http://dx.doi.org/10.4314/gjl.v10i1.2

DISCURSIVE REPETITIONS AND VOICES IN NIGERIAN CLINICAL MEETINGS

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Abstract
Previous studies on discursive repetitions have acknowledged other-repetitions/reformulations in consultative meetings but have neither focused on the occurrences of a combination of self and other repetitions nor connected them to the polyphonic dimensions of the interactions. Arguing that discursive repetitions sometimes work to demonstrate multiple voices on diagnoses and health state assessments in Nigerian hospital meetings, and that they consequently exert an influence on the negotiation of clinical outcomes, the paper analyses 100 repetitions in 30 doctor-patient interactions in Out-Patient Department clinics in South-western Nigerian hospitals. The analysis shows that doctors repeat (non)-contiguous constituents of their turns in a way that superposes the conjectural voice of the doctor, the medical institutional voice, the voice of medical science and the voice of culture (parenting). Repetitive turns and voices are negotiated with consultative parties' common ground of medical procedures, previous joint/separate clinical encounters and patients' preferences, eventuating in three clinical outcomes: verdicts on patients' health state, commitment to adherence and admittance of non-compliance with regimens.

Keywords: Nigerian consultative meetings; discursive repetitions; polyphony; negotiation of clinical outcomes

1. Introduction

Discursive repetitions, the interactively grounded re-statements/reformulations of a speaker's (self) and a hearer's (other) earlier utterances, are crucial to pragmatic interpretations of discourses. The repetitions by both parties are often triggered by emergent factors such as the perceived absent-mindedness of a co-interactant, reference to

a prior turn, adjacency-constrained emphasis and participants' emotional state-reflective processes. The repetitions' co-textual nature necessarily insists on sequentially determined or contextually shaped meanings, which demand finding a link between different lexical and syntactic elements in an interaction and connecting this to the overall goal of the interaction.

In clinical meetings, discursive repetitions possess the co-textual and contextual qualities observable in all discourses in which they are used. Beyond these, they sometimes demonstrate multiple voices which are reflections of the roles they play at a time, and consequently the interpenetrations of the contexts in which such roles are played (Sigurd and Odebunmi 2019). In several instances, clinical voices show that doctors are at once physicians, counselors, law enforcers and empathisers. These voices in diagnostic utterances, sometimes conveyed by discursive repetitions, are linked to doctors' assessments of patients' health states and the parties' negotiation of clinical outcomes. Yet, this value notwithstanding, the medical pragmatics scholarship in Nigeria has not attended to the connection between discursive repetitions, voices and clinical events. This sync is also yet to be addressed at the global level of the scholarship where, to the best of my knowledge, only other-repetitions/reformulations in Swedish medical interactions (Lindström 2011) have been studied.

A majority of the studies (and a very small number in Nigeria) in the West, which, to a large extent, are sandwiches in larger concerns, have focused on increments in hospital meetings (Bolden, 2000; Maynard 2003; Mikesell 2009; Fox et.al 2013; Amusa 2020). Nigerian and African scholars with an interest in clinical discourse, like some of their Western counterparts, have focused on several aspects of discursive encounters in clinical care in general within which discursive repetitions are situated, but not strictly on the repetitions (Salami 2007; Odebunmi 2008, 2016, 2020; Adegbite and Odebunmi 2010;);Wei and AliMayouf, 2009; Odebunmi and Amusa 2016; Boluwaduro 2018; and Amfo et al. 2018). The silence on discursive repetitions is perhaps due to their uncommon occurrences in several clinical encounters and the greater preponderance of increments than 'mere' repetitions in several encounters in certain climes and clinics. It may as well be due to scholars' different foci from the repetitive turns. While non-incremental repetitions and reformulations occur in several consultative encounters in Nigeria, scholars still do not pay attention to the repetitions in spite of their pragmatically significant role in the clinics.

Ultimately, whether in Nigeria or the West, where some documentation of the repetitions has been done, no effort that I am aware of has connected these repetitions (self, other or a combination of both) to the voices enacted in the clinical events, important as

this is in the clearer understanding of clinical encounters and how meanings are constructed relative to roles and contexts of participants. The current research identifies types and constructional constituents of discursive repetitions, establishes connections between the repetition types and the voices enacted in the interactions and examines how clinical outcomes are negotiated through the interplay of discursive repetitions and voices. In dealing with these research objects, the study addresses two important questions: What forms of discursive repetitions interact with participants' voices in hospital meetings? and what pragmatic implications does this relationship have for clinical negotiations and outcomes?

In Section 2 below, I provide the theoretical premise on which the study is placed; in Section 3, the methodology; in Section 4, the analysis and findings; and in Section 5, the conclusion.

2. Theoretical insights

The study is anchored to two main theoretical poles: Martin and Rose's concept of tracking and the theory of polyphony. They are complemented by some insights from Istvan Kecskes' (2014) socio-cognitive approach, Caffi's (2002, 2007) (and Mey's (2017) concept of (de)responsibilisation and conversation analysis. Martin and Rose's nuanced textuality model of tracking, "(keep[ing] track of who or what is being talked about at any point" (p.145), provides the resources to explain the connectivity of the discursive repetitions at different proximal or distal points in the sampled interactions. Of central relevance here is their identification of homophora, the reference which points outside the text on the premise of shared knowledge, as a communal tracker. There are also situational trackers, namely, endophora (co-text), which tracks preceding and following items, and exophora (context), which tracks things and people outside the text. Preceding trackers (anaphora) are two: direct anaphora which tracks reference directly backwards; and inferred anaphora (bridging), which tracks reference indirectly backwards. Following resources track items forwards in another group (cataphora) or the same group (esphora).

The concept of polyphony (Baktin 1981; Ducrot 1972; Roulet 2011) indicates that the discourse or utterance of only one speaker is capable of enacting different voices or points of view (superposition). The voices' nature which may or may not be explicit ties in well with the concern of the current research as it helps to explain the underlying varying voice expressions that are communicated in single utterances. The study equally benefits from polyphony's theorisation of voice tracking which identifies the current speaker from

the echoed one, and which consequently allows the recognition of the (past) voice reflected in a current speaker's speech that may not belong to the speaker. Culture or group-based (e.g., Yoruba or medical) voices are examples of such perspectives which may enact the view of an individual, that of an entire ethnic/cultural/professional group or that of a body of knowledge as will be shown presently. Intertextuality is another useful resource of polyphony. It addresses how the speaker's use of reproduction, expression or pointing echoes other discourses or points of view.

To explain how consultative parties in the clinics interactively orient to discursive repetitions and voices, additional insights were taken from Kecskes' (2014) socio-cognitive approach (SCA) and Caffi's (and Mey's) concept of (de)responsibilisation. SCA, a theory of intercultural pragmatics that accounts for interactants' common orientations to conversational meaning, deploys some of the following resources found helpful in my analysis: "intention" (apriori/emergent goals of interactants), "attention" ("…cognitive resources available to interlocutors that make communication a conscious action" (Kecskes 2014: 52)) and "salience" (drawing attention to the most vital information). The term, "deresponsibilisation", "*deresponsabilzzazione"* (Cafi 2002:118) or "deresponsibilities" (2007:159), lexicalizes avoidance of responsibility through the use of "bushes" (vagueness which reduces speakers' commitment to the certainty of their propositions). Its opposite is "responsibilisation" (Mey 2021). To responsibilise is thus to express direct commitment to the certainty of one's propositions. Some resources have been taken from the transcription models and descriptive tools of Conversation Analysis to complement the top-down instruments of the above theories. As mentioned in the methodology below, Jefferson's (2004) model of transcription has been adopted. In addition, CA resources such as turn, sequence, contribution and footing shift have equally been used.

4. Methodology

15 private and 10 government-owned hospitals in Oyo and Ondo States were conveniently visited for data as part of a larger project focused strictly on doctor-patient interactions in Out-Patient clinics. Thirty (30) out of about one-hundred and fifty (150) consultative conversations tape/video-recorded in these hospitals between 2015 and 2019 were selected because they have ample instances (100) of discursive repetitions. While all the instances of repetitions were considered in raising analytic categories, only seven in three interactions, which perfectly exemplify all the categories raised, are practically cited in conformity to the principles of the top-down analytical approach deployed. These

conversations, whose full transcripts are provided in the appendix to this paper, were conducted in a mix of English and Yoruba (the indigenous language of Southwestern Nigeria where Oyo and Ondo states are located). The linguistic choices by participants are consistent with Odebunmi's (2003, 2010 and 2013, 2016) observation that the context of consultative meetings, patients' level of literacy in English, patients' relationship with doctors, and doctors' or patients' preference determine the choice of communicative codes in Southwestern Nigerian hospital clinics. The sampled conversations, transcribed using the model developed by Gail Jefferson (2004), last approximately 2 mins (interactions 1 and 2), and 3 mins (Interaction 3). Instances of discursive repetition are in the bold font. The interlineal translation approach is used to translate Yoruba expressions to English; and the Yoruba words in the conversations are tone marked. Data interpretation sessions and brief discussions were held with two medical doctors, one each from the private and government-owned hospitals on the medical implications of the voices enacted in the interactions. Also, short discussions were held with 10 patients on the voices enacted by doctors' discursive repetitions[1]. The analytical method adopted is a function-driven top-down approach (Odebunmi 2018) which categorises the key indices of the research (discursive repetitions, voices and pragmatic implications) on the basis of their contextual occurrences in the conversations vis-à-vis the clinical orientations of both doctors and patients in apriori and emergent terms. Some bottom-up elements, using mainly CA theoretical properties, are combined with the top-down resources in some parts of the analysis. Finally, co-textual elements that thematically align with the discursive repetitions are tracked to fully account for their sequential and pragmatic properties.

5. Analysis

The analysis is developed in three sections in strict compliance with the objectives of the research. The first (5.1) deals with types of discursive repetitions, the second (5.2) with the voices enacted through the repetitions and the last (5.3), with the pragmatic implications of the connection between the repetitions and the voices as manifested in the negotiations of the clinical outcomes of the encounters.

The summaries of the three interactions (labelled "Texts 1-3 in the appendix) are provided below. The excerpts drawn from them are numbered as examples. To facilitate

[1] I am grateful to Drs Abraham Amao and Samson Ojo for their useful comments, particularly on enacted voices; and all the patients who participated in the discussions for their helpful contributions.

connection between the two categories of items, each example goes with its text source: for example, Ex 1: Txt 1 (Example 1: Text 1).

In Text 1, the patient (henceforth "Patient"), an undergraduate student of Yoruba ethnic extraction, presents with stomach pain and the doctor (henceforth "Doctor"), equally a Yoruba by ethnic affiliation, having once treated him for ulcer suspected ulcer. Patient's disagreement with Doctor's suspicion leads to the medical examination by which a diagnosis of ulcer is established. Following this, Doctor tracks the cause of the condition and offers recommendations. Linguistic choices in the interaction were made predominantly from English, the official code of communication in Nigerian schools and the preference of most undergraduate students in all communicative situations.[2] Yoruba choices, initiated by Doctor, are strategic.

