ADDIS ABABA UNIVERSITY

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Department of Linguistic

Medical Professional-Patient Communication in Outpatient Department of Kotebe Health Center: A Sociolinguistic and Pragmatic Study

By

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BY ABRHAM YOHANNES

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Declaration

I, the undersigned, declare that this thesis is my original work, has not been presented for a degree in any other universities and that all sources of material used for the thesis have been acknowledged.

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Confirmation

This thesis has been submitted for examination with my approval as thesis Advisor

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Abstract

Doctor and patient communication is one of the interpersonal communications and is centre for clinical function in building a therapeutic doctor and patient relationship, which is the heart and art of medicine. Therefore, it is important in the delivery of high-quality health care. But, patients complain that doctors are not willing to listen to them, do not answer their questions or inform them properly, they are authoritative and unhelpful. Doctors, on the other hand, criticize their patients for not following their advice.

The study focused on Outpatient department of Kotebe Health center, which is under Yeka sub city that provides primary health care for the general population which holds two doctors, four health officers, twenty three nurses and their patients. That is the communication between medical professional and patient from sociolinguistic and pragmatic aspects respectively. The first, contemplates the use of terminology, register, turn taking, solidarity and status, language and group membership, and code switching in language. The second, deals with the use of language in social context and emphasize the 'functionality' of utterances performed in medical contexts of interaction which attempts to address the speech act theory, the maxims and the paralinguistic feature of the language.

The methodology used to collect the data is techniques such as interview; observations and questionnaires. The qualitative data which was found from the interactions and quantitative data found from questionnaires were analyzed and tried to inspect the two questions; those are mentioned above. Moreover, the study shows both interlocutors' code switch from Amharic and to English and used terminologies during communication which has contribution for miscommunication and clarification. Variables such as age, gender, educational status etc. has big part in the interaction of the medical communication.

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CHAPTER ONE

INTRODUCTION

1. Background of the study

Communication is a process in which a message is sent from sender to receiver. It is a practice that the sender encodes message and the receiver decodes it. Communication may occur in small groups or in organizations where there is work to do, or several small groups that need to interact among each other within a single organization. Gumperz (1982) in his book *'Discourse strategies'* states that communication is a 'social activity that requires the coordinated efforts of two or more individuals' that construct talk to produce sentences. However, no matter how well rounded or stylish the outcome may be does not by itself constitute communication. Communication took place only when a common understanding is obtained among communicants. Therefore, it is necessary to have the knowledge and ability to create and sustain conversation. The knowledge also needs to be not only grammatical competence but also linguistic, socio-cultural knowledge, and understanding the nature of the conversation (Gumperz, 1982: 2).

Since, interpersonal communication is one type of communication, which is defined in many ways. Accordingly, Danton (2004) summed up some of the definitions given by scholars. For instance, (Miller, 1978) defines it based on the situation and number of participants involved and states that interpersonal communication occurs between two individuals when they are close in 'proximity, able to provide immediate feedback and utilize multiple senses'. Others such as (Peters, 1974) described interpersonal communication based on the degree of personal closeness' or perceived quality, of a given interaction; it includes communication that is private and occurring between people who are more than acquaintances. Another view of interpersonal communication is from the perspective of conversants' goals. According to this view, which is given by Canary, Cody, and Manusov (2003) which asserts that communication is used to attain or achieve personal goals through interaction with others (Danton, 2004: 50).

As one category of interpersonal communication, medical communication is central to clinical functions in constructing a good doctor-patient relationship, which is one of the major tasks in medical profession. In this regard, Van Naerssen in her article *'Medical Records Comments: One*

Variation of Physicians' Language' identifies two kinds of medical communication that includes doctor to patient and doctor to other medical personnel' communications (Naerssen, 1985:44). Then Naerssen claims that, impressionistically, both kinds belong to different registers, each with a range of variations within it.' The first is the interaction between two medical professionals (doctor with nurse, doctor with doctor, as well as nurse with nurse). The second is, the interaction between medical professionals with their patients, which includes interviews - called 'chief complaint', treatments, breaking bad news, consultation and follow-ups. Each part has its own structure and characteristic features that can be observed and analyzed either separately or as part of a larger discourse.

This study is limited to investigate the interview aspects by which the medical professional asks and the patient tries to explain what he/she feels. It also tries to view the most prominent aspect of the interaction that fully employs the use of conversation. Consequently, this study describes the sociolinguistic and pragmatics aspects of first contact that implies in outpatient department between medical professionals and patients in Kotebe health center, which is found at Yeka Sub-city, Addis Ababa. The study exclusively intends to analyze the contextual viewpoints of the doctors and patients' linguistic patterns used in the conversations and the pragmatic acts performed.

1.1. Statement of the problem

Research studies are mainly conducted to solve social problems and/or add valid knowledge to the existing ones. In this respect, this study attempts to investigate problems in medical communication and forward the possible solutions. The researcher was motivated to conduct this research as he has the experience in the area as a medical professional for years and observed the communication problems discussed here.

Having a good medical communication is important in the delivery of high-quality health care and has the potential to help regulate patients' emotions, facilitate comprehension of medical information, and allow for better identification of patients' needs, perceptions, and expectations. Patients reporting good communication with their medical care professional are more likely to be satisfied with their care, and especially to share significant information for accurate diagnosis of their problems, follow advice, and adhere to the prescribed treatment (Naerssen, 1985: 44).

However, according to Naerssen, ‘patients complain about their doctors that, they are not willing to listen, do not answer their questions, or inform them properly. In addition they are authoritative and unhelpful, at the same time; doctors criticize their patients for not following their advice’ (Naerssen, 1985: 43). In addition, some patients will want to know about their diagnosis but may not appreciate its significance and may be reluctant to ask, etc. (Bach and Grant, 2009: 93).

Although, there are many premises that could be taken as factors for such communication failures or gap, Bach and Grant (2009) indicate that one of the reasons is meaning, which is not only dependent on messages but also on the interaction between the individuals’ thoughts and feelings within the messages. Hence, meaning is not just ‘received’; it is constructed or built up from messages that are received and combined with social and cultural perspectives, such as beliefs, attitudes and values.

These are some of the problems in medical professionals and patients communication, which the researcher has noticed when he was practicing as a medical professional. Having this first hand information about the problems, the researcher endeavors to bring out the sociolinguistics and pragmatics aspects of medical professional and patient interaction in Amharic language and suggests remedies for the problems.

1.2. Objectives of the study

1.2.1. General objective

The major objective of the research is to analyze the sociolinguistic and pragmatic aspects of communication between medical professionals and patients.

1.2.2. Specific objectives

The study also has the following specific objectives:

- Demonstrating the use of terminologies, registers, code switching, and code mixing in patient and medical professional communication, when and why do interlocutors use these concepts in their conversation.

- Revealing how the ages, gender, cultural, social, and educational background of the individual interlocutors affect the discourse.
- Demonstrating how language shows solidarity, status and group identities, and how the use and meaning of word in medical context is interpreted. And,
- Identifying who violates the speech act theory and the maxims during communication, and how patient measure the paralinguistic features.

1.2.3. Research questions

Based on the objectives stated above, the study attempts to address the following two basic questions,

1. Why patients are ineffective in talking to medical professionals?, and
2. Why medical professionals do not talk more like an ordinary person, i.e. a patient?

1.3. Significance of the study

This study investigates some of the important points regarding medical communication and content of the language from sociolinguistics and pragmatic aspects. In other words, the study attempts to describe issues, which are related to language use and implications in communication. Therefore, the study, first, helps patient and medical professionals to have effective communication in asserting themselves while talking to each other. Second, it gives an idea or a hint about medical communication for medical professionals on how to talk and handle their patients. Third, it will serve as a resource for future researchers by being a springboard for further investigations. More especially, researchers who want to work on such areas as sociolinguistics, pragmatics and register studies on medical communication in Ethiopia can benefit from this study since such a research is relatively new in the country.

1.4. The scope of study

The health center has sixty-three medical professionals that are two doctors, five health officers, thirty-five nurses, four midwifery nurses, one health assistance, seven medical laboratory technicians and nine pharmacists and druggists with departments of at least ten. However, the study focuses only on medical professionals who work in the outpatient department and their patients. In

addition to this, this study is limited to the interview aspects that the medical professional holds with the patients, which contains the most prominent aspect of the interaction that fully employs the use of conversation. Moreover, it is obvious that medical communications are not conducted only orally but through writing, too. However, the study focuses only on the oral interaction. The excluded area, that is, the written communication will be relevant to the analysis of prescription, medication, and reports in medical records, none of which may share the characteristics of *'chief complain'* interaction. The study also excludes the interaction between doctors with other medical personnel.

1.5. Limitation of the study

Lack of knowledge and fear of losing confidentiality were the two problems that impede data collection. First, patients feel they came to the health center just for medical care; as a result, they felt uncomfortable to fill the questionnaires or give comments on existing situations of the medical service. Second, patients feared that the information they gave would go to a third party and cause unnecessary problems on them.

CHAPTER TWO

Related Literature and Conceptual Framework

2.0. Related literatures

According to Heritage and Clayman (2010), two major studies were launched in 1970s on doctor and patient interaction, as a systematic research domain. The first, conducted by Barbara Korsch and her colleagues at the Children's Hospital of Los Angeles, examined 800 pediatric visits. They found out that nearly a fifth of the parents and nearly half the parents, respectively, left the clinic without a clear understanding of what were wrong with their children and wondering what had caused their children's illness (Korsch and Negrete: 1972). Moreover, quarter of the parents reported that they had not mentioned their greatest concern because of lack of opportunity or encouragement. The study exposed a strong relationship between these and other communication failures and non-adherence to medical recommendations, showing that 56 percent of parents who felt that the physicians had not met their expectations were 'grossly noncompliant'. The second was; *Doctors talking to patients* conducted on the other side of the Atlantic (Byrne and Long: 1976) based on some 2500 audio recordings of primary care encounters, dissecting the medical visit into a series of stages, and developed an elaborate characterization of doctor behaviors in each stage. Drawing from Balint's (1957) proposal, 'the primary care visit had therapeutic value in its own right. Byrne and Long argued that doctor-centered behaviors, which are behaviors focused more on the expertise of the doctor than the needs of the patient– were prevalent and undermined the visit's therapeutic value to the patient' (Heritage and Clayman, 2010 :103).

Then Valero-Garces summarized after these results, many scholars have commenced to join the investigation on the medical communication internationally, especially from the perspective of discourse and conversation analysis such as (Coulthard and Ashby: 1976), (Labov and Fanshel: 1977), (Coleman and Burton: 1985), (Naerssen: 1985), (Myerscough: 1992), (Wodak: 1997), (Chimombo and Roseberry: 1998) and (Valero-Garces: 2002).

However, the concept of medical communication is new and untouched in Africa, especially in Ethiopia. With some exceptions such as, by Akin Odebunmi and Wale Adegbites (2006) in Southwestern Nigeria, that studied many recorded data between doctors and patients in thirty

hospitals. Which help them to concluded that, the structure of doctor and patient communication yields two parts in general, the first is to identify the problem, its symptoms, and sources, and the second is attempting to recommend solutions to the problem. Initially, the interaction is conversation and constituted by series of turn taking activities between the doctor and the patient. In addition, it contained a transaction, which is made-up of one or more exchanges and a number of moves and acts. Moves and acts observed in the interaction. After the initial occasional exchanges, which contain initiations and replies of greetings and summons, the transaction opens with a doctor's initiation move, which elicits information about the nature and symptoms of a patient's illness. This elicitation may reappear in resulting exchanges in the transaction in opening, bound-opening, or re-opening moves. Following this opening initiation is a response move supporting it by providing a reply to it. If the reply is satisfactory, the doctor makes a follow up supporting move, accepting the reply to it by going ahead to recommend prescriptions. But if the reply is unsatisfactory, the doctor either re-opens the elicitation or reacts to the reply by using pragmatic means to find out the problem, or even reacts and extract at the same time when necessary. The doctor can utilize challenging moves to condemn the action of a patient, accuse, wrong behavior or calm him. Lastly, the doctor can use initiation moves to issue directives to a patient when recommending solutions to the patient's problem (Odebunmi and Adegbites, 2006:501).

Moreover, Daniel Zewdneh, Kifle W/Michael, Sosena Kebede (2009) carried out research on '*Communication skills during patient interaction in an in-patient setting at Tekur Anbesa specialized teaching hospital (TASH)'* via observation on 472 practicing and studying doctors at Tekur Anbesa Specialized Teaching Hospital. The subjects included 98 consultants, 205 residents, 169 interns from all the major clinical departments. The medical practice at TASH shows obvious communication skill deficiency among all categories of physicians and the medical faculty should take the lead towards addressing the problem through curricular review and other relevant approaches at institutional level (Daniel et al, 2009: 8). Thus, As far as the researcher observation is concerned medical communication needs more attention. Therefore, this study of medical professional and patients interactions, from the perspective of sociolinguistic and pragmatics, is expected to give some hints on the concept.

2.1. Conceptual Framework

2.1.1. General principles of communication

The North American linguist and anthropologist, Dell Hymes, first introduced the phrase 'communicative competence' in the late 1960s (Hymes, 1962/1968, 1971). He used it to imply the following four areas of knowledge and use of language during communication:

- The ability to use a language involves knowing (explicitly or implicitly) how to use language in any given context.
- The ability to speak, and understand language is not based solely on grammatical knowledge but also on 'Communicative Competence'.
- What counts as appropriate language varies according to context and may involve a range of modes – for example, speaking, writing, singing, whistling, and drumming.
- Learning of appropriate language features through a process of socialization into particular ways of using language participation in particular communities (Hymes, 1968:93).

Bara Bruno also comments on the eight key points to produce effective communication those are first *cooperation,* which is a significant activity in which the interlocutors agree for communication acts on and the global significance of the interaction satisfies the motivations of all the participants. The relationship between agents in a communicative interaction thus presupposes some form of stable cooperation. Second, *common attention,* for communication to take place, contact conditions, the partner must have understood that the actions executed by the actor are expressive; that is to say, they constitute an attempt to establish a communication with them. Third, *communicative intentionality,* communication is openly intentional, i.e., the actor wants the partner to recognize not only the informational content of the communication act but also that she/he is attempting to communicate something relevant. Fourth, *communication is symbolic,* implies both participants construct the meaning of the interaction together. Fifth, *taxonomy of social interaction* entails the dimensions of durability and temporary of communication are irrelevant in respect to the other distinctions (Bruno, 1999:51).

The final input for the effective communication as stated by Bruno are *sharedness, conversation,* cultural *dependency, linguistic and extra linguistic functional systems,* meaning communication

takes place based on increasingly shared knowledge. The greater the knowledge shared, the more effective the communication. Interlocutors must employ forms of conversation that are appropriate to the situation: they must follow priority, comply with turn taking, ensure discourse coherence, a society has cultural norms must be respected linguistic and extra linguistic communication, respectively, that is two modes of realizing communication (Bruno: 1999: 53).

2.1.2. Medical communications

Tinsley Harrison in his book *Principles of Internal Medicine* writes 'the true physician has a Shakespearean breadth of interest in, the wise and the foolish, the proud and the humble, the stoic hero and the whining rouge. He cares for people.' Despite this fact, according to a manual prepared by U.S. Agency for International Development (USAID) organized for the Quality Assurance (1999) during health care visits, patients often communicate in their own dialects, accents, and slang. This can make understanding of the communication difficult for providers especially if the patients came from other regions of the country. In addition, patients describe health problems in unique ways, often reflecting their perspective on the illness, its origin, or severity. Sometimes local circumstances influence how patients perceive their illnesses symptoms and to which symptoms should give priority.

Regardless of the above limitations, it is understandable that patient and doctor communication is a collaboration act. Supported by opening, supporting moves and predominated by the interaction, while the confronted move seldom occurs. The doctor who elicits gives and confirms some information or gives directives to a patient very often initiates the opening move. In contrast, the patient who gives information at some point in the interaction often makes the supporting move. Furthermore, it contains the flouting of several conversations, participants' beliefs, and attitude towards the expressions, emotions, and compassion of the interlocutors (Odebunmi and Adegbites, 2006:501).

Because of these facts, Danial Zewdneh et al citing from Colman describe that in medical communication skills many scholars comment to medical professional many kinds of communication protocols to improve the doctor-patients' relation among these perspectives. The Macy Initiative in Healthcare communication is one of them, identified three broad domains of skills; specifically, communication with the patient, communication about the patient, and

communication about medicine and science. The second the Kalamazoo I Consensus Statement, which states the patient and medical professional, must perform these seven steps of the interaction. Which outlines seven essential communication tasks that should be part of communication-oriented medical course, that is to build the doctor-patient relationship, open discussion, gather information, understand the patient's perspective, share information, reach agreement on problems and plans, provide closure (Danial et al, 2009: 15).

However, to develop a good communication, there should be good patients-doctors relationships. In evaluating the character of physician-patient relationships, a preeminent health psychologist Dimatteo (1991), summed-up three basic models of the physician-patient relationship. The first, which is, *the active-passive model* where the patient is unable to participate in his or her own health care provision rather than the whole responsibilities lay on the doctor. The second is *the guidance-cooperation model*, where the physician takes immense of responsibilities for diagnosis and treatment and let the patient in some occasions. Moreover, the third is *the mutual participation model*, which involves physician and patient making joint decisions about every aspect of care, from the planning of diagnostic studies to the choice and implementation of treatment (Gordon and Edwards, 1995: 17).

Many modern researches favor the third model to accomplish a good health care for the patients. Regarding medical communications there are two types of communication. The first is the doctor-centered communication, which focus only on the symptom of the disease, motivated by laboratory diagnosis, the conversation is highly controlled by the medical professional and most of the questions asked are closed-ended questions plus medical professionals give mare instructions than advice to their patients (Chaisson:2010). The second, Patient-centred communication, which is, according to American Medical Association, respectful of and responsive to a health care user's needs, beliefs, values, and preferences. Any communication that affects health care users can be patient-centered, including oral, written, and nonverbal communications between individuals and practitioners, individuals and health care organizations, and between and among health care practitioners and health care organizations (Allhoff et al, 2006:18). Patient-centered care broadly defined as 'care that is respectful of and responsive to individual patient preferences, needs, and values' (IOM 2001). Patient centeredness is not limited to communication; it may also include other aspects of care such as convenience of office hours, ability to get appointments in a timely fashion,

being seen on time for appointments, attention to physical comfort, and having services near one's place of residence (Allhoff et al, 2006:99).

2.1.3. The Sociolinguistic aspect of communication

Many scholars define sociolinguistics in different ways. For instance, Coupland and Jaworski define it as it "is the study of language in its social contexts and the study of social life through linguistic" (1997:1). Trudgill also define "Sociolinguistic is the relationship between language and society" (2000: 21); and Chambers state "Sociolinguistic is a correlation of dependent linguistic variables with independent social variables" (2003: ix). However, the many different ways that society can impose on language make the field of reference extremely broad. Studies of the various ways in which social structure and linguistic structure come together include personal, stylistic, social, socio-cultural, and sociological aspects (Tagliamonte, 2006: 3).

Sociolinguistics argues that language exists in context, conditional on the speaker, who is implementing it where and why. Speakers mark their personal history and identity in their speech as well as their socio-cultural, economic and geographical coordinates in time and space. Of course, some would argue that, since speech is obviously social, to study it without reference to society would be like studying courtship behavior without relating the behavior of one partner to that of the other (Tagliamonte, 2006: 2). Consequently, the following two significant arguments support this view.

> 'First, you cannot take the notion of language X for granted since this in itself is a social notion as far as it is defined in terms of a group of people who speak X. Therefore, if you want to define the English language you have to define it based on the group of people who speak it. Second, speech has a social function, both as a means of communication and as a way of identifying social groups' (Tagliamonte, 2006: 3).

Depending on the above outlooks, standard definitions of sociolinguistics is that like this sociolinguistic studies verbal behavior in terms of the relation between the setting, the participants, the topic, and the functions of the interaction, the form and the values by the participants (Ervin-tripp, 1968: 193). 'Setting', which refers to place and time of situations, donates standard behavior patterns that took place during interactions situation. Function refers to the effect on the sender of

his actions. From this case Ervin-tripp cited from Skinner and conclude that language in its social use could viewed as operant behavior, which affects the speaker throughout the negotiation of a hearer, the difference between topic and function is similar to the one between manifest and latent content. It signifies that since in many speech situations the addressee is known and subsequent behavior of the sender is known, it is more often possible to delineate functions in ordinary speech than in the texts for which content analysis often is employed'(Ervin-tripp,1968:192). Therefore, sociolinguistics in communication especially in medicine observes the medical jargon or medical terminology, the register, code switching, the following concepts.

2.1.3.1. Medical jargons or terminology

Medical Jargons or Terminology is not as easy to separate these terms as one might think. It does not mean there are no definitions provided. However, all definitions are too broad, and they do not define precisely which words can be regarded as medical terms and which cannot. To show this here are some dictionary definitions: Webster's Dictionary defines jargon as 'the technical terminology or characteristic idiom of a special activity or group…obscure and often pretentious language marked by circumlocutions and long words' (Morasch, 2004:2). Terminology is a word or combination of words, especially one used to mean something very specific or one used in a specialized area of knowledge or work (Encarta dictionary, 2008). Term is a word or phrase used to describe a thing or to express a concept. Additionally, term is a lexical unit serving the language of profession, with precise, usually notional content, in its scientific branch unambiguous, stabilized, and standardized, without additional indications and emotional connotations (Concise Oxford Dictionary, 2010).

Accordingly, Laura Johnson Morasch (2010) sum-up medical Jargon is a language of familiarity. It can be a useful tool when everyone has a common understanding of the terms at hand. Therefore, medical jargon can be both a tool for effective and efficient communication, as well as a significant barrier to understanding. The sophistication of the audience determines whether jargon can hinder or help communication. The problems arise when physicians let jargon sneaks into their every day communications with patients. This is when physician language can separate, protect, and intimidate the patient. Good communication is the result of the use of common terms that understood clearly by both parties, who in this case are the physician and patient (Morasch, 2010: 3).

After commenting on the above arguable definitions of medical jargons, Miroslav Černý (2008) writes that the number of the most frequent groups of expressions appearing in medical encounters is not large. However, we can make distinction into five categories: diseases and their symptoms, methods of examination, surgical interventions, medical specialties, and hospital departments. However, even such delimitation is not without further complications too (Černý, 2008: 40). Because Miroslav Černý quoted from (Müllerová: 2000: 77), stated that, for example, a symptom is sometimes defined, at least on the part of the patient, as 'any subjective evidence of disease' (see MedicineNet.com), which is in sharp contrast with the definition of terms as presented above (Černý, 2008:41). Therefore, this point will be covered on page 41 of this research paper.

2.1.3.2. Register

A single speaker makes systematic choices in pronunciation, morphology, word and grammar reflecting a range of situational factors. Native speakers of a language choose among different words and grammatical structures depending on the communicative situation. Researchers study the language used in a particular situation under the rubric of register. Register is a linguistic term for any language variety defined by its situational characteristics, including the speaker's purpose, the relationship between speaker and hearer, and the production circumstances (Biber: 2006). Accent is also a function of register. According to Sanders, as social situation varies so does the register of the individual, or variation dependent on the setting and the relationship between interlocutors (Sanders, 1993: 27). As cited and elaborated by Sanders (1993: 38) (quoted in Offord: 1990), factors such as the age, sex, socioeconomic status, and regional background of both speaker and addressee, the degree of intimacy between the participants in the speech-event, and the formality of the situation affect one way or another, the communication so as the register employed by interlocutors (Offord: 1990).

Because of the omnipresent nature of register variation, which has been noted, Biber Derda summarizes the number of comments from scholars, such as Ure, and notes 'each language community has its own system of registers corresponding to the range of activities in which its members normally engage' (Ure, 1982: 5). Ferguson also defines 'register variation, in which language structure varies in accordance with the occasions of use, is all-pervasive in human language' (Ferguson, 1983: 154) or (Hymes, 1984: 44): 'no human being talks the same way all the

time and at the very least, a variety of registers and styles is used and encountered' (Biber, 2006:265).

Biber includes that, speech and writing can be considered as two very general registers. The most obvious difference between the two is the physical mode of production. In addition, spoken discourse is often interactive and speakers often do not plan their language ahead of time. In contrast, written discourse is usually not interactive. In fact, writers, except in letters, are usually addressing a large audience, rather than a single reader. At the same time, there are many more specified spoken registers. Similarly, there are many specific written registers. For example, e-mail messages are very different from textbooks (Biber, 2006:265).

2.1.3.3. Code-switching

The term code switching is normally applied to the alternation of languages within a conversation. Some authors use 'code is mixing' to refer to language mixing within the phrase or utterance, reserving 'code switching' for the alternation of languages in-between utterances or phrases (inter-sentential switching). Others employ 'code mixes' to signify the structures that are the product of language mixing and do not occur in the speech of monolinguals (Matres, 2009:101). Yet another use of 'code mixing' is as a cover term for various types of language mixing phenomena. In the absence of a consensus, Muller and Ball state that,

> 'The literature on code-switching is large and varied, originating in multiple traditions of scholarship and investigation: sociology, sociolinguistics, psycho- and neurolinguistics, applied linguistics and language teaching, in first and second language acquisition, and clinical linguistics, to name only a few. Different traditions bring with them different terminologies, and the scholarship on code-switching is no exception. Thus, one finds the terms code-switching and code-mixing, as well as (apparently) more straightforward terms such as borrowing, or loan word. Terminologies always include underlying assumptions about the phenomena thus labeled or described, and our definitions will be no different in this matter. So in our discussion, we shall use the term code switching to include all phenomena, where elements from at least two linguistic systems are used in the same speech situation' (Muller and Ball, 2005: 50).

As the result of these remarks, it is reasonable to use the two terms ‘code switching’ and ‘code mixes’ interchangeably. A distinction is commonly made between ‘alternational’ code switching, which implies alternating languages between utterances or sentences. In addition, ‘insertional’ code switching which refers to the insertion of a word or phrase into an utterance or sentence formed in a particular base or frame language (Matres, 2009: 101). Of course, these are not ‘either /or choices, they are extreme points continuum of possibilities, a very basic, but also very important characteristic of code switching is that it is not random. Just as monolingual speech or writing is rule governed, so is speech or writing that involves more than one language or language variety. There are systematic patterns we can observe; one might say that code switching has its own grammar, and the patterns we observe are constrained by the patterns (Matres, 2009:101).

The first considerable attention has been given in the literature to the distinction between single-word insertions and ‘borrowing’. In the broader context of general linguistics, ‘borrowing’ usually refers to the diachronic process by which languages enhance their vocabulary (or other domains of structure), while ‘code switching’ is reserved for instances of spontaneous language mixing in the conversation of bilinguals. This raises the issue of the precise criteria by which to distinguish established borrowings from spontaneous insertions in the speech of bilinguals. Some studies have relied on frequency measures, but comparability among them is impaired due to the absence of any uniform standard according to which a form’s frequency of occurrence could be assessed (Matres, 2009:106).

A further distinction criterion is the degree of integration of the item. Poplack, Sankoff, and Miller (1988) propose that lexical insertions fall into two groups: those that are structurally integrated from the onset, and those that are not. Structural integration can occur in the speech of bilinguals independently of frequency of use. It is therefore not necessarily the product of a prolonged, diachronic process. Poplack, Sankoff, and Miller (1988) wrap up that borrowing and code switching are separate phenomena from the onset. They introduce the term ‘nonce borrowing’ as ‘a designation for on-the-spot borrowings that are structurally integrated but have not necessarily reached a wide level of propagation within the speech community or even within a corpus’ (Poplack: 1980). As pointed out above, code switching in a text may occur between sentences, or within sentences. One approach to the study of intra-sentential code switching is to distinguish between base languages or matrix language, and embedded language, elements of which are

inserted into the matrix language. In Myers-Scotton's Matrix Language Framework (Myers-Scotton, 1993, 1995), the matrix language provides the grammatical frame, such that in mixed constituents, morpheme order will be that of the matrix language. Further, in mixed sentences, grammatical or systems morphemes are drawn from the matrix language (Matres, 2009:107).

ML: the language, which the speaker is speaking
EL: the language, which the speaker is briefly switched in to

Into this frame, content morphemes (e.g., nouns, verbs, adjectives) from the embedded language are inserted. A constraint in this framework is expressed by the so-called blocking hypothesis: only content morphemes from the embedded language that fulfill three congruence conditions can be embedded into the matrix language. In order to be embeddable, a content morpheme has to have a match in the matrix language that has the same grammatical status, takes or assigns the same thematic roles (or participant roles), and fulfills equivalent discourse and pragmatic functions. In addition, intra-sentential code switching may also involve "islands" from the embedded language, that is, constituents (for example, whole noun phrases, or verb phrases) that are formed from grammatical and content morphemes in the embedded language (Myers-Scotton, 1998:149).

The second, Inter-sentential code switching probably is easily conceptualized in terms of alternation, in a text, a speaker or writer alternates between using syntactically complete structures in two (or more) languages (Miller, 1991: 75). Myers-Scotton's framework rests crucially on the concept of insertion. Other discussions of intra- and inter-sentential code switching are based on the notion of alternation, more properly a switching back and forth between two language systems. She cities from Poplack (1980) and writes that 'sometimes I will start a sentence in Spanish, goes to English, after goes back to Spanish, and may finish in Spanish'.

According to (Poplack: 1980); (Sankoff and Poplack: 1987) code switching is most likely to occur at switch-points of equivalent constituent order, such that the order of the constituents on either side of the switch point must be grammatical according to the rules of both languages that are involved in the switch. In other words, the combination of morphemes and words resulting at the switch point must not violate the grammar of either language. Code switching will be covered from page 42 until 44, with regard of why and when the interlocutors used the concept.

2.1.3.3.1. When and how code switching with in interaction

'Why do we code switch at all?', 'When do we code switch?', and 'Why do we code switch at a particular point in the discourse?' are not questions which get simple answer. But, according to Gardner-Chloros' (1991) survey he concludes that, switching is constrained by the social situation, which is the identity of the interlocutors and the relations between them, the formality of the setting, and the roles that the languages play in the lives of individuals. At the same time it is motivated by a need to negotiate an adequate mode of communication that takes personal preferences and competence, accommodation to notions of the interlocutor's expectations, terminological issues, as well as conversational effects (such as topic change, constellation change, and inclusion or exclusion of interlocutors) into account. Each language may thus represent a whole array of functions and symbolisms at a given moment in conversation. Motivations to choose one language over another are therefore multiple and complex.

On the same side, the reliance on local interpretations of switching is criticized by Myers-Scotton (1993), who suggests instead that speakers' language choices are not random but predictable via a set of indicators that are associated with each of the languages in their repertoire. She proposes a model of markedness, which makes predictions about the choices that are available to speakers in a given interaction (Myers-Scotton, 1998:151).

Here are some reasons for code switching suggested by scholars.

1. In the case of, when the 'right word is missed in the ML

    - perhaps ML (= the local language) lacks a technical term found in EL (e.g. when discussing computers or linguistics, in EL Amharic)
    - the term in the EL may be the standard term in the context (even if ML does have an equivalent word)
    - the EL term may have an especially appropriate nuance or flavor or connotation foreigners in Ethiopia, when speaking English with each other, may add Amharic words or phrases which have special Amharic specific connotations (Amharic = EL) (Matras, 2009: 103).

- The EL term may be essential like a proper name, which has a unique reference such as a proper name. It would be completely strange to say 'Four kilo', 'New York' similarly with terms like "the registration office in Matras's Romany (German examples 'a frequent target for insertions from German language institutional terminology, including names for institutions and institutional procedures. Several of those in segment, for instance, *'Bestattungsinstitut'* 'funeral home', *'Meldeamt'* 'registration office', and *'Sterbeurkunde'* 'death certificate'(Matras, 2009:108).

2. Another example, is English discourse markers (EL) used when speaking Amharic (ML) phrases like 'anyway' 'by the way' 'of course', 'already', 'definitely' some of these have no good Amharic equivalent some of them even though that have not been known by the speaker (Thomson, 2001:148).
3. To make a side-comment about the main story line, story line implies the main line of the discourse, the story that you are narrating. The side-comment is an added comment about the story. When the speaker changes from story-line to side-comment the discourse function of the speech briefly changes radically and this radical change of function can be underlined by a simultaneous change of language (code switching); this is one possible 'special effect' of code-switch (Matras, 2009: 119).
4. Iconic use of code switching refers, if the speaker is bilingual in Amharic and English languages, and if he/she is talking about the use of languages: Amharic and English, then he/she may speak Amharic language when he/she talking about language Amharic, and the same when speak language English about language (Matras, 2009:117).
5. To create more distance or less distance from the hearer or for exclusion and inclusion purpose. *More distance*; when expressing disagreement if the ML is the familiar home language, and instead you briefly switch to a more 'official' language or to the language of wider communication, this can reduce intimacy and create distance example, bilingual English/Cantonese (Chinese) family in Britain (Matras, 2009: 127). *Less distance;* when the ML is the international language: example, English, and then a switch to the local nation language can reinforce intimacy and closeness to the interlocutors (Matras, 2009: 127). In both cases the 'special effect' of code switching is to increase or decrease social distance.
6. To give you an idea about the speakers potential, boast or show off

- As if to say, ‘Look, I can speak your language too’. Myers-Scotton’s example of a university lecturer from the University of Malawi, visiting her mother’s local village meets one man with only a little English, even though both speak the local language, and they speak English (Myers-Scotton, 1995:193).

7. ‘Fused lect’ (mixture by default) For a certain group of people, constant or frequent code-switching may itself be a mark of their identity as belonging to two ‘linguistic worlds’ this may be the normal form of linguistic communication. For this group Matras’s example: American Israelis (much code switching among themselves, English and Hebrew (Matras, 2009:122).
8. Exclusionist (‘secret’) use of language if two speakers are both bilingual in A&B languages may switch from A to B, so that a third person (who is present) will not understand (Matras, 2009:123).

2.1.3.4. Solidarity, status and power in language

The bondage between language and identity is very strong that a single feature of language use is sufficient to identity some one’s memberships in a given group. Languages symbolise identities and are used to signal identities by those who speak them. People can be categorized by other people according to the language they speak. As notes by Keller even a ‘single phonetic feature will be adequate to categorize an individual to a certain group.’ what's more is, other more complex symbolic language like a given name (Amharic name, Oromo name, Tigre name, doctor, teacher, engineer) may fulfill the same function (Keller, 2002: 317). Accordingly, theses points will be seen on page 91-93 of this research in the interactions.

2.1.3.4.1. Solidarity in language

Identity is a ‘heterogeneous’ concept which denote sets or made of many other identities, and at the same time it is endlessly created a new, dependent on a social situation happened on the individual, environmental, historical, institutional, economical, etc. Thus, the individual’s identities will vary on the variable or parameter to determine the identity; therefore, there are different types of identities under the umbrella of individual identity. These are personal identity, ethnic identity, linguistic identity, social identity, psychological identity, national identity. Subsequently Keller

entails that every person exploits different layers of identities forming more or less ‘interracial and encased network, some parts of which are loose and prone to frequent change and replacement, others being more or less permanent throughout the life span and across social and cultural space (Keller, 2000: 316). In this regarded Le Page remarks, that national, ethnic, racial, cultural, religious, age, sex, social-class, caste, educational, economic, geographical and occupational groupings are all predisposed to have linguistic connotation. Even though the degree varies from society to society and the perception of degree of co-occurrence may differ depending on the individual (Le Page, 1995: 248).

Accordingly, this research focuses on grouping, which is implied on medical professional and their patients in medical communication. Each group has its own language or variety of a language, register, and terminologies. As, medical professionals have medical jargon and registers which can show group membership of their own speaking that language variety, jargon gives a sense of belonging to the group. Therefore, in every day communication, person or group uses language for inclusion and exclusion purpose to their individual group or out of their group respectively (Johnstone**,** 2008:129). As mentioned, in code switch, register and terminologies are good indicators of solidarity in interactions.

2.1.3.4.2. Status and power in language

Lindström citing from (Roter: 2000) states that, as in many other social activities, for example, communication in a classroom, business meeting, and so on, the relationship between the participants in a medical consultation is unequal. Due to the doctor’s experience and knowledge, the physician is the one responsible for the interaction, while the patient is a relatively passive participant, whose involvement ranges from simply answering the physician’s questions to actively participating in discussions and decision-making. Although the degree of asymmetry in encounters between a physician and patient varies, it is the physician who has experience, knowledge, and power who must take responsibility in the interaction and come up with explanations of the patient’s problems and possible solutions for them, that gives him more power and status than the patient does. (Lindström, 2008: 17).

At the same time, Marianne et al in the journal of OCSCPM on ‘Gender, power, and non-verbal communication’ citing from (Schmid Mast et al: 2009) note that the ‘clinician and patient

relationship is hierarchical, with the provider having more power,' defined as 'access to scarce resources', than the patient does. In general, doctors have more medical knowledge, thus more clinical competence than patients do. Furthermore, seeking help is fundamentally a position of powerlessness. Discomfort, pain, or anxiety about the diagnosis or treatment might accompany the patient and contribute to his or her loss of power.

Thus, in many cases, in terms of social standing and high income the medical professional has higher status. Obviously, how any clinician behaves towards his or her patient will be varied and these affect outcomes, such as results showed that patients spoke less, provided less medical information, and agreed more when interacting with 'high-dominance' compared to 'low-dominance' providers. The clinician who adopts a dominant style might be having shortcoming since the diagnosis is mainly based on provision of the medical history. Moreover, provider dominance has interrelated with reduced patient satisfaction (Schmid Mast et al, 2009: 6).

2.1.3.5. Social roles and variables in language

The process of interaction makes possible for people to construct and renegotiate their associations with each other constantly. Through discourse moves, participants maintain and signify equality, inequality, solidarity, or detachment. However, there are situations in which social roles are relatively preset, and in which people are expected to use and interpret discourse relatively in advance. A common, usually pre-set pair of discourse roles consists of those 'doctor' and 'patient' (Johnstone, 2008:139). Even though, in some situations, it may be unclear to one or more of the participants what role is being assumed by others, or what roles they should themselves adopt, and a person can be acting in more than one role, each associated with a different voice 'register' or a different 'frame' for understanding. However, sometimes people can go into a situation expecting that they will have to negotiate about social and linguistic roles. Alternatively, it can cause difficulties determining what role they should hold during certain interaction. Therefore, many variables might affect directly or indirectly the social role of interlocutors and the interaction. For example, gender, power, age, educational background, etc.

In addition to the use of language through register, Johnstone (2008) remarks, one of the many ways in which social identities and discourse roles can be indexed is using forms or address. In some situations, address is expected to be reciprocal that is everyone calls everyone else by first name, for

example, ‘by a title and last name combination in western society, or by some other formula. In non-reciprocal situations, one person is expected to employ one form of address and the other person another.’ In English, the choices might include first name, nickname or short form of first name; last name only; title (Dr., Ms., Reverend) plus last name; title only (your Honor, officer); ‘dad, mama, sis, and other terms for family members or quasi-family members; sir or ma’am; numerous forms like, honey, bro, sweetie, old man, mate, and so on’ (Johnstone, 2008:128).

It is also possible to use no term of address at all. Every time a form of address is used, it helps create, change, or reaffirm a social relationship, in addition to indexing a set of conventional expects. Depending on the situation, calling a professor by his or her first name can be either completely expected or remarkably unexpected, as can using the title-plus-last-name formula. Nevertheless, it is expected that choice of address forms are always in some ways a strategic move as well as a response to a situation. In addition, many variables affect the social role of interlocutors, and direct the interaction through, certain path. Such as, gender, power, age, educational background, etc (Johnstone, 2008:129).

