A SOCIOLINGUISTIC STUDY OF DOCTOR-PATIENT INTERACTION: A CASE STUDY OF ABUTH, SHIKA

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BEING A POSTGRADUATE SEMINAR PAPER PREPSENTED IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE AWARD OF A MASTER DEGREE (M.A) IN ENGLISH AND LITERARY STUDIES, AHMADU BELLO UNIVERSITY, ZARIA

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DECLARATION

I declare that the work in this thesis entitled "A Sociolinguistics Studyof Doctor-Patient Interaction: A Case Studyof ABUTH, Shika" has been written by me in the Department of English and Literary Studies, Ahmad Bello University, Zaria, under the supervision of Dr S. Abaya and Dr Shade Frank-Akale. The information derived from the sources of this study has been duly acknowledged in the text and a list of references provided. No part of this thesis was previously presented for another degree or diploma at any university.

| --- | --- | --- |
| Name of student | Signature | Date |

CERTIFICATION

This thesis entitled "A SOCIOLINGUISTIC STUDY OF DOCTOR-PATIENT INTERACTION: A CASE STUDY OF ABUTH, SHIKA" byMurjanatu Suleiman ShikaSuleiman meets the regulations governing the award of the degree of Master of Arts (English and Literary Studies), Ahmadu Bello University, Zaria, and is approved for its contribution to knowledge and literary presentation.

Dr. S. A. Abaya Chairman, Supervisory Committee	(Signature)	(Date)
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Professor KabiruBala Dean, School of Postgraduate Studies	(Signature)	(Date)

DEDICATION

This thesis is dedicated to God almighty for giving me the grace to complete this thesis.

ACKNOWLEDGEMENTS

With the sincere delight of a man who has welcomed and accepted God to live his live in his life, I give thanks to God for showing me mercy in my years of ignorance. It is not by my strength that I was able to complete this laborious research but the deep inputs and sagacity of my teachers were instrumental to the completion of this work. It digs deep into my heart to say 'Thank you' for the very impactful process they took me through during the course work and practical sessions of this completing my study. I must document my boundless gratitude to my supervisors, Dr S.A Abaya and Dr (Mrs) Shade Frank Akale for their deep-seated contributions and dedications to making this work a success. Through their efforts, I have discovered that real education lies in the process of writing a research than its completion. Thank you.

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ABSTRACT

The research entitled, "A SOCIOLINGUISTIC STUDY OF DOCTOR-PATIENT INTERACTION: A CASE STUDY OF ABUTH, SHIKA" explores the Sociolinguistics factors that constitute barriers in the communication between doctor and patients in the Ahmadu Bello University Teaching Hospital (ABUTH) Shika. It shows how factors such as language, sex, gender, religion and the register of medical practice affects diagnosis, recommendations and the rendering of care. Because of the location of the area of study, and the seeming language diversity of both the workforce and patients in ABUTH, the problem of effective communication arise. ABUTH is located in a predominant Hausa community in Shika yet English language or un-standardized version of Hausa is mostly used for diagnosis. This problem is made worse by the use of Medical language in the encounter that takes place between doctors-patients. This study, using Frankel's Functional Model of Communication, a theory under the tenet of Clinical Research, shows how the social relationships or power structure between doctor and patients affects the administering of care in medical encounter. The data were collected using covert observation and interview. The conversations between doctors and patients are tagged in interlocutions and each interlocution is analyzed along with the different social factors which affect doctor-patient conversation. The study finds out that the deployment of the language of medicine in the medical encounter between doctors and patients in ABUTH Shika affect diagnosis and the administering of care as doctors interrupt conversations with patients the assumption that the trajectory of patients' conversation.

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CHAPTER ONE

GENERAL INTRODUCTION

1.0 Background to the Study

Language is one of the important elements of development. It is the most basic tool for negotiating or ensuing interaction within or among a group, vocation, profession or occupation. It is important to development because it embodies the means by which humans in societies interact and seek understanding. Every society or vocation or field of discipline has its own language or jargons which they speak in the course of their work. The medical science is one of the disciplines that is known to have a wide array of jargons in its register. The medical practitioners in the Ahmadu Bello University Teaching Hospital (ABUTH)Shika put this jargon, or their medical parlance to use in the course of carrying out their duties. This practice, Oboho (2011) observes, affects the information-sharing that takes place between doctor and patient.

Premised on Oboho's observation and the veracity that occupational parlances affect effective, communication, it is imperative that this researcher inquires into the Sociolinguistic levels of interaction between doctor-patients in the ABUTH in Shika.

Sociolinguistics is the hallmark of the interface(s) between use of language and the society in which such languages are used (Radford 1999). The human society is clearly distinguished by the languages we use to communicate and as such, Sociolinguistics helps us to focus on the effects of the society on language. The language(s) we speak clearly marks the extent of developmental phenomenon in human race and this calls for the need to question the need for any reason of ill-feelings or bitterness amongst humans, which often raises the question between two feuding persons, especially when there are barriers in the communication.

The relationship between language and society is that of one not doing without the other. They are interrelated and interconnected. In the medical practices, the relationship does not only depend on the patient/doctor interaction but on the cultural background, socio economic status, beliefs, and religious factors circled around both the physician and the patient.

Outside the world of research laboratory and clinicals, there exist the daily routine of medical practice, a communication situation in which a doctor attempts to understand the problems of a patient and the patient attempts to understand the doctor's diagnosis. The initial symptoms are of critical importance as they guide the doctor's search towards the clinical signs of the condition. Communication is involved at all points in the medical consultation.

Communication in health practice is the bridge that spans the gap between the mind of a doctor and the patient. These communication skills that broaden to include the knowledge, attitude and skills which enable a doctor to know and respond to the disease as itaffects the mind and body of a patient. The bedrock of a good communication in health practice is not only the ability of the doctor to know the general background of the patient but also the ability of the doctor to feel the distress of the patient caused by the disease process. Once this ability is in place, the doctor becomes motivated to find a tune of communication and reorient service towards a more patient-centred-approach. The absence of these elements poses a great number of barriers that hinder the smooth communication which may never translate into action (Fagorusi 2011).

Effective communication without any barrier requires that intellect and emotions be joined together in the service of the alleviation of suffering and the promotion of health care by doctors adjusting their behaviour and attitude to the need and desires of the different patients and account for the impact of emotional, educational, and psychological issues on the main biomedical

ailments. It could be deemed to involve both content and form; the content is the product of the doctor's thoughts and the form is shaped by social situation in the context of the interaction.

1.2. Statement of the Research Problem

Social barriers or social differences inmedicalencounter impede effective communication; hence, information sharing between doctor-patientis problematic. In theAhmadu Bello University Teaching Hospital(ABUTH) Shika, as well as many other teaching hospitals, doctors underestimate patients' desire for information and misperceive the information giving by patients.This is because medical doctors strike the "all-knowing" position [by their guesses] in the communication process and as a result,diagnosis along with treatments is affected. More so, the transmission of information is related to characteristics of patients (sex, education, social class, and prognosis), doctors (social-class background, income, and perception of patients' desire for information), and the clinical situation (number of patients seen). Doctors' nonverbal communication abilities are associated with outcomes of medical care such as satisfaction and compliance. More so, social factors such as religion, status, sex and the age difference between doctor and patience affect the interaction that takes place between doctor and patient in the Ahmadu Bello University Teaching Hospital, Shika. Therefore, it is imperative to examine the nature of the Sociolinguistics relationships between doctors and patients and to see how treatments can bettered through effective communication.

1.3. Research Questions

This work seeks to answers to the following questions:

i. What are the characteristics of the conversation between doctor and patient in ABUTH?

ii. What are the sociolinguistic barriers in doctor/patient communication in ABUTH?

iii. How does the social factor affect the communication between the doctor and the patient?

iv. Who or what creates more of these barriers in the communication process between the doctor and patient?

v. To what extent can doctors and patients manage the factors that constitute problems that affects their communication?

1.4 Aim and Objectives of the Study

The aim of this study is to investigate the Sociolinguistic barriers in doctor-patient communication. In the light of this, specific objectives of the study are:

i. To revealthe range of communication between doctor-patient and how several factors or barriers impede effective communication.

ii. Toidentify the techniques that could be used to eliminate these barriers for a more positive and clearer communication between doctors and patients.

iii. Toascertainhow these barriers affect the rendering of care, diagnosis and treatment.

iv. Toexplain the factors that constitute barriers in doctor-patient relationship.

v. To demonstrate how doctors and patients can seek understanding and be understood.

1.5. Scope and Delimitation of the Study

This study focuses on the Sociolinguistic barriers that underpin the communication between doctors and patients. It focuses on the social impediments in the doctor-patient interaction in Ahmadu Bello University Teaching Hospital.

1.6. Justification of the Study

It is no doubt that there have been several works on the Sociolinguistic barriers in the communication that ensue between doctors and patients as far as medical encounters are concerned. Such works includeOken (1961), Reiser (1980), Kennell et al (1991) and Disbow, Bennett and Owings (1993) all of which are international works. Nonetheless, within the English and Literary Department of the Ahmadu Bello University, two works have been done but neither approached their studies from the bastion of Sociolinguistics. These works are Olu's (1995) "A Functional Study of the Language of Medicine: A Case study of Faculty of Medicine, ABU Zaria" and Ojo's (2009) "A Pragmatic Discourse Analysis of Language Use in Hospitals". As it stands, this is the first study that takes a Sociolinguistics look into the doctor-patient interaction in the ABUTH. This researcher embarks on this study with a view of contributing to the body of extant researches in the interdisciplinary studies of medicine and language in Nigeria.

CHAPTER TWO

REVIEW OF RELATED LITERATURE

2.0Introduction

The chapter two of this work is meant to review related literature in the area of Sociolinguistics. In the course of the review, authorial and topical issues are discussed. For authorial review, the works of Oken (1961), Reiser (1980), Kennell (1991), Disbow, Bennett and Owings (1993), Bamaiyi (2010), Joshua (2006) and Ibrahim (2011)are examined within the scope and historical development of Sociolinguistics.And for topical review, the work examines notions of communication, its processes, language and communication, barriers in communication,and the theoretical framework used in carrying out the investigation.

2.1Overview of Sociolinguistics

Sociolinguistics is a sub-discipline of linguistics that deals with the relationship between language and society. The term Sociolinguistics was first coined by Currie (1952) to mean the study that dwells on language in its social context and shows insight into the structure of both language and societies.

Holmes (1992:16) says, "Sociolinguistics' aim is to move towards a theory which provides a motivated account of the way language is used in a community and of the choice people make when they use language". Gumperz (1971:223) on the other hand, observes that Sociolinguistics is an attempt to find correlation between social structure and linguistic structure and to observe any change that occurs.

As a sub-discipline of linguistics, it also deals with any point at which these rules make contact with the society such as; where several other ways of expressing the same thing are chosen by different social groups (Coates 1993), Hudson (1996) Fielding and Frazer, (1978).

Sociolinguistics looks at how language influences society and also how that society influences language. This work basically focuseson language and society in relation to doctors-patient communication.

Meyerhoff (2006) posits that Sociolinguistics is a very broad field, and it can be used to describe many different ways of studying language. A lot of linguists might describe themselves as sociolinguists, but the people who call themselves sociolinguists may have rather different interests from one another and they may use very different methods for collecting and analyzing data. This can be confusing if one is coming new to the field. Is Sociolinguistics about how individual speakers use language? Is it about how people use language differently in different towns or regions? Is it about how a nation decides what languages will be recognized in courts or education? These are some of the questions that come to the minds of those who study the subject anew. If the answer to these questions is yes, it therefore means that Sociolinguistics concerns itself with how language, as a tool for social control, is studied in connection with the society.

Joshua (2006) in Ojo(2009) gives an encompassing explanation of Sociolinguistics when he explains Sociolinguistics as the study of language in relation to social factors, including differences of regional, class, and occupational dialect, gender differences and bilingualism. This explanation sees Sociolinguistics as the study of how language serves and is shaped by the social nature of human beings. Joshua (2006) explicating further, affirms that occupational dialect, language or jargonsimpedes communication especially when it used outside occupational environment. Joshua's affirmation may carry substance but it has over time raised questions because most occupational languages or jargons have found their ways into everyday use. For example, mathematical words, communication terminologies, medical, legal, theatrical words

have all found expression in daily usage. One key instance is the use of laparotomy in creative writing to mean a criticism or appraisal. This is a word that its domain in medical science but it has found a place in writing.

Thus far, there have not been any studies on the Sociolinguistic study of doctor-patient interaction in the ABUTH, Shika. The closest research that has been conducted on this area is that carried out byOlu (1995) and Ojo (2009) of the Department of English and Literary Studies in Ahmadu Bello University in Zaria and Ibrahim (2011) of ABUTH. The research, which is archived in the Department of Surgery, ABUTH, Shika examines the communication between the surgeon and the patient within a clinical context. The team of researchers finds training on communication skills important and suggested training in them. The research concludes that "residents (doctors) face difficult communication challenges with patients and families. There is a dire need for improved education in communication skills" (Ibrahim 2011).

Against this background, it can be argued that the quality of interaction or communication between medical doctors and the patients are important cornerstone to the art of surgery and care. This, and as Ibrahim *et al* observe, places Sociolinguistics on a very important pedestal. Surgery or care is a core clinical skill which may be complex because it involves interaction between individuals in unequal positions and may be associated with personal and intimate issues of vital importance and could be emotionally laden.

In the last decade, there has been an increasing recognition need to incorporate teaching of communication skills in the curriculum of both undergraduate and postgraduate students in medicine and surgery. However, no teaching hospitals have seriously adopted it despite the

recommendation by the West African College of Surgeons. The laxity of adopting this recommendation by teaching hospitals constitutes a barrier to effective doctor-patient interaction.

2.1.1Applications of Sociolinguistic Research

From its inception, Sociolinguistics has been concerned in a very practical sense with the functions language fulfils in social institutions and the organization of society. Research into the relationship between dialect and social class grew out of a perception that in many settings, language was used as a means of social control and status differentiation. Much work reflects a desire to understand better the ways in which language is used to perpetuate social distinctions, power differentials, advantages, and stigmas. Thus,Sociolinguistics has always been and continues to be a field of scholarship in which potential applications of research findings are readily apparent. For example, school curricula have traditionally presupposed standard language, ignoring the fact that the standard is accorded preferred status for social reasons alone and is hence closer to the speech of some children than to that of others. By virtue of this class-related distinction and the higher prestige associated with standard language, the language that is spoken in the surroundings of children's primary socialization influences their life chances was recognized as one of the linguistic mechanisms of sustaining social systems, a mechanism that stood in the way of realizing equality of opportunity.

Many Sociolinguistic projects were therefore designed not only to understand the properties and functions of class-specific speech and the differences between standard language and dialects, but also to enable both teachers and pupils to cope with these differences with muchdeference and thus help reduce language-related prejudice. Languages in socialization and in education are two areas of applied Sociolinguistic scholarship that have been especially active and prolific.

In the wake of extensive migration across linguistic and national borders, education systems in many countries have been confronted with school populations of diverse linguistic backgrounds. The presence in many societies of linguistic minorities – both autochthonous and recent migrant communities – has put the issue of bilingual education on the agenda of municipal, regional, and national governments. More often than not, the public debate surrounding language and the rights of linguistic minorities is controversial and highly politicized. In some cases, the courts have become battlegrounds for issues having to do with community rights and claims by speakers of minority languages to have their children instructed in these languages (Cummins, 1984; Hakuta, 1986).

