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UNITE DE RECHERCHE ET DE FORMATION DOCTORALE EN LANGUES ET LITERATURES

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A DISCURSIVE ANALYSIS OF THE LANGUAGE OF HOSPITAL RECEPTIONISTS: THE CASE OF SOME HOSPITALS IN YAOUNDE

A Dissertation Submitted in Partial Fulfillment of the Requirements for the Award of a Master's Degree (MA) in English

SPECIALISATION: SOCIOLINGUISTICS

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DEDICATION

TO MY PARENTS**:**

AWAH HANS MBEH AND GRACE ETAH:

MY SISTER:

MBEH SILVIAN FEMBE

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ABSTRACT

This research on the language used by hospital receptionists stems from the premise that many hospitals in Cameroon, though with well-trained personnel, still do not use language appropriately especially when receiving patients. The conviction in this research is that, by examining the issue from the point of view of how receptionists talk to patients, some insights might be revealed as to why complaints keep persisting despite improvements in the health care facilities. In this light, the main objective of this work is to investigate the discursive and linguistic strategies used in the hospital reception discourse in two-well selected hospitals in the capital city, Yaounde. Two methods are actually used in the collection of the data for this work; the use of recorded reception sessions and questionnaires. Discursive and linguistic strategies are noted as they have a vital role in shaping healthcare moods. This work is undertaken within the framework of Critical Discourse Analysis drawing especially from Tuen Van Dijk's Socio-Cognitive Approach which states that properties of language that can vary as a function of social power should be considered when analyzing language (Van Dijk, 2023). Discourse plays a very important part in medicine and medical discourse in the broadest sense has profound anthropological significance, as modes of social action, writing, and speaking help constitute medical institutions, curative practices, and elations of authority in and beyond particular healing encounters. Based on the analysis of the corpus under study, we realized or noticed that the manner or ways in which hospital receptionists use language is not appropriate as seen from the discursive and linguistic strategies which emanated from the data. The study also revealed the poor use of kinetics in the method of communication and interaction. These findings led us to the conclusion that language used during receptionists-patients interaction in hospitals is the course of the persistent complaints about the manner in which receptionists receive patients in hospitals. A change in the language during patient-nurse/doctor encounter at the level of the receptionist will boost healthcare processes and improve the healing situation in our hospitals.

Keywords and Expressions: Discourse, CDA, Hospital Receptionists.

RESUME

Cette recherche sur le langage utilisé par les réceptionnistes des hôpitaux part du principe que de nombreux hôpitaux au Cameroun, bien que disposant d'un personnel bien équipé, n'utilisent toujours pas le langage de manière appropriée en particulier lorsqu'ils reçoivent des patients. La conviction de cette recherche est qu'en examinant la question du point de vue de la façon dont les réceptionnistes parles au patients, on pourrait comprendre pourquoi les plaintes persistent malgré l'amélioration apportes aux établissements de soin de santé. Dans cette optique, l'objectif principal de ce travail est d'étudier les stratégies discursives et linguistiques utilisées dans le discours d'accueil des hôpitaux dans deux hôpitaux bien choisir de la capital, Yaoundé. Deux méthodes sont utilisées pour la collecte des données dans le cadre de ce travail : l'utilisation des séances d'accueil enregistre et de questionnaires. Les stratégies discursives et linguistiques sont notées car elles jouent un rôle essentiel dans la formation des états d'âme en matière de soin de santé. Ce travail a été entrepris dans le cadre de l'analyse critique du discours, en s'inspirant notamment de l'approche sociocognitive de Tuen Van Dijk, qui affirme que les propriétés du langage qui peuvent varier en fonction du pouvoir social doivent être prises en compte lors de l'analyse du langage (Van Dijk, 2023). Le discours joue un rôle très important en médicine et le discours médical au sens large a une profonde signification anthropologique, car les modes d'action sociale, d'écriture et de parole contribuent à constituer les institutions médicales, les pratiques curatives et les relations d'autorités dans et au-delà des rencontres de guérisons particulières. Sur la base de l'analyse du corpus étudié, nous avons réalisé ou remarqué que la manière dont la réceptionniste de l'hôpital utilise la langue n'est pas appropriée comme le montre les stratégies discursive et linguistiques qui émanent des données. L'étude a également révélé la faible utilisation de la cinétique dans la méthode de communication et d'interaction. Ces résultats nous ont amenés à conclure que le langage utilisé lors de l'interaction entre les réceptionnistes et les patients dans les hôpitaux est à l'origine des plaintes persistantes concernant la manière les réceptionnistes accueil les patients dans les hôpitaux. Un changement dans le langage utilisé lors de la rencontre entre le patient, l'infirmière et le médicine au niveau de la réceptionniste stimulera les processus de soin de santé et améliorera la situation de guérison dans nos hôpitaux.

***Mots clés et expressions** : Discours, CDA, Réceptionnistes d'hôpitaux.*

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LIST OF CHARTS

LIST OF ABBREVIATIONS

- CA: Conversational Analysis
- LSI: Language and Social Interaction
- CDA: Critical Discourse Analysis
- SCA: Socio-Cognitive Approach
- DM: Discourse Markers
- IRF: Initiation Response and Follow -up
- UK: United Kingdom
- HGOPY: l'hopital Gynechologie et Obstetrique du Yaoundé
- YS: Yes
- AV: Average
- GD: Good
- VG: Very Good
- BD: Bad
- SM: Sometimes
- R: Receptionists
- P: Patient

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CHAPTER ONE

GENERAL INTROIDUCTION AND BACKGROUND TO THE STUDY

1.0 Introduction

According to Abram (1997), every attempt to definitively say what language is, has been subject to a curious limitation. This is because the only medium with which we can define language is language itself. We are therefore unable to circumscribe the whole of language within our definition. It may be best, then, to leave language undefined, and to thus acknowledge its open-endedness, its mysteriousness. Nevertheless, by paying attention to this mystery we may develop a conscious familiarity with it, a sense of its texture, its habits, and its sources of sustenance. Abram (ibid: 53) follows that the more prevalent view of language, at least since the scientific revolution, and still assumed in some manner by most linguists today, considers any language to be a set of arbitrary but conventionally agreed upon words, or "signs," linked by a purely formal system of syntactic and grammatical rules. Language, in this view, is rather like a code; it is a way of representing actual things and events in the perceived world, but it has no internal, non-arbitrary connections to that world, and hence is readily separable from it.

Sirbu (2015) sees language as essentially a means of communication among the members of a society. In the expression of culture, he see's language as a fundamental aspect; it is the tool that conveys traditions and values related to group identity. She holds that the need to communicate triggers both the occurrence and the development of a language, and this need arises and becomes stronger and stronger when one has someone else to communicate with, that is where there is a society. Society acquires awareness through contact and communication between its members. The significance of communication between people according to SIRBU is what equates the significance of language, which is the most important means of communication.

To Chamman (2015), language is an abstract system of symbols and meanings. These systems include grammar that relates to meaning so that we can communicate with each other, as

language plays very important role in the development of a person's personality; not only in personality but by learning skills in communication, which also increases a person's cognitive skills. He adds that language is not the creation of one person or of one period but it is an institution, on which hundreds of generations and countless individual workers have worked. Language to him is also the ability to acquire and use complex systems to communicate, particularly the human ability to do so. Language is a man's first asset; to some philosophers, language maybe the instrument of thought, for we think through language. Language is an extremely important means of interaction with people around us. Without language, we cannot communicate with people as it serves as a verbal tool for communication.

According to Whorf (2013), language shapes thoughts and emotions, determining one's perception of reality. The scope of language is widened with the widening scope of human activity. (Mill, John Stuart 1973) referred to language to be 'the light of the mind'. Language is the bridge that connects individuals and the outside world. A quote from the status of linguistics as a science by Sapir Summarizes it "*human beings do not live in the objective world alone, nor in the world of social activity as ordinarily understood but are very much at the mercy of a particular language which has become the medium of expression for their society"*. Language is a living and dynamic phenomenon, and people have always found ways of expressing their thoughts, feelings, even in the most tightly controlled and oppressive societies. The role of language on our lives is incomparable. It is not just refrained to being a means of communicating one's thoughts and ideas to the rest, but has also become a tool for forging friendships, cultural ties as well as economic relationships. We use language to let others know how we feel, what we need and to ask questions. We can thus, modify our language according to the situation on ground.

Conversation analysis, the mood of analysis which subsequently grew into conversational analysis began with a puzzle. This style of work which has come to be known as conversation analysis is associated with the pioneering research of Harvey Sacks (Sacks 1964). . As (Schegloff 1992a) reports in his introduction to the published collection of Sacks lectures, (Sacks 1964) had been examining a corpus of recorded telephone calls to the Los Angeles Suicide Prevention Center. Conversation Analysis has evolved over several decades as a distinct variant of ethno mythology. Its beginning can be traced to the mid-1960s where the doctoral research and the unpublished but widely circulated lecturers of Harvey Sacks. Two key figures whose writings (separately and

together with sacks) contributed to the emergence of conversational analysis were Gail Jefferson, one of Sacks first students and Schegloff. Sacks (ibid), like (Garfin, 1967) was preoccupied with discovering the methods or procedures by which humans coordinate and organize their activities, thus with the procedures of practical common-sense reasoning in and through which social order is locally constituted. Sacks began examining talk as an object in its own right, as a fundamental type of social action, rather than primarily as a resource for documenting other social processes, He came to recognize that the talk itself was action. It was in the details of the talk that we could discover just how just how what was getting done was accomplished systematically and procedurally, then and there, by the co-participants themselves. This to sacks appeared to be a fruitful way of investigating the local production of social order.

Sacks (1964), argued that sociology could be a natural observation of science concerned with the methodic organization of naturally occurring events, rather than with behavior that was manipulated through experimental techniques or other interventions such as surveys, interviews and the likes. It could be committed to direct observation of this organization rather than dependent upon analytic theorizing and a combatant reliance on idealized models of actions.

To Ainsworth-Vaughn (2000), Discourse is assumed to be the transparent vehicle of meaning. For this reason, the praxis literature does not provide discourse data, although it does provide on speakers intuition and it can have tangential bearing upon discourse issues in the first step of the research. This first steps involve assigning a single functional meaning to each utterance and then coding utterances into functional categories, so that they can be quantified. He also affirms that research has an implicit or explicit orientation towards the balance of power between patients and physicians. Patients and care givers may have an agenda regarding who will speak, about what and when, and patients and care givers may each have an agenda regarding treatment. He concludes that there are two kinds of power at issue; control over the emerging discourse, and control over the future action which are very crucial in discourse.

According to Kamalu et al. (2015:177), conversation analysis (CA) is an approach to discourse which has been articulated by a group of scholars known as ethno methodologist. They are known

as ethno methodologist because they set out to discover what methods people use to participate in and make sense of interaction. They examine what people do with their words when they are not consciously producing samples for linguists. They felt that examples produced by professional linguists were unnatural, since utterances were not embedded in actually occurring talks, because actual talk by contrast was typically found in every day conversation (Mey 2001:1370).

Schiffrin (1990) notes that even though conversation analysis has its roots in sociology, it differs from other branches of sociology because rather than analyzing social order per say, it seeks to discover the methods by which members of a society produce a sense of social order. It source much of our sense on social roles. CA avoids positioning any categories (whether social or linguistic) whose relevance for participants themselves is not displayed in what is actually said

1.1 BACKGROUND

1.1.1 Discourse

Marahimin defines discourse as "the ability to move (under consideration) by a sequence of regular and proper communication ideas, either orally or in writing formal and regular (Marahimin, 1994; 26).

James (2009) opines that Discourse plays an important part in medicine, and medical discourse in the broadest sense has profound anthropological significance, as modes of social action, writing and speaking help institute medical institutions, curative practices, and elations of authority in and beyond particular healing encounters. His view describes cultural variations in medical discourse and variations across genres and registers. It also surveys two approaches to analyzing medical discourse; Conversational Analysis (CA), and discourse studies, echoing Foucault's' work, attempting to spur dialogue between them. Such dialogue could be fruitful because, despite hesitancy to invoke macro social variables, conversational analysts as well as Foucauldian discourse analysis have reflected on medical authority. (James, ibid) in his book *Medical Discourse* also affirms that studying discourse (language in its fullness) and medicine together brings us to culture as discursively constituted.

1.1.2 Medical Discourse

Historically situated, medical discourse plays a role in cultural production and reproduction and effective intervention in those practices requires insightful assessment of communicative practices, in sociocultural context. (Hodge et al., 1996) affirms that Speech, gestures, postures and other acts jointly produce meaning in medical interaction. During the physical examination, patients constitute themselves as clinical objects, gazing away with apparent disregard while making their subjectivity a clinical resource. Medical teamwork is coordinated by talk and gestures and this first starts with the receptionists themselves. Talk can elicit and coordinate physical activities, as when a receptionist or member of staff tells a patient how he/she should act or lay.

Medical discourse inspired two streams of works beginning in the 1960s. One US based, specialized in micro analytic (the Natural History of an interview Project: (Condon and Ogston 1966, Schften 1973). Face to face interaction of patients, receptionist and physicians remains the focus of what emerged as Conversational analysis (CA), mostly within sociology. The qualitative analytic approach of CA reflects (Garfunkel's, 1967)) ethno methodology, viewing social actors like doctors and patients as constituting shared world by means of particular actions, especially talks. Instances of medical discourse are typically circulated to the extent that they are coherently structured, that is, their linguistic expressions and denotative meanings are memorably patterned.

The prerequisite for developing effective interventions aimed at improving communication in medical settings is an adequate understanding of site-particular communicative practices including the linguistic genres and registers in use and ideologies of communication that shapes these practices. Instances of medical discourse typically circulate to the extent that they are coherently structured. That is their linguistic expressions and denotative meanings are memorably patterned. The anthropological significance of medical discourse becomes clear through acquaintance with its scope of variation, its potential for generating particular kinds of subjects, the complexities involved in the reproduction of power and inequality at sites of such discourse work in general (Wilce, 2009).

Studies in medical discourse have contributed to broader anthropological projects including the analysis of ideologies that empower some communicators and stigmatize others as pre-modern (Briggs, 2005). Rooted in close analysis of dyadic clinical encounters and other forms of medical

discourse, recent studies trace interaction between globally circulating discourse forms and local traditions that have constituted medical relationships, broadly construed.

To Maynard and Heritage (2005), introducing CA in medical education "facilitates the bio psychosocial approach to interview as well as a more recent emphasis on relationship-centered care" be used to constrain the doctor's responsibilities for patients suffering by the receptionist. (Salmon and Hall 2003, pp. 1969), these ideological representations of discourse as empowering or culturally competent for example or language ideologies are as important to analyze as clinical interactions, communication among practitioners especially receptionist, affects health seekers' experiences.

This assertion is supported by analysis of many sorts of discursive events, involving practitioners interacting with each other (Linthorst et al. 2007), (Martin 1992). Programs that train mental health providers in cultural competence involve Meta discourse, reflecting on practitioners or health givers and institutions' communicative forms. Such problems aim to improve communication and care given by receptionist and the medical staff (but are often undermined by establishing premises about cultural citizenship which should not be the case (Giordano 2008) specialized discourse genres arose in modern Europe along with science such as medicine in histories for which we must account for if we are to contextualize medical discourse (Berkenkotter 2008) (Coker 2003).

General practice receptionists have an important role in the delivery of primary care; they are the first point of contact with the entire service, and access is initially obtained through them. Previous studies have shown that, while receptionist asserts that they wish to help patients, they are often perceived as rude, impersonal, insensitive and arrogant, although the communicative styles of receptionist are sometimes perceived as negative, this has only recently been explored through analysis of naturally occurring examples of their interaction with patients. Also (Hewitt et al., 2009) asserts receptionists are the first point of contact with the health services of most by patients and they have an important role in facilitating access to healthcare services. To them, interaction between receptionists and patients consist mainly of verbal routines that are shaped by the administrative tasks completed through them. They also reveal that receptionist communicate with patients using styles that display three dominant approaches: task centered, conventionally polite and rapport building.

To Kendon and Ferber (1973:665), the first task of every human ethologist, like that of an ecologist who sets out to study a bird or a fish or a monkey, must be systematic description. He must set out to see what behavioral structures the human being has. In doing this with people, it would be best to begin with those aspects of behavior which are most likely to be shared with others. To them, language and social interaction (LSI) have developed a whole range of distinctive and ordinary conceptual and methodological positions concerning the analysis of ordinary spoken interchange. To him, the field as a whole has been aptly defined as an interdisciplinary approach to studying the everyday practices and details that make up the complexities and multi-functionality of human communication.

1.1.2 Role of Language

Fitch and Sanders (2004:xv), holds that from at least the 1980s onwards, increasing attention has been given to the relationship between structures and patterns of language use and the organization of identities and large-scale institutional context. (Huctchby and Wooffitt 2008), language cannot be fully understood without being placed in the context of social interaction; social interaction cannot be fully understood without taking account of the role of language use; language use is the primary feature of a multimodal system for the accomplishment of social interaction. Language and social interaction research methods have developed over the last fifty years and now inform work in a wide range of social science disciplines across the globe. The central aim of work in this field is to examine the role of language in performing social actions and constructing social and interpersonal relationships. The main impetus originated in a philosophical and sociological critique of the form of linguistics found in truth-conditional semantics and descriptive syntax or critique which emphasized the performative nature of the spoken word and the central relationship between linguistic meaning and interactional context.

Every work in ordinary language philosophy in the 1950s and 60s,influenced linguist in the 1960s and 70s, including the important subfield of discourse analysis and interactional sociolinguistics; while in the same period, similar ideas influenced new directions in sociology and anthropology, such as the sub-field of linguistics; anthropology and conversational analysis. Language and social interaction have now become established as thriving international and interdisciplinary field whose maturity is reflected by series of contributions from other domains.

Grasping the impact of medical discourse in particular, requires a general understanding of the functions of language, which in turn helps us avoid essentializing the medical domain. What any bit of language is apparently about is only the beginning of its signifying activity. Reference and prediction targeting something to which a linguist expression corresponds (referring), and saying something (predicting) it is only the most salient of linguistic functions. Dominant "referencialist" ideologies (Hills,2008), representing languages prime function as clear, realistic or sincere reference rather than performing social acts, help undermine the sociopolitical agency of patients in therapeutic programs(Carr 2006; Desjerlais 1997). Referring is social action, for example, directing a doctor's attention towards mutually constructing the object of a clinical encounter (Angstrom 1995).

Talking about sickness may point to apparently non-medical topics such as the speaker's threats other than sickness; relationships, family resources, and other moral order. Attentions to the whole patterns of signs in discourse events also help free us from the hold of referencialist language ideologies. Discourse regarded as healing may never refer to sickness or healing or to those present, recognizing the vast potential role or scope of discourse work on the role of communication among practitioners affects health seekers experience. This assertion is supported by analysis of any sort of discursive events involving practitioners interacting with each other (Inthorst et al. 2007), (Martin, 1992)

The stakes of medical discourse go beyond meaning and the reproduction of cultural sensibilities and encompass social reproduction or transformation. Balancing verbal avoidance by some and production of proprietary sickness stories by others is a key form of reciprocity that sustains an aboriginal community (Sanson, 1982). Research conducted by (Heritage and Clayman, 2010) reveals the delicacy between the boundaries of ordinary and institutional conversation. The duo recognized the difficulties in defining the two variants of conversation (institutional and interactional), but did emphasize that the context of institutional technique employed by the speaker which influenced their devotion to explore the prudence of doctor talks in two comparable settings. (Bryne and Longs 1976) research was influential in exploring the popularity of doctor-patient centered consultations during the late twentieth century. These are perspective in recognizing how general practitioners relied on language to assert their power, enabling them control consultations. This resulted in the duo being heralded was among the first researchers to

systematically interrogate the structures of the consultation. (Harvey and Keteyko 2013:8), due to their establishment of a six phrase consultation sequence outlined below:

- Greeting and relating
- Discovering the reasons for attendance
- Conducting a verbal or physical examination or both
- A consideration of the condition
- Detecting further treatment
- Terminating the interview

Through their analysis of the six phases, they realized that doctors relied on their medical prestige and sociocultural authority; verbally and nonverbally guide patients through the phrases, concluding with the diagnosis treatment plan. By using specific verbal communication (Byrne and Long 1976) noted that general practitioners like receptionists, could linguistically prop into a patient's medical background, relying on questions such as open and closed, to gather a detailed medical history. Similarly, they also noted that non-verbal behaviors such as the use of silence or back channeling tokens were also rallied upon to indicate understanding and to provide encouragement during interactions which resulted in significant changes to the medical curriculum with medical students/ receptionist taught on how to utilize their clinical skills during consultation in order to prevent dysfunctional communication (Tale, 2010:12).

Mishlers (1984) research was insightful in exploring how doctors use the 'voice of medicine' to assert their authority. He ascertained that occasionally, a struggle for control can occur between doctors, receptionists and patients who are emulated by conflicts between the voice of medicine and the voice of the life world. To him, the voice of medicine is representative of the technical jargon associated with medicine, which happens to be critical and theoretical whereas the voice of the life world considers the patient's personal experiences of events and problems. (Mishler, 1984:14), the voice of medicine is able to dominate due to the paternalism and power associated with medicine but occasionally, patients attempt to exert the voice of the life world to facilitate their perspective or opinions. This, results in a deviation in medical agenda, as the patient are eager to provide a detailed explanation of their problem which includes extraneous information but they are also accurately aware that they must cooperate and defer to the voice of medicine. Such tension according to (Mishler, ibid), is an excellent example of how doctors react of their status is

threatened, but also exhibits how doctors, patients and receptionists have different perspectives towards illness.

Wilce (2009) suggest that discourse plays an important role in medicine and medical discourse in the broadest sense (discourse in and about healing, curing, or therapy; expressions of suffering; relevant language ideologies) has profound anthropological significance. He states that as modes of social action, writing and speaking help constitutes medical institutions, curative practices, and relations of authority in and beyond particular healing encounters. (Wilce ibid) describes cultural variation in medical discourse and variation across genres and registers. It then surveys two approaches to analyzing medical discourse: conversation analysis (CA) and discourse studies echoing Foucault's work, attempting to spur dialogue between them. He (Wilce ibid) suggests that such dialogue could be fruitful because, despite hesitancy to invoke macro social variables, conversation analysts as well as Foucaultian discourse analysts have reflected on medical authority. (Wilce, ibid) reviews recent attempts to contextualize closely analyzed interactions — written exchanges as well as face-to-face clinical encounters vis-à-vis the global circulation of linguistic forms and ideologies.

Insights from the analysis of medical discourse have been applied, for example, to training and certifying new doctors. (Roberts & Sarangi, 1999) worked collaboratively with the Royal College of General Practitioners to improve forms of doctor-doctor communication. Such collaboration can benefit patients and doctors, immigrants and non-immigrants. UK doctors whose linguistic experience is with fluent English speakers might expect patients to maintain a factual orientation. Immigrant patients, however, sometimes bring to clinical encounters a troubles-telling orientation (Jefferson and Lee 1992) (Wilce, 1998). Thus, in multicultural societies, doctors' "training for uncertainty" (Fox, 1957) must now include training for managing "interactional uncertainty" (Roberts et al. 2004).

1.2 MOTIVATION

Having observed that patients complain a lot about the health care services provided by some hospitals, I was prompted to carry out a comparative study of the health care services provided by two different hospitals; one being a public hospital, and the other a private hospital, at the level of the services offered by receptionists .In order to observe the various problems faced by patients

when they visit the hospitals and in the problems faced by the receptionists which hinder them in providing good quality health care at their level, this research, there was a need to carry out this research. I was also motivated to carry out this research in order to obtain an academic certificate which will enable me go further in carrying out more research within the domain of language and health. Our motivation is on the language used by hospital receptionists in communicating with patients in some hospitals in the city of Yaounde.

1.3 RESEARCH PROBLEM

Within the Cameroonian context, it has been observed that most of the hospitals which are well equipped, with well-trained doctors and nurses still do not provide adequate healthcare services for their patients. Most at times, the receptionist do not even know their role or how to receive patients nor have a mastery of good communicative skills which are an important aspect in improving the health of patients. Most of the patients who visit the hospitals, most at times, do not come with a stable mindset due to the psychological and physical trauma they are facing. They, sometimes, have different thoughts running through their minds and at that point, getting information correctly and following instructions given, is a big task which the receptionists need to accomplish by using the right choice of words and gestures at the right time and place. The language used by the receptionist does not help patients in carrying out what is demanded of them since the receptionist do not take note of the non-verbal elements of communication such as facial expressions, eye contact and gestures such as agitations made by patients. This work sets out to investigate the reasons why patients are disgruntled about the services offered by the receptionist's taking into consideration the language aspects.

1.4 OBJECTIVE

This work aims at investigating the language used by hospital receptionists, so as to identify the inconsistencies in the various discourses brought out from the data, examine the discourses and analyze these discourses from a critical discourse analytical perspective in relation to the

communicative patterns obtained in the data. It equally seeks to examine the manner in which receptionists in private hospitals as well as those in state-owned hospitals interact with patients.

We will attempt an identification and classification of the various discourses that will emanate from the data under study. Given that the language used by hospital receptionists is in appropriate, we will examine the various reasons and the effect the language has on the patients.

We will equally identify the different linguistic strategies used in the data and analyze them. This is to show the importance that linguistic strategies have in communication and when used inappropriately, leads to misunderstandings and disputes between the parties involved.

1.5 RESEARCH QUESTIONS

This research is guided by a number of questions:

1) How do receptionists in private and public hospitals interact with patients?
2) What strategies do receptionists used to give directions to agitating patients?
3) How does receptionists' language impact the patients?

1.6 SIGNIFICANCE OF STUDY

For any piece of research to be considered scholarly, it must have an impact on the society. The work will be significant in a number of ways to the world of scholarship.

First, this field of research is new to the world. Discourse analyses as well as medical discourse are new forms or fields where research can be done, with receptionists – patients' relationship not being an exemption. This work will be relevant in that its findings will contribute to the field of medical discourse.

Secondly, the work is current. The issues discoursed are current happenings going on not only in Cameroon but in the world at large; Every town, city or country has something they can link up with in this work if they can have access to and read this work.

Thirdly, the work is practical. Every individual in the society has one or two things to say about hospital receptionist at different angles and levels, and the findings can be tested at any level.

1.7 SCOPE OF STUDY

This work is limited to two hospitals in Yaoundé; one being a state owned and the other an institutional owned hospital. The data collected are gotten from one-on-one interview sessions with the patients and the receptionist on the other side, questionnaires, and observations, confrontations between the patients and the receptionist and kinetics. We confine ourselves to the Gynecological and Obstetric hospital and the Presbyterian Health Complex Yaoundé. This study generally falls under the sociolinguistic field of study and most especially in the area of discourse analysis. The scope of this study can therefore be identified as language in context, especially in the context of discourse analysis. It will explore linguistic forms and choices that are directly or indirectly used by receptionists in private and state hospitals to convey information or instructions to its patients or on how to make them feel at ease in the hospital environment. The hospitals are geographically located in an accessible area where an influx of patients is worth noting. This study is situated within the domain of sociolinguistics and limited to the subdomain of medical discourse which is further limited to the language of hospital receptionist.

1.8 DEFINITION OF KEY TERMS

For clarity in the terms used and for a better understanding of a research work, it is always proper for the researcher to define the key notions in the work. For that reason, the following is a definition and explanation of some of the important terms in this study. The definitions and explanations make explicit the way the various terms are used in the current study.