2.1.3.5.1. Gender in doctor and patient communication

Matsuka citing Butler (1990) states gender is used to refer to the ‘social or cultural aspect of sex, the biological or physiological distinction between males and females’. However, Butler argues that ‘sex’ and ‘gender’ are not simply physiological differences. According to her, in addition to social labeling, gender is ‘performativity’ (Matsuoka, 2011:3). Implying that, unlike sex, gender refers denoting the attributes culturally ascribed to women and men. As result, gender is a characteristic that is associated with variation in communication style. Research shows that the communication styles of men and women differ. According to Lindström, quoting from Tannen (1999) women in interaction focus on intimacy, which is defined as ‘key in a world of connection where individuals negotiate complex networks of friendship, minimize differences, try to reach consensus, and avoid the appearance of superiority, which would highlight differences’. On the contrary, men tend to focus on independence, in which ‘a primary means of establishing status is to tell others what to do, and taking orders is a marker of low status’ (Lindström, 2008: 19).

Moreover, the interpersonal styles of women disclose more information about themselves in discussion; they have a warmer and more engaged style of nonverbal communication and they

encourage and make easy for others to talk to them more freely and in a warmer and more intimate way. In contrast to men's trend to assert status differences, there is proof that women take greater pains to minimize their own status in an attempt to equalize status with a conversational partner. Women are also more accurate in judging others' feelings expressed through nonverbal cues and in judging others' personality traits (Schmid Mast, 2009:69).

There is also practical evidence that women smile much more than men smile and disclose more information about them in dialogue. They also encourage, and facilitate others to talk to them more freely and in a warmer and more intimate way than men. Within society, women behave less dominantly and are less likely to embrace hierarchies, be competitive, take on leadership positions, or emerge as group leaders than men. Although the sexes do not differ in how successfully they lead teams, their leadership style is different; women are more democratic or participative, while men are rather autocratic and directive as leaders. In general, women apply influence more gently, whereas men tend to be forceful and explicit (Schmid Mast, 2009:69). Consequently, this point will be considered on the texts 4 and 5 of this research on page 54-75.

2.1.3.5.1.1. Male and female medical professionals in medical communication

Lindström citing from Roter and Hall (2004) remarks, male and female physicians have different styles of communicating with their patients. They found that female physicians conduct longer consultations than male physicians do, which clearly show their tendency to create friendly atmosphere than male physicians. In addition, consultations with female physicians include more positive talk, psychosocial counseling, psychosocial question asking, emotionally focused talk and emphatic communication than consultations with male physicians (Bylund and Makoul, 2002; Roter and Hall, 2004). An exception is obstetrics and gynecology, where male physicians are reported to provide more emotional talk than female physicians are (Bylund and Makoul, 2002); (Lindström, 2008: 19).

In addition, citing Meeuwesen et al. (1991) Lindström comments that, female physicians providing more feedback, smiles and nods than their male colleagues do in non-verbal behavior. Conversely, male physicians tend to be 'more imposing and presumptuous' meaning giving more advice and paraphrases and more verbally dominant while female physicians are more attentive and non-

directive meaning they are more subjective and objective information and acknowledgments (Lindström, 2008: 19).

2.1.3.5.1.2. Male and female patients in medical communication

Lindström comment that, as observed by Roter and Hall (2004), female patients show more participation in interactions with physicians in general. Particularly, in female-female consultations; patients are more inclined to seek a partnership relationship with female than male physicians do. However, no difference has been found in the number of questions asked by the patients during consultation with female versus male physicians (Lindström, 2008: 19). Additionally, Govender citing (Elderkin-Thompson and Waitzkin, 1999; Caljouw et al., 2008) remark that women patients are more tending to seek interpersonal relations and have emotional reactions to events, while men are more likely to give objective reports of events. This is reflected in female patients' are being more inclined to simply discussion, their problems with physicians rather than presenting the problems for physicians to solve. Females are also more critical of the care provided and tend to change physicians due to communication problems more often than male patients. As result, female patients get more time from their physicians and more explanations rephrased from medical terminology in lay terms than male (Govender, 2007: 10).

2.1.3.5.2. Age in medical communication

Aging is central to human experience. It is the achievement of physical and social capacities and skills, a continual unfolding of the individual's participation in the world, construction of personal history, and movement through the history of the community and of society. If aging is movement through time, age is a person's place at a given time in relation to the social order: a stage, a condition, a place in history. Age stratification of linguistic variables, then, can reflect change in the speech of the community as it moves through time (historical change), and change in the speech of the individual as he or she moves through life.

Robinson et al citing Halter (1999) and Ostuni E (1994) state, the communication process in general is complex and can be further complicated by age. One of the biggest problems physicians face when dealing with older patients is that they are actually more heterogeneous than younger people

are. Their wide range of life experiences and cultural backgrounds often influence their ‘perception of illness, willingness to adhere to medical regimens and ability to communicate effectively with health care providers.’ Communication can also be hindered by the normal aging process, which may involve sensory loss, decline in memory, slower processing of information, lessening of power and influence over their own lives, retirement from work, and separation from family and friends. At a time when older patients have the greatest need to communicate with their physicians, life and physiologic changes make it the most difficult (Robinson et al, 2006:2). Moreover, Ecker (1998:105) citing Guttmann (1975) states that “there is a universal cross-section between gender and age, claiming that while women become more autonomous, competitive, aggressive, and instrumental with aging, men become more dependent, passive, and expressive”. Therefore, this factor will be considered on text 1 and 2 on page 44 untill 54.

2.1.4. The pragmatic aspect of communication

Early scholars such as Morris, Carnap, and Peirce, initiated pragmatics as a field of linguistic inquiry, in the 1930s for syntax, which addresses the formal relations of signs to one another; semantics is the relation of signs and what they denote, and pragmatics is the relation of signs to their users and interpreters (Morris, 1938: 6). Then, the landmark event in the development of a systematic framework for pragmatics was the delivery of Grice’s (1967). Followed by Bar-Hillel (1971: 405) warns that ‘Be careful with forcing bits and pieces you find in the pragmatic wastebasket into your favorite syntactico-semantic theory’ and follows Bates (1976) who defines pragmatics as refers to the study of the use of language in context, by real speakers and hearers in real situations (Horn, 2006: Xi).

Despite these efforts, there is no single accepted definition of pragmatics but there are three major aspects of pragmatics development. The first of these is the development of communicative functions, the way the child comes to be able to express a range of intentions, such as requesting, greeting, and giving information, through a variety of communicative behaviors, such as gesture, vocalization, and language. The second aspect is that of the child’s response to communication, the way the child reacts to and understands communication from other people. The third aspect is the way the child participates in interaction and conversation, looking at the child as a participant in social interactions involving initiation, turn taking, and repair (Dewart and Summers, 1995: 5).

Generally, pragmatics refers to the social language skills we use in our daily interactions with others. Pragmatic language includes the appropriate content of our words, how we say them, and our use of body language. Pragmatic skills are vital for communicating our personal thoughts, ideas and feelings. Children, adolescents and adults with poor pragmatic skills often misinterpret another person's communicative intent and have either difficulty responding appropriately verbally or non-verbally (Laurencer, 1999: I).Therefore, the term pragmatics covers the study of language use, and in particular the study of linguistic communication in relation to language structure and context of utterance. For instance, pragmatics must identify central uses of language, it must specify the conditions for linguistic expressions (words, phrases, sentences, discourse) to be used in those ways, and it must seek to uncover general principles of language use. In the 1970s, linguists such as Ross (1970) and Lakoff (1970) attempted to incorporate much of the work on performatives, felicity conditions, and presupposition into the framework of Generative Semantics (Newmeyer: 1980, Harris: 1993). With the breakdown of Generative Semantics, pragmatics was left without a unifying linguistic theory. In what follows we will focus on the central use of language: communication. We will see what problems it poses to pragmatics and what structure it has. Finally, we will turn to some special topics in pragmatics (Akmajian, 2001:362).

Therefore, linguistic skills alone are not enough for successful communication. In communicative situations, listeners need to work out the meaning of a linguistic expression based on the contextual factors of the situation and because of their world knowledge and experiences. That is why pragmatic comprehension considered as an ability to utilize context in comprehension. Thus, communicating successfully calls for the ability to go beyond the information given linguistically (Loukusa, 2007: 21).

2.1.4.1. Speech act theory

In place of the initial distinction between 'constatives and performatives', Austin replaced a three-way contrast among the kinds of acts that are performed when language used. Namely locutionary, illocutionary, and perlocutionary acts that show the distinctions between all of which are characteristic of most utterances, including standard examples of both performatives and constatives (Sadock, 2006:54).

As Austin puts it, *locutionary acts are* the acts of speaking. Acts involved in the construction of speech, such as uttering certain sounds or making certain marks, using particular words and using them in conformity with the grammatical rules of a particular language and with certain senses and certain references as determined by the rules of the language from which they are drawn. *Illocutionary acts* are acts done in speaking (hence illocutionary), including and especially that sort of act that is the apparent purpose for using a performative sentence. They are Austin's central innovation. Austin called attention to the fact that acts of stating or asserting, which are presumably illocutionary acts, are characteristic of the use of canonical constatives, and such sentences are, by assumption, not performatives. The conclusion was drawn that the locutionary aspect of speaking is what we attend to most in the case of constatives, while in the case of the standard examples of performative sentences; we attend as much as possible to the illocution (Sadock, 2006:53).

Perlocutionary act which is a consequence or by-product of speaking, whether intended or not, as the name demonstrates to suggest, perlocutions are acts performed by speaking. According to Austin, perlocutionary acts consist in the production of effects upon the thoughts, feelings, or actions of the addressee(s), speaker, or other parties. Austin (1962: 101) illustrates the distinction between these kinds of acts with the (now politically incorrect) example of saying "Shoot her!" which he forms three parts as follows:

Act (A) or Locution
He said to me "Shoot her!" meaning by shoot "shoot" and referring by her to "her."
Act (B) or Illocution
He urged (or advised, ordered, etc.) me to shoot her.
Act (C) or Perlocution
He persuaded me to shoot her.
Locution: "Don't move or I'll shoot you!"
Illocution: threatens the addressee;
Perlocution: induces the addressee to stand still.
Locution: "I didn't break the vase!"
Illocution: protests her innocence;
Perlocution: convinces the addressee of her innocence (Sadock, 2006:53).

However, it is crucial under Austin's system that we able to distinguish between the three categories; it is often difficult in practice to draw the requisite lines. Especially the problems of separating illocutions and locutions frustrating, on the one hand, and illocutions and perlocutions on the other, the latter being the most troublesome problem according to Austin himself. Austin's main suggestion for discriminating between an illocution and a perlocution was that the former is 'Conventional', in the sense that at least it could be made explicit by the performative formula; but the latter could not' (Austin, 1962: 103). This, however, is more a characterization of possible illocutionary act than a practicable test for the illocution of a particular sentence or an utterance of it (Sadock, 2006:54). As a result, this theory will be seen on text 9 and 10 on page 80-90.

2.1.4.2. The maxims

Kecskes, (2006: 106) citing from (Grice: 1961, 1989: 368–372) states cooperation is the ruling element of verbal communicative interaction. In his paper, Grice argued that utterances automatically create expectations that guide the hearer toward the speaker's meaning. He considered communication both rational and cooperative, and claimed that the inferential intention-recognition is governed by a cooperative principle and maxims of quality, quantity, relation, communicative principles and manner, which speakers are, expected to observe. The interpretation that a hearer should choose is the one that best satisfies his/her expectations. Moreover, this perspective is called inferential communication.

Since then, Grice's inferential approach to communication has been so fundamental that all subsequent pragmatic theories have been influenced by it. Researchers have accepted and relied on the inferential nature of communication, but some have questioned the cooperative principle and maxims as the governing communicative principle of communication. Several critics of the Gricean view such as Keenan (1979 and Thomas (1995) expressed their skepticism about the universality of maxims, arguing that different cultures have different principles or maxims. According to (Gumperz: 1978), culturally colored interactional styles create culturally determined expectations and interpretive strategies and can lead to breakdowns in intercultural and interethnic communication. Others, such as (Sperber and Wilson, 1995), argued that cooperation is not essential to communication and suggested a reduction of Grice's maxims to a single principle of relevance. According to this view, a rational speaker will choose an utterance that will provide the

hearer with a maximum number of contextual implications in a minimum processing effort (Kecskes: 2006:107). Maxims will be seen on this paper on text 9 and 10 on page 83-91.

Despite these arguments, Adrian and his colleagues remark that according to Grice, 'conversation is cooperation', participants may be expected to comply with general principles of cooperation, such as to make the appropriate contribution to the conversation. 'To make your conversational contribution as required, at the stage at which it occurs, by the accepted purpose or direction of the talk exchange in which you are engaged'. It should be noted that the four principles do not apply exclusively to language, but to action in general (Adrian et al: 2001:399).

1. The maxim of quantity, which refers to a contribution quantitatively adequate, for instance, if I am making mayonnaise and I ask you to add two egg yolks, I expect you to add two, not one or four. Make your contribution as informative as is required (for the current purposes of the exchange) and do not make your contribution more informative than is required.
2. The maxim of quality implies an authentic contribution. For example, if you offer me a glass of what we take to be cognac, I expect the glass to contain cognac, and not colored water, or even brandy. So, try to make your contribution true. The quality maxim may be specified further into, do not say what you believe to be false and do not say that for which you lack adequate evidence.
3. The maxim of relation that shows a contribution appropriate to the stage the exchange has reached. For instance, if we are at dinner, I do not expect to start with apple pie, which will be acceptable later on, when we get to the dessert (be relevant).
4. The maxim of manner refers truthfulness, informativeness, relevance, and clarity, to do so rapidly and in an orderly manner. For example, if we are working together on assembling the video recorder, then I must know what you will be doing, and I expect you to carry it out in a reasonable time and without any incongruities (Greenall, 2006: 569).

2.1.5. The paralinguistic features of language

Paralinguistic descriptions of the source's presumed emotional state or of his or her manner of speaking may also have an impact on the hearer's evaluation of the source and the reliability of the reported proposition(s). Body language can reveal a lot about the way a person is feeling, when giving information to another person, his facial expression will show if he is happy or not with what

you are saying or doing. As speech, plays such an important role in interpersonal relationships, its production is often modified by paralinguistic features express the attitude of the speaker toward the listener and/or toward what is being said. Whereas it seems plausible that basic human emotions such as fear, anger, or timidity are expressed similarly in all languages, it seems probable that attitudes that are more culturally conditioned are more likely to be variable in their expression across languages (Kecskes, 2006:107).

2.1.5.1. Paralinguistic features in interactions

It is claimed that 80% of communication between individuals is non-verbal; other studies have linked body language with satisfaction but practically of 'desirable' body language remain problematic probably because it is so context-dependent and individually specific. Comparatively, few studies are conducted on relationships of body language and its outcome, but many studies are conducted on body languages linked with relationship and satisfaction (Pawlikowska, 2011: 75). Information is conveyed as words, tone of voice, and body language. Studies have shown that of the information communicated, 7% is in words, 38% in vocal tones that include verbal intonation, paralinguistic, and 55% of it is in body language; verbal communication consists of all the messages other than words that are used in communication (Collins, 2009:66).

There are five types of non-verbal communications: i) *appearance*, when you are speaking to one-person face-to-face, personal appearance and appearance of your surrounding convey non-verbal messages. When we say personal appearance, we are talking about clothing, hairstyle, neatness, and jewelry, cosmetics, and body size. Appearance of surrounding implies room size, location, furnishings, machine, architecture, wall decoration, lighting, and the other related features where people communicate. ii) *Facial expression*, a facial expression results from one or more motions or positions of the muscles of the face. Seven universally recognized emotions shown through facial expressions: fear, anger, surprise, contempt, disgust, happiness, and sadness. iii) *Eye contact*, but here are cultural differences, eye cues, communicating attention, facilitating learning, duration, shyness should be considered. In most formal conversation, maintaining eye contact from 70% to 80% of the time plays important role. Make everyone feel included and important. Look at the person you are speaking to you. If you are addressing a small or large group, break the room in to three parts. Focus on one individual, make a point, shift your gaze to another part of the room, make a point, and do the same for the other of the room. Not giving eye contact: if you are in the same

room as someone else and do not have eye contact with the person you are speaking to, then you have not engaged with that person. For instance, giving eye contact in English culture is 'look at me when I am speaking to you' and therefore not giving someone eye contact can be interpreted as either you are not talking to the person, or you have no respect for the person. When listening we need to:

- see the person's eyebrows move
- see the person's mouth and watch it move (Collins, 2009: 67).

iv) *body language*, posture, gestures and body movements convey message and add to or subtract your oral message. Gesture implies a body gesture or movement made with a limb, especially the hands, to express, confirm, emphasize or back up the speaker's attitude or intention. Posture refers the bearing or the position of the speaker's body. When the speaker is slouched or erect, his or her legs crossed or arms folded, such postures convey a degree of formality or relaxation. According to Suzan Collins on 'Effective Communication', it is necessary to beware of cultural differences. In Japan, a smile can mean one is embarrassed. Additionally, female staff dressed inappropriately; for example, wearing tight blouses or tops, showing cleavage, wearing tight short skirts showing shape of thighs, or revealing their thighs: staff should not be wearing this to work, but if one did, it could be interpreted as provocative and teasing. On the other hand, male staff dressed inappropriately: for instance, wearing tight or short shorts or not wearing a shirt could be interpreted as provocative and teasing. In addition, standing with hands on hips, with shoulders back can be interpreted as you being unhappy or angry. Pointing: this can mean two things. Pointing to an object can mean you are hoping that the individual will follow your finger and look; in contrary, pointing a finger at a person can mean that you are angry and having a go at that person or telling him off. Nodding can mean the person is saying 'Yes'; however, it means the opposite in Syria. Starring: directly staring at the individual, without blinking, can be interpreted as you being upset, angry or annoyed at him (Collins: 2009:66, 67).

iv) Voice pitch refers how thick and how thin your voice is. Rate, for example, is the number of words you speak in one minute. Volume is how loud and quiet you speak. Tone is the intonation of where you rise and where you drop your voice. Vocal quality implies the natural quality of the voice one has. English speakers who are being particularly polite to the interlocutor often speak

higher in their voice range, relatively softly, and with a 'breathy' voice, whereas those who are being aggressive typically speak lower in their pitch range, more loudly, and with a 'harsher' voice quality. Speakers who are being sympathetic or kind speak low in their voice range, slowly, and typically with a 'creaky' voice (Collins, 2009:68).

Most non-verbal communication does not have such complex properties and, indeed, there is often ambiguity about how non-verbal cues should be interpreted. Examples of non-verbal behaviors include facial expressions conveying emotions, eye gaze, gestures, posture, touching, tone of voice and speech modulation and duration. In medical interaction, the clinician's non-verbal behavior can definitely have an impact on patients. Thus, the distancing behavior of physical therapists, such as absence of smiling and looking away from the patient, related to decreases in patients' physical and cognitive functioning. Moreover, non-verbal behavior can help to make possible more diagnosis that is accurate (Schmid Mast, 2009: 63).

The last points in non-verbal communications are time, space, silence, smell and touch. For example, being late is a sign of disrespect in many cultures (especially in western), thus be in time or on time. At the same time, being silent during interaction may carry negative, positive, or neutral response depending on cultural differences. Smell, fragrance, air freshener and body perfume carry various messages. Moreover, touch also carry massages that imply kindness, sympathy, motivation and other meaning depending on the culture verities (Collins, 2009:68).

Space also depends on cultural perspective and personal preferences, which determine how, close the other interlocutor to be when communicating with him, this is his personal space. It is important that the other (Interlocutor) know the distance the individual prefers. Get it wrong and it can stop the person communicating; it can cause distress, discomfort and (for some people) fear if their personal space is invaded. Space between people can differ and this will depend on the relationships we have. Most relationships involve what we call social space, which can be between four and nine feet (1.2–2.7 meters) and personal space between friends can be 18 inches to four feet (0.45–1.2 meters).

Personal space is very important and if you are too close to an individual, he could feel intimidated.

- Intimate distance: 6–24 inches (15–60 cm) is acceptable in close relationships.
- Personal distance: 2–4 feet (0.60–1.2 meters) is acceptable at social gatherings.

- Social distance: 4–12 feet (1.2–3.66 meters) is used when we are speaking to people we do not know.
- Public distance: over 12 feet (3.66 meters) is acceptable when addressing a large group (Collins, 2009:67).

Because the paralinguistic features are not simple ideas, which will be explained in word, this research implemented table 2 to signify how the interlocutors implemented these features. Therefore, symbols from table 2, page 41 are putdown in the interactions.

CHAPTER THREE

3.1. The Research methodology

The choice of appropriate research methods depends on the nature of the problem and types of data. For this research, primary data was used to evaluate and address the problems under investigation. Moreover, since society is dynamic the study employed a cross sectional design, which produced findings that can represent the present situation only. Data were collected through three major tools: questionnaire, both for patients and medical professionals, interviews with the medical director of the health center and direct observations during doctor and patient interaction. The study utilizes qualitative approach for the observation and quantitative for the questionnaire. A balanced strategic employment of these research methods is expected to generate findings with high reliability and validity.

3.1.1. Study area

Kotebe Health Center is one of the oldest and fourth health centers under the Yeka Subcity's health office, which is found in the northern part of Addis Ababa, Yeka Subcity, Kebele 19, Lokai-woreda 16, which provide of primary health care for the public who live in the kebele. According to the health office, it is one of the best health care providers for the majority of the Subcity's population. It was established under the vision of developing a model health center, which can provide an excellent health service. Its mission is to develop collaboration between the Kotebe's general communities and the stakeholders in providing good disease prevention, result oriented quality health service, and produce healthy productive generation.

As stated by the Yeka Sub-city office, the health center has to provide health services for about 115,081 people per year for those people, who live under five woredas with its twenty-five departments[1]. To provide the services to those people, the health center has eighty staff members of whom are sixty-three health professionals and seventeen non-medical supporting staffs.

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1. Outpatients department, 24 hours emergency room, laboratory room, pharmacy, in-patients (till referral), injection room, pre-antenatal care, family planning, delivery room, post-antenatal care, mothers and child care, pediatric ward, health education, tuberculoses and leprosy department, sexually transmitted diseases prevention department, voluntary counseling and testing (VCT), HIV treatment and follow-up, psychiatric ward, etc.

3.1.2. Study population

According to the medical director of the health center, the center has sixty-three medical professionals, consisting of two medical doctors, five health officers, eleven nurses (with first degree in nursing), twenty-four nurses (who have diploma in nursing), four midwife nurses, a health assistance, seven medical laboratory technicians and nine pharmacists and druggists. Nevertheless, because of large size of the study population the research will focus only on the medical professionals who work at the outpatients' department[2].

The other group is the patients who come to the medical outpatient department[3] (OPD). These are group of patients, who come to the health center for treatment because of one physical problem. These groups of patients are different from the rest of the patients, because unlike the pregnant women seen in ANT, infants and children for vaccine, and HIV and Tuberculoses patients, who has to come frequently, treated as follow-up. These groups come for medical care and might not return to the health center so treated in outpatient department.

3.1.3. Sample size

Medical interaction contains two groups of interlocutors that have two different roles. Those are doctor or medical professional and patient. The sample of this research includes both parties, particularly medical professionals who worked in the outpatient department (OPD) and their patients who came to the health centers from December 1 until January 20, 2012. Out of forty-two medical professionals who work in the health center, thirty of them, which is two doctors, five health officers and twenty-three nurses, are working in the outpatient department and were taken into the research sample.

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2. The total population of patients that get service in the health center is 165,081 per year. Out of these, the number of patients in OPD is 700 per month.
3. According to National Services of Scotland, *outpatient department* is a hospital department, which is primarily designed to enable consultants and members of their teams to see outpatients at consultant clinics. It consists of one or more consulting rooms and associated support accommodation, example, nurses' station, treatment rooms, waiting areas. An outpatient is a patient who is not hospitalized for 24 hours or more but who visits a hospital, clinic, or associated facility for diagnosis or treatment.

However, the medical laboratory technicians, pharmacists and the remaining nurses who work as consultant and in other departments such as in the antenatal care, etc. are excluded. On the other hand, the patients' population is heterogenic and enormous. As the medical director stated during interview the OPD observes seven-hundred patients every month. As result, random data collection technique is implemented to validate the sample size of the patients. Then, out of seven hundred patients, two hundred ten patients, i.e. almost one third of the total population, were included.

3.1.4. Data collection

The data collection technique involves an interview with the medical director, questionnaires to health professionals and their patients, and observation.

3.1.4.1. Interview

It is a structured interview and contains open-ended questions for the medical director. The questions are planned and helped to determine the statistical data of patients and the medical professionals and the amounts of observations that can be recorded using voice recorder.

3.1.4.2. Questionnaire

The study used questionnaires, which hold questions of twenty-eight and twenty-seven for medical professionals and their patients, respectively. Two kinds of questionnaires were prepared in English for thirty medical professionals and in Amharic for two hundred ten patients. The first questionnaire was distributed to the thirty medical professionals that worked in the OPD and the second questionnaire was distributed for two hundred and ten patients by using a random selection technique. The contents of the questions were multiple-choice types and open-ended questions that could give the opportunity for the participants expressing their perception and ideas freely. Except that the medical professionals' were prepared in English, the language usage is more professional. However, the patient's questionnaire used simple Amharic words. The questions for both groups were almost the same. The two questionnaires were prepared, organized, and distributed during observation period. The data found through the questionnaires were analyzed by using software called SPSS version 15.

3.1.4.3. Observation

The total number of the subjects, who were observed for the study, is thirty: two doctors, five health officers and twenty-three nurses that help the doctors and the health officers to write prescriptions and do other medical activities in the outpatient department. One hundred fifteen interactions were observed and recorded. Out of the 115 patients and doctors, communications ten were selected and analyzed by using microanalysis method, which is a kind of analysis of medical discourse. The observation took place in real situations when the patients came to see their medical professionals successively for about two months. The researcher personally observed the doctor and patients communications every two days. This research also employed voice recorder to capture some features of the dialogue between medical professionals and patients by selecting an average of 15 interactions of each medical professional 16, which give 115 dialogues. Then, the recorded Amharic data were written and translated to English.

3.5. Data analysis

The data gathered via the three techniques: interview, questionnaires and observation, have very important input for the findings of the research. First, the input of the interview provided information to determine the number of the medical professionals and patients, which are participated in the research. Second, the quantitative data found from the questionnaires was analyzed by means of a computer program called SPSS. Third, the data found from the observations were analyzed by using a technique called the microanalysis of medical discourse, initiated within anthropology and sociology. The technique organizes fundamentally ethnographic and interpretive methodology to disclose the background orientations, individual experiences, sensibilities, understandings, and objectives that are seen in the medical visit. In this regard, Heritage and Maynard commented, “it is the context of history taking; the basic mechanism of this suppression is the simple three-part sequence of actions through which history taking is repeatedly transacted as follow:

Doctor: Symptom question
Patient: Response
Doctor: Evaluation or acknowledgment, etc (Heritage and Maynard, 2006: 6).

CHAPTER FOUR

4.0. Analysis of the data

As it is stated in the objective part, the focus of this research is the sociolinguistic and pragmatic aspects of medical professionals and patient communication. These include collecting Amharic cultural medical terminologies used by patients and doctors, terms that are used to signify doctors and patients status and solidarity and to show when the doctor and the patient code switch during interaction. In the pragmatic analysis, the special attention paid to participants, their shared knowledge, what they have implied through words, which is not overtly stated (Adegbija: 1995). In addition, violations of maxims and the speech act theories are also get consideration.

To explain these points, the analysis implemented two major methods that are the observation and questionnaires. The observation contains twelve interactions between different patients and doctors. The interactions are recorded and written down in three lines that is the Amharic version, the transcription and the translation version of English. Additionally, two types of questionnaires were prepared in English for 30 medical professionals, 210 for patients in Amharic then distributed through different techniques to find quantitative and qualitative data.

4.1. Analysis of interactions based on observation

The first point noticed in this research is the amount of time given to a single patient. As time and space is ‘everything’ in communication. Despite this fact, the doctors usually limit themselves to a few technical questions, give little attention, and time to understanding the disease. Even with this fact, the length of time they give for interaction is often short in terms of patients being able to explain their problems. In some instances, this may be appropriate since physicians find it convenient to do so in a system that requires briefness with little or no attention to personal interaction (Danial et al, 2009: 4).

According to Danial Zewdneh et al. (2009), citing Colman (2007), affirm that countries all over the world are seriously assessing how their doctors communicate with patients. This goes beyond the ability to diagnose and treat health problems and addresses a sympathetic and a more

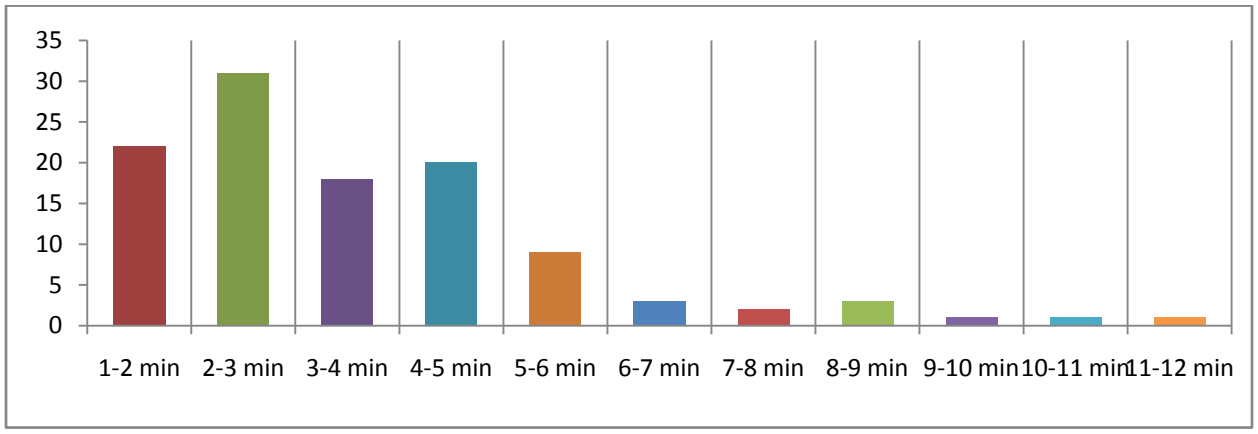
personal communication to which no educational system has given a solution yet (Danial Zewdneh et al, 2009: 5). It is apparent that giving the necessary time for a patient is important but doctors get this fact impracticable. The reason is that always the doctors have too little time in the face of too much workload, which is the case mainly in Ethiopian context. Moreover, according to the researcher's observation the compound of *Kotebe Health Center* have several problems to produce quality interaction between patients and doctors. This situation attributes to some reasons including the noise pollution due to the construction process within the health center, and other medical professional interrupted the conversations while medical professional and patients are interaction in the examination room.

Therefore, total of hundred fifteen interactions are examined through observation within a total of seven hour and twenty-six minute. This implies that, from the total 115 observations, 4 interactions that is (3.5%) last in the time interval of 0-1minutes of duration. The other 22 interactions that is (19.1%) ended in the time interval of 1-2 minutes. 31interaction that is (27.0%) last into 2-3 minutes. 18 interactions that is (15.7%) is in interval of 3-4 minutes, 20 that is (17.4%) fell into 4-5 minutes and 9 that is (7.8%) in interval of 5-6 minutes. However, the remaining time within 7-12 minutes, which holds total of 10%. That is 3 minutes which is (2.6%) fell into 6-7 minutes 2 minutes which is (1.7%) fell into7-8minutes 3 which is (2.6%) in interval of 8-9minutes. The remaining three which hold (0.9%) each in interval of 9-10, 10-11, 11-12 minutes intervals. As we seen below, in table-1, doctors do not spend much time to discuss problems of the patients' rather undertake a simple medical investigation. As we can see the descriptive statistics of this data, the minimum range of one patients' examination time is 0.22 sec and maximum time is 11 minutes and 26 seconds. That gives a median of 6 minutes and 14 seconds with the mode of 2-3 minutes, out of 7 hours and 26 minute of a total data with 115 frequencies, which gives 4 minutes 30 seconds. These findings signify that ninety percents of the medical communications between the patients and medical professionals ends within one to six minutes

Time of interval (in seconds)	Frequency	Relative frequency
0-1	**4**	**0.035**
1-2	**22**	**0. 191**
2-3	**31**	**0.270**

3-4	**18**	**0.157**
4-5	**20**	**0.174**
5-6	**9**	**0.078**
6-7	**3**	**0.026**
7-8	**2**	**0.017**
8-9	**3**	**0.026**
9-10	**1**	**0.009**
10-11	**1**	**0.009**
11-12	**1**	**0.009**
	15	**1.000**

Table-1 the time interval and frequency of patient's interaction with the doctor in examination room



Graph-1-Frequency chart of physician-patient interaction time: Kotebe Health center (OPD)

After seeing the average time given for single patient, the next observation of the research will be the qualitative analysis of the sociolinguistic, pragmatic and paralinguistic aspects of the communication. It is necessary to present and observe the full communication to provide the whole representation. Subsequently, 12 texts or interactions are selected out of 115 interactions. Above every interaction of texts, there is a short description of the participant's description of age, gender and years of experience. Amharic is working language of the interlocutors and below each text, brief comments are recommended by the researcher to analyze the sociolinguistic and the pragmatic aspects of the communication. In addition, to signify the implication of the

sentence in the communication, the analysis contains signs that are indicated on table 2 to show the paralinguistic features of the communication. To avoid repetition the number of the examples and the number of lines are used in the explanation part rather than writing them on the analysis. Besides that, to keep patients and doctors' confidentiality, the term 'doctor' is used for the two doctors, five health officers. Names of patients and doctors also left out. The interactions are analyzed using microanalysis of medical discourse technique, which are used ethnographic and interpretive methodology to disclose the background orientations, individual experiences, sensibilities, understandings, and objectives that inhabit the medical visit.

Transcription symbols	**Paralinguistic features**
= =	laughs
(+)	Pause of up to one seconds in the middle of speech
(4)	Low pitch (murmuring)
(3)	Pause of more than seconds in the middle of speech
... /.....\\ ...	Simultaneous speech
- - -	Incomplete or cut-off utterance

Tabel-2 signs used to show paralinguistic features in the 12 texts analyzed, these signs are adapted from George Major, Janet Holmes. On paper, how do nurses describe health care procedures? 'Analyzing nurse and patient interaction in a hospital Ward on Australian journal of advanced nursing, volume, 25, Number 4'.

4.1.1. Terminologies in the medical interactions

This research, under medical terminologies clarified, medical terminologies are very important to simplify the communication and at the same time are the cause for misunderstanding. Moreover, as (Černý, 2008:41) it is summarized the point, the mostly used terminologies or medical jargons can be grouped under five categories; these are symptoms, methods of examination, surgical interventions, medical specialties and hospital departments.

Accordingly, here are some of the medical terminologies that are used by the patients and doctors: and classified in to five groups those are name of medications, name of diseases, or

Name of medications	Name of diseases	Name of procedures	Name of depart,
Psychotropic	*Asthma,*	*Ultrasound*	*Hospital*
Cimitedine	*HIV*	*Colonoscopy*	*Pharmacy*
Cagamaite	*TB*	*Operation*	*Sick leave*
Syrup	*Blood group*	*Ultra sound*	
Omprazol	*CD4*	*Refer*	
	Negative	*X-ray, Stereoscope*	

medical tests in laboratory such as CD4 and blood group and contribute medical help for the doctors significantly. Name of procedures also hold the name the instruments. The last groups are Name of the departments and Name of conditions that are not necessarily medical terminology but used mostly in medical communication such as sick leave.

As the following twelve interactions, show both the doctors and the patients implement the terms now and then during interaction. Because the terms do not have equivalent, words in the langue-franca that is Amharic.

4.1.2. Code switching and code mixing in the medical interactions

Considering that, people have many reasons to code switch during interaction, one can conclude that this points also applied in medical interactions. As seen the following examples, during most of the communication the interlocutors use Amharic as langue-franca and code switched to English. Though insertion or alteration, with some exception of using Orommifa language that is five out of one hundred fifteen interactions. During the Orommifa interactions though, the interlocutors code switch to Amharic especially aleterational code switching.

Here are some examples of *insertional code switching*, the first, which have no equivalent word in Amharic or lack a technical term used to show or explain the situations. As stated by (Matras, 2009: 103) since the interaction is some home a professional discussion between the medical professional and patient (nonprofessional) the topic forced both the interlocutor to insert medical terminologies to their discussion.

Doctor: - - -CD4 □□□ □□□ □□□
Doctor: HIV □□□□□□ □□□□□?
Doctor: - - - **Psychotropic** - - -
Patient: □□ **Cimitedine, Cagamaite** □□□□□□□□□□□□□□□ □□ □□□□□□

Patient: □□ **Nerve** □□□ □□□□- - -
Patient: Copy Machine □□ □□ □□□□□::

The second, reason of the insertional code switching during medical communication is as the term in the EL (English) may be the standard term in the context even though the ML (Amharic) has a word for it. Such as

Patient: - - - □□□ □□□□□□□□ - - -**Blood group** □□□□□ □□ □□	'däm-mïrmärra'
Doctor:- - -□□□ **Pharmacy** □□□□□	'mädhanit bett'
Patient: - - -□□ (3) **laboratory** □□□ □□□□□ □□□ □□□ □□?	'labratori kïfill'

The third reason for insertional code switching during conversation between doctor and patients is 'Fused lect' (mixture by default) for a certain group of people, constant or frequent code-switching may itself be a mark of their identity as belonging to two 'linguistic worlds' this may be the normal form of linguistic communication (Matras, 2009:122). Moreover, as the following examples show patients and doctors code switch without any selection of the word in English or Amharic. Even though, the term they use has equivalent term in Amharic.

Patient: □□□ **apparent** □□□□ □□□- - - ?
malät u'p-arunt mïnamn yähonu
Maybe they are apprentices
Patient: □□ □□ □□□ □□□□□ **negative** □□ □□ □□□ □□□□□- - -
ay zïm bïläw mäğğämäreya ne-gu-tiv bïčča bïla näbär yäsätt'äččïññ
I mean first they give me the result by writing only negative, then I argued with them so she Add (write). .
Patient: □□ □**micro** (3)□□□ □□□□ □□□□□□ □□□□□ □□□□- - -
ïnna bä-mi-kïrow dïgami ïyïïññ ïndäzihïma ayhonïm alïkowatt
Then, I told her to see it again - - on micro

As the insertional code switching interlocutors, have many reasons to implements the alterational code switching too. Here are some examples that explain why interlocutors use alterational codes switching. Unlike, in insertional code switching, the medical professionals commonly implement this type of code switching, especially when the language switching is from Amharic to English or vice versa. The first reason is to show solidarity or group memberships by exclusionist ('secret') use of language if two speakers are both bilingual here the medical professionals are Amharic and English languages speakers and switch from Amharic to English. So that a third person (who is present) will not understand them and even, talk him (Matras, 2009:123).

Doctor one: □ □□ **stereoscope** - -- □□□ □□□ □□
yä –ïne 'ste-ree-u,skowop nägär yäläm yänne
Do you see my stereoscope here?
Doctor two: - - -**'it is deaf and blind'** □□□ □□□ □□□ and = =

it is def ‘and blind---mïnm nägär yäläm
‘it is deaf and blind’ it does not work

Moreover, as the following example shows the interlocutors’ especially medical professionals, code switch mixture by default constant or frequent code switching between two medical professionals (Matras, 2009:122). Here are example between doctor and nurse,

Doctor: - - - □□□□□ □□□□□□□ □□□□□
lä čč'ägurawo ïndayïkäbd ayfäčč'’ïm. Then continue to interact with the nurse for your stomach, it will not digest easily
Doctor - - - **thirty tab oprazole** - - -

Last but not least, is Alterational code switching to demonstrate less distance and more distance between the interlocuters. According to Matras, when expressing disagreement or in this context to show friendly atmosphere, if the ML (Amharic) is the familiar home language,

Doctor: □□□□ □□ □□□□□□?
mïnïdn näw yämïtïččïyïw
What do you speak?
Patient: □□□□
oromäññа
Doctor: Natti himi
nati himi
Okay speak up

In addition, at this interaction the interlocutor again code switch to Amharic, to a more ‘official’ language, or to the language of wider communication. When the ML is the international language example, English, and then a switch to the local or national language can reinforce intimacy and closeness to the interlocutors (Matras, 2009: 127). In this case, the medical professional codes switch to Amharic when he talks with the nurse, to explain and show inclusion.

