

A SOCIOLINGUISTIC INVESTIGATION OF  
SOURCES OF INTERACTIONAL ASYNCHRONY AND  
SYNCHRONY IN INTERCULTURAL MEDICAL CONSULTATIONS  
IN THE MEDIUM OF ENGLISH  
IN AN URBAN SETTING IN SOUTH AFRICA



THESIS

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## ABSTRACT

This thesis examines sources of interactional asynchrony and synchrony in intercultural medical consultations between South African English speaking doctors and Zulu-English speaking patients in an urban setting in South Africa.

It employs, principally, the theory and methods of Interactional Sociolinguistics to identify and describe sources of asynchrony and synchrony in medical encounters. The thesis provides a review of the South African and international literature relevant to the analysis of doctor-patient interaction. Having noted the significant absence of research that utilizes a model of language use such as Interactional Sociolinguistics, the author reviews South African and international interactional sociolinguistic research literature with a view to identifying an appropriate research framework for the analysis of selected medical consultations.

The thesis reports the findings of the fine-grained analyses of three consultations. The societal consequences of the asynchrony evident in two of the consultations are explored drawing, in particular, on insights provided by Critical Language Study. The relative synchrony of the third consultation is traced to the participants' use of positive politeness strategies to generate the "co-membership" of maleness. The significance of this discovery is explored in some depth.

Finally, attention is given to further research possibilities arising from the present study.

## TABLE OF CONTENTS

1.0	<u>INTRODUCTION</u>	
1.1	STATEMENT OF THE PROBLEM .....	1
1.2	AIMS OF THE STUDY .....	3
1.3	HYPOTHESES .....	4
1.4	BACKGROUND TO THE STUDY .....	4
1.4.1	Health care in South Africa .....	4
	Public health care in South Africa .....	4
	Private health care in South Africa .....	5
	Private medical consultations .....	7
1.5	INTERCULTURAL COMMUNICATION .....	9
1.6	OVERVIEW OF THE THESIS .....	10
2.0	<u>REVIEW OF LITERATURE</u>	
2.1	SOCIOLOGICAL ACCOUNTS OF THE DOCTOR-PATIENT RELATIONSHIP .....	11
2.2	THE DOMINANT BIOMEDICAL PARADIGM OF HEALTH CARE .....	12
2.3	EMPIRICAL STUDIES OF DOCTOR-PATIENT INTERACTION .....	14
2.4	INTERACTIONAL SOCIOLINGUISTICS .....	17
2.5	INTERACTIONAL SOCIOLINGUISTICS IN THE SOUTH AFRICAN CONTEXT .....	23
2.6	CRITICAL LANGUAGE STUDY .....	24
2.7	SUMMARY .....	26

3.0	<b><u>BACKGROUND TO THE STUDY AND METHODS OF INVESTIGATION</u></b>	
3.1	<b>BACKGROUND TO THE STUDY</b>	27
3.1.1	The research site	28
3.1.2	The participants	29
	The patients	29
	The doctors	30
3.2	<b>LANGUAGE MEDIUM</b>	30
3.3	<b>METHODS OF DATA COLLECTION</b>	31
3.3.1	Collection of interactional data	31
3.3.2	Patients' consent	31
3.3.3	Problems and limitations of data collection	32
3.4	<b>METHODS OF DATA ANALYSIS</b>	34
3.4.1	Preliminary analysis	34
3.4.2	The structure of medical consultations	34
3.4.3	Transcription: some problems and limitations	35
3.4.4	Analysis	36
3.5	Summary	39
4.0	<b><u>ANALYSIS OF CONSULTATION 1</u></b>	
4.1	<b>INTRODUCTION</b>	40
4.2	<b>BIOGRAPHIES OF PARTICIPANTS</b>	40
4.1.1	The patient	40
4.1.2	The doctor	40
4.3	<b>SYNOPSIS OF POST-CONSULTATION INTERVIEWS</b>	41
4.4	<b>ANALYSIS OF SOURCES OF INTERACTIONAL ASYNCHRONY IN CONSULTATION 1</b>	42
4.4.1	Different schemata and politeness strategies	42
4.4.2	Different schemata, different politeness strategies and different contextualization cues	45
4.4.3	Different culturally-specific schemata, interacting with a repair strategy	53
4.4.4	An accumulation of sources of interactional asynchrony in consultation 1: the interaction of different schemata, ways of being polite and contextualization cues	62
4.4.5	<b>SUMMARY</b>	72

5.0	<u>ANALYSIS OF CONSULTATION 2</u>	
5.1	INTRODUCTION .....	73
5.2	BIOGRAPHIES OF PARTICIPANTS .....	73
5.2.1	The patient .....	73
5.2.2	The doctor .....	74
5.3	SYNOPSIS OF POST-CONSULTATION INTERVIEWS .....	74
5.4	ANALYSIS OF SOURCES OF ASYNCHRONY IN CONSULTATION 2 .....	77
5.4.1	Different schemata, different ways of being polite and different contextualization cues .....	77
5.4.2	Different ways of regulating turn-taking, different contextualization cues and different ways of being polite .....	84
5.5	SUMMARY .....	90
6.0	<u>ANALYSIS OF CONSULTATION 3</u>	
6.1	INTRODUCTION .....	91
6.2	BIOGRAPHY OF THE PATIENT .....	91
6.3	SYNOPSIS OF POST-CONSULTATION INTERVIEWS .....	91
6.4	ANALYSIS OF A SOURCE OF INTERACTIONAL SYNCHRONY IN CONSULTATION 3 .....	93
6.4.1	Positive or solidarity politeness strategies .....	93
6.5	SUMMARY .....	105
7.0	<u>SOCIETAL CONSEQUENCES OF INTERACTIONAL ASYNCHRONY AND SYNCHRONY IN INTERCULTURAL MEDICAL CONSULTATIONS</u> .....	106
7.1	SUMMARY OF MAIN EMPIRICAL FINDINGS .....	107
7.1.1	Differences in culturally-specific schemata .....	107
7.1.2	Systematic culturally-specific differences in contextualization cues .....	107
7.1.3	Culturally-specific ways of accomplishing repair .....	108
7.1.4	Culturally-specific ways of being polite .....	108
7.2	CONSEQUENCES .....	110
7.3	FURTHER RESEARCH POSSIBILITIES .....	114
7.4	CONCLUSION .....	117

**APPENDICES:**

Appendix 1. PATIENTS' CONSENT FORM ..... 118

Appendix 2. TRANSCRIPTION CONVENTIONS ..... 119

Appendix 3. TRANSCRIPTION OF CONSULTATION 1 ..... 120

Appendix 4. TRANSCRIPTION OF CONSULTATION 2 ..... 128

Appendix 5. TRANSCRIPTION OF CONSULTATION 3 ..... 134

Appendix 6. POSITIVE POLITENESS STRATEGIES ..... 137

**BIBLIOGRAPHY** ..... 138

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I, Elizabeth Mary Waterfall, hereby declare that the whole thesis is my own original work.

## **1.0 INTRODUCTION**

### **1.1 STATEMENT OF THE PROBLEM**

In South Africa an urban middle class of black African people is emerging from the restrictions placed upon them by the policies based on the ideology of racial separation, apartheid. In terms of these policies, educational, economic, social and professional mobility of these people was restricted. Moreover, access to certain domains was denied them, one such domain being medical practices staffed mainly by white people who practise traditional Western medicine. Although the segregation of private medical practice was never enforced by law, segregation was the norm. However, in recent years access for black Africans in urban areas to these practices has been gradually increasing. One consequence of this structural change is that those involved are obliged to engage in intercultural communication.

Significantly, interactional sociolinguists such as Gumperz (1971, 1972, 1977, 1979, 1982a & b, 1986), Erickson & Shultz (1981 & 1982), Varonis & Gass (1985), Chick (1985, 1986, 1987 & 1989), Fiksdal (1990) and Roberts, Davies & Jupp (1992) have pointed out that increased contact between previously segregated groups of people of different sociocultural backgrounds does not necessarily lead to more effective communication, essential for more equitable access to societal resources such as health care. Ironically, what is more likely to result is what they term interactional asynchrony (see e.g., Chick 1985:301) in which speakers experience uncomfortable moments during an interaction. Similarly, the doctors and patients, of different sociocultural backgrounds, who were the subjects of this study reported experiencing a relatively high degree of discomfort or interactional asynchrony during the medical consultations under investigation.



Interactional asynchrony (Erickson & Shultz 1982) and Gumperz (1982a & b) is defined as the inability of speakers to establish and maintain conversational co-operation in terms of which conversational rhythm and synchronicity of verbal and non-verbal behaviours are impaired or lacking. This lack of conversational co-operation frequently results in uncomfortable and stressful intercultural encounters. For instance, speakers of different sociocultural backgrounds may misinterpret one another's conversational signals; they may find difficulty in developing conversational themes together; they may feel they are being constantly interrupted by one another, and they may have difficulty in accurately predicting "significant next moments" (Erickson & Shultz 1982) in the discourse as a consequence of failing to select cues which are vital to the interpretation of the meaning of the message.

On the other hand, interactional synchrony is the ability of speakers to establish and maintain a smooth flow of conversational co-operation. Speakers feel comfortable speaking with each other; interruptions are minimal; verbal and non-verbal cues are interpreted with facility and conversational themes flow easily between speakers who generally develop good opinions of their interlocutors.

Significantly, in the case of asynchrony, because speakers are usually unaware of the effects of their different sociocultural backgrounds and particular communicative conventions, they tend not to identify the cause of interactional asynchrony as having a linguistic dimension. Instead, they account for it in psychological terms by attributing negative traits to their interlocutors such as their being unco-operative, rude, dominating, stupid, arrogant, etc. Over time, repeatedly asynchronous intercultural encounters between these people are likely to result in the development of negative cultural stereotypes which generate and reinforce discrimination. In addition, it is important to emphasize that, given South Africa's history of enforced racial segregation, it is very likely that racist attitudes contribute in no small way to asynchronous encounters.

## **1.2 AIMS OF THE STUDY**

Based on the theory and methodology of Interactional Sociolinguistics (see 2.4 for a detailed description) and employing insights from Critical Language Study (see 2.6 for the rationale for the use and explanation of these insights), this study aims to identify, describe and explain sources of interactional asynchrony and synchrony in intercultural medical consultations in the medium of English in an urban setting in South Africa. Simultaneously, it intends to outline the impact of interactional asynchrony on a societal resource such as health care as practised in a private medical practice in South Africa.

I continue this introductory chapter by hypothesizing why miscommunication may occur in some intercultural medical consultations. After that, I outline the background to the study in terms of which both public and private patients are served in South Africa. In conclusion, I state briefly what I mean by intercultural communication, with particular reference to South Africa.

### **1.3 HYPOTHESES**

On the basis of related research (including my own pilot studies for an earlier degree in Applied Linguistics), I hypothesize that the following sources, interacting at the level of discourse, contribute substantially to the relatively high degree of interactional asynchrony reported in a number of the consultations:

1. differences in culturally-specific schemata;
2. systematic, culturally-specific differences in contextualization cues;
3. culturally-specific differences in ways of being polite and
4. culturally-specific ways of accomplishing repair.

### **1.4 BACKGROUND TO THE STUDY**

Recognizing that consultations do not take place in a socio-historical vacuum and that it is necessary to ensure that the analysis of the patient-doctor data is adequately contextualized, I propose in this introduction to outline some of "the fundamental issues" (Kandiah 1991:348) relevant to the structural background of health care in South Africa, such as racial prejudice and discrimination, the institutional authority of medicine, and socio-economic inequalities. Although general public health care will be discussed briefly, the focus will be on health care in some private medical practices run by white doctors in South Africa.

#### **1.4.1 HEALTH CARE IN SOUTH AFRICA**

##### **Public health care in South Africa**

Critics of the health care services in South Africa, e.g., Kriel (1986), Benatar (1991 & 1992), De Beer & Broomberg (1990), Broomberg, de Beer & Price (1990) and Boonzaaier (1988) are unanimous, not only in their condemnation of apartheid, but also in their vilification of the resulting financial, structural and functional inequities in health care. These inequities include: the relative inaccessibility to health care facilities for many black Africans, the unaffordability of the services and the

unwillingness of some white doctors to attend equitably to the health needs of black African patients.

Two prevailing criticisms are:

1. that there is a maldistribution of doctors per capita in the public and the private sectors. Statistics demonstrate that in 1990 59% of all doctors in South Africa were in private practice; only 41 % were practising in the much larger public health sector;
2. that there is also a maldistribution of doctors between the metropolitan areas of the country - 82 % - and the non-metropolitan areas - 18 % (Masobe 1992).

The consequences of these findings are that more doctors, both specialists and generalists, are being relatively well remunerated by practising in well-equipped private medical practices in metropolitan areas, with relatively few patients, many of whom are employed and members of medical aid schemes. In contrast, fewer doctors in the public health sector are having to attend to many more patients with very restricted public health funds. A result of this imbalance is that millions of financially disadvantaged black Africans have been and are, generally, underserved in terms of public health services.

### **Private health care in South Africa**

Prior to, as well as since the National Party's rise to power in 1948, access to private health care - in the form of some private practices - has been limited for some race groups in South Africa. Jamieson (1988), for example, in a study done in 1986/87 in the Johannesburg/Witwatersrand area, showed that many white private general practitioners discriminated among their patients by either not seeing so-called non-whites at all (12% of doctor respondents) or making them wait in a separate waiting room (40%) or seeing them in a separate consulting room (40%). Several reasons for the above were cited by those doctors. They include reasons of economics, i.e., the doctors feared that their white patients would go elsewhere if they consulted them in the same consulting rooms as blacks did; a second reason cited was that separate systems were in operation, e.g., no appointments are made for black African patients,

"package deals" including medication are the norm and black African patients are attended to by black nursing sisters. In addition, several paternalistic and bigoted reasons were given such as "they prefer to be with their own kind"; "they smell"; "I can never understand them". Jamieson concluded that "although this differentiation is not usually intended to be discriminatory, it has the effect of being just that" (1988:407). This conclusion was corroborated by the black African informants in this study.

Furthermore, discriminatory and paternalistic attitudes towards black Africans have also been adopted in some medical textbooks which are still read by students in medical school libraries today. They advocate attitudes such as those implicit in the following extracts:

"It is true that we have to pander - possibly not in the highest traditions of the Royal Colleges - to inherited attitudes in our patients, who think differently from white people and whose traditions of medical management are perhaps far more primitive and basic than those of the better educated European city counterpart" (Campbell, Seedat and Daynes eds. 1973:481)

and

"It is clearly necessary that within a reasonable period of time the doctor must become sufficiently competent in the languages concerned to check that his interpreter is correctly interpreting his words of wisdom and also replying correctly to the doctor's questions" (ibid:484). (My emphases)

Implicit in the above is the assumption that black African patients are different and deficient and therefore must be treated in a different way to white patients, in separate consulting rooms.

Others, though, have called categorically for the end of discrimination in access to health care, and for the abolition of racial prejudice in medical practice. For

example, De Beer & Broomberg (1990:119) state "the end of apartheid must bring with it the end of segregation and racial discrimination in health care. Indeed, we would do well to remove all discriminatory practices from the health sector even before a new government forces us to do so." Also, Kriel (1986:9), in condemning what he calls the "institutionalised injustice," of racism with its effects on both doctors and patients, says "a segregated health service is fundamentally an unjust health service."

Despite little real progress towards an egalitarian democracy until very recently, some gradual structural change in South Africa, such as the abolition of job reservation for whites in 1979, the repeal of the Pass laws in 1986 which prohibited blacks from seeking work and accommodation in the cities, the abolition of the Group Areas Act in 1991 which forced people to live in racially segregated areas, etc., resulted (by the time that data for this study were collected) in some black Africans having more equitable access to medical and other services. For example, Benatar (1991:33) states that "in 1978 blacks represented only 4 percent of all those with medical insurance; this had increased to 18 percent by 1987."

However, as noted above, research elsewhere has shown that successful intercultural communication, essential for equitable access to societal resources such as health care, does not depend on structural change alone. It depends, also, on the interlocutors' desire to communicate successfully with people whose cultural groups differ from their own (Hackman 1977; Singh, Lele & Martohardjono 1991), the quality of that communication, and their awareness of the potential for miscommunication.

### **Private medical consultations**

A consultation is private when a doctor is consulted by a patient who, perceiving him/herself to be ill, makes an appointment and pays fees, in accordance with private tariffs, for the sole use of that doctor's time and services such as a medical examination, a diagnosis and treatment.

Currently in South Africa, if patients are employed, they are most usually members of medical aid insurance schemes to which they pay a percentage of their salaries for medical insurance, a further percentage being paid by their employers.

Consultations are usually gate-keeping encounters (Erickson & Shultz 1982; Fiksdal 1990) within the institution of medicine. Gate-keeping occurs in these encounters in which patients, having perceived the need for health care, consult doctors who are the institutional gate-keepers in the sense that they determine patients' access to health opportunities, the valued objective. To elaborate, doctors in their roles as gate-keepers have the responsibility and authority to either open or close the gates of access to alleviation of pain by means of prescribed medication, reassurance from the threat of disease, counselling, referral to medical specialists, diagnostic tests, hospital care, etc.

Medical consultations are conducted through the medium of communication, both verbal and non-verbal. If miscommunication occurs between participants in a medical consultation, discrimination in the form of misdiagnoses may result, doctors thus failing to attend to the real needs of patients. If this happens to patients from historically powerless groups such as blacks, women and immigrants, their "powerlessness" can be perpetuated.

The private medical consultations investigated in this study involve intercultural communication between white male South African English (SAE) speaking doctors and their black African Zulu-English (ZE) speaking patients, all of whom, as the analyses reported on in 4.0, 5.0 and 6.0 show, rely to various degrees on culturally-specific knowledge and the communicative conventions of their own sociocultural groups.

## 1.5 INTERCULTURAL COMMUNICATION

Particularly in South Africa, with its history of apartheid, interactional sociolinguists need to be explicit about what they mean by culture and intercultural communication because, as Malan & Walker (1990:110) explain: "culture has become extremely problematic (in South Africa), especially with the linking of culture with race, language and nation for the purpose of state policy," (my emphasis). For example, researchers who focus on cultural differences and intercultural (mis)communication are sometimes accused of contributing a rationale for the ideology of apartheid by highlighting cultural differences while ignoring what is universal. In addition, they have been viewed as distracting attention away from necessary structural change, such as the removal of racial discrimination.

In rebuttal, interactional sociolinguists in South Africa, like their colleagues in the UK and the USA, believe that by undertaking fine-grained sociolinguistic analyses of sound-or-videotaped interactions across domains between people from different sociocultural groups, they will be able to demonstrate how speakers from those different groups employ different interactional micromechanisms which may exacerbate the misvaluation of each other, resulting in discrimination and negative cultural stereotyping.

Significantly, interactional sociolinguists such as Chick (1985) are at pains to point out that the findings of such small-scale qualitative studies should be combined with those of larger quantitative studies (e.g., Schlemmer 1977) in order to highlight the reciprocal relationship between what occurs in microcosmic settings and what occurs in the larger society. To my knowledge, however, no study regarding the macrosituation of racial discrimination in private medical practice has been undertaken in South Africa. Therefore, my general account of public and private health care in South Africa (provided in this chapter, 1.4.1) has to suffice for the purposes of this study.

I turn now to a discussion regarding how "culture" is viewed in this study. Interactional sociolinguists view culture, not as pre-existing in the form of material artefacts or static abstract knowledge, but rather as dynamically created, maintained and changed by interlocutors through communication. To elaborate, they believe that language is a prime



bearer and reflector of sociocultural knowledge, the norms and values of which are being negotiated and re-negotiated by members of cultural groups as they interact with members of their own groups and those of others.

In addition, the term "culture" is used in this study to refer to the sub-culture of the institution of medicine which consists of a paradigm set of members' beliefs, norms, values, procedures, behaviours and attitudes. How far participants are within or outside the sub-culture will depend on their sense of belonging and familiarity with that set.

In summary, culture in this study will refer, not only to the different language and ethnic groups represented by the participants in the study, but also to the culture of medicine and its participants, doctors and patients.

## **1.6 OVERVIEW OF THE STUDY**

In the following chapter, I review the literature pertinent to the study of the doctor-patient relationship, their interaction and the contributions Interactional Sociolinguistics and Critical Language Study may make to the study. In 3.0, I outline the background to the study in terms of where the research data were collected, details about the participants of the study, the methods of data collection, transcription and analysis and the problems related to those. 4.0, 5.0 and 6.0 contain the fine-grained analyses of 3 intercultural doctor-patient interactions. In the final chapter, 7.0, I discuss my findings and draw conclusions based on the theory and methodology of Interactional Sociolinguistics, with insights from Critical Language Study.

## **2.0 REVIEW OF LITERATURE**

In this chapter, I review the literature relevant to the study. Most of the references were obtained by means of Dialog Searches, viz., ERIC (1983-1988) and (1989-1993) and CD ROM-MEDLINE (1989-1993). Manual searches were undertaken of the INDEX MEDICUS, (1983-1988; 1989-1994), INCH (Microfiche Press Cutting Service, Institute for Contemporary History, Bloemfontein), MLA (Modern Languages Association) and the University of Natal AFRICANA Special Collections.

The review begins with a brief description of sociological literature relevant to the doctor-patient relationship. This was undertaken in order to understand how these accounts might contribute to one of the aims of this study, viz., the identification, description and explanation of sources of interactional asynchrony and synchrony in medical consultations. Thereafter, a description of literature relevant to doctor-patient interaction is given. The following section, 2.4, will deal with a review of what Interactional Sociolinguistics, as a theory of language use (see 1.2), has to offer to the better understanding of the sources of asynchrony and synchrony in doctor-patient communication, in the particular context of intercultural medical consultations in South Africa (see 2.5). In conclusion, this chapter reviews, in 2.6, what Critical Language Study might contribute to the study of intercultural doctor-patient communication, focusing as it does on the social relations of power.

### **2.1 SOCIOLOGICAL ACCOUNTS OF THE DOCTOR-PATIENT RELATIONSHIP**

A myriad of anecdotes, jokes, popular magazine articles, as well as academic articles and books (e.g., Barnlund 1976; Shuy 1976; Brice Heath 1979; McWhinney 1989) attest to the stereotype that communication between doctors and patients is problematic. However, early researchers of doctor-patient interaction such as Parsons (1951), began, not with the communication between them as a topic in its own right, but rather with sociological theories of the relationship between the role of doctors as healers and patients as sick people. The notion that became popular was that of ill health as a form of deviant sociological behaviour involving the sick withdrawing from society and only being restored to it by the healing administered by doctors.

Of relevance to this study, Parsons, however, was one of the first to suggest that medical consultations are fundamentally unequal or asymmetrical encounters between doctors, in their roles as the institutional gatekeepers of scientific and medical knowledge, and patients who seek to benefit from that knowledge. The reader will note that in 4.0 and 5.0 of this study, I found that asymmetry was particularly evident in my data of medical consultations conducted in South Africa. Parsons (1951) suggests also that these asymmetrical role relationships between the participants are, in fact, essential to achieving a therapeutic relationship. He sees the doctor's control of the consultation in terms of its form and function as fundamentally necessary to healing.

This research, extended by other sociologists such as Freidson (1972), Korsch, Gozzi & Francis (1968), Pendleton & Hasler (1983) and Morgan (1991), is limited, from the perspective of this study. It is so, firstly, because conversational features of the communication, such as medical jargon, are of interest to the researchers only insofar as they point to sociological aspects of the structure, organization and outcomes, such as patient satisfaction and compliance, of the doctor-patient relationship. For them, the microlevel of actual talk between the participants in the encounter is not an object for empirical enquiry in its own right.

A second limitation is that, because the researchers are not linguists, they do not analyse doctor-patient discourse in terms of a linguistic theory such as Interactional Sociolinguistics.

From the point of view of Critical Language Study (see 2.6 below), the most important limitation is that all these researchers tended to take for granted, and thereby promote, the prevailing ideological assumption that the doctor has to be in control of the action and interaction.

## **2.2 THE DOMINANT BIOMEDICAL PARADIGM OF HEALTH CARE**

According to Kuhn (1967), the theory and practice of medicine, as a scientific discipline, is based on a set of received beliefs, the assumptions of which tend to be shared as given by

doctors and not made explicit. He refers to this set as a paradigm which informs and guides medical agendas. It is inculcated by doctors' experiences in the medical education systems, their role models, their perceptions of the role of patients and the perceptions of patients of what constitutes a doctor. These in turn are reinforced by the institution of medicine as a profession. All the above are implicit in the philosophical assumptions or ideology of what it means to be a doctor (Kriel 1985; 1989).

