

CODE SELECTION AT FIRST MEETINGS: A PRAGMATIC ANALYSIS OF DOCTOR-CLIENT CONVERSATIONS IN NIGERIA¹

Akin Odebunmi

(Fellow of the Humboldt Foundation at FRIAS, University of Freiburg, Germany, & University of Ibadan, Nigeria)

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Abstract

Existing studies on doctor-client interactions have mainly focused on monolingual encounters and the interactional effects and functions of the languages used in the communication between doctors and their clients. These studies have neither examined the several codes employed in single encounters and their pragmatic roles nor given attention to communication at doctor-client first meetings. This paper closes this vacuum by cataloguing the generic structure of the interactions at first meetings in Nigerian hospitals and examining the pragmatic features and functions of the codes used by doctors and clients at the different units of the generic structure. Ten interactions were

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sampled from 75 audio-recorded doctor-client interactions in selected state government-owned and private hospitals in Southwestern Nigeria. The transcripts were analysed with insights from theoretical perspectives on code selection, Stephen Levinson's notion of activity types and Skirant Sarangi's concept of discourse types. 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 types run through the generic structure of the interactions, namely, non-strategic and strategic. Non-strategic choices are necessitated by cultural and institutional routines, and linguistic routines. Strategic choices are characterised by context-shaping and context determined acts. The former acts are marked by code negotiation cues while the latter are characterised by institutional and local contextual constraints. 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. Code choices, non-strategic and strategic, are very vital tools in gaining access to the events at doctor-client first meetings. The phenomenon of code selection 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. 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.

Key words: Doctor-client conversations; activity type; discourse type; generic structure; non-strategic/strategic code selections; context-shaping/context-determined acts

1. Introduction

Language use (and selection) is very vital to communication in the hospital. This is because it forms the nucleus of the encounter between the doctor and the client, and bears the burden of the whole process of hospital interaction. The selection of the right code or its variety thus goes very far in bringing alive a positive relationship between the doctor and the patient, and putting on course the healing process which is the ultimate goal of the encounter.

The significance of language use in medical discourse 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 and Maynard (2006). They 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 Bale's (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 Francis et.al 1969; Korsch et.al. 1968; Freemon et.al 1971 and Korsch and 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 1994a, 1994b; Roter and Hall 1992).

The microanalytic approach which originates in anthropology and sociology 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...” (Heritage and Maynard 2006:4)) 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 and Maynard, p.4). Scholars in this tradition are recently investigating doctor-client relationship with respect to how practitioners suppress clients' experience. This, by Heritage and Maynard's (2006) account, is traceable to the social, economic and institutional power that is ascribed to doctors (cf. Atkinson 1995). The present study identifies with the micro analytic tradition.

Scholars in the micro analytic school have 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; Perakyla 1998; Fisher and Groce 1990; Mishler 1997; Odebunmi 2005, 2006, 2008). Efforts have not been put on several (possible) codes in the interactions, and the pragmatic roles of these codes. Another neglected area is focus on doctor-client first meetings, which, of necessity, differ in discourse structure and function from subsequent meetings. In fact, influential as Heritage and Maynard (2006) is, it has neither been directed exclusively towards the dynamism of code selection nor ventured strictly into doctor-client first meetings and how code choice strategies are deployed in the negotiation process.

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. This is because beliefs at

this meeting necessarily differ from beliefs at others. The encounter is new, and so caution is needed by both parties to negotiate their preferences. Thus, Clark's (1992:4) first of the properties of action tradition, „common ground”, may not be easy to achieve. In Clark's words, „the participants in a conversation work together against a background of shared information ...called common ground” (1992:4). At first meetings, very little background information is available to both parties; hence, much of the information is largely negotiated in the local context. This readily demonstrates the relevance of the other two properties of Clark's action tradition:

- As the discourse proceeds, the participants accumulate shared information by adding to it with each utterance;
- Speakers design their utterances so that their addressees can readily identify what is to be added to that common ground (Clark 1992:4-5).

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

75 audio recordings of doctor-client interactions were randomly made in selected state-government owned and private hospitals in Southwestern Nigeria in 2002, 2007 and 2009. The recorded interactions were a mix bag of all meetings in the hospital: first, second, multiple, follow-up and visitation. Only ten of these, which were selected, were interactions between doctors and their clients at first meetings. The transcripts were analysed with insights from theoretical perspectives on code selection (and mixing/switching), Stephen Levinson's notion of activity types and Skirant Sarangi's discourse types.

In the next section (3), I discuss the concept of code selection and I review perspectives on code-mixing/switching. I also relate these to hospital interactions (in Nigeria). 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 selection and hospital interactions in Nigeria

The term „code” refers to a linguistic variety (cf. Boztepe 2003) used in communication. This linguistic variety or language could be the standard form or could refer to varieties or dialects of the

standard code/language. Participants in conversations reach for whatever code they could competently or otherwise use in particular situations. This process is what I call „code selection”, which in the monolingual setting may involve only one language, and in a bilingual setting two languages. I, therefore, propose two types of code selection: simple and complex. The simple code selection occurs between monolinguals who draw only on the standard dialect of the language of communication and its varieties (formal or informal). This is captured in the chart below:

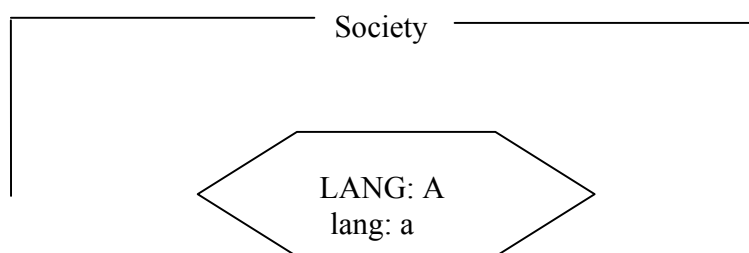


Figure 1: Simple Code Selection

„LANG: A” refers to the standard dialect, and „lang: a”, its varieties. The complex code selection is opted for among bilinguals, and it involves two standard dialects (A and B), their varieties and other dialects of the standard language. This type of code is the focus of the present study. In Southwestern Nigeria, Standard English (LANG:A) and Standard Yoruba (LANG:B) are used. Varieties (lang: a/b) of these are also used. In addition, dialects of Standard English (Lang: B) (e.g. Nigerian English/ Pidgin English) and Standard Yoruba (Lang: B) are used (e.g. Egba/Ekiti). This presents a complex linguistic picture, and naturally introduces language choice negotiation into conversations. Figure 2 shows this complexity (“P” in the figure refers to “Participant”).