In Text 2, the patient, who is of Yoruba ethnic extraction and who is an academic in the university in which the hospital is situated, is in the clinic on a routine visit for a clean bill of health. In spite of his high level of competence in English, he and the doctor communicate predominantly in Yoruba. Doctor checks his blood pressure following which he announces the reading. This reading, preceded by a seemingly negative evaluation of Patient's condition, is completed quickly with an intensified repeat of the original (negative) evaluation.

In Text 3, used to exemplify the patient-centred approach[3] to medical care in Odebunmi (2020), Doctor had checked Patient's BP at the outset of the consultation but did not disclose the reading until the tail end of the meeting. In between these ends, he severally encourages 60-year-old Patient to compromise the dosage of her prescribed medicines to suit the observance of the religious fast in her church. Doctor, rather than use the BP announcement for diagnosis at the close of the consultation, uses it as a discursive tool of constructing negative clinical assessment. Patient is Yoruba by ethnic affiliation and is literate in English, but she speaks Yoruba predominantly with Doctor as a mutual code choice and perhaps as an index of a level of extra-consultative relationship with the doctor (see Odebunmi 2020).

[2] Unlike in primary and secondary schools in Nigeria where administrators and teachers enforce the use of English in the school premises, no one does on Nigerian university campuses, but it is recognised by all parties as the official code and deployed in all official (teaching and administrative) encounters. Outside official scenes, the choice of codes is determined by interactants' contexts, preference and convenience.

[3]The patient-centred approach ensures a smooth relationship between the doctor and the patient and naturally increases patient satisfaction as therapies are mutually decided by the parties (cf Odebunmi 2020).

5.1 Discursive repetitions

Two operational types of discursive repetitions occur in the interactions: non-contiguous and **c**ontiguous. Each is structurally anaphoric in nature and is discursively constructed or co-constructed as an index of a diagnostic or post-diagnostic statement. I take them in turns below.

5.1.1 Non-contiguous discursive repetitions

Non-contiguous repetitions, which are always self-repetitive, do not occur in the same sentences or the sentences next to the repeated contributions. Either an intervening sentence or structure appears between them and the original contribution or several turns appear between the repeated and the repeating sentences/turns. In either position, they are functionally connected to diagnostic and post-diagnostic utterances of the doctor. Both diagnostic and post-diagnostic speeches reflect full constituent direct anaphoric repetitions. I look more closely at these repetitions together with their structural and functional features below.

Full Constituent Direct Anaphoric Self Repetitions (FCDASR)

The FCDASR re-presents the whole stretch of the original contribution. This repetition occasionally comes with an increment which often signifies the motivation for it. In most instances of diagnostic repetitions, the increment is an adverbial element. Example 1 below (from Text 1) demonstrates these features.

Ex 1: Txt 1

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9. DR: So, >what's the complaint?< (0.03)
10. PAT: I do have stomach pain (.)
11. DR: Stomach pain↓ I hope it's not the ulcer pain↓ or ( ) you having at one point in time like that (0.03)
12. PAT: No:: =
13. DR: Where is the pain? (.)
14. PAT: At the middle here↓

15. DR: It's the ulcer pain (.)°Lie down let me check it° ( ) **IT'S THE ULCER PAIN NOW↑**, ṣe ìgbà yẹn náà
16. Is time that it
17 Was that time too
18. ṣe period exam? **bó yá o ò KÍN JẸUN DÁADÁA:** Ìgbà August Ìgbà yẹn, <hope it's not exam period?> (0.02)
19. Is period exam? Maybe you don't eat very well. Time August time then, hope it's not exam period
20. Was it the exam period? Maybe you don't eat well. That time was August; I hope this is not an exam period
21. Did you use any drug like Ibuprofen or Felvin? =
22.PAT: No (0.02)
23. DR: And you didn't take Alabukun↓=
24.PAT: >No< (0.02)
25.DR: You are having ulcer pain now, so **máań jẹun DA:DA: báyìí? (0.04)**
26. You eating very well now?
27. A re you actually eating well?
28.PAT: **Mò**<**'un** try **báyìí**>
29 I trying now
30. I am trying to eat well now
31.DR: °You can't afford not° to eat on time **o**, if you have ulcer (.)
32.PAT: °Super pain°
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At Lines 11 – 12, Patient disaligns with Doctor over his pre-diagnostic proposal of ulcer ("I hope it's not the ulcer pain") which differs from Patient's perspective of his (Patient's) health condition. With the article "the", Doctor evokes apriori common ground with Patient, a referential indexication of an earlier diagnosis by Doctor. At Line 15, following Patient's affirmation of the point of the body where he experiences pain in response to the question at Line 13, Doctor makes the same proposal (i.e. that the condition is ulcer). Knowing that a guess does not suffice to establish a diagnosis, he invites Patient to the examination couch for medical examination (Line 15b).

After the examination, Doctor repeats the exact wording of the pre-examination utterance albeit loudly and with the adverbial "now" (Line 15c). The intervening contribution, "Lie down let me check it", separates the original expression from the full-constituent-repeating expression. While the repeating utterance counts as a diagnosis only after the examination when it becomes a scientific statement (details later), the adverbial "now" provides the motivation for its insertion. "Now" is used in Nigeria as a Standard English and a Nigerian English word to mean respectively "this time/ moment" (which is capable of cancelling the common ground on earlier diagnosis, and is, therefore, not relevant to the context) and "the expected assumed mutual orientation to earlier expressed knowledge" (which is consistent with the current context). By the use of "NOW" (with the marked rising pitch, pronounced with a fall-rise intonation typical of its Nigerian English rendition), Doctor implicates the following:

i. That he had earlier suggested the diagnosis of ulcer to Patient and expected Patient to accept his suggestion;
ii. That Patient's refusal to agree with his proposal caused him to take the extra effort of examining him;
iii. That his earlier conjecture is now confirmed;
iv. That much unnecessary time has been expended on the interaction.

Without the incremental adverbial, the repetition can only serve the pragmatic purpose of confirming Doctor's earlier guess. In the sub-section that follows, I analyse the (co)construction/co-constitution of FCDASR.

Co-constructing/co-constituting FCDASR

While only Doctor produces diagnostic discursive repetitions, the two parties co-construct and co-constitute them for consultative effectiveness. The pre-repetitive "I hope it's not the ulcer pain↓ (Line 11), in spite of the common ground evoked with "the", is not co-constructed as ulcer with Patient's disaffiliative turn at Line 12. This disaffiliative situation inspires a number of Doctor-initiated turns which build up to the pre-diagnostic utterance at Line 15a and which reflect the parties' co-constitution of the ailment and diagnosis. Earlier at Lines 9 - 10, both Doctor and Patient co-constitute the object of Patient's visit. In response to Patient's broad spectral condition suggestion at Line 10, "I do have stomach pain, following Doctor's broad request at Line 9, Doctor at Line 11 produces a weak

diagnostic proposal by evoking Patient's ailment biography. When Patient denies the biographical reality (Line 12), Doctor pursues the weak proposal further by asking a more specific question which demands to know the location of the pain in Patient's stomach (Lines 13-14).

Patient's specification of the point of the pain motivates a strong diagnostic proposal (Line 15a), and this invites science – the examination - at Line 15b. Science authorises diagnostic repetition (Line 15c) which singly constitutes the diagnosis. After Doctor has determined the diagnosis following the examination conducted, he has to also determine and announce the predisposing factor for the ailment to effectively treat and control it. For this, he needs not only his knowledge of Medicine but also Patient's experiential input. Immediately after the repetitive turn that announces the diagnosis, Doctor evokes another biographical log to determine the temporal location of Patient's last episode. In a series of rhetorically-structured questions between Lines 15c and 18a, he traces the episode to a semester examination period which immediately tracks the predisposing factor for the ulcer to Patient's poor eating habits. Doctor deresponsibilises himself by his construction of starvation as the candidate for the ulcer with the use of the modal verb "bóyá (maybe). Since this, a weak proposal, unlike the diagnosis, cannot be scientifically determined, Doctor tactfully abandons it and ventures to make more scientific efforts. Between Lines 21 and 24, both parties co-construct ulcer-aggravating medicines (Ibuprofen, Felvin and Alabukun[4]) as irrelevant candidates in Patient's case because Patient did not use them. These candidates brushed off, Doctor returns to his earlier weak proposal. After a post-diagnostic repetition of the earlier announcement of the diagnosis, Doctor strategically introduces the discursive repetition of the starvation disposition factor: "só máa ń jẹun DÁADÁA báyìí?". Discursively unstructured as a rhetorical question, the interrogative receives an affiliative response from Patient. The repetition here, unlike the original/repeated contribution, takes a negotiative form and thus an interpretation that Patient's view is requested. Apart from the earlier one being an accusation, Doctor leaves no space in the turn for Patient's response. The 0.04 time lapse in the current sequence provides the salience to the Patient of the floor for his perspective. By his response at Line 27, he co-constitutes the starvation perspective of Doctor's and co-constructs his responsibility for his own health condition, his utterance implying that he only recently picked up a fair eating routine/habit. Stylistically, the discursive repetition of the starvation factor is a slightly extended FCDASR in the interrogative rather the statement form in

[4]Alabukun is a Nigerian indigenous acetylsalicylic commonly used by many Nigerians, particularly the illiterate/ semi-literate and alcohol drinkers respectively for headache and for intoxication suppression

which the repeated version is constructed to serve Doctor's goal of negotiating Patient's perspective and cooperation. Sequentially, it comes way after Doctor's check on Patient's treatment biography.

5.2. Contiguous discursive repetitions

The contiguous discursive repetition occurs either in the same grammatical structure as the repeated one or in the structure appearing immediately after it. It is of two key types: intensified full constituent self/other anaphoric repetition and reduced-constituent self/other anaphoric repetition. While the former is associated with positive clinical assessments, the latter is often used to indicate negative clinical assessments. Both respectively refer to doctors' comments indicating that the patient's response to treatment or level of adherence to regimens is cure-consistent/progressive and is cure-inconsistent/retrogressive.

Doctors carry out clinical assessments at different points of their encounters with in-patients (those on admission or observation) and out-patients (those who visit only for medical attention who may or may not be put on admission). The ones considered in this research are those that take place during consultative meetings in the outpatient context. I consider the repetition types and their corresponding assessment manifestations in turns below.

