

**Conversational Analysis of Doctor-Patient Discourse in North Central Nigeria:
A Study of Nasarawa State University, Keffi Health Services Unit.**

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Abstract

Conversation analysis is an area of sociolinguistics with links to ethno methodology which analyses the structure and norms of conversation in face to face interaction. Conversation analysis is used to describe the basic mechanism in which conversation is based. This is so because in every conversation, each speaker is entitled to 'turns' where a turn is his or her right obligation to speak. Conversation is therefore organized in such a way that only one speaker at any one time speaks, thereafter, changes of speaker occurs as turns. If speaker change does not occur, what results is a monologue or soliloquy, not a conversation or dialogue. Turn taking therefore becomes an essential component of conversation. This paper is premised on analysing and examining turns in doctor-patient discourse. The paper has as its area of study Nasarawa State University, Keffi school clinic, through the use of an eclectic model to analyse the study data and at the end, findings of the study are discussed.

Keywords: Conversation analysis, sociolinguistics, discourse analysis,

Introduction

Man as a social being has an innate desire to communicate, converse, interact, dialogue with other members of his community. The means by which this is achieved is through the use of language. Communication, using language could be by verbal or non-verbal means. Whether man uses verbal or non-verbal means to communicate, turns are being taken by interlocutors when conversation is going on.

Many scholars have in various ways studied, examined and analysed conversational discourses and exchanges. Prominent among these scholars are Sinclair and Coulthard (1975), Stubbs (1983), Cook (1989), Levinson (1995), Yule (1996), Mey (2001), Onedeko (2000&2002), Olaniyan and Oyekola (2002) and David (2006). Most of the past works on conversation analysis have viewed conversation as an informal spoken discourse which takes place between two or more conversationalists (interactants) in institutionalized settings like religious services, law courts, classrooms and the like. For example, Levinson (1983) partially towing the line of Sinclair and Coulthard (1975) and working on insights from Grice (1975) who highlights conversational structures and conversational implicatures with more emphasis

on how "it is possible to mean (in some general sense) more than what is actually said (i.e. meaning more than what is literally expressed by the conventional sense of the linguistic expressions uttered)".

Grice (1975)'s work is useful in that it has created an insight into how effective meaning negotiation can be enhanced through the cooperative efforts of the interactants. Also, Mey (2001:138) focuses on organization of conversation as a social interaction, conversational management and maintenance techniques with a view to acquainting conversationalists (participants) with basic skills through which "a conversation that has halted or has trouble maintaining the proper speed, can be helped along."

Similarly, David (2006) investigated the cooperation in conversation that existed between participants in the presidential Media Chat of Obasanjo's regime and submitted that from studying verbal codes, non-verbal codes (semantics) can also be studied and analysed since they are all used in communication. This paper deviates from the earlier studies made and looked at turn-taking between the doctor and patient using as its base for the study, the



Nasarawa State University Keffi Health Services unit to get the study data.

Review of Related Literature

According to Crystal (116), of the many types of communicative acts, most study have been devoted to conversation which is seen as the most fundamental and pervasive means of conducting human affairs. Hornby (230) says conversation means talking. This can be viewed from the formal and informal viewpoints. Similarly, Schegloff (128) observes that conversation can be referred to as the chaining principle, when he says that conversation sequences can be described by the formula –a –b –a –b –a –b where ‘a’ and ‘b’ are parties in the conversation. Also, Yule (143) opines that conversation can be described as an activity where for the most part, two or more people take turns at speaking. This means that conversation is an ‘exchange’ which takes place between two people or more. From above, the discourse strategies or turns between Doctors and patients in any hospital or clinic can also be considered as another form of conversation since there is the chaining principle, turn-taking and exchange of ideas.

The first major concern with conversational analysis was pioneered by a breakaway school of sociology known as ethnomethodology which became popular in the 1950’s. Owen (249) asserts that ethnomethodology refers to the methods used by people to build the social world in which they live. Parts of the efforts at building human society were furthered by Schegloff and Sacks (1973), who paid close attention to ‘orderliness’ of conversation, an aspect often neglected by scholars. This paper therefore has attempted to look at this area that is often neglected by scholars and tried to bring out to the readership findings made in the study concerning turns in conversation. Again, according to Crystal (116), a comparison has been drawn with games such as chess; where conversation can be thought of us as having an opening, a middle and an end of the game. The participants make their moves just as in the game of chess and often seem to follow

certain rules as the dialogue proceeds. A successful conversation is not however a game; it is more than a mutually satisfying linguistic exchange.