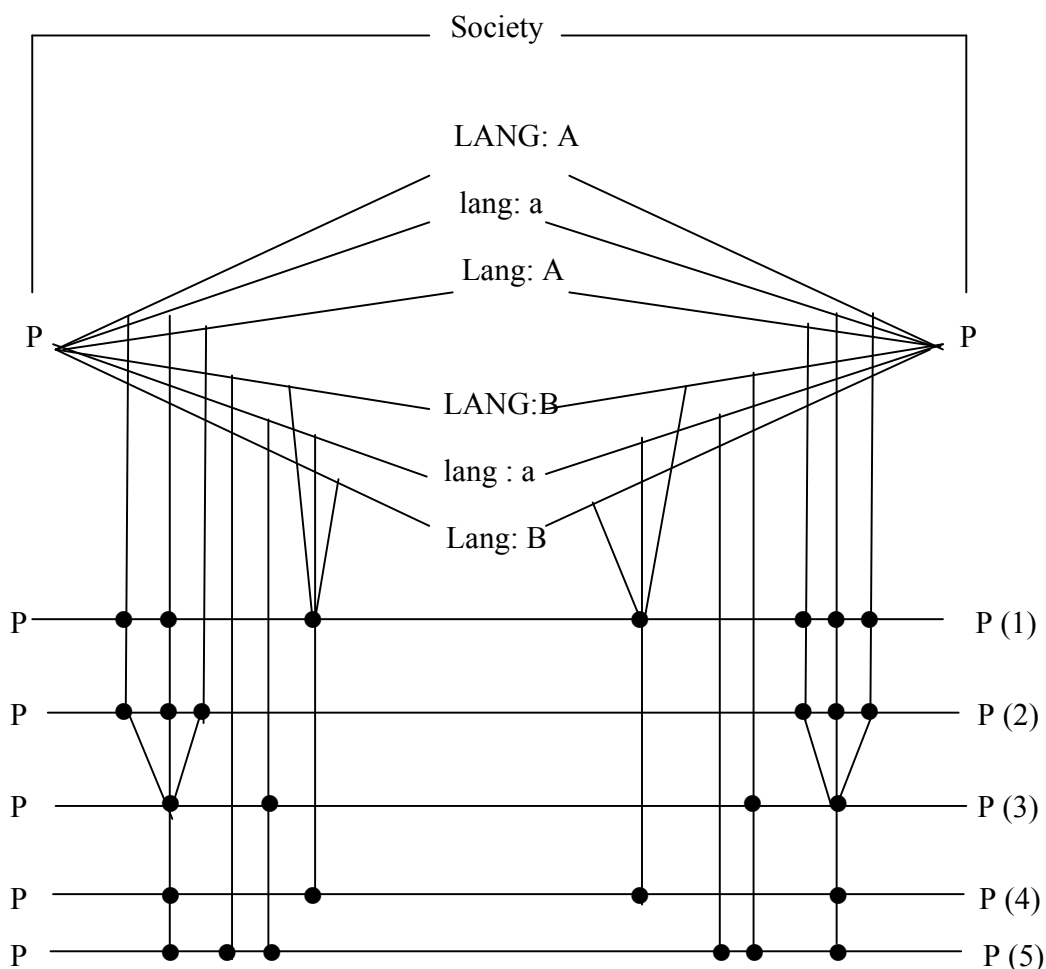


Figure 2: Complex Code Selection

By „codes”, in this paper, I refer to the above mentioned dialects and varieties, and by „code selection” I mean the use of these codes in alternate or alternative terms.

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. It is interesting to note that there are situations, in the Nigerian hospital, where the code a participant (who is, many times, the client) can not use is employed among hospital workers to discuss the condition of the monolingual discourse participant. But this is outside the scope of the present paper.

The fact that codes can be mixed by discourse participants in any situation they judge it necessary only points to the dynamic nature of human communicative needs. In the words of Leung (2010):

Managing linguistic and cultural variations has now become vital to our lives. Apparently code-mixing has become socially and communicatively unavoidable and it helps us to develop and improve relationship and enables us to adjust and adapt to the environment we are in. (Leung 2010:417)

The discourse of code alternation has led to the development of various terms by language scholars enroute to capturing the theoretical essence of the phenomenon. These include: „code-switching”, „code-mixing”, „code alternation” and „language mixing” (Gumperz 1982; Myers-Scotton 1980, 1983, 1987, 1992, 1993, 1998, 1999; Poplack 1980, 1993; Auer 1984, 1988, 1990, 1995, 1998, 1999, 2009). All of these terms describe the position of codes in discourses in as systematic a way as the contextual uses of the codes have permitted. They also address the linguistic and sociolinguistic relationship between the different codes that participants make use of in conversation.

I will not go into the details of the arguments that have been advanced by the scholars in defining and defending the terms because the present paper is not strictly a paper in code-mixing. Just a few bits from the argumentations would suffice. In this connection, I will adopt the two terms ‘code-switching’ and „code-mixing” as defined by Auer:

Code-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)

Auer (2009), therefore, sees code-switching as functional language alternation and code-mixing as 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). These

studies have presented such functions as establishment of rapport, elaboration of a message, conveyance of attitudes (Tay 1989); symbolization of group identity and solidarity, and marking of shift in style (Boztepe 2003). 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.

Of great relevance to this paper are Auer's types of code-switching (which I would also extend to code-mixing where necessary in the analysis). He 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 strategic 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 strategic agenda.

The two functions are relevant to the communication between the doctor and the client in the Nigerian hospital as would be shown in the data analysis. On certain occasions, language choice in the encounter is a matter of preference by either party, which in the interaction influences the other party. But on some other occasions, tact comes into play, usually by the doctor but sometimes by the client.

