UNIVERSITÄT BAYREUTH

(Non)Adherence in Doctor/Patient Interactions in Nigerian HIV Clinics

A Thesis submitted to the Universität Bayreuth in fulfilment of the requirements for the award of Doctor of Philosophy in English Linguistics

By

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Declaration

I hereby affirm that I have produced the thesis at hand without any inadmissible help from a third party or the use of resources other than those cited; ideas incorporated directly or indirectly from other sources are clearly marked as such. In addition, I affirm that I have neither used the services of commercial consultants or intermediaries in the past nor will I use such services in the future. The thesis in the same or similar form has hitherto not been presented to another examining authority in Germany or abroad, nor has it been published.

Bayreuth, 13.06.2018   Eniola Olamide Boluwaduro

Dedication

To my husband, Stephen Boluwaduro; for enduring the pain of separation while I pursued my career – I love and adore you my dearest.

To my son, Bethel Boluwaduro; for being patient with mummy while she wrote her PhD thesis – you will forever mean a lot to me, my darling son.

To my daughter, Peniel Boluwaduro; for lovingly crowning the journey with your birth – I love you baby girl.

To my parents, Mr and Mrs Adedoyin; for giving me feet to fly – God bless you abundantly.

Above all, glory to God.

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this is what yields more lasting results. You taught us to frown at mediocrity and always reach far beyond the stars. These creeds have helped shaped my excellent work ethics. Thank you for modelling true character in your children.

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Table of Contents

Abstract

In the context of chronic-routine doctor/patient consultations, interactions are focused on care and support for the patients, which is achieved when patients periodically attend the routine consultations and adhere to medical recommendations. This study examines the consultations between female HIV-positive patients and doctors/counsellors in outpatient clinics covering Nigeria's south-western geo-political zone. It specifically discusses the interactional activities prevalent in the consultations, and participants' (doctors, counsellors and patients) views on patients' adherence behaviours, as recovered from interview data. Using insights from conversation analysis (CA) and socio-cognitive theory (SCT) as methodological and theoretical backgrounds respectively, this study qualitatively analyzes transcribed data derived from seventy audio recordings of doctors' conversations with female HIV-positive patients. Supplementary data include seventeen semi-structured interviews with the research participants, which were subjected to inductive thematic analysis. This study also considers data from patients' case notes, current reports on HIV/AIDS in Nigeria from international organizations, and participant observations.

Findings from this study reveal that the notion of adherence is a multi-dimensional concept that entails both adherence to medications and compliance with other medical recommendations (including regular clinic visits and CD4 count cell tests). Taken together, these expectations are used as indicators of patients' willingness to take an active role in adhering to treatment regimens. While doctors make provision for solicitation of patients' medical concerns among others pertinent concerns in the consultations, the opening phases, history-taking phases and treatment discussion phases are majorly contextualized by one central objective: doctors' expectations of patients' nonadherence to medical recommendations. Participants orient to this expectation as they negotiate interactional trajectories that seek to address patients' nonadherence through practices of accusations, and explicit and implicit references to adherence during medical history-taking. When patients are accused of nonadherence, they often respond by justifying their behaviours with accounts. However, responses are more cooperative when accusations are absent. During treatment discussions, adherence is ensured through instructions on drug use, explanations about the importance of regularly conducting CD4 count cell tests and planning next appointments to the clinics. These findings are further supported by results from the analysis of interview data which show that doctors and counsellors constantly work with the beliefs that patients' nonadherent behaviours do exist, and can be attributed to their social situations, including subjective beliefs

about illness. Another significant finding is that patients who indulge in alternative therapeutic options do so in pursuit of optimizing positive treatment outcomes. Hence, they treat these alternative options as facilitator and motivators for optimizing the outcome of treatment regimens. However, doctors and counsellors view these options as barriers to adherence. It is suggested that doctors and counsellors view patients' adherence behaviours by subscribing to their subjective beliefs. This study contributes to the discourse on doctor/patient consultations in Nigeria by discussing how these adherence-related interactional dynamics are negotiated between doctors, patients and counsellors in the routine medical context of HIV consultations in south-western Nigeria.

