Discourse Devices and Pragmatic Functions in Doctor-Patient Verbal Interactions at University of Ilorin Teaching Hospital, Ilorin, Nigeria

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Abstract: *Discourse devices are the linguistic tools employed to address inherent problems in conversation for health purposes. Doctor-patient verbal interactions face major problems in clinical discourse due to differences in linguistic, sociolinguistic, cultural backgrounds as well as professional and communicative styles of doctors and patients. Therefore, this study explored language use in doctor-patient interactions with the aim of revealing the specific discourse devices employed to enhance diagnostic communication at the University of Ilorin Teaching Hospital (UITH), Ilorin. The theoretical framework adopted for this study is conversation analysis while the conceptual framework is discourse devices. Fifty tape recordings of doctor-patient verbal interactions were made at UITH, Ilorin, from which twenty-five interactions were purposively selected for their strategic content. Thereafter, the data were orthographically transcribed and analysed qualitatively and grammatically, using discourse analysis. The identified discourse devices perform a number of pragmatic functions. Eleven discourse devices were dominant in the data. Doctors employed phatic communion for opening consultations; direct and indirect questions for diagnosis; language switch for explicitness, informativity and mutuality; rapport expressions for cordiality, solidarity and open communication; and religious belief for encouragement and solidarity. Counselling was employed to guide the patients on how best to handle their health. The patients employed answer for response to queries; closing of conversations for terminating consultations; repetition for emphasis; and circumlocution for communicating medical information. Interrogatives were employed for eliciting information. Declaratives were employed for providing information. Language switch, realised by alternate use of English and Yoruba, was employed for clarity. Rapport expressions, realised by social questions, were deployed for ensuring cordiality. 'Sorry' is a culture-bound expression used for empathy and sympathy. Imperatives were employed for giving directives. Some of the observable problems exhibited the possibility of doctors upsetting patients who engaged in injurious health practices. Discourse devices were deployed for addressing specific communication and health challenges during diagnosis at the University of Ilorin Teaching Hospital, Ilorin. Knowledge of the discourse devices and their pragmatic functions, therefore, is important for a better understanding of diagnostic discourse in the Nigerian context.*

Keywords: *Discourse Devices, Pragmatic Functions, Doctor-Patient Interactions, Diagnostic Discourse, University of Ilorin Teaching Hospital*

1. INTRODUCTION

Discourse is an integral part of diagnostic activities in medical settings as it is one of the fastest ways by which practitioners get to know the ailments patients suffer from. It is also medium by which practitioners talk about treatment management plans. Stubbs (1983:1) defines it as the organization of language above the sentence or above the clause, often constituting a coherent unit such as a sermon, joke, or narrative. Given the importance of human well- being, both the doctors and the patients must be able to understand each other so that the doctors should be able to diagnose the patients appropriately, thereby achieving the objectives of medicine.

Appropriate use of language plays an important role in engendering a positive relationship between doctors and patients, thus setting in motion the therapeutic process that is the ultimate goal of medical practice (Odebunmi, 2010). Its skillful use enables doctors to obtain all sorts verbal information necessary for making good diagnoses.

2. THEORETICAL FRAMEWORK

The theoretical framework adopted for this study is conversation analysis as enunciated by Harold Garfinkel (1967, 1974), but then applied to conversation most notably by Harvey Sacks, Emmanuel Schegloff and Gail Jefferson (1974). The conceptual framework is discourse devices.

3. DISCOURSE AND DISCOURSE DEVICES

Foucault (1969) defines discourse as ''Systems of thoughts composed of ideas, attitudes, and courses of action, beliefs and practices that systematically construct the subjects and the worlds of which they speak.'' It has its roots in the Latin language. The meaning of the term differs slightly in different contexts. However, in Literature, it means writing or speech that is normally longer than sentences which deal with a certain subject formally in the form of writing or speech. Put differently, discourse is the presentation of language in its entirety while performing an intellectual inquiry in a particular area or field i.e. theological discourse or cultural discourse. On the other hand, discourse devices are the linguistic tools deployed during clinical interviews by both doctors and patients, albeit intuitively, to execute the talk. They are the linguistic tools employed to address inherent problems in conversations for health purposes.

3.1. Types of Discourse Devices

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

3.2. Language Switch (Code-Mixing and Code-Switching)

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

3.3. Rapport Expressions

The word 'rapport' originated from the French verb "rapporter" which means literally to carry something back and in the sense of how people relate to each other. It means that what one person sends out, the other sends back. For example, they may realize they share similar beliefs, knowledge or behaviour around politics, music or sports etc. It occurs when two people are in sync or on the same wavelength because they feel similar or relate well to each other. Rapport is theorized to include three behavioural components: mutual attention, mutual positivity and coordination (Graham, 2010).