In the Western world, the traditional biomedical paradigm of medicine has its source in the hypotheses of Descartes in the 17th century (Engel 1978; McWhinney 1989). This paradigm has 4 key assumptions. The first assumption is the Cartesian hypothesis that medicine is essentially mechanistic. That is, that the human body is a machine which can be understood by doctors in terms of its functioning. The second assumption, closely allied to the first, is that the whole body or "machine" can be reduced to its parts, e.g., the cellular and sub-cellular levels which can be investigated by physical or chemical means to establish, by differential diagnosis, the cause of the disease in a linear sequence of cause and effect. Thirdly, there is the assumption that the doctor is the detached observer/scientist who controls the data from the parts of the "machine" (i.e., the symptoms) in order to heal or repair the body, usually by means of some objective chemical, physical or technological means. S/he, therefore, according to the rationale usually provided in the paradigm, has to be in control of the interaction in order, not only to elicit information from the patient, who should be a passive recipient in the process, but also to examine the parts of the "machine", to label the problem in the form of a diagnosis and then to design a plan of action, viz., the treatment. The fourth, and most significant, assumption is that disease, in terms of the biomedical model, is viewed as the malfunctioning of a part or parts of the body.

Because the psychosocial aspects of disease and the healing process are largely neglected in this paradigm (Dali 1991), there is the tendency for doctors not to interact with patients as whole persons, within their cultures. Within this particular paradigm also, doctors' medical knowledge and grasp of the role of technology is crucial to the healing process. This accords doctors significant institutional authority over the patient. Such asymmetry affects the quality of interactions in ways that are examined in detail in 4.0 and 5.0 which deal with the analyses of intercultural doctor-patient interaction.

Within the last decade, this paradigm and its assumptions, which have become known as the "doctor-centred" model of health care, have been critiqued by several members of the medical fraternity, e.g., Benatar (1987), Levenstein (1984; 1988), Henbest (1989 a & b; 1991), Henbest & Fehrsen (1992), Helman (1984), to mention a few. Some, though, (e.g., Whittaker 1993) continue to expound the virtues of the biomedical model of health care and, as the analysis of my data reveals, it is "alive and well" in health care practice in South Africa.

### **2.3 EMPIRICAL STUDIES OF DOCTOR-PATIENT INTERACTION**

Attempts to analyse how doctors and patients actually interact began with the use of classificatory systems for analysing the interaction. For example, Bales (1950) devised an instrument called Interaction Process Analysis. It provided a taxonomy for the coding and classification of doctors' questions and patients' answers, a process which was carried out by researchers as doctors and patients talked to one another. Other researchers such as Katz et al (1967) and Stiles (1978) subsequently modified Bales's instrument to include other aspects of doctor-patient communication such as patients' questions and the classification of initiations and responses between speakers.

The chief limitation of these instruments is that, because their main function was to train medical students to communicate more effectively with their future patients, the focus was largely on the verbal behaviours of doctors. Very little attention was given to patients' initiations and responses.

A second limitation of such instruments is that they analyse verbal data quantitatively only. They, moreover, employ pre-specified and very broad categories into which the data were classified according to function and frequency of occurrence. They cannot, therefore, account for how, over the course of an interaction, interlocutors co-ordinate their behaviours in a synchronous way or why, sometimes, they fail to do so, which is the subject of this thesis. This method, therefore, could not attend to important variables such as the salience or ambiguity of an utterance in the actual interaction.

Investigations of how doctors and patients actually interact were attempted during the 1970's by doctors themselves such as Byrne & Long (1976). Of particular relevance to this thesis, in a major and detailed study, Byrne & Long analysed the interactional data from 2,500 private practice consultations. (Previous studies of doctor-patient communication had all been conducted in hospitals or clinics). Byrne & Long found that the consulting styles of the doctors in their study lay somewhere on a continuum between two poles, namely, either "doctor-centred" (where the focus was on the doctor's interpretation of the disease) or "patient-centred" (where the focus was on how the patient perceived the experience of ill-health) and that point in the continuum was reflected in the language the participants used to communicate with one another.

Amongst the limitations of their study was, firstly, that the researchers, once again, used checklists containing preconceived coding categories to quantify the communicative data and, secondly, they did not base those categories on any model of language use. They also, by implication, accepted that the doctor should be the dominant communicator in the interaction.

From the point of view of this study, other analyses of interaction conducted at that time such as those using Engel's Biopsychosocial Model (1978) were significant advances on previous attempts. This is because they took into account the multicultural nature of consultations in Britain. However, a limitation they shared was their concern with idealized models of doctor-patient interaction, i.e., with what that communication should be and not what it actually is.

It is evident from this review so far that studies employing quantitative data such as those above, while having the advantage over qualitative studies of generalizability, are not helpful for the investigation of the causes of asynchrony in intercultural medical consultations.

The late 1970's and early 1980's saw the increasing use of qualitative methods for the analysis of actual discourse. Studies investigating communication between doctors and patients as a topic in its own right, began to emerge: these include, amongst others, speech act analyses of psychotherapeutic discourse (Labov & Fanshel 1977), analyses focusing on the patient's contributions to the discourse (Mishler 1984; Fisher and Groce 1990), studies investigating the link between the institutional authority of medicine and the microlevel of

talk (Cicourel 1985; Fisher 1982; Fisher & Todd 1983, 1986) and studies analysing specific linguistic aspects such as turn-taking, topic control and interruptions by doctors (Zimmerman & West (1975), West (1984), Erickson & Rittenberg (1987) and Ainsworth-Vaughan (1992.)

However, the majority of the studies tend to play down the unique interactional context created through their discourse by participants in consultations. Why this notion of context is so crucial, for interactional sociolinguists, to the analysis of interactional data will be dealt with in detail later in this chapter (see 2.4). Moreover, few of the above studies attend specifically to communication between participants of different sociocultural groups in a medical encounter (cf. Erickson & Rittenberg 1987).

Recent studies by Henbest (1989a & b, 1991) and Henbest & Fehrsen (1992), researching intercultural communication at the Medical University of South Africa (MEDUNSA), emphasize that the patients' contributions are as important to the analysis as the doctors' in interactions. They advocate a paradigm shift towards a so-called "patient-centred" model of consultation for use in the vocational training of family practitioners. This model measures the degree to which the doctor facilitates the patient's verbalization of his/her symptoms, thoughts, feelings and expectations, which led to the decision to consult the doctor.

However, from the point of view of this thesis, the findings of these studies are not very helpful in terms of identifying and describing interactional asynchrony because they are still quantitative in design. For example, in Henbest & Fehrsen (1992), researchers code the first two minutes of the consultation by which it is claimed they can assess how "patient-centred" the consultation is. Furthermore, they do not use transcriptions so there is no means for other researchers to review the data and their interpretation of them. The major weakness is, however, although patients from eight South African indigenous language groups were involved in the study, no specific attention was paid to the differences in their sociocultural and linguistic backgrounds and the analysts relied on reports of interpreters to ascertain whether patients felt their symptoms, thoughts, feelings and expectations had been understood by doctors. One cannot, therefore, determine that utterances were correctly interpreted and conveyed. An associated limitation is that they once again were not based on a model of



language use and no explicit attempt was made to demonstrate how the researchers interpreted the patients' encodings of those perceptions across the eight indigenous languages.

## **2.4 INTERACTIONAL SOCIOLINGUISTICS**

Research methods that do allow for the investigation of the sources of interactional asynchrony and synchrony in intercultural encounters are those developed by the theory of Interactional Sociolinguistics (IS), a sub-field of Linguistics.

In attempting to achieve this goal, interactional sociolinguists carry out fine-grained, qualitative analyses of sound- and/or video-taped "speech events" (Hymes 1974) or episodes within them. The goal of IS is to discover and describe how language is instrumental in constituting and re-constituting social practices, such as prejudice and discrimination, between participants in interaction.

Of particular note in the field is research in multi-ethnic, industrialized, urban contexts in the United Kingdom by Gumperz (1971, 1972, 1977, 1979, 1982 a & b, 1986, 1991). His research emphasises that people, of oppressed ethnic minorities, need to interact effectively with dominant others in order to obtain valued goods and services such as jobs, loans, medical treatments, etc. Those dominant others, in environments and institutions such as education, medicine, the law and bureaucracy, are often white, mother tongue speakers of English. By conducting fine-grained sociolinguistic analyses of intercultural interactions, he found that, in gate-keeping encounters such as job application interviews, in which unequal power relations between interlocutors are well defined and gatekeepers control access to resources and opportunities, there was invariably a linguistic dimension to the discrimination of people whose sociocultural backgrounds differ to those of the gatekeepers. Since gatekeepers are generally ignorant of sociolinguistic diversity (Wolfson 1989), (i.e., the notion that different groups of people differ systematically in the ways in which they convey meaning and attitude in talk), they use their own frames of reference to interpret the behaviour of the opportunity-seeker and may deny access to valued goods and services based on the quality of the interaction in the encounter.



Since then, Tannen (1984, 1985, 1987), Varonis & Gass (1985) and Fiksdal (1990) in the USA, Chick (1985, 1986) in South Africa and Roberts, Davies and Jupp (1992) in the UK have added considerably to the body of interactional sociolinguistic research.

One of the strengths of IS is that it is eclectic. It draws on a variety of conceptual frameworks to enrich its ability to account for what is the main concern of this thesis, namely, sources of intercultural interactional asynchrony and synchrony.

A notion crucial to the theory of IS is how it treats context. It does not treat it as situationally fixed and already in existence prior to any interaction. Instead, it treats context as interactionally created and re-created by what participants are saying and doing. For example, participants signal to one another that they are chatting about the weather, that an interview is in progress, that an apology is being made, that complimenting is occurring, etc. They also signal what the relationship is between them, "who" they are in terms of their relative statuses and how their interaction is likely to unfold. The context, therefore, is what is being uniquely constituted and interpreted, moment by moment, in the interaction by participants who rely on interpretative schemata to do so.

Another very important notion in IS theory is that of schema. Bartlett (1932), Chafe (1977a), Tannen (1979) and Widdowson (1983), amongst others, explain that the contextualization process, referred to in the above paragraph, is guided by schemata. Schemata are cognitive structures in long-term memory which people rely on in working out what context they are in and in interpreting what other people intend by what they say and do in interactions, including what is expressed explicitly and what is implicit and therefore has to be inferred. In addition, schemata enable interlocutors to anticipate the likely unfolding of events in interactions and to identify, and then assimilate, what is particularly significant within those interactions.

Schemata are culturally-specific because they are based on the prior experiences and learning of speakers within their cultures or sub-cultures, such as the institution of medicine. Thus, people who are from different sociocultural backgrounds are likely to use different schematic knowledge to interpret messages being signalled by other interlocutors in a situation.

Widdowson (1983:41) distinguishes between two types of schemata: frames of reference and rhetorical routines. He explains that the former enable people to interpret the propositional or semantic content of the message; the latter enable people to make sense of the illocutionary activity of the discourse, e.g., to recognize cues to such speech events as medical consultations, court hearings or classroom interaction, amongst others. Both frames of reference and rhetorical routines can be culture and situation-specific.

In the context of intercultural medical consultations, then, schemata would be likely to include culturally-specific, as well as institution-specific, frames of reference such as expectations and assumptions about linguistic and/or paralinguistic cues to meanings embedded in the situation, as well as the rights and obligations of speakers. They would also include knowledge, expectations and assumptions about the rhetorical routines of how consultations tend to be organized and about appropriate behaviour of doctors and patients.

Fehrsen and Lor (1984:928) refer to what they term "the general practitioner's frame of reference" which they say develops through sequential stages. Beginning with basic scientific knowledge in the pre-clinical student years, medical students evolve through the "secondary paradigm" of applied medicine in the clinical years of study and the year of internship and develop a personal frame of reference, based on experience with his/her patients. They explain that "in the frame of reference of the GP, more than the cognitive domain is involved, such as his vocabulary, the nature of his concepts, the range of phenomena with which he deals or the way in which he structures his knowledge" (ibid:927).

A third important notion in IS is contextualization cues (Gumperz 1982a:131ff). Message interpretation is channelled by constellations of contextualization cues which interlocutors use to signal the context in terms of which the message is to be interpreted. They function at multiple levels of the verbal and non-verbal organization of the message form, including lexical, syntactic, prosodic and paralinguistic, proxemic and kinesic signals, formulaic expressions and code-, dialect- and style-switching and strategies of repair. These cues are salient only if participants possess the sociocultural knowledge of just what set of cues to attend to out of a myriad of features of the message form.

Within any interaction, speakers provide these cues, which constitute a metamessage to listeners as to how to interpret the message. These cues point to the relative importance of ideas and the relationship between them. Of significance to this thesis, it is when these expectations are not met about what aspects of the message form are salient that interactional asynchrony may result.

Another key notion in IS theory is that of face or public image. Prominent researchers in this field include Brown & Levinson (1987) and Scollon & Scollon (1983).

According to Brown & Levinson, people have the need to present and maintain kinds of public image or face: they need to be thought of as accepted members of a social group. This is referred to as their positive face needs. They also need to be perceived as individuals able to think and act independently of others, which is referred to as their negative face needs. Reconciling these different face-needs, they explain, is problematic especially as speakers have to balance their own face needs against those of others. People who are concerned to preserve their negative face (the need to be independent) may impose their will on others, while others who are concerned to preserve positive face for themselves may be imposed upon by others and thus have their negative face threatened.

To reconcile the rival claims of positive and negative face needs, interlocutors use politeness strategies which they acquire as part of their socialization into their cultures. Brown & Levinson identify 5 strategies including:

1. bald on record: e.g., Come here.
2. positive politeness: e.g., Please come here, dearest.
3. negative politeness: e.g., Would you mind awfully coming here?
4. off record: e.g., I need someone.
5. not done.

According to Brown and Levinson, which strategies speakers choose to use depends on their calculation of contextual variables. Firstly, the choice depends on the participants' moment by moment estimations of how close their relationship is with others (i.e., what distance (D)

there is between them). Secondly, it depends on how they see themselves as differing in terms of their status or relative power in that situation (i.e., what the power (P) differential is between them). Thirdly, the choice depends on how much of an imposition (R) what they are saying or doing is in their respective cultures. In other words, participants determine the extent or "weightiness" (W) of a face threatening act by adding the three factors inherent in the context, (D+P+R) and thereby concluding how much of a risk of face loss is involved and, therefore, what politeness strategy is appropriate.

The choice of politeness strategy is even more difficult in intercultural communication because what counts as very face- threatening in one culture may pose little threat in another and selection of the "wrong" strategy can lead to misinterpretation of intent and misjudgement of one another.

Scollon and Scollon (1983) refer to Brown & Levinson's first 2 strategies (that is, 1. bald on record; 2. positive politeness) as solidarity politeness strategies which include terms of endearment, laughter, friendly teasing or banter, being voluble, etc., i.e., being generally prepared "to share one's world-view". As the term suggests, their function is to emphasise the lack of social distance (-D), closeness or sense of solidarity between speakers. Such strategies are used, for example, to offset threat to negative face posed by impositions. They exploit the reality that people are more tolerant of importunities from those they feel close to than from strangers.

Scollon & Scollon refer to the other 3 strategies (that is, 3. negative politeness; 4. off record; 5. not done) as deference politeness strategies which, in turn, emphasize the social distance (+D) between participants. These strategies involve speakers showing that they respect hearers' needs not to be imposed upon. To be taciturn, i.e., to say little or even nothing, so as not to impose one's schematic world on the hearer, is included in these strategies.

An important element of these politeness theories is the notion that cultures develop so-called global, or as Brown & Levinson term them, general politeness systems. Depending on the sorts of social relationships that pre-dominate in a socio-cultural group, the different groups treat the three factors of power, distance and weight of imposition differently. The result is

that different cultures show preference for particular politeness strategies rather than others. In other words, their choice becomes customary or even conventional and targeted, as "good" behaviour. So, for example, if a cultural group typically employs distance behaviour (+P+D) in a wide range of social contexts, then a global politeness system of deference is likely to be constituted for that culture. If, on the other hand, a cultural group generally favours closeness (-P-D) between its members in a wide range of social contexts, then a global politeness system of solidarity is likely to develop and be maintained. An important point to bear in mind is that when speakers, who function within different global politeness systems, interact, they are likely to experience one another's choice of strategies as inappropriate. Face and politeness strategies will be discussed in more detail in the chapters dealing with the analyses of data.

Yet another concept that IS draws on in attempting to account for how interactional asynchrony and synchrony are accomplished, is that of Grice's (1975) notion of implicature or pragmatic inference which functions by means of what he calls "maxims of conversational co-operation." Speakers, Grice explains, either observe the maxims in order to communicate co-operatively or flout them for one reason or another. The maxims include: 1. quantity: say as much as but no more than is necessary; 2. quality: do not say what is false, be truthful; 3. relevance: be relevant; 4. manner: be clear, unambiguous, brief and orderly.

As Wolfson (1989:59) explains "these maxims give interlocutors the ability to interpret each other's comments by means of "conversational implicatures," so that the speaker's implied meaning is what is attended to."

The way these work in conversation is that if a hearer believes one of the maxims has been flouted, s/he will tend to look for a reason. Going beyond a speaker's apparent intention is the process called "implicature". For example, if an artist queries whether someone appreciates his painting and the critic offers that he likes the frame, the artist might well consider that the maxim of relevance has been flouted since the response is clearly not relevant to the question. The artist is likely to implicate that the critic is less than appreciative of the painting.

These concepts of conversational co-operation, flouting and implicature are integral to understanding how people interact, remembering always that the need to save face is one of the main motivations for flouting maxims.

Another notion that IS draws on is that of repair of some sort of "interactional trouble". According to Schegloff, Jefferson and Sacks (1977:339), repair is "a central conversational device" by means of which speakers correct or repair problems in their own utterances or those of others. They explain that, in their data, they found a preference ranking for repair, self-initiated self-repair being the most preferred by speakers because it is the least face-threatening. They suggest also that other-initiated self-repair would rank as relatively more than less face-threatening and other-initiated, other-repair is the most face-threatening of all the repair strategies.

It can thus be seen from the above account that IS is a very rich theory, drawing on a number of concepts to strengthen its ability to account for intercultural interactional asynchrony and synchrony. It is because of this richness that I will be drawing heavily on both the theory and the methods of IS in this study.

## **2.5 INTERACTIONAL SOCIOLINGUISTICS IN THE SOUTH AFRICAN CONTEXT**

Chick (1985) has shown how, in the context of unequal encounters between white, South African English speaking academics and black, postgraduate, Zulu English speaking students in South Africa, discrimination on the grounds of race is interactionally accomplished. He carried out microanalyses of a number of academic encounters which demonstrate how differences in sociocultural backgrounds and discourse conventions result in interactional asynchrony and contribute to the participants' misinterpretation of intent and misjudgement of ability. He argues that repeated encounters of this nature generate negative cultural stereotypes. He also argues that discrimination at the level of societal structures, such as those associated with apartheid, combines with the results of interaction to create "a negative cycle of socially created discrimination" (ibid: 316). This impacts on people to the extent

that access to the economy and other areas of social upliftment, such as education, is denied them and the social imbalances remain in place. What is unique about his study is that he focused not only on the causes of interactional asynchrony but also on the results of it, that is, how the inequities of apartheid are maintained or reproduced by means of the micromechanisms of interaction resulting in that "negative cycle of socially created discrimination" (ibid:316).

This study will draw on Chick's research and extend it into another domain of social interaction, viz., intercultural medical consultations, a move which he himself advocates (1985:300) as necessary in order for claims of generalizability to be made.

Finally, I turn to what Critical Language Study has to offer to the investigation of these encounters.

## **2.6 CRITICAL LANGUAGE STUDY**

Whereas most researchers in IS have tended to focus their attention on the identification and description of sources of miscommunication in multi-ethnic societies, Critical Language Study (CLS) is concerned with how asymmetrical relations of power are produced and maintained between people in institutions such as education, law, medicine, etc. Indeed, the researchers go further by examining the processes through which these inequities may be changed. For example, taking the view that language is never neutral, Critical Linguists such as Fowler, Kress & Hodge (1979), Kedar (1987) and Fairclough (1989, 1992) go beyond description and interpretation to the explanation of how language, viewed as discourse, reflects, and is used to maintain, particular social relations of power. I argue in this study that the two approaches to analysis, viz., IS and CLS, are complementary and that insights from CLS can usefully be employed to explicate the discourse in medical consultations between white, SAE speaking doctors and black African, ZE speaking patients.

In any institution, there is usually more than one ideology with its own assumptions about social relations of power which is reflected in its distinctive discourse (i.e., its preference for



certain linguistic features over others). The discourse communities attempt to propagate their ideology (of medicine, law, etc.) by getting their discourse conventions seen as appropriate, natural or "common sense" in that institution. That is, there is an ongoing, yet tacit, ideological struggle between dominant and subjugated discourses.

Critical linguists analyse the spoken and written discourse in the institutions of medicine, education, politics, the law and the press. They contend that these institutions, all of which function by means of unequal encounters, historically embody ideologies that legitimize power relations by controlling people through consent to implicit yet dominant conventions. In that way, for example, the ideology of medicine, its discourse conventions and its "common sense assumptions" such as the dominance of the doctor become accepted and sustained as common sense, "natural" or appropriate to consultations.

As referred to earlier in this chapter, the current dominant biomedical paradigm dictates that the doctor is always in control of the interaction like the teacher, the politician, the policeman and the editor. These, the more powerful partners in unequal encounters, use language which reflects and maintains a certain world-view of their respective ideologies, possibly to the detriment of those who are "powerless," because they uncritically accept the conventions of those in power as "common sense". One consequence is that the dominant Western ideology of medicine may not match the ideologies associated with traditional medicine which may be more familiar to ZE speaking patients. Another consequence is that the Western discourse of medicine does not allow for the extended negotiation essential in inter-ethnic consultations. Inequalities between people are thus maintained and reproduced over time. For example, research has found (West 1984:92) that doctors ask more questions than patients do and that patients seldom question doctors' right to do so. The discourse of medical consultations is thus likely to reflect how patients are manipulated into positions of responding to doctors' questions, thus maintaining the medical status quo, i.e., the doctor being the more powerful participant in the interaction with the "right" to ask the questions.



## **2.7 SUMMARY**

From this review, it will be apparent, firstly, that sociological accounts of the doctor-patient relationship gave way to research focusing on how doctors and patients communicate. Reviewing this literature was essential in order to understand that relatively little insight into the actual face-to-face interaction was gained by those quantitative approaches. I have argued in this chapter, that in order to understand the unique context that is created during a medical consultation, one needs to employ a theory of language use such as IS, together with CLS, so that the sources of interactional asynchrony and synchrony can be identified, described and explained.

In the following chapter, I describe in detail the research site and the methods by which the interactional data were collected. The problems and limitations of such methods will also be described.

### **3.0 BACKGROUND TO THE STUDY AND METHODS OF INVESTIGATION**

#### **3.1 BACKGROUND TO THE STUDY**

This research is the extension of two pilot studies that I conducted (Waterfall 1991 a & b) in which I identified and described some sources of interactional asynchrony and strategies conducive to synchrony in two intercultural medical consultations, between SAE speaking doctors and ZE speaking patients.

In (1991a), I found that there was a relatively high degree of interactional asynchrony in the consultation which could be ascribed to sources such as culturally-specific differences in schematic knowledge, different politeness conventions and different contextualization cues.

In (1991b), I found that the key-participants used particular strategies to generate and facilitate a comfortable understanding between them. The two most significant strategies were: firstly, the willingness of the native speaker (the SAE speaking doctor) to raise his "repairability threshold" (Singh, Lele & Martohardjono 1988:43) and, secondly, the use of mutual face-saving strategies.

Based on my findings of the above studies, I was of the opinion that a larger and more detailed study was necessary, not only to increase the generalizability of my findings, but also to discover what other sources and strategies might be in operation.

In order to collect authentic, interactional data which would allow me to investigate the differences in schematic knowledge, politeness strategies and other discourse conventions that I hypothesised would contribute to the relative asynchrony of intercultural medical consultations, I arranged for sound recordings to be made of naturally occurring consultations involving 3 SAE speaking white male doctors in private practice in Durban and 18 ZE speaking black African patients.

### 3.1.1 THE RESEARCH SITE

There were two principle reasons for the choice of that particular private practice as "a strategic research site" (Gumperz 1982a:1) for data collection. Firstly, in spite of the fact that, for reasons of confidentiality, private medical consultations are usually inaccessible, I gained relatively easy access to them because I know the members of the practice. Secondly, the doctors of that practice took a policy decision in 1985 to consult in a racially non-discriminating way in terms of access and service, despite the prevailing societal norms (see 1.4). I, therefore, felt that that particular research site would provide interesting "laboratory conditions" in which to investigate social change within the macrocontext of integrating private medical practices in South Africa and the role of discourse in this. Of central importance to the aims of the study (see 1.2), the policy decision ensured that the asynchrony evident in the data collected at this site would be more likely to have its source in the hypothesised mismatch of discourse conventions than the racial prejudice of the interlocutors.