5.2.1 Contiguous intensified full-constituent anaphoric self-repetition

The contiguous intensified full-constituent anaphoric self-repetition (CIFCASR) is a current speaker's contribution that repeats the whole of his/her earlier utterance (in the same sentence or in the sentence immediately preceding it) with an added intensifier that transforms the speech act of the repeated utterance (Capone 2005; Odebunmi 2011). The transformation in my data is often a movement from a pre-diagnostic pract[5] to a clinical assessment pract. Below, I analyse how CIFCASR reflects positive clinical assessments.

[5] A pract is a situated speech act (Mey 2001).

Managing a Tension between Positive and Negative Clinical Assessments Deploying (CIFCASR)

Doctors in consultative encounters with patients conduct positive clinical assessments by the use of CIFCASR through an interesting blend of tact and grammar. The interaction below demonstrates this point.

Ex 2: Txt 2

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15.DR: Fatunbi [Abel], okay (.) hmm:: ṣe wǫ́ntiṣe ÌFÚNPÁ yín lénìí?
16. okay, have they done hand pressure yours today
17. okay have they checked your blood pressure today?
18.PAT: Ẹ ní::↑ (.)
19. you said?
20. Pardon? (.)
21.DR: ṢE WỌ́N TI ṢE ÌFÚNPÁ YÍN NÍGBÀ TẸ́ Ẹ DÉ?
22. Have they done hand pressure yours when you arrived
23. Have they checked your blood pressure since you came?
24.PAT: Rárá
25. No
26. No
27.DR: Ẹ jé kíńṣe kí n mọ̀ (0.4) ((checks the patient's BP)) °Ṣéìtọ̀ yín ò kìńpǫ́n sá°?
28. Let me do let me know Hope urine yours not red?
29. Let me check Hope your urine is not coloured?

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67. DR: Ìfúnpá tímoṣe fún yín yẹn, °ó fẹ́ lọ sókè díẹ̀°, torí 150, 90 ni. °**Ó kàn fẹ́ lọ sókè díẹ̀ni°,**
68 Hand pressure that I do for you that, °it wants to go up small°, because 150, 90 is. °**It just wants to go up small**°
69. Your blood pressure was almost high°, because it was 150, 90. °**It was only almost high**°
70. kòtîì dé level tí a máa ń fún yàn lóògùn (0.03). >So, tíwǫ́n bá fẹ́ fi iyọ̀ sóunjẹ yín, ẹ kàn máa ní kíwǫ́n<

71. not at level that we give people drug (0.03) So, when they want to put salt in food your, you telling say that they
72. it is not serious enough for you to be placed on drugs (0.03)when salt will be added to your food, tell them to
73. dín in kù, THEN LÓÒRÈ KÓÒRÈ BÓYÁ, lẹ́yìn bíiọ̀sẹ̀ méjì, <ẹ kàn le lọ síbi tíwọ́ntiń check ẹ̀>, kíwọ́n bá a
74. reduce, then from time to time maybe, after like week two. You can go to place that they checking it, let them help
75. reduce it and occasionally maybe after two weeks, you may go somewhere to get it checked
76. yín check ẹ̀ kíèèyàn rí i pé kò lọ sókè, because tó bá lọ sókèèèyàn ò ní mọ̀. Ẹ pẹ̀lẹ́ o
77. you check it that somebody see that it not go up because if it goes go up, somebody will not know. You sorry o
78. to be sure it does not rise because if it does, one may not know.

The utterance "Ó kàn fẹ́ lọ sókè díẹ̀ni" (Line 67a) repeats Doctor's "°ó fẹ́ lọ sókè díẹ̀°, torí 150, 90 ni" (Line 67a) in the first part of the sentence immediately preceding it. This structure, with the addition of "ó kàn" and "ni" to the original contribution, makes it a CIFCASR. The original utterance, when, combined with the actual announcement of the BP reading, produces a negative assessment which is capable of scaring anyone without a BP history as the interaction seems to suggest of Patient. This negativity is grounded in three factors:

i. Predicating the announcement of Patient's diagnosis on the reference to the checked BP (67a: first part).

In the Yoruba communicative experience, a structure such as "X tímọ̀ṣe fún yín" is sometimes associated with bad news in the current context; good news is often presented directly without a prefatory rigmarole. Therefore, given Patient's uncertainty of his condition, he is more likely to perceive the news as negative. A video footage would have shown an expression of discomfort on the face of Patient.

ii. Sudden, slightly mitigated announcement of a high BP condition (Line 67a: second part).

This, following a scare-potential preface, carries with it a negative undertone, particularly when considered against the belief among many patients in Nigerian hospitals that a low degree of certainty expressed by a doctor is tantamount to a lie or a concealment of poor

health. So, for a typical patient, the current one not being an exemption, the slight mitigation does not amount to any level of good news.

iii. Connecting the BP figures to the slightly mitigated high reading.

The figure announced, 150/90, would sound high to anyone with or without a biography of hypertension. A literate patient like the current one in the consultative session could possibly have availed himself of the 140/100 upper limit of an average adult person's BP. Doctor's CIFCASR is best situated in the above picture. Sensing fear and discomfort perhaps on Patient's face, Doctor changes the footing of the communication. He quickly transforms the earlier negative clinical assessment pract of disclosure to the positive clinical assessment pract of fear/worry-allaying. This positivity transformation is indexicated by two discursive resources:

i. The deployment of downtoners

Doctor reaches for the combination of the cleft "Ó" (It (is)) and the intensifiers, "kàn" (only) "fẹ́" (almost) as additional structural elements to construct a repeat of his earlier seemingly negative assessment. These additional elements are understood by all competent speakers of Yorùbá to be imbued with the effect to tone down the seriousness of a previous harsh proposition, but its happiness depends strictly on the local context of an interaction. Doctor's goal is obviously to engage the downtoners to repair the suspected discomposure of patient, exploiting the cultural common ground of the structures. However, with the earlier negative assessment, compounded by the high BP figures, the context cannot effectively afford the repair and positive clinical assessment transformation. Doctor understands, by cultural declarative knowledge (see Kecskes 2014), that he needs much more than the downtoners which themselves, in practical structural and discursive terms, still implicate a level of a high BP, to convince Patient that some good news was intended to be communicated. Thus, he opts for a co-textual boost ("kò tíì dé level tí a máa ń fún yàn lóògùn", Line 70) to reinforce Patient's uptake of his transformed pract as shown in 'ii' below.

ii. Practal co-textual extension

Realising the need to increment the transformative discursive repetition for his intended effect, Doctor inserts “kò tíì dé level tí a máa ń fún yàn lóògùn” (it is not serious enough for you to be placed on drugs). This utterance implicates four things: a. that the down toner notwithstanding, Patient actually has a BP**;** b. that Patient does not have a clean bill of health; c. however, that his present condition requires no BP medication; d. that he may or may not require medication-based treatment ultimately. More details will be provided on this later under voices and clinical outcomes. Meanwhile, it is essential to note here that although the utterance serves as a co-text to Doctor’s self- repetition to reduce Patient’s fear of a high BP, it does not dispel the reality of a BP condition.

5.2.2 Contiguous reduced-constituent anaphoric self or other repetition

The contiguous reduced-constituent anaphoric self or other repetition (CRCASOR) is a repetition composed of a part of an original clinical assessment. In most instances of its occurrences, it reflects negative clinical assessments.

Constructing negative clinical assessment using CRCASOR

In constructing a negative assessment using CRCASOR, Doctor repeats a word, a phrase or a clause in the original structure which may or may not be in the same sentence as it. This is shown presently.

Ex 3: Txt 3

85. DR: Enhenh, so, tábáa tiẹ́ báti wá parí [fasting ẹ máa padà]
86. Yes, yes; so, if it once you now have ended fasting you will return
87. Yes, so once you finish the fasting, you will revert
88. PAT: > Hmm, màá padà [**sí** morning and night yẹn<=]
89 I will return to morning and night that
90. I will revert to the morning and night plan)
91. DR: **Ẹ máa lò ó bẹ́ẹ̀, toríón** reflect **lára** BP **yín báyìí, torí**=
92. You using it like that, because it reflecting on body BP you now because
93. Be using it that way because it is already affecting your BP because

94. PAT: **Óń reflect**, èmi ganń rí ìigbà tí mòń bọ̀=
95. It reflecting, I myself seeing it when I coming
96. It is affecting it, I too noticed it when I was coming
97. DR: **Torí** 156/94 **nimo** get **báyìí, àbí** 154/94, **so óńreflect**=
98. because 154/94 is I get now, or 154/94, so it reflecting
99. because 154/94 is my reading, or rather 154/94, so it is affecting it
100. **Óń reflect lára ẹ**. Uhn (0.01). So, **ṣe** bẹ́ẹ̀ ní complaint kankan?
101. It reflecting on body it. So, is it no complaint at any?
102. It is affecting it. So, do you have any complaint?

The interaction presents an interesting display and interplay of self and other discursive repetitions.

Contiguous Reduced-constituent Anaphoric Self-repetition (CRCASR) in the construction of negative clinical assessment

Doctor repeats himself at lines 91, 97 and 100, each of which is contiguously situated relative to the original structure. "Torí" (Line 91), the last item in the sentence, is a reduced constituent self-repetition of the preceding larger structure, Ẹ máa lò ó bẹ́ẹ̀, torí ó ń reflect lára BP yín báyìí". It reductively captures the adverbial clause, "torí ó ń reflect…". Its negativity stems from Patient's compromised regimens which have caused a rise in her BP. When Doctor observes at 91a that the compromised dosage of Nifedipine ("it") is reflecting on (affecting) Patient's BP, he is conducting a clinical assessment of her health state. The adverbial structure "torí" which repeats this initial assessment is grammatically redundant but is strategically salient. While footing shift from the collaborative construction of Patient's initiative as the right medical action to Patient's action as a health-hazardous action (see Odebunmi 2020) commences at Line 91a, its reinforcement and transformation as a warning pract are effected with the repeating "tori" at Line 91b. In the Yorùbá culture, "torí", used this repetitively as an adverbial head word is often a strategic insertion with an intended anaphoric referential effect. It carries the disowning implicature: "Just in case something bad happens, I should be seen to have done my bit". Thus, the negative assessment is indicated by situational trackers: a. anaphoric reference: "torí ó ń reflect" (Line 91b) which constructs indirect lexicalisation of non-compliance to regimen on BP in the current turn; and b. cataphoric reference: high BP: **"**Torí 156/94 ni mo get báyìí, àbí 154/94" which provides evidence for the health hazard Doctor indirectly lexicalizes.

