A CRITICAL DISCOURSE ANALYSIS OF DOCTOR-PATIENT CONVERSATIONS IN SELECTED RURAL HOSPITALS IN KADUNA STATE

BY
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M.A/ARTS/43769/2012-2013

DEPARTMENT OF ENGLISH AND LITERARY STUDIES
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A DISSERTATION SUBMITTED TO THE SCHOOL OF POSTGRADUATE STUDIES, AHMADU BELLO UNIVERSITY, ZARIA, IN PARTIAL FULFILMENT OF THE REQUIREMENTS FOR THE AWARD OF A MASTER OF ARTS DEGREE IN ENGLISH LANGUAGE.

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DECLARATION

I, **Rashidat Temitope Araoye,** hereby declare that this dissertation entitled "**A Critical Discourse Analysis of Doctor-Patient Conversations in Selected Rural Hospitals in Kaduna State**" has been carried out by me. The information derived from relevant literature has been duly acknowledged in the text and a list of references provided. No part of this dissertation has been presented for another degree or diploma at this or any other institution.

ARAOYE, Rashidat Temitope Date & Signature

CERTIFICATION

This dissertation entitled **A Critical Discourse Analysis of Doctor-Patient Conversations in Selected Rural Hospitals in Kaduna State** by ARAOYE, Rashidat Temitope meets the regulations governing the award of the degree of Master of Arts (M.A) English Language at Ahmadu Bello University, Zaria and is approved for its contribution to knowledge and literary presentation.

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DEDICATION

This dissertation is dedicated to my brothers - Abdulwaheed and Abdulazeez Araoye.

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ABSTRACT

The use of language in human communication is predicated on social relationships; hence when people converse, they are always aware of the social relationship which determines who controls and directs the conversation. This study focuses on doctor-patient conversations in rural areas. It investigates how language is employed as a tool of social dominance in doctor-patient conversations in selected rural hospitals in Kaduna State, Nigeria. The aim is to examine and understand the nature of doctor-patient conversations in the selected rural hospitals in order to reveal the underlying power struggle. The study employs the theoretical paradigm of Fairclough's (1989) Discourse as Social Practice which is used to analyse the data. A total of twenty (20) conversations between doctors and patients are recorded, translated and transcribed. Twenty (20) patients are also interviewed in order to determine the level of patient satisfaction and Five (5) different doctor-patient conversations are selected for analysis at the levels of description, interpretation and explanation as proposed by Fairclough (1989). The study reveals that doctor-patient conversation in the selected rural areas is shaped by both the institution of medicine and the customs and traditions of the people in such areas where it occurs. It also reveals that the presence of a traditional ideology of health in these rural areas has an impact on the power dynamics and results in a power struggle. Another finding is that the communication style of doctors in rural areas is disease-centred, as opposed to patient-centred which as proven by William, Weinman & Dale (1998) leads to higher patient satisfaction. Finally, this study has successfully confirmed the fact that conversations between doctors and patients in rural areas are laced with unequal power relationship which is seen in their use of language.

CHAPTER ONE

INTRODUCTION

1.1 Background to the Study

Human communication is not an isolated linguistic phenomenon; rather, it is embodied in the social relationships of the communicators (O'Neill, 1989). The way people use language is dictated by their awareness of who they are and to whom they are talking. The choice of words in conversations is more often than not, a conscious decision. When people talk, they are always aware of the social relationship which determines who controls and directs the conversation. It has, therefore, become undeniable that a language is a powerful tool with which human beings exercise control and social dominance over one another. This consequently motivated the present study which is an investigation of how language is employed in the exercise of social dominance in doctor-patient conversations in rural areas.

This study centres on Critical Discourse Analysis (CDA), which is an approach in Discourse Analysis that emphasises the study of language and discourses in social institutions. CDA draws on poststructuralist discourse theory and critical linguistics to focus on how social relations, identity, knowledge and power are constructed through written and spoken texts in different linguistic contexts (Wodak, 2002). CDA is founded on the idea that there is unequal access to linguistic and social resources. van Dijk (1998a) defines CDA as a field that is concerned with studying and analysing written and spoken texts to reveal the discursive sources of power, dominance, inequality and bias. CDA examines how these discursive sources are maintained and reproduced within specific social, political and historical contexts. In a similar vein, Fairclough (1993:135) defines CDA as:

> discourse analysis which aims to systematically explore often opaque relationships of causality and determination between discursive practices, events and texts, and wider social and cultural structures, relations and processes in order to investigate how such practices, events and texts arise out of and are ideologically shaped by relations of power and struggles over power; and to explore how the opacity of these relationships between discourse and society is itself a factor securing power and hegemony.

In other words, CDA produces insights into the way discourse reproduces (or resists) social and political inequality, power abuse or domination. Several scholars have worked within the CDA framework on areas such as media discourse, political discourse, gender discourse, and various institutional discourses such as classroom discourse and medical discourse. Fairclough and Wodak (1997: 271) summarise the main tenets of CDA as follows:

1. CDA addresses social problems.
2. Power relations are discursive.
3. Discourse constitutes society and culture.
4. Discourse does ideological work.
5. Discourse is historical.
6. The link between text and society is mediated.
7. Discourse analysis is interpretative and explanatory.
8. Discourse is a form of social action.

This study also centres on rural healthcare. The materialist conception of rural health care anchors on the fundamental assumption that health care is part and parcel of society. Health begins with the axiom that human beings are the basis of both the forces of production, the relation of production, social institution and practices in any society. Therefore, “appropriate human organismistic condition, that is healthcare can only be understood in the concrete

content of the particular mode of organization of production and the dialectal relationship between the production forces and relation (Sander Ialman, 1977:8).

The present lopsided distribution of health facilities between urban and rural areas in Nigeria is a carry-over from the colonial era; the urban areas where the educated, the rich and the powerful live, receive the lion share of the infrastructure. The irony of it is that majority of Nigerians live in the rural areas, which makes them unable to access adequate health care services. Findings by Cutler (2000) also indicate that rural and small hospitals are significantly disadvantaged in terms of performance compared to urban and larger hospitals.

Booking an appointment in advance with a doctor is optional in Nigerian hospitals (Odebunmi, 2013); patients can visit any hospital any time of the day they perceive the need for the attention of a doctor. According to Desjarlais-deKlerk and Wallace (2013), the location of practice, such as working in a rural or urban clinic, may influence how physicians communicate with their patients. Furthermore, doctors in hospitals in rural areas tend to know their patients on a more personal level than their counterparts in urban hospitals. Also, while hospitals in urban cities tend to be bigger and equipped with personnel, those in rural areas are usually smaller in size, under-equipped except for those areas where they have federal medical centres and other primary healthcare providers.

Westernized medicine does not have a long history in Nigeria or for the Hausa people. The medicine and practices of the west were introduced as recently as fifty years ago and, due to strong cultural and religious resistance, it hasn't become the predominant medical force that the Hausa people rely on (Mussein, Ismail, 1981:251). Despite the fact that western medicine has helped the people of Nigeria, including the Hausa, stave off a number of diseases such as

cholera, leprosy, and malaria, traditional (that is, non-western) medicine is still considered to be the singular means by which disease is to be treated (Mussein, Ismail, 1981:251).

Traditional medicine in Northern Nigeria where this study is situated, is heavily characterized by Islamic influence from the East as well as traditional African style herbology and religious practices which are still prevalent today. Many traditional healing methods such as religious and spiritual healing are often used alongside more modern scientific medicine among Hausa villages and cities (Nnadi, Eucharia E. and Hugh F. Kabat, 1984:93–98). For instance, most Hausa women still give birth at home. According to Okeshola and Sadiq, (2013), one of the key informants in their study (a traditional birth attendant) said: *"Ah! Actually the culture of we the Hausa people restrict women from coming outside, except at night. Women are not allowed to visit hospitals. When a woman is pregnant and when it is about one month to delivery she will go to her mother's house where she will deliver her baby. This is our culture"*. Reasons for the cultural belief were sought, and it was found that 29.5% (13) of respondents who opined to the cultural influence as regards the place of delivery mentioned that the privacy of women should not be exposed to others; and 70.5% (31) also affirmed that their culture perceived child delivery as natural. This present study will investigate if such peculiarities exist in the selected rural hospitals.

In general, power, and especially institutionally reproduced power, is central to CDA. The purpose of CDA is to analyse 'opaque' as well as transparent structural relationships of dominance, discrimination, power and control as manifested in language' (Wodak, 1995 cited in Blommaert, 2005). Furthermore, CDA sees discourse as an instrument of power which is of increasing importance in contemporary societies. Now, the way this instrument of power

works is often hard to understand, and CDA aims to make it more visible and transparent. This makes CDA very important to any researcher who intends to study institutional discourse, especially as it involves power struggle and social dominance made possible through language use. It is to this end that this researcher chooses to deploy CDA to study power relations in medical discourse with specific reference to doctor-patient conversations in selected rural hospitals in Kaduna State.

Despite its long tradition since the days of Hippocrates, the field of medicine, which is the source of data for this research, has only been systematically investigated from the mid-1960s (Černý, 2007:14). These investigations have been carried out by experts from various fields, including sociologists, anthropologists, clinicians themselves and linguists, among others. van Naerssen (1985) identifies two kinds of medical communication thus: doctor-patient and doctor-other medical personnel; this study focuses on the former. Doctor-patient communication is undoubtedly different from ordinary everyday conversation. As an institutional discourse, it is shaped by the institution in which it occurs- medicine and its ideologies.

Many scholars in different studies have made observations about the nature of doctor-patient interactions (E.g Waitzkin, 1985; Fairclough, 1992; Cerny, 2010; Sarfo, 2011; and Shika, 2012) but this work builds on Adegbite and Odebunmi (2006) which is a pragmatic study of discourse tact in doctor-patient interactions in South-Western Nigeria. This present study focuses on a critical discourse analysis of doctor-patient conversations in order to investigate the power relations, especially in rural areas which are bound to have their own peculiarities.

1.2 Statement of the Research Problem

The facts that language is a powerful tool used to control our society and that language and power are inextricably linked cannot be challenged. Generally, doctors are known for the dominance and social control which they exert over patients during consultations. In rural areas, where the majority of the patients are uneducated and have little or no access to medical information, it would be expected that they are easier targets of the doctors' domination. However, in rural areas, the traditional ideology of health and medicine exists side by side that of modern medicine, which is bound to result in a disparity between the health beliefs of the doctor and those of the patient. The fact that some patients go to the hospital with a pre-conceived notion about the nature of their illness, may result in the patients putting up some resistance to the doctors' domination.

It is to this end that this study seeks to examine the nature of doctor-patient conversation during consultations in selected rural hospitals in order to determine its distinctiveness. This study also seeks to interrogate the assumption that power is linked to language use in the social context of doctor-patient consultations (Adegbite and Odebunmi, 2006), especially in rural hospitals. Furthermore, the possibility of an inherent issue of social dominance/ power relations between doctors and patients due to the existence of a traditional ideology of medicine and health in rural areas will be investigated.

1.3 Research Questions

This study intends to provide answers to the following questions:

i. What is the nature of doctor-patient conversations in the selected rural areas of Kaduna State?

ii. How is power linked to language use in doctor-patient conversations in the selected rural hospitals?

iii. What are the mechanisms employed in the exercise and/or resistance of power within the structure of doctor-patient conversations in rural areas?

iv. How effective is the nature of doctor-patient conversations in meeting the health communication needs and patient satisfaction in rural areas?

1.4 Aim and Objectives of the Study

This study is embarked upon to examine and understand the nature of doctor-patient conversations in selected rural hospitals of Kaduna State, in order to reveal the underlying power dynamics. The specific objectives thus to:

i. examine the nature of doctor-patient conversations in rural hospitals;

ii. analyse how power is linked to language use in the utterances of doctors and patients during consultations in rural areas;

iii. analyse the extent of the exercise and/or resistance of power within the structure doctor-patient conversations in rural hospitals; and

iv. examine the effectiveness of the nature of doctor-patient conversations in meeting the health communication needs and patient satisfaction in rural areas.

1.5 Scope and Delimitation of the Study

This work focuses on the Critical Discourse Analysis (CDA) of selected conversations between doctors and patients during consultations in rural settings. The study is restricted to data from twenty (20) recorded conversations between doctors and patients during first time

consultations in selected hospitals in Giwa, Bomo, Bassawa and Hunkuyi rural areas of Kaduna State, Nigeria. The hospitals in these areas are chosen because of easy access to data and based on the willingness of the personnel in such hospitals to cooperate with the researcher. The study is mainly concerned with consultations which involve first time meetings between doctors and patients. This study is therefore, not in any way concerned with follow-up consultations. Areas of CDA such as power, ideology, and language and social control will be analysed using Fairclough (1989)'s model.

1.6 Justification for the Study

Several studies have been done on medical discourse. For instance, internationally, we have studies like those of Byrne and Long (1976), Waitzkin (1985, 1989), Meeuswen (2003), Cerny (2010), and Desjarlais-deKlerk and Wallace (2013), to mention a few. However, in Nigeria, such studies are relatively few (Adegbite & Odebunmi, 2006); and according to Odebunmi (2006), most studies on medical discourse in Nigeria have focused on the register, linguistics and pragmatics of the discourse (E.g, Ogunbode, 1991; Adegbite & Odebunmi, 2006; Odebunmi 2006, 2010; and Faleke, 2018). Other studies include Martins (2008), Ayigun (2012) and Shika (2015). By focusing on the Critical Discourse Analysis of doctor-patient conversations, this study attempts to fill the theoretical and analytical gaps left by earlier studies and to investigate the hitherto least studied area of power relations and ideology in doctor-patient conversations in rural hospitals.

Moreover, every context of language use is considerably distinguishable from others and by focusing on rural areas; this research examines data from a distinctive linguistic environment,

culture and context, thereby providing a basis of comparison for findings on medical discourse from other parts of the country and the world. It is hoped that findings from this study will inform general healthcare delivery in Nigeria, by providing insights on the level of patient satisfaction with the health communication practice in rural areas, as well as how it can be improved to achieve a higher level of patient satisfaction.

CHAPTER TWO

LITERATURE REVIEW

2.0 Preamble

This chapter presents the review of related literature to this study. It reviews the concepts of discourse in context, doctor-patient communication as an institutionalised discourse, the structure of doctor-patient communication and doctor-patient communication in relation to patient satisfaction. Also reviewed are the different approaches to the study of discourse and an overview of Critical Discourse Analysis, and its major approaches. The concepts of language, power, and ideology, some previous studies on doctor-patient communication and the theoretical framework adopted for the research are also presented.

2.1 Conceptual Review

This section discusses and reviews linguistic concepts which are related to the present study.

2.1.1 Discourse in Context

The term ‘discourse’ is used extremely diversely both within linguistics and its branches and within other areas of social sciences and humanities. However, in its rather strict linguistic sense, Asher (1994:941) refers to it as connected speech or writing occurring at supra-sentential levels. The word “discourse” according to Yule (2010), is usually defined as “language beyond the sentence” and so the analysis of discourse is typically concerned with the study of language in texts and conversation. Candlin (1997) sees discourse as a language in use; as a process which is socially situated. Johnstone (2002: 2) defines discourse as “actual instances of communication in the medium of language. Therefore, discourse can be used to refer to language in actual use, that is, in both speech and writing.

The word “context” is used by different authors and linguists for different but often interrelated and dependent notions. Context is a key concept for understanding the nature of communication in general. Brown and Yule (1983:25) describe context as “the environment” or “circumstances in which language is used”. Widdowson (2000) views context as “those aspects of the circumstance of actual language use which are taken as relevant to meaning”. Song (2010) classifies context into three: linguistic, situational and cultural context. Linguistic context refers to the context within the discourse, that is, the relationship between the words, phrases, sentences and even paragraphs. Situational context, or context of the situation, refers to the environment, time, place and so on, in which the discourse occurs, and also the relationship between the participants. Lastly, cultural context refers to the culture, customs and background of an epoch in language communities in which the speakers participate. Language is a social phenomenon, closely tied up with the social structure and value system of society and therefore, cannot avoid being influenced by all these factors like social role, social status, sex, age, and so on.

Discourse and the context in which it occurs are inextricably linked. Johnstone (2010) outlines the relationship between discourse and context by proposing the following as the different ways discourse is shaped by its context and how discourse, in turn, shapes its context:

1. Discourse is shaped by the world and discourse shapes the world.
2. Discourse is shaped by language and discourse shapes language.
3. Discourse is shaped by participants and discourse shapes participants.

4. Discourse is shaped by prior discourse and discourse shapes the possibilities for future discourse.

5. Discourse is shaped by its medium and discourse shapes the possibilities of its medium.

6. Discourse is shaped by purpose and discourse shapes possible purposes.

Context plays a very important role in the analysis of discourse. A discourse and its context are in close relationship. Song (2010) affirms that discourse elaborates its context and the context helps to interpret the meaning of utterances in the discourse. According to Stubbs (1983), the major focus in Discourse Analysis is the use of language in social context. Similarly, Asher (1994) states that Discourse Analysis is a contextually oriented approach to language and because of its focus on context, it naturally pays attention to the social relationship of participants. In other words, every instance of language use (discourse) is situated in a particular social context, which determines the kind of meaning communicated.

Therefore, conversations between doctors and patients can only be understood when the context- the institution of medicine, in which it occurs is taken into consideration. More so, the linguistic, situational and cultural context in which a particular doctor-patient communication occurs will determine the nature of the said communication which would be considerably distinguishable from those which occur in other contexts. For example, doctor-patient communication in rural areas can only be fully understood when the language, culture and social relationship between doctors and patients in that particular context is considered.

2.1.2 Linguistic Features of Conversations

Conversation is often used interchangeably with the term "discourse" . Brennan (2010) defines conversation as a joint activity in which two or more participants use linguistic forms and non-verbal signals to communicate interactively. She further states that "real conversations" are spontaneous rather than scripted and are shaped by cordinated behaviour of speakers and addresses. On what conversation is not, Warren (2006:8) states that a ritualised exchange such as a mutual greeting is not a conversation; an interaction that includes a marked status differential(like a boss giving orders) is not a conversation; and an interaction with a tightly focused topic or purpose is also not a conversation. For Thornbury and Slade (2006:28) conversation happens informally, symmetrically and for the purpose of establishing and maintaining social ties. No generally accepted definition of conversation exists, however it is undeniable that a conversation involves at least 2 people communicating.

Of importance to this study is the categorisation of conversation into institutional and non-institutional discourse. Non-institutional discourse or ordinary conversation as used by Hertage (1992) is a term that has come to denote forms of interaction that are not confined to specialised settings or to the execution of particular tasks. In order to understand non-institutional discourse, one has to understand institutional discourse, where the participants in the discourse are either restricted or there is a limit to the conversation in terms of the use of language, codes, topics, context or situation (Heritage, ibid). On the other hand, the non-institutional discourse has no limitation on the conversation between the interlocutors, or a restriction on the types of discourse; the context, situation, codes, choice of words, and language use.

Warren (2006) highlights some features of non-institutional conversations. Non-institutional conversation contains simple phrasal structures, shorter phrases and pausing, which occurs frequently. Discourse markers like *"right", "okay", "you know", "you see", "anyways", and "you see"* are used in everyday conversations to check understanding and keep the listener involved in the conversation. Also, non-instutional conversations are known for question tags like *"You couldn't carry this for me, could you?" and "Don't tell anybody about this, yeah?"*. Other features include but are not limited to Echo question(*You went where?)*, Repetition,and Ellipsis. Institutional discourse and its features, which the study is concerned with is discussed below.

2.1.2.1 Doctor-Patient Communication as an Institutionalised Discourse

"Institutional talk", or "institutional discourse", as the label suggests, is closely connected with the institutions, that is, the settings in which it occurs. These institutions and organisations such as school, court or medicine, to a large extent determine Fairclough's social context. In his view, all forms of discourse are shaped by these institutions, which are in turn shaped by wider power relations (Fairclough, 1989:17). According to Thornborrow (2002:2), institutional discourse can be characterised as (1) goal-oriented, (2) having differentiated, pre-inscribed participant roles, and (3) asymmetrical.

Goal-Orientation

This means that institutional discourse involves a task which the participants pursue their interaction, be it teaching at school or making a diagnosis and finding a treatment at the doctors. Doctor-patient discourse is goal-oriented. The doctors and their patients meet in order for the doctor to gain the necessary information, make a diagnosis and help (or at least attempt

to help) the patient. This goal-orientation determines most aspects of the interactions. It is because of this that patients sometimes provide their doctors with information about their life –information of a very intimate character – whereas doctors usually do not. As Beran states, "the doctor does not entrust the patient with his own life" (Beran, 1999: 5). It is also because of this that doctors tend to ask questions at the beginning of the interview in order to acquire the relevant information and make a diagnosis, while patients more often ask questions towards the end of the interview in order to discuss treatment with the doctor.

Institutionalised roles

In institutional interactions, there are differentiated, pre-inscribed participant roles, or institutional roles (for instance, a school teacher or a doctor). Institutional discourse "sets up positions for people to talk from and restricts some speakers' access to certain kinds of discursive actions" (Thornborrow, 2002:4). Thus, in doctor-patient discourse, the participants have differentiated, pre-inscribed institutionalised roles. The institution sets up roles for both doctors and patients. For example, the role of a doctor in doctor-patient communication typically (but not exclusively) involves asking questions in order to elicit the necessary information and make a diagnosis and it is the role of the patient to provide the information in order to get a diagnosis and treatment. Moreover, doctors are usually those who initiate as well as terminate the interviews.

Asymmetry

The relationship between participants is in terms of speaker rights and obligations asymmetrical. In conversations, asymmetry is manifested as "structurally asymmetrical distribution of turn types between the participants" (Thornborrow, 2002). It can be said that in

institutional discourse, to some extent, certain turn types are for a particular speaker is seen as legitimate and others are not. In other words, some participants tend to occupy certain discursive roles (for example, questioner, answerer or opinion giver) and others do not. And "although it may be open to any participant to ask a question, asymmetry emerges between those participants who are under some obligation to answer questions, and those who are not" (Thornborrow, 2002:134). It will be actually shown below that among these turn types, questions are of greatest importance. For example, it is the general view that in a medical interview the doctor asks questions and the patient answers them. Goffman (1983b:5) describes interactions (any interactions, not only doctor-patient ones) as "orderly" and says that this orderliness is "predicated on a large base of shared cognitive presuppositions" which are determined by society and its discourse, and they function as "rules for a game".

During any interaction, participants may occupy different discursive roles- one of a questioner or one of an answerer. Questions can be very powerful devices in interactions. What follows is that the role of a questioner is powerful. Contrary to the traditional view doctors indeed ask more questions than patients, Černý (2010) proposes that patients have become active "questioners" which would seem to suggest a challenge to the asymmetry in doctor-patient communication. Černý identifies some other ways in which the asymmetry manifests itself in doctor-patient communication. Černý claims that three main types of sequences occur in doctor-patient interaction: (1) eliciting, which is most frequent and most important, (2) directing, that is, "the doctor's command succeeded by the requested action realised by the patient", and (3) informing, that is, information-giving by the doctor, accompanied by an acknowledgement from the patient (Černý, 2010a, p. 67). Waitzkin (1985:81) also observes

that whereas patients almost always want as much information as possible, doctors sometimes (arguably unconsciously) tend to withhold it. The doctor's ability to control information, therefore, creates a basic asymmetry in the doctor-patient relationship. Waitzkin further suggests that doctors may withhold information and maintain uncertainty to preserve power in the doctor-patient relationship. However, it can be argued that, most people nowadays have a reasonable knowledge of medicine due to the ocean of information available on the internet which has reduced reasonably, the extent of asymmetry in the doctor-patient relationship and has tipped the scale in favour of the patients who now require less clarification of medical jargons from doctors. As such is not the case in rural areas where the majority have no access to information, it becomes necessary to investigate the extent of asymmetry in doctor-patient relationship in that particular context of language use.

Fairclough (1992a) discusses the changes in the social identities of doctors and patients and in the nature of the interaction between them. Juxtaposing two different medical interviews (a more traditional/conventional and an alternative/more contemporary interview), Fairclough observed an apparent reduction of overt markers of power asymmetry between doctors and patients in the alternative interview. Doctors in the alternative interview were observed showing sensitivity to patients, ceding control of topic to patients and collaboratively managing turn-taking with patients. Although recent years have witnessed this social change in the form of patient-centred approach to medical communication in the western world, it is arguable that asymmetry is still prevalent in doctor-patient communication, especially in Nigeria.

