints?**

Pt.: I feel itching all over my body, and I have taken lumartec.

Doc.: You will have to do a blood test.

Extract 138 (Interaction 53)

Doc.: Is that why you came?

Pt. Rel.: Yes.

Doc.: **Does he have any other complaints?**

Pt. Rel.: I only came to know what I can do about it.

In the extracts above, the doctors' contributions revealed that they had so much empathy for their cliients and wanted them to derive maximum benefits from their hospital visits. At 137, the doctor gave the patient the chance to disclose the remaining medical challenges confronted with to enable him treat all of them. Likewise in Extract 138, the Doc's bolded comment suggests he wanted his client to derive maximum benefits from the hospital visit. Undoubtedly, the offers meant more work for the doctors but they did not care because the well-being of the patients was paramount in their hearts. The tact maxim was grammatically realised by interrogatives in the extracts above and by declaratives in some other parts of the data. The tact maxim served the pragmatic purpose of showing compassion on the patients. ThIs enabled the patients to table all their

complaints and also enabled the doctors to offer them medically beneficial pieces of advice

4.4.2.2 Generosity maxim for compassion and advice

Generosity maxim served the pragmatic purpose of showing compassion on the patients and advising them in the data. More often than not, it was applied in the consultations involving the Docs and the Pts for the Docs reduced benefit to themselves and also maximised cost to themselves, too. The doctors, therefore, demonstrated a great concern for the patients' health. The extracts below were examined:

Extract 139 (Interaction 65)

Doc.: Se e mo wipe ewu wa ninu ki eniyan maa fi omi gbigbona mora ko tun maa roomuu? (Do you know that it is harmful to have hot bath and also drink hot water?)

Pt.: Rara. (No.)

Doc.: **Eyi maa nfa heart failure nigba okan ba nse ise agbara. (This causes heart failure when the heart overworks). Nitorinaa, ko dara. (So, it is not good.)**

Pt.: A ti gbo. (We have heard you.)

Doc.: So, e maa lo se awon test yii. (So, you go do nthiese medical tests.) E de tun lo gba awon oogun yii. (You will also go collect these drugs.) Ti esi awon test yen bati jade, e mu wa. (Bring the test result when it is out.)

In the emboldened contribution in Extract 139, Doc. showed a great concern for the patient's health by giving him useful medical advice. Doc. explained the danger inherent in having warm baths and also drinking hot water. Docs. succeeded in providing highly valuable medical advice to the Pts while also demonstrating empathy by employing the maxim in the Docs' bolded remarks in the samples above. In the consultations generosity maxim was realised by imperatives and declaratives grammatically.

4.4.2.3 Sympathy maxim for guidance, encouragement, empathy and advice

The sympathy maxim performed the pragmatic function of guidance, advice and pity in several of the consultations. Its deployment revealed that the Docs. empathised with the Pts. over some appalling medical challenges. Some of the contributions made to observe the maxim were found in the following extracts:

Extract 140 (Interaction 73)

Pt.: I was here last week and I was diagnosed with hernia.

Doc.: **Are you better now with the drugs that we gave you.**

Pt.: Yes.

Doc.: **I believe you have been told an ailment of this nature is best treated surgically.**

Pt.: Yes. But I don't want any surgery.

Doc.: Why don't you want to go for surgery?

Pt.: I am just scared of surgery.

Doc.: **There is nothing to be afraid about when we talk about surgery for minor ailments like this. What major discomfort do you feel now?**

Pt.: I suffer from constant stomach upset.

Doc.: Okay. Do you experience intermittent blockade during urination?

Pt.: Yes.

Doc.: **This recommended drug is just meant for prostrate enlargement. So, I advise you come back on time for the surgery. If it becomes an emergency issue, the doctors might say they don't have time for it again. So, take the drug as recommended and visit the hospital again in a month's time.**

Pt.: I have heard you, Ma. Thank you.

In the extract above, Doc. demonstrated empathy for the patients' medical condition and, consequently, advised him on how best to take care of his health in order to avoid health

crises. The doctor used this politeness maxim to protect the patient against the emergency health challenges associated with avoiding surgery when it was the only intervention available for his health condition. The deployment of the sympathy maxim performed the pragmatic function of offering guidance and encouragement to the patient.

4.4.2.4 Pollyanna principle - The ethical positivity tendency: To open up discourses

In the data, the Pollyanna principle was also seen at work.The incidence of the Pollyanna principle reveals that medical consultation focuses on the positive aspects of life rather than the unpleasant. This phenomenon arose from contextual views based on medical ethics and the patient-society's perception of doctors. Medical ethics demand that Docs use their professional expertise to treat patients, whether directly or indirectly, and not to harm them physically or psychologically. Similarly, patients also expect that doctors would attend to all their physical, emotional and medical wants. The Pollyanna principle is theorised to have three tendencies: referential or hinting tendency, ethical positivity tendency, and euphemistic tendency. However, only the ethical positivity tendency characterised the consultations studied.

Ethical positivity tendency, one of the Pollyanna principle tendencies, emphasises the ethical expectations of patients from doctors, especially in areas of sympathy, assurance, reassurance and medical care, etcetera. The ethical positivity tendency is concerned with doctors' contextual beliefs based on the patients' and society's perspectives because the hospital is regarded as a place of healing and relief by the patients and the general public. The Pts see the Docs as health givers. Therefore, they hold them in very high regard as a people to whom they can entrust their healthsecrets. According to Maboyeje ((1982:11) cited in Odebunmi, 2003), the health vocation also shares this vista:

> 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.

However, it is worth noting that some patients willfully restrict doctors access to medical information for reasons only they know about. All patients feel that doctors would provide

them with adequate care and empathetic attention.The data is replete with instances of this phenomenon as observable in the extracts below:

Extract 141 (Interaction 73)

Doc.: What is your complaint?

Pt.: **I was here last week and I was diagnosed with hernia.**

Doc.: Are you better now with the drugs that we gave you.

Pt.: Yes.

Extract 142 (Interaction 68)

Doc.: Kin lo se omo yin? (What is wrong with your child?)

Pt. Rel.: **O nyagbe sisan; igbe yen sipo gan-an ni. (She is running stool and it's so much.)**

Doc.: Ati ojo wo lo ti nyagbe?(Since when has she been running stool?)

Pt. Rel.: Lati ijarun. (Five days ago.)

Doc.: kin lo wa ninu igbe yen? (What is in the stool?)

Pt. Rel.: Kosi nnkankan nibe. (Nothing.) Omi lasan ni.(It's just water.)

Doc.: Omi lo wa nibe. (It's just water.)

As can be seen in the emboldened contributions of the patients in the extracts above, the use of the ethical positivity tendency made it possible for the patients to freely explain their ailments to the doctors as they had so much confidence in the doctors' ability to offer solutions to them. Complementarily, the Docs responded to the patients' trust in their abilities by prescribing one type of medication or the other treat their sicknesses. The deployment of the ethical positivity tendency served the pragmatic purpose of assisting the patients to open up on all their health challenges. It was grammatically realised by single words and declaratives.

ANALYSIS AND DISCUSSION OF THE DISCOURSE DEVICES AND PRAGMATIC FUNCTIONS IN DOCTOR-PATIENT CONSULTATIONS AT THE GENERAL HOSPITAL, KABBA, KOGI STATE

4.5 An overview of the section

Based on the data collected at the General Hospital in Kabba, Kogi State, the pragmatic functions of the various discourse devices and politeness maxims employed in consultations were investigated in this chapter. As a result, both the doctors' and patients' discourse devices and politeness maxims were studied.

4.5.1 Research questions One and Two: Which discourse devices are employed in doctor-patient consultations and what pragmatic 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 the doctors and patients alike employed to overcome the challenges. Discourse devices are used to realise the goals of verbal interactions. Therefore, in this study, they were realised by phatic communion, direct question, indirect question, answer, code alternation, face-threatening acts, circumlocution, rapport expressions, modality, counselling and closing.

4.5.1.1 Phatic communion for opening discourses and showing empathy

Given the delicate nature of medical consultations, a poor opening might jeopardise the outcome of any medical consultation. The physicians in this study used phatic communion at the start of most consultations to make the communication effective. During the consultations, it was typically demonstrated by showing empathy, greetings, and doctors inquiring about patients' well-being and social lives. Both the doctors and the patients used phatic communion to begin the clinical interviews in this study. The following extracts were studied:

Extract 143 (Interaction 76)

Doc.: **Kinni oruko e? (His name, please?)**

Pt.: Samuel Audu.

Doc.: Kinni ohun to see? (Could you tell me his health challenges?)

Extract 144 (Interaction 78)

Doc.: **How are you?**

Pt. Rel.: Fine.

Doc.: What's the name?

Extract 145 (Interaction 81)

Doc.: **I like your glasses.**

Pt.: Thanks, Sir..

Doc.: Have you taken your breakfast?

Extract 146 (Interaction 92)

Doc.: **Adewale Adeyemi!**

Pt.: Good morning, Ma.

Doc.: What is the problem?

A close examination of Extract 143-146 revealed that the doctors used phatic communion to begin conversations with the patients during the consultations. The doctor began the consultation with the patient in Extract 143 (Interaction 76) by using an indirect interrogative ('His name, please?') to learn the Pt's name. Doc greeted the patient, using an interrogative (How are you?) to start the consultation in Extract 144 (Interaction 78). Doc. began the interview with a declarative ('I like your glasses?') in Extract 145 (Interaction 91). In Extract 146 (Interaction 92), the doctor began the consultation by calling the patient's name (Adewale Adeyemi). The deployment of salutation, non-medical questions, expression of like for the patient's glasses and the calling of the patient's name during the consultations set the stage for a comfortable start of the clinical interviews. It

should also be emphasised that, as seen in the data, there were instances where patients initiated the consultations, primarily through the use of salutation. From the preceding discussions, it is evident that the doctors used a variety of tactics to begin their consultations with the patients.

