QUESTION-ANSWER IN DOCTOR-PATIENT DISCOURSE IN TWO FEDERAL TEACHING HOSPITALS IN EBONYI STATE

Toochukwu J. Ezeugo
Department of English Language and Literature
Faculty of Arts
Nnamdi Azikiwe University
Awka
toochukwuezeugo@gmail.com

&

Chinwe R. Ezeifeka
Department of English Language and Literature
Faculty of Arts
Nnamdi Azikiwe University
Awka
chiezeifeka@gmail.com

Abstract

The paper discusses question-answer adjacency pair in doctor-patient interview observed in two federal teaching hospitals in Ebonyi State. Four texts of doctor-patient conversations were analyzed. Conversational analysis (CA) and critical discourse analysis (CDA) were deployed to the Mood structure of selected clauses in the recorded doctor-patient interview in line with Halliday's Systemic Functional Grammar (SFG). Our findings showed that turn construction for doctor and patient do not vary in terms of lexical, phrasal, clausal or sentential structure, but turn allocation reveals subtle asymmetries where doctor turns seem to dominate. However, both participants enact roles to challenge or maintain dominance and asymmetry depending on the health and social condition of participants especially the patient. Patients whose sickness had lingered tend to challenge the doctor's questions and prescriptions. Enlightened patients were bold to debunk doctor's proposals in some cases. Doctors on their part take more turns with unenlightened patients in an attempt to establish understanding and rapport using vocatives, declarative imperatives, mostly subtle interrogatives and minimal polar questions. The paper therefore concludes that effective communication and mutual relationship between doctors and patients should be enhanced in medical institution.

Key words: question and answer, medical interview, doctor-patient discourse, dominance, asymmetry, critical discourse analysis, interpersonal meaning, Mood, systemic functional grammar

1. Introduction

Doctor-patient communication is no doubt unique and apparently different from ordinary every day conversation. It is a formal interaction as opposed to casual conversations. It is among the highly institutionalized forms of talk which has received considerable attention in discourse analysis research (Roter & Hall, 2006; Cordella, 2004; Ainsworth-Vaughn, 1998). This perhaps, is not so much because of the prestige attached to the medical profession as their indispensable roles in health care delivery and survival of humanity. Again, almost all the patients want to know their diagnosis and most patients also want to be informed about the chances that they will be cured. This therefore heightened the importance of the study of doctor-patient conversation.

Communication operates as an essential component of the medical encounter. During medical visits, doctor-patient communication constitutes the core component of clinical work that significantly affects medical outcomes associated with the diagnosis and treatment of illness (Ong *et al*, 1995). This suggests that if quality health care and treatment of illness will be achieved, communication must be effective. There is no gainsaying the fact that communication especially spoken communication is a pivotal feature in every human community and in any social setting, such as hospitals, schools, churches, markets and so on. However, discourse in social settings involves different ways of structuring areas of knowledge and social practice as well as different ways of structuring spoken and written communication. This implies that in social interaction, including doctor-patient's interaction, the social context and participants involved usually contribute to shape and determine the structure of the discourse which in turn reflects life realities. This is because language is not only used to describe reality but also creates it. Hence, discourse is both reflected and influenced by language. This influence is, however, constantly negotiated by participants involved in the conversation (Goffman, 1981).

In every social interaction, there is a unique discourse structure and mechanism that characterize them. Question-answer adjacency pair has been identified as the most common characteristics of institutional talk such as medical discourse. According to Thornborrow (2002: 4), question and answer "set up positions for people to talk from and restricts some access to certain kind of discursive actions". It can therefore be said that in institutional discourse as doctor-patients interaction, certain discursive roles are legitimately preserved for particular speakers and others are not. For instance, some have the role of questioning, that is, questioners, others answerers or opinion givers. This means that doctors use question to initiate and control discourse whereas the patients give answers to the questions as respondents. Although it may be open to any participant to ask questions but Thornborrow (2002: 134) argues that asymmetry always emerges between those participants who are under some obligation to answer questions and those who are not.

As a result of the social changes in the present society, as a result of education and enlightenment, the myth of traditional asymmetry of doctor-patient relationship in question-answers discourse structure has been altered (Humphreys, 1995). How this assertion applies or do not apply to Ebonyi State, where one of the present researchers

resides, however, has not been proven. The question therefore is, whether question-answer adjacency pair in doctor-patient interview in the two hospitals under study confirm or disprove this taken-for-granted asymmetry, how turns are allocated, who takes more turns and what are the nature of turn construction units and how these factors contribute to improving question and answer in doctor-patient interview towards effective interpersonal relationship between the doctors and patients, and ultimately enhancing health care delivery especially in Ebonyi State which is the point of focus in this work.