An interplay of CRCAOR (Contiguous Reduced-constituent Anaphoric Other-repetition) and CRCASR

Between Lines 94 and 100, both CRCAOR and CRCASR interplay. Patient's insertion at Line 94 of "Óń reflect" is a CRCAOR of Doctor's original structure at Line 91. By this insertion, she co-constructs Doctor's negative assessment of her health. At Line 100, Doctor's "So, Óń reflect" produces at once a CRCAOR and a CRCASR. First, it tracks Patient's repetition at Line 94 as a co-constructor of her uptake of his negative assessment announcement. At the same time, it tracks his own CRCASR at Line 91, with reference to Patient's CRCAOR at Line 94, as a co-constituent of his medical science (details later). Doctor's original contribution is structured as a combination of a logical connector and a code alternation whose discourse import produces the resultant medical authority that motivates Patient's CRCAOR at Line 94. Subsequent CRCASR and CRCAOR do not evoke the logical connection any more since the medical authority has been established. They rather only provide the speech acts that construct and co-construct the negative clinical assessment which rides on Doctor's routine code alternation. The assessment is indicated by prior indexes of non-compliance and poor health hinted at Lines 21, 22, 38 and 91 and the discursive accommodation of Patient's own negative assessment at Line 94. Ultimately, the co-construction of both CRCAOR and CRCASR implicates a collaborative conclusion on Patient's poor health.

5.3 Voices enacted in (post) diagnostic and clinical assessment discursive repetitions

Non-contiguous and contiguous repetitions superpose four voices, namely, Doctor's conjectural voice, the Medical institutional voice, the Medical scientific voice and the Life word, cultural voice. While non-contiguous repetitions permit all the voices, contiguous voices allow only the medical institutional, medical scientific and life word, cultural voices.

5.3.1 Doctor's conjectural voice

The doctor's conjectural voice is his/her own pre-scientific perspective which may or may not stand after medical scientific processes have been observed or conducted. It is a product of doctors' technical and experiential knowledge which is often expressed as a preliminary proposal to explain patients' conditions prior to examinations and tests. It may or may not terminate at the conjectural stage. The former happens when the outcome of examinations

and tests do not synchronise with the preliminary perspectives; the latter occurs when a sync occurs and the conjectural voice interlaces with the medical institutional and scientific voices as will be shown presently. The example below explains the conjectural voice.

Ex 4: Txt 1

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9. DR: So, >what's the complaint?< (0.03)
10. PAT: I do have stomach pain (.)
11. DR: Stomach pain↓ I hope it's not the ulcer pain↓ or ( ) you having at one part in time like that (0.03)
12. PAT: No:: =
13. DR: Where is the pain? (.)
14. PAT: At the middle here↓
15. DR: It's the ulcer pain (.)°lie down let me check it° ( ) **IT'S THE ULCER PAIN NOW**↑, ṣe ìgbà yẹn náà

The second verbalisation (Line 15) with "ulcer" in Ex 4: Txt 1 instantiates Doctor's conjectural voice which repeats and sustains his earlier declaratively-informed assumption at Line 11. It differs from the actual diagnostic repetition in 15c (IT"S THE ULCER…) by the latter's sequential position and the adverbial "now", both of which come after the examination.

One main feature of this voice is its openness to the patient's disagreement. In some instances, as evident in the full Text 1, patients sometimes pitch their personal experiences against doctors' guesses and find a disalignment between the experiences and doctors' preliminary proposals. In a way, this reflects some kind of claim to personal space which implies that only the owner of the body knows where it hurts. Except doctors' guesses tally one-to-one with patients' thoughts and exact experiences, sometimes, doctors' voices are refuted. This refutation often requires more clinical and discursive efforts on doctors' part. One of the doctors consulted for the discussion sessions (the one in private practice) confirmed that doctors' conjectural voices exist in the clinics but that doctors have to relate to them carefully to avoid wrong diagnoses given the possibility of the existence of multiple symptoms against single ailments. The doctor in the teaching hospital agreed that certain categories of doctors, particularly those in private practice exhibit conjectural voices, which to him is not consistent with standard medical practice. He personally de-

recommended physician guesses which he associated with incompetence, laziness and excessive urge for making money.

Doctor's seemingly common-ground motivated guess at Line 11 gets refuted at Line 12 by Patient. Driven by his competence, following a series of post-refutation questions, Doctor takes another guess, the non-contiguous discursive repetition which echoes the truth content of the pre-scientific, earlier guess, and which is followed by the scientific task of examination. Thus, the enacted doctor's voice does not self-terminate; rather, it interlaces with institutional and scientific voices. In the discussion sessions, the doctor from private practice confirmed the views of some patients that the scientific intervention of examinations made by Doctor was not being practised by a handful of Nigerian physicians who made recommendations on the basis of their preliminary guesses. He held the view that this is a dangerous practice, arguing that the guess of an ulcerous condition by Doctor in Text 1, without an examination, is refutable on the grounds that the same symptoms and body part sites mentioned by Patient could potentially produce a cancer or a pancreas disease. While the doctor from the teaching hospital agreed with this view in large measure, he insisted that doctors practise what he called "clinical acumen", rather than a guess, a conjecture of possible ailments based on the symptoms presented by patients, which itself must be confirmed by examinations and laboratory investigations for clinical accuracy, except in extremely clear and simple cases such as malaria. The submissions by the two doctors, irrespective of the angles of their arguments, validate the existence of doctors' conjectural voices in the clinics. This validation is as important as their emphasis that conjectural voices are weak bases for diagnoses and treatments.

5.3.2 Medical institutional voice

This is the enactment of a perspective that is reflective of hospital procedures and activities which do not necessarily come with a huge systematic scientific knowledge of disease. It contextualises agency, role, objects, and actions as medical-institutional and as a consequence demonstrates the institution's orientation to care, firmness, authority and responsibility. The medical institutional voice, however, overlaps with and/or subsumes the medical scientific voice at the level of authority. This is clarified in 5.3.3 below.

In this research, the discursive repetition by which the medical institutional voice is enacted is associated with doctors' diagnostic and post-diagnostic utterances as shown in Ex 5 and Ex 6 below.

Ex 5: Txt 1

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9. DR: So, >what's the complaint?< (0.03)
10. PAT: I do have stomach pain (.)
11. DR: Stomach pain↓ I hope it's not the ulcer pain↓ or ( ) you having at one part in time like that (0.03)
12. PAT: No:: =
13. DR: Where is the pain? (.)
14. PAT: At the middle here↓
15. DR: It's the ulcer pain (.)°lie down let me check it° ( ) **IT'S THE ULCER PAIN NOW**, se igba yen na
16. Is time that it
17 Was that time too
18. **se** period exam? **bo ya O KIN JEUN DA:DA:** Igba August **Igba yen**, <hope it's not exam period?> (0.02)
19. Is period exam? Maybe you don't eat very well. Time August time then, hope it's not exam period
20. Is it the exam period? Maybe you don't eat well. That time was August; I hope this is not an exam period
21. Did you use any drug like Ibuprofen or Felvin? =
22.PAT: No (0.02)
23.DR: And you didn't take Alabukun↓=
24.PAT: >No< (0.02)

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In this example, the medical institutional voice is enacted in the following ways:

a. The announcement of a diagnosis of ulcer by a physician

That follows an examination is an indication of a clear understanding of medical institutional operations. It, however, subsumes an underlying scientific knowledge that produces the diagnosis (the medical scientific voice) as will be shown in 5.3.3.

b. An expression of Doctor's Aesculapian power (physicians' use of medical knowledge to heal patients).

In addition to deploying discursive repetition in announcing the diagnosis which defines a doctor's reserve and vested authority to heal the patient, the use of "now", as explained earlier, also shows a level of doctoral authority.

c. Responsibilisation achieved with the direct announcement of the diagnosis.

This is typically the role of a doctor. With this unmitigated or unveiled announcement (see Odebunmi 2011), Doctor responsibilises himself for Patient's condition, and that singular act makes the announcement count as a medical institutional voice. He predicates the condition as an attribute of Patient (of course relying on scientific knowledge) and as a consequence, places the responsibility for the correctness and consequences on the institution Doctor represents.

Ex 6: Txt 2

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64. PAT: BEE ni sir (0.03)
65. Yes sir.
66. Yes sir
67. DR: Ifunpa ti mo se fun yin yen, °o fe lo soke die°, tori 150, 90 ni. °**O kan fe lo soke die ni**°,
68 The arm pressure that I do for you so, it want to go up small, because 150, 90 is. It just want to go up small
69. Your blood pressure increased a little bit. It is 150/190. It only increased a little bit sir.
70. koti i de level ti a maa fun yan loogun (0.03) So, ti won ba fe fi iyo sounje yin, ekan maa ni ki won
71. It has not reach level that we give person drug, so, if they want to put salt in your food, you just say they should
72. It requires no medication yet. Just instruct that the quantity of salt put in your food should

73. dikun, then lore koore boya, leyin bii o se meji, e kan le lo sibi ti won ti n check e, ki won ba
74. reduce it then, every time, maybe, after like two weeks, you can now go to where they check it, they should help you
75. be reduced, then occasionally, maybe after two weeks, you may then go to places where they read it so they can help
76. yin check e ki eeyan ripe ko lo soke, because to ba lo soke eeyan o ni mo. E pele o
77. you read it, so that one sees it does not go up, because if it goes up, person will not know. Sorry o
78. you read it to be sure it does not rise because one may not know it has risen. Sorry.
79. PAT: °Kini diabetes yen n ko sa?°
80. The thing diabetes that where it sir?
81. What of the diabetes issue, sir?
82. DR: Gbogbo e eni mot ii, test e nii, lab le ti maa se, won ye ito yin wo,won a ye eje yin wo.
83. All of them that I have tested is, lab is you will do it, they check your urine, they will check your blood
84. Everything has been included. You will carry out all the tests in the lab: your urine and your blood.
85. So e mu lo
86. So take it there

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Ex 6: Txt 2 provides a medical institutional voice in the context of clinical assessment. As discussed earlier, Doctor tries to manage the fairly bad news in a way that does not cause discomfort for Patient. Before he opts for the discursive repetition, he has tried out other options which could not be afforded by the context created by the first clinical assessment and the subsequent BP reading. To provide effective institutional service, Doctor has to orient to patient-centred care which privileges patient assurance as a cardinal focus. This approach requires a careful formulation of the news for the best effect and avoidance of physician blame in the long run. Doctor selects medical indexes of care which are best evident in a comparison between ***ókàn fẹ́*** lọ sókè díẹ̀ ***ni*** (double-intensification) and ***Ó fẹ́*** lọ sókè díẹ̀ (single intensification). With ***ó kàn fẹ́*** and ***ni,*** Doctor mitigates the hypertensive condition. In other words, he avoids the use of the technically correct term, "moderate hypertension" and thus deresponsibilises himself for the condition of Patient. This deresponsibilisation makes the repetition count as a medical institutional voice and

consequently reduces the condition scare while still picking out the referent but taking weakened responsibility for Patient's condition.

5.3.3 Medical scientific voice

The medical scientific voice refers to the enactment of a perspective that strictly articulates Medicine's systematic knowledge of disease. It illustrates the scientific resourcefulness that interacts with the medical institutional operations to produce the authoritativeness and reliability of medical practice within the (post)diagnostic and clinical assessment contexts.