The patients' appearance, consultation period, and African culture which requires salutation at the start of any talk together influenced their choices. From the following, it is obvious that greetings, interrogatives, proper nouns (patient names), and emotive expressions were used to begin the consultations with the patients, whereas the patients only used greetings or complaints (declarative). It served the pragmatic purpose of breaking the ice and creating an environment conducive for a smooth start of the consultations and preparation for the real diagnostic process.It also doused the tension generated by the Pts' ailments.

4.5.1.2 Circumlocution for providing clues to diagnosis of ailments

Majority of the patients had trouble knowing the nomenclatures of their diseases. As a result, they resorted to circumlocution. It was primarily used by patients during the consultations. Majority of the patients in this study appeared to be circumlocutory in their explanations of their ailments. They mentioned the symptoms rather than giving the particular names of their ailments. More often than not, this was due to their lack of understanding of the proper medical terminologies for their medical issues.There are copious instances of this phenomenon in the consultations. The accompanying extracts were studied:

Extract 147 (Interaction 76)

Pt.: Samuel Audu.

Doc.: Kin lo see? (What is wrong with her?)

Pt.: **Ara e ngbona? (He has high temperature.)**

Doc.: Lati igba wo? (Since when?)

Extract 148 (Interaction 85)

Pt.: **Ori nfo mi; ara de ndun mi. (I have a headache, and I also feel pains all over my body.)**

Doc.: Okay.

Pt.: **Aya de tun ndun mi. (I also feel chest pains.)**

Doc.: Se e ti se X-ray e? (Did you take an X-ray of it?)

Pt.: Beeni. (Yes.)

Doc.: **Se ko seyin bi iba? (Don't you feel feverish?)**

Pt.: Igba miran, o maa nse bee. (I do feel so sometimes.)

Extract 149 (Interaction 87)

Doc.: What is your complaint?

Pt.: **I can't breathe properly.**

Doc.: **Do you cough out phlegm?**

Pt.: Yes.

Doc.: **You will do all these tests. This one is X-ray.** You will take this to the Pharmacy.

Pt.: Okay.

The patients typically reported the symptoms of their ailments as if they were the true illnesses they were suffering from, according to the samples above. The fact that illnesses come in a variety of forms becomes clear from experience as humans. As a result, it is not uncommon for typhoid patients to complain of severe headaches, diarrhea, or high body temperatures, and patients who are not medical professionals may be unaware of the specific ailments they are experiencing. They would just be aware of the symptoms. As a result, all the Pts' bolded contributions in the preceding extracts are symptoms of illnesses whose real names the patients were unaware of. However, by mentioning these symptoms, the doctors were able to learn more about the patients' health problems.

Examining Extract 148 in particular: “Pt.: (**Ori nfo mi; ara de ndun mi. (I have a headache, and I also feel pains all over my body.) Aya de tun ndun mi. (I also feel pains in my chest.)),** the doctor's accompanying question in the same extract confirmed the patient's emboldened contribution was an indication of fever, not the real illness**: (Se ko seyin bii iba?)I (Don’t you feel feverish?).** As a result, when the true causes of the problems are addressed medically, the problems vanish. All the symptoms listed by the patients in the contributions above as diseases, such as headaches, high body temperatures, foot cramps, body discomfort, chest pain, and difficulty to breathe properly, were just signs of certain diseases, not the diseases themselves, which the doctors recognised.

The depolyment of circumlocution by the patients served the pragmatic function of providing clues to the patients' diseases' diagnosis. Patients were able to do this by describing the signs of their health challenges as a result of their limited or complete lack of medical expertise. By using circumlocution, the doctors were able to gain insights into the health concerns of the patients. Declaratives were used to realise circumlocution because it was intended to provide medical information from which doctors might make diagnoses.

4.5.1.3 Rapport expressions for geniality, empathy and acceptance

Doctors' antagonistic comments have the potentials to prevent patients from disclosing key medical information required for accurate diagnoses. The physicians in this study were able to overcome this obstacle by using rapport expressions. A careful examination of the data revealed that statements, indirect questions, and Wh-questions were used to realise rapport expressions. The use of rapport expressions for solidarity, empathy, and cordiality was critical since it enabled the doctors to become acquainted with and fraternise with the patients. The expressions of rapport were also intended to encourage open conversation between doctors and patients in order to gather accurate medical information that would help them make diagnoses and, eventually proffer prescriptions or treatment. I looked at the accompanying extracts:

Extract 150 (Interaction 77)

Doc.: **What is your name?**

Pt.: Olaide Ibraheem.

Doc.: **Kini age re**. (What is his age?)

Pt.: Two years.

Extract 151 (Interaction 86)

Doc.: **What is your position in your family?**

Pt.: I am the second child.

Doc.: Why are you here today?

Extract 152 (Interaction 94)

Doc.: Oke Hanath!

Pt.: **E nle, Sir, o. (Sorry, Sir.)**

Doc.: A dupe. (Thanks.) Se ko si ti a ri yin o? (What is the reason for your coming?)

The Docs ensured geniality with the Pts, using rapport expressions, according to the samples above. The doctors were able to be friendly as a result of their deployment. Doctors also used oral information gathering on both family history (FH) and social history (SH) to foster conviviality and open conversation, as shown in the extracts above and throughout the data. In Extract 150, the Doc employed an investigation into the patient's social history (SH) to establish some level of familiarity with the patient, thus enabling him to speak up on all his health issues. To encourage open dialogue, Extract 151 included a search into the patient's family history (FH).

The rapport expressions served the pragmatic purpose of encouraging open conversation and engendering conviviality between the doctors and the patients, while also engendering familiarity between them. Their use enabled the doctors to communicate with the patients

on the same wavelength, which enabled them to create a friendly environment in which patients would be more willing to divulge all the medical information needed to appropriately diagnose their illnesses.

Rapport expressions were used to gather information and deliver it by the doctors or patients, as the occasion dictated. They were realised by interrogatives and, occasionally, by declaratives in the consultations.

4.5.1.4 Code alternation for informativity, explicitness and mutuality

In the multilingual context of this study, certain patients' proficiency in only a code and the doctors' inability to discover second language equivalents for particular medical terms created a barrier. Patients and clinicians used language switching to tackle this challenge, which was necessary given the multilingual setting. It was achieved by combining Yoruba and English, as well as using Pidgin English within and across the exchanges. The numerous linguistic choices they made were analysed and debated because this is crucial for determining how successfully the codes were employed and determining the pragmatic purposes they served.

Relating the above to our data on doctor-patient consultations in the North-Central and South-West geo-political zones of Nigeria, it was 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 examined:

Extract 152 (Interaction 83)

Doc.: Adeniran Bose!

Pt.: Good morning, Ma.

Doc.: Good morning. What is your complaint?

Pt.: Pain in the abdomen.

Doc.: Where is the pain now?

Pt.: Here. (Touches her abdomen)

Doc.: Have you finished your drug.

Pt.: No. I still have some left for today.

Doc.: Just for today?

Pt.: Yes.

Doc.: Okay. Go get these drugs.

Pt.: What about the X-ray?

Doc.: There is nothing there. All you have is just ulcer.

Pt.: Thank you, Sir.

The doctor in the excerpt above greeted the patient and inquired about her health concerns in standard British English, having deduced from her physique that she was educated. The patient replied in the same language, and the entire interview was carried out in that language.

Extract 153 (Interaction 78)

Doc.: How are you?

Pt. Rel.: Fine.

Doc.: **What's the name?**

Pt. Rel.: Cornelius Judith.

Doc.: **What is happening? Does she have catarrh?**

Pt. Rel.: **Yes.** Ati wa ni bii two weeks ago. (We came about two weeks ago.)

Doc.: Oogun wo la ko fun-un? (What prescriptions were you given?)

Pt. Rel.: E ko oogun fun-un. (You prescribed some drugs for him.)

Doc.: Se a se **blood test** lojo tee wa yen? (Did you do blood test on the day?)

Pt. Rel.: Beeni. (Yes)

Doc.: A rii pe o ni malaria. (We can see you have malaria.)

Pt. Rel.: Beeni. (Yes.)

Doc.: **Did we give him any injection?**

Pt. Rel.: **No.**

Doc.: **Okay. Let me write the drugs to buy. If there is still any complaint, kindly bring him back.**

Pt. Rel.: **Thank you, Sir**.

In the excerpt above, the doctor used the Standard British English (SBE) to begin the interview and acquire information about the patient's social history (SH) and chief concern (CC) in order to determine the patient's health problem. The patient answered all the doctor's questions in the same language, but after answering a question about whether the patient had catarrh, the patient abruptly changed to Yoruba to provide more information on Pt. and Pt. Rel's previous visit to the hospital. Until it was time to offer recommendations, Doc. continued the interview in Yoruba. The pragmatic purpose of the Pt. Rel's abrupt switch from English to Yoruba was to implicitly inform Doc. that she was much cleverer in Yoruba than English, because using a language in which the patient is more proficient would allow for a clear explanation of the patient's medical challenges, thus enabling the doctor to understand the patient's health challenges.

In the data, there were additional instances of code mixing. As a result, the following extracts were studied.

Extract 154a (Interaction 88)

Doc.: **Complaint** yin? (What is your complaint?)

Pt.: Mo loyun mo de maa nri eje diedie losoosu. (I am pregnant but yet menstruate.)

Doc.: Nigbawo lese nnkan osu gbehin? (When was the last time you menstruated?)

Pt.: Osoosu. (Monthly)

Doc.: Bawo le se wa mope e loyun? (How did you know byou are pregnant?)

Pt.: Mo ti loo se **test** ni. (I had a pregnancy test.)

Doc.: Se e see losu to koja? (Did you menstruate last month?

Pt.: Beeni. (Yes.) Mo tun se losu yii. (I also menstruated this month.)

Doc.: Se e ti se **pregnancy test** ati **scan.** (Have you done pregnancy test and scan?)

