SOCIO LINGUISTIC ANALYSIS OF THE DOCTOR-PATIENT INTERACTIONS: A CASE STUDY OF ABUBAKAR TAFAWA BALEWA UNIVERSITY TEACHING HOSPITAL (ATBUTH), BAUCHI

BY

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SPS/09/MEN/00029

JUNE 2013

TITLE PAGE

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JUNE, 2013

DECLARATION

I Bello Abdullahi, hereby declare that this work is the product of my research undertaken under the supervision of Dr. Amina Adamu and has not been presented elsewhere for the award of a degree or certificate. All sources have been duly acknowledged. Any error or omission is not intended, thus highly regretted.

…….. June, 2013.
Bello Abdullahi SPS/09/MEN/00029

CERTIFICATION

This is to certify that the research work for this dissertation by Bello Abdullahi, SPS/09/MEN/00029, is carried out under my supervision.

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APPROVAL

This dissertation has been examined and approved for the award of the degree of **Master of Arts in English Language.**

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DEDICATION

This work is dedicated to my late brother **Ibrahim Bello Umar Gamawa** and also to my relatives and friends that passed away whom include; Usman Bello Gamawa, Baba A'uwa, Baba Alhaji, Alh. Usman Umar Gamawa, Hajiya Yaya, Hajiya Adda, Adda A'I Zango, Engr. Aminu Jibril, Baba Shitu Adebo, Alh. Abba K. Zadawa, Alh. Babagana Suleiman (zaki), Mal. Kawule Gamawa, Baba Jimoh Ibrahim, Umma Altine, Mabaruka Zango, Aliyu I. Zango, Baffah Maikudi, Aunty Biyoh, Aunty Fatima, Hadizan Babiya, Mal. Sagir, Auwalu DanMama, Usman Ahmad Adamu, Abubakar Abdulhamid, Arc. Aliyu Abdulhamid, Garba Abdulhamid, Fa'ik Shehu Awak, Comrade Abdulrasheed Ibrahim Bar, Abdulrahman Hussaini (Gazali), Dalhatu Bala Malami, Auwalu Yusuf Baba, Shagari Shaga, Abida Gamawa, Hafsatun Babiya, Baban Dagauda, Baba Mal. Kawu, Marafa Ahmad Maidala, Dada Gamawa, Baba Milili, Ibrahim Nahanka Gamawa, Hafsat Hassan, Fa'iza Hassan Adamu Shira, Adama Adamu Hussaini, Imrana Inuwa Dattijo, Mama Yalwa, Alh. Musa Mukkadas, LT. S.Y Maikyau, ASC Barr. Suleiman Kano, Muhammadu A.G, Alh. Kabiru Alkali and our beloved Baby Hafsat may their gentle souls rest in peace, ameen.

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ABSTRACT

There is a general outcry as regards the quality of medical care in most of the Nigerian Hospitals. This study focuses on the communicative relationship of the doctor and the patient which is set to identify and assess the problems that occur during interaction between doctors and patients at ATBUTH, Bauchi and also to examine and analyze the linguistic factors that influence or affect their communication. Lack of awareness and low level of educational background from the patients is another problem because most of the patients have communication problem with the doctors (most especially the non native doctors). Language variation is another problem that contributed in communication breakdown between doctors and patients at Abubakar Tafawa Balewa University Teaching hospital Bauchi. The study is meant to investigate and analyze the sociolinguistic problems in the Doctor – patient interactions; therefore, it gives insight into the Doctor-patient communication relationship and reveals the importance of good communication in conveying meaning in the spoken language. This study is therefore considered important because as a result of poor interaction between the doctors and patients leads to some scenarios where patients lost their lives and sometimes doctor lose his/her job. Finally, the study also suggests some possible ways that help both doctors and patients deal with their communication problem between them.

CHAPTER ONE

1.0 Introduction

This study describes the sociolinguistic problems in doctor-patient interactions in English in ATBUTH hospitals, Bauchi. It specifically intends to analyze the contextual beliefs of the doctor and patient, the linguistic patterns exploited in the conversations and the pragmatic acts performed in them. The spoken aspect of the conversation is described while the study excludes acts of writing performed by the doctor during interactions. It is believed that the excluded area will be relevant under an analysis of prescription, medication and reports in medical records all of which may not share the characteristics of diagnostic interaction. The findings of the study are expected to complement existing works on discourse analysis and medical communication in Nigeria among others. In recent decades, linguists have become interested in spoken language, crediting it with more significance than did the traditionalists of earlier centuries. This is because spoken language is more than just words; it is shaped by the social nature of human beings. Speech which refers to face-to-face interaction is one of the most useful and powerful emblems of social behavior that speaks volumes about who we are, where we come from and who we associate with. It is basic to social interactions, affecting them and being affected by them. Speech plays a

number of social functions in the social life of human beings. One of the various social functions that speech plays in social life is that it serves as a means of communicating with each other. This can establish, develop or reinforce social relations. Communication in this respect is a useful social tool functioning as a link in human relations. Bloomfield (1974: 325), one of the greatest linguists that ever lived, once declares that 'linguistic science is a step in the realization of man'. He is right by making this declaration because of all the abilities that distinguish man from the rest of the animal kingdom, language is the most prominent. Language, the well-studied means of communication has to be viewed in the context of other non-linguistic related to those of sociology, psychology and Anthropology. Richards (1928) defines communication as a distinct aspect of human enterprise. He says communication takes place when one mind so acts upon its environment that another mind is influenced and an experience caused so that both the speaker and the hearer have same experience. According to Runes (1962), communication is the intercourse between minds or selves whereby sensations, imagery or conceptual meanings are transferred from one source to the other. It involves ordinary sense mediated communication by means of speech, writing, gesture, facial expression, bodily attitude and allegedly direct contact between minds by mental telepathy and other occult means. This means that

communication directly or indirectly involves the transfer of information from one source to another. Spear (1970) says “communication is the transmission of information and communication is made up of four categories comprising the verbal communication which is what the person thinks; verbal communication of what the person feels; verbal communication of what the person experiences and non-verbal expressions, feelings and effect”. All those put together express communication as being the transfer of information from one source to the other either verbally, non-verbally or combination of these two. According to Krughinski (1978), before the advent of personal computers, human beings had many options of communications such as one way communication, two-way communication and multiple way communication. “He says that in one way communication immediate feedback is possible for example, one reading a book, magazine, paper and reading inscriptions on videocassettes”. While two way communications allows a person to initiate or introduce a conversation for example communication through telephone and multiple ways communication allow one or more people to interact with the other members of a given situation. Murphy and Peak (1974) says the “communication is a process of transmitting a message so that the recipient understands it”. Communication is considered effective when it achieves the desired reaction or response from the recipient,

simply stated, communication is a two way process of exchanging ideas, or information between human beings.

Murphy and Peak (1974) believes that "practicing the communication process is not simple, it is sometimes imperfect, complex and results in miscommunication". He who sends the message is the speaker and the "encoder" while he who receives the message is the listener, the "decoder".

According to Unoh S.O. (1987), there are various means of communication; we shall look into verbal language system as code for communication. Communication necessitates the conscious manipulation of physical forces and objects according to agreed rules and conventions.

1.1 Statement of the Problem

In a location such as a hospital, it is pertinent that there is no failure in the process of communication. However, difficulties arise due to the way most patients expressed themselves wrongly and lead to a situation where the doctors prescribed wrong medications to them.

Lack of awareness and low level of educational background from the patients also causes a problem because most of the patients have communication problems with the doctors (most especially the non native doctors). Language variation is another problem that contributed in communication breakdown between doctors and patients at Abubakar Tafawa Balewa University Teaching Hospital Bauchi.

1.2 Aim and Objectives of the Study

There is a general outcry as regards the quality of medical care in most of the Nigerian Hospitals. This study focuses on the communicative relationships of the doctors and the patients which is necessary for mutual understating and improvement of medical care in our hospitals.

The specific objectives are;

1. To identify and assess the problems that occurs during interactions between doctors and patients at ATBUTH, Bauchi.
2. To examine and analyze the linguistic factors that influence or affect their interactions.
3. To suggest some possible ways that help both doctors and patients deal with their communication problem between them.

1.3 Significance of the Study

Since the study is meant to investigate sociolinguistic problems between Doctor – patient interactions. It gives insight into the Doctor-patient communication relationship and reveals the importance of good communication in conveying meaning in the spoken language.

This study is therefore significant because as a result of poor interaction between the doctors and patients leads to some scenarios where patients lost their lives and sometimes doctor lose his/her job.

It also adds literature to the topic and inspire for more research in the area.

1.4 Scope and Delimitation

This scope of the study is at the Abubakar Tafawa Balewa University Teaching Hospital, Bauchi. The study is limited to the interactions made between doctors and patients in the hospital. However, total number of 50 (fifty) patients and 10 (ten) doctors where randomly selected.

1.5 Variables

The variables of this study are the doctors and patients *i.e.* to identify and analyze the communication problems among them at the teaching hospital, Bauchi.

1.6 Research Questions

The research is expected to answer the following research questions:

(i) Do the doctors have communication problems with patients?
(ii) Do patients have communication problem with doctors?
(iii) What are the factors that contribute to the problems?
(iv) What are the appropriate measures to be used to tackle the problems?

CHAPTER TWO

LITERATURE REVIEW

2.0 Introduction

This chapter generally reviews the related literature to the research topic, and specifically discusses theories on communication, sociolinguistics, second language acquisition, pragmatics of medical communication, social class, second language speech and pronunciation among others.

2.1 The Pragmatics of Medical Communication

Medical communication represents a series of institutional encounters that take place in the health care system. According to Heritage (1977: 164), participants in institutional encounters use a series of linguistic and interaction resources specific to the situation and in accordance with the participants' linguistic and cultural competence. Heritage (1977: 164) further identifies the characteristics of institutional interaction as follows CF Valero-Garces (2002): "(I) the participants possess some specific roles, (ii) a series of constrictions characteristic of the institutional context are important and (iii) inference marks and particular procedures associated to each institution exist". The characteristics above are complemented by the following elements: (I) assignment of the participants' roles, (ii) general structure, and (iii) sequential organization (IV) lexical choice and

(v) asymmetrical relationships. The observation above confirms the finding of scholars on institutional interactions as a whole. With respect to doctor-patients interaction, scholars have made observation in their studies.

Adegbite (1991 and 1995) in his analysis of Yoruba interactive encounters between herbalist and clients observes "that a situation of uneven power and social status between the participants leave control of strategic interaction in the hands of the herbalist who dominates turn-taking routines to his/her own advantage and sets the pace of the dialogue". Earlier, Coulthard and Ashby (1976) observe the recurrence of doctor-initiated exchanges in diagnostic interaction between doctor and patients. According to Coulthard and Ashby (1976: 76) "if a patient attempts to initiate, the doctor does not feel he/she has an obligation to respond". They observe that the interaction is made up of transfer exchanges in which information passes from the responding patient to the eliciting doctor and matching exchanges in which the patient presents information for the doctor to confirm. The negotiation of a shared orientation between doctor and patient takes place through series (sequences) of exchanges in a sequence until the doctor is finally able to match a medical diagnosis with the patient's problem.