List of Tables

List of Figures

List of Abbreviations

AHM   Alternative Herbal Medicine

AIDS   Acquired immune deficiency syndrome

APLWA Association of people living with AIDS

ART   Antiretroviral therapy

AT   Activity Type

ATO   Alternative treatment option

ARV drugs Antiretroviral drugs

CA   Conversation analysis

CAM   Complementary and alternative medicine

CD4 (T-cells) Cluster of differentiation 4

C-P   Counsellor-Patient

D-P   Doctor/Patient

Doc   Doctor

EDD   Expected date of delivery

EKSACA Ekiti state AIDS control agency

EMR   Electronic medical record

FUQ   Follow-up questions

GAT 2   Gesprächsanalytisches Transkriptionssystem

HIV   Human immunodeficiency virus

LACA   Local action committee against AIDS

LSACA   Lagos state AIDS control agency

MCA   Medical conversation analysis

NACA   National agency for the control of AIDS

NPLWA Network of people living with AIDS

OTCD   Over-the-counter drugs

ODSACA Ondo state agency for the control of AIDS

Pat   Patient

PLWA   People living with HIV/AIDS

PMTCT   Prevention of mother to child transmission

SCT   Socio-cognitive theory

TB   Tuberculosis

TCU   Turn constructional unit

THC   Traditional herbal centre

TM   Traditional medicine

TRP   Transition relevance place

UNAIDS   The Joint United Nations Programme on HIV/AIDS

VCT   Voluntary counselling and testing

1   Introduction and Background

"…institutional talk is normally informed by goal orientations of a relatively restricted conventional interactional form" (Drew & Heritage 1992: 22).

"The goals of medical CA are to understand and document what social actions and activities are accomplished by participants in medical encounters and how participants use interactional resources and sense-making practices to accomplish their goals, with the aim of identifying recurrent patterns of interaction" (Gill & Roberts 2013: 577).

Ethnographic and demographic studies have established that the incidence of new Human Immunodeficiency Virus (HIV) infections in Nigeria is on the rise due to some socio-cultural factors that influence patients' adherence to treatment recommendations (i.e. the willingness and cooperation to follow treatment directions; cf. Vrijens et. al.'s (2012) definition of adherence to medications as "the process by which patients take their medication as prescribed, described by three quantifiable phases: initiation, implementation, and discontinuation" (2012: 691). These adherence factors include cultural, religious and individual beliefs which engender religious sentimentality about healing, and beliefs that HIV is a non-existent disease among others (see Ajala & Olabisi 2008; Adeneye et al. 2009; Mbonu et al. 2010; Avert 2014). Consequently, researchers have identified that adherence to antiretroviral therapy is a problem among HIV-positive patients in Nigeria. Olowookere et al. (2008) buttress this claim with a report of 37.1% nonadherence rate in a cross-sectional survey of people living with HIV/AIDS in Ibadan, a South-western Nigerian state. Similarly, Igwegbe et al.'s (2010) study show a high prevalent nonadherence rate of 21.7% among 386 HIV-positive pregnant mothers in Nnewi, Nigeria (cf. Ekama et al. 2012).

To address the increasing incidence of patients' nonadherence to antiretroviral (ARV) drugs and the HIV disease, scholars have proposed a better social and professional relationship between patients and medical practitioners (including doctors and counsellors). Researchers have advised adequate prevention, bereavement and disclosure counselling and proper stigma management (Ifemeje 2011). This medical approach to the HIV menace is especially encouraged because studies on medical communication have shown evidence that medical encounters determine the impact of medical therapy on patients (see Heath, 1981; West 1983; West 1884a; West 1984b; Pilnick 2001, 2003; Wynn & Wynn 2006; Watermeyer & Penn 2009). While communication breakdown may occur between doctors and patients due to asymmetrical

relationships such as, for instance, existing power structures between both[1] (West 1984b; Goodyear-Smith & Buetow 2001), medical interactions should, nevertheless, be one of the most effective ways of educating patients and influencing their attitudes, actions, beliefs and impressions towards their medical concerns.

