DE GRUYTER MOUTON
DOI 10.1515/multi-2013-0017 — Multilingua 2013; 32(03): 373–403

Akin Odebunmi

Multiple codes, multiple impressions: An analysis of doctor–patient encounters in Nigeria[1]

Abstract: Existing studies on doctor–client interactions have largely focused on monolingual encounters and the interactional effects and functions of the languages used in the communication between doctors and their clients. They have neither, to a large extent, examined the several codes employed in single encounters and their pragmatic roles nor given attention to communication at doctor–client first meetings in a bilingual or multilingual setting. This paper catalogues the generic structure of the interactions at first meetings in Nigerian hospitals and examines the pragmatic features and functions of the codes used by doctors and clients at the different units of the generic structure. Seventy-five audio recordings of doctor–client interactions were randomly made in selected state-government owned and private hospitals in South-western Nigeria in 2002, 2007 and 2009. Analysis of transcripts was based on theoretical aspects of code alternation, Levinson's notion of activity types and Sarangi's concept of discourse types. Four discourse stages characterise doctor–client interactions at first meetings in Nigerian hospitals: Opening, Diagnostic Interaction, Announcement and Closing. Two code selection types run through the generic structure of the interactions: non-strategic and strategic. Non-strategic choices are necessitated by cultural, institutional and linguistic routines. Strategic choices are characterised by context-shaping and context determined acts. Codes are selected at the non-strategic level to express phatic communion, indicate deference and display personal styles. At the strategic level, they are employed to accommodate dispreferred code choices, relax tension, flaunt competence, assure, save face, joke, reformulate and warn.

Keywords: multiple codes, doctor–client interaction, activity types, discourse types, strategic choices, non-strategic choices

Akin Odebunmi: University of Ibadan, Nigeria, Odo-Oru Baptist Church, P.O. Box 659, Ogbomoso, Oyo State, Nigeria, e-mail: akinodeb@yahoo.com

1 This paper was part of the research work I undertook between April 2010 and March 2011 at the Freiburg Institute for Advanced Studies (FRIAS), University of Freiburg, Germany with the Alexander von Humboldt Fellowship award for experienced researchers.

1 Introduction

The significance of language use in medical practice has been reflected in the serious attention paid to it in the literature. A most recent and representative typification of studies on doctor–client interactions has been made by Heritage & Maynard (2006), who identify two directions in the research, namely, process analysis and microanalysis of discourse. The former, developed by Barbara Korsch and other scholars with her intellectual conviction, was built on Bales' (1950) coding system 'tagged Interaction Process Analysis'. Studies in this school focus on the role relationship in the encounter between the doctor and the client. The studies specifically concentrate on the satisfaction level of the client (see Korsch *et al.* 1968; Freemon *et al.* 1971; and Korsch & Negrete 1972). The process analysis engagement also benefits from the Roter Interaction Analysis System (RIAS) developed by Debra Roter and her colleagues. The coding system comprises 39 categories with 15 sub-divisions on socio-emotional behaviour and 24 on task-focused behaviour. With a scope beyond primary health care, it has shown how doctors and clients interact in the visits and how the patterns of interaction are tied up to the level of satisfaction of both doctors and clients (see Hall *et al.* 1994; Roter & Hall 1992).

The microanalytic approach originates in anthropological and sociological attempts to sidetrack the flaws of the process analytic approach (i.e. its non-'address[ing] [of] issues of content, context and meaning in medical interaction ...' by 'deploy[ing] an essentially ethnographic and interpretive methodology [in] disclos[ing] the background orientations, individual experiences, sensibilities and objects that inhabit the medical visit" (Heritage & Maynard 2006: 4). Scholars in this tradition have recently investigated doctor–client relationships with respect to how practitioners suppress clients' experience, a phenomenon that is, in accordance with Heritage & Maynard's (2006) account, traceable to the social, economic and institutional power that is ascribed to the doctor (cf. Atkinson 1995). The present study identifies with the micro analytic tradition.

Scholars in the micro analytic school have largely focused on monolingual encounters and the interactional effects and functions of the languages (e.g. Maynard 1989, 1991a, 1991b, 1991c, 1992, 2003, 2004; Salazar 1998; Peräkylä 1995; Fisher & Groce 1990; Mishler 1997; Odebunmi 2005, 2006, 2008). While a number of the studies in this tradition have been committed to interpreter-mediated encounters in the hospital setting (see Davidson 1998, 2002; Leanza 2005; Collins & Slembrouck 2007), not much effort has been put on several (possible) codes in the interactions and the pragmatic roles of these codes. Another neglected area, with a possible exception of Sarangi & Roberts (1999), is the focus on doctor–client first meetings, which, of necessity, differ in dis-

course structure and function from subsequent meetings. It is important to see how code selection in a bilingual setting contributes to meaning negotiation between the doctor and his/her client especially during first encounters.

In this paper, I look at the generic structure of doctor–client interactions at first meetings in Nigerian hospitals, and examine the pragmatic features and functions of the codes used by the parties as they appear at the different units of the structure.

2 Methodology and design

Seventy-five audio-recordings of doctor–client interactions were randomly made in selected state-government owned and private hospitals in South-western Nigeria in 2002, 2007 and 2009. The recorded interactions were a mixed bag of all meetings in the hospitals, first, second, multiple, and follow-up. Only ten of these, all of which were selected, were interactions between doctors and their clients at first meetings. All the interactions were considered in generating the generic catalogues and in classifying the strategies; illustrative examples for the strategies were taken from six of these interactions. Since all the ten first-meeting interactions were selected, the type of case or doctor played little or no role in the selection process. Informed consent was obtained from all the doctors, who also personally assisted in audio-recording the interactions because I could not be allowed into the consulting room for the privacy rights of the patients to be observed. As a native speaker of Yoruba and an English linguist, I translated the texts, but the translations were verified by an associate professor of Yoruba linguistics in the Department of Linguistics and African Languages, University of Ibadan, Nigeria. The transcripts were analysed with insights from theoretical perspectives on code selection (and mixing/switching), Levinson's notion of activity types, Sarangi's discourse types and the generic structure model.

In the next section, I discuss the concept of code selection and I review perspectives on code-mixing/switching. In section 4, I deal with the consultation structure and linguistic situation in the Nigerian hospital. I devote section 5 to the theoretical anchors of the paper, and section 6 to the analysis of the samples. In section 7, I conclude the paper.

3 Code alternation and hospital interactions in Nigeria

The term 'code' refers to a linguistic variety (cf. Boztepe 2003) used in communication. This linguistic variety could be the standard form or varieties or dialects of the standard code/language. In bilingual conversation, discourse participants often mix or alternate codes (Auer 1995, 1998, 1999, 2009). However, this does not happen in all situations, as sometimes certain participants can only cope with one code. These individuals communicate only in that code and the co-discourse participant is pragmatically constrained to switch to the code preferred by the other party even if his/her competence level in that code is low. The term 'code-switching' is thus associated with the concurrent use of two or more languages or language varieties in conversation. It provides these interactants with 'a resource for indexing situationally salient context in speakers' attempts to accomplish interactional goals' (Heller 1988: 3). For Auer,

> [c]ode-switching covers all instances of locally functional use of two languages in an interactional episode. Code-switching may occur between two turns, or turn-internally, it may be restricted to a well-defined unit or change the whole language of interaction; it may occur within a clause ... or between clauses. (Auer 2009: 491)

The phenomenon of code-switching has been approached from the perspectives of sociolinguistics, grammar and discourse/pragmatics. In the sociolinguistic approach, the focus has been on languages in contact in the bilingual or migrant context and on the social and political rationales for the use of the languages (see Moyer 1998; Milroy & Wei 1995; Poplack 1980; Zentella 1990; Yamamoto 2001; MacSwan 2000). Here research has also been directed towards a speaker's identification and alignment with a group (cf. Barker 1975; Hill & Hill 1986; Myers Scotton 1988, 1993; Myers Scotton & Ury 1977; Zentella 1997). Myers-Scotton's markedness model accounts for the social motivation for code-switching. She observes that in a multilingual setting, social roles are assigned to every linguistic variety in a multilingual setting; these roles are described as 'rights and obligations (RO) sets' (Myers-Scotton 1993: 84).She contends that using more than one language opens up the negotiation of social roles between speakers who understand the social meanings of the codes being used. The markedness model operates with one principle, 'The negotiation principle', fashioned after Grice (1975) and three maxims: unmarked choice, marked choice and exploratory choice maxims. She states the maxims respectively thus: 'Make your code choice the unmarked index of the unmarked RO set in talk exchanges when you wish to establish or affirm that RO set' (Myers-Scotton 1993: 114);

'Make a marked code choice when you wish to establish a new RO set as unmarked for the current exchange' (p. 131); 'When an unmarked choice is not clear, use CS [code switching] to make alternate exploratory choices as candidates for an unmarked choice and thereby as an index for an RO set which you favor' (p. 142).