Ex 7: Txt 1

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9. DR: So, >what's the complaint?< (0.03)
10. PAT: I do have stomach pain (.)
11. DR: Stomach pain↓ I hope it's not the ulcer pain↓ or ( ) you having at one part in time like that (0.03)
12. PAT: No:: =
13. DR: Where is the pain? (.)
14. PAT: At the middle here↓
15. DR: It's the ulcer pain (.)°lie down let me check it° ( ) **IT'S THE ULCER PAIN NOW**, se igba yen na
16. Is time that it
17 Was that time too
•
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•

"Now" in Ex 7: Txt 1 enacts the voice of medical science. First, it follows the sentence that bears the diagnostic announcement which itself, with the particulariser, "the", tracks earlier mentions (Lines 11b and 15a), makes exophoric reference to the physical co-presence (Clark 1996) of the consultative parties and implicates systematic medical knowledge.

The meaning of "now" indicates a firmer establishment of Doctor's diagnostic perspective as against earlier guesses. It comes with a comparative tone which places the earlier Patient-doubted conjectural voice against the new Doctor systematically-advanced

voice. It thus implicates Doctor's evocation, utilisation and confirmation of his knowledge of human anatomy and ulcer pathology. These scientific considerations, packed into the adverbial "now" and implicatively enriched in the main pre/post/diagnostic structures include, for example:

a. Peptic ulcer is located in the lining of the stomach or the upper intestine. This knowledge informs Doctor's question at Line 13: Where is the pain?
b. Patient's answer, "At the middle" (where the lining of the stomach is situated) confirms a Peptic ulcer condition to Doctor. Doctor's scientific knowledge motivates the stronger diagnostic claim he makes before he carries out an examination on Patient.

The post-diagnostic non-contiguous repetitions in Ex 8 and Ex 9 further demonstrate the voice of medical science:

Ex 8 Txt 1:

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15. DR: It's the ulcer pain (.)°lie down let me check it° ( ) **IT'S THE ULCER PAIN NOW**, se igba yen na
16. Is time that it
17 Was that time too
18. **se** period exam? **bo ya O KIN JEUN DA:DA:** Igba August **Igba yen**, <hope it's not exam period?> (0.02)
19. Is period exam? Maybe you don't eat very well. Time August time then, hope it's not exam period
20. Is it the exam period? Maybe you don't eat well. That time was August; I hope this is not an exam period
21. Did you use any drug like Ibuprofen or Felvin? =
22.PAT: No (0.02)
23.DR: And you didn't take Alabukun↓=
24.PAT: >No< (0.02)
25.DR: You are having ulcer pain now, so **ma n jeun DA:DA: bayi? (0.04)**
26. You eating very well now?
27. A re you actually eating well?

27.PAT: **Mo** <**'un** try **bayi** >
28**.** I trying now
29. I am trying to eat well now
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This utterance as an index of the medical scientific voice implicates, at least, two forms of knowledge on which Doctor's suspicion and diagnosis of peptic ulcer stands:

a. Acute starvation

This is enacted by Doctor's interrogative (Line 25, Text 1), but is equally pre-indicated by his weak effort to determine the cause of the ulcer with the deployment of probability modality (Line 18, Text 1). Doctor's co-textual reference to Patient's examination period-invoked hunger (Line 18, Text 1) and his general self-starvation practices implied at Line 28, Text 1 strengthen the medical scientific voice.

b. The use of ASA (acetylsalicylic) and other NSAIDS (Non-steroidal anti-inflammatory drugs)

Doctor's deployment of co-textual reference contiguous to the interrogative discursive repetition (Line 25) further establishes the voice of medical science. He attempts to rule out Patient's use of ASA (Alabukun) and NSAIDS (Ibuprofen and Felvin) which, by Doctor's knowledge of medicine, causes or aggravates ulcer.

The firmness that attends Doctor's post-diagnostic non-contiguous discursive repetitions and several co-texts, supported by an underlying demonstration of scientific knowledge, which present a tone of certainty, verifiability and affirmation produced following examination, add up to the medical scientific voice enacted in the interaction.

Ex 9: Txt 3
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85. DR: Enh enh, so, to baa ti e bati wa pari [fasting e maa pada]
86. Yes, yes; so, if it once you now have ended fasting you will return

87. Yes, so once you finish the fasting, you will revert
88. PAT: > Hmm, maa pada [**si** morning and night yen<=]
89 I will return to morning and night that
90. I will revert to the morning and night plan)
91. DR: **E maa loo bee, tori o n** reflect **lara** BP **yin bayi tori**=
92. You using it like that, because it reflecting on body BP you now because
93. Be using it that way because it is already affecting your BP because
94. PAT: **O n reflect**, emi gan n ri igba ti mo nbo=
95. It reflecting, I myself seeing it when I coming
96. It is affecting it, I too noticed it when I was coming
97. DR: **Tori** 156/94 **ni mo** get **bayi, abi** 154/94, **so o n reflect**=
98. because 154/94 is I get now, or 154/94, so it reflecting
99. because 154/94 is my reading, or rather 154/94, so it is affecting it

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This utterance is a combination of the English logical connector, "so", the Yoruba pronominal "ó" and continuous tense marker "ń", together with the English lexical verb "reflect. "So" produces a conclusion from the co-textual, "Torí 156/94 ni mo get báyìí, àbí 154/94" (Line 97) which presents a diagnosis based on the scientific information embedded in the BP reading figures. When combined with "ó ń reflect", a judgement or an assessment is produced, enacting a medical scientific voice built on the following knowledge:

a. Adults 60 years of age or older with systolic blood pressure of 150 mm Hg or more should be treated with a goal of reducing systolic blood pressure to less than 150 mm Hg.
b. Adults 60 years of age or older who have had a stroke or transient ischemic attack (mini stroke) should be treated with a goal of reducing their systolic blood pressure to less than 140 mm Hg.
c. Adults 60 years of age or older who are at high risk for cardiovascular events (e.g., heart attack) should be treated with a goal of reducing their systolic blood pressure to less than 140 mm Hg, but this decision should be made on an individual basis.
d. In adults 60 years of age or older, blood pressure treatment targets should be determined based on a patient's history and risk factors

(https://www.mcmasteroptimalaging.org/full-article/es/people-60-years-age-older-blood-pressure-targets-determined-based-history-risk-1627)

e. Nifedipine belongs to a class of medications known as calcium channel blockers.
f. It works by relaxing blood vessels so blood can flow more easily.
g. This medication must be taken regularly to be effective. (https://www.webmd.com/drugs/2/drug-8681-10/nifedipine-oral/nifedipine-oral/details)

Based on the above scientific facts, with co-textual reference to the drug Nifedine prescribed and the current BP reading, Doctor's medical science voice with "so, ǫ́ǹ reflect" foregrounds the following:

i. Patient is 60 years old, and Doctor's knowledge of her history and risk factor which lies in the parties' common ground, determined the treatment regimen with Nifedipine.
ii. The discursive repetition's pract of warning implicates a re-affirmation of existing hypertension.
iii. Patient's age requires her BP to be kept at less than a systolic reading of 150, which was the reason Nifedipine was recommended.
iv. For Nifedipine to be effective, Patient has to use it regularly, but in the current case, Patient has unilaterally stopped the use or altered the recommended instructions because she was observing days of fasting in her church.
v. Nifedipine is no longer effective in controlling the BP because of the alteration.

Consequent upon these check-listed features, Doctor attributes Patient's poor health to her non-adherence to the regimen given and thus shifts the blame of her medically dangerous action to her through the co-enactment of a medical institutional voice – the deployment of a deresponsibilising discursive repetition. More details are provided on the negotiation of clinical outcomes in Section 5.4 below.

In the discussion sessions, all the participating patients said they believe doctors more when they premise their information on medical scientific knowledge than when they counsel them in general or attempt to persuade them about their lifestyles or empathise with them. Some of them expressed the view that they sometimes suspect a possible disclosure of bad news or concealed information when doctors "try to be very nice to them". For most of them, direct or indirect evocation of medical scientific voice engenders

immediate satisfaction, fear, hopelessness or caution, the expression of which was confirmed by the two doctors. These perspectives could explain why Patient in Text 3 quickly drops her religious convenience position embraced up to the point Doctor shifts footing to the voice of medicine. While a good number of the interviewed patients appreciate patient-centredness and its attendant emotional succour, together with its prevention of complications, they nonetheless acknowledge the tentativeness of the clinical effects of the approach in negative news disclosure.

5.3.4 Life world, cultural voice

The life world, cultural voice indicates doctors' perspectives reflecting their socio-cultural rather than their medical professional attitudes to events in clinical consultations. It depicts a superposed perspective that shows an influence of doctors' cultural orientations on the interchanges in hospital meetings. The enacted voice, unlike other voices, is often strategically evoked and relayed in indigenous languages. When the code of interaction is English between speakers of the same language (Yoruba in the current case), doctors often switch to the indigenous language or use English in a way to give it the special enablement to carry the intended cultural message. Ex 10 and Ex 11 below are clear instantiations of the life world, cultural voice.

Ex 10: Txt 1

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15. DR: It's the ulcer pain (.)°lie down let me check it° ( ) **IT'S THE ULCER PAIN NOW**, se igba yen na

16. Is time that it

17 Was that time too

18. **se** period exam? **bo ya O KIN JEUN DA:DA:** Igba August **Igba yen**, <hope it's not exam period?> (0.02)

19. Is period exam? Maybe you don't eat very well. Time August time then, hope it's not exam period

20. Is it the exam period? Maybe you don't eat well. That time was August; I hope this is not an exam period

21. Did you use any drug like Ibuprofen or Felvin? =

22.PAT: No (0.02)

23.DR: And you didn't take Alabukun↓=
24.PAT: >No< (0.02)
25.DR: You are having ulcer pain now, so **ma n jeun DA:DA: bayi? (0.04)**
26. You eating very well now?
27. A re you actually eating well?
27.PAT: **Mo** <**'un** try **bayi** >
28 I trying now
29. I am trying to eat well now
30.DR: °You can't afford not° to eat on time **o**, if you have ulcer (.)
31.PAT: °Super pain°
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This interrogative, which has been cited earlier as an example of the medical scientific voice, and which tracks "It's the ulcer pain now… bóyá oò kì ń jẹun dáadáa" (Line 18), produces a lifeworld, cultural voice. While it implicates medical scientific knowledge, its distributional position immediately after the non-contiguous discursive diagnostic repetition is a footing shift to Yoruba from English with significant cultural implications. First, given the high contextual setting in which the clinical consultation takes place, the collectivist culture plays a significant role. The footing shift indexicates a movement from institutional formality to social familiarity (Line 18b), a cue that is consistent with "you-are- your- neighbour's- keeper ideology of the Yorùbá which culturally empowers a typical adult or elderly person to take freedom with and an interest in the affairs of a younger person and make repairs as deemed appropriate. The interrogative sounds conventional, and thus ordinary, to a cultural outsider, but to an insider, it comes with a tone of concern typically associated with a child-parent talk. This tone is inferably represented in the following interrogative enrichments: "Are you really sure you are eating well?"; Do you not think you are not being unfair to yourself by not eating well?"; "Do you not think your not eating well should be of serious concern?" Each of these enrichments comes within the affective parental stance in the Yorùbá culture, particularly when taken together with "bayi" which situates the talk essentially in the Yorùbá collectivist culture. It suggests a context where a sincerely concerned parent is interested in the wellbeing or wellness of a child, a relation or any member of the community.