In Nigeria, as in partly several bilingual communities in Africa (cf. Myers-Scotton 1993), except among the very elderly who are obstinately tied to maintaining the purity of the indigenous languages, code-mixing is a common practice among both the educated and the uneducated. Auer and Eastman's (2010) view aligns with this development: „What is happening in Brussels contrasts with the situation in urban areas in parts of Africa where code-switching is increasingly becoming the norm”. This differs from the practice in Hong Kong, for example, where „the mixing of two language codes seems like a common practice among the local population, especially those who have acquired higher qualifications” (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) they notice any health discomfort. They present duplicates of their registration documents, usually called „small cards” to hospital records officers who would pull out their case notes, which are still, in almost all hospitals, in the hard copy form. These are placed before the appropriate doctors, and clients have to sit outside the doctors’ offices, waiting for their turn.

At a client’s turn, he/she is invited through name calling (usually his/her full name without his/her title). He/she 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 done in the dialects and varieties already discussed in section 3, LANG:A, LANG:B, lang:a, lang:b, Lang:A and Lang:B (in single or combinational 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. English is used exclusively where the doctor (Doc) and client (CL) or his/her relation (also referred to as „client” in this research) can speak it. This English may be the Standard British/American variety (especially in grammar and lexis) or a combination of the standard variety and Nigerian English (the variety spoken exclusively by Nigerians). In most cases, however, as Bamgbose (1985) observes, the English spoken in Nigeria is largely an interlanguage variety, a marriage of the two dialects. The most interesting aspect of Nigerian English, which has also been considered relevant to this work, is the lexico-semantics. Words assume meanings strictly within the context defined by Nigerian socio-cultural practices. These words and their semantic colorations have been typified as: transfer (e.g. „I am coming” („I will be back presently”)), abbronymy² (e.g. NEPA-National Electric Power Authority), semantic shift/extension (e.g. „machine” (motorcycle)) and coinage (e.g. „bukateria” (cafeteria)) (cf. Bamgbose, 1985; Adegbiya, 1989; Bamiro, 1989; Jowitt 1992, 1995; Adamo, 2007).

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 and coinages. These words are largely used in oral communication, while the standard medical terms are used largely in written communication. In describing HIV/AIDS, for example, in some hospitals, the term „333” is selected. „Social disease” points to „gonorrhoea”, „GO” to „death”, „laughing gas” to „tetanus” and „RTC” to „the next appointment with the doctor”. When I asked one of the doctors if these innovations would not affect

² The term “abbronymy”, “abbreviation +acronym, was first used in Odebunmi (1996) to refer to letters or strings of letters, representing particular full word forms, which may or may not be pronounceable.

the universality of medicine, „he expressed a view that though universal meanings might be hindered yet, the development made medicine more interesting” (Odebunmi 2006: 37).

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 (Odumu 1993). Pidgin English combines English and indigenous language vocabulary elements, but it largely deviates from the two in grammar. For example, the Nigerian Pidgin form of „I will see you tomorrow” is „I go see you tomorrow”, and that of „He has gone” is „He don go”. The use of Pidgin in the hospital is largely negotiated. Many times, it takes some struggle for participants (especially doctors) to succumb to the pressure of clients’ choice of Pidgin, what Auer has rightly described as „participant-related code-switching” (Auer 1995, 2009). On some occasions however, doctors who are competent in Pidgin elect to interact with clients in it if they find it pragmatically convenient. Sometimes, depending on the relationship between the parties and the goals of the encounter, doctors and their clients code-mix English and Yoruba, the native language of the people in Southwestern Nigeria. But where the client cannot speak English at all, the language he/she speaks usually, Yoruba, is selected for communication, provided the doctor is also able to speak it.

Apart from the language of communication, 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 shortly.

5. Theoretical perspectives

This work benefits centrally from Stephen Levinson’s notion of activity types and Srikant Sarangi’s discourse types. I will take them in turn.

5.1. Activity type

The choice of the concept activity type (AT) is due to its reputation for being able to tackle institutional discourses such as hospital interactions. This is largely because in its broad stretch, it is capable of explaining 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 (which is based on Wittgenstein’s notion of language game (cf. Sarangi 2000, 2004) points to

any culturally recognised activity, whether or not that activity is co-extensive with a period of speech or indeed whether any talk takes place in it at all.... In particular, [it] refer[s] to a fuzzy category whose focal members are goal-defined, socially-constituted, bounded events with *constraints* on participants, setting, and so on, but above all on the kinds of allowable contributions. Paradigm examples would be teaching, a job interview, a jural interrogation, a football game, a task in a workshop and so on. (Levinson [1979] 1992:69)

This definition focuses on participants' use of language which is constrained by the activity they perform and the physical location of the talk. 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; Odeunmi 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 and Slembrouck (1996). Bourdieu's (1991) argument is that utterance meaning relies on the status of the speaker and the role he/she 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 that beyond Bourdieu' (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)

The application of this check list has been done in several studies of late (cf. Thomas 1995, Culpeper, Crawshaw and Harrison 2008). These studies include Thomas (1995), Dale et.al (1997), Sarangi (2000), Culpeper et.al (2008) and Odebunmi (2008).

One more point to make about AT is its appeal to rationality, a term associated with how problems are solved and how decisions are made. March (1988) differentiates between „calculated” and „systemic’ rationalities”. The former has a cognitive orientation and is individual-based, while the latter submits to practices and traditions that are group-accepted, which make it interactionally negotiated. In Levinson’s (1979) view, the choices of rational behaviour made by discourse participants depend on how they perceive the activity type and what their expectations of it are. These are derived from a combination of setting, background knowledge, personal belief, goal, setting and co-text (Dale et.al 1997: 658). For Levinson, a speaker’s language behaviour expresses his/her rationality. Thus, „to understand properly the rationality of an individual is to account for how he/she uses language in an activity type” (Dale et.al: 658).

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. It develops from the broad nature of AT which opens it to accommodating anything and which poses serious difficulty when it is used in analysing data.

Sarangi (2000) plugs the concept of discourse types (DT) into the broad circuit of AT to account for the specific linguistic acts that are performed in the activities. Sarangi sees DTs as:

[...] specific manifestations of language form in their interactional contexts (e.g. from utterance types such as how are you? What are we doing here? to the sequential organisation of questions and answers as in a cross – examination, to stylistic features as in promotional talk.