The most widely recognized conversational convention is that people take turns to speak and that is why Wardhaugh (287) says that conversations of whatever type have beginnings and endings. The beginnings could be started in different ways depending on the cultural setting, the circumstances, the participants and the nature of interaction. Similarly Mcshane (154) says, a conversation can begin with one or a combination of the followings: mutual greetings, self-identification, a request to converse and when this has been done, a topic is established and the discussion goes on until it comes to an end. Another way of starting a conversation is to begin with any of the attention-getters called vocatives such as ‘hey’, ‘Hello John’, ‘Excuse me’, ‘Hi’... It is also possible for one to start with no preliminaries. For example, one can just say something is wrong with this machine. Once the speaker has the hearer’s attention, one might then use a conversational parenthetical such as ‘you know’, ‘listen’, ‘know what’ etc. but the most common opening in casual conversation is the greeting, which has to do with the pleasure of meeting someone.

Another important organizational device used in conversation discourse is adjacency pair. This is a sequence of two utterances by two different speakers in which the second is related to the first in a specific way. It involves co-occurrence of certain kinds of utterances where for example, a greeting by one person leads to a greeting by another, a question by one person leads to an answer by another, a request or offer by one person leads to an acceptance or refusal by another, a complaint by one leads to an apology by another or some kind of rejection, a statement by one leads to a confirmation by another etc. The basic function of adjacency pair is to provide possibilities of both continuity and exchange; thus enabling both parties to say “something” which is related to the conversation that is going on. For a conversational turn taking



to succeed, everyone in a conversation must have an opportunity to speak. No one should monopolize or constantly interrupt other speakers.

According to Crystal (116), there is a great deal of ritual in conversation, especially at the beginning and end, and when topics change. It is the understanding of these rituals that help conversations to flow and lack of understanding of them bring about communication breakdown. The various characteristics, discussed above however complicate any investigation. This is so because people interact linguistically in wide range of social situations, on such a variety of topics, and with such an unpredictable set of participants. This has therefore proved very difficult to determine the extent to which conversational behaviour is systematic, and to generalize about it. However, from what has been discussed above, there is no doubt that a system of conversational turn taking exists and this is a highly structured activity, in which people tacitly operate with a set of basic conventions.

Apart from all that has been stated, the writer has also discovered that some works had been done on medical discourse in Nigeria. The few ones that the writer came across concentrated on register studies. For example, Ogunbode (1991) and Olorunfoba-Oju (1996). There are also some pragmatic explorations still on Medical discourse in the works of Odebunmi (2003) and Adegbite (2003) of hospital interactions in the country. No work, that the writer knows for now has handled turn-taking in hospital interactions in North-Central Nigeria. This work/study and paper will therefore add to the sparse literature hitherto existing on medical discourse in the country.

Theoretical Framework

The study operates strictly within the provisions of Sacks et al (1974) principle which opines that the person who starts speaking after the greetings are over, initiates the substance of conversation and how it is passed. Sacks et al substantiate the principle by saying that turn-taking is controlled by three principles where the

three principles are represented and controlled by p1, p2 and p3.

P1: The speaker selects the next speaker

P2: The first to talk becomes the speaker.

P3: The speaker continues his/her remarks.

The above principle by Sacks et al backed up by Sperber and Wilson's (1986) relevance principle become the framework upon which the analysis of the study data for this paper is depended upon.

To complement the above turn-taking principle, the writer has also decided to back up the above relevance principle with the maxim of relevance by Grice (1975). 'Relevance' according to Grice simply states that 'a speaker should be relevant and say things related to the current topic of the conversation'. It has to do with how relevant the information at hand is to the matter being discussed or how well what is said should be easy to understand within the context of what is being discussed. Sperber and Wilson (1986) went further to assert that to cooperate in conversation, only one principle; the relevance principle, is needed because the assumption or principle underlying the relevance theory is that in any given context, what people say is relevant. The principle is a further specification of the Gricean notion of cooperation or turn-taking in conversation.