Chimombo and Roseberry (1998) observe that discourse participation in medical communication involves more than one speaker and listener, i.e. relations and medical personnel other than the doctor and the client participate. Chimombo and Roseerry (1998) conceive of medical communication as a goal-oriented process that considers participants, medium, strategies, setting and theme.

In a recent study by Valero-Graces (2002) of interactions between doctors and immigrant non-native speakers of Spanish, the researcher observes some

Occurrences that indicate a modification of roles and relationships in the institution. In respect of the doctors Valero-Garces (2002: 492) observes:

- Exchange of roles
- Petition of information not strictly medical
- Higher percentage of bureaucratic negotiation and of casual inserts
- Frequent explanation
- Higher percentage in the use of certain speech acts, e.g. directives and co missives.

In contrast, the patients use such strategies as:

- requiring non-medical information
- mixing different levels of language
- using politeness systems in unexpected ways

- initiating conversational topics
- giving more information than requested
- repeating the same information several times
- asking for confirmation
- Preference for brief answers and direct questions

It is pertinent to find out which of the features observed above are confirmed by this study and which are not.

Coming to the pragmatics of social interaction, pragmatics approaches are concerned about language in use in social context and emphasize the 'functionality' (Hymes 1991) of utterances performed in different contexts of interaction (Austin 1962, Jacobson 1960, Searle 1969, and 1976).

According to Adegbija (1995:255) "pragmatic studies pay special attention to participants, their shared or mutual knowledge, what they have implied which is not overtly stated, etc. Discourse tact refers to the strategies employed by participants engaged in a discourse to give value to social interaction (Adegbija 1995). With reference to doctor-patient interaction in this paper, such strategies will be identified via the analysis of the following features:

(I) mutual contextual beliefs of participants

(ii) Locution, the structure of dialogue in the interaction

(iii) Illocution and per locution of utterances

(iv) Other pragmatic features pertaining to implicatures, politeness and pragmatic failure.

The social experience of participants is the main source of motivation for language use (Hymes 1962, Saville-Troike 1987). Two perspectives are available to us for describing the social context of events in this study. First is the perspective of registered studies from which Halliday (1978) has suggested three categories of field, tenor and mode. Second is the perspective of ethnography of communication from which Hymes (1962) has suggested the categories of setting, participant, ends, acts, key, instrumentality and genre (SPEAKING). A synthesis of these perspectives is utilized as a tool for analysis in this study. The structure of dialogue in social interaction has been described from the complementing perspective of 'structuration' and 'synchronization' (Richardson 1981, Adegbite 1995). The concept of structuration, on the one hand, is associated with the perspective of discourse analysis initiated by Sinclair and Courtyard (1975) and developed by other scholars CF Burton (1980), Courtyard and Montgomery (1981), Kindle (1986). It pertains to the description of discourse as 'product' in terms of constituent structural categories such as lesson, (interaction),

transaction, exchanges, and acts. On the other hand, synchronization derives from the description of discourse as a 'process' in which negotiations of acts of speech such as turn taking and interruptions in personal and institutional discourse are governed by social rules of speech behavior (Sacks, Schegloff and Jefferson 1974).

Austin (1962) elucidates the pragmatic theory of speech acts by identifying three types of acts: elocutionary, illocutionary and elocutionary. Locution is the actual utterances made by a speaker which is describable in linguistic (i.e. phonological, lexical and grammatical) terms. The analysis of locution in this paper utilizes categories employed in earlier description of structural grammar (Quirk, et. al. 1972), systemic functional grammar (Holliday 1985, Bloor and Bloor 1995) and text grammar (Holliday and Hassan 1976). Illocution refers to the intention(s) of the speaker in making an utterance. Such intentions are describable in terms of acts or functions of speech, e.g. elicit, inform, direct, argue, etc. (Austin 1962, Searle 1969, 1976). Per locution refers to the effect of an utterance on the hearer, e.g. whether a listener is persuaded or not by an argument.

Speech acts may be direct or indirect. According to Yule (1996) "we have a direct act when there is a direct relationship between a structure and function and an indirect act when there is an indirect relationship between a structure and

function". The concept of implicatures derives from the production and interpretation of indirect meaning of utterances that result from a flout or violation of certain maxims of cooperation-quantity, quality, relevance and manner (Grice 1975).

The concept of politeness and face go hand in hand. Politeness which is observable in situations of social distance or closeness is the means by which we show awareness of another person's face. Face being technically defined as the 'public self image of a person' (Goff man 1967, Brown and Levinson 1987, Thomas 1983, Yule 1996). Scholars have suggested several maxims of politeness (Layoff 1973, Leech 1983), especially the following maxims proposed by Leech (1983) have received wide attention: tact, generosity, approbation, modesty agreement, sympathy and Pollyanna.

The overtly antonymous concepts of pragmatic success and failure relate to understanding or misunderstanding the sense or force of an utterance. Thomas (1983) identifies two types of pragmatic failure viz. pragmalinguistic and socio-pragmatic failure. The former occurs "when the pragmatic force mapped by a speaker on to a given utterance is systematically different from the force most frequently assigned to it by native speakers of the target or when the speech act strategies are inappropriately transferred from L1 to L2" (CF Thomas 1983: 99).

The latter occurs when an utterance fails to conform to the social conditions placed on language in use.

2.2 Social Class

Linguistic evidence in human language behavior can determine the relative social status of speakers. This is possible because no two speakers of a language behave in the same way are bound to exist disparities in aspects of language such as grammar and the choice or vocabulary which may exhibit the in-equality among the speakers.

This linguistic inequality is not unconnected to social inequality. In fact, it is one of the most important factors perpetuating social inequality from one society to another. The linguistic differences have often resulted in the social stratification of people into social groups. Within social group, it is still possible to classify individuals into social classes.

Erinosho (1981) is of the view that "The study of social class is important because, it provides an insight into the basis of social behavior." He asserts further that "people who share the same social background tend to share similar values, norms and patterns of linguistic behavior". Scholars are of the view that the concept of social class can only be defined from a purely economic point of view. Scholars define social class in terms of power and social status. However, the concept of social stratification is somehow controversial. Its application is not universal

especially in a developing nation like Nigeria where there are no features for making social classes. This is not to say that the concept of social stratification does not apply to the Nigerian society.

For the purpose of this study, we shall define social classes as "aggregates of individuals with similar social and economic characteristics." (Trudge, 1975, P.35). "Social characteristics" here is used to include educational background.

Let us see how social class as to the concept of illness with special reference to the communicative relationship between the doctor and the patient, Social and linguistic behaviors. Also according to Trudgill (1975) "this observation is of particular relevance to the fields of medicine and Linguistic because clinical observations in Africa have it that social stratification can influence the concept of illness.

Ericnosho (1981) observed that highly educated people in Nigeria are less likely to think that various physical disorders are caused by witchcraft. In contrast, however, Ericnosho (1981) notes that "the non-literate or the lower class" are more likely to utilize the services of native healers at the out-set of physical illness. The importance of social class cannot be under-estimated along this line in the consideration of therapeutic relations. By therapeutic relations we mean, the relationship which exists between the Doctor and his patient.

From the study of social class, it has been gathered that communication between professionals and their clients is enhanced if they share a similar social background. Reports abound that doctors find it easier to communicate with patients with a similar social background.

In the next section, we shall discuss what the doctor should examine and evaluate in his interaction with the patient.

2.3 Communication

Communication is the interaction in one form or the other either by visual or auditory symbols. It actually involves the interaction of one or more people saying or doing something which will attract reactions in the minds of other people. Symbols such as words are what people use to communicate. A symbol is valid for communication when those using the symbols know what meanings the symbols represent. Symbols could be defined as the entire set of reactions that area called up in a person's mind when he uses that symbol. Meanings are defined as the entire set of reactions called up to mind by a symbol (Bello, 2007).

Communication could simply be defined as the dynamic unique process of calling up meaning by the use of symbols. It is defined by Brown (1920) as "the transmission, transfer or exchange of ideas, knowledge, belief or attitudes from one person to another"

Udal (1979), views communication "as the process by which one person or group shares and imparts information to another person or group so that both people and groups can clearly understand one another".

Language according to Anagbugo (2010) is used as a means of communication as it's most important and obvious use. Communication he added is a means of all kinds of "verbal" interactions among human beings such as exchange of ideas, feelings, information, est. Communication cannot be effective without at least two parties or individuals.

Communicative competence in its functional aspect is the ability to use language for socio-cultural and interpersonal purposes and the purposes can be illustrated under the heading of appropriateness of usage, conventional usage, transactional usage and interactional usage. It has been defined in its discourse aspect as the ability to use language in meaningful communication beyond sentence level. (CF Williams, 1990; 230) Performance on the other hand, has been defined as a language behavior that could be elicited and observed while competence can only be inferred as an underlying ability. Competence has to do with whether specific language ability is present while performance has to do with the strength of the ability (CF William, 1990:196). Similarly, Richards and Gennady (2005) suggest "listening, speaking, pronunciation, grammar, vocabulary, reading and writing as

ingredients of the ESL that combine together to enhance the communicative competence and performance of language learners".

Widows and Christopher (1980) opine that language teaching should focus on the functional and communicative competence of the learner. They saw communicative competence as "the desired goal in teaching second language i.e. the ability to use the linguistic system effectively and appropriately" (p.216). Kodiak (2007) says correct pronunciation is necessary for corrections of spelling. He added that 'one can easily realize the effects of wrong pronunciation and spelling on our speech or writing. Kodiaka (2007) lead to misunderstanding and confusion because they change the meaning of what one wants to say or write. When human beings communicate with one another, they usually do that through speech or writing. Speech involves language sounds which are associated with meaning. Knowledge of a language, therefore, presupposes knowledge of the speech sounds of the language and how these sounds combine with one another to form meaningful utterances (Onuigbo, 1982: 1)

According to Yule (2007:74) "the major function of language, is the transactional function, skills and information. In the interaction function, human use language to interact with each other socially and emotionally; how they indicate friendliness, co-operation, or hostility, or annoyance, pain, or pleasure" 74. In order to be able to communicate especially with their teachers in the target language (English), the

ESL students need the mastery of various linguistic tools such as the sounds system of the language, pronunciation, spelling, listening, reading and writing. Contributing to the discourse, Hedge (1980:80) argues that "for the ESL students to write effectively, they must possess: grammatical knowledge, a wide vocabulary, accurate spelling, mixed sentence usage, sentence and paragraph relation and good organization".