While activity type is a means of characterising settings (e.g. a medical consultation, a service encounter, a university seminar), discourse type is a way of characterising forms of talk (e.g. medical history taking, promotional talk, interrogation, troubles telling, etc.). (Sarangi 2000:1f)

Although Sarangi's adaptation of Levinson's AT agrees more with the concept of communicative competence by Hymes (1962) rather than accurately with Levinson's proposal, his argument is clear here. For him, 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 counseling (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. Specifically, I utilise the following notations due to Halliday and 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

A few studies have been committed to the generic or interactional structure of practitioner-client interactions. These include Mishler (1984), Heritage and Maynard (2006) and Adegbite (2009).

Mishler (1984) identifies three stages in the history taking segment of the encounter: Symptom Request (by the doctor), Response (by the patient) and Evaluation or Acknowledgement (by the doctor). In Heritage and Maynard (2006), several stages of the interaction are focused: seeking patients' presentation or account, patients' narratives of discovery of symptoms, patients' proposals and physicians' responses, history taking, diagnostic communication, treatment decisions, prescriptions and closing. Adegbite (2009) identifies in the herbalist-client encounters in Yoruba traditional medicine these structural constituents: monolingual narratives, descriptions, arguments, requests, diagnoses and prescriptions.

While these studies have made significant contributions to the structure of practitioner-client encounters, they essentially differ from the present study because the structural elements they identify range over several meetings. While limiting myself to only 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.

Four 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 generic structure (henceforth: GS) of each of these stages follows:

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. All the stages are optional: Instruction (Ins), Invitation (Iv), Response to Invitation (RI), Greeting (Grt), Response to Greeting (RG) and Plesantries (Pls). Ins is restrained in terms of position wherever it occurs. Iv, RI, Grt and RG occur more frequently than the others. Instruction is issued by the doctor to an attendant or nurse to invite the client; Invitation made through name-calling by the attendant or 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.

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:

$$[BR]^{\downarrow} (EI)^{\downarrow} (Int)^{\downarrow} \{CI^{\downarrow} CR^{\downarrow} CI^{\downarrow} CR^{\downarrow} \dots\}^{\downarrow} (Pls^{\downarrow}) (Ass)^{\downarrow}$$

The generic structure shows that only BR (Broad Request), always made by the doctor (Doc), CI (Condition Specific Information), always provided by the client (CL) and CR (Cue-based Request), always made by the doctor are obligatory. By BR is meant a general request made by Doc about the state of health of CL (e.g. What's your problem?; What can I do for you?). CI refers to the response of CL in which he/she specifies the actual problem (e.g. „It's malaria fever”), and CR refers to the request made by Doc based on the specific condition mentioned by CL (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. Pls (Pleasantries, usually jokes), and Ass (Assurance, e.g. There is no problem) are largely optional.

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:

$$(Ass)^{\downarrow} (TP)^{\downarrow} (Int)^{\downarrow}$$

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) occur sometimes 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.

Closing

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

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

Just like 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 GSs in the next section.

6.2. Code selection strategies: analytical design

It is useful to take a quick look at the code selection strategies that have been provided in the literature with respect to bilingual speech to see how the present study converges with or diverges from them before moving to the analysis proper. Research in code selection strategies or code switching has been observed to be pioneered by Blom and Gumperz (1972) who offer the influential distinction between situational and metaphorical code switching. Situational code switching, which is predictable, occurs when language choice is premised on „situational parameters such as participant constellation, topic, mode of interaction, etc” (Auer 1984: 88), in which case there is a perfect relationship between non-verbal cues and situation-prescribed language choice. Metaphorical code switching, which is not predictable, on the other hand, is determined by the speaker’s decision to switch codes in line with certain personally perceived conditions for such switches. The code change, moving away from the language of interaction in a local talk context, flouts the Gricean manner maxim, thus initiating „an implicature involving the categories ‘we code’ and ‘they code’” (Auer 1984: 88).

Blom and Gumperz’s (1972) model comes under serious criticisms from scholars for reasons that it does not provide sufficient details to characterise verbal behaviour and that it is difficult to separate situational and metaphorical code switching from each other. Gumperz (1982) himself recognises the problems with the model and revises it by offering the term „conversational code switching” which aligns more to metaphorical than situational code switching. He situates it in his pragmatic communication strategy christened „contextualization cues”: „a way of generating meaning by putting a linguistic action into some kind of context – fulfilling a large number of interactional functions” (Auer 2010: 88).

Models of code switching later proposed by other scholars rely largely on Blom and Gumperz's (1972) model, with modifications suiting the scholars' research conditions or addressing the imperfections in the model. Two of these are important to the present study, namely, Myers-Scotton's and Peter Auer's. I have already discussed Auer's proposals at some length, and so I will only refer to it briefly here as my analytical tool. Myers-Scotton (1993 [1980, 1983]) presents a model of code switching called „markedness model". In her view, certain social roles are attached to every language in a multilingual context. She christens these roles „rights-and-obligations (RO) sets (Myers-Scotton 1993: 84). „By speaking a particular language, a participant signals her understanding of the current situation and particularly her relevant role within the context" (Nilep 2006: 11). She identifies three code selection strategies in bilingual conversation, namely, the unmarked choice maxim, the marked choice maxim and the exploratory choice maxim. The unmarked choice, tallying in large measure with Blom and Gumperz's (1972) situational code switching, is the expected choice, and it occurs when situational changes necessitate code changes. The marked choice, largely synonymous with Blom and Gumperz's metaphorical code switching, is in operation when the need for situational negotiations of social variables enters into bilingual conversation. The exploratory choice is a kind of unmarked choice which is associated with norm clash and role relations. Of relevance to the present study are marked and unmarked choices.

Peter Auer (as stated earlier) has advanced, as a straightening of the curves in the Blom and Gumperz's model and Myers-Scotton's model, two types of code switching: participant-related code switching and discourse-related code switching. These derive in a large part from the predictable and the non-predictable dichotomies explored in the literature.