Pt.: Beeni. (Yes.)

Doc.: E je ki nwo **scan** teeya. (Let me see the scan result.)

Extract 154b (Interaction 90)

Pt.: Ara maa nro mi. (I have pains.) Igba mii, mo le sun, mo de le ma sun. (Sometimes I don't sleep.) Igba miran, araa mi de maa maa **warm.** (Sometimes too I have high temperature.)

Doc.: Igbawo le se nnkan osu gbehin? (When was the last time you menstruated.)

Pt.: Mo se ni this **month**. (This month.)

Doc.: Oogun wo le ti lo? (What drugs have you taken?)

Pt.: Mo lo **anacin, cyprotab**. (I took anacin, cyprotab.)

Doc.: Oogun wo le lo last? (What drug did you take last?)

Pt.: Mi o ti e mo. (I can't remember.)

Doc.: E maa se test. (You do a test.)

Pt.: Igba mii, o maa maa re mi. (Sometimes, I feel very weak.)

The doctors and patients in Extracts 154a and 154b mixed codes at the word level. They used a combination of English words (complaint, test, pregnancy test, scan, month, anacin, cyprotab) and Yoruba phrases to explain and learn about the patient's medical condition

and the medical tests they had done to help the doctor make a diagnosis. The doctors and patients were definitely mixing codes to communicate with one another, especially because some English words have no Yoruba equivalents.

The pragmatic function of the doctors' and patients' code-switching and code-mixing in Extracts 153, 154a, and 154b was to avoid communication breakdown because English cannot be avoided entirely when consulting with non-English-speaking patients as certain English expressions used in clinical discourse, such as X-ray, scan, ultrasound, and so on, have no Yoruba equivalents. Furthermore, when available, they may not be able to adequately represent the concept that the doctors or patients have in mind. Similarly, patients who were not very proficient in English shifted to Yoruba to hide their language inadequacies and speak intelligibly, as seen in the data.

The pragmatic function of the code alternation was to make the dialogue informative, explicit, comprehensible, and mutual. Its use assisted the physicians to accommodate the patients' linguistic deficiencies. It also allowed the doctors to overcome their linguistic shortcomings. As a result, they were able to fully comprehend the consultations. Code alternation was realised intra-sententially and inter-sententially through the alternation of English, Yoruba, and Pidgin English, as seen in the excerpts above.

Both the doctors and the patients employed Yoruba and English to make the discourses more understandable in Extracts 153 and 154a and 154b above. Code alternation was accomplished by switching between English and Yoruba intra-sententially and inter-sententially, as shown in the excerpts above.

4.5.1.5 Counselling for guidance, enlightenment and encouragement

A review of the data showed that certain Pts were engaging in health-harming behaviours. As a last resort, the doctors used counselling to prevent the patients from engaging in harmful health habits. This section covers examples of doctors using counselling as a tool to advise Pts on how best to manage their health, teach them the best health practices, or encourage them. I looked at the following extracts:

Extract 155 (Interaction 77)

Doc.: **E maa gbee si abe fan, ki e si maa fun ni nnkan ti ko gbona mu. (Put him under a fan, and don’t give him something hot to drink.)**

Pt. Rel.: Mo ti gbo. (I have heard you.)

Extract 156 (Interaction 80)

Pt.: Check up ni mo kan wa fun. (I only came for check-up.)

Doc.: Check up le kan wa fun. (You only came for check-up.)

Pt.: Beeni. (Yes.)

Doc.: Igbawo loogun yin tan? (When did your drug finish?)

Pt.: O to ose kan. (About a week ago.)

Doc.: **E ma maa je ko tan ti e fi maa wa. (Don’t wait till your drugs finish before you come back.) To bati nku eyo meji abi meta ni ki e ti pada wa. (Come immediately you have about two or three doses left.)**

Pt.: Mo ti gbo ohun ti e so. (I have heard you.)

The use of counselling for the purpose of guidance and enlightenment was indicated in the excerpts above. In Extract 155, the Doc advised Pt. Rel. to put Pt. under a fan and to also avoid giving him hot food to prevent heightening the temperature. At 156, the doctor advised Pt. to avoid using up all her drugs before coming to the hospital to replenish her stock to avoid health crises that may occur as a result of not having the required drugs upon which her health depended.

The analysis revealed that some Pts were obsessed with particular religious practices that were harmful to their health. In order to stop the problem from worsening, the Docs in this study used the Pts' religious doctrines to educate them about the impropriety of some of the doctrines they practised. As a result, through the employment of Biblical and Quranic explications, the doctors, being co-religionists, used their religious beliefs used as a tool to accomplish particular pragmatic functions in the consultations. The focus of this study was on how using an informed explanation of the patients' religious beliefs, specifically,

belief in occultism, benefited the doctors in establishing solidarity with the patients, correcting them, and encouraging them. The accompanying excerpt were examined:

Extract 157 (Interaction 92)

Pt.: O nje ki eru bami. (It frightens me.)

Doc.: Kinni yen n ba e leru fun. (Why does it frighten you?) Se eru mba e pea won aye lo faa ni? (Are you afraid it is spiritually motivated?)

Pt.: Beeni. (Yes.)

Doc.: O nroo pe boya won ran-an si e ni. (You think it is an attack.)

Pt.: **Mo n roo pe boya owo aye ni. (I was thinking it was caused by some devilish people.)** Ati pe kekere ni o ti maa nse mi. (In addition, I have had it from birth.) Apa yii naa detun nyomi lenu. (This arm also hurts me.) Mo de tun check BP mi. (I also checked my BP.)

Dr.: Kinni won pe BP reading e? (What was your BP reading?)

Pt.: Won ni 146 over 60. (146/60.)

Doc.: Je ki n check BP e nisisiyii. (Let me check your BP now.) 130/100. Se o maa nse aisun? (Do you keep late nights?)

Pt.: Beeni. (Yes.)

Doc.: Aisun naa le faa. (Late nights could also cause it.)

Pt.: Mhn. Pajapaja naa tun maa n mumi lese. (I also feel cramps in my feet.)

Doc.: Se o njeun daadaa.(Do you eat well?)

Pt.: Normal.

Doc.: Normal. **Mo ro pe mo ti salaye fun e pe ohun to nse e kii se owo aye. (I believe I have explained to you you condition is not a spiritual attack. Near fibroma la maa n pee. (We call it near fibroma.) Ara maa n le nigbamii. (The body swells sometimes.)**

O le pada wa fun iyen. (You may come back later for that.) A le ba e wo baa sele yo kuro nibe. (We can remove the swelling surgically.)

Pt.: o daa. (Okay.)

The patient in Extract 157 believed in occultism. So, she erroneously attributed her health condition (near fibroma) that was purely medical to a metaphysical attack. However, the doctor was able to correct her erroneous impression by explaining to her that her health condition was purely medical as evident in Doc.'s emboldened contribution in the extract. Deploying his knowledge of medicine, he was able to allay the patient's fear of a spiritual attack. The deployment of the doctor's religious belief in the form of counselling enabled the Doc. to enlighten the Pt. The counter-explanation given by the doctor performed the pragmatic function of enlightening the patient and allaying her fears.

The use of counselling performed the speech function of guiding the patients in the right direction. By deploying it, the physicians were also provided the opportunity to educate the Pts on health-harming actions and attitudes, as well as teach them how to live a healthy life.Grammatically, declaratives primarily realised counselling as it was used to provide enlightenment and guidance.

4.5.1.6 Answer and question for provision and elicitation of information for diagnoses

Verbal information is essential to complement laboratory test and augment medical data for rich and accurate diagnoses. As a result, question and answer are unavoidable during diagnostic interviews as diagnosis is based partly on the elicitation and supply of information. Doctors have to use questions to get relevant information from patients, and patients need to respond for the purpose of aiding the Docs in their diagnosis and treatment of the patients' health challenges. This part looked at how the doctors obtained medical information from the patients through direct and indirect questions, as well as how patients provided the necessary information through answers.

4.5.1.6.1 Direct questions with answers

Grammatically, in the investigation of the patients' health difficulties, direct questions were realised by interrogatives beginning with wh-elements, while replies were realised by declaratives. I looked at the following extracts.

Extract 158 (Interaction 76)

Doc.: Adenekan Yussuf!

Pt.: E kaaro, Ma. (Good morning, Ma.)

Doc.: Kinni ohun to se e? (What is wrong with you?)

Pt.: Aya mi nja gan-an. (I have palpitations.) O de tun ntami. (I also have heart burns.)

Doc.: Kin lo feel pe o le maa faa ki aya maa ja e? (What do you think is likely to be the cause of this palpitation? Ise kin lo n se? (What is you occupation?)

PT.: Fashion designing.

Doc.: Lati bii igbawo ni aya e ti nja ? (When did you begin to have the palpitation?)

Pt.: Bii two weeks. (About two weeks ago.)

Doc.: Se eni Kankan ko gbe ise fun e ti o ko tii se? (Don’t you have a paid job you have not delivered?)

Pt.: Rara. (No.)

Doc.: Kin waa lo ro pe o le faa? (What then do you is likely to be the cause?)

Pt.: Mi o mo. (I don’t know.) Sugbon , se e ri kinni to le si mi lara yii le faa. (But can you see the swellings on my body?)

Extract 159 (Interaction 16)

Doc.: What is the problem?

Pt.: I urinate too frequently.

Doc.: How many times in a day?

Pt.: About thirty times.

Doc.: What about before daybreak?

Pt.: Almost the same number of times.

Doc.: When did you start to urinate too frequently?

Pt.: At the beginning of this month.

Doc.: Do you feel a burning sensation during urination?

Pt.: Yes.

Doc.: Is anyone in your family diabetic?

Pt.: No.

Extract 160 (Interaction 79)

Doc.: Abiola Hammed. Kin lo se omo yin. (What is wrong with your child?)

Pt. Rel.: O n wuko. (He has cough.)

Doc.: To ba wuko se o maa nbi? (Does he vomit when he coughs?)