According to Revere (1961), "there are certain elements which are essential to any communication process including language. "

1. A code, an arbitrary pre-arranged set of signals. A language is merely one special variety of code and the linguistic deals in its strictest delimitation, only with this aspect of communication;

2. A channel: some medium by which the signals of the code are conveyed;

3. The process of encoding by which certain signals in the code are selected and put into the channel;

4. An encoder: the person or device which performs the process of encoding;

5. The process of decoding by which the signals are identified and a course of action is affected by them;

6. A decoder, the person of device by which the process of decoding is performed and whose course of action is thereby affected."

2.3.1 Communication: A Sociolinguistic Approach

The study of sociolinguistic phenomenon enriches the understanding of socio-cultural communication in valuable ways. Most works in this area relate linguistic data to socially significant contexts, thereby relating these two major bodies of theory concerning human behavior.

Biker (1975; 86) sees "human communication as an ongoing developmental sharing of information that creates identification between two 'or more person." 'Identification' here refers to the social identity of the speakers. This further sheds light on the assertion that social stratification conforms to linguistic behavior. Thus, each act of communication is shaped to some degree by the individuals involved. Communication according to Lyons (1977) is the way of transmission of information by means of established signaling system. "The term "established signaling systems" is employed to include both verbal and non-verbal codes of language.

Harvey Searle (1972) claim the listener is also an actor "not merely a passive receptor and information processing center." They maintain that the image of the individual as the "faceless, motionless listener" on the response end of the stimulus-response act is clearly an incomplete description of human behavior. Similarly, the speaker as the encoder, stimulus maker, is incompletely identified as

an ideal producer of sentences. He is as much a part of the socially structured scene as the listener.

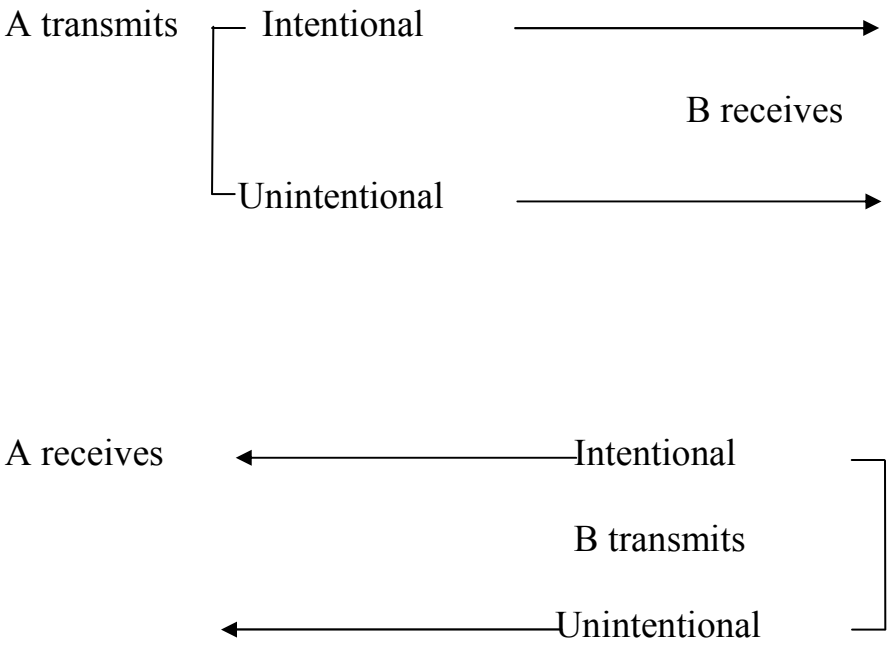
Verbal and non-verbal cues employed the social identity and the context of communication form the basis of raw data for the sociolinguist to work upon. In the same manner, the Doctor after getting himself acquainted with these variables would be able to tackle problems inherent in communication with his patients.

2.3.2 The Relationship between Verbal and Non-Verbal Communications

Verbal and non-verbal communications cannot be separated into mutually exclusive categories. In specific interactive situation such as interpersonal communication, the exchange of information is usually based on both.

In the proceeding chapter, communication was defined actively and passively. Actively, one communicates making used of verbal codes and to a greater extent controlling the linguistic items being used. Passively, however, one sends out information without intention. This can be represented according to Odumuh (1986) schematically.

2.3.3 Figure 1 John and Miller (1979)



This diagram explicitly explains the doctor-patient interaction. The important thing to note in the diagram is the crossover what the doctor transmits as unintentional may be picked up as intentional by the patient. It could also construe unintentional information as intentional. An observer can only begin to understand the content and of communication processes if he examines and evaluates extra linguistic variables. It should be noted however, that the non-verbal code can stimulate meanings that are unrelated to the verbal message. John and Miller (1979) also affect greatly the interpretation and understanding of verbal messages. In any case, non-verbal codes are important aspect of interpersonal communication

2.4 Communication: A Linguistics Approach

In any communicative activity, a minimum of two entities are involved vis a vis the speaker who is engaged in the process of encoding ideas into sounds and the listener who receives the information and decodes the speech sounds then meaning is derived. There must be a channel which must remain is open for effective communication to take place. Information contained in the message is "the objective substance of communication. We communicate to make someone aware of something he may not be previously aware of. Lyons (1977) presents a model of communication of Shannon (1949) from the point of view of communications engineering.

2.4.1 Figure: 2 Miller (1979)

Signal - Signal

Transmitted Received

X--------- transmitter--------- channel ----------receiver----------Y

Miller (1979) contends that "the message originated by x is encoded by the transmitter into a signal. The signal is sent over a particular communication channel to the receiver. The receiver decoded the signal into a message and passes the message unto Y."

The model is restricted in application to communication by the use of language. Rather, it fails to cover all other aspects of communication i.e. non-verbal communication.

For the purpose of this research, communication is defined actively and passively. Actively, one communicates with intention fully aware and to a greater extent controlling the linguistic items employed in the communication process. At this level, the social identifications of speakers and the listeners are taken into consideration. Passively, however, one communicates without intention, despite oneself, sending out information unconsciously. This can be given interpretation by anyone who knows what to look for in non-verbal communication.

2.5 Sociolinguistics

This is an inter-disciplinary field, sociology and linguistics. Sociology is concerned with the study of "human relationships and more specifically the formulation and perception of these relationships and of individuals who enact them within the broad context of human society." (Kenneth and Hones 1975, p.11).

Linguistics is the scientific study of languages. The scientific study of the systems of language. Sociolinguistic, therefore is the branch of linguistics that studies links between language and the society.

The definition of sociolinguistic given above is in a wider perspective i.e. macro sociolinguistic which deals with language as it pertains to the entire society.

However for the purpose of this research, sociolinguistics is defined from a narrower perspective i.e. micro sociolinguistics which deals with language behavior in specific interactive situations and linguistic deviation detectable from regional, social class, age, sex and educational background.

2.6 The Nature of Language

Language is peculiar to man; it is his chief means of communication with other human beings. It is through language that mutual understanding and meaning are communicated betweens speakers. Palmer (1976:17) says "language is a communication system. It is first spoken and secondly written, hence, there are many languages in the world that are spoken but not written". This explains the point of view that spoken language is primary and the written secondary. Both are referred to as modes of discourse by Osuagwu (1997:106). He adds that the modes of discourse can be sub-categorized according to registers which are also sub-discourse. By fields of discourses. He means the nature of the topic around which the language activity is centered.

Both speech and writing are means of communication however, we find differences between them which may be more important for those concerned with language in a formal academic context. We discover that it is easier and usual, for instance, to use formal language in writing and the informal in speech. Writing is also seen to be more prestigious than speech, perhaps because it is permanent as

witnessed in literature, law, education and so on and is also associated with literacy.

Language is made up of the purely linguistic properties and the extra linguistic factors that are always at play in any form of communication: be it spoken or written. To derive meaning appropriately is to pay attention to sociolinguistic and context of situational. Palmer (1976:51) reminds us that,

> Living languages must not be treated as dead ones, torn from their context of situation but seen as used by people for hunting, cultivating, looking for fish etc … it represents a far-fetched derivative function of language.

This explains why language functions as a tool that is capable of performing intended objectives. Language could be informative, directive, persuasive, per formative, expressive, emotive, etc. (Austin, 1962) depending on the context of situation of the discourse. For this reason, language is said to be always contextualized and not exiting in a vacuum.

Stern (1983) identifies that "in addition to the rules governing language, there are the extra-linguistic factors that determine linguistic competence". This is the distinction between language as a structure and language as actually used. They are the langue-parole theory composed by Saussure (Stern, 1983). This conception implies that language is made up of some organization governed by individual verbal behavior and generating acceptable language would mean abiding by certain

guidelines. It is quite factual to agree that "If we choose to disregard the rules of language or fail through ignorance to obey them, then language can become instead, a barrier to successful communication and integration …" (Crystal and Davys, 1980:4).

In the same vein, Chomsky (1965) creates a similar distinction between what he calls 'competence' from 'performance.' While competence refers to the knowledge of a language or the underlying system of rules, performance is the act of verbal behavior. We also find further elaborations that have been made by linguist's overtime to make clear the composition of any human language. They are:

Langue	-	parole
Competence	-	performance
System	-	use
Code	-	message
Language	-	verbal behavior
Form	-	function

The linguistic aspect of language as mentioned earlier, includes grammar, syntax, semantics and phonetics/phonology while the extra – linguistic properties are factors such as the status and relationship of speakers, the physical, cultural and psychological situation, the nature of the subject matter the primary/secondary

aims of participants. The latter are a powerful pool from which the language user must be able to respond adequately, alongside the linguistic items in order to derive intended communication objectives. Consequently, communicative competence has grown to mean much more than a good knowledge of the rules of grammar. Tar one and Yule (1989:17) observes that:-

> In relatively simple terms, there has been a change of emphasis from presenting language as a set of forms (grammatical, phonological, lexical) which have to be learned and practiced to presenting language as a functional system which is used to fulfill a range of communicative purposes. (Tar one and Yule 1989:17)

We can say that this shift in emphasis is as a result of fairly convincing arguments that the ability to use a language should be described as communicative competence. The components are: grammatical competence – which is as presented in the traditional language; sociolinguistic competence which is as accepted in the society and strategic competence which is known to be the ability to successfully get one's message across. These separations make it somewhat convenient to investigate language from a sociolinguistic perspective i.e. putting into consideration the extra-linguistic factors when communicating.

The scientific study of any human language can be achieved under these broad fundamental branches of linguistics: phonetics/phonology, syntax, lexis and semantics. Other sub-branches like sociolinguistics and applied linguistics for

example are amongst many other disciplines that are of interest in the field of linguistics and in the search for how language works.

The idea of function in language is viewed as belonging to the domain of stylistics discussed under sociolinguistics. Looking at language from the viewpoint of language and also allows linguists to appreciate and to examine the realities of language use. This is the motivation that ahs profoundly affected the domain of modern stylistics.