Doctor-Patient communication is undoubtedly different from the ordinary everyday conversation, mostly because it is specific to a particular context- the hospital in which it occurs. According to Holmes (cited in Černý, 2007:40), there are four factors that are always relevant when studying spoken communication: the participants, the social setting, the topic, and the function. All of these are present in doctor-patient communication set within the institution of medicine. However, the participants in doctor-patient communications always remain the same – "the doctor" and "the patient". It thus appears that in order to understand the nature of doctor-patient discourse, its classification within institutional discourse is of great importance.

2.1.3 Structure of Doctor-Patient Conversations

The structure of doctor-patient communications during health care visits have been identified by various scholars from their studies on medical discourse. Byrne and Long (1976) propose the following phases as the overall structure of doctor-patient visits:

1. Opening: doctor and patient establish an interactional relationship.
2. Presenting Complaint: the patient presents the problem or reason for the visit.
3. Examination: the doctor conducts a verbal or physical examination or both.
4. Diagnosis: the doctor evaluates the patient's condition.
5. Treatment: the doctor details treatment or further investigation.
6. Closing: the visit is terminated.

Meeuwensen (2003) also highlights the generally accepted sequence of the global phasing in medical interviewing as follows: (a) medical history, (b) physical examination, and (c) the conclusion segment. Relevant sub-divisions of the medical history include (1) presentation of complaint(s) and (2) clarification of complaint(s), while the conclusion segment discerns speaking turns referring to (1) diagnosis and (2) advice, prescription or referral.

Adegbite & Odebunmi (2006) in their study of doctor-patient interactions in South-Western Nigeria identify the overall structure as consisting of two parts: (i) identifying the problem, its symptoms and sources, and (ii) attempting to recommend a solution(s) to the problem.

This study will determine whether or not doctor-patient communication in the rural areas within this study adhere to any of the structures identified above.

2.1.4 Doctor-Patient Communication and Patient Satisfaction

Patient satisfaction is an important and commonly used indicator for measuring not only the quality of health care but also the success of doctors and hospitals generally. Many studies on doctor-patient communications have been carried out in order to investigate which communicative behaviours of both doctors and patients are significantly related to patient satisfaction. William, Weinman and Dale (1998) reviewed some of such previous studies and highlighted the following:

Information-Provision

Provision of information by doctors especially during an examination has been found to be positively related to patient satisfaction. In other words, the higher the information-provision by doctors, the higher the patient satisfaction. Information-provision by patients especially

during the presentation of complaint has also been found to be highly related to their satisfaction. That is, the ability of patients to be able to describe/explain their illnesses and circumstances in their own words invariably leads to their satisfaction.

Information-Seeking

The use of certain types of questions by doctors has also been found to be positively related to patient satisfaction. That is the use of open-ended questions, eliciting details and giving patients opportunities to ask questions often lead to patient satisfaction.

Doctor-Patient Relationship and Expression of Positive/Negative Affect

The doctor's tone, the degree of friendliness and general patterns of communication in which the doctors are friendly, approving, and engaged in social non-medical conversations are positively associated with patient satisfaction. On the other hand, antagonizing behaviours on the part of the doctor are negatively related to patient satisfaction.

Communicative Style

There are two major medical communicative styles- disease-centred and patient-centred. The disease-centred approach is doctor-led and involves the doctor concentrating on his/her own agenda through textbook style enquiries about patient's medical history. The patient-centred approach, on the other hand, is patient-led and involves the doctor adhering to patient's agenda, listening and responding to what the patient says and trying to understand the patient's experiences from the patient's point of view. According to William et al (1998), patient-centredness during consultations has been associated with the highest percentage of patient satisfaction. Other consultation styles include directing and dominating (dramatising,

exaggerating and dominating conversation); sharing and affiliative (friendly, encouraging, attentive, empathy, and acknowledging contributions). Directing and dominating styles have a negative influence on patient satisfaction, while sharing and affiliative styles have a positive effect on patient satisfaction.

The issue of patient satisfaction is important to this study because amongst the objectives of the study, is to determine the effectiveness of doctor-patient communication in meeting the health communication needs and patient satisfaction in rural areas. Therefore, the communicative behaviours highlighted above will be employed in structuring interview questions for the patients in the selected rural hospitals in order to determine their level of satisfaction with the prevailing nature of health communication in these areas.

2.1.5 Language and Power

Language is an inalienable component of the human society which encompasses the people's culture, social life and even their environment. Language is a very important means of communication between humans. Syal and Jindal (2008) argue that all the other means of communication used by humans such as gestures, nods, flags, maps, morse code, miming, dancing and so on are all extremely limited and depend only on language because they are not as flexible, comprehensive or extensive as language. Language is so important as a means of communication between humans, that it is very difficult to think of a society without language. It gives shape to people's thoughts; guides and controls their entire activities. Language is present in all activities and is used to communicate in all spheres of life – at home, social gatherings and places of work. Conversations between doctors and patients

which this study focuses on are only made possible via the language which is used to exchange information and resolve health issues.

Principally, language is used to communicate ideas, express emotions, record facts, worship, interact socially, as an instrument of thought, and expression of identity and to control reality. The latter which is relevant to this study, is the ingrained role of language in manipulating and controlling the reality we live in. To support this, Kuipers (1989) affirms that language, if properly understood and completely deployed, can, like any other piece of equipment, serve the intentions of its users. In other words, language can be manipulated by people to serve various purposes like persuade, deceive, manipulate or control others.

According to Wodak (2002), CDA sees language as social practice and considers the context of language use to be crucial. Furthermore, CDA sees discourse – language use in speech and writing – as a form of social practice. Describing discourse as social practice implies a dialectical relationship between a particular discursive event and the situation(s), institution(s) and social structure(s) which frame it. That is, discourse is socially constitutive as well as socially conditioned – it constitutes situations, objects of knowledge, and the social identities of and relationships between people and groups of people. It is constitutive both in the sense that it helps to sustain and reproduce the social status quo, and in the sense that it contributes to transforming it (Fairclough & Wodak 1997:258). Since discourse is so socially consequential, it gives rise to important issues of power. Therefore, discursive practices may have major ideological effects – that is, they can help produce and reproduce unequal power relations between, for instance- social classes, women and men, and ethnic/cultural majorities and minorities through the ways in which they represent things and position people.

The notion of power is highly important in CDA, and central to this study is how language is employed as a power tool by doctors during consultations with their patients in rural areas. According to Dahl (1957), the fact that some people have more power than others is one of the most palpable facts of human existence. The concept of power is as ancient and ubiquitous as any other concept of social theory. The issue of power has been handled in various disciplines such as philosophy, sociology and linguistics and has been developed and defined in different ways over time. Modern thinking about power begins in the writings of Nicollò Machiavelli (*The Prince*, early 16th century) and Thomas Hobbes (*Leviathan*, mid-17th century). Their books are considered classics of political writing, and the contrast between them represents the two main routes along which thought about power has continued to this day (Clegg, 1989). After the Second World War, the social sciences began taking an understandable interest in power. At that time, the work of Max Weber (1947) served as a point of departure for thought about power because it continued the rational Hobbesian line and developed organisational thinking. Weber's approach to power connected with his interest in bureaucracy, and linked power with concepts of authority and rule. He defined power as the probability that an actor within a social relationship would be in a position to carry out his will despite resistance to it. The activation of power is dependent on a person's will, even in opposition to someone else's.

Dahl (1961) sees power as involving the ability to make somebody do something that otherwise he or she would not have done. Thompson (1990:8) indicates that linguistics has defined power as a symbolic concept through the work of Pierre Bourdieu during the 1950s. For him, symbolic power is the aspect of most forms of power in social life. He also views linguistic utterances as relations of symbolic power in which the power relations between

interactants are actualized. Furthermore, he relates speech acts to social institutions claiming that “those institutions endow the speaker with the authority to carry out the act which his/her utterance claims to perform”. Likewise, Foucault (1980:98) relates the concept of power to the term discourse claiming that “power is relational and dynamic, showing itself in the minute interactions between and within people”. He also holds that there is continuous resistance to it from individuals who are its vehicles. From the point of view of critical discourse analysis power is seen “as already accruing to some participants and not to others and this power, according to Thornborrow, 2002:7) is determined by their institutional role and their socio-economic status, gender or ethnic identity. In other words, profession, status, gender or ethnic identity can determine whether or not certain people have power, as well as the extent of such power.

The relationship between social power and language is a permanent topic not only in CDA, but also in sociology and sociolinguistics (Wodak, 2001). Fairclough and other critical linguists have made various postulations in an attempt to demonstrate the relationship between language and power. For Fairclough (1989), language is centrally involved in power and struggles for power and it is also involved through its ideological properties. According to Fairclough, language and power are related in two ways: as power acts in discourse and behind discourse. Power in discourse is related to holders of power in social interactions and has three dimensions which Zupnik (1991) illustrates as: (1) control over the relations between individuals, (2) power or control over the content, and (3) control over "subjects". This type of power, as Fairclough claims, is concerned with discourse in which relations of power are exercised. To illustrate this point, he provides an example of an unequal interaction between a medical professor and a student. He shows that the professor exercises control over

the student's contributions in the opening turn, the way in which the student is explicitly told when to start talking, the explicit instructions, the way in which the student's contributions are evaluated and finally in the questions directed to the student. Power behind discourse, on the other hand, is said to involve the effects of power to show how orders of discourse are shaped and constituted. Power behind discourse is evident in the differentiation of dialects into "standard" and "nonstandard" and in the conventions associated with a particular discourse type.

Wodak (2002) also argues that the constant unity of language and other social matters ensures that language is entwined in social power in a number of ways: language indexes power, expresses power, is involved where there is contention over power and where power is challenged. Wodak states further that power does not derive from language, but language can be used to challenge power, to subvert it, to alter distributions of power both in the short and the long term. Language provides a finely articulated vehicle for differences in power within hierarchical social structures. Similarly, Abaya (2013) affirms that power relationship, in most social and political relations are usually constructed through written or spoken discourse. He further states that in such relationships, powerful participants control and constrain the contribution of non-powerful participants.

Language and power can thereby be considered to be highly related. Power is greatly dependent on language, as language plays a crucial role in the exercise of power and dominance. Language can be considered a tool with which people exercise control over others. With language, we influence and to an enormous extent, control events and even actions of others. It is for this reason that writers write; preachers preach; employers, parents,

and teachers scold; and politicians give speeches. All of them, for various reasons, are trying to influence our conduct - sometimes for our good, sometimes for their own. In doctor-patient conversations, language is the tool with which doctors dominate and control the verbal contributions of their patients.

2.1.5.1 Theorised Approaches to Power

There are various theorised approaches to power which have been postulated by various scholars over time. Some of the most widely accepted theories are examined below.

One-dimensional Approach

The one-dimensional view of power is often called the pluralist approach. Power is seen as a behavioural attribute that applies to individuals to the extent that they are able to modify the behaviour of other individuals within a decision-making process. The person with the power in a situation is the person who prevails in the decision-making process. In other words, power involves a focus on behaviour in the making of decisions on issues over which there is an observable conflict of (subjective) interests. Popular amongst the pluralists is Robert Dahl (1961) who located the discussion of power within the boundaries of an actual community. According to him, power is exercised in a community by a particular concrete individual while other individuals are prevented from doing what they prefer to do. Power is thereby exercised in order to cause those who are subject to it to follow the private preferences of those who possess the power. Power is the production of obedience to the preferences of others, including an expansion of the preferences of those subject to it so as to include those preferences.

According to Sadan (1997), the one-dimensional approach is based on assumptions that were sharply criticised by those who continued it. For example, that participation in power relations occurs overtly in decision-making arenas; that these political arenas are open to any organised group; that the leaders are not elites with interests of their own, but represent or speak for the entire public. All these assumptions lead to a conclusion which is characteristic of the one-dimensional approach: because people who have identified a problem act within an open system in order to solve it, and they do this by themselves or through their leaders, then non-participation, or inaction, is not a social problem, but a decision made by those who have decided not to participate. The constant connection between a low socio-economic status and minimal participation is explained as indifference, political incapacity, cynicism or alienation.

Two-dimensional Approach

The second dimension of power was brought forward in rebuttal to the pluralist theory and based on the assumption that it is possible to influence decisions by shaping the agenda, not merely by weighing in on existing decision points. Bachrach and Baratz (1962) in their "Two Faces of Power" pointed out that shaping the agenda is an important source of power that is overlooked in the pluralist model, the one-dimensional view. They dealt mainly with the connection between the overt face of power – the way decisions are made – and the other, covert face of power, which is the ability to prevent decision making. According to them, power is activated on the second, covert dimension, not only in order to triumph over the other participants in the decision-making process, but also to prevent decision-making, to exclude certain subjects or participants from the process (Bachrach & Baratz, 1962).

Since the two-dimensional approach, like the one-dimensional, assumed that the powerless are fully conscious of their condition, it was criticised for its inability to easily explain the

whole diversity of means that power exercises in order to obtain advantages in the arena. For example, how is the raising of issues for discussion prevented? This approach also did not recognize the possibility that powerless people are likely to have a distorted consciousness that originates in the existing power relations, and thus live within a false and manipulated consensus that they have internalized.

Three-dimensional Approach

This dimension introduced by Steven Lukes (1974), incorporates the views of the previously identified dimensions of power and delves deeper into the phenomenon of power. Power, as seen by Lukes (ibid) is measured also by the ability to implant in the minds of people, interests that are contrary to their own good. The third dimension that Lukes add to the discussion of power is the latent dimension. While the overt dimension (one-dimensional view) of power deals with declared political preferences, as they reveal themselves in open political play, and the covert dimension (two-dimensional view) deals with political preferences that reveal themselves through complaints about political non-issues, the third dimension deals with the relations between political preferences and real interests. The third, latent dimension is the hardest of all to identify because it is hard for people who are themselves influenced by this dimension to discover its existence.

According to this view, power can indeed be at work in ways that are hidden from the view of those subject to it and even of its possessors. The powerful may work to avert conflict by contributing (intentionally or unintentionally) to getting others to want what they want them to want, shaping their perceptions, cognitions and thus preferences. Power is thereby not just the ability to prevail over others in conflicts of interests and set the agenda of what such

conflicts are about, it also encompasses being able to secure their dependence, deference, allegiance or compliance, even without needing to act and in the absence of conflict.

A Fourth View: Michel Foucault

Any discussion on the subject of power would be incomplete without mentioning Michel Foucault (1977a; 1977b; 1980a; 1980b; 1982, 1989, 1990) whose view of power has been highly influential across many disciplines including Critical Language Studies. Foucault agreed that power is at its most effective when least observable but his focus shifted away from individuals and groups who dominate and are dominated. Instead, he saw power as operating 'through' individuals rather than against them; as 'constituting' the individual who is at the same time, its vehicle. Some of Foucault's views (cited in Sadan, 1997) on power are summarised below:

1. Power is not a commodity, a position, a prize or a conspiracy. It is the activation of political technologies and is concomitant with the social body. Power not only operates in specific spheres of social life, but occurs in everyday life.

2. Power relations are mobile, non-egalitarian and asymmetrical. We must not expect to find a stable logic in power, or a possibility of balance in its domain.

3. Power/knowledge functions through discourse. Relations of power "cannot themselves be established, consolidated nor implemented without the production, accumulation, circulation and functioning of a discourse.

4. Since power is not a thing, is not control of a set of institutions, nor a concealed historical pattern, the aim of the researcher of power is to discover how it operates.

5. Power has a direct and creative role in social life. It is multi-directional, and operates from the top down and from the bottom up.

6. Power is a general matrix of power relations in a given society at a given time. No-one is outside this matrix, and no-one is above it.

7. Domination, then, is not the essence of power. Domination does exist, but power is exercised upon the rulers too and not only upon the ruled.

8. Power masquerades as a supposedly rationalist construction of modern institutions, a regime of truth which induces and extends the effects of power.

From all the approaches to power discussed above, we can deduce that no matter the theory or approach, the premise of power remains the same- the ability to get individual(s) to consciously or unconsciously do whatever you want them to do. We can also make some other general observations about power. Firstly, in every society, there are individuals with more power than others- that is, there will always be the powerful and the less powerful/powerless. Now, this power is usually derived from the different political, social or cultural avenues available in the society which empowers such individuals. Secondly, power is realised and made possible through discourse and maintained by manipulating and controlling the worldview of people in a society. Thirdly, power is not always obvious and it is left to researchers to explore and expose how power operates both overtly and covertly in the society. In doctor-patient relationship, the doctor occupies the position of power and dominates over the less powerful patients. Power is exemplified at its peak in consultations that are doctor-led (also known as disease-centred communication style); where the doctor's

major focus is achieving the aim of the visit, which is to proffer solutions to the patients' health problems. In such consultations, we find the doctor in total control of the conversation; not encouraging the patients to ask questions or facilitating the patients' involvement in the decision-making regarding the solutions to the patient's health problems.

2.1.5.2 Bases of Power

Although there are undoubtedly many possible bases of power which may be distinguished, the most widely accepted is that proposed by French and Raven (1959). They identified the five bases of power as coercive, reward, legitimate, expert, and referent, to which a sixth-informational power, was later added by Raven when he revised the model in 1965. Although from the six bases of power, the most relevant to this study are expert and informational power, all six bases are discussed below.

Coercive Power

This type of power is based on the idea of coercion. Coercive power involves the use of threat of force to gain compliance from another. Such force may be physical, social, emotional, political, or economic. The main idea behind this concept is that someone is forced to do something that he/she does not desire to do and the main goal of coercion is compliance. Raven (ibid) argues that coercive power's influence is socially dependent on how the target relates to the change being desired by the influence agent. Furthermore, a person would have to be consistently watched by the influencing agent in order for the change to remain in effect. Threats and punishments are the most common tools of coercion. These can come in the form of threat of job loss, demotion, denied privileges or undesirable assignments. This source of power can often lead to problems and in many circumstances it involves abuse.

Reward Power

Reward power is defined by French and Raven (ibid) as a power whose basis is the ability to reward. It is based on the right or ability to offer tangible, social or emotional rewards to others for doing what is wanted or expected of them. Reward power is also based on denial of valued materials for failure or refusal to do what is desired or expected of them. This type of power is also based on the idea that we as a society are more prone to do things and to do them well when we are getting something out of it. The strength of the reward power increases with the magnitude of the rewards which a person perceives that the other person with such power can mediate for him. The problem with this type of power is that when you use up available rewards, or the rewards do not have enough perceived value to others, your power weakens. One of the frustrations with using rewards is that they often need to be bigger each time if they are to have the same motivational impact. Even then, if rewards are given frequently, people can become dissatisfied by the reward, such that it loses its effectiveness. For example, teachers are wielders of reward power which they use as a tool to motivate their pupils/students.

Legitimate Power

Legitimate power comes from an elected, selected, or appointed position of authority and may be underpinned by social norms. Legitimate power stems from social norms requiring that the target of influence comply with the request or order of the influencing agent. According to French and Raven (ibid), legitimate position power, the most obvious form of legitimate power, stems from a social norm that requires that we obey people who are in a superior

position in a formal or informal social structure, such as a supervisor or a higher ranking military officer. Other examples include the right of parents to influence children, of older people to influence younger ones, and of teachers to influence students. Other, more subtle forms of legitimate power based on social norms include the legitimate power of reciprocity, legitimate power of equity, and legitimate power of responsibility. The reciprocity norm states that if someone does something beneficial for us then we should feel obliged to reciprocate. Legitimate power of equity also called a "compensatory norm," would be something like "I have worked hard and suffered and therefore I have a right to ask you to do something to make up for it." Finally, the norm of legitimate power of responsibility, also called the "power of the powerless," suggests that we have some obligation to help others who cannot help themselves or depend on us.

Expert Power

Expert power is based on what one knows, experience, and special skills or talents. Expertise can be demonstrated by reputation, credentials certifying expertise, and actions. The effectiveness and impacts of the expert power base may be negative or positive. According to Raven (ibid), there will be more use of expert power if the motive is a need for achievement. It involves the ability to administer information, knowledge or expertise to another. Also, when individuals perceive or assume that a person possesses superior skills or abilities, they award power to that person. For example, doctors are wielders of expert power which they derive from their expertise in human health, thereby leading to patients recognising that power and awarding it to them.

Referent Power

This type of power has its basis in the identification of an individual with another person or a social entity. That is, a feeling of oneness or a desire for such an identification. It is in the nature of people to possess a desire to become closely associated with individuals or group to which they are highly attracted. A person may be admired because of specific personal traits which would create an opportunity for interpersonal influence. French and Raven (ibid) argues that the use of this power base and its outcomes may be negative or positive. Referent power in a positive form utilizes the shared personal connection or shared belief between the influencing agent and target with the intention of positively correlated actions of the target. Referent power in a negative form produces actions in opposition to the intent of the influencing agent. The responsibility involved in this type of power is heavy and the power easily lost, but when combined with other forms of power it can be very useful. Referent power is commonly seen in political and military figures.

Informational Power

This sixth base of power proposed by Raven (1965) involves the ability of an agent of influence to bring about change through the resource of information. Raven arguably believes that information has the potential to influence. Informational influence results in cognition and acceptance by the target of influence. The ability for altered behaviour initiated through information rather than a specific change agent is called socially independent change. In order to establish information power, an agent of influence would likely provide a baseline of information to a target of influence to lay the groundwork in order to be effective with future persuasion. Information power comes as a result of possessing knowledge that others need or

want. In the field of medicine, Doctors have informational power to an extent, which makes it possible for them to dominate over patients. However, access to medical information via the internet has arguably tipped the scale of power in favour of those patients who are internet savvy. In relation to this study, the resulting power imbalance between doctors and patients in rural areas can be attributed to the supremacy of information on the part of the doctors, and to the lack of information on the part of the patients. In other words, since majority of the patients in rural areas have little-to-no access to medical information; it makes it easier for doctors to exercise informational power and dominance over them.

2.1.6 Language and Ideology

Before trying to understand the relationship between language and ideology, the concept of ideology should also be clarified. Ideology is itself a complex notion. The field of ideology is filled with a morass of contradictory definitions, widely varying approaches and huge controversies over terms, phenomena, or modes of analysis. Thompson (1990) points out that the concept of ideology first appeared in late 18th century France and has thus been in use for about two centuries. The term has been given a range of functions and meanings at different times. For Thompson, ideology refers to social forms and processes within which and by means of which, symbolic forms circulate in the social world, and the study of ideology is a study of the ways in which meaning is constructed and conveyed by symbolic forms of various kinds.

According to Blommaert (2005), ideology has indeed been a very fertile topic of investigation in CDA, as well as other related branches of discourse analysis. Blommaert further state that the reason for this is that discourse (or semiotic behaviour at large) has been identified by

almost every major scholar as a site of ideology. Wodak (2002) points out that, Ideology, for CDA, is seen as an important means of establishing and maintaining unequal power relations. CDA takes a particular interest in the ways in which language mediates ideology in a variety of social institutions. One important definition provided by the Encyclopedia Britannica (Vol.20. 1985: 768) is that an ideology is "a form of social or political philosophy in which practical elements are as prominent as theoretical ones; is a system of ideas that aspires both to explain the world and change it". Eagleton (1994:8) defines ideology as a "set of discursive strategies for legitimizing a dominant power". In doing so, he clearly rejects the concept that all thought is ideological, leading to the view that "to study ideology is to study the ways in which meaning serves to sustain relations of domination" (Thompson 1984:4). In the words of Thompson (ibid), ideology is "linked to the process of sustaining asymmetrical relations of power—to maintain domination...by disguising, legitimating, or distorting those relations". It can, therefore, be argued that ideology is one mechanism by which a ruling group tries to deceive and control the ruled.

Critical discourse analysts use the concept of ideology "in the neutral sense of a worldview, a largely unconscious theory of the way the world works accepted as common-sense" (Fowler 1985:65). The term 'common sense' is taken by van Dijk (1998) to mean "the implicit social knowledge that group members take for granted in their everyday social practices". This implicit social knowledge differs from group to group, and thus results in a complex web of multiple ideologies, such that it makes sense to refer throughout to ideologies in the plural, rather than ideology in the singular. van Dijk (1993a: 258), sees 'ideologies' as the 'worldviews' that constitute 'social cognition': ''schematically organised complexes of

representations and attitudes with regard to certain aspects of the social world. Fairclough has a more Marxist view of ideologies and conceives them as constructions of practices from particular perspectives:

> Ideologies are representations of aspects of the world which contribute to establishing and maintaining relations of power, domination and exploitation. They may be enacted in ways of interaction (and therefore in genres) and inculcated in ways of being identities (and therefore styles). Analysis of texts…is an important aspect of ideological analysis and critique … (Fairclough, 2003: 218)

According to Blommaert (2005) ideologies are closely linked to power. The nature of the ideological assumptions embedded in particular conventions, and the nature of those conventions themselves, depends on the power relations which underlie the conventions. Also, ideologies are a means of legitimizing existing social relations and differences of power, simply through the recurrence of ordinary, familiar ways of behaving which take these relations and power differences for granted.