The grammatical approach, which takes a psycholinguistic dimension, explores bilingual language processing. It provides models which tell bilinguals from monolinguals in terms of their language internalisation processes. As such, scholars in this school have addressed how bilinguals construct messages, how they gain lexical access and how they integrate lexical and syntactic forms in producing and understanding language (see Bialystok 2001; Dussias 2001; Grosjean 1997; Muyksen 2000; Myers-Scotton & Jake 2002). The scholars of the grammatical approach contend that code-switching is governed by linguistic constraints and that switches are systematic.

In Blom & Gumperz's (1972) influential work on code-switching, the two terms, 'situational code switching' and 'metaphorical code switching' were introduced. The former occurs when 'a change in linguistic form represents a changed social setting' (Nilep 2006: 8); the latter is applied when two language varieties are used in the same social setting. Gumperz (1982), realising the imperfection of describing a switch as either situational or metaphorical, introduced 'conversational switching' which made use of only metaphorical switching. He treats the switch as a contextualisation cue, his list of functions of code switching including quotation marking, addressee specification, interjection, reiteration, message qualification and 'personalization versus objectivisation' (Gumperz 1982: 80).

The discourse approach to code switching, proposed by Auer (1984, 1995, 1998, 2009) takes the position that code-switches are subject to 'local processes of language negotiation and code selection' (Auer 1995: 121). Auer (1998: 14) identifies eight conversational loci where code switching frequently occurs:

1. Reported speech
2. Change of participant constellation (addressee selection and the use of code switching to include/exclude/marginalize participants or bystanders).
3. Parentheses or side comments.
4. Reiterations (quasi-translations into other language for the purpose of putting emphasis on demands, requests, for clarification, attracting attention and the regulations of turn taking).
5. Change or activity type (also referred to as mode shift or role shift).
6. Topic shift.

7. Puns, language play or key.
8. Topicalisation and topic/comment structure.

Code-switching in Nigerian hospitals is experienced in respect of 2, 4, 5 and 7 above. For Auer (2009), code-switching is functional language alternation and code-mixing is non-functional language alternation. He posits that 'the frequent variation between the two "codes" has become a mode of interaction in its own right, that is a new code with rules and regularities of its own' (Auer 2009: 491). Many studies on code-switching have supported Auer's observation about the function-based dimension (cf. Boztepe 2003; Tay 1989; Baredo 2000; Shin 2010). Yet, leaving code-mixing out of the functional category requires great caution. Sometimes, like code-switching, items in code-mixing are employed for strategic purposes. This functional dimension has been explored by Tay (2003) and Leung (2010). I admit, however, that the strategic engagement of code-mixing is limited in scope.

Auer (2009) identifies discourse-related code-switching and participant-related code-switching. The former describes 'the use of code-switching to organise the conversation by contributing to the interactional meaning of a particular utterance' (Auer 1998: 4). This picks out the pragmatic value of code-switching as it reveals the marking of a new footing in the choice of language. The latter (participant-related code-switching) refers to situations in bilingual conversation where participants merely prefer a language as against another without necessarily pursuing a strictly pragmatic agenda.

In Nigeria, as in partly several bilingual communities in Africa (cf. Myers-Scotton 1993), except among the very elderly who are tied to maintaining the purity of the indigenous languages, code-mixing is a common practice among both the educated and the uneducated (see Essien 1995 for an example from the Ibibio of Nigeria). Auer & Eastman's (2010) view aligns with this development, which differs from the practice in Hong Kong (Leung 2010: 417). It is therefore interesting to see how this practice of mixing/switching codes operates in the formal context of the Nigerian hospital.

4 Consultation structure and linguistic situation in the Nigerian hospital

Unlike the practice in most Western hospitals where appointments have to be booked with a doctor before a meeting, clients in Nigerian hospitals can go to any hospital almost any time of the day (day or night) if they notice any health

discomfort. They present duplicates of their registration documents, usually called 'small cards' to hospital records officers who will pull out their case notes, which are still, in many hospitals, in the hard copy form. These are placed before the appropriate doctor, and clients have to sit outside the doctor's offices, waiting for their turn. At a client's turn, s/he is invited by having her/his name called out (usually her/his full name without a title). S/he is seated, in most cases, on the left side of the doctor's table, and consultation, usually lasting between 3–20 minutes, ensues.

Communication in Southwestern Nigerian hospitals is carried out in Standard British or American English, Nigerian Pidgin and Yoruba (in single or combinatorial forms). The code selected is determined by what either party first selects or maintains, what a party insists on in the course of the conversation, or what the interactional context necessitates. I have personally observed that English is used exclusively where the doctor (Doctor) and client (Client) or her/his relation (also referred to as 'client' in this research) can speak it. In most cases the English spoken in Nigerian hospitals is an interlanguage variety (cf. Bamgbose 1982 on Nigerian English in general).

English usage in the hospital reflects the linguistic character of the larger Nigerian society. In other words, many expressions used, especially by doctors and other medical professionals are instances of shifts/extension, transfer, abbronymy (Odebunmi 1996) and coinages. These expressions are largely used in oral communication while the standard medical terms are largely used in written communication. Another dialect of English used in Southwestern Nigerian hospitals is Pidgin English, which is more popular in the big cities where the multilingual nature of Nigeria is most manifest. The use of Pidgin in the hospital is largely negotiated between doctors and clients (Odebunmi 2012). Sometimes, depending on the relationship between the parties and the goals of the encounter, doctors and their clients code-mix English, Pidgin and Yoruba, the native language of the people in Southwestern Nigeria. But where the client cannot speak English at all, the language s/he speaks usually, Yoruba, is selected for communication, provided the doctor is also able to speak it.

Apart from the language, the culture of the Yoruba also impinges on the interaction between the doctor and the client. This has been extensively discussed in Odebunmi (2003, 2006 and 2008). The major issue raised in these publications is that the Yoruba place great importance on deference and pleasantries, which they also expect from the doctor. This will be shown in the analysis below.

5 Theoretical prespectives

This work benefits centrally from Levinson's notion of activity types and Sarangi's discourse types. Also relevant is the concept of generic structure potential, in systemic functional grammar, which provides the tool for analysing the structure of doctor–client interactions. I discuss activity and discourse types in 5.1 and 5.2 respectively, and explain the symbols for generic structure catalogues in section 6.

5.1 Activity types

The choice of activity type (AT) lies in its reputation for being able to tackle institutional discourses such as hospital interactions. This is largely because it is capable of accommodating the activities of the participants (i.e. doctors and clients), the contextual rationale for the activities and the pragmatic influence of the activities.

The notion of activity type focuses on participants' use of language which is constrained by the activity they perform and the physical location of the talk (cf. Levinson [1979]1992: 69). These place high constraints on the contributions that could be made by the parties in interaction. This constraint factor brings in the pragmatic context, which gets the interactants to negotiate their meanings and intentions rather than depending strictly on the provision of the setting of interaction, a standard stance of the traditional concept of context (cf. Gumperz 1982; Levinson 1979, 1992; Thomas 1995; Mey 2001; Odebunmi 2008).

Levinson (1997) presents the position that utterances are capable of designing their own contexts. This same position is held by scholars such as Bourdieu (1991), Thomas (1995) and Sarangi & Slembrouck (1996). Bourdieu's (1991) argument is that utterance meaning relies on the status of the speaker and the role s/he plays in the interactional context. These status and role shift with activities, causing 'the interactional context [to] influence the sense and force of what is meant' (Sarangi 2004: 137). It may be argued, though, that beyond Bourdieu's (1991) argument, utterance meaning may be influenced by topics or other local interactional circumstances which are neither status nor role as reflected in my analysis in the present study.

Levinson (1992) states that the constraints placed on the contributions participants can make to an activity come with certain expectations, which correspond to 'the functions that any utterances at a certain point in the proceedings can be fulfilling' (1992: 79). This is because there is always a set of inferential schemata attached to an activity. These schemata 'help to determine how what

one says will be taken, that is, what kinds of inferences will be made from what is said' (1992: 97). Ultimately, the picture we have is that each discourse participant plays a communicative role that suits the interactional context and that is sensitive to the dynamism of the activities being carried out.

Thomas (1995) specifies the interactional features of AT as follows:

1. The goals of the participants
2. Allowable contributions
3. The degree to which Gricean maxims are adhered to or are suspended
4. The degree to which interpersonal maxims are adhered to or are suspended
5. Turn taking and topic control
6. The manipulation of pragmatic parameters (i.e. power, social distance)

5.2 Discourse types

'Discourse types' as a theoretical concept is credited to Sarangi (2000). The concept forms a sort of complementary relationship with AT. Sarangi (2000) plugs the concept of discourse types (DT) into the broad circuit of AT to account for the specific discourse/pragmatic acts that are performed in the activities.