Considerable pressure has been put on several countries – traditional immigrant countries such as the United States and Australia as well as former colonial powers such as Britain and France, and target countries of modern labour migration such as Germany – to redefine themselves as multilingual and multicultural and to adjust their school systems accordingly. This in turn has generated counter pressure on the part of those who do not want to see the school charged with the responsibility to teach and thereby support community languages. In this unresolved dispute, bilingual education is regarded as socially beneficial or disruptive, as a social asset or a threat to national cohesion, largely dependent on political inclinations. As García (1998) makes apparent, sociolinguists have an important role to play in this controversy, not just because they are called upon as expert witnesses by both sides, but also because their expertise is in demand when it comes to designing and evaluating bilingual education programmes.

Sociolinguists are also actively engaged in language-related problems of professions outside education (Trudgill 1984). Communication difficulties and breakdowns have been studied in the medical services delivery system (Mishler 1984), control towers and cockpits (Cushing

1994),business negotiations (Stalpers 1993), the judicial system (Solan 1994), and various other professional settings (Grimshaw et al. 1991). Recent years have seen the development of the role of language advisors in public administration and increased interest in language in industry and other areas of the economy (Coulmas 1992). Limitations of space make it impossible to survey more than one of these fields of applied sociolinguistic scholarship. In view of the ever-growing importance of litigation in modern society, especially in the United States, the legal profession has been selected for this purpose. Finnegan (1998) examines the contributions that sociolinguistic scholarship can make to resolving criminal cases and civil disputes.

In the same vein, Daoust (1998) provides a state-of-the-art report on language planning, an area of particular importance for a proper understanding of the intricate relationships between society and language, because it has to do with society's deliberate intervention in the course of a language's development. Other branches of the language sciences have very little to say about this, and theoretical linguistics in particular is both unable and disinclined to deal with it, since the very notion of planning a language interferes with its point of departure, the construct of "natural language." As a matter of fact, however, language planning is much more common than is usually thought. Language planning operates on the micro- and macro-levels of Sociolinguistics dealing with such issues as graphization, standardization, lexical augmentation on one hand, and status, prestige, and the functional allocation of languages in a society on the other.

While in most other fields of language-related inquiry language is taken as an object which has an existence of its own with which the speech community is confronted, language planning highlights a different aspect of the social nature of language, emphasizing as it does that, in some

respects at least, speakers and writers are the creators and masters of their language, hence the importance of language planning for the sociolinguistic enterprise as a whole.

2.2 Language and Communication

2.2.1 Language

Language is an indispensible tool for communication, socialization and interaction with one another. Language has, for centuries, remained the driving force with which thoughts are conveyed. Whether it is in spoken or in written communication, language plays the role of transmitting ideas, knowledge, experience and thought. It has been extensively described by researchers based on their beliefs and orientations. Few of these definitions shall be considered, including a working definition for this work.

The most frequently quoted definitions of language both within linguistics and outside is that of Sapir. Sapir (1921:8) one of the well-known American linguists and also one of the two who popularised linguistic determinism and the linguistic relativity hypothesis, defines language as a "purely human and non-instinctive method of communicating ideas, emotions and desires by means of voluntarily produced symbols." This definition, as Lyons (1981) observes, suffers from several defects. For example, a lot more is communicated than just ideas, emotions and desires. Moreover, it does not say what kind of symbols are produced, whether it is light, electromagnetic, sound, etc. (Essien, 2003). Another popularly quoted definition of language is that of Bloch and Trager (1942:5), as "a system of arbitrary vocal symbols by means of which a social group co-operates." This definition did not refer to the communicative functions of language; instead, it puts all the emphasis upon its social functions, which is a narrower view of the role language, plays in a society. However, as Essien (2003) observes, the definition advances Sapir's voluntarily produced symbols by stating that such symbols are vocalic, that is,

they concern sound. Chomsky (1957:19), the most influential and greatest linguist of our time, defines language in this manner: “a set (finite or infinite) of sentences, each finite in length and constructed out of a finite set of elements.” This purely structural definition did not say something on the communicative function of a natural or non-natural language. The last definition we will consider and which is our preferred one for this study is that of Essien (2003:14): “a system of structural arbitrary vocal symbols by means of which human beings make meaning and communicate, meet, interact with each other in a given community.” This definition has made explicit that language is a system, that is, a system of rules and principles in which sound, structure and meaning are integrated for communication. More so, language is a system because the components are ordered and not haphazard. It is primarily vocal in which the sounds correspond to meaning otherwise we would be making just noises. This implies that language in all its ramifications is meant for meaningful communication. We use it positively to teach, inform, explain, direct, inspire or negatively deceive, mislead, lie, or insult.

2.2.2Communication

Communication (from Latin "*communis*", meaning *to share*) is the activity of conveying information through the exchange of thoughts, messages, or information, as by speech, visuals, signals, writing, or behaviour.Communication for de Valenzuela (1992) is “any act by which one person gives to or receives from another person, information about that person's needs, desires, perceptions, knowledge, or affective states. Communication may be intentional or unintentional, may involve conventional or unconventional signals, may take linguistic or nonlinguistic forms, and may occur through spoken or other modes.”

Communication requires a sender, a message, and a recipient, although the receiver doesn't have to be present or aware of the sender's intent to communicate at the time of communication; thus communication can occur across vast distances in time and space. Communication requires that the communicating parties share an area of communicative commonality. The communication process is complete once the receiver has understood the message of the sender.

Human spoken and pictorial languages can be described as a system of symbols (sometimes known as lexemes) and the grammars (rules) by which the symbols are manipulated. The word "language" also refers to common properties of languages. Language learning normally occurs most intensively during human childhood. Most of the thousands of human languages use patterns of sound or gesture for symbols which enable communication with others around them. Languages seem to share certain properties although many of these include exceptions. There is no defined line between a language and a dialect. Constructed languages such as Esperanto, programming languages, and various mathematical formalisms are not necessarily restricted to the properties shared by human languages. Communication is the flow or exchange of information within people or group of people.

A variety of verbal and non-verbal means of communicating exists such as body language, eye contact, sign language, haptic communication, chronemics, and media such as pictures, graphics, sound, and writing.Manipulative Communications was studied and reported by Bryenton(2011). According to Bryenton,these are intentional and unintentional ways of manipulating words, gestures, etc. to “get what we want”, by demeaning, discounting, attacking or ignoring instead of respectful interaction. Sarcasm, criticism, rudeness and swearing are examples.

Convention on the Rights of Persons with Disabilities also defines the communication to include the display of text, Braille, tactile communication, large print, accessible multimedia, as well as written and plain language, human-reader, augmentative and alternative modes, means and formats of communication, including accessible information and communication technology.Feedback is critical to effective communication between participants.

Nonverbal Communication

Nonverbal communication describes the process of conveying meaning in the form of non-word messages. Research shows that the majority of our communication is non-verbal; also known as body language. In fact, 63-93% of communication is non-verbal. Some of non-verbal communication includes chronemics, haptics, gesture, body language or posture; facial expression and eye contact, object communication such as clothing, hairstyles, architecture, symbols, infographics, and tone of voice as well as through an aggregate of the above.

Speech also contains nonverbal elements known as paralanguage. These include voice lesson quality, emotion and speaking style as well as prosodic features such as rhythm, intonation and stress. Likewise, written texts include nonverbal elements such as handwriting style, spatial arrangement of words and the use of emoticons to convey emotional expressions in pictorial form.

Oral Communication

Oral communication, while primarily referring to spoken verbal communication, can also employ visual aids and non-verbal elements to support the conveyance of meaning. Oral communication includes speeches, presentations, discussions, and aspects of interpersonal communication. As a type of face-to-face communication, body language and choice tonality

play a significant role, and may have a greater impact upon the listener than informational content. This type of communication also garners immediate feedback.

Business Communication

A business can flourish when all objectives of the organization are achieved effectively. For efficiency in an organization, all the people of the organization must be able to convey their message properly.

Written Communication and its Historical Development

Over time the forms of and ideas about communication have evolved through the continuing progression of technology. Advances include communications psychology and media psychology; an emerging field of study. Researchers divide the progression of written communication into three revolutionary stages called "Information Communication Revolutions". During the first stage, written communication first emerged through the use of pictographs. The pictograms were made in stone; hence written communication was not yet mobile. For the second stage, writing began to appear on paper, papyrus, clay, wax, etc. The third stage is characterized by the transfer of information through controlled waves and electronic signals.

Communication is thus a process by which meaning is assigned and conveyed in an attempt to create shared understanding. This process, which requires a vast repertoire of skills in interpersonal processing, listening, observing, speaking, questioning, analyzing, gestures, and evaluating enablecollaboration and cooperation.

Misunderstandings can be anticipated and solved through formulations, questions and answers, paraphrasing, examples, and stories of strategic talk. Written communication can be clarified by planning follow-up talks on critical written communication as part of the every-day way of doing

business. A few minutes spent talking in the present will save valuable time later by avoiding misunderstandings in advance. A frequent method for this purpose is reiterating what one heard in one's own words and asking the other person if that really was what was meant.

Effective Communication

Effective communication occurs when a desired effect is the result of intentional or unintentional information sharing, which is interpreted between multiple entities and acted on in a desired way. This effect also ensures the message is not distorted during the communication process. Effective communication should generate the desired effect and maintain the effect, with the potential to increase the effect of the message. Therefore, effective communication serves the purpose for which it was planned or designed. Possible purposes might be to elicit change, generate action, create understanding, inform or communicate a certain idea or point of view. When the desired effect is not achieved, factors such as barriers to communication are explored, with the intention being to discover how the communication has been ineffective.

Hyme (1974) proposes an ethnographic framework of a communicative event given all factors that are relevant. He makes use of the word “speaking” as acronym for the various factors he sees relevant.

S - Setting and scene(s) – mean time & place where speech takes place while scene means or refers to the abstract psychological setting.

P- Participant – which include various speakers and listeners addressor = addressee, sender – receiver

E- Ends – those are the expected outcomes of an exchange as well as the personal goals the participant hope to achieve in a particular occasion.

A- Acts sequence – Actual form & content of what is said that is the precise words used, how day are used and the relationship of what is said to the actual topic at hand

K- Tone, manner or spirit in which a particular message is conveyed serious, precise, mocking, sarcastic etc. it could also be recognized nonverbally by certain behaviors such as gestures, posture etc.

I- Instrumentalities is the choice of channel in communication. Oral or written and also the dual form for speech apply such as language, dialect, code or register that is chosen.

Formal written legal language is one instrumentality even code switching between one language& the other is another.

N- Norms of interaction and interpretation. This the specific behave & properties that attach to speaking & also to how it may be viewed by someone who does not share than. E.g loudness silence,

G- Genre refers to dearly demarcated types of utterances; E.g poems, riddles, proverbs, prayers etc. These are usually done in specific ways apart from the usual speech.

Process of Communication

In other to fully understand the process of communication, one needs to have an understanding of the attached word to the subject matter "process". Berlo (1960:23) defines process as "something that does not have a beginning, an end, or a fixed sequence of event. It is not static, at rest. It is moving". Therefore, the entire ingredient within a process interacts; each affects all of the others.

Webster dictionary defines "process" as "any phenomenon which shows a continuous change in time" or "any continuous operation or treatment". From the Rhetoric, Aristotle (cited in Berlo 1960:29) says that, one have to look at three communication ingredients, the speaker, the speech,

and the audience. Meaning, each of the elements is necessary to communication; therefore, we can arrange our study under these three headings of:

i. The person who speaks

ii. The speech produced

iii. The person who listens

1. Shannon and Weaver (1949:5) say the ingredient in communication includes:

i. A Source

ii. A Transmitter

iii. A Signal

iv. A Receiver

v. Destination.

Nevertheless, Shannon and weaver have almost the same elements with that of Aristotle with just an addition of a transmitted. In whatever form it is in, the basic element must consist of who is communicating, why he is communicating and to whom he is communicating. In any communication process, there are elements to take in to account (Berlo 1960) they include:

a. We initiate communication

b. We respond to communication

c. We serve as communication observers or analysts.

Before the process takes place, there are some basic responsibilities a sender needs to put in place, they include:

a. Accuracy

b. Brevity

c. Clarity

That is, the sender must ensure that the message is accurate not approximate, very brief and not too long; the message should be clear; and should not be ambiguous.

The receiver also has three responsibilities, which are:

a. Attentiveness b. Biasfree c. Complete understanding.

Absolute concentration is needed on the message by the receiver whether listening or reading before it will be registered in his mind for understanding (Basvanthappa 2009).Presently, this study will make out communication process to consist of the following:

a. Source b. Encoder c. Message

d. Channel e. Decoder f. Feedback

i. Sources: will be the intended message. Berlo (1969:30) says it is that idea, needs, intentions, information, and a purpose for communicating.

ii. Messages the form of purposed source. Berlo also put it as "a behavior available in physical form - the translation of ideas, purposes, and intentions into a code, a systematic set of symbol". This is usually through language.

iii. Encoder is the person sending or transmitting the message. The encoder takes the ideas of the source and put it in a code, expressing the source's purpose in the form of a message.

iv. Channel is the medium use in transmitting the message. It is the carrier of message. There are several ways in which messages could be sent. It usually could be orally or written depending on the situation.

v. Decoders the intended perceiver of the message. The decoder is also call the receiver of a message.

vi. Feedback refers to information relayed from later to earlier stage. It also helps to reveal whether or not the meaning of the message sent is receive and understood.

In every encounter between the doctors and patients, these processes of communication are experienced and it is that which makes it easier to have a smooth communication but in case there is a problem, then we have a barrier in transmission. Other than that, both parties will be fully satisfied with their roles and communication achieved.

Therefore, for a better and smooth communication, the procedure must be in a process form: of the source, the encoder, the message, the channel, the encoder and the possible feedback.

Diagram

Source

Encoder --r Message --P. Channel -P. Decoder Feedback (Process of Communication) 2.2.4 Medium of Communication

a. The two basic medium of communication include;
b. i. Oral
c. ii. Written Communication
d. a. Oral Communication: This refers to communication through speaking. In any oral communication, there must be an objective message, which is not just to speakbut to accomplish an action.
e. Every Oral Communication must have deeded objectives of the message, formulate message with listeners in view, also content (which is designed with objective and listener in mind) and ensure that your receiver can hear to assimilate your message (Basvanthappa, 2009).

f. Written Communication: This refers to communication put down in written text. This also involves some kind of authority. For instance, an order of sick-leave must be in writing. It also formulates enforcement. This is use in keeping permanent records and in doing so; messages must be clear, correct, complete and concise. The language must be easily intelligible especially to the person concern. Use of simply words and phrase should be employ and avoid ambiguous terms. (Basvathappa, 2009).

g. There are three forms of written communication. They include:

Reports

ii. Letters/Memos

iii. Notices

Anytime you expect your receiver to retain information for a longer period and for future use then it is better to give it in writing.

In doctor-patient communication, both oral and writing communication is applicable in every encounter. For instance, at every visit a patient goes to the hospital to see his/her doctor, speech is constant (oral) in the process of explaining what you came for. Subsequently the doctor put down your explanation down on his patient report sheet (written) and then writes your prescription of medication on his medication sheet form for your treatment, in essence, both oral and written communication takes place at the doctor's office the hospital.