Useful background information is that, prior to 1985, the doctors of that practice ran a racially segregated facility in a busy shopping and meeting area of the wharf. They had inherited that facility from the previous associates of the practice. However, in 1985, they decided, amongst other reasons, that this was discriminatory in practice and effect, with the result that that surgery-site was sold and they consolidated their services in their existing surgery. This resulted in the assimilation of all their patients into one multicultural practice, which was unconventional at that time in South Africa's history.

The practice is owned by four doctors and staffed by one nursing sister and two staff nurses. There are three other staff-members involved in administration. There is also one general factotum/interpreter. It is thus a relatively large operation which functions in the city centre, drawing its patients from a large mix of multicultural, multilingual and cosmopolitan professionals, office-workers and families from the suburbs and from some of the black African townships.

Several reasons were given anecdotally by some patients and ZE speaking informants as to why many black African patients came such relatively long distances to consult doctors in the city centre. One of the reasons was that, for the very reason of distance, these doctors are perceived to be "safe." They explained that, because the doctors are not directly involved in the communities of their patients with consequent little or no contact with their families and friends, they feel more secure in confiding in them. A second reason given is that the patients are attended to on an equitable service basis, with no overt racial or financial discrimination either in the waiting room, the consulting room or any other form of service. This is in contrast to the status quo (see Jamieson 1988 in 1.4.1) in many white-run practices where, for example, black, cash-paying patients (as opposed to those who are members of medical aid schemes) are made to wait in separate waiting-rooms and are attended to in separate consulting rooms on a first come, first served "package deal" (medication included) basis. (See 1.4.1 for more detail). They cannot, therefore, make appointments. This situation is unacceptable to most patients because of work and other commitments. Another reason given is that they perceive city doctors to be superior to the doctors in their own townships or adjacent suburbs. A fourth reason given was that they come into the city centre to shop and therefore take the opportunity to consult a doctor at the same time, thus saving themselves time and additional transportation costs.

### **3.1.2 THE PARTICIPANTS**

#### **The patients**

The average age of the 18 patients was 36 at the time of the recording. There were male and female patients, two of whom brought children with them. Some were patients of long standing; others were new to the practice. All the patients were at the time in full-time employment and all, except one, were members of medical aid schemes. 8 patients were teachers. The others were from a very wide range of occupations, for example, nurses, computer operators, book-keepers, train drivers, personnel officers, etc. According to the ZE speaking informants, patients in such occupations represent a range within the black African middle class in South Africa.

Some of the above information was gathered from the patients themselves on their consent forms (see Appendix 1). Other information was gathered, by the practice nursing sister for ethical reasons, from the personal detail sheets attached to their medical records.

### **The doctors**

The four medical practitioners were between the ages of 40 and 55 at the time of the recording. Three of the doctors had trained at a medical school in the Cape and one in the Transvaal. They had all had some hospital practice experience, in the form of internship and two had been trainee specialists at one time or another. All have had more than 10 years of general practice experience. They run their practice on a fee-for-service basis, which involves obtaining payment for their medical services and procedures from medical aid schemes which charge individual, employed patients for that service. They also have a substantial number of cash-paying patients who are entitled to a discount on the charges. Three of the doctors agreed to participate in the study, by having their consultations with patients recorded and then discussed over a period of some months.

Further relevant details about the patients and the doctors, whose interactions were chosen for further analysis, will follow in the chapters dealing with analysis.

## **3.2 LANGUAGE MEDIUM**

The consultations took place through the medium of English. All the doctors are speakers of South African English. One of the doctors can speak Zulu, having grown up in the region. However, he elects not to speak Zulu to his patients because he feels that he might thereby lose the trust of his patients who might feel less free to confide in him if they knew he could speak and understand Zulu. The other doctors' ability to speak Zulu is limited to the expression of simple instructions if the patient is entirely unable to speak English. If this is inefficient, the practice general factotum, who is a ZE speaker, is asked to translate or interpret. All the doctors report, however, that it was clear from the reactions of most of

their ZE speaking patients that they wanted the doctors to speak only in English to them. In sum, it appeared that all the interlocutors had the desire to have English as the medium.

### **3.3 METHODS OF DATA COLLECTION**

#### **3.3.1 COLLECTION OF INTERACTIONAL DATA**

Consistent with the methods developed by interactional sociolinguists such as Gumperz (1982a), Varonis & Gass (1985) and Chick (1985), the consultations were recorded by means of a small, unobtrusive tape-recorder situated on the desk between the doctors and their patients, during a 10 day period in May 1992. The relative unobtrusiveness of the recorder was important so as not to disturb the patients unduly.

I could not be present during the recordings for ethical reasons. Instead, I spent time in the waiting room and the administrative office, observing the ways in which interactions were conducted generally between staff and patients. These included: the staff knowing who the patients were and sometimes greeting them by their first names and being greeted in return, this usually containing the terms Sister (as in Nursing Sister) and Doctor; enquiring after the health of family members; laughing and joking with the patients, etc.

#### **3.3.2 PATIENTS' CONSENT**

Any patient who is a non-native speaker of English and who was willing to sign first-person consent (IJsselmuiden & Faden 1992) on the consent form (see Appendix 1) in order to participate in the study, was recorded at some time on the days on which the recordings were done.

Prior to the consultations, the patients were approached for their consent by the surgery nursing sister. She explained the consent form to the patients, focusing on the need to research communication between doctors and patients in private practice

settings. She did not, however, indicate explicitly to the patients that they would definitely be recorded during the consultation for which they were booked, with the result that the patients were not always aware of whether they were, in fact, being recorded or not.

It was made clear that participation was voluntary and that patients could refuse to be recorded. For example, on seeing the university letter-head on the consent form, two patients refused consent because they said they "wanted nothing to do with politics." Possibly relevant background information is that this stage of the research was conducted at a time when the university was embroiled in student protests which were being extensively reported in the daily press.

Written consent having been obtained, the forms, together with the patients' medical files, were handed to the doctors by the nursing sister as she conducted the patients to the consulting rooms. This functioned as a signal to the doctor that the patient had consented to the recording of the consultation.

### **3.3.3 PROBLEMS AND LIMITATIONS OF DATA COLLECTION**

There are a number of problems associated with recording interactional data. Most importantly, interactional sociolinguists have discovered that it is entirely normal, when people are aware they are being recorded, that they alter their speech in one way or another. Therefore, there is no guarantee that the language they are using is natural. This is known as the observer's paradox which makes it exceptionally difficult to obtain truly naturally occurring interaction. Wolfson (1976), however, suggests that there is no such thing as natural speech in any absolute sense because speakers constantly monitor their own speech and that of others and alter their speech according to the context.

Difficulty was experienced, also, in obtaining good quality recordings. The recorder was in a static position on the doctors' desks, as mentioned earlier. In order to

maintain the unobtrusiveness of the recorder, the doctors could not take it with them into the examination cubicle, with the result that some parts of valuable recordings were unintelligible. Future research of this kind would necessitate the use of more sophisticated microphones. Doctors also had to be relied on to activate the recorder, in time, before the consenting patient entered the consulting room. A number of recordings had to be discarded because the recorder was either activated too late or the tape of 30 minutes a side, ran out too soon.

A third difficulty was that only the linguistic and some paralinguistic data could be captured, with the result that non-verbal aspects of the interaction could not be recorded. Researchers of nonverbal communication between doctors and patients claim that nonverbal cues account for as much as 65% of the social meaning of a consultation and are therefore vital aspects of communication (e.g., Pietroni 1976). As will be argued in the following chapters, information of that type which could have been captured by videotaping, would have complemented, and even perhaps explicated more fully, the verbal data.

Lastly, an important limitation of this method of data collection is that the analyst, unlike the participants, cannot take into account what went before or after those recordings. All that is captured is a few moments in time between people who are creating the context of that particular private medical consultation.

Despite these limitations, I trust the analysis that follows will show that the data collected by this method is sufficiently authentic to allow one to claim that the sources of asynchrony and synchrony identified are ones that adversely (or positively) affect communication in consultations in this practice generally.



### **3.4 METHODS OF DATA ANALYSIS**

#### **3.4.1 PRELIMINARY ANALYSIS**

After the interactional data had been collected, they were subjected to a preliminary phase of "exhaustive data treatment" (Mehan 1979:37). This involved listening to the recordings many times to obtain a sense of what was going on generally and then to establish potentially significant aspects of the interactions. This allowed the analysis to be, at least in part, data- rather than hypotheses-driven. That is, I allowed the data to suggest patterns of sources of interactional asynchrony not predicted by previous studies and these I subsequently investigated.

#### **3.4.2 THE STRUCTURE OF MEDICAL CONSULTATIONS**

My preliminary analysis revealed that most of the recorded consultations had a structure of 6 sub-sequences that Ten Have (1989) claims is the distinguishing feature of a genre typical of the medical consultations that adhere to the biomedical paradigm. Ten Have refers to this structure as "the Ideal Sequence" (ibid:18) and explains that sub-sequences of the consultation unfold through time from the beginning to the end of the consultation:

1. opening
2. complaint
3. examination or test
4. diagnosis
5. treatment or advice
6. closing.

Such a structure is apparently a part of the schematic knowledge of doctors and some of the patients and informants, because, during the post-consultation interviews, they frequently referred to such sub-sequences in the following ways: "when we greeted,"

"when he was examining me," "then I told her what to do," "he is telling her what is wrong with her," etc.

Ten Have argues that, consistent with the dominant biomedical paradigm of Western medicine, (see 2.2) this sequence is organized to serve the specific interactional purpose of the participants' exchange of information about symptoms, their meanings and their treatment. He further contends that each sub-sequence is governed by conversational norms orientated to by participants, which are different to the norms inherent in other sub-sequences within the discourse. So, for example, discourse during the history-taking of the complaint differs from the discourse during the treatment sub-sequence of the consultation. Coherence in medical consultations, in Ten Have's view then, functions at the abstract level of sequential configuration and expectations in which speakers construe relationships among the discourse sub-sequences.

### **3.4.3 TRANSCRIPTION: SOME PROBLEMS AND LIMITATIONS**

After repeated replays of the recordings, rough transcriptions were made of all of them. Every consultation was treated as a potentially valuable source of insights. However, drawing on what I discovered from the preliminary analysis (see 3.4.1), and on information supplied given by the informants, I selected the recordings of three consultations for more accurate transcription (see Appendices 3, 4 & 5) and fine-grained analysis. For the transcription conventions please see Appendix 2.

Transcription of selected recordings is an essential, if sometimes problematic, aspect of interactional sociolinguistic research. For example, transcribing is not a one-off mechanical exercise of laboriously transliterating speech sounds to marks on a page of paper. It involves being physically able to hear the speech sounds, sometimes having to interpret what is being said and sometimes re-interpreting that in the light of additional information given by participants and informants, and then having to make decisions about how to visually represent that recorded speech in the form of transcriptions.

Some important features complementary to speech such as gestures or facial expressions cannot be captured in transcription, with the result that sometimes sources of meaning to the participants, are lost. Also, features such as accent, pitch and loudness or softness of voice have to be represented by diacritics, that is "marks placed over, under or through a letter to show that it has a sound value different from that of the same letter without the mark" (Richards et al 1985:80). Such transcription is inevitably selective which means that it is an interpretation of the discourse rather than a reproduction of it.

An additional problem of transcription involves the use of the word-processor to set the interactional data to paper. While being exceptionally useful in some ways, it does set limitations on how speech can be displayed because particular line and page settings circumscribe how readers will perceive the written data.

In brief, the transcription process has what Stubbs (1983: 228) calls "an estrangement effect," because it places on paper, for interpretation, recorded speech which may not necessarily have been interpreted by the interlocutors in the same way. This is so because listeners attend selectively to what is perceptually salient for them in the speech of others, thereby creating coherence from what might look fragmentary, ambiguous or incoherent to readers. However, interactional sociolinguists utilize the method of triangulation to obviate this problem.

#### **3.4.4 ANALYSIS**

Consistent with the methods of interactional sociolinguists such as Gumperz (1982a&b) and Chick (1985), attempts were made to obtain a convergence between the hypotheses of interactional asynchrony and synchrony in the selected consultations, the internal evidence of the transcribed data of those recordings and the interpretations of the participants and other informants, some of whom share and some who do not share the socio-cultural backgrounds of the participants.

As an instrument of convergence, the process of triangulation was used. Triangulation refers to "collecting and comparing different perspectives on a situation" (Stubbs 1983:234). An underlying principle of triangulation is that the interpretations of the researcher should be compared with, and informed by, the interpretations of the participants. In that way, I sought confirmation of the existence and nature of the sources of interactional asynchrony and synchrony in the consultations.

Sociolinguists tend to agree that it is valid to use participants as informants when analysing discourse. Stubbs (1983), for example, argues that researchers should take more notice of what native speakers say about their own language. Also, Wolfson (1989:44), although cautious about native speakers' intuitions about sociolinguistic rules, nevertheless contends that native speakers "often have good insights into the meanings behind various means of expression". She adds "What is important to remember is that while our intuitions as native speakers are far from adequate to the description of sociolinguistic rules, we would be completely unable to make sense of these rules if we had no intuitions at all. Inadequacy is not the same as absence of knowledge" (ibid:44)

Other researchers who have investigated what occurs in medical consultations, such as Byrne & Long (1976:10), have also used self-reported interpretations by the doctors as evidence of what they understood to be occurring during consultations. Along similar lines, I approached the doctors as key-participants, for their comments about, and interpretations of, the recorded consultations. This took place during semi-structured post-consultation interviews, each approximately 2 months after the consultations, because time had to be allowed for transcription, preliminary analysis and reflection on my part.

Semi-structured interviews are defined as those for which a list of essential questions is prepared and additional questions are asked when the need for them arises. The rationale for the choice of this method was to reduce the imposition on the doctors' time.

Consistent with the methods developed by Gumperz (1982a) and Chick (1985), I attempted to retrieve the inferential and interpretative processes of the participants by playing recordings back to them a number of times so that they could listen to them, in their entirety, to refresh their memories. They also had the transcriptions and the doctors, the medical records of those consultations, to refer to where necessary. Their opinions were elicited about what was going on generally in the consultations, what their intentions, assumptions and expectations had been, and what they thought the intentions, assumptions and expectations had been of the patients. Elicitation techniques, in the form of probing questions, were used to generate further hypotheses about what features of the message form or contextualization cues (Gumperz 1982a; Chick 1985) the interlocutors attended to and how these were actually interpreted by their fellow-participants.

Owing to the fact that I needed information from participant-patients as well as the participant-doctors, a number of patients, whose consultations had been recorded, were approached for their interpretations. Because of an awareness that they were full-time employees and thus their free time was at a premium, I undertook a rapid elicitation of information, again by means of semi-structured interviews.

It is my impression that the patients interviewed were co-operative and genuinely forthcoming, but the possibility must be allowed for that the interpretations might have been contaminated by many variables, not the least of which was the fact that I am a white, SAE speaking woman.

Working from the assumption that not even the participants themselves would be able to recall their exact interpretations of consultations that had occurred in the past, and also being aware that the patients might have told me what they thought I wanted to hear, five ZE speaking informants were approached to act as additional informants.

One of them is a secondary school principal and an applied linguist in his early forties. He was able to provide me with an informed insider's or "emic" view (Erickson & Shultz 1982:57) of what was likely to have been salient and meaningful

for the ZE speaking patients, especially the male patients. The second informant, who is also a principal in his fifties, was able to provide a check on the information and interpretations of the first. The third informant is a secondary school Biology teacher in her thirties who was able to provide me with many additional insights. The fourth informant is the general factotum/interpreter of the medical practice used in this research. She is in her mid-thirties. Although I was aware that using her information might possibly contaminate the data because she is so closely involved with the practice, I decided that what she had to offer in terms of inside knowledge pertaining to how the doctors function and what was likely to be occurring between them and their patients, more than compensated for possible contamination. The fifth informant is a woman in her sixties, who was able to provide valuable information regarding ZE speaking patients' likely sociocultural assumptions and expectations. Other contact with ZE speakers in my own workplace and elsewhere was also utilised in my search for validation. They listened to the recorded consultations and the analysis proceeded in the same fashion as with the participant-doctors and patients.

In addition, recordings and/or transcriptions of four of the consultations were discussed in four graduate research seminars with some linguists and applied linguists, both SAE speakers and ZE speakers. Several valuable points of information were added to the convergence process in this way.

### **3.5 SUMMARY**

To sum up, the interpretations of the participants and the informants were used to test my hypotheses about the sources of interactional asynchrony and synchrony in intercultural medical consultations.

In the following chapter, 4.0, I present a fine-grained analysis of the consultation between Dr A and Mr S, the patient.

## **4.0 ANALYSIS OF CONSULTATION 1**

### **4.1 INTRODUCTION**

In this chapter, I outline, firstly, the biographies of the participants whose interaction was selected for closer analysis. Secondly, I give a synopsis of the post-consultation interviews that I conducted with the participants and informers. The rest of the chapter is devoted to a detailed analysis of sources of interactional asynchrony. This chapter and the next, 5.0, focus on how interlocutors, in intercultural medical encounters, misinterpret one another's intentions, attitudes and abilities, resulting in interactional asynchrony.

### **4.2 BIOGRAPHIES OF PARTICIPANTS**

#### **4.2.1 THE PATIENT**

Mr S, a Zulu-English speaking patient of 30, consulted Dr A for the first time, as a new patient, on a Friday in May 1992 complaining about dizziness, which he said he had been experiencing for eight months. Mr S lives and works in a town in Zululand as a personnel officer for the regional government authority and is a member of a medical aid scheme. During the consultation, he also volunteered the information that he is a part-time student at a local, historically black university. According to Dr A, the participant-doctor, Mr S wore tinted, thick-lensed glasses to the consultation. The doctor evaluated him as a "quite proficient" speaker of English.

#### **4.2.2 THE DOCTOR**

Dr A is in his early fifties. He qualified in the Cape Province in 1964. After completing his internship at a large urban provincial hospital, he spent a further year

there as a medical officer in the various teaching departments. He then entered private general practice in the city. He is thus a doctor with 26 years of experience. He joined the practice concerned in this study in 1986. He is a native SAE speaker. He speaks no Zulu and said he seldom uses the services of an interpreter because most of his African patients are office workers and professionals who are able to speak English. He considers himself "patient-centred" in his approach to the health care of his patients, but volunteered that often their expectations of him, and constraints of time, force him to be what he called "disease-centred".

### **4.3 SYNOPSIS OF POST-CONSULTATION INTERVIEWS**

Everyone who listened to the recording of this 16,5 minute consultation, including Dr A, described it as unsuccessful and very stressful. He and Mr S apparently misinterpreted one another frequently. A number of "uncomfortable moments" (Erickson & Shultz 1982:104-113) are evident and it is clear that Mr S made very little progress with what he hoped to achieve in consulting Dr A. The informants who listened to the recording tended to argue that both participants would probably have arrived at the end of the consultation with a poorer opinion of one another.

Evidence for this interpretation includes the fact that Dr A, during the post-consultation interview, stated that he judged Mr S unco-operative in the description of his symptom, as long-winded and as "a difficult patient". McWhinney (1989:96) defines "a difficult patient" as "one with whom the physician has trouble forming an effective working relationship." Furthermore, Dr A reported that he had understood what the patient was saying about his symptom, but not what he meant. He added he sensed that the consultation had been a disappointment for Mr S and that he had wanted something more from him, but he was unsure what it was. He concluded that the consultation had been a frustrating failure for both of them. Of relevance to the issue of the consequences of such failures is Dr A's interpretation of the miscommunication in psychological terms, rather than in sociocultural or linguistic terms.



Further evidence for this interpretation is that the ZE speaking informants tended to blame the doctor, not only for what they called his "impoliteness", but also for his not working together with Mr S to determine what Mr S wanted. Most of the ZE informants saw Mr S's intention as seeking medical advice and reassurance about the cause of his dizziness from Dr A, something which he did not get.

In summary, neither Dr A nor Mr S, according to the informants, appeared to be satisfied with either the process or the outcome of the consultation.

#### **4.4 ANALYSIS OF SOURCES OF INTERACTIONAL ASYNCHRONY IN CONSULTATION 1**

##### **4.4.1 DIFFERENT SCHEMATA AND DIFFERENT POLITENESS STRATEGIES**

I hypothesised that much of the interactional asynchrony in the first selected example in Consultation 1, as identified by the ZE speaking informants, is a function of different culturally-specific schemata about how a consultation should be initiated as well as of how potentially face-threatening that activity is.

As explained in 2.4, schemata are cognitive structures in long-term memory on which people rely to interpret what other people mean by what they say and do in interaction. As noted in 2.4 also, because schemata are based on prior experiences, it is likely that speakers, engaging in intercultural medical consultations, will use different schemata to interpret messages being signalled by interlocutors.

In addition, I hypothesised that the interactional asynchrony, experienced in this consultation is also a function of the ways in which the participants negotiate issues of face and politeness in terms of their respective roles and statuses. The theoretical politeness model of Brown & Levinson (1978,1987), modified by Scollon & Scollon

(1983) and explained in 2.4, can be used to understand how speakers do this.

The reader will find it helpful at this point to read the complete transcript of the discourse of Consultation 1 which is to be found in Appendix 3.

I turn firstly to the opening sub-sequence which was perceived by the ZE speaking informants as asynchronous. There is evidence that this asynchrony has its source in the participants' different assumptions and expectations, (i.e., their schemata) about how consultations should be initiated.

- 001 D:       ..... right good afternoon ... right it's your first time here  
002 P:       yes  
003 D:       yah what is the problem today  
004 P:       aah there's a problem with the .. got some dizziness

Having listened to the recording, some of the informants who share the patient's cultural background, said it was unlikely that Mr S would have been comfortable with this initial sub- sequence of the consultation because he would not have considered it "polite enough". The reasons they gave were that Dr A did not greet Mr S by name prior to demanding from him the reason for his visit, did not introduce himself by name, and did not enquire about the patient's well-being and health and that of his kin. They saw these as reasons for the patient's discomfort, and for his failure to take the opportunity to respond verbally in the 6 second pause between Dr A's

- 001 D:       good afternoon

and the rest of his utterance in the same turn, in which he asks Mr S whether it is the first time he is consulting him as a patient. Since the tape-recorder was activated for 24 seconds before any speech was recorded, one can rule out the possibility that the greeting occurred prior to the above exchanges between the doctor and the patient.

One ZE informant commented insightfully that since Mr S lives and works in a town populated almost solely by traditionally conservative Zulu speakers, and also attends a historically-black university populated largely by black African students, his face-to-face spoken contact with mother tongue speakers of SAE was likely to have been limited. This might have meant that he had little experience with the communication conventions of SAE speakers, including the conventions of politeness. His own sociocultural expectations might have been that certain ritualized verbal and/or non-verbal conventions are essential for appropriate politeness in interacting with a speaker of a perceived higher status, such as a doctor. This was viewed as plausible by most of the ZE informants.

According to some of them, it was likely that Mr S perceived the doctor as rude in 001-004 because he would not have felt that what had occurred up to that point was sufficient for Dr A to move on to the next sub-sequence, the taking of the history of the symptom.

What also points to this interpretation is that, in terms of the norms of ZE speakers, the doctor did not do enough to negotiate mutually acceptable relations with his interlocutor. In her studies of requests in Zulu, De Kadt (1992a & b) found that " **a setting of politeness** is created primarily by a considerable number of non-verbal factors such as posture, gesture, direction of gaze, etc., as well as **by ritualized greetings, health enquiries, etc.,**" (1992b:70) (my emphases). It seems that in cultures where asymmetrical relations are the norm (i.e., where status is emphasized) negotiation of social relations has to be extended. It is not a matter of some groups of people being more polite than others, but rather a matter of different groups markedly favouring or preferring different strategies of politeness and having differing expectations about how extended this negotiation should be.

According to the ZE informants, the brevity of the participants' negotiation of social relations at the beginning of this consultation was probably a source of discomfort for Mr S, for whom it would have been unusual. By contrast, Dr A's interpretation was very different. He stated, during the post-consultation interview, that he thought the opening

sub-sequence was unproblematic for the patient. He said that he had greeted the patient and had asked him whether it was his first time there as a patient.

001 D: ..... right good afternoon ... right it's your first time here

002 P: yes

When I put it to him that he already knew that information because it would have been evident from the medical record, he said he used it as part of his greeting of a new patient. Apparently, he saw this as appropriately polite, possibly because it matched the rhetorical routine (Widdowson 1983) he probably would have drawn on in deciding how such a consultation with a new patient, minimally, should begin: greeting the patient and establishing whether s/he has old or new status.