The contribution, taken as a whole, meshes with aspects of institutional care (in which the doctor expresses empathy towards the patient), but further implicates cultural inclusivity and thus a more socially-welcome invitation of biographical accounts contra clinical medical approaches. The uptake of this culturally-ingrained perspective to which Patient is familiar informs his quick cooperative response at Line 28 by which he co-constructs Doctor's thesis of starvation and consequently the cause of Patient's ulcer condition with him. This means that patients seem to cooperate better with doctors when a cultural voice to which both parties orient is enacted in the consultative meetings. This, in fact, is the view of most of the patients and the two doctors interacted with.

Ex 11: Txt 3

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79. Dr: It's okay↓ So, **E SI LE MAA LO ONI** TWENTY **YEN EYO KOOKAN LALALE**=
80. You still can using that one twenty that one one one in night night
81. You can still be using the twenty milligram one, one every night
82. Pat: >**Mo N LOO**<↑=
83. I using it
84. I am using it
85. DR: **Enh enh**, so, **to baa ti e bati wa pari** [fasting e maa pada]
86. Yes, yes; so, if it once you now have ended fasting you will return
87. Yes, so once you finish the fasting, you will revert
88. Pat: > Hmm, **maa pada** [**si** morning and night yen<=]
89 I will return to morning and night that
90. I will revert to the morning and night plan)
91. Dr: **E maa loo bee, tori o n** reflect **lara** BP **yin bayi tori**=
92. You using it like that, because it reflecting on body BP you now because
93. Be using it that way because it is already affecting your BP because
94. Pat: **O n** reflect, **emi gan n ri igba ti mo nbo**=
95. It reflecting, I myself seeing it when I coming
96. It is affecting it, I too noticed it when I was coming
97. Dr: **Tori** 156/94 **ni mo** get **bayi, abi** 154/94, **so o n** reflect=
98. because 154/94 is I get now, or 154/94, so it reflecting
99. because 154/94 is my reading, or rather 154/94, so it is affecting it

100. **O n** reflect **lara e**. Uhn (0.01). So, **se bee ni** complaint **kankan**?
901. It reflecting on body it. So, is it no complaint at any?
102. It is affecting it. So, do you have any complaint?
103. Pat: **Rara** sir=
104. No sir
105. Dr: **E le maa lo**=
106. You can be going go
107. You can now leave
108. Pat: Okay sir=
108. Dr: **E pele o**.
109. You sorry please
110. Take care please

This word, in addition to serving as an adverb of reason, provides a cultural intervention in the Yorùbá context of consanguinity. In its suggestion of "Just in case something bad happens; I should be seen to have done my bit", it presents the claim that Doctor has provided the required information for Patient to live healthy: to return to her dosage of Nifedipine for the treatment of high BP as was being used before the fast began. The consanguineous voice is the perspective that is found in the elder/younger and superior/subordinate persons' cultural interactions where the former lays claim to greater wisdom and expects the latter to be guided by such or be ready to take responsibility for the consequences of the resultant disobedience. Thus, in Ex 11: Txt 3, Doctor's life word, cultural voice provides a warner, disowning tone in bad consequences and seems to suggest a poor prognosis in situations of continued non-adherence.

5.4 Negotiating clinical outcomes with discursive repetitions and voices

Doctor and Patient through the deployment of discursive repetitions and enacted voices negotiate three clinical outcomes: joint verdicts on Patient's health state, Patient's commitment to adherence and Patient's admittance of non-compliance with regimens. Except in about five of the interactions, the outcomes are not found at once in all the 30 sampled interactions. To save space and avoid repetitions, Text 3 which more clearly exemplifies all the outcomes is used for the analysis in this section. The outcomes are sequentially rather than categorially discussed to allow for a good flow and a clear

demonstration of context-shaped and context-determined choices and strategies deployed by the parties.

Two discursive repetitions used in the interaction are "Torí" and "(so) óń reflect". Doctor's self-repetitive "Torí" (Line 91) issues a sudden disowning warning contra preceding turn. The repetition is discursively designed as a strong health warning, relying on attention (Kecskes 2014) based on the apriori common ground at Lines 85-91a&b where both draw on the knowledge of the recommendations made by Doctor, the fasting rites of Patient and her alteration of the regimen plan prior to the current interaction. "Torí" serves as an assumed reference to these with the expectation that without an explicit statement, Patient would perceive the connection between her choice treatment plan and the medically acceptable practice. The verbalised declarative shared knowledge of medical institutional and scientific standards by Patient at Line 88 as a response to Doctor's hinted dosage restoration at Line 85 comes off as Patient's co-construction of the compliance expectations from her. Doctor, having established this co-knowledge with Patient, undertakes two discursive actions. First, at Line 91a, he indirectly accuses Patient of non-adherence. While "Ẹ máa lò ó bẹ́ẹ̀…" admits and authorises Patient's knowledge of her expressed treatment plan, it implies that Patient did not follow the plan for effective control of her BP. To reinforce this move, he suddenly announces his verdict on Patient's poor health and strengthens this with the repetition of "torí", carrying a strong force of accusation, itself premised on their shared discursive knowledge of Patient' negative role on the management of her BP condition.

Patient co-constructs Doctor's self-repetition of "torí" as a warning intention by recognising the cultural voice as an appeal to sobriety, caution, and adjustment (Line 94). This is demonstrated through Patient's repetition of Doctor's "ó ń reflect" at Line 91, enhanced by the realisation cue latch at Line 94, as an admittance of Doctor's medical scientific truth; and thus an alignment with Doctor's verdict on the poor state of her health. The preceding sequence (Line 94: èmi gan-an rí i …) orients to the salience of Doctor's "torí" and scientific voice (óń reflect) as a co-construction (with Doctor) of health hazard and thus an admittance of non-adherence to regimens due to religious obligation.

At Lines 97–100, Doctor's repetitive "Ó ń reflect" occurs in two forms: the first" so ó ń reflect" (Line 97) comes as a conclusion pract, as earlier pointed out, following the warning "torí" and the announcement of Patient's heart state. The second at Line 100, "Ó ń reflect lára ẹ" comes as a preceding contribution to Doctor's closing of the consultative session. Combining both repetitive turns, Doctor evokes medical authority with its attendant medical scientific voice by co-constructing Patient's admittance of non-

adherence at Line 94 as the right clinical action. This co-construction is achieved at different levels. First, in respect of the first at Line 97 which is an interplay of CRCAOR and CSCR, he co-constructs Patient's view and knowledge as the right medical perspective through the deployment of the reason ('torí") and the logico-conclusion ("so") markers at Line 97. Second, following the "so" construction is a latching version of the "ó ń reflect" repetition, "Ó ń reflect láraẹ̀ (Line 100), in which Doctor discursively meshes Patient's admittance of non-adherence with his own medical view as a proposal for a final agreement on the clinical event. By this clear negative evaluation of Patient's health, Doctor has responsibilised, as an institutional act, for her poor health. In the same Line, Doctor further establishes the authority of his declaration by the use of the Yorùbá affirmation marker "Uhn", designed doubly as authority and a reaction-inviter from Patient. Then, in alignment with the principles of patient-centred medicine, he observes a very short in-talk pause to allow Patient's uptake of his negative evaluation and a TRP for her contribution. He continues as a current speaker when Patient does not take up the floor. This implicates Patient's acceptance of Doctor's position as the right medical direction and her commitment to adherence to regimens following Doctor's negative evaluation and its implications for her health. He now selects "so" as a conclusion marker with a pragmatic role.

Based on the overall negotiated clinical outcomes, "so" serves as a logical concluder of the parties' co-constructed position that Patient's action is responsible for her poor health and a signal of the conclusion that the two parties are agreed on Patient's fault and her commitment to adherence. Still following the principles of patient-centred medicine to ensure that his inferences are fully co-constructed with Patient, Doctor requests for Patient's complaint (Line 100). Her "no-complaint" response implicates the acceptability of her responsibility for her poor health and the commitment to a positive change.

6. Conclusions

In this paper, I have identified two key discursive repetitions in clinical interactions: non-contiguous full-constituent self-repetitions in diagnostic and post-diagnostic contexts and contiguous full/reduced-constituent self/other- repetitions in positive and negative evaluative contexts. I have argued that they enact four discursive voices: conjectural, institutional, scientific and cultural, and that the interaction between the repetitions and voices produces the negotiation of three clinical outcomes: joint agreement on Doctor's verdicts, Patient's admittance of non-adherence and Patient's commitment to adherence.

With the application of the model of discourse tracking and the theory of polyphony, supported by Kecskes' socio-cognitive approach and Cafi's (and Mey's) concept of (de)responsibilisation, I have shown that repetition-grounded voice salience and common ground largely constrain co-construction and negotiation of meaning, social perspectives and medical knowledge in the encounters. This study connects with Lindström (2011) only in its exploration of other repetitions in consultative meetings, not in its comparison of the rate at which different categories of doctors repeat their patients' utterances. It also only partially aligns with Bendix (1980) which emphasizes doctors' repetition of patients' last words. Beyond these studies, in the research, I have given attention not only to other-repetitions but also to self-repetitions of doctors and patients. I have in addition shown a link between the repetitions and the voices enacted in the encounters together with the discursive negotiation of clinical outcomes through the deployment of repetitions and voices.

In particular, I have claimed that while all the four voices of discursive repetitions play significant roles in consultative meetings in Nigerian hospitals, the medical scientific voice and the lifeworld cultural voice appear more directly impactful on patient believability of the medical process and cooperation for information and medical effectiveness. I have focused only on the broad, non-differential discursive repetitions achieved with linguistic resources from both English and Yoruba. I have not explored a comparison between English and Yoruba repetitions and their discursive impacts on the sequential contexts and clinical outcome negotiations. Future research can pay attention to these aspects. Future research can also focus exclusively on and expand the pragmatic features and implications of each of the voices. Such research can also investigate in detail the relative impacts of the voices on the effectiveness of care in Nigerian hospitals.