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

3.4. Phatic Communion and the Social Importance of Phatic Utterances

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

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

Phatic communion is taken to designate some sort of minimalist communicative practice, though along several possible dimensions.

The 'mereness' of phatic communion […] by virtue of its low interest value, low informative value, low relevance, perhaps also its low worthiness, presupposes an alternative mode of 'true' or 'authentic' discourse from which phatic talk deviates. (1992: 210)

Malinowski (1923) draws a distinction between language used as an instrument of reflection and language used as a mode of social action. This distinction reinforces Malinowski's idea that "[…] talk was either giving information ('communication'), or doing something social ('phatic communion') (Tracy and Naughton, 2000: 71).This underlying idea is observable in the works of some authors that have differentiated between two main functions of language: representative and expressive (Buhler 1934), referential and emotive (Jackobson 1960), ideational and interpersonal (Halliday 1973), descriptive and social-expressive (Lyons 1977), or transactional and interactional (Brown and Yule 1983).

3.5. Counseling

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

3.6. Direct and Indirect Questions

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

3.7. Answer

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

3.8. Religious Belief

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

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

3.9. Circumlocution

Circumlocution refers to when a particular thing is described in many words where a few words could suffice. It is also known as the act of "talking around" and occurs when people do not know the correct term to describe what they seek. It is also a rhetorical device that can be defined as an

ambiguous or paradoxical way of expressing things, ideas or views. In fact, when somebody wants to stay ambiguous about anything and he does not want to say it directly, it means he is using circumlocution. This is a usual practice among learners of a new language or people entering an unfamiliar domain. In this study, we study circumlocution in the medical domain where accurate understanding in it is of prime importance since wrong information can have a large effect on people's actions.

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

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

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

3.10. Repetition

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

3.11. Closing

Clinical interviews cannot go on indefinitely. So, there is always the need to bring them to a close, and this has to be done in a way that permits or encourages another visit if there is the need for such. Principally, closing is deployed to terminate discourses. The deployment of all the discourse devices above will be examined to reveal the specific pragmatic purposes served and the extent of their effectiveness as well as their linguistic realisations.

4. METHODOLOGY

Fifty tape recordings of doctor-patient verbal interactions were made at the University of Ilorin Teaching Hospital (UITH), Ilorin, Nigeria. Twenty-five of them were purposively sampled based on their strategic content. The texts were orthographically transcribed. The data were analysed qualitatively. The various discourse devices employed in the interactions were identified, and the pragmatic functions of each were also stated. The study was conducted in a multilingual setting. So, English Language, Yoruba and Pidgin English were used in the interactions. Contributions in English were retained both those in Yoruba Language and Pidgin English were translated into English to ensure comprehension. Thereafter, the data were subjected to discourse analysis. The subject for this study was restricted to doctors and patients alone, and an ethical approval was obtained to collect the data used for the study. The theoretical framework adopted for this study is conversational analysis as enunciated by Harold Garfinkel (1967,1974), and later applied by Sacks et al (1974) while the conceptual framework is discourse devices.

5. DATA ANALYSIS AND DISCUSSION

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

5.1. Phatic Communion: To Open Up Discourses and Show Empathy

Given the sensitive nature of clinical interviews, a bad opening potentially hinders the success of any clinical interviews. To address this problem, phatic communion was employed by the doctors in this study at the beginning of most diagnostic sessions. It was generally realized by greetings,

demonstration of empathy, enquiries by doctors about patients' well-being and social life during consultations. In this study, the doctors employed phatic communion to open the interviews. The following extracts were considered:

Extract 1 (Interaction 7)

Doc.:   What do you do?

Pt.:   I am a student.

Doc.:   What name do your friends call you?

Pt.:   PF

Extract 2 (Interaction 18)

Doc.:   Gloria David

Pt.:   Good morning, Madam.

Extract 3 (Interaction 25)

Doc.:   Sorry, Ma.

Pt.:   Thank you.

Doc.:   What's your name?

Pt.:   Adeola Gabriel.

Doc.:   What complaints do you have?

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

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

5.2. Circumlocution: Description of Symptoms of Ailments

Research has revealed that most patients are faced with the problem of not knowing the particular names of their ailments. As a result, they resort to circumlocution, which is the description of the symptoms of the ailments suffered by the patients. It was employed mainly by the patients in the interactions. In this study, most patients tended to be circumlocutional in their talk with the doctors as they employed indirect ways of explaining their ailments. Instead of mentioning the real names of their ailments, they described the symptoms. Most of the time, this resulted from their lack of the knowledge of the appropriate medical terminologies for their medical conditions. The data were replete with examples of this phenomenon. So, the following extracts were considered:

Extract 4   (Interaction 2)

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

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

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

Patient: Rara. [No].

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

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

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

Extract 5   (Interaction 7)

Doc.:   So, why are you here today?

Pt.:   My teeth.