In the same vein, medical conversation analysts have extensively documented the importance of medical interactions on patients' health-related behaviours. This phenomenon may be described as the "goal orientation" (Drew & Heritage 1992: 22) of participants who interact in medical institutions. As Gill and Roberts (2013) assert (captioned above), medical conversation analysis seeks to understand and document how participants in medical encounters engage social actions, activities, interactional resources and sense-making practices to accomplish their goals (2013: 577). This, they state, "permits fine-grained analysis and systematic documentation of the organized procedures the participants used to accomplish a wide variety of medical activities" (2013: 577). Hence, a study of interactional activities and conversational actions is crucial in understanding speaking practices in medical encounters and its consequences on participants' joint accomplishment of interactional goals, such as addressing participants' social behaviours. However, despite the wealth of research on medically-oriented interactional goals in d-p (doctor/patient) interactions and how the CA methodology reveals "participants' real-time, concrete behaviours" (2013: 577), one research focus remains unexplored, i.e., how interactional activities in HIV consultations, as a specific chronic-routine institutional context, are driven towards the goal of accounting for patients' adherence. Although Peräkylä, Silverman and Bor have published detailed and extensive reports of their conversation analytic study on communication between medical practitioners and Acquired Immune Deficiency Syndrome (HIV/AIDS) patients in primary care visits in some English clinics (see Silverman & Peräkylä, 1990; Peräkylä & Silverman 1991; cf. Peräkylä & Bor 1990; Silverman, Peräkylä & Bor 1992; Peräkylä, 1995), they pay specific attention to HIV/AIDS counselling and "how professionals and clients organize their talk in relation to the "delicate' issues" (Silverman & Peräkylä 1990: 293). They discuss various phenomena such as "delay in the production of 'delicate' items" and "the interactional problems of addressing dreaded issues" in HIV/AIDS counselling. Conversely, the

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[1] Goodyear-Smith and Buetow (2001) view the concept of power issues in doctor-patient relationships from the point of view of asymmetrical relationship between both. They state that power is necessary in all social relationships and doctors and patients need power in order to "fulfil professional obligations, formulate values and achieve health needs" (2001: 11).

present study does not entirely focus on participants' "delicate talks" about HIV but on interactional activities, in relation to patients' adherence behaviours. Therefore, this study significantly differs in terms of research focus, institutional context, cultural settings and participants' selection.

The focus on patients' adherence is crucial because it exemplifies the phenomenon of shared/non-shared decision-making between doctors and patients (see Stevenson et al. 2000), patients' expertise and doctoring styles. It also advances the discussions on the problem of compliance among patients. This research focus becomes even more important in the HIV context because patients' adherence to medical recommendations has consequences on their medical well-being – the success of the antiretroviral therapy (ART) depends on the consistent intake of the ARV drugs. Therefore, the present study fills this research gap by discussing how doctors interactionally establish female HIV patients' adherence to medical recommendations and how patients orient to this trajectory. It focuses on how participants in a two-party interaction (doctors and female HIV-positive patients) negotiate issues of patients' adherence, from conversation analytic and ethnographic perspectives. The issues to consider are how these consultations are interactionally organized, the cultural influences, beliefs and social constructs that influence the disposition of female HIV-positive patients towards the HIV disease, and how doctors and counsellors explore their consultations with the patients to not only influence, but also understand their health-related behaviours. It examines the ability of doctors in HIV outpatient clinics and counsellors in the heart to heart centres, to act as psychological aids that help female HIV patients' willingness to manage their ailment. This study is gender biased due to the social-cultural vices against women in South-western Nigeria and how women's health-related behaviours can be understood. Thus, as a further step in examining how doctors and female HIV-positive patients orient to the routine concerns in the HIV consultations, this study approaches the discourse on HIV differently from what obtains in the existing literature on medical communication and patients' adherence.