Finally, this research has demonstrated that clinical conversations provide useful insights into the design of diagnostic contents and clinical assessments; and combine effectively with polyphony to show how doctors and patients satisfactorily negotiate therapeutic outcomes in clinical meetings. It, therefore, has presented a useful resource for physicians, particularly in high-context cultures, to navigate patient-centred practice in consultative meetings.

Acknowledgements

I appreciate the invaluable comments of Prof. Peter Auer of Freiburg University, Germany and Prof. Karin Birkner of Bayreuth, Germany on the early draft of this paper.

References

Adegbite, Adewale and Akin Odebunmi. 2006. "Discourse Tact in Doctor-Patient Interactions in English: An Analysis of Diagnosis in Medical Communication in Nigeria." *Nordic Journal of African Studies* 15(4): 499–519.

Amfo, Nana, Ekua Houphounet, Eugene Dordoye and Rachel Thompson. 2018. "The Expression of Mental Health Challenges in Akan." *International Journal of Language and Culture* 5(1): 1–28.

Bakhtin, Mikhail. 1981. "Discourse in the Novel." In *The dialogic imagination: Four Essays*, edited by M. Mikhail, 273-335. Texas: University of Texas Press.

Bendix, Torben. 1980. *Din nervösa patient : Det terapeutiska samtalet: Introduktion till en undersökningsteknik du aldrig fick undervisning i*. Lund: Studentlitteratur.

Bolden, Galina. 2000. "Toward Understanding Practices of Medical Interpreting: Interpreters' Involvement in History Taking." *Discourse Studies* 2(4): 387-419.

Boluwaduro, Eniola (2018): *(Non) Adherence in Doctor/Patient Interactions in Nigerian HIV Clinics*. PhD Thesis. University of Bayreuth. epub.uni-bayreuth.de/3828/ [01.02.2020].

Caffi, Claudia. 2002. *Seilezioni di pragmaticalinguistica*. Genova: Name.

Caffi, Claudia. 2007. *Mitigation*. Oxford: Elsevier.

Capone, Alesandro. 2005. "Pragmemes: A study with Reference to English and Italian". *Journal of Pragmatics* 37: 1355-1371.

Ducrot, Oswald. 1972. *Dire et ne pas dire*. Hermann.

Fox, Barbara, Sandra Thompson, Cecilia Ford and Elizabeth Couper-Kuhlen. 2013. "Conversation Analysis and Linguistics". In *The Handbook of Conversation Analysis* edited by Jack Sidnell and Tanya Stivers, 726-740. Chichester, UK:Wiley-Blackwell.

Kecskes, Istvan. 2014. *Intercultural Pragmatics*. Oxford: Oxford University Press.

Lindstrom, Nataliya. 2011. "Use of Other-repetitions/reformulations as Feedback by Foreign and Swedish Physicians in Medical Consultations." In *Proceedings of the 3rd Nordic Symposium on Multimodal Communication* Vol 15 edited by Patrizia Paggio, Elisabeth Ahlsen, Jens Allwood, Kristiina Jokinen, CostanzaNavarretta, 10-17. Helsinki: Northern European Association for Language Technology.

Maynard, Douglas W. 1991. "The Perspective-Display Series and the Delivery and Receipt of Diagnostic News". In *Talk and Social Structure. Studies in Ethnomethodology and Conversational Analysis* edited by Deirdre Boden and Don H. Zimmerman, 164-192. Cambridge: Cambridge University Press.

Maynard, Douglas W. 2003. "Bad News Good News: Conversational Order in Everyday Talk and Clinical Settings". Chicago: University of Chicago Press.

Maynard, Douglas W. 2004. "On Predicating a Diagnosis as an Attribute of a Person." *Discourse Studies* 6(1): 53–76.

Mey, Jacob. 2001. *Pragmatics. An Introduction*. Malden: Blackwell.

Mey, Jacob. 2021. "In Tempore Opportuno: Of Certainty and Uncertainty in (Non) Time." In *Pragmatics, Discourse and Society: A Festschrift for Akin Odebunmi*, edited by Niyi Osunbade, Foluke Unuabonah, Ayo Osisanwo, Funke Oni and Akin Adetunji, 1-25. Cambridge: Cambridge Scholars Publishing.

Mikesell, Lisa. 2009. "Conversational Practices of a Frontotemporal Dementia Patient and His Interlocutors." *Research on Language and Social Interaction*, 42(2): 135–162.

Odebunmi, Akin. 2008. "Pragmatic Strategies of Diagnostic News Delivery in Nigerian Hospitals." *Linguistic Online* 36(4): 21-37.

Odebunmi, Akin. 2016. "'You didn't give me to go and buy': Negotiating Accountability for Poor Health in Post-recommendation Medical Consultations." *Journal of Pragmatics* 93: 1-15.

Odebunmi, Akin. 2018. "Current Approaches to Analysis in Pragmatics Research." A presentation at the First Pragmatics Research Workshop of the Nigerian Pragmatics Association, Lagos State University, Nigeria, 18 July 2018.

Odebunmi, Akin. 2020. "Negotiating Patients' Therapy Proposals in Paternalistic and Humanistic Clinics." *Pragmatics* 31(1): 430-454.

Odebunmi, Akin and Oluwaseun Amusa. 2016. "Discursive Practices in STI/HIV Diagnostic Encounters in Ondo State, Nigeria." In *Grammar, Applied Linguistics and Society* edited by Akin Odebunmi, Ayo Osisanwo, Helen Bodunde and Stella Ekpe, 502-545. Ile-Ife: Obafemi Awolowo University Press.

Roulet, Eddy. 2011. "Polyphony". In *Discursive Pragmatics* edited by Jan Zienkowski, Jan Ola Ostman and Jef Verschueren, 208-222. Amsterdam: John Benjamins.

Salami, Foluke. 2007. *A Speech Act Analysis of Doctor-patient Conversational Interactions in Selected Hospitals in Ibadan*. Unpublished MA thesis, University of Ibadan.

Sigurd, D'hondt and Akin Odebunmi. 2019. "Identity and Consultative Differentiality in Nigerian Clinical Encounters." Paper presented at the 16th International Pragmatics Conference held at the Hong Kong Polytechnic University, 9-14 June 2019.

Wei, Li and Mayouf Ali Mayouf. 2009. "The Effects of the Social Status of the Elderly in Libya on the Way they Institutionally Interact and Communicate with Younger Physicians." *Journal of Pragmatics* 41(1): 136-146.

Appendices

Transcription Notations

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

Text 1

1. DR: °Olorundare°
2. PAT: Good morning, sir
3. DR: Hey, how are you? What's your name? =
4. PAT: Olorundare Femi =
5. DR: Sit down
6. PAT: She's not there
7. DR: She didn't check your BP?

8. PAT: Yes=
9. DR: So, what's the complaint?
10. PAT: I do have stomach pain
11. DR: Stomach pain, I hope it's not the ulcer pain or ( ) you having at one part in time like that
12. PAT: No:: =
13. DR: where is the pain?
14. PAT: At the middle here
15. DR: It's the ulcer pain (.) lie down let me check it ( ) it's the ulcer pain now, **se igba yen na**
16. Is time that it
17. Was that time too
18. **se** period exam? **bo ya O KIN JEUN DA:DA: Igba** August **Igba yen**, hope it's not exam period? (0.02)
19. Is period exam? Maybe you don't eat very well. Time August time then, hope it's not exam period
20. Is it the exam period? Maybe you don't eat well. That time was August; I hope this is not an exam period
21. Did you use any drug like Ibuprofen or Felvin? =
22. PAT: No (0.02)
23.DR: And you didn't take Alabukun↓=
24.PAT: >No< (0.02)
25.DR: You are having ulcer pain now, so **ma n jeun DA:DA: bayi?**
26. You eating very well now?
27. Are you actually eating well?
27.PAT: **Mo <'un** try **bayi** >
28 I trying now
29. I am trying now
30.DR: °You can't afford not° to eat on time **o**, if you have ulcer (.)
31. PAT: °Super pain°
32.DR: And ( ) **me je ji**, when you urinate did you feel pain? =
33. And the two, when you urinate, do you feel pain?
34.PAT: No
35.DR: Let me check ( ) bi mo se gba yen se kodun e sha?
36 as I hit it that, did it not pain you really?
37 As I hit it, did it really pain?
38.PAT: Odun mi ni ibi bayi
39. It pains me in here this.
40 It pains me here
41. DR: And you said you don't e ( ) to ba to o ma feel pain (.)

42. And you said you don't ( ) if you urinate, you feel pain (.)
43. And you said you don't feel pains; if you urinate, you feel pain?
44.PAT: Bi ijeta ibiyi ko dada pe n kan wuwo
45. Like three days ago, this place looks like something heavy
46. Three days ago, I felt heavy here.
47. DR: Ni be
48 There
49. At the spot
50. PAT: Bee ni
51. Yes
52. Yes
53. DR: Ok sha l'ogun ni sha
54. Okay, just use drug is so
55. Okay, just make sure you use your drugs
56. PAT: Ra ra. I always have difficulty sleeping at night
57. No no, I always have difficulty sleeping at night
58. No no, I always have difficulty sleeping at night
59.DR: Hmm, and you are writing exam, so o kin kawe oru?
60. Hmm, and you are writing exam, is it you don't read in late night?
61. Hmm, and you are writing exam, I hope you don't read late into night
62. PAT: Mi o kin kawe oru o, ale ni kan
63. I don't read in late night, night only is it
64. I don't read late into night; only at night
65. PAT: Hmmm (.)
.
.
.