1.8.1. RECEPTIONIST

The Cambridge Advanced Learner's dictionary (2008) defines a receptionist is an employee taking an office or administrative support position. The title is attributed to the person who is employed by an organization to receive or greet any visitors, patients or clients and answer telephone calls.

1.8.2 DISCOURSE

Discourse is a social interaction in which the emergent construction and negotiation of meaning are facilitated by the use of language. The work of Goffman forces structural attention to the context in which language is used: situations, occasions, encounters, participation framework. (Darty Ofica 2005) defines discourse from a linguistic point of view as referring to the speech patterns and how language, dialects, and acceptable statements are used in a particular community. Discourse as a subject of study looks at discourse among people who share the same speech conventions. Moreover, discourse refers to the linguistics of language use as a way of understanding interactions in a social context, specifically the analysis of occurring connected speech or written discourse (Dakowska, 2001) in (Hamuddin, 2012). As a macro level in society, discourse impinges on patients and doctor as part of social context in the medical field. Meanwhile as micro level, discourse influences for doctor-patient interaction, in communication about illness, healing or medical treatment.

Discourse as a subject of study looks at discourse among people who share the same speech conventions. Moreover, discourse refers to the linguistics of language use as a way of understanding interactions in a social context, specifically the analysis of occurring connected speech or written discourse, Dakowska (2001). As a macro level in society, discourse impinges on patients and doctor as part of social context in the medical field. Meanwhile as micro level, discourse influences for doctor-patient interaction, in communication about illness, healing or medical treatment. Hamuddin (2012)

According to the formalists or structuralists paradigm, discourse is “language above the clause” (stubbs, 1983:1). This approach to discourse focuses on the form which “language above the sentence” takes, looking at structural properties such as organization and cohesion, but paying little attention to the social ideas that use and interpret language. (Brown and Yule, 1983:1) states that “the analysis of discourse is, necessarily, the analysis of language in use. As such, it cannot be restricted to the description of linguistic forms independent of the purpose or functions which these forms are designed to serve in human affairs.

Kress and Leeuwen as seen in Paul Emerson's article (2008) on media discourse, also talk about discourse from a different angle. They put "mode" at the center of every discursive activity. They show diagrammatically how "modes" relate to discourse, distribution, design, and production

Cook (1989) describes discourse as language in use or language used to communicate something felt to be coherent which may or may not correspond to a correct sentence or series of correct sentences. He posits that discourse does not have to be grammatically correct, can be anything from a grunt or simple expletive, through short conversation and scribbled notes, a novel or a lengthy legal case. What matters to him is not the conformity of rules, but the fact that it communicates and is recognized by its receivers as coherent.

To Scollon and Scollon (2001:538), a discourse is a language or system of representation that has developed socially in order to make and circulate a coherent set of meanings about an important topic area. It refers to socially shared habits of thoughts, perception, and behavior reflected in numerous texts belonging to different genres.

To the Journal of Education and Practice (2011), in social science, a discourse is considered to be an institutional way of thinking, a social boundary defining what can be said about a specific topic. Discourse affects our views in all things. To (Wodak 2002:7), discourse carries the history, way of life of people. It is language use in speech and writing which is a form of social practice.

TO Wodak and Meyer (2009:3),discourse means anything from history, narratives , text , talk, a speech, topic-related conversation; stretching the meaning of discourse from a genre to a register and a code and language. (Lupton 1992:145) defines discourse as a group of ideas or patterned way of thinking which can be identified in textual and verbal communication and can also be located in a wider social structure.

Discourse is seen as a culturally and socially organized way of speaking. (Richardson, 2007:24) notes that researchers who adopt this definition of discourse 'assume that language is used to *mean* something and *to do* something" and that this "meaning and doing" is linked to the context of its usage. If we want to interpret a text properly, we need to work out what the speaker or the writer is doing through discourse and how this 'doing' is linked to wider interpersonal, institutional, and socio-cultural arm of social practice material contexts." *texts* refers to the "observable product of

interaction," whereas discourse id "the process of interaction itself: a cultural activity" (Talbot, 2007)

Foucault (1961) refers to discourse as the use of communication (written or spoken) to construct knowledge and truth. He suggested that truths that shape our lives do not simply exist but are created through discourse. He believed that constructed discourse benefits the most powerful in society and can be used as a form social control. The view of language as action and social behavior is emphasized in CDA which sees discourse-the use of language in speech and writing- as a form of social practice that is most useful for our analysis of medical discourse, as it involves a two-way relationship between a "discursive event" (i.e., any use of discourse) and the situation, institution and social structure in which it occurs : discourse is shaped by these but it also shapes them(Fairclough,1992:62).In other words, language represents and contributes to the (re)production of social reality.

1.8.3 DISCOURSE ANALYSIS

Slembrouk (1998-2003), defines discourse analysis as an attempt to study the organization of language above the sentence or above the clause, and therefore to study larger linguistic units, such as conversational exchanges or written text. It follows that discourse analysis is also centered with language use in social context, and in particular with interactions or dialogue between speakers. (Cheek 1997) defines discourse analysis as providing insights into the functioning of bodies of knowledge in their specific situated context by generating interpretative claims with regard to the power effects of a discourse on groups of people, without claims of generality to other contexts.

Discourse analysis is concerned with language use beyond the boundaries of a sentence/utterance. It is also concerned with the interactive or dialogic properties of everyday communication. It attempts to study the organization of language above the sentence or above the clause and therefore to study larger linguistic units such as conversational exchanges or written texts. It follows that discourse analysis is also concerned with language use in social contexts and in particular with interaction or dialogue between speakers. (Andrea 2013), Discourse analysis is a general term of approaches to analyzing written, spoken or signed language use. It does not only study the meaning of sentences beyond their meaning, but also the natural occurring language use. Discourse analysis is often described as language in use or socially situated text and talk." For

example, analysts ask how written, oral and visual texts are used in specific contexts to make meanings, so this is not an abstract field of knowledge.

Khalil (2006) opines that discourse analysis is an approach to the analysis of language which focuses on knowledge about language beyond the word, clause, phrase, and sentence that is needed for successful communication. It also looks at the patterns of language across texts and considers the relationship between language and the social and cultural context in which it is used. It also considers the ways the use of language presents different views of the world and different understandings while examining how the use of language is influenced by relationships between participants as well as the effects the use of language has on social identities and relations, while considering how views of the world and identities are constructed through the use of discourse. Discourse analysis is also defined as the analysis of language 'beyond the sentence'. This contrasts with types of analysis more typical of modern linguistics, which are chiefly concerned with the study of grammar: the study of smaller bits of language, such as sounds (phonetics and phonology), part of words (morphology), meaning (semantics), and the order of words in sentences (syntax). Discourse analysis studies large chunks of language as they flow together. In other words, *discourse analysis* can also be defined as the study of language viewed communicatively and /or communication viewed linguistically. It involves reference to concepts of language in use, language above or beyond the sentence, language as meaning in interaction, and language in situational and cultural contexts. Discourse analysis has taken a variety of social science disciplines, such as Linguistics, Anthropology, Sociology, Social psychology, translation studies among others.

Stubbs (1983:1) perceives discourse analysis as a conglomeration of attempts to study the organization of language and therefore to study larger linguistic units, such as conversational exchanges or written text. He asserts that what matters in the study of discourse, whether as language in use or as language beyond the clause, is that language is organized in a coherent manner such that it communicates something to its receivers.

To Potter (200]4:3), discourse analysis has an analytic commitment of studying discourse as texts and talk in practice. That is, the focus is not on language as an abstract entity such as a lexicon and set of grammatical rules (in linguistics), a system of differences (in structuralism), or a set of rules for transforming statements. It is a medium for interaction; analysis of discourse becomes,

then, analysis of what people do. Johnston(2008:3) opines that we call what we do discourse analysis rather than language analysis because we are not centrally focused on language as an abstract system, rather, we are concerned with the functional aspects of language use, focusing on what people do with language or what language can do for its users.

Kamala and Osisanwo (2020) see discourse analysis as a broad field of study that draws some of its theories and methods of analysis from disciplines such as linguistics, sociology, philosophy and psychology. To them, discourse analysis has provided models and methods of engaging issues that emanate from disciplines such as education, cultural studies, communication and a host of others. It is the analysis of language in use. By language in use, it means the set of norms, preferences and expectations which relates language to context. It studies the relationship between language (written, spoken-conversation, institutionalized forms of talk) and the context in which it is used.

1.8.4 CRITICAL DISCOURSE ANALYSIS (CDA)

Norman Fairclough (1995:132) defines Critical Discourse Analysis (CDA) as to systematically explore often opaque relationships of causality and determination between discursive practices, events, and texts, and a wider social and cultural structures, events and texts which arise out of and are ideologically shaped by relations of power and struggles over power.

To Van Dijk (2001:352), critical discourse analysis is a type of discourse analytical research that primarily studies the way social power abuse; dominance and inequality are enacted, reproduced, and resisted by text and talk in the social and political context. With such dissident research, critical discourse analysis takes explicit position, and thus wants to understand, expose, and ultimately resist social in equality. Critical discourse analysis views language as a social practice, and takes consideration of the context of language use as an important aspect. Wodak and (Meyer 2001:1).

To Wodak and Meyer (2009), CDA is a gateway to show how social phenomena are interconnected, to produce knowledge that helps social actors emancipate themselves from domination through self-reflection, and to describe, explain and eradicate delusion, by revealing structures of power and ideologies behind discourse by making visible courses that are hidden. To them, CDA is a discipline designed to question the status quo, by detecting, analyzing, and also

resisting and counteracting enactments of power abuse as transmitted in private and public discourses. Critical discourse analysis is understood to be critical in different ways; its commitment to the analysis of unequal access to power, privileges, and, and material and symbolic resources(Fairclough 2009); its interest in discerning the prevailing hegemonic social practices have caused such social wrongs, and in developing methods that can be applied to their studies(Bloor and Bloor 2007). It focuses on the opaque relationship between discourse and societal structure; and it does so through open interpretation and explanation, by relying on systematic scientific procedures, that is, by achieving distance from the data and setting them in context.

Critical Discourse Analysis (CDA) is also considered as a "theory and method of analyzing the way that individuals and institutions use language (Richardson, 2007:1). CDA focuses on "relations between discourse, power, dominance and social inequality" (Van Dijk, 1993:249) and discourse (re)produces and maintains these relations of dominance and equality because of their concern with the analysis of the "often opaque relationship" between discourse practices and wider social and cultural structures. CDA practitioners take an "explicit socio-political stance" (ibid, 252). CDA primarily studies the way social power abuse; dominance and inequality are enacted, reproduced, and resisted by text and talk in the social and political context. With such dissident research, critical discourse analysts take explicit position and thus want to understand, expose and ultimately resist social inequality (Dijk, 1998:352).

1.9 OVERVIEW OF THE RESEARCH DESIGN

This section describes the research design adopted for this study. A research design refers to the overall strategies that a researcher chooses to integrate the different components of the study in a coherent and logical way. It constitutes the totality of the methods of data collection, presentation and analysis. Kothari (2005:31) says, "A research design is the arrangement of conditions for collection and analysis of data in a manner that aims to combine relevance to the research purpose with economy in procedure. In fact, the research design is the conceptual structure within which research is conducted; it constitutes the blueprint for the collection, measurement and analysis of data. As such the design includes an outline of what the researcher will do from writing the hypothesis and its operational implications to the analysis of data."

1.10 STRUCTURE OF THE WORK

This study comprises five chapters. The first chapter features the general introduction, the goals or objectives, the motivation, significance of the study, the scope of study, the research questions, and the research design for the study. Chapter 2 discusses the theoretical framework and review of related literature. In Chapter 3, the research methodology is outlined and the methods of data collection are explained. Chapter 4 presents the analyses of the data and interpretation of the results. Chapter 5 is the conclusion and it discusses the key findings, states the limitations of the study and indicates areas for further research.

1.11 CONCLUSION

This chapter has provided a general overview of the work and has outlined the background knowledge of the study. The two institutions under study – The Gynecological and Obstetric hospital and The Presbyterian Health Complex Yaounde was presented, with highlights on the fundamental tenets so as to provide better clarity to the discussions that will follow. The different trends in language, discourse, discourse analysis and critical discourse analysis have been explained to demonstrate the trajectory that they have taken with the passage of time. Key issues relating to the subject were discussed to show their relatedness to the current work. In a nutshell, the fundamental elements of this work have been discussed.

CHAPTER TWO

THEORETICAL CONSIDERATIONS AND THE REVIEW OF LITERATURE

2.0 INTRODUCTION

This chapter presents the theoretical considerations and some concepts used in the study. In the chapter, we further present a comprehensive review of literature and show how they are linked or divergent to the present study. The chapter further carries out a comprehensive review of themes from other works and how they are linked or divergent to the present study. Discourse analysis is the working tool of the data, so a review of the relevant literature in this domain is vital. Here, key topics like the framework used for the analysis, the performative use of language, knowledge on discourse, medical discourse and a host of others are examined.

2.1 FRAMEWORK FOR ANALYSIS

Being critical to the successful use of the method by an experienced researcher, the framework analysis methodology approach allows researchers to ensure that they handle the data per predetermined procedures. It is a set of codes organized into categories that have been jointly developed by researchers involved in analysis that can be used to manage and organize the data. Framework creates a new structure for the data (rather than the full original accounts given by participants) that is helpful to summarize/reduce the data in a way that can support answering the research question. It is also considered as a systematic and flexible approach to analyzing qualitative data and is appropriate for use in research terms even where not all members have previous experience of conducting qualitative research. (Nicole k. et al.,2013) It is also useful where multiple researchers are working on a project, particularly in multidisciplinary research teams were not all members have experience of qualitative data analysis and for managing large data sets. It is most commonly used for thematic analysis of semi-structured interview transcripts.

Also considered as a panacea for problematic issues commonly associated with qualitative data analysis (Richard Y. et al.,1995)

2.1.1 Van Dijk's Socio-cognitive Approach

Within the overall framework of critical discourse analysis (CDA) studies, the socio-cognitive approach (SCA), developed by (Teun A. van Dijk 2014a, b, 2015a, 2018) focuses on the cognitive aspects of discourse production and comprehension. Van Dijk posits that there are no linear correspondences between discourse structures and social structures but discourses function through a cognitive interface; the mental representative of language users as individuals and as special members. (Van Dijk,2015a p. 64) as he points out, although discourse is socially conditioned and impacts upon the functioning of the society, with the formulation and interpretation of discourse is the aggregate function of the participants underlying cognitive processes, personal and socially shared knowledge. Van Dijk emphasizes that the framework draws on a multitude of methods and concepts from wide-ranging disciplines, such as social psychology, cognitive psychology, sociolinguistics and sociology, all of which are instrumental in understanding the role of knowledge in the most comprehensive of its kind. (Van Dijk 2018, p. 28) maintains that it is not the social situation that influences discourse, but the way the participants define a situation. The central idea on socio-cognitive approach (SCA), relates to the most basic problems of phenomenological sociology: inter-subjective understanding, the relationship between subjective and objective knowledge, and our own constitutive role in the construction of social meaning, situation, that is social reality.

SCA's aim is to track down and map the network of knowledge, beliefs, prejudices, attitudes that are directly or indirectly operationalized and triggered by individuals when producing and interpreting discourse. It also explains how cognitive approaches actually determine discourse structures and their interpretation in a particular communicative situation. SCA is widely applied by critical discourse scholars due to its broad integrative perspective. SCA also draws on Conversation Analysis (CA), a field that evolved from Harold Garfunkel's ethnomethodology, which was predominantly based on Schutzs phenomenological sociology. To understand why a particular speech or text is structured in the way it is, researchers need to reconstruct the motives, interest, and intentions and goals of the speaker. Conversely, to understand why and how discourse influences social actors as its audience, Dijk says it is crucial to clarify why and how the content

is relevant and comprehensible to the receiver. SCA is interested in what the speaker has in mind and how it is decoded by the receiver. Dijk argues that participants of communicative situations, for an effective interaction, needs to read each other's mind in a metaphorical sense. To understand action he puts, including communicative actions, an intention has to be attributed to the observed conducts of the actors (Van Dijk 2012b). Speakers should adjust their style, selection of words to the presumed interest, relevance and knowledge of the receiver to make sure their intention is intelligible to the latter. Dijk, however, notes that, intentions themselves are not "observable" they can only be more or less accurately inferred by the receiver (Van Dijk 2012a, b). It is crucial to clarify why and how the content is relevant and comprehensible to the receiver.

To put it simply, the puzzle SCA is interested in is what the speaker has in mind and how it is decoded by the receiver. Van Dijk argues that participants of communicative situations, for an effective interaction, need to "read" each other's mind in a metaphorical sense. To understand actions, including communicative actions, an intention has to be "attributed" to the observed conducts of the actors (Van Dijk, 2012b). To him, Speakers adjust their style, selection of words to the presumed interests, relevance and knowledge of the receiver to make sure their intention is intelligible to the latter. However, as he notes, intentions themselves are not "observable"; they can only be, more or less accurately, "inferred" by the receiver (Van Dijk, 2012a, b). It generally holds that both the speaker and the receiver construct subjectively meaningful mental models of one another's intentions, identity, and knowledge of the entire setting to decrypt each other's messages and navigate in the communicative situation (Van Dijk, 2015b).

Dijk maintains, mental models to him, "define and control our everyday perception and interaction in general and the production and comprehension of discourse in particular" (Van Dijk 2014a, p. 49). We create mental models based on our past experiences stored in the Episodic or Autobiographical Memory. Mental models are "subjective representations of events or situations" with a schematic structure allowing us to categories and identify ongoing experiences. This subjective representation also consists of the particular and personal emotions, opinions, sounds, gestures, visions accompanying the situation in which the experience unfolds (Van Dijk, 2018). Van also points out that the significance of a car, for example, varies when driving for pleasure and when cycling in traffic. Van Dijk calls this phenomenon "the multimodal nature of knowledge" which derives from various emotions and sensory experiences (Van Dijk, 2012a). Navigating in

the communicative situation, participants dynamically draw on and "update" their mental models, discourse thus becomes subjectively meaningful. In fact, as we shall see later, revision is needed only if a preliminary available mental model is not sufficient enough to make sense of something, and shows inconsistency with one's total configuration of experiences that are relevant in the context of the particular situation. Due to the uniqueness of mental models, the participants' respective interpretation of the same discourse, is necessarily different (Van Dijk 2018)

The two main types of models that the SCA defines are the situation models and the context models. Situation models or semantic models represent the individuals' subjective understanding of the situation, or their take on the subject matter, that is, what the discourse is about, or the experience aims at. Semantic models are the cognitive correlates of the "intentional" and "referential" function of language. Context models or pragmatic models account for how individuals define the circumstances of an experience or the communicative situation in which they are involved in terms of relevance. Context models represent the "socially" and "communicatively" relevant characteristics of a situation. They help to avoid ambiguity and orient participants to act and speak appropriately (i.e., accordingly) in a particular social situation. They control the content, style and genre of discourses, depending on spatiotemporal factors, the institutional environment, the identity, status and role of participants, and their D. Gyollai relationship. For example, we explain the circumstances of the same accident to a friend in a different manner than to the police (Van Dijk, 2014b, 2015b, 2018). Although it is uniquely constructed, mental models are based on, and "instantiated" from, the socially shared generic knowledge of the participants which manifests in language. Thus, language is indicative of, and makes the subjective interpretations of participants mutually accessible. Essentially this is why individuals, using the same language, can understand each other in a conversation. (Van Dijk, 2018 pp. 49-61)

Another scholar who was interested in the role of subjectivity in the construction of social reality, and, conversely, how individuals' understandings and actions are influenced by socially pre-established structures was (Alfred Schutz 1970, Pp. 25, 79–122). Schutz opines that the social world is constituted and manifests in the first-person perspective; it appears intelligibly only through subjective interpretations, in the subjective meaning context of lived experiences. Thus, according to him, in order to understand how society functions, social sciences should focus on

the individual to whom it meaningfully exists (Schutz 1972, Pp. 74–86, 139–144.). Schutz's point of interception was his criticism of Max Weber's social action theory. Weber had recognized the fundamental role of subjectivity in the constitution of social reality: the meaning of social relations and structures is derivative of, and reducible to, as Weber calls it, the "intended meaning" individuals "attach" to their own acts. Thus, Weber argued that sociologists can only understand and describe the former through the interpretation of the latter. While Schutz had agreed with the key tenet of Weber's framework, he problematized that the "intended", or more accurately, the subjective meaning of an action had not been addressed by Weber in its actual complexity. Weber did not differentiate between the meaning of our own acts and that of others. Nor did he explain how these meanings are constituted, established and interpreted, and the different forms in which the other self is given to the self; that is, how we come to understand others in the first place. Schutz points out that Weber's failure to adequately conceptualize these issues has the sociocognitive approach in critical discourse studies and the... led to inconsistencies and contradictions in his theory. As he argued, it is only through a systematic analysis of the concept of meaning and the process of meaning-constitution that we can understand "the intended meaning" of an action, hence the meaning structure of the social world (Schutz 1972, pp. 1–20).

2.2 REVIEW OF RELATED LITERATURE

In this section, works related to this research era are presented in a bid to show its novelty. The review is divided into critical works on the performative use of language, discourse, discourse analysis, critical discourse analysis and medical discourse. The presentation is thematic and chronological in nature. At the end of the presentation, we establish how the study differs from the previous ones as far as the treatment of themes is concerned. This is done in a bid to ensure the originality of our work.

2.2.1 PERFORMATIVE USE OF LANGUAGE

Baringa (2009) studied language from a performative perspective and suggested that though researchers across the sciences speak of a language turn; most research exploring culture still assumes a traditional perspective on language, which conceives meaning as representation. In her paper, she explained the central points of the performative perspective of language: first, that, words do things; second that the meaning of an utterance is not directly given by the utterance;

and third, that meaning is in use. On the performative view of language, she articulated that the most common view of language accepts what (Bruno Latour 1993) ironically calls the 'big divide,' the division of reality into objective and subjective, nature and society/culture, material and mental, observable and invisible. Language, according to this perspective, is on the side of culture, and the objects words are referring to, are placed on the side of nature. In this way, words point towards an outside objective reality. The relationship between language and reality is conceived as one of univocal reference. However, she gives a contrary view of this observation, citing (Wittgenstein 1953) who points out the following about language: First, words do things. The utterance 'I declare the meeting open' marks the beginning of the meeting and not simply describes a state of affairs. Second, the meaning of an utterance is not directly given by the literal utterance.

To understand what is meant with "I'll see you" we need to put those words into a specific context. Depending on the situation, we could give that utterance a friendly sense or a confrontation alone. And third, meaning is in use. The phrase "I'll see you" is dependent on the context of use for its particular meaning. Therefore, language is performative depending on the context or situation of usage. Words may mean one thing in one culture and a completely different thing in another culture. Also, the inherent or purpose of usage of language and the belief system of both speaker and listener are cardinal to performative language.

The above presentation gives an insight into the scope that has been covered on the study of speech acts. It equally demonstrates the range at which language has been studied as far as discourse is concerned.

2.2.2 KNOWLEDGE ON DISCOURSE

Hassan (2015) asserts that in the humanities and social sciences, the term discourse describes a form or way of thinking that can be expressed through language. Discourse is seen to affect our views on all things; it is not possible to avoid discourse. Discourse is a way of representing aspects of the world, the process, relations and structures of the material world, the mental world of thoughts, feelings beliefs, and the social world. Discourse has become both the means and the end of knowledge and its transmission. To him, discourse is shaped by many factors such as cultural, language, participant, and history. He opines that discourse shapes and reshapes the thought and

practices of the speech community who owns it, it is to them, a replicator, re-constructer and preserve of social change.

Levine (1971:13), the power of discourse in defining and shaping the realities of contemporary society cannot be underestimated. Discourse to him, carries the tradition, culture and way of life of its speakers. Discourse cannot be conceptualized without the people, nor can the people without their discourse; the people and its discourse are in each other's pocket. Levine (ibid) reiterates that to know the discourse means to know the people who use it. Studying the discourse of a particular society gives the whole picture as to who they are, what their beliefs and values are and how and why they use their discourse. He also postulates that nothing defines people better than their discourse. It unfolds the values, cultural themes and beliefs of people that defines how and why they live the way they do. Fairclough after Halliday's Systematic functional linguistics established that discourse contributes to the construction of social identities, social relations, and systems of knowledge and meanings. (Wodak 2002:17).this makes discourse to be seen from three different perspectives: an identity function, a rational function and an ideational function. These three perspectives on which (Fairclough 1995) has constructed, concludes that it is a useful framework for the analysis of discourse as social practice. Discourse has both the means and the end of knowledge. (Phillips 2002:

Piurko (2015), investigated the use of Discourse Markers (DM) in legal and media discourses in the spoken and written genres. In order to achieve the aim of the study, she set out on the following objectives: to analyze the frequency and the functions of discourse markers in four genres: editorials and interviews; conventions and criminal trials; to compare the characteristic patterns of forms and functions of discourse markers in each genre. The approaches to her research were quantitative and qualitative as well as discourse analysis method were chosen for the analysis. The results of this study revealed that the general distribution of discourse markers and the functions of these items in the four genres are quite different. The frequency of occurrences of discourse markers were higher in the spoken genres than in the written ones, furthermore, the textual discourse markers are more frequent than interpersonal in the analyzed genres. Despite the fact that textual functions of discourse markers were prevailing, the interpersonal functions also fulfilled significant role in the texts, especially in the spoken discourse. On the whole, the results of the analysis showed that the frequency of DMs in the texts and their functions can be influenced

by the genre. This leads to a conclusion that the forms and functions of DMs which correspond in the interviews and trials indicate the similar communicative purposes of the two genres.

Zare de Belder (2012) investigated the role of doctor talk in two contrasting encounters namely institutional and domestic. According to Heritage & Clayman (2010), in institutional encounters participants 'are tied to their institutional-relevant identities', whereas during domestic encounters, speakers rely on linguistic characteristics attributed to ordinary conversation such as vague or non-literal expressions (Wardhaugh, 2011: 271). She did her research and in the data obtained, transcript I was obtained from Channel 4's medical series Embarrassing Bodies where a general practitioner, Dr. Bernadette 'Pixie' McKenna, was consulting an eighty-five-year-old female patient, who was diagnosed with the skin condition pruritus. In contrast, transcript II involved research participants and explored a conversation between a doctor and his eighty-one-year-old grandmother in a domestic setting. The study aimed to explore whether the power recognized in doctor talk was solely prevalent in institutional settings. By collecting data of a doctor interacting with a family member in a domestic situation, it enabled her to compare the power of doctor talk in two comparable settings and to explore whether the environment could affect a doctor's authority. Since Henderson's (1935) groundbreaking research concerning doctor talk, she had been intrigued by the facet of health care communication. According to her, Silverman et al. (2005) had estimated that 'doctors perform 200,000 consultations in a professional lifetime'. These statistics reflected the professional and cultural authority associated with doctor talk, thereby reiterating the significance of this discipline. Moreover, research conducted by Heritage and Clayman (2010) also revealed the delicacy between the boundaries of ordinary and institutional conversation. The duo recognized the difficulties in defining these two variants of conversation, but did emphasize that the context of institutional conversation did impact the interactional techniques employed by the speakers, which influenced her decision to explore the prevalence of doctor talk in two comparable settings. As a result, she decided to probe further into the fascinating demesne of health care communication in medical discourse.