Language has a crucial role in the ideological process. It is the linking element between individuals' knowledge of the world and their social practices since it mediates individuals' thought and behaviour. Language and ideology as an instrument in the hands of the powerful have an overarching hold on people. It would be very difficult to find a site of social practices where language and ideology do not play a major role. According to Zaidi (2012), despite its various and at times contradictory definitions, the consensus remains amongst the philosophers of ideology, that its aim is to affect the political economy of social relations. The relationship between language and ideology is so ingrained and basic that it would be difficult to see either operate in isolation from each other. It is through the combination of language

and ideology that status quo is maintained in society and truths and falsehoods spread and crystallized.

Hodge, Kress and Jones (1979:81) draw attention to the importance of language for the study of ideology: “Ideologies are sets of ideas involved in the ordering of experience, making sense of the world”. This order and sense are partial and particular. The systems of ideas which constitute ideologies are expressed through language. Language supplies the models and categories of thought, and in part, people's experience of the world is through language. The ideological aspect of language does not lie in the linguistic system, which is autonomous, but in the use of language, which is not (Fiorin, 1988). As products of their relations with others and of their comprehension of these relations, individuals interpret their experiences according to their position in the economic structure of the society in which they live. Thus, representing people's minds and consequently embodying different worldviews, language reflects the structure of the society in which it is used (Fowler et al., 1979).

Ideology is, in general, an interlocking set of ideas and doctrines that form the distinctive perspective of a social group. Al thusser (1971) argues that through such ideas and doctrines, ideology represents-on an imaginary level- individuals' relationship to the real conditions of their existence. This imaginary quality of ideology, which patterns how individuals perceive and interpret their experience, contributes to ideology's impact on society. Waitzkin (1989) believes ideology can achieve a most profound effect on social life because it helps shape a population's perceptions and interpretations. At a macro level structure in society, ideology impinges on patients and doctors as part of the social context of medical encounters. At the micro level of interpersonal interaction, elements of ideology appear in doctor-patient

communication. What patients and doctors say when they meet reinforces their particular 'ideologic' conceptions about social life. It is, therefore, the interest of this researcher to determine whether or not such ideological forms establish or sustain relations of domination, especially as it concerns doctor-patient conversations in the selected rural areas of Kaduna State.

2.1.7 Approaches to the Study of Discourse

When we think of discourse, the first thing that comes to mind is probably the linguistic sub-field - Discourse Analysis. However, Johnstone (2010) argues that it is not uncommon for researchers who have no training whatsoever in general linguistics but whose studies involve studying language and its effects, to use the term 'Discourse Analysis' for what they do, how they do it or both. The study of discourse has therefore evolved from fields such as Linguistics, Sociology, Philosophy, Anthropology and Psychology. Brown and Yule (1983) consider the study of discourse as the study of language in use. They further extend this by identifying the purpose for discourse analysis as the investigation of what the language is used for. For Yule (2010), the analysis of discourse is typically concerned with the study of language in texts and conversation.

There are different perspectives to the study of discourse. Schiffrin (1994) singles out 6 major approaches to discourse which include the Speech Act approach, Interactional Sociolinguistics, Ethnography of communication, Pragmatics, Conversational Analysis and Variation analysis, all of which are summarised below. However, one of the most recent approaches to the study of discourse is Critical Discourse Analysis, which is the preoccupation of this present study and will be discussed in greater detail.

Speech Act Approach

J. L. Austin (1962) and John Searle (1969, 1979) developed Speech Act Theory from the basic belief that language is used to perform actions and thus, its fundamental insights focus on how meaning and action are related to language. Schiffrin (1994:49) argues that "although speech act theory was not first developed as a means of analyzing discourse, some of its basic insights have been used by many scholars to help solve problems basic to discourse analysis". Speech act theory focuses on the fact that by saying something, one is also doing something. Much of the speech act theory has been concerned with taxonomizing speech acts and defining felicity conditions for different types of speech acts. For example, Searle (1969) suggests the following typology of speech acts based on different types of conditions which need to be fulfilled for an act to obtain: representative (e.g. asserting), directives (e.g. requesting), commissives (e.g. promising), expressives (e.g. thanking) and declarations (e.g. appointing)'. According to Schiffrin (1994), the theory is basically concerned with what people do with language and with the functions of language. Despite the emphasis on language function, speech act theory deals less with actual utterances than with utterance-types and less with the ways speakers and hearers actually build upon inferences in the talk, than with the sort of knowledge that they can be presumed to bring to talk. Language can do things; can perform acts, because people share constitutive rules that create the acts and that allow them to label utterances as particular kinds of acts.

Interactional Sociolinguistics

This approach represents the combination of three disciplines: anthropology, sociology, and linguistics. Interactional sociolinguistics was founded by linguistic anthropologist John J.

Gumperz (1971, 1982 & 1986). Interactional sociolinguistics is a sub-discipline of linguistics that uses discourse analysis to study how language users create meaning via social interaction. Gumperz (1982) argues that the focus of this approach is on how people from different cultures may share grammatical knowledge of a language but contextualise what is said differently to produce different messages. Topics of interest include cross-cultural miscommunication, politeness, and framing. According to Tannen (2006), interactional sociolinguists analyse audio or video recordings of conversations or other interactions and focus not only on linguistic forms such as words and sentences but also on subtle cues such as prosody and register that signal contextual presupposition.

Ethnography of Communication

Ethnography of communication was originally developed in the 1960s and 1970s by the linguistic anthropologist Dell Hymes, partly in response to Chomsky's influential view that, in order to understand language scientifically, it must be abstracted from its contexts of use and examined as an internal, rule-governed formal system. While in no way denying the importance of linguistic form, Hymes (1964) sees the need to study it in a social context. Ethnography of communication studies how language is used in socio-cultural contexts for socio-cultural purposes. In order to understand how language is employed in systematic, rule-governed ways to perform a social action, Hymes proposed that researchers describe what was linguistically expected of individuals in particular speech communities (Bhatia In Bhatia et al, 2008), and what they could actually do. Ethnography of communication was thus developed as a common theoretical framework for such descriptions. According to Hymes (1974a: 20), the ethnography of communication is not an approach that can “simply take

separate results from linguistics, psychology, sociology, ethnology, as given and seek to correlate them". Rather, it is an approach that seeks to open new analytical possibilities. It seeks to do so by analysing patterns of communication as part of cultural knowledge and behaviour: this entails a recognition of both the diversity of communicative possibilities and practices (i.e. cultural relativity) and the fact that such practices are an integrated part of what people know and do as members of a particular culture (i.e. a holistic view of human beliefs and actions).

Pragmatics

This approach owes its origin to P.H Grice (1975) and his cooperative principles. It started with the theory of conversational implicature which was first presented by P.H Grice in a series of William James university lectures at Harvard University in 1967. According to Schiffrin (1994), the approach that Gricean pragmatics offers to discourse analysis is based on a set of general principles about rationally-based communicative conduct that tells speakers and hearers how to organise and use information offered in a text, along with background knowledge of the world (including knowledge of the immediate social context), to convey (and understand) more than what is said - in brief, to communicate. Thus, what Gricean pragmatics offers to discourse analysis is a view of how participant assumptions about what comprises a co-operative context for communication (a context that includes knowledge, text and situation) contribute to meaning and how these assumptions help to create sequential patterns in the talk. Modern approaches to pragmatics recognise that human communication largely exploits a code (a natural language), but they also try to do justice for the fact that human communicative behaviour relies heavily on people's capacity to engage in reasoning

about each other's intentions, exploiting not only the evidence presented by the signals in the language code but also evidence from other sources, including perception and general world knowledge.

Conversational Analysis

The paradigm of Conversational Analysis (CA) developed quite independently of any linguistic paradigm. Its discipline of origin was sociology. The sociologist Harold Garfinkel (1967) was the founder of ethnomethodology, a sub-field of sociology, which later developed into conversation analysis. Other members of this group are Harvey Sacks, Emmanuel Schegloff and Gail Jefferson. This approach focuses on the sociological aspect of language and is based on cultural expectations and the impact of culture on conversational exchanges. According to Crystal (1997:56), CA emphasises the need for empirical and inductive work. On this basis, natural conversations are systematically analysed to determine what properties govern the way in which conversations proceed. C. A concentrates on how people interact in ways that maintain the social structure of the situation in which they find themselves. Schiffrin (1994: 239) posits that CA approaches (e.g. Schegloff (1972, 1979), Schegloff and Sacks (1973); Schegloff et al., 1977) consider the way participants in talk construct solutions to recurrent problems in conversation in order to create social order. She further states that it is possible to analyse members' 'knowledge of their own ordinary affairs' by analysing specific micro-structural patterns such as turn-constructional units, turn-taking procedures, adjacency pairs, various types of sequences (e.g., pre-sequences, insertions and repairs) and preference organisation.

Variation Analysis

Variation analysis (VA) is a linguistically-based approach that adds social context to analyses of the use of language (Schiffrin, 1994:291). The method goes back to a theoretical approach developed by the sociolinguist William Labov in the late 1960s and early 1970s, and its mathematical implementation was developed by Henrietta Cedergren and David Sankoff in 1974. Variationist approach stems largely from studies of variation and change in language i.e. fundamental assumptions of such studies arc that linguistic variation (i.e. heterogeneity) is patterned both socially and linguistically and that such patterns can be discovered only through systematic investigation of a speech community (McCarthy et al. 2002). Thus, variationists try to discover patterns in the distribution of alternative ways of saying the same thing, that is, the social and linguistic factors that are responsible for variation in ways of speaking. The focus of research in VA is on structural categories within texts. VA discovers patterns in the social distribution of variants, constrained socially and linguistically. It analyses both interpersonal and intrapersonal variations at both sentence and discourse levels.

It is important to note that all the approaches to the study of discourse above have something in common- they all deal with language in actual use, as well as the functions attached to language use in different contexts ranging from social to cultural contexts. However, CDA, which this study is hinged on, is an interdisciplinary approach to discourse which encompasses every other approach by drawing insights from them and goes beyond the functions of language use, to the role of language in structuring and maintaining power relations in the society. CDA is undeniably an invaluable research tool for any researcher interested in exploring the manipulative, dominance functions underlying language use.

Hence, the choice of CDA as the main theoretical basis of this study and the major theory with which the selected interactions between doctors and their patients in the selected rural areas within this study will be analysed.

2.1.8 Critical Discourse Analysis (CDA)

Critical Discourse Analysis (CDA) is an approach to the study of discourse. CDA emerged from 'critical linguistics' (CL) which developed at the University of East Anglia in the 1970s, and the terms are now often interchangeable (Wodak 2001). Critical Discourse Analysis began to gain momentum in the late 1970s, in a series of publications which initially set out to bring Halliday's Systemic Functional Linguistics into a more broadly social perspective capable of taking in political issues of power and control. According to Wodak (2002), the 1970s saw the emergence of a form of discourse and text analysis that recognized the role of language in structuring power relations in society. At that time, much linguistic research elsewhere was focused on formal aspects of language which constituted the linguistic competence of speakers and which could theoretically be isolated from specific instances of language use.

Critical discourse analysis started in the mid–1980s as a new direction in the work of Fairclough (1989) in the United Kingdom, Wodak (1989) in Austria and van Dijk (1993) in the Netherlands (van Leeuwen, 2006). As a movement, it began in 1992 at a meeting in Amsterdam with presentations by van Dijk, Fairclough, Wodak, Kress, and van Leeuwen, which were later published as a special issue of *Discourse and Society* (4, 2, 1993). The group gradually expanded and continued to meet annually from 1992 onward. Another early collection of influential papers was published a few years later (Caldas-Coulthard and

Coulthard, 1996). Since then critical discourse analysis, now usually referred to as CDA, has been a fast-growing and increasingly interdisciplinary movement. A first large-scale international conference was held in 2004 in Valencia and two new journals started in the same year- *Critical Discourse Studies* and *The Journal of Language and Politics.*

The term "Critical Discourse Analysis" itself appears to have first been used by Fairclough in an article published in 1985 (Fairclough 1985: 739) but was popularised by the highly influential book 'Language and Power' (Fairclough 1989). The term was consolidated by the publication of 'Critical Discourse Analysis' (Fairclough 1995), which was subtitled 'The critical study of language'. According to van Leeuwen (ibid), critical discourse analysis moved beyond critical linguistics in a number of ways, amongst which is the attempt to ground critical discourse analysis in critical social theory and to articulate the relation between discourses and the social practices in which they are embedded. Critical discourse analysis also moved beyond critical linguistics in adopting a much more fully interdisciplinary approach which studies not only texts and transcripts of talk, but also their contexts, whether by historical or ethnographic methods. Critical discourse analysis has also moved beyond language, taking on board that discourses are often multi-modally realized, not only through text and talk but also through other modes of communication such as images (Kress and van Leeuwen, 1996). By the early 1990s, discourse had also become a key term in postmodern philosophy and cultural studies, and critical discourse analysis explicitly distanced itself from the dominant tendency in these fields to reduce the social to discourse, and discourse only.

Blommaert (2005) asserts that the intellectual history of CDA is far wider and deeper than often suggested. Wodak (2001) supports this by stating that the manifold roots of CDA lie in Rhetoric, Text Linguistics, Anthropology, Philosophy, Socio-Psychology, Cognitive Science, Literary Studies and Sociolinguistics, as well as in Applied Linguistics and Pragmatics. Wodak (ibid) further states that CDA has never been and has never attempted to be or to provide one single or specific theory and neither is one specific methodology characteristic of research in CDA. On the contrary, studies in CDA are multifarious, derived from quite different theoretical backgrounds, oriented towards very different data and methodologies. Although critical discourse analysis is not associated with a specific school of linguistics or discourse analysis, many have followed Fairclough (1989) in drawing primarily on the systemic-functional linguistics of Halliday (1989). Overall, critical discourse analysis has moved towards more explicit dialogue between social theory and practice, richer contextualization, greater interdisciplinarity and greater attention to the multimodality of discourse.

Much has been written in recent years about CDA in its broadest sense. The concept appears to be quite difficult to define in simple terms and this is probably due to the nature of CDA. It encompasses a number of general tenets and uses a large range of techniques. van Dijk (1998) defines critical discourse analysis as a type of discourse analytical research that primarily studies the way social power abuse, dominance, and inequality are enacted, reproduced, and resisted by text and talk in the social and political context. This definition not only establishes the preoccupation of CDA with power; it also establishes the role of language as a tool of control dominance. Scollon (2001: 140) sees CDA as “a program of social analysis that critically analyses discourse - that is to say language in use - as a means of addressing social

change". Scollon's definition emphasises the focus of CDA on social problems especially as it concerns abuse of power and social inequality. Luke (2002: 100) asserts that CDA involves a principled and transparent shunting backwards and forth between the micro-analysis of texts using varied tools of linguistic, semiotic and literary analysis, and the macro-analysis of social formations, institutions and power relations that these texts index and construct. This definition suggests CDA's preoccupation with both micro and macro analysis of discourse. van Dijk (1998) supports this by stating that that "CDA has to theoretically bridge the well-known "gap" between micro and macro approaches"… because "in everyday interaction and experience the macro and micro level form one unified whole". van Dijk goes further to say that language use- discourse, verbal interaction, and communication belong to the micro level, while power, dominance, and inequality between social groups are typically terms that belong to a macro-level of analysis. From all these definitions, it becomes apparent that CDA is concerned with analyzing language in use as it pertains to social dominance, control and power inequality in the society.

It is generally agreed that CDA cannot be classified as a single method but is rather viewed as an approach consisting of different perspectives and various methods for studying the relationship between the use of language and social context as to how discursive power can be exercised in order to control the 'mind'. As Fairclough (1989: 42) calls it "…a particular form of social practice, in the centre of which power and ideology mutually influence and interact with one another". CDA provides some approaches to research with the primary aim of uncovering the relationship between language, society, power, ideology, values and opinions. Hence, CDA is continuously enriched with new approaches within the field of language and communication.

Wodak (1996) submits those notions of ideology, power; hierarchy and gender variables are relevant for an interpretation and/or explanation of the text. Thompson (1990) sees the study of ideology as a study of "the ways in which meaning is constructed and conveyed by symbolic forms of various kinds". This kind of study will also investigate the social contexts within which symbolic forms are both employed and deployed. In furtherance of her argument, Wodak (ibid) points out that for CDA, language is not powerful on its own and that it gains power by the way the people make use of it. This, according to Wodak, explains why CDA chooses the perspective of those who suffer and critically analyses the language use of those in power, who are responsible for the existence of inequalities and who also have the means to improve conditions. From the aforementioned about CDA, it could be argued that its primary objective is to establish the relationship between language, power, and control. That is, how power, through language could be used as a means of social control and dominance. This present study examines how language is used by doctors in rural areas as a "power" tool to control and exert dominance over patients during consultations.

2.1.8.1 Approaches to the Study of CDA

There are three main directions in CDA- van Dijk's social cognitive model, Wodak's social and historical model and Fairclough's discourse as social practice.

Socio-cognitive Model

This model of CDA was proposed by van Dijk (1995). For van Dijk, it is the socio-cognition- social cognition and personal cognition- that mediates between society and discourse. He defines social cognition as "the system of mental representations and processes of group members". In this sense, for van Dijk, "ideologies are the overall, abstract mental systems that organise socially shared attitudes". Ideologies, thus, indirectly influence the personal

cognition of group members in their act of comprehension of discourse among other actions and interactions. He calls the mental representations of individuals during such social actions and interactions "models". For him, "models control how people act, speak or write, or how they understand the social practices of others. Of crucial importance here is that, according to van Dijk, mental representations "are often articulated along “Us versus Them” dimensions, in which speakers of one group will generally tend to present themselves or their own group in positive terms, and other groups in negative terms" (van Dijk, 1995: 22). Analysing and making explicit this contrastive dimension of “Us versus Them” has been central to most of van Dijk's research and writings (1988, 1991, 1993, 1995, 1996, 1998a, 1998b). van Dijk believes that one who desires to make transparent such an ideological dichotomy in discourse needs to analyse discourse by examining the context of the discourse: historical, political or social background of a conflict and its main participants; analysing groups, power relations and conflicts involved; identifying positive and negative opinions about “Us” versus “Them”; making explicit the presupposed and the implied; and examining all formal structure: lexical choice and syntactic structure, in a way that helps to de-emphasize polarized group opinions.

Social and Historical Model

This direction in CDA is associated with Wodak and her colleagues in Vienna (The Vienna School of Discourse Analysis). Wodak bases her model "on sociolinguistics in the Bernsteinian tradition, and on the ideas of the Frankfurt school, especially those of Jürgen Habermas (Wodak, 1995: 209). Wodak has carried out research in various institutional settings such as courts, schools, and hospitals, and on a variety of social issues such as sexism, racism and anti-Semitism. According to Wodak (1996), “Discourse Sociolinguistics

is a sociolinguistics which not only is explicitly dedicated to the study of the text in context but also accords both factors equal importance. It is an approach capable of identifying and describing the underlying mechanisms that contribute to these disorders in a discourse which are embedded in a particular context whether they be in the structure and function of the media, or in institutions such as a hospital or a school and inevitably affect communication. The term “historical” occupies a unique place in this approach. It denotes an attempt on the part of this approach "to integrate systematically all available background information in the analysis and interpretation of the many layers of a written or spoken text" (1995: 209). Focusing on the historical contexts of discourse in the process of explanation and interpretation is a feature that distinguishes this approach from other approaches of CDA especially that of van Dijk.

Discourse as Social Practice Model

Fairclough (1989) is considered to have contributed to the field of CDA most significantly, with his three-dimensional model of CDA and his approach to language study. Fairclough, in his earlier work, called his approach to language and discourse Critical Language Study (1989: 5). This model sees CDA as a method for examining social and cultural modifications that could be employed in protesting against the power and control of the elite group on other people. Fairclough described the objective of this approach as "a contribution to the general raising of consciousness of exploitative social relations, through focusing upon language" (1989:4). That is, raising awareness on how language can influence the dominance of one group of people in the society over others. This aim, in particular, remains in his later work that further develops his approach so that it is now one of the most comprehensive

frameworks of CDA (Fairclough, 1992, 1993, 1995a, 1995b; Chouliaraki and Fairclough, 1999). For Chouliaraki and Fairclough (1999: 6) CDA "brings social science and linguistics… together within a single theoretical and analytical framework, setting up a dialogue between them". The linguistic theory referred to here is Systematic Functional Linguistics (SFL), which has been the foundation for Fairclough's analytical framework as it has been for other practitioners in CDA. Fairclough's model is both theoretical and practical in nature, which makes it ideal for investigating power relations in the society.

Fairclough's inter-disciplinary approach to the study of discourse views 'language as a form of social practice (Fairclough 1989: 20) and focuses on the ways social and political dominance is exercised in discourse by 'text and talk'. The main thrust of his framework is that language is an irreducible part of social life. Fairclough draws a distinction between three stages in doing critical discourse analysis: description of the text, interpretation of the relationship between text and interaction, and explanation of the relationship between interaction and social context. In this approach to CDA, there are three analytical points of focus in analysing any communicative event- text, discourse practice and social practice, which will be explained in detail in the theoretical framework.

2.2 Review of Previous Studies

Olagunju (2012) examines the nature of the conversations between soldiers and corps members in order to demonstrate that power is linked to their utterances. The study employed Fairclough's (1989) model of CDA for analysis of data and found that conversations between soldiers and corps members on camp is military inclined and laced with unequal power. Similar to Olagunju's work, this present study also employs Fairclough (ibid)'s model as

theoretical framework.Lawan (2016) examined the metaphoric use of language in the acceptance and inaugural speeches of both presidents using a critical metaphorical analysis. The findings revealed out that metaphors perform different functions aside being an element of literary aesthetic or verbose display of intellect in language proficiency.

Odebunmi (2006) examined the pragmatic roles that locutionary acts play in understanding the communication between doctors and patients. The study employed J.L Austin's locutionary acts as the theoretical framework but with restrictions to the lexical occurrences and lexical relationships observed in the discourse. His findings are that two categories of locutions are engaged in hospital interactions, namely, locutions intended to be understood by non-professionals and locutions not intended to be understood by non-professionals. However, it can be argued that nowadays, due to the availability of health information on the internet, patients are now able to understand even those locutions not intended to be understood by non-medical professionals. Odebunmi also observed that locutions in medical discourse in south-western Nigeria bring standard lexical choices and local linguistic initiatives of medical practitioners into a pragmatic union. In other words, the linguistic context in which a particular medical discourse is situated would influence the nature of the discourse. Therefore, it is to be expected that the nature of medical discourse in this study which is situated in north-western Nigeria, would be considerably different from that which is situated in any other part of the country.

Adegbite and Odebunmi (2006), describe discourse tact in diagnoses in doctor-patient interactions, analysing areas like the mutual contextual beliefs of participants, speech act patterns, and other pragmatic features from the perspective of the pragmatics of discourse.

Their findings show the existence of asymmetrical power by observing that the doctor-patient interaction during diagnosis is dominated by the doctor eliciting information from the patient while the patient also tries to respond appropriately. Adegbite & Odebunmi also recommend that medical communication requires the attention of language scholars "in order to gain insight into the language as an act of social behaviour and action, especially with respect to the institution of medicine". This justifies this researcher's need to study doctor-patient conversations, a form of medical discourse, in order to explore the power relations, especially in a rural area which is bound to have its own peculiarities. It is important to note that the present study differs from that of Adegbite & Odebunmi (ibid) in that it seeks to investigate doctor-patient interactions from the perspective of Critical Discourse Analysis.