This paper therefore uses an eclectic approach already briefly discussed as championed by Sacks et al (1973), Grice (1975), Sperber and Wilson (1986) to critically analyse the study data.

Methodology

The method adopted for the collection of data for the study was to visit the Nasarawa State University, Keffi Health Services Unit, where the Doctor-Patient discourse or turn-takings were recorded and dubbed in a small tape recorder. Apart from the recording that was done, the researcher had ample opportunity of watching both the verbal and the non-verbal behaviours of the interlocutors while the recordings were going on at close range and notes were taken to complement what was recorded. In all, fifteen recordings of the different Doctor-Patient

discourses which can be termed speech events were recorded. The same speech events have been numbered for easy identification during the analysis. After a careful examination of the recordings, only three discourses of speech events of the Doctor-Patient were critically selected for transcription as the main data for analysis. The data was transcribed after the tape recorder was played over and over and the texts are written below for analysis.

TEXT I

(A patient enters the consulting room where the doctor was sitting and sits down facing the Doctor).

1. Doctor: Peter, what is the problem? (Doctor checks the patient's card).
2. Peter: I feel very feverish and I have a slight headache.
3. Doctor: You feel feverish?
4. Peter: Yes, doctor.
5. Doctor: How old are you?
6. Peter: I am twenty three years old.
7. Doctor: Step on the weighing scale.
8. Peter: Doctor, I also feel very cold.
9. Doctor: Is there any sign of pneumonia?
10. Peter: I don't know doctor.
11. Doctor: Any cough?
12. Peter: Yes, sir.
13. Doctor: Lie down on the bed, let me examine you because----Pneumonia-----
(The doctor and Peter walked towards the direction of the bed and the patient lies down on the bed while the doctor examines the patient).
14. Peter: Okay.
15. Doctor: Do you experience any pain here?
(Doctor asked while touching Peter's chest).
16. Peter: Yes, doctor.
17. Doctor: You have symptoms of pneumonia. So, I will send you to the laboratory to run a test--, Make sure you go straight to the University clinic laboratory for the test, because you students do go outside the school to run tests.
18. Peter: But Doctor, there is a very long queue at the laboratory.

19. Doctor: Just follow my instructions. Why I am telling you this is--- you see, most of these laboratories outside the school don't have reagents. Please, patiently wait.
20. Peter: Okay. (Peter walks out of the room without saying anything).

TEXT II

1. Kennedy: Good morning Sir.
2. Doctor: Yes, sit down Kennedy, what's the problem?
3. Kennedy: I have a serious headache and I throw up anything I take in.
4. Doctor: Do you feel feverish?
5. Kennedy: Yes, Doctor.
6. Doctor: You will start with these drugs---
(Doctor writes on a sheet of paper)
7. Kennedy: I also don't have appetite.
8. Doctor: Yes, it is always like that, they will give you some multivitamins in the Pharmacy.
9. Kennedy: ----- silence.
10. Doctor: Do you react to chloroquine?
11. Kennedy: No, unless...
12. Doctor: What level are you?
13. Kennedy: I am in my final year and I will want to come back here for my Masters.
14. Doctor: That is good, so you go straight to the pharmacy.
15. Kennedy: Thank you Doctor. (Kennedy walks out of the consulting room).

TEXT III

(The Doctor calls out the next patient).

1. Doctor: Dorothy Alumbugu.
2. Dorothy: Good morning Sir, (Dorothy enters looking weak).
3. Doctor: Good morning, what is the problem?
4. Dorothy: I have a severe headache and I don't see well.
5. Doctor: Any other thing?
6. Dorothy: I also have abdominal pain.
7. Doctor: The last time you were here; I prescribed some drugs for you, isn't it?
8. Dorothy: ---- silence. (Dorothy nods her head indicating that what the Doctor said is true).
9. Doctor: How old are you?
10. Dorothy: I am twenty seven.