1.1   Aim of the Research

This study examines the interactions between female HIV-positive patients and doctors and counsellors. It examines how the research participants orient to adherence-related issues as the

interactional goal of the consultations. It also discusses the views of patients, doctors and counsellors on facilitators and barriers to patients' adherence to treatment recommendations.

1.2 Research Questions

The specific research questions for this study are:

(i) What types of preliminary sequences and question designs open the consultations between female HIV-positive patients and doctors, and what response designs do these opening questions solicit? This will account for how question designs set the interactional goals of the consultations and how participants orient to these interactional goals.

(ii) How is patients' adherence negotiated in the history-taking activity? This will reveal the types of adjacency pair structures and social actions that are evident in this activity, and its impact on doctoring styles.

(iii) How do doctors ensure patients' adherence during treatment discussions? This question will show doctors' practices in the treatment discussion phases, and its implications on presumptions about patients' adherence.

(iv) What are the opinions of the research participants regarding the social factors influencing patients' adherence to medical recommendations? This will ensure that patients' adherence is not only examined in the doctor/patient consultations but also from ethnographic perspectives.

1.3 Organization of the Thesis

Chapter 1 introduces the study against the background of existing works on medical conversation analysis. The chapter sets a foundation for the thesis by focusing the research aims on the phenomenon of interactional activities and patients' health-related behaviours.

Chapter 2 discusses the theoretical foundations for this study and reviews the relevant literature which is pertinent to the research aims. The chapter specifically discusses two theoretical foundations: CA and ethnography, while elucidating the relevant thematic research areas within the two theoretical fields.

Chapter 3 discusses the HIV situation in South-western Nigeria where the study was conducted. It introduces the geographical location and language distribution of Nigeria's south-western geopolitical zone and describes the researcher's experience on the health care practices at the select outpatient clinics in south-western Nigeria. The chapter further reports relevant information from the secondary materials gathered at the outpatient clinics (sensitization materials and participants' interviews) as well as information from international organizations, and interviews with members of the Association of People Living with AIDS (APLWA).

Chapter 4 discusses the methodology for data collection and analysis. Data sampling techniques include audio recordings, semi-structured interviews, and supplementary materials from patients' case notes, the print media and HIV/AIDS reports on Nigeria from international organizations.

Chapter 5 examines the opening question designs adopted in the d-p consultations and its interactional consequences. It shows the interactional goals of the consultations and how participants orient to these interactional goals.

Chapter 6 builds on findings from chapter 5 by discussing adherence-related negotiations in the medical history-taking activity. It examines implicit and explicit adherence-related questions, their sequence structures and actions, and the implications on doctoring styles and patients' responses.

Chapter 7 discusses how adherence is ensured during treatment discussions. It elucidates on doctors' speaking practices during this activity and patients' consequent orientations.

Chapter 8 examines the participants' perceptions of patients' nonadherence, by analyzing data recovered from interviews.

Chapter 9 summarizes and concludes the study by stating the major findings and its practical implications for patients' health-care in South-west Nigeria. The chapter also discusses the contributions of this study to existing literature.

2 Theoretical Foundation: Methodological Basis and Findings of Selected Literatures

> "The field of Conversation Analysis (CA) began with just three people, Emanuel Schegloff, Harvey Sacks and Gail Jefferson. It grew, as many new enterprises do, out of dissatisfaction with the methodologies and theories of the time, as they pertained to everyday social behavior" (Stivers & Sidnell 2013: 1).