Kris A. Drass (1982) worked on negotiation and structure of discourse in medical consultation and realized that, the idea that consultations between medical practitioners and patients involve negotiation is not new. According to him, previous studies have identified a number of important features of this negotiation process. Included among these are power (Scheff, 1963), control of

information by the medical practitioner (Waitzkin and Stoeckle, 1976; Silvennan, 1981) and 'setting, language, latent status, stereotypical categorization of illness, tendency towards typing error, and organizational clue (Anderson and Helms, 1979:269). However, well-grounded empirical studies designed to describe in detail the actions used by participants in medical consultations to carry on negotiations are rare as he discovered in his research. One possible reason for this was the difficulty in conceptualizing social process so that the interrelationship of actions can be described. Recent work in the area of discourse analysis has provided concepts and methods which can be used to address this problem. By focusing on the organization of talk in everyday settings he says, discourse analysis provides a means for identifying units of interaction, relationships among units, and relationships between higher levels of analysis (e.g., organizational and social structural levels) Sociology of Health and Illness, as well as negotiation and the structure of discourse in medical consultation, and interactional process. The purpose of his work was to present an empirically grounded model of medical negotiation developed through an analysis of medical practitioner-patient discourse. In addition to this presentation of the model, the utility of the model was demonstrated by discussing how context, defined in terms of phases in the ongoing discourse, affects a patient's opportunity to have an impact upon the definition of his/her medical problem. He presented his analysis starting with general conflict negotiation model of medical interaction. He realized that although Freidson developed this model for understanding physician-patient interaction, he believed that it was a general model applicable to the relationship between members of any service occupation and their clientele. The basic assumption he had of this model is that interaction between consultants and clients was based on conflict. This conflict to him was inherent because consultants and clients bring different perspectives to the interaction. As a result of the conflict, Freidson believed that consultant-client interaction necessarily involved negotiation: 'the negotiation of separate conditions and of separate perspectives and understandings.' He realized that the general differences between consultant and client that create conflict and tension in the interaction must be resolved through negotiation if the client's problem is to be defined and managed. Thus, in consultant-client encounters, interactional process is a negotiation process. Freidson's conflict-negotiation model provided a good general orientation to the basic structure of consultant-client encounters and can be used to study medical practitioner-patient encounters. However, it had three major limitations as a guide for empirical analysis. First, Freidson gave no indication of the types of activities used by consultants and clients to conduct

negotiation. Second, although Freidson based the need for negotiation on the different perspectives of consultants and clients, he never explicitly stated how these perspectives entered discourse and affected negotiation. Third, Freidson treated negotiation as an undifferentiated social process; his model did not take into account how the nature of negotiation may change during the course of an encounter based upon changes in the goals of participants. Thus, he suggested that in order to be useful empirically, Freidson's basic insights must be supplemented with theoretical work which addresses these problems. This could be done through the work on the analysis of medical discourse.

Toxvig et al. (2017) studied Denmark's public health policy concerning overweight among pregnant women. She observed that in Danish public health report classified being overweight during pregnancy as a chronic disease, marking a discursive shift from its previous classification as a risk factor for complications in maternal and foetal health. This discursive shift was considered a breach in the discursive field. Health care professionals' approach to governing overweight pregnant women was affected by this breach in the discursive field. Thus, overweight pregnant women had become an issue for medical experts, who were encouraged to use stricter rhetoric when addressing them. He also discovered that this shift also rendered pregnant women subject to interventions by medical experts. The aim of his article was to critically analyzed recommendations for how health professionals should govern these high-risk individuals and to discuss the implications of such governance for overweight pregnant women. In his study, overweight was classified and severe obesity was classified on the basis of pre-pregnancy weight. He also realized that the theory of social construction and the concept of governmentality were applied in the discourse analysis of the prevention of overweight among pregnant women in Denmark. Using a discursive approach, his study analyzed the central governmental documents of discuss obesity prevention. Three forms of freedom (as discipline, as solidarity and as autonomy) were transferred to three forms of governing and constitute the conceptual framework. His main finding was that public health programs encouraged governing through solidarity, including a palette of autonomy-making, responsibility-making and disciplinary technologies, to promote physical health. Public health programs conjure an image of overweight individuals as strongly burdened subjectivity. He concluded his investigation by stating that the implications for overweight pregnant women were the formation of new subjectivity, engagement in patient

associations, the threat of exclusion from communities and social citizenship and other forms of stigmatization.

Elena Piurko (2015) worked on discourse markers, their function and distribution in the media as well as in legal discourse and she realized that, discourse markers play an important role in achieving the communicative goals of socially situated language both in written and spoken discourse. As she pointed out in the work of Kohlani (2010, 5), discourse markers function across sentences boundaries to connect textual units above the sentence and guide the text receivers' interpretation of text according to the text producers' communicative intentions. She realized that despite their considerable role in producing texts, discourse markers are thought to be semantically empty and grammatically optional. However, rather than seeing them as meaningless and merely stylistic, Brinton (1996) claims that discourse markers fulfill a variety of pragmatic functions on the textual and interpersonal level of discourse. Discourse markers, which signal various kinds of boundaries, and assist in turn taking in spoken discourse or marking of episodes in written discourse, are claimed to fulfill textual functions. She opines that, discourse markers with interpersonal functions express the speaker or writer's attitude, and keep intimacy between the participants. Indeed, discourse markers are communicative tools which organize and evaluate the ideas in the discourse, thus, the use of these linguistic elements is tied to the communicative purpose of the text. Due to the fact that a genre comprises a class of communicative events defined by a set of communicative purposes (Swales, 1990, 58), forms, frequency and functions of discourse markers which renders text acceptable to differ among genres. Piurko's study focused on distribution and functions of discourse markers in different genres and follows the concept of genre developed by Swales (1990) and Bhatia (2013).

She realized that, studies related to analyzing the function and distribution of discourse markers across genres are numerous. They have focused on various aspects of discourse markers in genres, for example, variation of conjunctive discourse markers in the genres of textbooks and scientific research articles (Verikaitė, 2005), use of discourse markers in telephone conversations and television interviews (Verdonik, et al., 2008), discourse markers in essays (Feng, 2010), the function of discourse markers in Arabic newspaper opinion articles (Kohlani, 2010), inferential discourse markers in research articles of psychology across English and Persian (Kaveifard & Allami, 2011), causal markers across genres of newspaper articles, blogs and research papers

(Mulkar Mehta, et al., 2011), forms and functions of discourse markers in President Obama's political speeches (Ismail, 2012), discourse markers in academic report writing (Sharndama,Yakubu, 2013), the functions and the importance of discourse markers through political discourses in Albania (Dylgjeri, 2014). She concludes by saying that although discourse markers have been examined in different genres, still, relatively little attention has been given to the media discourse of editorial and interview genre and to the legal discourse of convention and trial genre.

Bider et al. (2007) explored how structured discourse and organization can be investigated using corpus analysis; they offered a structure seven –step corpus-based approach to discourse analysis that resulted in a generalizable description of discourse structure. The article focused in particular on analyses that used theories on communicative or functional purposes of text as the starting point for understanding why texts in a corpus are structured the way they are, before moving to a closer examination and description of the linguistic characteristics and overall organizational tendencies reflective of the corpus. (Biber et al.), referred to it as a 'top-down approach' to the analysis of discourse structure. (In a bottom-up approach, the lexical and/ or form-focused corpus analysis comes first, and the discourse unit types emerge from the corpus patterns.) The primary goal of his article was to provide a description of the process for carrying out a corpus-based discourse study using the approach introduced by Biber et al., and to show how it can be applied to move analyses.

Muhammad et al. (2009), worked on doctor-patient conversation with focus on the Pakistani hospital. The study analyzed of the communicative patterns between doctors and patients by applying (Sinclair and Coulthard's 1975) IRF (Initiation, Response and Follow-up) Model. The focus of the study was to investigate the discourse features of the language used between the doctors and the patients in a hospital setting. It further explored how doctors and patients make sense of each other's talk. The data was electronically recorded and then transcribed in terms of Dijk's transcription key with the modification. IRF structural patterns of the original model were applied with modification due to changes in the context in which the communication between the participants of the discourse took place. The discourse structure found in the data varied from that of the classroom discourse investigated by Sinclair and Coulthard. The study showed significant difference in the use of language in spoken and written form between the doctors and the patients. It also revealed that commonality, solidarity and familiarity in exchange structure were lacking in

the communication between the doctors and patients which resulted to misunderstanding of the talk. The study also found out that there are many language barriers that occur in a conversation, if the speakers communicate in such a way that they follow a set pattern, they can overcome with these barriers through which a successful communication can be achieved. Similarly, the study was intended to find the answer of the question whether the doctor made the sense of the patient or not. It was found out in the analysis that at some moments, doctor made the sense of the conversation of the patients. But most of it was observed that patients, from the rural areas who could not speak even the native language very clearly could not communicate well in the hospital. Doctors also presented the ignorance of the understanding of the conversation made by the patients; he was in need of the attendant who could communicate the patients' message to him. For such a case, it was suggested that doctors must be multilingual; he should speak even all native languages and foreign language as well to communicate successfully. Because the pain or disease that can be explained by the patient itself, cannot be explained by others. Doctors can have better understanding of the communication if they know the specific language. It has been observed that sometime patients did not make sense of the talk or advises of the doctors because of the language used by the doctors during the medical checkup. Some doctors used acronyms or abbreviation in their communication so it was not possible for the patients even for the attendant to understand the doctors.

Alexander C. l Holden (2019) analysis examined the discourses within online media that related to dentistry and oral health, contributing to developing understanding of the underlying social and political contexts that may affect the promotion of oral health. The increased mediatization of society meant that media representations of the dental profession and oral health were of increased importance. The search for online media sources relevant to dentistry and oral health was carried out using Google News. Discourse analysis was used to explore online media sources that discussed oral health, the dental profession and dentistry more generally. One hundred and seventy-one articles were included, and three overarching discourses were identified from the selected online sources; 1) Power and Professional Status; 2) Advancement of Social Control and; 3) neoliberal Attitudes towards Oral Health care. He concluded that the theory of the social contract provides a conceptual framework to explore the relationship between the dental profession and society, the nature of this is discoverable through analysis of the discourses within online media. Within the sources examined, the dental profession frequently invokes neoliberal discourses that

placed personal responsibility to be an important factor in preventative oral health. There was also frequent suggestion of a stronger link between oral and systemic health than is evidenced within the academic literature. Analysis of the media sources examined also suggests that the representations of oral health and dentistry also serve to reinforce the artificial separation of the mouth and the body, with dental services being separate from other health care activities.

Javad et al. (2012) carried out a research on discourse markers claiming that they are linguistic elements that index different reactions and conference between units of talk. They (Javad et al.) asserted that development of these forms were on conversations rather than written materials. The study was an investigation on the development of discourse markers in the abstracts of ESP articles along with their lexical complexity. They also examined the frequency of discourse markers and the pate of lexical complexity was estimated based on the percentage of lexical words to total words on whole texts and also based on the proportion of lexical to function words. The result of his analysis revealed that, contrastive and additive markers were the most frequently used ones in their article. As far as lexical density was considered, there were no function words, articles on psychology were less complex than the ones in the other fields.

Piurko (2015) investigated the use of discourse markers in legal and media discourses in spoken and written genres. Her objectives were set on; analyzing the frequency and the functions of discourse markers in four genres; editorial and interviews, conventions and criminal trials, to compare the characteristic patterns of forms and functions of discourse markers in each genre. Her approaches were based on quantitative and qualitative as well as discourse analysis methods. The outcome of the study revealed that the general distribution of discourse markers and the functions of the four items used for the study were quite different. She (Piurk) also noticed that the data showed that the frequency of the occurrence of discourse markers were higher in the spoken genres than in the analyzed genres, despite the fact that textual functions of discourse also fulfilled a significant role in texts, especially in the spoken discourse. She concluded on the basis that the frequency of discourse makers in texts and their functions could be influenced by the genres, and on that, the forms and functions of discourse markers, corresponds to the communicative purposes of the two genres.

According to Crystal (1966) the reason for intelligibility in language or discourse is that language is somehow destined to be unintelligible and that the primary cause of misinterpretation is in

human beings rather than in the easy and correctable modes of transmission. He continued that it is important to focus on the human potential for improvement, to study where things can go wrong when people use language wrongfully. Crystal affirmed that there are three variables that the public speaker must bear in mind: the subject matter, the audience and their needs and supposed that paradox is usually not needed in the hospital just like too much coldness and formality which are characteristic of receptionists and communication of any kind in hospitals. This kind of text is difficult for the receptionists as they find such language sometimes unfamiliar to their daily routine of welcoming and speaking to patients. Drawing from what people can understand and what they cannot, he suggested that just like in homiletic communication where no single sermon can say everything on a particular subject, receptionists should not form or possess a particular style or form of receiving patients just because they have been working with patients for a long time and therefore they think all patients are the same and they know how all of them reach when they visit the hospitals. He underlined the following as linguistic habits which cause difficulties in comprehension: jargons, ill-defined terminologies, academic equivocation, irrelevant facts, incoherent arguments, and clichés which all contribute to unintelligibility.

Crystal (ibid) concludes that the role of linguistic communication should be self-evident. That there are two linguistic sides to ecumenism: the reduction of understanding between groups and an increase of understanding among others and that ; we must consider internal problems like the questions of a realistic and effective language and a clearer way of addressing patients for better understanding and communication.

2.2.3 Research on Medical Discourse

In 1976, Patrick Byrne and Barrie Long published a path-breaking study of the doctor–patient relationship in primary care encounters. Based on some 2,500 tape-recorded primary care encounters, Doctors Talking to Patients anatomized the medical visit into a series of stages, and developed an elaborate characterization of doctor behaviors in each of them. Drawing on (Michael Balint's 1957) proposal that the primary care visit has therapeutic value in its own right, Byrne and Long focused on the ways in which its therapeutic possibilities were attenuated by the prevalence of doctor-centered behaviors in the encounters they studied. The study was also conceived as an intervention: physicians were invited to use its coding framework to evaluate their own conduct, and to modify it in a more patient-centered direction. Not surprisingly, given these

goals, doctors talking to patients were in itself somewhat doctor-centered. The authors had little to say about patients' contributions to the encounter or the sociocultural context of social interaction in primary care. Byrne and Long's project of anatomizing the primary care visit was from a primarily sociological and interactional perspective. From the standpoint that physicians and patients – with various levels of mutual understanding, conflict, cooperation, authority, and subordination – jointly constructed the medical visit as a real-time interactional product. Within this orientation, they considered some of the social, moral, and technical dilemmas that physicians and patients face in primary care, and the resources that they deploy in solving them. Their objective was to open the study of doctor–patient relations to a wide range of social and interactional consideration search; to set out the conceptual context of the studies, and to consider what they might contribute both to the social scientific investigation of primary care and, in keeping with Byrne and Long's original objective, to its practice. Medical discourse exists in communication within the professional community and in doctor-patient communication.

Nan Wang et al. (2020) studied the challenges in medical conversation with structured annotation. In her research she realized that medical conversation is a central part of medical care yet, the current state and quality of medical conversation is far from perfect. They realized that a substantial amount of research had been done to obtain a better understanding of medical conversation and to address its practical challenges and dilemmas. In line with this stream of research, they had developed a multi-layer structure annotation scheme to analyze medical conversation, and were using the scheme to construct a corpus of naturally occurring medical conversation in Chinese pediatric primary care setting. Some of the preliminary findings were reported regarding how a medical conversation starts, where communication problems tend to occur, and how physicians close a conversation. Challenges and opportunities for research on medical conversation with NLP techniques were discussed and it was observed that medical conversation is at the core of medical care; through conversation, doctors collect the information needed to form a diagnosis and provide a treatment recommendation for the patient's condition. Effective communication is essential for achieving optimal medical outcomes. Yet breakdowns in doctor-patient conversation are common in medical practices. They cited examples from the largest proportion of hospital and community health services complaints in the UK which were about communications with medical professionals in 2017-2018 (NHS, 2018).

They realized that, a better understanding of medical conversation (e.g., how it is conducted; what practical problems and dilemmas doctors and patients face) could improve not only the quality of care, but also the efficiency of the health care system. In their work, they first reviewed the major issues that medical conversation research had investigated; they then introduced the data and methods that they used to analyze medical conversation; lastly, they presented some preliminary findings based on our analysis of the corpus and concluded with a discussion on implications of the study and future work.

Talley Janine (2016) worked on the role of narratives and metaphors in health literacy and realized that, the concept of health literacy emerged several decades ago as a response to recognition that certain kinds of knowledge, understanding and skills were associated with good health. The ideas encompassed by the term were exemplified in definitions such as the following from the World Health Organisation 'Health literacy represents the cognitive and social skills which determine the motivation and ability of individuals to gain access to, understand and use information in ways which promote and maintain good health'. To her, health literacy had attracted increasing interest from academics, researchers and practitioners in recent years, most importantly because low health literacy had been associated with poorer health and wellbeing outcomes.

These included, problems in accessing and using health services, using medications and managing personal health. Kickbusch, Pelikan, Apfel and Tsouros reported association with riskier behavior, poorer health, less self-management, and more hospitalization and costs. Concerns were so great as to support its establishment as a pressing topic by the WHO, and in policies across the globe such as the Healthy People 2020 initiative of the United States Department of Health and Human Services. In her work,, she discovered that the role of narrative and metaphor in relation to the elements of health literacy were discussed, and the case argued for a more central place for them in the discourse and practice of the field. Narrative, metaphor and health literacy Narrative and metaphor have traditionally been viewed as merely linguistic devices employed in the communication of ideas. Whilst they are mentioned in this capacity in examples of key texts on health literacy, for example by Zarcadoolas, Pleasant and Greer2 and Osborne, they had not attracted significant attention as having any more fundamental importance, or central position in this field. However, as a result of recent work in areas such as cognitive psychology and cognitive linguistics, it might be argued that this position needs to be reviewed. In wider

thought and discourse about how they engaged with the world, narrative and metaphor have moved to center stage. The role of narrative and metaphor as fundamental at the level of conceptual processing mechanisms and the making of meaning is an idea that has been developing over several decades. Narrative and metaphor are now seen as integral to cognition and the products of cognition including communication and action. The work of Bruner in particular had contributed to the changing awareness of the role of narrative, which he proposed as being one of the two main strategies for understanding the world (alongside logical-scientific thinking); arguing that it was through narrative that reality is constructed. She concluded by stating that information is integrated into a sequence and running storyline, narrative is created. Arguments are similarly made for metaphor as an organizing principle of thought. Ortony and Lakoff and Johnson supported the view that metaphor is central to cognition; this being achieved through the connections it enables between new and existing domains of thought and the development of conceptual frames. Lakoff indeed argued that most of our conceptual system is metaphorical.

Mohammed Afzaal et al. (2019) carried out a research on the communicative patterns of doctor-patient conversation in some Pakistani hospitals by applying Sinclair and Coulthard's (1975) IRF (Initiation, Response and Follow-up) Model. Their focus of this study was to investigate the discourse features of the language used between the doctors and the patients in a hospital setting. It further explored how doctors and patients make sense of each other's talk. The data was electronically recorded and then transcribed in terms of Dijk's transcription key with the modification. IRF structural patterns of the original model were applied with modification due to change in the context in which the communication between the participants of the discourse took place. The discourse structure found in the data varied from that of the classroom discourse investigated by Sinclair and Coulthard. Their study showed significant difference in the use of language in spoken and written form between the doctors and the patients. It also revealed that commonality, solidarity and familiarity in exchange structure were lacking in the communication between the doctors and patients which resulted in misunderstanding of the talk. Human beings are blessed with a language which is the greatest gift of God and makes human being different from other animals. Humans use language for communication and the most important feature of language is communication. Communication is the process which involves active participation of both the speakers and the hearers. They sometime exchange their ideas, feelings, emotions and information either by following the rules of communication or by violating these rules of

communication. Successful communication can be achieved if speakers use linguistics, contextual and grammar knowledge of the language. The study analyzed the linguistic patterns, and features of the discourse taking place between the doctors and patients, and the ways how the doctors-patient conversation was made comprehensible. Customarily, medical professionals like doctors, non-medical staff, nurses and attending staff speak to patients in a hospital. Dijk (2001) defines discourse analysis in his essay "Critical Discourse Analysis" as "Critical discourse analysis (CDA) is a type of discourse analytical research that primarily studies the way social power abuse, dominance, and inequality are enacted, reproduced, and resisted by text and talk in the social and political context," (p. 349). The term discourse refers to the language used in public speeches or in spoken interaction. In the past, discourse analysis focused on different stages formal spoken and written language, symbols, abbreviations, medicine, interviews, TV programs, movies, novels, poetry, and social interaction, etc. However, while describing the structure of language, Deborah Cameron (2001) argued that "from linguist's discourse analysis takes a concern with the structure of a language and the distribution of linguistics forms," (p. 124). Therefore, linguistics discourse analysis can bring changes in the field of communication. In order to have successful communication specifically in classroom, Sinclair and Coulthard (1975) developed a pattern for the successful communication in classroom interaction between the teachers and the students. Sinclair and Asher also worked in making analysis of the conversation between the doctors and patients in the hospital, and the purpose was to provide a linguistic pattern between the two speakers.

Ronald E. 2016) investigated the role and importance of uncertainty in medical practice. He realized that medicine is an uncertain practice but as physicians they are taught that they can (and must) control and manage disease, patient behavior, and that they are expected to always provide the right answers when confronted with ambiguities and uncertain situations. He brought out the fact that physicians often feel powerless, lack of control, and heightened frustration when faced with certain situations and even when they feel they are in comfortable situations and can exert some level of control— for example, diagnosing and treating a routine case of hypertension, making a tissue diagnosis of breast cancer, or removing a benign skin lesion—the physician can harbor doubts and anxieties about how effective they are in restoring the patient to a state of optimal health. He also realized that despite the gains in medical knowledge that have been made in recent decades, physicians and patients all too often remain frustrated in confronting the

uncertainties surrounding our inability to treat many diseases and illnesses and to engage the patient in shared decision-making. In the cause of his investigation, he decided to ask the question: Why is this so? Why are physicians, in general, unable to understand and appreciate that ambiguity is a normal part of the practice of medicine and that learning to effectively incorporate uncertainty in our daily practice and in our educational curricula should be a routine part of what we do? He later realized in answering the question that ambiguity is in our everyday lives and it is impossible to prepare for every contingency or unknown event.

This analysis examines the discourses within online media that relate to dentistry and oral health, contributing to developing understanding of the underlying social and political contexts that may affect the promotion of oral health. The increased mediatization of society means that media representations of the dental profession and oral health were of increasing importance mouth and the body, with dental services being separate from other health care activities.

The public pays attention to the media and subsequently, specific health issues may be influenced through exposure and discussion in this arena. Barker, reported that 75% of people claim they rely on the media's coverage of health issues to make health decisions. This may be on an individual level, affecting change on attitudes and behaviors, or on a larger, societal-level where social norms, customs, values and health policy are developed through being featured within the media. The media is not only a conduit for transmitting information about the health care industry, but it is also responsible for developing narratives, setting agendas and constructing realities. Due to the increasing mediatization of society, the health professions have been highlighted as being under greater scrutiny than ever before. This makes analysis of the media exposure of oral health and the dental profession an important exercise in order to build understanding of how the profession interacts with, and was perceived by, society. Understanding how oral health is presented in the media was also essential to contribute to future health promotion strategies. He suggested that the media was an important influence on the public image of a profession. It was therefore essential for professions and their members to be aware of how the media was portraying them, and take appropriate action where necessary, in order to maintain their professionalism.

Alexander C. (2019) examined media portrayals of dentistry and oral health to develop understanding of the hidden messages relating to the dental profession and the provision of oral

health services that exist within the mass media. He observed that previous research examining oral health messages in the mass media had taken a content analysis approach. That highlighted a narrow breadth of oral health material examining print and television media, noting that there was a lack of social context given for preventative or health-promoting behaviors in dentistry. He pointed out that his research used discourse analysis to explore the social, cultural and political context of dentistry and oral health more deeply, examining how the language of the texts might speak to the rules, conventions and institutions within which the discourse around oral health and the dental profession was produced and circulated. He added that, the quality of information within articles reporting on oral health was also important; work examining articles in UK newspapers that featured oral cancer found that stories missed opportunities to provide key public health messages. Whilst the focus of his work was not to examine the quality of oral health information, understanding how systemic and oral health is discussed in relation to one another was important, being an important discourse within the dental profession. In order to examine the relationship between the dental profession and society, he used discourse analysis which had been conducted within the conceptual framework of the social contract on specific health issues which may be influenced through exposure and discussion in this arena. Barker, his findings reported that 75% of people claim they rely on the media's coverage of health issues to make health decisions. That may be on an individual level, affecting change on attitudes and behaviors, or on a larger, societal-level where social norms, customs, values and health policy were developed through being featured within the media. He also discovered that the media was not only a conduit for transmitting information about the health care industry, but it was also responsible for developing narratives, setting agendas and constructing realities. Due to the increasing mediatization of society, he realized that the health professions have been highlighted as being under greater scrutiny than ever before. That made analysis of the media exposure of oral health and the dental profession an important exercise in order to build understanding of how the profession interacts with, and was perceived by, society. Understanding how oral health was presented in the media was also essential to contribute to future health promotion strategies. He concluded by stating that the media was an important influence on the public image of a profession. It was therefore essential for professions and their members to be aware of how the media is portraying them, and take appropriate action where necessary, in order to maintain their professionalism.

Grit et al. (2002) analyzed recent dynamics of the Dutch health care sector, a hybrid system of public, private and professional elements, in terms of clashing discourses. They discovered that the Dutch health care system was a hybrid system of public, private and professional elements. Constitutionally, the Dutch State was responsible for the accessibility, the quality and the efficiency of health care. Nevertheless, he discovered that the government had just a minor role in the realization of these aspects of health care and therefore depends crucially on the cooperation of private parties such as insurance companies, private institutions of health care and professional provision as well as a number of other organizations. The parties were mutually dependent on each other. As a result, the Dutch health care sector did not have one power center that can interfere unilaterally in the organization of health care. Decisions may simply seem to "happen." The fact that different actors contributed to the provision of health care causes confusion about the responsibility for providing good care. When many parties are involved, the contribution of separate actors was difficult to determine. He also observed that the problem of the distribution of responsibilities was aggravated by the unstable conjuration between the different actors. In his analysis, he brought out the fact that since the eighties, different committees commissioned by the government had argued in favor of using more market elements in the health care system. Many organizations of health care, without a prompt motive, became more interested in the methods of private enterprise. Institutional changes had ensued the management of those organizations acquired a stronger position. Those developments were labeled as "economization."

Irina et al.(2020) studied the sentiments in Russian medical professional discourse during the Covid-19 Pandemic. They observed that medical discourse within the professional community had undeservingly received very sparse researchers' attention. Medical professional discourse exists offline and online. They carried out sentiment analysis on titles and text descriptions of materials published on the Russian portal Mir Vracha (90,000 word forms approximately). The texts were generated by and for physicians. The materials included personal narratives describing participants' professional experience, participants' opinions about pandemic news and events in the professional sphere, and Russian reviews and discussion of papers published in international journals in English. They presented the first results and discussion of the sentiment analysis of Russian online medical discourse. Based on the results of sentiment analysis and discourse analysis, they described the emotions expressed in the forum and the linguistic means the forum participants used to verbalize their attitudes and emotions while discussing the Covid-19

pandemic. Their results showed the prevalence of neutral texts in the publications since the medical professionals were interested in research materials and outcomes which expressed negative sentiments by colloquial words and figurative language.

Medical discourse exists in communication within the professional community and in doctor patient

Caroline et al. (2011) examined the use of English discourse markers in Spanish language consultations. The data for their research was being derived from an audio-recorded corpus of Spanish language consultations which took place in a small community clinic in the United States as well as post consultation interviews with patients and providers. Through quantification of the use of discourse makers in the corpus and discourse analysis of transcripts, they demonstrate that English-speaking dominant medical providers use English discourse markers more frequently and with a broader range of functions than do Spanish-speaking dominant medical providers and patients.