Martins (2008) analyses the lexicon of medical registers with the aim of identifying the words, phrases and expressions peculiar to the field of medicine with particular reference to prescription and medical records. Using systemic functional linguistics as a theory, the findings show that the complexity of medical language is due to the use of technical terms which have their origin in Greek and Latin. It was also observed that medical terms are context dependent within the field of medicine and medical practitioners keep their use of language very brief and descriptive. Although, studying medical register is important and serves as a bedrock to other studies, there is more to medical discourse than the vocabulary employed in that context of language use. This present study delves deeper into the medical discourse by examining how doctors employ language as a tool of control and domination over patients during consultations.

Ayigun (2012) examines language in specific medical communication context between doctors and patients by using not only J.L Austin and Searle's speech act theory but also Grice's cooperative principle to determine the illocutionary forces of the utterances of doctors and patients. The findings show that doctors' use of language depends on their patients' use of language. Ayigun's study is similar to that of Odebunmi (2006) as they are both pragmatic studies and both employed different aspects of speech act theory to examine conversations between doctors and patients. This present study however differs because it employs a different linguistic parameter- critical discourse analysis, to examine doctor-patient conversations.

Desjarlais-deKlerk and Wallace (2013) examine the communication styles used during doctor-patient interactions in urban and rural family practice settings in Western Canada. Using a grounded theory approach, communications between doctors and patients were categorized as either instrumental or socio-emotional. The findings reveal that the physicians in small, rural towns appear to know their patients and their families on a more personal level and outside of their office, and engage in more socio-emotional communications compared to those practicing in suburban clinics in a large urban centre. In other words, interactions between urban doctors and their patients had a mixture of instrumental and socio-emotional communications, while interactions between rural doctors and their patients tended to be highly interpersonal and often involving considerable socio-emotional communication and relationship-building. These findings suggest that the very nature of rural societies have an effect on the resulting doctor-patient conversations and to an extent distinguishes them from those which occur in urban areas. Hence, this present study also examines conversations

between doctors and patients in selected rural hospitals in order to determine the nature of power relationship which ensues in that particular socio-linguistic context.

Suleiman (2015) explores the sociolinguistic factors that constitute barriers in the communication between doctors and patients in the Ahmadu Bello University Teaching Hospital. Frankel's functional model of communication was employed as a theoretical framework for analysis and it was discovered that the language of medicine affects diagnosis and healthcare as doctors were observed interrupting conversations. Shika's study is especially important to literature on medical communication in Nigeria where patient-centredness is at its lowest and rarest. This present study is similar in that one of its objectives is to determine the effectiveness of doctor-patient communication in meeting health needs and patient satisfaction. However, this present study goes further to expose those communicative behaviours of doctors which are deterrent to patient-centredness while taking insights of the patients themselves into consideration.

In all these studies, the purpose has been clear - to examine how medical discourse, set within the institution of medicine is broached, structured and employed for health communication. These studies have all concentrated on linguistic description of medical language, mostly from different pragmatic and sociolinguistic perspectives. None of these studies have been undertaken from a critical discourse analysis viewpoint. Hence, this present study differs because it aims to explore how the nature of doctor-patient conversations can reveal the power asymmetry, as well as its role in maintaining and challenging the unequal power distribution especially as it concerns the rural area.

2.3 Theoretical Framework

Fairclough (1989)'s model has been adopted as the theoretical framework for this study. In this approach to CDA, there are three analytical points of focus in analysing any communicative event- text, discourse practice and social practice.

Text

In Fairclough's model, analysis at the level of text involves linguistic analysis in terms of vocabulary, grammar, semantics, the sound system and cohesion- organisation beyond the sentence level (Fairclough 1995a:57). Following SFL, Fairclough also views text from a multi-functional perspective. According to Fairclough, any sentence in a text is analysable in terms of the articulation of these functions, which he has relabeled representations, relations, and identities. It is however important to note that the text could be any object of analysis, including verbal or visual texts.

Discourse Practice

Discourse practice can be best described in terms of production and reception of a 'text' in a particular 'context'. According to Fairclough (1995a:58-59), this dimension has two facets: *institutional process* (e.g. editorial procedures), and *discourse processes* (changes the text goes through in production and consumption). For Fairclough, "discourse practice straddles the division between society and culture on the one hand, and discourse, language and text on the other". The linguistic analysis at this level is what Fairclough calls "intertextual analysis" which focuses on the borderline between text and discourse and involves looking at the text from the perspective of discourse practice and looking at traces of the discourse practice in the text.

Social Practice

The last dimension is discourse as social practice and the focus of analysis is on discourse in relation to power and ideology. It sees language as a socially-conditioned process by other non-linguistic aspects of the society. Fairclough distinguishes between 'power *in* discourse' and 'power *behind* discourse' (1989:43-76). 'Power *in* discourse' as a form of social practice is exercised through language in various ways, for example in face-to-face encounters, whereas 'power *behind* discourse' describes the formation of power relations as to which social bodies, organisations and institutions form the power relationships behind discourse. By analysing language or discourse as social practice, one commits oneself not only to analysing texts or the processes of production and interpretation, but to analyze the relationship between texts, processes and their social conditions (Fairclough, 1989:26). Such social conditions involve both the immediate conditions of situational context and the more remote conditions of the institutional and social structure.

According to Fairclough (ibid) one does not have to carry out analysis at all the levels highlighted above but any level that might "be relevant to understanding the particular event" (p. 62). To this end, this study employs Fairclough's "Discourse as a Social Practice" for the analysis of data. It is important to note that the choice of Fairclough's "discourse as social practice dimension" as a theoretical framework for this study is borne out of the fact that socio-cultural context, as well as power and ideology, are central to viewing discourse as a social practice and also very important to this study. Fairclough argues that utterances are meaningful only in their situational, cultural, and ideological contexts. More so, conversations between doctors are patients are situated within the institution of medicine without which they

cannot be understood. Furthermore, doctor-patient conversations in rural areas are bound by such cultural and ideological undertones which guide the nature of their conversations and needs to be understood in order to account for the resulting power relationship between doctors and patients in that particular context.

Additionally, Fairclough (ibid) proposes three (3) stages of analytical procedures which will be employed in this study. The stages include:

a. Description: this is concerned with identifying and labeling the formal properties of the text.

b. Interpretation: this is concerned with the relationship between the interaction and the text, where the text is seen as the end product of a process of production and as a resource in the process of interpretation.

c. Explanation: this is concerned with the relationship between interaction and social context, with the social determination of the processes of production and interpretation, and their social effects.

CHAPTER THREE

RESEARCH METHODOLOGY

3.0 Preamble

This chapter focuses on the methodological processes employed in the course of this research. It presents the sources of data, the data collection techniques and the technique that will be employed in the analysis of data.

3.1 Sources of Data

The major data used for this research is from the hospitals in the selected rural areas of Kaduna State, which include Giwa, Bomo, Bassawa and Hunkuyi, where twenty (20) conversations between doctors and patients during first-time consultations were collected.

3.2 Method of Data Collection

The techniques employed in collecting data for this study are described as follows:

a. Audio-tape recording: a total of twenty (20) conversations between doctors and patients in the selected rural hospitals were recorded, from which five were selected for analysis. Only conversations between doctors and patients during first-time consultations were recorded. Permission was taken from the patients with assurances that the recording is strictly for academic research purposes and their names would be changed to maintain anonymity.

b. Interview: for the purpose of this study, the researcher sought out patients in the waiting area of the hospitals after their consultation with the doctors and asked some questions (see appendix B) which would provide an insight into their

experience and gauge their level of satisfaction. Due to the low literacy level in the rural areas, the interview questions were structured in such a way that the responses were limited to basically yes or no. A total of twenty (20) patients were interviewed in all the hospitals.

c. Diary: a diary was used by the researcher as a supplement to enter both the linguistic and paralinguistic responses of patients like facial expressions and body gestures during the interviews. However, since the observations entered into the diary are highly objective and cannot be easily authenticated, the diary is excluded in the appendix of this work.

3.3 Transcription of Data

Since the researcher is not proficient in Hausa, which is the language spoken mostly in the rural hospitals selected for this study, only the doctor-patient conversations in English language are transcribed by the researcher. Those conversations in Hausa were transcribed and translated by a native speaker of the language. As a necessary procedure for ensuring objectivity and reliability of data, the transcriptions were cross-checked by another native speaker of the language.

3.4 Method of Data Analysis

The three stages of analytical procedure proposed by Fairclough (1989) which include description, interpretation, and explanation as explained in the theoretical framework, were employed for the analysis of data for this study. The nature of the analysis differs in each stage. The first stage of the analysis, that is, description, is concerned with identifying the formal properties of the text. The second stage of interpretation involves analysing the way in

which participants arrive at their understanding of discourse on the basis of their cognitive, social, and ideological resources. That is, the ideological mindsets that prompt and control the nature of the conversation between doctors and patients. Lastly, the third stage involves an explanation of the relationship between the social events- in this case, consultations between doctors and patients, and the power structures that affect them and how they are affected by them.

In order to achieve all of the above, the selected transcripts of the recorded conversations between doctors and patients were examined and also analysed at the levels of word, sentence, textual structure, register, style and speech acts. At word level, the choices of words through the use of pronouns and modal auxiliary verbs were identified while considering how they reveal the unequal power relationship between the doctors and patients. At the sentence level, the concern was identifying how the sentence types and the use of active/passive voice are deployed as a power tool by doctors to dominate and control patients. The textual structure involved looking at the turn-taking structure of the conversations, as well as the interactional control features and conventions used. The level of register/style involved identifying the medical jargons and the extent of their usage and also the stylistic distinctions in their use of language generally. At the level of speech acts, the particular kinds of speech acts which are peculiar to the context in which doctor-patient conversations in this study are situated are analysed.

Lastly, frequency tables are used to do a quantitative analysis of the the responses of patients during the interviews on patient satisfaction which was done after their consultations with the doctors

CHAPTER FOUR

DATA PRESENTATION, ANALYSIS AND FINDINGS

4.0 Preamble

This chapter comprises the analysis of the collected data - conversations between doctors and their patients during first-visit consultations in selected rural hospitals, and a general discussion of the analysis. The data analysis is aimed at establishing how language is linked to power in doctor-patient conversations in rural hospitals.

4.1 Presentation of Data

To achieve the aim and objectives of this study, five different doctor-patient conversations (A,B,C,D,E) have been selected for analysis from the twenty collected in this study. The transcribed conversations are all presented in Appendix A; each conversation has been tagged an exchange and identified as A-T. The conversational turns are marked D and P; where 'D' represents doctor and 'P' represents patient (see Appendix A). All the names of patients have been changed by the researcher for anonymity and confidentiality.

4.2 Analysis of Data

The analysis of the selected data is based on the descriptive, interpretative and explanatory stages of analysis adopted from Fairclough (1989). The description for all conversations are done in a tabular form, the interpretation is done with illustrations at the word level, sentence level, register/style, turn-taking, and speech acts and the explanation for each datum follows immediately after interpretation. Frequency tables are also used to present and analyse the responses from the interviews in a bid to discover the level of patient satisfaction with the

health communication in the rural hospitals. Lastly, a general discussion of the analysis is presented.

4.2.1 Analysis of the Nature of Doctor-Patient Conversations

The analysis at this level covers the entire recorded conversational exchanges, which are analysed in a tabular form in order to present a full description of all the conversations at a glance. The participants and the languages spoken in the various consultations are identified and the nature of each consultation is summarised.

Table 4.1: Linguistic Description of the Nature of Doctor-Patient Conversations

Exchanges	Participants	Language Spoken	Nature of Consultation	Nature of conversation
A	Male doctor with female patient	Hausa	The patient here is a young pregnant woman in her mid-twenties, who has come to complain about a lack of movement in her womb.	Institutionalized Doctor-patient goal-oriented,restricted and medically structured conversation (formal)
B	Male doctor with a nursing mother and her baby	Hausa	The nursing mother has brought her son with complaints about an illness which started about a week after his delivery.	Institutionalized Doctor-patient goal-oriented, restricted and medically structured conversation (semi-formal)
C	Male doctor with an old woman	Hausa	The patient is an old woman in her 70s who is hypertensive and has come to complain about a range of symptoms.	Institutionalized Doctor-patient goal-oriented, restricted and medically structured conversation

				(informal)
D	Male doctor with a male patient	English with a bit of Hausa at the opening.	The patient is a young man in his 30s who has come to complain about fever and other symptoms.	Institutionalized Doctor-patient goal-oriented, restricted and medically structured conversation (formal)
E	Male doctor with a female patient and her toddler	Hausa	The patient is a middle-aged woman whose child has not been feeling well and who also has an additional symptom being treated with traditional medicine.	Institutionalized Doctor-patient goal-oriented, restricted and medically structured conversation (formal)
F	Male doctor with female patient	Hausa	The patient is a young woman with pregnancy symptoms.	Institutionalized Doctor-patient goal-oriented, restricted and medically structured conversation (semi-formal)
G	Male doctor with an elderly man	Hausa	The patient is an old man with a range of symptoms.	Institutionalized Doctor-patient goal-oriented, restricted and medically structured conversation (informal)
H	Male doctor with a woman and her son	Hausa	The woman brought her two years old son after he had been ill for four days.	Institutionalized Doctor-patient goal-oriented,

				restricted and medically structured conversation (formal)
I	Male doctor with a middle-aged woman	English	The woman had complaints about stomach aches and the size of her stomache.	Institutionalized Doctor-patient goal-oriented, restricted and medically structured conversation (semi-formal)
J	Male doctor with female patient and some student nurses.	Hausa with side-talks with Nurses in English	The patient had complaints about a range of symptoms.	Institutionalized Doctor-patient goal-oriented, restricted and medically structured conversation (formal)
K	Male doctor with female patient in her mid-thirties	Hausa	The patient came with assumptions that she was pregnant without proper testing.	Institutionalized Doctor-patient goal-oriented, restricted and medically structured conversation (informal)
L	Male doctor with middle-aged female patient	Hausa	The patient had complaints of incessant coughing.	Institutionalized Doctor-patient goal-oriented, restricted and medically structured conversation

				(informal)
M	Male doctor with young female patient in her early twenties	Hausa	The patient complained about a range of symptoms which surfaced about four days before.	Institutionalized Doctor-patient goal-oriented, restricted and medically structured conversation (informal)
N	Male doctor with middle-aged woman	English	The patient had complaints about constant internal heat.	Institutionalized Doctor-patient goal-oriented, restricted and medically structured conversation (formal)
O	Male doctor with an elderly male patient	Hausa	The patient had confusing symptoms and body pains.	Institutionalized Doctor-patient goal-oriented, restricted and medically structured conversation (informal)
P	Male doctor with young female patient	Hausa	The patient had complaints about not getting better after prior treatment prescribed at another clinic.	Institutionalized Doctor-patient goal-oriented, restricted and medically structured conversation (informal)
Q	Male doctor with Young female patient	English	The patient had complaints about incessant headaches.	Institutionalized Doctor-patient goal-oriented,

				restricted and medically structured conversation (formal)
R	Male doctor with a nursing mother and her baby	Hausa	The patient is a mother with a sick baby.	Institutionalized Doctor-patient goal-oriented, restricted and medically structured conversation (informal)
S	Male doctor with teenage female patient	English	The patient had complaints about pains at the site of a prior surgery.	Institutionalized Doctor-patient goal-oriented, restricted and medically structured conversation (semi-formal)
T	Male doctor with a nursing mother and her baby.	Hausa	The woman had complaints about breast-feeding the child.	Institutionalized Doctor-patient goal-oriented, restricted and medically structured conversation (informal)

From the analysis of the five conversations between doctors and patients in this study (See appendix A), the researcher made a number of observations about the nature of doctor-patient conversation in the selected rural areas chosen for this study. Firstly, hospitals in the selected rural areas are frequented by more female than male patients. Out of the twenty (20) doctor-

patient conversations collected, seventeen (17) are female patients and only three (3) are male patients; meanwhile the doctors in all the consultations are male. Secondly, Hausa is the major language spoken in the selected hospitals. However, there are instances where English is spoken, especially when the patient speaks English. Thirdly, there are instances where there is evidence that modern medicine is consulted as a second choice after traditional medicine. Lastly, the analysis shows that the conversational exchanges reflect the cultures and traditions of the people in the selected rural areas. For instance, the culture is one which distributes power based on age and gender.For example, in Exchange C, the patient is a woman who is older than the doctor . Consequently the doctor is seen deferring control as observable below:

D- *What is your name Mama?*
P- *Rahmatu Rabi*
D- *From which town?*
P- *Jambaba*
D- *What is wrong with you?*
P- *Good morning first*
D- *Good morning*
P- *I saw the help you have given my son.*
D- *Okay.*
P- *Thank you. My body has been paining me and I feel dizzy.*

(Exchange C, line 1-10)

Furthermore, the nature of the conversations in all Exchanges are institutionalized, goal-oriented, restricted and medically structured. The doctor-patient conversations in the selected hospitals ranges between semi-formal, formal and informal, depending on the patient in the particular consultation. For instance, as illustrated below in Exchange B, the doctor is very formal , while in Exchange C, the conversation is informal.

(i) *P- Good afternoon.*
D- Good afternoon, you can take a seat.

D- *What is the problem?*

P- *It's my child, at night his body gets hot; he breathes heavily and when I try to breastfeed him, he can't hold it*

D- *How many weeks old is he?*

P- *4 weeks*

D- *Okay, was his pregnancy up to 9 months?*

P- *Yes*

(Exchange B, line 1-10)

(ii) *D-* *What is wrong with you?*

P- *Good morning first*

D- *Good morning*

P- *I saw the help you have given my son.*

D- *Okay.*

P- *Thank you. My body has been paining me and I feel dizzy.*

(Exchange C, line 5-10)

4.2.1.1 Analysis of the Structure of Doctor-Patient Consultation

The analysis of the structure of doctor-patient conversations in the selected rural areas conforms best to the classification by Byrne and Long (1976). This is because out of all the structures reviewed earlier in the chapter two of this study (Byrne and Long, 1976; Meeuswensen, 2003; and Adegbite & Odebunmi, 2006), only the classification by Byrne and Long (ibid) accounts for the opening and closing phases of a consultation which cuts across all the selected doctor-patient conversations. Thus, the overall content structure of conversations between doctors and patients during consultations in the selected rural areas are summarised as (i) Opening (Ex. A, lines 1-6), (ii) Presentation of complaint (Ex. A, lines 7-8), (iii) Verbal/Physical examination (Ex. A, lines 9-21), (iv) Diagnosis (Ex. A, lines 22-26), (v) Treatment (Ex. A, lines 27-37); and (vi) Closing (Ex. A, line 38). Below is a sample:

OPENING:

D- *What is your name?*

P- *Safiya*

D- *Safiya what?*

P- *Safiya Bello*

D- *From which town?*

P- *Nasarawa Gangara*

PRESENTING COMPLAINT:

D- *What is wrong with you?*

P- *There is no movement in my stomach and I also feel abdominal cramps.*

EXAMINATION:

D- *Okay, for how long have you noticed there was no movement?*

P- *All I know is that I don't feel any movement.*

D- *I don't understand, for how long has there been no movement?*

P- *5 to 6 months now.*

D- *So, did you come to the hospital at all since then?*

P- *I went to the Chemist.*

D- *You went to the Chemist!!!*

P- *Yes*

D- *But it is only when you have prescription you are supposed to go to the Chemist.*

P- *(silent)*

D- *Right?*

P- *Yes, it was after I went and did not feel any better that I decided to come here.*

D- *Okay. May God help us!*

DIAGNOSIS:

D- *So, now I can see that you were told to do a scan...*

P- *Yes, on Monday and I did it.*

D- *From the result, I can see that the pregnancy is 5 months and the baby is not correctly positioned but the baby is healthy, no problem.*

P- *(Silent)*

TREATMENT:

D- *So now, I will refer you for ante-natal. The nurse will continue checking you and provide all necessary assistance that you need. She will give you an appointment; it could be after every week or thereabout.*

P- *(Silent)*

D- *Do you know the vaccination they give to pregnant women?*

P- *No*

D- *You don't know? Is it that you have never gone for ante-natal before?*

P- *Truly, since I always feel normal, I don't go and even though...*

D- *(Interrupts) No, stop that, the ante-natal is very important. Now you must go and resume your ante- natal. I will send you there and by God's grace, everything will be alright.*

P- *(Silent)*

CLOSING:

D- *Thank God*

The opening phase in the structure of doctor-patient conversations in the selected rural areas involves the doctor and patient exchanging greetings and establishing an interactional relationship (Ex. E, lines 1-4). During the presentation of the complaint, the doctor initiates the topic in the form of an inquiry into the reason for the patient's visit (Ex. E, lines 5-11). The verbal/physical examination phase involves the doctor conducting an examination of the patient's health concerns either by asking questions about the issue or just making a visual

observation of the patient's condition as in this exchange where the doctor observes some paleness and swelling on the child's body (Ex. E, lines 12-24). The diagnosis phase involves the doctor evaluating the patient's condition but in this particular exchange E, the evaluation and the examination stages are intertwined. The treatment phase involves the doctor prescribing a treatment or the need for further investigation (Ex.E, lines 25-27). Lastly, the closing phase involves utterances that signal the end of the conversation (Ex. E, lines 28-29).

It is important to note that in this study, the closing phase is the shortest phase in all the conversations recorded; with the consultations terminating with phrases such as "da ikon Allah Zaki samu sauki" (By God's grace, you will be healed), "Nagode"(Thank you) and "Thank God". Also, the physical/verbal examination phase is the longest phase in all the consultations running for as long as twelve lines and more (E.g, Ex. A- lines 9-21; Ex.B- lines 7-32).

Lastly, there are instances where a stage runs into another, thereby leaving no clear demarcation as to where one ends and the other starts. For example, in exchange C (see below), we have the opening (lines 1-9), the presentation of complaint (lines 5 &10-12), verbal and physical examination (lines 13-19 & 29-40), diagnosis (lines19-28), treatment (lines 41-43) and closing (lines 44-45).

OPENING

D- *What is your name Mama?*

P- *Rahmatu Rabi*

D- *From which town?*

P- *Jambaba*

D- *What is wrong with you?* ***(PRESENTATION OF COMPLAINT)***

P- *Good morning first*

D- *Good morning*

P- *I saw the help you have given my son.*

D- *Okay.*

PRESENTATION OF COMPLAINT

P- *Thank you. My body has been paining me and I feel dizzy.*

D- *Okay.*

P- *I shiver*

VERBAL/PHYSICAL EXAMINATION

D- *What about nausea?*

P- *My body shivers and when I walk, I feel dizzy like I will fall.*

D- *Anything else?*

P- *Lack of sleep.*

D- *We like to hear from the patients', so we will know the right thing to do. May God heal you!*

P- *Ameen*

D- *(Checks patient's B.P) What we can see now is that your blood pressure has risen a bit. Do you know you are hypertensive?*

P- *I know*

DIAGNOSIS

D- *The problem with hypertension is that it is not something that just heals once and for all. No, it does not heal completely. You can only take drugs to manage it. Anyone who is hypertensive needs to come to the hospital regularly so that the B.P can be checked and monitored. So that whenever it rises, then drugs will be given.*

P- *(Silent)*

D- *Do you understand?*

P- *Yes.*

VERBAL/PHYSICAL EXAMINATION

D- *What about sleep?*

P- *I don't sleep. That is why I brought the drug you gave my son. Yesterday, it really disturbed me, so he gave me this drug.*

D- *(Shockingly) He gave you his drug!!!*

P- *Wait, let me show you*

D- *So without a doctor prescribing the drug, you just took it?*

P- *It is the one that the boy brought*

D- *But it is not yours and you took it!*

P- *That is why he told me to come with it so that you will see. If you say I should continue taking it, then I will and if you say I should stop, I will stop.*

D- *Okay. Now I am saying you should stop taking it because it is not yours and it can cause additional problems. Please, stop taking drugs that are not meant for you.*

P- *Okay. Wait, my body is always weak both day and night.*

TREATMENT

D- *We will do a blood test now. After then, we will know what is wrong.*

P- *Truthfully, the way this body shakes is really disturbing me.*

CLOSING

D- *Don't worry about that. By God's grace, you will be healed.*

P- *Ameen.*

From the illustrationa above, we see that all the phases of the conversation are not sequential, making it difficult to distinguish between the phases.

4.2.2 Analysis of Power Relations in Doctor-Patient Conversations

In this section, the five selected conversations are analysed individually at word level, sentence level, turn taking, and the level of register, style and speech acts in order to reveal the interconnectedness of language, power and ideology in doctor-patient conversations.