Model of Communication

These are steps that help to understand what communication is, describing what really occurs when two or more people interact. They include.

i. Linear Model

ii. Transactional Model

h. Linear Model:- In this kind of communication, it been described like giving an injection, this is a senders ideas and feeling into some sort of message and then conveys them to the receiver who decodes them. Basically, an important element of the linear communication is channel: that is the method by which a

i. Message is conveyed from one person to another or between people. For most people, face-to face contact is the most familiar channel. Especially in our case study doctors - patient interaction, but there are other channel such as writing and even mediated communication channels which deals with email, telephones, instant messaging, faxes, and voice mail have a great difference in the effect of a message. For instance, a type written note to your doctor would not explain vividly what pains you are experience and thus would not have a great effect than if you are to see him yourself.

j. There are several factors to be consider when choosing a channel, they include;

k. - Time Required for feedback

l. - Amount of information conveyed

m. - Sender's control over how message is compose

n. - Control over receiver's attention

o. - Effectiveness for detailed messages

For illustration, our case study will be used as example, which is doctor - patient interaction.

- Definitely it is a face -to - face channel
- Its immediate (that is after contact has been established) - Highest

- Moderate - Highest - Highest

In transactional Model: The in transactional model reflects the fact that we usually send and receive message simultaneously. Here, the roles of sender and receiver that was separate in

superimposed and redefine as those of communication. That is to say the term reflect the fact that at a given moment we are capable of receiving, decoding and responding to another person's behavior while at the same time that other person is receiving and responding to ours too. For instance as you are telling a story to a friend he yawns or Imagine someone eating one spoon of your prepared food and runs to the toilet.

a. This shows that nonverbal behaviors sure as these shows that faceto-face communication is a two - way affair.

The in-transactional model also shows that communication is not what we do to others but what we do with others. Psychologist Kenneth Gergen captures the relational nature of communication well when he points out how our success depends on interaction with others; he says "... one cannot be attractive without others who are attracted, a `leader' without others willing to follow, or a `loving person' without others to affirm with appreciation. Hence, communications are transactional in nature especially when they involve more than one person.

This is also in a case of a doctor and his patient in the hospital where they converse together in other to understand the problem of the patient and a proper treatment to be administered.

Functions of Communication

Berlo (1960:8) citing Aristotle notes that the prime function of communication is information sharing and persuasion. It is an attempt to sway other men to the speaker's point of view. This view of function of communication became popular in the 18th century when a school of thought known as Faculty Philology was developed. The school sees the function of communication in three ways;

i. Informative

ii. Persuasive

iii. Entertainment

However, Adler and Rodman (2006:11) view the function of communication base on the needs it satisfies.These needs include;

i. Physical needs

ii. Social needs

iii. Practical needs

iv. Identity needs

Physical Needs: - Communication is very important and necessary in physical health. A lot of research have been done and clearly shows a wide range of hazards associated with lack of close relationship. This includes;

- People who lack strong relationship have two or three times the risk of early death, regardless of whether they smoke, drink alcoholic beverage, or exercise regularly.
- Terminal cancer strikes socially isolated people more often than those who have close personal relationship.
- Divorced, Separated, and widowed people are five or ten times more likely to need hospitalization for mental problems than their counter parts.
- Pregnant women under stress and without supportive relationship have three times more complications than pregnant women who suffer from the same stress and with strong social support.
- Social isolated people are four times more susceptible to the common cold than those who have active social networks.

Research has also indicated that social isolation is a major risk factor contributing to coronary disease, comparable to physiological factors such as diet, cigarette smoking, obesity and lack of

physical activity. This is definitely showing the importance of having personal relationship just like in an old paraphrased song, which says, "people who need people" aren't "the luckiest people in the world, "they are the only people!

Social Needs: - Communication provides a vital link with others and thus, researchers and theorist have identified a range of social needs we satisfy when we communicate. These include:

a.- Pleasure; (because I want to have a good time)

Affection; (to let others know I care)

Inclusion; (because I need someone to be with) Escape; (I put off something I should be doing) Relaxation; (because it allows me to be stress - free) Control; (for instance, I want someone to get something I don't have).

Life would have been empty if these social needs were not satisfied and to fulfill them will be very impossible without communicating with others. Some theorists have argued that communication is the primary goal of human existence. Anthropologist Walter Gold - Schmidt terms the drive for meeting social needs as the "human career".

a. Practical Needs:-Communication is the tool that lets us tell the doctor or direct him to where it hurts, inform the plumber that the broken pipe needs attention now! and tell the cook the food is
b. Salty. Apart from these needs, researches demonstrate that communication is an important key to effectiveness in a variety of every day setting. For instance several employers identified communication skills as the top characteristics that employers seek in job candidates. It was rated as more important as than technical competence, work experience, or academic background.

Communication is just as important outside of work too as in the case or married couple who were identified as effective communicators reported happier relationships than did less skillful husband and wives.

Identity Needs: - Communication is a vital tool in human lives and indeed the only way- human being learns who he is. Our sense of identity comes from the way we interact with other people: that is; smart or stupid, ugly or attractive, inept or skillful. All these are based on how others react to us.

Communication is very important too and to deprive it will mean no sense of identity. It also shape's our identity. In 1970 it~ was reported that authorities discovered a twelve year old (whom they called "Genie"), who had spent virtually all her life in an otherwise empty, darkened bedroom with almost no human contact. The child could not speak and had no sense of herself as a person until she was removed from her family, and "nourished" by a term of caregivers.

Like Genie, each of us enters the world with no clue of who we are. We gain an idea of who we are from the ways others define us. "The messages we receive from childhood are the strongest but the influence of others continues throughout life".

a. Some scholars argue that we are most attracted to people who confirm our identity and this confirmation comes in many ways depends on self- image of the communicator. It is also said that people with relatively high self - esteem seek out others who confirm their value and, as much as possible, avoid those who treat them badly. If you viewed yourself as a loser, you may associate with others who will confirm that self-perception.

The role of communication in shaping identity works in a second way. Besides others' messages shaping who we think we are, the messages we create often are attempts (some more conscious than others) to get others to view us the way we want to be seen. For example, the choice we

make about how to dress and otherwise shape our appearance are usually attempts to manage our identity (Adler & Rodman 2011).

Our identity comes almost exclusively from communication with others (Combs andSnygg 2001).

2.3 Health Communication

From time long-established, communication has been identified as the inalienable endeavour which are integral to human existence (Rogers et al, 1985). Although there has been countless definitions given to the word, the semantic implication that could be inferred is that it has to do with the process of sending or disseminating and receiving information. It is the avenue through which members of a society are informed (Chaffe, 1982:112). It is pertinent to note the word 'informed' when they know about happenings around them. On the other hand, people are informed when they receive information that influence or modify their attitudes, opinions or behaviour (Fee, 1987:112).

The scope of health communication includes disease prevention, health promotion, health care policy, and the business of health care, as well as the enhancement of the quality of life and health of individuals within the community. This may also include reproductive and sexual health concerns. Disease prevention is cheaper given the huge cost involved in obtaining quality health care which is almost non-existent especially in third world countries.

Health Communication is an important field of study within Sociolinguistics and has developed over the last thirty years. It is concerned with the "central role of human and mediated communication in the provision of health care delivery and health promotion" (Kreps and Query, 1990: 293). Health communication as a field of study has two major interdependent branches –

provision of health care and promotion of public health. According to Matteucc (2012), the health care delivery scholars examine how communication influences the delivery of health care. The scholars have primary interests in the ways interpersonal and group communication influences, health care delivery, focusing on issues such as the doctors/patients relationship, therapeutic communication, health care teams, health care decision-making, and the provision of social support. On the other end, the health promotion scholars study the persuasive use of language to promote public health. The scholars in the field have interests in Sociolinguistics especially as it concernshealthcare delivery, treatment, implementation and evaluation of persuasive health communication campaigns to prevent major health risks and promote public health. Many health promotion scholars are concerned with evaluating the use of mediated channels of communication to disseminate relevant health information. Other scholars have developed campaigns for preventing public risks for contracting diseases such as Cancer, Heart disease and HIV/AIDS. In Nigeria, it is common to see adverts campaigning on the prevention of malaria, the early detection of cancer, the risk associated with early initiation of unprotected sex, the need to breast feed a child thoroughly and other related adverts. However, most of the adverts or publicity, seldom consider their language use on their campaigns. This affects the message that is passed on to the public.

Fishbein and Cappella (2006:39) further argue that for individuals, effective health communication can help raise awareness of health risks and solutions, provide the motivation and skills needed to reduce these risks, help them find support from other people in similar situations, and affect or reinforce attitudes. Health communication also can increase demand for appropriate health services and decrease demand for inappropriate health services. It can make available information to assist in making complex choices, such as selecting health plans, care

providers, and treatments. For the community, in this case, Shika, health communication can be used to influence the public agenda, advocate for policies and programmes, promote positive changes in the socioeconomic and physical environments, improve the delivery of public health and health care services, and en- courage social norms that benefit health and quality of life.

Health communication also occurs across different channels of communication. It could be face to face communication between doctors and patients, members of health care teams, and support group members are the focus of many health communication studies – broad range of personal (telephone, mail, fax, e-mail) and mass (radio, television, cinema, new communication technologies) communication media are also the focus of health communication inquiry. Health communication could also occur in diverse social contexts - homes, schools, offices, clinics, and hospitals. In addition to this, diverse issues are also involved. They include the following - role of interpersonal communication in developing cooperative health care provider/consumer relationship; role of comforting communication in providing social support to those who are troubled. It also includes the effects of various media and presentation strategies in the dissemination of health information to those who need such information, the use of communication to coordinate the activities of interdependent care providers and the use of communication for administering complex health care delivery systems.

Health communication as a health discipline facilitates the delivery of high quality health care by disseminating vital health information to the public. The mass media, particularly the internet, plays a primary role in this regard. Moreover, health communications is concerned with fostering strong links between health professionals and patients. By enhancing health professional-patient communication, patients can make informed decisions regarding their health, and healthcare providers can ensure that their patients adhere to clinical recommendations and treatment

programmes. Effective communication guides the public, the news media, healthcare providers, and patients to respond appropriately to disease outbreak. Effective health communication is essential because it equips the public with the tools and knowledge to respond appropriately to health crisis such as flu outbreaks, HIV/AIDS, other Sexually Transmitted Infections and malaria. Some features of effective health communication helps to catalyze behavioural changes on a societal level. A high impact health communication galvanizes entire communities into action, prompting them to live a healthy lifestyle by taking the necessary measures to prevent disease and to protect, maintain and improve their own health, such as good nutrition, regular exercise, responsible sexual behaviour, eschewing destructive behaviours such as cigarette smoking and drug abuse.

Those who design interventions to improve health behaviours are faced with a number of decision points when developing interventions. These decisions include the primary goal of the intervention, its target population, and the selection of messages for the intervention. Fishbein and Cappella (2006:39) explains that information and education play vital roles in promoting health including preventing, managing, and coping with disease, and in supporting appropriate decisions across the spectrum of health care. For individuals, effective health communication can help raise awareness of health risks, provide motivation and skills to reduce them, bring helpful connections to others in similar situations, and offer information about difficult choices, such as health plans and providers, treatments, and long-term care. For the wider community, health communication can set the public and social agenda, advocate for healthy policies and programs, promote positive changes in the socioeconomic environment and health infrastructure, and encourage social norms that benefit health and quality of life.

Health communication encompasses the study and use of communication strategies to inform and influence individual and community decisions that enhance health. It links the domains of communication and health and is increasingly recognized as a necessary element of efforts to improve personal and public health. Health communication can contribute to all aspects of disease prevention and health promotion and is relevant in a number of contexts, including health professional-patient relations, individuals' exposure to, search for, and use of health information, individuals' adherence to clinical recommendations and regimens, the construction of public health messages and campaigns, the dissemination of individual and population health risk information, that is, risk communication, images of health in the mass media and the culture at large, the education of consumers about how to gain access to the public health and health care systems, and the development of tele-health applications (Fishbein and Cappella 2006).

The practice of health communication has contributed to health promotion and disease prevention in several areas. One is the improvement of interpersonal and group interactions in clinical situations (for example, provider-patient, provider- provider, and among members of a health care team) through the training of health professionals and patients in effective communication skills (Jackson and Duffy 1998). Collaborative relationships are enhanced when all parties are capable of good communication. Another area is the dissemination of health messages through public education campaigns that seek to change the social climate to encourage healthy behaviours, create awareness, change attitudes, and motivate individuals to adopt recommended behaviours. Campaigns traditionally have relied on mass communication.

To date, Nigerians have been swamped by a message culture which in the context of health tends to tell people what is good for them, and generally has been rather didactic in nature. Educational and communication channels are filled with radio jingles, public service adverts soap operas,

brochures, posters and health talks: all produced to sensitize and mobilize people as a result of their increased awareness and knowledge. The assumption is that if people know about risk factors for disease and about ways to minimize the risk of illness, they will take desired action.

In reality, these approaches have not been sufficiently targeted to their audiences and their needs and have suffered from insufficient resources and/or professional engagement about the choice of communication vehicles to use and its actual impact. Awareness and increased knowledge does not necessarily translate into behaviour change. The extent to which an individual or community is 'empowered' to make decision to change their behaviour is determined by social factors such as gender, resources, class and education.

These are underpinned by a pre-requisite which provides the essential link in the developmental chain, that is, self-efficacy which centres on "… people's beliefs and about their capabilities to exercise influence over events that affect their lives. Self-efficacy beliefs determine how people feel, think, motivate themselves and behave" (Bandura, 1994).

All communication is contextual; it does not happen in isolation and depends on whom and where people are, and their cultural and societal relationship to each other. Complex health care challenges increasingly call upon a more holistic response. In order to catalyze behavioural changes at a societal scale, health communication, as in the interactions between doctors and patients, must also address the cultural and Sociolinguistics dimensions of health care challenge.

In communicating health, it is not about passing information but understanding the context in which the information is disseminated. For example, in human reproduction, the key to human survival and the continued good healthy living of billions of people in the world, has always been among the most challenging and sensitive areas in public health (Piotrow*et al.*,1997). It is

however a painful fact that many people would rather argue that reproduction is not a public health issue and what should be left to individual reasoning, personal choice, family privacy, religious injunction, or traditional convention, what they fail to realize unfortunately is that in matters of reproduction and sexual behaviour, private behaviour has public consequences. One of the major challenges to the designing, implementing, and evaluating public health programmes in teaching hospitalsis the inattention given to the role of Sociolinguistics and this inattention, over time, has constituted a bottomless barrier in the interaction between doctors-patients. Since there are implicit power relations at work in many cultures that can hinder effective health care delivery if they are not taken into account during programme planning, it is necessary to mind the place of statuses, roles, language, gender in rendering healthcare. These are barriers to effective interaction in the medical domain. For instance, in indigenous communities where men are the primary health care providers, young single women from health care organizations who attempt to serve as health care providers are often met with suspicion and mistrust. Knowing the existence of such a cultural mind-set in advance allows healthcare managers to allocate human resources in a suitable manner.

In view of themany barriers to effective doctors-patients interaction, what is needed is systematic health communication strategy in the view to reorienting and conscientizing people and an adoption of principles of Sociolinguistics in promoting healthcare (Adejimola 2010:117). Essentially, communication is a tested and trusted process of enhancing change in knowledge. Enhancing this change in knowledge requires a vehicle, language; not what is said but how it is being said; what information is passed; and what message is gotten. Having said this, however, it is pertinent to consider a communication strategy that could carry along with it Sociolinguistics assumptions. Many of such strategies abound but in functional terms, according to (Piotrow et al,

1997:112), systematic communication strategy must make provisions for the following to be effective - an assessment of the communication needs of the patients; relevant training communication skills and management; specific product like posters, videos, brochures and others; technical assistance to communication strategies and campaigns; evaluation of communication interventions. Often, especially when working in a different cultural and social context, it is necessary to engage with a community “from within” in order to build an environment of trust. Understanding the cultural practices of a given community can shape the problem-solving approach in crucial ways. To engage strategically with culture in developing healthcare programmes is to look at the way in which culture influences lifestyles, in particular their attitudes towards health, and using the knowledge thus acquired to develop a culturally-relevant intervention programme.