2.7 Memory Processes

According to Piaget and Inhaler (1973) "memory can be viewed in terms of memory in the strict sense and memory in the wider sense". Piaget and Inhaler (1973) indicate that memory in the strict sense basically means the remembering of a specific event accompanied by the definite feelings on the members part that the event occurred at a particular time and place in the past and that he personally experienced it e.g. he could remember seeing a particular person lying on something with four stands when the person was lying there and why. Memory in the wider sense means the retention of all the products and achievements of one's cognitive development to date.

2.7.1 Phases of the Memory System

There are three phases of memory system namely; buffer, primary and secondary memories (Miller and John-Laird, 1976). Other theorists refer to them as sensory register, short-term memory or working memory, and long-term memory.

2.7.2 Buffer Memory

At this phase, the individual's attention to the environment or the perceptual field is based on either the properties of the perceptual field, request for information by another individual or on the internally generated demands for information.

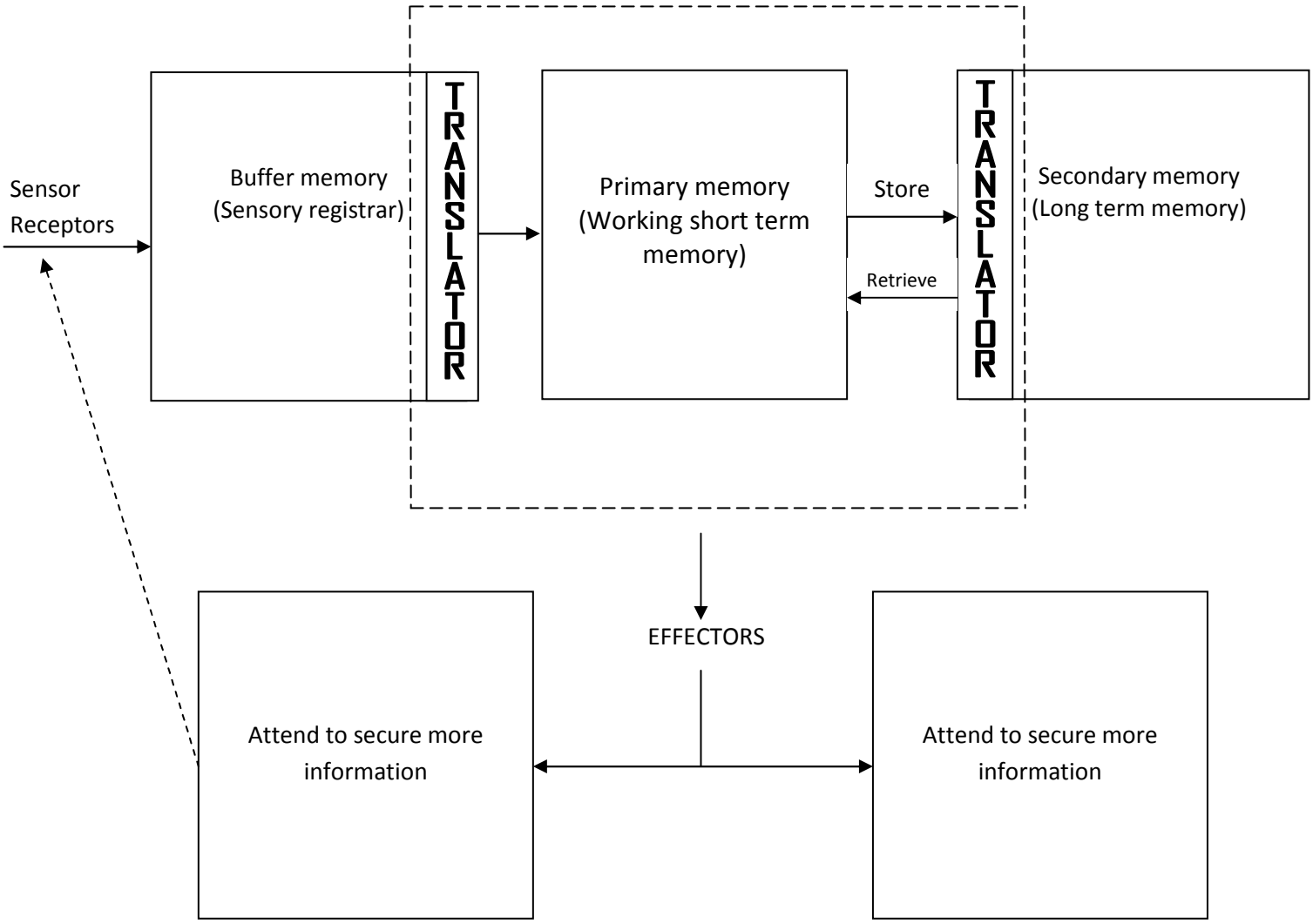
2.7.3 Primary Memory

Information from the buffer memory is passed and stored in the primary memory for further procedure into the secondary memory. The transferred information actually does remain in the primary memory for long but by means of rehearsal and elaboration. It could stay for a relatively longer duration of 10-30 seconds.

2.7.4 Secondary Memory

Secondary memory in individuals is made up of almost an unlimited capacity and high ability over a long period of time, to process and store information for future use by means of remembrance (CF Wausmeirer and Allen 1978). It is said by John and Miller (1979) that for incoming information to be stored in secondary memory, it must be translated into a neutral form within the information processor.

2.7.5 A diagram is given below to show how the memory system works (Miller and John – Laird, 1979)



2.8 Second Language Acquisition

The researcher finds it necessary to discuss second language acquisition because English is used as a second language (L2) in Nigeria. As second language teachers and learners, we need to know how it is acquired and the factors affecting second language learning generally and second language speech in particular. Dulay, Burt

and Krashen (1982:10) define second language acquisition (henceforth SLA) as the process of learning another language after the basics of the first (L1) have been acquired starting at about five years of age and thereafter. Children have easier time learning a second language but anyone can do it at any age. Basically, learning a second language takes a lot of practice. SLA researchers, according to Carter and Nunan (2001:87) look at acquisition in naturalistic contexts where learners pick up the language informally through interacting in the language and in classroom settings. Researchers in SLA are interested in both product (the language used by learners at different stages in the acquisition process) and process (the mental process and environmental factors that influence the acquisition process).

Dulay, Burt and Krashen (1982:14) focus on aspects of the learners' language environment which are said to be directly related to successful second language acquisition. There are:

1. Naturalness of the environment, i.e., the degree which focuses of communication is on content rather than on linguistic form. It is shown that performance where the focus is on natural communication is better than in a formal environment where focus is on the conscious acquisition of linguistic rules. Some exposure to formal environments however is said to be

beneficial especially to adults to be consciously aware of what they are learning.

2. The learner's role in communication. The learner participates in full two way communication i.e. the learner respond in the target language not in a way communication where the learner only listen or reads but does not respond verbally. It is communication in which the learner listens or reads and also responds verbally and writes.

3. Availability of concrete referents: these are subjects and events that can be seen heard or felt.

4. Target language models. The learner's choice of models affects the quality of speech produce.

Dulay, Burt and Krashen (1982) shows the following preferences on the choice of models by learners; peers over teachers, peers over parents and members of one's own ethnic group over non members.

Yarima (2007:101) also investigated the effects of language environment on SLA. The result indicated a significant relationship between the host environment as a sociolinguistic determiner and the performance of student learning second language. His finding is in line with Mason (2006:9) who funds out that in SLA,

the environment like the psychological and physiological variables play a vital role.

Furthermore, this implies that with exposure to language environment factors, sequential language acquisition becomes a creative process by which the rules of a language are gradually internalized. It is a natural process not brought about by formal teaching. Once the system of rules has subconsciously become an integral part of the target learner's store of knowledge. He will be able to produce it.

2.8.1 Motivation

In SLA, motivation may be thought of as the incentive, need, desire that the learner feels to learn the second language (krashen 1982). Three kinds of motivation affect language acquisition (CF Krashen 1982) integrative motivation, instrument motivation and social group identification.

2.8.2 Integrative and Instrument Motivation

According to Gardner and Lambert (1959) in Dulay, Burt and Karshen (1982:47) integrative motivation is the desire to achieve proficiency in a new language in order to participate in the life of the community that speaks the language. On the other hand, instrumental motivation is the desire to achieve proficiency in a new language for utilitarian reasons, such as getting a job. It reflects a practical value and advantage of learning a new language.

Dulay et. al. (1982:48) say that "a number of studies have shown the value of integrative and instrumental motivations, pointing out how each of these types of motivation appears to relate to second language proficiency. Both types of motivation according to Dulay (1982) can positively influence the rate and quality of SLA under certain condition.

2.8.3 Social Group Identification

This is the desire to acquire proficiency in a language spoken by a social group which the learner identifies. Conversely, lack of identification with a given group may result in a learner not wanting to acquire the language or language variety spoken by that group. Some children have been observed to tend towards the dialect or language spoken by members of their own ethnic group (CF Dulay et. al). This shows that the importance of language as an identification marker of the preferred social group cannot be overestimated in the second language classroom.

2.8.4 Target Language Models

The source of the language the learners hear is another significant factor that affects SLA. There may be many speaker models available as anyone who speaks the target language is a potential model but learners do not draw on them equally. Unexpected learning outcomes may well be results of selective attention to different speaker models rather than results of some inherent learning problems.

Language learning research provides various examples of appearance preference for certain speaker models over others under certain circumstances, preference which seems to have obvious effects on the quality of the learner's speech. Dulay et. al. (1982:29) write that: "to date, evidence has been presented which demonstrate speaker model preference of three sorts: peers over teachers, peers over parents and own ethnic group members over non-members".

Therefore, students need to have positive and realistic role models who demonstrate the value of being proficient in the target language. It is also helpful for students to read literature about personal experiences of people from diverse language backgrounds. Through discussions of the challenges experienced by others, students can develop a better understanding of their own challenges.

2.8.5 Peer Groups

Looking at contextual factors in SLA, Walqui (2000:2) points out that, teenagers tend to be heavily influenced by their peer groups. In second language learning, peer group pressure often undermines the goals set by parents and teachers. Peer pressure often reduces the desire of the student to work toward native pronunciation because the sounds of the target language may be regarded as

strange. For learners of English as a second language, speaking like a native speaker may consciously be regarded as a sign of no longer belonging to their native language peer group. Walqui suggests that in working with secondary school students, it is important to keep these peers groups influence in mind and to foster a positive image for proficiency in second language.

2.8.6 Emotional State

The learners' emotional state in combination with attitudes and motivation affect what the learner admits for further processing. According to Dulay et al (1982:52), research has shown for example, the effect of various forms of anxiety on acquisition. The less anxious the learner, the better language acquisition proceeds. Similarly, relaxed and comfortable students apparently can learn more in shorter periods of time accordingly.

2.8.7 Class Interaction

Language learning does not occur as a result of the transmission of facts about language or form a succession of role memorization drills. It is the result of opportunities for meaningful interaction with others in the target language. Therefore, lecturing and recitation are not the most appropriate modes of language use in the second language classroom. Teachers need to move toward more richly

interactive language use, such as that found in communication language Teaching (Wood 1981)

McCain (2000:2) presents four factors which according to him are more relevant to second language acquisition: personality, motivation and environment.