From all these models, I have come up with two terms which have been applied to my data, namely, non-strategic code selection and strategic code selection. The non-strategic code selection agrees in part with Myers-Scotton's unmarked choice maxim as it has to do with expected code choices. By non-strategic code selection I mean bilingual language choices characterised by routine linguistic behaviours. The strategic code selection relates largely to Myers-Scotton's marked choice maxim and Auer's discourse-related code-switching. It also establishes a relationship with aspects of Auer's participant-related code-switching. It therefore refers to strictly goal-driven choices drawn upon by discourse participants to pragmatically express their intentions. The new terms are necessary because there are no single terms to describe the features that characterise my data. The coverage of the features, in the data, cuts across all the major models, (Blom and Gumperz's, Myers-Scotton' and Peter Auer's), thus making it difficult to adopt only one of these without

running risk of representativeness. The table below shows the points of convergence and divergence between the models clearly:

Scholars	Strategies + Features A	Strategies + Features B	Strategies + Features C
Blom and Gumperz	<u>Situational Switching</u> + predictable + situation determined	<u>Metaphorical Switching</u> – predictable + personal goal determined	_____
Gumperz	_____	<u>Contextualisation Cues</u> – predictable + local situation + personal goal determined	_____
Myers-Scotton	<u>Unmarked Choice Maxim</u> + predictable + situation determined	<u>Marked Choice Maxim</u> – predictable + local situation + personal goal determined	<u>Exploratory Choice Maxim</u> – predictable + socio-cultural values + local situation + personal goal determined
Auer	<u>Participant-related Switching</u> ± predictable + situation determined	<u>Discourse-related Switching</u> – predictable + local situation + personal goal determined	_____
Odebunmi	<u>Non-Strategic</u> ± predictable ± cultural presupposition + situation determined	<u>Strategic</u> – predictable + local situation + personal goal determined + group goal determined	_____

Table 1: Code Selection Strategies

I will now discuss each of the strategies in turn.

6.2.1. Non-Strategic Code Selection

Two factors often necessitate the non-strategic type, namely, observance of cultural and institutional routines, and observance of linguistic routines. Across all the examples in the analysis, Standard British/American English is italicised, Yoruba is underlined, Pidgin is represented in Courier 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. 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 it does not occur at all in Closings.

Cultural routines occur in Greetings, Response to Greetings and Pleasantries. For example, in Interaction 1, the following exchange takes place between the Doctor (Dt) and the Client (Cl).

Ex. 1: (Interaction 1)

Dt: *O:::h (.) Mr. Azeez (.), good morning (.). You welcome--*

→Cl: **Ye::: s (.)**

Greeting in Ex.1 features two codes. Doc uses Standard English in expressing his phatic communion, but CL replies in Nigerian English (henceforth: NE). In NE, „ye:::s”, as produced by CL here, elongated at mid-tone, when said by the elderly or people that are advanced in age, usually means „thank you”, especially in Yoruba land. In line with my definition of non-strategic code choice, the word is selected simply to observe the necessary cultural routine. No strategic agenda on the part of CL is suspected. In` other words, CL simply fulfils a cultural expectation through a code he finds convenient.

The alternation of Standard English and NE between participants also occurs in Interaction 4:

Ex. 2: (Interaction 4)

Dt: *Good morning, **dear**=*

Cl: *Good morning, **ma**—*

„Good morning”, a Standard English expression and both „dear” and „ma” (NE words) are mixed by both participants. „Dear”, as used by Doc, 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 Doc. „Ma” in NE is used in referring 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 Interaction 2 (At =Attendant)

Ex. 3: (Interaction 2)

Dt: ((To the attendant)) *Alright, call in the next patient*

At: Baba () =
(Mr.)

→ Cl: *Sa::*

Doc 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 NE 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. While „sir” is a Standard English word, the replacement of the long /ɜ:/ with the Yoruba /a:/, which is again elongated, gives it a pragmatic meaning. In Nigerian hospitals, „sa::” and „yes” (or „ye::s not said at mid tone) are synonyms, which mean „I am available” or „I am already on my way”. Sometimes, the elongated „sa::” or „yes::” is used to occupy space so that the attendant or the doctor would not invite another client if the Response to Invitation is not loud enough.

6.2.1.2. Linguistic Routines

The strategy here agrees with the view on code-mixing as a communicative practice that reveals a rule-governed language behaviour and talk habits that have more to do with individual styles than with what the context determines (cf. Myers-Scotton 1993). In fact, in Nigeria, code-mixing is widely used and is almost inevitable in two-party or multi-party talk both among the educated and the uneducated.

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. This rare occurrence might be accounted for by the oddity that might attend the structures that characterise Opening. For, example, it will be awkward to say „*E* good morning” (You good morning) or „*E* good bye” (You good bye) except in an extremely jocular context which excludes hospital consultative interactions.

Good examples of code-mixing that demonstrate linguistic routines can be found in Interaction 6:

Ex. 4: (Interaction 6)

27. → Cl: >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 days two is malaria caught me suddenly)
28. (How it started is that I had catarrh. After the catarrh, on the second day, I had fever all of a sudden)
31. → <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)
32. (all my hands and legs were cold. I went for treatment. Yesterday I)
35. → notice ara riro to <wa tun lagbaa gan> (0.5).
(notice body pain that was again serious very)
36. (noticed serious body pains)
37. O tun wa remi, enu mi n koro; <mo weaki gan ni>
(It again was tired me, mouth my getting bitter. I weak very)
38. (Also I am weak, my mouth is bitter; I am very weak)
39. (0.5)
40. → Dt: So, major thing to ku ni pe o re yin?--
(So major thing that remains is that it weak you)
41. (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 „finkin finkin” for „catarrh” and „iwosan” for „treatment”. The same applies to Doc who inserts „So, major thing”. It is obvious from these instances that no strategic intent is displayed. Rather, each participant naturally contributes with his peculiar style. CL merely objectively describes his state of health and the steps taken while Doc responds to these by trying to measure the extent to which CL still needs help. In fact, expressions like: „Mo sick” (I am sick), „Mo ni malaria” (I have malaria fever), „Mo ni cold” (I have cold) are routinely made in Nigerian hospitals or other locations where health issues are focused. One point to note with respect to the

word „kata”, however, is that it is gradually phasing out the Yoruba equivalent, „finkin finkin” which is hardly known to many children or young adults brought up exclusively in the Western fashion. This development validates Auer and Eastman’s (2010) observation that „Bilingual 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”. Invariably, the next few generations of Yoruba speakers may fully loan the word „kata” into Yoruba, just as the Hausa „wahala” has been permanently integrated into the language.

Another instance of code-mixing showing linguistic routines is found in Announcement in Interaction 8. After the doctor and the client have come to a common ground on the client’s condition, the doctor announces the Therapy Procedure:

Ex. 5: (Interaction 8)

26. Doc: Ara yin o gbona?↓=

(Body your not hot)

27. (You don’t have temperature?)