2.4Barriers to Effective Human Communication

Barriers to effective communication can retard or distort the message and intention of the message being conveyed which may result in failure of the communication process or an effect that is undesirable. These include filtering, selective perception, information overload, emotions, language, silence, communication apprehension, gender differences and political correctness. This also includes a lack of expressing "knowledge-appropriate" communication, which occurs when a person uses ambiguous or complex legal words, medical jargon, or descriptions of a situation or environment that is not understood by the recipient.

Physical Barriers

Physical barriers are often due to the nature of the environment. An example of this is the natural barrier which exists if staffs are located in different buildings or on different sites. Likewise, poor or outdated equipment, particularly the failure of management to introduce new technology,

may also cause problems. Staff shortages are another factor which frequently causes communication difficulties for an organization. Whilst distractions like background noise, poor lighting or an environment which is too hot or cold can all affect people's morale and concentration, which in turn interfere with effective communication.

System Design

System design faults refer to problems with the structures or systems in place in an organization. Examples might include an organizational structure which is unclear and therefore makes it confusing to know who to communicate with. Other examples could be inefficient or inappropriate information systems, a lack of supervision or training, and a lack of clarity in roles and responsibilities which can lead to staff being uncertain about what is expected of them.

Attitudinal Barriers

Attitudinal barriers come about as a result of problems with staff in an organization. These may be brought about, for example, by such factors as poor management, lack of consultation with employees, personality conflicts which can result in people delaying or refusing to communicate, the personal attitudes of individual employees which may be due to lack of motivation or dissatisfaction at work, brought about by insufficient training to enable them to carry out particular tasks, or just resistance to change due to entrenched attitudes and ideas.

Ambiguity of Words/Phrases

Words sounding the same but having different meaning can convey a different meaning altogether. Hence the communicator must ensure that the receiver receives the same meaning. It is better if such words are avoided by using alternatives whenever possible.

Individual Linguistic Ability

The use of jargon, difficult or inappropriate words in communication can prevent the recipients from understanding the message. Poorly explained or misunderstood messages can also result in confusion. However, research in communication has shown that confusion can lend legitimacy to research when persuasion fails.

Physiological Barriers

These may result from individuals' personal discomfort, caused—for example—by ill health, poor eyesight or hearing difficulties.

2.4.1Functions of Language in Communication

1. Therapeutic/Regulatory (regulating the behavior of people).
2. Instrumental (satisfying sum material needs)
3. Interactional (maintaining social relationship)
4. Personal (pressing personality)
5. Heuristic (investigation, the environment)
6. Imaginative (playing & creating)
7. Representational (expressing positions)

We learn language in order to use it in describing things that people do with communication. This is where the issue of communicative competence comes in to play.Gumpers (1972) explains the term by saying, "whereas linguistic competence covers the speakers ability to produce grammatically correct sentences, communicative competence describes his ability to select from the totality of grammatically correct expressions available to him, forms which appropriately effect the social norms governing behaviour in specific encounters. In essence, it is different

learning a language (linguistic) competence and quite another in learning how to use that language (communicative competence)SarilleTroike (1996:363).

"Communicative competence extends to both knowledge and expectations of who may or may not speak in certain setting; when to speak and when to remain silent, whom one may speak to, how one may talk to persons of different statues and roles, what nonverbal behaviours are appropriate in various contexts, what the routines for turn taking are in conversation enforce discipline, and the link – in short, everything involving the use of language and other communicative dimensions in particular social setting."

Therefore, in learning to speak (talk) we are obviously trying to communicate in various ways suitable to the environment in question. And this is different from one group to the other; meaning must learn the different ways of each group (Language) to be able to set in to the society.

2.5 The Language of Medicine

The language of medicine, Okoobo (2012) argues, is rooted in Greek despite the overabundance of medical terms in Latin. The language of medicine, just like history itself, cuts through time. From Greek to Roman, Latin, Arabic to English, different medical terms have emerged to show the different landscapes and sociolinguistic culture which the medical discipline has gone through. However, of all these languages and cultures, MacClean and Maher (1994) note that English Language emerged as the predominant lingua franca in medicine in the 20th century. Supporting this claim, Rogulj and Cizmic (1999) submits that English is "by far the most used language in international medical meetings as well as the main medium for medical textbooks, journals and abstracting indexes". Marusic (2005) further explains that English has steadily

replaced other languages in research literature and has become the lingua franca of the international science community. The implication of this on this study is that the language itself constitute barrier in a Hausa dominated community like Zaria. Secondly, the parlance of medical science during interaction with patients sometimes distorts what is understood from what is said from doctor-patient. This is because of the use of the use of the medical variety of English.

According to Hudson (1980:24), varieties of language use abound in different occupation. Variety of language, Hudson note, is "a variety set of linguistic items with similar social distribution." According to Olu (1995), it could be defined in terms of specific sets of linguistic items or human speech patterns. For example, sounds, words, grammatical features which can uniquely associate with some external factors like geographical areas in social group.

English language is an instructional language, the most pervasive in the world in the field of medicine. English has a lot of varieties. It contains the sum total of all the terms in all its dialects, with Standard English as one dialect among others. Occupation, social life and education are the major determinant of the varieties of language. Standard English is the ideal variety of English that we use for expression when we wish to communicate with wider population. Its varieties, Oluobserved, are differentiated by the kind of linguistic terms used. There is the occupational variety and social variety. Each of the two varieties has their own register and styles which are limited to them.

The language of medicine, being one of these occupational varieties of Standard English, is used by the medical professionals or by people who operates within medical setup. Thus, during medical conversation, words belonging to the medical register are mostly used. Register is a variety of language distinguished by according to use (cf. Olu 1995; Wallwork 1969). For

Wardbough (1980), it is a set of vocabulary items associated with distinctoccupational or social group. Wilkinson (1971) sees it as the kind of variety of English appropriate for a particular purpose in a particular situation having regard to subject, addressee and context.

Register serves as a means ofexcluding outsiders because unless someone is acquainted with its registers, he or she cannot understand what is being said. The spoken form of language of medicine is mostly interrogative form, where patient answers question. It also involves the use of conversation.

The style used in medical conversation, Ojo (2009) note, is the stiffformal method done with certain degree of formality in order to ensure maximum comprehension of the subject under discussion. It involves declarative statements, questions, answers and instructive statement.

More, the use of emphasis on key point or words in order to communicate effectively in a particular context. Words in the medical practice are also used economically. Thus, the use of precise abbreviation is rampant. Medical language all over the world has the same characteristics and whoever is in medical profession learns the language alongside the profession with its appropriate usage (Olu 1995).

Medical language is flexible in nature. It can adapt to different situations within medical setup. As Olu notes, one can easily identify medical language. For instance, when two medical practitioners are discussing an issue that is purely medical, words such as “diagnose”, “operated”, “pathology” and “recommend” would be found.

In medical encounters, the tone of impersonality is a commonplace. The tenses of medicine during diagnosis, prescription or care-rendering are given on the collectives. Plural pronouns are

most used. For instance, examples such as, “we” advice that…, “it was discovered by “us” that…are mostly used to signify that decisions are taken collectively.

2.6Doctor-Patient Communication

Communication and relationship have long been understood as important in medical care. For example, as noted earlier, early Greek physicians such as Plato warned that telling bad news to patients should be avoided because it could worsen their condition (Reiser 1980). This view of avoiding certain types of communication continued into the modern era and was reflected in the first code of medical ethics adopted by the American Medical Association in 1847, which stated, “It is a sacred duty [of a physician] to avoid all things which have a tendency to discourage the patient and depress his spirits.” A study by Oken (1961) confirmed that things had not changed much as late as the 1960s.

In a study, according to Frankel (2000) a suggestion by the surgeon of an early return of bowel function following abdominal surgery resulted in a 3.9-day difference in experimental versus control subjects (2.6 versus 6.5 days). It also reduced the length of hospital stay by half (from 8.1 to 4.1 days) (Disbrow, Bennett, and Owings 1993). Another study of pregnant women, some of whom received continuous emotional support from a doula (a woman specifically trained to provide such support) and others who received usual care, produced significant differences in a range of outcomes from the duration of labor to neonatal hospitalization (Kennell et al. 1991). Finally, a report by Smyth et al (1999), demonstrated that patients with rheumatoid arthritis (RA) and asthma who wrote about the emotional experience of these two chronic diseases three times a week for twenty minutes got nearly the relief of symptoms that patients taking ingested or inhaled steroids did.

Research demonstrating the effects of communication and interaction on medical care processes and outcomes has drawn increasing interest and attention from linguists, clinicians, medical educators, and policy makers. A body of research representing a new synthesis of basic and applied knowledge of language in the context of clinical practice has emerged as a result. An early paper by Inui and Carter (1985) provide a useful frame of reference for this type physician patient communication research. They argued that in addition to developing objective scales and measures of communication, it is important to retain the full richness of and complexity of human interaction by exploring it naturalistically and sequentially. At the time they lamented, "the most commonly applied analytic strategy is to develop communicator profiles based on frequencies of behaviours of various types. This approach is analogous to describing 'Hamlet' as a play with 21 principal characters, a ghost, a group of players, and various numbers of lords, ladies, officers, soldiers, messengers and attendants–one of whom is already dead, one of whom dies by drowning, one by poisoned drink, two by poisoned sword, and one by sword and drink!". Following Inui and Carter's analogy, Frankel argues that there is a need to understand communication in medical encounters in its broad sociolinguistic context that is defined by the moment-by-moment organization of interaction in face-to-face encounters. He tries to clarify and refine the contribution of sociolinguistic micro interactional analysis to our understanding of the clinical care process and its outcomes. He uses the phrase "sociolinguistic turn" to denote a historical trend within the social and behavioral sciences and a growing recognition within the clinical sciences, that "the doctor-patient relationship is the heart of medical practice".

2.6.1 Sociolinguistic Barriers in Doctor-Patient Communication

Waitzkin (1984) acknowledges that the barriers that affect communication in medical encounter vary. According to him, this barrier ranges from listening to speaking.

1. **Listening barriers** -

(a) Interrupting the speaker

(b) Rushing the speaker to complete what he/she wants to say

(c) Not maintaining eye contact with the speaker

(d) Making the speaker feels as if he/she is wasting their time

(e) Being distracted by something which is not part of what is going-on

(f) Completing the speaker's thoughts ahead of him /her

(g) Ignoring the speaker's request

(h) Adding someone examples to the speakers story

(i) Forgetting what is being discussed

(j) Not asking/asking too many question for the sake of probing

2. **Speaking barriers** -

(a) unclear message

(b) Uses of medical grammars that can't be understood by the hearer

(c) Incomplete sentences

(d) Lack of consistency in the communication process

(e) Not seeking clarification while communicating to the hearer

(f) Emotional block which can lead to indifference, hostility toward the subject

(g) Words having different meaning to different people thus blocking communication.

(h) Use of negative

Basically, language barrier poses a lot of problems for the physician to understand the problems of the patents this could lead to misinterpretation of the patients compliant and also incorrect diagnoses.

Another problem with language barriers in the health care system is the absence of an effective interpreter or the proxy interpreters who sometimes misinterpret what the patient or physician says and who does not also understand the importance for confidentiality when it comes to medical profession/problems. Patients also might not explicitly explain their problems to the doctor because of the present of the interpreter who might/may be a friend, family or staff. In most cases, sexual transmitted diseases, sexual abuse, domestic violence and drug abuse are common illness that the patient may not be comfortable with the presence of a third party.

An additional issue with communication barriers in the hospital, according to Oboho (2011), includes child patient. Some children cannot speak to say what is wrong with them clearly or may sometimes hide or lie in order to avoid possible punishment from their parent. Most of the cases include children suffering from domestic abuse, sexual abuse either from their guardians or parent and may be scared to say what happened. This leads the doctor to one side story/biased diagnosis.

2.7The Patient in Theories of Social Action

Sociological Theory

Parsons (1951) is credited with first theorizing about the social relation between doctor and patient. In essence, Parsons' view of the social world of doctors and patients took the perspective of the professional. Disease, the sick role, and less dramatic forms of disequilibrium like failure to follow "doctor's orders" were viewed as a form of deviance. Doctors were seen as technical experts with high decision-making status. Patients were seen as dependent and. unable to discern the causes of their problems. A quote from *The Social System* is instructive: The patient has a need for technical services because he doesn't— nor do his lay associates "know" what the matter is or what to do about it. . . . The physician is the technical expert who by special training and experience and by an institutionally validated status is qualified to help the patient. (Parsons 1951: 441)

The trouble with Parsons's formulation was that it reduced the patient's role to being passive and dependent and the definition of the situation as being totally under the control of the physician (professional dominance).

Common sense and experience make clear that patients in a medical encounter bring their own thoughts, feelings, experiences, and sense-making practices (lay diagnoses, for example) to bear on whatever ails them. For Parsons, the details of just how lay and professional perspectives come into play in and through face-to-face interaction was de-emphasized in favour of the more abstract concept of how social roles, norms, and institutions exert effects on a particular type of social relation.

Cognitive Theory

In the mid-1970s, Becker (1974), Becker and Maiman (1975), and Rosenstock (1974) began to focus on patient perceptions of health and health care as a mediating factor in understanding health behaviour. The Health Belief Model focused attention on the influence that perceptions of health and illness, susceptibility, severity, and costs had on outcomes such as adherence to medical recommendations. In a related development Kleinman (1980), an anthropologist and physician, coined the term "patient explanatory models" to characterize patients' thinking about the causes and consequences of disease and illness. Kleinman's conceptualization, informed as it was by an anthropological preoccupation with understanding the worldview and experiences of patients, was broader and more inclusive than the Health Belief Model.

The concepts of health beliefs and explanatory models as cognitive structures clearly showed that patients' views of themselves and their health status affected subsequent behavior such as following medical recommendations. That this was so was well demonstrated. *How* it was accomplished in the face-to-face meeting of a physician and patient remained a "black box" open to speculation but with very little empirical evidence. From the perspective of cognitive theory, language performance was at best an indirect link to cognition and the processes that underlie it. The representation of the patient was certainly fuller and more complete than it was in Parson's scheme but still lacked the specificity of being able to track and understand the moment-by-moment development of the encounter over time.

Sociolinguistic Theory

In the late 1970s, a new view of the doctor-patient relationship began to emerge. In a classic paper in the journal *Science*, Engel (1977:132) calls attention to the medical interview as a bio psychosocial event, not merely as a point of information transfer. In Engel's view, a medical model must "take into account the patient, the social context in which he lives, and the complimentary system devised by society to deal with the disruptive effects of illness".

Although Engel was an internist and not a sociolinguist, his emphasis on the social context of the encounter and the biological, psychological, and social aspects of care that converge there quite naturally implicated language and social interaction as the medium through which care is delivered and received. Engel reminded us of a very simple but powerful truth and that is that medicine is practiced one conversation at a time.

During this same time period sociolinguists such as Shuy (1976) and Tannen and Wallat (1983) began to focus on issues of language performance in the medical encounter. Shuy (1976:376) analyses a number of examples of miscommunication between doctors and patients, for example:

Doctor: *Has there been any history of cardiac arrest in your family?*

Patient: *No, no one's ever been arrested*

Shuy's analysis invited an appreciation of the "delicate" nature of the doctor patient relationship, with respect to language, and the ever-present potential for misunderstanding and miscommunication to occur. Tannen and Wallat's study, in a pediatric context, focuses on the use of linguistic register to convey meaning differentially. The authors audio-taped a pediatrician talking with a family about a child's medical condition and the same pediatrician presenting the case to her colleagues. They noted that by intonation and other paralinguistic features, the pediatrician conveyed a different impression to the family about the seriousness of the child's

condition than she did to her colleagues although the language is much the same. Within the sociological tradition of symbolic interaction, scholars such as Emerson (1970) focuses on the use of language and nonverbal behavior such as eye gaze to analyse how gynecologists and patients sustained definitions of reality in the examination room. Studies like these were useful in calling attention to the moment-by-moment organization and flow of language exchange in and through which speakers construct social reality.