It is therefore against this backdrop, that this paper explores the role of question and answer in doctor-patient discourse in two Federal Teaching Hospitals in Ebonyi State, (FETHA 1 and FETHA 2). This paper hopes to provide evidence that would either support or challenge previous researches that question and answer in doctor-patient is a textual struggle for dominance. It also surveys how the interlocutors negotiate meaning; who controls the discourse, how power is negotiated and how both achieve a common ground for effective communication and achievement of communication goals. For the purpose of this study, the terms *doctor-patient discourse, medical interview, medical discourse or medical communication* shall be used interchangeably.

2. Conceptual review:

2.1. Question-answer in Medical Interviews

Question and answer has been described as a perspective of medical practice, where the doctor, tries to "enter the patients' eyes" (McWhinney, 1989: 35). This means that with question and answer, doctors attempt to satisfy the patient's health needs. In the words of McWhinney (1989: 874): "Its aim is to diagnose a disease rather than to understand the patient". This implies that doctors use question and answer to resolve biomedical issues rather than the issue of interpersonal relationships. In addition to the above view, it is argued that, for doctors, this adjacency pair "often introduce, develop and dissolve topics" (Paget, 1983: 123). To the patient, they serve as a means of exchanging information with the doctors (West, 1993: 127). This suggests that through question and answer, both doctors and patients become active interlocutors in medical interaction. To Humphreys (1995), question and answer is one of the linguistic approaches that enable doctors to control the structure and content of medical consultation. This implies that question and answer serve as a linguistic tool upon which doctors assume power of expertise over the patient. This undoubtedly supports the argument that doctors were constructed as being primarily "collectors and analysers of technical knowledge elicited from patients" (Mishler, (1984: 10).

Drawing from the above point, Cerny (2010: 54) postulates that questions are the focal point of medical encounter and their centrality is rooted in the fact that they "constitute key mechanisms by which power can be exercised and restricted in discourse". As a result of the relatively prescribed roles of doctor and patient in medical discourse, it is accepted as normal and as a norm for doctors to ask questions and patients to give answers. This is because doctors and patients are target-oriented in their interaction. Hence, Humphreys (1995) argues that the meeting of a doctor and patient is not for formality but for a purpose. Thus he writes:

> The doctors and their patients meet in order for the doctor to gain the necessary information, make a diagnosis and help (or at least attempt to help) the patient. This goal orientation determines most aspects of interaction because the patients do provide their doctors with information about their life … (p. 22).

Judging from the assertion above, it could be said that the goals of the doctor and the patient position doctors as questioners and seekers of biomedical information from the patient. Patients on the other hand are answerers or suppliers of their biomedical data. This is perhaps, why doctors according, Byrne and Long (1976:14), ask more questions at the beginning while patient initiate more question at the end of the consultation. However, Boreham and Gibson (1978) point out that patient questions are not focused on the diagnostic process, but on whether they will be cured and when (408).

This argument underscores the importance of question and answer in doctor-patient's discourse, as it is cardinal in diagnosis. However, Paget (1983) points out that, it is discouraging that when patients do ask questions, they may be ignored by doctors. This may be because doctors do not want to be challenged. West (1993) discovered that assertive patients who repeat questions when they are not answered receive less answers than others. She claimed that "the very legitimacy of the physician's authority may be threatened by patient's inquisitiveness" (p.153).

Notwithstanding the fact that question-answer structure in doctor-patient conversation assigns a discursive role, health satisfaction remains the major desire of patients in medical encounter. Engel (1977) however points out that patients' perspective of illness is nuanced by various social, psychological, biological factors which affect the physician's mode of treatment of a disease (103). Patients are usually interested in satisfying the doctors; hence, they tend to furnish them with useful answers to their questions. However, patients almost always want as much information as possible 'even when not necessary' and doctors frequently do not realize this preference (Davis, 1971: 72). This implies that patient's satisfaction highly depends on the doctor's abilities to grasp and respond appropriately to the patients' emotional expressions, personal and social concerns and psychological needs during discourse.