2.8.8 Opportunity

Opportunity and motivation according to McCain (2000:2) works together to effect language acquisition. McCain (2000) further says that motivated students are more likely to seek out opportunities that utilize language skills. McCain quotes Krashen (1982) who argues that: "the learner improves and progresses…when he or she receives second language input that is one step beyond his or her current stage of linguistic competence". For example, if a learner is at stage "I" then acquisition takes place when he or she is exposed to competence input that belongs to level 'I + 1'. Krashen (1982) further says that the learner can still follow the conversation but is exposed to new words or concept. McCain (2000:2) cites examples with theories and teachers who stress that varied and frequent comprehensible input keys to acquisition and that the number of opportunity the brains has to store and reinforce patterns, accents, concepts and meanings of language; that the better this information would be stored and process.

2.8.9 Personality

Personality, according to McCain (2000:3) can also affect second language acquisition. In combination with environment, it can act to inhibit learners or encourage increased opportunity. McCain goes further to say that "introversion has the greatest chance of negative affecting SLA". Students that are afraid of embarrassing themselves by speaking incorrectly or by not being able to speak at all may try to avoid opportunities that would otherwise aid their learning. If teachers correct mistakes and further embarrass shy students, it may isolate students even more. Instead, repeating the corrected statement allows feedback without damaging student ego.

In conclusion, all of these external and internal characteristics affect the way in which language is acquired by the brain. Increased input, lowered anxiety, strong motivation and positive environments help the process of language acquisition progress. It is an interesting overlap between the physical process of the brain and the more mental processes of the mind. While language acquisition is ultimately completed and stored in the brain, emotional and environmental factors greatly affect the process by which it is acquired.

2.9 Second Language Speech/Pronunciation

Writing on second language speech development, Bygate (2001) in Carter and Nunan, 2001:16) states that speaking in a second language (L2) involves the

development of a particular type of communication skill and that oral language tends to differ from written because of its circumstances of production. At the same time, some of the processing skills needed in speaking differ from those involved in reading and writing, adding that there is confusion in current developments between speaking as a skill in its own right with speaking as a central medium for learning. Bygate (2001) further points out that the audio lingual approach to language teaching though the first to offer a clear perspective in the teaching of oral skills, has omitted to take account of two aspects of language in communication which are:

1. It neglected the relationship between language and meaning
2. It failed to provide a social context within which the formal feature such as politeness could be associated with functional aspect.

This brings about the development of the communication approach which emphasizes the functional use of language and the learner as the center of learning in the teaching of language. Nevertheless, none of these approaches were anchored in the study of naturally occurring oral interactive discourse or in the development of oral L2 skills. Recently, skills based model have been used to study oral L2 use within the context of a task approach.

Researchers by Selinker and Douglas (1985), Zelengler and Bent (1991) and Bardovri and Hartford (1993, in Carter and Nunan 2001:16) show that context familiarity with interlocutor, content and type of speech act could impact on non-native speaker talk.

A review of yet another study (Skehan, 1996) by Carter and Nunan on second language pronunciation suggests that speaker's fluency, accuracy and complexity of speech demand capacity and increasing attention to one would limit ones capacity for others with developing implications. That task focus could affect learners' development. For instance, less exploratory or fluent use of language will be likely encouraged if learners are made to focus their attention on accuracy alone. Likewise, pushing them to develop fluency on the other hand might encourage greater use of formulaic chunks of language, discouraging attention to accuracy and reducing speaker's capacity for processing complex language. According to the study, different task types can also differ in their impact and linguistic complexity seemed affected by the cognitive complexity of the task.

Although it is not yet certain whether the use of these tasks can have a long term effect on learners oral language development, task repetition has been shown to have effects on subsequent performance. For instance a student repeating a task carried out two days earlier without any warning on the second occasion produced

significantly more accurate vocabulary, improved a number of collocations and produced more accurate grammar (Carter & Nunan, 2001:17).

In terms of integrating fluency and accuracy Bygate (1987) in Carter and Nunan (2001:18) suggests that learners can usefully practice different patterns of discourse, in terms of 'interaction routines; or information routine'. Willis (1996) as quoted by Bygate (2001:18) proposed the use of a cycle of activities around a central task, involving an 'input phase', a 'rehearsal phase' and a performance phase': where learners first hear a recording of native speakers undertaking a similar task to the one they are to do, providing them with a rough model. They then perform the task in small groups, during which student express themselves without worrying about errors. The teachers observe and provide feedback and finally; students perform the task before the class, with focus on all round performance. Repetition is central to this cycle, but with the assumption that fluency; accurate and complexity will only be integrated towards the end of the cycle.

Major implication emerging from the research is that oral language processing requires integration of accuracy, complexity and fluency. And for the development of oral abilities in children, courses are designed to vary the emphasis on fluency, accuracy and complexity.

2.10 Restricted and Elaborate Codes in Doctor – Patient Interaction

Bernstein (1971) identifies two categories of language vis a vis, elaborate and restricted codes. These codes are distinguished by the extent to which each facilitates speaker's intention to express himself in a verbally explicit form.

Hudson (1980) defines elaborate code as a kind of speech relatively explicit, making fewer assumptions about the hearer's knowledge and is said to be a kind of code associated with schools. Hudson (1980) futher defined restricted code as "a kind of assumption about the knowledge shared by the hearer".

In the beginning of this chapter, it was noted that doctors find it easier to communicate with patients from a similar social background with them. This reflects Bernstein's distinction. A Doctor communicating with a patient form a similar social background with him, would refer to the elaborate code system. Thus, he selects his lexical items from a large assumption that he is being understood.

The use of the elaborate code with a patient belonging to the lower cadre of the social stratum will definitely not work out. The patient is not likely to understand the meanings of questions and required answers for the diagnosis. This is because the elaborate code is too complex for the patient to comprehend.

Therefore, language in terms of speech used in interaction should be determined by the nature of the social stratification. Berstern (1971) confirms this view.

According to him, "the nature of social relationship regulates the nature of speech encounters and creates for the speakers different orders of relevance and relation. Any speech form adapted at a particular situation is taken as the consequence of the form of the social relation and is a quality of social structure"

However, the meaning of the Doctor's interaction with the patient without having some insight into the patient's social decisions and expectations is incomplete. This discussion forms the basis of what shall be discussed in the next chapter

2.11 Theoretical Framework

The theoretical framework of this study is derived from the work of Van Naerssen (1985) where she identifies two kinds of medical communication thus: doctor-patient and doctor-other medical personnel. She claims that, impressionistically both kinds belong to different registers, each with a range of variations within it. Eventually, she concentrates herself on the doctor-other medical personnel communication. Dentist-patient communication by Coleman and Burton (1985) where they identify exposure to speak the language, motivation to listen and read the language and the use of communication to do things helped to boost our communication skills ability between the dentist and the patient. I therefore intend to view the sociolinguistic problems in doctor-patients interaction in these respects.

CHAPTER THREE

METHODOLOGY

3.1 Introduction

This chapter discusses the methodology of the study generally and specifically it discusses the data collection procedure which includes the research instrument, research settings (population and sample), interview techniques and the problems in data collection respectively.

3.2 Problems in Data Collection

In a study of this nature, emergences of problems are expected to erupt. This is so because despite one's attempt to avoid areas of conflict during the research, one is led by circumstances to be faced by some unavoidable problems.

In the process of this research, the researcher was confronted by some unavoidable problems. One of such problems was the initial refusal of the management of Abubakar Tafawa Balewa University Teaching Hospital to allow the researcher access to the patients for interview. I was termed a member of staff of the Criminal

Investigation Department (C.I.D) as a result I was not given the required attention and cooperation.

Furthermore, the patients were suspicious of the purpose for which the information is required of them. They feared being victimized by Doctors if they give much needed information on what they know as regards the attitudes of the Doctors. Another problem encountered was in communication since not all the patients interviewed were able to speak good English. As regards difficulty in communication, this was settled since the researcher could speak Hausa fluently. Hausa and English were the major languages used for the interview.

3.3 Method of Data Collection

The methods used in collecting data in this study are oral interviews and observations method. *i.e.* "primary and secondary source". Primary source include: Oral interviews and Radio tape recorder, while the secondary source of data include: Conference papers, books and journals.

3.4 The Population and Sample

The population of this study is drawn from Abubakar Tafawa Balewa University teaching hospital of Bauchi State. Considering the time and other factors, it is not possible to interview and tape record the voices of the entire population. Thus, the

researcher selected fifty (50) patients and Ten (10) doctors. The accidental sampling is used where all those selected where based on their availability.

3.5 Research Instrument

The research instruments used for the study are: interviews and observations. These instruments are used because the study focuses on spoken aspect of language study. So they will help in providing quick and efficient way of data collection and analysis.

3.5.1 Observation Method

This is the first method employed by the researcher. The researcher spent three months visiting ATBUTH Bauchi to assess the kind of interactions and relationships existing between doctors and patients of different categories and from various wards. During this period, the following wards were visited: Maternity ward, Psychiatry ward, Pediatric ward and the Out-patient Department (O.P.D). However, the interview was accidently conducted with the majority of the respondents from the Out-patient Department. The researcher observed how doctors react to patients whenever they call for help.

In general, this method enabled the researcher to gain insight into the nature of the existing communication process.

3.5.2 Data Collection Procedure

A pilot study was conducted by the researcher for about a period of forty (40) days in other to be possibly assured that the problems between doctor patient interaction is real.

An interview questions is design and distributed accordingly. The interview questions was collected using "on the spot" collection method (NKPA in Hassan, 2007). The method was adopted to avoid cases of missing or unreturned questions.

Special request was made to the doctors and Hospital management team to allow the researcher access to some doctor – patient records which are private and confidential.

3.5.3 Interview Technique

Interviews were conducted orally and informally. The questions (CF Appendix A) were structured along the line of those in the interview questions. From this method, the researcher got several opinions which served meaningful purposes in the analysis of data. Data analysis is now given.

CHAPTER FOUR

4.0 Introduction

This chapter presents the data of the study collected using the methods stated in the previous chapter. It also analyses and interprets the findings in an attempt to answer the research questions.

4.1 Data Presentation and Analysis

This section focuses mainly on the analysis of data presented in the chapter three from the topic sociolinguistic problems in Doctor-patient interaction at the Abubakar Tafawa Balewa University Teaching Hospital, Bauchi.

In the presentation of data, a tabular format is used. In all, a hundred respondents were interviewed: Fifty (50) patients and Ten (10) doctors. The percentages is calculated and fixed beside each category in the table.

Patient's marital status, educational background, sex etc are analyzed to see how these individually and collectively influence the doctor-patient interactions.