Exchange A

At the word level, the doctor in this exchange arrogates power to himself by exerting dominance over the patient through his choice of words as can be seen from the way he uses

the singular personal pronoun '*I*' during the consultation. For instance, the first person singular personal pronoun is used five times:

> *I don't understand, for how long has there been no movement?*
> *So, now I can see you were told to do a scan.*
> *From the result, I can see that the pregnancy is five months.*
> *So now I will refer you for ante-natal....*
> *I will send you there....*
>
> *(Exchange A lines 11,21,23and35)*

The doctor in this exchange employs the use of the modal auxiliary verbs "must" and "will" to exert control and dominance over the patient. The use of "must" as in *"Now you must go and resume your ante-natal"* signals obligation on the part of the patient to carry out the doctor's orders, while the use of "will" as in "*I will refer you for ante-natal"* signals a sort of notice about the next course of action over which the patient has no say/choice.

At the sentence level, the doctor employs different types of sentences amongst which are interrogative, declarative, imperative and exclamatory sentences, mostly to issue orders and exert control over the patient. This is evident in the following examples:

Declarative:	*So now, I will refer you for ante-natal.*
Interrogative:	*Okay, for how long have you noticed there was no movement?*
Imperative:	*No, stop that, the ante-natal is very important.*
Exclamatory:	*You went to the Chemist!!!*

(Exchange A, lines 26,9,34,and15)

In addition to the sentence types, the researcher also observes that the doctor's utterances are mostly in the active voice since the aim is to get the patients to carry out his orders which are

in the form of prescriptions. Examples of sentences in active voice from exchanges A (see appendix A) include: "*I will send you there ...*", "*...I will refer you for ante-natal",* and "*She will give you an appointment"(Lines 35,26,and 27)*

The turn-taking structure of the conversations between the doctor and patient in this exchange shows that turn-taking rights are unequal. According to Sacks, Schegloff and Jefferson (1974) the techniques for selecting speakers are interactionally oriented to, by the parties involved in a conversation following three main rules- (1) current speaker may select next speaker (2) the next speaker may self-select and (3) if neither '1' nor '2' happens, the current speaker may (but need not) hold the floor. In this exchange, the doctor is in full control of the turn-taking system, while the patient only takes turns when offered by the doctor.

Every institution which uses language has its own register which is peculiar to that context of language use. The term "register" is a manifestation of variety associated with a particular context of language use. In the institution of medicine, certain operational terms are common to that context alone. In Exchange A, *"Chemist"* and *"Ante-natal"* are the two medical registers employed.

In the area of style, one discovers that the language use in this Exchange is characterised by evidence of code-mixing by both the doctor and the patient. Such instances are given below and could be as a result of the fact that there is no single word in Hausa language that can adequately replace those words. For example, the word *"Chemist"* can only be described as *"gidan magani"* in Hausa meaning "the home/house of drugs".

(i) P- Na je Chemist

(ii) *D-* *Chemist kika je!!!*

(iii) *D-* *Yanzu zan tura ki ante-natal... (Lines 14,15,and 27)*

The utterances of the doctor in Exchange A are dominated by particular speech acts. Searle (1976) distinguishes a number of broad classes or families of speech acts according to their illocutionary forces- declaratives, representatives, directives, commissives and expressives. Declaratives include words that change the world by their 'very' utterance, such as 'I bet' and 'I resign'. Representatives include acts in which the words state what the speaker believes to be the case, such as 'describing', 'predicting', and 'claiming'. Directives encompass acts in which the words are aimed at making the hearer do something, such as 'commanding', 'requesting', and 'suggesting'. Commissives include acts in which the words commit the speaker to a future action, such as 'offering', or 'promising'. Expressives include acts in which the word states what the speaker feels, such as 'deploring', 'apologizing', and 'regretting'. In Exchange A, the analysis shows that the doctor's utterances are constituted by directive, commissive and representative speech acts:

Directives: (i) *"Now you must go and resume your antenatal"(Line34)*

Representatives: (i) *"But it is only when you have prescription you are supposed to go to the Chemist"(Line 17)*

(ii) *"...I can see that the pregnancy is 5months and the baby is not correctly positioned but the baby is healthy, no problem"(Line 23-24)*

Commissives: (i) *"So now, I will refer you for ante-natal"((Line 26)*

(ii) *"I will send you there..." (Line 35)*

The presence of power is evident in the analysis above. From the doctor's choice of words in addressing the patient, it becomes obvious that the power relationship between the doctor and patient is unequal. The patient is seen taking turns only when offered by the doctor as suggested by Fairclough (1992:140). Such turn "offerings" are usually in the form of questions. The fact that the conversation is structured around the doctor asking questions and the patient answering is evidence that the doctor is the powerful participant in this consultation.

In Exchange A, it is also observable that the ideological leaning of the patient regarding decisions about health issues is one which the doctor disagrees with. The patient had consulted a chemist regarding her pregnancy and just now coming to the hospital for the first time in her six (6) months old pregnancy. The doctor's shock and displeasure is adequately expressed in "*You went to the Chemist!!!"* and "*"No, stop that..."* after the discovery that the patient, from all indications does not believe in ante-natal. The doctor attempts to control and influence the patient's ideology by telling her the right thing to do and ensure that the patient behaves and thinks differently in the future:

(i) *D-* *"But it is only when you have prescription you are supposed to go to the Chemist"*

P- *(Silent)*

D- *Right? (Lines 17-19)*

(ii) *D-* *No, stop that, the ante-natal is very important. Now you must go and resume your ante- natal. I will send you there and by God's grace, everything will be alright. (Line 34-35).*

Exchange B

At the word level, the doctor in Exchange B employs the use of the plural personal pronoun *"we"* not only to arrogate power to himself but also to arrogate collective power to all doctors in totality and the institution of medicine within which they operate. Examples are as follows:

(i) *"This baby, we must admit him"(Line 34)*

(ii) *"Then we will give him the necessary medications..."(Line 34)*

(iii) *"...what we see here is that this baby is too ill..."(Line 35)*

The doctor also employs interrogative, declarative, imperative and exclamatory sentences to issue orders and exert control over the patient. Declarative sentence as used by the doctor is to inform the nursing mother about his decision regarding the baby's health. Interrogative sentence like the example given below is used derogatively to undermine the mother's behaviour which in this case is assuming traditional medicine had any effect on the child's health. Imperative sentence as used below is to signal an obligation on the part of the nursing mother to submit her baby for admission and the exclamatory sentence expresses the doctor's shock and disbelief about the mother's behaviour. Examples include:

Declarative:	*"We are admitting him"*
Interrogative:	*"And how do you know it is better?"*
Imperative:	*"This baby (pauses) we must admit him"*
Exclamatory:	*"You took him to a traditional doctor!!!"*

Exchange B (Line 40,23, 34, 17)

The turn-taking structure of the conversations in this exchange also shows that between turn taking rights are unequal between the doctors and patients. The doctors have total control of turn-taking and do not wait to be offered turns but take them when the patients are done answering their questions or when the doctors feel they have provided enough information. All these are evident in Exchange B (See appendix A).

Also, in Exchange B, "baby-friendly" and *"zazzabi*" (fever) are the only significant medical registers employed. *"Baby-friendly"* is a medical term which signifies exclusive breast-feeding of an infant for the first 6months.Also, the usage of the register exemplifies another instance of code-mixing in line 32 as thus: *"Ba kiyi baby friendly ba? Kho kin yi?"* (*You did not do baby friendly or did you?).*

In Exchange B, the doctor's utterances are mostly constituted by directive, commissive and representative speech acts. For example:

Directive: *"This baby, we must admit him"*

Commissive: *"Then, we will give him the necessary medications"*

Representative: *"...what we see here is that this baby is too ill..."*

(Exchange B, line 34 -35)

Directive speech acts as used by the doctor in Exchange B is mostly to issue orders which the nursing mother is expected to carry out. Commissive speech acts as used is to indicate the doctor's intentions which he consequently carries out. Lastly, representative speech acts are employed to state the doctor's observations and make claims he believes to be true.

The interconnectedness of power, language and ideology is exemplified in this consultation. Through the use of language, the doctor is able to control and exert his "superior" power in the form of dominance over the patient. One way the doctor's use of language depicts dominance is kind of questions he employs during this consultation with the nursing mother. For instance, the use of *'wh'* questions which calls for specific details or information as in: *"When you used the medicine, was there relief from the headache"* and *"how do you know it is better?".* We also observe a manifestation of ideological differences in terms of the patient's traditional ideology and the doctor's modern ideology of medicine. We discover that the nursing mother had tried traditional medicine and it was only after a realisation that her baby was not getting better that she decided to go with modern medicine. The doctor's skepticism about traditional medicine is amply expressed:

D- *You took him to a traditional doctor!!! So, why didn't the traditional medicine work?*

P- *They said he had headache*

D- *What did they give you when you went to the traditional doctor?*

P- *They gave us medicine that I rubbed on him after his bath and another for drinking*

D- *When you used the medicine, was there relief from the headache?*

P- *The head is better than before*

D- *And how do you know it is better?*

P- *Before, the head was separated and down but now it's coming together and better than before.*

D- *Did he also recover from the fever?*

P- *No*

D- *The fever was not going down and you did not take him to a real doctor!!?*

P- *(Silent)*

(Exchange B,line 17-32)

From the excerpt above, the researcher notes that regardless of the doctor's attitude, the patient is un-deterred. From her defensive responses to the doctor's questions, the patient goes ahead to stand by her ideologies.

Exchange C

At the word level, the doctor in Exchange C also employs the use of the plural personal pronoun *"we"* to arrogate collective power to all doctors in totality and the institution of medicine within which they operate. Examples are as follows:

(i) *"We like to hear from the patients', so we will know the right thing to do"*

(ii) *"What we can see now is that your blood pressure has risen a bit"*

(iii) *"We will do a blood test now"*

(Exchange C, lines 17,19 and 41)

There is also evidence of the interplay between language and power through the use of some sentences by the doctor to achieve dominance over the patient. Examples of such sentences are given below:

Declarative :	*We will do a blood test now*
Interrogative :	*So without a doctor prescribing the drug, you just took it?*
Imperative:	*Don't worry about that.*
Exclamatory:	*He gave you his drug!!!*

Exchange C (Lines 42, 34,44 and 32)

The turn-taking structure of this conversation which is between a doctor and an older woman is noticeably different from other Exchanges in this study. The turn-taking system of Exchange C is structured around both the doctor and the patient sharing turns. In the opening

of this consultation, the patient "hijacks" the conversation by insisting they exchange greetings first and getting the doctor to acknowledge her son's prior visit to the doctors'. Contrary to the turn-taking structure of other Exchanges, the patient does not wait to be offered turns by the doctor.

At the level of register, the doctor in Exchange C uses the Hausa phrase in line 23 *"Matsalar hawan jini"* (meaning problem with rising blood), in lieu of the word "*Hypertension*"; and *"Hawan jini"* (rising blood) in lieu of "Blood Pressure". This choice is arguably because the doctor realises that the usage of the medical jargons "Hypertension" and "Blood Pressure" (or even B.P as popularly called) would have been incomprehensible to the old woman.

The doctor's' utterances are mostly constituted by directive, commissive and representative speech acts:

Directives: *(i) "Now I am saying you should stop taking it ..."(Line 38)*
(ii) "Don't worry about that"(Line 43)
Commissives: *(i) "We will do a blood test now"(Line 41)*
(ii) "We will know what is wrong"(Line 41)
Representatives: *(i) "We like to hear from the patients..."(Line 17)*
(ii) "You need to come to the hospital regularly…"(Line 23)

Directive speech acts are used by the doctor in this study to command issue orders which he expects the old woman to obey. Commissive speech acts are used by the doctor to indicate his decisions regarding solutions to the woman's health concerns. Lastly, representative speech acts are employed by the doctor to influence the patient's ideology of modern medicine. By saying "*we like to hear from the patients"* the doctor advertently influences the patient's view about doctors.

The manifestation of power as a result of ideology is exemplified in Exchange. Evidence of power struggle stems from the social roles that the doctor and patient occupy in the rural societies within this study. The cultural context in which the doctor-patient conversations in this study occur is one which accrues power to individuals based on age. The patient in Exchange C is a woman who is older than the doctor. The researcher argues that, on the part of the patient, she recognises the doctor's expert power in terms of medical knowledge as observable when she said: *"...If you say I should continue taking it, then I will and if you say I should stop, I will stop"(Line 37-38)* and on the other hand, the doctor recognises the fact that he is obligated to be respectful to this patient who is much older than he is and is thereby forced to relinquish a little bit of control in the consultation. Hence, the observable peculiarities in the structure of this consultation show the interconnectedness of language, power and ideology.

Exchange D

At the word level, there is only one instance of the use of the singular personal pronoun 'I' during the consultation, as in: "*I will just write some drugs for you".* The doctor also employs the use of the modal auxiliary verb "*will"* to exert control and dominance over patient. The use of *"will"* in "*I will just write some drugs for you"* by the doctor in Exchange D signals a sort of notice about the doctor's decision over which the patient has no say/choice.

At the sentence level, the conversation is structured around interrogative sentences, with declarative sentences occurring only at the opening and closing of the consultation. Interrogative sentences are used by the doctor not only to seek for information but also to control the amount of information provided by the patients. Examples include:

Interrogatives:

(i) Okay, do you get very hot?

(ii) What about your stomach, does it ache?

(iii) Does the stomach feel swollen

(iv) Do you purge?

(Exchange D,line 18-24)

Declarative: *I will just write some drugs... (Line36)*

In addition to the sentence types, it is also observable that the doctor's sentences are in the active voice. For example, *"I will just write some drugs for you..." and "... you also need to do some tests...".* The language of the doctor depicts not only authority but also power and the patient have to obey the orders/instructions without negotiation. The choice of the active voice as opposed to the passive voice gives credence to how power is exercised through the instrumentality of language in doctor-patient conversations in the rural areas within this study.

Similar to previously analysed exchanges, the turn-taking structure of Exchange D shows that turn taking rights are unequal between the doctors and patient. The doctor can be observed to be in full control of the turn-taking system, with the exception of when the patient greets the doctor at the opening with "*Salamu alaikum" (Peace be upon you),* thereby to some extent, controlling the topic of the doctor's turn.

At the level of style, there are instances of code-switching at the opening of the consultation where the doctor says: *"You are welcome. Okay. Sannu."(Line 1),* switching between English and Hausa and giving the patient the option of choosing the language of the consultation. The patient replies in line 2: *"Salamu alaikum" (Peace be upon you),* introducing Arabic, a language from which Hausa (the language of wider communication in the rural areas within

the scope of this study) has borrowed extensively from, before the consultation continues in English.

The doctor's use of language reflects the power and dominance he has over the patient. Control over the introduction and change of topic is another way doctors in this study exercise control over the organisation of their conversations with patients. The excerpt below is very revealing:

D- *So, what are your problems?*

P- *I don't feel well*

D- *Okay*

P- *Since last week, I usually feel cold in the evenings*

D- *Okay, you feel cold?*

P- *Yes, I usually feel very cold and feverish with headaches.*

D- *Okay, do you vomit?*

P- *Last night, I threw up about three times but since I haven't eaten since then, there has been no vomiting and...*

D- *(Interrupts) so when do you feel feverish?*

P- *In the evening*

(Exchange D,line 7-17)

From the above, when the patient introduces "fever" to the conversation, the doctor ignores that information, mostly because he did not request for it. Surprisingly, the doctor introduces the same topic later on. This is an indication of how much the doctor needs to be in control of the conversation.

Exchange E

At the word level, the doctor Exchange E employs a combination of both the singular personal pronoun *'I'* and the plural personal pronoun *"we"* during the consultation. By employing *"we"* in example (iii) below, the doctor gives the patient a false sense of inclusion by making it seem like she has a say in the doctor's decision. Through the use of these pronouns, the doctor is able to assert his power while also exerting dominance over the patient. Instances of such usage include:

(i) *I can see that her body is pale*
(ii) *So what we will do now since I have seen the nature of the body...*
(iii) *What we will do now is that...*
(iv) *From what I can see, I don't think she will need any transfusion.*

(Exchange E, lines 16,19,30 and 31)

At the sentence level, the doctor employs interrogative, declarative, and exclamatory sentences. Declarative sentences as used below is seen as an attempt by the doctor to assertively control and influence the mindset of the patient regarding her decision. Interrogative sentences are used by the doctor not only to seek for information but also to control and limit the extent of information provided by the patients. Lastly, exclamatory sentence as used below is to express the doctor's shock over the patient's behaviour. For example:

Declarative: *You are really supposed to be disturbed and show concern.(Line 18)*
Interrogative: *Was that all that happened?(Line 12)*
Exclamatory: *For 3 days now! (Line 18)*

The turn-taking rights are unequal between the doctor and the patient in Exchange E. However, there is an instance where the patient interrupts the doctor and took a turn without being offered by the doctor:

D- *"For 3 days now (shakes his head) you are really supposed to be disturbed and show concern. So what we will do now since I have seen the nature of the body and..."*

P- *(Interrupts) "That one is "saifa""*

D- *"So you don't come to the hospital because of "saifa"?"*

(Exchange E, line 18-23)

The utterances of the doctor in Exchange E are dominated by commissive and representative speech acts. A commissive speech act like *"We will take her blood for testing..."(Line 30)* indicates the doctor's intentions which he will consequently carry out. A representative speech act like: *"You really should have been disturbed"(Line 18)* is employed by the doctor not only to reprimand the patient but also to attempt to influence the patient's behaviour in the future.

According to Malmkjaer (2010), every time we direct language at some audience, we perform three simultaneous acts: a locutionary act, an illocutionary act and a perlocutionary act. A locutionary act being the act of saying in the full sense of saying; an illocutionary act being the act which is the act performed in saying something; and a perlocutionary act being the act performed by or as a result of saying. Many utterances contain indicators of illocutionary force, including word order, stress, punctuation, the mood of the verb, and Austin's performative verbs (Malmkjaer, 2010). The illocutionary force of an utterance, according to Lyons (1977), refers to its status as a promise, a threat, a request, a statement, and so on. In

this study, evidence of illocutionary force can be seen in the doctors' utterances, especially through the use of auxiliary verbs or what Austin calls "performative verbs" such as "can", "should", "must", "will" and so on. We discover that it is only the doctor in this context of language use who can invest his utterance signal with the illocutionary force of a request or command and succeed in getting the patient to obey. For example, the doctor's utterance: *"This baby (pauses) we must admit him"* is an illocutionary act intended to perform the function of command/order. The perlocutionary effect of this utterance on the patient is that the patient, through her knowledge of the conventions guiding the power relationship in that context of language use, consequently adheres to the order by submitting the baby to admission in the hospital. All these give credence to not only to the interconnectedness of language and power but also the power imbalance between the doctors and their patients in rural areas.

Ideology is also manifested in Exchange E in a myriad of utterances. According to Waitzkin (1989), what patients and doctors say when they meet reinforces their particular 'ideologic' conceptions about social life. There is an obvious difference between the doctor's and patient's ideologies. For example, we see a manifestation of the patient's worldview as thus:

(i) *D-* *Right now, I can see that her body is pale. You did not notice?*

P- *God is my witness, today is just the 3rd day since all these started.*

(Lines 16-17)

(ii) *P-* *(Interrupts) That one is "saifa"*

D- *So you don't come to the hospital because of "saifa"?*

P- *No, we only treat it traditionally. So I did not know I was supposed to come to the hospital because of that...*

(Exchange E, line 22-25)

Not only did the patient wait for three days before considering her child's condition serious enough for a visit to the hospital, she also believes some illness/symptoms can only be treated with traditional medicine. The doctor on the other hand has a conflicting worldview and is quick to express not only his displeasure but also his opinion as exemplified in the excerpts below:

(i) D- *So you don't come to the hospital because of "saifa"?*

D- *For 3 days now! (shakes his head) You are really supposed to be disturbed and show concern. So what we will do now since I have seen the nature of the body... (Exchange E, lines 23, 18, and 19)*

(ii) D- *You are supposed to come to the hospital so that you can be sure of what caused the swelling.*

P- *(Silent)*

D- *Okay?*

P- *Okay (Exchange E, lines 26-29)*

Despite the doctor's attempt to influence the patient's worldview, excerpt (ii) above shows that the patient remains non-committal, until forced by the doctor to acknowledge by saying *"Okay?"*.

4.2.3 Analysis of the Mechanisms Employed in the Exercise and/or Resistance of Power

The major mechanisms employed by the doctors in the exercise of power over the patients in the analysed exchanges and those employed by the patients to resist total domination by the doctor are examined.

Questions

Question is the most powerful tool employed by the doctors in this study in their exercise of power and dominance over the patients. The type of questions employed by doctors in this study is mostly closed questions which confine the patients' answers and leave no room for elaboration. According to Luo Xi (2015), although closed questioning is more efficient for the doctor, it does not favour patients. Some of these questions are 'yes' or 'no' questions (e.g, "*Do you know the vaccination they give to pregnant women?*" "*At that time, did he have fever*?") while others are 'wh' questions which calls for specific details or information about the patients' condition (e.g, "*What about nausea", "How many weeks old is he?"*). The only time the doctors are observed using open questioning is at the beginning of the consultations (presentation of complaint stage) when they ask questions like *"What is the problem?"* and *"What is wrong with you"*in order to determine the purpose of the patients' visit.

Topic Control

The doctors in this study have absolute power over topic control.Through the control of topic; the doctors dominate over patients during consultations. The doctors introduce and choose "relevant" topics which are in accordance with the agenda of the consultation. Even when the patient tries to deviate by providing too much information, the doctor simply picks out the relevant information and asks questions about it. This corroborates Fairclough (1992)'s claim

that doctors in a traditional medical encounter have absolute power over topic control. For instance, in exchange A (see appendix A), when the doctor asked what was wrong and the patient replied *"There is no movement in my stomach and I also feel abdominal cramps"(Exchange A, line 8)* the doctor's next question was *" ...how long have you noticed there was no movement?"(Exchange A, line 9);* thereby choosing the more relevant aspect of the patient's response as the next topic.

Interruption

From the earlier analysis of exchanges, it is also observed that another way the doctors maintain control of the consultation is through the use of interruption. The doctors employ interruption as a mechanism to control and limit the patients' responses to answers that are considered to be relevant. Below are instances of interruption in Exchange D:

(i) *P-* *"Last night, I threw up about three times but since I haven't eaten since then, there has been no vomiting and..."*

D- *(Interrupts) "So when do you feel feverish?"*

(Exchange D, Line 14-16)

(ii) *P-* *"Yesterday, I did not take any medicine and I..."*

D- *(Interrupts) "What about the day before?"*

(Exchange D, line 33-34)

However, the study also observe instances where it is arguable that the patients also use interruption to maintain some iota of control in the conversations. For example, as illustrated below in the extract from Exchange E, the patient arguably interrupts the doctor in order to

display her own knowledge concerning her child's health issues especially as the doctor has been adequately expressing his displeasure over her attitude.

D- *"For 3 days now (shakes his head) you are really supposed to be disturbed and show concern. So what we will do now since I have seen the nature of the body and..."*

P- *(Interrupts) "That one is "saifa""*

D- *"So you don't come to the hospital because of "saifa"?"*

(Exchange E, Line18-23)

Silence

The researcher observes that the patients in this study employ silence as way of resisting total domination by the doctors during consultation. According to Fairclough (1989) silence is a weapon for the less powerful participants, particularly as a way of being non-committal about what the more powerful participants say. For example, in the excerpt from Exchange E below, the patient's silence when the doctor insinuated his superiority (and that of doctors in general) in terms of health issues, is seen as a form of resistance to the doctor's domination.

P- *No, we only treat it traditionally. So I did not know I was supposed to come to the hospital because of that.*

D- *You are supposed to come to the hospital so that you can be sure of what caused the swelling.*

P- *(Silent)*

D- *Okay?*

P- *Okay*

(Exchange E, Line 24-29)

By being non-committal, she leaves the doctor to infer whatever he chooses, while also retaining a modicum of control. However, it is important to note the doctor is able to regain

dominance by forcing the patient out of silence and into a response by asking the question *"Okay?"*.