DTs relate to talk forms that are goal-driven while ATs provide the broad contextual background that can influence how DTs are interpreted. Whatever is said by participants is bound to be constrained by the institutional context. DTs thus refer to specific acts performed in ATs such as advice (DT) in counselling (AT), questioning (DT) in interview (AT), and presentation (DT) in seminar (AT).

DTs, as Culpeper *et al.* (2008) rightly observe, strike a complex relationship with ATs. They also have a lot in common with Mey's (2001) practs. While I am not exploring these relationships in this paper, it seems operationally safe to see DTs as specific acts, relative to ATs, and strictly institutionally-based, relative to practs as a preliminary distinction between the concepts. In this research, I operationally treat DTs as situated speech acts (cf. Mey 2001). Overall, ATs and DTs are language behaviours based in the institutional and professional domain, a factor that establishes their relevance to the analysis of doctor–client encounters.

6 Analysis and findings

Two levels of analysis are carried out in this study. The first is the generic structure of the interactions between doctors and their clients; the second is

the code selection strategies that are used in the interactions. First, I tackle the generic structure, adopting notations from Systemic Functional Linguistics. The generic structure model is chosen because it is capable of systematically explaining the interactional stages of the encounters and thus serving as a lead up to the main pragmatic analysis. Specifically I utilise the following notations due to Halliday & Hassan (1989): ( ), indicating optionality; unbounded elements ☞, showing the obligatory status of the items; indicating iteration; }, showing that the degree of iteration for elements in square brackets is equal; ^, indicating sequence; and [ ] specifying restraints on sequence.

6.1 Generic structures of doctor–client interactions at first meetings

While limiting myself to first meetings, I hypothesise that first meetings present different structural constituents from other meetings because of the restriction with respect to common ground. Hence, the generic structure of the meetings detaches, in some respects, from that of other meetings already attempted in the literature (see Byrne & Long 1976; Mishler 1984; Heritage & Maynard 2006; Adegbite 2009).

Four discourse stages are identified in the interactions: Opening, Diagnostic Interaction, Announcement and Closing. The generic structure of these stages is presented below:

[(Opening)]^ [Diagnostic Interaction]^ [(Announcement)]^ [(Closing)]

The catalogue shows that the only compulsory element in the interaction is Diagnostic Interaction (DI). Opening, Announcement and Closing are optional. It also shows that each is restrained in terms of position of occurrence. For example, Announcement cannot come before Diagnostic Interaction. The GS of each of these stages follows:

6.1.1 Opening

Opening covers the pre-business stage of the consultation. It is characterised by an exchange or sharing of social information between doctors and clients:

[(Ins)]^ (Iv) ^ (RI) ^ (Grt) ^ (RG) ^ (Pls)

Opening at first meetings does not have any compulsory element: Instruction, Invitation (Iv), Response to Invitation (RI), Greeting (Grt), Response to Greeting

(RG) and Pleasantries (Pls). Instruction is restrained in terms of position wherever it occurs. Instruction is issued by the doctor to an attendant or nurse to invite the client; Invitation made through the calling out of a name by the attendant or the nurse identifies the client that is due for consultation with the doctor; Response to Invitation is the verbal acknowledgement of the invitation extended to the client; and Pleasantries refer to jokes or other relaxing talk by doctors or clients.

6.1.2 Diagnostic Interaction (DI)

Diagnostic Interaction describes doctor–client exchanges that centre on the client's health condition. It is structurally captured in the catalogue below:

[BR]^ (EI) ^ (Int) ^ {CI^ CR^ CI^ CR^ ...}^ (Pls^) (Ass)

The generic structure shows that only BR (Broad Request), always made by Doctor, CI (Condition Specific Information), always provided by Client and CR (Cue-based Request), always made by the doctor are obligatory. By BR is meant a general request made by Doctor about the state of health of Client (e.g. 'What's your problem?'). CI refers to the response of Client in which s/he specifies the actual problem (e.g. 'It's malaria fever'), and CR refers to the request made by Doctor based on the specific condition mentioned by Client (e.g. 'When did it start?'). BR always occurs at the initial part of the interaction, but CI and CR could be intervened by other optional stages such as EI (Echoic Information) and Int (Interjection). Echoic Information refers to a client's response which merely repeats the contents of the Doctor's BR (e.g. 'What's the problem (BR)' – 'There is really a problem' (EI)), while Interjection is used to refer to all forms of interactive insertions that are not part of the main consultative line, e.g. 'Sorry Baba'). Int is repeatable at some other points in the interaction. CI and CR always have an equal number of occurrences. In other words, a piece of Condition specific information provided necessitates a Cue-based request. Pls (Pleasantries, usually jokes), and Ass (Assurance, e.g. 'There is no problem') are largely optional.

6.1.3 Announcement

Announcement refers to the doctor's disclosure of his observation regarding the client's state of health and subsequent medical procedures or activities to the client. The generic structure follows:

(Ass)^ (TP) ^ (Int)

No unit in Announcement is obligatory. In fact, in all the interactions studied, only TP (Treatment Procedure), which is iterative, is announced (e.g. 'I will examine you'). Ass (Assurance) and Int (Interjection) sometimes occur when Treatment Procedure is being announced. This generic structure is largely opposite to the structure of multiple meetings where three types of announcements are possible: Prescription, Therapy Procedure and Follow-up Interaction.

6.1.4 Closing

Closing signals the end of the consultative session. Its generic structure is presented below:

(App)^ (Rapp) ^ (FR) ^ (RFR) ^ (DC)

Just as in Opening and Announcement, no unit in Closing is obligatory. App (Appreciation, e.g. 'Thank you'), Rapp (Response to Appreciation, e.g. 'Thank you'/'Okay'), FR (Follow-up Request, e.g. 'When should I come back?'), RFR (Response to Follow-up Request, 'Monday next week') and DC (Departure Communication, 'Bye', 'Till Friday, doctor') are optional. App and RApp are, however, more frequent because they align with cultural doxas in Southwestern Nigeria.

I now move to the code selection strategies that characterise the generic structures in the next section.

6.2 Code selection strategies: Analytical design

From all the code selection models reviewed in section 3 above, I have come up with two terms: non-strategic code selection and strategic code selection, which have been adapted from Myers' Scotton's unmarked choice maxim and a part of Auer's participant-related switching, Gumperz's conversational switching, Myers Scotton's marked choice maxims and Auer's discourse-related switching. Therefore, non-strategic code selection, in this research, means predictable bilingual language choices which may be institutional or contextual; strategic code selection refers to unpredictable language choices in bilingual encounters which are tied to institutional or local interactional contexts. The strategies are taken in turn.

6.2.1 Non-Strategic code selection

There is non-strategic code selection, or what I term 'interactional routines', when the choices made in the conversations are predictable to participants. Two categories of these routines occurred: cultural and institutional routines, and linguistic routines. Across all the examples in the analysis, Standard British/American English is italicised, Yoruba is underlined, Pidgin is represented in bigger bold fonts and Nigerian English simply appears in bold. Arrowed lines point to the items being focused at particular points of the analysis.

6.2.1.1 Observance of cultural and institutional routines

Cultural routines are common in Openings, while institutional routines occur more frequently in Diagnostic Interactions. Sometimes, institutional routines occur in Openings where there are Invitations, but they do not occur at all in Closings.

Cultural routines occur in Greetings, Response to Greetings and Pleasantries. Alternations of Standard English and NE between participants occur in the interaction below:

(1)

Doctor: *Good morning*, **dear**=
Patient: *Good morning*, **ma**—[2]

'Good morning', a Standard English expression and both 'dear' and 'ma' (Nigerian English words) are mixed by both participants. 'Dear', as used by Doctor, is an NE word for giving positive face to strangers, and not necessarily, as in Standard English, for expressing love or intimate relationships. This expression of respect is reciprocated by CL with the choice of 'ma' (from the Standard English word 'Madam') which gives regard to the greater age and institutional authority of Doctor. 'Ma' in NE is used to refer to a female person who is either older or has greater status than the speaker.

Institutional routines, as earlier stated, are observed in Invitations in Openings. An instance can be cited in below:

2 Utterances in standard British English are given in italics, those in Nigerian English are in boldface, those in Yoruba are underlined and those in Nigerian Pidgin English are recte.

(2)

	Doctor:	((To the attendant)) *Alright, call in the next patient*
	Attendant:	Baba ( ) =
		('Mr.')
→	Patient:	**Sa::**

Doctor initiates Invitation through Instruction directed at the attendant who carries it out by calling out: 'Baba', to which CL responds 'Sa::' ('sa::' is a combination of Standard English and Nigerian English sounds). It is equivalent to the Standard English 'sir' when neither elongated nor adapted to the peculiar Nigerian interactive context. It is interesting to note the institutional power attached to the doctor's position: the attendant is a woman, but CL's Response to Invitation points to the doctor and not to the attendant who is rated lower than the doctor. The doctor is thus perceived as the superior agent in the whole consultation process. It is important to note that all the institutional and cultural cues are expected by participants in the interactions and are therefore merely regarded as givens. They serve as discourse types of phatic communication, summoning and deference.