4.1 Background Information and Analysis

4.1.1 Table 1 - Sex Category of Patients on Admission

SEX	NO. OF	PERCENTAGES

	RESPONDENTS	
MALE	27	54
FEMALE	23	46
TOTAL	50	100

Table 3.1 shows that 54% of the respondents interviewed are male patients while 46% are female patients. From the information gathered from the Doctors, communication between them and male patients is tractable. They observe that most male patients could speak Pidgin English, at least, even the uneducated ones. He needs to communicate with people outside his ethnic group. Pidgin English is a kind of relief for the uneducated man because rules of grammar, the paradigmatic and systematic rule of combination are of less importance here. However, this is the language associated with the lower class in our society.

Furthermore, in a society like ours, western coupled with ancient beliefs are factors affecting the educational and exposure. They are relegated to the background. This could be linked to the fact that 36% out of the 44% without formal education are female patients.

4.1.2 Table 2 - Patients Level of Education

QUALIFICATION	NO. OF	PERCENTAGE

	RESPONDENTS	
1st Sch. Leaving cert.	12	24
Secondary School	8	16
Above Sec. School	2	4
University Graduate	6	12
Non-formal Education	22	44
TOTAL	50	100

As shown in the table, 24% of the patients interviewed had First school leaving Certificate. 16% of the respondents completed secondary education with only 4% above secondary school, which is equivalent to General Certificate of Education, (G.C.E.) Advanced Level. 12% of the respondents are University Graduates while 44% have no formal education in the sense that they have not been to school.

Highly educated people are not affected by preventable diseases partly because their level of personal hygiene is high because they live in clean environment. This is evident in the fact that 21% out of the 44% without formal education are suffering from preventable diseases.

54% of the Doctors are of the view that communication is easier with educated people. This is in line with the earlier argument that communication is enhanced between people that share similar educational and social background.

At the Abubakar Tafawa Balewa University Teaching Hospital, the languages of interactions are: Hausa, English and other native Bauchi State languages. Hausa and English are the most dominant. The choice of English and Hausa is based on the diverse linguistic situations obtainable in the hospital.

4.1.3 Table 3 - Language Patients Prefer to Speak with the Doctor

LANGUAGES	NO. OF RESPONDENTS	PERCENTAGE
English	18	36
Hausa	26	52
Hausa & English	3	6
Others	3	6
TOTAL	50	100

36% of the respondents prefer to speak English with the Doctor during consultations. 19% out of this number are Coordinate Bilinguals[2] who speak both Hausa and English perfectly but prefer to speak English with the Doctor because they do not understand Hausa. The remaining 17% speak English with the Doctor because they do not understand his mother tongue.

52% of the respondents speak Hausa with the doctor through an interpreter[3]. However, 62% of the doctors interviewed neither speak nor understand Hausa. These doctors are not satisfied with the way these interpreters present the medical history of the patients. They complain that important and necessary points for diagnosis are lost via this process. An example of an interpreter who wrongfully presented a patient's problem was cited by one of the doctors interviewed. He prescribed medicines for malaria fever instead of typhoid fever. This manifests the ability of the interpreter in translating Hausa to English.

6% of the patients speak Hausa and English with the doctor because they are compound bilinguals. They mix these codes to express themselves better.

"Others" in the table stand for other native Bauchi State languages which are also interpreted to the doctor.

72% of the patients do not ask questions during consultations with the doctor. However, this is not just a matter of being shy, though this could be a factor; Patients may feel that they know their stand; it is not up to them to ask questions. Looking at this from a wider perspective, the notions of social class and educational backgrounds come in here. The most dominant in this category are those with little or no formal education. According to them, they do not ask

questions because they believe the doctor knows better than they do, and that they can entrust their lives or health to the doctor.

The remaining 28% ask questions relating to the result of medical tests performed on them and how soon they will be discharged. Respondents in this category are drawn from the table above secondary school level and University graduates. These are enlightened people who feel they should be informed about their own stage of health. This factor reflects their socio-linguistic expectations. Furthermore, they ask for explanation where the medical procedures are not explained.

4.1.4 Table 4 - Doctor's Non-Explanation of Medical Procedures

RESPONSES	NO. OF RESPONDENTS	PERCENTAGES
ALWAYS	4	54
NOT ALWAYS	2	16
SOMETIMES	3	18
NOT AT ALL	1	12
TOTAL	10	100

Explanation of medical procedures here involves step by step explanations of medical tests and reasons for operations performed on patients.

The 16% who always have medical procedures explained to them are mainly educated people who communicate effectively with the doctor.

4.1.5 Table 5 - Number of Patients attended Daily

NO. OF PATIENTS	NO. OF RESPONDENTS	PERCENTAGE
Less than 20	4	8
20 – 30	9	18
30 – 40	28	56
40 - and above	9	18
Total	50	100

Table 4.1.6 shows that majority of the Doctors attend to between 30-40 patients daily. It is too cumbersome for a Doctor to attend to 36 patients in a day. This reduces his chances of paying more and desired attention to the patients. As a result of this heavy work-load, it becomes very difficult for them to give explanations of medical procedures they perform on patients.

For instance, one of the patients explained:-

> Since i.ve been on admission two months ago, my Doctor has never given explanations obligatorily on the results of laboratory tests performed on me. I've taken this up myself to ask for explanations.

In the last chapter, it is observed that Doctors communicate easily with patients sharing similar social and educational backgrounds with them. However, the research carried out shows something contrary to the earlier assertion made. 54% of the Doctors are of the view that communication is enhanced between them and patients sharing similar education and social backgrounds. 48% disagree with this view. The reason they give is that most educated people feel they know the nature and cause of the disease that bring them to the Hospital.

One of the Doctors at A.T.B.U.T.H comments:

> They come to the Hospital armed with medical terms they have little or no knowledge of. For instance, one of my patients told me this morning that he is hypertensive because of pains around the chest. It took me quite a long time to convince him that his problem is not hypertension but rather a disease associated with the lungs.

Furthermore, these patients are very difficult to convince when it comes to operation. Most of them believe that they can use drugs as an alternative to being operated on.

52% of the Doctors interviewed rate the patients' communicative competences as unsatisfactory. 24% agree that the patients' communicative competences are partially satisfactory while another 24% says it is fair. The reason for this is not far-fetched. Most of the patients are illiterates, 44% have no formal education.

Furthermore, given a situations such as feeling unwell and being asked to describe one's state, only a few people have the ability to expound their state in a logically precise and well-sequenced manner. This is not the question of middle class versus lower class. The kind of communication here cuts across class background and relates more to the differences between a professional training and lack of it.

4.2 Raw Data Analysis

4.2.1 Interactions made Between the Doctors and the Patients

DOCTORS	PATIENTS	PERCENTAGES
Doctor 1	5	10%

Doctor 2	5	10%
Doctor 3	5	10%
Doctor 4	5	10%
Doctor 5	5	10%
Doctor 6	5	10%
Doctor 7	5	10%
Doctor 8	5	10%
Doctor 9	5	10%
Doctor10	5	10%
TOTAL	50	100%

The table above illustrates the interactions made between the doctors and the patients where each of the ten doctors attends to five patients. Here are some examples of how the interactions occurred but limited to two patients per doctor:

Example 1

This interaction took place at the General Out Patient Department of the Teaching Hospital:-

D1: What is your Problem?

P1: My stomach is paining me.

D1: Since when?

P1: Yesterday in the afternoon.

D1: I will prescribe some drugs for you.

P1: Thank you.

Example 2

D1: How are you?

P2: I am fine sir.

D1: What is your problem?

P2: I am just having problem with my bladder.

D1: I will send you to the laboratory for some tests.

P2: OK Sir.

Example 3

D2: Have a sit please.

P2: Thank you Doctor.

D2: Any problem?

P2: Yes Doctor, for the past two days I could not be able to eat solid food because of my throat.

D2; I will prescribe some drugs for you.

P2: Thank you Doctor.

Example 4

D2: Please come inside.

P2: Ok Doctor.

D2: What happened?

P2: I have a swollen leg.

D2: Since when?

P2: Somebody hit me while playing football yesterday.

D2: Go to the X-ray laboratory for an X-ray and bring back the result.

P2: Yes sir.

Example 5

D3: Any problem?

P1: My chest is paining me Doctor.

D3: For how long?

P1: Four days.

D3: Take this, go to the laboratory for scanning.

P1: Ok.

Example 6

D3: What is worrying you?

P2: Chronic Ulcer

D3: Have you taken any drugs before?

P2: Yes sir,

D3: Are you with the drugs or the prescription?

P2: No sir, I left them at home.

D3: You need to bring them before I could prescribe another drug for you.

Example 7

D4: What is your problem?

P1: I usually have problem with my sight at night.

D4: How do you see things that are near and those that are far?

P1: I can see near objects fairly but I cannot see far objects.

D4: Go to the laboratory and conduct a sight test and bring back the result.

P1: Ok, thank you.

Example 8

D4: What happened to your eyes?

P2: Somebody hit my left eye with a stick.

D4: Since when?

P2: Two days ago.

D4: You will undergo some tests first.

P2: Ok Sir.

Example 9

D5: Madam.

P1: Yes Doctor.

D5: Can you read those letters over there?

P1: I can only read the big letters Doctor.

D5: You have a minor problem, just use these eye drops and drugs for four weeks and come back.

P1: Thank you Doctor.

Example 10

D5: Welcome.

P2: Yes Sir.

D5: What is your problem?

P2: I cannot read Newspaper Doctor.

D5: Let me examine your eyes and recommend the appropriate glasses for you.

P2: Yes sir.

Example 11

This conversation took place at the Genecology Ward of the Teaching Hospital.

D6: Hajiya, what is wrong with you?

P1: Stomach problem.

D6: Go and undertake an Ultra Scan and bring the result to me.

P1: Thank you, sir.

Example 12

D6: Why are you here Madam?

P2: My back and waist are paining me.

D6: For how long?

P2: Two weeks and some days.

D6: Have you taken any medication?

P2: No.

Example 13

D7: Hello, what is the problem?

P1: I am not alright; I am vomiting for the past three days.

D7: Do you feel feverish?

P1: Yes.

D7: Conduct a test and let me see the result.

P1: Ok.

Example 14

D7: Welcome Hajiya Amina.

P2: Good afternoon Dr. Yusuf.

D7: Where have you been to?

P2: I travelled to Saudi Arabia.

D7: You have missed your Ante-natal two times.

P2: What can I do Doctor?

D7: You can do it now but try not to miss it again.

P2: Thank you Doctor, I will try.

Example 15

D8: Any problem?

P1: Yes, I had a dislocation on my left hand.

D8: Do you have any other problem apart from the dislocation?

P1: No.

D8: Go and do a X-ray to ascertain the extent of the problem.

P1: Ok, thank you.

Example 16

D8: What is wrong with your son?

P2: He has been crying since yesterday in the night.

D8: Did you give him anything?

P2: No.

D8: Bring him here; take this and buy the prescribed drugs for him.

P2: Ok.

Example 17

D9: Madam, stop and talk to me.

P1: Ok Doctor.

D9: What is the problem?

P1: I have a right leg ulcer.