> "CA works from raw data to noticings of patterns using a combination of distributional regularities, commonalities in contexts of use, participant orientations and deviant case analysis" (Stivers & Sidnell 2013: 2).

This chapter discusses the theoretical foundation that guides the research enquiry. Furthermore, it reviews selected literature that border on the analytical focus of this thesis. This study is based on two theoretical foundations namely: Conversation Analysis (with a specific focus on the methods of observing medical interactions i.e. medical conversation analysis (MCA) and the socio-cognitive theory of health behaviour. However, the main theory adopted for data analysis is conversation analysis. The following sections briefly discuss the basic methodological underpinnings of both theoretical foundations.

2.1 Conversation Analysis: A Brief Introduction of Relevant Concepts

As enunciated by Stivers and Sidnell (2013), CA employs more practical methodologies for understanding human social behaviour – necessitating its introduction into linguistics research. Sidnell (2010) states that "CA aims to describe, analyse and understand talk as a basic and constitutive feature of human social life" (2010: 1). The study began in the 1970s from the seminal papers published by Harvey Sacks in 1967 and Emanuel Schegloff in 1968, where they described the organization of human interactions. Stivers and Sidnell (2013) capture Sacks and Schegloff's thought in their description of the uniqueness of the CA methodology and its basic distinctive approach to studying human interactional behaviour. They posit that CA considers language in fine-grained detail that describes practices, actions, activities and the overall structures of interactions. This attention to fine-grained detail is an inductive qualitative method that explains the organized patterns of interaction structures "on case-by-case analysis" (Stivers & Sidnell 2013: 2). Hence, the data must be a detailed transcription and analysis of turn and sequential details of audio or video records of natural conversations (2013: 2). In CA, the following basic interactional properties are important: turn-taking, action, preference, sequence and repair (Sidnell 2010). CA

also accounts for other interactional properties such as the following discourse fragments: fillers, silence, overlaps, pauses and emotions (e.g. laughter). These properties are crucial in accounting for how interlocutors produce and interpret actions. The following sections briefly discuss the basic properties.

2.1.1 Turn-Taking

In any joint human activity that involves verbal exchange or interaction, participants contribute to the ongoing interaction through a turn-taking system. With this system, participants locally organise and manage their contributions in a way that enables each participant to get a turn to speak at the appropriate time. As Sacks, Schegloff and Jefferson (1974) assert, turns are the basic unit of interactions and they are economically distributed to give participants allocated opportunities to speak. Therefore, the turn-taking system is organised to reduce gaps, overlaps and silence, and to ensure that one party is talking at a time (Sacks 2004: 37). Exceptions to this rule include joint vocal occurrences, such as joint laughter and joint singing. However, in most interactions, participants' turns are produced with a coordination of allocated turns (turns-at-talk). In other words, turns are "locally-managed, party-administered, interactionally controlled and sensitive to recipient design" (Sacks, Schegloff, & Jefferson 1974: 696). When constructing turns-at-talk, the following basic features are important: speaker selection, TCU (turn constructional unit), TRP (transition relevance place), overlaps and interruption. Extract 2-1 illustrates this organisation of turns-at-talk. Here, there are multi-party participants talking about the patients' reason for visiting the clinic. The participants include a doctor, a female HIV-positive patient and a nurse. In the beginning, the doctor self-selects a single unit turn that completes the action of soliciting the patients' medical complaints (line 01).