6.2.1.2 Linguistic routines

By linguistic routines I mean code-switched choices that are so routinely made by doctors that they are expected at certain points in their speeches. In this case, the linguistic elements are more connected with the doctors' talk style than a strategic language use.

Code selections revealing linguistic routines are found almost exclusively in Diagnostic Interactions and Announcements. The few instances found in Openings occur as nomenclatural prefixes to signal greater age (e.g. 'Baba Sunday Azeez' in Interaction 1). No instance of code-mixing is found in Closing. Good examples of code-mixing that demonstrate linguistic routines are cited below:

(3)

→	27. Patient:	>Bo se bere nipe< mo ni <*kata* [catarrh]. *After kata* yen bi ijo keji ni iba mu mi ojiji>;
		(How it started is that I had catarrah. After catarrah that like days two is malaria caught me suddenly)
		('How it started is that I had catarrh. After the catarrh, on the second day, I had fever all of a *sudden*')
→	28.	<Gbogbo owo ati ese tutu>. Mo lo gba *treatment*. (0.2) Ni ana mo
		(All hand and leg cold. I went to take treatment. In yesterday I)
		('All my hands and legs were cold. I went for treatment. Yesterday I …')

→	29.	*notice* ara riro to <wa tun lagbaa gan> (0.5).	
		(notice body pain that was again serious very)	
		('noticed serious body pains')	
	30.	O tun wa remi, enu mi n koro; <mo *weaki* gan ni>	
		(It again was tired me, mouth my getting bitter. I weak very)	
		('Also I am weak, my mouth is bitter; I am very weak')	
	31.	(0.5)	
→	32. Doctor:	*So, major thing* to ku ni pe o re yin?--	
		(So major thing that remains is that it weak you)	
		('So, the major complaint now is that you are weak')	

CL inserts English 'kata', 'after kata', 'treatment' and 'notice' into his Yoruba speech. Each insertion agrees with grammatical rules in Yoruba, and each of the insertions is recognised as an English word by any competent Yoruba speaker of English as there are alternative Yoruba words for them, for example *finkinfinkin* for 'catarrh' and *iwosan* for 'treatment'. The same applies to Doctor who inserts 'So, major thing'. These instances, and others noticed in the pre and post consultative encounters, show that no strategic intent is in play, given the pattern of code selection that characterises this conversation. Each participant naturally contributes to the conversation with his peculiar style. CL merely objectively describes his state of health and the steps taken while Doctor responds to these by trying to measure the extent to which CL still needs help. In fact, expressions like the following which align with the participants' code-mixed utterances: 'Mo sick' ('I am sick'), 'Mo ni malaria' ('I have malaria fever'), 'Mo ni cold' ('I have cold') are routinely made in Nigerian hospitals. One point to note with respect to the word 'kata', however, is that it is gradually phasing out the Yoruba equivalent *finkinfinkin*, which is hardly known to many children or young adults brought up exclusively in the Western fashion. This development validates Auer & Eastman's (2010) observation that '[b]ilingual talk may not only reflect convergence between two languages but also actively contribute to it, making the two languages more compatible than they used to be'.

6.2.2 Strategic code selection

Strategic code selections are made largely by Doctor, but sometimes by Client as a pragmatic response to certain contextual conditions. In the meetings studied, Diagnostic Interaction accounts for the largest number of instances of this strategy, while Announcement and Closing yield very few instances. No strategic code selection is made in Opening. This could be accounted for by the new encounters in which Doctor and Client are located, which offers them no shared

background knowledge or common ground on which strategic communication could be built. Two pragmatic acts characterise strategic code selections: context-shaping and context-determined acts. Context-shaping acts are indexed by code negotiation cues, while context-determined acts are characterised by institutional and local contextual constraints. I take these factors in turn.

6.2.2.1 Context-shaping acts: Code negotiation cues

Sometimes, codes are negotiated between Doctor and Cient. This situation works in concert with Auer's concept of participant-related code-switching. There is sometimes a contest for the code for a while between Doctor and Client until one of the parties yields to the pressure of the other and switches to the other's code choice. This switch, as will be seen shortly, is shaped by the context of the interaction.

An interesting instance of this code selection strategy is provided in the interaction that follows:

(4)

→	1. Doctor:	((To the attendant)) *Alright, call in the next patient*
	2. Attendant:	Baba ( ) =
		('Mr.')
	3. Patient:	**Sa::**
		('Sir')
	4.	(0.5)
	5. Doctor:	Too Baba, [**sorry**].
		(Oh! elderly man)
		('Oh! old man')
	6. Patient:	[MORING]
	7. Doctor:	*Any problem*? ↑=
	8. Patient:	Ah, Doctor, oh na wa::: o::: na problem dey o::--
		(Ah, Doctor, oh! serious o!. It problem there is o)
		('Ah, Doctor, it is serious; there is a problem!')
	9. Doctor:	**Oh, sorry- sorry**=
	10. Patient:	*A*–
	11. Doctor:	**Sorry** (.)
	12. Patient:	*A:* °This leg <dey trouble me:: well well [seriously>] (.)
		(This leg is troubling me seriously seriously)
		('This leg is troubling me seriously')
	13. Doctor:	[( )] (.)
	14. Patient:	*E::*, na <*yesterday*> this thing happen o (.)
		(It yesterday this thing happen o)
		('It was yesterday this thing happened!')
	15. Doctor:	*Just yesterday*? ↑=
	16. Patient:	EN. *I went to farm yesterday* NOW
		('Yes. I went to the farm yesterday; you see!')

17.	*By the time I came back*, *a* (.) me i no enjoy myself	
		(I, I not enjoy myself)
		('I, I did not enjoy myself')
18. Doctor:	**Sorry** (.)	
19. Patient:	Na *this moring*,<the thing wey dey make an so worry now>	
	(It was this morning, the thing which is making it so worrisome now)	
	('It was this morning, what makes it worrisome now';)	
20.	(.) this moring wen i wake up (.), i don carry my:: hand	
	(This morning, when I woke up, I had carried my hand)	
	('This morning, when I woke up, I lifted my hand,')	
21.	<no do- no gree>	
	(Not move – not agree)	
	('It did not co-operate')	
→ 22. Doctor:	He no gree carry am! (.)	
	(It not agree carry it)	
	('It did not co-operate!')	

Doctor opens the consultation in a mixture of Yoruba (Too Baba) and NE (**sorry**). 'Sorry' in NE is used to sympathise with an addressee whether or not one is responsible for their mishap, which differs from the use of the word in Standard English. Client responds in Pidgin (Moring). In the Diagnostic Interaction, Doctor makes his Broad Request in English (line 7), but Client supplies his Echoic Information in Pidgin (line 8). Client here merely reformulates Doctor's question and circumlocutes with the clause NA 'problem dey' which does little to address Doctor's question. Doctor switches to NE in his Interjection (**Oh, sorry, sorry**, line 9), but Client insists on Pidgin in his Condition Specific Information (lines 12 and 14). Doctor continues in English in the subsequent Cue-based Response (line 15), but Client sticks with Pidgin with little intervening Standard English (line 16). The insistence of Client on his code choice eventually influences a switch from Doctor who sees the need to strike a linguistic association with Client at the critical point of the encounter, i.e. when Client is providing a historical account of the ailment (lines 19–21).

Doctor eventually submits to the linguistic sway of Client to be able to allow him to relate well with him and allow him more freedom with his preferred code. But Doctor, after this submission, occasionally switches to English as the exchanges progress. One reason for this is Doctor's limited competence in Pidgin as shown in his expressions. His 'He no gree carry am', for example, should, in Pidgin, be expressed as, 'He no gree make u carry am'. So when Doctor says:

(5) <*Anyway*> (.). *But have you::* (.) *ever visited any hospital in the past*?—

it is most likely that he could not reach for the right Pidgin expression to convey his point. The same happens in his next Cue-based Response:

(6)

Doctor:	[*And did they tell you your*]
Patient:	[dey worry me]
	(is worrying me)
Doctor:	blood pressure is high? =

But Client's insistence on Pidgin brings him back to Client's code preference in his confirmatory check on Client's hypertensive condition:

(7)

Dem no tell you –
(They not tell you)
('They did not tell you')

The conversation, by and large, shows that Doctor tries partly to accommodate the client's code choice despite his institutional power to be able to ensure a successful professional transaction. A similar situation has been noted by Myers-Scotton (1993).

6.2.2.2 Context-determined acts

The two context-determined acts, institutional contextual constraints and local contextual constraints are taken in turn.