D9: This is serious; I will refer you to the National Hospital Abuja.

P1: Ok Doctor.

Example 18

D9: Young man, have a seat.

P2: Thank you sir.

D9: What is your problem?

P2: I can't sleep for three days now.

D9: I would prescribe a drug that will help you sleep, then come back after a day.

P2: Ok.

Example 19

D10: What is your name?

P1: My name is Nabi'atu.

D10: Any problem? You don't look sick.

P1: Yes, I only I want to check my blood pressure and seek appropriate advice.

D10: Then bring your hand.

P1: Ok.

Example 20

D10: You are welcome, have a seat.

P2: Thank you Doctor.

D10: Any problem?

P2: Yes, I am bleeding since yesterday evening and I am three months pregnant.

D10: Let me examine you thoroughly to ascertain the condition of the pregnancy.

P2: Ok Doctor.

4.2.2 Instances where the Doctor and the Patient Speaks the Same Language

LANGUAGES SPOKEN	DOCTORS	PATIENTS	PERCENTAGE
Hausa	3	35	65
English	6	15	25
Hausa/English	1	5	10
TOTAL	10	50	100

The table above shows that 65% of the patients preferred to speak Hausa Language with the Doctors because it is the most popular language in the region. Hausa is the mother tongue of most of the people of that geographical area. Also about 25% of the people whom are mostly the educated ones speak English to the Doctors while 10% speaks both English and Hausa. Here are some examples of how the interactions that took place at the Teaching Hospital:

Example 1 - HAUSA TO HAUSA

D: Barka da Zuwa

P: Sannu da aiki Likita.

D: Menene yake damunki?

P: Zazzabi da Ciwon kai.

D: Zan tura ki wajen gwaji.

P: Nagode Likita.

Example 2 - ENGLISH TO ENGLISH

D: You are welcome.

P: Thank you Doctor.

D: What is your problem?

P: Chest pain.

D: I will direct you to X-ray department.

P: Ok Doctor.

Example 3 - Hausa and English

D: What is your problem?

P: Wallahi ciki na ne yake ciwo.

D: Tun yaushe?

P: Since in the morning.

D: Ba damuwa, I will recommend Ultra Scan for you.

P: Thank you, Likita.

4.2.3. Instances where the Doctor and the Patient use Different Language Background Which Led to Communication Breakdown

LANGUAGES SPOKEN	DOCTORS	PATIENTS	PERCENTAGE
English	7	5	10
Hausa	1	40	80
Pidgin	2	5	10
TOTAL	10	50	100

The table above shows some scenarios where by the patients speaks different language to the doctors and the patients do not understand the language the doctors speaks and vice versa. A serious communication breakdown has been observed. About 7 doctors speaks English Language to 10% of the patients where by the patients does not understand what the doctors were saying. Also 80% of the patients expressed their problems in Hausa to the doctor where he did not understand what they were saying and 2 doctors were able to speak Pidgin English to 10% of the patients, yet they could not understand each other. In this respect therefore, difficulties arise because the doctors could not be able understand the patients' problems and prescribe medication appropriately to the patients as evidenced in examples below:

Example 1 - Doctor to Patient

D: You are welcome Mr. Hassan.

P: Mene?

D: What is your Problem?

P: Ban gane ba.

D: It seems you don't understand me; I have to know your problem first.

P: Me kace?

D: I cannot take any action on you.

P: Ikon Allah.

Example 2 - Patient to Doctor

P: Likita wuya na yana ciwo.

D: What?

P: Likita tun jiya bana iya juya wuyan.

D: I can't understand you.

P: Bana jinka fa.

D; it seems there is a problem here.

Example 3 - Doctor here Speaks Pidgin English to the Patient

D: Una welcome.

P: Likita kace mene?

D: Wetin de disturb you?

P: Ban gane ba.

D: Wetin be your problem?

P: Wannan yaren likitan bana ganewa.

D: I go look for translator.

4.2.4 Instances where Effective Communication was achieved

MODE OF COMMUNICATION DOCTOR – PATIENT	NO. OF PATIENTS	PERCENTAGE
English to English	8	16
Hausa to Hausa	40	80
Pidgin to Pidgin	2	4
TOTAL	50	100

From the table above, an effective communication is achieved. There is a free flow of information in the conversation. About 16% of the patients are able to communicate to the doctors in English. Hausa to Hausa interaction takes place between 80% of the patients and the doctors while 4% of the patients are able to speak Pidgin English with the doctors. Below are some of the examples:

Example 1 - English to English

D: You are welcome.

P: Thank you Doctor.

D: What is your problem?

P: I have a swollen hand.

D: What happened?

P. I hit it with a car door.

D: I am sorry; I will prescribe some drugs for you.

P: I am grateful, Sir.

Example 2 - HAUSA TO HAUSA

D: Barka da zuwa

P: Nagode Likita.

D: Menene yake damun ki?

P: Ciwon ciki ne tun jiya.

D: Zan tura ki wajen gwaji kije a yi miki.

P: To nagode Likita.

Example 3 - PIDGIN TO PIDGIN

D: Wetin de worry you?

P: Doctor, na my leg dey pain me.

D: Wetin happen to di leg?

P: I no know, E jus dey pain me.

D: You go go buy dis drugs.

P: No wahala.

4.2.5. Instances of Harassments by the Doctors

INSTANCES OF HARASSMENTS	NO. OF DOCTORS	PERCENTAGES
Always	5	50
Sometimes	3	30
Not at all	2	20
TOTAL	10	100

The table above indicates a scenario whereby the harassment occurs between the doctors and the patients which as a result successful diagnosis cannot be achieved. It is paramount for the doctor to tolerate whatever act exhibited by the patient as most of these patients did not go to school. They lack manners of associating with people. About five doctors constituting 50% of the doctors in the study area always harass their patients in the course of consultation and 30% of the doctors sometimes harass their patients while 20% do not harass their patients at all as seen in examples below:

Example 1 - ALWAYS

D: Who is next on the cue?

P: I am.

D: Answer me and come in quickly!

P: Yes sir.

D: What is wrong with you!

P: I am sick.

D: I knew you are sick, just tell me what is your problem or you get out of my office.

P: Take it easy Doctor.

D: I will call the next person because I don't have your time.

Example 2 - SOMETIMES

D: Good afternoon.

P: Thank you Doctor.

D: Any problem?

P: Yes sir, amma ban san me yake damu nab a.

D: Then get out of my office since you don't know what is wrong with you.

P: I am sorry please.

Example 3 - Not at All

D: Good morning.

P: Thank you Doctor.

D: Any problem?

P: Yes, my right arm is seriously paining me.

D: Since when?

P: Yesterday.

D: Take these drugs it will relieve the pain and come back after three days.

P: Thank you, Sir.

4.2.6. Instances Where Simple and Complex Words are Used by the Doctors

WORDS USED	NO. OF DOCTORS	PERCENTAGES
Simple	6	60
Complex	3	30
Simple/Complex	1	10
TOTAL	10	100

The table above shows the scenarios where simple words were used between the Doctors and the patients to the extent that even those that did not go to school but can understand little English would understand what the doctor is saying and also the doctor would properly understand the problems of the patient. When complex words especially those that has to do with medical terms were used, even the educated patients would not understand them. The episodes below show the use of simple and complex words between the doctors and the patients:

Example 1 - SIMPLE WORDS

D: What is your problem?

P: I have a deep cut on my thigh.

D: I can see it from here, you will undergo surgery.

P: Ok, thank you sir.

Example 2 - COMPLEX WORDS

D: How can I help you?

P: My Sickle Cell is disturbing me.

D: I will prescribe DF118 for you.

P: I don't understand Doctor, what is it?

Example 3 - SIMPLE/COMPLEX WORDS

D: You are welcome.

P: Thank you.

D: From the Laboratory report, it has indicated that you have diagnosed with a left leg Sickle Cell Ulcer.

P: I don't understand.

D: Don't worry I will explain it for you.

P: Thank you.

CHAPTER FIVE

SUMMARY, CONCLUSION AND RECOMMENDATIONS

5.0 Introduction

This chapter being the final, summarizes the findings of the study, concludes and makes general suggestions and recommendations based on the findings.

5.1 Findings

The following are the summary of some findings of this study.

1. Based on the interactions made between doctors and patients at ATBUTH, Bauchi. It was found that most of the patients that patronize the hospital speak their local dialect which is Hausa with only few that speaks English.
2. It is found that due to language variation, there are instances of communication breakdown leading to difficulties in understanding the patients' problems in order to prescribe medication appropriately as most of the patients cannot ask questions regarding their health history.
3. Patients' level of education is very low as most of the people of the region do not further their education beyond Senior Secondary School as it is mentioned in the previous chapters.
4. Most of the non-native doctors do have serious problems in prescribing medications to the patients without the use of interpreters as most of the patients understand their local dialects as illustrated in the raw data analysis of the interactions between the doctors and the patients.
5. It is found that instances of harassments do occur as a result of variation in language between the doctor and the patient whereby inability of the doctor and the patient to understand each other may lead to one harassing the other intentionally or unintentionally.

6. It is found that there is free flow of communication between the indigenous doctors and the patients leading to proper diagnosies and medications.

7. It is found that most of the people patronizing the hospital on daily basis are female patients as it is shown from a table in the previous chapter.

8. During the course of the research, it is discovered that most of the doctors in the teaching hospital prefer to speak English to the patients, even the indigenous and regional doctors from the northern part of the country.

9. It is found that most of the patients whom where been diagnosed by the doctors are children and aged on patients.

10. It is found from the analysis that the patients lack proper orientations, hospitals protocols and medical procedures.

5.1 Summary and Conclusion

So far, we have looked at language in social context and at the same time related this phenomenon to doctor – patient interactions. Each of the different branches of the linguistics can be a key to the identification of sociolinguistic problems in doctor – patient interactions.

People of different regional, social and educational background always differ, to some degree in the form of language they use. Furthermore, these differences can

hinder free exchange of meaning. Variations can occur due to different uses of sounds and voice qualities. These are treated under phonology and phonetics. There may be more fundamental variations affecting the way people build up their words (Morphology), put words into sentences (Syntax), give meanings to utterances, (Semantics) and construct larger patterns of meanings out of them (Discourse).

Most patients begin at random, introduce a range of observations as they come to mind. It may be therefore, that the most important factor in patients mind will not appear first in the sequence. Doctors who attempt to clarify patient's exposition one point at a time, run the risk of prematurely focusing on a factor which will eventually turn out to be minor or unimportant. There is a great deal to be said for attending to the whole medical history rather, the Doctor should recapitulate with more specific questions. Expecting the patient to go straight to the point is not realistic for many patients either find it difficult because of their own psycholinguistic limitations or feel they should not because of their different socio-linguistic expectations.

In relations to the point mentioned above, it is worth pointing to the importance of the use of language to set an atmosphere for diagnosis, e.g. social chat about weather, health and family. Many patients, mostly educated ones feel that some

form of "phobic exchange"[1] is necessity before the commencement of real diagnosis.