Extract 2-1: *Constructing Turns-at-talk in a d-p Consultation*
(In all extracts, Doc = Doctor, Pat = Patient)
```
01   Doc: madam KILO seyin tefi fe ri DOCtor?
          madam WHY do you want to see a DOCtor?
02   Pat: ((silence))
03   Doc: (to an attendant nurse) <<all> won o DAhun o>
                                    she isn't resPONDing o
04   Nur: <<ff> esoro: -->
             talk:
05        a be won ki won to dayin lohun ni i:
          we PLEADED with the doctor to meet with you
06   Doc: ani KILO se yin:
          i say WHAT is the matter with you:
```

```
07    Pat:  <<p>  hmm:: ko si pupo>
                 hmm:: nothing much
08:   Doc:  esoro      [siTA  ]
             speak       louDER
09    Nur:             [esoro:] eyin ni won n bawi i
                        talk:   you are being asked a question
```

By the complaint solicitation question, the doctor has automatically selected the patient as the next speaker. In line 02, the patient's silence signals that she does not take the turn allocated to her. To address the problem of silence and continue with the interaction, the doctor pursues a response by turning to the nurse. His rapidly spoken and pitched "She isn't responding o" (line 03), selects the nurse as the next speaker. In pursuance of getting the patient to talk, the nurse then takes her own turn by again, selecting the patient to speak, first with a single turn unit "talk" (line 04), followed by another unit "We pleaded with the doctor to meet with you" (line 05). When the patient still does not speak, the doctor addresses her again "I say what is the matter with you?" (line 06). The patient finally takes her turn softly (line 07) but interestingly, the doctor and nurse overlap in their subsequent turns in lines 08 and 09. The overlapped turn units "louder" and "talk" are considered overlaps and not interruptions because there is no evidence that the doctor has already completed the first part of his turn. Hence, the nurse may have projected a point of possible turn completion – a possible TRP for her to take a turn. It is, however, evident that both doctor and nurse are aligned in the action projected – both pursue the same type of action that seeks to make the patient speak about her medical complaints. In this circumstance, an interruption is less likely due to the joint action projected by the doctor and nurse. Alluding to the uniqueness and wide applicability of the turn-taking system, Sidnell (2010) states that "the system defines and delimits units of social life" (2010: 47). It also shows what actions participants in an interaction are performing, and in what interactional contexts.

2.1.2   Action

Having briefly considered the organisation of turn-taking in section 2.1.1, it is expedient to turn to a brief discussion on the notion of "action". In CA, actions are understood in terms of adjacency pairs "in which actions are grouped together and related to one another to form sequences of actions" (Sidnell 2010: 59). An adjacency pair occurs when:

- a sequence of two actions is adjacent

- it is produced by different speakers

- is ordered as first pair part and second pair part and

- pair-type related so that a particular type of first pair part requires a particular type of second pair part (Schegloff 2007b: 521-541).

Examples of different types of adjacency pairs are greeting sequences and offer-acceptance sequence. These paired actions or sequences of actions "lead to a consideration of the distinctive way in which understanding is achieved and sustained in conversation" (Sidnell 2010: 59). To illustrate the organisation of adjacency pairs in human interaction, let us consider extract 2-2. Here, a doctor and patient are conversing. In line 01, the doctor asks the patient about a certain previous incident.

Extract 2-2: *Paired Action in a d-p Consultation*
```
01    Doc:  WHAT happened?
02    Pat:  i was the one that=
03                        =[explained to you that:::      ]
04    Doc:      <<all>    [>what happened, i have forgotten<]>
05    Pat: <<all> that i said [i was arrested     ]
06    Doc: <<all>             [cover your nose now]=
07         =cover your nose>
08         (.)
09    Pat: that i told you i was arrested
10         and taken to kiRIkiRI prison for over a year
11    Doc: <<p> so:::>
```
Due to the linguistic form of his self-selected turn at line 01, the doctor's utterance performs the action of requesting for information. His "What happened?" is produced with a rising intonation – the pronoun "what?" requests for information by specifying the noun "happened", to indicate the exact kind of information that is asked. Having completed the first pair part of an adjacency pair with the question, the patient responds with an adequate and related second pair part – she responds to the question in lines 02 and 03. Thus, we may observe that the patient understood the previous turn as a question that requires a response. Clearly, line 01 is a question but it appears that it performs another type of action besides its formal properties. The utterance appears to be accusing the patient of a previous action (no-clinic visits) that does not align with the institutional relevancies. An evidence of this is that the patient offers an extended explanation about why she was absent from the clinic. Her explanation about being arrested (lines 02 - 10) is an account that justifies its conditional relevance upon an understanding of the first pair-part action (i.e., an accusation).