#### **4.4.2 DIFFERENT SCHEMATA, DIFFERENT POLITENESS STRATEGIES AND DIFFERENT CONTEXTUALIZATION CUES**

There is also evidence that different, culturally-specific schemata and different ways of being polite interacted with different expectations of what counts as a contextualization cue, at the level of discourse, to cause asynchronous moments during this consultation.

As explained in 2.4, interactional sociolinguists view contextualization cues as messages about the message in that they signal what the context is in terms of which the message is to be interpreted. Furthermore, the ability of participants to dove-tail their contributions to one another's in order to develop a theme, depends on their shared assumptions and/or expectations about how prosodic, lexical and syntactic cues interact to signal specific meanings in the context.

It seems that Dr A, in his second elicitation in 003,

003 D: yah what is the problem today

004 P: aah there's a problem with the .. got some dizziness

is being guided by a medically culturally-specific rhetorical routine in which he elicits information from the patient whom he expects to respond by telling him what "the problem" (i.e., his symptoms) is. To enable the patient to access such a routine he supplies, as a contextualization cue, **the problem**. He thus attempts to alert the patient to the discourse task (Gumperz 1982a:208) he is assuming that they, as participants in the consultation, are about to engage in, i.e., Dr A signals that he is assuming that Mr S has a problem which is medical in nature, and that Mr S views health professionals as people who solve problems. He is also assuming that in identifying **the problem** Mr S will be indirectly requesting a medical diagnosis of the cause of the symptom of dizziness, as well as treatment. In other words, Dr A is assuming that he has initiated an exchange consisting of rapid and systematic elicitations of information by the doctor from the patient about his problem and the patient responding to those elicitations.

The informants, who share Mr S's cultural background, suggested this "up-front", or in Brown & Levinson's (1987) terms, bald-on-record demand by Dr A for Mr S to name the problem would have been a further source of discomfort for the patient at the beginning of the consultation. Assuming that he would have had little contact with SAE speakers as a group, they suggested that his expectations would have been that they would together arrive at the reason for his consulting Dr A by means of a more measured and circumlocutory route. In other words, Mr S's interpretation would have been guided by a different rhetorical routine and frame of reference, incorporating different assumptions about the roles of the health professional and his/her patients.

Since general practice consultations in the Western biomedical tradition, are almost always time-driven (Fisher 1982:59), it is likely that what constrains interactional behaviour here is also the value the doctor places on the patients getting rapidly to the reason for their visits. In other words, Dr A would have been expecting Mr S to

respond briefly and to the point regarding the above elicitation. Consistent with his sociocultural expectations as a SAE speaker, as well as his expectations and assumptions of the rhetorical routines of medicine as an institution, he would have expected the patient to co-operate as an interlocutor by orientating to the Gricean maxim of Manner (see 2.4) which specifies that interlocutors make their contributions to the conversation as briefly and perspicuously as possible.

What contributes to the confusion that ensues is that Mr S appears, at this point (004), to be behaving consistently with Dr A's expectations because he says his problem is dizziness, a symptom which is essentially "medical" in nature.

The ZE informants translated the patient's use of the word dizziness into the Zulu term, **izululwane** a sensation experienced when the human body is rotated. They, however, cautioned that, because the patient did not speak English "well," he might have been using "dizziness" to describe another sensation altogether. Therefore, the ZE informants suggested that what Mr S meant by "dizziness" and what the doctor understood by his use of the term might have been different. They also pointed out that Dr A did not ask him to describe what he meant by his use of the term. He seemed to take the term the patient was using at face value and began to question him about its history. This contributes to the asynchrony evident from very early on in the consultation.

According to Levenstein (1990:55) "symptoms are signs or indications of illness" and that in presenting a symptom, patients are translating into words their interpretations of how they feel". Levenstein adds that dizziness or "giddiness" is a particularly problematic symptom for two main reasons: firstly he found, in a study, that of 30 patients presenting with the symptom, 6 described vertigo, 15 felt either "lightheaded" or "unsteady" and 9 had other explanations; secondly, 22 patients were ultimately diagnosed as having some sort of physiological cause for the symptom whereas 8 were diagnosed as having some sort of psychosocial problem such as depression or anxiety. Levenstein concludes (ibid:56) that "symptoms are inevitably associated with fears and

Between **005** and **034**, (see Appendix 3) of Consultation 1 which precedes the extract below, the doctor establishes, by means of the patient's responses to his elicitation, the history of the symptom, i.e., the general duration of the dizziness, its specific time of occurrence and a description of its specific sensation.

035 D: mmm ... do you think there might be .. something wrong  
with you are you worried that there's something  
particular wrong with you

036 P: mmm I don't know because I'm studying

037 D: yes

038 P: now I don't know if the studies are worrying me

**035** as a turn consists of 2 elicitations, the syntactic form of both being yes/no questions:

1. do you think there might be .. something wrong with you
2. are you worried that there's something particular wrong with you

According to Dr A, his intention in the first elicitation of **035**, was to obtain a confirmation or a denial as to whether Mr S was afraid or not of **something** being seriously **wrong** with him such as a brain tumour, of which headaches (see Appendix 3:**029**) and dizziness are possible symptoms.

To elicit confirmation or denial, Dr A repeats the words **something wrong**, slows down his rate of speech and heavily stresses the additionally inserted word, **particular**.

These paralinguistic elements, I suggest, are contextualization cues Dr A uses to signal that it is this part of his utterance that he wants Mr S to attend to and build on. I suggest, further, that he does so to encourage the further development of the theme of dizziness, as a medical condition.

As mentioned above in 2.4, the ability of speakers to reach consensus on what themes to build on depends on the degree to which they share assumptions and expectations about what count as contextualization cues such as the above (slowing the rate of speech and heavy stress). According to ZE informants, these prosodic features were probably not salient for Mr S. Chick (1985:307-8) suggests that "given that the prosody of Zulu, a tone language, is very different than that of English, it should not be surprising to find that there are systematic differences between S.A. English and Zulu-English in this respect". He hypothesizes that "the signalling load marked prosodically is less in Zulu-English than in S A English". If this is valid, it is likely that ZE speakers find some meanings signalled prosodically by SAE speakers difficult to interpret. Further research undertaken by Gennrich-de Lisle (1985), regarding problems experienced by speakers of Black South African English with particular reference to the role of prosody, lends validity to Chick's hypothesis above.

What apparently adds to interactional asynchrony stemming from a mis-match of culturally-specific contextualization cues, is the high degree of indirectness used by both participants.

For example, in 035, Dr A says:

035 D:     mmm ... do you think there might be .. something wrong  
          with you are you worried that there's something  
          particular wrong with you

**Something wrong** is a formulaic, euphemistic utterance that has implicit meaning



specific to the Western medical tradition. As Dr A explained, he was trying to establish whether Mr S was concerned that he might have a brain tumour or something equally physiologically threatening. This very indirect or, in Brown & Levinson's terms, off-record (1987:69) expression of meaning would probably have been inaccessible to Mr S.

Mr S's response in 036

036 P: **mmm I don't know because I'm studying**

and his recycling of that response in 038

i.e., that there is something integrally associated with **studying** (and not something physiological) that is causing the dizziness, is internal evidence that he has misinterpreted the indirect force of Dr A's elicitation, namely, that Dr A was trying to establish whether Mr S was fearing the worst.

Mr S's responses in 036 and 038 are also very indirect. According to ZE informants, for Mr S to respond to the elicitation in too direct a way would have been impolite according to the targeted sociocultural politeness norms of Zulu, when faced with a direct elicitation by a person of perceived higher status such as a doctor. In their opinion, Mr S was telling the doctor what the real problem is, but politely, "not in a straight way" i.e., that studying (or something to do with studying) was the cause of the dizziness.

Evidence that he displays conventional deferential politeness is his conventionally indirect (or off-record) and hedged preface **I don't know** to his response in 036, which he repeats in 038, i.e., he elects to display ignorance in order to offset the possible imposition to Dr A's face.

036 P: mmm I don't know because I'm studying

037 D: yes

038 P: now I don't know if the studies are worrying me

Since Dr A felt that Mr S's contribution was irrelevant to the theme he felt they were developing together, he did not, for example, ask Mr S to elaborate on the link between his studies and his dizziness, which is presumably what he would have done had he thought Mr S's responses were relevant. Dr A does refer to studying in 041, but because he does not explore the implicit link between studying and dizziness, Mr S, according to ZE informants, probably experienced 041 as an interruption:

**040 P: (?) too much**

**041 D: what are you studying**

042 P: I'm doing B Admin with with er Westville

043 D: mmm ... and how is your appetite

Mr S's disappointment in not getting the reassurance or medical advice he expected no doubt accounts for the stress he experienced and his sense of dissatisfaction with the consultation as a whole.

Ironically, Dr A saw his elicitation in 041 as building on what he saw as Mr S's agenda at this point, namely to establish solidarity between them, i.e., not as an interruption, but as showing an interest in what Mr S was doing as a person outside the consultation.

Internal evidence that Dr A did not perceive the contextualization cue **I don't know** as significant is to be found in his recycling of the topic of studying when he attempts to elicit a response, later in the consultation, in:

049 D: mmm and how's the studying going do you find it easy  
to study or

and again later in the consultation in:

112 D:        **does it worry you at night when you're trying to study your books  
or when do you study**

and again, much later in the consultation after the examination sub-sequence, in

118 D:        **mmm .. now do you do  
much studying in the evening**

119 P:        **yeah I have to**

120 D:        **mmm do you find the dizziness has worried you then**

121 P:        **yes (?) when I'm trying to do assignments**

122 D:        **mmm mmm .....**

According to the ZE informants, one of the possible consequences of the doctor recycling the topic of studying is that Mr S might have assumed that Dr A was beginning to understand how he was linking the topic of studies with the sensation of dizziness and thus might have been expecting Dr A to offer him a solution. Dr A, on the other hand, was merely making social chat about Mr S's studies. This type of mismatch of expectations also occurs later on in the consultation, (see Appendix 3:123 ff), when the patient tries, once again, to tell the doctor what he thinks the real cause is of the dizziness.

Dr A, however, showed that he did not have this understanding when he reported, subsequent to the consultation, that he was unsure whether the studying was causing the dizziness or the dizziness was causing the problem with studying, i.e., what was cause

and what was effect was not clear to him. His use of the additive, co-ordinating logical connector **and** in **049** (below) suggests that studying is but one item on his check-list of the patient's activities of daily living: the state of his appetite in **043** and his sleep behaviour in **047** (see Appendix 3), all of which are potentially relevant to his diagnosis:

**049 D:       mmm and how's the studying going do you find it easy to study or**

To sum up, what is of crucial importance here to Dr A's misunderstanding is his literal interpretation of Mr S's **I don't know** in **036** and **038**.

#### **4.4.3 DIFFERENT CULTURALLY-SPECIFIC SCHEMATA, INTERACTING WITH A REPAIR STRATEGY**

There is also evidence to suggest that different, culturally-specific schemata, interacting with ways of accomplishing repair of "interactional trouble", were sources of interactional asynchrony in this consultation as well.

The culturally-specific schemata in question are rhetorical routines orientated to by doctors trained in the medical education systems of the dominant biomedical paradigm (see e.g., Cicourel 1987). The three doctor-informants also confirmed that "taking a history from a patient" is an actively taught skill in the clinical years of the medical schools they attended. These rhetorical routines correspond closely, in terms of structure, to Ten Have's (1989) "the Ideal Sequence" referred to earlier in 3.4.2. As explained in 3.4.2, this sequence ideally consists of 6 linear sub-sequences, the second sub-sequence being at issue here, viz., the complaint. This is the sub-sequence in which the doctor usually elicits symptoms of the complaint from the patient. Significantly, embedded in this sub-sequence, is a move intended to elicit whether the patient (particularly if new to the doctor) had previously been treated for the complaint. The rationale for this is that if treatment had been sought before, the doctor could then go on to elicit whether it was effective or not and why. This "sub-sub-sequence" is essential,

in terms of the biomedical paradigm, because it functions interactionally to move the discourse into the next, and third, sub-sequence: the examination of the patient in order to determine whether more of the same treatment is called for or something different.

Such structures, as noted above (see 3.4.2), have particular coherence for doctors trained in the education systems of the dominant biomedical paradigm, and some patients who have access to the rhetorical routines that inform them. Those who do not have such access, however, may find it difficult to discover coherence in the interactional sequences.

Because discourse occurs in real time, participants in discourse experience each stage one at a time in a linear fashion (Chick: personal communication). These stages seem to be signalled in medical discourse by doctors' elicitations. For example, Dr A initiates by means of some sort of elicitation, Mr S replies and then the doctor evaluates his response. Where the sequence is successfully completed, what Mehan (1979:55) calls "symmetry" is achieved between initiations (by doctors) and replies (by patients).

For example:

- 005 D: yah .. how long have you been dizzy  
006 P: since since er the end of last year .. in September  
007 D: yah

Where, however, no reply or an inappropriate reply (in the view of the doctor) occurs after the initiation, resulting in "interactional trouble", the discourse continues by means of "extended initiations" (Mehan 1979) or repairs until that symmetry is established. By means of these strategies, speakers repair their own utterances or those of other speakers. For example:

- 009 D: um .. now describe the dizziness .. what does it feel like  
010 P: um .. just like you know .. like .. got some drug

- 011 D: uh uhm yah  
012 P: sometimes sometimes just for a  
013 D: does it feel  
014 P: fall down  
015 D: fall down .. does it feel as if you're moving  
016 P: yes  
017 D: as if your head is turning  
018 P: yes always .. as I'm sticking to the floor  
019 D: yah .. it feels as if things are going  
020 P: things are going  
021 D: mmm

(No doubt the presence or absence of patients' non-verbal responses plays an important role, also, but since these were not recorded, it is not possible to consider them in the analysis.)

The following is taken from the history-taking sub-sequence of the consultation. To contextualize the extract, after Dr A had asked Mr S when the symptom occurred, he asked him to describe the symptom (009-022). He also asked Mr S if the symptom occurred while he was lying down (023-026); whether there were any other symptoms (027-034); whether he was worried there was something particular wrong with him (035-042); and whether his other daily activities such as sleeping and eating were normal (043-056).

The discourse continues:

- 057 D: yah .... is this the first time you've tried to get help  
for the dizziness  
058 P: no it's not for the first time  
059 D: mmm so what other sort of treatment have you had

- 060 P: sorry
- 061 D: I say what other treatment have you had for this dizziness  
have you had any pills or anything
- 062 P: yes I've had some ah treatment
- 063 D: mmm and has it helped has it been effective  
at the time
- 064 P: no
- 065 D: what sort of treatment have you had
- 066 P: they usually give me pills
- 067 D: mmm what sort of pills do you know the names  
of some of them
- 068 P: oaaah
- 069 D: (laughs)
- 070 P: not so good
- 071 D: mmm and you say there's been no improvement ..  
actually while you've been taking the pills is it no better
- 072 P: no no improvement

My initial impression was that this particular episode was an "island" of synchrony within an otherwise relatively asynchronous consultation. It appeared to me as if Dr A was being helpful by trying repeatedly to clarify his elicitations for Mr S. They also seemed to be building on one another's contributions and generally co-operating with one other.

However, during a post-consultation interview with Dr C, one of the informants, I became aware that this was a naive interpretation on my part. He suggested that Dr A probably experienced part of the discourse as asynchronous because he would have felt that the consultation was "going nowhere". Dr A concurred with Dr C's interpretation. In fact, he said his feeling about this part of the consultation, which he identified as a specific topic area within the history-taking sub-sequence, was one of frustration because

Mr S apparently could not, or would not, give him the information he was seeking.

It is no doubt because of these feelings of frustration that Dr A attempts at this point in the interaction to effect repair. In doing so, he consistently chooses self-initiated self-repair strategies. For example,

**061 D: I say what other treatment have you had for this dizziness  
have you had any pills or anything**

See also Appendix 3: **063**, **067**, and **071** for further examples of the same self-initiated, self-repair by Dr A.

Significantly, some ZE informants expressed the view that Dr A's repeated questions seemed to make Mr S uncomfortable. This suggests that Mr S did not interpret Dr A's elicitations as initiated repairs, and that, ironically, Dr A's attempts to restore synchrony probably contributed to a higher level of conversational asynchrony. This is the picture that emerges from the fine-grained analysis of **057-072** reported below.

In **057**, Dr A responded to the patient's message in **056** (that he cannot concentrate on reading for any length of time) by saying **yah**, the intonational pitch movement of which was intended, according to Dr A, to signal a transition from one topic area, **043-056**, (his elicitations, and the patient's responses, regarding his appetite, sleep and ease or difficulty of study) to another topic of previous treatment for the symptom. He now intended to elicit from Mr S whether he had had any previous treatment, and, if so, of what type and how effective it had been.

Dr A's **yah** is followed by a pause of 12 seconds, during which he wrote notes on the medical record. He used his next elicitation to initiate the topic of previous treatment:

**057 D: yah .... is this the first time you've tried to get  
help for the dizziness**



In response to my question whether this was not an embarrassing elicitation for a new patient to answer, Dr A said he was aware that new patients (i.e., those who had not consulted him before) generally found this sort of question face-threatening because it might oblige them to admit that they had been treated by someone else previously for the same symptom. However, no doubt prompted by the biomedical rhetorical routine referred to above, he stated that he needed to know that information so that he did not repeat or add superfluously to previous treatment. The patient's "admission" that he had previously sought "help", an expected move in terms of the rhetorical routine that channelled Dr A's production and interpretation, led him to anticipate that Mr S would go on to elaborate on the previous treatment.

Accordingly, when such elaboration was not forthcoming, Dr A felt he had to ask the question again. In linguistic terms, he repairs his question in **059** by making explicit what was implicit in **057** in order to elicit from Mr S what the **other (i.e., specific) sort of treatment** had been.

**059 D:       mmm so what other sort of treatment have you had**

He accentuates the word **other** presumably for contrastive purposes, i.e., to signal to Mr S that he would like him to elaborate on previous, rather than current, experience. However, given what was noted above in 4.4.2, it is unlikely that Mr S recognised this cue in **059** as salient.

It also appears that Mr S did not share Dr A's culturally-specific expectations, in terms of the biomedical paradigm, that, having established that he had had previous treatment, that he now reveal its type, in order to aid the doctor's selection of differential diagnoses, thereby moving the consultation along into the next sub-sequence, which would have been, according to Dr A, the physical examination of the patient.

It is also likely that Mr S's understanding of the word **treatment** in **059** was different

from that of the doctor for whom it is, presumably, a superordinate lexical item (Hurford & Heasley 1983:105) for medical procedures which effect a resolution or a cure of a symptom. This likely difference in interpretation was suggested by some of the ZE informants who said that the doctor had initially used the word **help** in 057 and that the patient probably did not interpret the term **treatment** as a synonym for **help**. According to them, this would probably have discomforted Mr S. Internal evidence of this difference in interpretation is the repair Mr S attempts to initiate in his next turn:

060 P: **sorry**

The significance of this is that the patient's prompt probably threatened the doctor's negative face, i.e., his freedom to complete his agenda. This conclusion is consistent with Dr A's observation that this part of the consultation "was like pulling teeth," i.e., he felt that he and Mr S were making exceptionally slow progress with the consultation. The more he tried to clarify what he was hoping to obtain from the patient in the way of information, the more Mr S seemed to be stalling with his responses.

In 061 Dr A self-repairs in response to Mr S's prompt by recycling his initiation and providing an example of the sort of treatment he would like Mr S to report on:

061 D:       **I say what other treatment have you had for this  
                  dizziness have you had any pills or anything**

That Dr A is aware that, in terms of his own norms, repetition with increasing explicitness is potentially face-threatening for the listener, is evident from his use of the mitigator **I say** which prefaces the repair. However, it would appear that here again his concern is principally with his own negative face. The **have you had any pills or anything** part of 061 is a self-initiated self-repair in the same turn of

061 D:       **I say what other treatment have you had for this  
                  dizziness.**

Schegloff, Jefferson and Sacks (1977) classify this type of repair as Preference 1, the least face-threatening to the speaker.

To continue with the analysis: Dr A chose to move on in **063** to elicit information from the patient regarding another sub-topic, namely, the efficacy of the treatment:

**063 D:               mmm and has it helped**  
**has it been effective at the time**

Again the elicitation is complex because not only does it contain an immediate self-initiated self-repair **has it been effective at the time**, but the word **effective** is also more technical than **helped**.

According to Dr A, the patient's response to these elicitations

**064 P:       no**

was not sufficiently informative because he was expecting Mr S to elaborate on the effect of the treatment. This is supported by internal evidence a little later in the consultation. Dr A in **071**, presumably feeling that he had not resolved the issue as to the efficacy of the treatment, recycles the propositional content of the elicitation in **063** in what he assumes are more accessible terms:

**071 D:       mmm and you say there's been no improvement ..**  
**actually while you've been taking the pills is it no**  
**better**

In **065**, the doctor recycles the sub-topic of **sort** of treatment by repeating the propositional content of **059** and **061**, again using the superordinate lexical item **treatment**. The patient responds in **066** by using the word **pills** as his information,

066 D:       they usually give me pills

a lexical item which had been supplied previously by the doctor in 061:

061 D:       I say what other treatment have you had for this  
              dizziness have you had any pills or anything

In 067, Dr A, wanting to elicit more precise information about **what sort of pills** Mr S had been given previously, asks an elliptical yes/no question, apparently building on the **patient's** use of the word **pills**:

067 D:       mmm (do you know) what sort of pills

and, in the same turn, immediately self-initiates a self-repair in the form of a yes/no question

067 D:       do you know the names of  
              some of them

My interpretation is that Dr A was feeling insecure at this point about what, and how much sense Mr S was making of the consultation. I suggest, Dr A, by repairing his own elicitations, appeared to be checking Mr S's interpretative ability. Yet, during the post-consultation interview, Dr A evaluated him as being "quite a proficient speaker of English".

However, he gets what he perceives as contradictory messages from Mr S. Consistent with the first stage of the rhetorical routine that channels Dr A's production and interpretation, Dr A tries, firstly, to establish whether the patient was treated before, and, secondly, what sort of treatment was given. At first, Mr S does not seem to understand **treatment** in 059. Then, when Dr A moves on to the topic of treatment with the concern

with **pills** in **061**, Mr S, by referring to **treatment** in **062**, seems to be returning to an earlier stage in the rhetorical routine. Then, Mr S identifies **treatment** as exemplified by **pills** in **066**. Dr A feels obliged to repair and is, thus, unable to proceed to the next sub-sequence, creating the perception of slow progress or, as Dr A, put it, "pulling teeth".

It seems, therefore, that a mismatch of culturally-specific schematic knowledge, together with attempts at repair, created as many interactional problems as they solved and it is this that caused the relatively high degree of interactional asynchrony in this sub-sequence.

#### **4.4.4 AN ACCUMULATION OF SOURCES OF INTERACTIONAL ASYNCHRONY IN CONSULTATION 1: THE INTERACTION OF DIFFERENT SCHEMATA, WAYS OF BEING POLITE AND CONTEXTUALIZATION CUES**

It is important to acknowledge at this point that interactional asynchrony occurs also in intra-cultural encounters often because the participants bring to them different ideological assumptions about social relations of power that should obtain between patients and health care providers. However, the potential for asynchrony in interethnic encounters is often very much greater because, over and above these differences in ideological assumptions, participants rely on different contextualization cues, schemata and ways of being polite.

I turn, finally, to a closer examination of the discourse between **122** and **136**. This closer examination is prompted by the observations of Dr A and the ZE speaking informants that the exchanges **in this section** were very uncomfortable for both him and Mr S. I will be arguing that the perception of discomfort was owing to an accumulation of several asynchronous moments in the consultation **prior to this section** of the discourse, as discussed in detail above.

- 122 D: mmm mmm .....
- 123 P: and aah another problem .. another thing
- 124 D: mmm
- 125 P: I don't have I don't know if maybe the glasses cuz I  
have changed the glasses last year
- 126 D: mmmm
- 127 P: so I had the line which was not .. tinted like this
- 128 D: mmm yah
- 129 P: so they gave me red eyes I think
- 130 D: uh huh .. (?) might have started
- 131 P: (?) the change of glasses maybe affected me
- 132 D: shouldn't really
- 133 P: and when I put them on
- 134 D: mmm
- 135 P: since the first time I I seem to be the first one who .. I seem  
to be wearing the glasses for the first time
- 136 D: yes ..... right what I want to do .. that one ear is as I say  
very blocked up with wax

After the doctor says in:

122 D: mmm mmm .....

a pause of 21 seconds follows, the longest one in the consultation up to that point. During this pause, Dr A was writing down on the patient's medical card the details of what he had found on examination of Mr S, as well as what his decisions were going to be in terms of the treatment of the symptom.