6.2.2.2.1 Institutional contextual constraints

Institutional contextual constraints, which occur only in Diagnostic Interaction and Announcement, are acts determined by the rapport between the norms of medical practice and the context of doctor–client interactions. In example (8), the institutional contextual constraint is revealed through the informing discourse type at the Diagnostic Interaction stage. This involves a switch between Pidgin English and Standard English. It thus exemplifies Auer's discourse-related code-switching. It happens at the point where Doctor and Client share information about Client's hypertensive condition:

(8)

49. Doctor:	[And did they tell you your]
50. Patient:	[dey worry me]
	('They were worrying me')

51. Doctor:	blood pressure is high? =	
52. Patient:	No=	
53. Doctor:	Dem no tell you –	
	('They did not tell you')	
54. Patient:	No, dem no tell me *A:*(.)	
	(No, they not tell me)	
	('No, they did not tell me')	
→ 55. Doctor:	As the thing be now (.). Okay. I will look into your problem. I will examine	
	('As the thing is now')	
56.	you; you understand, and be able to see. But as i be now, you no fit carry your leg and hand (.)=	
	(But as it is now, you not can carry your leg and hand)	
	('But, as it is now, you cannot move your leg and hand')	

Doctor demanded to know if the diagnosis of high blood pressure had been announced to Client earlier (lines 49–53). Client's Condition Specific Information, in Pidgin, indicates otherwise. All along, Doctor had interacted with Client in his chosen code, i.e. Pidgin. He attempts to continue under the influence of this imposition at the moment he embarks on explaining Client's condition and analysing the prognosis of his condition, spurred by Client's Condition Specific Information (line 54) and expression of pain (*a:*) when he says, 'As the thing be now,' but there is a frame shift with Doctor's sudden switch to English (line 55). After a brief pause, he changes the direction of his discourse, perhaps considering the needlessness of pursuing the prognostic explanations, given Client's limited education, which might turn the whole effort into a clumsy verbalisation, especially because Doctor himself has limited Pidgin. He then prioritises healing as Client's ultimate goal and abandons the information process he had attempted to embark upon. This change is signalled by the transition marker 'okay' (line 55), which is followed immediately by an English utterance: 'I will look …'. At this point, he intends to demonstrate his competence to assure the client of ability to heal him. To do this successfully, he has to push aside his poor Pidgin. He thus takes up his power as a doctor and speaks authoritatively to Client. But as soon as he completes this act, he comes back to Pidgin, which he alternates with English up to the end of the Diagnostic Interaction.

6.2.2.2.2 Local contextual constraints

By local contextual constraints I mean pragmatic conditions, other than institutional constraints, as seen in 6.2.2.3, that influence utterances within the immediate situation of talk. These factors, in the context of doctor–client first meet-

ings, have little to do strictly with doctoral authority; rather they work more closely with the variables of the situation and the goal of the encounter as designed by either party. Unlike the acts under institutional constraints which can be performed by almost any Doctor, given the same condition, acts here depend strictly on the individual doctor's approach and the affordances of the context. Local contextual constraints are features, largely, of Diagnostic Interaction. However, very few instances are observed in Announcement and Closing. An interesting demonstration of these constraints is observed in the following interaction:

(9)

	16. Doctor:	Se ese re ko wu?=
		(Does leg you not swell?)
		('Is your leg swollen?')
	17. Patient:	Ko wu=
		(It not swell)
		('It is not swollen')
	18. Doctor:	Kin lo ti lo si i?=
		(What you have used to it?)
		('What have you been using?')
	19. Patient:	Mo ti lo oogun si i. Oogun Yo'oba ni mo saaba maa n lo si i.
		(I have used medications to it. Medications Yoruba are I mostly used to it)
		('I have used medications. I have mostly used Yoruba medications')
→	20. Doctor:	**O::kay:** @
	21. Patient:	(said no word, but stared at the doctor)

When asked here about the medications he has taken since the onset of the illness (line 18), the client digresses, 'Mo ti lo oogun si i,' using an avoidance strategy. He flouts the Gricean maxim of quantity, but observes the maxims of relation, quality and manner. He addresses Doctor's Cue-based Response, but Doctor requires more definite Condition Specific Information which Client hesitates to supply. He provides this in his next statement, 'Oogun Yo'oba ni mo saaba maa n lo si i,' which again is not specific enough but is adequate for Doctor's needs at that point. Doctor's elongated '**okay**' (a switch to English), with a laugh not warranted at this critical point of the interaction, said as a response to this Condition Specific Information is not neutral. In actual fact, with the laugh, it carries Doctor's denigration of traditional medicine. It is an NE expression for 'I can see why'. It therefore conveys Doctor's conclusion about the prolongation of Client's condition. This consideration turns the expression into a face-saving strategy. Damage could be done to Client's negative face if the statement is made uneconomically in Yoruba: 'A bajo ti aisan re

fi pe' ('No wonder your sickness has lasted so long'). Gaining an uptake of Doctor's criticism and contempt of the therapy he had undergone, Client's silence and stare at Doctor's face could be said to imply his admittance of Doctor's covert charges.

I have argued earlier in this paper that contrary to some opinions in the literature, code-mixing can be used to perform strategic functions. A good example is offered in Nigerian sexual discourse. Many Nigerian adults, especially married males, are shy to tell pharmacists or chemists that they want to buy 'condoms' because it is associated with heterosexuality. To avoid the attendant stigma, many of these men prefer to say, 'Mo fe ra CD' (I want to buy CD), playing on the double meaning of the computer 'CD' and the private abbreviation of 'condom', the knowledge of which they share with many of the salespeople, to prevent other customers form accessing knowledge of the object of their purchase. This type of strategic use of code-mixing is carried into the consultative context of the Nigerian hospital. When it occurs, it foregrounds participants' (usually Clients') points. Some interesting instances can be found in the interaction below, which is basically in Yoruba:

(10)

	27. Patient:	>Bo se bere nipe< mo ni <kata [catarrh]. After kata yen bi ijo keji ni iba mu mi ojiji>;
		'How it started is that I had catarrh. After catarrh that like second day was malaria caught me suddenly')
		('How it started is that I had catarrh. After the catarrh, on the second day, I had fever all of a sudden)
	28.	<Gbogbo owo ati ese tutu>. Mo lo gba treatment. (0.2) Ni ana mo
		('all my hands and legs were cold. I went for treatment. Yesterday I
	29.	notice ara riro to <wa tun lagbaa gan> (0.5).
		(noticed serious body pains')
→	30.	O tun wa remi, enu mi n koro; <mo weaki gan ni>
		('Also I am weak, my mouth is bitter; I am very weak')
	31.	(0.5)
	32. Doctor:	*So, major thing*to ku ni pe o re yin?--
		('So, the major complaint now is that you are weak')
→	33. Patient:	O re mi. Mo weaki (.)
		(It weak me. I weak)
		('I am weak. I am weak')

'Kata', 'treatment', 'notice', and 'so major thing' play no strategic roles in the interaction as observed earlier. However, 'weak[i]', repeated twice is strategic. Client has earlier, in line 30, expressed his weakness in Yoruba: 'O tun wa remi'; then in English: 'Mo weak[i]'. The same is repeated in line 33: 'O remi; mo weaki'. Client's repetition of his present health condition in English works

to foreground his point, which he believes could best be told to an orthodox practitioner in Nigeria in English, which is generally recognised as the language of doctors' training, and which patients often believe gives a clearer picture of their conditions to doctors. This clicks the right space as Doctor is able to pick the import of the emphasis and then repeat the condition in Yoruba, and not in English: 'So major thing to ku ni pe o re yin'. His response in Yoruba, and his consistency in the choice of Yoruba to describe Client's state of health, seems to contradict Client's belief about the Nigerian bio-medical institution's identification with English. Doctor is more dynamic in his choice of codes. The prefatory part of his Cue-based Request is performed in English ('So, major thing'), but the main issue is constructed in Yoruba ('ni pe o n reyin') which is CL's native language, and which Doctor sees as a better code to negotiate the common ground with Client.

At this point, I turn to the strategic use of code-switching. Codes in this capacity occur between English and Yoruba, English and Pidgin, and Standard English and Nigerian English. At the stage of Diagnostic Interaction or Announcement, participants switch their codes to relax, flaunt, assure, joke and warn.