Doctor: Maalif beektaa aannan dhuguu jedhama = = □□□□ □□□ □□□ □□□□□□□ □□□□- - -
------ yäboräna lïğğočč hïmäm ayawïkaččäwïm yïbalal
It is said, it isn’t common to see sick person from Negel borne

4.1.3. Age as factor in the medical interactions

Eckert asks couples of questions on the impact and resolving the ambiguity between age grading and change in apparent time involves tackle with some fundamental linguistic issues. Those are to what extent, and in what ways, can a speaker’s language changes over the life course? How these changes are embedding in life stages and life events? In addition, to what extent does age interact with other social variables, such as; class, gender, and ethnicity? Answers to these questions require an understanding of the linguistic life course. Yet although age is one of a

small number of social variables routinely included in community studies, there has been no concerted study of variation from a life-course perspective (Eckert, 1998:105).to show these points here are two examples which hold two deferent age group below,

Text-1

A young male patient at the age of 20 with a disease of sexually transmitted disease who come for the second time with his male friends and start to communicate with a female young doctor and start to talk as;

1. **Patient:** □□□□ □□□ □□□□□ □□□□□ □□□□□ □□□ □□□□ □□□□□□ □□□□ □□□ □□□ □□□ □□□ □□□ □□□□□□□ □□□□ □□□- -
   baläfäw yähonä mädhanit sätt'ïtäšïññ näbär hïmämu t'äftuwal yämeyamäññïm t'äfïtowal ahun dägmo fäsaš aläw sïššäna yakk'att'ïläññal mïnamïn nägär
   You gave me a medication last time. The pain is gone…the pain is gone. This time, it has discharge and it has burning feeling while I urinate, something like . . .
2. **Doctor:** □□□ □□□□ □□□□ □□?
   ahun sïmetïh ïndäza näw
   Is that what you feel now?
3. **Patient:** □□!
   awo
   Yes!
4. **Doctor:** □□□ □□?
   fäsaš allä
   Does it have discharge?
5. **Patient:** □□!
   awo
   Yes!
6. **Patient:** □□ □□□□ □□□?
   mïn aynät fäsaš
   What kind of discharge is it?
7. **Patient:** □□
   näčč'
   White
8. **Doctor:** □□□□□□?
   yakk'att'ïlïhall
   Do you have burning sensation?
9. **Patient:** □□□□ □□□ □□□□□□
   šïnten sïšäna yakk'att'ïläññall
   It burns me while urinating
10. **Doctor:** □□□□□□ □□□□?
    wägäbhïnïmm yammïhall
    Do you have back pain too?
11. **Patient:** □□ □□ □□□□ (+) □□□□ □□□□□□ = =
    arä mïn wägäben wägäben ayïssämmaññïmm
    It is not my back I feel pain, (laugh) I don't have back pain
12. **Doctor:** □□□ □□ □□□?

sïnt gize honäh
How long is it?

13. **Patient:** □□□ (+) □□ □□□□ □□□□□□
ahun bäkk'a samïnt ayhunnäññïmm
It isn't even a week.
14. **Doctor:** □□□□□ □□□□□?
ïndäzih käğğämmäräh
Since, you start to feel like this?
15. **Patient:** □□□□□□ □□□□□ □□□□□□□□ □□□ □□□□□ □□ - - -
mädhanitun ïndäzih ïyätäkkätatälku sïwït' ïndäzih honnä
While - - I took the medication properly then it became like this - -
16. **Doctor:** □□□ □□□□? (4) □□□ □□□□? □□□ □□□ □□□ □□ □□?
hïmäm yälähm hïmäm yäläwïm yaläw ahun fäsaš bïčča näw
Don't dou have pain? (Lower pitch). Don't you have pain now? Is it only a discharge?
17. **Patient:** □□□□ □□□ □□□□□□
fäsašna sïšäna yakk'att'ïlläññall
A discharge and pain while I urinate.
18. **Doctor:** □□ □□□ □□□?
šïtta alläw fäsaššu
Does the discharge have a smell?
19. **Patient:** nodding (no)
20. **Doctor:** □□□ □□ □□□ □□□□□?
sïnt k'än honäh käğämmäräh
How long is it since it started?
21. **Patient:** □□□ □□□□□ □□□□ □□□□ □□ □□ □□□ □□ □□□ □□□ □□ - - -
ïzih yämätt'ahut yaläfäw samïnt näw sost k'än wäyïmm arat k'än
I came here last week so it is almost three or four days----
22. **Doctor:** □□□ □□□□ □□□□?
g^{w}adäññ a aläččïh aydäl
You do have a girl friend, right?
23. **Patient:** □□ (4)!
awo
Yes! (Lower pitch)
24. **Doctor:** □□ □□ □□□□□ □□□□□□□?
käsow gar gïnññunät tadärgalaččïhu
Do you have sexual intercourse with her?
25. **Patient:** ... /.....\\ ... □□□ - - - □□□ □□□
mist mist bäyatt
(Interrupting) wife, you can call her wife
26. **Doctor:** □□□□ □□ □□ □□□□□□? □□□□□□□?
bä-anïd lay näw yämïtnorot tägabtaččïhull
Are you living together? Are you married?
27. **Patient:** □□□ □□ □□□□□ □□ □□□ □□□□□
anïd lay banïnorm yaw mist bäyatt
Of course, we don't live together, but you can call her wife.
28. **Doctor:** □□ □□□ □□□□ □□□□□ □□□□□□□□□ □□□□?
ïššig^{w}adäññ a aläččïh gïnïññunät tadärgallaččïhu aydäll
Ok, you do have a girl friend. You have sexual intercourse with her, right?

29. **Patient:** □□::
awo
Yes.
30. **Doctor:** □□ □□□□□ □□□□ □□□ □□□?
ïsʷ-a ïndäzih aynät sïmet alät
Does she have sign like this?
31. **Patient:** □□?? (3) □□□□□□ □□□□□□- - -
ïrä alsämahum ïskkä-ahun
I didn't hear her talking about it until now.
32. **Doctor:** □□□□□□ □□? □□□□□□□□ □□□□?
alsämahum näw tänägagïraccïhuwal bägïlïtt'
Is it you didn't hear her? Otherwise, did you talk about it openly?
33. **Patient:** □□
awo
Yes
34. **Doctor:** □□□□□□□□!? □□□□□□ □□ □□□ □□□□□□□□□□?
tänägagïraccïhuwal alsämahum näw wäyïs alïtänägagäraccïhum
Did you talk about it? Are you saying that you didn't hear or didn't talk about it?
35. **Patient:** □□□□□ □□□□□□□□ □□□□□□□ □□ □□ □□□□□ □□□□ □□□ □□□□ □□- - -
mänägagär ïnïnägagäralän andäbabäk'ïm gïn ïnne ïndäzih aynät sïmet yälatïm ïsʷ-a
We talked about these things freely but I don't think she has the same signs.
36. **Doctor:** □□ (+) □□□□□□ □□□ □□□□ □□ □□□□□? □□□□□ □□□?
Yï-he yä-abaläzär bäššïtta mïlïkkït näw aydäläm
You know this is a symptom for, sexually transmitted infection, don't you?
37. **Patient:** □□ □□□□□□ □□□□□ □□::
ïnne yämemäsïlläññ ïndäziya näw
I think so, yes it is a sign.
38. **Doctor:** □□□□ □□□□ □□□ □□□□□□ □□□ □□□□ □□□□ □□□□ □□□□□□ □□□ □□□ □□□□□□ □□□□□□□ □□□□ □□ □□□□□ □□:: □□□□□ □□□□□□ □□□ □□□ □□□ □□ □□□ □□□□ □□□ □□:: □□□□ □□□ □□□□ □□□□:: (+)□□?
masakäk ïndäzza sinnor yä-abaläzär bäšätta mïïlkkït näw sïläzih yä-abaläzär bäšätta dägmo bä-abïzañña w yämettälaläfäw bägbïrä sïgga gïnññunät näw gïnññunät yämïtadärïg kähun dägïmo ïsʷ-am garï linnor yïccïlal malät näw sïläzeh mätt'ïta mätakäm aläbatï--
You know itching and similar symptoms like these are the indication of sexually transmitted infection? In addition, sexually transmitted infections are transferred through sexual intercourse since you have relation with her; she might have sexually transmitted infection too. Therefore, she also needs to come here and get treatment, okay?
39. **Patient:** □□ □□□□□□□□□
heğğe ïnägratallähu
I will go and tell her.
40. **Doctor:** □□ □□□□□□□ □□□□. □□□□ □□□□ □□□□ (+) □? □□□□□□ □□□ □□□ □□□□□ □□□ □□ □□□□□ □□□□□□ □□□ □□□ □□□□ (+) □□□□?
heğğe ïnägïratalähu sayhun ïsʷ-anm yäzäh mätt'ïtäh ï mïkïnyatum anïttä ïzih ïyämätt'ah asïrr gizze mädhanit bïtwäsïdïm mïnm t'ïkk'ïm yäläwïmm
Telling her it is not enough. You need to bring her here. Is it ok? Because, it is useless for you to come here even ten times, unless she also comes and treated. Don't you think so?
41. **Patient:** □□
awo
Yes.

42. **Doctor:** HIV □□□□□□ □□□□□?
HIV tämärmïräh tawkk’alähh
Do you have HIV screening test before?
43. **Patient:** □□ □□□□□□□□□
awo ïmärämäralähhu
Yes, I have.
44. **Doctor:** □□ □□ □□□□□□□□?
mäčče näw yätämärämärkkäw
When was that?
45. **Patient:** □□ (3) □□□□ □□ □□
ïrrä bäkk’ïrïbb gizze näw
Recently
46. **Doctor:** □□□ □□ □□□?
sïnt gizze honäh
How long? Be specific
47. **Patient:** □□ □□□□ □□□□ □□□□
wär mïnamn behonäññ näw
About, one month
48. **Doctor:** □□□ □□ □□□ □□□□□ □□□□□ □□□□□□□
ïnka ïššï yïhïn laboratore asärtäh tïmätt’alläh
Ok, take this; you will bring a laboratory investigation.

After 30 or 40 minutes, the patient brings back urine result, and the doctor with patient’s friend start to talk at the doorstep.

49. **Doctor:** □□□ □□□□ □□□□ □□□□□!?
wäyïm yïgbana mäsmat yïfälïgall
He wants to enter and need to listen?
50. **Patient:** □□ □□ □□□□□□□::
ïrä ïnne ïnägräwallähu
It is not necessary. I will tell him.
51. **Doctor:** □□□□□□□?
ïnägräwallähu
Are you going to tell him?
52. **Patient:** □□ (3) □□Ws□ □□□ □□□□□ □□□ □□□ □□?
awo laboratore yalot tämariwočč naččäw ïnde gänna
Yes----are those people in laboratory room students?
53. **Doctor:** □□□ □□□?
tämarri malät
What do you mean students?
54. **Patient:** □□□ □ÜT□□ □□□□ □□□- - - ?
mallät a’aparänït mïnamïn yähonu
I mean， are they on apprenticeship- - ?
55. **Doctor:** □□□□□
aydälämm
No, they are not.
56. **Patient:** □□ □□ □□□ □□□□□ □¶□ííß □□ □□ □□□ □□□□□ □□□□ □□ □□□□□ □□□□□ □□ □□□□□ □□ □□□□ □□□□□□ - - - -

ay zïm bïlläw mäğğämärreya negative bïčča näbär yäsätt'äččïññ ïndet näw ïndäzih yämihonäw bïye sïkkärakär näw yïhnïn yäčč'ämäräččïww

I mean first they give me the result by writing only negative then I argued with them, then she writes some additional....

57. **Doctor:** = = □□□ □□□□□□□□?

manat yämïtïčč'ämrïlïhh

Who is she that has added for you?

58. **Patient**□ □□ □ M¨ŒZ (3)□□□ □□□□ □□□□□□ □□□□□ □□□□- - -

ïnna bä-mayïkïrro dïgami ïylïññ ïndäzehïma ayïhonïm allïk^{w}att

Then, I told her to see it again - - on micro

59. **Doctor**□ □¶pííß □□ □□□□□- -- □□□□□ □□ □□□ (showing the libratory request form)

negative bïčča aydäläm yïheññawm ïkko aläww

The result don't only say negative there is also. . .

60. **Patient**: □□□□□□ □¶pííß □□ □□ □□□ □□□□□ □□□ □□□□□ □□ □□□□□ □□□□□ □□□ò □□□□□ □□□ □□□□□ □□□□ □□ □□□ □□□□□ □□□□□□□(3) (3)□□□□□ □□ □□□□□□□:: (4)

bämäğğämärriya negative bïčča bïlla näbär yässätt'äčč'ïññ täkkärakïre näw ïndäzih yämmihhonäw tamïme aydällä ïnïde yämätt'ahut alku^{w}at käzza dïgami ayäččïna č'ämärräččïw täkkärakïre näw yasïčč'ämärkutt

At first she only write negative then I told her it is impossible, I come here because I am sick then she saw it again and add more (pause for about fifteen seconds) I made her add more by argument. (With low pitch)

61. **Doctor**□ □□□ □□□□□□□ □□ = = (while writing medication on the request) □□□□ (+)□□ □□□□□ □□□□□□□::

gäbäya asmäsälïkkäw ïkko bäl g^{w}adäññahïm ïndïtïtakämm

You seem like you are in market. Do not forget to bring your girl friend.

62. **Patient**□ □□

ïššï

Ok

63. **Doctor:** □□ □□□□ □□ □□□□ (3) (3) □□ □□□ □□□□ □□□□? □□□ pharmacy □□□□□

wïhha bäbïzzat t'ätt'a hulïgizze lella kusïll yälähïm aydäll yïhïn farïmasi wïsädd

Drink more water. Do you not have other wound? (Pause for another 15 sec while writing) Take it to pharmacy.

On this communication, it is clear that the young patient shows a different behavior from most of the patients. Even though, he comes to be treated for sexually transmitted disease, which is considered as taboo, in the Ethiopian society unlike other patients he starts the discussion with doctor. The patient explained what he feel freely. Even if, he does not tell what his disease is clearly (on text-1-line-36). For the question the doctor asks, he answers that he agreed that he has STD. In addition, since the patient is young he tries to show that he is careless about his problems and the social outlooks. He shows this by using of the talks he made such as on (line-60) and he tries to show that if his friend listens the disease he has he is not bothered him much for example, on (line-49) he answers that I will tell him after I left the examination room. Of course, the Ethiopian society is traditional; especially the elderly people and have serious

perception on marriage but the patient explains that his girl friend or 'wife' according to him, even though she is not living with him she is his wife on (line-25). However, unlike him the doctor avoid calling her wife just girlfriend.

On the other hand, the doctor is clearly violating the maxim of quantity, repeatedly, for example on (line-13, 20) these are the same kinds of questions. The doctor might ask these questions to check the patients' accuracy on giving answers because many patients or people do not use the time or place adjectives properly but the patient here gives answer almost the same. Additionally, the doctor also seems to fear that the patient might probably violate the maxim of quality by giving incorrect information on (line-30-35). That is why; she repeats the question as notice on (line-61). It seems the doctor used this sentence not to remind him but to make him take it series about bringing his girlfriend and get the necessary treatment. The doctor only uses some medical jargons and word by inserting to the metalanguage, such as HIV, Laboratory, Negative. This is because there is no equivalent Amharic word for the first one. On the other hand, the patient use first language influenced English (such as be-micro - - and apparent which means *apprentice*). Despite all these facts, the doctor and the patient had a very friendly and informative communication and the patient surely can benefit out of it. It is clear that the patient's age has huge role for this effective communication.

When the interaction observed in terms of speech act theory, for example, on (line 36, 37) of line-36,

Doctor: □□ (+) □□□□□□ □□□ □□□□ □□ □□□□□? □□□□□ □□□?
Yï-he yä-abbalazär bäššïtta mïlïkït näw ayïdällämm
You know this is a symptom for, sexually transmitted infection, don't you?

The locutionary act, it is a question, the perlocution act is the doctor told for the patient you have sexually transmitted disease. However, the patient on line-37,

Patient: □□ □□□□□□ □□□□□ □□::
ïnne yämemäsïlläññ ïndäzeya näw
I think so, yes it is a symptom.

locutionary act is an affirmative sentence, the illocutionary act is, it is a kind of agreement and kind of comment but the perlocution act is the patient says i know i have sexually transmitted disease.

Text-2

An old patient of around 54 years old, who has epilepsy and come to take a medication because he finished what he takes on the previous visit and the doctor is male who has long year of experience; (The doctor read the patients name on the card) and start the discussion as follow;

1. **Doctor:** □□ □□ □□□ □□?
   zare mïn honäw mätt'o
   Why have you come today?
2. **Patient□** □□ □□□ □□□ □□□□ (+) □□□□□ □□ □□□□□ □□ □□□□ □□ □□□□ □□□
   ïza närïv čïgïr aläbïññ baläfäwïm ïkko bäsïdïst wär bä-arat wär yïsätt'äññ näbär
   I have a nerve problem, last time, I used to take once in every four or six months and it has been two years.
3. **Doctor □** □□□□□□ □□□□ □□□□□? (Nodding his head to encourage the patient to talk)
   mädhanitun bädänïb yïwäsïdalu
   Do you take the medication properly?
4. **Patient□** □□□□□□ (quickly the patient seemed happier because he felt the doctor understood his problem) □□□ □□□□□□ - -
   ïwäsïdallähu bätt'am alakk'owarïtt'ïm
   Yes, I take the medication properly - -I don't interrupt it either.
5. **Doctor□** □□□ □□ □□□□□□?
   yäwär näw yämissätt'ïwott
   Is it monthly that the medication provided to you?
6. **Patient□** □□□ □□ □□ □□□□ □□ □□□□ □□ □□□□□ □□□□□□ □□ □□ □□□□ - - -
   yäwär näw awo yähullät wär yäsosït wär yïsät'äññal ïtt'äkk'ämallähu mata mata sïlähun
   Yes, for one, month two, three month, I took them at night since - - - (pause)
7. **Doctor:** □□□ □□□ □□□□ □□ □□□□□ □□□ □□ □□□ □□? □□□ □□ □□□□□ □□ □□□ □□□ □□? □□□ □□□ □□□□ □□? □□□ □□□□□□?
   käzih bäfet yä-arat wär täsätt'ïtot näbär mïn honäw näw arat wär yäwäsädut yät lehidu honäw näw lämïn wäsädu yä-arat wär lämïn asïfälägïwot
   During your previous visit, you took for four month, what happen to you? Where did you go? Why did you take the medications for four months? Why is it required?
8. **Patient□** □□ (+)□□ □□□□□- - -?
   ïnne-nïğğa ïnïgïdeh
   I don't know, may be- -
9. **Doctor□** □□ □□□□ □□□□□□ □□□□□□ □□□□□□ □□□□□ □□□□□□□ □□□□□ □□□□□ (3)□□□□□ □□□□ □□ □□□□□ □□ □□□ □□□ - - -
   awo ïnanït ïndïtïmätt'u yämefälägäw mädhanitun bätïkïkïll mäwïsädaččïhun ïndäzih ïndäzih lämayät näw sïmetaččïhu lay yaläw läwïtt'
   Well, you people are expected to come here because it is necessary to check either you took the medication properly or to see if there is any change of signs on your feeling
10. **Patient□** □□
    awo
    Yes
11. **Doctor□** □□□□ (3)□□□ □□□□□ □□□□□□ □□□□□(+) □□ □□□ □□ □□□ □□□?
    läwïtt'očč ïnïğğe ïnanïtän lämamällaläs aydälläm gïn arat wär dägïmo bäzahha
    Just to see changes - - not to make you tired but four month is to long?
12. **Patient□** □□□□ □□□ □□ □□ (4) - - -
    ayïdällä ïsuma bïzzu näw
    Of course it is long but - - (like murmuring)
13. **Doctor:** □□□ □□ □□ □□□□
    hulät wär bäkk'i näw
    Two month is enough.

14. **Patient:** □□ □□
    bäkk'i näw
    Yes, it is enough
15. **Doctor:** □□□ □□□ □□□ □□□ □□□ □□□□□ □□□ □□□ □□□□?
    k'ïrïb ïzih säfär dägïmo kähonu bäyäwäru bemätt'u čïgïr yäläwm
    If you are living around here, it is better to come every one month
16. **Patient:** □□ □□□ □□□□ □□
    awo ïzečč marïyam natt
    Yes, it is here around Mariam church.
17. **Doctor:** □□ □□□□- - -
    awo
    Yes, it is necessary to observe it- --
18. **Patient:**]□□ □□□□ □□ □□ (3) □□□□ □□ □□ □□□□ □□ □□□□- -
    sallit mïhïrät zïkk' bïla yähulät wär wäy yä-anïd wär yïdäräg
    It is around 'Sahelit Mehert' church therefore you can give me for one month or two month- -
19. **Doctor:** □□□□□ □□□□□ □□ □□ □□?
    bätïkïkïl ïyäwäsäddu näw mata mata
    So, do you take it properly, at night?
20. **Patient:** □□□□□ □□□□ □□□□□ □□ □□□□□□□□- - -
    baläbetem ïnïdehu täkätatïlla näw yämïtaswäsïdäññ
    My wife she looks over me whether I took it or not.
21. **Doctor:** □□□□□ □□□□?
    yïwäsïdallu ahunïmm
    You still taking the medication?
22. **Patient:** □□
    awo
    Yes

The doctor start to talk with a nurse and give order to give him a medication for the patient

23. **Doctor:**]¨□rZÛíŒ
    sayïkotïropik
    Psychotropic

And return his attention to the patient to fill the prescription and ask the patient's name, and age

24. **Patient:** □□□ □□□ □□□ □□
    ïdïme hamïssa arat näw
    My age, it is 54
25. **Doctor:** □□□□ 54 □□□□□ 54 □□□□□□ □□□ □□□□ □□□□□ . . . .
    amnam hamïssa arat zänïdïrrom hamïssa arat ayïčč'ämïrïm ïnïde ïrïsom ïngïdeh
    Your age, last year was fifty-four and still today, it says it is fifty-four. Isn't it add-up?
26. **Patient**: □□□□ □□□□□. . .
    dämïrot ïngïdeh
    You may add it up. .
27. **Doctor:** □□□ (giving prescription)
    yïhïww
    Take this.

The patient is old and without doubt is illiterate so like most patients of his age, during the interaction the patent speaks with low pitch voice, which signifies respect to authority figures such as doctors. In addition to this, the patient seems to avoid mentioning his disease almost throughout the interaction, which might be, he is uncomfortable talking about his diseases. This can also be seen that the patient can use the Amharic term for epilepsy that is 'yämett'ïl bäššïta'

but the patient says - - nerve- -On (text-2-line 2) and he do not says much after that but tries to remind the previous visit that took place before six month on (line -2). That is way the answer he gave for the question on (line-3) it is a kind of relief respond on (line-4) 'I take the medication properly - -I don't interrupt it either'. It probably is the impact of the society's perception on epilepsy, that the patient avoids calling his disease freely and discussing his feeling because even though the doctor gives the opportunity to talk about his problem on (line-11). The patient ignores the invitation and focus only on taking his medication. The patient acts like this because; the society perceives epilepsy as a disease, which has an association with some bad spiritual possession.

The doctor on other hand should give the opportunity to explain himself rather than he focuses only on the immediate problems of the patient rather he should at least measure the patients understanding about the diseases. Because, it is clear that the patients can be discriminated because of his health problems. As it can seen the patient cannot even explain what his problem is to the doctor. In addition to that, the doctor on (line-9) does not mention the patient's disease too, but says 'you guys' (2nd person plural). Which is a kind of discrimination term, as the whole the doctor should focus his interaction on education rather than asking the patients 'past history' on how often the patient took the medication.

To see the communication from the maxims perspective, the doctor on (line-7) disobeys the maxim of quantity by asking the same question repeatedly. About code switch, the doctor code switch while he communicates with the nurse on (line-23) and the patient (line-2) because of 'missing the right word' that is missing in the Amharic (Matras: 2009:108).

4.1.3.1. Comparison of the interactions (Age) on text 1 and 2

As stated above, age plays significant role during interactions and older patients are actually more diverse than young patients meaning they have wide range of life experiences and cultural backgrounds, which often influence their perception of illness and willingness to adhere to medical routines. These could cause problems to physicians when dealing with them, but in addition to these facts, communication can also be hindered by the normal aging process, which may involve 'sensory loss, decline in memory, slower processing of information, lessening of

power and influence over their own lives, retirement from work, and separation from family and friends' (Robinson, 2006:74).

However, studies have shown that older patients receive less information from physicians than younger patients do, when, in fact, they desire more information from their physicians. Because of their increased need for information and their likelihood to communicate poorly, to be nervous and lack of focus, older patients are going to require additional time and attention from their doctors (Robinson, 2006:75).

As the above two examples, show that even if, two persons have the same problems, which are sexually transmitted disease and epilepsy both considered as taboo in the society, age difference by itself cause distinction in addressing these issues. On the first example, the young patient starts the discussion and unlike the second patient, he even asks his questions to the doctor. In addition to that, the patient has casual interaction and when the doctor asks the questions on (line-36) he respond freely. Moreover, the choice of language is more relaxed that the second meaning we can see more code switching than the second interaction.

Contrary to this, the second patient on the second example had a very formal interaction, and can be said he did not benefit out of the communication. Because the patient did not participate in the interaction actively but give few unclear answers to the doctor. Furthermore, the patient was uncomfortable to discuss because, first the patient show repeated pause while he speaks which might show the sign of anxiety and did not even once, asks one question to the doctor. Besides, to this while the first patient states when the symptoms started clearly on (line-12, 13) the patient on the second fail to explain his first visit, age and address on (line-6, 16, 26).

4.1.4. Patient's gender as factor in the medical interactions

As stated in chapter two, gender refers denoting the attributes given culturally ascribed to women and men. As result, gender is a characteristic that is associated with variation in communication style. Researches show that the communication styles of men and women differ (Matsuoka: 2011:3).

Text-3

A young female doctor and a thirty-six year male patient complaining of serious headache and back pain, the communication takes place as follow:

1. **Doctor:** □□□□ □□ □□□□□?
   mïnïdn näw yämeyamïh
   What is your problem?
2. **Patient:** □□ □□□□ □□□ □□ □□□□□□□
   ras mïttatna bäzzih lay yïtt'äzätt'ïzäññall
   It is a headache and serious muscle pain (arthriligia).
3. **Doctor:** □□ □□ □□□□□?
   mäčč näw yäğğämäräh
   When did it start?
4. **Patient:** □□□□ □□ □□□ □□ □□□ □□□□□ □□ □□□□□ □□□□ □□ □□ □□□ □□ □□□ □□□□ □□□□□ □□□□ □□□ □□□- -
   k'oyïto^{w}-al bäkka ahun ras mïtatu ïyäčč'ämärä mätt'a mätt'äzïtt'äzu bäkïrïb gïzze ras mïttatu gïn bätt'am k'oyäbïññ bättäwässän gezeyat hullät sost
   It stays longer but now the headache getting worse. the arthriligia stays shorter time. However, the headache keeps for very long, within two, three …
5. **Doctor:** □□□□ □□ (+) □□□ □□ □□□□□?
   bäkk'ïrïb gezze sïnït k'än yïhhonnäwall
   How many days is it?
6. **Patient:** □□ □□□ □□□□□ □□□ □□□□□- - -
   ras mïtattu käsamïnït bällay yalïfäwall
   The headache is more than one week
7. **Doctor:** □□□□ □□□ □□ □□□?
   gunïhïn sïnït gezze hunäh
   How long the pain is on your backside since it started?
8. **Patient:** □□□□ □□□□ □□ □□ (+) □□□ □□ □□□□□□□?
   yïheññaw bäk'ïrïb k'än näw ïzeh gar yït'äzät'ïzäññall
   This one, it is very short time, it felt serious muscle pain (arthriligia) around here.
9. **Doctor:** □□ □□□?
   sall alläh
   Do you have cough?
10. **Patient:** □□ □□□□
    sall yälläññïmm
    No, I don't have cough.
11. **Doctor:** □□□ □□□□ □□□□□?
    seggarra mïnamïn tačč'äsalläh
    Do you smoke something like cigarette?
12. **Patient:** □□ (+)□□□ □□□□□ □□□□□ □□ □□□□□(4)
    awo seggarra ačč'äsallähu ïtt'ätt'allähu č'att ïkk'ïmallähu
    Yes, I do smoke; I drink and chew 'chate'too.
13. **Doctor:** □□ (+)□□ □□ □□□ □□□ = = □□□ □□□ pílí □□□ □□□□?
    yïh t'ïrru näw k'ätt'ïl bärïtta
    Oh- - keep it up (laugh) by the way, do you have a history of TB?
14. **Patient:** nodding (no)
15. **Doctor:** □□□ □□□□□? (Pause) writing □□□□ □□ □□□ □□? (Mrx)
    yïzuh ayawïkk'ïm šïnïth lay čïggïr allä
    No? Do you have urinary problem?
16. **Patient:** □□□ □□□□□
    čïggïr yälläbïññïm
    No, I do not have.
17. **Doctor:** □□□□ □□ □□ □□□□ (+) □□□ □□ □□□□?
    makk'at'äl tollo tollo mämït'at mät'ïto tollo matt'adäff
    Burning while urinate and comes up frequently, and is it tries to come out immediately?
18. **Patient:** □□ (+) □□□□□ □□□□ □□□ □□□□(4)
    ay ïndäzeh aynät nägär yälläññïmm
    No, I do not have these problems.
19. **Doctor**: □□□ □□□ □□ □□□□□□?

anïd anïd gezze mänïtt’äbatt’äb
What about urine interruption while urinating?

20. Patient: □□□□□ □□□□ □□□ □□□□
ïndäzeh aynät nägär yäläññïm
No, I don’t have it too.

21. Doctor: □□□□ □□□**?**
tïkkussat alläh
Do you have fever?

22. **Patient:** □□□□ □□□□
tïkkusat yäläññïm
I do not have fever.

23. **Doctor:** □□□ □□□ □□□?
bïrd bïrd mallätt
Do you feel cold?

24. Patient: □□ □□□□□ □ □□□□□ □□ □□□ □□ □□ □□□ (+)□□ □□□ □□□ □□□ □□ □□□□□ □□□□ □□□- -
bäkk’a mätt’äzïtt’äz bäğğärïbayye lay wïggat ïnna ras mïttatu bätt’am käbad näw seğğämïräññ
mänäsat lärassu
No, I only feel dizzy, back pain and head ache. The headache gets worsen. When it started, I could not even stand. . .

25. Doctor: □□□□ □□ □□□□ □□□□□ □□ □□□ □□□ □□□**?**
tïkusat gïn yällähm šïnïtïhm lay adis näggär yälläm
However, you do not have fever … and while you urinate, there is no new thing?

26. **Patient:** (nodding) pause

27. **Doctor:** □□□□ □□□□□ □□□□ □□?
yämïgb fïlagot ïndet näw
How is your appetite?

28. **Patient:** □□□ □□□□□
mïgb ïbälallähu
I eat food, it is normal.

29. Doctor: □□□□□□ □□ □□□ □□□□ □□□□ □□□□ □□ □□ □□□ □□□□**?**
ïndädïrow näw mïnm lïyunät yälläwïm täkk’ïmatt’ wäddä lay mallät mïnamn
It is as usual, there is no difference at all. Do you have vomiting and diarrhea something like that?

30. **Patient:** □□□ □□□
minm yälläm
There is nothing

31. **Doctor:** □□□ □□□(+) □□□□□ □□□ □□ □□□□ □□(+) □□□ □□ □□□□ □□ □□□?
mïnm yälläm siğğämrïh käbadd ïkk’a manïsatt wïhha näffas lay mäggallätt’ allä ïnde
When it started, do you by chance picked-up heavy thing or did you stay at cold?

32. **Patient:** □□ □□ (+) □□□ □□□ □□□□□ □□ □□□□ - - -
awo awo sïraye ïrassu yägulïbbät sïrra sïllähonä
Yes- - Yes, my job is labor work - - -

Pause while the doctor writes then

33. Doctor: □□.□□.□. □□□□□ □□□□□ □□□□□□?
HIV asärïttäh tawïkk’alläh tämmärmïrräh
Have you been screened for HIV before?

34. **Patient:** □□□□□
alawïkk’ïmm
Not before today

35. **Doctor**: □□□□□□ □□□□ □□?
lämämärïmärr fäkk’adäññä näh
Are you voluntary to be screened?

36. **Patient:** □□□□□ (+)□□□□ □□□- --
asballähu ïskäzza dïräs
I am planning, until then - - -

37. **Doctor:** □□, □□ □□□□□□ □□□□ □□?

ay zarre lämämärïmär fäkk'adäññna näh
No, I mean, are you voluntary to be screened today?

38. **Patient:** □□□□ □□□ □□□ □□□ (3)
yïčč'allal minm čïggïr yälläm
It is possible (Pause)

39. **Doctor:** □□□ □□□ □□□□□□ □□□□□?
käzeh bäffet tämmärïmïräh attawïkk'ïm
Have you not been screened before today?

40. **Patient:** □□□□□
allawïkk'ïm
No, I did not

41. **Doctor:** □□Ws□ □□ □□
laboratore sïtt' ïšše
Go and give laboratory

Giving the laboratory request after 30 or 40 minutes, the patient comes back to the doctor, with the result and starts to discusses

42. **Doctor:** □□□□□ □□?
ballätïdar näh
Are you married?

43. **Patient:** □□
ay
No

44. **Doctor:** □□□ □□□□- - ?
yässet g^{w}adäññas
Do you have a girl friend?

45. **Patient:** □□
ay
No

46. **Doctor:** □□□□(3) □□□ □□.□□.□. □□□□ □□□ □□ □□ □□□□ □□□ □□□ □□□ □□□?
yällähm wïtt'etu HIV bäddämh wïsïtt' allä näw yämmelläw käzeh bäfet tawïkk' näbär
No? However, the result says that, you have HIV in your blood. You do not know before?

47. Patient: □□
ay
No

48. Doctor: □□□□□ □□**?**
ïrgïtt'äññna näh
Are you sure?

49. **Patient:** □□
awo
Yes

50. **Doctor:** □□□□□- - -?
bä-ïwnätt
Really - --?

51. **Patient:** □□□□□
bä-ïwnätt
Really.

52. **Doctor**: □□□□ □□□ □□□□ □□□□□□ □□□ □□ □□? (3) □□ □□□□□ □□□□□□□□ □4□□ □□□ □□ □□□ □□ (+) □□?
sïläzeh ïzzih kïtïtïl tïğğämïralläh mallät näw ï ïnna atïččägär anagänaññïhallän kä-arratäññaw kïfil gar mallät näw ïšši
Therefore, you will start a follow-up here. Is that Okay? (Pause) Moreover, don't worried, we will contact you with them.

53. **Patient:** □□
ïšši
Ok

54. Doctor: □□□ □□□ □□□ □□ □□□□□□ - --
bägeze mawäkk'u lantä näw yämitt'äkk'ïmïhh
Then you will start up there, it is good for you to know in advance ok!

55. **Patient:** □□(+)□□ □□□ □□□ □□□
ïššï awo minm čïggïr yälläm
Ok - - --yes, there is no problem.

56. **Doctor**: □□□□ □□□ □□□□ □□□□ □□□□ □□□□□ □□□ □□ (+) □□□□□□ □□□ □□□□□ □□□ □□□□□ □□□ □□ □□ □□□□ □□□ □□□□ □□□□□□□ □□□□□ □□□ □□ □□?
sïlläzeh ahun bäššïttam yälähm agatt'ame sïlläraslh bïläh näw manïññawïnm ïzzeh yämätt'awïn t'äyïkk'u sïllämibal näw ïnna sïlläzeh ahun tïhedïna yäminägïrruhïn tïsämalläh mallät näw ïššï
Therefore, now you do not have any sickness, I just order for you, the investigation patients are encouraged to get screen and now you will go to them and listen, ok.

57. **Patient:** □□
oke
Okay

58. **Doctor:** □□□ □□□□ □□□□ □□□□□ □□□□□□□□
läzeh amämäññ lalkäw mädhanit ïtt'ïflïhalähu
I will write some medication now for the disease you are complaining, so you feel all right

59. Patient: □□□□ □□□□□□□?
sekïlif tïtt'ïfilïññaläšš
Could you write me a sick leave?

60. **Doctor:** □□ (+)□□□ □□□□ □□□□□ □□ □□□□ □□□□□□□
ïššï ïččin sekïlif mädhanit bet mähatäm tasdärïgallähh
Ok - - -this is your sick leave go to the pharmacy and get stamp.

61. **Patient:** □□□ □□ □□ □□□□□□? still looking the sick leave
anïd k'än näw yätt'afïššïlïññ
You only give me one day.

62. **Doctor:** □□ □□□□ □□ □□ □□□□□□□□?
awo yäzzaren bïčča näw yämnïtt'ïfillaččïhu
Yes we only allowed to write for today.

63. **Patient:** □□□ □□□ □□ □□□□□□□ □□ □□□
anïd sost k'än bïttadärïgelïññ t'ïrru näbär
It is good if you give me at last three days.

64. Doctor: □□□□□□□ □□□□ □□ □□□□□□- - -
ïndäbäššïttaw aynät näwa yämnïtt'ïfäww
We write according to the disease- -

65. **Patient:** □□□(+)□□ □□ □□ □□□□□□ (3)□□□ □□□□□ (3) □□□ □□□ □□ □□□□□□- -
ahun ïkuw sïrra botta ïskitäwäññ rasen yämiyammäññ mïnall arrat k'än bïtïtt'ïfilïññ
Now- -- I could not work because of my headache. Please write me at least four days.

66. **Doctor:** □□□ □□□□□□ □□□□□□ □□□□□□ □□□□ □□□□□□ □□□□□- -- -
ïññan rasaččïnïn yasïkk'ätt'anal mädhanitun wïssädna kalïttäššalläh tïmätt'aläh
We will be facing a problem and take the nod action if there is no charge. We will see -- -

67. **Patient:** □□□ □□□ □□ □□ □□□ □□□□□ □□□□□
anïd sost k'än ïnne ïrase allïgäbam ahun
Now, I will not going to enter to work for about three days.

The first parts of the communication go smoothly in this communication (text-3-line-1-10) until the doctor gives a kind of negative compliment on (line-13). Despite this negative complement, the patient seems very cooperative throughout the entire communication. However, it gives the impression of he (the patient) already knows he is positive for HIV because the reaction of the patient was a surprising and unbelievable even to the doctor. That is why the doctor asks him on

(line-46-51) again after she already finished the discussion. It is reasonable to conclude that the patient is in fact violating the maxim of quality by giving false information. It could be that he wants to re-check. Alternatively, he might believes after a while the HIV could disappear. Anyway, whatever the reason, the patient does not bother whether he had HIV; rather he argued more about getting sick leave more time to rest, on (line-59-67). Moreover the patient address his problem and answers the questions raised by the doctor he don't even tries to deny he smokes cigarette and chew 'chat' on (line 11, 12). It is clear that the patient speaks with confidence, which is good because it helps him to have a very understandable communication from both sides. The patient is male and this has very big role for the productive communication.