They also argued that such use of English discourse markers serves to exacerbate the power relationship between providers and patients even though the use of English discourse markers did not cause overt miscommunication in the ongoing interaction. They realized that implications for providers who use a second language in their medical consultations were brought out as part of the dominant features of interaction in clinical consultancy. The medical consultation was one of a number of institutional encounters that could be labeled gatekeeping encounters as medical providers controlled access to information that patients need. Therefore, medical consultations, like many types of bureaucratic interactions, carry with them an inherent social inequality between interactants that is taken for granted a priori and reproduced interactional. This asymmetrical relationship between providers and patients affords the medical establishment social control when it comes to patients' diagnoses, treatment options, and interaction options within the medical consultation.

They also found out that for some patients, ways that providers interaction lead to better meaning making than it does for other patients. Language concordance between providers and patients have been argued to be fundamentally important and the best practice in the medical consultation, more beneficial than cases of interpreter used or cases in which providers and patients had no access whatsoever to a shared language. However, their results had demonstrated that even when there is

language concordance, treating patients who speak English (in the case of their study context, the UK) proficiency could result in linguistic and cultural misunderstandings. Furthermore, in clinical settings that promote themselves as multilingual, one language might be privileged. Their findings demonstrated that language concordant medical facilities in the Texas borderlands privilege English over Spanish, which led to worse health outcomes for Spanish-speaking patients. Their findings also demonstrated that English-speaking dominant medical providers used English discourse markers more frequently and with a broader range of functions than do Spanish-speaking dominant medical providers and patients. They argued that such use of English discourse markers served to exacerbate the power relationship between providers and patients even though the use of English discourse markers did not cause overt miscommunication in the ongoing interaction. Their data also demonstrated that some providers who use second language Spanish code switch, using English discourse markers during the consultation.

Jason Hancock et al. (2015) worked on medical students and junior doctor's tolerance of ambiguity, a development of a new scale and they realized that the practice of medicine involved inherent ambiguity and uncertainty, arising from limitations of knowledge, diagnostic problems, ambiguities of treatment and outcomes, and unpredictability of patient response (Geller, Faden & Levine, D., 1990). The ability of physicians to tolerate ambiguity was therefore of significant interest, with implications for doctors' mental health and wellbeing, staff retention in the medical profession, and specialty choice. Low tolerance of ambiguity had been linked with low patient and physician satisfaction, increased risk of physician burnout (Lim, 2003; Cooke, Doust, & Steele, 2013), more negative attitudes towards underserved population (Wayne, Dellmore, Serna, Jerabek, Timm, & Kalishman, 2011), and personality traits such as dogmatism, conformity and rigidity (Budner, 1962; Furnham, & Ribchester, 1995). They had also argued that evidence-based complex decision-making, which required the integration of individual patient perspectives and research evidence that may be incomplete, poor quality or conflicting, is only possible if the clinician is able to understand the limits of their own, and of scientific, knowledge and manage the associated uncertainty (Knight, & Mattick, 2006) It was understandable, therefore, that undergraduate medical education had been encouraged to introduce educational strategies that will increase medical students' tolerance of ambiguity (Luther, & Crandall, 2011) but the challenges were formidable. There was a fundamental lack of conceptual clarity around the term 'tolerance of ambiguity' and whether it could be changed over time in individuals or populations, or what

strategies might enable it to change. There might also be unintended consequences associated with increasing all medical students' tolerance of ambiguity (Hancock & Mattick, 2012). Crucially, they realized that the tools available to measure tolerance of ambiguity were also crude, despite over 60 years of research, and that provided a particular barrier for the evaluation of educational strategies aimed at increasing learners' tolerance of ambiguity.

Hancock et al. (2015) studied the practice of medicine which involved inherent ambiguity, arising from limitations of knowledge, diagnostic problems, complexities of treatment and outcomes and unpredictability of patients' response. He found out that doctor's tolerance of ambiguity is hampered by poor conceptual clarity and inadequate measurement scales. The aim of the study was to make some tentative insights into whether the tolerance of ambiguity of students changes during medical school, and also to seek conceptual clarity around tolerance of ambiguity, offer a measurement scale that can support the evaluation of educational strategies and make use of a modern visibility assessment framework to evaluate the validity of the scale used in undergraduate medical student and foundation doctors. They (Hancock et al.) aimed to create and pilot a measurement scale for tolerance of ambiguity, scaled items were generated by literature review and expert consultation. They found out that based on their case study, 411 medical students and foundation doctors in Exeter, UK, were asked to complete the scale. Psychometric analysis enabled further scale refinement and comparison of scale score across subjects. The ability by physicians to tolerate ambiguity was therefore of significant interest, with implications for doctors' mental health and wellbeing, staffing retention in the medical profession, and specialty choice. He concluded by stating that undergraduate medical education should be encouraged to introduce educational strategies that will increase medical student's tolerance of ambiguity.

Maurizio (2005), investigated on some of the trends which characterized medical discourse, explored the complex nature of its realizations. He (Maurizio) brought out some important variations which were derived from a host of factors which included cultural aspects, community membership, professional expertise and generic conventions. After the presentation of this study, his principal results from the investigation into medical discourse(text), presented some significant data which originated from a research he carried out which centered on specific discourse and the case study of his project which was on the relationship between socioculturally oriented identity

factors and textual variations in English specialized discourse, with focus on the identification of identity traits typically of medical English compared to other different branches of learning.

Drass (1988) worked on the usage of audio tape recording of consultation between mid-level providers and patients in a health maintenance organization. The aim of his studies was to present an empirically grounded model of medical negotiation developed through an analysis of medical practitioner-patient discourse. His findings presented a model of medical negotiation which his model conceptualizes negotiations as a process in which mid-level providers and patients introduce their perspectives on the definition and treatment of medical problems by linking together units of discourse such as acts, turns, sequences and phases. The model, he said, was clearly to locate negotiations in observable activities of interactions and to demonstrate how the process changed over the course of a medical history. He concluded by stating that because of the formal yet flexible nature of the model; it lends itself for use in comparative studies of medical practitioner-patient negotiation. His model merged from the idea that consultations between medical practitioners and patients involves negotiation which to him was not how previous studies had identified a number of important features of those negotiations process which included power (Scheff, 1963) control of information by medical practitioners (Waitzkin and Stoeckle,1976) and setting language .His conclusion focused on the organization of talk in everyday settings, discourse analysis, provide a means for identifying units of interaction, relationship among units, and relationship between higher levels of analysis and interactional processes.

Wang et al. (2014) worked on the challenges in medical conversation which, according to him, to him is a central part of medical care. He developed a multi-layer structure annotation scheme to analyze medical conversation in using Chinese pediatric primary care setting as his case study. His findings were reported on; how a medical conversation should start, where communication problems tend to occur and how physicians close a conversation. They point out, through conversation; doctors collect the information needed to form a diagnosis and provide a treatment recommendation for the patients' condition. They (Wang et al.) posited that effective communication is essential for achieving optimal medical outcomes yet, breakdowns in doctor-patient conversation are common in medical practices. They used the United Kingdom health services as their focal point where they studied the way communication between community health service personnel and medical professionals (NHS, 2018). The findings were concluded on the

bases and recommendation that for a better understanding of medical conversation, care givers should improve not only on the quality of care, but also on the efficiency of the health care system.

Masukume and Zumla (2012) undertook a research on analogies and metaphors in clinical medicine. He stated that medical images of clinical signs and pathology were communicated through metaphors in the 19th and 20thc to make recognition easier in anticipation of the clinical counterparts when encountered in medical practice. He says they have served as teaching aids, enhancing memory retention for medical students, nurses and doctors and have withstood the test of time. Medical practitioners assert the fact that language (discourse) makes use of a lot of metaphors and medical jargons sometimes reduces the patients abilities to understand what is being said and thereby reduces the patients understanding of what is being said, where to go and what not to do given the fact that the use of metaphors portrays a sense of inadequateness in the understanding of things.

Drass (1988) carried out a study on the structure of discourse in medical consultation, insisting that using audio tape recordings of consultations between mid-level providers and patients in a health maintenance organization, a model of medical negotiation. He explains that the model conceptualizes negotiations as a process in which mid-level providers and patients introduce their perspectives on the definition and treatment of medical problems by linking together units of discourse. He (Drass) says the model clearly locates negotiation in observable activities of interactions and demonstrates how the process changes over the course of an encounter as providers and patients participate in the taking of a medical history, the performance of a physical examination, and the discussion of the problem and treatment. Well-grounded empirical studies designed to describe in detail the actions used by participants in medical consultations to carry on negotiations are rare. He says one possible reason for that is the difficulty in conceptualizing social processes so that the interrelationship of actions can be described. By focusing on the organization of talk in everyday settings, discourse analysis provides a means for identifying units of interaction and relationships among units, the relationships between higher levels of analysis and interactional processes (Corsaro, 1981)

He concludes that because of the formal yet flexible nature of the model, it lends itself for use in comparative studies of medical practitioner-patient negotiation.

2.3 CONCLUSION

This chapter has discussed related literature and the theoretical frameworks used in this work. We have reviewed literature related to the current dissertation in a bid to show its novelty. The review has been done under four subsections: performative use of language, discourse, discourse analysis, critical discourse analysis and medical discourse. We have equally presented the theory which is used in this study. That is the socio-cognitive theory propounded by Van Dijk. This section therefore showed the limitations of previous works. It also shows what the current work is going to add to the field of scholarship and therefore its significance.

CHAPTER THREE

METHODOLOGY

3.0 INTRODUCTION

This chapter presents the various steps and procedures followed in the collection and analysis of data in the current study. According to Kothari (2004), research methods may be understood as all those methods/techniques that are used for conducting research. Research methods or techniques, thus, refer to the methods the researchers use in performing research operations. It is a way to systematically solve the research problem. Thus, when we talk of research methodology we not only talk of the research study and explain why a particular method or technique is used and why others are not used so that research results are capable of being evaluated either by the researcher himself or by others. To this effect, this section describes the process of data collection, tools used in its collection, how it is analyzed and presented. It also explains the context of the corpus that is used in this project and outlines the method for data analysis. The main method used is analyzing questionnaires, recordings and observable actions.

3.1 THE RESEARCH DESIGN

This study relies on a single framework because of its focus on the aspect of language in use. This work uses a case study research design, a form of quantitative and quantitative descriptive research design. It looks at statistical data to answer the questions of how many items are to be observed and how data is going to be gathered. The data were carefully selected from conversation recordings between receptionists and patients as well as questionnaires. In order to ensure the validity of our study, we recorded data from the discussions or conversations receptionist had with patients in the two hospitals under study. The data was then scanned to avoid recorded

conversations which had nothing to do with the subject of the study. In collecting the data, we carried out an internship in the various hospitals for one month each to observe how interaction takes place and how the receptionists use language in communicating with patients. The two hospitals are the Presbyterian Health Complex and the Gynecological and Obstetric hospital Yaounde (HGOPY). The choice of the design is justified by the fact that it deals with quantitative and qualitative data. The design aims to find out about what obtains in these hospitals and in particular, about the aspect of the way they make use of language.

3.2 METHODS OF DATA COLLECTION

Burgoyne (1994:195) posits that everyone who wishes to carry out scientific research must first and foremost put into perspective the four fundamental questions.

1. What research questions are to be answered?
2. What analysis will provide a useful response to the question?
3. To conduct this research, what does one need and from whom?
4. What are the particular steps to obtain in recording the data?

Question (1) has been answered in the formulation of the research questions while question (2) has partly been answered in the choice of the theoretical framework. This chapter provides answers to question (3) and (4) as their focus is the principal concern in this section.

This study considers the language used by hospital receptionists in receiving patients in hospitals and our choice of study are from two hospitals: one being a state owned and the other a private or institutional owned hospital. The recordings were obtained on the basis of a ‘one-on-one conversation by the receptionists and the patients during their interaction. Twenty (20) recorded conversations where gotten from the two hospitals under study while a hundred and fifty (150) questionnaires were filled.

3.3 PRESENTING THE CHOICE OF THE STUDY

3.3.1 DATA SITE

The data used for this study comes from the Presbyterian Health Complex and the Gynecological Obstetric and pediatric hospital in Yaounde, political city of the country. These hospitals were

chosen because of their location, the various departments or services they have as well as their reputation and their impact on patients or the society. The hospitals are well known to the public for the services or departments and the type of services they render in their different localities where they are located. The gynecological and obstetric hospital is well known for the different departments they have such as pediatric, gynecological and obstetric, chirurgic, gastroenterologist general medicine, cardiology, clinical laboratory services, echography, dental, ophthalmology unit, and a host of others which accounts for the influx of patients on a daily basis, who sometimes visit the hospital due to referrals from other hospitals which they had visited and could not get solutions their problems. This is also the case of the Presbyterian health complex who are known especially in the treatment of eye problems and other related body diseases and being a church owned, patients visit knowing that the spirit of God is present in the hospital environment and in the heart of the workers. Accessibility was also a concern when the choice of case study was being considered. In all, the choice of hospital under study was influenced by the above-mentioned points which have a great impact on the data under study.

3.3.2 SAMPLE POPULATION

The data was collected in 2022, within a two-month two-week period. The period of study ran from….To…..The data were collected during the day and the night period with the day period serving as a major source of data collection due to the influx of patients during that period. About 97% of data was collected during that period. The data was collected from the different sections of the hospitals and it was on a one- on- one basis where patients were able to pour out their feelings and worries about the various services not just at the level of the receptionists but even about other aspects they weren't satisfied about. The participants were made up of mothers, fathers, young men and women aged 15 to 80 years who came to the hospital because they were sick or visiting a patient or to inquire about other issues. The discussions were done at random based on the patient's willingness to interact.

3.4 DATA COLLECTION TOOLS

The data for this work comprises recorded discussions between patients and receptionists, patients and patients, receptionists and receptionists. It also comprises discussions between social workers (such as cleaners) and patients. Part of the data is also gotten from questionnaires, non-linguistic

and observable aspects of communication. Due to the need for a quantitative analysis, a statistical data of the number of patients who were interviewed and served questionnaires is required.

In this light, the most important tool used in the collection of data is the recording machine. A digital recorder is used and all the recorded sessions between the receptionists and the patients, patient to patient and receptionist to receptionist and patients to social workers were being recorded and later transcribed not forgetting the non-linguistic and paralinguistic aspects of communication.

3.5 DATA SOURCES

This work under study has five main streams of data.

1. Recorded discussions between receptionists and patients in the hospital

2. Recorded discussions with receptionists and receptionists about patients

3. Recorded discussions between patients and patients discussing on their various worries

4. Recorded discussions between patients and social workers

5. Observable facts

3.5.1 INTERVIEWS

This phase has to do with interviews with the patients, the receptionists and the care givers. This took a form of a question and answer session as some guided questions had been prepared for the said exercise. The question samples can be seen at the appendix at the end of this work.

During the interview, the individual is given the latitude to express him /herself in either pidgin, English French. Interviews have both verbal and non-verbal components. The aim of the interview is to gather information, and the adequacy of the data gathered depends in large part on the questions asked by the interviewer (Monster Career Coach, 2006).In such an interview, attention would be given to the patient's physical health and to any symptoms of behavioral disorder that may have occurred in order not to strain the patients' health.

The type of interview design used in this research is the face-to-face contact between an interviewer and interviewee is directed towards eliciting information that may be relevant to particular practical applications under general study or those personality theories(or hypothesis)

being investigated. That is exactly what is required in this research. With the face-to-face interview, the interviewee get to not only to hear and record what the patients have to say but they also get to see and feel the patient's state through the mind's eye or observable factors which will go a long way in ascertaining the data quality. Interviews are one of the best forms of data collection instruments.

3.5.2 PARTICIPANT OBSERVATION

According to Oxford concise dictionary (2018), observation means "accurate watching, knowing of phenomena as they occur in nature with regard to cause and effect or mutual relations." This meaning of observation highlights two points. Firstly, in observation an attempt is made to discover casual and other relations between facts of a phenomenon; secondly, phenomenon is watched realistically and precisely and the facts written down. Marshall and Rossman (1989:79) define observation as "the systematic description of events, behaviors, and artifacts I the social setting chosen for study." Observation enables the researcher to describe existing situations using the five senses, providing a 'written photograph' of the situation under study (Erlandson, Harris, Skipper, and Allen, 1993). DeMunk and Sobo (1998) describe participant observation as the primary method used by anthropologists doing fieldwork. Fieldwork involves " active looking ,improving memory, informal interviewing , writing detailed field notes, and perhaps most importantly, patience" .Participant observation is the process enabling researchers to learn about the activities of the people under study in the natural setting through observation and participating in those activities. It provides the context for development of sampling guidelines and interview guides (DeWalt and DeWalt, 200

Observation methods are useful to researchers in a variety of ways. They provide researchers with ways to check for non-verbal expressions of feelings, determine who interacts with whom, grasp how participants communicate with each other, and check for how much time is spent on various activities(Schmuck,1997).Participant observation allows researchers to check definitions of terms that participants use in interviews, observe events that informants may be unable or unwilling to share when doing so would be impolite, impolitic, or insensitive and observe situations informants have described in interviews, thereby making them aware of distortions or inaccuracies in description provided by those informants.

Quantitative research, however, focuses on gathering numerical data and generalizing it across groups of people or to explain a particular phenomenon (Babbie Earl, 2010). Quantitative methods used in this work emphasize objective measurements and the statistical numerical analysis of data collected through interviews and questionnaires.

Qualitative data, on the other hand, involves processes such as coding, categorizing and making sense of the essential meanings of the phenomenon (Russell Bernard H, 2006). This has to do with the organization and the interpretation of the information in order to discover any important underlying patterns and trends. Qualitatively, the non-verbal aspects of communication in the interviews are analyzed qualitatively as well as the discourses and the discursive strategies. During the different interview phases, the non-verbal aspects of communication like tone, voice quality, gestures proxemics are also given due consideration.

3.6 JUSTIFICATION OF THE DATA SITES

Situated in the heart of the political capital of Cameroon, the Yaounde Gynecology, Obstetric and Pediatric hospital specializes in caring for women and children. The hospital was built with the assistance of the government of China. Opened on the 28th of March 2002 by the President of the republic accompanied by the Chinese Vice-minister of health, the outpatient care began on April 1st, 2002. Located in the heart of the center region on 1564 Rte de Ngousso, the hospital receives an influx of patients on a daily bases. These patients are not just from the city itself but from neighboring villages, towns and why not countries like Gabon, Chard, Congo, and Equatorial Guinea just to name a few that are being referred to the hospital due to its well-known services it renders. The Presbyterian Health Complex Yaounde is an institution of the Presbyterian Church in Cameroon. It is the leading eye care provider in Cameroon and the Central African sub-regions.

The hospitals are also well known for their well trained and qualified teams of health personnel especially the doctors who are always there to make sure they treat their patients in the best possible means they can. This health personnel has had more than 20 years of working experiences which adds to the reason for the massive influx of patients on a daily. Most of the health care personnel ranges from professors, doctors, senior lecturers who lecture in our state-owned Universities and even private universities.

The hospitals are also referred to as teaching hospitals as they receive an influx of student doctors and nurses, and also those who take an internship on health administration and a host of other academic purposes which also adds to the visibility of the hospitals. And, also, due to the cosmopolitan nature of the city where they have an influx of foreigners and also other health experts from around the globe, the hospital serves are a reference of other hospitals in the town.

Another reason for the choice of these hospitals is also due to their accessibility. They are less difficult to reach the hospital as the hospital is found on a tarred road not far from the central town and they are also surrounded by transport agencies which in case of any emergency, vehicles can easily have access to where the hospital is located. It is also easy to get accommodation as hotels and guest houses are not far from these hospital premises. they are also one of the hospitals which were interested in the topic of this research as they were on the stage of rectifying some of the issues about the hospitals which most of their patients were complaining about and it was also on the season of the appointment of a new director of the gynecology, Obstetric and Pediatric hospital and the Presbyterian Health Complex had moved to their new site some 3 years back; this made the research to be timely.

Also, language use was one of the reasons for the choice of these hospitals, Most of the health personnel are less bilingual which makes it difficult for them to communicate and for those speaking only English to be able to express themselves since they mostly communicate with their colleagues or patients in their mother tongue due to the level of patients who visit the hospitals on a daily. This is due to the multilingual nature of the country which comprises 247 indigenous languages excluding English and French. But for the Presbyterian Health Complex, the language use there is made up of English, French and Pidgin English which is a lingua franca. The use of these languages enables them to cut across literates, semi-literates and illiterates. With these, they are able to meet the diverse demands of the patients.

3.7 DATA SELECTION

The data for this work comprises recorded interviews, discussions, questionnaires and participant observation from the gynecology, Obstetric and Pediatric hospital and the Presbyterian Health Complex Yaounde. The recorded materials are made up of recorded discussions between receptionists and patients in the hospital, recorded discussions with receptionists and receptionists

about patients, recorded discussions between patients and patients discussing on their various worries, recorded discussions between patients and social workers.

With regard to the recorded interviews, patients were interviewed at random and there was no time frame given for the interviews as patients were allowed to express themselves freely with some guided questions involved. Due to the nature of data at hand, it was necessary to identify and select the material that will be needed for analysis since sometimes some of the data isn't in conformity with the topic at hand; this is due to the fact that patients sometimes in expressing themselves talk even about their worries out of issues related toothier health. The data (questionnaires) were later grouped according to age, gender and the guided questions administered.

3.8. ANALYTICAL METHODS

To Chilton and Wodak (2007), Critical Discourse Analysis (CDA) is a multi-method framework and requires different sorts of data. For this research, the data is made up of audio recordings of discussions between receptionists and patients at different levels, including questionnaires and observation during a two months' intensive session in the two hospitals under study. The data is analyzed both qualitatively and quantitatively. A qualitative analysis is carried out in order to investigate on the linguistic and discursive strategies used when receptionists interact with patients in the hospitals under study in order to bring out the loopholes in the way they use language and how they use it to interact with the patients. The quantitative analysis is used to quantify and interpret the utterance and the acts they perform and also in a bid to investigate on the various levels of discourses at which language is being used when interacting with patients.

According to Kothari (2005), "quantitative research is based on the measurement of quantity or amount. It is applicable to phenomena that can be expressed in terms of quantity." Quantitative analysis, which compliments qualitative analysis, is used to quantify and analyze various linguistic acts under study. We identify, explain and examine the various speech acts in the language. The framework adopted for this study is the Critical Discourse Analytical framework and this framework makes use of the socio-cognitive Approach of Teun van Dijk. In chapter four, we classify and analyze them in different categories; the various categories will be explained stating

exactly their functions and role they perform. The analysis will be done in a form of tables and charts. This is done in a bid to ease understanding of the various discourses which will be analyzed.

3.9. THE LANGUAGE OF THE DATA

The primary data for this work is in English, and French, which happens to be the official languages of the country as well as Pidgin which is a lingua franca in Cameroon. This languages happen to be the official working languages of the hospitals due to the fact that the hospitals welcome on a daily, patients who speak either English, French or Pidgin English (Kouega, 2007).

The secondary data also comprises these three that is; English, French and pidgin since all the questionnaires administered are either answered using any of the three languages in others to make the patients feel comfortable in answering the questions without language being a hindrance. The patients, receptionists and social workers make use of these languages to ease communication due to the fact that all the patients who visit the hospital are not of the same educational background.

3.10 TRANSCRIPTION

Speaking broadly about transcription means converting audio recorded transcription dictation to the format but transcription is a lot more than that. Basically, it depends on the client's requirement (Williamson, 2009). Transcription is the operation of transferring audio-or videotaped materials into verbatim documents (Meghan Cope, 2009). It is also an action of providing a written account of spoken words. In qualitative research, transcription is conducted by an individual or a group of people(s) which interviews are generally written verbatim. Transcription differs depending on the needs of the transcriber. It is a time-consuming activity. There are three types of transcription format which are used for transcribing audio files around the globe (Gail Jefferson, 1963). The three types are; verbatim, edited and intelligent transcriptions.

The three formats have their own weaknesses and failures and they clearly depend on the clients as to which one he or she requires. Verbatim transcription of data which has been recorded is good in data management strategy in linguistic research and also considered as an integral part of the analysis and interpretation of the verbal data. The basics of verbal data are becoming more widely embraced in health care research, interviews are being used to collect information for a wide range of purpose (Halcomb E. and Davidson p. 2006). In this work, we will be using the verbatim

transcription due to the advantages it bears and its importance in linguistic analysis. With this type of transcription, every single detail is taken into account, that is, every single word, verbal or non-verbal, mumbling, agitation and all other actions by the speaker are taken into consideration with the verbatim transcription. It also requires the transcriber to transcribe all the forms of turn taking, back channels, overlaps, repairs and all kinds of emotions displayed during and in the recorded file.

Paralinguistic aspects are worthy of note with this format of transcription especially when analyzing language use and it's only through this method of transcription that one can bring out all these aspects. These aspects include hesitations, laughter openings and banging of doors, silence, coughing and a host of others. An appendix page of the transcriptions will be recorded in the work.

3.11 TRANSLATION

Newmark (1988:5) describes translation as "the rendering of meaning of a text into another language in the way that the author intended the text." (Nida and Taber, 1982:12) sees translation as consisting in reproducing in the receptor language the closest natural equivalent of the source language message.

The recording or data is translated from French and Pidgin to English. Every aspect of the data is translated word verbatim. After this process, the analysis of the text is carried out in its original language. The transcribed text is being transcribed in order to show the non-verbal aspects of the language, while the text is translated in a literary way therefore losing its originality which makes it to lose some of its qualities in the process of translation.

3.12 DATA CODING

Coding is the analytic task of assigning codes to non-numeric data. Coding language data is a technique used in a variety of research traditions. In traditional content analysis, coding falls under the heading of " human coding" and makes use of a codebook which, according to (Neuendorf,2016) should be set up in advance of coding and should be so complete and unambiguous as to almost eliminate the individual differences among coders. In qualitative analysis, coding is treated as an activity that creates and assigns a word or phrase to symbolize,

summarize or otherwise capture some attitude of a portion of language-based or visual data, often in interaction with that data of language is inherently multidimensional (Saldana,2016;1). As such, coding frequently has dimensions to it as well. An analyst considering how to code a piece of language of ten sees multiple ways to make it (Krippendorff, 2013).

The data used in this study is gotten from the primary and the secondary source of data. These data has undergone the procedures of translating and transcribing and later the coding process. The coding was done in two forms; that is in distinguishing the data gotten from the receptionists and of the patients, there was a need for coding. During analysis, the data were referenced using particular codes. The codes consist of letters and numbers where the initial (P) for patients is used and the numbering (1, 2, 3…) is used to differentiate one speaker from another. It is the same procedure that ids done for coding the data gotten from the receptionists where and the numbering system (1, 2, 3…) differentiate the data gotten from one receptionist to another. These methods can be seen applicable in the data gotten from the recorded conversations and the data gotten from the questionnaires administered.

3.15 CONCLUSION

With the hope of bringing clarity to our work, this chapter has discussed all the issues related to the methodology used in this study. In this light, the methods of data selection, collection and the procedures used have been clearly stated. Also, the work has clearly been circumscribed. The recordings and questionnaires have all been situated in specific contexts. This section serves to provide guarantees that appropriate procedures of data collection were followed or applied, ensuring that the method of data collection was scientific, good correct and replicable. It also provides assurance that the analysis was scientifically carried out in this study.