The doctor's turn in 122 allowed him to hold the floor (Edelsky 1981) while he was writing. It also signalled, according to Dr A, the completion of one topic: the time of

occurrence of the dizziness, and the potential transition to another, which would have been a suggestion of treatment involving the removal of excessive wax from the patient's ear which, he felt, might have been causing the sensation of dizziness.

However, perhaps because the patient did not recognise this turn as a floor-holding strategy, because it would depend on his having access to the relevant rhetorical routine, Mr S claims the floor in 123:

**122 D: mmm mmm .....**

**123 P: and aah another problem that .. another thing**

Significantly, this is the first and only time that he claimed the floor in the consultation. By doing so, he changed the structure of the consultation because what he said was not a response to an elicitation posed by Dr A. Research has shown that claiming the floor from doctors by patients is an infrequent occurrence, at least in Anglo-American Western settings (Fisher & Groce 1990:232). In their study, only 16.3% of patients claimed the floor to initiate an utterance which was not in response to the doctor's elicitations.

Several of the ZE speaking informants and Dr C agreed that in 123 the patient was attempting to tell the doctor what he wanted. Several SAE speaking informants also said that the patient might have thought he had the right to the floor after the doctor's last turn in 122 and the long pause of 21 seconds. In addition, some of the ZE informants suggested that the patient had realized by then that Dr A had decided that the problem was caused by excessive ear wax, which, according to Dr A's medical frame of reference, could have been causing the symptom, as stated above. Probably for reasons of politeness, the patient initiated, very indirectly, disagreement or rejection of Dr A's diagnosis by means of

**123 P: and aah another another problem that .. another thing.**

Informants, who shared the patient's sociocultural background, suggested that by his doing so indirectly, he was acknowledging the right of the doctor to his interpretation of the problem, which was different from his own, viz., an incorrect prescription for the lenses of his spectacles.

A number of ZE informants added that by that time he had probably given up trying to hint to the doctor that he was associating the symptom with an activity related to studying. They interpreted what followed as Mr S's attempt to suggest to the doctor that the change of glasses the previous year was the likely cause of the dizziness. They added that, although the patient would probably have recognized that this suggestion would be a threat to Dr A's face, he would have felt obliged to make it because the doctor had not interpreted his previous attempts (036 and 038) as suggestions.

Another source of asynchrony was suggested by a comment by Dr C, one of the informants, that Dr A had failed to interpret 123 correctly, namely as a prelude to the real reason for the consultation. Dr A acknowledged that he had been expecting the beginning of the closure of the consultation, but possibly because his interpretation was channeled by a quite different rhetorical routine from Mr S, he stated that he had certainly not expected the real reason for the consultation to be forthcoming at that stage in the consultative process, i.e., in Mr S's next turn in 125:

125 P:        I don't have I don't know if maybe the glasses cuz I have changed the glasses last year

Instead, cued by the words **another problem/another thing**, his expectation was that Mr S was going to tell him that he had another problem, **secondary and additional to**, the **primary** complaint of dizziness. Hence, what appears to be an incorrect choice of a lexical item by Mr S triggers the wrong expectation in Dr A. The source of interactional asynchrony here, then, is the mismatch of culturally-specific rhetorical routines and frames of reference.



In addition, Dr A said that he regarded what Mr S said in

**123 P: and aah another problem that .. another thing**

as a delaying tactic, obstructing his intentions to treat the symptom by syringing the excessive wax from Mr S's ear.

Internal evidence that he was not paying full attention to what Mr S was saying is to be found in:

**124 D: mmmm**

the level tone of which, Dr A said, was intended to signal not that Mr S should continue, but that, since he was busy writing on the medical record, he should put whatever he was attempting to say on hold. Therefore, although he was hearing the patient's voice, Dr A was not in fact listening to the meaning of what he had to say. Rather, he was intending to get on with the treatment of syringing Mr S's ear.

A number of ZE informants felt that **mmmm** might have been interpreted by Mr S as a signal for him to continue. What lends credence to this interpretation is that Mr S persists between 125 and 136 with his attempts to tell the doctor what he thinks the cause of the problem is.

**125 P: I don't have I don't know if maybe the glasses cuz I  
have changed the glasses last year**

**126 D: mmm**

**127 P: so I had the line which was not .. tinted like this**

**128 D: mmm yah**

**129 P: so they gave me red eyes I think**

**130 D: uh huh .. (?) might have started**

- 131 P: (?) the change of glasses maybe affected me  
132 D: shouldn't really  
133 P: and when I put them on  
134 D: mmm  
135 P: since the first time I seem to be the first one who.. I seem  
to be wearing the glasses for the first time  
136 D: yes ..... (24.5 secs)

In the dominant biomedical paradigm, the role of patients is to describe symptoms, not provide diagnoses which is the interpretive function of doctors, ratified by their training, their medical knowledge and the history of the institution. For instance, Cassidy (1938:175-9) suggests that the only thing that doctors wanted to hear from their patients was "an account of their symptoms, as concise as possible and chronological". I suggest, therefore, that patients, who attempt to offer information regarding what they feel to be the reason for the consultation, contest the assumption about who is the more powerful participant in that consultation. They are most likely not deliberately doing so, but they bring assumptions about asymmetry in power relations from their own background and they see their challenging of diagnoses as very risky. Hence, their very deferential "I **don't know**" when they mean the opposite. I suggest also that the presumption is perhaps seen as more outrageous when it comes from a member of a subordinate group.

According to the ZE speaking informants, in 125, 127 and 129, Mr S was telling Dr A in a deferential way, by means of repetition and hedging, that his previous glasses (lenses) had not been tinted and he felt that he had been affected by the change to tinted lenses. He was, therefore, acting in accordance with the culturally-specific, targeted Zulu norms of being deferentially polite by assuming that if the person being addressed refuses to acknowledge the meaning of one's words, one has to persist. However, in the opinion of several ZE speaking informants, Dr A seems to be refusing to build on Mr S's contributions to the discourse in 125, 127, 129, 131, 133 and 135.

Mr S's persistence was unsuccessful because the doctor says in 132 **D: shouldn't really.**

Instead, Dr A interpreted the patient to be providing a self-diagnosis, one which he does not take seriously because it comes from the wrong source (the patient himself) and at the wrong time (just before the treatment for what Dr A had diagnosed) in terms of his rhetorical routine which is closely aligned to "the Ideal Sequence" of Ten Have (see 3.4.2). He considered this mismatch of expectations irritating because he felt he had already established the cause of the dizziness and had no more time to discuss what he considered to be an **additional problem**. He, therefore, rejects Mr S's assertion in 132.

Fisher and Groce (1990:237) found a similar phenomenon in their study of Anglo-American medical encounters when doctors "rejected 50% of the accounts patients volunteered." (It should be noted, therefore, that it is not only people (such as some ZE speakers) unfamiliar with the dominant Western model of medical consultations who engage in "inappropriate" behaviours.) I suggest that this rejection reflects a clash between different ideologies, that is, assumptions about social relations of power between doctors and patients.

Despite Dr A's discouragement, Mr S persisted in 133 and 135 in elaborating on the reason for his assertion in

131 **P: (?) the change of glasses maybe affected me**

by means of

133 **P: and when I put them on**

134 **D: mmm**

135 **P: since the first time I seem to be the first one who .. I seem to be wearing the glasses for the first time**

Dr C and the ZE speaking informants suggested that Mr S was trying, in 135, to tell Dr

A that when he put his glasses on, it seemed to him as if it were for the **very first time every time**. Because he does not mention **dizziness** directly in 135, they again interpreted him as being deferential.

I turn now to the question of what it was about the above discourse that accounts for Dr A's perception that he had not understood the patient at the time of the consultation.

As mentioned earlier, it seems that Mr S was trying to tell Dr A that **every time** he wore the glasses it felt like the **first time**. Mr S, however, does not use the phrase **every time**. Instead, he repeats the word **first** three times. Although Burt & Kiparsky (1972) would classify this use of a single wrong word as a local error only, and therefore not sufficient to effect gross miscommunication (unlike global errors such as paragraph misconstruction), I argue that because it was repeated three times, and because it came at a point when the lengthy consultation was already so cumulatively asynchronous for both participants, it was probably enough to cause misinterpretation on the part of Dr A, with the result that he was unable, or unwilling, to build on Mr S's attempts to self-diagnose. I suggest also that Dr A would have worked harder to try to understand Mr S if he had not felt that Mr S was trying to usurp his role.

According to most of the ZE informants, Dr A behaved as if the patient had not told him anything. When asked why they thought Mr S had not pursued his theme, they said it would have been very impolite for him to have done so, possibly because his more indirect attempts to disagree had not been built on by Dr A. That is, a more direct disagreement might have been even more face-threatening when the indirect disagreement has been ignored. By remaining silent, he appeared, to Dr A, to concur with his treatment suggestion to remove the wax in his ear. However, Mr S would have withdrawn from the encounter continuing to feel very "bruised".

According to some ZE speaking informants, to compound Mr S's sense of discomfort, he apparently again interpreted the doctor's level tone in

134 D:                   mmm

as an invitation to continue to elaborate on his diagnosis and the basis for it. Dr A said

it was not a signal to continue, but rather, again, a floor holding signal that called for Mr S to be silent while he was busy writing on the medical record. Therefore, although he was hearing Mr S's voice, he was not in fact listening to the meaning of his utterance in 135.

Dr A's

**136 D: yes**

overlaps with Mr S's last words in 135. This seems to stop Mr S from making any further attempts to persist with telling Dr A what the real problem was. Also, he does not try to reclaim the floor in the manner of 123, after the long pause. Some ZE informants thought it likely that Mr S had realized that Dr A did not understand, or was unwilling to consider, what he had been told about the glasses and therefore Mr S desists in his attempts.

Dr A retained the floor in his turn 136 by signalling a move to the next sub-sequence, using the transition marker (Fisher & Groce 1990:239) **right**, and justifying his treatment choice of syringing the wax out of the patient's ear,

**136 D:                   yes .....(24.5 secs) right what I want to do ..  
                          that one ear is as I say very blocked up with wax**

**137 P:           yes**

which he undertakes while talking in 140 (see Appendix 3).

Further evidence that Dr A was adhering to his medical frame of reference of a physiological cause for Mr S's dizziness (as well as his rhetorical routine that after diagnosis by him, he prescribes treatment or a further course of action) is to be found in his suggestion in 162 (see Appendix 3) that further blood tests should be done to check

for anaemia and diabetes. He suggested also that Mr S return for the results of the blood tests the following Friday.

According to the doctor, Mr S returned the following Friday. The test was normal in that it did not show the patient to be either anaemic or diabetic. However, what was significant about his return was that his parting words to the doctor, after having received the results, were:

**"the glasses seem to make the cause of the dizziness."**

Only then, perhaps encouraged by the doctor's apparent misdiagnosis and the indignation he had nursed in the interval, is he direct.

Upon realising he had made a misdiagnosis, the doctor wrote down the patient's exact words. Significantly, Mr S has not consulted Dr A again.

#### 4.4.5 SUMMARY

Thus, the fine-grained analysis of the discourse of this consultation reveals several sources of interactional asynchrony that led the participants to judge it an uncomfortable encounter. The sources of interactional asynchrony include culturally-specific mismatches of schematic knowledge, misinterpretations of various contextualization cues as well as mismatches regarding the role of indirectness as a way of being polite. Furthermore, the doctor's attempts at repair, which led to further unravelling of the interaction rather than to its repair, contributed in no small way to the general interpretation of this consultation being asynchronous.

In the following chapter, I undertake the fine-grained analysis of another consultation. It will be seen that many of the same kinds of sources of asynchrony are operating in that consultation. However, the fact that the patient in the following consultation is a female ZE speaker tends to illuminate further the asymmetrical social relations of power inherent in some intercultural medical consultations.

## **5.0 ANALYSIS OF CONSULTATION 2**

### **5.1 INTRODUCTION**

I begin this chapter, like 4.0, with brief biographies of the patient, whose consultation was the second one selected for fine-grained analysis, and the doctor. Thereafter, I give a synopsis of the post-consultation interviews I conducted with the participants and informants.

The latter part of this chapter is again, like 4.0, devoted to the detailed analysis of some sources of interactional asynchrony in the discourse of the second consultation that was selected. It is worth noting now that while many of the same kinds of sources of asynchrony were operating in this consultation, e.g., mismatches of schematic knowledge, different politeness conventions, different contextualization cues, etc., there is the added dimension that the patient in this case is a female Zulu-English speaker.

### **5.2 BIOGRAPHIES OF PARTICIPANTS**

#### **5.2.1 THE PATIENT**

Ms M, the patient, is a 36 year old ZE speaker. She is unmarried and has no children. She was an illegitimate child. She lived for many years with her father's brother and his family in Umlazi, one of the townships in the Durban area, in which many black Africans live. Having matriculated at Adams Zulu Training College, she obtained a Bachelor of Commerce degree from the University of Natal. She is currently working as a supervisor of accountants in the Durban Corporation. Prior to that, she worked for 4 years as an accountant for the Kwazulu Transport Company. Dr B, whom she consulted, judged her proficiency in English to be "good." She told me she had learnt to speak the language at school, and also by interacting with staff and the public in her two places of employment.



Information obtained from the medical record, via the practice nurse, was that she had consulted Dr B approximately four times a year since 1984. She was thus an infrequent yet established patient of his. Except for two occasions when she had had to consult two of the other associates, (because Dr B was on vacation) she had always had access to Dr B. She had suffered intermittently from arthritis for which he treated her in the past.

### **5.2.2 THE DOCTOR**

The details regarding Dr B were obtained from him during a post-consultation interview. He is in his early forties. He was born in Natal and has spent most of his life here. After graduating from the University of the Witwatersrand, he joined the general practice concerned in the study.

He is a SAE speaker. He stated that he "can converse in Zulu" and thus never uses an interpreter. He explained that he elects, however, not to speak Zulu to the majority of his black African patients because he says they prefer to speak English during consultations with him. According to his colleagues, he is a sociable and extroverted man. He sees between 10 and 18 black African patients a day, in addition to other patients. He estimates that about 75% of those patients are members of medical aid schemes. He reckons his average consultation time is 5 minutes per patient.

## **5.3 SYNOPSIS OF POST-CONSULTATION INTERVIEWS**

This 7,5 minute consultation was selected for analysis because of the disparity between the perceptions of the participants and the informants about how relatively interactionally asynchronous the consultation was.

Dr B, the participant-doctor, perceived this as a comfortably synchronous consultation, attributing this to the established nature of their relationship. In addition, he expressed the belief

that Ms M would have been satisfied because she got what she came for, i.e., a prescription for flu medication. He, however, hedged that conclusion by observing that, generally, she is "a worrier." When I asked him what she worried about, he said her job was stressful. He suggested further evidence of a successful consultation was the way in which they joked and laughed together.

Dr C, an informant-doctor, agreed that the consultation seemed to be synchronous and that Ms M might simply have been wanting a prescription. He added, though, that she might have been wanting more from Dr B because, in his experience, patients who consult doctors for flu "can mean a lot of things." This alerted me to the possibility that there was again more to this consultation than what was immediately apparent from the preliminary analysis.

A ZE speaking informant in her late sixties agreed with Dr B's perception that the patient would have been generally satisfied with the consultation, and stated she thought that Ms M would be likely to consult him in the future. Slight reservations she had about the interview were reflected in her observation that the patient "was not too sick" and therefore would have been happy to make small talk with the doctor because "talk is nice."

By contrast, a younger ZE speaking informant, a teacher, expressed the view that an educated black African person, such as Ms M, would have objected to the doctor's raising of political and religious issues during a medical consultation. Having listened to the recording, she pronounced him arrogant and "cheeky" by which she said she meant "he was rude to her."

Other ZE informants who were approached for their comment on this consultation were more or less equally divided in their interpretations between evaluating this as a successful or unsuccessful consultation. Significantly, their interpretations tended to depend on their age: the older ones tending to agree with the first older, ZE speaking informant; the younger, with the second.

At the beginning of the post-consultation interview, Ms M said she expected from Dr B what

she would from any doctor: to be able to talk to him because, as she put it, "talking heals", to be examined, and for medication to be prescribed if he thought it necessary. She said that she had consulted Dr B because she "was not feeling well." She added that she had been intending to travel to Johannesburg the following weekend to attend a church conference. She was concerned that her flu symptoms might worsen while she was away and she would not have easy access to medication. She, therefore, consulted Dr B to obtain prophylactic medication. She volunteered that at times she felt "exhausted."

Later in the same interview, she revealed the real reason for her consulting Dr B. This was for what she called, "the underlying tensions of daily life" which included not only her job and her commitments to her church activities, but also how she had been personally and "painfully" affected by the violence in her township. She told me that two "brothers" to whom she had been close had been violently killed in January 1992 and that, even more importantly, a male relative, whom she called her "uncle", had also been shot dead and burnt in his car just after the above murders. She had had to identify his body. She had felt very close to him because he had cared for her after her mother and grandparents had died. As she put it "it was just the end of everything" and she felt she "had still not recovered." Just before her "uncle's" death, she had bought a house into which she had had to move his wife and their six children, for whom she now felt morally and financially responsible. She explained also that, although the consultation seemed successful in that she and Dr B appeared to be communicating well and making small talk, it had, in fact, been very stressful and uncomfortable for her because she had been unable "to share" her problem with Dr B.

The post-consultation interview, therefore, revealed that she had consulted Dr B for a much more serious psychosocial and emotional problem than simply wanting to obtain medication for flu, which she told me she could have bought cheaply at a pharmacy. The fact that she is a member of a medical aid scheme is perhaps significant. It allowed her to seek counselling from her doctor, knowing she would not have had to pay the full consulting fee out of her own pocket.

As I will be referring extensively to the interactional data of this consultation, the reader will find it helpful at this stage to read the full transcription (see Appendix 4).

## **5.4. ANALYSIS OF SOURCES OF INTERACTIONAL ASYNCHRONY IN CONSULTATION 2**

### **5.4.1 DIFFERENT SCHEMATA, DIFFERENT WAYS OF BEING POLITE AND DIFFERENT CONTEXTUALIZATION CUES**

I hypothesized that mismatches of culturally-specific schemata, ways of being polite and different contextualization cues were sources of interactional asynchrony in this consultation.

Having listened to the recording of the consultation, Ms M said the dilemma for her during the consultation was when and how to tell Dr B why she was consulting him because she felt, probably like Mr S., she could not tell him "in a straight way. " She added that it would have been "rude" for her, particularly as a black female patient, directly to broach the subject of what was troubling her, even if he requested her to do so. She explained that the preferred strategy was to start by discussing generalities and then to work slowly towards the real reason for the consultation.

This strategy is evident in two sections of the discourse which Ms M identified as being where she had tried to tell him what her real problem was, 016 and 052.

After they have greeted one another, (001-006), he elicits from her that she has flu and that she has spent the previous Sunday in bed (007-014) to which he responds:

**015 D:       so you had a good long weekend relaxing doing  
              nothing cos you  
              weren't well ... eh ....**

In response to his elicitation, **eh**, (above) she says,

016 P: (sighs) I don't know what's going on .. and  
tomorrow I'm leaving for Pretoria I said no I've

017 D: Pretoria what are you going to do up there you going to  
do a course or what

She tells him that she is going to a church conference. He asks her to which church she belongs. She replies that she is a Methodist. The doctor claims that the Methodist clergy are ANC sympathisers, which she disputes. He adds, although he used to belong to the Methodist Church, he now attends the Anglican Church because his wife is Anglican. He tells her a joke about a particular Methodist minister who used to read fiction while supposedly reading the Bible. At this point (051), he declares his intention to examine her:

051 D: all right let's have a looksee

052 P: at the same time I want you to give me treatment for this  
arthritis (?) I don't know now my life's complicating or  
but now I did a lot of washing over the weekend ey  
my hand was

053 D: yah well it's probably that and you've got a bit of fever with your flu  
too

I suggest that her utterances

016 P: (sighs) I don't know what's going on  
  
and

052 P: I don't know now my life's complicating

were, like Mr S's utterances I don't know (4.4.2), contextualization cues functioning to

alert the doctor to her main purpose in consulting him. However, Dr B does not appear to grasp the significance of her cue **I don't know** because he was not listening to her and also because he had already decided what the problem was, namely, that she was "a worrier" and an arthritis-sufferer. He, therefore, assumed that that was what she had come to him for.

In Ms M's opinion, she felt that Dr B had not attended to her agenda, which was to get him to listen to what she had to say. By contrast, Dr B explained in the post-consultation interview that, at this point in the consultation, he considered her negative assertion in

**016 P: (sighs) I don't know what's going on**

to be irrelevant to the theme she introduced in referring to travelling to a conference in Pretoria. (This is similar to Mr S's apparently irrelevant reference to "studying" in the previous consultation - see 4.4.2).

Likewise, in **052**, he considered the part of her utterance

**052 P: ..... I don't know now my life's complicating ...**

to be irrelevant to the theme of arthritis that he felt she introduced later in **052** when she referred to the pain in her hand probably caused by a lot of hand-washing of clothes for the family. The consequence of his considering her contributions to be irrelevant was that he did not perceive what she was saying to be vitally important to her agenda.

Dr B explained, further, that he had been led by Ms M to believe that she was consulting him for two medical complaints. She had told him that she had flu (**008**); then, she told him about the arthritis in her hand (**052**), which, in his opinion, was an on-going problem for which she had periodic treatment. He expressed the view that he had accordingly acted correctly by prescribing flu medication and "rubbing stuff" for her hand. He felt,

therefore, that he had attended to her agenda.

At this point, I offer three further examples of the same contextualization cue, viz., **I don't know**, used by three other black African patients in the corpus. (I underline the relevant text for ease of reading). This is used, as I have suggested before, as a deference politeness strategy, disclaiming special knowledge or understanding of the complaint while asserting such knowledge. The examples are all to be found at relatively advanced stages in the consultations when doctors had already made "first diagnoses" on the strength of what the patients had told them was their complaint. Also, they are taken from consultations where "new", i.e., not mentioned before, symptoms are being revealed by patients. They are, therefore, not "follow-up" consultations for previously diagnosed complaints. The patients who were approached, or informants in their absence, interpreted the consultations from which these were extracted as generally uncomfortable because they had found it difficult to tell the doctors why they were really consulting them.

1. **Consultation between Dr B and Mr Si who has told the doctor he has flu  
(but knows he has a problem with his bladder)**

P: there's something ah you know I've been I don't know you remember  
you took a view for .. anyway I pass urine hmmm too often you know

D: yah

P: maybe I'm I don't know that for that short time subsided later  
came back again came back again now it's worrying me ... again I don't know  
if I can problem for another

2. **Consultation between Dr C and Mr Nx who has told the doctor he has a sore foot  
(but knows he is getting a cold)**

(pause)

P: excuse me d what I notice maybe I don't know what is the  
changing season or .. during the night time

D: mm

P: I've got headache

**3. Consultation between Dr C and Mr M who has told the doctor he has flu (but knows he has a problem with his bladder)**

P: eeh the other thing I don't know if there's something wrong with my  
with my urine bladder mmm I think you're going to check it because my  
urine ah it stinks a lot

As noted in 4.4.4, I remind the reader that what is evident in these extracts is that patients seem to perceive that their assertions about their own knowledge of the reasons for the consultations are face threatening for doctors. This is probably so because, in terms of the dominant biomedical model, doctors are the participants in consultations who are ratified by their training, their medical knowledge and the history of the institution, to elicit information from patients and then to interpret the meaning of that information for patients.

I suggest that those ZE speaking patients, who attempt to offer information regarding what they feel to be the real reason for the consultation, bring assumptions about asymmetry in power relations from their own backgrounds and that they see their challenging of medical diagnoses as very risky.

In addition, such deferential strategies are also potentially face threatening for patients themselves because their offers may be rebuffed or ignored by doctors. For example, I remind the reader that I mentioned in 4.4.4 that Fisher & Groce (1990) found that 50% of the patients in their study had their offers of their own perceptions of the problem rejected by doctors. Patients thus risk being embarrassed or ridiculed by their doctors if they venture to diagnose what the problem is. I suggest, therefore, that patients need to employ a politeness strategy to re-dress those potential threats to the face of doctors and themselves.



In this study, the patients seem to re-dress the potentially face-threatening act of telling the doctor what is really wrong with them by using the formulaic negative assertion **I don't know**. This appears to function as a prelude to what Mankazana (1987) calls "the second diagnosis" in which patients attach their own interpretations to sensations of ill-being, which are, in essence, the real reasons for the consultations. ("The first diagnosis" refers to the doctor's diagnosis).