Pt. Rel.: Rara. (No.)

Doc.: Se ara e o gbona? (Does he have high temperature?)

Pt. Rel.: Ara e o gbona. (No.)

Doc.: Se a ri elomiran to nwuko nile yin? (Does anybody else in your family also cough?)

Pt. Rel.: Emi naa maa nwuko leekookan. (I also cough sometimes.)

Doc.: Okay.

Pt. Rel.: Iko yen kin je ki o sun; even gan-an eemeta lo yagbe loru. (The cough so much disturbs his sleep; he even defaecated thrice last night.)

Doc.: E ra awon oogun yii ki e si loo bi won ba se ni ki e loo. (Get these drugs and give him as recommended.) Ti e ba loogun yii ti ko sis i iyapada, e pada wa. (If the situation remains unchanged, come back.)

Pt.: E see, Sir.

One of the first diagnostic tools used by the doctors to study the ailments of the patients was direct question. Its use enabled the Docs to professionally intervene in the Pts' medical challenges. A close examination of the extracts above revealed how the doctors used direct questions to gather information on the Pts' social history (SH), family history (FH), and history of present illness (HPI) in order to arrive at diagnoses. In response, the patients used answers to provide the necessary information, thus making the consultations result-oriented.

The direct questions served the pragmatic purpose of making the Pts aware that the information being sought was critical to the diagnosis of their health problems and eventual healing. Patients were able to express their medical problems through answers to the questions. In conclusion, the direct questions in the consultations served the pragmatic purpose of eliciting information for diagnoses.

4.5.1.6.2 Indirect questions with answers

During the consultations, statements were used to answer indirect queries. The indirect questions have the appearance of declaratives, yet they are basically interrogative. I looked at the accompanying extracts:

Extract 161 (Interaction 82)

Doc.: Odun meloo le fi loogun yen? (For how many years did you take the drugs?)

Pt.: Osu meta. Won ni ki n loo gba nibikan. (Three months. I was asked to collect it somewhere.

Doc.: **E de loo lodun meji? (You took it two for years?)**

Pt.: Osu meta. (Three months.)

Doc.: **E de loo pe? (You completed the dosage?)**

Pt.: Enh. (Yes.) Sebi lehin yen, mo de tun ti wabi.(I even came here after taking it.)

Doc.: Eleyii tun ti to ose meji. (This is also about two months.)

Pt.: Beeni. (Yes.)

Doc.: Eje wa nibe, Sir? (You spit blood, Sir?)

Pt.: Rara. (No.)

Doc.: Ti tele yen nko? (What about the former ones?)

Pt.: Ko seje nibe. (There was no blood in it.) O de maa nremi latinuwa. (I also feel dizzy.) Mo de tun maa nlaagun.(I also sweat.)

Doc.: O maa nreyin latinu wa. (You feel dizzy.) Loru naa, e maa nlaagun? (Do you also sweat in the night?) Se e ki nmi gulegule? (Does your heart not palpitate?)

Pt.: Mi o mi gulegule. (No.) Aya de tun maa n tami ti moba wuko. (I also feel a burning sensation in my chest when I cough.)

Doc.: **Aya maa ntayin. (You feel a burning sensation in your chest.)**

Pt.: Beeni. (Yes.) O tun de maa nmu ki imu mi di finkinfinkin.(It also gives me catarrh.)

Extract 162 (Interaction 94)

Doc.: **E sure pe doctor leni to rii yin? (Are you sure the person you saw was a doctor?)**

Pt.: **Nhn. (Yes.)**

Doc.: **E baa ninu office doctor bayii? (You met him in a doctor's office like this?)**

Pt.: **Ni egbe office to wa loke yen ni. (Beside the office over there.)**

Doc.: O le je awon to nye eje wo le n pe ni doctor. (The person could be one of the laboratory staff.) E kan n suffere ara yin. (You only punish yourselves by seeing non-doctors.)

A close examination of Extracts 161 and 162 revealed that the primary tools used in clinical interviews are information seeking and gathering. The use of indirect questions to obtain information on the Pts' history of present illness (HPI) is evident from the Docs' contributions above. The contributions of the Pts, on the other hand, provided responses (answers) to the Docs' questions. The elicitation and provision of information in this case gave the doctors insights into the potential causes and the real nature of the patients' health issues, thus enabling them to render some medical assistance. The physicians primarily sought information about the Pts' health concerns, and the Pts provided them. This demonstrates that oral diagnosis in the consultations being studied was a collaborative effort between the Docs and the Pts.

The direct and indirect questions were bolded in every instance. There are instances of indirect questions in Extracts 161 - 162. The pragmatic function of the indirect questions was to render the consultations less interrogative to enable the Pts who were clearly ill find the exercise less stressful, and as a result, be encouraged to cooperate in releasing all of the information needed to unravel and treat their sicknesses. The direct questions performed the pragmatic function of informing the patients that the data being sought from them were critical to treating their health problems.

The answers logically accompanied the questions. They performed the speech function of delivering the information needed to make diagnoses. Because the consultations were strictly investigative, their deployment was unavoidable. They supplied the diagnostic “raw materials” needed to understand the patients’ ailments. Without them, it was improbable for them to acquire insights into the Pts' health problems unless they conducted laboratory tests on them, as the extracts above demonstrated. Owing to the fact that some diseases are mainly investigated through oral gathering of information (question) and provision of information (answer), question and answer are very essential diagnostic tools used during consultations.

The direct questions were realised by interrogatives involving subject-verb inversion and questions introduced by WH-elements, while the indirect questions were realised by

declaratives, as shown in the samples above. The indirect questions, however, have the illocutionary power of interrogatives. Declaratives were used to create all the answers.

4.5.1.7 Closing for concluding the discourses

After gathering information on the patient's chief concern (CC), history of present illness (HPI), family history (FH), and social history (SH), the consultations needed to be wrapped up so that the patients could either go get some medicines or do both. The patients employed closing in an attempt to create this chance. Expressions of gratitude and welcome were used to bring the consultations to a close. A comprehensive examination of the data found that a variety of strategies were used to end doctor-patient meetings. However, the most used were comments like: 'Goodbye' and 'Thank you,' which were spoken by the patients after the doctors had prescribed tests or drugs. Here, I studied how these closing tactics were used in the consultations.

Extract 163 (Interaction 91)

Doc.: You will neither eat nor drink when coming.

Pt.: Okay.

Doc.: **So, go buy these drugs.**

Pt.: **Thank you.**

Extract 164 (Interaction 96)

Doc.: **E lo si next room. (Go to the next room.) E so fun won pe won da yin duro. (Tell them you have placed on admission.)**

Pt.: **E see, Sir. (Thank you, Sir.)**

Extract 165 (Interaction 90)

Doc.: E loo se awon test yii ki e si mu esii re wa.(Go for this test and bring the result when it is out.) E mu iwe yii lo si ile oogun. (Take this prescription to the pharmacy.)

Pt.: **E see. (Thank you.) O dabo. (Bye bye.)**

Doc.: **O dabo. (Bye bye.)**

In all the extracts, the patients most of the time closed the dialogues, but the doctors also closed the consultations on occasions. After hearing the doctor's last comments and collecting prescription, the patient ended the consultation with the phrase "Thank you" in Extract 163 (Interaction 91). Similarly, after the doctor's final advice, the patient concluded the consultation by saying: "E see, Sir'', (Thank you, Sir.) in Extract 164. After the doctor had recommended a test, she said "O dabo. (Bye bye.) and the doctor responded by saying: "O dabo". (Bye bye.) to end the interview in Extract 165. The use of the terms mentioned in 163 - 165 to end the discourses provided apposite conclusions for the consultations.

Closing performed the pragmatic function of bringing each of the consultations to an end, as seen in the analyses and discussions above. The consultations could not but come to an end at some point. As shown in the excerpts above, closing signalled the conclusion of the consultations, as shown by the bolded expressions. In general, in all the consultations, closing was the last discourse device used. Declaratives were used to realise closing grammatically.

4.5.1.8 Modality for showing asymmetry of knowledge and power, obtaining medical information, and answering doctors' questions

The findings on the pragmatic functions of modality as deployed by the doctors and patients in our data were discussed here.

4.5.1.8.1 Pragmatic functions of modality

4.5.1.8.2 Statement for expressing asymmetry of power and knowledge

Extract 166 (Interaction 82)

Doc.: Aya maa ntayin. (You feel a burning sensation in your chest.)

Pt.: Beeni. (Yes.) O tun de maa nmu ki imu mi di finkinfinkin.(It also gives me catarrh.)

Doc.: Okay. Imu finkinfinkin. (Catarrh.) E maa lo se test meji. (You **will** do two tests.) Won a gba kelebe yin. (Samples of your phlegm will be collected.) Maa de tun ko oogun funyin. (I **will** also recommend some drugs for you.)

The two instances of the modal auxiliary verb (**will**) are examined in the extract above. They expressed epistemic certainty, which is the highest level of assurance based on the speaker's understanding of the statement.The doctor employed **will** (i) to inform the patient of the need to do two medical tests to enable him diagnose the patient's health challenge appropriately and (ii) to communicate his decision to recommend some drugs for the patient to treat his ailment.

The doctor's medical expertise and +higher role status enabled him to subtly command the patient to undergo some tests and to also promise drug recommendation. The first instance of the deployment of **will** in the extract above performed the pragmatic function of expressing a subtle command to stress the inevitability of the two tests in order to ensure proper treatment for the Pt's medical challenges. The second instance of the deployment of **will** performed the pragmatic function of revealing his treatment plan to the patient and to also show the patient he was an authority in the discourse situation. Thus, beyond the discourse function of **will** to express volition in the extract above, it performed the pragmatic function of a subtle command and disclosure of the treatment plan.

4.5.1.8.3 Questioning for obtaining medical data

Extract 167 (Interaction 93)

Doc.: Igba yen naa looyi bere sii ko e. (That was when you also began to feel unstable?)