From the foregoing, one can argue that the role of question-answer structure in doctor-patient discourse is indispensable. Not only does question serve as information seeking mechanism; and answers as feedback to doctors' elicitation but also they serve as a means of challenging dominance and asymmetry in doctor-patient relationship. Although it appears a clear fact that in medical communication between doctors and patients, asymmetry arises with doctors being more in power and patient less, yet, question and answer to a large extent serve as a veritable tool to restrict subordination and dominance in institutional discourse as evident in recent researches.

2.2. Turn construction and allocation in medical discourse

Participants in medical discourse no doubt acknowledge the need for even distribution of turns. As we shall discuss in the section on conversation analysis, a turn is delineated between the beginnings of the current speaker utterance until a possible completion point

where the next speaker takes over. Patients operate on the turn made available by doctors, doctors on the other hand allocate patients' turns only on the ground of information seeking from the patients. Unequal distribution of turns and roles in doctor-patient interaction leads to dominance and sometimes information withholding.

Mishler (1984) also insightfully explored how doctors use 'voice of medicine' to assert their authority and turns. He claims that occasionally a struggle for control can occur between doctors and patients; this is evident in conflict between the 'voice of medicine' and the voice of the life world' (p.14). He claimed that the "voice of medicine" has a set of purposes and goals to be achieved by the interaction and information offered by the patient is restricted by means of interruptions, topic changes, questions, etc. The result is that the "voice of the life world" (the everyday social circumstances of the patient) is excluded from the consultation. This implies that the doctors use this voice of medicine to allocate more turns to themselves as they operate from the experience and knowledge of medicine, while the patients have less turns in their voice of the world. According to Bloor and Bloor (2004), this disproportionate allocation of turns

> …may have the effect of excluding the patient from effective participation in the decision simply through their structuring of the consultation without regard for the patient's purposes. Thus, while the doctor may have a diffused, culturally approved 'right' to legislate by fiat in health and illness, the totality of his routines are practical embodiment of his dominance in the medical encounter (p.54).

The above assertion agrees that the doctors are seen as being concerned with asserting and sustaining dominance over the patients at each and every turn, excluding any possibility that the patient might take any part in determining the outcome of the encounter. On the other hand, the patients are always seen trying to challenge the doctor's control over the discourse. In other words, participants in doctor-patient discourse attempt to assert their perspective in the encounter, hence mutually preserving dominance in the interaction.

3. Theoretical Framework

In this work, an integration of conversational analysis, critical discourse analysis and systemic functional grammar will be used as the analytical models of the data collected.

3.1. Conversational Analysis

Conversational analysis (CA) is a significant method for investigating the structure and process of social interaction between humans. It investigates how utterances, by virtue of sequence in which they appear, perform a recognizable social action. At the roots of conversational analysis is the idea of social interaction as an independent locus of order (Sacks *et al*, 1974. In conversational analysis, interaction is considered as a distinctive characteristic of social institutions with distinct order. This implies that it organizes the interactive platform and serves as a basis for specific institutional variations (such as the distinctive turn-taking organizations of court-room interaction or news interview, for instance), (Drew & Heritage, 1992). This form of analytical frame helps to structure roles in discourse (Who does what? At what time?)

This theory is therefore important in data analysis of this work because doctor-patient discourse is a form of an organized institutional discourse. Again, basic aspects of human

sociality that reside in talk are elucidated in conversational discourse, hence its importance in this work. Conversational analysis as a theoretical frame in this work seeks to find out: the role of question and answer as a conversational style in doctor-patient discourse, how turns are taken and managed in medical interaction and how interpersonal roles are enacted in the establishment of common ground for mutual understanding.

3.2. The Mood Structure in Systemic Functional Framework

The systemic functional grammar propounded by Halliday is a useful discipline and interpretative framework for studying language as a social semiotic and as a text or discourse. The model explores the grammar of the metafunctions of language, which are the meaning potentials carried by language. Halliday (1973) sees language as conveying three meaning potentials simultaneously in a piece of text or discourse. This meaning include: the ideational, the interpersonal and the textual functions. These meaning potentials are realized at the lexicogrammatical level with the notions of transitivity, mood/modality and theme. This subsequently relates to the contextual dimensions of field, tenor and mode (Eggins, 2004: 141-187). Since our focus in this work is on the interpersonal relationships of doctor and patient interview, we shall concentrate on the Mood system. Mood in systemic functional grammar has been described as "the grammar of the clause in its interpersonal aspect" or the grammar of personal participation (Halliday, 1973: 42).