28. Cl: Rara--

(No)

29. (*No*)

30. Doc: Ti e ba to ko niyin lara?--

(If you urinate it not inconvenience you body)

31. (When you urinate, you don’t have difficulty)

32. Cl: O n nira die=

(It inconveniencing little)

33. (I am having some difficulty)

34. →Doc: *Yes::: Mo fe se test ito yen. Ti mo ba se e tan, n te ba maa nilo,*

(Yes. I want do test urine that. If I do if finish, what you will need)

35. (I want to examine that urine. After the test, whatever you’ll need;

36. → maa check e—

(I will check it)

37. I will check it

38. Cl: Nigbawo? =

39. (*When?*)

40. Doc: Nisin-in (.)

41. (Right now)

Between lines 34 and 36, Doc inserts English „yes:::”, „test” and „check” into his utterance to describe respectively his conviction that CL needs an examination, the laboratory activity to be carried out on CL and the dependence of CL’s treatment on the examination. CL opts for Yoruba throughout the encounter. This may be due to her limited competence in English, which is the case with a number of Nigerians who understand basic English but who could neither speak nor write it. Her not code-mixing partly indexes this. A confirmation for this is further got in CL’s interrogative regarding the procedure, „Nigbawo?”, which fits with Doc’s discourse and which shows that she perfectly understands Doc’s lexical choices in English. But she prefers to speak in Yoruba. A more pragmatic explanation for her choice is the fact that no question is posed to her by the doctor in English. If this had been done, she would perhaps have been prompted to demonstrate her competence in English. Given that no interactive prompter in English is produced from CL prior to Doc’s selection of „yes”, „test” and „check”, no intention other than merely communicative is feasible, which makes the code-mixing a reflection of Doc’s linguistic routine.

6.2.2 Strategic code selection

Strategic code selections are made largely by Doc, but sometimes by CL as a pragmatic response to certain contextual conditions. In the meetings studied, Diagnostic Interaction takes the largest instances of this strategy, while Announcement and Closing give very few instances. No strategic code selection is made in Opening. This could be accounted for by the new encounters in which Doc and CL 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 Doc and CL. 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 Doc and CL 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 interaction.

An interesting instance of this code selection strategy is found in Interaction 2:

Ex. 6: (Interaction 2)

1. Doc: ((To the attendant)) Alright, call in the next patient
2. At: Baba ()=
3. (Mr.)
4. Cl: **Sa::**
(Sir)
5. (0.5)
6. Doc: Too Baba, [**sorry.**]
(Oh! elderly man)
7. (Oh! old man)
8. Cl: [good moring]
9. Doc: *Any problem?* ↑=
10. Cl: Ah, doctor, oh na wa::: o::: na problem dey o::--
(Ah, doctor, oh! serious o!. It problem there is o)
11. (Ah, doctor, it is serious; there is a problem!)
12. Doc: *Oh, sorry- sorry*=
13. Cl: *A*--
14. Doc: **Sorry** (.)
15. Cl: *A:* °This leg ^dey trouble me:: well well [seriously^] (.)
(This leg is troubling me seriously seriously)
16. (This leg is troubling me seriously)
17. Doc: [()](.)
18. Cl: *E::*, na <yesterday> this thing happen o (.)
(It yesterday this thing happen o)
19. (It was yesterday this thing happened!)
20. Doc: *Just yesterday?* ↑=
21. Cl: En . *I went to farm yesterday* now
22. (Yes. I went to the farm yesterday; you see!)

23. *By the time I came back, *a* (.) me i no enjoy myself*
(I, I not enjoy myself)
24. (I, I did not enjoy myself)
25. Doc: **Sorry** (.)
26. Cl: 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)
27. (It was this morning, what makes it worrisome now ;)
28. moring wen i wake up (.), i don carry my:: hand
(This morning, when I woke up, I had carried my hand)
29. (This morning, when I woke up, I lifted my hand,)
30. no do- no gree>
(Not move – not agree)
31. (It did not co-operate)
32. → Doc: He no gree carry am! (.)
(It not agree carry it)
33. (It did not co-operate!)

Doc 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. CL responds in Pidgin („Moring”). In the Diagnostic Interaction, Doc makes his Broad Request in English (line 9), but CL supplies his Echoic Information in Pidgin (line 10). CL here merely reformulates Doc’s question and circumlocutes with the clause „na problem dey” which does little at addressing Doc’s question. Doc switches to NE in his Interjection („Oh, sorry, sorry”, line 12), but CL insists on Pidgin in his Condition specific Information (lines 15 and 18). Doc continues in English in the subsequent Cue-based Response (line 20), but CL sticks to Pidgin with little intervening Standard English (line 21). The insistence of CL on his code choice eventually influences a switch from Doc who sees the need to strike a linguistic association with CL at the critical point of the encounter i.e. when CL is providing a historical account of the ailment:

Ex. 7: (Interaction 2)

26. Cl: Na this moring, <the thing wey dey make an so worry now> (.)

27. (It was this morning, what makes it worrisome now ;)

28. this moring wen i wake up (.), i don carry my:: hand

29. (This morning, when I woke up, I lifted my hand,)

30. no do- no gree>

31. (It did not co-operate)

32. →Doc: He no gree carry am! (.)

33. (It did not co-operate!)

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

Ex. 8: (Interaction 2)

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

It is obvious that he could not reach for the right Pidgin expression to convey his point. The same happens in his next CR:

Ex. 9: (Interaction 2)

Doc: [*And did they tell you your*]

Cl: [dey worry me]

(is worrying me)

Doc: *blood pressure is high? =*

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

Ex. 10: (Interaction 2)

Doc: Dem no tell you--
 (They not tell you)
 (They did not tell you)

The conversation, at large, shows that the doctor tries to partly accommodate the client's code choice despite his institutional power to be able to ensure a successful professional transaction his little competence in Pidgin notwithstanding; for example, where he says, „He no gree carry am” (line 32), he is expected to say, „He no gree make you carry am”. A similar situation has been noted by Myers-Scotton (1993). No instance was found of the situation where a doctor opts for Pidgin without being constrained. However, there are many instances of this in other meetings which are not covered in the present study.