During Diagnostic Interaction in the conversation that follows, Doctor reaches for a joke (Pleasantries) as a device to relax the tension of Clients:

(11)

	1. Doctor:	*Good evening. What's wrong with your baby?–*
	2. Father:	*It's cold and stooling, – and the stooling is frequent* (.)
	3. Doctor:	*For how long has she been stooling like that? =*
	4. Mother:	*For about 24 hours now* (.)
	5. Doctor:	*What have you used for her? =*
	6. Mother:	*I've been giving her ORT –*
		('Oral therapy')
	7. Doctor:	*Does she take it well? =*
	8. Mother:	*She has finished a sachet.*
	9. Doctor:	(Feels the baby's body) (.)
	10.	*Does she run temperature?–*
	11. Mother:	*Not really –*
→	12. Doctor:	((comically)): *Well*, omo yin fe jagbado ni=
		(baby your wants eat maize)
		('your baby wants to eat maize')
	13.	[☺]
	14.	(0.5)
→	15.	*She's praying for another set of teeth. She'll be okay.*
	16.	((writes his prescription))
	17.	(0.9)

After Doctor has taken the baby's diaorrhea (stooling) history, he switches from English to Yoruba at the point he is expected to move to Announcement. Doctor's switch to Yoruba at line 12 is a joke (a pleasantry), '... omo yin fe jagbado ni' introduced at a critical point in the Diagnostic Interaction. This is effective because both Doctor and the parents or clients laugh, recognising the punch line of the joke. The switch is strategic as it changes the footing of the interaction; it helps to cheer up the parents who are worried about the health condition of their baby. The joke is built on the (superstitious) belief among the Yoruba that a baby would fall ill constantly when s/he is growing teeth. This is equally linked with the desire of the baby to participate in the annual consumption of maize in the particular year, as believed by the Yoruba. Doctor, however, performs a further pragmatic act. Even when Clients laugh, which may be a response to the switch to Yoruba or to the punch line of the joke, he reformulates by a switch to English for a clearer meaning (line 15: 'She is praying for another set of teeth')

Finally, Doctors, after interactively establishing the linguistic competence of certain clients, code-switch, having reckoned that another code might be more effective in expressing their perspective. The following interaction provides an excellent example:

(12)

8. Doctor:	Kin lo n se o?--	
	(What is doing you?)	
	('What is the problem with you?')	
9. Patient:	*Malaria*ni--	
	(Malaria is)	
	('It is malaria fever')	
10. Doctor:	Lati igba wo?--	
	('Since when?')	
11. Patient:	Yio ti to *last week* (.)	
	(It should have been last week)	
	('It should be since last week')	
12. Doctor:	Oogun wo lo lo nigba yen?–	
	(Medications which you used at that time?)	
	('What drug did you use then?')	
13. Patient:	*Fansida*=	
14. Doctor:	O de lo o tan↑ Se e se *LAUTECH*?=	
	(You and used it finish? Is it not LAUTECH?)	
	('And you completed the dose. Is it LAUTECH?')	
15. Patient:	Bee ni–	
	('Yes')	
→ 16. Doctor:	*Nowadays, you don't treat Malaria on your own; the resistance is*	

17. *high=*
18. Patient: *Yes sir.*

'Malaria' and 'Fansidar', selected by Client, are not strategic. But Doctor changes the footing of the interaction with the switch to English: 'Nowadays, you don't treat Malaria on your own; the resistance is high', by moving from the discourse type of informing to that of warning. He is able to locate the competence of Client to cope with full English from his Cue-based Request: 'Se e se LAUTECH' (enrichable as 'Are you a student of LAUTECH'), to which Client responds: 'Beeni'. 'LAUTECH' (Ladoke Akintola University of Technology) is the only university in the town where the hospital is situated. Doctor's decision to switch is therefore built on the assumption that a university student in Nigeria should speak and understand English well. This is confirmed in Client's prompt switch to English: 'yes sir'. Doctor has reckoned the medium of English the best to communicate with the elite group, especially higher institution students in Nigeria whose competence in their native languages is sometimes very poor. The English medium is therefore considered the most appropriate container for the warning Doctor intends to get across.

7 Conclusion

It has been shown in the analysis and findings that four stages characterise doctor–client interactions at first meetings in Nigerian hospitals: Opening, Diagnostic Interaction, Announcement and Closing. While Diagnostic Interaction is obligatory, all the others are optional. Each of the stages is characterised by sub-stages/units that are largely optional.

Two code selection techniques, developed from the literature on code alternation and theoretical insights from AT and DT, run through the generic structure of the interactions, namely, non-strategic and strategic. Non-strategic choices are guided by cultural, institutional linguistic routines while strategic choices are characterised by context-shaping and context-determined acts. Unlike non-strategic choices which occur at different stages in the consultations, strategic choices occur only in Diagnostic Interactions and Announcements. Codes are selected at the non-strategic level to express phatic communion, indicate deference, display personal styles and accommodate dispreferred code choices. At the strategic level, they are employed to relax tension, flaunt competence, assure, save face, joke, reformulate and warn.

While DT is evident in the two code selection strategies, AT, especially as systematised by Thomas (1995) is more pronounced in the strategic than the

non-strategic approach. The latter manifests institutional, cultural and linguistic discourse types influenced by the goals of the participants and awareness of institutional power. The former takes into account the whole of Thomas' (1995) AT heuristic: the goals of the participants; the amount of the contributions allowed, turn-taking and topic control considerations and the manipulation of pragmatic parameters which bend power scale to the doctor; and observance/non-observance of Gricean and interpersonal maxims which get participants engaged in context-sensitive goal negotiations.

Overall, the phenomenon of code selection in Nigerian hospitals reflects the multi-code nature of the interactions, shows the culture–institution nexus that governs the meetings, reveals linguistic flexibilities despite the dominance of English in the Nigerian orthodox medical institution and presents a context-sensitive communicative terrain that permits linguistic and goal negotiations. The several codes in the encounters are thus shown to give context-controlled impressions which ultimately constrain the discourse choices made by participants. Future research can compare codes at first and subsequent meetings, and investigate the point of contact between first meetings in African and Western hospital interactions.

Bionote

Akin Odebunmi is Senior Lecturer in the Department of English at the University of Ibadan, Nigeria. His research interests are in Pragmatics, Semantics and Medical Discourse. Some of his recent publications are 'A pragmatic reading of Ahmed Yerima's proverbs in *Yemoja, Attahiru* and *Dry Leaves on Ukan Trees*' (in *Intercultural Pragmatics*, 2006), 'Locutions in medical discourse in Southwestern Nigeria' (in *Pragmatics*, 2006), 'Ideology and body part metaphors in Nigerian English' (in *Review of Cognitive Linguistics*, 2010), "'Concealment in consultative encounters in Nigerian hospitals' (in *Pragmatics*, 2011), '"The baby dey chuk chuk": Language and emotions in doctor–client Interaction' (in *Pragmatics and Society*, 2012) and 'Participation configuration in a Nigerian university campus' (in *Pragmatics and Cognition,* 2012).

References

Adegbija, E. & A. Ofuya (eds.). 1996. *English language and communication skills for medical, engineering, science, technology and agriculture students*. Ilorin: University of Ilorin Press.

Adegbite E. 2009. Corporate governance in Nigeria. *Journal of Corporate Governance* 1(1). 45–48.

Akpata, E. S. (ed.). 1982. *Medical ethics*. Lagos: Lagos University Press.

Auer, Peter. 1984. *Bilingual conversation*. Amsterdam: Benjamins.

Auer, Peter. 1988. A conversation analytic approach to code-switching and transfer. In Monica Heller (ed.), *Codeswitching: Anthropological and sociolinguistic perspectives*. 53–74. Berlin: Mouton de Gruyter.

Auer, Peter. 1990. A discussion paper on code alternation. In European Science Foundation, Network on Code-switching and Language Contact, Papers for Workshop on Concepts, Methodology and Data, Basel, January 12–13, 1990. 69–89.

Auer, Peter. 1995. The pragmatics of code-switching: a sequential approach. In L. Milroy & P. Muysken (eds.), *One speaker, two languages: Cross-disciplinary perspectives on code-switching*. 115–135. Cambridge: Cambridge University Press.

Auer, Peter. 1998a. Introduction: Bilingual conversation revisited. In P. Auer (ed.), *Code-switching in conversation*. London: Routledge, 1–24.

Auer, Peter (ed.). 1998b. *Code-switching in conversation*. London: Routledge.

Auer, Peter. 1999. From code-switching via language mixing to fused lects: Toward a dynamic typology of bilingual speech. *The International Journal of Bilingualism* 4(3). 309–332.

Auer, Peter. 2009. Bilingual Conversation. In N. Coupland & A. Jaworski (eds.), *The new sociolinguistics reader*. 491–511. Basingstoke: Palgrave Macmillan.

Auer, Peter & Carol M. Eastman. 2010. Code-switching. In Jürgen Jaspers, Jan-Ola Ostman & Jef Verschueren (eds.), *Society and language use*. 84–112. Amsterdam: John Benjamins.

Bales, Robert Freed. 1950. Interaction process analysis: A method for the study of small groups. Cambridge, Mass.: Addison-Wesley.

Bamgbose, A. 1982. Standard Nigerian English: Issues of identification. In Braj B. Kachru (ed.), *The other tongue: English across cultures*. 148–161. Urbana: University of Illinois Press.

Bamgbose, Ayo, Ayo Banjo & AndrewThomas (eds.). 1995. *New Englishes: A West African perspective*. Ibadan: Mosuru Publishers.

Baredo, Imma Munoa. 2000. Pragmatic functions of code-switching among Basque–Spanish bilinguals. *Actas do i Simposio Internacional Sobre o Bilingüismo*. 528–541.

Barker, G. C. 1975. Social functions of language in a Mexican–American community. In E. Hernández-Chavez, A. D. Cohen & A. F. Beltramo (eds.), *El Lenguage de los Chicanos: Regional and Social Characteristics of Language used by Mexican Americans*. 170–182. Arlington, VA: Center for Applied Linguistics.