However, in terms of Brown & Levinson's politeness theory (1987:68), there is an inherent tension in the patients' negative assertions of **I don't know**. For example, in Consultation 2, Ms M gives Dr B weak hints in 016 and 052, that she has problems. Simultaneously, however, she indicates a desire to be deferential by using a formulaic negative politeness hedge **I don't know** to counteract the face-threatening act of presuming that the purpose of her assertion is relevant in that context.

The outcome of these negative assertions is that she, like Mr S in 4.0, apparently diminishes her own competence as a "knower of her own state of mind." She does this by denying that she knows what the problem is and, simultaneously and implicitly, defers to the competence of the doctor, so as to make her attempts more acceptable to him. Put simply, it works in the following way: "I am incompetent to know because I am not a doctor; you are institutionally ratified to know because you are the doctor, the expert; therefore I am downgrading myself by saying 'I don't know' so as to defer to you and not to offend you, but in fact I do know and I am here for you to confirm that and affirm me."

Research into sociocultural customs of black Africans (e.g., McCord (with Scott Douglas) 1946; Ngubane 1977; Buhrman 1984; de Villiers 1991), which were confirmed by many of the ZE speaking informants, suggests that these expectations and assumptions are consistent with, or perhaps have their origin in, patients' previous consultative experiences with **sangomas** or black African healers. These expectations and assumptions would be based on the "you're getting warmer principle," whereby the

**sangoma** asserts, by means of a circumlocutory route, a number of possible reasons for patients being there. They, in turn, either confirm, by means of hand-clapping and chanting **siyavuma** (we agree), or deny, by means of **ngchase** (I don't know) whether the **sangoma** is getting closer to what they perceive to be the real reason for their being there. The assumption is thus that the **sangoma** already knows and will tell patients why they are there.

It is thus not expected of **patients** to tell the **sangoma** directly what the real reason is for the consultation because that would usurp the role of the **sangoma** and thus be face-threatening. I suggest that telling the doctor, whose consultative role and function, for some black African patients, might be rather similar to those of a **sangoma**, is therefore a direct threat to his/her face, so, I argue, deference politeness strategies, such as the negative assertions "**I don't know**," are employed to re-dress the potential threat.

In addition, some older ZE speaking informants also suggested that this schema could be grounded in patients' experiences with so-called "old doctors," i.e., those serving only black African patients in unintegrated practices and clinics. The expectation is that doctors will tell the patient, via the interpretations of a black African nurse, the cause, "right or wrong," of a complaint. This problematic state of affairs has been researched recently by Crawford (1994) who found that white doctors speaking English tended to get grossly reductive summaries of the patient's complaint via the translator. One of the results of this is that much that is possibly vitally relevant, is excluded from the translation.

I asked the doctors participating in this study, in the light of their experiences, how they would generally expect SAE speaking patients to preface their attempts to tell them why they were being consulted. They said that many patients tell them directly what the problem is and thus had little need of a preface. Others, who may have already made their own diagnoses of the problems, offer these, also towards the end of consultations, but usually by means of a phrase such as "by the way, ..... ." This is usually readily

identified, and usually dispreferred (as alluded to earlier in 4.4.4) by SAE speaking doctors as a prelude to the announcement of the real reason for a consultation.

I suggest that, because Mr S, Ms M and the other ZE speaking patients, employ a strategy different from that expected as a signal, i.e., something like "by the way," SAE speaking doctors do not always recognize these patients' attempts for what they are. Instead, they interpret the patients' utterances as introducing irrelevancies to the consultations, at the wrong time.

#### **5.4.2 DIFFERENT WAYS OF REGULATING TURN-TAKING, DIFFERENT CONTEXTUALIZATION CUES AND DIFFERENT WAYS OF BEING POLITE**

During the interview with Ms M, she confirmed what my listening to the tape-recording had led me to suspect, namely, that she felt she had been frequently interrupted and not given the chance to speak by Dr B. His perception, by contrast, was that he had given her ample opportunities to speak and that he had not interrupted her. Sociolinguistic research (e.g., Chick 1985:309), has confirmed what there is an awareness of: that a source of interactional asynchrony in communication between ZE speakers and SAE speakers in South Africa, is culturally-specific differences in ways of regulating turn-taking in intercultural conversations. Miscommunication from this source is possibly the source of these widely held negative cultural stereotypes: SAE speakers say that, in general, ZE speakers do not take the opportunity to speak when they can; when they do, they seem to have nothing much to say for themselves and don't get to the point because they speak too slowly. Conversely, ZE speakers say that, in general, SAE speakers keep interrupting them before they have completed their point, jump to conclusions about what they want to say and speak too fast, a conversational convention which they consider impolite.

Chick (1985) quotes anecdotal evidence, which he confirms in that study, for why there is a relatively high degree of interactional asynchrony experienced during intercultural

encounters in the academic domain in South Africa. These include: "that pauses of relatively short duration do not function as turn exchange signals in Zulu English, and that Zulu-English speakers are generally more tolerant of extended monologue than S.A. English speakers" (ibid:309). SAE speakers, on the other hand, tend to be uncomfortable with even small pauses in conversation and therefore take the turn, essentially orientating to the Gricean maxim of Manner by speaking briefly and to the point. Chick (1985:309) goes on to postulate that these characteristics of Zulu-English might relate, firstly, to the survival of the Zulu oral tradition and, secondly, to what is considered "good" or "targeted" behaviour within the culture. I suggest, in addition, these differences are evident especially in conversations between ZE speakers and speakers of SA English where there is a high degree of power asymmetry between the participants, such as white doctors and black patients, especially females. These, I suggest, have their origins in decades of racism and sexism where expectations were that female, black patients be deferential to white, male doctors.

Chick also found (ibid:307-8) that mismatches in turn-taking behaviour include differences in contextualization cues such as prosodic cues. For example, SAE speakers tend to assume that a low pitch intonation at a syntactic boundary signals an upcoming turn change. ZE speakers, on the other hand, tend not to employ intonation to signal turn change possibly because Zulu is a tone language by which I mean "one in which the meaning of a word depends on the tone used when pronouncing it" (Richards et al 1985:294). ZE speakers, therefore, tend to be frequently interrupted by SAE speakers. Chick's data demonstrates, thus, that ZE speakers and SAE speakers apparently do not share contextualization cues used in regulating turn-taking. Mismatches of these kinds may lead to interactional asynchrony.

At this point, I return to the examination of extracts from Consultation 2. During her interview, Ms M pointed out several places in the discourse of the consultation where she had had the sense that Dr B was interrupting her. Owing to limitations of space, I intend examining the evidence in only two of the identified instances, viz., 016-017 and 103-104.

In the first instance to be examined, Ms M felt she was interrupted by Dr B in 017:

- 015 D: so you had a good long weekend relaxing doing nothing  
cos you weren't well ... hey
- 016 P: (sighs) I don't know what's going on and tomorrow  
I'm leaving for Pretoria I said no I've
- 017 D: Pretoria what are you going  
to do up there you going to do a course or what

Ms M explained that, in addition to her interpretation that he had ignored her "**I don't know**" in 016, she had felt offended by Dr B's words in 015 because she had had anything but a "good long weekend doing nothing." While feeling "unwell", she had had to do all the family's washing by hand and generally prepare for her trip, as a delegate, to a Black Methodist Church conference in Pretoria.

I argue further that her perception of interruption had a lot to do with his unwillingness to build on her topic. She felt thus that Dr B in 017 was interrupting her response in 016 in order to shift the focus of the consultation to what was more important to him and to what he wanted them to talk about, i.e., social chat about the Methodist Church and politics.

Dr B stated that he felt that he had not interrupted her and interpreted his words in 017 as a display of solidarity or rapport, showing a polite interest in her life outside the consultation, a topic which, he said, she herself had raised in 016. He cited the fact that she continued to respond to his questions about the conference in 018 ff as evidence that she was not averse to their making small talk about the topic.

In the light of the discussion about the difficulty ZE speakers have in developing their own agendas when interacting with individuals of a perceived higher status referred to in the previous chapter (4.4.4), I suggest that she felt interrupted especially because she

was beginning to develop her theme of telling him her problems, "but not in a straight way," a point at which it was crucial that she not be interrupted. Her trip to Pretoria was not what she was wanting to talk about. However, once he had taken up the topic of Pretoria, (and the associated topic of the church) by repeating **Pretoria**, with increased amplitude and stress, that is the direction in which the talk went, whether she wanted it to go that way or not. She was obliged to relinquish her agenda for the time being and comply with the flow of the conversation as it was being steered by Dr B.

The second instance to be analysed occurred later in the consultation after Ms M had been examined. She had made a second attempt in **052** (see Appendix 4) to tell Dr B that she had problems, but he had returned the talk in **057** to the topic of the Black Methodist Church and had just finished telling her an anecdote, **096-102**, regarding a black Methodist Church parishioner he had known as a child:

**102 D: every time she used to say come here my darling (p.& d. laugh)  
poor Florence I don't know what's happened to her**

After this in **103**, Ms M tries again to tell him what she is worried about. During the post-consultation interview, she explained that she felt it was her last chance to tell him about her concerns but that she knew it would be difficult, and even impolite to do so, for three reasons. Firstly, it would be so because Dr B had already begun to write the prescription for flu medication, a rhetorical routine she knew signalled the closing of a consultation; secondly, because it had already been a long consultation and she knew many patients were still waiting to consult him, and thirdly, because the talk had swung so definitely away from **her** problems to the more general topics of church and politics, she knew it would be difficult to get it back to what she wanted to discuss.

The consultation continues:

103 P: I'm worrying that (6,5 seconds)

104 D: ok and you want something

Dr B reported that he had interpreted her utterance in 103 as her way of trying to remind him that she also wanted him to prescribe medication for her arthritis. He said he understood her falling intonation ("her tailing off") and the silence of 6,5 seconds as signalling her reluctance to remind him in so many words in case he was embarrassed by having forgotten her mention of the sore hand during the examination, 051-056. He felt he had to assert himself in his role as doctor to reassure her because she was "a worrier." He saw his utterance of 104 as completing what she had begun to say in 103 and not as an interruption. He explained that what he had meant was:

104 D: ok and you want something (for your hand)

Consequently, he did not develop the topic as she had anticipated by, for example, saying: "what are you worrying about?"

Ms M indicated that she did not perceive the silence of 6,5 seconds as an opportunity for Dr B to take the turn. During the interview, she was unequivocal about having been interrupted and not having the opportunity to tell him what she was worried about. She concluded that Dr B was not open to hearing about her fears and grief. Faced by what she perceived as discouragement, she did not persist in her attempts and consequently lost the opportunity to be counselled by him.

Her volubility and laughter in 105 directly after the perceived interruption,

105 P: oh you belong you belong to to to Desmond Tutu (p. laughs) he's an Anglican

I suggest, signals her acceptance that it is his agenda that is going to be developed, i.e., the "safe topic" (Brown & Levinson 1987:112) of the Church. Rather than persist with

the face-threatening action of trying to steer the course of the interaction in the direction of interest to her, she appears to have decided it was preferable to seek a way to conform to his expectations about what they were talking about.

The consensus of the older ZE speaking informants was Ms M "was talking nicely to the doctor" in 103 **I'm worrying that**. By that they said they meant that Ms M spoke slowly and in a low pitch to Dr B, speech behaviour which they saw as appropriately deferential.

I suggest that Ms M "was talking nicely" because the point she was trying to make was crucial for her in the consultation, i.e., to tell him why she was consulting him. However, her slow rate of speech leads to a pause in the discourse of 6,5 seconds, which, in terms of SAE norms, is more than sufficient to signal a turn change. Dr B explained he started talking at that point because he thought she had said what she had wanted to say.

Bennett's view (1981:187) is that "when interruptions do occur, the understanding participants have of them will be heavily affected by their beliefs of the moment. If there is some reason for one or more participants to believe that he/she is losing some rights toward leading the discourse to some other person, whether one is willing to relinquish these rights gracefully or finds oneself foaming at the mouth depends upon "who" one is at that time." I suggest that the relatively high degree of interactional asynchrony in this consultation is the outgrowth of "who" Ms M is in the total encounter: a black female who is an established patient, known to be a "worrier". The consultation was one to which she came traumatised, during which she was unable, through her own attempts, to get Dr B to listen to her. During the consultation, she felt she was consistently frustrated and interrupted and she felt coerced into consenting to talk about topics which she felt were offensively irrelevant to her.



## 5.5 SUMMARY

The consequence of such mismatches in ways of regulating turn-taking, contextualization cues and ways of being polite is that Ms M remained essentially misdiagnosed, her true concerns not heard or treated. The tragedy is, however, that both she and Dr B, for the best of motives, persisted in interactional behaviour which failed to bring either satisfaction. To date, she has not consulted Dr B again.

Thus far, I have presented evidence which suggests that the relative asynchrony during this consultation can be accounted for in terms of mismatches in schematic knowledge, different ways of being polite and different contextualization cues particularly those that signal turn change. Significantly, the findings of this chapter confirm what I identified in 4.0, viz., that Zulu-English speaking male and female patients tend to prefer to employ a deference politeness strategy such as **I don't know** to hint to doctors what the real reasons are for consulting them. It is clear that the participant-doctors of this study are not alert to this strategy, with the result that patients' concerns are not attended to in a manner meaningful to them.

I turn now to the analysis of a consultation which I intuitively felt was relatively asynchronous for the patient. However, further analysis caused me to reconsider my hypothesis.

## **6.0 ANALYSIS OF CONSULTATION 3**

### **6.1 INTRODUCTION**

I begin this chapter in the manner of 4.0 and 5.0 by outlining the biography of the patient. Dr B's details are recorded in 5.2.2. Thereafter, I give a synopsis of the post-consultation interviews with participants and informants. The reader will note that, whereas my focus in 4.0 and 5.0 was on sources of interactional asynchrony, in this chapter the focus is on a source of **interactional synchrony**.

### **6.2 BIOGRAPHY OF THE PATIENT**

The patient is Mr K, who is 32 years old. This consultation is a follow-up to one which had taken place three weeks previously in which he complained that he was not being sufficiently sexually active with his wife. According to a note made by the doctor at the time on the medical record, Mr K's wife was accusing him of having girlfriends in the city. She lived in rural Kwazulu while he worked in Durban and returned home for weekends and his annual holiday. According to the practice nurse, the couple had been married a number of years and were childless, although Mr K had apparently fathered a son by another woman.

During the previous consultation, the doctor had done a rectal examination on Mr K and had treated him for prostatitis (an acute infection of the prostate gland) with an antibiotic and vitamin injection.

### **6.3 SYNOPSIS OF POST-CONSULTATION INTERVIEWS**

Dr B's recollection of this 5,75 minute consultation was that it was relatively comfortable

and unstressful, despite the sensitive nature of Mr K's complaint and the fact that he had come back to tell Dr B that the previous treatment had not worked. He gave two reasons for his evaluation: firstly, Mr K had returned a third time, a month after this recorded consultation, for more of the same treatment because he said it had worked the second time; secondly, he felt Mr K understood that he, as a man, would appreciate his anxieties regarding his sexual performance. He also pointed to several places in the discourse where they had laughed and joked together.

I established from the majority of the male informants, both ZE and SAE speakers, as well as the older female ZE speakers, that this consultation was relatively successful. They noted that there were few "uncomfortable moments" and that it appeared that Dr B and Mr K understood one another and Mr K left the consultation "quite happy". They said the relationship between the participants seemed to be cordial. One ZE speaking informant said the doctor "didn't throw his weight on the patient" by which he said he meant the doctor came down to the patient's level in terms of his understanding of his problem. Another ZE speaking informant said Dr B also didn't project himself as an important person. They said he was trying to relax Mr K so that he would feel free to tell him everything he needed to know to cure the problem. Some of the male ZE speakers said it was apparent to them that Dr B had had many years of experience with similar problems of ZE speaking males. In general, they characterized the consultation as "mantalk" or "bartalk" about Mr K's problems with his sexual performance.

Dissent from this generally male view was, however, voiced by some of the younger ZE and SAE speaking female informants who felt that Dr B was patronising and offensive. This, they claimed, would have made the consultation relatively uncomfortable for Mr K.

## **6.4 ANALYSIS OF A SOURCE OF INTERACTIONAL SYNCHRONY IN CONSULTATION 3**

### **6.4.1 POSITIVE OR SOLIDARITY POLITENESS STRATEGIES AS A SOURCE OF INTERACTIONAL SYNCHRONY**

Close examination of the discourse of this consultation suggests that the interactional synchrony of this consultation is a function of the participants' success in using positive politeness strategies, or in Scollon & Scollon's (1982) terms, solidarity politeness strategies, to negotiate a close, trusting relationship of male solidarity. So, although each participant has possibly many identities external to the consultation (in terms of ethnic group, race, language, etc), they negotiate the construction of a common male identity or, in Erickson & Shultz's (1982) terms, "co-membership" of maleness within the consultation. According to most of the male ZE and SAE speaking informants and some older female ZE speaking informants, this sense of solidarity is salient throughout the consultation to the extent that it appears to override their other identities.

Since I have already given a full account of face needs and politeness strategies in 2.4, I remind the reader of just those features most pertinent to this analysis.

All people have negative face needs, i.e., they need to be free not to be imposed upon by others. They also need to feel accepted and approved of by others, i.e., they need to preserve positive face. Furthermore, they need to attend to the positive and negative face needs of other people. The way in which reconciliation between their own needs and the needs of others occurs involves a delicate balancing act of choosing appropriate politeness strategies to re-dress potentially face-threatening acts.

Brown & Levinson (1987) suggest that people choose to use particular politeness strategies based on three factors inherent in the context: 1. their on-going estimation

of how close their relationship is with others (i.e., what **distance (D)** there is between them); 2. how they differ in terms of their status in that situation (i.e., what the **power (P)** differential is between them) and 3. how much of an **imposition** what they are doing or saying is in their culture (**R**). In other words, participants determine the extent of "weightiness" (**W**) of a face threatening act by adding the 3 factors of (**D+P+R**) inherent in the context and then conclude how risky the interaction is. A significant point to bear in mind is that just as their sense of existing social relations constrains their choice of strategies, so too their choice serves to establish and maintain various types of social relations.

Also, according to Brown & Levinson (1987:101), unlike negative politeness which is redressive of a specific face-threatening act, e.g., to apologize, "in positive politeness the sphere of redress is widened to the appreciation of the alter's wants in general or to the expression of similarity between ego's and alter's wants." This is possibly the kind of situation De Kadt (1992a:70) is referring to in her finding that "a setting of politeness" is essential when requesting something of someone in Zulu (see 4.4.1).

In more detail, Brown & Levinson (1987:101-129) postulate 3 "super" positive politeness strategies, viz., 1. participants claim "common ground"; 2. they convey that they are co-operators; 3. a speaker fulfils hearer's wants (for X). Brown & Levinson, in their theory, further sub-divide these 3 strategies into 15 positive politeness strategies (see Appendix 6). In the analysis below, these strategies will be discussed and referred to by a number in brackets, viz., (1) - (15).

I suggest that Dr B uses positive or solidarity politeness strategies to re-dress what was potentially a very face-threatening situation for Mr K in terms of his perceived loss of sexual potency. In turn, Mr K uses solidarity politeness strategies to re-dress the potentially face-threatening act of offending Dr B by telling him the treatment he had given him before has not worked. The use of these strategies results in the creation and maintenance of a symmetrical solidarity politeness system in which

relatively little distance and power (-D; -P) exists between the doctor and the patient. I argue that this generates the interpretation of a relatively high degree of **interactional synchrony** in this consultation. According to Chick (personal communication), it is unusual for ZE speakers to use such strategies when communicating "up" i.e., with speakers of a perceived higher social status such as white, South African male doctors. I suggest it is possible for Mr K to use such strategies because more equitable relations, namely, the solidarity of sharing "man problems" had already been negotiated during the previous consultation, before he has to address them again in this consultation.

I turn now to examine in particular two extracts from the recorded consultation, namely, **001-015** and **038-054**. I will refer, from time to time, to other parts of the discourse so the reader would find it helpful at this stage to read the full transcription (see Appendix 5).

This is a follow-up consultation which means that the history of the symptom had already been taken by Dr B three weeks previously. Thus, the usual sub-sequence of history-taking is truncated.

- 001 D: good morning  
002 P: morning doctor  
003 D: how are you  
004 P: yah I'm fine .. as I'm so bad .. I can't  
005 D: Mr Eric  
006 P: no cure  
and st .. still I I used that medicine but hey  
007 D: you're  
st .. you're still (laughs) st  
008 P: still carry on with the the the  
009 D: still complaining no power nothing eh

- 010 P: nothing nothing and now it's going worse cos .. before .. I  
was doing even er one round now one round I'm
- 011 D: maybe you're  
just get .. maybe you're just getting madala now hey
- 012 P: ah no I don't think so
- 013 D: hey
- 014 P: no
- 015 D: ok

According to Dr B and all the informants, in

- 004 P: .. I'm so bad

and

- 006 P: no cure

Mr K is telling Dr B directly or "bald on record" (Brown & Levinson 1987:94-101) that, although he has taken the medicine which had been given to him in the previous consultation, the problem is still there. According to the ZE speaking informants, this would normally have been a risky thing to do, given the sociocultural norms referred to in the analyses in 4.0 and 5.0. Those revealed that ZE speakers tend to avoid such direct or bald on record strategies in a perceived face-threatening situation.

However, the ZE informants suggested Mr K did so because he apparently felt he had to get to what the problem was as rapidly as possible. As one informant put it: "it was an innocent statement; an informative statement." They suggested also that Mr K appeared to feel he could tell Dr B directly because he (Dr B) already knew about the problem, the two of them having negotiated "co-membership" of maleness during the previous encounter.

During the post-consultation interview, Dr B explained that Mr K's return, during his holiday from his rural home many kilometres away, was a good enough indicator that he trusted him. He said he was therefore not offended by being told the medication had not worked. He said he tried to put Mr K, who "was in a nervous state," "at ease" by helping him to get to the point of why he was consulting him a second time. He added that he understood Mr K was embarrassed by what he perceived as a failure of manhood. He interpreted his role, therefore, as one of "putting Mr K at ease." He said that he was treating Mr K's problem as psychological because he needed a morale booster in order to resume what he would consider normal sexual relations. He thought that Mr K had an infection of the prostate gland, perhaps contracted by liaisons with other women in the city (see Appendix 5:023), as discussed in his previous consultation. He suggested that the infection had initially caused Mr K pain which inhibited his desire to have intercourse with his wife while he was on holiday. Thus, Dr B felt he needed to bolster Mr K's psychological frame of mind and hence his emphasis on autosuggestion in

025 D: .....just talk nicely to your body and say hey come on

and

027 D: you must say to it come I want to have a nice holiday

and treatment with a vitamin placebo, 038.

Fine-grained analysis of the discourse between 006 and 010 revealed that the participants jointly construct the "telling" of the problem, using the solidarity politeness strategy (5) of repeating part of what each other has said in a previous turn.

006 P: no cure and st .. still

I I used that medicine but eh

007 D: you're

st ... you're still (laughs) st



- 008 P: st carry on with  
the the the
- 009 D: still complaining no power nothing eh
- 010 P: nothing nothing

In 007 Dr B repeats Mr K's word **still** in 006; Mr K, in turn, attempts to repeat the same word in 008; in 009, Dr B again repeats the word, saying

- 009 D: still complaining no power nothing eh

Mr K then repeats Dr B's **nothing** twice in 010.

One of the ZE speaking informants saw Mr K as being "verbally overloaded" in this beginning sub-sequence, meaning that, although he "could hear what Mr K had to say," he suspected Mr K was not that proficient in English and that Dr B was helping him, in a supportive fashion, to explain what the problem was, "to draw out of him as much as possible."

In 009, Dr B also employs the solidarity politeness strategy (4) of using a Zulu-English formulaic slang (4) expression in 009 **no power** to connote the absence of sexual potency. Dr B assumed this would be a term that Mr K, as a fellow-male, would understand. It seems then that this device functioned as a marker of male identity, signalling common ground between them as males.

It may be seen also as an exemplar of the doctor's solidarity politeness strategy (7), namely that of presuming that his patient understands and shares the association with the use of the ZE expression.

The ZE speaking informants suggested that Mr K demonstrated his understanding of Dr B's reference to **no power** by repeating (5) the doctor's word in 009 **nothing**, twice in

010 P: nothing nothing and now it's going worse cos .. before ..  
I was doing even er one round now one round I'm

and by using a ZE slang expression (4), viz., 010 **one round** used formulaically by male ZE speakers to denote one episode of intercourse. According to them, this functioned to indicate to Dr B that, between them, they understand the male "code" pertaining to sexual activities.