6.2.2.2. Context-determined Acts I: Institutional Contextual Constraints

Institutional contextual constraints, which occur only in Diagnostic Interaction and Announcement, are acts determined by the interaction between the norms of medical practice and the context of doctor-client interactions. In Interaction 2, the institutional contextual constraint is revealed through the informing act 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 Doc and CL share information about CL's hypertensive condition:

Ex.11: (Interaction 2)

49. Doc: [And did they tell you your]
 50. Cl: [dey worry me]
 51. (worrying me)
 52. Doc: *blood pressure is high?* =
 53. Cl: No=
 54. Doc: Dem no tell you--
 55. (They did not tell you)
 56. Cl: No, dem no tell me *a:*(.)
 (No, they not tell me)
 57. (No, they did not tell me)

- 58.→Doc: As the thing be now (.). *Okay. I will look into your problem. I will examine*
 (As the thing is now)
59. *you; you understand, and be able to see. But as i be now, you no fit*
 (But as it is now, you not can)
 (But, as it is now, you cannot
60. carry your leg and hand (.)=
 (carry your leg and hand.)
 (move your leg and hand.)

Doc had demanded to know if the diagnosis of high blood pressure had been announced to CL earlier (lines 49-52). CL's Condition specific Information, in Pidgin, indicates otherwise. All along, Doc had interacted with CL in his chosen code i.e. Pidgin. He attempts to continue under the influence of this imposition at the moment he embarks on explaining CL's condition and analysing the prognosis of his condition, spurred by CL's Condition-specific Information (line 56) and expression of pain (*a:*) when he says: „As the thing be now”, But there is a frame shift with Doc's sudden switch to English (line 58). After a brief pause, he changes the direction of his discourse, perhaps considering the needlessness of pursuing the prognostic explanations, given CL's limited education which might turn the whole effort into a clumsy and rigmarolling verbalisation, especially because Doc himself has limited Pidgin. He then prioritises healing as CL's ultimate goal and abandons the information process he had attempted to embark upon. This change is signaled by the transition marker, „okay” (line 58b), which is followed immediately by an English utterance: „I will look ...” (line 58c). At this point, he intends to demonstrate his competence to assure CL of healing. 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 CL. 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.

6.2.2.3. Context-determined Acts II: Local Contextual Constraints

By local contextual constraints I mean factors that influence or condition utterances within the immediate situation of talk. These factors, in the context of doctor-client first meetings, have little to do strictly with the 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 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 Interaction 3:

Ex. 12: (Interaction 3)

16. Doc: Se ese re ko wu?=
(Does leg you not swell?)

(Does leg you not swell?)

17. (Is your leg swollen?)

18. Cl: Ko wu=
(It not swell)

(It not swell)

19. (It is not swollen)

20. Doc: Kin lo ti lo si i?=
(What you have used to it?)

(What you have used to it?)

21. (What have you been using?)

22. Cl: 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 to it. Medications Yoruba are I mostly used to it)

23. (I have used medications. I have mostly used Yoruba medications)

24. →Doc: **O::kay: @**

CL, here, when asked about the medications he has taken since the onset of the illness (line 22), goes roundabout: „Mo ti lo oogun si i”, engaging an avoidance strategy. He flouts the Gricean maxim of quantity, but observes the maxims of relation, quality and manner. He addresses Doc's Cue-based Response, but Doc requires more definite Condition-specific Information which CL hesitates to supply, knowing the negative natural reaction of a typical orthodox medical practitioner to traditional medicine in Nigeria. But he seems to foresee Doc repeating his Cue-based Response or losing his temper (as is characteristic of many doctors in Nigeria), and he quickly provides the Condition-specific Information in his next statement: „Oogun Yo'oba ni mo saaba maa n lo si i”, which again is not specific enough but is adequate to provide Doc with the information required. Doc'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 Doc's denigration of traditional medicine. It is an NE expression for „I can see why”. It therefore conveys Doc's conclusion about the prolongation of CL's condition. This consideration turns the expression into a face-saving strategy. Damage could be done to CL'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).

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 offers itself in the Nigerian sexual discourse. Many Nigerian adults, especially married males, are shy to tell pharmacists or chemists that they like to buy „condom” 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 sellers, to prevent other people access to 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 CLs') points. Some interesting instances can be found in Interaction 6, which is basically in Yoruba:

Ex. 13: (Interaction 2)

27. Cl: >Bo se bere nipe< mo ni <kata [catarrh]. After kata y en 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)
28. (How it started is that I had catarrh. After the catarrh, on the second .day, I had fever all of a sudden)
31. Gbogbo owo ati ese tutu>. Mo lo gba treatment. (0.2) Ni ana mo
32. (all my hands and legs were cold. I went for treatment. Yesterday I
35. notice ara riro to <wa tun lagbaa gan> (0.5).
36. (noticed serious body pains)
37. → O tun wa remi, enu mi n koro; <mo weaki gan ni>
38. (Also I am weak, my mouth is bitter; I am very weak)
39. (0.5)
40. Doc: *So, major thing to ku ni pe o re yin?--*
41. (So, the major complaint now is that you are weak)
42. → Cl: O re mi. Mo weaki (.)

(It weak me. I weak)

43. (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. CL has earlier, in line 37, expressed his weakness in Yoruba: „O tun wa remi”; then in English: „Mo weak[i]”. The same is repeated in line 42: „O remi; mo weaki”. CL’s repetition of his present health condition in English works to foreground his point which he believes could best be told 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 Doc 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 CL’s state of health, seems to contradict CL’s belief about the Nigerian bio-medical institution’s identification with English. Doc 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 Doc sees as a better code to negotiate the common ground with CL.

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 NE. At the stage of Diagnostic Interaction or Announcement, participants switch their codes to relax, flaunt, assure, joke and warn. An instance in Interaction 2 is presented below:

Ex. 14: (Interaction 2)

Doc: *Alright. Me I go take your blood pressure now.*

(I will take your blood pressure now)

((To the attendant)): *Get me the sphyg*

Alright ()

((Checks the blood pressure))

Doc switches from English, „Alright” to Pidgin English, „Me I go take your blood pressure now” as a strategic means of maintaining intimacy with CL, who is an old man, to soften the tension he has expressed with respect to his condition. But beyond that, with the choice of „Me I go...” (I, I will),

which pragmatically compares, especially when related to the earlier part of the interaction where CL asks if CL has been informed about his blood pressure status, Doc makes a pragmatic point. He, in a way, flaunts his competence, as the expression sounds like an implicit way of saying, „If those doctors did not know that they should check your BP, I will do so now”, a way of assuring CL of a more effective treatment.