Pt.: Beeni. (Yes.)

Doc.: Se o le se ise ile? (Can you perform domestic chores?)

Pt.: Diedie. (A little.)

Doc.: Omo meloo lo ti bi? (How many children have you?)

The modal auxiliary verb **can** (an instance of epistemic possibility) was used in the extract above by the doctor to find out whether the patient had the ability to do household chores. In response, the patient told the doctor she could only do little household chores. Beyond the grammatical function of expressing epistemic possibility, **can,** by virtue of its deployment here, performed the pragmatic function of investigating the patient's ability to participate in household activities.

Beyond the epistemic modality function of expressing possibility/impossibility or probability, it performed the pragmatic function of expressing certainty and uncertainty in the various medical contexts above.

4.5.1.8.4 Face-threatening acts

Through direct and indirect expressions, frank talk, rebuke, and courteous expressions in the data, FTA with redress (positive politeness) and FTA without redress (negative politeness) realised politeness in consultations. The purpose of this investigation into the use of politeness was to see how the patients' faces were threatened with redress and without redress, as well as how the diagnoses were given courteously. Furthermore, an investigation into how the use of the face-threatening acts improved the communication was attempted.

4.5.1.8.4.1 Face-threatening acts without redress (negative politeness) for correcting and checking patients' unwholesome health practices

Face-threatening act without redress (negative politeness) was realised by reprimand, courteous expressions and frank talk. The extracts below were considered:

Extract 168 (Interaction 92)

Pt.: O nje ki eru bami. (It frightens me.)

Doc.: Kinni yen n ba e leru fun.. (Why does it frighten you?) Se eru mba e pea won aye lo faa ni? (Are you afraid it is spiritually motivated?)

Pt.: Beeni. (Yes.)

Doc.: O nroo pe boya won ran-an si e ni. (You think it is an attack.)

Pt.: Mo n roo pe boya owo aye ni. (I was thinking it was caused by some devilish people.) Ati pe kekere ni o ti maa nse mi. (In addition, I have had it from birth.) Apa yii naa detun nyomi lenu. (This arm also hurts me.) Mo de tun check BP mi. (I also checked my BP.)

Dr.: Kinni won pe BP reading e? (What was your BP reading?)

Pt.: Won ni 146 over 60. (146/60.)

Doc.: Je ki n check BP e nisisiyii. (Let me check your BP now.) 130/100. Se o maa nse aisun? (Do you keep late nights?)

Pt.: Beeni. (Yes.)

Doc.: Aisun naa le faa. (Late nights could also cause it.)

Pt.: Mhn. Pajapaja naa tun maa n mumi lese. (I also feel cramps in my feet.)

Doc.: Se o njeun daadaa.(Do you eat well?)

Pt.: Normal.

Doc.: Normal. **Mo ro pe mo ti salaye fun e pe ohun to nse e kii se owo aye. (I believe I have explained to you you condition is not a spiritual attack. Near fibroma la maa n pee. (We call it near fibroma.) Ara maa n le nigbamii. (The body swells sometimes.)** O le pada wa fun iyen. (You may come back later for that.) A le ba e wo baa sele yo kuro nibe. (We can remove the swelling surgically.)

Pt.: o daa. (Okay.)

Doc.'s foregrounded contribution in Extract 168 showed that Doc. threatened the Pt.'s face by not mitigating his correction of Pt.'s erroneous expression of belief in occultism as he unequivocally told the patient that her health condition was purely medical, and not metaphysically induced as Pt. erroneously explained. The doctor frankly corrected Pt.'s erroneous belief that her medical condition was spiritual. The goal of FTA without redress was to provide Pt. with accurate and forthright information regarding her illness, as

required by medical ethics, and to rectify her incorrect belief. As a result, Doc. did not spare Pt. from knowing the real diagnosis.

The extract above, in which Doc. reprimanded the Pt's for her incorrect belief that her health condition was metaphysically induced is a good example of a face-threatening act without redress. Doc. confirmed his claim by telling Pt. the name of the ailment she suffered from (near fibroma), which was a true diagnosis of her medical condition. The pragmatic purpose served by the FTA was intended to not only rebuke the patient for holding the erroneous belief but to also protect the Pt against undue emotional stress on account of a false metaphysical attack claim that could spell a doom for her health. Therefore, the Doc threatened the Pt's face by scolding her for not finding out her real disease and for engaging in self-diagnosis. Thus, the Doc threatened the patient's face with no mitigation.The FTA without redress was realised by declaratives. At other times, it may be realised by interrogatives.

4.5.1.8.4.2 FTA with redress (Positive politeness) for tactfully obtaining information for diagnoses tactfully, allaying fears and correcting patients unwholesome health practices

FTA with redress (positive politeness) was achieved by courteous expressions, and direct and indirect talks in the data. The study found that doctors limited the risk to patients' faces by talking about their problems in a roundabout way. This can happen during consultations, and doctors will then use FTA with redress (positive politeness). Patients' true health issues are also hidden from them atimes for reasons best known to doctors. In the data, majority of the cases of FTA with redress (positive politeness) appeared as mitigated threats, indirect expressions, direct expressions, and courteous expressions. The following extracts were examined.

Extract 169 (Interaction 82)

Doc.: Odun meloo le fi loogun yen? (For how many years did you take the drugs?)

Pt.: Osu meta. Won ni ki n loo gba nibikan. (Three months. I was asked to collect it somewhere.

Doc.: **E de loo lodun meji? (You took it two years?)**

Pt.: Osu meta. (Three months.)

Doc.: **E de loo pe? (You completed the dosage?)**

Pt.: Enh. (Yes.) Sebi lehin yen, mo de tun ti wabi.(I even came here after taking it.)

Doc.: Eleyii tun ti to ose meji. (This is also about two months.)

Pt.: Beeni. (Yes.)

Doc.: **Eje wa nibe, Sir? (You spit blood, Sir?)**

Pt.: Rara. (No.)

Doc.: Ti tele yen nko? (What about the former ones?)

Pt.: Ko seje nibe. (There was no blood in it.) O de maa nremi latinuwa. (I also feel dizzy.) Mo de tun maa nlaagun.(I also sweat.)

Doc.: **O maa nreyin latinu wa. (You feel dizzy.) Loru naa, e maa nlaagun? (Do you also sweat in the night?)** Se e ki nmi gulegule? (Does your heart not palpitate?)

Pt.: Mi o mi gulegule. (No.) Aya de tun maa n tami ti moba wuko. (I also feel a burning sensation in my chest when I cough.)

Doc.: **Aya maa ntayin. (You feel a burning sensation in your chest.)**

Pt.: Beeni. (Yes.) O tun de maa nmu ki imu mi di finkinfinkin. (It also causes catarrh for me..)

In the extract above, the doctor employed indirect expressions to obtain information for diagnosis. Therefore, the doctor used FTA with redress (indirect expression) to investigate the extent of the Pt.'s compliance with medical prescriptions and other possible health challenges faced by the Pt. to enable him proffer appropriate medical solutions to the Pt.'s ailments.

4.5.1.9 Research questions Three and Four: Which politeness maxims are deployed in the consultations and what pragmatic functions do they perform?

Sympathy maxim, tact maxim, and the Pollyanna principle are some of the politeness maxims observable in the consultations. These were covered in more details below.

4.5.1.9.1 Tact maxim for compassion and permission

The tact maxim was observed in the data, and was realised by interrogatives and declaratives. It dictates "Minimise cost to other, maximum benefit to other." Majority of the doctors' contributions demonstrated that they cared deeply about their patients as they were offered the opportunity to get the most out of their hospital visits, despite the fact that this meant more work for them. The accompanying extracts were studied:

Extract 170 (Interaction 76)

Doc.: E o se rii. (You have never done it.)

Pt.: Beeni. (Yes.)

Doc.: **Kin lo tun ku? (What else?) Catarrh nko? (What about catarrh?)**

Pt.: Ko ni catarrh. (No.)

Doc.: **A maa se blood test fun yin ka le mo ohun to nfa ara gbigbona yen. (We will do a blood test for him to know the cause of the high temperature.)**

In extract 170, the doctor’s emboldened contributions revealed that he was so empathetic to the patient and wanted her to gain maximum benefits from her hospital visit. Undoubtedly, these offers meant more work for the doctor but he did not care because the well-being of the patient was paramount in his mind. The tact maxim was grammatically realised by declaratives and interrogatives. It performed the pragmatic function of allowing them Pts to table all their complaints and enabling doctors to show them compassion.

4.5.1.9.2 Generosity maxim for compassion and advice

The maxim performed the pragmatic function of showing the patients compassion and advising them in the consultations. Most of the time, the maxim was implemented in doctor-patient consultations when the doctors' profit was decreased and their expense was maximised. Therefore, the Docs demonstrated great concerns for the Pts' well-being. The extracts below were examined:

Extract 171 (Interaction 79)

Pt. Rel.: Iko yen kin je ki o sun; even gan-an eemeta lo yagbe loru. (The cough so much disturbs his sleep; he even defaecated thrice last night.)

Doc.: **E ra awon oogun yii ki e si loo bi won ba se ni ki e loo. (Get these drugs and give him as recommended.) Ti e ba loogun yii ti ko si si iyapada, e pada wa. (If the situation remains unchanged, come back.)**

Extract 172 (Interaction 80)

Doc.: Igbawo loogun yin tan? (When did your drug finish?)

Pt.: O to ose kan. (About a week ago.)

Doc.: **E ma maa je ko tan ti e fi maa wa. (Don't wait till your drugs finish before you come back.) To bati nku eyo meji abi meta ni ki e ti pada wa. (Come immediately you have about two or three doses left.)**

Pt.: Mo ti gbo ohun ti e so. (I have heard you.)