Mood therefore encompasses the interpersonal meaning of roles and relationships, types of clause structure (indicative, imperative), the degree of obligation and certainty expressed (modality), the use of tags (Mood tags), vocatives, epithets, attitudinal words which are either positively or negatively loaded, expressions of intensification and politeness (Halliday & Matthiessen, 2004: 30). The Mood element carries the nub of the argument, the burden of the clause which cannot disappear when the responding speaker takes up his/her position in the grammatical subject slot.

Since question-answer adjacency pair belongs to the Interrogative Mood of the clause, this system has been applied to the present study to determine the following: how the choice of the speakers as 'subject' presents them as 'modally responsible' to their proposals, how the choice of clause form by the respondent speaker challenges dominance and how the choice of Mood (interrogative – polar and Wh-questions, declarative, imperative, mood tags, vocatives, etc) determine the alignments of power and asymmetries in doctor-patient interview.

3.3. Critical Discourse Analysis (CDA)

Critical discourse analysis is a research paradigm which linguistically tackles the problems of social dominance and positions in interaction. It attempts to choose the perspectives of those who suffer most and critically examines those in power, those who are responsible and those who have the means to bring solution to the social problems and improve conditions (Wodak & Meyer, 2001: 10). In CDA, the notion of *critical* is primarily applied to the engagement with power relations associated with the Frankfurt school of critical theory (Roger 2). In this, it argues against a realist, neutral and rationalist view of the world.

This work applied CDA in line with Chouliaraki and Fairclough (16) that CDA is both a theory and a method, in that it offers not only a description and interpretation of discourses in social context but also an explanation of why and how discourses work (Rogers, 2004). Though this view was countered va Dijk who claims that CDA is neither a theory nor a method, but simply "a perspective for doing scholarship" (2001: 96), the framework has been adopted in this paper to investigate how awareness and consciousness of doctors and patients and indeed all text producers and consumers to the fact that discourses and texts are indeed interpersonal sites of struggle and the enactment of dominant ideological positions (Ezeifeka, 2013). CDA thus provides a linguistic means of deconstructing dominant ideologies and subtle asymmetries that are hidden in texts and discourses.

Insights derived from CDA which centres on the discursive dimensions of use and abuse of power shows that such institutional discourses as doctor-patient interaction could actually be characterized by the power structures and dominant ideological positions. In fact, CDA proponents share the view that the relationship between language and society is dialectical: that is, discourse is shaped by social structure and at the same time shapes the social structure (Johnstone, 2008: 9-18), and that discourse can sustain as well as subvert power structures, the present work analyzes the selected textual data to determine power play and ideologies which doctors and patients hold about their institutional roles and health experiences respectively.

4. Methodology

Conversations were recorded between doctors and patients in the two federal teaching hospitals in Ebonyi State: Federal Teaching Hospital 1 and 2 (henceforth FETHA1 and FETHA2). Four conversations between doctors and patients (two from each of the teaching hospitals) were surreptitiously recorded on tape and analyzed in this paper. For ethical reasons, the participants were told that the interview will be tape recorded for research purposes and they granted permission to us to sit in and record the proceedings. Four textual samples (Texts 1-4) were used for analysis and these were drawn based on the four research questions raised in the study

5. Data Analysis and Discussion

5.1. Question-answer and asymmetry in medical discourse

Text 1 below was drawn from FETHA1 during a medical interview with a patient whose ailment could be regarded as 'embarrassing' to the patient to relay to a second person. This is obvious from the relatively long pauses between turns.

Text 1:

1. D: Hello, good morning, sit down, what is the problem?
2. P: Doctor, I don't know what is going on [in… er ….
   D: [what's that?
3. P: My scrotum
4. D: hmm (0.2) how does it look like?
5. P: Ptshmm (sighs)…….rashes

6. D: Ok, let me look at it. Hmm (0.4) how….
7. long has it been? (0.7)
8. P: I just discovered it two days ago
9. D. I think… (0.10)
10. P: sometimes I get some relief of the pains especially in cool environment (0.3)
11. D: I will give you something to apply on it
12. But we also need to take a sample for a lab test.
13. Eh…..the test will tell if it will be taken for
14. Surgical operation (4.0)
15. P: But eh doctor, you said you will write a…
16. [cream for me to apply on it. Let me apply the cream first before (0.3)
17. D: [yeah … something for you …
18. D: yeah, if after two weeks of using the cream, no
19. Improvement, we'll go for surgery
20. D: what do you think?
21. P: No problem