Doc.:   What's wrong with your teeth?

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

Extract 6 (Interaction 10)

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

Pt.:   Shola Ola.

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

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

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

Pt.:   Rara. [No.]

The extracts above revealed that the patients mostly mentioned the symptoms of their ailments as if they were the real sicknesses they suffered from. This becomes obvious through experience as human beings that sicknesses have many manifestations. Therefore, it is not uncommon for patients that suffer from typhoid to complain about severe headache, diarrhea or body temperature, and the patients, being non-medical experts, may not know the particular ailments being suffered from. They would only know the symptoms. Therefore, all the patients' emboldened contributions in the above extracts are symptoms of certain ailments whose real names the patients did not know. However, the mention of these symptoms enabled the doctors to actually know the health challenges the patients faced. Looking specifically at Extract 4: 'Ori n fo mi.' [I have a headache.]; 'Gbogbo ara n wo mi.' [I experience general body weakness.], the patient's emboldened contributions were manifestations of high blood pressure, and not the real sicknesses, as confirmed in the doctor's accompanying question in the same extract: 'Se ifunpa nyin ko ga?' [Don't you have high blood pressure?]. Thus, as always, when the real ailments are confronted medically, the ailments disappear. All the symptoms: headache, high body temperatures, cramps in the feet, chest pain, burning sensation in the stomach and general body weakness mentioned by the patients in the extracts above as diseases were merely symptoms of certain diseases, and not diseases themselves, but the doctors understood this.

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

5.3. Rapport Expressions: Cordiality, Sociability and Acceptance

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

Extract 7   (Interaction 3)

Doc.:   In what class are you?

Pt.:   JSS 111.

Doc.:   Which school?

Pt.   Deeper Life Secondary School, Moniya.

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

Pt.   Second.

Doc.:   How many children?

Pt.:   Three.

Doc.:   Do you take sweet?

Pt.:   That was before.

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

Pt.:   I take it occasionally.

Extract 8 (Interaction 14)

Doc.:   Ok. How old are you?

Pt.:   I am fifty-two.

Doc.:   You are Yoruba?

Pt.:   Yes.

Doc.:   What do you do?

Pt.:   Teaching.

Doc.:   A teacher. Primary or secondary?

Pt.:   Primary.

Doc.:   You are married?

Pt.:   Yes.

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

Pt.:   Yes.

A perusal of the extracts above revealed that the doctors ensured geniality with their patients through rapport expressions. Their deployment enabled the doctors to be friendly. In addition, they employed elicitation of information on both family history (FH) and social history (SH) to engender conviviality and open communication. In Extract 7, the doctor used a probe into the patient's family history (FH) to create some level of familiarity with the patient to enable the patient open up on all his health challenges. Extract 8 featured a probe into the patient's social history (SH) to promote open communication as well. The rapport expressions performed the pragmatic function of engendering open communication between the doctors and the patients, and at the same time familiarizing the doctors with the patients. Their deployment enabled the doctors to be on the same wavelength with the patients in order to create a friendly atmosphere that could encourage the patients to release all the information needed to accurately diagnose the patients' ailments.

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

5.4. Language Switch: Informativity, Explicitness and Mutuality

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

The following extracts were considered:

Extract 9 (Interaction 1)

Doc.: Good morning, madam.

Pt.: Good morning.

Doc.: What are your complaints?

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

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

Pt.: On the right side.

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

Extract 10 (Interaction 13)

Doc.: Sit down here.

Pt.: Ok.

Doc.: How are you today?

Pt.: Thank God. I am coping.

Doc.: See ti lo gba a won result yen? [Have you collected the medical test result?]

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

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

Pt.: Ok. I drink a lot.

Doc.: You have to stop it.

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

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

Extract 11 (Interaction 20)

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

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

Doc.: Result test wo leyii?

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

Extract 12   (Interaction 18)

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

Pt.: The thing is curable?

Doc.: Yes. It is curable.

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

In Extract 11, the doctor and the patient mixed codes at word level. They alternated the English words (Monday, complain, doctor, X-ray, result, test, step, X-ray centre) and Yoruba phrases to explain and know the medical condition of the patient and the medical tests he had done to enable the doctor get a diagnosis. The doctor engaged in code-mixing here obviously to enable the patient understand him very well, especially as some of the English words do not have Yoruba equivalents, having sensed that the patient did not understand English that much.

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

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

5.5. Counselling: Guidance, Enlightenment and Encouragement

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

Extract 14   (Interaction 5)

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

Pt.:   Thank you.

Extract 15   (Interaction 8)

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

Pt.:   Thank you.