- 11.Doctor: I will send you down to the laboratory.
- 12.Dorothy: Okay.
- 13.Doctor: So that you can run a test, and come back tomorrow to get the result. Dorothy, now go straight to the laboratory.
- 14.Dorothy: Okay sir.
- 15.Doctor: When are you starting examinations?
- 16.Dorothy: Next month.
- 17.Doctor: It's okay, you can go.
- 18.Dorothy: ----- walks out of the consulting room without saying anything.

Method of Analysis.

A proposed model of analysis in a tabular form is used to analyse the study data. In the table, anywhere there is a plus (+) sign, it means the principle of turn-taking or maxim of relevance is obeyed and anywhere the minus (-) sign is seen in the table, it means that either the

principle of turn-taking or the maxim of relevance is not obeyed. This is done in such a way that at a glance, each of the conversational turns, otherwise known as exchanges which have been numbered are placed on the left hand side and one is able to identify the utterances made either by the doctor or the patient and see from the right hand side the ones that either obey the principles of turn-taking represented by the symbol p1, p2 and p3 or the maxim of relevance and those that do not obey them. By so doing, each participant's contribution shall be analysed under the rules guiding turn-taking earlier on proposed by Sacks et el (1974), or Grice (1975) and Sperber and Wilson (1986).Since the selected samples of exchanges to be analysed have been variously numbered, the researcher shall begin his analysis by analysing text 1.

Analysis
 Table 1
 ANALYSIS OF TEXT 1

SPEECH EVENTS	TURN – TAKING			RELEVANCE
	P1	P2	P3	RELEVANCE
1.	+	+	+	+
2.	+	+	+	+
3.	+	+	+	+
4.	+	+	+	+
5.	+	+	+	+
6.	+	+	+	+
7.	+	+	+	+
8.	+	+	+	+
9.	+	+	+	+
10.	+	+	+	+
11.	+	+	+	+
12.	+	+	+	+
13.	+	+	+	+
14.	+	+	+	+



15.	+	+	+	+
16.	+	+	+	+
17.	+	+	+	+
18.	+	-	-	+
19.	+	+	+	+
20.	+	+	+	+

In the analysis of text 1 analysed in the table above, the analysis shows that apart from number 18 of the study data where principle 2 and 3 were not obeyed, every other speech event obeyed the principles of turn-taking and relevance, meaning that the doctor and patient discussion to a large extent followed the laid down principles of turn-

taking and relevance. This could be so because both discussants are learned and are aware of the importance of asking the right questions and giving the right answers. These factors help the smooth flow of information from the beginning to the end, which made the conversationalists not to have problems.

TABLE 2:

ANALYSIS OF TEXT 2

SPEECH EVENTS	TURN – TAKING PRINCIPLES			RELEVANCE
	P1	P2	P3	MAXIM OF RELEVANCE
1.	+	+	+	+
2.	+	+	+	+
3.	+	+	+	+
4.	+	+	+	+
5.	+	+	+	+
6.	+	+	+	+
7.	+	+	+	+
8.	+	+	+	+
9.	-	-	-	-
10.	+	+	+	+
11.	+	+	+	+
12.	+	+	+	-
13.	+	+	+	-
14.	+	+	+	+
15.	+	+	+	+



The analysis of text 2 in the table above shows that apart from conversation 9 where two of the principles of turn-taking were violated due to silence by one of the interlocutors every other speech event obeyed the principle of turn-taking.

Also, conversations number 12 and 13 do not fit into the maxim of relevance because the interlocutors totally derailed from the main reason of the conversation and as such became irrelevant to the discourse at hand.

TABLE 3
 ANALYSIS OF TEXT 3

SPEECH EVENTS	TURN – TAKING PRINCIPLES			RELEVANCE
	P1	P2	P3	MAXIM OF RELEVANCE
1.	+	+	+	+
2.	+	+	+	+
3.	+	+	+	+
4.	+	+	+	+
5.	+	+	+	+
6.	+	+	+	+
7.	+	+	+	+
8.	+	+	+	+
9.	+	+	+	+
10.	+	+	+	+
11.	+	+	+	+
12.	+	+	+	+
13.	+	+	+	+
14.	+	+	+	+
15.	+	+	+	-
16.	+	+	+	+
17.	+	+	+	+
18.	+	+	+	-