During Diagnostic Interaction in Interaction 7, Doc reaches for a joke (Pleasantries) as a device to relax the tension of CLs. The CLs in this interaction are the father and mother of a baby brought to the hospital for diarrhea. After Doc has taken their account of the baby’s sickness, he opts for Pleasantries (Mth = mother, Fth = father):

Ex. 15: (Interaction 7)

1. Doc: *Good evening. What’s wrong with your baby?--*
2. Fth: *It’s cold and stooling, -- and the stooling is frequent (.)*
3. Doc: *For how long has she been stooling like that? =*
4. Mth: *For about 24 hours now (.)*
5. Doc: *What have you used for her? =*
6. Mth: *I’ve been giving her ORT --*
7. *((Oral therapy))*
8. Doc: *Does she take it well? =*
9. Mother: *She has finished a sachet.*
10. Doc: *((Feels the baby’s body)) (.)*
11. *Does she run temperature?--*
12. Mth: *Not really --*
13. → Doc: *((comically)): Well, omo yin fe jagbado ni=*
(baby your wants eat maize)
14. *(your baby wants to eat maize).*
15. [😊]
16. (0.5)
17. → *She’s praying for another set of teeth. She’ll be okay.*
18. *((writes his prescription))*
19. (0.9)

After Doc has taken the baby's diarrhea (stooling) history, he switches from English to Yoruba at the point he is expected to move to Announcement. Doc's switch to Yoruba at line 13 is a joke (a pleasantry), „... omo yin fe jagbado ni” introduced at a critical point of the Diagnostic Interaction. This is effective because both the doctor and the parents 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 she/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. Doc, however, performs a further pragmatic act. Even when CLs 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 17: „She is praying for another set of teeth”)

Another interesting case of strategic code-switching occurs in Interaction 3:

Ex. 16: (Interaction 3)

1. Doc: Abeeb Salami=
2. Cl: *Sa::*
(Sir)
3. (0.6)
4. Doc: Kin ni o de? (.)
(What happens?)
5. (What is the problem?)
6. Cl: Mo n wu iko--
(I am coughing cough)
7. (I am coughing)
8. Doc: Lati igba wo ni o ti n wu 'ko?--
(Since when you were coughing cough?)
9. (Since when have you been coughing?)
10. → Cl: *Like one good year* (.)
11. Doc: Igba wo lo maa n wuu ju? =
(When you are coughing most?)
12. (When do you cough most?)

13. Cl: Igba ti mo ba sun lale
(When I sleep at night)
14. (When I am asleep in the night)
15. (0.3)

„Like one good year” (line 10), which is CL’s Condition-specific Information is not provided in Yoruba, the dominant code of the encounter, not because CL does not have the right expression but because he needs a face-saving strategy which English readily provides. It is sufficiently embarrassing to live with a cough for a whole year without seeking medical attention. The potential face threat that may attend CL’s expression of this embarrassing situation causes him to reach for English. This goal becomes clearer in his subsequent Condition-Specific Information which he provides in Yoruba. Finally, participants at first meetings use code-switching when they have interactively established the linguistic competence of co-participants, having judged that another code would be more effective in expressing their perspective. Interaction 9 provides an excellent example here:

Ex. 17: (Interaction 9)

- 8.Doc: Kin lo n se o?--
(What is doing you?)
9. (What is the problem with you?)
- 10.Cl: Malaria ni--
(Malaria is)
11. (It is malaria fever)
- 12.Doc: Lati igba wo?--
(Since when?)
13. (Since when?)
- 14.Cl: Yio ti to last week (.)
(It should have been last week)
15. (It should be since last week)
- 16.Doc: Oogun wo lo lo nigba yen?--
(Medications which you used at that time?)
17. (What drug did you use then?)
- 18.Cl: Fansida=

- 19.Doc: O de lo o tan↑ Se e se LAUTECH?=
 (You and used it finish? Is it not LAUTECH?)
20. (And you completed the dose. Is it LAUTECH?)
- 21.Cl: Bee ni--
22. (Yes)
- 23.→Doc: *Nowadays, you don't treat Malaria on your own; the resistance is high*=
25. Cl: *Yes sir.*

„Malaria” and „Fansidar”, selected by CL are not strategic. But Doc 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 CL to cope with full English from his Cue-based Request: „Se e se LAUTECH” (enrichable as „Are you a student of LAUTECH), to which CL responds: „Beeni”. „LAUTECH” (Ladoke Akintola University of Technology) is the only university in the town where the hospital is situated. Doc'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 CL's prompt switch to English: „yes sir”. Doc 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 Doc intends to pass across.

7. Conclusions

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 run through the generic structure of the interactions, namely, non-strategic and strategic. Non-strategic choices are guided by cultural and institutional routines, and 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.

Finally, the phenomenon of code selection 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. 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.

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9. Appendix

GSP Notations

- (), indicating optionality;
- unbounded elements, showing the obligatory status of the items;
- $\left\{ \right.$ indicating iteration;
- $\left. \right\}$, showing that the degree of iteration for elements in square brackets is equal;
- \wedge , indicating sequence;

- [] specifying restraints on sequence;

Transcription Notations

- []
- [] indicating overlap;
- (0.2) indicating elapsed time in tenths of seconds;
- (.) indicating a brief
- (), indicating inaudibility
- < > talk said more slowly than surrounding
- > < talk said more quickly than surrounding talk
- @ laughter
- 😊 collective laughter
- \$ smile
- ::: prolongation
- ↑ ↓ high or low pitch
- (()) transcriber's descriptions
- WORD (upper case) loud sounds relative to the surrounding talk
- °word° word/utterance indicating that the sounds are softer than the surrounding talk
- = no break or gap
- - - indicate a short or untimed interval without talk

Analytical Conventions

- Standard British/American English: *italicised*
- Yoruba: underlined
- Pidgin: Courier
- Nigerian English: **bold**
- Arrowed lines: items being focused at particular points of the analysis.