The doctor after informing the patient he has HIV in his blood, she (the doctor) starts to reassure the patient's mind by using psychological and therapeutic method. Besides, during communication the doctor use the Amharic term 'mïnamn' such as on (line 11, 29) which has no specific implication but gives the discussion a more casual sense rather formal interaction. The doctor used many closed-ended questions, but it could be more productive to let the patient explain and states why he came to the health center. As Bylund and Makoul (2002) Roter and Hall (2004), remark female physicians conduct longer consultations than male physicians do, which clarify their tendency to start partnership building largely than male physicians. In addition, consultations with female physicians include talk that is more positive, psychosocial counseling, psychosocial question asking, emotionally focused talk and emphatic communication than consultations with male physicians. Therefore, this female doctor seems to be friendly to patient and avoid being bossy, of occur, she asks many question but at the same time tries to reassure the patient by giving positive feedback on (line-56). She even used the first person plural (we) to inform the patient that it is impossible to give him a sick leave beyond the necessary amount on (line-66).

Text- 4

A young female who is married and probably having a sexually transmitted diseases and came to the health center to get treated and the doctor having a more than twenty years of experience and the discussion goes as follows,

1. **Doctor:** □□ □□□?
   mïn honïšš

What happened to you?

2. **Patient:** □□?(4)
ï
Oh?

3. **Doctor:** □□ □□□? □□ □□□□□?
mïn honïšš mïn yïssämaššall
What happened to you? What do you feel?

4. Patient: □□(+)□□□□□ □□ □□□□□□□ □□□□ □□□□ □□□ □□□□□□
ïne mahïtt'änen näw yämiyakk'at'ïläññ šïnïtten sïššäna yakk'att'ïläññall
Me- -- I have burning on my uterus. When I urinate, I feel burning.

5. **Doctor:** □□□□□□?
yakk'att'ïlïššall
Do you feel burning?

6. **Patient:** □□□□ □□□□- - - (4)
ahunm ahunm
Frequently

7. **Doctor:** □□?
ï
Oh?

8. **Patient:** □□□□ □□□□ □□□□□ - - -
ahunm ahunm yaššänaññall
I urinate frequently. - - -

9. **Doctor:** □□ □□□□?
mäčče ğämäräšš
When did it start?

10. Patient: □□□ (+) □□□□ □□□□ □□
ahun samïnt lehunäññ näw
Now - - -it is almost a week.

11. **Doctor:** □□□□? (3)□□□ □□□□ □□ □□ □□□ □□□□?
samïnt šïnït makk'at'äl bïčča näw fäsaš yälläwm
Is it one week? - - -is it only burning or do you also have discharge?

12. **Patient:** □□□
yälläm
No, there is pus

13. **Doctor:** □□□ □□□?
mäggïl yïz^{w} -all
Does it have pus?

14. Patient: □□□ □□□□□□
ïssun alïyazzäññïm
No, I don't have that.

15. **Doctor:** □□□ □□□□□ □□□□ □□□□□□?
ïzeyya mähatt'äniš akababi yasakïkïššall
Do you have itching around your uterus?

16. **Patient:** □□ -- - -
ay
No

17. **Doctor:** □□ □□ □□□□□ □□□□□□?
wädä tačč yïwäggaššal kämahïtt'äniššš
Do you have pain, which pushed you from uterus?

18. **Patient:** □?
ï
Oh?

19. Doctor: □□ □□ □□□□□□- - -**?**
wädätačč kämahïtt'äniššš
Is there pain toward your uterus - --?

20. **Patient:** □□□□□□ □□ □□□□ □□ □□□ □□ □□□□□□□
aywäggañ̃ïm gïn makk’att’äl näw bätt’am näw yämiyakk’att’äläñ̃
No, I do not have that but I have burning, and the burning is severe.
21. **Doctor:** □□□ □□□ □□ □□□□□? (showing around pelvic)
ïzzih ïzzih gar ayamïššïm
Do you not feel pain around here?
22. **Patient:** □□ □□□□
awo yamäñ̃ñall
Yes, I do have pain.
23. **Doctor**: □□□□ □□□? (Pause)
baläbett alläšš
Do you have husband?
24. **Patient:** □□ (3) (4)
awo
Yes, I do have (Pause)
25. **Doctor:** □□.□□.□ □□□□□□ □□□□□□
HIV tämärïmïräšš tawïkk’iyalläšš
Have you been screened for HIV before?
26. **Patient:** □□
awo
Yes
27. **Doctor:** □□□ □□?
k’ïrb gizze
When was it?
28. **Patient:** □□
awo
Yes
29. **Doctor:** □□?
mäčče
When was it?
30. **Patient:** □□□ □□ □□□□ □□
hullät wär behonäw näw
It is only, two month.
31. **Doctor:** □□□ □□**?**
dähïnna näw
Was the result all right?
32. **Patient:** □□ = = (shy)
awo
Yes (laugh)
33. **Doctor:** □□□ □□□? (3)□□□ □□ □□□□□□□ □□
mïnäw sakk’ïšš hullum säw ïyättämärämärrä näw
Why do you laugh? - - - -Everybody is being screened.
34. **Patient:** □□ □□□(+) □□□□□□□□ (4)
I am already screened.
35. **Doctor:** □□ □□□□ □□□ (+) □□□□□?
ïssu yamäñ̃ñal yïllal balläbetïšš
Did your husband also have any relevant signs?
36. **Patient:** □□
ay
No, he didn’t say.
37. **Doctor:** □□□ □□□□□ □□□□ □□□□?
šïnït akk’att’äläñ̃ mïnamn allalämm
Did he not talk about any burn while urinating?
38. **Patient:** □□
ay

He did not say.

39. **Doctor:** ምንድን□ነው□የሚሰራው ?
mïnïdn näw yämissäraww
What is his job?

40. **Patient**: እህ ? (4)
ï
Oh?

41. **Doctor:** ምንድን□ነው□የሚሰራው **?**
mïnïdn näw yämissäraww
What is his job?

42. **Patient:** እንዴ□እረ□ጉዴ (+) = = እረ□ጉዴ and shy a lot
ïnde ïrrä gudde ïrrä gudde
What… what do you mean? Laugh

43. **Doctor:** እውነቴን□እኮ□ነው = = ሹፌር□ነው ?
ïwnäten ʻïkko näw šuffer näw
I am serious- - -- (laugh) is he a driver?

44. **Paient:** እረ (+) ምንም□ችግር□የለውም = =
ïrrä mïnm čïggïr yälläm
Oh- - -There is no problem (laugh)

45. **Nurse:** አይ□የሚያመው□ከሆነ□እሱም□እንዲመረመር□ነው□እንጅ□ለሌላ□ጉዳይ□አይደለም
ay yämiyammäw kähunä assum andimärämärr näw ïnïğğe lälella guday aydällämm
We mean no harm, if he has the same signs as you do, he should come and get treated.

46. **Doctor:** ምን□መሰለሽ□ሽንት□ቤት□የጋራ□ነው?
mïn mässäläšš šïnït beï yägarra näw
Do you use public toilet?

47. **Patient:** አዎ (3)
awo
Yes (pause for about 1 minute)

48. **Doctor:** ምን□መሰለሽ□እንደዚህ□ሽንትን□አብዛኛውን□ጊዜ□የሚተላለፈው (+) ማለት□ነው□የተወሰነ□ፐርሰንት□ግን□ከሽንት□ቤት□ከምናምን□ነው የሚመጣው□አብዛኛውን□ጊዜ□ግን□የሚመጣው□ከሰው□ነው (+) የሚተላለፈው□ማለት□ከጓደኛ□ከባለቤት□እንደዚህ□አይነት□ነገር□ሲመጣ (+) ማለት□ከጓደኛ□ከባለቤት□እንደዚህ□አይነት□ነገር□ሊመጣ□ይችላል□ማለት□ሰማኒያ□አምስት ÛY\□r , ሰማኒያ□አምስት□በመቶ□እንደዛ□ነው የቀረው□ግን□ከሽንት□ቤት□አካባቢ□እናንተ□ብዙ□ጊዜ□አገራችሁ□ቆም□ብላችሁ□ስለምትሸኑ□ፀሃይ□ባለ□ጊዜ□ሽንት□ቤት□ከገባሽ - -
mïn mäsäläšš ïndäzih šïnïtïn abïzaññaw gizze yämittälaläfäw mallät näw yätäwässänä perïsänït gïn käšïnït bet mïnamn näw yämimätt’aw abïzaññawïn gizze gïn yämimätt’aw käsäw näw yämittälalläfäw malät kägʷ-adäñña käballäbet ïndäzih aynät näggär semätt’a malät kägʷ-adäñña käballäbet ïndäzih aynät näggär limätt’a yïččïlal malät näw …
I mean if you use public toilet. Especially during warm hour you could get contaminate since you girls sit when you urinate. However, most of the time it transfers from people to people. This means from boy and husband. Which is 85 percent is through sex but as I told you in rare cases it can transfer via toilet contamination too- - -

49. **Patient**: አዎ (+)በተለይ□በዛ□ይሆናል - - -
awo bättäläy bäzza yïhunall
Yes, it could be through it. - --

50. **Doctor:** ሊሆን□ይችላል□ለማንኛውም□ይህን□መድሃኒት□እስክትጨርሽ□ድርስ□ግንኙነት□አታደርጊም (+) መድሃኒቱን□ከጨረ ^ሽ□በኋላ□ይሻልሽ□ይሆናል ከተሻለሽ (3) እንደገና (3) ካመመሽ□ግን□እንቺና□ሰውየው□አብራችሁ□ነው□የምትመጡት
lihun yïččïlall lämanïññawïm yïhïn mädhanit ïskïtïčč’äršš dïrräs gïnïññunät atadärïgim mädhanitun käčč’äräšš bähʷ-alla yïššalïšš yïhonal kätäššaläšš ïndäggäna kamämäš gïn anïččena säwïyäw abraččïhu näw yämïtïmätt’utt
May be, therefore until you finished this medication, you will not going to have intercourse with your husband. After you finished this medication, you might get better. Nevertheless, after you get better and get started a gain you and the man has to come together.

51. **Patient:** እሺ
ïšši
Ok!

52. **Doctor:** እሺ ?- - ካልሆነ□ሁልጊዜ□ጤና□ጣቢያ□እየተመላለስሽ□ነው□የምትደክሚው

ïššï kalïhunä hulïggizze t’enna t’abiya ïyätämälaläsïšš näw yämïtïdäkkïmiww
Ok? Otherwise, you will come always to this health center.

53. Patient: □□
ïššï
Ok!

54. **Doctor:** □□□□ □□□□□ (+) □□□ □□□□□ □□□□ □□□□□ □□□□ (3) □□?
sïläzzeh abäraČČïhu yïhïn mädhanet č’ärïsäš ïnïdäggäna kamämäš ïšše
Therefore, comeback together if you do not get better. Ok?

55. **Patient:** □□
ïššï
Ok

56. **Doctor:** □□□□□ □□ □□
mädhanit bet hiğğe
Go to pharmacy

In this interaction, like most of her gender group and age group, the patient is uncomfortable to discuss about her problems with authority figure such as doctor. If the female is from countryside in Ethiopia like this case, they will be definitely shy when they are talking with male especially if the male is ‘unknown male with lots of questions’ and the topic is about pregnancy, genital organs, and problems associated with things on (text-5-line-4, 6, 8). That is why she speaks with low pitch.

The patient’s anxiety seems to be shown by talking in a very low pitch on (text-4- line-6, 24, and 34) in her speech. Moreover, she (the patient) laughed frequently on (line-42, 44) not a sign of happiness rather is being shy. Furthermore, when the doctor informs her disease could be STD she reacted in laughter and responded there has to be other reason. Because, according to the patients understanding it is impossible to have STD, since she is married. That is why the doctor also starts to use another way of strategy, rather than, telling her the cause of the problem. He assured her on (line-46, 48).

In terms of, the speech act theory, there are examples on (line-39-44) the doctor asks on (line-39, 43). That is locutionary act meaning the acts of speaking on (line-41)

Doctor: □□□□ □□ □□□□□?
mïnïdn näw yämissäraww
What is his job? (Question)

Illocutionary acts are acts done in speaking including and especially that sort of act that is the apparent purpose for using a performative sentence.

What is your husband’s job?

However, the *Perlocutionary act* which is a consequence or by-product of speaking, whether intended or not, as the name demonstrates to suggest, perlocutions are acts performed by

speaking is the doctor implies that, it is your hasband who is responsible for your diseases, so he also has to come and get medication with you. That is why the patients respond on (line-42)

Patient: □□□ □□ □□ (+) = = □□ □□ and shy a lot
ïnde ïrrä gudde ïrrä gudde
What… what do you mean? Laugh

Meaning that, I do not have any infidelity problem in my home, you have to look for other problems that can cause my sichness. Nevertheless, the doctor insists asking questions such as (line-43)

Doctor: □□□□□ □□ □□ = = □□□ □□?
ïwnäten ïkko näw šuffer näw
I am serious- - -- (laugh) is he a driver?
Paient: □□ (+) □□□ □□□ □□□□ = =
ïrrä mïnïm čïggïr yäläwm
Oh- - -There is no problem (laugh)

The patient interpreted the implication of the question rather than answering the direct question. Meaning she understand the perlocutionary act of the question, since drivers are the most HIV and STD exposed part of the society and according to the doctor's opinion, he is the one who is causing this problem. That is why the doctor responds this information on (line-50). His(the doctor's) sentence began with 'May be', so it shows that even though the doctor told the patient there is other options or cause for her sickness.it is clear that he conclude she has STD. he used an Amharic terms 'malät' and 'ïnïtïn' repeatedly though out their talk and it shows he might be uncomfortable on (line-6, 12). When the doctor explains the mode of the transmission on (line-48) for the disease, he used very vague sentences, which do not make sense. He used the term 'mallät' and 'mïnamn', which is synonym with 'meaning' and 'something' respectively. However, both of them do not have significance in this sentence but it seems used to make the discussion casual and the doctor also tries to avoid mentioning the husband's responsibility by diverting the discussion to other possibilities by saying at the end of (line-48) 'it can be toilet contamination.

Despite all this problems though, as the communication illustrates the doctor handle, the communication very casual, friendly and the way the doctor asks the questions are good. Because, on the first part of the conversation the doctor asks series of questions about the symptoms the starts to explain and he didn't focus on the physical problem that is the sickness but goes beyond that and asks the social situation of the patient.

4.1.4.1. Comparison (the impact of gender) in the interactions of text 3 and 4

While, observing the two interactions, it is clear that gender has significant role in the medical communications. As many researcher such as, Wodak and Benke quoting from Eckert and McConnell-Ginet (1992) agreed ‘women's language has been said to reflect their conservativeness, prestige consciousness, upward mobility, insecurity, deference, nurture, emotional expressivity, connectedness, sensitivity to others, solidarity. In addition to this, men's language is heard as exhibit their toughness, lack of affect, competitiveness, independence, competence, hierarchy, control (Wodak and Benke, 1998:88).

As the third text, which is male patient, shows even though, he has HIV. The patient does not show fear or intimidation while discussing with the female doctor, address what he feel and even challenge the doctor’s comment on (lines, 59-63). On the contrary, the female patient on text fourth, she has sexually transmitted diseases, which is ‘unspeakable’, issues according to the society’s perceptions. As result, the patient when she hear the news she react shy on (text-4. line. 18, 32, 42) and unlike the male patient there are remarkable number of pause between sentences and she speaks with very low pitch which show nervousness.

In addition to these facts, the male patient asks and expresses his opinion to the doctor freely with clear sound. Moreover, at the end of the discussion he challenges the doctor to make adjustment on the number of the date, although not succeeds. Nevertheless, the female although the doctor offered opportunity in text (text-4-line. 25) she did not use it.

4.1.5. Gender of medical professionals’ in medical communication

As stated on chapter two of this research, gender associated with variation in communication style. In medical and routine communications, differences in the interpersonal style of women as compared with that of men are well documented. Women reveal more information about themselves in conversation, they have a warmer and more engaged style of nonverbal communication and they encourage and facilitate others to talk to them more freely and in a warmer and more intimate way. In contrary to that, males show a tendency to assert status differences. There is also, evidence that women take greater efforts to downplay their own status in an attempt to equalize status with a conversational partner and women are more accurate in judging others.

Text-5

An older woman who knows that she has a gastric ulcer for the last twenty years and came to consult the doctor and get some medication; and the **male** doctor who has more than twenty years experience, speaks Amharic as second language, and initiate the discussion as follow; **(**watching her card).

1. **Doctor:** □□□□ □□ □□?
   sïmïwot man näw
   What is your name?
2. **Patient:** x
3. **Doctor:** □□□□ □□ □□ □□□□□ □□□□□?
   mïnïdn näw zarre yämätt'ubät mïknïyatt
   Why do you come here today?
4. **Patient:** □□□□□ □□□ □□□□
   č'äg^{w}-arayen bätt'am yamäññall
   I have gastric pain
5. **Doctor:** □□□□ □□□□□?
   ïndet adärägott
   What do you feel?
6. **Patient:** □□□□□□
   yakk'att'ïläññall
   I feel burning
7. **Doctor:** □□□□ □□ □□ □□□ □□ □□□ □□□ □□?
   makk'att'äl bïčča näw wäys lella näggär abro allä
   Is it only burning what you feel? Or, do you have other problem?
8. **Patient:** □□□□ □□□□ □□□□ □□□□□□□□ □□□□ □□□□□□□ - - -
   yämïgb fïlaggot yäläññïm yakk'ïläššälïššäññal dägmom ayïffäčč'ïlïññïmm
   I don't have good appetite; I also have nausea and have difficulty of digestion.
9. **Doctor:** □□ □□□ □□□□□ □□□ □□?
   k'učč' yïllal ayfäčč'ïm mallät näw
   Do you mean the food you eat isn't digested?
10. **Patient:** □□
    awo
    Yes
11. **Doctor:** □□□? - - □□□□ □□□ □□□ □□ □□□□ □□ □□□ □□?
    lelas tïwïkät nägär wäym lella abrot yallä nägär allä
    What else do you feel? - -Do you have vomiting and other symptom?
12. **Patient:** □□ □□□□ □□□□ (she shows her chest area) □□□ □□□□ □□□□□□ □□□□ □□ □□- -
    ay tïwïkät yäläññïm ïzzih akababe yakk'att'läññal gonäbäs k'äna sïll
    I do not have vomiting but I have burning around here while I am work - -
13. **Doctor:** □□□□□ □□□ □□? (+) □□□□ □□□□ □□□ □□ □□□?
    yasayuññal ïzih näw tïwïkät yäläwïm sïnït geze honäw
    Let me see? Is it here? You don't have vomiting, How long is it?
14. **Patient:** □□ □□ □□□- - -
    bïzu geze honäw
    It is long time- - -
15. **Doctor:** □□□□ □□□ □□□?
    bägïmt sïnït amätt
    Be specific, how long is it?
16. **Patient:** □□ □□□ □□□□□::
    haya amät yïhonäwall
    At least, it is twenty years.
17. **Doctor:** □□ □□□□□ □□ (+) □□ □□□ (+) □□ □□□□ □□□□□?
    mïn ïyäwäsädu näw haya amät mïn hïkïmïna wäsïdäwall

What did you take for treatment since then?

18. **Patient:** □□ □□□□ □□ □(+)□□□- -
bäzu hïkïmïna näw se simïte
It is plenty, such as C- - cimit - -
19. **Doctor:** □□□□□?
simetedïn
Do you mean Cemitedine?
20. **Patient:** □□ □□□□□□□□□□ □□□□□□□□□□□□□□ □□ □□□□□□
awo simetidïn kagamit yämett'ätawïn fäsaššun bïzzu gezze ïwäsïdallähu
Yes, it is Cimitedine, Cagamaite and syrup; I took them for many years.
21. **Doctor:** □□ (3) □□□□ □□□□ □□□ □□□?
Ï- ïnäsun siwäsïdu läwïtt' aläw
Ok! - - Do you feel better while you take these medications?
22. **Patient:** □□ □□□□ □□□□□::
awo bätäläy simetidïn
Yes, especially when I took Cemitedine
23. **Doctor:** □□□□□ □□□?
yïkk'änïsal wäyïs
Does it gets better or?
24. **Patient:** □□
awo
Yes
25. **Doctor:** □□□□□ □□□□ □□□ □□□□ □□ □□□□ □□□- - -?
yämädanïs mïlïkït alläw läräğğïm geze yämätäw nägär
Does it show a sign of healing or getting better for longer time?
26. **Patient:** □□
awo
Yes
27. **Doctor:** □□□ □□□- - -?
aläw wäyïss
Yes you mean it gets better or?
28. **Patient:** □□ □□ □□ □□□□□ □□□□ □□□ □□□□□ □□□- - -
awo bäsu näw yätäššaläññ bämähall ahun tänäsabïññ ïnïğği
Yes, it was getting bettre because of it, but it relapses again now.
29. **Doctor:** □□□□ □□□□□ □□□□ □□□□?
sïläzeh labäratore tayïtäw yawïkk'allu
Therefore, you had a laboratory investigation for it too?
30. **Patient:** □□
awo
Yes
31. **Doctor:** □□ □□ □□□? □□ (+) □□□□ □□□□ (3) □□□□?
mïn alä alot dämu täsäïrïtto wïtt'etun nägärot
What did they said? Did they tell you the blood result is?
32. **Patient:** □□□□ □□□□ □□□□□□- - -
yäčč'äg^{w}-ara k'osïllät ïndaläbïññ
Yes, they said i have gastric ulcer.
33. **Doctor:** □□□□ □□□ □□ □□- - -?
k'osïllät alläw alu ïšši
They told you. You have ulcer. ok!

The doctor start to talk with a nurse and order to write her(patient) oprazole!

34. **Doctor:** □□ □□ □□□□ □□ □□ □□□□ □□- - -?
mïn mïn siwäsïdu näw gïn kämïgb gar
Regarding food, What onset the pain? Oh?
35. **Patient:** □- - -?
ï-ï

iOh- - - ?

36. **Doctor:** □□□ □□□□ □□□□ □□ □□□□□□?
mïgïb mïnamn siwäsïdu näw yämisämawott
The pain starts while you take food?

37. **Patient:** □□□□(+) □□□□ □□□□□□ □□ □□ □□□□□□□- - -
ïnïğğära mïnamn yïsïmamañña dabo näw yämayïsïmamañña
Well, injera don't- - cause my pain, bread on the other hand is not good for me- -

38. **Doctor:** □□□□□□ (+) □□□ □□ □□□□□ □□□□ □□□□□ □□□ □□□□ □□- - -?
yastamïmallu käzih bet hïkmïnaw bädänb nägïrotal käzih yakämot säw
You handle it well, they told you from this house when you get treatement?

39. **Patient:** □?
hï
What?

40. **Doctor:** □□□ □□□ □□□□ □□□□ □□□□□ □□□□□□□□ □□□□ □□□ □□□□ □□□□□□ □□□□ □□□□ □□□□□□□ □□ □□□□ □□□ □□□□ □□□□□□□ □□□ □□□□□?
käzeh bäfit setakämu yämïgb amägagäb hunetta bäsïnt bäsïnt sä-at lïyunät ïndämebälla mïngize mäbïllat ïndaläbot mïn aynät mäbïl mäbïllat ïndaläb^{w-}ät mïkïr wäsïdäwall
Did they told you about the way you should eat? in what interval you should eat. What kind of food you should eat?

41. **Patient:** □□ □□ □□□□ □□ □□□□□□ □□□ □□□□□□ □□□□□ □□□ □□….
tollo tollo mäbïllat bado ïndayïhon fesaš yämiyakk'att'ïl andanïd ïndä bona
They told me that i have to eat frequently not to get hunger, and not to drink hot fluids and coffee . . .

42. **Doctor:** □□□ (3)□□ □□
gobäz lïkk näw
You are doing good- - you are right.

43. **Patient:** □□ □□□□ □□□□ □□□□ - - -
bona bärïbäre mïnamn nägäročč
I have to avoid Coffee, peppery food and other similar things - -

44. **Doctor:** □□□□ □□□ □□ □□ □□□ □□□□ □□□ □□ □□□□□□ □□□□ □□□□ □□:: □□ □□ □□□ □□□□ □□□□□ □□□□□□□ □□□□□ - - -
sïläzzih ïrïso raso lïkk hakim honäwall mallät näw sïläbäšïtawo bädänïb ïyawkk'u näw tolo tolo tïnïšš mäbïlat läčč'äggorawo ïndayïkäbïd ayïfäčč'ïm
So, you also are like medical expert for your disease. You need to eat in small amount to aviod over load of stomach other wise it will not digest.

And the doctor starts to give order to the nurse in English 'thirty tab oprazole'

45. **Doctor:** □□□ □□□□□ □□□□□ □□ □□ □□ □□□□ ‰□Ý□□G □□□□ □□□□□ □□□□□? □□□ □□□□□□□□□ □□□□□:: □□□ □□□□□□□ □□□ □□□□ □□□ □□□□□□□ □□□ □□□ □□□ □□□□□ □□□ □□ □□□ □□□□:: □□□ □□□□ □□?
yïhn mädhanit ïngïdeh t'ott ïnna matta yïwïssädu omprazol yämibal bïlïčč'ïlïčč' yïwäsïdallu mïgïb yämayïsïmamawotïn aywïsädu wätät yämisïmamawot kähon afïläññña näggär yämisïmamawot kähon tïnïš tïnïš bätäläyayu ačč'ïr gizze wïsïtt' yïmägäbu sïrawo mïnïdn näw
You will take this medication. it is called omprazole. It has a bright color and drinks milk if it is convenient, eat injera and food in small amount. What is your job?

46. **Patient:** □□í M□□ □□ □□ □□□□□::
koppe maššïn lay näw yämesärraw
I work on copy machine.

In this example, the patient has gastric ulcer for the last twenty years and that makes her well informed to discuss about her disease with the doctor. Here, the patient knows what to do, what to take, what makes her feel better while her pain started, that is why the doctor on (text-6-line-44) promoted her as medical person. However, like most of the patients she uses unclear time adverb to explain, when the disease started on (line-14). The doctor repeated the question in the different direction on (line-15).

Regarding, code switch the patient uses almost three terms by insertion on (line-20, 46) Cimitedine, Cagamaite and syrup because there is no equivalent Amharic terms. The doctor on the other hand, implements insertion while talking with the patient on (line-19 and 45) because he is repeating the patient's word on the first case and using his own on the second, and in both cases the doctor insert the name of medication, which do not have equivalent terms in Amharic. Only the insertion used by the doctor on (line-29) 'has' equivalent term that is 'mïrïmärra' according to the context of the discussion can be implemented. However, he uses alterational code switching while he discusses with the nurse that is on (line-44). Unlike the previous cases, it is not because of missing the intended terms but could be a remark given by Matras (2009) certain group of people, constant or frequent code-switching may itself be a mark of their identity as belonging to two 'linguistic worlds' this may the normal form of linguistic communication that is 'Fused lect'.

In addition to this, the doctor seems to focus only on the sickness or pain only, rather than on the whole problems of the issue. Because, during the whole interaction the doctor asks a close-ended questions that are focused, on what he wants out of the discussion. Rather, he should ask the patient open-ended questions that give the opportunity to the explanation of her, which is the patient's general situation.

Within interaction between, the nurse and the doctor, the doctor gives order to the nurse to measure the blood pressure of the patient's. Giving order to someone is a one of the many ways, which people use to signify status, because not only in this text but also in all of the texts the doctor gives orders to the nurse not the other way round. Additionally, in most cases the doctor uses English language to give orders to the nurse. For example, as seen above on (line-44) the doctor gives the order in English and the reason could be 'fused lect' or solidarity, which is used to form professional solidarity between the doctor and the nurses by discussing the same point in English, which is most of the time not understandable to the patients.

Text-6

A **female** doctor with more than twenty years of experience, looking on the patient's card and a male patient at his sixty enters to the examination room with his friend coughing persistently and the doctor start the discussion by saying,

1. **Doctor:** □□□□ □□ □□□□□ □□ x?

mïnïdn näw yamämäwott atto
What is your problem Mr X?

2. **Patient**: □□□ □□ □□□□ □□□ □□□□□ (+)□□□ □□□□ □□□
bïrd näw mäsäläññ bïrd sanbayen ïnğa samïnt honoññall
I think I have flu on my lung, and it is almost a week

3. Doctor: □□□□ □□□□□**?**
Ïndet adärägott
What do you feel?

4. **Patient:** □□□□□
yafïnäññall
It suffocates me.

5. **Doctor:** □□□?
mafänn
You have suffocation?

6. Patient: □□ - -- □□□□ □□□□ (3) □□□ □□□□□
awo lälletïm lä-ande täññïčče aladïrm
Yes, it makes difficult for me to sleep because of breathing difficulty.

7. Doctor: □□□**?**
mafänn
You have suffocation?

8. Patient: □□
awo
Yes

9. **Doctor:** □□□?
lelas
What else?

10. Patient: □□□□□:: (3) □□
yasïläññal bäkk'a
I only have coughing, that is it.

11. Doctor: □□□ □□□?
masal aläw
Does it also have Cough?

12. **Patient:** □□? □□□ □□□ □□□□- - -
sal bätt'am bätt'am bähayïll
Yes, I have cough, and it is very serious cough- - -

13. **Doctor:** □□□ □□□ (+) □□□ □□ □□?
akïtta aläw däräkk' näw salu
Does it have sputum? Is it just dry?

14. **Patient:** □□□ □□
däräkk' näw
It is just dry sputum.

15. **Doctor:** □□□ □□□ □□□□□□?
mïnm akïtta ayïwätt'awïm
Are you saying; it doesn't have any sputum?

16. **Patient:** □□□□□
yïwätt'awall
There is sputum.

17. **Doctor:** □□ □□□□□ □□□□□ □□□?
mïn yïmäsïlal yämewätt'aw akïtta
What does it looks like?

18. **Patient:** □□ □□
näčč' näw
It is white.

19. **Doctor:** □□- - - □□□?
oke lelas

Ok! (Pause), what else do you have?

20. **Patient:** □□ □□ □□ (3) □□ □□□ □□ □□□ □□□- - -
yïhe bïčča näw ïnna ahun hode k'osällä ahun
This is it. (Pause) and I feel pain on my abdomen.
21. **Doctor:** □□□ □□□□□ □□□ □□?
bäsallu mkïnïyatt malät näw
Is it because of the cough?
22. Patient: □□□ □□□□□ □□ (+) □□□ □□□ □□□□□ □□ □□
bäsallu mïkïnïyatt awo k'osällä ahon sebïsbïññ gize näw
Yes, I think it is because of the coughing, I come here because it gets severe.
23. **Doctor:** □□□□ □□□?
tïkosat alott
Do you have fever?
24. **Patient:** □□□□ □□□□□ □□ □□ □□□□□ □□ □□□ □□□□ □□
tïkosat andanïd gize alä andanïd gize dägïm k'äzïkk'aza näw
Yes, I have fever sometimes but sometime I feel colder.
25. **Doctor**: □□□ □□□ □□□□ □□? □□□□□ □□□ □□□□?
ahun bäzih samïnt näw
Does it happened only in this week or there was also such fever, previously?
26. **Patient:** □! (+)□□□ □□□ □□□□ □□
a- ahun bäzih samïnt näw
Oh - - -it started only in this week.
27. Doctor: □□□ □□□□ □□ □□□□□ □□□□?- - - □□□ □□□- - -?
anïd samïnt näw käğämärot t'äkk'ïlalla labät nägär
Are you saying, it has been only one week? Do you have sweating too?
28. **Patient:** □□□
yälämm
No
29. **Doctor:** □□□? (3) □□□ □□□□ □□ □□□□□□?
yäläm mafänu matta matta näw yämiyafïnott
No, there is no sweating? (Pause) Does the suffocation happen only during night?
30. **Patient:** □□ □□ □□ □□ □□ □□ □□□□□ □□□□ □□ □□ □□ □□□□□ □□□ □□□□□. .
mata lay näw k'očč' byi näw yämadïrräw ïndehu k'očč' bye näw yämadïräw käzarre yïššaläññal
It happen only at night, I spent the whole night without sleep I thought it will get better but
31. **Doctor:** □□ □□ □□□ □□?
k'än k'än dähna näw
Do you feel better at day?
32. **Patient:** □□ □□□□□ □□□□□ □□□ □□□□ □□ □□□□□□- - -
kän yïtäwäññal ïndäwïm ïziya alïgaw lay ïnïdätäññahhu
It gets better at day while I slept on bed- - -
33. **Doctor:** □□□□□ □□ □□?
yïtäwotal k'än k'än
Does it get better during day?
34. Patient: □□□□ □□ □□□□ □□□□□ (3)□□□□□- - -
kätäññahu gïn samïnt yïhonäññal tätäññahuss
Nevertheless, it has been a week since I slept
35. **Doctor:** □□□ □□□?
bäzehu bäsallu
Is it because of the cough?
36. **Patient:** □□□ □□□
bäzehu bäsallu
Yes, it is because of the cough.
37. **Doctor:** □□□ □□□ □□□ □□ □□□□? □□□ (3) □□□ □□□□□?
käziya bäfit mïnm sal yälotm asïmma näggär yawïkk'utall
Do you have a history of cough or Asthma?

38. **Patient:** □□□□□ □□□□□
yäläbïññïm ïndawïmm
No, I don't have any history of asthma.
39. **Doctor:** □□□?
č'ärïsso
Don't you have any history?
40. **Patient:** □□ □□□ □□ □□□□- - -
ïnne agär bet kägäbahhu
Since I came to my home country - - -
41. **Doctor:** □?
hï
Hi?
42. **Patient:** □□□□ □□□□□ □□ □□□ □□□ □□□ □□ □□□□- - -
takïmem alawïkk'ïm ïnna ahun kägize bähowalla näw yäyazäññ
I am a healthy person; it is after a while I got sick-- -
43. **Doctor:** □□□ □□□□□□ (3) □□ □□ □□□□□□?
bïrd ïndämättawo mïčč näw yämisämawott
Do you think you got 'bïrd' or 'mïčč'
44. **Patient:** □□□ □□□ (+) □□ □□
ïndä bïrd mïčč näw
I think it is 'bïrd' - - - or 'mïčč'
45. Doctor: □□□ □□ □□□ □□ □□?
bïrd näw wäyïss mïčč näw
Is it 'bïrd' or 'mïčč'?
46. Patient: □□□ □□□ □□□□ □□□ □□□ □□□ □□ □□ □□□□ - - -
yähonä nägär šätättäññ mänässa yähonnä k'ošaša bota k'omme šätätäññ
It started when I passed through filthy way I smell bad odor since then it get worse- -
47. Doctor: □□ □□□□ □□ . . . . □□□□□ □□□ □□□□□? □□□□□ □□□?
šïtta bäziyaw bäkk'a wädiyawïnu mäsal ğämärïwot masïnätt'äs aläw
It started to cough immediately. Do you have sneeze too?
48. **Patient:** □□□□□ □□□□□□□(3)□□□□□□□
bämähakäl yasïnnätt'ïsäññall yasïnnätt'ïsäññall
Sometimes yes- - -there is sneezing
49. **Doctor:** □□□□□ □□□? □□□ □□□ □□□ □□ □□ □□□ □□□?
masïnätt'äs aläw dïmïtt' aläw ïnde sirr sirr yämill dïmïtt'
Do you have a snazzy? Do you hear a sound like 'sir' 'sir' whiles you breathing?
50. **Patient:** □□ □□ □□□
awo awo alläññ
Yes, yes there is a sound.
51. **Doctor:** □□□□□□ □□□□□ □□□□ □□□□□ (3) □□□□□ □□□ □□□ □□□ □□□ □□ □□□□□ □□□? she starts to listen the chest with stereoscopy at the same time
därätïwon awïlïkk'äw wädälay yïtänïfïssu mïlasotïn yawïtt'u bäfit alïffo alïffo sal aläbïwot ïnde
Put off your cloth and breath, show me your tongues, do you have cough previously?
52. **Patient:** □□□ □□□ □□
anïd anïd gize
Yes, there was sometimes
55.**Patient's Friend:** □□□ □□ □□□□□□□□ □□
ahun näw yätt'änäkäräbaččäw sallu
It is now that, it gets serious
56. **Doctor:** □□□□□□□□ □□□□ □□□□□□ □□ □□?
yätt'änäkäräbaččäw sayïhon yäğämäraččäw mäčče näw
I am not asking you when it gets serious, but when does it get started?
57. **Patient:** □□□ □□□ □□□
tïnïšš tïnïšš näbär
Previously, it was mild.

58. **Doctor:** □□ □□□□□
k’oy yïtänïfïsso
You Stay still, breathe.
59. **Patient:** □□
awo
Ok

Pause for about 1minute while the doctor writing on the patient card and have talk with the nurse then order the nurse to bring stereoscope from other examination room:

60. **Doctor:** □□ □□□□□□ □□□□ □□□□ □□□□□□ □□□□?
rağğ tänäsïtačč̈ïhu yïzačč̈ïhu mämïtt’att tïč̈ïlalačïhu ayïdäll
Can you bring X-ray result from other place, right?
61. **Patient’s Friend:** □□:: (3) □□ □□□ □□□ □□□ □□□□□□□□ - - - □□□□□□ □□□□□ □□ □□
ïšše ïšše čïggïr yäläm yädäm aynätačč̈äwïnïm bïlädïgïrop beyawïkk’ot t’ïrro näw
Ok! Ok, there is no problem and it is good for him to know his blood group too?
62. **Doctor:** □□□ □□□□□□□ □□□ □□□□□? □□□□□□□□?
yädäm aynätačč̈äwïn mawäk’ yïfälïgallu yasïfällïgačč̈äwall
Do you need to know blood group too?
63. **Patient’s Friend:** □□ - - □□□□□□□□ □□□□□?
awo ïnïfällïgïwallän aynättunn
Yes- - - we need to know the type?
64. **Doctor:** □□□□ □□□□□ □□?
lämïgb amägagäb näw
Is it for food selection?
65. **Patient:** □□ □□□□□□□□ □□
awo lä-amägagäbačč̈äw näw
Yes, it is for food selection.
66. **Doctor:** □□ □□□ □□□ □□□ □□□ □□□ □□□□□□?
däm gïfit wäyïm sïkk’o^{w}-ar käzih bäfit yatt’äkk’ačč̈äwall
Do you have history of diabetes or blood pressure?
67. **Patient:** □□ □□□□□□□ □□□□- - -
ïrrä ayawkk’ačč̈äwïm bäfïtt’umm
Never, he was always healthy
68. **Doctor:** □□□ □□□ □□□□□? (+)□□□ □□□□ □□□□ □□□□□?
šïnït čïggïr yällačč̈äwïm šïnït makk’att’äl mïnamn yällačč̈äwïmm
Do you have urinary problem while you urinate?
69. **Patient:** □□ □□□ □□□□□- - -
allä ahun käğämäräññ
Yes, there is since this pain started.
70. **Doctor:** □□?
awo
Yes?
71. **Patient:** □□□ □□□□□ □□□□□□ □□ □□
ahun käğämärräññ yakk’at’ïläññall bičč’a näw
Yes, since it started and the color turned to yellow.
72. **Doctor:** □□□ □□□□?
k’äyärrä mälïkkun
Is the color changed?
73. **Patient:** □□
awo
Yes
74. **Doctor:** □□□- --?
dämna
blood and - - -?
75. **Patient Friend:** □□□□□□- - -

bïlädïgïrop
Bloodgroup

76. **Doctor:** □□□ □□□□□□ □□□ □□□□ □□□□□ □□□□□□ □□□□□ □□□□□□ □□□□□ □□□□□□ □□□□□□□::
gäbaññ bïlädïgïrop lellamm mïrmära azïğğallähu šïnïtaččäwïn yïmärïmärru rağğaččäwïnm yïmärïmäru ïndädäräsä tamätt'ačč^{w}-alaččhu
Ok! I order the blood group and other investigation so you will bring the urine result and the x-ray

77. **Patient:** □□
ïššï
Ok

This communication is one of the best medical communications that are seen during the observation. Because the doctor gives the patient full attention in regarding time, space and gesture. The doctor shows respect by using 'anïtu' although she is also older who has twenty years experience. The doctor also spends long time by discussing the patient's problems and gives the opportunity to explain himself.