Bendix, E. (ed.). 1990. *The uses of linguistics: Annals of the New York Academy of Sciences*. New York: New York Academy of Sciences.

Bialystok, E. 2001. *Bilingualism in development*. Cambridge: Cambridge University Press.

Blom, J.-P. & J. J. Gumperz. 1972. Social mixing in linguistic structures: Code-switching in Norway. In J. J. Gumperz & D. Hymes (eds.), *Directions in sociolinguistics*. 407–434. New York: Holt Rinehart & Winston.

Boden, Deirdre & Don H. Zimmerman (eds.). 1991. *Talk and social structure: Studies in ethnomethodology and conversational analysis*. Cambridge: Cambridge University Press.
Bourdieu, P. 1991. *Language and symbolic power*. Edited by B. Thompson, translated by G. Raymond & M. Adamson. Cambridge: Polity Press.
Boztepe, Emma. 2003. Issues in code-switching: Theories and models. *Working Papers in TESOL and Applied Linguistics* 3(2). 1–27.
Byrne, P. S. & B. E. I. Long. 1976. *Doctors talking to patients: A study of the verbal behaviour of general practitioners consulting in their surgeries*. London: Royal College of General Practitioners.
Clark, Herbert. 1992. *Arenas of language use*. Chicago: University of Chicago Press.
Cole, P. & J. L. Morgan (eds.). *Syntax and semantics*, Volume 3: Speech acts. New York: Academic Press.
Collins, M. 1983. *Communication in health care*. Toronto: The CV Mosby Company.
Collins, James & Stef Slembrouck. 2007. 'You don't know what they translate': Language contact, institutional procedure, and literacy practice in neighbourhood health clinics in urban Flanders. *Journal of Linguistic Anthropology* 16. 249–268.
Coupland, N. & A. Jaworski (eds.). 2009. *The new sociolinguistics reader*. Basingstoke: Palgrave Macmillan.
Culpeper, Jonathan, Robert Crawshaw & Julia Harrison. 2008. 'Activity types' and 'discourse types': Mediating 'advice' in interactions between foreign language assistants and their supervisors in schools in France and England. *Multilingua* 27. 297–324.
Dale, Andrew, Anne Davies & Li Wei. 1997. Developing a typology of rapists' speech. *Journal of Pragmatics* 27. 653–669.
Davidson, Brad. 1998. Interpreting Medical Discourse: a Study of Cross-linguistic Communication in the Hospital Clinic. Doctoral Dissertation, Department of Linguistics, Stanford University.
Davidson, Brad. 2002. A model for the construction of conversational common ground in interpreted discourse. *Journal of Pragmatics* 34. 1273–1300.
Drew, P. & J. Heritage (eds.). 1992. *Talk at work: Interaction in institutional settings*. Cambridge: Cambridge University Press.
Dussias, P. E. 2001. Sentence parsing in fluent Spanish English bilinguals. In J. L. Nicol (ed.), *One mind, two languages*. 159–176. Oxford: Blackwell.
Essien, Okon. E. 1995. The English language and code-mixing: A case study of the phenomenon in Ibibio. In Ayo Bamgbose, Ayo Banjo & AndrewThomas (eds.), *New Englishes: A West African perspective*. 260–283. Ibadan: Mosuru Publishers.
Fisher, Sue & Stephen Groce. 1990. Accounting practices in medical interviews. *Language in Society* 19. 225–250.
Freemon, B., V. F. Negrete, M. Davis & B. M. Korsch. 1971. Gaps in doctor–patient communication: Doctor–patient interaction analysis. *Pediatric Research* 5. 298–311.
Giles, H., W. Robinson & P. Smith (eds.). 1980. *Language: Social psychological perspectives*. New York: Pergamon Press.
Gladwin, T. & W. C. Sturtevant (eds.). 1962. *Anthropology and human behavior*. Washington: The Anthropology Society of Washington.
Grice, H. P. 1975. Logic and conversation. In P. Cole & J. L. Morgan (eds.), *Syntax and semantics*, Volume 3: Speech acts, 41–58. New York: Academic Press.
Grosjean, F. 1997. Processing mixed language: Issues, findings and models. In A. M. B. de Groot & J. F. Kroll (eds.), *Tutorials in bilingualism: Psycholinguistic perspectives*. 225–254. New York: Lawrence Erlbaum Associates.

Groot, A. M. B. de & J. F. Kroll (eds.). 1997. *Tutorials in bilingualism: Psycholinguistic perspectives*. New York: Lawrence Erlbaum Associates.
Gumperz, John. 1982. *Discourse strategies*. Cambridge: Cambridge University Press.
Gumperz, J. J. & D. Hymes (eds.). 1972. *Directions in sociolinguistics*. New York: Holt Rinehart & Winston.
Gunnarsson, Britt-Luise & Per Linell (eds.). 1997. *The construction of professional discourse*. London & New York: Longman.
Hall, J. A., J. T. Irish, D. L. Roter & C. M. Ehrlich. 1994. Gender in medical encounters: An analysis of physician and patient communication in a primary care setting. *Health Psychology* 13. 384–392.
Halliday, M. A. K. & R. Hassan. 1989. *Language, context and text: Aspects of language in a social-semiotic perspective (2nd edition)*. Oxford: Oxford University Press.
Heller, Monica (ed.). 1988. *Codeswitching: Anthropological and sociolinguistic perspectives*. Berlin: Mouton de Gruyter.
Helm, David, Tim Anderson, Albert Meehan & Anne Rawls (eds.). 1989. *The interactional order*. New directions in the study of social order. New York: Irvington.
Heritage, John & Douglas Maynard. 2006. *Communication in medical care: Interaction between primary care physicians and patients*. Cambridge: Cambridge University Press.
Hernández-Chavez, E., A. D. Cohen & A. F. Beltramo (eds.). 1975. *El Lenguage de los Chicanos: Regional and Social Characteristics of Language used by Mexican Americans*. Arlington, VA: Center for Applied Linguistics.
Hill, J. H. & K. C. Hill. 1986. *Speaking Mexicano: Dynamics of syncretic language in Central Mexico*. Tuscon: University of Arizona Press.
Hymes, Dell. 1962. The ethnography of speaking. In T. Gladwin & W. C. Sturtevant (eds), *Anthropology and human behavior*. 13–53. Washington: The Anthropology Society of Washington.
Jaspers, Jürgen, Jan-Ola Ostman & Jef Verschueren (eds.). 2010. *Society and language use*. Amsterdam: John Benjamins.
Kachru, Braj B. (ed.). 1982. *The other tongue: English across cultures*. Urbana: University of Illinois Press.
Korsch, B. M., E. K. Gozzi, E. K. & V. Francis. 1968. Gaps in doctor–patient communication: I. doctor–patient interaction and patient satisfaction. *Pediatrics* 42. 855–871.
Korsch, B. M. & V. F. Negrete. 1972. Doctor–patient communication. *Scientific American* 227. 66–74.
Leanza, Yvan. 2005. Roles of community interpreters in pediatrics as seen by interpreters, physicians and researchers. *Interpreting* 7(2). 167–192.
Leung, Chi-Hong. 2010. An empirical study on code mixing in print advertisements in Hong Kong. *Asian Journal of Marketing* 4. 49–61.
Levinson, S. C. 1979. Activity types and language. *Linguistics* 17. 365–399.
Levinson, S. C. 1992. Activity types and language. In P. Drew & J. Heritage (eds.), *Talk at work*: Interaction in institutional settings. 66–100. Cambridge: Cambridge University Press.
MacSwan, J. 2000. The architecture of the bilingual language faculty: Evidence from intrasentential code switching. *Bilingualism, Language and Cognition* 3(1). 37–54.
March, James. 1988a. Bounded rationality, ambiguity and engineering of choice. In J. March (ed.), *Decisions and organisations*. Oxford: Blackwell.
Maynard, Douglas W. 1989. Notes on the delivery and reception of diagnostic news regarding mental disabilities. In David Helm, Tim Anderson, Albert Meehan & Anne