In extracts 171 and 172, the doctors showed tremendous interest in the patients' health by offering them useful medical advice. In Extract 171, the doctor showed the Pt. compassion by recommending some drugs for her and also advising her to take the drugs as prescribed and to come back if after taking the drugs her health condition remained unchanged. In Extract 172, the Doc. advised the Pt. to constantly guard against allowing her drugs get exhausted before coming for more at the hospital to prevent health crises. By deploying the generosity maxim in the doctors' emboldened contributions in Extracts 171 and 172,

the Docs. succeeded in demonstrating empathy and giving the Pts. certain healthful pieces of advice at the same time. The generosity maxim was grammatically realised by imperatives and declaratives in the consultations.

4.5.1.9.3 Sympathy maxim for guidance, empathy and advice

The sympathy maxim was observed in many of the consultations. It performed the pragmatic function of guidance, empathy and advice. The sympathy maxim enabled the doctors to pity the patients on some dreadful ailments. One of the comments used to observe the maxim was found in the extract below:

Extract 173 (Interaction 94)

Pt.: **E nle, Sir, o. (Sorry, Sir.)**

Doc.: A dupe. (Thanks.) Se ko si ti a ri yin o? (What is the reason for your coming?)

In Extract 173, the doctor demonstrated empathy for the patient's health challenges and, consequently, used the empathetic expression: (Pt.: E nle, Sir, o. (Sorry, Sir.)) to show the Pt. compassion. The doctor employed this discourse device to relieve the patient's discomfort, having sensed he was in great pains.

4.5.1.9.4 Pollyanna principle - The ethical positivity tendency: Opening up talks

In the data, the Pollyanna principle was also applied. The incidence of the Pollyanna principle revealed that medical consultation gives greater attention to the positive aspect of life more than the negative side. This phenomena emerged from the patient-society's perspective of doctors, as well as contextual opinions based on medical ethics.. Medical ethics demands Docs use their professional competence to treat patients, whether directly or indirectly, and not to harm them physically or psychologically. On the other hand, Pts. also expect that Docs would attend to all their physical, emotional and medical wants. Referential tendency, ethical positivity tendency, and euphemistic tendency are the three inclinations of the pollyanna principle. However, only the ethical positivity tendency characterised the consultations studied.

Ethical positivity tendency, one of the tendencies of the Pollyanna principle, emphasises the ethical expectations of patients from doctors, especially in areas of sympathy, assurance, reassurance and medical care, etcetera. The ethical positivity tendency is concerned with doctors' contextual beliefs based on the patients' and society's perspectives. Patients and the general public see the hospital as a place of healing and relief, and doctors are viewed by patients as health solution providers. As a result, they hold them in high regard as persons they can trust with their secrets. According to Maboyeje ((1982:11) cited in Odebunmi, 2003), the health vocation also shares this vista:

> 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.

However, It is worthy of note that some patients intentionally deny doctors access to some medical data for reasons known only to them. All patients believe they would get adequate care and compassionate attention from doctors. Therefore, majority of them disclose all their medical challenges to doctors, expecting the doctors would cooperate with them. The data is replete with instances of this phenomenon as observable in the extracts below:

Extract 174 (Interaction 81)

Pt.: **Mo nwuko ati catarrh. (I have cough and catarrh.)**

Doc.: Igbawo lo ti bere? (When did they start?)

Pt.: O maa to osu to koja. (About last month.)

Extract 175 (Interaction 88)

Doc.: Complaint yin? (What is your complaint?)

Pt.: **Mo loyun mo de maa nri eje diedie losoosu. (I am pregnant but yet menstruate.)**

Doc.: Nigbawo lese nnkan osu gbehin? (When was the last time you menstruated?)

Pt.: Osoosu. (Monthly)

Doc.: Bawo le se wa mope e loyun? (How did you know you are pregnant?)

The application of the ethical positivity tendency enabled the patients to freely explain their health problems to the doctors, as seen in extracts 174 and 175, because they had complete faith in the doctors' ability to meet their medical needs. The doctors reciprocated the patients' trust in their medical abilities by prescribing a type of medication to treat them or prescribing medical tests to help them comprehend their medical challenges and prescribing appropriate treatments. The ethical positivity tendency served the pragmatic purpose of enabling the patients to open up on all their ailments. It was realised grammatically by single words and declaratives.

4.5.1.10 Lexical and Grammatical Devices In Doctor-Patient Interactions and Pragmatic Functions at General Hospital, Abeokuta and General Hospital, Kabba

4.5.1.10.1 Collocation for connecting texts

This section examines the lexical analysis and description of the discourse devices deployed in the text. This is predicated on the idea that a text's function is determined by the frequency with which lexical features appear 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, my focus here was to study the different ways in which the deliberate use of particular lexical items realised 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. The analyses below were undertaken.

In this study, lexical cohesion was achieved through collocation. In a dialogue, lexical cohesiveness refers to how some words appear to move very closely together. The utterance of one term conjures up images of the other or other group members. 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 consultations. 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. The data, however, contained phrasal verbs exclusively. The following excerpts were considered:

Extract 176 (Interaction 76)

Doc.: Is this the first time you have **come to** this **hospital**?

Pt.: Yes.

Doc.: Did you ever test positive to **diabetes** or **hypertension**?

Pt.: Diabetes.

Doc.: In what hospital do you treat it and what **drugs** were you given **to treat** it?

Extract 177 (Interaction 82)

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 178 (Interaction 65)

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 176 and 177 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 176, 177 and 178. 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.** 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 consultations employed lexical items to create collocative cohesion in the discourse.

4.5.2 Grammatical analysis

This section examines the grammatical analysis and description of the discourse devices in the texts. This is predicated on the concept that a text's functionality is determined by the frequency with which grammatical features appear 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 realised meaning in the consultations 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.

4.5.2.1 Modal auxiliaries for expression of views, opinions, decisions and expectations

As helping verbs, modal auxiliaries were employed in the consultations. They assisted both the doctors and the patients in expressing their views, opinions, decisions and expectations. The following extracts were examined:

Extract 179 (Interaction 32)

Doc.: I **should** remove the milk teeth.

Extract 180 (Interaction 74)

Doc.: Let me have them. How many types of drug are you taking?

Pt.: Two.

Doc.: But I **can** see three types here.

Extract 181 (Interaction 62)

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 182 (Interaction 90)

Doc: I am asking this question because if we are not careful, we may not really know where the blood comes from.

Pt.: I do not 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 183 (Interaction 68)

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 184 (Interaction 87)

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 179, the doctor deployed the modal auxiliary **should** to express the patient's expected treatment. In Extract 180, the doctor used **can** to express his view of the number

of drugs the patient had brought to the hospital. In Extracts 181 and 182, the doctors deployed **could** and **might** to express possibility. In Extract 181, 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 182, the doctor employed **might** to inform the patient's mother about the possible inadequacy of using only three pampers for her baby daily. In Extract 183, 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 184, the doctor employed **will** to reveal his decision to treat the patient for malaria.

A meticulous read-through 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.

4.5.2.2 Imperatives: giving orders

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

Extract 185 (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 186 (Interaction 56)

Doc.: **So, go and take the test and bring the result.**

Extract 187 (Interaction 79)

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 188 (Interaction 64)

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 185, 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 186, the doctor used the imperative "**So, go and take the test and bring the result**" to tell the patient the steps to take to enable him diagnose his ailment appropriately. In Extract 187, 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 patient tostay away from applying any cream on her baby's body as the health challenge the patient's baby faced was just a reaction to some strong creams the patient's mother had administered on the patient. Similarly, in Extract 188, 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 medication. In essence, the deployment of the various imperaves enabled the doctors to stabilise the patients' health.

4.6 Discussion of findings

A number of studies have been carried out in medical discourse. Notable among these are: Harlen (1977), Oloruntoba-Oju (1996), Odebunmi (2003, 2006); Adegbite and Odebunmi (2010), Faleke and Alo (2010|), Taiwo and Salami (2010), to mention but a few. All these studies examined medical discourse with focuses ranging from register analysis, mutual contextual beliefs, selection of discourse acts and it how eases or hampers verbal interactions in medical classes, code selection to power-play in doctor-patient consultations, etc. In spite of the fact that all the afore-mentioned studies shared similar study locations and subjects, they all came up with different findings.

Another thing that is common to all the clinical discourse scholars is that they all made efforts to assist the people outside the doctor-patient verbal interactions understand the goings-on in the discourse. This view is consistent with the findings of Odebunmi (2003, 2006), Adegbite and Odebunmi (2010), Taiwo and Salami (2010), and Faleke and Alo (2010). There is an area of convergence here between this study and the ones mentioned above as it revealed the specific discourse devices deployed in the doctor-patient discourse and their pragmatic functions to also enable the people outside the interaction understand the goings-on there.

However, beyond Odebunmi's (2003, 2006, 2010) studies just revealing the generic structure of doctor-patient verbal interactions at first meetings, the two factors that account for patients' beliefs in hospital interactions, and the pragmatic features of English usage in doctor-patient verbal interactions, this study has revealed the thirteen discourse devices deployed in doctor-patient interactions and their pragmatic functions, i.e.: (i) phatic communion for opening discourses and showing empathy, (ii) circumlocution for providing clues to diagnosis, (iii) rapport expressions for geniality, conviviality and recognition, (iv) counselling for guidance, enlightenment and encouragement. Other discourse devices include: direct questions, indirect questions, code alternation, modality, answer, face-threatening acts with redress, face-threatening acts without redress, repetition and closing. It is interesting to note that no earlier studies have done this.

Moreover, this study found that the doctor-patient verbal interactions were fundamentally transactional in nature. This finding of the current study is similar to those of Adegbite and Odebunmi (2003, 2006) that found that the transaction involved in doctor-patient diagnostic interaction in terms of i) mutual contextual beliefs of participants, ii) patterns of speech act (locutionary, illocutionary and perlocutionary) in exchanges, moves and acts in the interaction was essentially a consultative one in which the process of diagnosing patients' health challenges was negotiated between the doctor and patient. The findings of these studies and mine agreed that diagnosis was a collaborative effort between a doctor and a patient.