4.2.4 Quantitative Analysis of Responses on Patient Satisfaction

In this section, the researcher attempts to determine the effectiveness of doctor-patient conversations in meeting the health communication needs and patient satisfaction in the selected rural areas. In order to gain insight into the level of patient satisfaction, a total of twenty patients were interviewed after the conclusion of their consultation with different doctors. The frequency tables below were generated from the responses of such patients:

Table 4.2 Doctors' Tone

How would you describe the doctor's tone or behaviour?	Frequency	Percent	Valid Percent
Official	8	40.0	40.0
Friendly	12	60.0	60.0
Total	**20**	**100.0**	**100.0**

Table 4.2 above shows that the tones of 40% of the doctors in this study are considered by the patients to be official, while that of 60% are considered to be friendly. This supports the observation made by Desjarlais-deKlerk and Wallace (2013) that the doctors in small rural towns tend to engage in more socio-emotional communication than their counterparts in large urban centres. This is because the nature of rural societies ensures that the doctors know their patients and their families on a more personal level both in and outside the clinics which consequently affects positively, the nature of doctor-patient conversation, as well as patient satisfaction

Table 4.3 Doctors' Attention

Was the doctor paying attention when you were describing your condition?	Frequency	Percent	Valid Percent
Yes	11	55.0	55.0
No	9	45.0	45.0
Total	**20**	**100.0**	**100.0**

Table 4.3 above shows that 55% of the doctors in this study paid attention when their patients were describing their conditions, while 45% did not pay attention. When doctors pay attention when a patient is describing his/her condition, it invariably leads or at least contributes to over-all patient satisfaction. Majority of the patients seem to be satisfied with this aspect of the doctor's behaviour. However, the difference in percentage between the doctors who were paying attention and those who were not is not much.

Table 4.4 Information Seeking

Were you comfortable asking the doctor questions?	Frequency	Percent	Valid Percent
Yes	9	45.0	45.0
No	11	55.0	55.0
Total	**20**	**100.0**	**100.0**

Table 4.4 above shows that, 45% of patients were comfortable asking questions during their consultations with the doctors while 55% were not comfortable asking questions. The inability of patients to ask their doctor questions has a negative implication on patient satisfaction. The fact that the patients are aware of the medical superiority of doctors over them is enough reason to be 'timid' or uncomfortable during conversations with them. Also, the lack of informational power about health issues on the part of patients puts them in a

position where they do not know the right questions to ask. However, the researcher observed that some patients (especially female) were not comfortable talking with the male doctors probably due to the cultural norms in that particular context which does not allow females to socialise with males outside their immediate family. This is responsible for the patients being uncomfortable asking the doctors questions.

Table 4.5 Room for Expression

Did the Doctor give you enough room to express yourself?	Frequency	Percent	Valid Percent
Yes	11	55.0	55.0
No	9	45.0	45.0
Total	**20**	**100.0**	**100.0**

Table 4.5 shows that 55% of patients believe that the doctors gave them room for expression, while 45% believe the doctors gave inadequate room for expression. Now, this result has a positive implication for patient satisfaction in rural areas. However, in this study, doctors are observed using questions to elicit required information from the patients and ensure they do not give what they consider "irrelevant" information. Also there is little to none evidence of the doctors in this study encouraging their patients to ask questions.

Table 4.6 Brushed-Off Questions

Did the Doctor seem to have brushed off any of your questions?	Frequency	Percent	Valid Percent
Yes	17	85.0	85.0
No	3	15.0	15.0
Total	**20**	**100.0**	**100.0**

Table 4.6 above shows that 85% of patients are of the opinion that the doctors brushed off some of their questions while only 15% of patients believe none of their questions were brushed off by their doctors. The alarming difference between the two sets of responses has negative implications for patient satisfaction with the health communication in the selected rural areas.

Table 4.7 Information Provision

Did the Doctor provide you with enough information or explanation about your condition?	Frequency	Percent	Valid Percent
Yes	13	65.0	65.0
No	7	35.0	35.0
Total	20	100.0	100.0

Table 4.7 above shows that 65% of doctors in the selected rural areas provided their patients with enough information about their diagnosed condition, while the remaining 35% did not provide (or provided little) their patients with such information about their condition. Since provision of information by doctor has been found to be positively linked with patient satisfaction, this study concludes that majority of the patients in this study are satisfied with this particular aspect of the health communication.

Table 4.8 Medical Jargon Usage/Clarification

		Did the Doctor make use of words you did not understand?		Total
		Yes	No	
If yes, did he clarify its meaning?	**Not Applicable**	0	35.0	35.0
	Yes	40.0	0	40.0
	No	25.0	0	25.0
	Total	**65.0**	**35.0**	**100.0**

Table 4.8 above shows that the doctors in the rural areas most often make use of medical jargons which the patients do not understand. 65% of the patients agree that the doctors make use of medical words they do not understand, while only 35% disagree. Of the 65% of patients who agree, 40% agree that the doctors do clarify the meaning of such medical jargon after its usage, while 25% say they do not clarify.

Table 4.9 Consultation Time

Do you feel like the Doctor rushed your consultation?	Frequency	Percent	Valid Percent
Yes	14	70.0	70.0
No	6	30.0	30.0
Total	**20**	**100.0**	**100.0**

Table 4.9 shows that 70% of the patients believe their doctors did not spend enough time on their consultation, while 30% believe the consultation time was enough. This result has negative implication for patient satisfaction in rural areas. The researcher observes that most

of the rural clinics in this study were flooded with patients, which could be responsible for the amount of time spent on consulting with a single patient.

4.3 Discussion of Findings

Doctor-patient conversation in the rural areas within this study, like any other medical discourse in any other context, is shaped by the institution of medicine in which it occurs. This institution ascribes roles to both its doctors and their patients which guides the resulting nature and structure of any conversation between them. These role relations are asymmetrical in nature, with the doctors controlling and dominating the conversation and the patients having very limited freedom during the consultation. This study shows that the doctors exert dominance over most of the patients during the consultations by controlling the amount of information provided by the patients and issuing orders/commands about the solutions to their health problems. This is evident in the excerpt below:

(i) *D-* *What is wrong with you?*

P- *There is no movement in my stomach and I also feel abdominal cramps.*

D- *Okay, for how long have you noticed there was no movement?*

P- *All I know is that I don't feel any movement.*

D- *I don't understand, for how long has there been no movement?*

P- *5 to 6 months now.*

(Exchange A, Line 7-12)

(ii) *D-* *So now, I will refer you for ante-natal. The nurse will continue checking you and provide all necessary assistance that you need. She will give you an appointment; it could be after every week or thereabout (Exchange A, line 26-28).*

The cultural context, in which the doctor-patient conversations in this study occur, also helps in the shaping of the ensuing nature of the discourse. This is exemplified by the presence of a

strong religious content in the use of language as observed in the analysis from the use of phrases such as: *"Thank God" "May God help us" and "May God heal you/her"* by both doctors and patients. Furthermore, there are certain customs and traditions which guide the health beliefs of people in the rural areas of Kaduna State selected for this study. These belief systems inherently influence the nature of doctor-patient conversations in the selected rural areas. From the conversations presented for analysis, there is evidence of power struggle resulting from ideological differences between traditional health beliefs of the patients and the modern health beliefs of the doctors. For example, we discover instances where it is obvious that some patients only consult medical doctors after the traditional medicine yields no result. The following conversation from exchange B is quite revealing:

P- *"They thought it was headache, so we took him to a traditional doctor"*

D- *"You took him to a traditional doctor!!! So, why didn't the traditional medicine work?"*

P- *"They said he had headache"*

D- *"What did they give you when you went to the traditional doctor?"*

P- *"They gave us medicine that I rubbed on him after his bath and another for drinking"*

D- *"When you used the medicine, was there relief from the headache?"*

P- *"The head is better than before"*

D- *"And how do you know it is better?"*

P- *"Before, the head was separated and down but now it's coming together and better than before"*

D- *"Did he also recover from the fever?"*

P- *"No"*

D- *"The fever was not going down and you did not take him to a real doctor!!?"*

P- *(Silent)*

(Exchange B, line 16-32)

From the excerpt above, the doctor is very skeptical of the traditional route the patient chose to explore before coming to the hospital. The very nature of the doctor's questions reveal an attempt to discredit the traditional doctor and the traditional health beliefs generally. The doctor's exasperation when he said: "*You took him to a traditional doctor!!!"* and "*The fever was not going down and you did not take him to a real doctor!!?"* was all meant to communicate his displeasure/judgment on traditional health care to the patient.

The analysis presented earlier translates to an evidence of the presence of power in doctor-patient conversations in the rural areas within this study, as well as the ideological leaning of both the doctors and the patients. In rural hospitals, as discovered in this study, the doctors are found asking all the questions, while the patients provide answers to the questions. The doctors occupy the role of speaker while the patients occupy the role of listener. Thus, we find cases where the doctor asks for information and the patient provides the requested information. Asking for information or action puts the doctor in a position of power. It is important to note that giving information can also arrogate power to the individual giving the information, except when it is being asked for. This is probably why whenever doctors in this study find the patients offering unrequested information, they are quick to cut them off in a bid to regain power and dominance over the conversation. An example can be seen in the extract from exchange D, lines 13-16 (see appendix A) below:

D- *"Okay, do you vomit?"*

P- *"Last night, I threw up about three times but since I haven't eaten since then, there has been no vomiting and..."*

D- *(Interrupts) "So, when do you feel feverish?"*

It is noticeable in the example above that the patient is providing too much 'unwanted' information to a question that requires less information. The doctor, discovering this fact, immediately cuts the patient off by requesting for relevant information.

The analysis of the structure of doctor-patient conversations in the rural areas within this study conforms to the classification by Byrne and Long (1976). The overall content structure of conversations between doctors and patients during consultations in rural areas can be summarized thus: (i) Opening (Ex. A, Lines 1-6); (ii) Presentation of complaint (Ex. A, Lines 7-8); (iii) Verbal/physical examination (Ex. A, Lines 9-21); (iv) Diagnosis (Ex. A, Lines 22-26); (v) Prescription (Ex. A, Lines 27-37) and (vi) Closing (Ex. A, Line 38).

Evidence of power also stems from the social roles that the doctors and patients occupy in the rural societies within this study. The doctor inherits the power of his role from the institutional organisation, as well as from social class and age. The professional power combined with that of class, age and even gender makes it easy for doctors in the selected rural areas to dominate over patients during consultations. The kind of prestige attached to the doctors' profession places them in the higher social class in the rural society, which in itself is a position of power. Most of the patients in the selected rural areas belong to the lower social class, which makes it easier for them to be controlled and dominated over by the doctors. Also, the researcher notes that gender plays a major role in the power relation between doctors and patients in the selected rural areas. For example, male patients were observed to be more comfortable with the male doctors, while the female patients were more deferent, shy and less comfortable with the male doctors, making the female patients easier targets of the doctors' control and domination. The cultural context in which the doctor-patient

conversations in this study occur, is one which distributes power to individuals based on age. The "turn" the conversation below takes, reveals a lot:

D- *"What is your name Mama?"*
P- *"Rahmatu Rabi"*
D- *"From which town?"*
P- *"Jambaba"*
D- *"What is wrong with you?"*
P- *"Good morning first"*
D- *"Good morning"*
P- *"I saw the help you have given to my son"*
D- *"Okay."*
P- *"Thank you. My body has been paining me and I feel dizzy."*
D- *"Okay."*
P- *"I shiver."*

(Exchange C,line 1-12)

The patient in the conversation above is an old woman, who with the advantage of age is able to control and dominate the conversation without interference from the doctor. Ordinarily, the doctor would have cut the patient off when she did not give an immediate response to the doctor's questions but went on about ensuring they get pleasantries out of the way. Instead, the doctor is forced to indulge the patient because of her old age, till she was ready to get back to the purpose of her visit to the hospital.

In doctor-patient conversations in the selected rural areas, language serves two distinct purposes. The first is its general usage as an instrument of communication to elicit information that will aid in proffering solutions to health problems, as well as documentation

of the problems. The second is its usage as an instrument of control and domination over patients during consultations. The latter is the usage of interest to this study. Through the skillful use of language which is observable in this analysis, doctors in this study are able to achieve their goal of dominance over patients. Through the use of the singular personal pronoun *'I'* and plural personal pronoun *"we"*, the doctors in this study are able to arrogate power not only to themselves but also the institution of medicine within which they operate. Also, the modal verbs *"must", "can", "should"* and "*will"* are employed by doctors in this study to achieve dominance during conversations with their patients. Compared with other verbs, modal verbs are easily identified and understood and then accepted because at the time of utterance, there is little to no time for the addressee to reflect. This makes the use of modal verbs a very effective power tool.

The use of active voice by the doctors also ensures that their language depicts not only authority but power and the patients "obey" the orders/instructions without any argument. Doctors unequivocally arrogate power to themselves when dealing with patients as observed in their use of declarative, imperative and interrogative sentences mostly for issuance of commands, and turn taking denial all to exert dominance over the patients. For example, with the use of interrogative sentences like: *You don't know? Is it that you have never gone for ante-natal before?(Exchange A,line 32)*; although the aim is to ask for information, the whole essence of asking puts the doctor in a position of power and renders the patient powerless. Also, from the nature of the speech acts which constitutes the doctor-patient conversations in this study, the researcher observes that the doctors' utterances are mostly directed towards issuing commands, orders, and instructions. In other words, the doctors' aim is most often

than not, getting the patients to obey orders and carry out instructions. All these give credence to how power is linked to language use in the selected doctor-patient conversations.

Another important observation is that doctor-patient conversation plays a role in sustaining the existing power relations in the society. Since ideology is a means through which unequal power relations are established and maintained, any attempt at influencing the ideologies of the patients is an attempt at maintaining existing status quo in the society. Language and the way it is used are important to the ideological process. In this study, the doctors, through their use of language, are able to influence the mindset of the patients not only regarding their health concerns but also regarding the maintenance of the existing power relations in medical discourse. For example, doctors attempt to control and influence the patients' ideology by telling them not only how they should feel - "*You are really supposed to be disturbed and show concern"* "*Don't worry about that"(Exchange C, line 43) ;* but also what they should do - "*You are supposed to come to the hospital so that you can be sure of what caused the swelling"(Exchange E,line 26) "Now I am saying you should stop taking it …"(Exchange B, line 28).* The nature of these utterances is to ensure that the patients behave and think differently in case of future occurrence.

The doctors also employ language as a tool of promoting the propaganda of the institution of medicine. Utterances such as: *"We like to hear from the patients, so we will know the right thing to do", "Anyone who is hypertensive needs to come to the hospital regularly", (Exchange B, line 17, 22 and 23) "But it is only when you have prescription you are supposed to go to the Chemist. Right?"* and *"No, stop that, the ante-natal is very important" (Exchange A, line 17 and 34)* are all geared towards ensuring that power is arrogated to the institution of

medicine and that the modern health beliefs and knowledge of the patients in rural areas are shaped in line with the bureaucratic objectives of the institution of medicine. Finally, the ability of the doctors in the rural hospitals to control and dominate over patients during consultations ensures that what has become "common sense" in terms of the nature and structure of doctor-patient conversations is maintained. Ideology, therefore, works alongside language as a power tool of social domination and control.

Our analysis has also revealed the existence of some mechanisms employed by both doctors and patients in the exercise and resistance of power. There are two major mechanisms employed by the doctors in this study in the exercise of power over the patients- questions and interruption. Questions are observed to be the most powerful tool used by the doctors to not only take control but also maintain such control and domination over the patients during consultations. With the use of questions such as *"What is your name?"* "*What is the problem?"* and *"So have you taken anything?"* doctors in this study are able to seize and maintain total control of the conversation, while the patients are restricted to providing answers only to the questions asked. Furthermore, open-ended questions are absent in the doctors' use of language. This enables the doctors to control both the turn-taking and the flow of content, thereby discouraging patients' self elaboration of topic. For example in exchanges A and D, questions such as: *"What is wrong with you? "Okay, for how long have you noticed there was no movement?" What about your stomach, does it ache? So when do you feel feverish?* and so on are observed.

Interruption is used by the doctors to limit and restrict the patients' responses to only information that are considered to be relevant. The use of interruption by doctors also ensures

that patients do not provide too much information. On the other hand, the patients in this study also employ two major mechanisms to resist total domination by doctors- interruption and silence. Interruption is used by the patients to regain some control over the conversation, while silence is used by the patients to resist total domination by the doctors especially when they do not agree with whatever the doctor is saying. From the example presented from exchange E below, the researcher concludes that the patient's traditional health beliefs is responsible for the patient's display of resistance to the doctor's domination, as the patient is seen interrupting the doctor and later on using silence as a tool of resistance. However, the doctor still manages to regain control by ensuring the patient acknowledges an understanding of the information.

Patient satisfaction is very important and its attainment in any medical institution is synonymous with not only good quality health care but also the success of the doctors and the hospital in its entirety. The frequency tables (4.2 – 4.9) presented earlier are quite informative and have reveal a number of facts. Firstly, the doctors in the rural areas within this study provide their patients with adequate information about their health issues. However, they do not give the patients enough room to express themselves. As observed in the analysis, the doctors' use of close-ended questions ensures that the patients are restricted to providing just the right amount of information needed by the doctors. Secondly, the doctors in the selected rural areas do not give their patients opportunities to ask questions and sometimes brush-off what they consider to be unnecessary questions. As observed in the analysis, the unequal turn-taking rights between doctors and patients during conversations does not allow for many opportunities for the patients to ask questions. Thirdly, the doctors display a generous amount of friendliness with their patients and even sometimes engage in non-medical conversation

with them. Lastly, the medical communication style of the doctors in this study is observed to be disease-centred. This is evidenced in the way the doctors dominate and control the conversations during the consultations. By and large, the existing nature of doctor-patient conversations in the rural areas within this study is still largely paternalistic and needs to be improved upon in order to achieve maximum patient satisfaction.

4.4 Major Findings

This work documents and examines different conversational exchanges between doctors and patients during consultations in selected rural hospitals. It identifies how the doctors, through the instrumentality of language, dominate and control the patients during consultations. The study has been able to come up with the following major findings:

i. Doctor-patient conversation in the rural areas within this study is still very traditional with no evidence of Fairclough (1992)'s "social change" which the institution of medicine is undergoing in the western world and some urban parts of Nigeria.

ii. There is unequal power relationship between doctors and patients in the selected rural areas which is manifested in the unequal distribution of turn taking rights during their conversations and the control doctors have not only over the subject and content of the conversations but also the on the amount of information provided by the patients during consultations.

iii. Social class, age and gender all influence the nature of doctor-patient conversations in this study. The low social class of the patients makes it easier for the doctors to dominate over consultations. The doctors cede a little bit of control when dealing

with older patients; and the female patients exhibited timidity during consultations with male doctors.

iv. The presence of a traditional ideology of health in the selected rural areas has an impact on the power relations between doctors and patients.For instance, we discover that majority of the patients go to the hospital only as a last resort and most of the instances of power resistance exhibited by patients in this study are when the doctors call the practice of traditional medicine to question.

v. The use of words/phrases with religious content is typical of doctor-patient conversations in the selected rural areas. For example, “Thank God”, “By God’s Grace” “May God heal you” and so on.

vi. The structure of doctor-patient conversation in the rural areas within this study conforms to Bryne and Long (1976)’s classification. That is, opening, presentation of complaint, verbal/physical examination, diagnosis, prescription and closing.

vii. Although previous studies like Washer (2009) has shown that “medspeak” is often used by doctors as a way of asserting their power, in this study we find no such cases as the doctors were observed using terms the patients would understand and clarifying or ensuring the few medical jargons used are understood by the patients.

viii. Through skillful use of language, doctors achieve control and dominance over patients during consultations. For instance, with the use of modal auxiliary verbs, doctors are able to explicitly tell the patients what they can or cannot do.

ix. From the illocutionary forces of the doctors' utterances, we see the interconnectedness of language and power. In this context of language use, the doctors are the only ones with the institutional and expert power to command/order/instruct as exhibited in their utterances which are dominated by directive, commissive and representative speech acts.

x. Language has the power to influence ideologies. Through the use of language, the doctors in this study attempt to influence the mindsets of the patients regarding modern medicine by telling them how they should feel(*"You should be worried", "Don't worry"*) and what they should do (*"You are supposed to come to the hospital...", "Stop taking drugs that are not meant for you"*).

xi. Conversational features like the use of close-ended questions, turn control, topic control and interruption are employed by the doctors in this study to dominate over patients during consultations. The patients on the other hand employed interruption and silence, arguably, to resist total domination by doctors during consultations.

xii. Two categories of medical registers were observed in the course of this study. One category involves descriptions of ailments, while the other involves diagnosis and treatment.

xiii. The communication style of doctors in rural areas is disease-centred, as opposed to patient-centred which has been proven to lead to higher patient satisfaction. Hence, the patients are not satisfied with the communication style of doctors in the rural hospitals.

4.5 Summary of Analysis

This chapter has been able to present, analyse and examine the selected data from those collected in the selected rural hospitals. Five different conversational exchanges between doctors and patients during consultations have been analysed in order to achieve the aim and objectives of this study. The researcher observed from the analysed exchanges, that doctor-patient conversation in rural areas is shaped not only by the institution of medicine but also the cultural context in which it occurs. Also, from the analysis, the researcher confirmed that there is unequal power in doctor-patient conversation in the selected rural areas. Patients were observed putting up a certain amount of resistance to total domination by doctors during consultations and through the doctors' use of language when dealing with patients; the interconnectedness of language in the exercise of power is confirmed.

CHAPTER FIVE

SUMMARY, CONCLUSION AND RECOMMENDATIONS

5.0 Preamble

This chapter serves as the concluding section of this study. It gives a summary, conclusion, recommendations and suggestions for further research. It also states the limitations to the study and the contribution to knowledge.

5.1 Summary

This study is *"A Critical Discourse Analysis of Doctor-Patient Conversations in Selected Rural Hospitals in Kaduna State"*. The work in its opening chapter, deals with the background to the study, statement of the research problem, aim and objectives, the scope and delimitation and the justification for the study. The study discusses concepts such as language in relation to communication, power, and ideology; doctor-patient communication: its structure and its relation to patient satisfaction; critical discourse analysis: its emergence, overview and major approaches. It also reviews previous literature on critical discourse analysis and doctor-patient conversation and presents Fairclough (1989)'s "Discourse as Social Practice" as a theoretical framework. The methodological processes employed in the course of this research which includes the sources of data, the data collection techniques and the method of data analysis are mentioned. The presentation and analysis of selected conversational exchanges between doctors and patients during consultations are carried out in order to reveal not only the nature of doctor-patient conversations in rural areas but also the manifestation of power and ideology. Some major findings include the presence of a traditional ideology of health which results in attempts by patients to resist dominance;and

the communication style of doctor-patient conversations in the selected rural areas is found yo be disease-centred which has a negative implication for patient satisfaction. A summary of the whole study is provided, recommendations and suggestions for further research are offered. The study also states the limitations to the study, contribution of the study to knowledge and a conclusion.

5.2 Conclusion

This study concludes that in the doctor-patient conversational exchanges in this study, there is unequal power relationship between the doctors and their patients. The research also concludes that the nature of doctor-patient conversation in rural areas is shaped by both the institution of medicine and the customs and traditions of the people in the rural areas in which it occurs. Another conclusion is that, through the skillful choice of words and different sentence types, doctors achieve domination and control over patients. The utterances of doctors in this study are directed towards issuing commands, orders and instructions. However, some patients find a way to resist total domination by doctors. The study also concludes that the communication style of doctors in rural areas is disease-centred, as opposed to patient-centred which has been proven to lead to higher patient satisfaction. Finally, this study has successfully established the fact that conversations between doctors and patients in rural areas are laced with unequal power relationship which is made possible through the instrumentality of language.

5.3 Contribution to Knowledge

By focusing on a Critical Discourse Analysis of doctor-patient conversation in selected rural hospitals, this study fills an analytical gap left by previous researches and proffers data and

findings from a distictive linguistic context which is distinguishable from any other context of doctor-patient conversation. Also, by discovering instances of power resistance by patients in the selected rural areas, this study has disputed the general conception that doctors are always in total control of conversations during consultations.

By exposing those communicative behaviours of doctors which are deterrent to patient-centredness, this study has shown that medical communication in the selected rural areas is still largely paternalistic and disease-centred. The findings therefore inform general healthcare delivery in Nigeria, by providing insights on the level of patient satisfaction with the health communication practice in rural areas, as well as how it can be improved to achieve a higher level of patient satisfaction.

5.4 Recommendations

The researcher proffers the following recommendations to enable an improvement in patient satisfaction and general healthcare delivery in rural areas. These recommendations can also be useful to medical institutions in other geographical areas and not necessarily limited to the areas within this study.

1. Patient-centredness should be adopted as a communication style. That is, more emphasis should be placed on friendliness, attentiveness, empathy, acknowledgement of patients' contribution and encouragement of patient participation in decision making regarding the course of treatment.