The most sustained and systematic treatment of the doctor-patient encounter as a moment-by-moment language performance comes from the twin sociological traditions of ethno-methodology and conversation analysis. Early work by Cicourel (1983) focuses on asymmetries of language in the medical encounter and its textual representation in the patient's medical record. In this important study, Cicourel (1983) traces the transformation of a conversational exchange between a physician and patient into a written entry in the patient's medical record. The written entry made clear that much of the patient's perspective and meaning were lost in translation to a clinical description of a particular pathology. Mishler (1984) argues much the same point from a purely discourse point of view. He distinguishes between what he terms "the voice of medicine" and "the voice of the life world," and argues that physicians routinely fail to respond to the latter and insist upon the former as a frame of reference. As a result, patients are routinely reduced to clinical categories based on a model of pathology.

In the mid-to-late 1980s, studies began to appear, largely in the sociological literature, applying the pioneering work of Sacks, Schegloff, and Jefferson (1974) and Schegloff, Jefferson, and Sacks (1977) on conversational turn taking and repair to a variety of organizational settings. The approach provided a comprehensive conceptual scheme, based on utterance exchanges as the unit of measure, for understanding the interactional dynamics of conversation. Application of the

model to understanding medical encounters began in the mid-1980s with the appearance of an edited volume by Fisher and Todd (1983) that blended conversation, and analytic and ethno-methodological studies and continued in the following year with a special issue of *Discourse Processes* (1984) devoted primarily to microanalysis of the physician-patient relationship.

In the decade and a half that has elapsed since the first applied studies using conversation analytic theory appeared, two streams of scholarship have emerged. One is primarily concerned with the sociological or social science implications of micro-interactional analysis of physician-patient encounters; the other with the clinical or educational implications of such analysis. This framing follows a distinction made many years ago by Levine, cited in Freeman, Levine and Reeder (1963), between sociology *of* medicine and sociology *in* medicine.

2.8Theoretical Framework

The theoretical framework adopted for this work is what Frankel (2000) tagged, *A Functional Model of Communication for the Medical Encounter.* With language exchange as a focus for research on the medical encounter, Frankel designs this model for considering the evidence that such exchanges make a difference in the course, direction, and outcomes of care. This theory has its roots under Clinical Research.Clinical research can be defined as research that is relatedtoexperiences and descriptions of individual andinterpersonal problems, transition, and change. This includes social science and medical science studiesofhumanbehaviourandinteractions, cognition, andsomaticexperiences fromavarietyof perspectives.Transitionandchangecanoccuraspartofone'slifecourseexperiencesorasaresult ofclinical intervention.

There is general agreement among scholars of the medical interview (Bird and Cohen-Cole 1990; Cohen-Cole 1991; Lazare, Putnam, and Lipkin 1995) that there are three tasks or functions to be accomplished in each visit.The first task is data gathering, the goals of which are to establish a diagnosis, be able to recommend treatment, and predict the course of illness. The second task is relationship building; the objectives here are to create a safe environment for the patient to provide diagnostic information and tell his or her story, to relieve physical/emotional stress, and to negotiate an acceptable treatment plan. The third task is sharing diagnostic information (good news, bad news, no news) and educating patients about their conditions and treatment. This has an implication for Sociolinguistics which contributes immensely to clinical research.Sociolinguistics plays a role in Frankel's model of communication in clinical research. It looks at the language and the behavioural relationships between doctor-patients in medical encounter. This theory is underpinned under several functions which by default finds expression in Sociolinguistics.

Function 1: Data gathering. Many medical interviewing textbooks teach that patients come to a physician with one well-formulated complaint or concern, which is referred to as the "chief complaint." The physician's job is to focus on the chief complaint, eventually making a diagnosis and recommendation for treatment.

Little attention is paid to the social or linguistic context in which patients experience illness or the linguistic forms of expression these experiences take in the medical encounter.

In an early study of data gathering, Beckman and Frankel (1984) investigated the openings of seventy-four routine encounters at an internal medicine clinic. Our initial interest was stimulated by literature, primarily in psychiatry, that had focused on patients' "hidden concerns" at the very end of the encounter, where they are typically very difficult for the physicians to deal with. A

study by Barsky(1981) is typical of this view and essentially argued that “hidden concerns” or hidden agendas were a characteristic of patients who were hostile, angry at their physicians, or otherwise psychologically distressed. While this might have been true in psychiatry, it did not seem to have a perfect translation into the world of internal medicine. Our point of departure was to look not at the very end of the encounter but rather at its beginning, and to pursue the question on interactional rather than psychiatric grounds by asking whether there was a relationship between interactional “troubles” at the beginning and concerns raised late in the visit.

This researcher adopts this theory because it puts at its centre the texture and nature of language in the social relationship between clients (doctors) and patients. The theory seeks to accommodate researches from other disciplines outside medical science that contributes to the rendering of effective healthcare services to the public. The theory doesnot differentiate between clientsandpatients;rather, theword, ‘client’ isused to refertobothpatientsandclients which in this case study means doctors-patients.

CHAPTER THREE

RESEARCH METHODOLOGY

3.0 Introduction

This chapter consists of the methodological processes that are employed in the course of this investigation and how they are used to give plausible answers to its research questions. The main focus of the chapter is to discuss the sources of data, method of data collection, techniques of data interpretation and justification of the research methodology.

3.1 Sources of Data

As primary source of data, this thesis depends largely on the raw (oral) texts collected from the conversational situations that ensued between doctors and patients at the Ahmadu Bello University Teaching Hospital, Shika.

3.2 Method of Data Collection

The method used in collecting the data for this work is discussed as follows:

a. **Covert Observation:** The research largely depends on covert observational technique. The researcher devotes the study to the investigation of the interactions between doctors and patients.Covert observation, according toMcKeshnie (2008) is a particular type of participant observation in which the identity of the researcher, the nature of the research project, and the fact that participants are being observed are concealed from those who are being studied. Investigators using covert observation adopt the research role of complete participant.

b. **Interviews:**Interviews are used to authenticate the covert data collected from the doctor-patients interactions that took place in the ABUTH, Shika. The interviews are largely unstructured. The essence of making the interview unstructured is to create an unbiased encounter which a structured interview would have had on the study. Under this type of interview, the purpose or intent of the researcher is hiding so as to allow the interviewed express themselves generously. This instrument removes the ceiling or limits which a midget or a recording device would have had on the interrogated.Bello and Ajayi (2000) describethis type of interview as a psychological and sociological measuring instrument. Information elicited through interview can be used in measuring human abilities and dispositions that are directly observable. It could also be used as an evaluation process which involves at least two people (the interviewer and the interviewee) in an oral or written discussion with the aim of obtaining information from the interviewee. On this work, the researcher shall use structured interview and focus group discussion to extract information.

Sample Procedure

Sampling refers to the procedure applied to select units of analysis from a larger population. Researchers have to choose between probability and non-probability sampling. Probability samplings are drawn according to mathematical procedures where the chance of each participant being chosen is known and calculated. Non-probability samples mean that each unit in the population does not stand equal chance of being selected and that the researcher often predicts and controls the inclusion of the units (Du Plooy, 2001). The goal of this study is to obtain specific information about the manners of conversations that takes place between doctors and patients. Hence, non-probability sample will be used. There are various ways of conducting a

non-probability sample. For example, a convenience sample, purposive sample, volunteer sample and snowball sample (Du Plooy, 2001). The most frequently used and applicable non-probability sample for interviews is purposive sampling. According to Vaughan et al (1996), purposive sample is designed to select participants based on predetermined requirements and characteristics.Hence, participants in this study are chosen based on the following criteria: they are medical doctors or Nurses in ABUTH Shika, and patients in ABUTH Shika.

Purposive sample was adopted as the procedure for sampling the population in this study. The rationale that underpins this choice is the fact that materials used were the ones that suited the purpose of this researcher. The population used for the analysis is the Ahmadu Bello University Teaching Hospital in Shika.

Transcriptions

Interviews are mostly audio-recorded and then transcribed before they are analyzed. Another case scenario is that they are written directly on the paper issued by the investigator. For the recorded interview, this study will transcribe only the relevant data relating to the items for each study. That is, the transcription is fragmented into "exchanges" to feed different units during analyses.

3.3. Method of Data Analysis

The data of the study are analyzed using both textual and conversational analytical methods. The responses will be arranged in simple tabulation tagged "exchanges" and will analyze each exchanges based on its locution. This method agrees with the principles of the *Functional Model of Communication for the Medical Encounter* as explained by Frankel. Frankel designs this

model for considering the evidence that such exchanges make a difference in the course, direction, and outcomes of care.

CHAPTERNFOUR

PRESENTATION OF DATA AND ANALYSIS

4.1. Introduction

This chapter presents the data for analyses of this study. Each datum is termed 'interlocution'. Interlocutions A and B shows the complaints with interrupted and complete solicitation of concerns in the conversation between doctors and patients. Interlocutions C and D analyzeempathic and missed empathic opportunities in medical encounter. Interlocution E shows the relationship between language and the dialogic of status in ABUTH Shika. Interlocution F illustrates the relationship between how gender or sexuality affect treatment. Interlocution G demonstrates how language uses affect therapy. Interlocutions H and I indicate how religion and the dominant (Hausa) language spoken in Shika affect the conversations between doctors and patients.

4.2 Presentation of Data

To achieve the aim and objectives of this sociolinguistic exercise, seven vital different data will be selected and presented for analysis. Each datum will be tagged an ***interlocution*** for proper identification. There are several conversational exchanges and speech situations between doctors and patients in the hospital. Seven of these interlocutions will be presented for ease of analyses and comprehension.

However, the researcher deems it fit to employ domain as a sociolinguistic variable for a clearer picture of the analysis. Domain is a field of language. It is the physical context or situation in which a communication exchange takes place.

Thus, this chapter will juxtapose the language or interactions between doctors and patients in the ABUTH, Shika with issues of gender, status, age, sex, timing/urgency, personality and

behaviour, and how they affect the entire process that leads to the therapeutic recovery of a patient from an illness. The chapter considers language as one of the therapies in the medical domain and will attempt to analyze the interlocutions between the doctor and the patient.

Different interlocutions ensue between doctors and patients in the hospital. In this presentation of data, each datum is tagged "interlocution", numbering from A to G. This researcher decodes the illocution of doctor-patient by placing the question and answer in the medical encounter within the context of native speakership; intended meaning and interpretation caused by social factors as age, sex and status etc. The presentation is as follows:

INTERLOCUTION A

SPEAKER(S)	**AGE**	**SEX**	**STATUS**	**GENDER**
Doctor	About 38 years	Male	Literate	Male
Patient	Late 40s	Female	Literate/Public servant	Female

Complaint with interrupted solicitation of concern.

S/N	**Doctor**	**Patient**	**Illocution**	**Comment**
I	Hello, Ms. Lawal. What problem are you having?	I have chest pains…	Patient's intended answer is, "I feel pains on my chest". This is because it was her first visit to the Doctor and her situation has not been diagnosed. Thus, Doctor has	Complaint with interrupted solicitation of concerns

			to interrupt her.	
ii	When did it begin? (Interruption)	It started about three months and...	Patient intended answer: 'it began (not started) about three months ago…'. This is because when it started has not been ascertained.	On this interaction, medically speaking, there is a difference between "begin" and "started". 'Begin' here means when the pain began to be felt, not when it 'started'
Iii	Can you tell me more about it?	It's a gnawing pain that hurts in the centre of my chest.	Intended question and precise answer	Correctly interpreted and communicated
Iv	Does the pain go into the arms or to your neck?	Yes	Intended meaning	
V	Is it worse when you exercise?	Yes	Intended question and answer	
Vi	Do you smoke cigarette?	Silence… Yes, but when I am…	Intended question but discrete answer	Patient's hesitance brings out the status, age, gender disparity between Doctor-Patient and places a restriction on further questioning concerning

				smoking.
vii	Are you currently taking any medication?	No	Intended question	The Doctor has not prescribed any medication yet. What medication would she probably be taking?

This is a conversation between a learned patient and a medical doctor with much intermission due to the Doctor's premeditating forecast or seemingly understanding of the Patient's dilemma. Here, there is a complaint with interrupted solicitation of concerns. The age, gender and status disparity is highlighted when Doctor edged on pressing Patient about smoking. However, the differences are put to a stop by the understanding resulting from the statuses of both doctor-patient. The conversation, even with interrupted solicitation of concern, is smoothened by the level of literacy and nearness of statuses between Doctor and Patient. Nonetheless, the interaction in the interlocution B below is in converse with this

INTERLOCUTION B

SPEAKER(S)	**AGE**	**SEX**	**STATUS**	**GENDER**
Doctor	About 56 years	Male	Literate/Middle Class	Male
Patient	About 28	Female	Literate/Middle Class	Female

Complaint with completed solicitation of concern

S/N	Doctor	Patient	Illocution	Comments
I	Hello, Ms.Danladi What problems are you having?	I feel pains on my chest.	Intended question and answer and to the point	Complaint with completed solicitation of concern
ii	Uh-huh.	It's a serious pain.	"Uh-huh". A sound made to solicit more information about her pain	Medical Doctor use gestures and exclamatory sound during interaction. They use it to either empathize and sustain interaction
iii	Uh-huh.	It seems to start in my chest and it goes to my arm and jaw.	Intended answer: 'start' in this context, is correct because it does not precede Doctor's inquiry	
Iv	(silence)	It's really frightening.	Probingly	Silence during interaction with patient in medical science is a way of communication. It nudges the conversation and makes patient want to fill the gap by giving more information.
	I see!	You know, my	Unintended answer.	Because no question

V		father died from a heart attack and I'm afraid that the same thing may happen to me.		was asked the answers given were uncoordinated and do not relate to Danladi's problem.
Iv	I can see that you're concerned, and I'll certainly talk with you more about your chest pain. Before we start, however, is there anything else that's bothering you that I need to know about?	No, that's all.	Intended answer.	

4.2 Complaints with Interrupted Solicitation of Concerns and Completed Solicitation of Concerns

In 69 percent of the visits to ABUTH, Shika, the patients' statement of concerns were interrupted, primarily by the use of narrowly focused, closed-ended questions. In only one of the interrupted statements did the patient raise additional concerns at the beginning of the visit. From the medical encounter presented in *interlocutions* A and B, it can be understood that a strong statistical association between patients who were interrupted early in their statements of concern and concerns raised at the very end of the visit affects how care is given and received especially when patients build in their cognition that they are less understood. It is observed that in internal medicine visits, it was not so much that the concerns or agendas were hidden when it is completely interactional but that concerns were prevented from being expressed at the beginning of the visit. According to the questions asked by Doctor and response given in interlocutions A

and B (*i* and *ii*), the question "*What problem are you having?"* is meant to generate appropriate information that will help Doctor diagnose the problem. Hence, interruption is used to block any added information which may compound the encounter between the patient and medical personnel. From the interlocutions and exchanges above, Doctor controls the encounter. He asks, gets answers and interrupts any other information he deems unnecessary to the problem. This finding has several implications. First, it suggests that interruption discourages patients from adding additional concerns at the beginning of the visit.