In 011 Dr B employs the solidarity politeness strategy (4) of codeswitching into colloquial Zulu, using an expression, **madala**, to suggest to Mr K that his problem might be caused by age. It is simultaneously strategy (8), banter or pleasant chaffing. Dr B stated that he used **madala**, explaining that the word depended for its humour on their mutual knowledge that Mr K, at 32, was younger than the doctor himself who was in his early forties. This was confirmed by both the ZE and SAE speaking male informants who interpreted Mr K's response in

012 P: ah no I don't think so

as evidence that he recognized the purpose of 011. One ZE speaking male informant, who agreed that Mr K would have recognized this as solidarity behaviour commented that "it was a pure joke."

I put it to Dr B that a young female ZE speaking informant had suggested that the slang use of the word was offensively insulting to Mr K who was a relatively young man and that he might have taken offence at being thought to be too old for sexual activity. Dr B's response was that because he used the slang form **madala** instead of **umdala**, the correct Zulu form, Mr K would have recognized that it was only a joke intended to put him at ease and not to be taken seriously. He also pointed to the freedom Mr K felt to disagree with him in 012

012 P: ah no I don't think so

and

014 P: no

Significantly, Dr B accepts this disagreement

015 D: ok

which is itself another solidarity politeness strategy (6), i.e., avoiding disagreement.

Dr B pointed to further banter (8), referring to age in

019 no good to get old eh

thus, further stressing solidarity with Mr K. Dr B suggested, in addition, that a ZE speaking female informant would not necessarily interpret the colloquial reference **madala** in the same way as a ZE speaking male would.

I suggest, in the light of the above evidence, that solidarity politeness is thus encoded in their repetition of one another's words, their use of jargon to connote a lack of sexual potency, their laughter, Dr B's switch to a slang form of a Zulu word and pleasant banter, all strategies which emphasise their "co-membership" of maleness (Erickson & Shultz 1982), sharing a background knowledge and attitude to age as a possible cause of loss of sexual potency.

In the physical examination sub-sequence, **017-031** (see Appendix 5), Dr B does a rectal examination and establishes that the prostate has improved. In **025** during the examination sub-sequence, Dr B employs the solidarity politeness strategy of jargon (4), promising to give Mr K

025 ..... another double shot ..... fix you up

referring to a double injection of hormones and vitamins, which he promises will

provide the solution to his problem.

Upon hearing where the patient's home is in rural Kwazulu, he asserts further common ground (7) by demonstrating a knowledge of the area.

I turn now to the analysis of the second extract, 037-054, which encompasses the treatment sub-sequence of the consultation.

- 037 D: ok .. I'll give you this and then I'm going to give  
you some other stuff to sort you out .....
- 038 D: ok right come let's give you this lot and that'll  
sort you out now ..... after this you won't have  
any excuses hey (d. laughs)
- 039 P: I don't think now cos even I can find out (?) doctor
- 040 D: doctor yeah  
ok .. just take ... 2 teaspoons ... 3 times a day ok
- 041 P: 3 times a day .. ok
- 042 D: that's what I take too it's good stuff
- 043 P: ok
- 044 D: it makes you strong and it'll sort you out and you  
can enjoy the rest of your holiday as well (d. & p. laugh)
- 045 P: yah please cos you know I'm not enjoying any more now
- 046 D: (laughs) hey you must enjoy the company of your  
wife still so that's ok hey
- 047 P: (sighs) yah
- 048 D: hey
- 049 P: but
- 050 D: hey
- 051 P: what sort of a fine thing is that  
(d. laughs) and they expect some babies nothing I've got nothing
- 052 D: no  
that'll come that'll sort you out ... ok
- 053 P: ok doctor

In 038 and 039, Dr B administers the hormone and vitamin injection. Dr B's comment regarding

038 D: .....after this you won't have any excuses hey  
(d. laughs)

was that this was further banter (8) to put Mr K at ease, laughing at the same time, to indicate that what he was saying is to be taken as a joke. This was confirmed by the male ZE speaking informants, one of whom said that no man would take offence at the doctor's laughter because it was "solidarity laughter".

The fact that Dr B gives Mr K a sample bottle of medication is also significant because, seeing as Mr K is a cashpaying patient, he would have had to pay for prescribed medication at a pharmacy. Dr B gives it to him, another solidarity politeness strategy (15).

According to them, Dr B, by re-iterating that the injection and the bottle of vitamin syrup will **fix him up/sort him out** (025; 038; 040; 052) demonstrates good intentions towards Mr K, reassuring him that his positive face-needs will be taken care of and emphasising his co-operation with Mr K by promising a solution, positive politeness strategy (10). By doing so, he claims that what Mr K wants for himself, he too wants for him.

Also, in

038 D: **ok right come let's give you this lot**

Dr B calls on their assumptions of co-operation by including both of them in the activity, i.e., positive politeness strategy (12). He does so by using the inclusive **let's** (let us). In his interpretation, he did so to indicate it was in their mutually shared interests, as males, that they solve the problem together.

According to the informants, Mr K, in 041, repeats (5) Dr B's instructions in 040 regarding the vitamin syrup, thereby tacitly agreeing that that is what he must take in order to be healed.

Dr B interpreted what he said in

**042 D: that's what I take too it's good stuff**

as an endorsement of the effectiveness of the vitamin syrup, thus asserting common ground (7) with Mr K, implying that as a fellow-male he is also in need of medication and that it was good enough for both of them. This interpretation was confirmed by the male ZE speakers who perceived it as a gesture of solidarity.

In 045, Mr K's you know,

**045 P: yah please cos you know I'm not enjoying any more now**

claims Dr B's knowledge of that kind of situation is equivalent to his (7), thus tacitly agreeing with Dr B that their maleness is what they have in common.

In

**046 D: hey you must enjoy the company of your wife still so that's ok hey**

Dr B presupposes knowing, i.e., positive politeness strategy (7), what Mr K wants, suggesting to him that his values, i.e., enjoying the (social) company of a wife, are the same as the doctor's own. His assumption that Mr K can have a good social relationship with his wife operates as an expression of good intention, indicating they share common ground. Dr B said his intention with that statement was to downplay Mr K's anxiety regarding his sexual performance by introducing another facet of marriage to the consultation, viz., social compatibility.

Throughout the consultation, Dr B frequently employs a tag question, **hey**, most usually tacked onto a turn (e.g., **011; 019; 025**; etc) or operating as a full turn, e.g., **013**. Dr B interpreted this as his way of getting Mr K to agree with him and to draw him into the talk. This interpretation was confirmed by all the informants, most of whom agreed that Mr K would have understood what Dr B meant by the tag. I suggest, therefore, that this tag question functions as yet another strategy of solidarity politeness (5) in order to obtain agreement from Mr K, drawing him into the discourse by soliciting his collaboration in the healing process.

Interspersed with Dr B's tag questions, from **046 to 050**, Mr K displays token agreement with the doctor in

**047 P: (sighs) yah**

a solidarity politeness strategy (6), mitigating the fact that he is, in fact, disagreeing with him. This "preference for agreement" (Sacks and Schegloff 1973) functions by Mr K's apparent desire to appear to agree with Dr B that the (social) company of a wife is sufficient.

Chick (1985:314) suggests that the communication style of ZE speakers (at the time of data collection, a dominated group in South Africa) is that "which assumes a relationship of +P+D", i.e., a global deference politeness style (speaking "upwards" towards a person of a perceived higher status). He makes the point, though, that this style is "targeted" in the sense that it is a conventionalized usage (i.e., most likely not actually felt) because it has saved ZE speakers from appearing to challenge the authority of the (until recently) dominant group of whites. The disadvantage of using this style, however, is that ZE speakers were likely to be "treated as doormats", further entrenching them as dominated. By the same token, when they refuse to be treated in that manner, their use of solidarity politeness strategies results in the negative cultural stereotype of their being construed as arrogant, cheeky, too familiar, etc.

Since SAE speakers in general tend to use a global solidarity politeness style (speaking "downwards" towards a person of a perceived equal or lower status) as represented, for example, in Dr B's banter, a potentially asynchronous encounter could have ensued in terms of power play on the part of Dr B and "cheekiness" on the part of Mr K. I suggest this situation was avoided, not only by the participants' "co-membership" of maleness having been negotiated in a previous consultation, but also by their mutual use of solidarity politeness strategies. These appear to over-ride the inherently asymmetrical relationship of SAE speaking doctor and ZE speaking patient.

## **6.5 SUMMARY**

To sum up, the fine-grained analysis of the interactional data of this consultation has revealed a significant finding: that asynchronous intercultural communication is not necessarily inevitable because participants can, in some circumstances, negotiate a mutually agreeable and synchronous conversation.

I turn now to the final chapter of this study in which I summarise what my analyses reveal about the sources and the consequences of interactional asynchrony and synchrony. To conclude the study, I suggest several recommendations for further research.



## **7.0 SOCIETAL CONSEQUENCES OF INTERACTIONAL ASYNCHRONY AND SYNCHRONY IN INTERCULTURAL MEDICAL CONSULTATIONS**

This study involves the investigation of the sources of interactional asynchrony and synchrony in three intercultural medical consultations in an urban setting in South Africa and an examination of the potential impact of such consultations on health care, as a societal resource.

In this chapter, I summarize the main empirical findings of the study and discuss a number of consequences of interactional asynchrony and synchrony. Finally, I outline recommendations for further research.

Consistent with the theory and methodology of Interactional Sociolinguistics, the interactional data were analysed with a view to identifying and describing the sources of interactional asynchrony and synchrony in the discourse of SAE speaking doctors and their ZE speaking patients. Insights from Critical Language Study were used to explain how these impact on health care as a societal resource.

On the basis of related research (see 2.0), I had hypothesized that the following sources, interacting at the level of discourse, would contribute to the relatively high degree of asynchrony reported in a number of the consultations:

1. differences in culturally-specific schemata;
2. systematic, culturally-specific differences in contextualization cues;
3. culturally-specific ways of accomplishing repair and
4. culturally-specific differences in ways of being polite.

## **7.1 SUMMARY OF MAIN EMPIRICAL FINDINGS**

For the purposes of this summary, I will present the findings for each consultation under the heading of each hypothesized source.

### **7.1.1 DIFFERENCES IN CULTURALLY-SPECIFIC SCHEMATA**

In Consultation 1, I found that differences in culturally-specific schemata accounted for much of the interactional asynchrony experienced by both Dr A and Mr S, the patient. Of significance were their different perceptions of how consultations should be initiated, particularly with new ZE speaking patients. Secondly, I found that their schematic knowledge also differed considerably regarding how indirect the patient should be in telling the doctor the reason for the consultation. Thirdly, their knowledge differed regarding how direct the doctor should be in eliciting the reason for the patient's consulting him. Finally, differences in schematic knowledge pertaining to the rhetorical routines of medicine as a culture, appeared to account for the doctor's perception of a lack of coherence and progress in the structure in particular parts of the consultation.

In Consultation 2, I also found a mismatch in schematic knowledge between how Ms M, the patient, was indirectly attempting to tell Dr B the real reason why she was consulting him and what he thought was irrelevant information.

### **7.1.2 SYSTEMATIC CULTURALLY-SPECIFIC DIFFERENCES IN CONTEXTUALIZATION CUES**

In Consultation 1, mismatches in what counts as a contextualization cue, interacting with other sources at the level of discourse, were found to account for much of the interactional asynchrony reported. I found that the doctor used prosodic cues intended to signal what the discourse task was that he wanted the patient to engage in with him. I found that the patient either did not perceive these cues as salient or misinterpreted them. Furthermore, I found that the patient

used contextualization cues, such as **I don't know** to indicate what was important to him, which were not recognised as such by the doctor.

I found a similar pattern of mismatches in contextualization cues in Consultation 2, as well as in 3 other consultations in the corpus. Although Dr B is said to be a fluent speaker of Zulu, he misinterpreted the cue that could have alerted him to the patient's real reason for consulting him.

I also found that mismatches in terms of prosodic contextualization cues, such as what the relative length of pause signalled to each of the participants, contributed substantially to the perception of whether or not they were being interrupted, resulting in the consultation being perceived by the participants as relatively asynchronous.

### **7.1.3 CULTURALLY-SPECIFIC WAYS OF ACCOMPLISHING REPAIR**

Building on the insight that "where there is asynchrony, repair is difficult to affect" (Chick 1989:157), I found in Consultation 1 that, ironically, repeated attempts at repair, in interaction with other sources, increased the level of asynchrony, particularly where asynchrony already existed. For the doctor who had been trained in the rhetorical routines of the dominant biomedical paradigm, the perception was generated of an extremely slow and even stalled consultation.

### **7.1.4 CULTURALLY-SPECIFIC WAYS OF BEING POLITE**

I found that differences in face considerations and ways of being polite were a further source of friction in the asynchronous consultations. These issues were found to be such an integral part of the reported asynchrony that they could not be analysed separately from the other sources in a discrete way.

In Consultation 1, I found that Dr A, consistent with his culturally-specific schema, started off on the wrong foot with his patient by not negotiating the

initiation of the consultation politely enough, according to the interpretations of the informants who shared Mr S's sociocultural background. In doing so, he threatened Mr S's face, resulting in asynchrony.

Consistent with the global politeness system of ZE speakers hypothesized by Chick (1985), I found Mr S preferring to employ a deferential politeness strategy to approach the real reason for consulting Dr B. In doing so, he leaves implicit his own diagnosis of the source of the dizziness he is experiencing. The doctor misinterprets this politeness strategy, assuming genuine ignorance on the part of the patient.

In Consultation 2, again, I found that much of the asynchrony reported had its source in the misinterpretation by Dr B of the deferential strategies employed by Ms M. It is for this reason that her real reason for consulting him remained unheard. Her self-report points to the possible genesis of the ZE politeness system: she claimed that because she had a history as "a worrier" and because she is a black female, she felt unable to assert her own agenda and obliged to discuss matters with Dr B which had little immediate relevant value for her.

Regarding the analysis of the interactional data of Consultation 3, I found that my initial hypothesis, that it was an asynchronous encounter, had to be revised in the light of strongly positive agreement by both SAE and ZE male informants that it was a synchronous encounter.

Contrary to Scollon & Scollon's recommendation (1983:186) that "the only way to untie the double bind of interethnic gatekeeping encounters is for the gatekeeper to voluntarily use strategies of deference," the analysis revealed that the mutual employment of positive or solidarity politeness strategies functioned, rather, to generate the interpretation of synchrony. Although one must be cautious about generalizing excessively on the basis of a single encounter, this is a very significant finding because, on the evidence of this consultation, what seems critical to interactional synchrony appears to be the negotiation of "co-

membership" (Erickson & Shultz 1982), perhaps even where this is not very evident. To illustrate this, the reader will remember that the younger, female ZE speakers did not interpret the consultation as synchronous because they did not share the "co-membership" of maleness with the participants.

It is evident from these findings, thus, that the four research hypotheses were confirmed. In addition, a strategy to generate interactional synchrony, namely the negotiation of "co-membership", was revealed.

It remains now for me to discuss the impact of interactional asynchrony and synchrony on health care as a societal resource in a desegregating micro-site such as the private practice where the research-data were collected.

## 7.2 CONSEQUENCES

In the discussion that follows, I shall consider the societal consequences of interactional asynchrony and synchrony.

The reader will remember that, in 1.1, I referred to the structural constraints of apartheid under which the majority of people lived in South Africa. One of the most tragic outcomes of these constraints was the inability of people from different cultural groups to generate and sustain long-lasting friendships with people of other groups. According to Gumperz (1982a), these are necessary, although not sufficient, if people are to learn to become aware of the different sociolinguistic behaviours of speakers of other groups. The outcome of this is that when people from different sociolinguistic groups interact, they bring with them the implicit, culturally-specific communicative conventions of the groups to which they belong. These are likely to be the sources that contribute to interactional asynchrony.

This study has provided evidence that, even in desegregated environments in South Africa, like the urban medical surgery referred to in 3.1.1, where there was professed

anti-discrimination, interactional asynchrony in consultations is very evident. However, this study was also able to provide evidence that such asynchrony is not inevitable.

The consequences of the relatively high degree of interactional asynchrony are manifold, as attested to in the two consultations, analysed in 4.0 and 5.0.

The intentions and motives, the attitudes and abilities of patients like Mr S and Ms M were misinterpreted by the doctors concerned. Furthermore, their real concerns remained unheard. Ms M, for example, lost the opportunity for counselling and Mr S was blamed by the doctor for being unco-operative. They both lost the opportunity to obtain a hearing of concerns that were meaningful to them. They both felt frustrated, dissatisfied with the processes and outcomes of the consultations. Ms M attested to anger. Mr S made it quite clear in the follow-up consultation that he thought the doctor had misdiagnosed his problem. The outcome of both of these asynchronous consultations is that the patients did not return to those doctors, so any potentially positive doctor-patient relationship is negated. Because general practitioners are in the vanguard of primary health care in South Africa, the delivery of health care is at stake. If this high level of asynchrony occurs in **private** consultations, where it is in the economic interests of the doctor to retain as many patients as possible, then how much more does this occur in the **public** health system? A ready answer comes to mind: researchers (e.g., Crawford 1994; Ngqakayi 1994) are already beginning to document profound asymmetries in that domain.

Another outcome is that doctors may remain unaware of the real life experiences of their patients, as in the case of Ms M, who had experienced great trauma regarding the only close family she knew. Doctors, therefore, run the risk of being stereotyped as "insensitive". In turn, the behaviour of black African patients subsequent to unsatisfactory, asynchronous encounters generates negative stereotypes about such patients, such as "African patients shop around"; they don't come back to one, but go to another GP;" and "they give the impression that they don't want to develop a relationship with SAE speaking doctors". The patient who does not return is thus blamed and is seen as being transient and 'shopping around'. The outcome is that doctors feel slighted by these patients and become cynical.

The fact that a number of patients were members of medical aid schemes is significant because it allowed someone like Ms M to seek counselling for her emotional trauma. That this was denied to her, fueled her anger and frustration. Significantly, and on a larger scale, this also has implications for whether the limited economic resources of the country are rationally employed. Du Toit (1988:409), researching the financial position of the GP within the medical aid system to see what costs are bound up with his (sic) servicing, states: "it is the GP as a script writer who causes the highest cost of all sections controlled by him". If then GPs write scripts for conditions that have been misdiagnosed, and the patient goes to another GP for the same complaint, this results in the extra costs being ultimately paid by the consumer, the patient, in the form of increased medical aid expenses being deducted from his/her earnings. This waste affects what can realistically be accomplished with the limited funds available.

A further consequence is that the doctor fails the patient in terms of abrogating accountability and responsibility (Parr 1987) for the health and well-being of that patient. This can result in a loss of confidence in the ability of doctors to heal patients and hear their concerns.

As mentioned above, repeatedly asynchronous encounters generate negative cultural stereotypes which in turn impact negatively on further effective communication because participants tend to perceive selectively only the negative traits that feed into the stereotype. Over time, these are used as rationalization for maintaining "the social barriers and power differential among the different groups which made it difficult in the first place for people to learn the communication conventions and backgrounds of the other groups" Chick (1985:317). Chick refers to this as "the negative cycle of socially created discrimination" (ibid:317).

Insights from research undertaken by critical linguists such as Fairclough (1989; 1992) have proved useful in further explicating the connection between language use in asymmetrical situations such as medical consultations and unequal relations of power. They also serve to expose the hidden dimension of ideology which is implicit in how institutions such as law, education and medicine are structured.

In the dominant biomedical paradigm, it is a given that doctors have the right to exercise most of the interactional power in medical consultations. As referred to in 1.4.1, doctors are gatekeepers to medical knowledge and treatment; they are privy to clinical experiences and medical research. They have the power of the cultural institution of medicine to pursue health and medical goals and to control medical resources.

One of the chief means whereby those doctors, trained in medical education systems promulgating the biomedical model, retain and exercise institutional power is through the use of medical frames of reference and the rhetorical routines of consultations. The reader will recall the detailed discussion of these in 4.4.3. These conventions, which are essentially controlled by doctors, sustain established social relations of power. The power in question here resides in the common-sense assumptions implicit in the particular discourse conventions, such as: who initiates the consultation, who controls the sub-sequences of the consultation, who regulates the turn-taking or interrupts in order to control the discourse, who selects the discourse type, who controls the topic or topics, who asks the questions in a strategic sequence, who pronounces the diagnosis and who prescribes treatment. Thus, the powerholders assume and exercise ideological power by projecting their own discourse conventions as 'legitimate,' 'natural' or 'common sense'. The contributions of the non-powerful participants are not only constrained by these strategies, but also their uncritical acceptance of these legitimizes the imbalance in the relations of power.

It is important to realise that it is not that patients are coerced into being passive recipients of doctors' diagnoses and treatments. Rather, they are obliged to consent to the institutional power of doctors through, for example, not being able to be "heard" in consultations and (in the case of Mr S, Ms M and other patients from dominated and thus traditionally "powerless" groups in South Africa) not having the strategies in a second language to persist with the telling of their agendas. This is, of course, not confined to patients whose sociocultural backgrounds are different to the doctors'. However, it is just so much worse in the case of those patients referred to above.

Recent criticism of the dominant medical paradigm, referred to in 2.3, by a pressure-



group of those practitioners who favour a more "patient-centred" approach (e.g., Henbest 1989a & b, 1991, 1992; Levenstein 1984, 1988) appears to be resulting in an ideological struggle within the culture of medicine. This social contestation of power is occurring in, and through, language use. By that I mean that some patients are now beginning to be encouraged, in a few medical education systems, to express their thoughts, feelings and beliefs which might, in time, result in their having more say regarding their perceptions of their own state of illness.

### **7.3 FURTHER RESEARCH POSSIBILITIES**

The following examples of further research possibilities relate to issues that have arisen during the conducting of the research and the writing up of this study.

In the first place, future interactional sociolinguistic research into the discourse of medical consultation should employ videotaped material in order to capture the non-verbal elements of the interaction. The advantage of this, however, would have to be weighed against the disadvantage of the possibly unethical intrusiveness of the camera. Also, technologically better sound equipment must be employed so as to obtain clearer tape-recordings of the interactional data.

Secondly, research, such as the topic of this study, should be complemented by macrosociolinguistic studies, as advocated by Chick (1985:300), in order to confirm the generalizability of such microsociolinguistic studies.

Thirdly, investigations such as this present study should also be complemented by studies in other domains such as integrated out-patients' departments in hospitals, or specialist clinics servicing, for example, diabetic or obstetric patients, etc. The data resulting from such sources are likely to reveal valuable insights into how multidisciplinary medical team-members such as general practitioners, specialists, nursing staff, physiotherapists, occupational therapists, and the like, interact with patients and with each other.

In the fourth place, future research should involve interactions in even more complex situations such as pediatric or geriatric consultations where the asymmetry of social relations is likely to be more exaggerated owing to the age differentials between the participants.

New research ground could be broken by investigating so-called "patient-centred" consultations, such as those undertaken at MEDUNSA (see 2.3) for medical student training purposes, in order to establish the degree to which the discourse allows more contributions from patients and encourages the disclosure of the patients' own explanatory interpretations of their illnesses, rather than doctor-elicited questions. This could be further developed, in the form of a longitudinal study, by following those students into practice, to establish whether they continue to use the "unconventional" discourse they have learnt or whether they revert to those conventions of the traditional biomedical paradigm. Additional research, building on the above, could relate to the degree to which other practising doctors would be willing to undergo post-graduate vocational training in this innovative field.

In the sixth place, Ainsworth-Vaughan (1992) reports that there is some degree of change in discourse norms where American women doctors are involved. Building on that, additional research should be undertaken by investigating the discourse between SAE speaking women doctors and their patients, men and/or women who are native speakers of any of the indigenous languages, e.g., Zulu, Xhosa, Sotho, etc. This would be a particularly interesting study as it would be likely to illuminate an intriguing matrix of institutional authority, gender and discourse conventions.

I agree with Singh et al (1988:47) who insist that any future research in this field should be bi-directional. That is, research should be undertaken co-operatively by interactional sociolinguists whose different sociocultural backgrounds are those of the people whose discourse is being investigated. The aim of this would be to provide more of an intercultural analysis of how and why interactional asynchrony and synchrony occur and their consequences.

Much that is fruitful could be learnt by researching the sociolinguistic conventions of traditional healers or **sangomas** in black South African communities. "Importing" some elements into conventional Western medical discourse might even be useful, although in Critical Language Study terms, this would mean that the latter would be somewhat "colonized" by the former discourse with which many speakers of indigenous languages are likely to be familiar in schematic terms. However, some critical linguists, e.g., Fairclough (1989) would be wary of the motives of such research because they see colonization of one type of discourse by another as potentially problematic in terms of reproducing further asymmetrical power relations.

Finally, a specific research area that most certainly needs further investigation is the role of silence in intercultural medical consultations in South Africa. It appears from this study that silence, as a strategic resource in consultation, could be put to more use than it is currently. This would necessarily have implications for the time-management of private medical practices.