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

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

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

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

The extracts above revealed the deployment of counselling for the purpose of guidance and enlightenment. In Extract 14, the doctor advised the patient to use a soft toothbrush as the most appropriate type for his teeth, and also highlighted the damaging effect of using a hard toothbrush. At 15, the doctor taught the patient the best way to manage his hypertensive condition in order to avoid the complications (stroke and diabetes) that could result from poorly managed hypertension. She further taught the patient about how he could safely embark on a long journey and yet be adequately equipped medically for the trip.

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

5.6. Religious Belief: Guidance, Encouragement and Enlightenment

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

Extract 16   (Interaction 14)

Doc.:   Do you feel abdomin- stomach pain?

Pt.:   Yes. During Ramadan fast.

Doc.:   Is it a mild stomach ache?

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

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

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

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

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

Extract 17 (Interaction 19)

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

Pt.:   Ah. No.

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

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

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

Pt.:   Okay. I will take it.

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

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

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

Religion as a very important tool in doctor-patient verbal interaction assists doctors in educating patients. In Extract 16, the patient suffered acute stomach ache during Ramadan Fast but, despite this, she observed it as a matter of religious obligation. She disclosed to the doctor that she was a muslim and the doctor, being a fellow muslim, too, was able to educate her that Islam exempts the sick from fasting, with the option of providing food for those fasting. This therefore enabled the doctor to correct the erroneous belief the patient held, using Quranic teachings. It also made the patient to accept the fact that she needed to stay away from fasting since her health could not cope with it.

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

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

5.7. Question and Answer: Elicitation and Supply of Information for Diagnosis

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

5.7.1. Direct Questions with Answers

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

Extract 21 (18 (Interaction 3)

Doc.:   How are you?

Pt.:   I am fine.

Doc.:   Why did you come this morning?

Pt.:   I have problem with my teeth.

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

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

Extract 19   (Interaction 9)

Doc.:   What do you do?

Pt.:   I am processing my admission.

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

Pt.:   Economics.

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

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

5.7.2. Indirect Questions with Answers

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

Extract 20   (Interaction 5)

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

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

Doc.:   It comes and goes.

Pt.:   Yes.

Extract 21   (Interaction 16)

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

Pt.:   Beeni. [Yes.]

A careful look at Extract 20 and 21 revealed that the main instrument in clinical interview is seeking and giving information. Evident from the doctors' contributions above is the deployment of indirect questions to obtain information on the patients' history of present illness (HPI). On the other hand, the patients' contributions supplied answers to the doctors' questions. Here, the elicitation and supply of information provided insights for the doctors into the likely causes of and the real nature of the patients' health challenges and, consequently offered them the opportunity to intervene professionally. The doctors mostly sought information about the patients' health challenges while the patients provided them, thus revealing that both the doctors and the patients worked dependently in matters of oral diagnosis.

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

The answers naturally followed the questions as they performed the communicative function of presenting the information needed for diagnosis. Their deployment was inevitable as the discourse was purely investigative. They generated the raw materials for diagnoses. As the extracts above

revealed, the answers were what the doctors needed to make diagnoses, without which it was impossible for them to gain insights into the patients' medical challenges, except the doctors were going to conduct laboratory tests on them. Question and answer are very important diagnostic tools in clinical interviews in view of the fact that there are some medical conditions that can only be investigated through (elicitation of information) question and (supply of information) answer.

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

5.8. Closing: Concluding the Discourses

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

Extract 22   (Interaction 4)

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

Pt.:   Thank you, sir.

Extract 23   (Interaction 8)

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

Pt.:   Thank you.

Doc.:   Please, take good care of yourself.

Pt.:   Thank you and God bless.

Extract 24   (Interaction 15)

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

Pt.:   Like last week.

in your urine. If there is no evidence of infection in that test, then you will have to take another test. In

Doc.:   Alright. You will this take form to the nurses. I want us to do urinalysis. It will show if there is infection addition, they will measure your height and weight. In fact, they should have taken all the vital signs before you came here. After that, I will take your blood pressure myself.

Pt.:   Thank you.

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

Emerging from the above discussions is that closing performed the pragmatic function of bringing each of the interactions to a close. The clinical interviews could not but end at a particular time.

Therefore, as can be seen in the extracts above, closing indicates the end of the interactions as signalled by the emboldened expressions above. Generally, closing was the final discourse device employed in all the clinical interviews. Grammatically, it was realized by declaratives.

6. FINDINGS AND CONCLUSIONS

This study has proved that discourse devices are indispensable communication tools for doctors and patients alike because their use facilitated the discourse, thus making it result-oriented. The various discourse devices performed the pragmatic functions of opening up the discourse, showing empathy, describing symptoms of ailments, ensuring cordiality between doctors and patients, making the discourse informative and mutual, offering guidance, enlightenment and encouragement to patients, eliciting and supplying information for diagnosis, and bringing the discourse to a close. In sum, a discourse-pragmatic analysis of doctor-patient verbal interactions engenders a better understanding of doctor-patient discourse.

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