Second, the pattern of interruption, which was generally after the first stated concern and after a mean time of eighteen seconds, suggests that the doctors in the study believed that the patient's first stated concern was the pressing concern and the one of utmost importance from the patient's point of view. Neither of these assumptions appears warranted. When all the concerns, whether they were interrupted or not, are abstracted and looked into closely, there is usually no association found between the serial ordering of the concerns and their medical or clinical importance. In fact, a close study of the medical encounter in *interlocution* D shows that patients may view their third concern as being most important. Yet, in 85 percent of the visits in ABUTH Shika, patients did not get to discuss more than their first stated concern.

The mismatch between patient priorities and problems that actually get discussed is one with several potential consequences for the quality and satisfactoriness of care provided. For example, viewing the three functions as a nested set of communication skills immediately makes obvious that relationship building and diagnostic news delivery, which in turn affect outcomes like adherence with medical recommendations, hinge on agreement or, at least, alignment between the patient's priorities for care and the doctor's approach. If diabetic foot care is the first thing mentioned by the patient but his primary concern is impotence, the likelihood of the patient's

following the care path recommended for a foot ulcer is diminished. In a significant way the opening of the encounter and the elicitation of the full spectrum of concerns from the patient at the beginning of the visit is the gateway to effective and satisfying care. It may also have effects of its own. The question, for example, asked in *iv*of interlocution A was not given a certain answer even though the illocution seems to be precise.

Again, it is important to look into Doctor's use of *Uh-huh uh-huh*in interlocution A in agreement with the concerns of Patient. *Uh-huh* is usually used inattentively and in a way that removes the recipient from the core of information giving or subject matter under discuss. Though Patient sees the sound as agreement or consent to concerns, it may however contribute to the misapprehension of intent in doctor-patient relationship. For better care to ensue in clinical or medical domain, it is germane that the medical personnel deploy effective language and communication skills to solicit information concerning the condition of patients. While many definitions of empathy exist, they are typically based on cognitive conceptualizations, making their use in social interaction research limited. As well, they are sometimes contradictory. Some authors argue that empathy is having the same emotion as another, "feeling another's pain" as it were. Others argue that empathy is the skill of recognizing and accurately reflecting another's emotions so as to be present to, but not experiencing, the emotion itself. The one element that all definitions included was that empathy was a response to another's emotions.

Given the lack of empirical study of empathy as a communication phenomenon in medical encounters, this work chose a descriptive approach and began by selecting doctor-patient interactions at random from a large corpus. It deliberately limits itself to exploring verbal empathy, as this seemed the most basic and straightforward. It reasons that additional

elaborations, incorporating nonverbal and paralinguistic features, could be added to the basic model at a later time.

The observational strategy was quite simple. The researcher reviewed the texts looking for words or phrases uttered by the patient that contained positive or negative emotion. Considering the range of assessment terms "horrible," "okay," "great," both horrible and great would be flagged for further review. We then looked to see what the doctor's response was to the patient's expression of emotion and labeled that sequential interlocution an empathic opportunity since it represented an option for the physician to either respond to or deflect the emotion in some way.

INTERLOCUTION C

SPEAKER(S)	**AGE**	**SEX**	**STATUS**	**GENDER**
Doctor	About 33 years	Male	Literate/Middle Class	Male
Patient	About 66 years old	Female	Literate/Middle Class	Female

This interlocution is between a doctor and a sixty-six-year-old patient who had returned to the hospital for follow-up care illustrates an empathic opportunity and an empathic response on the doctor's part.

S/N	**Doctor**	**Patient**	**Illocution**	**Comments**
i	How do you feel about the cancer—about	Well, it bothers me sometimes but I don't think aboutit.	Intended question and answer	Complaint with empathic opportunity.

	the possibility of it coming back?	But I'm not as cheerful about it as I was when I first had it. I just had very good feelings that everything was going to be all right, you know. But, now I dread another operation.		
ii	You seem a little upset; you seem a little teary-eyed talking about it.		Intended statement soliciting empathy	

4.3 Empathic Opportunity

Let us note the use of emotion words like "bothers me," "not as cheerful," and "dread," all of which convey frank emotion. Note also that the doctor's response is to reflect what he is observing to the patient: "You seem a little upset," "you seem a little teary-eyed." Although it is not reproduced in the example, the patient's response to the doctor's statement is a strong agreement followed by an elaboration of the reason for her dread—a friend of hers had died recently because she didn't act quickly enough when she began to have symptoms. From an interactional perspective, one test of the accuracy of an empathic response to patient emotion is the extent to which the patient agrees and continues to exhibit the emotion. Educationally, such a principle is important in teaching about the range of possible responses to patient emotion and how to judge their impact.

While empathic responses to patients' expression of emotion help create and sustain the physician-patient relationship, they did not occur with great frequency in our data. A cursory look into *interlocution* C shows the encounter of complaint of empathic opportunity between doctor-patient

INTERLOCUTION D

SPEAKER(S)	**AGE**	**SEX**	**STATUS**	**GENDER**
Doctor	About 33 years	Male	Literate	Male
Patient	About 30 years	Female	Semi-literate	Female

The above interlocution illustrates a missed empathic opportunity where it is more frequently found that the response to patients' expressions of emotion was "missed" by the doctor.

S/N	**Doctor**	**Patient**	**Illocution**	**Comments**
I	Does anybody in your family have breast cancer?	No.	Intended question and answer	Complaint with missed empathic opportunity
Ii	No!	Now I just start (unintelligible) after my womb was removed. I have been taking estrogen, right?	The intended remark from Doctor is meant to carry a question mark (?).	Patient intuited the omission from Doctor and answered. Nevertheless, she had an existing knowledge on what to take after hysterectomy. Thus, she proceed to seek confirmation from Doctor.
iii	Yeah?	You know how your breast gets	Probingly and Missed empatheticopportunit	Confirmatory question from Doctor that nudges

		real hard and everything? You know how you get of scared?	y	Patient to speak more. Doctor, being male and gendered, is estranged from her explanation. His knowledge is limited within medical practice. Thus, he misses Patient's concerns.
Iv	How long were you on the estrogen?	Oh, maybe about six months. But I think this one is different. Its not cancer. I think is fibroid tumors.	Intended answer: 'I am not sure it is cancer'	Patient's probe in into Doctor's understanding of her problem because Doctor seems to be removed or distanced from her description. This is caused by factors such as one of status difference and gender issues.
V	Yeah, what, how, when were you, when did you have the, uh, hysterectomy?	Silence	Patient's silence shows her obliviousness of the word, 'hysterectomy'.	Missed empathetic Opportunity

4.4 Missed Empathic Opportunity

In this example, the patient's response to the doctor's question about taking estrogen includes a statement about fear, "You know how you get sort of scared?" In response, the doctor directs a

question to the patient about the length of time she was taking estrogen, thereby either ignoring or choosing not to deal with the emotion.

The pattern of doctors choosing to focus on facts rather than feelings was quite consistent where empathic opportunities occurred. Nevertheless, the researcher was surprised by the relatively small number of instances found. The researcher hypothesized that there might be more to emotion in the medical encounter than its frank expression. Given the asymmetries of power and status that are claimed to exist in the doctor-patient relationship and patients' potential reticence to "come right out" with emotions, the researcher wondered whether patients might first hint that they had something of an emotional nature to bring up and "test the waters" by hinting at it. The data below displays a complaint with missed empathic opportunity.

However, there is also a Potential Empathic Opportunity (PEO).PEOs are hints about emotion but do not contain the emotion itself. They are often terminated during diagnosing concerns but they are somewhat related to concerns in interrupted solicitation of concern in medical encounter.

The above interlocution has a lot to do with complaint with interrupted and completed solicitation of concerns. It is uneven with the medical encounter that patients' first concerns, or their description of it, determines the questions that follow and the prescription that will be given. Whilst in the above interlocution, Doctor and Patient are engaged in a conversation about cancer in order that the appropriate care is given or prescribed, patient's first concern is fibroid tumor. However, this concern does not set the agenda for the questions that follow. More, Doctor, as seen in *v* of interlocution D does change the line of his questioning (*iv*) as regard the

concern raised by Patient. This further buttresses the degree of the extant missed empathic opportunity which occurs in rare cases in ABUTH.

INTERLOCUTION E

SPEAKER(S)	**AGE**	**SEX**	**STATUS**	**GENDER**
Patient	Late 40s	Female	Illiterate	Male
Doctor	About 32 years	Male	Literate	Male

S/N	**Patient (Market woman)**	**Doctor**	**Illocution**	**Topic of Discourse**
I	*Almost kneeling* Good morning sah! How work?	Work's fine. How are you?	Patient's action shows respect	Conversation between a male Doctor and a market woman. Respect shown to Doctor is referential to the occupation, not age.
Ii	Dem sey I get ulcer.	Ulcer?	Patient's intended statement is 'I have ulcer'. Doctor's inquiry suggest how she got to know about that.	Here, Patient's seem to be in charge of the interaction. Her role in this interaction is gendered towards a male assertiveness during conversation.
Iii	Yes sah!	For whia and how e dey do	Intended question effectively asked in	Here, status issue is being raised as Doctor

		you?	pidgin.	stem to speak in language Patient could relate with.
Iv	E dey make belle dey always pain me for dis side *touches the left-hand side of her stomach.*	Do you eat on time?	Intended	Doctor code-switches unconsciously at interval. He does this unknowingly because of the position his status pits him.
v	I dey eat every time	Do you like peppery food?	Inappropriate answer to inquiry due to misapprehension. Intended question "you dey chop your food on time?"	
Vi	*Silent*	How often you dey take soft drinks?		Now, there is a language or communication barrier between the two as the silence of Patient suggest incomprehensiveness to Doctor's inquiries.
Vii	Minerals?	Yes	Intended	
Viii	Tiri tines evyday if I chop finish			

4.5 Language and the Dialogic of Status inAhmadu Bello University Teaching Hospital (ABUTH), Shika

Language use, in medical or clinical encounter, according to Holstein and Gubrium (1997:113-129) is vital in active interviewing and diagnosing concerns of patients. It could be used both

descriptively and prescriptively in rendering care. In ABUTH, the use of language in diagnosis is robust because of the mass of lingo-diversity in its workforce and the influxes of patients from diversified ethnics and background seeking care. These influxes of diversified peoples come furnished with different statuses and this has added and depth and has made the medical personnel deft in their use of language to address peoples of different statuses and background. From the interlocutions A to D, one could apparently see that Patients in the encounter therein are learned and polished even though gaps could still be spotted on their spoken English. The encounter presented in interlocution E shows another level of language and status relationship between doctor and patient.

A dialogic, that is, dialogue and logic, ensued between the two variables. Dialogic is a term mainly used to describe the logicality or the formal processes used in thinking and reasoning in dialogue. This is usually influenced by social or economic status. A dialogical conversation ensued between the variables in interlocution E. The initial courtesy of Patient in her first visit is one that first and foremost evokes status and respect. This is further deepened by her use of pidgin. She courtesies, "*Goo mornisah!*" and then proceed to inform Doctor of her concern. Doctor, in the encounter, replies "*Work's fine. How are you?*". Here, Doctor remains within its framing in terms of his use of language and in line with his status. However, the course of the encounter changes when Patient, ripostes with, "*Dem sey I get ulcer*". Doctor deftly switches from his medical linguistic framing to the level where communication between doctor-patient can ensue. For the purpose of meaningful information sharing and proper diagnosing of concern, Doctor detaches himself both from his social and linguistic status to a level where there can be an exchange of concerns between doctor-patient. The example as shown in the interlocution above is an indicator of language switching and status shifting in ABUTH.

Notice the incomprehension and incoherence between doctor and patience. Even though a shift and language has occurred it is observable that doctor relies on the first concern of patient (market woman). Though he tries to come to terms with patient he does so unsuccessfully perhaps because there are no simplifications for medical jargons. In medical term, how best can medical languages be simplified for the unlearned to understand; during discussion of concerns or prescription, how can language be used without causing any barrier between doctor and patient or, better, if the barrier status place on doctor- artisans relationship can be broken down by language use, how can the dictionary or vocabulary for medical jargon be translated in pidgin, Hausa or any of such other languages? From the field study conducted at the ABUTH, this researcher uncover that the sociolinguistic interaction between doctor-patient interactions is majorly intervallic or intermittent. This is because of the either misapprehension or misinterpretation to questions. Questions and responses are solicited randomly and with languages which doctor and patient labouriously understand.

Another level where status, though this time in gender lines, is highlighted is the interlocution F, a medical encounter between a young female doctor and a male student. For this encounter, this researcher discovers that gender relationship and language use is deployed as a form of therapy in the ABUTH. The manners and ways language are used in medical encounter could be healing and at the same time liquidating. The research from the ABUTH shows that patients respond better when there is a shared concern between them and their attendant doctor. The language and communication skill deployed during different medical encounters contribute to the level of recovery of patient.

For some medical personnel in ABUTH, who despite the amount of patient to attend to, deploys good language and communication skill during diagnosing, their patients, more than any other,

tend to recover faster because of the removal of social (status, language) hindrances from the fraction of interaction.

The existence of gendered role in Interlocution E is also germane in this analysis. From the above Interlocution, there is a swap of characterization as Patient controls the interaction instead of Doctor. She controlled and direct the conversation before Doctor takes it over. Her action falls outside the bracket of female genderization of unassertiveness. In spite of her status, her knowledge of her problem and clairvoyance or preciseness to answer makes her distinct from her gender. This facilitated the attention and care given to her.

Examples from interlocutions F and G show different approaches to patient's care.

INTERLOCUTION F

SPEAKER(S)	**AGE**	**SEX**	**STATUS**	**GENDER**
Doctor	About 30 years	Female	Literate	Male
Patient	About 25 years	Male	Literate	Male

This is an interlocution between a male student and a young female doctor whose conversation would have been hindered because of the social cum biological difference between the two. Here, the professionalism and care of the young female doctor helps the male to open up on his illness even though it was done in the most conventional way.

S/N	**Doctor**	**Patient**	**Illocution**	**Comments**
i	*Smiling* Hey, how are you?	Fine	Patient's intended answer is not certain	Conversation between a young female doctor and a male student

ii	Fine? Huh! Why are you here then? (*Smiles again*)	*Gestures* I got boil	Doctor's intended meaning, 'No, you are not fine'	From here both sex and gender differences begin to play out.
iii	Where?	*Silent*	Probingly	The sex difference slows down Patient's answer.
iv	*Looks into his card. Smiles* on your thigh or?	(*Gestures*) On my thigh	Intended answer is YES.	The intended answer to Doctor's inquiry is slowed down because of the unwillingness to state the obvious. However, Patient's repeated Doctor's observation instead saying a simple YES.
V	What happened?	*Silent*	Intended	
vi	What medication are ~~we~~ taking?	*Smiles*	Correct Intended question	The use of 'WE' is mostly use in medical encounter to show care and impersonality.
vii	Don't worry, you're ok. It's nothing. Don't worry ~~we~~ would deal with.	*Smiles*	Care	

Words such as "*do not worry*", "*We would deal with*", *You will be fine*" sways in most of the medical encounter. And more, the use of *we* by different medical personnel is empathic in that it reduces the burden of patient after every medical encounter. In the ABUTH, there seem to be a relationship between language use and providing care however the gaps that exist in the line of diagnosis.