South Africa is at a stage when now, more than at any other time in its history, people need to communicate co-operatively in order to re-build a society in which everyone can live in relative harmony. Much more work, therefore, needs to be done in the field of interactional synchrony. Although using the evidence from only one type of encounter, and therefore being wary of lack of generalizability, it is clear that asynchrony does not always have to happen in intercultural encounters. Synchrony is possible. Engendering "co-membership," by employing positive or solidarity politeness strategies, (see 6.0) is one way of ensuring that people of different sociocultural groups can be united by commonalities.

This is not an exhaustive list of further research possibilities. It is likely there are many more that would be worth pursuing with the ultimate purpose of discovering how people can communicate more co-operatively, despite their sociocultural differences.

## **7.4 CONCLUSION**

In this study, I have attempted to identify, describe and explain a number of sources of interactional asynchrony and synchrony in 3 intercultural medical consultations in an urban setting. I have also attempted to outline the impact of interactional asynchrony on a societal resource such as health care as practised in a private medical practice in South Africa. My hope is that this research will contribute to the better provision of health care in that setting. What is necessary, I believe, is that power-holders and gate-keepers of health-care not only be made aware of the potential sources of asynchrony and make allowances for them as Chick suggests (1985:318), but that they actively seek to develop strategies conducive to interactional synchrony.

APPENDIX 1

PATIENTS' CONSENT FORM:



University of Natal

Faculty of Humanities  
Department of Linguistics

King George V Avenue Durban 4001 South Africa  
Telephone (031) 8162617 Fax (031) 8162214  
Telegram University Telex 621231SA

CONSENT TO ACT AS SUBJECT

DATE: .....

This study examines, for research purposes, how doctors and patients communicate.

1. I am willing to allow the researcher to collect information by tape-recording the interview between me and my doctor.
2. I understand
  - a) that I will not be identified by name
  - b) that I will not be able to be identified by anyone other than the doctor and the researcher.

SIGNATURE: .....

NAME: (Full name) .....

DATE OF BIRTH: .....

TEL NO: (WORK) .....

(HOME) .....

WITNESS: .....

*The University of Natal rejects apartheid.  
It is an equal opportunities,  
affirmative action University.*

## **APPENDIX 2**

### **TRANSCRIPTION CONVENTIONS:**

**001ff** = turn numbers

**D** = Doctor

**P** = Patient

**....** = speech pause

**(?)** = unintelligible speech

**APPENDIX 3**  
**TRANSCRIPTION OF CONSULTATION 1**

001 D: ..... right good afternoon ... right it's your first time here  
002 P: yes  
003 D: yah what is the problem today  
004 P: aah there's a problem with the .. got some dizziness  
005 D: yah .. how long have you been dizzy  
006 P: since since er the end of last year .. in September  
007 D: yah in .. every day .. all the time  
008 P: it's almost every day but not in the morning  
009 D: um .. now describe the dizziness .. what does it feel like  
010 P: um .. just like you know .. like .. got some drug  
011 D: uh uhm yah  
012 P: sometimes sometimes just for a  
013 D: does it feel  
014 P: fall down  
015 D: fall down .. does it feel as if you're moving  
016 P: yes  
017 D: as if your head is turning  
018 P: yes always .. as I'm sticking straight  
to the floor  
019 D: yah .. it feels as if things are going  
020 P: things are going  
021 D: mmm  
022 P: sometime  
023 D: yah does it ever worry you in your .. when you're lying down  
024 P: .. mmm  
025 D: say if you turn over in bed  
026 P: no I don't affect me so much when I'm lying down  
027 D: mmm ..and as well as dizziness is there any other problem  
028 P: no it's only

- 029 D: no headache
- 030 P: headache yes it's changed
- 031 D: uhm
- 032 P: headache and dizziness
- 033 D: uhm
- 034 P: but dominate this dizziness
- 035 D: mmm ... do you think there might be .. something wrong with you are you worried that there's something particular wrong with you
- 036 P: mmm I don't know because I'm studying
- 037 D: yes
- 038 P: now I don't know if the studies are worrying me
- 039 D: yah
- 040 P: (?) too much
- 041 D: what are you studying
- 042 P: I'm doing B Admin with with er Westville
- 043 D: mmm ... and how is your appetite
- 044 P: appetite no it's all right
- 045 D: it's all right you're eating
- 046 P: yah
- 047 D: everything else all right you're sleeping ok
- 048 P: yes
- 049 D: mmm and how's the studying going do you find it easy to study or
- 050 P: because of this problem I I don't .. cope
- 051 D: is  
it more difficult than it used to be
- 052 P: yes yes
- 053 D: mmm
- 054 P: because I can't .. stick straight to the book
- 055 D: uhm yah
- 056 P: for a long time
- 057 D: yah .... is this the first time you've tried to get



help for the dizziness

058 P: no it's not for the first time

059 D: mmm so what other sort of treatment have you had

060 P: sorry

061 D: I say what other treatment have you had for this dizziness have you had any pills or anything

062 P: yes I've had some ah treatment

063 D: mmm and has it helped  
has it been effective at the time

064 P: no

065 D: what sort of treatment have you had

066 P: they usually give me pills

067 D: mmm what sort of pills do you know the names of some of them

068 P: oaaah

069 D: (laughs)

070 P: not so good

071 D: mmm and you say there's been no improvement ..  
actually while you've been taking the pills is it no better

072 P: no no improvement

073 D: mmm

074 P: because I also have changed the doctors

075 D: yah ... have you had any tests x rays or blood tests or anything

076 P: I had an x ray but it was not for the .. for the head

077 D: er

078 P: but for the chest

079 D: uh uhm .. and was that normal

080 P: I'm sorry

081 D: was there no any problem with that x ray

082 P: no there's nothing

083 D: mmm

084 P: it was proved

- 085 D: mmm
- 086 D: ... right let's .. look in your ears for anything (?).....  
can you hear with that ear
- 087 P: no
- 088 D: (laughs) .. let's check your blood pressure ... so do  
you feel the time has come to see a specialist ..  
have some special x rays or something mmm
- 089 P: I think I see the specialist
- 090 D: mmm try to get to the bottom of this a cure
- 091 P: yes
- 092 D: uh uhm just let me turn .... does that make you feel  
dizzy
- 093 P: no it it comes from maybe I'm in a motor vehicle
- 094 D: mmm
- 095 P: and  
then it takes a draai like this .. and then
- 096 D: yah yah .. you drive
- 097 P: .. I drive .. I drive
- 098 D: do you find it a problem while driving
- 099 P: I find it a problem
- 100 D: just stand up please .. let's stand away from the desk..  
just put your feet together .. close your eyes (?) keep your eyes closed  
.. all right you can sit down here .. open your eyes ... all right let's  
take the glasses off .. look straight just at the bottom corner there keep  
your eyes fixed on one place .. I'm going to look into your eyes .... (?)  
it's ok ..... all right put your glasses back on please ..... ok so does this  
.. do you think this worries you every day or how frequently would you  
say it comes
- 101 P: (?)
- 102 D: this dizziness
- 103 P: every day
- 104 D: every day but only for a short period each time

- 105 P: yes only for a short period of time
- 106 D: mmm ... mmm
- 107 P: specially in the morning
- 108 D: mmm
- 109 P: yah
- 110 D: do you think it's affected by eating
- 111 P: uhm I'm not sure
- 112 D: does it worry you at night when you're trying to study your books  
or when do you study
- 113 P: (?)
- 114 D: when
- 115 P: it worries me most .. when I haven't done for a long time
- 116 D: yah uhm
- 117 P: but I don't think it affect me
- 118 D: mmm .. now do you do much studying in the  
evening
- 119 P: yeah I have to
- 120 D: mmm do you find the dizziness has worried you then
- 121 P: yes (?) when I'm trying to do assignments
- 122 D: mmm mmm .....
- 123 P: and aah another problem that .. another thing
- 124 D: mmm
- 125 P: I don't have I don't know if maybe the glasses cuz I have changed the  
glasses last year
- 126 D: mmmm
- 127 P: so I had the line which was not .. tinted like this
- 128 D: mmm yah
- 129 P: so they gave me red eyes I think
- 130 D: uh huh .. (?) might have started
- 131 P: (?) the change of glasses maybe affected me
- 132 D: shouldn't really
- 133 P: and when I put them on

- 134 D: mmm
- 135 P: since the first time I I seem to be the first one who .. I seem  
to be wearing the glasses for the  
first time
- 136 D: yes ..... right what I want to do .. that one ear is as I say  
very blocked up with wax
- 137 P: yes
- 138 D: that can affect your balance too so I think we must clear  
that up
- 139 P: ok
- 140 D: let's get some warm water .... won't you come and sit  
in this chair here .... put this towel over your shoulder .. I'm just going  
to squirt water (?) .... let's have a look .... walk .... ok that's that did  
they do any blood tests at all
- 141 P: no
- 142 D: just the x ray
- 143 P: they did the blood test
- 144 D: mmm what did that show
- 145 P: (sighs)
- 146 D: do you know what they were looking for
- 147 P: no
- 148 D: to see if  
you're anaemic or
- 149 P: no no I'm not sure
- 150 D: mmm
- 151 P: but they just
- 152 D: took the blood .. how long how long ago was that .. way  
back in September November
- 153 P: what the blood test
- 154 D: yeah
- 155 P: it was in September
- 156 D: yah it's a long time ago eh

- 157 P: mmm
- 158 D: what's your age now you're now turning thirty
- 159 P: thirty yes
- 160 D: mmm ..... right I'm going to suggest we'll  
see if .. cleaning that wax out of the ear makes any difference cos  
it can do if you're off balance
- 161 P: mmm
- 162 D: one ear blocked up and the other not it can affect your ..  
feeling of balance and get those blood tests  
done .. today's Friday will it be possible to see you  
about Monday or Wednesday
- 163 P: (?)
- 164 D: or next Friday whenever whenever it's possible for  
you to come in
- 165 P: I think it's best Friday because I'm in the hostel  
writing a test
- 166 D: ah ok I would suggest that's what we do and if we find  
if we find anything wrong in the blood we can  
take a step there otherwise I would suggest we ask  
then one of my neurosurgical colleagues to have a look  
at you possibly with the view to doing a scan although  
there's certainly no .. sign at the moment of any serious problem
- 167 P: er
- 168 D: but you know if these problems persist  
for six months
- 169 P: mmm
- 170 D: or so then we try and find a cause .. ok this laboratory is just along the  
end of the .. passage if you take the second last door on the left as you  
go down there and you should find them there .. ok and come back and  
see us next Friday just take that form with you they'll take the blood  
and then you can go and see if doing that ear has made any difference
- 171 P: ok

**173 P:** **ok**

**APPENDIX 4**

**TRANSCRIPTION OF CONSULTATION 2**

- 001 D:           afternoon my dear
- 002 P:                               hello d
- 003 D:                               how are you
- 004 P:           ey no I'm all right and you
- 005 D:           ah can't complain
- 006 P:           mm
- 007 D:           how's the aches and pains
- 008 P:           I've got some flu
- 009 D:                               flu
- 010 P:           two days
- 011 D:                               yah
- 012 P:           my body was too too sick I was (?) the whole day yesterday
- 013 D:           yah
- 014 P:           Sunday I was in bed
- 015 D:           so you had a good long weekend relaxing doing nothing cos you  
weren't well ... hey
- 016 P:           (sighs) I don't know what's going on and tomorrow I'm leaving for  
Pretoria I said no I've
- 017 D:                               Pretoria what are you going to do up there you  
going to do a course or what
- 018 P:           I've got to attend a conference from tomorrow up to Sunday
- 019 D:           what a
- 020 P:                               a church conference
- 021 D:                               church one I thought it was something to do with  
the Corporation no
- 022 P:           no uhuh
- 023 D:           which church what church do you belong to
- 024 P:           Methodist
- 025 D:           Methodist .... bunch of ANC nowadays (p. laughs)   eh   eh
- 026 P:           why

- 027 D: cos they are
- 028 P: no they're not
- 029 D: yes
- 030 P: why
- 031 D: yes I know I used to belong to it (d. laughs)
- 032 P: and then why did you run away
- 033 D: no cos I married an Anglican you know you know what the wife's like  
I go to the Anglican church now
- 034 P: oh Anglican
- 035 D: I'm confirmed a Methodist and brought up in the Methodist church
- 036 P: (?) then don't you like Methodists
- 037 D: yah but they're all ANC man old Bruyn and all those guys
- 038 P: yah but that means nothing
- 039 D: they're one sided they haven't got a broad overview of things like me
- 040 P: maybe before
- 041 D: eh (p. & d. laugh)
- 042 P: maybe before they were like that they were but that doesn't mean you  
are you are like that
- 043 D: oh yah no we had lovely we actually had very nice ministers
- 044 P: ah .... no I don't think I
- 045 D: Reverend Massey was there for years and years  
and years
- 046 P: I remember .....
- 047 D: he got killed in a car accident fell asleep in his car
- 048 P: shame
- 049 D: he was naughty he used to sit there reading his Bible (p. laughs) and  
you'd look inside and there was a cowboy book (p. laughs) sitting there  
reading it
- 050 P: ooh (p. & d. laugh)
- 051 D: all right let's have a looksee
- 052 P: at the same time I want you to give me treatment for this arthritis (?) I  
don't know now my life's complicating or but now (?) I did a lot of



washing over the weekend ey my hand was

053 D: yah well it's probably that

and you've got a bit of fever with your flu too

054 P: (?) this this this kind of thing it makes me (coughs)

055 D: stop worrying

Deni when those things all your blood tests start going funny

056 P: ok

057 D: what are you in the church that you're going for a conference are you the treasurer or something hmmm

058 P: (?)

059 D: you're an accountant I would expect that

060 P: um

061 D: of which which church which one

062 P: Methodist church

063 D: yah but which church

064 P: but this one is not for for everybody

065 D: yah

066 P: it's just for black people black Methodists

067 D: why do we now separate them aren't they supposed to be together now  
(p. laughs)

068 P: no we are ... but at the same time we (?)

069 D: but we're all our people

070 P: no but blacks are are not a lot of advantages

071 D: course they are they're more advantaged these days

072 P: no before most of them

073 D: (?) somebody like Robert Madlala misbehaves (p. laughs) he would have been chucked out the first day let alone (?) eh

074 P: no

075 D: course

076 P: (?) grassroots (?) just a forum where (?)

077 D: but we're all our people

078 P: uhuh black people operate (?) black people

- 079 D: black South Africa nowadays eh
- 080 P: mmm
- 081 D: (?) the ANC
- 082 P: mmm
- 083 D: (?) more gays than ANC (p. & d. laugh) go on we'll fix you up
- 084 P: yah (d. laughs) I mean if you (?)
- 085 D: no I don't think you belong to any  
political party but I'm just saying
- 086 P: (?) you must listen to Jesus  
Jesus was more concerned with (?) people and their grassroots
- 087 D: yah
- 088 P: and he would really ... spend most of his time and that's what  
we are trying to do I mean so that (?) in our church everything is
- 089 D: no I agree I think it's interesting one of um ..
- 090 P: we are going into these geographic  
circuits we'll be mixing with the whites and then now our people most  
of them are not ready ... firstly it's the language you know the ways of  
worshipping and what have you
- 091 D: yah
- 092 P: and those are the things that are being discussed there and it's it's sort  
of you know bridging the gap
- 093 D: gap yah
- 094 P: so that's the only forum where we train and educate our
- 095 D: yah well that's good
- (4.5 secs)
- 096 D: so do do you wear one of those one of those black skirts with red top  
and white hat and all that sort of thing
- 097 P: mmm I wear
- 098 D: do you
- 099 P: mmm I'm president of the manjanu
- 100 D: there used to be a .... black lady who used to live down the road when  
I was little Florence I still remember her she used to used to love me to  
death

- 101 P: mmm
- 102 D: every time she used to say come here my darling (p. & d. laugh) poor Florence I don't know what's happened to her
- 103 P: I'm worrying that
- 104 D: ok and you want something ...
- 105 P: oh you belong you belong to to to Desmond Tutu (p. laughs) he's an Anglican
- 106 D: he is
- 107 P: yah
- 108 D: let me tell you something he's much better behaved now than what he used to be
- 109 P: yah and you are quite right ..... maybe it's because things have changed as well
- 110 D: yah he's there's nothing there's nothing wrong with him
- 111 P: can I have my I forgot my my
- 112 D: number
- 113 P: medical card
- 114 (?)
- 115 D: well it's like all these guys hey you get this guy old not to talk about religion but Harry Gwala now this idiot in Maritzburg
- 116 P: yeah oh that one
- 117 D: ANC guy but he's worse than the Inkatha warlords the way because he says go and fight I mean he's mad
- 118 P: yah
- 119 D: they must they must if the ANC had any brains they they should ostracize him and say eh that's not what we say that's what
- 120 P: that's not what we are here for
- 121 D: mmm
- 122 P: no they must
- 123 D: do that all right well enjoy Pretoria
- 124 P: ok
- 125 D: I will suggest that you take .. long johns and lots of jerseys cos it's very cold up there
- 126 P: I packed I packed yesterday and it's even worse with flu you know

- 127 D:       cos a friend of mine phoned me two nights ago from Joburg and I said  
              are you doing any running he said no it's too cold in the mornings the  
              day time's ok but during the night
- 128 P:       very cold in the morning (d. laughs) ok
- 129 D:       all right enjoy it
- 130 P:       thank you
- 131 D:       ok bye

APPENDIX 5

TRANSCRIPTION OF CONSULTATION 3

001 D: good morning  
002 P: morning doctor  
003 D: how are you  
004 P: yah I'm fine .. as I'm so bad .. I can't  
005 D: Mr Eric  
006 P: no cure and st .. still  
I I used that medicine but eh  
007 D: you're  
st ... you're still (laughs) st  
008 P: still carry on with the the the  
009 D: still complaining no power nothing hey  
010 P: nothing nothing and now it's going worse cos .. before .. I was doing  
even er one round now one round I'm  
011 D: maybe you're just get .. maybe  
you're just getting madala now hey  
012 P: ah no I don't think so  
013 D: hey  
014 P: no  
015 D: ok  
016 P: I don't know what's wr  
017 D: go through there let's have a .. feel of that  
prostate again and make sure that that's all clear because .. and I'll  
have to give you some Depotrone  
018 P: (?)  
019 D: no good to get old hey  
020 P: ey no (?) I'm at home now  
021 D: you've taken holiday now I know  
022 P: now I can't ey (d. laughs) (p. laughs)  
023 D: yah it's all  
the girlfriends you have during the week (?) that causes the  
problems and you go home the wife (?) and they wonder why  
..... up a bit more .... how's that feel

- 024 P: yah no problem (?)
- 025 D: it's nice and soft .. all right you must just continue .. I'll give you another double shot..... fix you up ... it's much softer than the last time ... it's cured there so you should be there just talk nicely to your body and say hey come on (p.& d. laugh) hey
- 026 P: um yah
- 027 D: you must say to it come I want to have a nice holiday (laughs) where're you from Ndedwe
- 028 P: yah
- 029 D: no Impendle nice and cold there
- 030 P: mmmmm special now oh very bad I'm wearing a jersey ..... and a coati (?) I think it works better now
- 031 D: yah (?) ..... right .... mustn't drink beer at home hey
- 032 P: no I don't drink at home (?)
- 033 D: you either fall asleep or
- 034 P: the time before I was drinking (?) oooh one week
- 035 D: (laughs) you're lucky usually it works the other way round hey
- 036 P: yah (?) (d. laughs)
- 037 D: ok .. I'll give you this and then I'm going to give you some other stuff to sort you out .....
- 038 D: ok right come let's give you this lot and that'll sort you out now ..... after this you won't have any excuses hey (d. laughs)
- 039 P: I don't think now cos even I can find out ..... doctor
- 040 D: doctor yeah
- ok .. just take .. 2 teaspoons .. 3 times a day ok
- 041 P: 3 times a day .. ok
- 042 D: that's what I take too it's good stuff
- 043 P: ok
- 044 D: it makes you strong and it'll sort you out and you can enjoy the rest of your holiday as well (d. & p. laugh)
- 045 P: yah please cos you know I'm not enjoying any more now (d. laughs)
- 046 D: (laughs) hey you must enjoy the company of your wife still so that's ok hey
- 047 P: (sighs) yah

048 D:               hey

049 P:               but

050 D:               hey

051 P:               what sort of a fine thing is that (d. laughs) and they  
expect some babies nothing I've got nothing

052 D:               no that'll come that'll sort you out ... ok

053 P:    ok doctor

054 D:               so enjoy the rest of your holiday

055 P:               ok

056 D:               ok bye

057 P:               I hope so now this thing will

058 D:    ok

059 P:    bye bye

060 D:    bye

# APPENDIX 6

## POSITIVE POLITENESS STRATEGIES

(Brown & Levinson 1987:102)

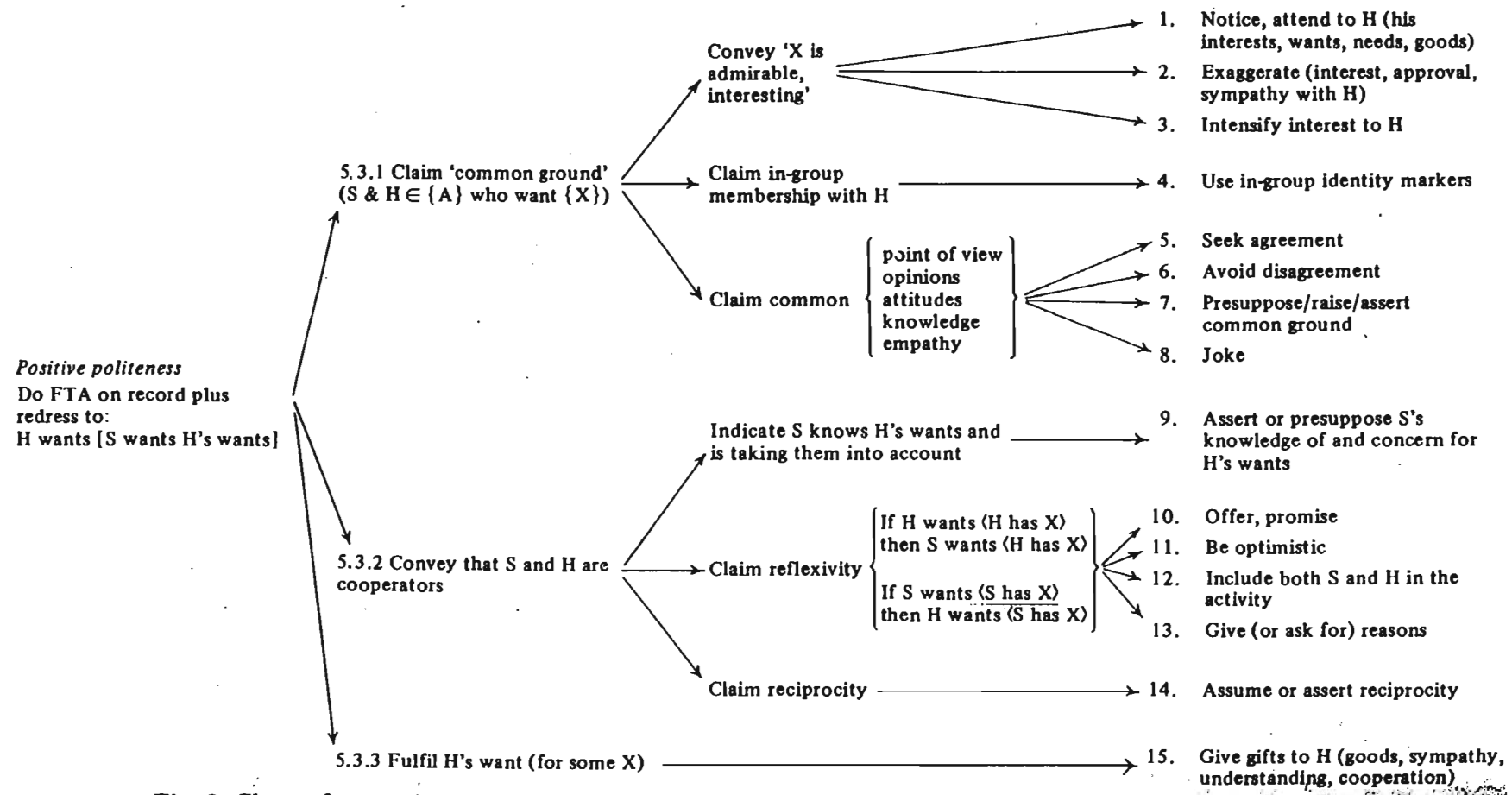


Fig. 3. Chart of strategies: Positive politeness



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