Rawls (eds.), *The interactional order. New directions in the study of social order*. 54–67. New York: Irvington.
Maynard, Douglas W. 1991a. Deliveries of diagnosis and problems of meaning. Lecture sessions, University of Amsterdam.
Maynard, Douglas W. 1991b. Interaction and asymmetry in clinical discourse. *American Journal of Sociology* 97. 448–495.
Maynard, Douglas W. 1991c: The perspective–display series and the delivery and receipt of diagnostic news. In Deirdre Boden & Don H. Zimmerman (eds.), Talk and social structure: *Studies in ethnomethodology and conversational analysis*. 164–192. Cambridge: Cambridge University Press.
Maynard, Douglas W. 1992. On clinicians co-implicating recipients' perspective in the delivery of diagnostic news. In Paul Drew & John Paul Heritage (eds.), *Talk at work: Social interaction in institutional settings*. 331–358. Cambridge: Cambridge University Press.
Maynard, Douglas W. 2003. Bad news good news: *Conversational order in everyday talk and clinical settings*. Chicago, IL: Chicago University Press.
Maynard, Douglas W. 2004. On predicating a diagnosis as an attribute of a person. *Discourse Studies* 6(1). 53–76.
Maynard, Douglas & John Heritage. 2005. Conversation analysis, doctor–patient interaction and medical communication. *Medical Education* 39. 428–435.
Mey, J. 2001. *Pragmatics: An introduction*. Oxford: Blackwell Publishers.
Milroy, L. & Li Wei. 1995. A social network approach to code-switching. In L. Milroy & P. Muysken (eds.), *One speaker, two languages*. 136–157. Cambridge: Cambridge University Press..
Milroy, L. & P. Muysken (eds.). 1995. One speaker, two languages: Cross-disciplinary perspectives on code-switching. Cambridge: Cambridge University Press.
Mishler, Eliot G. 1984. *The discourse of medicine: Dialectics of medical interviews*. Norwood, NJ: Ablex Publishing.
Mishler, Eliot. 1997. *The interactional construction of narratives in medical and life-history interviews*. In Britt-Luise Gunnarsson & Per Linell (eds.), The construction of professional discourse, 223–245. London & New York: Longman.
Mondada, Lorenza. 1998. Therapy interactions: Specific genre or 'blown up' version of ordinary conversational practices. *Pragmatics* 8(2). 155–165.
Moyer, M. G. 1998. Bilingual conversation strategies in Gibraltar. In P. Auer (ed.), *Code-switching in conversation*. London: Routledge.
Mundy-Castle, A. C. 1982. *Medical ethics: A psychologist's view*. In E. S. Akpata (ed.), Medical ethics, 17–20. Lagos: Lagos University Press.
Muyksen, P. 2000. *Bilingual speech: A typology of code-mixing*. Cambridge: Cambridge University Press.
Myers-Scotton, Carol. 1980. Explaining linguistic choices as identity negotiation. In H. Giles, W. Robinson & P. Smith (eds.), *Language: Social psychological perspectives*. 359–366. New York: Pergamon Press.
Myers-Scotton, Carol. 1983. The negotiation of identities in conversation: A theory of markedness and code choice. *Journal of the Sociology of Language* 44. 115–136.
Myers-Scotton, Carol. 1987. Code-switching and types of multilingual communities. In P. Lowenberg (ed.), *Georgetown University Roundabout on Languages and Linguistics*. 61–82. Washington DC: Georgetown University Press.

Myers-Scotton, Carol. 1988. Codeswitching as indexical of social negotiations. In M. Heller (ed.), *Codeswitching: Anthropological and sociolinguistic perspectives*. Berlin: Mouton de Gruyter.

Myers-Scotton, Carol. 1992. Comparing code-switching and borrowing. *Journal of Multilingual and Multicultural Development* 13. 19–39.

Myers-Scotton, Carol. 1993. *Social motivations of code-switching*. Oxford: Clarendon.

Myers-Scotton, Carol. 1998a. A theoretical introduction to the markedness model. In C. Myers-Scotton (ed.), *Codes and consequences: Choosing linguistic varieties*. 18–38. New York: Oxford University Press.

Myers-Scotton, Carol (ed.). 1998b. *Codes and consequences: Choosing linguistic varieties*. New York: Oxford University Press.

Myers-Scotton, Carol. 1999. Explaining the role of norms and rationality in code-switching. *Journal of Pragmatics* 32. 1259–1271.

Myers Scotton, C. & J. L. Jake. 2001. Explaining aspects of code switching and their implications. In J. L. Nicol (ed.), *One mind, two languages*. 84–116. Oxford: Blackwell.

Myers Scotton, C. & W. Ury. 1977. Bilingual strategies: The social functions of code-switching. *International Journal of the Sociology of Language* 13. 5–20.

Nicol, J. L. (ed.). 2001. *One mind, two languages*. Oxford: Blackwell.

Nilep, Chad. 2006. Code-switching. *Sociocultural Linguistics Colorado Research in Linguistics* 16.

Odebunmi, Akin. 1996. Abbreviation and acronyms in MESTA texts. In E. Adegbija & A. Ofuya (eds.), *English language and communication skills for medical, engineering, science, technology and agriculture students*. 248–261. Ilorin: University of Ilorin Press.

Odebunmi, Akin. 2005. Politeness and face management in hospital conversational interactions in south-western Nigeria. Ibadan: *Journal of English Studies* 2. 1–22.

Odebunmi, Akin. 2006. Locutions in medical discourse in Southwestern Nigeria. *Pragmatics* 16(1). 25–41.

Odebunmi, Akin. 2008. Pragmatic strategies of diagnostic news delivery in Nigerian hospitals. *Linguistik Online* 36(4). 21–37.

Odebunmi, Akin. 2012. 'The baby dey chuk chuk': Language and emotions in doctor–client interaction. *Pragmatics and Society* 3(1). 120–148.

Oloruntoba-Oju, T. 1996. Aspects of communication in the medical class. In E. Adegbija & A. Ofuya (eds.), *English language and communication skills*. 187–201. Ilorin: University of Ilorin Press.

Peräkylä, A. 1995. *Aids counselling: Institutional interaction and clinical practice*. Cambridge: Cambridge University Press.

Peräkylä, A.1998. Authority and accountability. The delivery of diagnosis in primary health care. *Social Psychology Quarterly* 61(4). 301–320.

Poplack, S. 1980. 'Sometimes I'll start a sentence in English y termino en espanol': Toward a typology of code-switching. *Linguistics* 18. 581–618.

Poplack, S. 1993. Variation theory and language contact. In D. Preston (ed.), *American dialect research: An anthology celebrating the 100th anniversary of the American Dialect Society*. 251–286. Amsterdam: Benjamins.

Preston, D. (ed.). 1993. *American dialect research: An anthology celebrating the 100th anniversary of the American Dialect Society*. Amsterdam: Benjamins.

Roter, D. L. & J. A. Hall. 1992. *Doctors talking with patients/patients talking with doctors: Improving communication in medical visits*. Westport, CT: Auburn House.

Salazar Orvig, Anne. 1998. Interpreting and diverging in clinical interviews. *Pragmatics* 8(2). 167–184.
Sarangi, Srikant. 2000. Activity types, discourse types and interactional hybridity: The case of genetic counselling. In S. Sarangi & M. Coulthard (eds,), *Discourse and social life*. 1–27. London: Pearson.
Sarangi, Srikant. 2004. *Language/activity: Observing and interpreting ritualistic institutional discourse*. Cashiers de Linguistique Francaise 26. 135–150.
Sarangi, S. & M. Coulthard (eds.). 2000. *Discourse and social life*. London: Pearson.
Sarangi, S. & C. Roberts (eds.). 1999. *Talk, work and institutional order: Discourse in medical, mediation and management settings*. Berlin: Mouton de Gruyter.
Sarangi, Srikant & Stef Slembrouck. 1996. *Language, bureaucracy and social control*. London: Longman.
Shaw; Jane R., Cindy L Adams, Brenda N. Bonnett, Susan Larson & Debra L. Roter. 2004. Use of the Roter Interaction Analysis System to analyze veterinarian–client–patient communication in companion animal practice. *Journal of the American Veterinary Medical Association* 225(2). 222–229.
Shin, Sun-Young. 2010. The functions of code-switching in a Korean Sunday school. *Heritage Language Journal* 7(1). 91–116.
Tanner, B. 1976. *Language and communication in general practice*. London: Hodder Stoughton.
Tay, Mary. 1989. Code-switching and code-mixing as a communicative strategy in multilingual discourse. *World Englishes* 8(3). 407–417.
ten Have, Paul. 1989. The consultation as a genre. In Brian Torode (ed.), *Text and talk as social practice*. 427–453. Dordrecht: Foris Publications.
Thomas, Jenny. 1995. *Meaning in interaction: An introduction to pragmatics*. London & New York: Longman.
Todd, Alexandra D. 1984. The prescription of contraception. *Discourse Processes* 7. 171–200.
Torode, Brian (ed.). 1989. *Text and talkas social practice*. Dordrecht: Foris Publications.
Wadensjö, Cecilia. *Interpreting as interaction*. London & New York: Addison Wesley Longman.
Yamamoto, M. 2001. *Language use in interlingual families: A Japanese–English sociolinguistc study*. Clevedon, Bristol: Multilingual Matters, Ltd.
Zentella, A. C. 1990. Integrating qualitative and quantitative methods in the study of bilingual code-switching. In E. Bendix (ed.), *The uses of linguistics: Annals of the New York Academy of Sciences*. 75–92. New York: New York Academy of Sciences.
Zentella, A. C. 1997. *Growing up bilingual*. Oxford: Blackwell Publishers.