4.5.1 Gender Relationship, Sexuality and Treatment

In the medical practice generally, there have been much debate surrounding the genderization of medical doctors in their efforts to provide treatment to patients. The root of the debates have been that: whether medical doctor of an opposite sex would be able to get appropriate diagnosis, or examine patients given the fact that the body, in most parts of Africa, is the most precious and sacred form of personal information. Whilst this debate still holds water within the parenthesis of medical practice, for research in the humanities, and especially in Sociolinguistics, gender relationship, sexuality and treatment constitute an emergent subject of discuss. The interlocutions A, B, C, D, E, and F are replete with such examples. However, interlocution F, more than other highlights the conversation and response between a male patient and a female doctor. The use of both verbal and nonverbal communication is evident on the interlocution especially as it brings to light the gender-language relationship, which this research study termed as "genderlect", between a young female doctor and a male student in ABUTH.

Medical doctors communicate with patients of the opposite gender differently whether they are aware of it or not. This is manifested on the amount of attention given to patients of the opposite sex irrespective of the timing and schedules within the medical domain… For healing arts such as medicine, this interesting communicative characteristics is relevant to the therapeutic community.

Interlocution F demonstrates some of these gender-linked variables. To illustrate some of these variables in ABUTH, it is vital to look into the encounter in the mentioned interlocution.

Doctor: (*Smiling*) Hey, how are you?
Patient: Fine.
Doctor: Fine? Huh! Why are you here then? (*Smiles again*)

Patient: (*Gestures*) I got boils.

This preliminary discussion indicates the frequency of genderlect in ABUTH where for the female doctor, smiling is an interactional phenomenon while for men, it is an emotional expression. The use of gestures, despite the received emotional expression, can be, arguably, interpreted as being dominant. The other conversation that ensues from there are one that is modified by gender. The sizeable amount of nonverbal communication that runs through the medical encounter of interlocution F suggests the leverage which gender has on language. The female doctor pressed on thus;

Patient: I got boils
Doctor: Where?
Patient: *Silent…* (*Gestures*) On my thigh.
Doctor: What happened; what medication have you taken?
Patient: *Silent*; *Smiles…*

Whilst silence for doctor-patient conversation could mean uncertainty or agreement, for the male doctor and female nurse, it is not. This is evident in interlocution G. Here, sensitivity of gender-lect arises. Assessment of the evidences gathered from the ABUTH suggests that sensitivity among male doctors is often judged by female standards, whereas assertiveness is judge by male standards. The male doctor in the ABUTH has a special need to feel in control. As seen in almost all the interlocutions, when a male doctor feels a female patient is trying to him, he becomes uneasy.

Another stimulating observation about doctor-patient interaction and genderlect in the ABUTH is that when male doctors explain things to female patients, and sometimes, nurses, many male doctors sometimes behave as if the female gender is not able to grasp technical explanation as

well as men. While this is not generic in the ABUTH, it is responsible for the missed empathic opportunities in both complete and interrupted solicitation of concern.

More, during any conversation between doctor-patient in the ABUTH, as the evidences show, male doctors interrupt more than their female counterpart. The act of interrupting has more to do with dominance and control, rather than simply making verbal sounds when someone else is talking. Although certain situations warrant a doctor interrupting a patient, they are not done with tact and sensitivity.

In terms of physical positioning and eye-contact during an initial patient intake in the ABUTH, there are additional gender differences. Male doctors make direct eye contact with female patients and less with male patients. For instance, whilst standing in a treatment room, the male doctor is more apt to face his female patients squarely and make direct eye contact, while conversely, he stands at angle to male patients and make less eye contact. Female doctors, adversely, in a similar situation, face another female patient squarely and make direct eye contact.

Another apparent discourse in gender specific framing of how male and female doctors communicate differently is the notion that male doctors approach conversation in a competitive mode. That is, they talk to preserve their independence, negotiate and maintain their status. Women, conversely, communicate by using cooperative mode. While both techniques can be rationalized successfully, male doctors should defer to the female approach, and whenever possible, as Eisenberg (1994) suggest, communicate cooperatively. Bluntly put, the female doctor, arguably, is more suitable to offer understanding, whilst the male doctor offers advice. Every patient wants more than just to be heard, but to be understood in terms of thoughts,

feelings, and fears. It would therefore not be out of place to suggest that doctors in the ABUTH adopt a cooperative form of doctor-patient communication.

4.6 Language and Therapy in ABUTH, Shika

Language and relationship have always played an importantrole in medical care. Never has the need and opportunity to understand theintersection of biology, psychology, and language represented by the medicalencounter been greater than it is today. Historically, this is a time when languagestudies, which typically have their origin in nonclinical disciplines suchas linguistics and sociology, are being embraced as a powerful new tool forlearning and understanding in medicine. The synthesis that has emerged usingfunctional models of the interview such as the Three-Function Model hasalready contributed significantly to a range of challenging problems, time, affect, accuracy, etc. These factors are underlined in interlocution G.

Barnlund (2008) describes organizations that profess to encourage employees to adopt certain behaviors, while compensating for behaviors contrary to what they say they want. Medicine is the classic example. The profession states it is one driven by the qualities of compassion, caring, and patient-centered focus, yet the system rewards physicians on the basis of production, that is, the volume of patients seen. How can one deliver compassionate care, communicate effectively, and be patient-centered when patients are scheduled every 5 minutes? Timing is one of the factors that affect effective communication as most medicos are always in a haste to meet set amount of patients per day. While this may be evident in the interlocutions, the accuracy of care given and its resultant in language use could be said to be different in ABUTH.

In ABUTH, the presentation of information to both doctor and patient is important to aid understanding. Simply put, the communicator (doctor) considers the audience (patient) before

making the presentation itself and in cases where it is not possible, the medical personnel, at least, however laboriously, try to simplify his/her vocabulary so that patients can understand what is presented in the speech situations.

In the corpus of the interlocutions, it is not clear whether language is being conceived as a form of therapy in the ABUTH but evidences from some of the doctors show that it is rather an individual linguistic approach or linguistic ability to diagnosing than a medical one. It is worthy to compare the medical encounter in interlocution F and G in terms of timing, accuracy, effect and language use.

INTERLOCUTION G

SPEAKER(S)	**AGE**	**SEX**	**STATUS**	**GENDER**
Doctor	About 55 years	Male	Literate	Male
Patient	About 31 years	Female	Literate	Female

S/N	**Doctor**	**Nurse**	**Patient**	**Illocution**	**Comments**
	How are you today?	*Silent*	Good	Intended meaning	Conversation between/among Doctor, Nurse and Patient.
	Nurse, why haven't you administered this	I was waiting to see how well he would		Precise intent and answer	

	prescription?	respond to previous treatment			
	Is that what you're taught?	But sir is it not proper to…		Behavioural/Personality	
	Why don't you just do what I say?	Sorry			
	Have you eaten?		Not yet sir		
	Nurse, after breakfast let him take this one and the one there (*Looks into Patient's file*).	Ok sir.			
	I have to attend to twelve other patients	Alright sir. Eat your food. I would come see you immediately after	Ok Nurse.	Time and urgency	

Here, there is a tendency that the reward It is the reckless to reward for A (productivity) while hoping for B (compassionate caring, effective communication and patient-centeredness). Without the system changing, or physicians changing their income expectations (and hence their

behaviors related to patient care), this cycle will see no end. Patient satisfaction in ABUTH will continue to plummet and physician liability skyrocket.

It is this single-minded productivity focus that has resulted in a sense of urgency in a physician's office, and reduced communication effectiveness not only between the patient and physician, but between the physician and his or her staff. It is a set-up for misunderstandings, miscommunications, and errors, and it is no wonder that it can lead to patient safety issues, compliance failures, poorer outcomes, and increased liability. To effectivise treatments or medication in a medical domain, adept understanding and use of medical Sociolinguistics may be needed, or, if possible, added as part of training of medical personnel in Nigeria and most especially the ABUTH

INTERLOCUTION H

SPEAKER(S)	**AGE**	**SEX**	**STATUS**	**RELIGION**	**GENDER**
Doctor	About 29 years	Male	Literate	Christian	Male
Patient	About 28 years	Female	Literate	Muslim	Female

Religious belief and sex affects doctor-patient interaction in ABUTH, Shika

S/N	**Doctor**	**Patient**	**Illocution**	**Comments**
i	*Smiling* Hey, how are you?	*Looks away* Fine	Intended meaning	Conversation between a young male doctor and a female Muslim. The Patient could not look at Doctor who needed her attention for proper

				diagnosis.
ii	Welcome (*opens up her file*) are you better?	*Gestures* Yes	Involuntarily she meant "not really"	Interaction is hampered by three factors here: religion, sex and gender.
iii	Okay?	*Silent*	Probingly	The sex difference slows down Patient's answer.
iv	*Looks at her. Smiles* You need to continue with these other medicine. Take it to	(*uncomfortably*) Okay	She wants to take her leave	She could not withstand the probing look of Doctor and hurries to leave without sharing her issues.
v	What happened?	Nothing. Would come again	I will come again	

Discussion on Interlocution H

Religion and sex are factors that affect interaction in ABUTH Shika. Certain religious belief, in terms of male-female, discourages enclosed discussions especially when they are unmarried. This is further complicated by the sex/gender roles differentiation which religion creates. From the above discussion, being in an enclosure with the male doctor affect the idea of privacy, during diagnosis, in medicine.

INTERLOCUTION I

SPEAKER(S)	**AGE**	**SEX**	**STATUS**	**OCCUPATION**	**GENDER**
Doctor	Mid 40s	Male	Literate	Doctor	Male
Patient	Mid 50s	Male	Illiterate	Farmer	Male

Effective communication takes place between Doctor-Patient of same language or dialect.

However, pain or other factors may affectsuch interaction in ABUTH, Shika

S/N	Doctor	Patient	Illocution	Comments
i	Yi`hakuri. Ina yakemakiciyo? (Sorry. Where is paining you?)	Ќasancikinake mum ciyo, kumawanilokaci yakanhauharќ irj ina (The pain moves from my abdomen up to my chest)	Intended meaning	Conversation between a doctor and a farmer. The farmer enters with pains. Doctor welcomes him and they converse in Hausa without any barrier.
ii	Kina ɗaukan kaya masunauyi ne? (Do you carry heavy load?)	Najigonashekara njiyakuma, bayannadawaogi da ne yafaramumciyo (I went to farm yesterday when I returned home I started feeling pain)	Inappropriate answer to Doctor's question	Diagnosis is hampered by the pain of farmer. He gives differing answer to doctor's probation. The answer does not follow Doctor's question.
iii	Waniirinaikikike yi a gonan? (What kind of work do you do at the farm?)	Buhunmasaranen akedauka (I carry bags of maize)	Intended question and answer	Mutual understanding unhindered by any factor and sustained by similarity in language.
iv	OK			Silence. Doctor waits for more information from patient through nonverbal form of silence.

v	Da yaushe ne kikeyinciwon? (When do you usually feel such pains?)	Duksandanajiego nanayiaikisosai, ammawannazafi nyafimusosai (Anytime I go to the farm and returns home. I work very hard but this pain now is overwhelming)	Intended meaning	Doctor diagnosing the cause of the pain
vi	Shekarankanawa ? (How old are you?)	Hamsin da waniabu (fifty something)	Intended meaning	Doctor links the source pain to patient's aging and makes recommendation.
vii	Ok, Karkidamu. Ok, Karkadamu. Kakaiwannadaki nmagani, asubakimagungu nasaikasha. Kadainadaukan kaya masunauyi (Don't worry. Take this to the pharmacy they would give you drugs to drink. But you should stop carrying heavy things).	Toh, nagode (Ok, thank you)	Intended meaning	Doctor refers patient to the pharmacy and gives professional advice along.
viii	Allah	Amin amin		

	yabadasauki (Allah makes you get better)			

Discussion on Interlocution I

ABUTH is located in a speech community in Shika. As a result, Hausa is expected to be the dominant language deployed in doctor-patient conversation. The conversation in interlocution I show that where two speakers (doctor and patient) converse in native dialect or same language during conversation, communication is usually effective as direct questions and answers are usually understood. However, the level of pain felt by patients may affect the response giving to doctors during diagnosis. Again, from the conversation, it is noticed that one of the two variables is not a native speaker of Hausa but proper diagnosis was administeredbecause doctor understood the occupational dialect of patient even though it was rendered in Hausa.

4.7The Future of Sociolinguistics in Doctor-Patient Communication Research based on the Data.

Sociolinguistic micro-interactional analysis has already made several significant contributions to the understanding of the dynamics and outcomes ofspecific communication exchanges involving data gathering, relationship building,and sharing of diagnostic and prognostic information. Several outstandingquestions that might usefully be addressed by this approach still remain.

The first has to do with improving understanding of the impact of thephysician-patient relationship over time. At present, virtually all communicationresearch has been cross-sectional. This is an appropriate method for studyingencounters between physicians and patients that are episodic. A study of physician-patient communication in the emergency room benefits from a

cross-sectionalresearch design, although even in this context it would miss the relationshipbetween the staff and so-called “frequent fliers,” in other words, patients whopresent to the emergency room frequently. A cross-sectional design might alsobe appropriate in studying some types of specialty care, for example, an anesthetist-patient communication, where the relationship is likely to be limited to asingle encounter.

One of the defining features of treatments, which represent the largestsource of medical visits in the ABUTH and Nigeria at large, is that it is continuous. Althoughpatients may experience episodes of illness or needs care from time to time, it is assumed thata continuousrelationship with one’s own doctor and skillful use of language adds value and reduces the costsof treatments or care over time. Going to the emergency room for one’s treatment as naive and with the attendant doctor not being skilled in communication or language use during confidence-building on the patient, as some teaching hospitals are in Nigeria, treatments are likely to be hampered with different medical concerns arising from the sloppy use of language. Despite the assumption that continuity of treatment or care adds value to the processes and outcomes of care, there are almostno longitudinal studies of communication between physicians and patients, andcertainly none with a sample size large enough to generalize to the medical caresystem in ABUTH as a whole.

One tantalizing avenue of study to consider in this area has to do with communicationconsistency within a single relationship. The question here as one of the respondents asked is, “dophysicians consistently respond to the same patient cues?”In the area of relationshipbuilding, for example, does the skill of empathy and language get used consistently over time?

CHAPTER FIVE

FINDINGS, SUMMARY AND CONCLUSION

5.0. Introduction

This chapter serves as the concluding part of the study. It takes a look at the major findings in the study, summary and conclusion.

5.1. Findings

This work documents and examines different conversational exchanges as ensued between doctors and patients at the ABUTH Shika. It identifies the different contexts in which Sociolinguistic study of the language interactions between doctors and patients is carried out. In the light of the foregoing, the study finds out that the theoretical bastion adopted for this research thrives on the interpersonal relationship and conversation between patients and medical personnel. The theory has its footing on clinical research and Frankel's explanation of the theory suits researches in the social sciences or research in the humanities.

The study finds out that a strong statistical association between patients who were interrupted early in their statements of concern and concerns raised at the very end of the visit affects how care is given and received especially when patients build in their cognition that they are less understood. More, for better care to ensue in clinical or medical domain, it is germane that the medical personnel deploy effective language and communication skills to solicit information concerning the condition of patients.Empathic responses to patients' expression of emotion help create and sustain the physician-patient relationship though they did not occur with great frequency.

Language is not used creatively enough to aid therapy and this in turn slows down the pace of patient's level of recovery.

The medical personnel in ABUTH Shika are flexible and most of them have knowledge of Hausa language. Nonetheless, their knowledge is not original enough for the community to which ABUTH is located.

In spite of the homogeneity of the location of ABUTH, the needs of patients from diversified ethnics and backgrounds seeking treatments are meant without language constituting any default barrier in conversation. Barriers only surface when the medical personnel deploy the language of medicine in diagnosis.