Moreover, this study found that the politeness maxims: tact maxim, generosity maxim, sympathy maxim, and ethical tendency positivity characterised the interactions studied

and performed specific pragmatic functions. This finding is in line with Odebunmi (2003) who equally submitted that doctor-patient interactions were characterised by the same politeness maxims. However, there is an important area of dissimilarity between the two studies. While Odebunmi (2003) found that conversational maxims were observable in doctor-patient interactions, this study did not make such a finding.

More importantly, apart from the fact that this study used four hospitals while Odebunmi (2003, 2006, 2010) used only one or two in each instance, the location of this study covered South-Western and North-Central geopolitical zones of Nigeria for the purpose of enriching the data but the coverage of Odebunmi (2003 and 2010), Adegbite and Odebunmi (2006), Taiwo and Salami (2010), and Faleke and Alo (2010) was restricted to only South-Western Nigeria. In addition, this study found that the same discourse devices were deployed in all the study locations but in different percentages. This study also employed both the qualitative and quantitative methods to provide statistical inferences in its analyses but all the afore-mentioned studies only used the qualitative method. Similarly, this study also found that the pragmatic analysis of the various discourse devices deployed in the interactions enhanced the communication between the doctors and patients and performed specific therapeutic functions but Odebunmi (2003, 2006, 2010) did not make such a finding.

The discourse devices addressed specific communication and health challenges thus underscoring the centrality of their knowledge to a better comprehension of diagnostic discourse in doctor-patient consultations in Nigerian context.

Research questions One and Two: Which discourse devices are employed in the doctor-patient consultations, and what pragmatic functions do they perform?

A total number of thirteen discourse devices were discovered to have been used in the interactions, each performing specific pragmatic functions. Their deployment aided the success of the various diagnostic sessions as all of them proceeded from opening to closing. Phatic communion was realised mostly by greetings, expression of empathy, and social questions. It performed the pragmatic From the analyses, it can be seen that the phatic communion's conventional uses have been extended here to include elicitation of

information on social life.function of opening up the diagnostic interviews on a friendly note as an ice breaker.

The patients used circumlocution because, as non-medical specialists, they tended to beat about the bush when discussing their health issues due to their ignorance of the correct medical terminologies for their illnesses. Its use served the pragmatic purpose of making the patients provide clues to the diagnosis of their ailments through the description of ailments' symptoms. Circumlocution was realized by questions introduced by Wh-elements, indirect questions, and declaratives.

Rapport expressions were deployed chiefly by the doctors to create a friendly atmosphere that could encourage the patients to cooperatively release all the critical information from which the doctors could reach diagnoses. They served the speech purpose of engendering conviviality and cordiality between the Pts and the Docs to enable them operate on the same wavelength. They were generally realised by interrogatives and declaratives.

Code alernation was realised by code-mixing and code-switching in the consultations. It served the pragmatic purpose of endowing the discourses with informativity, mutuality and explicitness. 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 deployed in the discourses.

Counselling was realised by declaratives and rhetorical questions. It performed the pragmaticfunction of guiding, correcting, enlightening the patients on wholesome health practices that could make them live healthily.

Modality was realised by modal auxiliaries and lexical verbs. It was employed by both the doctors and the patients. It performed the pragmatic function of showing asymmetry of knowledge and power, methods of obtaining medical information, and providing answers to doctors' elicitations.

Direct and indirect questions were realised by interrogatives and declaratives, respectively.They performed the speech functions of eliciting information to reach diagnoses. Even though both the direct and indirect questions were deployed to obtain

information from the Pts, indirect questions performed an additional pragmatic function of making the clinical interviews appear less stressful to enable the patients release all the information needed for accurate diagnoses.

Answer was realised by declaratives in all the interactions. It followed all the questions naturally and served the speech function of supplying the information required for diagnosis.

Repetition was realised by reiteration of same or similar expressions or ideas in the consultations. Used mainly by the patients, it performed the pragmatic function of confirming or emphasising certain items of information to draw the doctors' attention to complaints requiring urgent attention or confirming or clarifying a particular item of information.

Closing was employed in all the interactions after information had been obtained on CC, HPI, FH, SH and OAP for diagnosis and after Docs had recommended drugs and, or tests 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. It was realised by expressions of gratitude, prayers, and salutation.

Face-threatening act with redress and face-threatening act without redress were used to realise politeness in the consultations. Generally, face-threatening acts were realised by declaratives and interrogatives involving frank talk, courteous expressions and reprimand. They performed the pragmatic 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.

Research questions Three and Four: Which politeness maxims are deployed in the consultations and what pragmatic functions do they perform?

The tact maxim, generosity maxim, sympathy maxim, and the Pollyanna principle characterised the consultations. Realised by interrogatives and declaratives, the tact maxim served the speech function of enabling the doctors advise the patients, fraternise with them, and to give the patients more opportunities for medical attention.

The sympathy and generosity maxims were realised by interrogatives and declaratives. They performed the pragmatic function of advising, pitying and directing the patients. However, the pollyanna principle was realised mainly by declaratives, and it performed the pragmatic function of opening up the clinical interview sessions.

Research question Five: Are there similarities and differences in the use of the specific discourse devices amongst the four hospitals selected for this study, and how frequently are the discourse devices deployed?

The discourse devices used by both the Docs and the Pts in the four hospitals selected for this work were examined to pin point the differences and similarities observable in the interactions under study. In addition, the frequency of occurrence of these discourse devices in the consultations was examined by counting the number of times each of them was used and representing them in simple percentage terms. Therefore, on the basis of quantitative data analysis, these similarities and differences were calculated and analysed accordingly.

The doctors and patients sampled in the four 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 the four 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, at UITH, Ilorin was 382, at GH, Abeokuta 413 and, at GH, Kabba was 397. The differences in the frequency of occurrence were borne out of the fact that UCH, Ibadan and GH, Abeokuta 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, Ibadan doctors employed indirect questions 34 times, UITH, Ilorin doctors employed them 28 times. GH, Abeokuta doctors employed them 7 times while GH, Kabba doctors did not employ them at all. UCH, Ibadan doctors, UITH, Ilorin doctors and GH, Abeokuta doctors used indirect questions 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 produce all the data needed to make good diagnoses.

UCH, Ibadan, UITH, Ilorin, GH, Abeokuta and GH, Kabba 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, UITH patints used it 417 times, GH, Abeokuta 403 times while it was employed 398 times by GH, Kabba patients. The differences in the frequency of the occurrence resulted from the varying number of questions the doctors asked in each hospital.

Face-threatening acts were employed 69 times by UCH doctor, 93 times by UITH doctors, 45 times by GH, Abeokuta doctors, and 47 times by GH, Kabba doctors, thus showing that UITH and UITH doctors were more factual in the presentation of their diagnoses, medical advice and condemnation of unwholesome health practices than their GH. Abeokuta and GH, Kabba counterparts. Language switch was employed by UCH doctors 56 times, UITH doctors 47 times, GH, Abeokuta 59 times and GH, Kabba doctors 51 times. This showed that UCH and GH, Abeokuta 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, UITH 94 times, GH, Abeokuta 103, and GH, Kabba 106 times. The pragmatic import of the differences in the frequency of occurrence is that GH, Abeokuta and GH, Kabba doctors were a little more given to promoting open communication between them and their patients than their UCH and UITH counterparts.

Circumlocution was employed by UCH patients 298 times, UITH patients 306 times, GH, Abeokuta patients 301 times, and GH, Kabba 307 times. The differences in the frequency of occurrence are infinitesimal but then pointed out that GH, Kabba patients made greater efforts to explain their ailments. Religious belief was used by UCH doctors 14 times, UITH 9 times, GH, Abeokuta 1 time, but GH, Kabba doctors made no use of religious belief at all. The differences in the frequency of occurrence arose from the fact UCH, UITH and GH, Abeokuta doctors viewed religion more as a salutary instrument for guidance and enlightenment than GH, Kabba doctors.

Lastly, UCH doctors employed counselling 72 times, UITH doctors 50 times, GH, Abeokuta doctors 56, and GH, Kabba doctors 49 times. The disparity observable in the frequency of occurrence resulted from the fact that UCH and GH, Abeokuta doctors offered more medical advice and guidance than UITH and GH, Kabba doctors. 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 occurrence of the discourse devices deployed by UCH, Ibadan, UITH, Ilorin, and GH, Abeokuta are insignificant. This resulted from a number of factors. The doctors in the four hospitals had similar medical trainings, had the same cultural base, had same language mix and practised similar religions. Similarly, the patients share the same cultural base, had same language mix and practised similar religions.

4.7 Summary

The various discourse devices deployed in the consultations performed specific pragmatic (speech) functions that contributed immensely to the comprehension and success of the consultations. They enhanced the success of the clinical interviews as their deployment enabled both the doctors and the patients to cooperatively investigate the ailments, while the doctors prescribed appropriate treatments to the health challenges faced by the patients. Most of the discourse devices were employed intuitively. They, nonetheless, contributed in no small measure to the success of the clinical interviews. In addition, as observable in the consultations, no clinical interviews can be successfully conducted without a recourse to the discourse devices.

CHAPTER FIVE

Summary, Conclusion and Recommendations

5.1 Summary

Analyses of hospital verbal exchanges between doctors and patients in Nigeria's South-West and North-Central geopolitical zones were conducted, using Discourse Analysis techniques. A perusal of the data revealed that certain discourse devices (phatic communion, question, counselling, 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. The deployment of the discourse devices by the doctors, as seen in the present study, performed the pragmatic functions of assisting the doctors to: i) make appropriate diagnoses, ii) reveal their diagnoses to the patients harmlessly, iii) obtain adequate information about the patients' history in order to make accurate diagnoses. Similarly, the discourse devices deployed by the patients enabled them also to (a) explain their medical challenges, (b) emphasise their pressing ailments to the doctors to enable them know how to intervene professionally, (c) respond to the doctors' questions by providing the pieces of information needed to make diagnoses and to (d); bring the clinical interview sessions to a close.