On the other hand, it is a good example to see how doctors violate the maxims because; the doctor in this interaction applied the same question repeatedly. Of course, the doctor does this to have a clear understanding of, what the patient is saying. However, it is overly done the doctor continues to press for more information until she is satisfied on (text-7-line 4-7).

Concerning, code switching the patient's friend is code switch. Unlike, the other patients seen in texts, here he seems to 'give the doctor an idea about the speaker's potential'. According to, Myers- scotton's example of a university lectures from the University of Malawi, visiting her mother's local village one man with only a little English even though both speak the local language the person speak English (Myers-Scotton, 1995:193). The same thing seems happened, the patient's friend says 'look, I can speak English and understand some ideas about medicine too'. Because as observed on (line 4-61, 75) he can use the Amharic equivalent term 'yädäm 'aynät mïrïmärra'. Moreover, he that is the patient's friend respond on (lines-63, 65) *'we need to know the type'* and *'Yes, it is for food selection'.*

Then again, the doctor keeps talking the whole time in Amharic with the exception of using once on (line-76). In addition, the doctors also sometimes use 'Amharic terminologies' on (line-43) which according to Morasch, good communication is the result of the use of common terms that understood clearly by both parties, which in this regard is the physician and patient (Morasch, 2010: 3). The doctor seems to work and believes on this point even though the Amharic terms do not have a clear meaning to the interlocutors.

4.1.5.1. Comparison of medical interactions (medical professionals' gender) 5 and 6

When we see the three excerpts on 5 and 6 gender of the medical professionals is one factor that affect the content of the interaction. The first point, to support this assumption is unlike the first discussion on excerpts 5 conduct by male medical professional, the female medical professional took longer time to interact with her patient. Second, the female on (text- 6. lines. 3, 19) asks open-ended questions, which give the opportunity for the patient to express his opinion. Third, the female doctor uses a paralinguistic features like body contact, touching to check-up his vital sign. That helps the patient to develop trust and friendly during communication. Fourth, the female doctor unlike the male doctor act too friendly by asking and commenting feedback on the points rose to encourage the patient to keep up the discussion. Which is an evidence to the literatures commented by Bylund and Makoul (2002) and (Roter and Hall (2004), that is female physicians conduct longer consultations than male physicians do, which clarify their tendency to start partnership building largely than male physicians. In addition, consultations with female physicians include more talk that is positive, psychosocial counseling, psychosocial question asking, emotionally focused talk and emphatic communication than consultations with male physicians.

On contrary, the male doctors on excerpts 5 the discussion is very hierarchy and formal, which is only, focused on medical topic, implying that the doctor ask close-ended questions and do not give the opportunity to explain their opinion. Moreover, on text-5 the doctor orders to the nurse to check the vital sign of the patient even though he has stereoscope of his own. He seems to avoid any attachment to the patient but focusing on professional topics only.

4.1.6. Education as factor influencing medical interactions

Educational status of the patients is also another factor that affects the content, the trend and the atmosphere of the communication. The United States Ministry of health and child welfare (health education center) prepare a manual in title 'Interpersonal communication manual for trainer of health services provides', which states, patients' education give a chance for the patient to explain how much and how often should the medication should be taken, and the possible side

effects of the medication. It also helps to conduct self-administration of some medications such as insulin and give the knowledge to the patients about the disease and means of transmissions (1998:33).

Text-7

Female patient in her 30 who has hemorrhoid and came to the heath centre to get referral from the health center and have good knowledge about her diseases. She wants to go to the nearest hospital. Therefore, she is having a discussion with female doctor who have more than twenty years of work experience,

1. **Doctor:** Mrs. □□□□ □□ □□□□ □□□□?
   mïndïn näw yamämäš nïgäriññ
   Tell me, what do you feel?
2. **Patient□** □ (+)□□□ □□□□ □□□□ □□□□□□ □□ □□□□□ (4) (showing on her stomach)
   Ï-ïzih akababi yamäññal yakk'att'ïläññal däm yïwätt'aññall
   I feel sick around here, it burns - - - it bleeds (low pitch)
3. **Doctor:** □□□□ □□ □□ □□?
   sägärašš lay däm alä
   Is there blood on your stool?
4. **Patient:** □□
   awo
   Yes
5. **Doctor:** □□
   oke
   Okay
6. **Patient:** □□□ □□□□□□□□ □□□ □□ □□ □□□ □□ □□□□□□□□ □ □□□□□□ □□□□□ □□□□□ □□□□ □□□□ □□□ □□ □□□□ □□□□□ □□ □□□□□ …. □□ □□□□□ □□□□□(+) □□□□ □□□□□□□ - - - (4)
   yïhäw alïtïrasawïnïd hakim bet hiğğe näbär ïnna alïtïrasawïnïd na kollonïsïkopi tayïččalähhu opïrešš'ïn mädärräg aläbïšš alloññ ïna gänïzäb sïläleläññ ïnna gïnïññonät bïzzo hosïpital tayïččalähu mädäbäkk'o sïlalasïfälägä
   This is ultrasound result, I went to clinic and they saw an ultrasound and colonoscopy. They said I have to have operation but since, I do not have money and I want to be open, I went to many hospitals.
7. **Doctor:** □□ (+)□□ □□ □□ □□□□□□ □□□ □□□□□
   aha lïk näw ïko kädäbäkïšïmma mïnun takkämïššïww
   Yes if you hide your problem, you cannot get a good medication
8. **Patient:** □□ - - - □□ □□□ □□□□□□ □□□□□□ □□□
   awo ïnna akk'ïme sïllämayïččïl bägïlïtt'ïnät mätt'ahu
   Yes,- - - and since I cannot afford the money I came here.

The doctor looking on the results and the patient start to explain about the situation

9. **Patient:** □□ □□□□ □□□□ □□□ □□□□
   ïssu kolalitt aläbïšš täbïye näw
   That one, they told me I have kidney problem.
10. **Doctor:** □□ - - □□□ □□□ □□□ □□□□□ □□□ □□ □□□□□
    awo bägïrra bäkol yägïrra yäkolalit t'ätt'är alä yïlall
    Yes, it states you have kidney stone at lift side of your body
11. **Patient:** □□ □□□□□ □□□ □□□□ □□□□ □□□□
    ïssu yäkolalit namuna ïnïtn täsärïtto näw
    In addition to that, it is a sample taken from the hemorrhoid
12. **Doctor:** □□□□ □□□ □□□ □□□□□ □□ □□□□□ □□□□ □□ □□□□- - -
    sïläzih ahun yaläš kinïtarrot näw yäwïsïtt'ïna yäwïčč'ïm näw yämiläww
    Therefore, now you have internal and external hemorrhoid

13. **Patient:** □□□□□ □□ □□□□ □□
käwïsïtt’ïm alä käwïčč’ïm allä
Yes, it is inside and outside my body
14. **Doctor:** □□□□ □□□ □□□□□ □□□ □□□□ □□□□ □□ □□□□? (+) □□□□ □□□□□ □□□ □□ □□□□ □□□□□□□□ □□ □□ □□□□□ □□□□□ □□ □□ □□□□□ (+) □□?
sïläzzih ïsun hosïpital hedäšš mätayät fälïgäš näw aydäl sïläzzih wïtt’etïšïn yağğïna wädä mïnilikk ïnïtt’ïfïlïššalän ïššï yaw opïrišš’in kasïfälägä ïzza näw yämisärrot ïššï
So, do you want to go to hospital, oh? Therefore, you will take the results and we will write for you to Minilik hospital. If operation is necessary, they will do it there.

The doctor starts to ask the name and addresses again to write on the referral paper to hospital at the same time asks questions,

15. **Doctor:** □□□□□ □□□□ □□□□□ □□□ (+) □□□ □□ □□? □□□□□
mädhanit mïnamn tätt’äkk’ïmäšš ïnbi bïllo näw kinïtarottu
You ofcourse, try medication and it did not work right?
16. Patient: □□ □□ □□□ □□□ □□□ □□□?
awo wädä hullät amät gädäma honäw
Yes, it is almost two years
17. **Doctor:** □□□ □□□ □□□?
mïnm ïnbi aläšš
You try everything and didn’t work?
18. **Patient:** □□ □□ □□□□□
awo yaw alïkk’omäm
Yes, it didn’t stop.
19. **Doctor:** □□□□?
yïdämall
Is it still bleeding?
20. **Patient:** □□ (+) -□- - -□. □□□□ □□□ □□□ □□□□ □□□ □□□□□□□
awo kä- kä käwïsïtt’ ïndä mägïll aynät nägär yïwätt’awall
Yes, it comes out from the inside and it looks like pus.
21. Doctor: □□□□**?**
yïwätt’all
Does it get out?
22. **Patient:** □□□ □□□□ □□□□ □□□□□□ (+)□□□ □□□ □□□ □□□□□ □□ □□□ □□□ □□□ □□ □□ □□□□□□ □□□□□
bätt’am k’oyäbïññ bämïgb sïkk’ott’att’äräw mïgb ïndä hïtt’an ïyäbällahu yaw sïnt amät sost gizze näw kollonïsïkopi yättayähott
It has been many years, I try to control it by food like body and I had three colonoscopy results.
23. **Doctor:** □□□□ □□?
altay bïllo
Is it because, it is invisible?
24. **Patient:** □□ □□□□ □□□□□ □□□ □□□ □□ □□□
ay ïnïtïn anïğätïš wïsïtt’ čïgïr kallä täbïllo
No, they told me, I had intestinal problem.
25. **Doctor:** □□□ □□ □□□ □□□□□ □□□□□□□□
ahun gïn mïnm ïndälell t’ïfäwïlïššall
Now they write to you, it doesn’t have any problem.
26. **Patient:** □□ □□□ □□ □□□□ □□□ □□□□ □□□ □□□□ □□ □□□ □□ □□□□□ (Dr X) mentioning a fameus physician □□□ □□□□□ □□□ □□ □□□□□ □□□□□□□
gïn sost gizze dägagïmo sittay yïhïnïno näbär yätayäw ïnna sost gize yätayähut doctor x ïnïğği yämänïdär hakim gar aydälläm yätayähott
However, I had seen (Dr X) three times and he says the samething. Three times, I didn’t go to other places.
27. **Doctor:** □□□□□ □□□ □□ □□□□□ □□ □□□ □□□□ □□::
wïtt’etočč’in yïzäšš hiğğe sïtïheğğem ïššï mïnilik hiğğe
Go to Minilik ok! When you go don’t forget to take your the results.

The dialogue between the female doctor and patient is clear. The patient is successful in addressing her social, financial and physical problem to the doctor. Then the doctor gives the needed solutions to the problems. The patient came to the health center not to get medical care because, the patient clearly states she does not have money on (line-6 and 8) and she has been treating her disease for about two year. Moreover, she states many doctors comment to have operation. Therefore, she is in the health center to get referral paper.

The patient has hemorrhoid, which is taboo according to the society. The physical problem that makes people uncomfortable to talk about as the patient mentioned on (text-7-line-6) and before that, she did not tell her disease to the doctor. She was talking things that are related to the topic but not directly forward. For example, on (line-2) the patient says; I feel sick around here, it burns - - - it bleeds (low pitch). The patient speaks and gives details information about what she undergoes. It is obvious on (line-2, 4) from her voice quality that she was uncomfortable talking about it too because people used very low pitch to signify their discomfort about the topic. Despite the discomfort, the patient has information about her disease so it was not difficult for the doctor to explain the situation to the patient. In addition to that, the patient even knows what to do now and what should be done in the future, consequently it is clear that this doctor and patient have a very fruitful discussion.

The mention a fames doctor's name on (line-26) to explain how much she tries to get a solution for her disease and tries to show how desperate she is, in addition to this, the patient has kidney stone, which is another complicated problem. The patient used an insertional code switching during the interaction. Since, there are no equivalent terms for the words on (line-6).

At the same time, the doctor assured her it is normal to talk whatever the problem is with the doctor to get a better solution on (line-7). The doctor also encouraged the patient to explain herself and tries to created a friendly atmosphere by asking a questions such as on (line-14-18) which are not specific on the disease but about on (line-14) the medication and about the food too. After the questions and seeing the patient's endoscopy and colonoscopy results, the doctor comment the patient to go to the nearest referral hospital called 'Minelek hospital' and remained her to take the whole results, which is a very friendly and helpful interaction.

Text-8

A young female doctor asks a 10-year female patient's mother. The girl seems to have gastric problem but she and her mother convinced that she has heart problem. Hence, the doctor tries to convince the mother as follow;

1. **Doctor:** □□□ □□□ □□?
   mïnon amott näw
   What is her problem?
2. **Patient:** □□□□ □□□ □□□□
   zïm bïlla lïben tïlaläčč
   She complains, she has pain on heart.
3. **Doctor:** □□□ (+) □□ □□ □□ □□□□□?
   lïbon yättu garr näw yämiyamatt
   On her heart, where does it hurt?
4. **Patient mother:** □□□ □□□ □□□□ □□□□□□ □□□□ □□ □□ □□□□ (+)□□□ □□□ □□□□
   dïkm nägär yïlattal yïdäkïmäññall tïllalläčč zïm bïlla mätäññat ras^{w}-an bätt'am yamattall
   She complains, she felt tiered always and, she slept for long hours with in a day.
5. **Doctor:** □□□□? □□ □□ □□ □□□□ □□□□□? □□
   mätäññat yätu garr näw lïbïšïn yamiyamïšš mitt'a
   She sleeps? Where exactly does it hurt?
6. **Patient:** □□ □□ (showing on the chest)
   ïzzi garr
   Here it is.
7. **Doctor:** □□□□ □□ □□□□□□□?
   ïndet näw yämiyadärïgïšš
   What do you feel?
8. **Patient:** □□□□ □□□□□ (4)
   mätäññat yakk'ïtäññall
   I can't sleep.
9. **Doctor:** □□□ □□□□? □□ □□ □□□□? □□□ □□□ □□ □□□ □□□ □□□ □□ □□□?
   dïkïm yïlïšal täññi täññi yïlïšal dïkam aläšš ras mïtat aläšš lellas mïn aläšš
   You feel tired. You feel sleepy, do you have headache? What else do you have?
10. **Patient mother:** □□□□ □□□ □□ □□□
    tïkussat bätt'am näw yalatt
    She also has fever.
11. **Doctor:** □□□□□□ □□□?
    yatäkussatall lelas
    She has fever. Ok what else does she have?
12. **Patient mother:** □□□ □□□□□ (4)
    mïgb atbälamm
    She doesn't eat food. (Low pitch)
13. **Doctor:** □?
    hï
    Come again?
14. **Patient mother:** □□□ □□□□□
    mïgb atbälamm
    She does not eat food.
15. **Doctor:** □□□ □□□□ □□□□?
    mïgb fïlagot yälatïmm
    She doesn't have an appetite?
16. **Patient mother:** □□ □□ □□□□ □□□□
    wïha bïčča mätt'ätt'at näw
    Yes, she only drinks water.
17. **Doctor:** □□□□□ □□□□ □□□□ □□□ □□?

mïrakk’ïššïn sïtïwïčč’i yamïššall ïnde mett’a
Do you have pain while you swallow your saliva?

18. **Patient:** nodding (no)
19. **Doctor:** □□□□ □□□□□□□□? □□□ □□□ □□□□? □□□□□□□□? □□□ □□□□ □□□□ (□□□ □□□) showing on the hand □□□□□ □□□ □□ □□□ □□□ □□□□?
hodïšïn ayïkk’orïtt’ïššïm bïrd bïrd yïlïššal aybärïdïššïm bïrd ïndih simättašš ïzih ïzih golïbätïšš mïnïšš garr dägïmmo yäläšïmm
Do you have pain on your stomach? Does your temperature get colder? Do you felt pain or tired?
20. **Patient:** nodding (no)
21. **Doctor:** □□ □□ □□□□□?
mäčče näw yäğämäratt
When did it start?
22. **Patient mother:** □□□ (4)
hamoss
It started on thundery. (Lower pitch)
23. **Doctor:** □□□ □□?
hamoss lätt
Is this Thursday?
24. **Patient**: □□
ïh
Oh
25. **Doctor:** □□□□ □□ □□□?
täkk’ïmatt’ mïn alatt
Does she have diarrhea?
26. **Patient:** □□□□
yälatïmm
No
27. **Doctor:** □□□□ □□□□ □□□□ □□□?
šïnïton sïtïšänna makk’att’äll alatt
Does she have burning while she urinates?
28. **Patient mother**: □□□□□□□ □□□□□□□ - - -
yämiyakk’att’ïlat aymäsïläññïmm
I don’t think so. - - -
29. **Doctor:** □□□□□□□? □□ □□ □□ □□ □□□□ □ (3)□□□□ □□ □□?
ayakk’att’ïlaššïm bäkk’a zïm bïllo ras mïttatïna lä-tïkussat bïčča näw
Do not you feel burn when you urinate? You only have headache and fever.
30. **Patient mother:** □□□ □□□ □□□□ □□□□□□ □□□ □□□ □□□□ □□□□ □□□
lïbon bätt’am yamatal yïdäkïmatal tïkossat nägär bätäläy sïtïtt’ätt’a bätt’amm
She also has pain on her heart, feels tired, and has fever especially when she takes hot drinks….
31. **Doctor:** □□□ □□ □□ □□ □□**?** □□ □□ □□**?** □□ □□ □□**?** □□ □□ □□ □□**?** □□□ □□□□ □□□ □□□ □□ □□□□□ □□□□□□ □□□□ □□ □□□ □□ □□ □□□□□ □□ □□□□ after seeing the patient for a while back to the chair and paused for at least 1minites.
ïsïtti yät garr näw lïb yät gar näw lïb yät alä lïb yät gar näw ïnde sïnïtäññа kïfïl tämarri näšš läsayïnïs astämarišš tanagïrre lïb ïzih gar näw bïlañññaläčč näw yämïlläww
Where is your heart? Show me, where your heart is? What grade are you? Does it hurt when I touch it? I will tell to your science teacher that you told me where the heart is.
32. **Doctor:** □□□□□□ □□□**?**
yasgäsattall ïnde
Does she have gas?
33. **Patient mother:** □□□□□□ (3)□□::
yasgäsattall awo
Yes, she has gas. - - yes
34. **Doctor:** □□□ □□□ □□□□□ □□□□?
bïrd bïrd aylattïm aydäll
Does she feel cold frequently?

35. **Patient mother:** □□□ □□□□ □□□□ □□ □□□
bätt'am hayïlläññа tïkussat näw yallat
She has very series fever.

The doctor starts to give order and tell write her □□□ □□□□□□□ □□
sïttol egzamïneššïn bïčča
Only stool examination

36. **Doctor:** □□Ws□ □□□□ □□□□ □□□□ □□□□ □□□ □□
labïratori mïrïmra sägäranna yäššïnït adïrïga tïmïtt'a
You will bring Stool and urine examination

This interaction is focused more education, which the health education is given by the doctor to the patient because the patient's mother concludes her daughter has heart disease. Because it seems the patient's mother and the patient convinced that she, which is the patient, has heart diseases because the symptoms she shows looks like a heart diseases on (text-8-line-4).

Besides, during the conversation the doctor tries to clear out what the real problem is and even at (line- 31). The doctor asks and uses a very good approach of teaching the patient and her mother. The doctor asks where the heart anatomical position is to convince the patient. That is a good strategy because instead of telling the patient she is not a heart patient the doctor leads the patient to a better conclusion.

Conversely, when (line- 31) seen under speech act theory

Locutionary acts stated,

Doctor: □□□ □□ □□ □□ □□**?** □□ □□ □□**?** □□ □□ □□**?** □□ □□ □□ □□**?** □□□ □□□□ □□□ □□□ □□ □□□□□ □□□□□□ □□□□ □□ □□□ □□ □□ □□□□□ □□ □□□□ after seeing the patient for a while back to the chair and paused for at least 1minites.
ïsïtti yätt grr näw lïb yät gar näw lïb yät alä lïb yät gar näw ïnde sïntäññа kïfill tämarri näšš läsayïnïs astämarišš tanagïrre lïb ïzih gar näw bïlaññaläčč näw yämïlläw
Where is your heart? Show me, where your heart is? What grade are you? Does it hurt when I touch it? I will tell to your science teacher that you told me where the heart is.

Where is your heart?

Illocutionary acts: it is question

Perlocutionary act: you do not a have heart disease you have gastric ulcer.

That is why the doctor starts to asks questions, which are more relevant to the gastritis on such as (line-32, 33 and 34).

The patient and her mother on the other hand, seem to have a little information on health and seem to transfer a contradictory information because the mother on (line-4) gives an information that signify the patient has problem of sleeping and contrary to this information the patient on (line-8) responed she can not sleep. In addition to this, on (line-3) the doctor asks where the

patient's heart is. Then, where it hurts? However, on (line-4) the patient's mother resoned, which is irrelevant to the questions, which is *'She complains, she felt tiered always and, she slept for long hours with in a day.*

4.1.6.1. Comparison (education) influencing medical interactions 7 and 8

Accordingly, here are two excerpts that, two patient on text 7 and 8, the first patient has good knowledge, what to do regarding her disease. In contrary to this, the second patient do not have clue about her daughter's disease. That is why she, the patient's mother, thinks her daughter has heart disease. As result, the first patient and the doctor have very informative communication. For example, on (text-7-line-6, 8 and 11) the patient gives the necessary information with certainty. Because, of the patient's educational background that is familiarity about her disease the doctor does not spend much time to convince or argue other health issues to the patient but focused on the solution.

Alternatively, the second patient has no knowledge about the health issues as (text-8-line- 2, 28, 30) the patient's mother speaks with uncertainty and the doctor on (line-32) makes it clear that it is not heart disease rather simple gastric upset. Additionally, the second doctor tries to give health related information by redirecting the conversation and asking questions on (line-25, 27and 29). These questions give the impression that the doctor is tring to divert the attention of the patients and her mother from the heart diseases.

However, these two texts clearly show that the educational background of the patient and familiarity of the patient's about their diseases has big role on the productivity of the communication

4.1.7. Maxims and speech act in the medical interactions

Text- 9

A man at age of mid, 30 raped by his friend so developed a psychotic disease, believed that all his symptoms are associated with this past story. Therefore, he attempts to convince the doctor even though the patient probably has a parasitic infection. The doctor has more than twenty years of experience. The discussion went as follow,

1. **Doctor:** m.x □□□ □□?
   dähïnna näh

How are you?

2. **Patient:** ደህና እግዜአብሔር ይመስገን !
dähïnna ïgïzi-abïher yïmäsïgän
I am good thanks to god

3. **Doctor:** ምንድን ነው ኮፍያው ?
mïnïdn näw kofïyaw
Why do wear cap now?

4. Patient: ያው ትንሽ ብርድ ነው ለጠዋት
yaw tïnïš bïrd näw lätt’äwat
It is because of the morning’s cold.

5. **Doctor:** እኮ ፊትህም አይታይም እንዴት አድርጌ ልይህ ? ስንት ሰዓት (+) መቼ ነው የሚወርደው? ባንዲራ ነው? (የባንዲራ ቀለም ያለው ከፍያ) አይደለም == ደህና ነህ ምንድን ነው የሚያምህ ?
ïko fetïhïm ayïtayïm ïnïdet adïrïgge lïyïh sïnït sä-at mäčče näw yämewärïdäw banïdera näw ayïdälläm dähïnna näh mïndïn näw yämeyamïh
How can I see your face? The cap covers your face. At what time does, the flag going to down? (Laugh). How are you? What do you feel today?

6. **Patient:** እኔ ትንሽ ጉዳት አንድ ጓደኛዬ አድርሶብኝ ነው
ïnne tïnïš gudat anïd g^{w}adäññaye adïrïsobïññ näw
My friend cause me little damage

7. Doctor: እ?
ï
Oh?

8. **Patient:** እና በተኛሁበት ቦታ ምን እንደበላኝ አላውቅም በተኛሁበት በሽንት መፀዳጃ ትቦዬ ላይ ደፍሯኛል እና ያ ውስጡ ምን ቁስል እንደፈጠረ አላውቅም- - - (4)?
ïnna bätäññahubät bota mïn ïnïdäbällaññ alawïkk’ïm bäšïnït mätt’ädağğa tïboye lay däfïroäññal ïnna ya wïsïtt’u mïn k’osïl ïnïdäfätt’ärä alawïkk’ïm
He raped me while I slept; I do not know what he gave me to eat, so I do not know what happened. I think there is a wound - - -

9. **Doctor:** እ?
ï
Oh?

10. **Patient:** ያ አሁን በውስጡ ቁስል ተፈጥሮ እኔ ምንም አልገባኝም ነበር ልጁ ለካ እንደዛ እንዳደረገ የሆነ ነገር አለው የሰራው ነገር አለ - - -
ya ahun bäwïsïtt’u k’ossïl täfätt’ïrro ïnne mïnïm alïgäbaññïm näbär lïğğu ïnïdäza ïnïdadärägä yähonä nägär aläw yäsäraw nägär allä
There is a wound now, I don’t understand what the son did but something happened - -

11. **Doctor:** ምንድን ነው የሰራው?
mïnïdn näw yäsärraw
What did he do?

12. **Patient:** ማለቴ የብልግና ስራ ነው (+) እና አሁን መፀዳጃ ቱቦዬ ራሱ ለመፀዳዳት ስሞክር ሽንት ለመሽናት ስሞክር ችግር አለው ውስጡ እንደ ትል ተፈጥሮ መሰለኝ ሆዴ ይጮሃል ቀንም ሆነ ማታ ይጮሃል በቃ እንጀራ ምሳ ሰዓት ከዛ ውጭ አንድ አንድ ዳቦ እየበላሁ ዳቦና ደረቅ ብስኩት እበላለሁ ምግብ ትቼ ማለት ነው እንጀራ ስበላ በጣም እየጮኸ (+) ድምፅ ራሱ መተኛት አልችልም እዛ አጠገቤ ልጆች ራሱ ይደነግጣሉ በቃ ሩሩ ነው የሚለው እንደመኪና ነው ውስጥ (+)ውስጥ ትል ምናምን ተፈጠሯል አልፎ አልፎ ደግሞ ከመፀዳጃ እንትን ላይ ማለት ነው የበሰበሰ ነገር ይወጣል ፈሳሽ ነገር : : ኮተቤ ላይ ማለት ቀበሌም ሄጄ አቅም ስለሌለኝ ጠይቄያለሁ ከዛ (he shows card given by authority to get free medication)
malätte yäbïlïgïnna sïra näw ïnna ahun mätt’ädağğa toboye raso lämätt’ädadat sïmokïr šïnït lämäšïnat sïmokïr čïgïr alläw wïsïtt’u ïnïdä tïll täffätt’ïro mäsälläññ hode yïčč’ohal k’änïm matam yïčč’ohal bäkk’a mïsa s’ä-at kätza wïčč’e anïd anïd dabo ïybbälahu dabona däräk’ bïsïkut mïgb tïčče mallät näw ïnïğära sïbälla bätt’am ïyačč’oh dïmïtt’u rassu mätäññat alïččïlïm ïzza att’ägäbe lïğğučč rassu yïdänägïtt’allu bäkk’a rro-rro näw yämelläw ïnïdä mäkena näw wïsïtt’ wïsïtt’ tïll mïnamïn täfätt’ïrr^{w}-al alïfo alïfo dägïmo kämätt’ädağğaye ïnïtïn lay mallät näw yäbäsäbäs nägär yïwätt’al fäsaš nägär kotäbe lay malät heğğe sälleläññ t’äyïkk’eyalähu käzza
I mean, some dirty thing happened to me. When I try to excrete, my rectum has pain. I think it creates worm, my stomach has sound at night and day because of this. I only eat injera at lunch otherwise; I only eat bread or biscuit I do not eat if I eat injera. It makes sound and makes difficult to sleep even the people around me can hear it like car sound. I am certain that there is

also some kind of worm and sometimes some dirty thing comes through my rectum I went to Keble because I cannot afford.

13. **Doctor:** ... /......\\ ... እዛ ስትጠየቅ ነው ይህን የምታሳያቸው እሱን ያዘው
ïzza sïtïtt'äyäkk' näw yïhïn yämïtasayačäw ïson yazäw
You will show them when they ask you there.

14. **Patient:** እቺን ወረቀት ሰጡኝ እና ሳንባዬን በጉንፋን በሕመም በቁስል - - -
ïččen wäräkk'ät sätt'uññ ïnna sanïbayen bägunïfan bähïmäm bäkk'osïll
They gave me this paper and my lung cough hurts- - -

15. **Doctor:** መቼ ነው የደፈረህ ?
mäčče näw yädäfärräh
When did he rap you?

16. **Patient**: እ? 2002 ከሰኔ ወር 2002 10ኛ ወር አካባቢ በዛ ሰዓት ነው የነበርኩት አሁን አሞኝ ከእዚህ ምንም ዘመድ የለኝም ክፍለ ሃገር ነበር
የመጣሁት ከሰው ጋር ስራ ውዬ ---
ï 2002 käsäni wärr 2002, 10ñña wärr akababe bäza sä-att näw yänäbärïkut ahun amoññ käzeh mïnm zämäd yäläññïm kïfïllä hagär näbär yämätt'ahut käsäw gar sïrra wïyye
Oh? 2002, since June 10, around 2002 at that time- I did not have a relative here.

17. **Doctor:** እና ደፍሯህ ዝም አልከው ?
ïnna däfïrroh zïm allïkäw
Did you keep queit, after he raped you?

18. **Patient:** አይ ፖሊስ ጣቢያ ሄጄአለሁ በዛን ሰዓት ስሄድ አጠገቤ ያሉት ትልቅ ሰው ነበሩ ተወው ምናምን አሉኝ ስነግራቸው አልገባቸውም (+)
እንደዚህ መጥፎ ስራ ሰርቶብኛል የብልግና ስራ ልክሰሰው ስለው ሰውዬው ተወው አሉኝ ፖሊስ ጣቢያም ስሄድ ትክክለኛውን መረጃ አምጣ
ሲሉኝ ተናድጄ ሄድኩ ክፍለ ሃገር ጥዬ ሄድኩ አሁን ግን ሰውዬውን ራሱን አግኝቼ በራሴ እሄዳለሁ ብዬ ነው የመጣሁት ሰውዬው አምልጧል
አሁን ፖሊሶች ነግሬያቸው ቀበሌም ነግሬያቸው ቀበሌ የሚሰሩ ሰዎች እኛ ህክምናህን ውሰድና ወይም operation ተደረግ ትሉ መውጣት- - -
ay polles t'abeya heğğe-allähu bäzan sä-at sïhed tïlïkk' säw näbärru täwäw mïnamïn alluññ sïngïraččäwïm alïgäbaččäwïm ïnïdäzzeh mätt'ïffo sïrra särïtobïññal yäbïlïgïna sïrra lïkïsäsäw sïllaw säwyew täwäw alloññ polles t'abeya tïkïkïläññawïn märräğğa amïtt'a seluññ tänadïğe hedïkku kïfïllä hagär t'ïye hedïkku ahun gïn säwäyäwïn rassi agïññïčče bärase ïhedalähu beye näw yämätt'ahut . . .
No, I went to the police station. However, while in station i talked with an elder man and he told me to forget it because he did not understand it. The police men also told me to bring evidence then I got frustrated and left to I my home now I return here to take him to police by myself of course he is near to be found but I went to kebele and the told me to get medication first- --

19. **Doctor:** ኤች . አይ . ቪ ተመረመርክ?
HIV tämärrämärïkk
Were you screened for HIV?

20. **Patient:** ያኔ መጥቼ ተመርምሬያለሁ እዚህ መጥቼ የለህም ተብያለሁ
yane mätt'ïčče tämärïmïreyallähu ïzzeh mätt'ïčče yälähïm täbïyallähu
I came here at that time and checked. You told me I am negative.

21. **Doctor:** ሣል አለብህ እንዴ ያስልሃል ?
sall alläbïh ïnïde yasïlïhall
Do you cough?

22. **Patient:** አንድ አንድ ጊዜ ሣል አለ (3)አዎ
anïd anïd geze sall allä awo
Yes, I have cough sometimes- - - yes

23. **Doctor:** አክታ አለው ?
akïtta aläw
Does it have sputum?

24. **Patient:** አዎ
awo
Yes

25. **Doctor:** ምን ይመስላል
mïn yïmäsïllall
What does it looks like?

26. **Patient:** ነጭ
näčč'

White

27. **Doctor:** □□□□ □□□□ □□□?
yämïgb fïlagott aläh
Do you have an appetite?
28. **Patient:** □□□ □□□□ □□□ □□□ □□□□□ (+) □□□ □□□□ □□ □□ □□ □□□□□□□
bïzum fïlaggot yäläññ wïsïtt’e sïlätägoda sä-atu sedärïs zïmm bïyye näw yämïbällaw
Not much since I have the problem in my body, I just eat for the sake of eating
29. **Doctor:** □□□ □□□□ □□(+) □□□ □□□ □□□□□ □□ □□□□ □□□□□ □□ □□□ □□ □□□□□□ □□□ □□ □□□ □□□ …
ahun mïnïdn näw hulun nägär kä-ïnïtïnu gar mayayaz yäläbïhïm ïšše hodïh lay yätäfätt’äräw čïgïr lella čïgïr ïnïğğ
Well you do not have to relate everything with the thing ok. What happened in your abdomen does not have any connection with - - -
30. Patient: □□□ □□ □□□□
tïlïmma alä yïčč’ohall
However, I am sure there is worm.
31. **Doctor:** □□□□ □□ □□□□□ □□□□□ (3) □□ □□□□□ □□□□□ □
käzeññaw garr magänaññät yäläbïhm ïšše labïratore asärïttäh na
You should not associate everything with it- -- ok. Bring laboratory result and

The patient is clearly nervousness about the discussion. That is why; he talks not only about the problem he has but also about the time, it started. It is common for patients to give less or more information than required during diagnosis. In this situation, the patients believed that all his problems caused because of the ‘rape’ and even though he said he was raped he is uncertain about it too (text-9-line-8) he shows hesitation. Because, he explained, he was sleep while his friend raped him.

However, it is brave of him to speak up about what he believed happened since it is taboo to speak up about these things. Most probably, that is the reason, why the patient develops a psychiatric case, disappointment and he use very low pitch on (line-8, 12, and 18) he feel that even the police cannot do anything about it. When mentioning about his problem, the sad thing that is observed during this discussion is, even the doctor avoids responding to the psychological disappointment the patient feeling.

However, the doctor utilizes ‘relevant information’ according to the doctor observation (line-31), and discards ‘irrelevant ones’. That is the doctor discards all the informations that the patients give and select only some.

Doctor: □□□□ □□ □□□□□ □□□□□ (3) □□ □□□□□ □□□□□ □
käzeññaw gar magänaññätt yälläbïhm ïšše labïratore assärïttäh na
You should not associate everything with it- -- is it ok? Bring laboratory result and

Nevertheless, the fact is, the medication give to this patient is useless. Since it does not address the central point of the problem that is the psychological issue, which is for the comment the

doctor give on (line-29) the patient responds on (line-30). This statement clearly indicate that the patient after interacting the doctor is the same patient before interacting the doctor, which is the patient does not benefited out of the communication.

Text- 10

A female doctor and an elderly male patient, who has vomiting and diarrhea, he came to check if there is complication. The interaction goes as follow;

1. **Doctor:** □□ □□□?
   mïn näbärr
   What can I do for you?
2. **Patient:** □□□□□□
   astawäkäññ
   I vomited
3. **Doctor:** □□□□ □□□ □□ □□□□□? □□□ □□□ □□□ □□ □□□□□?
   yäbälut nägär näw yämiwätt'aw ways hamot nägär näw yämiwätt'aww
   Is the vomit kind of food you eat or bill like?
4. **Patient:** □□□ □□□□□ □□
   yäläm yäbällahut näw
   No, it is a food.
5. **Doctor:** □□□□ □□□ □□?
   Yäbällut nägär wätt'a
   Is it just a food?
6. **Patient:** □□
   awo
   Yes
7. **Doctor** □ □□? (+) □□ □□□□□□ □□□□ □□?
   ïšši lela yämissämawot mïndïn näw
   Ok? - - --What are the other problems you feel?
8. **Patient:** □□ □□□ □□□□ □□□□ □□□□ □□□□ □□□□□□ □□□□ □□ □□□□□□□- - -
   ïnna ahun lägizzew ïnïtn lämallät näw lämanïññawïm mïnilik näw yämkätattälläww
   I come only to be seen for now, because I have followed up at Minilike.
9. **Doctor** □ ... /.....\\ ... □□□□ □□ □□□□□□ □□□□□?
   mïnilik näw yämittakkämott ayïdällämm
   Is it Minilik hospital where you have been seen?
10. **Patient:** □□□□ □□ □□
    mïnilik näw awo
    Yes, it is Minilike.
11. **Doctor:** □□ □□□ □□□□?
    ras mïtatt aläwott
    Do you have headache?
12. **Patient:** □□□ □□□□ □□□□
    ahun lägizzew yälläññïmm
    I don't have now.
13. **Doctor:** □□□ □□□□? □□ □□ □□□□□?
    yäläm aydäll č'äww mïn aybällumm
    You don't have? Do you eat salt?
14. **Patient:** □□ (+) □□□□□□ □□ □□□□□ □ (+) □□□□ □□ □□□ □□□□□□ □□□□□
    č'äww yätägäññäbbätt näw yämïbällaw ïndih yallä nägär yämisäralïññ yälläm
    Salt - -- I eat everywhere, since nobady prepare for me at home, - - -

15. **Doctor:** የተገኘበት□ማለት□እንዴት - - -?
yätägäññäbätt mallät ïndett
What do you mean everywhere?

16. **Patient:** ውጭ□ነዋ□የምበላው□ያው□ውጭ□የተሰራውን□ነው £ምበላው□ሆቴል□ቤት□ምናምን□ጨው□አትስሩ□ለማለት□አልችልም- - -
wïčč’ näwwa yämïbällaw yaw wïčč’ yätässärrawïn näw yämïbälaw hotel bet mïnamïn č’äw atsïrru lämallät alïččïllïmm
I eat outside my home in hotel so I cann’t order them to do a food without a salt only for me - - --

17. **Doctor:** ታዲያ□እኮ□ጨው (+) ጨው□አትስሩ□ማለት□አይችሉም□ግን□ያው□ለራሶ□ጥንቃቄ(+) ቤት□ውስጥ□ማድረግ□አይችሉም□ቤት□ውስጥ□መብላት□አይችሉም?
tadiya ïkko č’äw atsïrru mallät ayïččïllum gïn lärassu t’ïnïkk’akk’e bet wïsïtt’ madïrräg ayïččïllum bet wïsïtt’ mäblat ayïččïllumm
Of course, it is hard you cannot say, ‘do not add salt but you have to be carful, why don’t you eat at home.

18. **Patient:** የት (+) እኔ□ማዘጋጀት□አለመድኩም□ያው□ውጭ□ነው□የምበላው - - -
yät ïnne mazäggağät allämädïkkum wïčč’ näw yämbällaww
I don’t have the habit to prepare at home so I eat outside

19. **Doctor:** ታዲያ□ይሄ□እኮ□ለርሶ□ጥሩ□አይደለም□ማለት **?**
tadiya yïhe ïko lärrïsso t’ïrru aydälläm mallätt
But, it real is a hurmful for you I mean - - -

20. **Patient:** ወድጄ□ነው? ግዴ□ነው□እንጄ□ወድጄ□እኮ (+) አይደለም።
wädïğğe näw gïde näw ïnïğğe wädïğğe ïko aydällämm
I doing have a choice, do I?