CHAPTER FOUR

DATA PRESENTATION AND ANALYSIS

4.0 INTRODUCTION

As earlier stated, this work aims at investigating the language used by hospital receptionists, so as to identify the inconsistencies in the various discourses brought out from the data, examine the discourses and analyze these discourses from a critical discourse analytical perspective in relation to the communicative patterns obtained in the data. It equally seeks to examine the manner in which receptionists in private hospitals as well as those in state-owned hospitals interact with patients.

This chapter, therefore, presents and analyzes the various utterances which form the corpus for the current study. The texts will be analyzed and through the analysis, discourses will be brought out using the linguistic traces. This is done to show the level of the language use if it is appropriate or not. For the sake of making the work more scientific and presentable, we have only made a summary presentation of the various corpora in the work. The data itself is found in the appendices. The utterances from the language of the various speakers are analyzed with the ultimate goal of providing answers to the research questions. This will be done through identifying and naming the discourses using some linguistic analytical processes. The analysis will be amplified with graphs in a bid to bring out the level of satisfaction obtained at the various hospitals at the level of the services they render. The data for this section comes from the recorded discussions receptionists have had with patients, patients with patients, and receptionist with receptionist and patients and social workers in a bid to show the diverse levels of the discourses. The secondary data comes from questionnaires which were administered to receptionists and patients of the various hospitals. The data will be analyzed using the qualitative and the quantitative methods of data analysis. This section identifies and name the various discourses used and also analyzes the linguistic strategy which has been used in the discourses under study.

4.1 CLASSIFICATION OF THE VARIOUS DISCOURSES

This third section of the analytical chapter attempts to answer the research question (3), "How does receptionists' language impact the patients?"

Cook (1989) describes discourse as language in use or language used to communicate. Something felt to be coherent which may or may not correspond to a correct sentence or series of correct sentences. He posits that discourse does not have to be grammatically correct, can be anything from a grunt or simple expletive, through short conversation and scribbled notes, a novel or a lengthy legal case. What matters to him is not the conformity of rules, but the fact that it communicates and is recognized by its receivers as coherent. The various discourses gotten from the primary and secondary data will be analyzed using some linguistic components. Discourses do not just reflect or represent social entities and relations, they construct or constitute them; different discourses constitute key entities in different ways, and position people in different ways as social subjects (patients, receptionists), and it is this social effects of discourse that are focused on in discourse analysis. The discourses used are identified through linguistic traces, vocabulary, phrases and clauses that are found in the data.

4.1.1 DISCOURSE OF IMPATIENCE

Worthy of note in the ethics of health workers is a very important characteristic known as patience. The noun "patience" is the capacity to accept or tolerate delay, problems, suffering without becoming annoyed or anxious (Oxford Languages) Health workers are to exercise a level of patience which goes beyond the physical eyes of the patients. This is very important as it creates an environment where patients can freely express themselves without fear or guilt. It creates an environment built on trust and the freedom of expression. You cannot be able to help someone without listening to what they have to say which is why it is an important factor at the level of medical discourse. Impatience is said to be one of the named discourses highlighted in the data collected. Just one example from the data collected will be used for this analysis.

R: 12, 12….13….14…15…I deh call all this number now,noman no wan anser small tim you go see as them go slop for front we start deh tok foolish weh man don fes tire finish(talking to a colleague beside)

R1: **I no fes get me that kind time for waste**. If a call yah nam or numba one tim you no answer, I just pass the tin if you like you bi na big mami that one no concern me. Them no fes know how stress deh for this tin weh man deh do here say work…..**I no fit just wait make dem transfer me comot for this useless place man deh shidon every day…I don tire mi**(speaking with an angry face) (aside;patient asking another patient if her number has been called)

P: a salute ma. U don call ma numba, a bi go deh for dat cona deh ansah some call (pointing at the direction)

R: woana see how wona deh mak man deh vex hala wona nor….before a wan stat call numba nobi a tok for here say make anyman put ear for ground so make wok waka quick quick?? **A don pass you numba since and a no dh go back for deh ma** (continue calling other numbers)

EN:

R: 12, 12….13….14….15….I am calling this numbers now and nobody wants to answer. Very soon you will see that they will fill this front section and start speaking gibberish with the tiredness on one's body (talking to colleague beside with an angry face)

*R1**: I do not have such time to waste.** If I call your number or name and you don't answer, I'll just skip I don't care if the person is an old woman that's not my business. They don't know the stress that is in this thing we do here called a job**….can't wait to be transferred from this useless place that we sit in everyday…I am tired**(speaking with an angry face)(aside :patient asking another patient if her number has been called)*

P: greetings ma. You called my number. I was taking a call at that end (pointing to the direction)

*R: Do you people see how you make one to get annoyed and start shouting at you people…before I started calling this numbers, did I not make an announcement here that people should pay attention and listen to their numbers so we can do this work quickly?? **I had called your number and I am not going back to it now ma** (continue calling other numbers)*

The second linguistic trace that shows impatience is the use of the clause "**R: I no fit jus wait for comot for this useless place" [R: I cannot wait to leave this useless place]** this clause reveals the degree of impatience and carefree attitude that the receptionists portray when dealing with patients in the hospital. To them, the area of work that they are in is considered as nothing, "useless' so therefore, they can do whatever they dim fit to do or on how to receive the patients.

Discourse is identified through linguistic traces which can be a word, a phrase, a clause or a sentence. The first linguistic trace identified is the use of the negative auxiliary "do not have such

time to waste" which is used in this discourse. Waste time is a verbal phrase which indicates that time is used in an unproductive manner. This shows the receptionists lack of patience in dealing with patients when they visit the hospital. It also reveals the carefree attitude of receptionists in shouldering the responsibility of the said position they occupy in the hospitals.

The above examples reveal the level of impatience receptionists possess in dealing with patients when they visit the hospitals for whatever health challenges they might be facing; such an act makes the patients to feel less of themselves they by bringing down the performance of the hospital as a whole.

4.1.2 DISCOURSE OF INATTENTIVENESS

Paying attention to every detail being said or done by a patient is one of the most important characteristics of a receptionist. Inattentiveness as defined by Nigg (2011) is the difficulty in concentrating and focusing, getting distracted thereby having poor concentration and organizational skills. This notion stems from the viewpoint that most patients as well as the receptionists themselves sometimes forget the reason for which they are there. They meet friends, relatives, neighbors and the rest and dive into conversations or sometimes put headphones, engage in unceremonious movements and the patients end up not giving the right information needed, the receptionists end up mixing the information given by the patients, patients unable to listen to their numbers or names when being called and at the end feel disgruntled about the services in the hospital. This goes same for the receptionists. This can be seen evident when in the data collected

P: Liboudi….yes after nkolbisson (interruption) chairman…na you take this piikin ei card, you hear tin weh ei tok...ei say na you don orientate ei badly….mal…na so ei tok for hear.

R2: You call that number?

R1: ***I don callam for deh woside ei deh...****then ei deh tok say na you indicate for ei poorly……mah tok make you hear tin weh ei deh tokam….na ur pikin nor*

R2: ***They had called that number even the name since……Why did you not answer?***

*P****: I was here and I asked they said they did not hear my number***

R1: I called more than two times and I even had to call from the other side. ***You did not hear*** *but the man beside you tapped you but since you had an earphone, you did not know him, you chose to ignore him and kept your earphone on. It will be the same people like who will say that the*

hospital has poor services(I keep telling you patients not to use your phones in the hospital especially if you are standing here but you will not listen….who are we to give you people instruction?)

It is evident that being inattentive sometimes leads to the patient ending up disgruntled and not being able to see the positive side of the services being offered and all this sometimes leads to verbal disputes between the two parties.

4.1.3 DISCOURSE OF REPETITION

This discourse comes up when the receptionists try to be on the same line of information with the patients. He or she turns to reiterate on certain information for emphasis because of the importance attributed to them .and in order to get the exact information from the patients. It also serves as a source of consciousness to the patients for them to be able to rethink on the information they are given out. Must patients sometimes fill the forms given to them as concerns some vital information and they sometimes give out wrong information in these forms. The receptionist on her part has to take this form and key in the information in the machine and by so doing, he or she has to make sure that the information which he or she is keying in is the right information given by the patients. She/he turns to say or read out this information a number of times in the hearing of the patient or care taker. This aspect can be seen in the dialogue between the receptionists and the patient

R: Tankou…..Tankou…..number 18…. (background noise)

P: sorry the noise was too much I could not hear you

R: are you not those making such noise? It is in the hospital that some of you hold your village meetings and solve family problems. Where is the form i gave you to fill? (patient handing over the form) stay there till I am done with you madam I don't want to call you again. (typing). Your name is Tankou Ernestine right?

P: yes

R: when were you born and where?

*P: **1972 in Garoua***

*R: **you say 1972 in Garoua**?*

P: yes

R: where do you leave currently….i mean which quarter do you leave in and who can we contact in case of an emergency?

P: I ***leave in Sa'a. I just came for my appointment with the doctor and I leave alone but I have my neighbor who helps in taking care of me sometimes*** *the one on that paper*

R: ***you say Sa'a****……?? And* ***the neighbor's name is Jackline****?*

P: ***yes Jackline***

R: OK. Take your card….This is yours…(handing a paper over) and this one here is mine…I will keep this. It has been two months since you came here so you will pay for consultation then you go to that other door by your right(pointing at the door) drop your book in that box and wait.

The above dialogue shows that though the patient has filled in the form with his/her vital information, it is said not to be enough as writing sometimes may be distorted by other mental thoughts in the mind of the patient in the process of given out information. The receptionist has to ask again or reiterate on some of the information so as to be certain that the information given was valid before saving it in the machine. This is seen when he repeats the information given by the patient to the hearing of the patient so as to be sure if the information given by the patient is what he registered in head **P: 1972 in Garoua……. R: you say 1972 in Garoua?** It is important to always check the information given before it is being registered in the machine as this information will be of great help or use in administering treatment since some of the information such as age occupation and others are taken into consideration during examination and treatment.

4.1.4 SEXIST DISCOURSE

Sexiest language is commonly understood as language that has bias towards a particular sex. This is a prominent discourse in the phase of receptionists-patient interaction. It is mostly obtained when blame has to be given either for negligence, comportment or some kind of misbehavior in relation to the opposite sex. There are times when receptionists are confronted by patients of some or opposite sex in the way they receive patients or act in front of patients. Sometimes gender role attributes are brought out either to vindicate or accuse. Most of the male patients feel comfortable talking about their worries to male receptionists while this is not the same for female patients. The

prefer having male receptionists attend to them than female receptionists. This is because they feel that female receptionists who suffer from low self-esteem always tend to transfer their fears and failures to the female patients especially if they notice that they are better off in one way or the other. This therefore hinders or turn to act on the way they receive their female patients they tend to extend it and be bitter to other women without minding who they are.

P: good morning……good morning……madam I am greeting you at least reply the greetings nahh

R: asayh ehhh….na by force for answer your salute….abeg…..i take God name beg you,ei too early for start add to my stress…wetin you want?

P:hmmm….i do sometin bad for greet you? Or na mi don make you vex dis morning before you leave you house….abeg any man get ei problem but no carry your own deh come vex with pople weh no know wetin deg happen. If you nobi wan work today you for better shidon for house

*R**: madam wetin you want? Or them send you for mi this morning?***

P: what a bad way to talk to someone….yeusshhhh(walks to the next receptionists who happens to be a male) good morning sah

R1: good morning madam(with a smile) how can I be of help?

P: I am here to see a gynecologist don't know if they work today.

R: let me check (looking in the computer)…yes you have Dr. Mbu and Dr. Chu

P: Thank God. I will like to see Dr. Mbu please.

R: OK. You will have to go to his secretariat which is behind this block (pointing to the direction) so you can book an appointment with him if you don't have one yet. Consultation fee for him to attend to you is twenty-five thousand francs since he is a specialist and the director. If you are lucky, he might attend to you today if not you will only come back on the date which will be given to you

P: thank you very much for this information. I ***almost went back home because of the way your colleague spoke to me****. She is so disrespectful and ill-mannered. She does not know how to talk to patients or* ***maybe she did that because I am a woman like her I don't know. She has attended***

to two male patients while I was standing here and watching. She did not talk to them like the way she spoke to me.

R: You are welcome

Drawing from Foucault's theories, many researchers have analyzed gender in relation to existing social and cultural structures. Some theorists argue that the way language is used re-enforces existing power, while others claim that discourse simply reflects the existing state of affairs (Geek, 2003). Gender role is generally neither positive nor negative; they are simply inaccurate generalization of the female attributes since each person has individual desires, thoughts feelings and emotions they go through and learning how to deal with it regardless of their gender are a call for concern. From the dialogue above, it is evident that the female receptionists does not know how to deal with her emotions and feelings which hamper her job and her choice of words are not the best for a person serving people of diverse origin. Her action is said to bring about the issues of gender roles in communication. In the phrases **"assay hehhh…na by force for answer your salute (looking at her phone)….abeg…I take God name beg you, ei too early for start add my stress…wetin you want….madam wetin you want or them send you for me this morning."** It reveals the lack of language skills in dealing with and attending to patients. The exclamation "**hhmmmm**" by the patient reveals a sense of disbelief in the reply she gets from the receptionists. Someone she thinks should even be the first to welcome her in the hospital.

4.1.5 DISCOURSE OF COMPREHENTION

The principal aim of this discourse is centered on the transmission of information be it on an interactive base or on the basis of a question and response session. By this, information is said to be of great value and importance in medical discourse since it deals with a one-on-one interactive based on the health of an individual sometimes not only physically but through other media as well. The primary role of communication is to share information. One of the roles and the most important of a receptionist is communication; in receiving or dealing with patients, communication is involved and the right form of communication brings about patient satisfaction while the wrong form, medium or wrong choice of words brings about disgruntlement and dissatisfaction from the patients as well as the receptionists. Here is an excerpt from the data

R: Danny….How old are you?

P: I was born in 84 so…

R: ehhhh….. (Aside) papa first door behind…..be quick

P: 39 yrs ehhh

R: 39?

P: born in 83…….It should be 39 yrs, right? (background noise)

R: are you sure you are 39 yrs…..So you don't know your age?

P: at least I know the day I was born na brother.

R: I will write 39 as you have said…..are you Catholic or Protestant?

P: protestant

R: protestant?

P: yes

R: where do you leave?

P: Liboudi

R: it is in simbockor nkolbisson?

*P: LIBOUDI…..yes after nkolbisson(interruption)…..***chairman…..na you make this pikin card?.....You hear tin weh ei deh tok?....ei say na you don orientate ei poorly….mal….naso ei tok for hear**

R: you call that number?

R2: I don callam for deh woside ei deh……..then ei deh tok now say na you indicate for her poorly…..mah tok meh you hear tin weh ei deh tokam…..na your pikin nor

R1: they had called that number and even the name since….Why did you not answer?

P2 : I was here and I asked they said they did not hear my name nor number

R2: I called it there more than two times and I even had to call from the other side. You did not hear but the man heard and tapped you. Very soon you people will say we say we are not doing our work properly, and you even tell your big brother that he orientates you poorly……how bad of you (patients murmuring in the back)

R1:Nkolbison, which area precisely..?

P2: l say Liboudi

R1: profession (interruption ... patient greeting)….good afternoon

*R1: **Yes good morning. One minute please, let me finish attending to this patient…..(He continues with patients in front of him) profession madam***

P: accountant.

*R1: **Take….Keep this card very well, make sure whenever you are coming to this hospital for checkups or anything related to this service, bring that card because we go use na he for attend to you easily….This other one, you go use pay for casher….that window for behind you, pay for deh then you take the two papers them you go put for inside that small box opposite the window…..Them go attend to you fo deh.***

P1: thank you….How much I to pay?

R: 2500

*P1: OK thank you **very much** bro*

Discourse is identified through linguistic traces which can be a word, a phrase, a clause or a sentence. In the above interaction, the patient makes use of the adverb "very much" which is to show the level of satisfaction obtained from the interaction he had with the reception due to the choice of words and the smooth flow of information between the two parties. It is also evident in the dialogue that the wrong choice of words leads to poor flow of communication when the patient feels neglected and shares her feelings with another receptionist who later transfers the information by quoting from the words of the patient in "**....ei say na you don orientate ei poorly….mal….naso ei tok for hear"[she says you are the one who orientated her poorly…bad…that's what she said here]** This is to show what the poor flow of information can do; it leads to disgruntlement and the transfer of blame from one end to the other. It is important to note that the choice of words is very important when interacting with people, not just words themselves but every aspect related to communication such as gestures, facial expressions, movements or signs go a long way in the transfer of information and how it is received by the receiver.

4.1.6 DISCOURSE ON NEGLIGENCE

This discourse comes up when the patient in checking his or her registration file discovers that all what was given as information to the receptionists was not taken down and those that were taken down were not taken down correctly due to lack of concentration and negligence on the side of the receptionists. In the morning when they came for work, knowing that they came in late and they have to take over from the person who worked during the night and check if there were any emergency cases for follow-up and some other issues pertaining to the change of shift, they (receptionists) sluggishly take their sits, check their phones and reply to messages forgetting that there are people who came very early in order to finish on time and go back to their houses. In line with this, the receptionists will check the faces of those whom she has been attending to regularly even when they come as early as the others. In the process of feeling in the number as tests to be carried out as prescribed by the doctor, the receptionist due to negligence registers a different test in place of another and when being confronted by the patient on what she has done, she acts all mighty and care free

P: hello!! Please can you recheck this. ***I was at the caissse for the tests the doctor prescribed which I know will not be more than 50 thousand and I am surprised they are telling me it is sixty-five thousand,*** *I don't understand.*

R: Am I the one who wrote you the tests to do madam? ***Please shift…if you don't have the money, go and tell the doctor not me.(looking at the patient with an angry face****)*

P: I beg your pardon…I simply asked you to check what you have registered in your machine because what they have for the tests I have to do is not what I have and you are shouting.

R: (looking at her phone) I will not check…come and beat me… (verbal dispute between the two)

R2: hello Ma….Please can I have the paper? Come over (patient hands in the paper while talking to the other receptionists) take…it has been corrected…you can go pay (patient goes to pay)

*R2: (to R1) I don't like what you do sometimes…what was there in checking the tests you registered and you always do this you are lucky she had not paid for that test…****the last time*** *you did and we had to help you in paying the extra tests you made that man to pay for which* ***almost made you lost your job*** *still you have not learned your lesson.*

R1: heyyyy….Don't shout on my head I beg you. Why are you making like a saint? As if you have never made an error while keying in information merrdddee…you people should stop doing this…did you not hear the way the woman was talking to me? I did not see the writing very well and I registered what I saw. How was it my problem?(murmuring)

R2: Can you hear yourself?? When I do not see the writing don't I give the patient to take it back or I take it to the doctor if the people in front of me are not many? Sometimes are you not the one who tells me what is written on the paper… ***you are always doing this*** *and when one corrects you, it becomes a personal problem. This negligence will cost you your job one day.*

The principal objective of this discourse is not to reprimand but to raise awareness about certain aspects that are not taken seriously by the receptionists. The statement "**You are always doing this"** reveals the level of negligence which the receptionist's overlooks and that has been noticed by her own colleagues who turn to give her words of cushion but these words fall on deaf ears. Not only is she noticed for her level of negligence but also in her choice of words and her manner of approach which goes a long way in contradicting the characteristics of what a receptionist I all about. These can be seen in words like "**please shift, I will not check…come and beat me, heyy…don't shout on my head I beg you.**" These phrases are to reveal the choice of words used by the receptionists when dealing with patients. The tone in these expressions expresses the care-free attitude of the receptionists and her poor choice of words. She feels she owes the patient no explanation as to the nature of the tests since she is not the one who administered the tests to be done on her. The phrase "**the last time**" is a confirmatory statement that it is not the receptionist's first tine of acting the way she did. It has been a current issue and nothing has been done about her attitude and compartment.

4.1.7 LACK OF DUTY CONSCIOUSNESS

One of the characteristics of receptionists is in being apt and duty conscious but this is not the case in the hospitals as the receptionists not only lack a sense of duty consciousness but they are also lazy and hostile. This is said to be the case the receptionists when patients are in front of them for either one or more health challenges they face and sometimes in the way they attend to visitors who visit patients in the hospital is a disturbing factor. They sometimes forget that there are patients in front of them whom they need to attend to, they end up discussing with colleagues about

things that are not important forget about the patients and when they are reminded by the patients about attending to them and on being conscious, it ends up becoming a problem for both parties.

R:stuipp… answer nor….i don't have the whole day just for you.

P: I dong deh show you ma card **since** you de na only for your phone…how you want make a do saah? Who na no know say wona shoulder people them live ehh

[R: can you answer….i don't have the whole day just for you]

[P: I have been showing you my card since but you have been on your phone….What do you want me to do sir? You people don't know that you are responsible for the lives of people]

From the above data, it is evident that lack of duty consciousness plays a vital role in the characteristics of the receptionists as to the role they play. The word "**since**" as highlighted in the data which is used as an adverb of time reveals the level of the receptionists' distraction and lack of duty consciousness when the patient has been presenting her card as demanded by the receptionists but due to his/her inattentiveness and lack of duty consciousness has been on her phone and neglected the patient who has been standing and waiting. This aspect is a factor that reduces productivity and efficiency of the receptionists in a high degree as patients sometimes feel neglected and ignored due to such acts and where there is inefficiency due to lack of duty consciousness, health is being hampered with. Stress is put on the clause "**responsible for people's lives."** This hyperbole stresses on the need for the receptionists to be conscious about the role their post of responsibility plays in the lives of the patients as more concern has to effort has to be put in in being duty conscious efficient and active. Patients' satisfaction has to be the upmost responsibility of the receptionists as to the services they render and the organization of the patients when in the hospital premises.

4.1.8 DISCOURSE OF IDENTIFICATION

The Oxford Advanced Learner's dictionary (2008) defines identification as an action or process of identifying someone or something or the fact of being identified. One of the roles of the receptionists is in the identification of the receptionists before being attended to by a doctor or specialist. This process is very important because the information collected serves as the patients pass to be received by the doctor or specialist in the hospital. The identification process is done by

the patient filling in his or her personal information on a form given by the receptionist or placed in an area where visible for the patients and sign-post writing and pasted on the wall for illustration. The receptionist collects the form, registers the information collected with the patient standing in front of the receptionist for confirmation and validation of the information given. The information after registration, a card is being issued for the public hospital and for the private hospital; a number or a card is issued depending on the department. This card has the information concerning the patient who has all been registered in the patient's hospital file created in the hospital.

P: good morning. Consultation for pediatric the child is sick.

R: give me the child's card.

P: the child does not have a card. When I gave birth to her, they gave her but my name since we had not given her a name yet.

R: give me your card then.

P: I don't know where I have left the card…. Looked for it and did not see.

*R: madam…..Shift this way….You are not the only person I should attend to…..there is a long Line behind you….**You are not a new comer here and you know how important those cards are….if you have even a receipt of any payment you made within that period you were here**, give it or you go to the department the last time you were here asking for the child's hospital file to my colleague, he will attend to you(talking while attending to the next person)*

Based on the data, the cards are said to be of great importance to the patients and the receptionists due to the fact that it saves time in taking down the information all over again, the past medical record of the patient is not lost, and less financial constrains in doing some of the tests all over again which had earlier been done in a short period of time. The adverb "**how**" which acts as a modifier to the adjective "**important**" reveals the value or significance of the card as a means of identification which is known by the receptionists and the patients. These identification processes are of great importance in the domain of medical discourse as well as other fields. There is nowhere or field in the world where identification is not done. It reveals or shows how important the role of identification plays in our daily life.

4.1.9 STIGMATIZATION AND NEGLIGENCE

Stigmatization is said to be an action of describing or regarding someone or something as not good enough or in a way that shows that they do not deserve respect (Oxford Advanced Learner's Dictionary, 2008). Health-related stigmatization results to neglect and thereby causing more harm to the patients not only physically, but mentally, psychologically, socially and otherwise. Stigmatization is said to be one of the greatest challenges faced by patients in the hospitals. Neglect comes in when the stigmatization process must have played. Patients visit the hospitals knowing and believing that they will be treated or whatever challenges that brought them to the hospital will be sorted out but this is not the case as some patients leave the hospitals worst then when they visited it. This act is said to be done not just by the receptionists but the health personnels as a whole are the ones who practice this more than some patients.

R: **(***receptionists gossiping) humm…have you seen that woman mah mah…..she has a very big wound on her leg…..**I'm sure Doc. will not even touch it….He will send but those students….You know him*

R1) ***that's what he always does*** *and* ***I hate it****…….I feel sorry for the patients sometimes but me…I can't get involved ohh….he behaves as if they forced him to be a doctor…if he sees them, you will see the way he will keep that his ugly face*

The data presents the level of stigmatization patients face in the hospitals due to their health challenges and these acts are carried out by the health personnel themselves who are the ones who are supposed to administer treatment and make sure the patients are well taken care of but this is not the case. The "**always**" in 'that's what he always does' reveals the consistency in which this particular act is being done by the one who is supposed to facilitate the healing process of the patient but he does the opposite thereby putting the receptionists in a tight position and as a result, making them accomplices to this act. Stigma related to race, sex, gender, class and occupation intersects with health-related stigmas. 0nce a stigma is applied, it manifests in arrange of stigma experiences (lived realities). Some patients prefer not to visit the hospitals due to the fear of anticipated stigma (expectations of bias being perpetrated by others if their health condition becomes known) caused by health personnel. Stigmatization and neglect are some of the causes of high death rates faced in the world today.

4.1.10 TASK CONFLICT

Krietner & Kinicki (2010; 373) defines conflict as a process in which one party perceives that its interests are being opposed or negatively affected by another party. The notion of task conflict sets from the call from the various departments found in the hospitals and on the notion of 'division of labor' where each department is assigned to a particular task and therefore, it is a normal routine for that department and if this routine is distorted, it distorts the functionality of the service rendered as well. Worst is the case when these services do not know what to do due to the fact that a particular task has not been identified as theirs and by so doing, attention will not be given to that case if it reaches the said department. These actions are known as structural antecedents to conflict and it occurs due to discrepancies among workers about which professional or department is responsible for performing certain roles or making treatment decisions. This conflict is said to have an effect on two parts.

4.1.10.1 Impact on the Patients

The patients are said to be like a camel's back which suffers from all the conflicts concerning tasks in the hospitals. Receptionists and health personnels at times are caught in the middle of their job in the face of ethical rights and the need to maintain their jobs. This is said to be the case as seen in the data when

R) weeeehhhh…..ehhhhmmm……where do we send them to….Pediatric or emergency?

R1) you know this is what we faced the last time with the other patient….They came and we sent them to emergency **it became a problem….**Major came and shouted at us that it's a case for pediatric then pediatric came and said it was for emergency. I do not want to send them where it will end up being a problem for me (patient standing confused and nodding the head in disbelieve)

R: they are really getting us confused…..What are we going to do now ?**See the child's body is all wounds…..The child is seriously in pains…even the father…….Mon Pere(exclamation) …** just rushed to the emergency center with the child….if they don't attend to you, go with the child to the director's office.

The data shows the effect that task conflict has on the receptionists as well as the patients. The use of the subordinating conjunction "**or"** in the question asked by the receptionists to the

colleague reveals the level at which this conflict has on them in carrying out their responsibilities as the job demands. They are caught in the middle of the patients and the department where these services are rendered.