In addition, at the grammatical level, imperatives were also exclusively deployed by the doctors. Similarly, certain discourse devices were exclusively used by the patients, too as a result of their –higher role occupant status in the discourse setting by virtue of their lack of knowledge of medicine.

5.2 Conclusion

This work has contributed to the existing knowledge in medical discourse in many ways. In the first instance, it is an effort at studying the discourse devices deployed in doctor-patient consultations for the purpose of understanding their pragmatic functions and how they aided the doctors in their efforts to diagnose the patients' medical challenges, using discourse analysis techniques. 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 consultations, b) the actual politeness maxims employed in the interactions and their pragmatic functions; and c) the similarities and differences observable in the deployment of specific discourse devices in the four hospitals selected for the study and their frequency of occurrence; . All these were achieved through the amalgam of the Polieness Theory of Brown and Levinson (1987), Dan Sperber and Deidre Wilson's (1986) Relevance Theory, complemented by insights from M.A.K. Halliday's Systemic Functional Linguistics, among others.

The work has revealed the non-natural meanings derivable from doctors and patients' verbal contributions during the clinical interviews. The deliberate deployment of pragmatic devices enabled the interlocutors to mean more than they said. Thus, it enhanced the communication greatly. In addition, purely because the interactions were formal, the difference in knowledge and power schemas between the two classes of interlocutors influenced and controlled their contributions. The examination of pragmatic cues in this type of discourse underscores the need to be alert to every such usage during clinical interviews in order to be sufficiently informed and be saved from being deceived by the surface meaning of their contributions.

Lastly, by using discourse analysis and pragmatics techniques, the study has demonstrated how Discourse Analysis can offer a sophisticated insights 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 medical consultations.

5.3 Recommendations

More studies can be carried out on the consultations between other groups of medical professionals and patients. In addition, a study of the consultations between traditional healers and patients can also be undertaken. Any effort in these directions will, no doubt, complement this study.

5.4 Contribution to knowledge

Communication plays a critical role in the efficiency of health-care delivery. For example, the quality of doctor-patient verbal interactions might influence whether or not patients provide appropriate and correct diagnostic information, as well as their subsequent adherence to prescribed treatment.

Furthermore, the outcomes of this study will certainly corroborate doctors' intuitive judgments of their contributions during diagnosis or diagnosis delivery. By pin pointing the ways in which the different discourse devices emerged in the encounters, these findings demonstrated how these practices operate and identify their likely pragmatic uses. As a result, they provided a solid foundation for evaluating the potential interactional and pragmatic repercussions of using one form over another.

In conclusion, a discourse analysis of verbal exchanges in hospitals leads to 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. This study will be disseminated to health practitioners by publishing it and by also presenting papers on it at conferences.

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Tables

Table 4.1: Frequency of occurrence of the discourse devices deployed by the patients and doctors in UCH, Ibadan, consultations

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 %
Modality	14	1.00%
Answer	420	29.19%
Circumlocution	197	13.6%
Closing	25	1.74%
Total	**1439**	**100%**

Table 4.2 : Frequency of occurrence of the discourse devices deployed by the patients and doctors in UITH, Ilorin, consultations

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%
Modality	9	0.65%
Answer	414	29.80%
Repetition	8	0.60%
Circumlocution	199	14.34%
Closing	25	1.80%
Total	1388	100%

Table 4.3 : Frequency of occurrence of the discourse devices deployed by the patients and doctors in General Hospital, Abeokuta, consultations

Discourse devices	**Total number of occurrences**	**Percentage**
		%
Phatic Communion	25	1.74%
Direct Questions	387	25.26%
Indirect Questions	04	2.10%
Rapport Expressions	111	9.21%
Language Switch	34	2.17%
Face-Threatening Acts	71	7.26%
Counselling	34	2.68 %
Modality	0	0.00%
Answer	437	34.14%
Circumlocution	225	17.16%
Closing	25	1.74%
Total	**1353**	**100%**

Table 4.4 : Frequency of occurrence of the discourse devices deployed by the patients and doctors in General Hospital, Kabba, consultations

Discourse devices	**Total number of occurrences**	**Percentage**
		%
Phatic Communion	25	1.74%
Direct Questions	431	28.53%
Indirect Questions	20	3.58%
Rapport Expressions	120	9.49%
Language Switch	25	1.98%
Face-Threatening Acts	46	3.31%
Counselling	27	2.01 %
Modality	02	0.50%
Answer	449	32.03%
Circumlocution	236	18.12%
Closing	25	1.74%
Total	**1406**	**100%**

Table 4.5 : Cummulative frequency of occurrence of the discourse devices deployed by the patients and doctors in all the consultations

Discourse devices	**Total number of occurrences**	**Percentage**
		%
Phatic Communion	100	2.90%
Repetition	8	0.60%
Language Switch	287	4.16%
Circumlocution	818	11.05%
Direct Questions	1573	21.76%
Indirect Questions	100	2.90%
Answer	1709	24.25%
Counselling	218	3.26%
Face-threatening Acts	289	3.84%
Rapport Expressions	405	5.06%
Modality	37	0.74%
Closing	100	2.90%
Total	4820	100%

Table 4.6 : Discourse devices, excerpts and pragmatic functions

S/N	Discourse devices	Excerpts	Functions
	Phatic Communion	What do you do?	For opening interactions
	Direct Questions	Why did you come this morning?	For elicitation to make diagnoses
	Indirect Questions	You feel it every morning morning.	For making the clinical interview appear less stressful and making the patients cooperate to release the information needed to make diagnoses.
	Rapport Expressions	E pele. [Sorry.] What is your name?	For promoting open communication and cordiality.
	Language change	Se e ti lo gba awon result yen?	For clarity of expressions and accommodation of patients' linguistic backgrounds.
	Face-Threatening Acts	You needn't tell your wife lies.	For correcting, reprimanding patients.
	Counselling	Use medium toothbrush always. It's the most suitable for you.	For guiding patients right.

Table 4.6 (Contd.) : Discourse devices, excerpts and pragmatic functions

S/N	Discourse devices	Excerpts	Functions
	Modality	Can you describe the pain to me? Is it a sharp pain?	For obtaining medical information.
	Answer	I feel a burning sensation all over my body	For supplying the required information to make diagnoses.
	Circumlocution	I have body pain	For explaining ailments.
	Repetition	I should remove the milk teeth. Remove the milk teeth.	For emphasizing patients' medical challenges
	Closing	Thank you. Bye bye, Ma.	For rounding off the clinical interviews

Figures

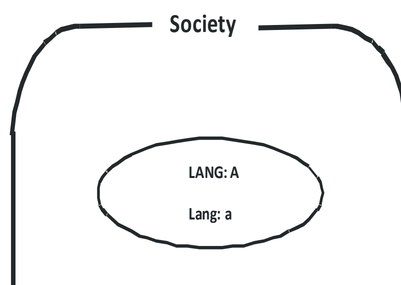

Figure 2.1: Simple code choice

(cf. Odebunmi 2010:6)

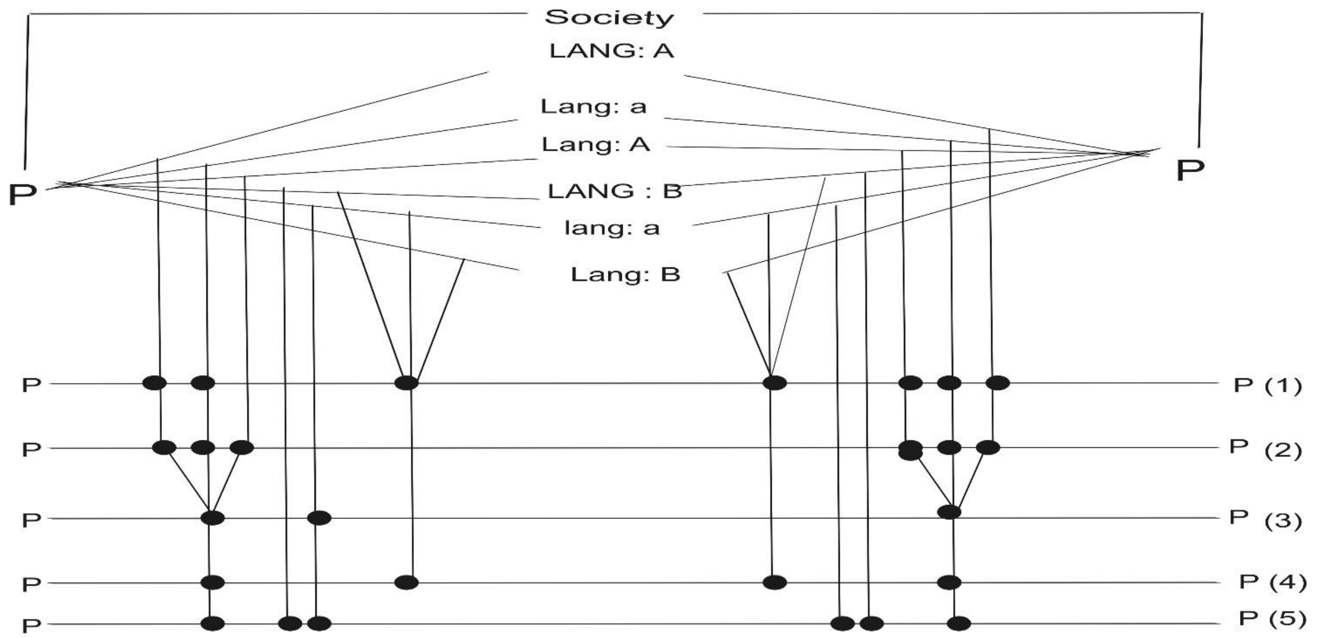

Figure 2.2: Complex code choice

(cf. Odebunmi 2010:6)