21. **Doctor:** ምክንያቱም (+) ከፍ□ሊል□ይችላል□እኮ□ደምዎት□እ ? (+) ደምዎት□ደሞ□ከፍ□ካለ□ድንገት□ሊጥሎት□ይችላል፡
mïknïyattum käff lel yïččïllal ïko dämïwot ï dämïwot dämmo käf kallä dïngät lett’ïlot yïččïllall
Because it could elevate - - your blood - - -and if your blood get higher it could make you fell suddenly.

22. **Patient:** እኮ□እኔ□ምን□ላድርግ ? እኔማ□በተቻለኝ□ምን (+) ስኳርም□አለብኝ□ስኳር□ደንበኛዬ□እዛ□እንትን□አለ።□አሁን□በቀደም□ትናንት□ነው□ሄጄ□ነበር፡
፡□አንድ□ስድስት□ወር□ቀጥሮኛል።
ïkko ïnne mïn ladrïg ïnema bätäččalläññ mïn sïkorïm aläbïññ dänbäññaye ïzza ïntïn allä ahun bäkk’ädäm tïnanïtt näw hiğğe näbär anïd sïdsïtt wär k’ätt’ïroññall
Of course, what can I do I am also diabetic so I check and follow up every six month with my client.

23. **Doctor:** አሁን□ያለው (+) ተቅማጥና□ቁርጠት□ነው□ያለው ?
ahun yalläw täkk’ïmatt’ïnna k’orïtt’ät näw yalläw
So now, you have only diaharia and nausea?

24. **Patient:**□ኪኒኑን□ይሰጠኛል□እንትን□የስኳርና□የደሙን□ይሰጠኛል
kinenon yïsätt’äññal ïntïn yäsïkorïna yädämon yïsät’äññall
He always gives me the medication for the blood and diabetic.

25. **Doctor:**□□□□ መድሃኒት□መውሰድ□ብቻ□አይደለም□እሺ□አባት□በምግብ□መከላከል□አለቦታ□ብስጭት□ካለ□ብስጭት□ንዴት□ካለ□ንዴት- -
sïläzeh mädhanit mäwïssäd bïčča aydälläm ïšši abat bämïgb mäkälakkäl aläbotta bïsïčč’ït kallä bïsïčč’ït nïdett kallä nïdett
It is not only medication you have to take, but has to control it with food too, disappointment and anger that too.

26. **Patient:** ነበር□እኮ□እኔ□ጡረተኛ□ነኝ (+) አሁን□ዛሬ□ሁሉ□ነገር□እየጨመረ□ነው□በአስር□ሳንቲም□የምንበላው = = ዛሬ□አስር□ብር□ሽሮ□ራሱ□ዶሮ□ስጋን =
=ተይው□ስጋው□ድሮ□በ50 ሳንቲም□የምንበላው□ሦስት□አይነት□ቅልጥም□ነበር□የምንበላው□አሁን□አገሌ□ጨምሯል□እንጨምር□ነው□የተያዘው፡በዛ□ላይ
ምን□ታክላለች ? ስለዚህ□ወዳጄ□ሳይሆን□ግዴታ□ነው።□መድሃኒቱም□ያው□ዝምብሎ□መዋጥ□ብቻ□በዛ□ላይ□ውድነቱ ?
näbär ïkko ïnne t’urättäñña näññ ahun zarre hullo nägär ïyäčč’ämmär näw bä-asr sanïtim yämïnïbbällaw zarre asr bïrr šïrro rasso dïrro sïggan täyw sïggaw dïrro bä 50 sanïtem yämnïbälaw sost aynät k’ïlïtt’ïm näbär yämnïbällaw ahun ïgälli č’ämïrrowall ïnïčč’ämïr näw yätäyazzäw bäzza lay mïn takkïlaläčč sïläzzih wädïğe sayïhon gïdetta näw mädhanitom yaw zïmïbïllo mäwatt’ bïčča bïzza lay wïdïnättu
I am just a retired person to day everything is getting expansive before 50 years a thing that cost 10 cents cost10 birr(laugh) today’s ‘shore’ let meat (laugh) it used to cost fifty cents with three types of bones now it is a competition even the medication it is useless --so it is impossible for me eat home.

27. **Doctor:** ... /......\\ ... ያው□እሱም□እንዳለ□ሆኖ□እርሶ□ደግም□የተቻሎትን□ማድረግ□ነው።
yaw ïssum ïndall hono iriso dagïm yätäččallotïn madïräg näw
Of course, there are many problems but you have to try

28. **Patient:** □□□ □□□ (+)□□□□ □□ □□□□□ □□□□ □□□□ □□□ □□ □□□□ □□□□ □□--
ïsuma mäččem amarračč’ ïko lämadïräg andäññа economе čïgïr allä t’urättäññа yä-ärrat mätto
Of course … but to choice first there is financial problem I am retired and only get 400 -
29. **Doctor:** □□□ □□□□ □□□ □□□ □□ □□□□□□?
ahun täkk’ïmatt’u nïfïtt’ nägär näw yämimässïlläw
Now, does the diarriea have mocius?
30. **Patient:** □□ □□ □□□□ (+) □□□□□ □□□ □□□□ □□□ - - -
ay ïssu ïntïn aydälläm bätt’am ïntïn bïl^{w}-all
No - - - it – no -
31. **Doctor:** □□ □□□ □□?
näčč’ k’äčč’ïn näw
Does it is white and watery?
32. **Patient:** □□□ □□□
k’äčč’ïn hono^{w}-al
Yes, it is watery
33. **Doctor:** □□□ □□□ □□ □□ □□ □□□□□?
k’äčč’ïn nägär näw zïm bïllo yämiwwätt’aw
Does it just water which flows?
34. **Patient:** □□□ □□ □□ □□□□
anïd gzze bïčča näw
It is only once.
35. **Doctor:** □□□□ □□ □□□□ □□?
k’orïtt’ättu ahunm allä
Is the pain on your stomach still active?
36. **Patient:** □□□□ □□
yïčč’ohhal hodde
My stomach has sound.
37. **Doctor□** □□□□□?
yïngog^{w}-all
Does it have sound?
38. Patient: □□ (+) □□□□□ □□ □□ □□□□□□□□ □□ □□ □□□□□ □□□ (+) □□□□ □□□□ □□ □□ (+)□□ □□□□□□□□ □□□□□ □□□ □□□□ (+) □□□□ - - -
awo yïngog^{w}-all ïnne lella ïndayasïkkättïl bïye näw yämätt’ahutt ïzzih bägizzew lïttayäw bïye näw mïn yallïdärräsïkubät hosïpital yälläm yäkatit pawïlloss
Yes - - -it has sound I came here for fear of complication - -- it is good to been seen on time on time, I mean I went many hospitals for this sake, yekatite pawlos - -
39. Doctor: □□□? □□□ □□□? □□Ws□ □□□□□ □□□□
lämïnno lädäm gïfittu labïratore asärïttäw yïmätt’allu
For what reason is it? Is it for the Blood pressure? You will have labratory investigation.
40. **Patient:** □□□ □□□ - - -
ïsïtti kähunn
We will see

In this interaction, the patient violates almost three of the maxims that are maxims of quantity, relation, and manner (Adrian et al: 2001:399).

For example, on (text-10-line-8) the patient violate maxim of relation because on (line-7) the doctor asks him wither he has other additional problems but he respond as follow

Doctor□ □□? (+) □□ □□□□□□ □□□□ □□?
ïššï lella yämisämawot mïnïdn näw
Ok? - - --What are the other problems you feel?
Patient: □□ □□□ □□□□ □□□□ □□□□ □□□□ □□□□□□ □□□□ □□ □□□□□□□- - -
ïnna ahun lägizzew ïntïn lämalät näw lämanïññawïm mïnilik näw yämkätatälläww

I come only to be seen for now, because I have followed up at Minilike.

The patient states he comes for check up only. Despite that, the doctor asks him a series of questions but he repeatedly responds irrelevant answers. For example, for the question on (line-7, 13, 16 etc.) and the patients responded on (line-8, 14 etc) an answer which is in his mind. That is a violation of relevance.

For example, for the question asked by the doctor on (line-13) the doctor seems to ask, do you eat salt? However, the patient responds irrelevant answers so the patient is violating maxim of quantity.

Doctor: □□□ □□□□? □□ □□ □□□□□?
yäläm aydäl č'äw mïn aybällum
You don't have? Do you eat salt?
Patient: □□ (+) □□□□□□ □□ □□□□□ □ (+) □□□□ □□ □□□ □□□□□□ □□□□□
č'äww yätägäññäbät näw yämbällaw ïndih yallä nägär yämissärallïññ yälläm
Salt - -- I eat everywhere, since nobady prepare for me at home, - - -

Moreover, in the regard of maxim of quantity it is seen on (lines-26, 20). For the manner, it is clear that, it is different from culture to culture but it looks likes, the patient has behavioral problems or it seems he is dissatisfied about everything around him. Because, it seems that he knows that the doctor cannot do anything about the problems he is talking like on (line-26). Yet, he still talks about it.

On the other hand, the doctor also violate maxim of 'manner' as the society put the rule that states, it is rude to interrupt while the elders talk on (line-27). What is more, the last point that should be considered in this interaction is the respond on (line-40). That is, the patient last comments, which is very interesting term that signifies the patient's perception of medicine.

Patient: □□□ □□□ - - -
ïsïtti kähunn
We will see

Locution act: the patient responds 'we will see'

Illocution act: it is comment with negative sense

Perlocution act: I know it is useless but let us try anyway.

The patient already says this word on (line-26), not directly but explains that even the medication is useless and expensive so it is impossible and useless to take medication.

4.1.7.1. Comparison of the medical interactions of 9 and 10

As Kecskes, remarks citing Grice, remarks a rational speaker will choose an utterance that will provide the hearer with a maximum number of contextual implications in a minimum processing effort. Consequently, each participant strives to make the discussion acceptable in quantity, quality, relation and manner by the other interlocutor (Kecskes: 2006:107). Nevertheless, despite this fact, it is not easy to put general rules putting which one is the right answer for the questions asked by the other party. Because, it really is depend on contextual and cultural issues of the participants of the communication. For example, here are two examples that are picked for comparison. On the text-9, the patient commits maxims of quantity

11. **Doctor:** □□□□ □□ □□□□?
    mïnïdn näw yäsärraw
    What did he do?
12. **Patient:** □□□ □□□□□ □□ □□ (+)□□ □□□ □□□□ □□□ □□ □□□□□□ □□□□ □□□-

Rather according to Grice, the patient should respond just - - -□□□□- --

The other example is maxim of manner and relation, which is committed by the patient on the text, 10 that is, paralinguistic features, which have frequent pause and acting carelessness, is the observe manner and the relation is revealed by the answer given to the following question.

25. **Doctor:** □□□□ □□□□□ □□□□ □□ □□□□□ □□ □□□ □□□□ □□□□□ □□ □□ □□□□ □□ □□□□ □□ □□□ □□ □□□

26. **Patient:** □□□ □□ □□ □□□□ □□ (+) □□□ □□ □□ □□□ □□□□□ □□ □□□□ □□□□ □□□□□□ = = □□ □□□ □□ □□ □□ □□ □□□ = =□□□ - - -

The doctor was not expecting an answer when she giving these advices but the patient implicates that yes you are right and I understand what you are saying but your advice is useless for me.

The other observation seen is on (text 10-line 39and 40) under speech act theory is,

39. Doctor: □□□? □□□ □□□? □□Ws□ □□□□□ □□□□
    lämno lädäm gïfittu labïratori asärïttäw yïmätt'allu
    For what reason is it? Is it for the Blood pressure? You will have labratory investigation.
40. **Patient:** □□□ □□□ - - -
    ïsïtti kähun
    We will see

Locution act: the patient responds 'we will see'

Illocution act: it is comment with negative sense

Perlocution act: I know it is useless but let us try anyway

4.1.8. Solidarity in the medical interactions

As Keller (2000), the individual's identities will vary on the variable or parameter to determine the identity, therefore there are different types of identities under the umbrella. An individual can

exploits his identities according to different layers by forming heterogeneous identities. To manifest these identities every individual uses his gender, profession, religion, ethnic etc according to the situations ask.

In the following interaction, a young girl in her late twenty came to the health center having cough and seen by a doctor who has more than twenty years of experience. Both speak Oromiffa as first language and the patient seems to know this fact and the interaction,

1. **Doctor:** □□□□ □□? □□□ □□ ? □□□□ □□ □□□□□ ?
   ïndet näw sällam näšš mïnïdn näw yämiyamïšš
   How are you? Are you ok? What is your problem?
2. **Patient:** □□□□ □ (+) □□□□ □□□□□::
   gonïffan ï amarïññа alïččïmm
   I have cough - - - oh – I do not speak Amharic
3. **Doctor:** □□□□ □□ □□□□□□?
   mïnïdn näw yämtïččïyïww
   What do you speak?
4. **Patient:** □□□□
   oromïññа
   Orromigna
5. **Doctor:** □□?
   ïšši
   Okey?
6. **Doctor:** Natti himi
   Okey, speak
7. **Patient:** Naqufaasisa Na hoo'isa
   Cough and fever
8. **Doctor:** Akkitaa qabaa? Kanbiraan hoo?
   Do you have sputum? What ealse do you have?
9. **Doctor:** Maalif beektaa aannan dhuguu jedhama = = □□□□ □□□ □□□ □□□□□□□ □□□□
   -----yäbborränna lïğğočč hïmäm ayawïkk'aččäwïm yïbbalall
   You know why they drink milk (laugh) it is said, it is not common to see sick person from Negel borne
10. **Nurse:** □□□□ □□ □□□□□?
    ïndäzza näw yämmiballäw
    Is it like that
11. **Patient:** essa deemu amma?
    Where shall I go?

This communication is casual interaction. That seems to be influenced by the patient speaking Oromiffa and her being female. Unlike most of the preceding and following interactions, the doctor is acting too friendly. In addition, the doctor even uses a proverb to make the patient feel easy and friendly on (line-9). Language use signifies many things in the communication and choice of language at special situation might mean many things. For instance, the patient speaks Amharic but prefer to use Oromiffa to create less distance between her and the doctor because as

Matras (2009) remarks, when the ML is the international language example, English then a switch to the local nation language can reinforce intimacy and closeness to the interlocutors. Therefore, in this context the patient switches from Amharic to Oromiffa. Amharic, which is a langue-franca and 'everybody speaks it', but oromiffa in this communication creat ethnic solidarity between the patient and the doctor.

Moreover, like the patient the doctor use an inclusion approach by alteration of the meta-language here Oromiffa to Amharic especially with laughter on (line-9). That might seems the doctor tries to create more distance from the patient but it is clear that he continue the meta language after the alterational code switch of the sentence. Consequently, the doctor switches from Oromiffa to Amharic for inclusion purpose to show the nurse 'this is what we are talking about and that is why we are laughing'. In both cases, the 'special effect' of code switching is to decrease social distance.

Doctor two examining a patient and at the same moment, another physician (doctor one) enters to the office and say.

1. **Doctor one**: □□□□ □□□ □□□
   ïnïkkon dähna mätt'ašš
   You welcome
2. **Doctor Two:** □□□□ □□□ □□□
   ïnïkkon dähna k'oyähh
   Well stay
3. **Doctor one:** □□□ □□?
   dähna näšš
   Are you fine?
4. **Doctor two:** □□□
   allähu
   Yes, I am fine.
5. **Doctor one:** □□□ □□□□□□□ - -- □□□ □□□ □□?
   Yä-ïnne sïtetïsïcop näggär yälläm yänne
   There is my stereoscope in? - - -
6. **Doctor two**: 'it is deaf and blind' □□□ □□□ □□□ = = she gives him and show the stereoscope
   It is def aenïd blaend --minim näggär yälläm

Each group has its own language or variety of a language, register, terminologies, and language, which makes him different from others. As, medical professionals have medical jargon and registers which can show group membership of their own. Speaking that language, variety, jargon gives a sense of belonging to the group. Therefore, they implement these features to form this professional solidarity in many cases. For example, these two doctors exchange greeting in Amharic, but on (line-6) while doctor one asks the second doctor about professional question,

where his stereoscope is? The second doctor responds the stereoscope does not work. However, the doctor responds it in English since it is a professional topic.

4.1.9. Pragmatic failure in the medical interactions

Doctor and patient interactions are succeed on the successful production and interactions of the successful production and interpretation of utterances by participants. To prevent pragmatic failure or misunderstanding, the participants must struggle to inquire about clarifications until messages are understood clearly. Despite this safety measures, however a few instances of misinterpretation of sense in utterances are observed during interactions (Adegbite, 2006: 515). Even though, the magnitude and risk of the misunderstandings might vary according to the individual interlocutor and context, the danger in medical communication can cost life. The following two examples below signify miscommunication made in interactions that can lead to confession or even to serious damage.

1. **Doctor:** □□ □□□□ □□□ □□□□□□?
   ïnne yämlïšš ïnnatt ayassïllïššïmm
   By the way, miss, don't you have cough?
2. **Patient:** □□□□ □□□□□□ □□ □□ □□□□ (4)
   samnït yalämälläwät' allä dïdd mädmatt
   It has passed a week there is no change

This dialoged is taken from (text-12, line-1, and 2); the interaction does not make sense. It cause very huge miscommunication, the doctor asks the patient, if she has cough but the patient respond on (line-2) that she has kind of gingivitis which is Inflammation of the gums. The misunderstanding probably happened because of nervousness on the patient's side.

1. □□ (3) □□ □□ □□ □□□□□□ □□ □□□□?
   ok - - - (pause 20 sec) when did you see blood in sputum?
2. **Patient son:** □ (+) □□□ □□ □□ □□ □□ -□ - - -
   Oh…. It is Sunday when I oh…
3. **Doctor:** □□ □□□ □□□□ □□□□□ □□□
   You don't see it since then?
4. **Patient son:** □□□ □□□ □□□□□□?
   there wasn't before Sunday.
5. **Doctor:** □□□ □□□ □□□□ (+) □□□□□ □□□

The last example to observed here on the pragmatic failuer is from (text-11,line-49-53) which takes between the doctor and the patient's son. That is happened on (line-49) the doctor asks when was the blood seen in the sputum, but the patient's son respond that the blood was seen on sunday. And the doctor continue, does is happened since then (on line-51) but the patient's son

repond it does not happened before that day. There is a clear miscommunication between the doctor and patient' son.

4.1.10. Language use in medical communication

Matsuoka citing from (Linell and Luckmann, 1991: 4) language is an important instrument to transform information, for gaining and keeping power and to show respect etc. However, as Gumperz and Cook-Gumperz summarized that 'ethnically different speakers are not able to handle the formal criteria for giving information or producing contextually relevant talk in situations with which they have little direct experience', such as job interviews, public debates, or discussions such as medical communications (Gumperz and Cook-Gumperz,1992: 14).

Even though, many reasons can be remarked for this difference, chapter two of this research paper comments, citing (Hymes: 1968) that, to produce communication, an interlocutor have to know at least two language skills out of four. Those are, associate with the ability to speak and understand language, which is not based solely on grammatical knowledge rather on communicative competence, and to know what counts as appropriate language varies according to context, and may involve a range of modes such as on speaking, writing etc.

Moreover, common cultural dependency, linguistic and extra linguistic functional systems, implying, communication takes place based on increasingly shared knowledge. The greater the knowledge shared, the more effective the communication. Consequently, Interlocutors must employ forms of conversation that are appropriate to the situation. That is, they must follow priority, comply with turn taking, and ensure discourse coherence (Bruno, 1999: 53). To show this here are example,

Text-11

An old woman, who have very serious cough, came with her son. Male doctor with many years of experience saw them. Three of them are bilingual; Amharic is their second language with much influence of first language and start the discussion as follow:

1. **Doctor:** □□□ □□□ □/□ x?
   dähna adärro wäyzärro
   good morning mrs x
2. **Patient**: □ **(+)** □□□□□□□ □□□□□
   ï ïgïze-abïher yïmäsgänn
   Thaks to god I am ok.

3. **Doctor**: □□□□ □□ □□□□□□?
   mïnïdn näw yämeyamwott
   What is the problem?
4. **Patient son:** □□□□ □□□ □□□□ - - -
   yamattall bïrd amottall
   she has cough
5. **Doctor:** □□□□ □□□□□**?**
   mänagär ayïčč̈illom
   She can not speak?
6. **Patient son:** □□□□□ - -- (4)
   sikäbïdatt
   It is difficult for her - - -
7. **Patient:** □□□ □□ □□□ - - -
   bäğğorro näw ïnïğğ
   I only hear but could. . .
8. **Doctor:** □?
   ï
   Oh?
9. **Patient:** □□□ □□□□□□ □□□ □□□ □□□□□ - - -
   bäğğorro ïwäsdallähu ïnïğï mälïss alïčč̈ïlïmm
   I only hear but could not answer.
10. **Doctor:** □□□□ □□□□ □□□□ (+)□□ □□□□ □□ □□□□□□□□□□
    bädänb yïsämallu aydäll gïn mämälläs näw yämiyasïčč̈ägïračč̈äw
    You can hear but she can not give the answer.
11. **Patient**□ □□
    awo
    Yes
12. **Doctor:** = = □□□□ □□ □□□□□
    mïnïdn näw yämiyamott
    (Laugh) What is the problem?
13. **Patient**□ □ **(** +**)** □□□□□ □□ □□□□ □□□ □□□□ □□ □□□□□ □□□ □□ □□□□□□□□□ □□□ □□□□□ (+) □□□□ □□□□ □□□□ □□□□ □□□□□ (+) □□□ □□□ □□□ □□□□□□□ □□□□□ - - -
    ï ïyamämmat näw malätïm lïbon yamattal ïna yasïllatall däräkk' sall näbär baläfäw täkïllähayïmanott abnätt käfïtäññä kïllinik asakïme näbär ahun dägïmmo mälïsso agäräššäbatïnna yasïllattall
    She feel sick, I mean, she feel sick around her heart, she had dry cough last time I took her to Tekle himanot I mean Abnet higher clinlic but now it relapse …
14. **Doctor**□ □□□ □□□ □□?
    akïtta aläw salu
    Does the cough have sputum?
15. **Patient son:** □□□ □□□ □□ □□ □□□□ □□□ □□□□ □□□ □□□□□□ □□□ □□ □□□? □□ □□□ □□□□□ □□□ □□□□ □□□ □□ □□□ - - -
    akïtta aläw ïnna ïza näbärräč wädänne sïtïmätt'a mäkinna sinïgäčč'agäčč' yïhun mïn yïhun däm č'ämïrro kätïllanïtt wädiyya ïntïn sillat näw ahun
    Yes it has sputum, she came from her country by car, the travell was so long and hard for her as a result I saw a blood in the sputum - - -
16. **Doctor:** □□□□ □□ □□□?
    akïttaw däm aläw
    The sputum has blood?
17. **Patient son:** □□□□ □□ □□ □□□ (+) □□ □□□□ □□□ □□□ □□ □□□□□□□□□□
    akïttaw lay däm awätt'a ïnna kä-ïgïrr^{w}-a ğämïrro ïsïkä raso^{w}-a yïkkorätt'ïmattall
    Yes there is blood on the sputum and she had also has arthralgia from her foot untill…
18. **Doctor**□ □□ (+) □□□?
    ïššï lelas
    What else?

19. **Patient:** □□□ □□□□ - --(4)
yäfittu yïššalall
The previous was better- - -
20. **Doctor□** (3) □□□ □□□ □□□□**?**
läwïtt’ aläw käbfittu
- - - there is an improvement from the previous one.
21. **Patient:** □□
awo
Yes
22. **Doctor□** □□□ □□□ □□□□□□ □□□□ □□?(+) □□□ □□□□□□?
ahun bätt’am yasïččägärot mïnïdn näw kälella yämisämawott
what is your biggest problem now?
23. **Patient□** □□□ □□□ □□□ □□□ □□□□ □□□□….
ïzičč tägïrre ïndä bïrd adrïgo läntïn
From my foot till … I fell cold.
24. **Doctor□** □□□□□□□□?
yïkk’orätt’ïmotall
You have arthralgia.
25. **Patient:** □□ □□□□□□ □□□□ □□□□□□□ □□ □□ □□□ □□□□ □□□ □□ □□□□□□□
awo yïkk’orätt’ïmïnna bähayïll yïkk’orätt’ïmäññal mätto yïhe bähode yïgäbanna bärass näw yämiwätt’aww
Yes, I have very serious pain, from my stomach till my head.
26. **Doctor:** □□?
ï
Oh?
27. **Patient□** □□ □□ □□□ (+)□□..
ïssu näw ahun ïnne
That is it…yes, I - -
28. **Doctor□** □□□ (+)□□ □□□ □□□□□□?
lelas lela ahun yämisämawutt
What else, what else do you fell now?
29. **Patient□** □□ □□□ □□ □□□ (+) □□□
lela yälämm lela yälämm- yälläm
That is it, that is it
30. **Doctor □** □□ □□□ □□□?
lela nägär yälläm
That is it?
31. **Patient□** □□
awo
Yes
32. **Doctor□** □□ □□ □□ □□□?
matta matta lab alott
Do you have sweeting while you sleep?
33. **Patient□** □□□□
tïttoññall
Now it stops
34. **Doctor:** □□□ □□□□ □□□?
bäfit yalbot näbär
You used to have a sweating?
35. **Patient:** □□(+)□□□ □□□ □□ □□ □□□ □□ □□□□ □□□ □□□ □□□ □□ □□□□□□□
awo bäfitt anïd gize lab anïd gizze tïkussat näbär ahun ïssu täššïloññall
Yes- - - prevently I had sweating and fever, now I is improved.
36. **Doctor:** □□□ □□□□ □□□?
ahun tïkkussat yäläm
now there is no fever

37 . **Patient:** □□
awo
Yes
38. **Doctor:** □□□□ □□□□ □□□□ □□?
yämïgb fïlagot ïndet näw
How is your appeitite?
39. **Patient:** □□□ □□? (4)
k'onïǧo näw
It is good
40. **Doctor:** □□□□ □□□□□?
bädänïb yämägäballu
You eat properly?
41. **Patient□** □□
awo
Yes
42. **Patient son:** □□□ □□□□ □□□□□ (4)
mïgb ïnïkowwa atbälamm
She doesn't eat food
43. **Doctor:** □□□ □□□□□ □□□ □□ □□ □□□□ □□□ □□□ □□?
yïhäw ïbälallähu ïyallu näw ïsaččäw manïn lïmän ïššï
But she says she eats properly, which one of you should I belive?
44. **Patient son:** □□ (+) □□□□□ □□□□□ □□□□ □□ □□ □□□□- - -
ïnne sïnakk'ärrïb kalbällačč ïngïdi ïnne gar kämätt'ačč
I - - - she doesn't eat when we gave her since she came…
45. **Doctor:** □□□□□ □□□□?
säwïnätott käsïtto^{w}-all
Do you have weight loss?
46. **Patient:** □□ (+) = = □□□□□□ □□□□ □□□□□ □□□ □□□□ □□□□ (+) □□□□ □□□□□□□
arä alïkkäsahum bäššïttay käläkkälläññ ïnïǧǧe kämätt'ahu alïkässa ïnïtïn alalïkumm
I didn't lost weight , my disease prevent me…but I didn't lost weight?
47. **Doctor:** □□ □□□□ □□ □□□□□□ (+) □□ □□ □□□□□□?
lela mïnïdn näw yämissämawot lela alä yämissämawot
What else? Do you have any other symptom?
48. **Patient:** □□□□ □□□□ □□□ □□ □□□□ □□□□ □□ □□ □□□ □□□ □□ - - -
yäläññïm ahun tïnïš yïhe kä-ïgïrre tänäsïtto hullo botta därïsso ïrïsu näw
No I don't have except a little pain from my foot till the my whole body….
49. **Doctor:** □□ (3) □□ □□ □□ □□□□□□ □□ □□□□?
ïššï mäčče näw däm kä-äkïttaččäw gar yäwätt'aw
ok - - - (pause for about 20 sec) when did you see blood in her sputum?
50. **Patient son:** □□ (+) □□□ □□ □□ □□ □□ □ - - -
ï ïhud k'änn näw ïnne wäd ï
Oh…. It was sunday when I oh…
51. Doctor: □□ □□□ □□□□ □□□□□ □□□
käzza bäh^{w}-alla tïllanït kätïllanït wädiya
What about since then yesterday, day before yesterday?
52. **Patient son:** □□□ □□□ □□□□□□?
käziya bäfit alnäbärrämm
There wasn't before sunday.
53. **Doctor:** □□□ □□□ □□□□ (+) □□□□□ □□□
käziya bäh^{w}-alla tïllant kättïlant wädiya
After that, yesterday the day before yesteday the day before yesteday?
54. **Patien son:** □□□□□□ □□□ □□ □□□□ □□□ □□ □□□□ □□ □□□ □□ l□□□ □□□□□ □□□□ □□□□□□ □□□□□□□ ……
alnäbärräm hullät matta wätt'abïññ alläč käzza tïtotal ïnne dägïmmo yanne bämäkinna sïlämätt'ačč sïtïmätt'a sinïgäčč'agäčč' tätt'äratt'ärïkku
No she said she had it for two nights then it stops and I thought it is because of the car shaking

Nurse: □□□ □□□□□ □□ □□□□□ □□□?
bäfet yänäbärrobbät bota yasïllaččäw näbär
Had she cough were she leved before?

55. **Patient:** □□ (+) □□□□ □□□ □□□□ □□□ □□□□ □□□ □□□□□ □□□ □□ □□ □□ □□□ □□□ □□□ □□□ □□ □□□□ □□□□□ □□ □□□ □□□□□ □□□ □□□□ □□□□□ □□□□□□ □□□□ □□□□□ □□□□ □□ □□ □□ □□□□□□□
awo käkfïllähagär sïtmätt'a bätt'am yasïllat näbär ïndawïm däräkk' sall näw sallu lärassu bätt'am däräk' näbär ïzza hïkïmïnna käğämärräč šall bïll^{w}-at näbär bäzzam ïnïtn ïndawm bämmäğämärriya yäsätt'at mädhanit alïššal sill lella näw yäkk'äyärrutt
Yes- - when she came from her home town she had very serious cough, it was a dry cough. then after she started the medication it get better at fast, then they change the medication because it dose not work.

56. Doctor: □□□ □□ □□□□**?**
käyät näw yämätt'utt
Where did you come from?

57. **Patient son:** □(+) □□ □□□ □□□□(4)
kä-wädä däbbob näw
From southen area

58. **Doctor:** □□ □□□□ □□□ □□?
yät akababe malät näw
be specifically?

59. **Patient son:** □□□□ □□□□ (+) □□□□ □□□□ □□
anğama yämeball anğama yämeball bota
Anjame- - it is called Anjame

60. **Doctor:** □□ □□ □□□ □□?
wäba allä ïnde ïza
Is there malaria there?

61. **Patient son:** □□ (+) □□ □□□
wäba wäba yäläm
There is no malaria

62. **Patient**: □□□ □□ □□ □□□ □□□□ □□ □□□ □□ □□ □□□ □□□:: (+)□□ □□□□ □□□ □□□□
yäläm wäba ïza bäkk'olla zämädočči yallu agärr allä dïrro ïhed näbär awo bähagärre yälläm wäba
Malaria is found only on the moutainous region. Where my relative lived. But not where my country is.

63. Doctor: □□□**?**
yäläm
There is no?

64. Patient: □□
awo
Yes

65. Doctor: □□□□ □□□□□?
yïz^{w}-ot ayawïkk'umm
You don't have history of malaria?

66. **Patient:** □□
awo
Yes

67. **Doctor:** □□□ □□ □□□□□(giving the laboratory request form for the son)
yïčč̈n wädä labïratori
Take this to laboratory

It is clear that Amharic language is second language for the patient and her son. Despite this fact, though both do their best to produce a productive communication. During the interaction, the interesting thing seen in this communication is on (text-11-line-25, 48). The patient attempt to create a picture in the mind of the doctor it is how most of her age group people use to describe

their pain. It could be as result of the cultural background of the society that most of the stories and tells were transferred though oral literature for century. That has very big chance of being forgotten easily. Therefore, the society seems to produces a mechanism, which helps to remember ever details of the stories, by narration technique. Thus, during the interaction unlike her son the old patient explains herself through this technique, which she thinks it help the doctor. Another issue that should be observed in this text is the pragmatic failure happened between the doctor and the patient's son that is on line-51, 52, and 53).

Both the patient and her son do not know what her physical problem is because during the conversation. They use unclear terms to describe the disease on (lines-13, 15, and 17). It is because not only Amharic is their first language, but also lack of knowledge on disease. That is why even the patient's son, who is young explain his mother problem on (line-15).

The doctor also has problem of explaining his thoughts easily. Because, during the whole interactions he asks very short questions, which shows he want to focus on the physical problem only. In addition to that, the doctor speaks with kind of authority especially on (line- 5 and 45).

For example, on (line-5)

Doctor :□□□□ □□□□□**?**
männagär ayïčč'illomm
She can not speak?

As Lindström (2008) remarks male physicians are 'more imposing and presumptuous' meaning they give more advice and paraphrases and more verbally dominant than female physicians. Accordingly, the doctor signifies more authority by asking series of questions and ordering the patient's son even implies to keep quiet, let your mother talk.

Any observer can propose that, the participants (patients and doctors) in the above texts share common cultural, social and language background. That is why the interactions are conducted somehow smooth. Nevertheless, it is clear that the working language Amharic is second language for all of the participants. For this reason, there is significant, number of errors, in sentence structure, and phonetic while interacting between doctors and patients sides. For instance, on text-11, caused because of word order, and using of 'inappropriate words'

1. **Line. 9. Patient:** □□□ □□□□□□ □□□ □□□ □□□□□ - - - she should say

   - - -□□□ □□□□□- -

2. **Line.22. Doctor**□ □□□ □□□ □□□□□□ □□□□ □□?(+) □□□ □□□□□□?

He should say: □□□□□□ □□□ □□¼□□□ □□□ □□□□□□ □□□□ □□?

3. **Line. 48. Patient:** □□□□ □□□□ □□□ □□ □□□□ □□□□ □□ □□ □□□ □□□ □□ - - -
She should say □□□ □□□ □□□ □□□□:: □□□ □□ □□□□ □□□□□□ □□□□□□ □□□□□- - -

(Text-5-line38-40)

47. **Doctor:** □□□□□□ (+) □□□ □□ □□□□□ □□□□ □□□□□ □□□ □□□□ □□- - -?
yastamïmallu käzzih bet hïkmïnnaw bädänb nägïrrottal käzzih yakämott säw
You handle it it well from this house treatement, they told you?
48. **Patient:** □?
ï
What?
49. **Doctor:** □□□ □□□ □□□□ □□□□ □□□□□ □□□□□□□□ □□□□ □□□ □□□□ □□□□□□ □□□□ □□□□ □□□□□□□ □□ □□□□ □□□ □□□□ □□□□□□□ □□□ □□□□□?
käzzeh bäfet setakämu yämïgb amägagäb hunetta bäsïnt bäsïnt sä-at lïyunätt ïnïdämebälla mïnïgezze mäbïllat ïnïdalläbot mïn ayïnät mäbl mäbllat ïnïdalläbot mïkïr wäsïdäwall
Did they told you about the way you should eat? in what interval you should eat. What kind of food you should eat?

The doctor makes lots of error on line-47 on sentence order, and added some extra unnecessary words such as 'bet' that is why the patient get confussed and asks clarification. Line-49 seems some improvement.

4.1.11. Personal Behavior in medical communication

Text-12

A female patient who came back with a result, to show a laboratory result for a male doctor with twenty years experience. The laboratory result confirms that she has HIV in her blood. It was a random HIV screening test meaning the patients came to the health center for other reason (other sickness) but the doctor encouraged her to do the screening test. Therefore, the doctor first has to inform her she has HIV and followed to reassure her as follows;

3. **Doctor:** □□ □□□□ □□□ □□□□□□?
ïnne yämïlïšš ïnat ayaslïššïmm
By the way, miss, don't you have cough?
4. **Patient:** □□□□ □□□□□□ □□ □□ □□□□ (4)
samïnt yallämälläwätt' allä dïd mädïmatt
It has passed a week there is bleeding.
5. **Doctor:** □□□ □□□□ □□ □□□□?
yïhes masakäkk mäčče ğämäräšš
The Itching, when did it start?
6. **Patient:** □□ □□□□ □□□ (4)
wär akababe honnäw
Almost a month (very low pitch)
7. **Doctor:** □□□ □□?
hollät wär
Is it two month?

8. **Patient:** □□ □□
   ay wär
   No, it is a month.
9. **Doctor:** □□ □□ □□□□□□□?
   bïzu näw yämiyasakïkïšš
   Is the itching a lot?
10. **Patient:** □□ □□□□□□□ □□ □□□□□- - -- (4)
    awo ïndämäkk'ïllat bïllo salawïkk'äw
    Yes it gets red, accidentally- - --
11. **Doctor:** □□□□? □□□□□□□ □□□□?
    k'oyäbïšš alïkk'änäsïššïm kïbdätt
    How long is it? Don't you lose weight?
12. **Patient:** □□□□□□□□
    altämäzänkomm
    I was not weighted.
13. **Doctor:** □□□□□ □□ □□□ □□□ □□ □□□□□ □□□□□□□
    käg^{w}adäññašš gar amätt näw abračč'ïhhu yänäbäračč'ïhutt
    You were together with your boy friend for one year.
14. **Patient:** □□
    awo
    Yes
15. **Doctor:** □□□□ □□□ □□□ □□□ □□□□?
    käziyas bäh^{w}-alla g^{w}-adäññа norošš yawïkk'all
    Have you been in any relationship, since then?
16. **Patient:** □□□□□(+) □□□ □□□ - - - (4)
    ayawïkk'ïm kä-assu wädih
    No, I didn't have- - -(murmuring)
17. **Doctor:** □□ □□ □□**?**
    alä gïn ïsu
    Is he still alive?
18. **Patient:** □□!
    awo
    Yes
19. **Doctor:** □□□□□?
    taywaläšš
    Do you see him?
20. **Patient:** □□
    awo
    Yes
21. **Doctor:** □□□ □□?
    dähna näw
    Is he all right?
22. **Patient:** □□!
    awo
    Yes
23. **Doctor:** □□□ □□ □□.□□.□ □□ □□□ □□ □□ (+) □□ □□ □□ □□□□?
    ahun ïko HIV alä yïllall däm lay gïn alä gïn g^{w}-adäññašš
    The result says you have HIV- - -are you sure your boyfriend is still alive?
24. **Patient:** □□ !
    awo
    Yes
25. **Doctor:** □□ □□□□? (+) □□ □□□ □□□□□□□□□ □□□□ □□□ □□□ □□□□□□□□□?
    ïrä ïbakkïšš käzza bäh^{w}-alla altägänaññačč'ïhum kä-anïd amätt wädih altägänaññačč'ïhumm
    Are you sure? You didn't see each other since then?
26. **Patient:** □□□□□□□□ (whispering**)**

altägänaññänïmm
We did not meet.