We note the doctor's impersonal and aloof introduction of the interview to establish an air of institutional authority. This is establishing the "footing" as Goffman (1972) would claim, to delineate the stance and alignment in terms of the different obviously asymmetrical roles. In spite of this "superior" stance, or set or positive, projected self, which sets the tone for the doctor's footing in this encounter, the patient in Text 1 uses the Vocative "Doctor" not only to bridge the gulf the doctor is creating, but also to whet the doctor's ego and enact a negative politeness strategy (Brown & Levinson, 1987). It is evident in Text 1 that turn allocation in the question-answer pair is three turns for the doctor as against the patient one question-turn. This confirms the assertion that doctors ask more questions and patients give more answers. It also confirms the subordinate position which this adjacency pair confers on the patient. However, because conversation is a negotiation, the patient has to solicit for a common ground whereby, in spite of the doctor's desire for distance, the patient needs to impose on his power face. This strategy seems to have worked subsequently as the doctor became friendlier and the patient's opinion is carefully accommodated in the decision making process through a question raised by the doctor in lines 20 and 2; "D: what do you think?" "P: No problem". The doctor thus seems to take a cue from the patient's need for solidarity and deliberately poses the question to the patient to get him involved in the resolution of the topic. In this way, consensus and common ground is established for the treatment of the ailment.

Again, it would seem that the patient does more work at establishing this common ground. We note that the vocative was used twice by the patient without any by the doctor. It is the ability to break through the power face of the doctor through these vocatives that enables him to make his own input in quite an assertive manner in line 16 of the above Text, 'let me apply the cream first before….' Without such shared mutual relationship, not much communication would have taken place. Even though the patient could not give vivid and precise answers to doctor's questions probably because of anxiety or lack of medical knowledge, the doctor managed to decipher meaning from the fragmented answers provided by the patient.

The following text (also from FETHA1) show that doctors' questions do not always dominate in medical interview.

Text 2

1. D: you have to prepare for surgery immediately,
2. We have to remove the lump
3. P: doctor, is it a major operation?
4. D: no, it a minor operation. Just to remove the lump
5. P: I'm afraid, how long will it take?
6. D: you don't have to be nervous, it's a minor surgery,
7. We will give you a partial anesthesia,
8. you can walk home the same day or the next day
9. P: when will the operation be done?
10. D: it has to be done 8 o'clock tomorrow morning

In the above text, three questions were raised by the patient with none by the doctor. However, the doctor's institutional role confers on him/her the authority to pronounce the verdict on the patient's condition which triggers off question-turns by the patient. This seems to challenge the point that doctors are questioners while patients are answerers, rather it affirms that question-turns are determined by the context of situation; before, during and after diagnosis. During diagnosis, doctors operate as authority figures because of their expertise which has increased patients' dependence and doctors' dominance (Freidson, 1970: 60), but this also appears to have been challenged in this study as the doctor needs to assure the patient that his welfare is the core of the encounter.

Text 3 was got from FETHA2, the patient refuses to be intimidated in the discourse rather presents contrary response to the questions raised by the doctor as in the following lines:

Text 3:

1. D: have you treated malaria, e-e what malaria drugs do you take?
2. P: No malaria drugs works on me. My condition is very serious.
3. D: Why do you say that?
4. P: My previous doctors have prescribed me all kinds of medications;
5. But none have ever worked.
6. D: You still haven't told me the medications you have taken.
7. P: Medicine hasn't yet come up with a cure for my condition.
8. And I really doubt if it ever can…
9. D: don't you think we can still try another drug?
10. P: what drugs doctor?
11. D: I will prescribe a drug that you will take just for two days
12. It will make you to sleep and have some rest
13. P: will it make me better
14. D: yes, I believe it will.

In the above extract, the patient's experience on the treatment of his sickness and his health condition has given him the courage to challenge the intended dominance of the doctor. Thus, he refused the propositions of the doctor in line 2 and 7: P: *No malaria*

drugs works on me. My condition is very serious. *P: Medicine hasn't yet come up with a cure for my condition*. A critical view of the patient's reaction will reveal that his authoritative response is as a result of his psychological condition created by ill health. However, the doctor's palliative question (line 9) created harmony in the discourse such that in Lines 10 to 14, both parties arrive at a point of common ground.

It is also noteworthy that the patient responded to the doctor's questions with a strong assertion to show he is no longer satisfied with previous medical encounters and doubts the present encounter. In fact, he/she reluctantly endures the interaction. However the mild response of the doctor to the patient's last question in line 14: "yes, I believe it will" indicates a strong assurance and hope to the patient.