4.1.10.2 Hierarchical Conflict

Hospital employees experience conflict quite frequently in the workplace due to its high – stress environment. Most conflict research reveals that the majority of health care conflict arises from interpersonal and intrapersonal communication difficulties (ship, 2009). Incompatibility between and among co-workers who include tension, annoyance, bossy attitude and a host of others contribute to this, they forget to note that individuals vary in attitudes opinions ,beliefs , culture, emotional stability , maturity, education gender and language which makes their reaction to specific stimuli to differ(jha&jha,2010;77). These differences cause some individuals to perceive some matters as undermining their positions or refuting their views. Health care workers like receptionists are able to refuse patients care assignments which are ethically and morally correct due to the fact that they do not want to get into conflicts which their superiors thereby putting their jobs on the line.

R1: They came and we sent them to emergency ***it became a problem****….****major came and shouted at us*** *that it's a case for pediatric then pediatric came and said it was for emergency so* ***I don't want to send them where it will end up being a problem for me****(patient standing confused nodding in disbelieve)*

As seen in the data, it is evident that though the receptionists feel sorry for the patients and will want to help in the most possible way, this is said to be hindered by the hierarchical structure of the hospital where if the dispatch of duties for the various departments has not been stated, it becomes a conflict on which department will administer to a particular case in the hospital. The case is seen to be a one where the receptionists feels disrespected when the past tense of the verb to shout is being used on the receptionists the last time she had to use her intuition in sending the patient to the department where she thought are the ones to treat the said case but this act was not taken likely by the person in charge who thinks the receptionist is undermining his position and authority. This there makes the receptionists to have a sense of fear in her and does not want the same scenario to repeat itself.

4.1.11 FRUSTRATION AND INTOLERANCE

Cambridge Advanced Learner's Dictionary (2008) defines frustration as the feeling of being upset or annoyed as a result of being unable to change or achieve something or less confident because you cannot achieve what you want. Frustration has a lot to do on the efficiency of work put in on a daily basis by the receptionists. Job satisfaction at this point will be on a scale of zero due to the fact that the receptionists do not value the position they are in thereby leading to intolerance as the receptionists do not value the nature of work they do and this therefore brings in intolerance as they are there doing the job not because they like or have a passion for what they are doing but because they do not have a choice thereby limiting their level of competence which has an effect on how they receive patients in the hospital. Their customer care turns to drop and when frustration and intolerance are at work, conflict turns to be on a rise as every little thing being said or done by a patient or a colleague turns to fuel the negative emotions of the said party.

R1: ***I no fes get me that kind tim for waste.*** *If a call yah nam or numba one tim you no answer, I just pass the tin if you like you bi na big mami that one no concern me. Them no fes know how stress deh for this tin weh man deh do here say work…..****I no fit just wait make dem transfer me comot for this useless place man deh shidon every day…I don tire mi(speaking with an angry face)*** *(aside;patient asking another patient if her number has been called)*

[I do not have such time to waste. If I call your number or name and you don't answer, I'll just skip I don't care if the person is an old woman that's not my business. They don't know the stress that is in this thing we do here call a job….can't wait to be transferred from this useless place that we sit in every day…I am tired(speaking with an angry face)(aside :patient asking another patient if her number has been called)]

The dominant discursive strategy used in the above conversation is the use of vivid description and illustration as the receptionist's facial expression describes or brings to light the way she feels and expresses some emotions in which her words can note describe. It also presents the poor manner in which she receives patients as a smile is absent in her manner of approach "**I no fit just wait for comot for this useless place."** It also illustrates the poor manner in which she communicates and receives patients due to her choice of words and her facial expression and gestures "**I just pass the tin if you like you bi na big mami that one no concern me"** This

sentence also reveals the reveal the level of frustration and intolerance receptionists possesses as she is unbothered about the way she communicates and receives patients not minding the age, sex or race. Using the adjective '**useless'** to describe the environment and nature of the job, she does reveal her level of frustration and a non-sentimental attachment nor fulfillment in the job. Neglect is a consequence of intolerance and frustration.ac

4.2.0 LINGUISTIC STRATEGIES

Language plays a significant role in health care delivery and mediating people's experiences of and beliefs about health care and its services. Linguistic strategies are the ways in which speakers manipulate their linguistic content of speech for their purpose. Linguists build on the macro-sociologist notion of the group, status, role and social, function in their discussions of social norms in language usage. Understanding presupposes the ability to attract and sustain others' attention in a conversation and this can only possible with the right choice of words used. We will be looking at the linguistic strategies which have been used in the data under study.

4.2.1 The Use of Auxiliary Verbs

The first linguistic strategy we will be looking at is the use of auxiliaries. The Oxford Advanced Learner's Dictionary defines an auxiliary as a verb such as 'be', 'do' and 'have' used with main verbs to show tense and to form questions and negatives. Auxiliaries are important in that it helps to make the meaning of a clause clear. The main verb shows what is happening in the sentence while the auxiliary verb gives more information about that sentence. During a heated argument between a receptionist and a patient on the manner of approach, the patient has noticed in one of the receptionists, which later developed into a verbal confrontation, the receptionist makes the statement; *R1:* ***I no fes get me that kind time for waste [****I do not have such time to waste****]***

The verb **'to do'** is used to indicate that somebody has performed an action, a task or an activity. When used in the negative form, it shows denial or refusal. In the statement made by one of the receptionists, the negative auxiliary "**do not'** is used which brings out or indicates the level of frustration and anger that the receptionists have towards their job. They made use of the negative auxiliary to show the level of dissatisfaction they feel in the function they are called up to do in the hospital and on the services they render. Not having the time to satisfy the patients' needs goes against medical as well as the hospital ethics.

The next situation or instance in which auxiliary verb is used is in the manner in which the receptionist addresses the patient when the patient discovers that the receptionist has erroneously registered a test which the doctor did not prescribe and when she confronts the receptionists about it, it leads to a dispute.

P: I beg your pardon…I simply asked you to check what you have registered in your machine because what they have for the tests I have to do is not what I have and you are shouting.

R: (looking at her phone) I **will not check**…come and beat me… (verbal dispute between the two).

From the data above, the negative use of modal auxiliaries **(will not check)** is an indication of rudeness. The manner of response which the receptionist gives to the patients indicates in her tone the level of frustration and disrespect she has for the patients when addressing them. 'Will not' expresses a supposition of an action and when used in a negative form, it brings out the behavior of the patients. The sentence does not only portray the tone used to indicate anger and frustration, but it also portrays the attitude receptionists have towards their job.

The next linguistic strategy we will be looking at is the use 'will'. This is achieved through the use of the negative auxiliary 'not' which is brought out in the data.

R: wona see how wona deh mak man deh vex hala wona nor….before a wan sta t call numba nobi a tok for here say make anyman put ear for ground so make wok waka quick quick?? A don pass you numba since and **a no di go back for deh ma** (continue calling other numbers

R: Do you people see how you make one to get annoyed and start shouting at you people…before I started calling this numbers, did I not make an announcement here that people should pay attention and listen to their numbers so we can do this work quickly?? I had called your number and **I will not go back to it now ma** (continue calling other numbers).

From the data above, it is also evident that the patients are the ones that push the receptionists to their limits in disrespecting them by being unable to control their anger and frustration. Before starting each day activities, announcements are being made as to how the services operate and the various departments or rooms where each service operates are shown to the patients in order for them not to find themselves wanting. All this is done in the private hospital. Some patients during the course of these announcements do not pay attention to what is being said and at the end, they

find themselves feeling disgruntled about the treatment they get. This acts leads to the receptionists to take a stand not going back on their words so as to teach the patients some lessons in order for them to sit up. This brought about the use of the negative auxiliary 'will not.'

4.2. 2. The Use of Politeness Strategy

Modal verbs are auxiliary verbs that express necessity, possibility, permission, willingness, obligation or ability. Some of the modal auxiliary verbs are used to show the politeness in tone that some patients have when they approach these receptionists.

P: hello!! **Can you recheck this**? I was at the caissse for the tests the doctor prescribed which I know will not be more than 50 thousand and I am surprised they are telling me it is sixty-five thousand, I don't understand.

The linguistic strategy brought out here is the use of the modal auxiliary. This is achieved through the use of 'can.' Can be used as a politeness strategy to show how the patients address receptionists when they address them. Politeness are also sources of encouragements as the right choice of words sometimes boost the confidence and morals of the patients thereby reducing frustration and anger in them.

4.2.3 The Use of Indirect Questioning

Questioning here is used as a linguistic strategy of politeness. Questioning happens to be one of the major forms of interpersonal interaction and communication. Questioning sets the pace and sometimes directs the moods of communication and interaction. The data under study makes use of indirect questions as a form of politeness strategy.

R2: hello Ma…. **Can I have the paper**? Come over (patient hands in the paper while talking to the other receptionists) take…it has been corrected…you can go pay (patient goes to pay).

Indirect questioning used in the data acts as a source of politeness and comfort. This is because the patient after having been ill-treated by receptionists number 1(R1) is called by R2 to help in solving the patients problem. This helps in reducing depression knowing that there is someone person who can understand what the problem is and can help in solving it. Neglect and frustration can be solved through the use of indirect questioning as patients find it difficult sometimes to pose

or share with the receptionists what they are going through or the illness which brings them to the hospital with the use of direct questioning but with the help of indirect questioning, conversations are built, trust is conceived and answers are gotten without any form of stigmatization being felt by the patients as to the issues going on in their lives or whatever challenges they are facing.

The second level of questioning we will be looking at is the use of indirect questioning in a negative form which brings out the level of frustration and despair and the lack of patience in dealing with patients.

R: answer nor….i don't have the whole day just for you (shouting)

P: I dong deh show you ma card since you de na only for your phone…how you want make a do saah? Who na no know say wona shoulder people them live ehh

[R: can you answer….i don't have the whole day just for you] (shouting)

[P: I have been showing you my card since but you have been on your phone….What do you want me to do sir? You people don't know that you are responsible for the lives of people]

Dealing with patients requires a lot of patience and tolerance since these are people from diverse origins with different cultural backgrounds and orientation. Receptionists have the ability to heal patients without them (the patients) necessarily seeing the doctor depending on the medical disorder they are facing. This can only be done with the right choice of words being used by the receptionists. Tone being an aspect or a part of the language family helps in this process. Knowing when to and when not to shout or scold at patients is great essence when dealing with patients. The patient who is being shouted at gets tired of showing his card to the receptionists and is even tired of talking or replying to him due to the fact that he is being distracted by his phone while attending to patients. This leaves the patient frustrated and dumbfounded as he is being called by the receptionists to answer him in a hash tone which angers the receptionists.

4.2.4 The Use of Pronouns

A pronoun is a word that stands in for a noun, often to avoid the need to repeat the same noun over and over. They refer to things, people, concepts and places (Jack Caulfield, 2022). The pronouns used in the data under study include; possessive, demonstrative and interrogative pronouns.

4.2.4.1 Possessive Pronoun

R: OK. **Take your card….This is yours**… (handing a paper over) and **this one here is mine**…I will keep this. It has been two months since you came here so you will pay for consultation then you go to that other door by your right(pointing at the door) drop your book in that box and wait.

The possessive discourse used in the above data is used to show in importance of the cards being given in the hospital and also the importance of each and every document given needs to be kept carefully by the patients. The cards given are the properties of the patients and not the receptionist as he tells the patient that 'this is yours.' Tis reveal possession as the card is being given to the rightful owner to keep and the phrase used by the receptionists 'This one here is mine' also shows possessiveness as duplicates of certain documents are made and kept in the files the patients in the patients in the hospital in case it will be needed and to keep for record purpose as well.

4.2.4.2 Demonstrative Pronouns

Demonstrative pronouns used in the corpus under study are used for precession and efficiency purposes during communication. Using the right choice of words is an integral part in communication and using demonstrative pronouns in communication makes interaction more flexible and easy to process based on understanding.

R2: You call **that number?**

R1: I don callam for deh woside ei deh...then ei deh tok say na you indicate for ei poorly……mah tok make you hear tin weh ei deh tokam….na ur pikin nor

[I have called that number there, where is the person…then he's saying that you are the one who indicated poorly to him….let me say it so you can hear what he is saying…it's your child rights]

R2: They had called **that number** even the name since, more than three times……Why did you not answer?

P: I was here and I asked they said they did not hear my number

In the dialogue above, 'that' has been used for the purpose of precision. The calling of numbers is an integral part in helping the receptionists attend to patients successfully, without the patient's feeling neglected or looked down upon if they are being served after other patients especially when

they are come early to the hospital. Numbers are given based on the time when the receptionist visits the hospital. After sharing the numbers, information is given as to the various sections or steps to follow while in the hospital. Patients being unable to answer their number will not only lead to them feeling neglected (especially the new patients, since their cards have not yet been issued), but will also distort the work of the receptionists as they will need to be going forth and back with calling of names and numbers so as to be able to attend to all the patients whom they had given numbers to. '**That'** used here by the receptionists is to precise that the patient was inattentive because he did not just call the number more than once but he called the name as well and the patient did not answer either so he had to proceed with in attending to other patients. The corpus reveals that the patients sometimes are the ones who create problems for themselves and not the receptionists.

4.2.5 The Use of Paralanguage

The Oxford Advanced Learner's Dictionary (2008) defines Para-linguistics as 'relating to communication through ways other than words'. This includes the vocal elements of non-verbal language such as tone, facial expressions, body language, pitch, gestures, and eye contact. No oral communication is complete without Paralanguage. "The boundaries of paralanguage," says Peter Mathews, "are (unavoidably) imprecise" (Concise Oxford Dictionary of Linguistics, 2007) "We speak with our vocal organs, but we converse with our entire bodies. Paralinguistic phenomena occur alongside spoken language, interact with it, and produce together with it a total system of communication. The study of paralinguistic behaviors is part of the study of conversation: the conversational use of spoken language cannot be properly understood unless paralinguistic elements are taken into account" (David, 1968). The data makes use of a variety of Para-linguistic which is of great essence in the communication between receptionists and patients.

4.2.5.1 Body Language

Body language is an important aspect in verbal as well as non-verbal communication. This enables the speakers to know if the topic of discussion is found interesting by the listener or if the receiver is comfortable with the topic under discussion as well as it creates a sense of connection. Body language refers to gestures, facial expressions and postures of a person. Non-verbal behaviors (body language) can allow people to be at ease, build trust; connecting people easily with others as well as they can generate tension, and create uncomfortable environments for communication

to take place. Receptionists while interacting with patients have to look at the positive sights of somebody language features in order to create a sense of understanding and connection or to be able to create trust and take away all levels of anxiety from the patients but this is not the case as most receptionist lack the understanding of the role body language has in communication. How we say it is more important than what we say. Body language can make or break the interaction. It can represent respect, empathy, and so much more.

R1**:** I no fes get me that kind tim for waste**.** If a call yah nam or numba one tim you no answer, I just pass the tin if you like you bi na big mami that one no concern me. Them no fes know how stress deh for this tin weh man deh do here say work…..I no fit just wait make dem transfer me comot for this useless place man deh shidon every day…I don tire mi**(looking at a patient with an angry face)** (aside;patient asking another patient if her number has been called)

[I do not have such time to waste. If I call your number or name and you don't answer, I'll just

skip I don't care if the person is an old woman that's not my business. They don't know the stress that is in this thing we do here call a job….can't wait to be transferred from this useless place that we sit in every day…I am tired **(looking at a patient with an angry face**)(aside :patient asking another patient if her number has been called)]

The above are examples of body language features which have been used in the data. The receptionists believe that all patients are the same and should be treated the irrespective of the problem that brings them to the hospital and they see no remorse in taking poorly to the patients. This is said to be the case with one of the receptionists who explains to the college that patience is not part of her virtues and she has no pity patients who turn to stress her irrespective of their age and in saying this, she gazes at a patient with contempt with is visible in the way she stares at the patient with anger. This reveals the level of frustration and resentment she feels and due to the fact that she needs the salary, she just has to bear with whatever she faces in a disrespectful way. It is worth nothing that one of the best ways in receiving people be it those we are close to or are not fund of are in our facial expressions; Smiling they say are a thousand words left unspoken and smiles help in building trust and creating a sense of belonging and renewing hope in others. Most of the receptionists lack respect and therefore care less about their body language or the body language of the patient who sometimes due to pain and trauma finds it difficult to communicate verbally.

Sighs and murmurs which also happens to be aspect of body language are used in the data as elements to show dissatisfaction and frustration that patients and receptionists have or feel towards one another.

4.2.5.2 The Use of Gesture

Just like body language, gestures are as important in communication as spoken words are. It is a fundamental component of language that contributes meaningful and unique information to a spoken message and it reflects the speaker's underlying knowledge and experiences (Sharice et al., 2019). Our hands help us talk, think and remember, sometimes revealing knowledge that we cannot verbalize which are sometimes caused by our emotions. Gesture does not only contribute essential information to a message but it also facilitates the understanding of a message. Our postures and the positions of our hands can tremendously influence how seriously people take what we say. Slouching with our arms crossed, for instance, communicates a very standoffish or disinterested attitude, so listeners would probably be less inclined to actually pay attention. Pointing, on the other hand can be extremely effective in indicating or emphasizing something.

R: OK. Take your card….This is yours… **(handing a paper over)** and this one here is mine…I will keep this. It has been two months since you came here so you will pay for consultation then you go to that other door by your right**(pointing at the door)** drop your book in that box and wait

R1: They came and we sent them to emergency it became a problem….major came and shouted at us that it's a case for pediatric then pediatric came and said it was for emergency so I don't want to send them where it will end up being a problem for me**(patient standing confused, nodding the head in disbelieve)**

From the data, it is evident that different gestures have different meanings based on the purpose for which they are used. With R, the gesture used there brings out a sign of respect as the receptionist after explaining all that needs to be done, does not leave the file on the desk for the patient to collect but, he hands it over and not only does he hand the document over, he also indicates with a show of the figure and a facial expression which looked focused and serious to the patient the next step he has to take. Pointing at the door helps the patient to know the exact door which the receptionists are talking about and it also helps in saving the energy of the patient

who would have been confused mentally in deciding which door the receptionists was referring to if he had not shown it by pointing at the exact door.

Also, the services offered in the hospital and the way they are structured sometimes increase the frustration not only in the patients but to the receptionists as well as they find it difficult to know the exact department to send certain cases too. This seems to be the case as a patient walks in with an emergency problem and the receptionists do not know where exactly to send the patient to. This acts leaves 'the patient standing in disbelieve as he nods his head from left to right lacking the right words' to express the frustration and disbelieve he feels inside about the poor attitude of the receptionists and the services operate in the hospital. These gestures add more information to the receptive nature of the patients in the way they deal with patients in the hospital.

4.2.5.3 Sighs and Murmurs

Emotions can be expressed in different ways and the expression of these emotions is also considered as part of language. People sometimes sigh or murmur when they are frustrated, in despair, feeling sad or unhappy. Murmuring and sighing in communication is seen as being disrespectful especially if the speaker happens to be older than the receiver. It also portrays a negative view of the person who commits the act. Receptionists have the tendency to murmur and sigh especially if they find the asking for clarification more than once

R1: heyyyy….Don't shout on my head I beg you. Why are you making like a saint? As if you have never made an error while keying in information merrdddee…you people should stop doing this…did you not hear the way the woman was talking to me? I did not see the writing very well and I registered what I saw. How was it my problem? ***(Murmuring.)***

R**:** ***stuipp****… answer nor….I don't have the whole day just for you(looking at the patient with contempt)*

The data brings out the poor comportment or character of the receptionists in the way they respond to their colleagues as well as the patients when they are reprimanded on their actions. The data is gotten from two different discourses by different receptionists. The first example happens to be between two receptionists were R1 yells at R for pointing out what she did to the patient who was seen by R as an act of bad conduct and comportment in dealing with patients but R1 does not see the need for R to talk to her in that manner since she considers the act to be something trivial. This leads to her getting angry and talking to herself by **murmuring.**

Sighing here happens to be that of disappointment, frustration and intolerance as receptionists finds the presence of patients in front of them to be annoying and a waste of their time especially if they feel tired or are about to take a break. '**Stuipp'** here which is a sigh of frustration is seen in the way the receptionist demands information from the patient who happens to be standing in front of here. Her facial expression and comportment while talking to this patient reveals the level of frustration she has while attending to patients. Sighing in the above data also reveals the level of disrespect that some receptionists have towards their patients who sometimes affect the psychology and self-esteem of the patients. This act sometimes creates fear and anxiety which happens to be an emotional state when people feel uneasy and fearful. Fear also describes a reaction to immediate danger characterized by a strong desire to escape the situation and this happens to be what some of the things patient's face when they are being scolded at especially if they did nothing wrong. This makes the patients unable to express themselves especially if they find the character of the receptionists to be questioning especially at first sight. They sometimes leave the hospitals being unattended to because of the fear which has in instilled in them by the some negative actions from the receptionists.

4.2.5.4 Tone

Tone represents the 'quality' of sound, that which distinguishes it and makes it recognizable by its constant 'pitch'. According to (Mehrabian, 2013), the tone of voice we use is responsible for what about 30-40 percent of the message we are sending out. Tone involves the use, the level and type of emotion that one communicates and the emphasis that one places on the words that you choose. This is observed in the manner in which the receptionists interact with the patients. It brings out their mood during the conversation; that is if they are honest, serious, sad, jovial, passionate, and compassionate as well as other emotions. Some make use of an amusing tone when they are familiar with the patient or when they are in a happy mood. This helps in easing tension in the patients by creating a convivial atmosphere especially since they are aware of the fact the mood of the receptionists sometimes changes like that of a chameleon. They do not know the next moment when they receptionists who have always been smiling with them will have a mood swing. The receptionists use serious tone when they are moody and end up pouring out their frustration and anger on the patients by shouting at them or talking to them in a disrespectful manner. Tone has the power to boost the strength of the patients or help in reducing it and this is determined by the tone the receptionists use while interacting with the patients who whatever reason. A jovial, honest,

passionate and compassionate tone is what receptionists need to use while talking with the patients even they think they have a valid reason to do otherwise. It helps in the fast recovery of the patients and increases in them a sense of belonging knowing that they have someone somewhere who understands them and know the exact way and words to use in making their hearts to be at ease.

4.2.5.5 Exclamations

The next linguistic aspect we will be looking at is the use of exclamations. An exclamation, narrowly defined, is a sentence type that is used to express a strong emotional state. It contrasts in syntax or morphology with other sentence types which typically express statements, commands, and questions (Eugene et al., 2003). Most of the time, the patients use it to show consternation, dissatisfaction or shock when they listen or sometimes observe the way receptionists treats or respond to patients.

*R**: aseyhh ehhh**….na by force for answer your salute….abeg…..i take God name beg you,ei too early for start add to my stress…wetin you want**?***

*P**:hmmm**….i do sometin bad for greet you? Or na mi don make you vex dis morning before you leave you house….abeg any man get ei problem but no carry your own deh come vex with people weh no know wetin deg happen. If you nobi wan work today you for better shidon for house*

R:stuipp… answer nor….i don't have the whole day just for you.

R**:** ***(****receptionists gossiping)* ***hhmmm…weeehhh have you seen that woman mahh mmaaahh****…..she has a very big wound on her leg…..I'm sure Doc. will not even touch it….He will send but those students….You know him*

The first exclamation made by the receptionists "aseyhh ehh" indicates the receptionist's attitude towards her patients. To her, the patients greeting is not important and she says it adds to her stress and disturbs her. It is important to note that greetings creates room for a conversation as well as creating a subtle atmosphere for interaction.

The second exclamation 'hhmmm' reveals the shock that the patient feels due to the way the receptionists replied her just because she greeted her. She believes that the receptionist having a bad mood should not be a reason for her to lash out on people who have nothing to do with what she is going through and how she feels.

The third exclamation ‘stuipp’ by the receptionist brings out the level of frustration and intolerance she has towards her job. Scolding at patients as if they were children reveals her arrogant and disrespectful attitude towards the patients. This also reveals the receptionists’ level of laziness in administering her duties.

The fourth exclamation hhmmm weehh……. mahh mmaaahh made by the receptionists reveals the level of shock and compassion he has for the patient who has a big wound on the leg and feels sad because the doctor who is supposed to attend to patients with all forms of problems selects the ones to attend to and the one who does not appeal to his conscience is given to the medical doctors on internship who sometimes do a ‘trial and error method’ of healing since they are still learning on the best way to proper care of the patients by the senior doctors who have been doing so for a number of years. This indicates some levels of discrimination that patients go through or face in the hospital due to the health challenges they have. This is not caused by the receptionists only, but a good number of such cases are caused by the medical practitioners towards their patients.

4.3. LANGUAGE IMPACT ON PATIENTS

In the third part of the analysis, we will be examining the impact that the language used by the hospital receptionists has on the patients. It should be noted that language plays a vital role in communication and on the way patients adhere to information and directives given by the receptionists and if the language used or the manner in which the receptionists communicate with the patients is not clearly defined, it sometimes derails the patients thereby tempering with their healing as well as the level of satisfaction which the patients will obtain based on the services offered in the various hospitals under study. This section will be answering the third research question; how does receptionists’ language impact the patients? With respect to the answering of this research question, we will be examining the data gotten from the questionnaires which were administered in the hospitals under study. For the sake of making the work more scientific and presentable, the data has been classified according to the level of satisfaction obtained from the various questions found in the questionnaires. The analysis of the data will be presented in a pie chart where the percentages of impacts will be made visible. Only a summary of the data will be presented; the data itself is found in the appendices. The goal of this classification is to ease the understanding of the various levels of satisfaction gotten by the patients based on the data provided. In this section, we have seven (7) charts representing the seven questionnaires which were directly

answered by the patients based on the impact the language used has on them and the two other questions in the questionnaires will be presented in the fifth (5) chapter under recommendations since recommendations were given by the patients on how receptionists can ameliorate on the ways in which they receive patients for the satisfaction of all.

Based on the data gotten, the first part of this analysis will be the presentation of the impact the language used by the receptionists has on the patients by the receptionists. These impacts will be presented based on the age, range, as well as sex. The sex presented here is to show that the data is not gender bias. The correspondence was asked to indicate their opinions by choosing either of the options:

- Very good
- Average
- Bad
- Very bad
- Sometimes
- Yes
- No

These responses are represented on the table below depicting the level of impact the language used by hospital receptionists has on the patients based on the way the receptionists communicate with them, how they understand the terminologies used in passing across information, what they think about the attitude of the receptionists, how they feel when they talk with the receptionists and a host of others. An example of the questionnaire can be found on the appendices.