27. **Doctor:** አሁን□ምንድን□ነው□መሰለሽ? ይሄ□የሚያሳክከኝ□ህህ ? (+) መሃጸኔን□ላይ□ያሳክከኛል□ፈሳሽ□አለኝ□ያልሽኝ□ከርሱ□ጋር□የተገናኘ□ነው□አንድ□አንድ ጊዜ□አባላዘር□መስሎ□አባላዘርና□ያው□ኤች . አይ . ቪ (+) እንትኖች□ከበሽታው□የተያያዙ□ናቸው□ስለዚህ□ከዚያ□ጋር□የተያያዘ□ነው። (+) ስለዚህ አሁን□የሚመረመር□ነገር□አለ□ደም□ሲዲፎር□ነጭ□የደም□ሴል□ጋር□ከሱ□ጋር□የተያያዘ□ነገር□አለ።□ሲዲፎር□ይመርመርና□ሲዲፎር□ከተወሰነ□መጠን በላይ□ከሆነ□ማለት□አሁን□አልከሳሁም□ነው□ያልሽኝ□ሳልም□የለሽኝ (+) ያ□ከሆነ□ሲዲፎርሩ□ሊያንስ□አይችልም□ዞሮ□ዞሮ□ኖርማል□ሊሆን□ይችላል። ኖርማል□ከሆነ□ግን□መድሃኒት□አትጀምሪም□ግን□ያም□ሆነ□ይህ□ግን□የሆነ□ክትትል□ያስፈልገዋል□ዝም□ብለሽ□አሁን□አንዳንዴ□ሁልጊዜ□ሃኪም□ቤት ከመሄድ□አንዳንድ□ከባለሙያዎችጋር□የምታደርጊውነገር□ሊኖር□ይችላል።□ስለዚህ□አሁን□ኤች . አይ . ቪ□ክፍል□ያሉ□ባለምያዎች□አሉ□ከነሱ□ጋር ትነጋገሪና□የሚሆነውን□ያድርጉልሻል።

    ahun mïnïdn näw mäsälläšš yïhhe yämiyassakïkïš ï- -ï mähatt'ännen lay yasakkäññal fesašš alläññ yalïššïw kärïssu gar yätägänaññä näw anïd anïd gizze aballazär mäsïllo aballazärïnna HIV ïntïnnočč käbäšïttaw garr yätäyayazzu naččäw sïlläzzih ahun yämimärämär näggär allä däm CD4 näčč' yädäm sell garr yätäyayazzä näggär allä CD4 yïmärämärnna kätäwässänä mätt'än bälay kähon mallät ahun alkässahum näw yalïšïw sallïm yäläññïm ya-kähon CD4 liyans ayïččïlïm zorro zorro normal lihon yïččïllal normal kähon gïn mädhanit atïğğämïrem gïn yam honnä yïh gïn yähon kïtïtïl yasïffälïgäwall...

    Well now, the things you say... oh, the inching on cervix is the indication, the discharge are associated with it. All the same, it seems sexually transmitted infection, but it is the HIV signs. Therefore, now you will do blood investigations CD4 white blood cell. It is associated with it you will do CD4 and if it is normal and you do not have any physical signs so you will not going to start medication. Anyway, you will discuss with professionals. It is necessary for you to get counsel so go to them.

28. **Patient:** እሺ (4)

    ïšši

    Okay

29. **Doctor:** አሁን□እዚያ□ሄድሽና□መድሃኒት□ትወስጃለሽ□ማለት□አይደለም (+) ግን□የሚደረጉ□ጥንቃቄዎች□በግብረ□ስጋ□ግንኙነት□ጊዜ□ተቅማጥ□እንዳይዝ□ሳል እንዳይዝ□የምታደጊያቸው□ጥንቃቄዎች□ይኖራሉ።□አሁን (+) ደግሞ□እንደድሮ□አይደለም□አሁን□እናቶች□ኤች . አይ . ቪ□የያዛቸው□እናቶች□ቢወልዱ የሚወልዱት□ልጅ□ነፃ□ሆኖ□ነው□የሚወለደው□ስለዚህ□አሁን□እነዚህን□መድሃኒቶች (+)አሁን□አንቺ□እንቢ□ብለሽን□ነበር።□ብንተውሽ□ያሳዝነን ነበር□መመርመርሽ□ጥሩ□ነው□ነው።□ሲዲፎርሩ□አሁን□ባለው□ከሆነ□ደግሞ□ጥሩ□ነው□።

    ahun ïziya hedïšïna mädhanit tïwäsïğğalläš mallät aydälläm gïn yämidärägu t'ïnïkk'akk'ewoččïn bägïbïrrä sïgga gïnoññïnät gizze täkk'ïmatt' ïndayïz sall ïndayïz yämtadärïgiyačäw t'ïnïkk'akk'ewočč yïnoralu ahun ïndädïrow ayïdälläm ahun ïnatočč HIV yäyazačäw ïnatočč bewälïdo yämiwälïdot lïğğ nätt'a honno näw yämiwällädäw sïlläzih ahun ïnäzzihïn mädhanittočč ahun anïči ïnbi bïlläšš näbär bïnïttäwïšš yasazïnnän näbär mämärrïmärïšš t'ïrru näw CD4 ahun balläw kähon dägïmo t'ïrru näw

    Now, you going there don't mean you will start medication but they will tell you about precaution you take during sexual intercourse. When you have cough, diarrhea and now there is no problem, as HIV carrier mothers give birth to HIV free babies. It is good being screened in advance, but we are glad you know now, you said no at first, which was not good.

Here, the way the doctor interact with the patient seems too rude and do not evaluate the patients emotion because when (text-12-line-9, 11, 13, 15) the way the doctor asks a question is disoriented and only focused on what he wants to know and the way the question goes is impolite. He even informs the patient she has HIV but the way he tells her is not expected from any health professional. The doctor attempts to check the patients background on (line-15), but this sentence are not a kind of question that should be asked to a patient because it makes nervous.

Additionally, the patient is very shy by nature and shown it through very low sound volume which indicated by sign (4), from table-2). The most unconstructive question that the doctor asks to the patient and somehow unprofessional is on (line-9) which leads to bad psychological impact on the patient's perception. That is 'if someone is losing weight, with in a limited amount of time, he is

most defiantly an HIV patient'. Furthermore, the doctor asks many closed-ended questions even before hearing the previous question's answer, which inhibits the patients, chance to explain her worries and thoughts. At the end of the conversation, although, that is on (line-25) the doctor tries to uses a technique for psychological and therapeutic purposes called the Pollyanna principle. Those are 'doctors present cases from a positive rather than negative view through the use of avoidance strategies such hints, technical jargons and euphemisms' (Chimombo and Roseberry: 1998). Conversely, it does not seem to help the patient to get relaxed because as the discussion ends the patient on (line-26) respond but with very low pitch, which signify anxiety and lift the room.

It is obvious that physician's personal behavior has big role in creating a good and trusted medical communication and care.

4.1.12. Summary of the observation

Medical communication plays an important role in producing good relationship between the doctor and patient. That leads to a productive medical service. However, as this observation indicated to accomplish a productive communication, which brings better medical care both medical professional and patient must have adequate participation in the discussion and decision making. Even though in real situations it seems unattainable to achieve this goal, since the doctors and patients among themselves have tremendous difference. For example, as seen during observation,

Gender difference of patient clearly has impact on the content and quality of the discussion because male patients address their problems to doctors more freely and confidently than female patients do. Gender of medical professionals has major contribution too in the medical communication because it is observed that unlike male medical professionals females are more friendly, which focus on the patients background history, asked more open-ended questions, which gives opportunity for the patients to explain themselves.

Age of patient is also another point that has role on the communication. Because young patients tend to focus on short answers than elderly, but older patient patients used narrative methods, and implemented more proverbs to address their problems than young ones so took extra time.

Simultaneously, the young medical professionals has more quality of handling the patients than elders because they act friendly and asks social oriented questions but elder medical professionals tend to focus only on medical questions. In addition, the knowledge of patients about their disease, language skills and personals behavior also contribute to the communication.

4.2. Analysis of the questionnaires

Two types of questionnaires were distributed to the patients and medical professionals. Accordingly, the medical professionals and the patient's questioners have twenty-eight and twenty-seven questions for each, respectively. Those are assumed to give the intended results for the research. The questions on the questionnaire thought to produce needed results that are mentioned under the general objective and specific objectives of this research paper. For the reason of suitability the questions are seen depending on the topic rather that their consecutive number.

4.2.1. Results of the medical professionals' questionnaire

The first questionnaire developed for the medical professionals[4] are distributed for 30 of them that includes two medical doctors, five health officers and twenty-two Nurses. The Nurses meant to help the doctors in the Outpatient department (OPD) by writing prescription, checking vital signs that includes measuring temperature, blood pressure, pulse, height, weight and helping to conduct and elaborate some additional medical procedures. The questionnaire includes twenty-eight questions, which assumed to produce a good input for the objective of the research. Moreover, the questions are classified into two; the first and the third types of the questions are kind of multiple choice and these questions are analyzed by SSPS.

It is understandable that the analysis is more of quantitative analysis but since the research is sociolinguistic research, the researcher makes his best attempts to provide a qualitative analysis

too. That will provide evidence to the findings. The other types of questions are open-ended questions, which gives the opportunity to comment remarks on their perception for the medical professionals. In addition, almost all questions, the multiple choice and the open-ended questions, have a why questions that helps to provide the reason the questions are thought to be true by the respondent. Furthermore, as mentioned above, to avoid confusion, the analysis of the questionnaire goes on according to the relevance and topic of the questions rather than their numbers.

4. Terms such as Doctors and medical professionals are used interchangeably in this paper to show the two doctors and five heath officers who lead the diagnosis and interaction with the patient, to avoided prejudice and hasty generalizations.

And the scoring: since items in the questionnaire describe objective behaviors and perceptions of the respondents, for the analysis, a dichotomous scale ticking yes when behavior is agreed, and No if not agreed and for multiple choice or multiple stage method are implemented in this case.

$$\text{Total score in \%} = \frac{\text{Total No of yes answers}}{\text{Total No of answers}} \times 100$$

Nevertheless, the finding of the questionnaire does not necessarily represent the researcher points of view on the matter therefore on the conclusion part some comments will be provided.

(Item-1) focused on experience which states; how many years do you serve as a medical professional? From the 30 medical professionals, 13 of them respond that they have an experience of 0-5 years. 2 of them respond that 6-10 years, the other 4 of them, respond, they have 11-15 years. The remaining 3 of them affirm that they have 16-20 years and the last 8 of them answer that they have greater than twenty one years of experience.

(Item-2, 3) questions are statistical questions which are; (Item-2) how many patients do you see per a day? (Item-3)Who are the most common clients in the health center, according to age and gender?

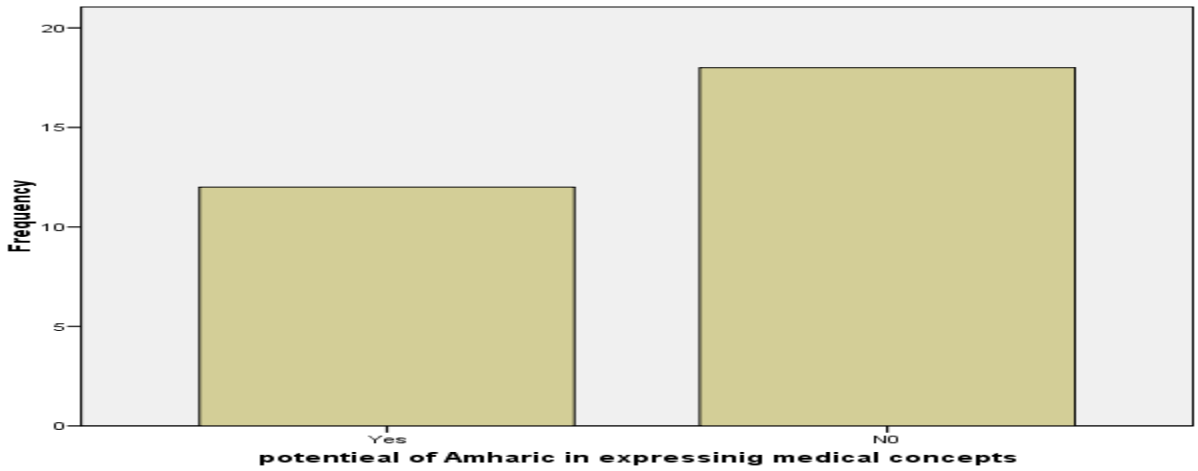
Number of patients/day Seen by the doctor		Most common patient in gender Seen by the doctor		Most common patient in age Seen by the doctor	
Valid	Frequency	Valid	frequency	Valid	frequency
5-15	3	Female	25	0-5	3
16-25	2	Ma le	5	6-10	1

26-35	6			11-15	2
>36	19			16-20	4
				>21	20
Total	30		30		30

Table -3 on frequency, gender and age of patients

(Item-13) Another statistical question, which goes with the above questions is, what are the most common diseases in this health center? Moreover, the medical professionals pointed out many diseases, and most of them are under the category of communicable diseases such as Tuberculoses, Pneumonia, sexual transmitted diseases, diarrhea, urinary tract infection, Acquired immune deficiency syndrome (AIDS), upper and lower respiratory diseases, acute fibril diseases, and parasitic infections, which are caused because of poor sanitation, poor personal hygiene and lower class status.

(Item-4) is about the awareness and attitude of the doctors' on Amharic language; accordingly, respondents are asked if Amharic express all the medical concepts that you want to express for your patient? Out of 30 medical professionals, 7 answers 'Yes'- Amharic express their thought. That is because, in the area of the target health center, it is not an option to speak Amharic but a must since many of our patients do not understand English and medical terminologies and concepts we (The MPs) have to attempt our best to express the concept in Amharic. Other respondents that are 23 answers 'No'- Amharic language do not have the potential to express the medical concepts because most of medical terminologies are Latin origin and the medical education is given in English. Thus, Amharic does not have words and concept to express the intended idea.



Graph-2-Ability of Amharic Language expressing Medical concepts

(Item-5, 6 and 7) questions focused on the perception of the doctors toward the patients' ability of communication skills or language skills. In other words, the next three questions focused on the perception of doctors toward patients' language ability to describe their thoughts, understanding of the doctors explanations, questions and comments and the ability to give a relevant answer for the questions or explanations, respectively. These questions not only show language skills- three language skills except writing- but also the patents' confidence, outlooks of authority figures (most patients and people believe that asking some authority figures such as doctor or elder and to refuse the order they gave is a sign of being impolite). In this respect the questions raises the following points.

(Item-5) Do your patients describe their disease and symptoms well in Amharic language? Out of 30 participants, 22 say 'yes' patients can describe their disease and symptom by using Amharic language because it is their native language even though they do not explain the medical concept scientifically they use cultural Amharic terminologies to explain their signs and symptoms. On the other hand, the other 8 of them reply 'No', patients could not explain their thoughts successfully though Amharic because there is lack of knowledge on medicine.

(Item-6) Do you feel that, your patients understand the questions you ask? 15 of the medical professionals state 'patients do understand our questions' because they respond that we (the doctors) explain the problem to the level of the patients understanding and use their mother language as means of communication. The others answer 'patients cannot understand the

questions we (the doctors) ask' because patients have expectations when they came here and attempt to convince us only what is important from their respect. As result, we prefer to diagnoses based on medical procedures and findings rather than based on the 'chief complain' implying that the patient is complain about his disease and symptoms are not put in to consideration.

(Item-7) Do most of your patients give answers relevant or helpful to the discussion you have? 24 medical professionals of them say 'yes patients give relevant answers, helpful to the discussions'. Although, the other 8 of them feel that the patients give irrelevant answer to the questions they are asked because their understanding of the disease is not scientific as a result most of the time their explanation is irrelevant and unhelpful to the diagnosis.

Q5-Patients ability to express medical concepts			Q6-Patients ability to understand the questions doctor explanation			Q7- patients ability to give a relevant answer to the questions		
Valid		Freq.	Valid		Freq.	Valid		Freq.
	Yes	22		Yes	24		Yes	15
	No	8		No	6		No	15
Total		30			30			30

Table-4 patients' ability to express, understanding and respond

(Item-8) focused on the communication, which asks the MPs, how the medical professional acts during the interaction and it have four choices of categories. These are, they act as boss, as subordinate, as professional, and as friendly toward the patient. Similarly, question was raised in (Item-9) how do you describe the interaction you have with your patient as formal, as casual or as argumentative discussion. The medical professionals answer for the first question, 1 medical professional respond that during a discussion he prefers to act as subordinate, which seems untrue. 13 of them responded they act as professional and the other 16 respond it is good to act friendly while conversing with a patient.

The other similar question asks that, in your opinion how the interaction should go between you (MPs) and the patients. Out of 30 MPs, 21 of the medical professionals answer the communication between them and the patient should be formal and the other 9 of them answers

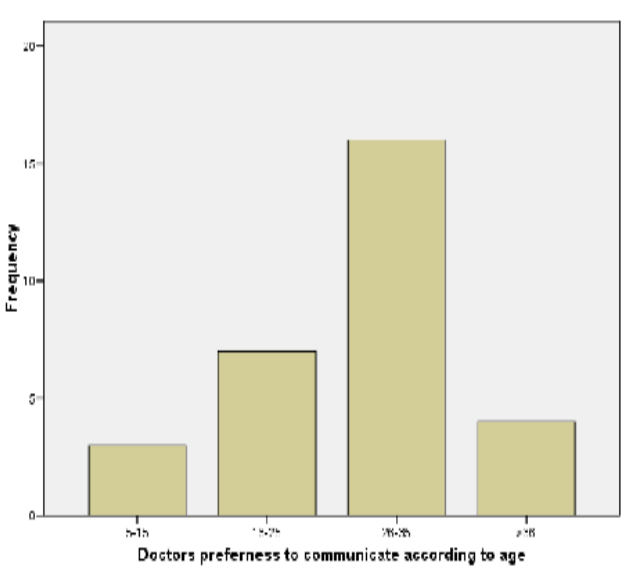
that the interaction can be conducted as casual talk because through this method they (patients) can open up to talk about their personal staffs. Graph-3 doctor patients' interaction

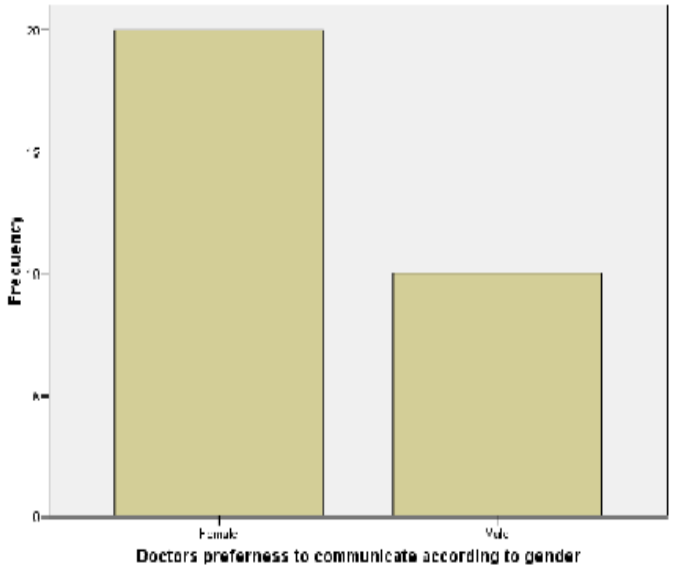
(Item-10) The other communication related question, which focused on the preference of the medical professional to communicate with patients according to their age, gender and educational status. Out of 30 medical professionals, depending age, 3 of them prefer to communicate with the age of 5-15 age of patients, because this age groups are easy to talk to and understand the explanation they are given easily. In addition to this, this age group knows medical terminologies better than the other age groups. The other 7, prefer to interact with the age group of 16-25 years. Because, the patients within this group understand medical concepts more than other groups do. The other 16 of them, answers that they prefer to, communicate with the age group of 26-35 years. Since, these are the most common age group clients in the clinic. The other 4 prefer to communicate with age group of greater that 31 year and older peoples because most of the communication goes smooth with this age groups.

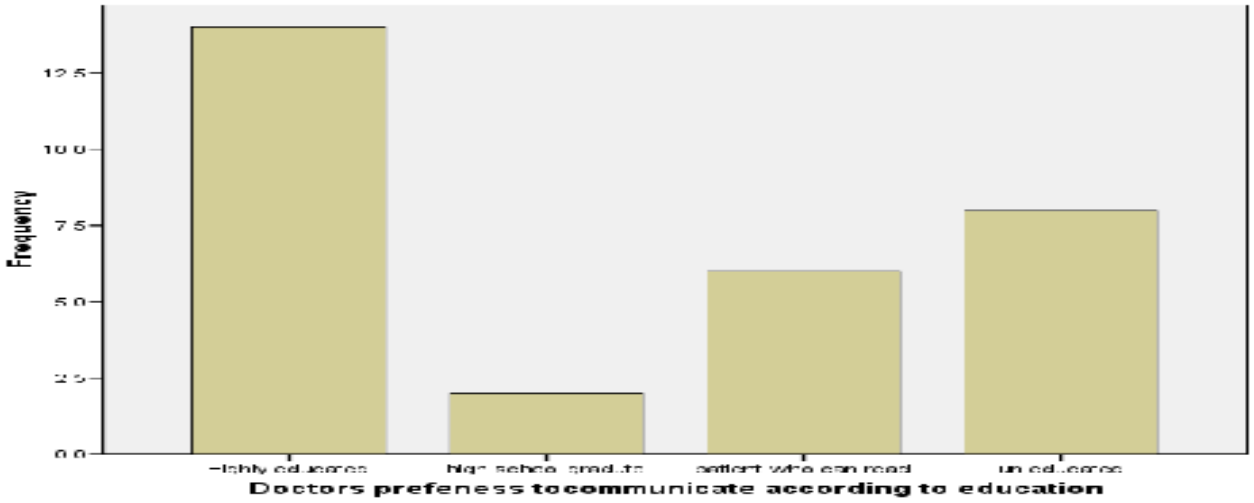
Besides that, on the gender of the patients, out of 30 medical professionals 20 of them prefer to communicate with female patients because female patients are more open and suitable to talk to than male patients are and they have more social and health risk than male and feel they (MP) can help them by doing so. The other 10 of the medical professionals prefer to interact with male patients because unlike female patients male patients do not feel shame to talk about their diseases.

The last classification is according to educational status of the patients and out of 30 MPs 14 of them, prefers to interact with highly educated patients because these patients are easy to talk to and their explanation is easy to understand (MP). The second group which includes 2 of them prefer to communicate with a patient who graduated from high school, because these group of patients understand some extents of medical terms and concepts. The third group which is 6 and the other 8 of them prefer to communicate with patient who can read or uneducated patients because, these are the most common patients in the health center.

(Item-22) is also a communication related question, which is; have you ever taken a communication (interpersonal communication) courses in university or a seminar after graduation from university? In this regard, out of 30 medical professionals, only 5 of the respondents answers ‘yes’. According to their answer, the respondents took health related communication course on seminar; but the other 25 medical professionals respond that they do not take interpersonal communication course. As the result of this finding shows it is reasonable to conclude that MPs do communicate with patients based on their experience, culture, individual behavior and environmental situations and do not have educational methodologies and potential to rearrange communication failure caused by the patient’s educational, cultural, social beliefs and physical problems. Also, as the findings of (Item-5,6,7) on page 63 shows patients need to be encouraged beyond the ‘normal situations’ because there is ‘language limitation’+ patients’ fear’+ ‘patient’s lack of language skills’. All these might lead to failure of communication or confusion.







Graph-4, 5, 6- Doctors' preference to patient's gender, Age and educational status

The other communication style and manner related questions are question number 24, 25, 26, 27 and 28; which holds five questions that focus more on cultural paralinguistic features. (Item-24) talking habits, such as talking the whole time during interaction or dominating the conversation, and the finding out of 30 medical professionals is 18 MPs prefer to keep quiet and let most of the talking to do by the patients; on the other hand, the other 12 of the MPs choose to have equal participation in the interaction.

(Item-25) focused on using the so called small talks to make the patient feel easy during interaction out of 30 MPs 15 of them do use small talk at the commencement of the interaction because it creates a friendly environment. The other 13 prefer to avoid small talk because they feel that they are busy to talk about 'small talks' or other issues. The other 2 of them responded that we (MPs) let patients to start the conversation.

(Item-26) focuses on questions on using courtesy words in Amharic such as (getaye, ïbakwotn, amäsägnalähu etc.). For the question out of 30 MPs 12 of them, answer that, they use courtesy words or phrases frequently during interaction. 17 respondents of them answers that they use occasionally and the remaining 1 respondent respond 'never'. (Item-27) is about acting serious or smells during interaction with the patients and the respondents answer 5 smell all the time during interaction and the other 24 respond they smell at only at appropriate time.

The last question, (Item-28), is about position of the MPs during interaction and the findings are 1 says during conversation he often prefer to cross his arms over his chest and listen the patient. The other 17 often prefer to lean slightly forward and face their body toward the patient; and the remaining 11 prefer to hear the patient while they write on the patient's card.

(Item-20) is also communication and culture oriented question that is; what communication problems have you encountered so far, while communicating with your patients? The doctors answer some of their experiences as follow. First, patients do not understand easily what the health professional is talking. Second, if the patient has a sexual transmitted disease like (AIDS) it will be difficult to make the patient convinced. Third, when patients come to them, they may not speak Amharic, as there are many patients in the health center whose first language is not Amharic, rather Oromigna, Guragigna etc. When patients come from rural areas, it will be another challenge to explain and convince some procedures to the patients. Moreover, some diseases do not have Amharic equivalent words. Such as Typhus and Typhoid, that needs explanations of the symptoms more. Some patients may even fail to trust or inform the necessary information about their medical conditions to the MPs because of some factors such as emotional variation, religious and traditional influences and others may complain traditional diseases such as 'buda bälaññ'.

(Item-11) the question is focused on using 'taboo words' during conversation that is, do most of your patients feel free to talk about their personal staffs or issues during conversation? Such as, how they are infected with HIV? For this question from total of 30 MPs, 9 of them answer that patients feel free to talk about how they are infected by HIV. Since these diseases are observed as other infectious diseases these days. Moreover, they came here to get psychological and professional help, so they talk freely. The other 21 answer that it is difficult for them to discuss this issue even with the MPs because there is a fear of stigma and discrimination from the society. Most of the patients lack education and do not know medical confidentiality (fear that the MPs may tell to other people what they know). In addition, most of the patients are traditional people and open dialogues are not commonly practiced in Ethiopia culture.

Graph-7-patients'freedom to express

Additional questions that are prepared for the medical professionals in the questionnaire are pragmatic oriented question (Item-14, 15, 16 and 17) and centered on the mostly used Amharic language expressions to explain medical problems. These are cultural terms used by the general population to explain some sorts of disease words such as 'bïrd mätañ̃', 'mïčč mätañ̃' and 'mägañ̃ña mätañ̃' or 'wïgatt'. What is interesting in these words is that all of them end with the word 'metañ̃'. The word implies 'someone or something hits the person who gets sick'. This is, in fact, unlike modern medicine insight which is 'diseases caused by germs', the Ethiopian society perceive diseases as some kinds of unexplained strike or hit.

(Item-14) what are the most commonly used Amharic terms used by the patients and here are some sets of terms by the medical professionals:

Amharic terms	**Literal meaning of the terms**	**Implication of the terms**
ho^{w}ïden-yïko'^{w}ïrïtt'äñ̃all	'My stomach cuts me'	'I have stomach pain'
k'o^{w}lïkk'o^{w}l-yïläñ̃all	'Something push me down'	'I have diarrhea'
šïkk'ïb yïläñ̃all	'Something push me up'	'I have vomiting'
lïben yïkädañ̃all	'My heart is being traitorous	'I feel exhausted'

	on me’	
yïkätäkïtäññall	‘Something hits me repeatedly’	‘I have a pain all over my muscles’
wïsïtt’en yïwäräññall	‘Something invades my internal body’	‘I feel dizzy’
yasïkk’ämïtt’äññall	‘Something makes me sit’	‘I have diarrhea’
ho^{w}den yamsäññall	Something disturbs my stomach’	‘I have stomach pain’
yïğğägäğğïgäññall	‘Pain goes with knife’	‘I have some kind of pain’

Of course, the patients implemented many other Amharic terms to explain their symptoms and diseases because to most of the patients' understanding it is not clearly known what really causes their disease. Patients implement many other similar Amharic terms to describe their illness some of them understandable some of them vague. For example, when we see the two Amharic terms, ‘ho^{w} ïden-yïko’^{w}ïrïtt’äññall’ and ‘ho^{w}den yamïsäññall’, both have the same meaning, for Amharic speaker, which are literal meanings of ‘my stomach cuts me’ and ‘something disturbs my stomach’ respectively. However, the patients implying that ‘I have stomach pain’. As it is stated on the list, other terms such as ‘k’o^{w}lïkk’o^{w}l-yïläññall’ and ‘yasïkk’ämïtt’äññall’ may seem they have very different literal meaning the patients used these terms to imply that ‘I have diarrhea’. Furthermore, sometimes the MPs also used these words to simplify or to explain what the problem of the patient is. As most of the terms and phrases show all of them have a suffix (-ññall) that is a third person male gender indicator but not necessarily man person but can also used for a thing too. Which signifies that unlike the English language speaker who says ‘I have diarrhea’ meaning I have a disease called diarrhea the Ethiopian culture perceive diseases as an internal problem but as something that are caused by some external factor that is mystery. (Item-15) what do you understand when a patient says ‘bïrd mätañ’ and almost all of the MPs

understand it as cough and even some of them specifically called it pneumonia and others as upper respiratory disease.

(Item-16) what do you understand when a patient says ‘mïčč mätañ̃ñ’ 14 MPs answer that it is a kind of febrile disease such as typhoid or typhus. 8 responded it is a lesion around mouth most likely herpes. The remaining 8 of them respond they are not sure what it meant because of different usage of the term. (Item-17) what do you understand when a patient says ‘mägañ̃ñ mätañ̃ñ’ or ‘wïgatt’. 5 of the respondents answer it is a draft, 3 respond it is wicked sprite and the remaining 22 reply that it is any disease that onset suddenly.

(Item-9) centers on the knowledge of patients in relation to the frequently used English terms by the MPs and how do the doctors see patents’ understanding concerning these words. Regarding the question, do you think that patients understand mostly used medical terminologies such as OPD, Ward, TB etc? Out of 30 MPs, 6 of them responded that ‘yes' patients are familiar with these terms because the MPs frequently used them. The other 24 reply that since most of the patients in the health center are illiterate, they do not understand even the Amharic explanations of the diseases given by the doctor. Thus, it needs to explain to patients with the simplest possible ways, even for those educated patients, since most of these terms are Latin origin, which is difficult to understand by most of the patients.

Graph-8-patients understanding of mostly used terms

And the last two questions are (Item-19, 23) the former question is a paralinguistic oriented question and asks, What are some of the benefits that are associated with the use of touch, such

as taking vital signs, even if the nurse already done the procedure during investigation? All medical professionals agree that it is very important to check the patient's vital signs. Because patients feel that, the doctor cares more for them and they feel that they are getting good medical care. This situation of having first hand observation develop trust between the MPs and the patients, it creates a sign of respect from the MPs side, promote a good communication environment (to be friendly) and it also help to get extra problems or diseases.

(Item-23) Do you have any comment on the perception of the society toward modern medicine? The MPs responded that the government or heath minister has to work on health education to the society because the society give low value to modern medicine and very low concept on the disease's mode or means of transmission. A very easily controlled and eradicable diseases are common here (at heath center) because of the poor personal hygiene. In addition, traditional medicine and beliefs are still there. For that reason it prevent them to act according to what they are told, meaning the tradition prevents the patients to act according to doctor's order concerning drugs. For example if they have been told to take for seven days and get better on third day they stop taking the drugs etc.

4.2.2. Results of the patients' questionnaire

The second questionnaire is prepared for medical outpatient department (OPD) patients. Unlike the first questionnaire, the following questionnaire was not distributed for all patients in the clinic because of population size and heterogeneous patients. Therefore, the method used to distribute this questionnaire is to know first the average number of patients in month, which is recognized through structured interview with the medical director of the heath center. Consequently, the medical director stated average number of 700 patients treated every month. As a result, more than one fourth of 700 patients were selected randomly which came to the clinic to get treatment. And that makes it 175 patients but after some observation it is thought that adding the date validate the result more; so 35 patients are added and make it 210 patients who came since December,1 till January, 20, 2012 which makes it almost eight weeks data collection. The questionnaire's questions are prepared in Amharic because most of the patients

do not understand English. Moreover, during filling the questionnaire a close evaluation of the researcher were needed to avoid misunderstanding of questions.

The questions in this questionnaire are classified in to three, a dichotomy yes or no, multiple questions and open-ended questions. Then, it is distributed to 210 patients; the first three questions are personal and statistical questions. These are gender, age and how often do the patient come to the health center.

The patients gave an answer as follows, out of 210 patients or participants[5], who fill the questionnaire, 122 that are (58.1%) are male, and 88 that are (41.9%) are female. In terms of age, out of 210 participants 4 of them that is (1.9%) are within the age of 0-8 year. 19 that is (9.0%) of them are within category of 9-15 years. 121 that is (57.6%) of them is within 16-25 years. and the remaining 66 that is (31.4%) are within age group of greater than 31 years old. For the question that, how often do you come to the clinic? 13 patients that is (6.2%) of them answer 'always', 33 that is (15.7%) say 'frequently' which implies they are regular customers.

5. Patients and participants are used in the patients' questioners interchangeably as result of all patients does not have the same situation meaning one patient might be feel one question represent his feeling but not the other although it does not let unanswered the question raised but respond the question as a participant of the research.

130 patients that is (61.9%) say they came to the clinic 'now and then' and the remaining 34 that is (16.2%) of them responded that it is their first time to come to the health center. Consequently, it seems reasonable to conclude that the sample is good enough and represent the actual situation of whatever the outcome is.

(Item-3) when we see the next questions, it focused on the patients' satisfaction which implies that, patient as individual or as group pleased from the service they get in the health center. From the 210 patients, 127 that is (60.5%) answer 'yes'- they are satisfied because the doctors gave us the necessary information and help. Conversely, the other 83 patients that are (39.5%) responded that they are not satisfied with the medical help they get. Because, first, they the doctor do not give them the opportunity to explain their problems. Second, they spend the

whole or half of their day in the health center to get the help they need. Even, some of them complain that it is their third or fifth doctor to be seen but still there is no change in their health. In addition to these points, the whole compound of the heath center is not attractive for patients; rather it could cause another disease.

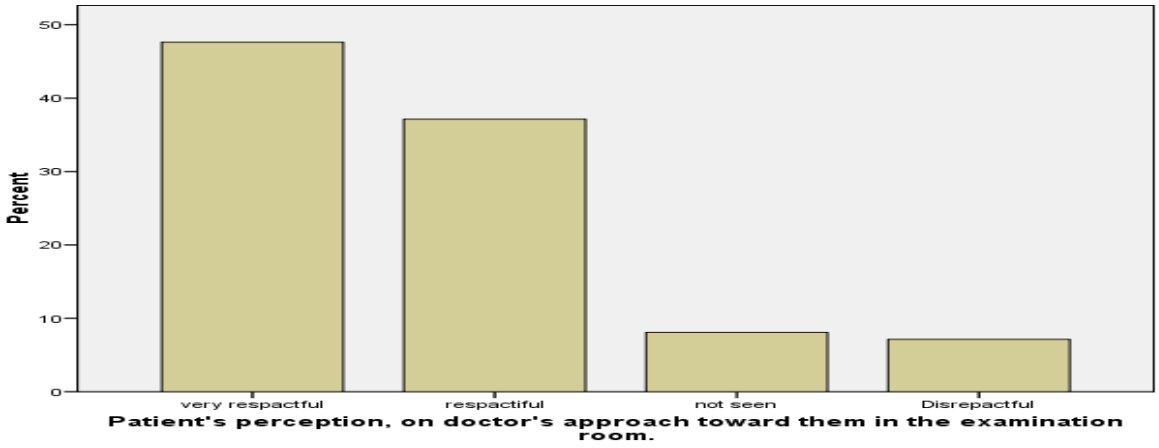
Graph-9- patients' satisfaction from the medical care they get

(Item-4) is then question that contemplates on different issues such as the patients' competence to speak the disease they have or the symptom for the doctor. As well, for this question, out of 210 participants, 200 that is (95.2%) patients answer that 'yes' I speak whatever my disease is since I come to the health center to get medical help. Otherwise, the MPs might loss the diagnosis. The other 10 patients that is (4.8%) reply that 'No' - I could not speak up all my problems because I feel shy. Others state that they had very little time to explain all things they want to discuss with the MP.

(Item-5) on perception of the patients' whether they feel the doctor understand their explanation of their feelings or not; out of 210 patients 161 that is (76.7%) responded that they feel that the doctor understand what they were talking during the examination. On the other hand, 49 that is (23.3%) of them answer that the doctors do not understand what they are talking about because doctors do not stop writing while they (the patients) talk and most of the time they ask a close

ended questions such as do you have this or that. Rather, it is better to ask open-ended questions; like what you feel.

(Item-6) focused on doctors' manner as observed by patients during communication. Whenever any communication is conducted, there are cultural expectations from both interlocutors that should be signaled. This includes using some respectful word and other paralinguistic's features observed by each other. According to the patients' observation, that is 210 participants, 100 participants that is (47.6%) of them state that the doctor was very respectful during their interaction. 78 participants that is (37.1%) answer that it was all right, because the MP was respectful. The other 17 that is (8.1%) of them answer that the doctor do not bother about my feelings rather only focused on his job meaning (he only asks series of questions and order me to do and finished the discussion). The remaining 15 that is (7.1%) of the patients feel that that MPs were acting disrespectful during the discussion. The most interesting finding that is seen on these questions is most patients measure the paralinguistic features of the doctor in respects of attitude toward them. Out of 210 participants 105 that are (50.0%) answer that, I do not mind because many doctors are too busy. Therefore, they need to do that to finish the job. Second, since they are writing what we (the patient) are talking it is acceptable. On the other hand, the other 79 that is (37.6%) answer that if he/she writes I (the patient) feel that the doctor is not listening to me.

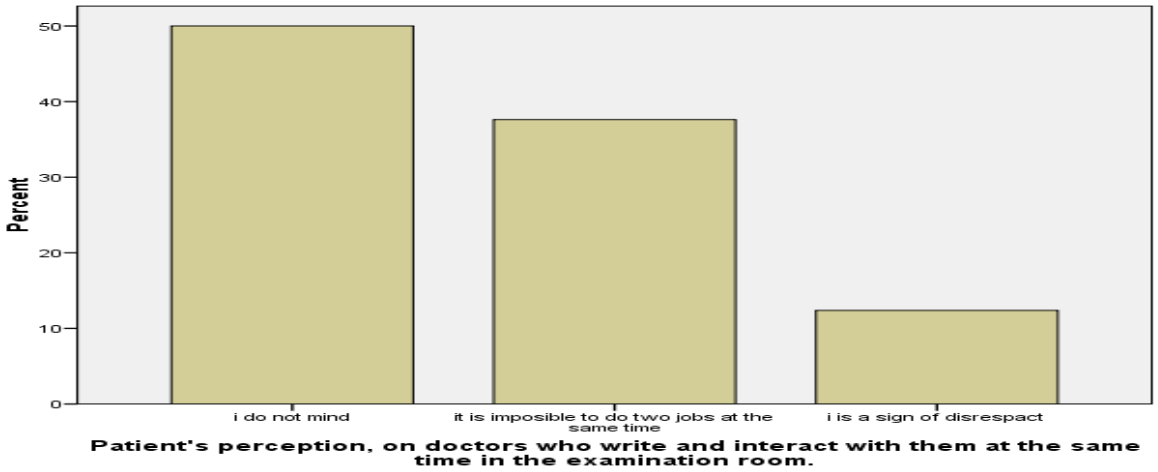


Graph-10-patients perception of respect shown by the doctor

Because, it is impossible to do two jobs at one time and there is saying 'nägär bä-ayn ygäball' meaning you need to keep eye contact when a person is talking to you. The remaining 26 patients that are (12.4%) responded that it is a sign of disrespect because while I talk if the doctors write I

feel like I am talking to nobody. In addition to that, as he is doing additional job he do not listen as a result he should quit writing and listen first and can write at the end of the discussion.