5.2. Mood element in doctor-patient discourse

We have earlier observed the role of Vocative in achieving solidarity in doctor-patient interaction. As we know, Vocative is an aspect of the Mood structure. The mood element is prevalent in doctor-patient discourse. In the extract below, the participants attempt to show the interpersonal meaning of their interactive roles and relationships. The mood element in the argument of Halliday and Matthiessen (2004) is the carrier of the nub of the argument, the burden of the clause which cannot disappear from the clause when the responding speaker takes up his/her position. This is evident in the example below.

Text 4:

1. D: you had some ear problem
2. P: yes
3. D: did you get some sort of hit or what?
4. P: well (.) I fell down on that side on Friday (.) afternoon
5. D. eyeah
6. D: it wasn't very hard, was it?
7. P: it was
8. D: was it on the whole of your head? It couldn't have caused this problem, could it?
9. P: Yeah I don't know. But it was a kind of the whole of this side of my head
10. D: Ok
11. (.)
12. D: was it swollen immediately?
13. P: I noticed a little later.

From the above conversation, the dominant clause is the polar interrogative rendered in a declarative mood structure which gives credence to the doctor's efforts to eliminate asymmetry that questions may bring in on the interview. Communication thus flow unimpeded as rapport and solidarity has been created with this tempered interrogative-declarative clauses The first declarative clause which is a veiled polar interrogative prepares the ground for the patient to either affirm or deny proposition in line 1: D: 'you had some ear problem.' The use of more polar questions (Yes/No questions) as against their wh- counterparts shows that doctors prefer simple structured answers than open-ended ones. It also shows that because the doctors are experts in these ailments, they tend to ask leading questions to enable the patients articulate their answers. Thus, the

propositions are realized by the interrogative mood of question concerning information about how the patient's illness was.

The doctor's choice of the subject, 'we' is replete in doctor's speech especially in the response to the treatment aspect of the patient. In Text 4, such utterances as: "D: **we** have to remove the lumps", "D: We will give you a partial anesthesia" seem to give away the doctor's role as a construction of the social institution in which he operates, not as an individual but as a corporate personality. This inclusive "we" used with the first person singular makes the doctor to hide in the crowd of other participants, diverts modal responsibility to other participants and thus divests him/herself of solely and directly responsible for the specified actions. The clauses with "we" as subject carry more of proposals and commitment. Again the use of the subject 'it' and the verbal element, 'wasn't' enables the doctor to know the truth value from the patient's response.

The mood element in the text above affirms the proposal of the doctor which appears in 'negative polarity', *it wasn't very hard* followed by the Mood tag, '*was it*?' further builds up the interpersonal rapport between the doctor and patient confirming the success of the interview The end of consultation which is marked by the doctor's prescription is concluded with a finite modal operator that refers to the doctor's disposition to follow up treatment with the modal of obligation *will*, as in: 'I will write out drugs for pain and antibiotics.'. This modal shows the doctor's commitment to the proposition.

6. Conclusion

In this paper, the role of question and answer in doctor-patient discourse has been analyzed, touching on such areas as the power structures and asymmetrical relations brought on by this adjacency pair, roles of participants including institutional and individual roles as well as how power is enacted and challenged by doctors and patients respectively. These have been determined through the mood element in the use of predominantly interrogative mood by using polar questions, some of which are rendered in veiled declaratives. It was also evident that doctors initiate exchanges and take more turns than the patients who mostly answer doctors' questions, but the fact that there may be more doctor-turns in some cases does not denote asymmetry but shows particular features of the different aspects of the encounter. It is observed that opening and supporting moves are dominated by doctors in the discourse; while the challenging moves occasionally occur in patients' responses. This shows that though power structures appear to be skewed in the doctors' favour, there are instances where the patients, by interpersonally negotiating the power face of the doctors, may appropriate and assert some degree of power in deciding the course of treatment.

Again, it is observed that question and answer is at the core of doctor-patient interaction and cannot be separated from it. Question and answer is also seen from this study as the technique for maintaining harmony and challenging asymmetry and dominance in doctor-patient discourse. However, it is observed that maintenance of asymmetry and challenging dominance is a consequence of belief of institutional roles and conditions of participants. Finally, the choice of subject and verbal element which constitute the mood element helps to assign meaning to the participants' roles and relationships as well as

making all the participants, both doctors and patients share mutual modal responsibility in the outcome of the medical interview.

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