In the analysis done above, all the conversations between the Doctor and the patient followed the principle of turn-taking but do not totally obey the maxim of relevance in conversations number 15 and 18 where the initiator of question 15 (the doctor) deviated from the discourse at hand. The question asked concerning examination was not really overtly relevant to the on-going discourse or discourse at hand. The writer strongly feels that the question is a misnomer because it was not relevant to the state of health of the

interviewee and therefore should not have been asked. Also, in speech event number 18, the response of the patient could not be analysed under the maxim of relevance because the patient was silent after being spoken to and since the writer was not out to analyse non-verbal acts or silence, he decided to submit that the action is not analysable using the method of analysis that has been adopted. Due to this, silence in this regard is not relevant. Again, one expects that in a normal conversational situation as seen in



Conversation 17 after the doctor had made his last remark by telling Dorothy to go, one would have expected that Dorothy should show gratitude that the doctor had spoken with her by giving her his attention but this she never did. What this situation readily suggests is that perhaps Dorothy is not fully satisfied with the level of engagement between the doctor and herself probably that is why she did not say her own concluding remarks before she finally left.

Observations and Submission from the Analysis

The writer discovered from the three texts that were analysed that most of the conversational exchanges followed the principles of turn-taking and obeyed the maxim of relevance. Findings reveal that it is easy for the rules of turn-taking to flow smoothly because most of the questions asked by the doctor in most of the times are what Quirk et al (392) call derivative questions and wh- questions that elicit responses whether verbal or non-verbal. For example,

A: What is your name?

B: My name is Kate.

A: What is the problem?

B: I have severe headache.

We also found out from the study data and the analysis done that most of the questions asked by the doctors are such that make the patients to feel at home. The language of discussion and communication is so simple and direct such that anybody whose second language is English can easily contribute well to the social discourse at hand. This situation consequently enables the patients to talk and express themselves freely with the doctor what their problems were without inhibitions. (This has to do with the three texts analysed).

Also, the environment where the study took place contributed in a great way to enhance the smooth flow of discussion. This is so because the environment is an academic environment, where it is believed that most of the people that come to the school medical centre or clinic are either learned or enlightened.

Again, we observe that some of the answers given by the patients are what Quirk et al (52) call yes-no questions which enhances the smooth flow of turn-taking. For example:

A: Do you react to chloroquine?

B: No.

A: Do you have any cough?

B: Yes.

We also observe that the answers given by the patients helped the doctor to understand the patient's problems and for proper diagnosis to be made by the doctor. The study data also showed that the use of greetings by both the doctor and patients at the beginning of discussions become the opening acts of greeting. Also, there was the use of farewells by both interlocutors. This situation indicated that as far as part of the convention in doctor-patient conversation, courtesy and politeness are always expected. This is exemplified below:

B: Good morning, Doctor

A: Good morning, sit down.

B: Thank you, Doctor.

Our analysis further showed that the doctor's questions to the patients are controlled and have direction. It also showed that the questions are a kind of routine laid down by the convention in medical language. This is illustrated thus:

What is your name?

What is the problem? Etc.

This study has interestingly shown the effectiveness of turn-taking in medical language. From the analysis in the three tables, it is very important for speakers to observe the rule of turn-taking and be relevant every time there is a discourse at hand. Finally, it is important to note that based on our study findings, the doctor-patient discourse follows the rules of turn-taking, except in some cases where there were communication breakdown.

Conclusion

The conclusion one can draw from this study is that by using the principle of turn-taking by Sacks et al (1972), Grice (1975) cooperative principle and Sperber and Wilson (1986) relevance theory, it has been practically possible for one to see how the doctor-patient discourse is



similar to any formal conversational or conventional situation. It is important to note that this study brings out the differences in conversations, showing how speakers adhere to the rules of turn-taking in discourses. The study has also showed and confirmed the fact that language is not used haphazardly but that language is structured in any socio-cultural setting. The study has also finally shown that

conversationalists, particularly in a doctor-patient discourse are usually knowledgeable and are conscious of the rules preceding any given conversation. Due to this development, there is always a good communication flow between the interlocutors especially in a medical discourse that takes place in an academic environment such as this.

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