It need a close observation of Item-6 and Item-12 because as I examine the dates, out of 17 that is (8.1%) of them answer that the doctor do not bother about my feelings rather only paying attention on his job. The remaining 15 that is (7.1%) of the patients feel that MP acts disrespectfully during the discussion. Writing while the patient could be one input for this.

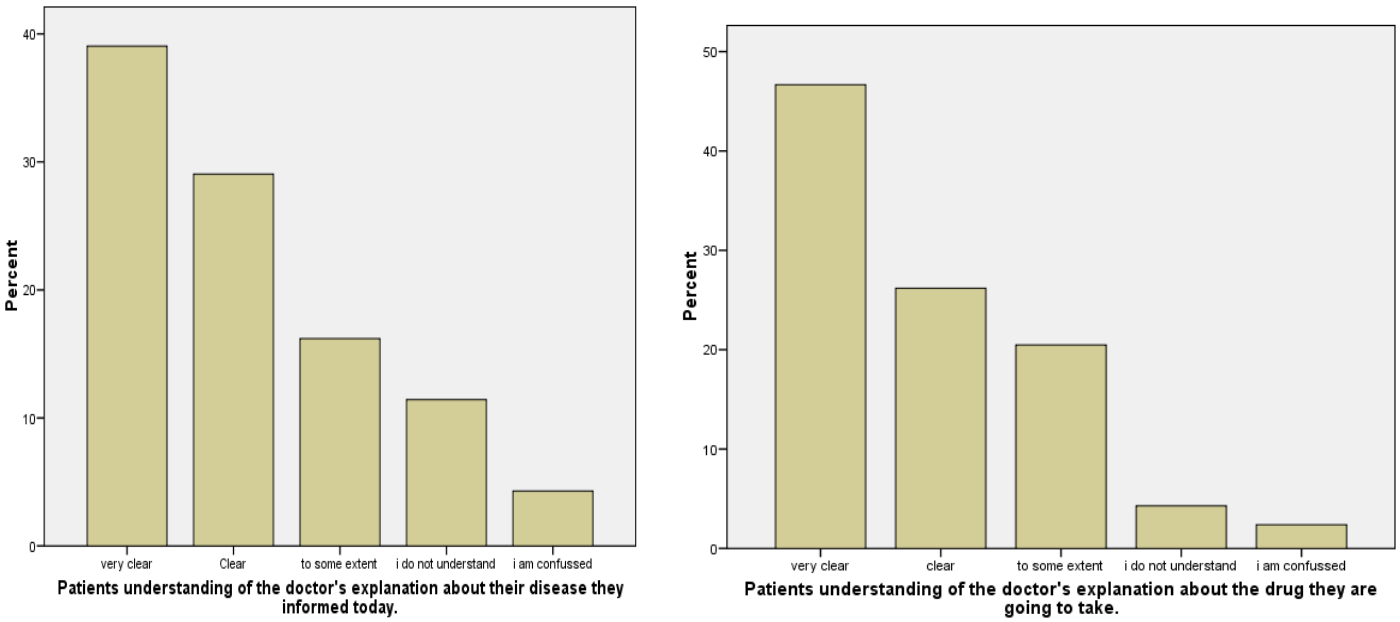


Graph-11- patients' perception on doctors writing while writing

(Item-7 and 8) focus on the ability of the patients' to understand the explanations, which are given about the drug and disease by the medical professionals. It is clear that one part of the patient doctor communication is to give the necessary information about the disease. For (Item-7) 82 participants that is (39.0%) of them answer that the explanation was very clear. The other 61 that is (29.0%) answer that it is clear; 34 that is (16.2 %) answer, they understand the explanation to some extent but since the doctor use new words that are not clear to them, they cannot say the explanation was good. Except, the remaining 24 patients that are (11.4 %) respond 'I do not understand everything the doctor was talking about' because he uses new words. The other 9 respondents that is (4.3 %) respond that the explanation make them confused. The reason they give for it is that, every clinic they go the doctors told them they have different diseases and here today the doctor informed them they have another disease.

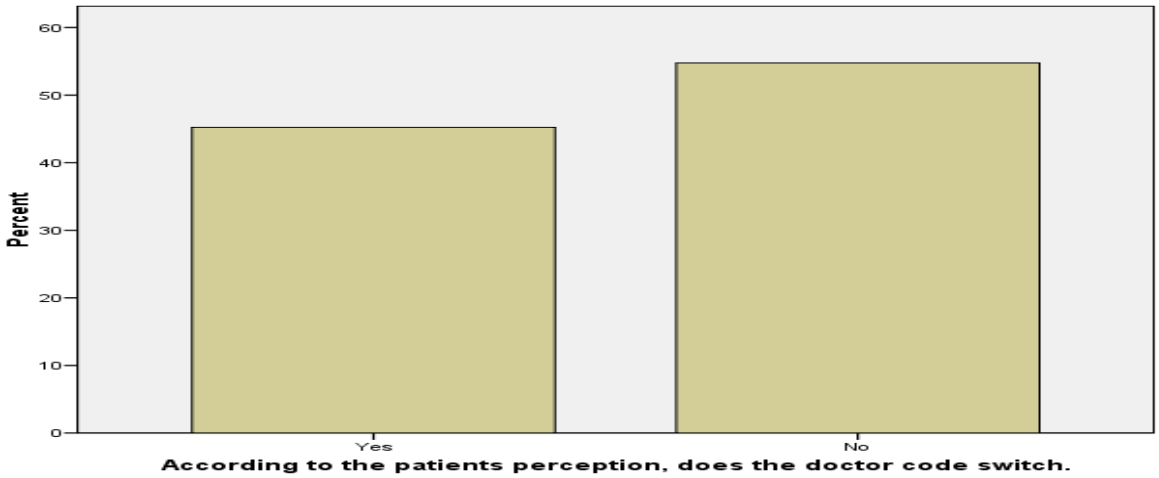
Likewise, the following (Item-8) is similar one except it asks about the drug. During the observation of the research, it is seen that the doctors do not give much information to the

patients' about the drug. Rather, they let the pharmacist to do that for them. See the data (the 12 texts shown). As a result, this question can include the discussion between the patient and pharmacists, which is a discussion about the drug. Although, the question is not that much different from (item 7) patients respond as follow; from the 210 participants, 98 that is (39.0%) of them answer that it is very clear for them because the explanation given to them 'slowly and repeatedly'. The other 55 that is (26.2 %) of them answer that the explanation was clear and 43 that is (20.5%) responded that they only understand the explanation to some extent because the doctor use some professional word and the explanation they give was little. The remaining, 9 that is (4.3%) answer that the explanation they hear from MP about the drug was hard to understand, 5 that is (2.4%) reply that the explanation was confusing and as result they are confused plus at the end of the discussion they fear to ask clarification again.



Graph-12, 13- patients understanding on an explanation about drug and disease

It is understandable that using other language that means code switching lead to confusion on the part of the listener, particularly when the receiver does not comprehend the words inserted or altered. Consequently, Item-9 asks that 'Do the MPs codes switch during the interaction with you and if the question is yes to what language?' Accordingly, 95 respondents that is (45.2%) reply that 'Yes' MPs code switch to English language; and the other 115 that is (54.8%) reply that 'No' MPs do not code switch during interaction.



Graph-14-do doctor code switch

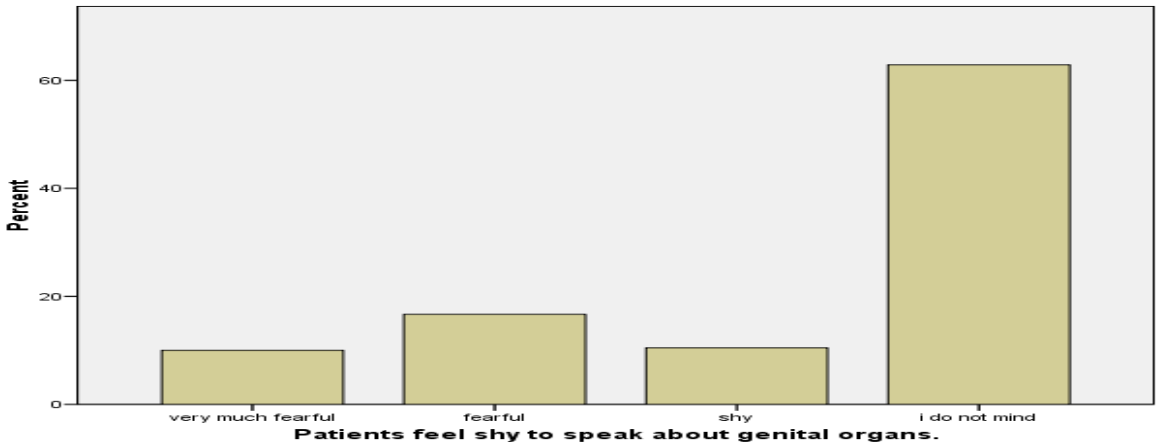
(Item-10) is about ‘cultural taboo’ words that includes talking about genital organs in public places. Many people feel shy or fear to talk these issues in many cultures and this tendency is mostly seen on the patients than on doctors. What is more, it might follow to the examination room and expressed through fear to explain about his/her disease to the medical professionals. Hence, out of 210 participants, 21 that are (10%) responded that they feel very fearful to talk about genital parts. Consequently, they are uncomfortable to talk about this thing freely especially when the doctor told them to take off their dress or trouser and show their genital organs it is very difficult for them. The remaining 35 that is (16.7%) respond that they are fearful to talk about it too, 22 that is (10.5%) respond that they are shy to talk and to show their genital. Nevertheless, the other 132 that is (62.9%) feel that these body parts are not different from the rest of their body. In addition to that, if they do not talk about their problems the doctor could not provide them with the solution. As the result show, the four groups can be categories in two big groups. That is, the first three groups can be incorporated in one group that is 78 that is (37.1%). For the reason even though the amount might differ, they are not comfortable to talk about it even with their doctor.

The patients suggest, these are some words that are considered taboo by most Amharic speakers and prefer to use the English equivalents, Such as:

Rather than

ko’^{w}lätt’	penis
k’ïzän	diarrhea
ïmïss	vagina
č’äβïtt’	gonorrhea
twkätt	vomiting
täkk’ïmatt’	diarrhea

In addition, out of 210 participants, 195 that are (92.8%) of them responded that even though they converse about these words and use these terms during ordinary talks while the discuss with their friends but while they are with doctors they feel shy. Still they use the terms because they do not have choice. Some of them say they do know the English equivalent of these words so they use the words freely, but the other 15 that is (7.2%) responded that they know the English words and prefer to use them rather than the Amharic.



Graph-15-patients confidence during interaction with Mps especially talking taboo

(Item-13) planned to check the patient’s Amharic ability to express medical concepts to the doctor and the perception of the patients toward Amharic language’s capacity to express medical problems. Accordingly, 210 patients respond to the question ‘can you express all your diseases and symptoms in Amharic?’ 146 that are (69.5%) participants answer that ‘Yes, I can express my problems only though Amharic because the language is my native or mother language.’ The other 64 that is (30.5%) respond that ‘No I cannot express my thought through Amharic only,

because Amharic is my second language and the others answer because some terms do not exist in Amharic word to express them such as typhoid, typhus etc.'

Graph -16-patients' capacity to express all diseases in Amharic

(Item-24) centers on the point of maximum quantity and asks questions do you feel that the doctor give the necessary answer or information's that you want when you ask him/ her or else he start to talk irrelevant or explain the problems in some obscure ways. Out of 210 patients, 130 that is (61.9%) responded that doctors give them a direct answer to the question they asked and because of these they are satisfied and understand what to do and what their problems is, etc. But the remaining 80 that is (38.1%) reply that the doctors do not provide the necessary information for them because for once they do not understand what disease they have, even though they ask to the doctor, they do not explained to them to the extent they understand.

(Item-11, 15, 16) focuses on the perception of the patients toward the doctors' occupation and gender. The society perceives that some professions are higher than others are. So, professions are chosen by one gender. For example, doctor should be male and female should be nurse. Therefore, one professional should get more respect than the rest. Furthermore, at the same time gender matter to some of the professional fields; for example, female should do some kind of jobs that are more 'simpler 'than those of male. As a result,

(Item-11) poses the question 'what do you prefer to call the MPs even though you are older than him/her is?' In Amharic there are word that are used to imply respect suffix (- tu) such as a'nte 'normal' for young person and 'antu' for elders and for person who deserve respect). Out of 210

participants 104 that is (49.5%) answer that they prefer to call them (antä) even to older MPs which shows friendly rather than disrespect but on the other hand 106 that is (50.5%) responded that they prefer to call (antu) even though they (patients) know they are older that the MPs because the profession deserve respect.

The next question (Item-15) focuses on gender and insight of the patients toward it. By which gender do you prefer to be seen during investigation? Out of 210 participants, 36 that is (17.1%) of them preferred male doctors because males are more concerned than females. Some of them in this group states, they want to be seen by the same gender to avoid discomfort. According to this group, female doctors seem to get angry more easily than males. The other 33 that is (15.7%) prefer to be seen by female doctors because of similar gender, they understand females' problems. The rest 141 that is (67.1%) respond that they do not bother about the gender of the doctors as long as the doctor pays attention to their problem and have a good knowledge of the science.

(Item-16) it is centered on the outlook of the patient toward the doctor. One way of showing authority is giving too much order than counsel. In this regard, how do the patients perceive the doctor, the question is; do you feel that the MPs give too much order? Out of 210 participants in this question, 111 that is (52.9%) answer that yes the MPs frequently give

Graph-17-Patients outlook on the doctor whether doctors give order frequently

order than advise, although many patients do not see it as a negative input and they explained that the doctor has to give orders otherwise people do not take it serious. In addition to this, 99

that are (47.1%) responded ‘No’- the doctors do not order too much rather we had a very good (friendly) discussion.

(Item-17, 18) are focused on Amharic and English terminologies used to explain a specific diseases and technical terms and here are some of them listed below given by the patients:

Amharic Terminologies	Meaning of the terms	English Terminologies
ko’^{w}rïtt’ïmatt	You have muscle pain’	typhoid
ras-mïtatt	‘You have headache’	blood pressure
masmäläss	‘You have Vomiting’	gastritis ulcer
tïkusatt	‘You have fever’	vomit
däm-mäläkiya	‘Blood pressure apparatus’	infection
wäba-amohall	‘You have malaria’	headache
k’orïtt’ätt	‘You have stomach pain’	HIV
täkk’ïmatt’	‘You have diarrhea’	CD4
twïkätt	‘You have vomiting’	Hemoglobin
yazorhall	‘Do you feel dizzy’	BP
ameba	‘Ameba’	Virus
sïgga däwwe	‘Leprosy’	Bacteria, germs etc

(Item-19) Which body parts do you feel shy to talk about and many patients answer. It is no problem for them to talk about their disease since they came to the health center to get medication. They do not bother about the problem. In contrast, patients also answer they feel more conserved to speak about genital organs that they are grow up in conservative society and to talk about this thing is being rude.

(Item-20) Many patients believe that most of medical professionals are careless and do not concern about the emotion of patients. The patients respond for this question as ‘Yes’ because many MPs are carless and they only think about money, they get bored as result of seeing many patients per a day, not putting themselves in the place of the patient, doing the job without interest rather to earn living form it, being inexperience mainly on teenage MPs. Because they talk and laugh in the diagnosis room during interaction with patient with other medical professionals and other related problems are the main sources of being sloppy.

(Item-23) ‘Where do you prefer to go when you get sick to the modern medicine or traditional medicine?’ This question is attempting to find out the patients’ perception toward medicine since Ethiopian society is more traditional society and prefer to explain heath problems more in mysteries ways such as ‘mägaññа mätaññ’, ‘mïčč mätaññ’ ‘bïrd mätaññ’ etc. The cause of the disease related to some mysteries events such as the cause of gonnorrhoeae (Neisseria Gonnorrhoeae) is urinating toward sun, even one person explain that the reason he had gonnorrhoerae was because he eats fish. Moreover, for this question, out of 210 patients 185 that is (88.1%) of them responded that they prefer to go to modern medicine because the procedures are scientific and facilitated with laboratory investigation and the MPs has a better understanding of the disease. On the other hand, the other 25 that is (11.9%) of them prefer to go first or for the disease that are serious to the traditional medicine such as holy water, because there are many disease that cannot treated by modern diseases so they choose to check first the traditional or both at the sometime. Another group of patients suggests that it is better to eat onion, ginger etc. rather than coming to clinic. Moreover, the same questions were raised that is

(Item-21, 22) what do you understand when a person said ‘bïrd mätaññ’ and ‘mïčč mätaññ’ and for the first question out of 210 participants 100 that is (47.6%) of them answer they are not sure what really mean but it certainly is a cultural disease and meaning. The other 110 that is (52.3%) attempt to answer in the categories of pain which happened on any part of muscles and most of them agreed that it is a result of a ‘clash of warm and cold air’. Implying that if someone stays on the warm temperature for a while and exposed to cold or if even he/she stays in the house and let one of the house’s window or door opened, ventilation come through it, then immediately he can say ‘bïrd mätaññ’. On the other hand, they also responded that ‘bïrd’ also could cause a respiratory disease that is cough. At the same time, the most confusing disease is ‘mïčč’. Out of

210 participants, 161 that is (76.6%) respond that it is not clear for them either; because some of them answer it has similarity with ‘bïrd’ even though, sometimes it is different. As result, they have no idea what actually, the term mean. However, they use the word anyway. The remaining 49 that is (23.4%) replied that it is a sore or wound on mouth area and caused because of eating or preparing spicy food or drinking coffee and exposed to sun. Others respond that that it is a serious stomach pain, or sense of cold all over the body and other associate it with any kind of sudden pain or diseases, even comment that ‘no need to come to doctor for this’ because the patient can be treated by ‘dama-kässe’ a herbal remedy prepared in house. Even though there is no plain, understanding of these diseases even the MPs used these terms during a conversation with the patients. The similar issues that are raised concerning the Amharic name of the disease is a name given to medical problems called Hypertension or High Blood Pressure: it refers ‘medical condition in which constricted arterial blood vessels increase the resistance to blood flow, causing an increase in blood pressure against vessel walls’ (Encarta: 2008) in Amharic called ‘däm bïzatt’. To medical problem called Anemia or blood deficiency: it refers ‘blood condition in which there are too few red blood cells or the red blood cells are deficient in hemoglobin, resulting in poor health’ (Encarta: 2008) called in Amharic ‘däm manäs’ which appears to be opposite to ‘däm bïzatt’ .

(Item 25, 26) asks that ‘what the Amharic words mean and how the patients understand them?’ Out of 210 participants 15 that is (7.1%) answer the correct answers but the rest of the participants answer, ‘däm bïzatt’ is more serious than ‘däm manäss’ and they cannot occur together. Because it seems that most of them are puzzled for the reason that the words ‘bïzatt’ = ‘high’ and ‘manäss’= ‘low’ are opposite words and if one thing is low cannot be high. Thus, the diseases do not happened together. And the last question is ‘what do you comment for the future to be improved on the quality of health’ and most of the patients reply that number of doctors should be increased, to produce a more quality job, and doctors should improve their medical knowledge and behavioral aspects and has to learn to listen more.

4.2.3. Summary of the questionnaire

The questionnaires help to close the gap, which are created during observation. Because, it is clear that direct observation affect the result by influencing the interlocutors, which means the

medical professional and the patients may not act as usual but creates artificial environments because of the researcher's presence in the investigation room. Accordingly, the questionnaires signify that patient's perception and understanding of modern medicine is very limited and employed vague terms to explain their illness. In addition, the patients associate and measure their satisfaction; not only with the care, they received but also by the communication, they had with their doctor.

At the same time, doctors also prefer to communicate with patients educated, young and male patients because according to them these patients are easy to interact with, they prefer to have formal interactions with their patients and most of them believe that Amharic language has inadequacy in explaining medical interactions

CHAPTER FIVE

5. Conclusion and Recommendation

5.1. Findings

1. Both doctors and patients code switch during communication and implemented insertion code switching most of the time, medical terminologies, which are not found in Amharic. However, during interactions of two medical professionals interlocutors favor Alteration Code switching from Amharic to English especially in medical topics.
2. Ninety percents of the patients and medical professionals' communications ends within one to six minutes. This does not give the opportunity for the patients to address their problems.
3. In medical communication, variables such as age, gender, educational level, doctors' personal behavior and language skills etc. has significant role in the production of good communication.
    - Medical professionals prefer young patient to elderly patients to talk to because they give short and precise answer.
    - Elderly patients commit more errors of maxims of quantity, and relevancy than young patients do.
    - Male patients are more comfortable than females in addressing their medical problems to their doctors.

- Many patients consider that if the doctor writes while discussing with them as ‘not good manner’ even as ‘disrespect’.
- Doctors prefer to communicate with highly educated patients than with the patients of illiterate.

4. Patients and doctors understand and implemented Amharic terms to describe their illness such as ‘mïčč’ ‘bïrd’ and ‘mägañña’ ---mätañ (3rd person). These sentences meaning in most cases differ according to the patient’s social understanding. However, the idea implies that the causes of the disease are something, mystery or not explained simply. Yet, the medical professionals also used these terms with their patients although they have no clear definition in medicine.
5. Young medical professionals are more successful in having a good communication with patients than the elders’ medical professionals.
6. There are many Amharic terms used by patients such as ‘masïkk’ämätt’’ and ‘masmäläss’, which have literally different meanings. That is ‘it makes me sat’ and ‘it makes me returned’ respectively, but they have different implications in the medical communication that are the first implies ‘I have diarrhea’ and the second implies ‘I have vomiting’.
7. Amharic terminologies such as bïrd, mïčč and mägañña etc are used by most patients and doctors which has many meaning according to the individual’s educational, cultural and social background to describe diseases which are unspecific and general for example bïdïd can mean simple cough and sometimes any febrile disease etc.

5.2. Conclusion

This study has attempted to investigate the two questions mentioned in chapter one of this research: why patients are unsuccessful in asserting themselves and in talking with medical professionals, and why medical professionals do not talk more like a customary person that is patients. Accordingly, after the analysis of this research paper, it is reasonable to develop some clear responses of the above two questions. Therefore:

1. The communications that are performed in the health center is doctor-centered communication, which makes the patient a passive participant of the communication.

2. Variables such as, culture, age, educational level, sex and religion affect the doctor and patient communications to the extent of miscommunication, mistrust, and failure to make full use of health care.
3. Most of the patients in the health center are traditional, with low educational status and believe that most diseases caused by some unknown factors. As results of these most of the patients do not understand the explanation given from the doctors, and do not explain their problems especially if the problems they have considered to be ‘taboo’.
4. In most interactions, doctors or medical professionals have a unique position of respect and power. Those are shown in decision making for the patients by their own, by asking series of close-ended questions that are focused on the doctors’ interests rather than questions that let patients to speak up about their problem or feeling.
5. Most of the medical professionals at Kotebe health center show obvious communication skill deficiency in all categories. Because, they use the traditional concept (Doctor-centered communication approach) that are restricted to physical illness and its intervention and treatment.
6. Effective doctor-patient communication can be a source of motivation, incentive and reassurance to patients. Despite this fact, most of the communications between the patients and doctors at Kotebe health center have very little time to produce all these point. Because, table-1 shows, the doctors spend very restricted time for single patient that prohibit developing trust between interlocutors.
7. Medical communication or the language of medicine can be regarded as either a multi-faceted register or series of registers. Nevertheless, the communications between the doctor and patient at Kotebe health center is kind simplified Amharic version that can be understand by any layperson. In addition, most of the communications between the doctors and patients are a kind of boss and subordinate type. Mainly, between the more experienced medical professionals and young patients are too formal.
8. Most complaints concerning doctors are related to issues of communication, not clinical competency. Patients want doctors who can skillfully diagnose and treat their sicknesses as well as communicate with them effectively. Doctors with better communication and interpersonal skills are able to detect problems earlier, can prevent medical crises and expensive intervention, and provide better support to their patients. This may lead to

higher-quality outcomes and better satisfaction, lower costs of care, greater patient understanding of health issues, and better adherence to the treatment process.

9. Patients prefer to communicate with a medical professional who listen to them, see them at the same time than a medical professional who writes on patient card, and listen.

5.3. Recommendation

The result of this research shows that both the doctors and patients have an important role to produce effective medical communication. Despite these facts, in a multicultural society, such as Ethiopia, people with different linguistic and cultural backgrounds may perceive health concepts and issues differently and this can lead to various problems such as miscommunication, unsuitable behaviors, doubt, and even failure of medical care. Therefore, to improve the quality of the medical communication these following points are forward.

1. Encourage health professionals to implement open-ended questions that allowed the patient to explain his problems and fears and let him involved in decision-making. As people are cultural beings, their views, and attitudes towards health are deeply influenced by their cultural and environmental background.
2. Training of health professionals in interpersonal communication and the use of communication technologies rather than focusing only on the medical science. In addition, the health center and Ministry of health should take the lead towards addressing the problems of interpersonal communications through curricular review and other relevant approaches at individual and institutional level. That let health professionals to have a high level of interpersonal skills to interact with diverse populations and patients who may have different cultural, linguistic, educational, and socioeconomic backgrounds.
3. To support an increase in health communication activities, research and evaluation of all forms of health communication will be necessary to build the scientific base of the field and the practice of evidence-based health communication. Collectively, these opportunities represent important areas for making significant improvements in personal and community health.
4. To give health education for the patients within the health center and to the general population though mass media that help to develop the public’s attitude and perception toward modern medicine and awareness on the transmission of some communicable

diseases. Additionally, support discussion to develop and how to prevent diseases by doing this the patients understanding of the medical concepts grows up and can be achieved a good communication.

Appendix -I

For medical professionals

Addis Ababa university postgraduate research

Dear sir/madam

I came from AAU, department of linguistic (sociolinguistic) to conduct a Master's research thesis on the 'medical professional-patient communication in outpatient department of Kotebe health centre: A sociolinguistic and pragmatic study and I believe that the research will be the preliminary point for further researches. Thus, your responses are essential for the success of the study; therefore, you are kindly requested to give your answers for the following questions, your response will be kept confidential. Thank you for your cooperation, in Advance.

A-Give your answers by marking ✓ on the box provide.

1. How many years do you serve as a medical professional?

☐ 0-5 ☐ 6-10 ☐ 11-15 ☐ 16-20 ☐ 21-above

2. How many patients do you see per day?

☐ 5-15 ☐ 16-25 ☐ 26-35 ☐ 36-above

3. Who are the most common clients in the health center?

Gender ☐ Females ☐ Males

Age ☐ 0-5 ☐ 6-10 ☐ 11-15 ☐ 16-20 ☐ 21-above

4. Do you think Amharic language express all the medical concepts that you want to express for your patient**?**

☐ Yes ☐ No

- Why?_____

_____

5. Do your patients describe their disease and symptoms well in Amharic language?

☐ Yes ☐ No

- Why?_____

6. Do you feel that, your patients understand the questions that, you ask?

☐ Yes ☐ No

- Why?_____

7. Do most of your patients give relevant or helpful answer to the discussion you have?

☐ Yes ☐ No

- Why?_____

8. How do you describe **yourself** and **the interaction** to your patients during visiting or communication with them? Respectively

Myself ☐ Boss ☐ ubordinate ☐ ofessional ☐ endly

The interaction as ☐ Formal ☐ Casual ☐ gument

9. Do you think that patients understand mostly used medical terminologies such as OPD, Ward, TB etc?

☐ Yes ☐ No

- *Why?*_____

10. As medical professional, I always prefer to communicate with patients of :

A. Age ☐ 5-15 ☐ 16-25 ☐ -35 ☐ -above

- Why? _____

B. Gender ☐ Females ☐ Iales

- Why?_____

C. Educational status ☐ Highly Educated ☐ High school graduate

☐ He/she can read ☐ Non-educated

- Why? _____

11. During conversation, most of my patients do feel free to talk about their personal staffs or issues such as how they are infected with HIV

☐ Yes, they do talk ☐ No they do not talk

- Why?_____

_____

12. Which medical problems do patients feel shy away during examination?

- Why?_____

_____

13. What are the most common diseases in this health center?

_____

- Why?_____

_____

14. What are the most commonly used Amharic terms that patients use to explain his/her disease?

_____

- Why?_____

_____

15. What do you understand when a patient say in 'ወባ ሆዴ'

_____

16. what do you understand when a patient says in Amharic ‘□□ □□□ ’

17. What do you understand when a patient says in Amharic ‘□□□ □□□’ or ‘□□□’

18. If a patient came with sexual transmitted diseases, how do you think he will explain his problems?

19. What are some of the benefits that are associated with the use of touch, such as taking vital signs, even if the nurse already done the procedure during investigation?

20. What communication problems have you encountered so far during communicating with your patients?

21. Describe your recent interaction with your patient, which shows your ability to create trust? What steps would you take to develop an effective relationship with your patient?

22. Have you ever; take interpersonal communication course in university or a seminar after graduation?

23. Do you have any comment on the perception of the society toward modern medicine?

B-In each of the following, read items A, B, and C, and then mark the one that best describes your communication style.

24. ___ A. When conversing with patients, I usually do most of the talking.
    ___ B. When conversing with patients, I usually let the patient do most of the talking
    ___ C. When conversing with patients, I try to equalize my participation in the conversation.
25. ___ A. I usually 'warm-up' new conversations with small talk.
    ___ B. I usually avoid small talk and jump into more important matters.
    ___ C. I usually avoid starting conversations.
26. ___ A. I frequently use ***courtesy words*** and phrases such as 'Please,' 'Thank you,' 'You're welcome,' 'I'm sorry' In Amharic language.
    ___ B. I occasionally use these courtesy words and phrases.
    ___ C. I never use these courtesy words and phrases.
27. ___ A. I tend to be serious and do not smile often while conversing.
    ___ B. I smile all the time while conversing.
    ___ C. I smile at appropriate times while conversing
28. ___ A. When I listen to the patient, I often cross my arms over my chest.
    ___ B. When I listen to the patient, I often lean back and turn my body away from the speaker.
    ___ C. When I listen to the patient, I often lean slightly forward and face my body toward the patient.

    ------D. When I listen to the patient, I often write on the patient card.

Appendix- II

For patients

[illegible] [illegible] [illegible] ድህረ ምረቃ

ሀሳብ መስጫ [illegible]

ውድ አቶ / ወ/ሮ/ ወ/ሪት /ወጣት

እኔ የመጣሁት ከአዲስ አበባ ዩኒቨርሲቲ የስነ -ልሳን ት /ክፍል ሲሆን የሁለተኛ ዓመት ድህረምረቃ ተማሪ ነኝ። የመመረቅያ ሁፌ በጤና ባለሙያና በታ <ሚ መካከል ባለ ውይይት ላይ ያተኮረ በመሆኑ ይህ እርሶ የሚሰጡት ሃሳብ (መልስ) ለጥናቱ ትልቅ ድርሻ የሚያበረክት ከመሆኑም በተጨማሪ በሃኪምና በታ <ሚ መካከል ያሉት የውይይት ችግሮችና መፍትሔዎቹ ምን እንደሆኑ ይጠቁማል ብዬ አምናለሁ። ስለዚህ ትክክል ነው ብለው የሚያምኑበትን ሃሣብ በነጻነት እንዲሰጡኝ እጠይቃለሁ። የሚሰጦቸው መልሶች ለሌላ ሦስተኛ ወገን እንደማይተላለፍ ላረጋግጥሎት እወዳለሁ። ስለትብብርዎ በቅድሚያ ከልብ አመሰግናለሁ።

ሀ/ ትክክለኛ ነው የሚሉትን መልስ በሣጥኑ ውስጥ ምልክት ያድርጉ በተጨማሪም ምክንያቱንም ያስረዱ።

1. ፆታ ወንድ ☐ ሴት ☑
   ዕድሜ ☐ 0-[illegible] ☐ 9-15 ☐ 16-25 ☐

2. ወደ ጤና ጣቢያው በምን ያህል የጊዜ ልዩነት ይመጣሉ ?
   ☐ ሁል ጊዜ ይመጣሉ ☐ በተወሰኑ ጊዜያት ይመጣሉ ☐ አልፎ -አልፎ
   ☐ አንድ ጊዜ ብቻ ነው የመጣሁት

3. ባገኙት ህክምና ረክተዋል ?
   ☐ አዎ ረክቻለሁ ☐ አይ አልረካሁም
   ለምን ?____________________________________

4. ወደ ጤና ጣቢያው ሲመጡ የሚሰማዉትን ሁሉ ለሃኪም ይናገራሉ ?
   ☐ አዎ እናገራለሁ ☐ አይ ምንም አልተናገርኩም
   ለምን ?____________________________________

5. ጤና ባለሙያዎች እርሶ የተናገሩት በትክክል ይገባቸዋል ?
   ☐ አዎ ይገባቸዋል ☐ አይ አይገባቸውም
   ለምን ?____________________________________

6. ከሚያክሞት የጤና ባለሙያ ጋር ባደረግኩት ውይይት የጤና ባለሙያው ?
   ☐ ☐

በደንብ በአክብሮት አናግሮኛል   በአክብሮት - አናግሮኛል   ትኩረትም

☐ አልሰጠኝ   ☐ አክብሮት በሌለው መንገድ ነበር   ያናገረኝ

ለምን ?____

7. ሃኪሙ ስለመድኃኒት የተናገረው ነገር ወይም የሰጠኝ ማብራሪያ ገብቶኛል።

☐ በደንብ ገብቶኛል   ☐ ገብቶኛል   ☐ ያን ያህል አይደለም

☐ አልገባኝም   ☐ ግራ ተጋብቻለሁ

ለምን ?____

8. ሃኪሙ ስለበሽታዬ የተናገረው ነገር ወይም የሰጠኝ ማብራሪያ ገብቶኛል።

☐ በደንብ ገብቶኛል   ☐ ገብቶኛል   ☐ ያን ያህል አይደለም

☐ አልገባኝም   ☐ ግራ ተጋብቻለሁ

ለምን ?____

9. ጤና ባለሙያው አንዳንድ ቃላት ከሌላ ቋንቋ ይጨምራል ?

☐ አዎ ይጨምራል   ☐ አይ አይጨምርም

አዎ ከሆነ መልሱ ምን ቋንቋ ?   እንግሊዘኛ ☐

ሌላ ቋንቋ ከሆነ ቋንቋ ስም ፃፍ   ----------------

10. የፆታ ብልት አካባቢ የበሽታ ምልክት አለብኝ ብሎ ለጤና ባለሙያው መናገር

☐ በጣም እፈራለሁ   ☐ እፈራለሁ

☐ አፍራለሁ   ☐ ምንም አይመስለኝም

ለምን ?____

11. ጤና በለሙያን ብዙ ጊዜ መጥራት የሚቀለኝ /በእድሜ ብበልጠውም /

☐ አንተ ብዩ ነው   ☐ አንቱ ብዩ ነው

ለምን ?____

12. የጤና ባለሙያው እኔ በማወራበት ወቅት መፃፉ

☐ ምንም አይመስለኝም   ☐ የሚጽፍ ከሆነ የሚያዳምጠኝ አይመስለኝም

☐

አክብሮት□የጎደለው□እንደሆነ□ይሰማኛል

ለምን ?____

13. በአማርኛ□ሁሉንም□የበሽታ□ምልክቶች□ወይም□በሽታዎችን□መግለጽ□ይችላሉ ?

☐ አዎ□እችላለሁ ☐ አይ□አልችልም

ለምን ?____

14. ከአማርኛ ይልቅ በእንግሊዘኛ የበሽታ ምልክቶች ወይም በሽታዎችን መግለጽ እመርጣለሁ ቃላት፡

ለምሳሌ፡

☐ Diahaerea/□□□□ አለብኝ ☐ vomit/□□□□□□□

☐ HIV/ ኤድስ ☐ gonorrhea /ጨብጥ

ለምን ?____

15. የሚያክመኝ□ጤና□በለሙያ□ፆታ□ወንድ□ወይም□ሴት□ቢሆን□እመርጣለሁ

☐ ወንድ ☐ ሴት ☐ ግድ□የለኝም

ለምን ?____

16. ብዙ□በሽተኞች□ጤና□ባለሙያው□መመሪያ (ትእዛዝ) መስጠት□እንደሚያበዛ (እንዲህ□አድርግ /እንዲህ - አታድርግ)፤ይሰማቸዋል።እርሶስ ?

☐ አ አዎ□ትእዛዝ□ያበዛል ☐ አይ□ትእዛዝ□አያበዛም

ለምን ?____

□/ □ባክዎን□ከታች□ባለው□ክፍት □□ □ሣብዎ□ ይፃፉ

17. ጤና□ባለሙያው□ህመምን□ለመግለጽ□የሚጠቀምባቸው□የአማርኛ□ቃላት□የሚያስታውሱት□ይኖራል ?__________

____

18. ጤናባለሙያው□ህመምን□ለመግለጽ□የሚጠቀምባቸው□የእንግሊዘኛ□ቃላት□የሚያስታውሱት□ይኖራል ?__________

____

19. ከሰውነት አካላት መካከል የትኞቹን ለመጥራት ይቸገራሉ ? ለምን ? ______________________________

20. ብዙ ጤና ባለሙያዎች ስለበሽተኞች ጉዳይ ደንታቢስ እንደሆኑ ብዙ ሰዎች ይሰማቸዋል። ለዚህ ምክንያቱ እርሶ ምንድን ነው ይላሉ ? ______________________________

21. በአማርኛ ብዙ ጊዜ “ብርድ መታኝ” ይባላል። ምን ማለት ይመስሎታል ? ______________________________

22. በአማርኛ “ምች መታኝ” ይባላል። ምን ማለት ይመስሎታል ? ______________________________

23. ሲያሞት ወደ ሃኪም መምጣት ይመርጣሉ ወይስ ወደ ባህል ህክምና ? ለምን ? ______________________________

24. ጤና ባለሙያው እርሶ ለሚጠየቁት ጥያቄ ቀጥተኛ (ግልጽ) መልስ ነው የሚሰጠው ? ወይስ ዙሪያ ጥምጥም ይሄዳል? ለምሣሌ፡ - ምንድን ነው ያመመኝ ብለው ሲጠይቁ ______________________________

25. በደም ብዛትና በደም ማነስ መካክል ያለው ልዩነት ምንድን ነው ? ______________________________

26. ሁለቱም በአንድ ወቅት አንድ ሰውን ሊያጠቁ ይችላሉ ? ______________________________

27. ጤና ጣቢያው የሚሰጠውን የሕክምና ጥረት ለማሻሻል ሊወስዳቸው የሚገቡ ምን ነገሮች አሉ ብለው ያምናሉ፡ ______________________________

Appendix-III

Interview questions for medical director

These are interview questions asked to the medical director of Kotebe health centre after introducing myself from where I came, I told him that MA thesis on 'sociolinguistic and pragmatic aspects of patient-medical professional communication in OPD: Kotebe health centre. In addition, asked him the following eight questions that help to conduct and determine the amount of the sample for the research.

1. ***How many workers does the health center have?***
2. ***How many health professionals are working in the health center?***
3. ***How many patients are seen in the health center per month and year?***
4. ***How many patients does the doctor has to watch within a day?***
5. ***How many departments does the health center have?***
6. ***What are the common diseases in the health center?***
7. ***Who are the most common clients in the health center? According to, age, gender, class etc?***
8. ***How many doctors, health officers and nurses are working within the OPD?***

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