Table 1: GENERAL FREQUENCY TABLE BASED ON THE QUESTIONNAIRE

QUESTION NUMBER	FREQUENCY			AGE	SEX
	V.G	AVE	BD		
1	31	56	13	16-69yrs	M/F
2	21	17	62	18-75yrs	M/F
4	20	57	23	18-75yrs	M/F
5	10	60	40	18-79yrs	M/F

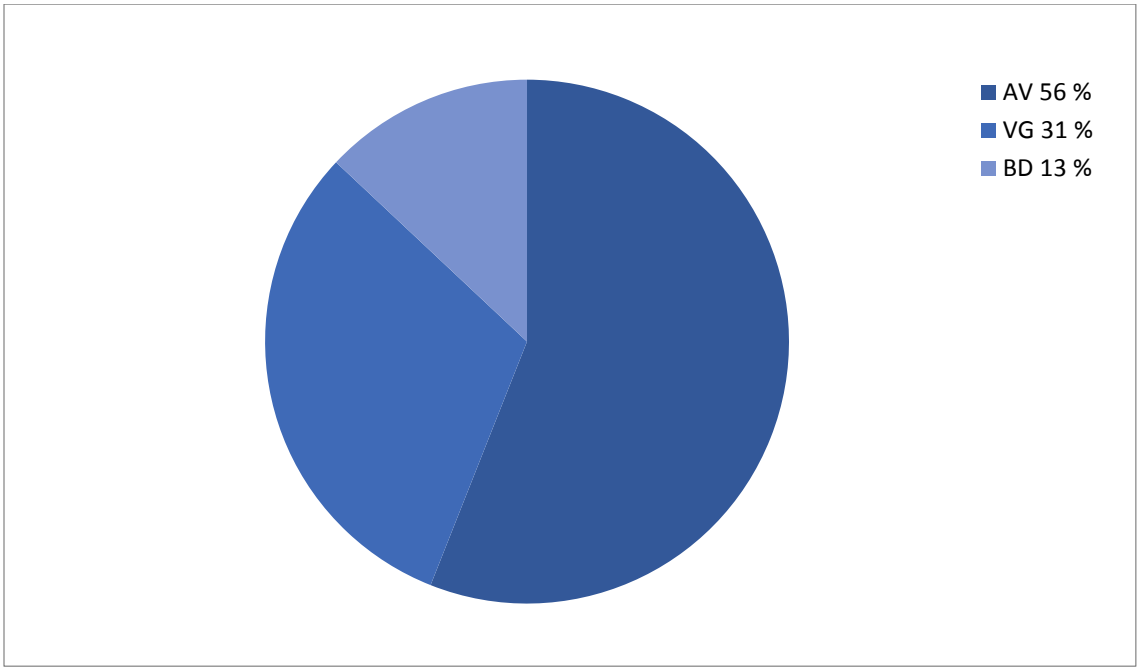
6	YES	NO	SM	18-85yrs	M/F
	10	45	55		
7	17	23	60	18-85yrs	M/F
9	YES		NO	18-85yrs	M/F
	80		20		

The table above illustrates the number of questions which were administered in the questionnaires, the frequency level of response obtained per question based on the responses, the age range of the patients who answered the questionnaires and the sex of the patients as well. From the table, question one (1) has a frequency of 31 for the number of patients who answered very well (VG) 56 patients on average (AV), and 13 patients on bad (BD) with an age range of 16-69yrs of male and female sexes. Question two (2) was no exception as 21 patients were satisfied with the level of language used (VG), 17 patients were on average (AV) while 62 (BD) patients did not like the way language is being used. The age range of the patients who answered question two were between 18 and 75years old of both sexes. Question four (4) has as frequency 20 patients who said very well (VG), 57 who said average and 23 patients who were disgruntled (BD). The age range was 18-75 years old of both sexes as well. Question five (5) has as frequency 10 patients who said very good (VG) based on the language used by the hospital receptionists, 50 patients who were on an average (AV) level of satisfaction and 40 patients who attested to the very poor (BD) level of language use, with an age range of 18-79years old patients of box sexes who answered question five on the questionnaires. On question six (6) and seven (7), which is on impact and attitude, of the language, the manner of response was different due to the way the question was set. 5 patients approved the way the language is being used (YES), 55 patients did not approve of the language being used (NO), while 40 patients answered by saying sometimes(SM) with an age range of 18-85 years old. Question seven (7) which has to do with the attitude of the receptionists, 17 patients were satisfied with the attitude (YES), 60 patients were unsatisfied (NO) and 23 patients were indifferent (SM) about the attitude of the receptionists. With respect to question nine (9) which has just two alternative answers, 80 patients attested (YES) to the fact that the language used is a hindrance to communication while 20 patients disagreed with this phenomenal on language being a hindrance.

Table 2: FREQUENCY BASED ON COMMUNICATIVE COMPETENCE

Question Number	Frequency			Age Range	Sex
	VG	AV	BD		
1	31	56	13	16 -69	M/F

Chart 1: FREQUENCY BASED ON COMMUNICATIVE COMPETENCE



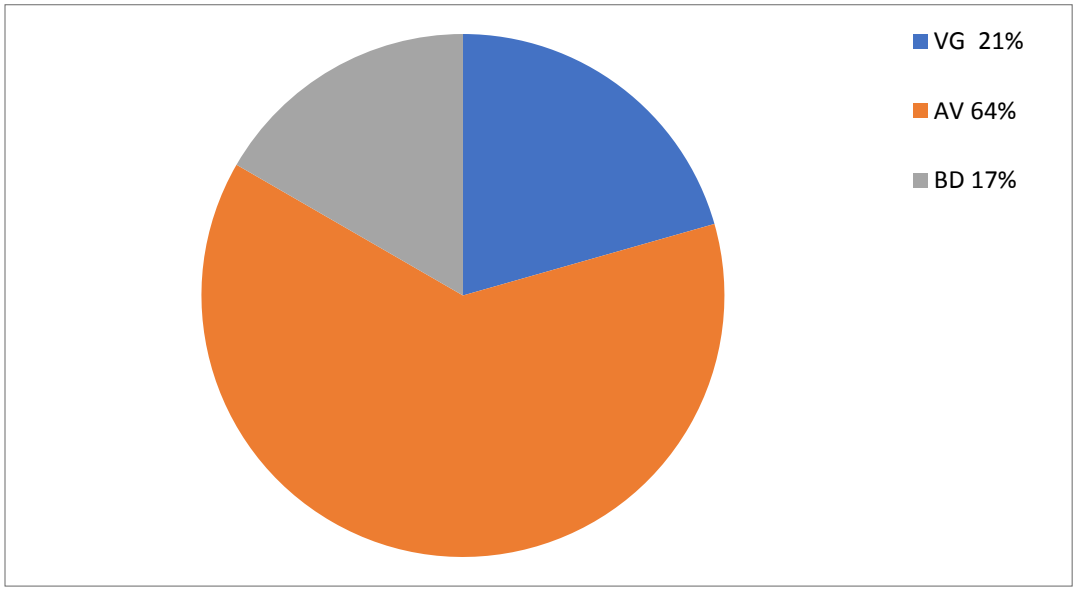
From the above chart, it is clear that patients are averagely satisfied with the way receptionists communicate with them when they visit the hospitals. This justifies the 56% frequency earlier presented in the table above. This is followed by the 31% satisfactory rate and the 13% disgruntlement rate respectively.

Table 3: FREQUENCY OF TERMINOLOGIES USED

Question Number	Frequency			Age Range	Sex
	Yes	No	SM		
2	21	17	62	18-75	M/F

The Oxford Advanced Learner's Dictionary (8th edition) defines terminology as the set of technical words or expressions used in a particular subject. With reference to medical discourse, the terminology used by hospital receptionists has to be simple and plain such that even illiterates can understand when directives are being given. Based on the data collected from the questionnaires, 64% of patients used for the study are unsatisfied with the way receptionists make use of medical terminologies without minding if they understand or what is being said or not.

Chart 2: FREQUENCY ON TERMINOLOGY USED



From the chart above, the various frequencies of the patient's satisfactory rate are illustrated. As indicated by the chart, the average level of patients who do not understand the terminologies used is most frequent. It is recorded 64 times, with a percentage of 74%. The patients who understand the terminologies used by hospital receptionists recorded 21 occurrences which

gives us 24% while those who understand nothing about the terminologies used by these receptionists recorded 17 occurrences given use a percentage of 2%. The least frequent is the percentage of patients who understand nothing at all in terms of terminologies being used by receptionist.

Table 4: FREQUENCY BASED ON RECEPTIONISTS ATTITUDE.

Question Number	Frequency			Age Range	Sex
	GD	BD	AV		
4	20	57	23	18-75	M/F

Chaiken (1993,p.1) Attitude is defined as a psychological tendency that is expressed by evaluating a particular entity with some degree of favor or disfavor. It is involves the expression of an evaluate judgment about a person's view and evaluates something or someone, a predisposition or a tendency to respond positively or negatively towards a certain idea, object, person or situation. Must of the patients in the hospitals complain about the attitude of the receptionists. They complain that the receptionists are unwelcoming in their attitude and comportment as they sigh, frown, groan and sometimes shout at the patients; their comportment when addressing the patients are said to be that of disrespect

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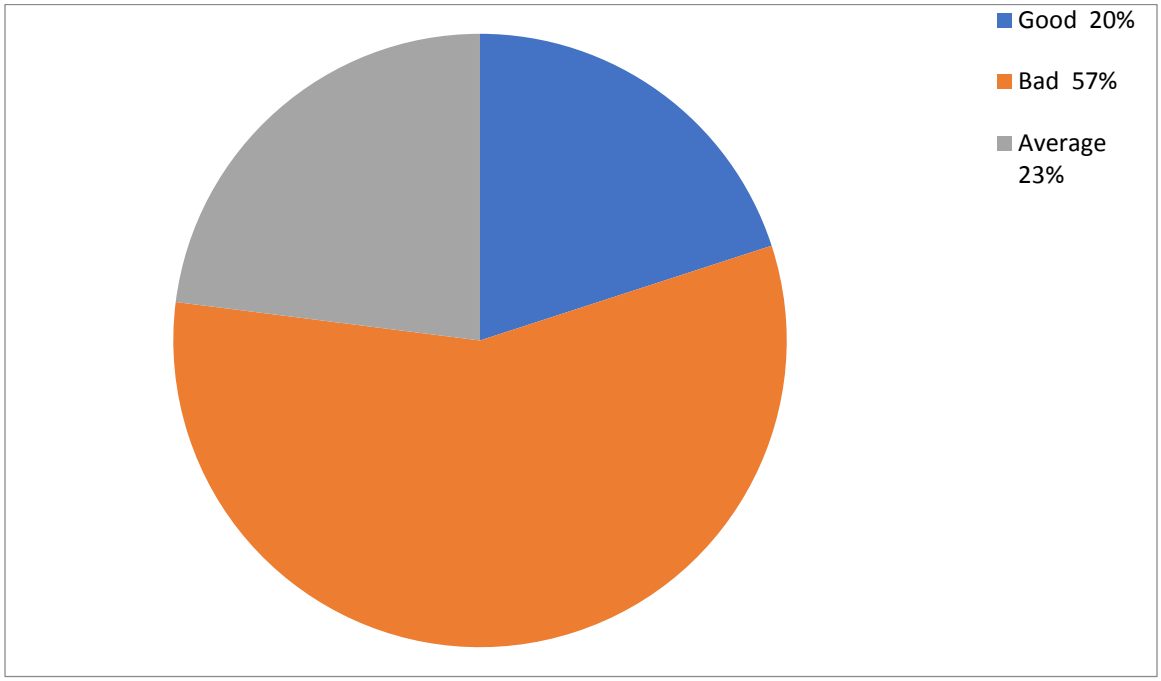
The statistics from the table above shows that question four which has to do with the way patients see the attitude of the receptionists when they visit the hospital. A hundred (100) patients answered this section of the question and 20 patients were satisfied with the attitude of the receptionists when they visit the hospital, 57 patients were unsatisfied with their manner of approach and attitude while 23 patients were on an average level of satisfaction based on the data gotten.

Chart 3: FREQUENCY BASED ON RECEPTIONISTS' ATTITUDE



The chart shows a preponderance of the number of patients who dislike the attitude of the receptionists. This is backed by a 57% percentage frequency on the chart above. Another act which we come across is that of those who are satisfied with the attitude of the receptionists when they visit the hospital. This gives us a 20% satisfactory rate while those (patients) who were averagely satisfied with the attitude of the receptionists have a percentage of 23. From the analysis of the chart above, it is evident that the attitude of the receptionists as seen or noticed by the patients is a problem as 57% of patients are dissatisfied with the attitude of the receptionists as seen on the chart above.

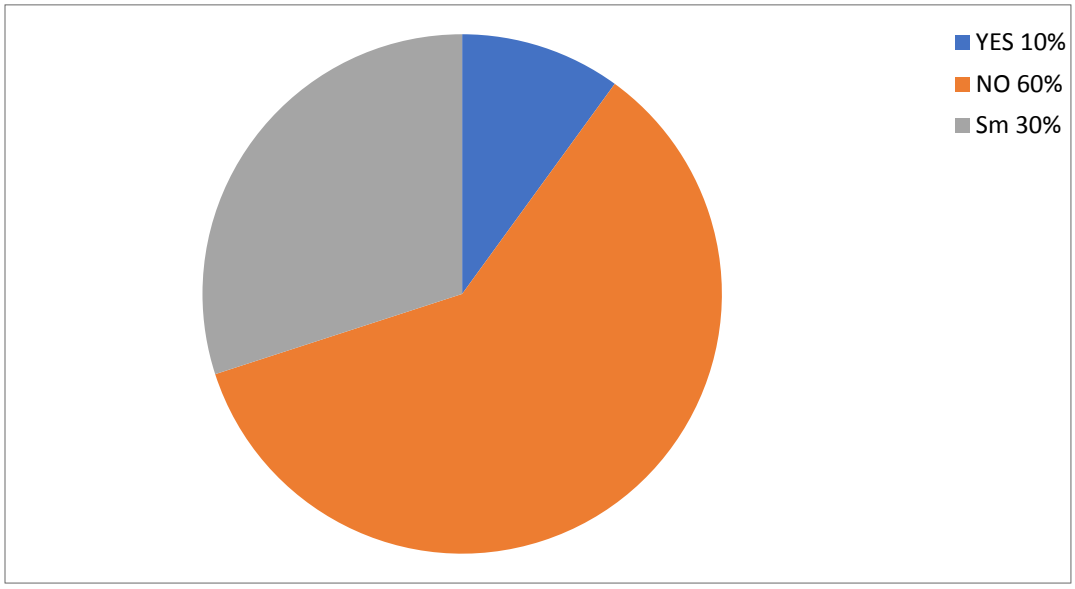
Table 5: FREQUENCY BASED ON LANGUAGE ETHICS

Question Number	Frequency			Age Range	Sex
	Yes	No	Sm		
5	10	60	40	16-85	M/F

Language ethics consider the ways to advance our understanding of the human communalities of moral and linguistic capacities and the challenge of linguistic differences and societal interdependence. This has to do with the way language is being used with respect to communication. Choosing the right words to be used at the right time when communicating is of great essence in communication. The wrong choice of words will lead to incomprehension and misunderstanding between the participants.

The table above shows the frequency of occurrences of individual responses based on the language used by hospital receptionists. Row one shows the question number. Row two indicates the number of times the question was answered based on each response given where 10 patients, were satisfied (Yes) with the way the language is used, 60 patients were unsatisfied (No) with the language used by the hospital receptionists and 40 patients attested to the fact that their satisfactory rate usually alternates (Sm) depending on how the patients attend to them (which is based on the language used) when they visit the hospital. The age range of participants who answered question five (5) was made up patients from 16 to 85years old of both sexes (male and female).

Chart 4: FREQUENCY ON LANGUAGE ETHICS



The chart shows that, the unsatisfactory act of the language used accounts for more than half the total number of patients' responses. This is evident by a 60% percent frequency on the above chart. The fluctuation in the level of satisfaction by some patients comes in second with a frequency of

30% while the least level which happens to be the satisfactory rate accounts for the 10% percent frequency rate as seen on the chart above.

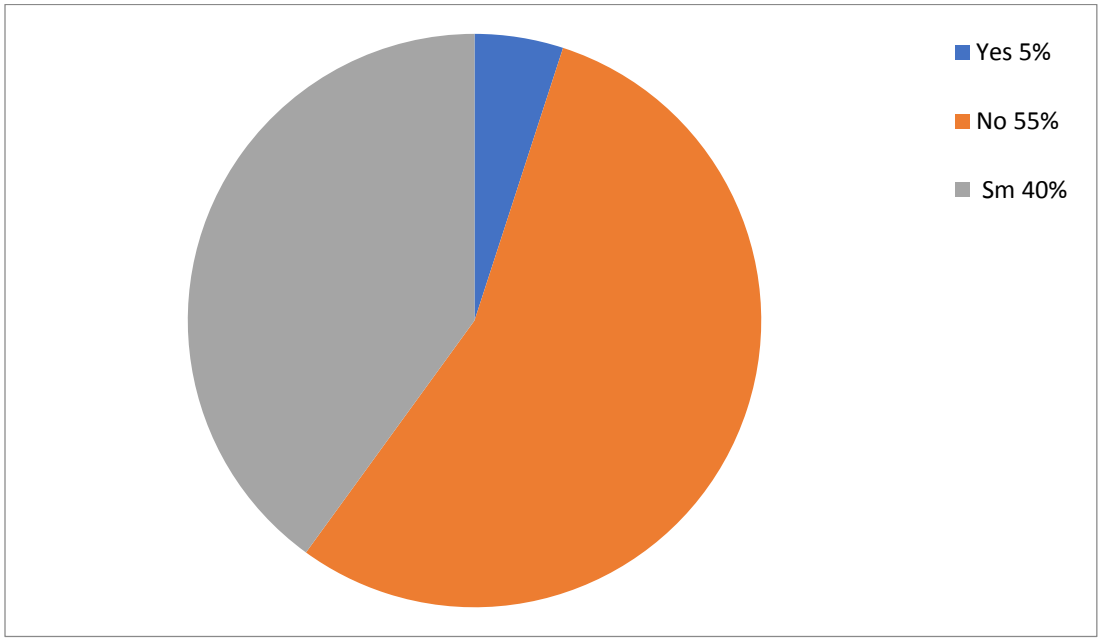
Table 6: FREQUENCY ON LANGUAGE IMPACT ON THE PATIENTS

Question Number	Frequency			Age Range	Sex
	Yes	No	SM		
6	5	55	40	18-85years	M/F

Language has the ability to bring people or a group of people together as well as it has the ability to cause conflict or separation. The language used by hospital receptionist has to be an embodiment of love, compassion, a show of positive emotion, and a host of others. The right choice of words used by hospital receptionists will not only help the patients in understanding what ids demanded of them but it will also show or reveal the social values that this receptionist has on their patients who will in the end result to a great level of satisfaction that these patients will have thereby boosting not only the morals or standard of the receptionists but that of the hospitals as well with the positive feedback which will be given by the patients wherever they may find themselves when asked as about the services offered by the hospitals under study.

In the above corpus of 100 respondents, we observe that the number of patients who were affected by the level of impact the language used by hospital receptionists has on them represented the highest level of frequency. This accounts for the frequency rate of 55 as seen on the table. The second level of impact was those who sometimes felt the impact and sometimes did not; this brought about the rate of 40 on frequency as found on the table while the least level was on the patients who have no worries about the language used. This accounts for the frequency rate of five (5) as seen on the table. The age range of those who answered question 6 was 18-85 years of male and female sexes.

Chart 5: FREQUENCY OF THE LANGUAGE IMPACT ON THE PATIENTS



From the chart above, it is clear that the level of impact that the language used by hospital receptionists when interacting with these patient is of great concern. This accounts for the 55% frequency rate of dissatisfaction (impact) as seen on the chart that the language used has on the patients. This is followed by a 40% frequency rate of some patients who think that it is not at random that the language used by this receptionist will have an impact on the patients while 5% of the patients have no disgruntlement about the language used thereby asserting the fact that the language used has no impact on the.

Table 7: FREQUENCY BASED ON POSITIVE ATTITUDE

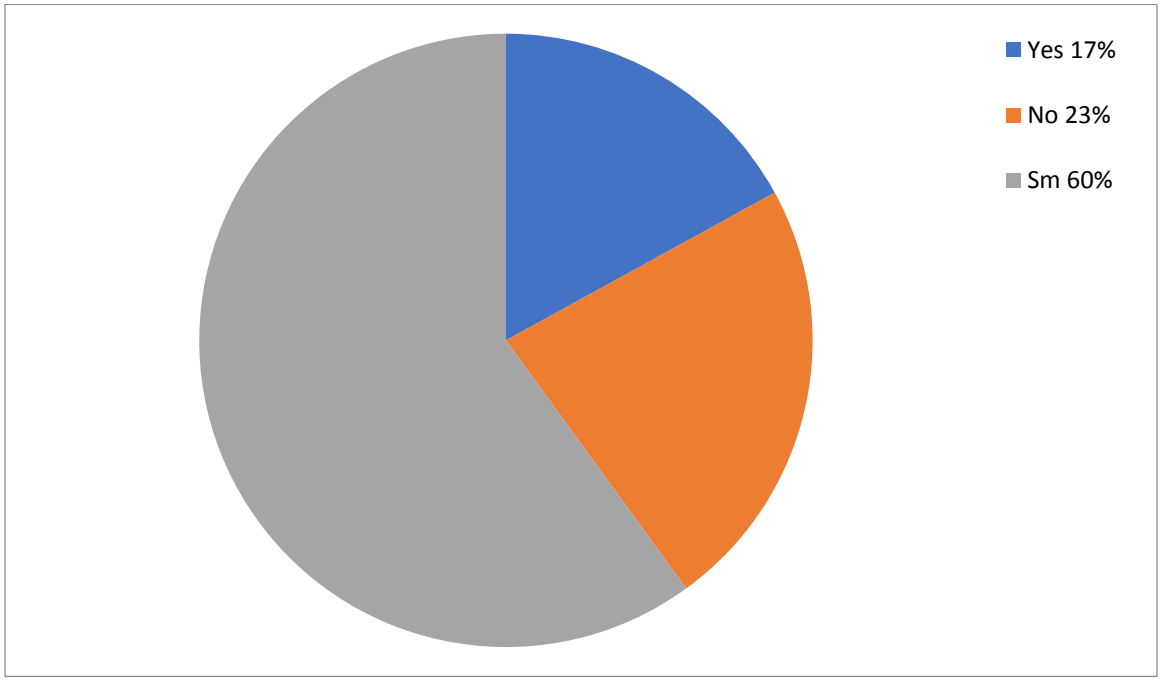
Question Number	**Frequency**			**Age Range**	**Sex**
	Yes	No	Sm		
7	17	23	60	18- 85	M/F

One of the characteristics that attracts people in getting into conversations and how this conversation turns out or the prolongation or longevity of the conversation will depend on the attitude of the two parties involved in the conversation. Kinesics, which happens to be “the

physical expressions like waving, touching and slouching," which are all forms of non-verbal communication and are part of body language which happens to play a vital role in the way receptionists interact and communicate with the patients. Question six (6) which ask the patients if they feel a sense of assurance when they talk with the receptionists takes kinesics into consideration based on participant observation in answering this question.

In the above data, 17 patients have no issues with the attitude of the receptionists based on the way they are being received as they step into the hospitals. 23 patients responded with a No which indicates that they are not well received by the receptionists while the highest frequency accounts for those who attest that the receptionists are sometimes welcoming and other times they act differently towards them. The age range of the patients who answered question 7 ranged from 18 to 85 years of with a greater number of males compared to females.

Chart 6: FREQUENCY BASED ON POSITIVE ATTITUDE



From the chart, the highest frequency rate 60% accounts for the number of patients who feel that the receptive nature of the receptionists varies depending on their mood while 17% percent of the patients see nothing wrong in the way receptionists receive them as soon as they step their feet into the hospital. 23% of the patients are unsatisfied with the way receptionists receive them as soon as they step their feet into the hospitals under study. The negative attitude towards their job

is said to be one of the reasons for the patients' unsatisfactory rate as seen on the percentages recorded in the chart.

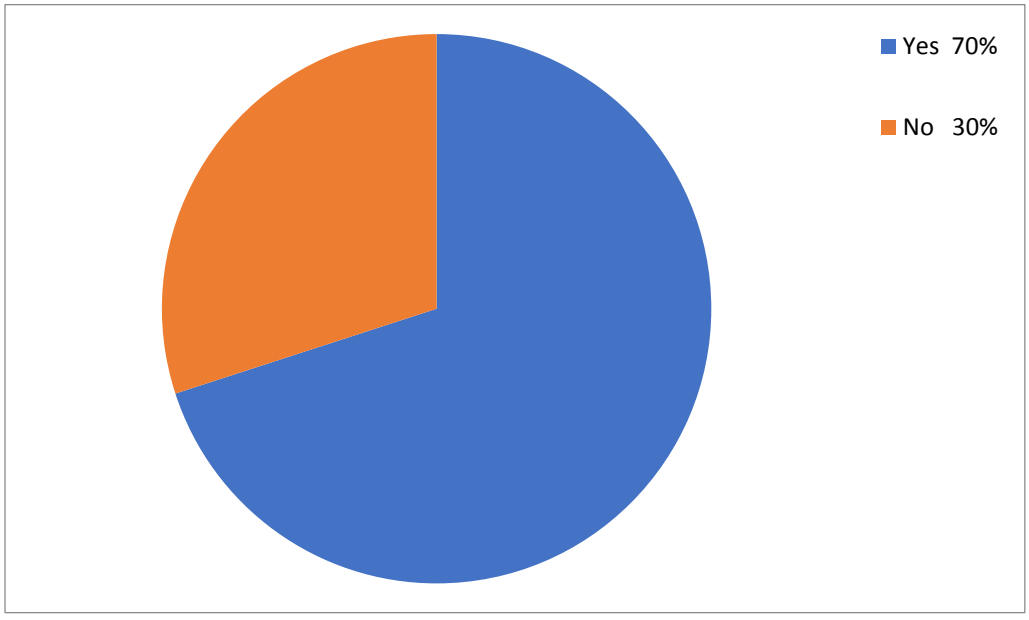
Table 8: FREQUENCY ON LANGUAGE AFFECTING COMMUNICATION

Question Number	Frequency		Age Range	Sex
	Yes	No		
9	70	30	18-85 years	M/F

For every language used in communication, there must be a chain of understanding between the two interlocutors. Without this link, there will not be a smooth flow of communication as one party will not be able to understand what the other party is talking about if the language being used is not mutually understandable by the two parties.

From the table, 70 patients attest to the fact that language is a hindrance to communication while 30 patients are of the opinion that language if not a hindrance to communication.

Chart 7: FREQUENCY ON LANGUAGE AFFECTING COMMUNICATION



The chart above shows that 70% of the patients are of the opinion that language is a hindrance to communication while 30% of the patients do not see language as a hindrance to

communication. Cameroon, being a bilingual country, it is imperative for all the workers to be bilingual. Cases have aroused where workers turn to shout or neglect its customers or clients because they speak a language which they seem not to be familiar with. This is the case of some of the hospitals especially private owned hospitals were because they are unable to pay for the services of their workers, they turn to employ people who are either fluent in one of the languages and not the two national languages thereby leading to verbal conflict sometimes between receptionists and patients or workers and their client due to uninteligility in the language used.

4.4 CONCLUSION

Based on the analysis made from the data under study, it is evident that receptionists do not have a good mastery of the language used especially when receiving patients in the hospital. This assertion stems from the discourse namings which have been backed by the use of tables and pie charts. We have looked at the discourse namings at different levels in other to better understand what they are all about. Also, we looked at the linguistic strategies used in the data in other to bring out the manner in which the receptionists manipulate words as well as the effects that the language used has on the patients.

CHAPTER FIVE

DISCUSSION OF FINDINGS AND CONCLUSION

5.0 INTRODUCTION

In the previous chapter, we analyzed and interpreted the various discourses which emanated from the data in this study. This chapter therefore, sets out to discuss and summarize the results obtained in chapter four above. These discussions are in a bid to provide valid answers to the three research questions which have been answered in the previous chapters, which are all indispensable items that featured in the preliminary chapter of this study. This chapter, in a nutshell, encompasses a summary of the work, discussions of findings, limitations and ends with recommendations and suggestions for further research and a conclusion.

5.1 SUMMARY OF THE WORK

This study has identified the various discourses which emanated from the data. It had shown how through the identification of the various discourses, the language used by receptionists and their choice of words are brought out in the various discourses and how these discourses portray some of the discrepancies patients complain about when they visit some hospitals. We classified the data under various discourses and analyzed each bringing out its linguistic traces. After analyzing the discourses, we discovered that most of the issues brought up in the discourses were issues related to the poor manner in the way receptionists use words (language) in communicating with the patients and how they receive these patients which was very poor of a receptionist in terms of characteristic. This answered research question one (1) which asked what the discourses that emanate from the patient-receptionist interaction. In this study, we have seen that language plays a performative role. This is because the flow of information and the level of interactiveness depends on the smooth flow of communication between the receptionists and the patients.