However, Doctors with a heavy schedule find this irritating to incorporate in the limited time they spend with each patient and yet there are patients from certain social background who would feel it was bad manners not to engage in this kind of chat.

Doctors should never forget that patients are already equipped with all kinds of ideas about the nature of diseases. Many of these ideas are stereotypes and acknowledging them is an essential part of any therapeutic strategy. One way, for instance, is actually to ask for the patient's family background to know whether the disease is hereditary. Furthermore, some patients react to certain drugs, this could be overcome by asking if the patient reacts to such drugs to avoid adverse effects such as irritation etc.

Doctors should always remember to observe non-verbal communications during consultations. For instance, a patient comes to the doctor to complain of pains in the chest. In the process, he coughs violently. It might not occur to the patient that the cough has anything to do with the pains he initially complained of. This is a non-verbal clue, when heeded to, will help the doctor in prescribing the suitable medicine. These non-verbal clues must be followed up with medical examinations.

On improving the communicative competence of patients, Seminars and mass literacy programmers should be organized always to enlighten them on the need to express themselves informatively to the doctors.

It is plain that the role of the linguist in this field is specific but potentially great. However, in a brief survey such as our space allows, we have time for no more than a bird's eye-view of this complex study. I hope it is clear even from only few examples that the contribution of linguistics to the understanding and practices of medical care is potentially great and that increasing attention will be paid to the need for empirical studies in research and a more systematic exposition of these factors in medical training.

5.2 Recommendations

In this section, we offer some recommendations that would help in improving the performance of communicative competence between the doctors and patients in the hospital. The recommendations are based on the findings of this research.

1. Establishment of national objectives for the teaching and assessment of knowledge, skills and attitude of communication at all levels.
2. Identification and further development of the necessary knowledge, skills and attitudes fundamental to establishing effective doctor-patient relationships.

3. Further development of sensitive, reliable and laid methods of evaluating foreign doctors' competence and performance as well as their ability to speak local languages.
4. Establishment of collaborative faculty development projects in doctor-patient interactions so that unnecessary lost of lives as a result of poor interactions between doctors and patients can be reduced or avoided.
5. Orientation lectures/workshops should be introduced for the patients by the hospital management or National Orientation Agency (N.O.A), in order for the patients to acquire more knowledge on how to interact with doctors in hospitals.
6. Selected Nigerian Teaching Hospitals in each region should be designated as Teacher Training Centers for doctor-patient interaction/communication skills training.
7. This document should be made available to all hospitals management boards, medical colleges, Faculties of Arts and Federal Ministry of Health's Curriculum Review Committee.
8. The government should be giving more priority to the indigenous doctors when employment because they can speak the mother tongue language of the patients.

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APPENDIX A

INTERVIEW QUESTIONS

Introduction: Please respond to the following questions accurately to the best of your knowledge.

Thank you.

1. What is your gender category?
   (a) Male ( ) (b) female ( )

2. How old are you?
   ……..

3. What is your educational status?
   (a) Primary school ( ) (b) secondary School ( ) (c) University ( )

4. How frequent you visit Hospital?
   (a) Daily ( ) (b) Weekly ( ) (c) Monthly ( ) (d) When Sick ( )

5. How much time do you spend in the Teaching Hospital?
   (a) 0 – 1 hour ( ) (b) 0 – 2 hours ( ) (c) 3 hours and above ( )

6. Did you always get the attention of the doctors?
   (a) Yes ( ) (b) No ( )

7. Do the doctors harassed you?
   (a) Yes ( ) (b) No ( )

8. Which of the doctors do you want to attend to you?
   (a) Indigenous doctors ( ) (b) Non – native doctor ( )

9. Which Language do you prepare to speak with the doctors?
   (a) Hausa ( ) (b) English ( )

10. How often do you have interaction problem with the doctors?
    (a) Once ( ) (b) Sometimes ( ) (c) Always ( )

APPENDIX B

Letter to Patients

January, 2012.

Dear Sir/Madam

I am a student studying English Language at Bayero University, Kano.

For my final year M.A English Language Dissertation. I am writing on the sociolinguistic problem between doctor – patient interactions.

Interactions is an important part of everyday life, but especially between doctors and patients, particularly when serious illnesses are involved. I know this from my own experiences.

Obviously, medical consultations are private and confidential, so in order to protect any one taking part, I would not be made aware of their identity. The finished report may include analysis of the conversation but no name would be used.

Your's sincerely,

Bello Abdullahi

APPENDIX C

Extracts from General Medical Council Website

Guidelines Regarding Informed Consent

1. Successful relationships between doctors and patients depend on trust. To establish that trust you must respect patients' autonomy - their right to decide whether or not to undergo any medical intervention even where a refusal may result in harm to themselves or in their own death. Patients must be given sufficient information, in a way that they can understand, to enable them to exercise their right to make informed decisions about their care.

3. Effective communication is the key to enabling patients to make informed decisions. You must take appropriate steps to find out what patients want to know and ought to know about their condition and its treatment. Open, helpful dialogue of this kind with patients leads to clarity of objectives and understanding, and strengthens the quality of the doctor/patient relationship. It provides an agreed framework within which the doctor can respond effectively to the individual needs of the patient.

   Additionally, patients who have been able to make properly informed decisions are more likely to cooperate fully with the agreed management of their conditions.

Providing sufficient information.

4. Patients have a right to information about their condition and the treatment options available to them. The amount of information you give each patient will vary, according to factors such as the nature of the condition, the complexity of the treatment, the risks associated with the treatment or procedure, and the patient's own wishes. For example, patients may need more information to make an informed decision about a procedure which carries a high risk of failure or adverse side effects; or about an investigation for a condition which, if present, could have serious implications for the patient's employment, social or personal life.

5. The information which patients want or ought to know, before deciding whether to consent to treatment or an investigation, may include:

- details of the diagnosis, and prognosis, and the likely prognosis if the condition is left untreated;
- uncertainties about the diagnosis including options for further investigation prior to treatment;
- options for treatment or management of the condition, including the option not to treat;
- the purpose of a proposed investigation or treatment; details of the procedures or therapies involved, including subsidiary treatment such as methods of pain

relief; how the patient should prepare for the procedure; and details of what the patient might experience during or after the procedure including common and serious side effects;

- for each option, explanations of the likely benefits and the probabilities of success; and discussion of any serious or frequently occurring risks, and of any lifestyle changes which may be caused by, or necessitated by, the treatment;
- advice about whether a proposed treatment is experimental;
- how and when the patient's condition and any side effects will be monitored or re-assessed;
- the name of the doctor who will have overall responsibility for the treatment and, where appropriate, names of the senior members of his or her team;
- whether doctors in training will be involved, and the extent to which students may be involved in an investigation or treatment;
- a reminder that patients can change their minds about a decision at any time;
- a reminder that patients have a right to seek a second opinion;
- where applicable, details of costs or charges which the patient may have to meet;

6. When providing information you must do your best to find out about patients' individual needs and priorities. For example, patients' beliefs, culture, occupation or other factors may have a bearing on the information they need in order to reach a decision. You should not make assumptions about patients'

views, but discuss these matters with them, and ask them whether they have any concerns about the treatment or the risks it may involve. You should provide patients with appropriate information, which should include an explanation of any risks to which they may attach particular significance. Patients whether they have understood the information and whether they would like more before making a decision.

Responding to questions

9. You must respond honestly to any questions the patient raises and, as far as possible, answer as fully as the patient wishes. In some cases, a patient may ask about other treatments that are unproven or ineffective. Some patients may want to know whether any of the risks or benefits of treatment are affected by the choice of institution or doctor providing the care. You must answer such questions as fully, accurately and objectively as possible.

Withholding information

10. You should not withhold information necessary for decision making unless you judge that disclosure of some relevant information would cause the patient serious harm. In this context serious harm does not mean the patient would become upset, or decide to refuse treatment.

11. No-one may make decisions on behalf of a competent adult. If patients ask you to withhold information and make decisions on their behalf, or nominate a relative or third party to make decisions for them, you should explain the importance of them knowing the options open to them, and what the treatment they may receive will involve. If they insist they do not want to know in detail about their condition and its treatment, you should still provide basic information about the treatment. If a relative asks you to withhold information, you must seek the views of the patient. Again, you should not withhold relevant information unless you judge that this would cause the patient serious harm.
12. In any case where you withhold relevant information from the patient you must record this, and the reason for doing so, in the patient's medical records and you must be prepared to explain and justify your decision.

    Presenting information to patients.
13. Obtaining informed consent cannot be an isolated event. It involves a continuing dialogue between you and your patients which keeps them abreast of changes in their condition and the treatment or investigation you propose. Whenever possible, you should discuss treatment options at a time when the patient is best able to understand and retain the information. To be sure that

your patient understands, you should give clear explanations and give the patient time to ask questions. In particular, you should:

- use up-to-date written material, visual and other aids to explain complex aspects of the investigation, diagnosis or treatment where appropriate and/or practicable;
- make arrangements, wherever possible, to meet particular language and communication needs, for example through translations, independent interpreters, signers, or the patient's representative;
- where appropriate, discuss with patients the possibility of bringing a relative or friend, or making a tape recording of the consultation;
- explain the probabilities of success, or the risk of failure of, or harm associated with options for treatment, using accurate data;
- ensure that information which patients may find distressing is given to them in a considerate way. Provide patients with information about counseling services and patient support groups, where appropriate;
- allow patients sufficient time to reflect, before and after making a decision, especially where the information is complex or the severity of the risks is great. Where patients have difficulty understanding information, or there is a lot of information to absorb, it may be appropriate to provide it in manageable

amounts, with appropriate written or other back-up material, over a period of time, or to repeat it;

- involve nursing or other members of the health care team in discussions with the patient, where appropriate. They may have valuable knowledge of the patient's background or particular concerns, for example in identifying what risks the patient should be told about;
- ensure that, where treatment is not to start until some time after consent has been obtained, the patient is given a clear route for reviewing their decision with the person providing the treatment.

APPENDIX D

Communication Skills

An effective effort has been devoted in recent years to improvement in skills in Communication. Deficiencies in this area are responsible for a high proportion of complaints and misunderstandings. Such skills have particular significance for the relationship between doctor and patient but they are important in other interactions, for example with medical and nursing colleagues.

Doctors must be good listeners if they are to understand the problems of their patients and they must be able to provide advice and explanations that are comprehensible to patients and their relatives. Skill in communication is also at the heart of counseling and is an essential ingredient in the establishment of effective

teamwork. It is one example of several skills that doctors share with nurses and other health care professionals; in this context, we note the moves towards shared courses in selected areas that are being developed in some schools. Finally, it is to be remembered that the written word is no less important than the spoken; students should be able to demonstrate proficiency in maintaining proper records and an ability to present a good quality written report.

APPENDIX E

KEY:

D: Doctor

P: Patient