This study found out that timing inhibits the accuracy of doctor-patient interactions. The amounts of patients assigned to one doctor are much; thus, the need to speed up conversation, without actually listening to patients' concerns affect treatment.

For the purpose of meaningful information sharing and proper diagnosing of concern, doctors detachthemselves both from their social and linguistic status to a level where there can be an exchange of concerns between doctor-patient.

Gender relationship and language use is deployed as a form of therapy in the ABUTH. The manners and ways language are used in medical encounter could be healing and at the same time liquidating. The research from the ABUTHShika shows that patients respond better when there is a shared concern between them and their attendant doctor. The language and communication skill deployed during different medical encounters contribute to the level of recovery of patient.

Sociolinguistic micro-interactional analysis has already made several significant contributions to the understanding of the dynamics and outcomes of specific communication exchanges involving data gathering, relationship building, and sharing of diagnostic and prognostic information.

5.2. Summary

This study is on "A Sociolinguistic Study of Doctor-Patient Interaction: A Case Study of ABUTH, Shika". The study has five chapters. Chapter one is titled Introduction and discusses the background of the study, the statement of the research problem, aim and objectives, the scope and delimitation of the study and the significance of the study. Chapter two reviews related concepts to the study and presents the theoretical framework. Concepts such as an overview and historical development of Sociolinguistics, notions of communication, its processes, language and communication, barriers in communication, and the theoretical framework used in carrying out the investigation.Chapter three is the methodology and constitutes the source of data, the method of data collection and the analytical procedure. Chapter four is data presentation and analysis. In this chapter, the data on the nature of conversation between doctors and patients was presented and analysed. Chapter five is the summary of the whole work and the conclusion to the study.

5.3. Conclusion

The sociolinguistic relationship between doctor-patient interactions in the Ahmadu Bello University Teaching Hospital (ABUTH) can be said, albeit arguably, to be very wide even though efforts have made to bridge the gaps. Whilst well-rounded communication and proficient language use remains a hurdle to be surmounted, timing has inhibited the accuracy of doctor-patient interactions. More so, factors such as status, gender, language use in rendering care or

treatment affects patient's level of recovery. The Evidences from the interlocutions show different cases of the sociolinguistic interaction between doctor-patient and have been discussed under different units. These units have all been geared into looking at the Sociolinguistics contact between doctor-patient in ABUTH Shika. The chapter affirms that the prospect of language as a means of therapy has not been committedly put to use in the ABUTH. However, it acknowledges the flexibility and skills doctor's apply in every medical encounter with patients. Nonetheless, these skills have to be honed, perhaps, by introducing a language session or course within the medical curriculum. Apart from the direct impact or extent medicine would have on patients, relationships with and the inventiveness of language to give confidence and stabilize the condition of patience is a fertile option which ABUTH could consider in both diagnosing and prescription.

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Appendix

INTERLOCUTION A

SPEAKER(S)	AGE	SEX	STATUS	GENDER
Doctor	About 38 years	Male	Literate	Male
Patient	Late 40s	Female	Literate/Public servant	Female

Complaint with interrupted solicitation of concern.

S/N	Doctor	Patient	Illocution	Comment
I	Hello, Ms. Lawal. What problem are you having?	I have chest pains…	Patient's intended answer is, "I feel pains on my chest". This is because it was her first visit to Doctor and her situation has not been diagnosed. Thus, Doctor has to interrupt her.	Complaint with interrupted solicitation of concerns
ii	When did it begin? (Interruption)	It started about three months and...	Patient intended answer: 'it began (not started) about three months ago…'. This is because when it started has not been ascertained.	On this interaction, medically speaking, there is a difference between "begin" and "started". 'Begin' here means when the pain began to be felt, not when it 'started'
Iii	Can you tell me more about it?	It's a gnawing pain that hurts in the centre of my chest.	Intended question and precise answer	Correctly interpreted and communicated
Iv	Does the pain go into the arms or to your neck?	Yes	Intended meaning	
V	Is it worse when you exercise?	Yes	Intended question and answer	
Vi	Do you smoke cigarette?	Silence… Yes, but when I am…	Intended question but discrete answer	Patient's hesitance brings out the status, age, gender disparity between Doctor-Patient and places

				a restriction on further questioning concerning smoking.
vii	Are you currently taking any medication?	No	Intended question	The Doctor has not prescribed any medication yet. What medication would she probably be taking?

INTERLOCUTION B

SPEAKER(S)	**AGE**	**SEX**	**STATUS**	**GENDER**
Doctor	About 56 years	Male	Literate/Middle Class	Male
Patient	About 28	Female	Literate/Middle Class	Female

Complaint with completed solicitation of concern

S/N	**Doctor**	**Patient**	**Illocution**	**Comments**
I	Hello, Ms.Danladi What problems are you having?	I feel pains on my chest.	Intended question and answer and to the point	Complaint with completed solicitation of concern
ii	Uh-huh.	It's a serious pain.	"Uh-huh". A sound made to solicit more information about her pain	Medical Doctor use gestures and exclamatory sound during interaction. They use it to either empathize and sustain interaction
iii	Uh-huh.	It seems to start in my chest and it goes to my arm and jaw.	Intended answer: 'start' in this context, is correct because it does not precede Doctor's inquiry	

Iv	(silence)	It's really frightening.	Probingly	Silence during interaction with patient in medical science is a way of communication. It nudges the conversation and makes patient want to fill the gap by giving more information.
V	I see!	You know, my father died from a heart attack and I'm afraid that the same thing may happen to me.	Unintended answer.	Because no question was asked the answers given were uncoordinated and do not relate to Danladi's problem.
Iv	I can see that you're concerned, and I'll certainly talk with you more about your chest pain. Before we start, however, is there anything else that's bothering you that I need to know about?	No, that's all.	Intended answer.	

INTERLOCUTION C

SPEAKER(S)	**AGE**	**SEX**	**STATUS**	**GENDER**
Doctor	About 33 years	Male	Literate/Middle Class	Male
Patient	About 66 years old	Female	Literate/Middle Class	Female

This interlocution is between a doctor and a sixty-six-year-old patient who had returned to the hospital for follow-up care illustrates an empathic opportunity and an empathic response on the doctor's part.

S/N	Doctor	Patient	Illocution	Comments
i	How do you feel about the cancer—about the possibility of it coming back?	Well, it bothers me sometimes but I don't think about it. But I'm not as cheerful about it as I was when I first had it. I just had very good feelings that everything was going to be all right, you know. But, now I dread another operation.	Intended question and answer	Complaint with empathic opportunity.
ii	You seem a little upset; you seem a little teary-eyed talking about it.		Intended statement soliciting empathy	

SPEAKER(S)	AGE	SEX	STATUS	GENDER
Doctor	About 33 years	Male	Literate	Male
Patient	About 30 years	Female	Semi-literate	Female

The above interlocution illustrates a missed empathic opportunity where it is more frequently found that the response to patients' expressions of emotion was "missed" by the doctor.

S/N	Doctor	Patient	Illocution	Comments
I	Does anybody in your family have breast cancer?	No.	Intended question and answer	Complaint with missed empathic opportunity
Ii	No!	Now I just start (unintelligible) after my womb	The intended remark from Doctor is meant to carry a question	Patient intuited the omission from Doctor and answered.

		was removed. I have been taking estrogen, right?	mark (?).	Nevertheless, she had an existing knowledge on what to take after hysterectomy. Thus, she proceed to seek confirmation from Doctor.
iii	Yeah?	You know how your breast gets real hard and everything? You know how you get of scared?	Probingly and Missed empathetic opportunity	Confirmatory question from Doctor that nudges Patient to speak more. Doctor, being male and gendered, is estranged from her explanation. His knowledge is limited within medical practice. Thus, he misses Patient's concerns.
Iv	How long were you on the estrogen?	Oh, maybe about six months. But I think this one is different. Its not cancer. I think is fibroid tumors.	Intended answer: 'I am not sure it is cancer'	Patient's probe in into Doctor's understanding of her problem because Doctor seems to be removed or distanced from her description. This is caused by factors such as one of status difference and gender issues.
V	Yeah, what, how, when were you, when did you have the, uh, hysterectomy?	Silence	Patient's silence shows her obliviousness of the word, 'hysterectomy'.	Missed empathetic Opportunity

INTERLOCUTION E

SPEAKER(S)	**AGE**	**SEX**	**STATUS**	**GENDER**
Patient	Late 40s	Female	Illiterate	Male
Doctor	About 32 years	Male	Literate	Male

S/N	Patient (Market woman)	Doctor	Illocution	Topic of Discourse
I	*Almost kneeling* Good morning sah! How work?	Work's fine. How are you?	Patient's action shows respect	Conversation between a male Doctor and a market woman. Respect shown to Doctor is referential to the occupation, not age.
Ii	Dem sey I get ulcer.	Ulcer?	Patient's intended statement is 'I have ulcer'. Doctor's inquiry suggest how she got to know about that.	Here, Patient's seem to be in charge of the interaction. Her role in this interaction is gendered towards a male assertiveness during conversation.
Iii	Yes sah!	For whia and how e dey do you?	Intended question effectively asked in pidgin.	Here, status issue is being raised as Doctor stem to speak in language Patient could relate with.
Iv	E dey make belle dey always pain me for dis side *touches the left-hand side of her stomach.*	Do you eat on time?	Intended	Doctor code-switches unconsciously at interval. He does this unknowingly because of the position his status pits him.
~~v~~	I eat always	Do you like peppery food?	Inappropriate answer to inquiry due to misapprehension. Intended question "you dey chop your food on time?"	
Vi	*Silent*	How often you dey take soft drinks?		Now, there is a language or communication barrier between the two as the silence of Patient suggest incomprehensiveness to

				Doctor's inquiries.
Vii	Minerals?	Yes	Intended	
Viii	Tiri tines evyday if I chop finish			

INTERLOCUTION F

SPEAKER(S)	AGE	SEX	STATUS	GENDER
Doctor	About 30 years	Female	Literate	Male
Patient	About 25 years	Male	Literate	Male

This is an interlocution between a male student and a young female doctor whose conversation would have been hindered because of the social cum biological difference between the two. Here, the professionalism and care of the young female doctor helps the male to open up on his illness even though it was done in the most conventional way.

S/N	Doctor	Patient	Illocution	Comments
i	*Smiling* Hey, how are you?	Fine	Patient's intended answer is not certain	Conversation between a young female doctor and a male student
ii	Fine? Huh! Why are you here then? (*Smiles again*)	*Gestures* I got boil	Doctor's intended meaning, 'No, you are not fine'	From here both sex and gender differences begin to play out.
iii	Where?	*Silent*	Probingly	The sex difference slows down Patient's answer.
iv	*Looks into his card. Smiles* on your thigh or?	(*Gestures*) On my thigh	Intended answer is YES.	The intended answer to Doctor's inquiry is slowed down because of the unwillingness to state the obvious. However, Patient's repeated Doctor's observation instead saying a simple YES.
V	What happened?	*Silent*	Intended	
vi	What medication are ~~we~~ taking?	*Smiles*	Correct Intended question	The use of 'WE' is mostly use in medical encounter

				to show care and impersonality.
vii	Don't worry, you're ok. It's nothing. Don't worry ~~we~~ would deal with.	*Smiles*	Care	

INTERLOCUTION G

SPEAKER(S)	**AGE**	**SEX**	**STATUS**	**GENDER**
Doctor	About 55 years	Male	Literate	Male
Patient	About 31 years	Female	Literate	Female

S/N	**Doctor**	**Nurse**	**Patient**	**Illocution**	**Comments**
	How are you today?	*Silent*	Good	Intended meaning	Conversation between/among Doctor, Nurse and Patient.
	Nurse, why haven't you administered this prescription?	I was waiting to see how well he would respond to previous treatment		Precise intent and answer	
	Is that what you're taught?	But sir is it not proper to…		Behavioural/Personality	
	Why don't you just do what I say?	Sorry			
	Have you eaten?		Not yet sir		
	Nurse, after breakfast let him take this	Ok sir.			

	one and the one there (*Looks into Patient's file*).				
	I have to attend to twelve other patients	Alright sir. Eat your food. I would come see you immediately after	Ok Nurse.	Time and urgency	

INTERLOCUTION H

SPEAKER(S)	**AGE**	**SEX**	**STATUS**	**RELIGION**	**GENDER**
Doctor	About 29 years	Male	Literate	Christian	Male
Patient	About 28 years	Female	Literate	Muslim	Female

Religious belief and sex affects doctor-patient interaction in ABUTH, Shika

S/N	**Doctor**	**Patient**	**Illocution**	**Comments**
i	*Smiling* Hey, how are you?	*Looks away* Fine	Intended meaning	Conversation between a young male doctor and a female Muslim. The Patient could not look at Doctor who needed her attention for proper diagnosis.
ii	Welcome (*opens up her file*) are you better?	*Gestures* Yes	Involuntarily she meant "not really"	Interaction is hampered by three factors here: religion, sex and gender.
iii	Okay?	*Silent*	Probingly	The sex difference slows down Patient's answer.
iv	*Looks at her. Smiles* You need to continue with these other medicine. Take it to	(*uncomfortably*) Okay	She wants to take her leave	She could not withstand the probing look of Doctor and hurries to leave without sharing her issues.
v	What happened?	Nothing. Would come again	I will come again	

INTERLOCUTION I

SPEAKER(S)	AGE	SEX	STATUS	OCCUPATION	GENDER
Doctor	Mid 40s	Male	Literate	Doctor	Male
Patient	Mid 50s	Male	Illiterate	Farmer	Male

Effective communication takes place between Doctor-Patient of same language or dialect. However, pain or other factors may affect such interaction in ABUTH, Shika

S/N	Doctor	Patient	Illocution	Comments
i	Yi`hakuri. Ina yakemakiciyo?	Ќasancikinake mum ciyo, kumawanilokaci yakanhauharќirj ina	Intended meaning	Conversation between a doctor and a farmer. The farmer enters with pains. Doctor welcomes him and they converse in Hausa without any barrier.
ii	Kina ɗaukan kaya masunauyi ne? (Do you carry heavy load?)	Najigonashekara njiyakuma, bayannadawaogi da ne yafaramumciyo (I went to farm yesterday when I returned home I started feeling pain)	Inappropriate answer to Doctor's question	Diagnosis is hampered by the pain of farmer. He gives differing answer to doctor's probation. The answer does not follow Doctor's question.
iii	Waniirinaikikike yi a gonan? (What kind of work do you do at the farm?)	Buhunmasaranen akedauka (I carry bags of maize)	Intended question and answer	Mutual understanding unhindered by any factor and sustained by similarity in language.
iv	OK			Silence. Doctor waits for more information from patient through nonverbal form of silence.
v	Da yaushe ne kikeyinciwon? (When do you usually feel such pains?)	Duksandanajiego nanayiaikisosai, ammawannazafi nyafimusosai (Anytime I go to the farm and returns home. I	Intended meaning	Doctor diagnosing the cause of the pain

		work very hard but this pain now is overwhelming)		
vi	Shekarankanawa ? (How old are you?)	Hamsin da waniabu (fifty something)	Intended meaning	Doctor links the source pain to patient's aging and makes recommendation.
vii	Ok, Karkadamu. Kakaiwannadaki nmagani, asubakimagungu nasaikasha. Kadainadaukan kaya masunauyi (Don't worry. Take this to the pharmacy they would give you drugs to drink. But you should stop carrying heavy things)	Toh, nagode (Ok, thank you)	Intended meaning	Doctor refers patient to the pharmacy and gives professional advice along.
viii	Allah yabadasauki (Allah makes you get better)	Amin amin		