Another concern of this study was the linguistic strategies that were used in the data under study. This was in line with research question two stated in chapter one of these studies. The question read thus: What strategies do receptionists use to give directives to agitating patients? Hence, we focused on the linguistic strategies used in the data to make the work more of a critical discourse analytical work. The use of negative auxiliaries, adjectives, pronounces, modal verbs, conditionals, negation, declarations, questioning as well as Para-language are the linguistic strategies brought out in this discourse. After the analysis, we realized that the various discourses and linguistic strategies brought out from the data proved that indeed, the language used by hospital receptionists was a problem that needed to be looked into.

Research question three (3) was concerned with looking at the impact the language used by the receptionists in the hospitals under study has on the patients. It is said that words spoken can never be taken back, to this effect, the language used by these receptionists will go a long way in the healing and speedy recovery of the patient's psychological, moral as well as physical healing or it may worsen the situation which they came to the hospital with. Either way, the language that has been used needs to be appropriate and well-pressed for a better understanding of the patients. We have looked at the various levels of impact that the language used has on receptionists. The analysis for this section has been done based on seven different perspectives; frequency based on the communicative competence of the receptionists, frequency based on medical terminologies used when receiving patients, frequency based on the attitude of the receptionists towards the patients, frequency based on language ethics, frequency based on the impact the language used has on the patients, frequency based on the social norms like positive attitude when receiving patents as well as the frequency based on the effects language has on communication. The analyses made were in a bid to answer the three research questions under study.

5.2 DISCUSSION OF FINDINGS

This research on the language used by hospital receptionists stems from the premise that many hospitals in Cameroon, though with well-equipped personnel, still do not use language appropriately especially when receiving patients. The conviction in this research is that, by examining the issue from the point of view of how receptionists talk to patients, some insights might be revealed as to why complaints keep persisting despite improvements in the health care

facilities. In this light, the main objective of this work was to investigate the discursive and linguistic strategies used in the hospital reception discourse in two-well selected hospitals in the capital city, Yaounde. To attain this objective, the study embarked on the identification and analysis of the various discourses that emanated from the interaction between the receptionists and the patients. The various discourses were identified and classified under various discourse namings to show the effects that the choice of words has on the patients based on the data under study. Based on the analysis of the corpus under study, some salient findings have been reached as seen below.

5.2.1 CLASSIFICATION OF THE VARIOUS DISCOURSES

The study shows that the speakers employ the use of a wide range of discourse namings. These discourse namings are classified and analyzed based on the different levels in which they are used and how they are used. We came across discourse namings such as that of *impatience, inattentiveness, reiteration, gendered discourse, information transfer, and negligence, lack of duty consciousness, identification, stigmatization and negligence, frustration and intolerance.* We also came across task conflict and this task conflict has an impact in two forms which were on the patients and on the hierarchical structures.

Impacts of Task Conflict

In task conflict, we realized that it has an effect on the patients as well as the hierarchical structure of administration. These discourses after being analyzed made us to understand that receptionists do not make use of the right communicative patterns needed in interacting with patients. They believed that based on their level of experience in the services which they are in, they think or feel that patients sometimes ‘act as children’ and therefore needed to be treated as such. They also think that patients are the once who sometimes course them to act the way they do especially if they (patients) fail to adhere to instructions given. This is evident based on the manner in which the receptionists answered the questionnaires and the interviews as well. They see nothing wrong in what they do. We noticed that the percentage of patients who were disgruntled about the services rendered by the receptionists based on their attitude, the language used, the receptive nature of the patients, and a host of other discourses wee on a rise and are a call for concern.

Linguistic Strategies Used

As has been mentioned earlier, linguistic strategies are the ways in which speakers manipulate their linguistic content of speech for their purpose. The data revealed the use of the following linguistic strategies;

The Use of Auxiliary Verbs

The study shows the use of the negative auxiliary "do not' ***[****I do not have such time to waste****]*** used by a receptionist in a verbal dispute scenario with a patient. The use of the negative auxiliary depicts the level of frustration and anger that the receptionists have towards their job. Not having the time to satisfy the patients' needs can be viewed as a breach to medical ethics. The use of modality was also observable such as '*can.'* This strategy was employed in a bit to express politeness (*hello!! **Please can you recheck this**?*).

The Use of Questioning

The study revealed the use of questioning which indicated that neglect and frustration can be solved through the use of indirect questioning as patients find it difficult sometimes to pose or share with the receptionists what they are going through or the illness which brings them to the hospital. In such a situation, through the use of direct questioning indirect questioning, conversations are built, trust is conceived and answers are gotten without any form of stigmatization being felt by the patients as to the issues going on in their lives or whatever challenges they are facing.

The Use of Paralanguage

The use of paralinguistic features such as body language, gestures, sighs and murmurs, tone, and exclamations were evident upon the analysis of the data. These features expressed different meanings such as mood, attitudes, and behavior. Murmuring, for example, brings out the poor comportment or character of the receptionists in the way they respond to their colleagues as well as the patients when they are reprimanded on their actions. Sighing here happens to be that of disappointment, frustration and intolerance as receptionists find the presence of patients in front of them to be annoying and a waste of their time especially if they feel tired or are about to take a

break. As concerns the use of tone, the receptionists used harsh tone when they are moody and end up pouring out their frustration and anger on the patients by shouting at them or talking to them in a disrespectful manner. The use of exclamation was observed in such exclamations as 'hhmmm' which reveals the shock that the patient feels due to the receptionist's reply to patient's greetings. She believes that the receptionist having a bad mood should not be a reason for her to lash out on people who have nothing to do with what she is going through and how she feels.

5.3 LIMITATIONS OF THE STUDY

The first limitation of this study is evident in the scope. This study considers just two hospitals in the center region precisely in Yaounde without taking into account the rest of the hospitals in the region and other regions of the country.

The second limitation of this study could be seen in the fact that though we used two hospitals (state and privately owned), no comparative study was done to see if the language used by these two institutions were similar or different.

Another scope-related issue is a limitation that stemmed from the theoretical framework employed in this study. This study analyzes medical language by using a multidisciplinary method of discourse known as critical discourse analysis (CDA). This framework adopted in this study analyzes the medical language using Van Dijks' approach to discourse analysis (Sociocognitive Approaches). It did not take into account other approaches such as those of Wodak (Discourse Historical Approach) and Fairclough (Social Semiotic/Multimodal Discourse analysis).

5.4 DIFFICULTIES ENCOUNTERED

While collecting data for this research endeavor, we encountered a series of difficulties as elicited below.

The first difficulty encountered involved the granting of my research ethical clearance by the institutions choosing for this study which delayed the progress of the work. It took about seven months before they could permit me to carry out research in their institution.

The second difficulty encountered was the issue of getting the patients to fill in the questionnaires. Somewhere reluctant to fill in the questionnaires or share their views because they think nothing will be done about the challenges they face.

The third challenge encountered was the issue of finance. Most of the material gotten for this study was gotten online and it was difficult getting some important materials since the books had to be bought and some of the websites where free books were found needed the universities to be members of those sites.

The last but not the least difficulty encountered was in getting the receptionists to answer the questionnaires given to them. They did not see the need to be interviewed and given questionnaires to answer knowing that they do their best in helping the patients with whatever they need when they visit the hospital. It had to take days and weeks in lobbying them to participant in answering the questionnaire.

5.6 SUGGESTIONS FOR FURTHER RESEARCH

Like every scientific endeavor, this study did not exhaust all the possibilities for research around the topic. As already been aforementioned, this study limits itself to the language aspect only as seen in the analysis. In this light, the study opens up the following possibilities for future research related to the study of the language of hospital receptionists.

Research should be carried out on the Language used by nurses and doctors in pre-natal counseling. This will help in solving some of the problems raised in this domain by pregnant women on the ways in which they are treated by the healthcare providers.

I also recommend that future research should investigate on media discourses of care providers on diabetic and saws on patients.

Another aspect which should be looked into is on Language and health in non-communicable diseases. These non-communicable diseases are seriously affecting the youths in the society today.

5.7 CONCLUSION

This study has examined the use of language by hospital receptionists in some hospitals in Yaounde. Some discourses and linguistic strategies that emanated from the data were brought out and analyzed. It also presented the discourses based on the frequency of distribution on tables and charts to ease the clarification of the data. The analysis of the discourses and linguistic strategies revealed that receptionists are of the dissatisfaction patients complain about based on the language used and the choice of words but this blame can be shared to a lesser extent with the patients as they sometimes are the course of whatever level of dissatisfaction they might complain about which is as a result of their inattentiveness and a host of other factors put together as revealed in the corpus. The receptionists sometimes forget about the important role they play in the health of the patients especially when they visit the hospitals for whatever reason. As a consequence, the study uncovers that language also happens to be a barrier to the level of satisfaction these patients as well as the receptionists might have in dealing with the patients**.**

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APPENDICES

APPENDIX 1: ETHICAL CLAIRANCE

REPUBLIQUE DU CAMEROUN
Paix-Travail-Patrie
MINISTERE DE LA SANTE PUBLIQUE
HOPITAL GYNECO-OBSTETRIQUE
ET PEDIATRIQUE DE YAOUNDE
HUMILITE – INTEGRITE – VERITE - SERVICE

HGOPY
YGOPH

REPUBLIC OF CAMEROON
Peace-Work-Fatherland
MINISTRY OF PUBLIC HEALTH
YAOUNDE GYNAECO-OBSTETRIC
AND PEDIATRIC HOSPITAL
HUMILITY – INTEGRITY – TRUTH - SERVICE

COMITE INSTITUTIONNEL D'ETHIQUE DE LA RECHERCHE
POUR LA SANTE HUMAINE (CIERSH)

Arrêté n° 0977 du MINSANTE du 18 avril 2012 portant création et organisation des Comités d'Ethiques de la Recherche pour la santé Humaines. (CERSH).

AUTORISATION N° 116 /CIERSH/DM/2021

CLAIRANCE ETHIQUE

Le Comité Institutionnel d'Ethique de la Recherehe pour la Santé Humaine (CIERSH) a réexaminé le 25 Aout 2021, la demande d'autorisation et le Protocole de recherche intitulé *« The language of hospital receptionists : the case of some hospitals in Yaoundé.»* soumis par l'étudiant MBEH Francisca NKENG.

Le sujet est digne d'intérêt. Les objectifs sont bien définis. La procédure de recherche proposée ne comporte aucune méthode invasive préjudiciable aux participants. Le formulaire de consentement éclairé est présent et la confidentialité des données est préservée. Pour les raisons qui précèdent, le CIERSH de HGOPY donne son accord pour la mise en œuvre de la présente recherche.

MBEH Francisca NKENG, devra se conformer au règlement en vigueur à HGOPY et déposer obligatoirement une copie de ses travaux à la Direction Médicale de ladite formation sanitaire./-

Yaoundé, le 26 AOUT 2021

LE PRESIDENT

Pr MBU Robinson
Directeur Général
HGOPY

N°1827 ; Rue 1564 ; Ngousso ; Yaoundé 5ème
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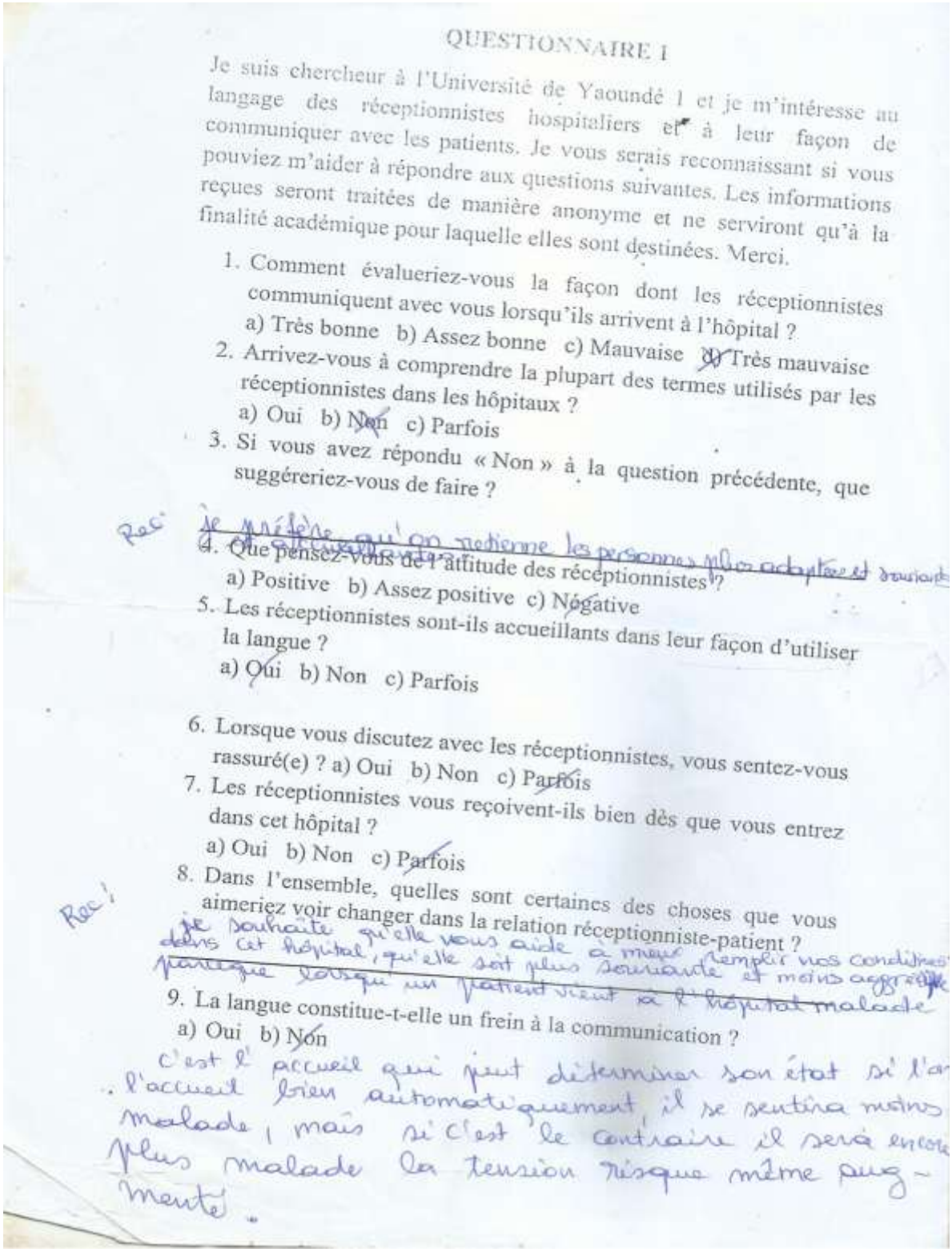
APPENDIX 2: Questionnaires



QUESTIONNAIRE I

Je suis chercheur à l'Université de Yaoundé I et je m'intéresse au langage des réceptionnistes hospitaliers et à leur façon de communiquer avec les patients. Je vous serais reconnaissant si vous pouviez m'aider à répondre aux questions suivantes. Les informations reçues seront traitées de manière anonyme et ne serviront qu'à la finalité académique pour laquelle elles sont destinées. Merci.

1. Comment évalueriez-vous la façon dont les réceptionnistes communiquent avec vous lorsqu'ils arrivent à l'hôpital ?
   a) Très bonne b) Assez bonne c) Mauvaise d) Très mauvaise
2. Arrivez-vous à comprendre la plupart des termes utilisés par les réceptionnistes dans les hôpitaux ?
   a) Oui b) Non c) Parfois
3. Si vous avez répondu « Non » à la question précédente, que suggéreriez-vous de faire ?

Rec : Je préfère qu'on retienne les personnes plus adaptées et souriantes

4. Que pensez-vous de l'attitude des réceptionnistes ?
   a) Positive b) Assez positive c) Négative
5. Les réceptionnistes sont-ils accueillants dans leur façon d'utiliser la langue ?
   a) Oui b) Non c) Parfois
6. Lorsque vous discutez avec les réceptionnistes, vous sentez-vous rassuré(e) ? a) Oui b) Non c) Parfois
7. Les réceptionnistes vous reçoivent-ils bien dès que vous entrez dans cet hôpital ?
   a) Oui b) Non c) Parfois
8. Dans l'ensemble, quelles sont certaines des choses que vous aimeriez voir changer dans la relation réceptionniste-patient ?

Rec : Je souhaite qu'elle vous aide à mieux remplir nos conditions dans cet hôpital, qu'elle soit plus souriante et moins agressive parfois lorsqu'un patient vient à l'hôpital malade

9. La langue constitue-t-elle un frein à la communication ?
   a) Oui b) Non

C'est l'accueil qui peut déterminer son état si l'accueil bien automatiquement il se sentira moins malade, mais si c'est le contraire il sera encore plus malade la tension risque même augmenté.

QUESTIONNAIRE 2

Je suis chercheur à l'Université de Yaoundé 1 et je m'intéresse au langage des réceptionnistes hospitaliers et à leur façon de communiquer avec les patients. Je serai heureux si vous pouvez m'aider à répondre aux questions suivantes. Les informations reçues resteront anonymes et ne serviront qu'à la finalité académique pour laquelle elles sont destinées. Merci.

1) Comment pouvez-vous décrire votre relation de travail avec les patients ? a) Très bonne b) Bonne c) Assez bonne d) Mauvaise
2) Pensez-vous que cela est dû à la langue utilisée?
   a) Oui b) Non c) Parfois
3) Les patients sont-ils bien accueillis dès leur arrivée à l'hôpital ?
   a) Oui b) Non
4) Que pensez-vous de l'attitude de vos patients ?
   a) Positive b) Assez positive c) Négative
5) À votre avis, diriez-vous que les patients arrivent à bien comprendre les instructions ?
   a) Oui b) Non c) Parfois
6) L'attitude des patients détermine-t-elle la façon dont vous leur parlez ?
   a) Oui b) Non c) Parfois
7) La langue constitue-t-elle un frein à la communication ?
   a) Oui b) Non c) Parfois
8) Comment gérez-vous les difficultés linguistiques ?
   Je peux passer le patient à mon collègue de cette langue
9) La langue utilisée pour communiquer avec les patients est-elle déterminée par la capacité des patients à communiquer avec les réceptionnistes ?
   a) Oui b) Non c) Parfois
10) Y a-t-il quelque chose que vous voudriez recommander d'améliorer dans la relation receptionniste-patient ?
   — formation des réceptionniste aux technique d'accueil
   — formation bilingue

APPENDIX 3: DIALOGUE BETWEEN RECEPTIONISTS AND PATIENTS

P: no the card is already there……it is forarandevour….this one …..nothe one infront of you…36

R: TANKOU

P: Tankou(background noise)

2) R: madam please move to the side

P: the child has to go to school

R: the child goes to which school?

P: this is the child nor…..that's her in the school uniform

R: the child is rushing to go to where and to write what?

P: (murmuring)

R: EHHHH…….what is she going to write?say you are the one who is in a rush and not the child(interruption….i have to go anfd drop the child in school)…..AHH AHHH…..say it like that……that child should be in prenursery….you are saying….(receptionist talking while taking down an info)the child is in class one not prenursery(patient talking)

R: she is in class one ehhh…..

P: YES…(murmuring)

3) R: Danny….how old are you?

P: I was born in 84 so…

R: ehhhh…..(papa first door behind)…..be quick

P: 39yrs ehhh

R: 39?

P:born in 83…….it should be 39yrs right? (background noise)

R:are you sure you are 39yrs…..so you don't know your age?

P:atleast iknow the day I was bornn na brother

R: ILL write 39 as you have said…..are you catholic or protestant?

P: protestant

R: protestant?

P:yes

R: where do you leave?

P: Liboudi

R: it is in simbockor nkolbisson?

P: LIBOUDI…..yes after nkolbisson(interruption)…..chairman…..na you make this pikin card?.....you hear tin weh ei deh tok?....ei say na you don orientate ei poorly….mal….naso ei tok for hear

R: you call that number?

R2: I don callam for deh woside ei deh……..then ei deh toknow say na you indicte for her poorly…..mah tok meh you hear tin weh ei deh tokam…..na your pikin nor

R1: they had called that number and even the name since….why did you noit answer?

P :I was here and I asked they said they did not hear my name nor number

R2:I called it there more than two times and I even had to call from the other side. You did not hear but th man heard and tapped you. Very swoon you p4eople will say we say we are not doing our work properly, and you even tell your big brother that he orientates you poorly……how bad of you(patients mourmouring in the back)

R1:Nkolbison, wc area precisely..?

P: l say Liboudi

R1: profession (interruption….patient greeting)….good afternoon

Yes good morning. One minute please, let me finish attending to this patient…..profession madam

P: accountant

R1: Take….keep this card very well, make sure whenever you are comimg to this ospital for checkup or anything related to this service, bring that card because we go use na he for attend toyou easily….this other one, you go use pay for casher….that window for behind you, pay for deh then you take the two papers them go put for inside that small box opposite the window…..them go attend to you.

P: thank you….how much am I to pay?

R: 2500

P: OK

4) R: madam …..go and pay at the caisse(aside….. give me that ei card)

R1: ask ei, ei came here last when…we go know whether nah….

R: ei say last two weeks

R1:hhhmmm… last two weeks then we cannot fine the card(murmuring)

P: please…..mine is to do an examination ehhh(background noise)

R: ehhh…..what number did I give you?

P: 32

R:ehhhh…….39 or 32?

P: 32…..the other was 31.

R:ok. Be patient……I"ll call you(R1: this one them don sleep soteh…..(pointing at two women)

R: yes Sir. How can we be of help?

P: my mum brought a book here which suppose to go to the doctor because we were hear two days ago and she was booked for operation.

R: what is her name?

P: sidiki Madi

R: OK….Paul……(another receptionist)…please take them to the director's office…..special case

Sir. Please follow him….

P: ok….merci

5) R: 28……..29……30….Tatiana Mbue……..madam Tatiana….

P: present.

R: what is it for madam?

P: huuhhh….I was here in December and was given a randevour to be back after three months which happens to be today.

R: OK.hopeyou know you are to pay a consultaion fee and you know wehave two service….the normal and the fast?

P:yes I do (intrude…..bro…..after this….i go where?

R: one minute madam….go put the card for that small box for my back….the first door(talking while typing)

P2: OK thanks.

R: take you card….pay at the caisse…..after that you know where to go to…..you are an old patient.

P: (smiling) yes I do thank you!

6) P: good morning. Consultation for pediatric the child is sick

R: give me the child's card

P: the child does not have a card. When I gave birth to her, they gave her but my name since we had not given her a name yet.

R: give me your card then

P: I don't know where I have left the card…. Looked for it and did not see

R: madam…..shift this way….you are not the only person I should attend to…..the is a long line behind you….you are not a new comer here and you know how important those cards are….if you have even a receipt of any payment you made within that period you were here, give it to my colleague, he will attend to you(talking while attending to the next person)

7)p: good morning….we were refered here from the teaching hospital

R: you were what???

P: they sent us here from the teaching hospital….my mum is sick and is in the taxi outside

R: ehhhhmmmm….where the nurses are is far…. If you can use that wheelchair and remive her fromte taxi or you go to the emergency unit over there(pointing to the deriction of the unit), they will attend to you there then you came back let us open a file for her……(patient runs and leave her books)…..came and take your books, they will need to go through it that way not here.

(Receptionists gossiping) hhmm…have you seen that woman mahmah…..she has a very big wound on her leg…..I'm sure Doc. Will not even touch it….shell send but those students….you know her

R1) that's what she always does and I hate it…….

8) P: want to pay for these tests(hands in the paper)

R: are you paying for all of this?

P: Yes except the two in red….i had done those somemonths ago and tey still want me to do it again when I don't even know if I'll have enough money.

R: madam……I am not the one who asked you to run these tests so I don't know why you are disturbing my ears…..take… go and pay…..when you are done, go to where you consulted the last time and take your file from there….that is when you are done from the lab.

9) P: (patient running inside with child in hand) please I need help…..the child got burnt by hot oil

R) weeeehhhh…..ehhhhmmm……where do we send them to….pediatric or emergency?

R1) you know this is what we faced the last time with the other patient…. They came and we sent them to emergency it became a problem….major came and shouted at us that it's a case for pediatric then pediatric came and said it was for emergency so I don't want to send them where it will end up being a problem for me(patient standing confused)

R: they are really getting us confused…..what are we going to do now ?see the child's body is all of wounds…..the child is seriously in pains…even the father…….Mon Pere, just rushed to the emergency center with the child….if they don't attend to you, go with the child to the director's office.

P: ok

R1: you see this type of case like this, they are those type that don't have even 25 to pay their bills that is why Mr…..doesn't want to get involved and it is having an effect on all of us….and we cannot report them to the major….you know how they are.

R: wwwhheehhhh…..this is really terrible, they should arrange their thing really fast if not…..somebody will die because of this.

10) P: since 7am I have been here…..what is all this? You people first of all came late and now you are attending to the people you know and your colleagues are there coming with books every now and then….do you people think we don't have things to do? This is absolutely unacceptable (patients murmuring)

R: madam….do you think we left our houses to come and play here….do you know what their problems are? You people just stand there and talk how you like….be very careful

P: don't talk to me that way…do you think I don't know what you people are doing? So all of us standing here, do you know the emergency we have to? because we are standing here? Why did they not come early like we did? Or you think we don't have somewhere important to be? You people are the once making this hospital to have a bad name.

R: when you finish talking, you go to the other person to serve you because I will not do that since you think you can talk to people anyhow as your mouth does not have control(patients murmuring in an angry mood)

P: you have you salary with the job that you don't even do very well……rubbish……after this I will write a complaint about you before I leave this hospital I promise you.

11) P: morning…wish to see a dermatologist

R: the dermatologist does not work today. Her working days are Mondays, Tuesdays and Thursdays. If its tat important, you can check at the general hospital.

P: OK….how about the radiologist?

R: do you have an appointment or you want to consult?

P: I want to consult

R: then you will have to be attended to by the doctor for general first and then he can send you to a radiologist if need be.

P: the thing is I had consulted in another hospital and was asked to see a radiologist so I just want to know how much the test will cost or if I need to do another consultation

R: madam…..i don't know what you really want. Take the straight path behind me and turn to your right. The only door on your left is the radiologists…ask him all your questions…..next

P: OK.

12) p: hello……you were the one who attended to me and I have a problem. I asked you not to register the two tests which were in red but you did so without even telling me the total bill I am to pay….i was talking to you and you did not even listen to me properly because you were on the phone and smiling…I could not do otherwise but to pay and now you added an extra 1000 to what I am to use to pay my taxi back home.

R: are you ok? Have I attended to somebody like you since morning?

P: don't talk to me that way...i am not your child….were you not the one working in this section yesterday (pointing at the place)….i even called you more than two times before you could look up and attend to me without even listening carefully to what I had to say….how rude of you….you are always like that and everybody complaints about you.

R: since you know too much, when they were telling you the amount to pay why did you not tell them that it was too much?

P; you are really sick in the head. Are you not the person I asked to tell me the bill and you just told me to go with it that way? I need my money back….if not for the fact that the other hospital I go does not have this section, you will never see me here….you are not even supposed to work here because you don't know your role honestly

R: I don't know why you are making all this noise….it was a simple mistake that you made and not me. Photocopy the receipt of what you paid and take it to the directorate, your issue will be sorted out there.