2. The use of open-ended questions should be employed in order to give the patients the opportunity to provide information and also seek clarification or further information about their health concerns.

3. Doctors should endeavour to pay attention during consultations, especially during presentation of complaint; interruptions from other hospital personnel should be minimized.

4. Adequate time should be spent on consultations to ensure that patients are not rushed.

5.5 Limitations to the Study

Due to the confidential nature of interactions between doctors and patients in hospitals, this research encountered some resistance during the data collection process. Some hospital personnel were adamant in their refusal to grant approval for data collection, expressing concerns over confidentiality. Consequently, the researcher had to express her assurance over the protection of confidentiality by changing the patients' names during transcription and the assurance that the data would strictly be used for academic research purposes.

5.6 Suggestions for Further Research

This study concentrated on an analysis of power in doctor-patient conversations in rural areas. Other researchers can explore other aspects of medical discourse such as communication between doctor-nurse, doctor-doctor, nurse-patient, and other medical personnel. The resistance of power by the less powerful in other contexts of language use can also be studied.Also, this study did not delve deep into the importance of efficient medical communication to patient satisfaction and general healthcare delivery. Hence, other researchers can explore the need for patient-centredness in medical health communication.

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APPENDIX A

Each datum is tagged an exchange for proper identification. Where 'D' represents doctor and 'P' represents patient.The Hausa transcriptions of those conversations which are originally in Hausa are presented below and followed by the translations in English. The five exchanges randomly selected and used for analysis are placed first for easy identification.

Exchange A

D- Ya sunan ki?
P- Safiya
D- Safiya Wa?
P- Safiya Bello
D- daga wace gari ?
P- Nasarawa Gangara
D- Meke damun ki ?
P- cikina ke cewo sannan bana jin motsi a cikin
D- Tun yaushe kika gane babu motsi?
P- Na dai san ba na jin motsi
D- Ban gane ba? Tun yaushe kika lura cewa ba kya jin motsi?
P- Zai kai wata biyar zuwa shida yanzu.
D- kin je asibiti tun sannan?
P- Na je Chemist
D- Chemist kika je!!!
P- Ae
D- Ba'a zuwa chemist sai likita ya bada sunayan magunguna da za'a siya
P- (shiru)
D- Koh?
P- A, ai sai bayan naje naga ban samu sauqi ba sannan nace bari nazo asibiti
D- Toh, Allah ya kyauta.
D- Naga a katin ki ance kiyi sikanin
P- A, ranar litinin aka saka kuma na zo nayi
D- Naga an rubuta a katin ki cewa cikin wata biyar ne sannan zaman jaririn ba daidai bane, banda wannan komai daidai yake.
P- (Shiru)
D- Yanzu zan tura ki ante-natal, za'a cigaba da dubaki kuma ana baki taimakon da kike buqata.
Za'a ba ki lokutan zuwa kamar ko wace sati haka.
P- (Shiru)
D- kin san allurar rigakafi da ake wa mata masu ciki?
P- A'a
D- Ba ki sani ba? Koh baki taba zuwa ante-natal bane?
P- Gaskiya gani nayi tunda garau nake jin jikina sai bana zuwa kuma...

D- (Karbi magana) Kina ji na, ante-natal na da gaggarimin mahimancin gaske saboda haka dole ne ki soma zuwa.Yanzu zan turaki wurin ante-natal kuma da yaddar Allah komai zai warware.
P- (Shiru)
D- Mun gode Allah

Translation

D- What is your name?
P- Safiya
D- Safiya what?
P- Safiya Bello
D- From which town?
P- Nasarawa Gangara
D- What is wrong with you?
P- There is no movement in my stomach and I also feel abdominal cramps.
D- Okay, for how long have you noticed there was no movement?
P- All I know is that I don't feel any movement.
D- I don't understand, for how long has there been no movement?
P- 5 to 6 months now.
D- So, did you come to the hospital at all since then?
P- I went to the Chemist.
D- You went to the Chemist!!!
P- Yes
D- But it is only when you have prescription you are supposed to go to the Chemist.
P- *(Silent)*
D- Right?
P- Yes, it was after I went and did not feel any better that I decided to come here.
D- Okay. May God help us! So, now I can see that you were told to do a scan...
P- Yes, on Monday and I did it.
D- From the result, I can see that the pregnancy is 5 months and the baby is not correctly positioned but the baby is healthy, no problem.
P- (*Silent)*
D- So now, I will refer you for ante-natal. The nurse will continue checking you and provide all necessary assistance that you need. She will give you an appointment; it could be after every week or thereabout.
P- (*Silent)*
D- Do you know the vaccination they give to pregnant women?
P- No
D- You don't know? Is it that you have never gone for ante-natal before?
P- Truly, since I always feel normal, I don't go and even though...
D- *(Interrupts)* No, stop that, the ante-natal is very important. Now you must go and resume your anti- natal. I will send you there and by God's grace, everything will be alright.
P- (*Silent)*
D- We Thank God

Exchange B

P- Barka da yamma.
D- Barka da yamma, zaki iya zama.
D- Menene matsalar ki?
P- Yarona ne, dadaddare yana daukan zafi; yana numfashi da nawyi, kuma sanda zan bashi mama yasha, baya iya reke wa (yaro na kuka a gefe)
D- Yaron satin sa nawa?
P- Sati hudu
D- Toh, cikin sa yayi wata tara?
P- A
D- Bayan kin haife shi, yana iyan shan mama a lokacin, ko sai daga baya?
P- Sai daga baya
D- A wannan lokacin, yana yin zazzabi?
P- A'a, kwananan ya fara zazzabi
D- Toh, tun lokacin kin kaishi asibiti ne?
P- Sun zata ciwon kai ne, shine muka kaishi asibitin gargajiya
D- Kin kaishi asibiti gargajiya !!! toh, mai yasa maganinsa baiyi aiki ba ?
P- Ance ciwon kai ke damun shi.
D- Me aka baki da kika je wurin likitan?
P- Sun bamu magani da nake shafa masa bayan yayi wanka kuma wasu na sha
D- Da kika yi amfani da maganin, da sauki ciwon kai din?
P- Ciwon kai yayi sauki akan da
D- Kuma taya kika san ciwon kai din yayi sauki?
P- Dama kan a rabe yake kuma yayi kasa amma yanzu yafara hadewa kuma yafi da sauki
D- Kuma ya warke daga zazzabi din?
P- A'a
D- Zazzabin bayayin kasan kuma baki kai shi wurin likitan gaske ba!!?
P- (Shiru)
D- Hmmm...kina yawaita bashi ruwa ya sha tun sanda kika haifeshi?
P- A, muna bashi ruwa.
D- Ba kiyi baby friendly ba? Kho kin yi?
P- A'a
D- Wannan jaririn, zamu bashi gado. Sannan zamu bashi magunguna da ya kamata a bashi tunwuri. Saboda abinda muka gani rashin lafiyarsa ya yi tsanani kuma babu magani da zamu bashi yanzu ahaka sai mun bashi gado.
P- Toh
D- Ya kai tsahon sati biyu bayan kin haife shi da wannan ciwon ya fara?
P- Kamar bayan sati daya
D- Toh. zamu bashi gado
P- Toh
D- A

Translation

P- Good afternoon.
D- Good afternoon, you can take a seat.
D- What is the problem?
P- It's my child, at night his body gets hot; he breathes heavily and when I try to breastfeed him, he can't hold it

(Baby crying in the background)

D- How many weeks old is he?
P- 4 weeks
D- Okay, was his pregnancy up to 9 months?
P- Yes
D- After you delivered him, was he able to breastfeed then, or was it later on?
P- It was later on
D- At that time, did he have fever?
P- No, he started having the fever only recently
D- Okay, have you taken him to the hospital since then?
P- They thought it was headache, so we took him to a traditional doctor
D- You took him to a traditional doctor!!! So, why didn't the traditional medicine work?
P- They said he had headache
D- What did they give you when you went to the traditional doctor?
P- They gave us medicine that I rubbed on him after his bath and another for drinking
D- When you used the medicine, was there relief from the headache?
P- The head is better than before
D- And how do you know it is better?
P- Before, the head was separated and down but now it's coming together and better than before.
D- Did he also recover from the fever?
P- No
D- The fever was not going down and you did not take him to a real doctor!!?
P- (Silent)
D- Hmmm...have you been giving him water to drink since you delivered him?
P- Yes, we give him water.
D- You did not do baby friendly or did you?
P- No
D- This baby (pauses) we must admit him. Then, we will give him the necessary medications he should have had. Because what we see here is that this baby is too ill and there is no medication we can give you that will be effective but to admit him.
P- Okay
D- Was it up to 2 weeks after delivery that this illness started?
P- Like 1 week after
D- Okay. We are admitting him
P- Okay
D- Yea

Exchange C

D- Mama yaya sunanki?
P- Ramatu Rabi
D- Daga ina kike?
P- Jambaba
D- Meke damun ki?
P- Da farko dai, ina kwana?
D- Ina kwanan ki?
P- Naga irin taimakon da kai ma dana
D- Toh
P- Nagode, ciwon jiki nake da kuma laulayi.
D- Toh
P- Rawar jiki nake
D- Laulayi fa?
P- Rawar jiki nake, idan nafara tafiya kuma sai nake laulayi kamar zan fadi kasa
D- Ba wani abu kuma.
P- Ba na samun bacci
D- Muna so muji isashshan bayani daga wajen mara lafiya, dan musan mai zamu iya masa. Allah ya kara sauki.
P- Amin.
D- (Duba hawan jinin mara lafiya) Munga jinin ki yadan hau kadan. Kin sanki na da cutar hawan jini ne?
P- A, na sani
D- Matsalar hawan jini ba cutace dake warkewa a qanqanin lokaci ba, ko kuma ke warkewagabaki dayaba. Saidai a rika shan magunguna dan a samu sauki. Ya kamata duk mai irin wannan cutan ya rika zuwa asibiti yaga likita ko wani lokaci domina dubako jinnin ya hau. Duk lokacin daya fara hawa sai a bada magani
P- (shiru)
D- Kin gane ?
P- A
D- Dangane da rashin bacci fa?
P- Ba na samun isashshan bacci shine dalilin dayasa nazo maka da maganin daka ba ma dana. Ajiya yayi mutukar damuna, sai yabani wannan maganin
D- (Mamaki) shine yabaki wannan maganin
P- Tsaya, bari na nuna maka
D- Kuma ba likitan da ya baki adadin dazaki sha, sai kawai kuma afara sha?
P- Shine wanda dan nawa ya kawo
D- Amma ai ba naki bane kuma kika sha?
P- Shine dalilin da ya sani na taho da maganin domin nanuna maka, idan kabana izini sai naci gaba da sha, idan kuma kace na dakata sai na dakata.
D- Toh, yanzu nace a daina sha saboda banaki bane kuma zai iya jawo wata cutar. Adaina shan magungunan da ba likita ya ba wa mutumba.
P- Yayi, na daina. Amma jikina yana ciwo dare da rana.

D- Zamu auna jinin ki yanzu. Bayan haka zamu ga abunda ke damunki kuma.
P- Gaskiya ayyada jikina ke rawa yana mutukar damuna.
D- Karki damu, da ikon Allah zaki samu sauki.
P- Ameen

Translation

D- What is your name Mama?
P- Rahmatu Rabi
D- From which town?
P- Jambaba
D- What is wrong with you?
P- Good morning first
D- Good morning
P- I saw the help you have given my son.
D- Okay.
P- Thank you. My body has been paining me and I feel dizzy.
D- Okay.
P- I shiver
D- What about nausea?
P- My body shivers and when I walk, I feel dizzy like I will fall.
D- Anything else?
P- Lack of sleep.
D- We like to hear from the patients', so we will know the right thing to do. May God heal you!
P- Ameen
D- (*Checks patient's B.P)* What we can see now is that your blood pressure has risen a bit. Do you know you are hypertensive?
P- I know
D- The problem with hypertension is that it is not something that just heals once and for all. No, it does not heal completely. You can only take drugs to manage it. Anyone who is hypertensive needs to come to the hospital regularly so that the B.P can be checked and monitored. So that whenever it rises, then drugs will be given.
P- *(Silent)*
D- Do you understand?
P- Yes.
D- What about sleep?
P- I don't sleep. That is why I brought the drug you gave my son. Yesterday, it really disturbed me, so he gave me this drug.
D- (*Shockingly)* He gave you his drug!!!
P- Wait, let me show you
D- So without a doctor prescribing the drug, you just took it?
P- It is the one that the boy brought
D- But it is not yours and you took it!

P- That is why he told me to come with it so that you will see. If you say I should continue taking it, then I will and if you say I should stop, I will stop.
D- Okay. Now I am saying you should stop taking it because it is not yours and it can cause additional problems. Please, stop taking drugs that are not meant for you.
P- Okay. Wait, my body is always weak both day and night.
D- We will do a blood test now. After then, we will know what is wrong.
P- Truthfully, the way this body shakes is really disturbing me.
D- Don't worry about that. By God's grace, you will be healed.
P- Ameen.

Exchange D

D- *(Calls next patient)* Jafar Lukman (*patient enters)* you are welcome, Okay, Sannu
P- Salamu alaikum *(Peace be upon you)*
D- Wa alaikum salam. Kana turanci? *(And upon you too. You speak English?)*
P- *(Replies in English)* Small small
D- You can sit down. You are Jafar Lukman right?
P- Yes
D- So, what are your problems?
P- I don't feel well
D- Okay
P- Since last week, I usually feel cold in the evenings
D- Okay, you feel cold?
P- Yes, I usually feel very cold and feverish with headaches.
D- Okay, do you vomit?
P- Last night, I threw up about three times but since I haven't eaten since then, there has been no vomiting and...
D- *(Interrupts)* so when do you feel feverish?
P- In the evening
D- Okay, do you get very hot?
P- Yes
D- What about your stomach, does it ache?
P- Yes, it aches
D- Does the stomach feel swollen?
P- No, it doesn't
D- Do you purge?
P- No purging
D- Is urination painful?
P- No
D- Your body, is there weakness?
P- I don't feel well, I feel weak
D- So have you taken anything?
P- Medicine?
D- Yes

P- Yesterday, I did not take any medicine and I...
D- *(Interrupts)* What about the day before?
P- The day before yesterday I took some cold drugs but there was no change
D- Okay. I will just write some drugs for you but you also need to do some tests to be sure.
P- Okay, thank you
D- Thank God

Exchange E

D- Yaya sunar yarinyar ki?
P- Zainab Musa
D- Daga ina ku ke?
P- Kauyen Dano
D- Meke damun yarinyar?
P- Zazzabi take tayi yau kwana uku, jiya kamar taji sauki nayi mata wanka har tana rarrafe wasa kuma zuwa can sai naji jikinta ya dan kara dumi.
D- Hmm
P- Na dan fita shinfidar da ita sai naji ta yanka kara, sai na rugo da gudu, sai na dauko tan a bata nono.
D- Shi kenan abin da ya faru?
P- Eh.
D- Amma wannan hasken da jikinta yayi fari, duk baku lura ba?
P- Wallahi duka – duka yau kwana uku wallahi da abin ya fara.
D- To kwana uku mutum na ciwo (girgiza kai), ai ya kamata ka nuna damuwa, koba haka ba?
D- To yanzu abinda zamu yi dake tun da kinji yanayin jikinta...
P- Eh.
D- Ga kuma wani kumburi a jikinta me kenan...
P- (katse magana) Wannan saifa mana
D- Saifan ba'a zuwa asibiti ne?
P- To oho mudai sai dai muyi na gargajiya ban sani ba ko ana zuwa asibiti.
D- Asibiti ya kamata kikai shi ki tambaya wannan kumburin sai a san wani magani ya kamata a bashi koba haka bane?
P- (Shiru)
D- Koh?
P- A
D- Yanzu abin d azan baki shawara, za ai awon jinni sai a san abinda ya kamata, sai a san abin da za'a cigaba da bata, amma gaskiya yana jin jikinta da ba sai an mata Karin jinni ba, kin gane da kyau?
P- A.
D- To Allah ya bada lafiya.
P- Ameen, Na gode

Translation

D- What is your Daughter's name?

P- Zainab Musa
D- Where are you from?
P- Local Dano
D- What is wrong with her?
P- She has had fever for 3 days now. It subsided yesterday and this morning, after I bathe her, she even played and crawled.
D- Hmm.
P- It was later I noticed that the temperature has risen again. So I lay her down and went outside, then I heard her scream. I rushed back in and picked her up and I noticed that she was only stretching her body.
D- Was that all that happened?
P- Yes
D- May God help us!
P- Ameen
D- Right now, I can see that her body is pale. You did not notice?
P- God is my witness, today is just the 3rd day since all these started.
D- For 3 days now (*shakes his head)* You are really supposed to be disturbed and show concern. So what we will do now since I have seen the nature of the body?
P- Yes
D- There is a swelling on her body, when did it start?
P- *(Interrupts)* That one is "saifa"
D- So you don't come to the hospital because of "saifa"?
P- No, we only treat it traditionally. So I did not know I was supposed to come to the hospital because of that.
D- You are supposed to come to the hospital so that you can be sure of what caused the swelling.
P- *(Silent)*
D- Okay?
P- Okay
D- What we will do now is that we will take her blood for testing, so that we'll know what to give her. From what I can see, I don't think she will need any transfusion. Do you understand?
P- Yes
D- May God heal her
P- Amin. Thank you.

Exchange F

P- Likita ina kwana.
D- ina kwana.
D- Hajiya ya sunan ki ?
P- Bilikisu Musa
D- Shekarun ki nawa?
P- *(shiru)*
D- Baki san shekarun ki ba ?
P- *(da kunya)*Ban sani ba.

D- Ina ga zaki iya kaiwa ashirin da biyar koh?
P- *(shiru)*
D- Allah ya taimake mu
D- Daga ina kike?
P- Unguwan Dana
D- Kauyen Dano?
P- A.
D- Meke damun ki?
P- Ciwon ciki kuma ko me na ci baya min dadi.
D- Kin yi jinin al'ada na wannan watar?
P- *(Da kunya)*A'a.
D- Ban ji me kika ce ba.
P- A'a
D- Koh kina tunanin ciki ne da ke?
P- *(Gunaguni)*
D- Hmmm. Abin da zamuyi yanzu shine za'a auna fitsarin ki domin mu san meke damunki takamaimai. Koh?
P- Toh.
D- Alhamdulilah.

Translation

P- Good morning doctor.
D- Good morning.
D- Madam, what is your name?
P- Bilikisu Musa
D- How old are you?
P- *(Silent)*
D- You don't know your age?
P- *(Meekly)* I don't know.
D- But maybe you will be around 25 right?
P- *(Silent)*
D- May God help us!
D- You are from which town?
P- Unguwan Dana
D- Local Dano?
P- Yes.
D- So, what is wrong with you?
P- Abdominal pains and I don't enjoy whatever I eat.
D- Have you seen your menstrual cycle this month?
P- *(Shyly)* I haven't.
D- I did not hear you.
P- I didn't
D- Or do you think you're pregnant?

P- *(Mumbling)*

D- Hmmm...So what we're going to do now is that you will be allowed to go get your urine sample and then bring it back for testing. After testing we will know exactly what is wrong with you. Okay?

P- Okay.

D- Alhamdulilah.

Exchange G

P- Ina kwana?

D- Ina kwana

P- Ya aiki da iyali?

D- Mun gode Allah.

P- Gaba daya jikina ke min ciwo

D- Duk jikin ki ke maka ciwo?

P- "Wallahi", kwana tara yanzu.

D- Sunan ka Alhaji Isa koh? Kuma tun kwana tara baka jin dadi ?

P- A.

D- Ka je asibiti tun lokacin?

P- A'a kawai na sha wasu magungunan mura ne tunda haka na ke tsammani, amma yau sai na ji jikin yayi tsanani.

D- Kamar ba ka jin dadi sam sam?

P- A. Sai na ji aka ce , Alhaji gara ka je asibiti

D- Allah ya taimaka mana, Alhaji abin yi yanzu shine tun da a ido kana da koshin lafiya

P- *(sai Alhaji ya katse likita)* kuma ina jin sanyi dan haka ma na kasa zuwa da wuri, kuma ga ciwon baya.

D- Bayan ka na ciwo?

P- A Wallahi

D- Ka dau abu mai nauyi ne da bayan ko kuma ciwo ne haka kurum?

P- Ni dai kawai nasan bayana na ciwo.

D- Kana tari ne?

P- A'a

D- Kuma baka gudawa?

P- A'a

D- Banda abin da ka lissafa baka jin jiri?

P- Bawani sosai ba saidai ciwon kai wani sa'in.

D- Toh bari mu gwada jinni ka daga nan za'a san wani mataki za'a dauka

D- Ina ga zai fi mu sa a yi maka gwaje-gwaje do min a iya tantance ainihin meke damun ka.

P- Toh.

D- Allah ya taimaka mana baki daya.

P- Amin. Amin.

Translation

P- Good morning

D- Good morning
P- How is work and family?
D- We thank God.
P- My whole body is paining me
D- Your whole body is paining you?
P- "Wallahi", for about 9 days now.
D- Your name is Alhaji Isa right? So, for 9 days you have not been feeling fine?
P- Yes.
D- Did you go to the hospital since then?
P- No, I just took some drugs for cold because I felt it was just catarrh, so I just took the drug, but it's like today, I feel worse.
D- Like you're completely not feeling fine?
P- Yes, then I heard like Alhaji... you better go to the hospital.
D- May God help us! What we're going to do now Alhaji is, since you are looking healthy...
P- *(Interrupts)* and I do feel cold.In fact, that is the reason why I could not come out early. In fact, the whole of my back is paining me.
D- Your back is paining you?
P- *(Swears)* Yes.
D- Is it like you carry something heavy on your back or just pains?
P- All I know is it is very painful.
D- Do you cough?
P- No
D- And you don't purge?
P- No
D- Apart from that, what about dizziness?
P- Not very much, justthat my head feels heavy sometimes.
D- Okay, so now let us check your B.P, when we see how it is, then we will know what next? *(Checks B.P)*
D- I think it is best we refer you for some tests, so we can be sure what is wrong with you.
P- Okay.
D- May God help us.
P- Amin. Amin.

Exchange H

P- Ina kwana?
D- Ina kwana. Me yake damun ku?
P- Danane.
D- Hajiya ya ya sunan yaron ki?
P- Mohammed Fahad.
D- Fahad. Shekarunsa nawa?
P- Biyu.
D- Toh me yake damunsa?
P- Zazzabin dare kuma Jikinsa da zafi.

D- Amma yana wasan sa da rana?
P- Yanzu dai ya daina.
D- Tun yaushe ya fara?
P- Kwana hudu
D- Kwana hudu kuma kina kallon dan ki a wannan yanayin ?
P- A kuma jiya da shekaran jiya ma kin cin abinci ya yi.
D- Yana Gudawa ne?
P- Da dai yana yi amma kwana biyu yanzu baya ma zuwa bayi.
D- Ya za'ayi wanda bai ci abinci ya je bayi? *(girgiza kai)*Allah ya rufa mana asiri
P- Yana yi amma ya daina.
D- Har yanzu yana shan nono?
P- A'a
D- Tun yaushe kika daina shayarwa?
P- Tun azumi.
D- Tun da azumi?
P- A, an jima da ya daina karba.
D- Alhamdulilah. Toh abun da zamuyi yanzu shine bazamu bashi magani ba tukunna sai mun auna jinin sa Sakamakwan ne zai bamu damar abun yi daga nan kingane?
P- A
D- Toh.

Translation

P- Good morning.
D- Good morning. What is the problem?
P- It's my child.
D- Madam, what is your child's name?
P- Mohammed Fahad.
D- Fahad. How old is he?
P- 2 years old.
D- Okay, what is wrong with him?
P- He has been having fever at night and high body temperature.
D- But does he play during the day?
P- Now, even during the day he doesn't.
D- How long has it been now since he has been like this?
P- 4 days
D- 4 days! And you have been watching your child for 4 days in that condition?
P- Yes, for 4 days, yesterday and the day before, he even refused to eat.
D- Does he purge?
P- Before, he was purging but these past 2 days he does not even go to the toilet.
D- How will someone who did not eat, go to the toilet? *(Shakes his head)* May God help us!
P- He started before but he stopped.
D- Does he still suck?
P- No

D- For how long now?
P- Since during fasting.
D- Since during fasting?
P- Yes, it's been long he stopped.
D- Alhamdulilah. So, now what we are going to do is that we won't give him any medications yet, until they take his blood and test. Whatever the result is, then we'll go forward from there. Do you understand?
P- Yes
D- Okay.