Text 2

1. DR: E pele sir, e joko sir se eyin le tele?
2. You sorry sa. You sit down sa; is it you that follows him?
3. You are welcome, sir. Sit sown sir. Are you the one that accompany him?
4.PAT: Doctor ( )
5.DR: Ok, epele sir
6. sorry sir
7. You are welcome, sir

8. PAT: Yes sir
9. DR: Kilo oruko yin sir?
10.What name you sir?
11.What is your name sir?
12.PAT: Fatunbi Abel
13.DR: Fatunde Abel
14.PAT: Fatunbi Abel [
15.DR: Fatunbi Abel, ok (.) hmm:: se won ti se ifunpa yin leni?
16. ↑ have they done hand pressure you today?
17. Have they checked your blood pressure today?
18.PAT: E ni
19. You say?
20. What did you say?
21.DR: Se won ti se ifunpa yin nigba te de?
22. Have they done arm pressure you when you came ?
23. Have they checked your blood pressure since you came?
24.PAT: Rara
25. No
26. No
27.DR: E je kin i se ki n mo(.) ((checks the patient's BP)) Se ito yin o kin po sa?
28. You let me do it and know. Is urine your not much
29. Let me read it to know I hope your urine is not excessive?
30. PAT: Hmm::, ito mi o kin n po, sugbo::n mo[ ]
31. Hmm::, urine mine is not always much but I
32. Hmm::, my urine is not excessive but I
33. DR: [E kan fe se test]
34. You just want to do test
35. You want to have a test
36. PAT: Bee ni
37 Yes
38. Yes ↓
39. DR: Hmm hun
40. I hear
41. That's okay
42. PAT: Mo kan ni ki n se, ki n mo bi ara mi se ri

43. I just say I do it for me to know how my body looks
44. I just want to do it to know the state of my health
45. DR: Fatunbi abi?
46. Fatunbi is it?
47. Your name is Fatunbi, right?
48.PAT: Bee ni
49. Yes
50. Yes
51. DR: Fatunbi kile pe?
52. Fatunbi what is it you called it?
53. Fatunbi what?
54. PAT: Abel
55. DR: Ok (.) Ara yin o de gbona
56. Body your is and not hot?
57. And you have no temperature?
58. PAT: Ara mi o gbona
59. Body me is not hot?
60. I have no temperature.
61. DR: Okay:. E ti jeun leni? (0.2)
62. You have eaten today?
63. Have you eaten today?
64.PAT: BEE ni sir (0.03)
65. Yes sir.
66. Yes sir
67. DR: Ifunpa ti mo se fun yin yen, °o fe lo soke die°, tori 150, 90 ni. °**O kan fe lo soke die ni**°,
68 The arm pressure that I do for you so, it want to go up small, because 150, 90 is. It just want to go up small
69. Your blood pressure increased a little bit. It is 150/190. It only increased a little bit sir.
70. koti i de level ti a maa fun yan loogun (0.03) So, ti won ba fe fi iyo sounje yin, ekan maa ni ki won
71. It has not reach level that we give person drug, so, if they want to put salt in your food, you just say they should
72. It requires no medication yet. Just instruct that the quantity of salt put in your food should
73. dikun, then lore koore boya, leyin bii o se meji, e kan le lo sibi ti won ti n check e, ki won ba
74. reduce it then, every time, maybe, after like two weeks, you can now go to where they check it, they should help you

75. be reduced, then occasionally, maybe after two weeks, you may then go to places where they read it so they can help
76. yin check e ki eeyan ripe ko lo soke, because to ba lo soke eeyan o ni mo. E pele o
77. you read it, so that one sees it does not go up, because if it goes up, person will not know. Sorry o
78. you read it to be sure it does not rise because one may not know it has risen. Sorry.
79. PAT: °Kini diabetes yen n ko sa?°
80. The thing diabetes that where it sir?
81. What of the diabetes issue, sir?
82. DR: Gbogbo e eni mot ii, test e nii, lab le ti maa se, won ye ito yin wo,won a ye eje yin wo.
83. All of them that I have tested is, lab is you will do it, they check your urine, they will check your blood
84. Everything has been included. You will carry out all the tests in the lab: your urine and your blood.
85. So e mu lo
86. So take it there
87. So take it there
88.PAT: ( )
89. DR: So, to ba ready e le mu wa. Hmm E pele o
90. So if it ready, you can bring it. Hmm. Sorry o
91. So when it is ready, you can bring it. Hmm. Take care
92. PAT: °Then kini kan ti mo samba maa bere nip e ::, mo maa feel pain ni epon, o maa n kan
93. Then something is I often will ask is that I often feel pain in my scrotum, it often
94. Then, there is a deep pain I feel in my scrotum; it often
95. ro mi ninu°
96. pains me inside
97. deeply pains me internally.
98.DR: Se ki n se pe after ti e bat i ni erection lo maa se bee sa?
99. Is it not that after you have erection that it does like that?
100. Does it occur after you have had erection?
101. PAT: Hun-hun, igba mii lowo ale, ti n bas a ti sun, a[ ]
102. Yes, sometimes, in the hand of night once I sleep it
103. Yes, sometimes it pains me and night when I'm sleeping
104. DR: [a kan maar o yin]
105. It will just be paining you
106. It will just be paining you
107. PAT: °A kan maar o mi°
108. It will just be paining me ↑

109. It will just be paining me
110. DR: Emi::, nkan to tun maa sele ni pe, ti e ba seleyi ni Monday (0.3) Ti e ba n to se e o ki n
111. I what that again will happen is that, if you this on Monday. When you are urinating, does not it
112. What happens is that, if you do this on Monday, when you urinate, I hope you do not
113. feel pain, sha?
114. feel pain just?
115 feel pain
116. PAT: Rara (0.3)
117. No
118. No
119. DR: Monday le maa wa se eleyi, but eleyi, eni le maa se eyi
120. Monday you will come do this but this one, today you will do it
121. You will come for this on Monday, but this one will be done today
122. PAT: ( )
123. DR: Ehn
124. What?
125.PAT: Se after ti mo ba ti ri won tan?
126 Is it after I have seen them finish?
127. Is it after I they have concluded with me?
128. DR: No, e mo pe test ti Monday yen
129. No, you know that test that Monday own
130. No , you know that test to be done on Monday
131. PAT: Ehn, eleyi ti e ni ki n se ni eni
132. Yes, this one that you said I should do in today
133. Yes, the one you said I should do today
134. DR: Ti iyen ba ti ready ki e mu pada wa. E pele o. E ba mi pe Mrs Oriyi
135. When that that one is ready, that you bring it back come. Sorry o. You help me call Mrs Oriyi
136 Once that one is ready, present it to me. Take care. Help me call Mrs Oriy.
PAT: Oriyi?
DR: Ehn

Text 3

1. Dr: °**Kini** initials **yin yen**°; B.O. **ABI**? =
2. What initials your you; B.O. Is not?)
3. What are those initials of yours; B.O. isn't it?

4. Pat: >Yes, sir<
5. Doc: Okay (0.13) °**E [me le yi wa**°] ((asks to have one of Patient's hands))
6. You can bring this come
7. Give me this
8. Pat: [°Okay °] (0.18)
9. Dr: °**Je ki n koko** check BP **won**° (0.07). °But **báwo lara yin**°?=
10. Let me first check BP them. But how body you?
11. Let me check her BP first. But how is your body/health
12. Pat: °Well-- **mo dupe lowo Olorun**°=
13. Well I thank hand God
14. Well, thank God
15. Dr: **Se e e ni** complaint **kankan**? =
16. Is it you have no complaint any?
17. Do you have any complaint?
18. Pat: °**Mi o ni** complaint°=
19. I not have complaint
20. I don't have any complaint
21. Dr: °Okay° ((measures her BP)) (0.36). **Igbawo le ti lo oogun yen** last Ma? (0.03)
22. When you use drug that last Ma
23. When was the last time you used the drug, Madam
24. Dr: **O** [**ti se die**]
25. It has done little
26. It's been a while
27. Pat: [**Ee ri naa pe**] (.)
28. You will see actually that
29. You would actually realise that
30. Dr: °**Kilo sele**?°=
31. What happens
32. What's the matter
33. Pat: **A WA NI** FASTING AND PRAYER **NI** CHURCH=
34. We are in fasting and prayer in church
35. We are observing a period of fasting and prayer in our church
36. Dr: Oka:::y↑=
37. Pat: Uhn=
38. Dr: Okay::↑ Enh, @ **E MA LO LAALE E, ABI SE** MARATHON **NI** FASTING YEN

39. You will use in night night, or is it Marathon is fasting that
40. Use it every night, or is the fasting absolute?
41. **NI**↑= ((enthusiastically))
42. It
43. Pat: No, **MO MA NLO LALE**=
44. I am using it in night
45. I use it in the night
46. Dr: **Enh::,EN BOYA** FOR THIS PERIOD **KE SI** GET **ONI** 30 MILLIGRAM **YEN**=
47. Maybe for this period you can get the one 30 milligram that
48. May be for this period, you should get the 30 milligram one
49. Pat: OKA::Y↓
50. Dr: Uhm: °so, **e maa loo leekan l'oj[umo**°]
51. you using it once in every day
52. use it once a day
53. Pat: [°**Lojumo**°] =
54. every day
55. Dr: Uhm:: for the period of the fasting=
56. Pat: **Igba ti AA BA TI** break fast **yen**=
57. When that we have broken fasting that
58. When we have broken the fast
59. Dr: **T'e ba ti** break, **e maa wa pada si ori oni** twenty=
60. If you have broken, you will come back to the head that of twenty
61. When you have broken the fast, you will revert to the 20 milligram dosage
62. Pat: °Okay°↓=
63. Dr: **MEJI NI** NIFEDIPINE **YEN**. >**IKAN WA TO JE** THIRTY MILIGRAM, **IKAN**
64. Two is nifedipine that. One is that is thirty milligram, one
65. There are two brands of Nifedipine. One is thirty milligram, the other
66. **WA TO JE::** TWENTY<=
67. is that is twenty
68. is twenty miligram
69. Pat: Okay↓
70. Dr: So for now=
71. Pat: **Ola gan lo maa pari**↑=
72. Tomorrow even will it end
73. It will even end tomorrow

74. Dr: **Ola lo n pari abi**?=
75. Tomorrow is it ending, it not it?
76. It is ending tomorrow, isn't?
77. Pat: **Enh**=
78. Yes
79. Dr: It's okay↓ So, **E SI LE MAA LO ONI** TWENTY **YEN EYO KOOKAN LALALE**=
80. You still can using that one twenty that one one one in night night
81. You can still be using the twenty milligram one, one every night
82. Pat: >**Mo N LOO**<↑=
83. I using it
84. I am using it
85. DR: **Enh enh**, so, **to baa ti e bati wa pari** [fasting e maa pada]
86. Yes, yes; so, if it once you now have ended fasting you will return
87. Yes, so once you finish the fasting, you will revert
88. Pat: > Hmm, **maa pada** [**si** morning and night yen<=]
89 I will return to morning and night that
90. I will revert to the morning and night plan)
91. Dr: **E maa loo bee, tori o n** reflect **lara** BP **yin bayi tori**=
92. You using it like that, because it reflecting on body BP you now because
93. Be using it that way because it is already affecting your BP because
94. Pat: **O n** reflect, **emi gan n ri igba ti mo nbo**=
95. It reflecting, I myself seeing it when I coming
96. It is affecting it, I too noticed it when I was coming
97. Dr: **Tori** 156/94 **ni mo** get **bayi, abi** 154/94, **so o n** reflect=
98. because 154/94 is I get now, or 154/94, so it reflecting
99. because 154/94 is my reading, or rather 154/94, so it is affecting it
100. **O n** reflect **lara e**. Uhn (0.01). So, **se bee ni** complaint **kankan**?
901. It reflecting on body it. So, is it no complaint at any?
102. It is affecting it. So, do you have any complaint?
103. Pat: **Rara** sir=
104. No sir
105. Dr: **E le maa lo**=
106. You can be going go
107. You can now leave
108. Pat: Okay sir=