Exchange I

P- Good afternoon
D- Hello, how are you?
P- Fine sir.
(A nurse walks in to talk to the doctor)
D- Sorry o, just a minute.
(Interruption)
D- Sorry please, let me just get this done.
P- Okay sir.
D- *(After some minutes)* Okay, yea, ehen, how are you?
P- Fine sir.
D- What is the problem?
P- I've been having chest pains for some days now.
D- Okay, which side exactly?
P- *(Touching the area)* here
D- But that is not your chest now, it's your stomach. Your stomach kindof starts from your chest.
P- But...
D- *(Interrupts)* Is it not here? *(Points to the area)* Madam,that is your stomach.
(Someone walks in)
D- *(To the patient)* Please just a moment
(The person leaves)
P- Ehen, please, I have another complaint, is it because [unclear] that my stomach is getting big?
D- *(Laughs)* Ehen, it's because you're eating too much. You should go on a proper diet; eat at the right time and don't leave your stomach empty for too long.
P- Okay.
D- Yea

Exchange J

D- *(kiran sunan mara lafiya)* Maryam *(mara lafiya ya shiga)* dasauri, sauri. kina jin turanci ko larabci?
P- Bani da lafiya
D- Yauwa, Me ke da mun ki?

P- Yau kwana biyu kenan inata zubar da jini.
D- cikin ki yayi wata nawa?
P- bani da ciki
D- Toh, Yaushe rabon da ki ga al'adar ki?
P- ina ganin shi kowani wata
D- kin ganshi wata da ya gabata?
P- A, kawai wannan watan ne
D- kina jin ciwon cikin kuwa?
P- A
D- Ki na samun kullutu tare da uhm...
(SN- Menstrual flow)
D- Good, I like that answer. *(zuwa ga mara lafiya)* banda zubar al'adar, kin san mai yake faruwa?
(Magana da daliban asibiti har mintuna biyu ko uku)
D- Za ki je a yi maki sikanin din mara domin a tabbatar da abin da ke damun ki
P- Toh, Nagode.

Translation

D- *(Shouting patient's name)* Maryam *(patient enters)* quickly, quickly. Do you speak English or Arabic?
P- I am ill
D- Okay, what is wrong with you?
P- I've been bleeding for two days now.
D- How many months pregnant are you?
P- I'm not pregnant
D- Okay, when last did you see your period?
P- I see it every month
D- Did you see it last month?
P- Yes, it's just this month
D- Do you feel any stomach pain?
P- Yes
D- Do you get fleshy/meaty discharge apart from the uhm...
(SN- Menstrual flow)
D- Good, I like that answer. *(To the patient)* Apart from the menstrual flow, which other thing takes place?
(Side talks with the student nurses present about the patient's condition for about 2-3minutes)
D- You will need to go for a pelvic scan so we can be sure of what exactly is wrong. Okay?
P- Okay, thank you.

Exchange K

D- *(kiran sunar mara lafiya)* Kafayatu Ibrahim! Ina kwana *(duba littafin asibitir mara lafiya*)
Kina da ciki? Wata nawa?
P- Eh
D- Cikinki wata nawa?

P- Karami ne
D- Ya karami ne? littafi ya nuna kina da ciki, ko dai har kin haife wancan ne?
P- A
D- Toh wata nawa?
P- Wata uku
D- Me yake damunki?
P- Zazzabi da yawa ciwon kai.
D- Sai mene? kina jin sanyi ne?
P- A'a
D- Ciwon ciki?
P- A
D- Kina fitsari da zafi? Akwai gudawa da amai?
P- A
D- Amma yawu fa?
P- A
D- Kin fara awo? Amma wa ya ce ki na da ciki?Kin yi awo ne ko dai domin ba kiga al'adar ki bane?
P- A
D- Ya kamata ki gane wai ba lailai bane mace kai da ciki daga bata ga al'adar ta ba. Akwai sauran abubuwa da ke hana jinin al'ada zuwa.
P- *(Shiru)*
D- To baki san asalin abubuwan da suke sa mutum zai sa baya ganin al'adar sa bas, to ya kamata gane idan mutum bai ga al'adar sa ba wai ya nuna tana da ciki bane, kin gane akwai abubuwa da yawa daya nuna mace ba zata ga al'adar taba, yan zu sai mu bari mu gani.
P- *(Shiru)*
D- Kina ji na? Za mu gwada ma ciki mu gani saboda abin da muke tsoro Kenan
P- Toh

Translation

D- *(Calls patient)* Kafayatu Ibrahim! Good day. *(Goes through patient's file)* Are you pregnant? How many months?
P- Yes
D- How many months?
P- It's small
D- Small how? But it shows here that you are pregnant. Oh! You have delivered that one already?
P- Yes.
D- Okay. How many months?
P- 3 months.
D- So, what is wrong with you?
P- Fever and headache
D- Anything else? Do you feel cold?
P- No

D- Stomach aches?
P- Yes
D- Is it painful for you to urinate? Do you vomit? Purge?
P- I vomit
D- Have you started ante-natal? Who even told you that you are pregnant? Did you get tested or you just did not see your period?
P- No, I didn't
D- Don't you know that there are other things that stop people from getting periods apart from pregnancy?
P- *(Silent)*
D- You should understand that when someone does not get her period, it does not mean she is pregnant. There are other things that stop women from getting their period.
P- *(Silent)*
D- Are you listening? Anyways, we will test you for pregnancy to be sure because what we are afraid of is...
P- Okay

Exchange L

D- Sanu da zuwa Anty
P- Ina wuni likita
D- Ga wuri zauna. Me yake damunki?
P- Tari ke damuna
D- Tun yaushe ya fara damunki?
P- Kwana biyu da suka wuce
D- Kina fitar da wani abu ne in kina tari?
P- A
D- Dan yi min bayanin yanayin abun da kike fitarwa yana da kauri ne koh ruwa-ruwa ne?
P- ruwa-ruwa ne
D- Kirjinki na ciwo ne idan kika yi tarin?
P- A
D- Kina gumin dare?
P- Wani sa'in ina yi
D- Anty, kina da zazzabi ne?
P- A'a
D- Yaushe raban da ke je a yi miki awan CBC?
P- Watan jiya
D- Anty, karki damu zamu baki magani amma za'a auna ki dan a tabbatar da cewa ba tuberculosis bane amma in har shine sai a fara daukan tsatsauran mataki akan sa.
P- Toh nagode
D- Mu godewa Allah

Translation

(*Patient is announced)*

D- Welcome, Aunty
P- Good afternoon doctor
D- Please have a seat. What is the problem?
P- I've been coughing
D- When did it start?
P- Two days ago
D- Is it productive?
P- (Silent)
D- Do you bring out something when you cough?
P- Yes
D- What's the nature? Is it watery or thick?
P- Watery
D- Okay, do you experience chest pains?
P- Yes
D- What of night sweat?
P- Sometimes
D- Aunty, do you have fever?
P- No
D- When was the last time you did CBC count?
P- Last month
D- Aunty, don't worry, we will give you medication but we will also give you one test to do so we can rule out tuberculosis because if it happens to be tuberculosis we will have to treat it aggressively. Okay?
P- Okay, thank you
D- Thank God

Exchange M

D- Yaya sunanki
P- Nafisa
D- Nafisa waye?
P- Nafisa Nura
D- Me ke damunki?
P- Zazzabin dare.
D- Zazzabin dare?
P- Da yawan ciwon kai, cikina na zafi wani lokacin yana ciwo
D- Kina da ciki ne?
P- Ban sani ba.
D- Baki sani ba, kina jin gudawa ne?
P- A'a
D- Cikinki na kumbura ne?
P- A'a sai dai ciwo
D- Sai dai ciwo ko? To kinje asibiti
P- A'a

D- Baki je asitibi ba?
P- A
D- Bakya jin ciwon kai, jiri fa?
P- Ina ji
D- Jiri fa?
P- Ina jin jiri
D- Akwai wani damuwa banda wannan?
P- Jikina yana zafi
D- Kina samun bacci?
P- Gaskiya bana bacci
D- Kwana nawa wannan ya fara?
P- Yau kwana hudu ne.
D- Zamu gwada gudun jininkimugani, sai mu baki magani ma ciwon jikin.
P- toh
D- Allah ya bada sauki.
P- amin, nagode

Translation

D- What is your name?
P- Nafisa
D- Nafisa who?
P- Nafisa Nura
D- What is wrong with you?
P- I have been having night fever, headache, stomach pain...
D- (*Interrupts)* You have stomach pain, are you pregnant?
P- I don't know
D- You don't know! So, do you purge?
P- No
D- Cough?
P- No
D- Does your stomach swell up?
P- No, it only pains me
D- So, did you visit the hospital?
P- Not until today
D- What about headache?
P- Yes, there is headache
D- Dizziness?
P- Yes
D- So, apart from all these, do you have any other complaints?
P- My body gets hot
D- Okay. Do you sleep?
P- I don't sleep
D- For how many days since all these started?

P- Like 4 days
D- We will check your B.P and then prescribe something for the body pain.
P- Okay
D- May God heal you.
P- Ameen. Thank you.

Exchange N

P- Good morning Doctor
D- Morning madam. Have a seat. What is the problem?
P- I have not been seeing my period
D- For how long now?
P- The first time I came to the hospital, you told me that you won't be around. That was when I did the test. So I met someone here and she asked of my card and I said there is no card. So she said there was no way they can know.
D- Okay. How have you been feeling exactly?
P- I feel heat from the inside
D- Does the heat come with sweat?
P- Like now that I am sitting normal, later I will feel heat around my entire body. Do you understand? So, if the body is hot, it comes with the sweating. When I start sweating, then my body returns to normal. When I start feeling that way, usually I don't know what is wrong but after I calm down, then I feel normal.
D- But do you feel dizzy?
P- No, and apart from that I don't feel any pain. And sometimes I itch.
D- Do you see white fluid?
P- Yes, I do see. Although I don't really know what it is but I just used to see stains on my underwear. I was once using a drug and I enjoyed it. Two in the morning, two in the afternoon, and two at night.
D- Okay. Since 2012, did you go for any check-ups?
P- No
D- No delivery?
P- Yes
D- But did you take injection for...
P- *(interrupts)* Family planning?
D- Yes
P- Yes, I did before.
D- Do you feel stomach cramps?
P- Sometimes I do but not all the time.
D- How old are you?
P- I was born 1975
D- 75?
(A nurse walks in and consults with the doctor)
D- Okay, that is 40.
P- Yes

D- Okay. There is nothing to worry about. From all indications, it is very likely you have been experiencing signs of menopause. But just to be sure, we will run some tests to confirm and move on from there. Okay?
P- Okay. Thank you

Exchange O

D- Ya Sunanka?
P- Mahmudu
D- Daga wane gari?
P- Kaza
D- Me ya faru da kai baba?
P- Nima ban gane jiki na ba
D- Baba idan baka fada mini ba bazan gane ba
P- Ina jin ciwonkafada da kafafuwa
D- Kafadu, kafafuwa suna ciwo, kasha wani magani?
P- A nasha na gargajiya,
D- Daka sha kaji saukin jikinka?
P- na dan ji saukai amma ciwon jikin bai tafi fa
D- Bari mu gwada jininka muga ya yake
D- *(auna jini)*To gaskiya jinin ya hau da yawa baba, zamu baka magunguna da zai dan saukar da shi da yaddar Allah za ka yi sauki. Sai ka rika zuwa kana yin awo a gani a san menene za'a cigaba don ka samu sauki da wannna yaje yawo din babu dadi, in kanada sarari kaje ko baba?
P- Ina jinka
D- To Allah ya bamu sa'a
P- Amin, nagode

Translation

D- What is your name?
P- Mahmudu
D- From which town?
P- Kaza
D- What is wrong with you Baba?
P- I don't understand my body system
D- *(laughs)* Unless you explain to me, I would not know too. Tell me this place is this, this place is that, then I will understand.
P- My shoulders pain me and my legs too
D- What else?
P- That is all
D- So, your shoulders and legs are paining you?
P- Yes.
D- Did you take any drug?
P- Yes
D- Which type?

P- Traditional drugs
D- Was there any improvement?
P- Yes, there was but the pain is still there
D- Let us check your blood pressure first, then we will move forward from there
P- Okay
D- *(Checks B.P)* To be frank, the blood pressure is very high Baba. We will write some drugs for you that you will be taking to regulate it and by God's grace, you will be okay. But you need to be coming for regular check-ups so we can monitor the blood pressure. Do you understand?
P- Yes
D- *(Hands over prescription)* May God heal you
P- Ameen. Thank you

Exchange P

D- Ya sunan ki?
P- Karimatu Bala
D- Meke damun ki?
P- Gudawa nake sosai
D- Kamar so nawa a rana?
P- Duk sanda na ci abinci ko na sha ruwa
D- ciwon kai fa?
P- A da ciwon jiki
D- Zazzabi?
P- A'a
D- Kin yi jinin al'ada na wannan watar?
P- A'a
D- Tun yaushe kika daina gani?
P- Wata biyu yanzu
D- Allah ya bada sauki.
P- Ameen
D- Tun da ya fara kin je asibiti?
P- A. Har ma an auna jini na.
D- Me suka ce bayan an auna jinin naki?
P- Sun ce cutar shawara
D- Sun baki….
P- *(Katse Magana*) Sun bani magani, sannan suka bani wannan kuma toh dan haka ne yasa nazo saboda hankalina bai kwanta ba.
D- Sai mun auna jinin ki da fitsarin ki sannan zamu iya rubuta miki maganin da zaki sha Allah ya bada sauki
P- Ameen.

Translation

D- What is your name?

P- Karimatu Bala
D- What is wrong with you?
P- I have been purging excessively
D- Like how many times in a day?
P- Anytime I eat or drink water
D- Do you have headache?
P- Yes and body pains
D- Fever?
P- No
D- Have you seen your period this month?
P- No
D- For how many months now?
P- 2 months now
D- May God heal you.
P- Ameen
D- Did you go to the hospital since it started?
P- Yes. They even did a blood test.
D- What did they say after the blood test?
P- They said it was typhoid
D- Did they give...
P- *(Interrupts)* they gave me drugs. Then this...as long as I will be healthy, then I won't have to eat anything. That is what is disturbing me.
D- You have to do urine and blood test. After then we will know what to prescribe for you. May God heal you!
P- Ameen.

Exchange Q

P- Good morning doctor
D- Good morning. You can have a seat. (*Patient seats)*What is the problem?
P- These past few days, I have been having headaches and I...
D- *(Interrupts)* Okay. Did you use paracetamol?
P- Yes but the headache always comes back
D- Okay. Is that all or do you have other complaints?
P- I have not been eating well because I have no appetite.
D- Okay.
(writes on a prescription slip and hands it over to the patient)
Get these drugs from the pharmacy
P- Okay. Thank you

Exchange R

D- Yaya sunansa

P- Abdulmajid
D- yaushe ya fara duk wanna?
P- bai dade ba
D- watansa sa nawa?
P- Watansa goma
D- Yana shan nono?
P- Yana sha.
D- Gudawa fa?
P- Yayi sau daya
D- Kuna kaishi rigakafi?
P- Muna kaishi wurin Ibrahim
D- Ba wai ana kaishi wajan Ibrahim ba, amma kina kaishi wajan da ake yin rigakafi wata – wata, yana tari?
P- Baya yin tari
D- Baki kaishi rigakafi ba ana yi mai na gida – gida, amma kina kaishi na sati – sati na kyanda, tarin shika, haka irin na ciwon hanta lomoniya da sauransu, wannan abin yana da muhimmanci yana da kyau ace ana kai yaro rigakafi kafin ciwon ya kwantar dashi da wahala azo gidan ma rigakafi ku bari ai musu? kuwa bakwa musus saurans rigakafin cigaba ne ko ci baya ne?
P- A'a
D- Yau wato dan Allah ya kamata in an samu lokaci ai rigakafi a duba muka shi a gani nauyin ya ragu kowane ya karuwa ba kullum sai dai kara kasa – kasa yake, wato kamata yayi ace ya fara rarrafeko ya fara tafiya, yana rarrafe?
P- A'A
D- Allah ya bada sa'a
D- Yanzu abinda za'a yi zan rubuta muku magunguna zai far anfani dasu. da fatan Allah ya bashi sauki
P- toh

Translation

D- What is his name?
P- Abdulmajid
D- When did he start all this?
P- Not long ago
D- How old is he?
P- 10 months old
D- Does he suck?
P- Yes, he sucks.
D- Does he purge?
P- Yes, he does.
D- Do you take him for immunisation?
P- They use to give him that of Ibrahim's
D- Apart from that, do you take him for immunization weekly?

P- Sometimes I take him. Although since I gave birth to him he has not been fine.
D- That is, he does not suckle or what?
P- He sucks
D- What about cough?
P- Yes
D- The problem is that you people do not take your children for immunization except for those ones they come around to give them. You don't take him to the hospital monthly for immunizations like pneumonia and so on. It is very important. Do you understand? They are supposed to immunize him, check his weight, and so on. It is important.
P- *(Mumbling quietly)*
D- At 10 months old, he should have started crawling or even walking. Does he crawl?
P- No
D- May God help us! I will just write some medications for him and with the help of God, it will heal him. Do you understand?
P- Yes.

Exchange S

P- Doctor, good afternoon.
D- You're welcome
P- Our Dad said that you people should bear with him. It's just that he doesn't have yet, that is why he has not brought it.
D- Okay, what's the problem?
P- Okay, it's my stomach. Whenever I sit down for like more than 3-4 hours, for me to stand up straight is a problem.
D- Okay
P- And my stomach here (*pointing*) used to pain me.
D- Okay
P- That's all
D- Okay
P- But the line, it is only scratch it used to scratch me.
D- Okay. Where the surgery is?
P- Yes
D- Is there any pores or water coming out of that place?
P- No. That's from the outside ba?
D- Yes. From the outside.
P- No
D- And the pain, does it feel as if it's hooking or sharp? Can you differentiate, sharp and hooking?
P- No. the pain is sharp.
D- Sharp. Okay. And it comes up whenever you sit for long, but whenever you get up for sometime, does it go or it doesn't?
P- It goes
D- So when did this pain start? Is it since you had the surgery?

P- No. it has just been for like a week now or two. Whenever I sit for long and want to stand straight, I can't.
D- Was there any specific activity you got involved in before the pain started?
P- (Mumbling) No sir
D- What do you do?
P- Like carrying of water but not heavy bucket, just that custard rubber...
D- (Interrupts) How often do you fetch the water?
P- Once in a while, not frequently.
D- But the day it started, was it much?
P- No.
D- Not much, okay. So how is your stool?
P- Okay
D- Is there any discharge?
P- No.
D- Okay. No discharge? (S*cribbles some things down*) Is there any swelling around the place? Do you normally touch it and feel any hardness?
P- Hmmm...but not that hard.
D- Which side specifically, right or left?
P- Hmmmm
D- *(Demonstrates)* This is left and this is right. Which side?
P- Both sides
D- Okay...
P- *(Interrupts)* And sometimes when I lie down, I feel as if something used to walk in my stomach.
D- *(Laughing)* With legs or hands? You should say something is moving, something cannot walk in your stomach. You know, your intestines are always moving which makes you a living thing. If they don't move, then you're dead. It's only when the movement affects your health negatively that there's a problem.
P- Okay
(*The doctor summons a female matron to examine the patient*)
D- Okay. So, it seems you are not experiencing any abnormal pain. It's not unusual for cramping to take place when you're healing from a surgery.
P- Okay.
D- So what will happen now is, I'll give some drugs that will help relieve the pain. But it's nothing to bother yourself about. Okay?
P- Okay.
D- I think that is all, so you'll take these drugs. (*hands patient a prescription and dismisses patient)*

Exchange T

D- Ya sunan yaron
P- Yusuf Mohammed
D- Me yake damunsa?

P- Da yasha nono sai ya amayar dashi.
D- Watansa nawa?
P- Watansa bakwai.
D- Kwana nawa kenan da farawarsa?
P- Kwana biyu
D- Kwana biyu ,aman kawai yakeyi?
P- yana amai bayan shayarwa sai kuma yana gudawa sau daya
D- A takaice amai guda nawa yake yi?,Gudawar yanayi kamar sau nawa?
P- In yayi sau daya shi kenan.
D- Daga nan baya karawa?
P- Aman ne dai daga yasha nono sai ya kara yi.
D- To kalar gudawar fari sol, ko kuwa normal bayan gari.
P- Fari ne
D- Kuma kin ce watan sa bakwai?
P- A
D- Hmmm, to Alhamdulillahi. yaya zafin jikinsa?
P- Yau ya fara yin zafi
D- Yau ya fara jin zafi me kuka bashi?
P- Na bashi O.R.S
D- O.R.S rowan gishiri da suga kenan ko?
P- A
D- Sayowa kikayi ko hadawa kikayi?
P- Sayowa nayi.
D- Sayowa kika yi?
P- A
D- Kin diga masa wani abu da ake ce masa Zinc Tablet
P- Na bashi guda daya, amma kuma dana bashi amai yayi
D- Bai sha ba?
P- Shima rowan gishirin tunda ya karba sau daya bai sake karba ba
D- To Allah ya basahi lafiya. Sugan yafi ma'ana tun gudawar da aman shike kawo ragowar rowan. Zamu bas hi magani da zai kara mashi ruwan jikinsa.
P- toh, nagode
D- Allah ya taimake mu
P- Amin

Translation

D- What is your Boy's name?
P- Yusuf Mohammed
D- What is wrong with him?
P- Whenever he breastfeeds, he throws up after
D- How old is he?
P- 7 months
D- For how long now?

P- 2 days
D- Is vomiting the only problem?
P- He only vomits after breastfeeding and then he purges but only once, not much.
D- What colour is the purge? White or is it normal?
P- Yes, white.
D- Okay. And you said he is 7 months old?
P- Yes
D- Alhamdulilah (*Thank God)* What about body temperature?
P- It started rising today
D- Have you given him anything?
P- I gave him O.R.S
D- Salt and sugar solution right?
P- Yes
D- Did you make it yourself or you bought it?
P- I bought it
D- Did you try Zinc tablet? Do you know it?
P- Yes. I gave him one but he vomited it. He didn't swallow it.
D- Okay. He didn't take it.
P- Yes. Even the O.R.S, he only took it twice and then refused to take it again.
D- Okay. May God help him! I'll write some drugs for you to buy and by God's grace, he will be fine. Also, make sure he takes the O.R.S; it is very effective, especially to replenish the body fluid he is losing due to the purging and vomiting.
P- Okay. Thank you.
D- May God help us.
P- Ameen.

APPENDIX B

INTERVIEW QUESTIONS

1. How would you describe the doctor's tone or behaviour?
   (a) Official (b) Friendly
2. Was the doctor paying attention when you were describing your condition?
   (a) Yes (b) No
3. Were you comfortable asking the doctor questions?
   (a) Yes (b) No
4. Did the doctor give you enough room to express yourself?
   (a) Yes (b) No
5. Did the doctor seem to have brushed off any of your questions?
   (a)Yes (b) No
6. Did the doctor provide you with enough information/explanation about your condition? (a) Yes (b) No
7. Did the doctor make use of words you did not understand?
   (a) Yes (b) No
8. If yes, did he clarify its meaning?
   (a) Yes (b) No
9. Do you feel like the doctor rushed your consultation?
   (a) Yes (b) No

APPENDIX C

Department of English and Literary Studies,
Faculty of Arts,
Ahmadu Bello University,
Zaria.
3rd March, 2015.

To whom it may concern,

REQUEST FOR ASSISTANCE WITH THE COLLECTION OF DATA FOR RESEARCH STUDY

I hereby write to seek your assistance with my research work titled: **A critical discourse analysis of doctor-patient conversations in Giwa, Bomo, Bassawa and Hunkuyi Areas of Kaduna State.** I am a Masters student in the department of English and Literary Studies, Ahmadu Bello University, Zaria and my research requires me to acquire recorded conversations between doctors and patients during consultations.

The interest in the consultations is strictly with the way language is employed in that particular context of usage. The recorded conversations shall be treated with utmost confidentiality and used for research purposes only.

Thank you for your anticipated cooperation.

Yours Faithfully,

Araoye Rashidat Temitope