This practice is also evident in extract 2-3. Here, a doctor addresses a patient by asking a question about her lips. His "What happened to the side of your lips?" (line 05) poses a question that solicits a response or answer about the side of her lips.

Extract 2-3: *Paired Action in a d-p Consultation*
```
05   Doc: what HAPpened to the side of your lips
06   Pat: <<p> they say: it's because of maLAria↓>
07   Doc: <<f> WHO SAID it's malaria that is BOthering you>?
08        you have been told to do a test =
09        you didn't do it-
```

When the patient responds, however, she orients to a different type of action aside from a mere response to a question. Rather than state what happened to her lips, she expresses a cause attribution. She attributes what the doctor noticed (possibly a lip blister), to the diagnoses of a third party "They say it's because of malaria". Thus, the patient does not hear the question in terms of its form, but she hears it as an accusation about the reason for the blister. She, therefore, justifies the cause of the lip problem by stating that she previously had Malaria. To clarify his initial utterance as an accusation instead of a question, the doctor's third turn offers evidence that buttresses the purpose of the question. In line 07-09, the doctor offers information about the patient's nonadherence to a medical test. With the question in line 05, he implicitly accuses the patient of non-medical testing and orienting to this action, the patient projected that an accusation was being performed. Thus, she justifies the cause of her lip problem to malaria. With these adjacency pair organisation, we see that actions are interrelated, intersubjective and pair-part related. A first pair-part action requires a second pair-part answer that completes the projected action. When the expected second action is not produced, that missing second pair part is "officially absent" (Sidnell 2010: 75).

2.1.3   Preference

The first pair-part of an action has preferred and dispreferred seconds. The preference system in conversation is described in terms of second actions that align with the "accomplishment of the activity underway" (Sidnell 2010: 77). A second action that accomplishes the current activity is preferred over the one that does not accomplish it. Thus, actions are "routinely implemented in ways that reflect an institutionalized ranking of alternatives" (Schegloff & Sacks 1973: 14). In the preference system, "acceptance" is the preferred second action for an "offer". Likewise, greeting

initiations should be accompanied by a second pair-part greeting. Extract 2-4 illustrates this phenomenon. Here, a doctor solicits a medical complaint from a patient. We previously considered this extract in our discussion of turn-taking (extract 2-1). We examined how the doctor, patient and nurse exchanged turns asking the patient to state the reason for her consultation with the doctor. In extract 2-4 (reproduced for convenience), the patient's response to the question at line 01, is silence.

Extract 2-4: *(Dis)Preferred Second Pair-Parts in a d-p Consultation*
                 (Cf. Extract 2-1)

```
01    Doc: madam KILO seyin tefi fe ri DOCtor?
           madam WHY do you want to see a DOCtor?
02    Pat: ((silence))
03    Doc: (to an attendant nurse) <<all> won o DAhun o>
                                        she isn't resPONDing o
04    Nur: <<ff> esoro: -->
               talk:
05         a be won ki won to dayin lohun ni i:
           we PLEADED with the doctor to meet with you
06    Doc: ani KILO se yin:
           i say WHAT is the matter with you:
07    Pat: <<p> hmm:: ko si pupo>
              hmm:: nothing much
08:   Doc: esoro      [siTA  ]
           speak       louDER
09    Nur:            [esoro:] eyin ni won n bawi i
                       talk:   you are being asked a question
```

Her silence is considered a dispreferred second because it does not accomplish the projected activity or action of soliciting her medical complaint. Furthermore, in lines 06, the question about her medical complaint is responded to, with an elongated turn initial which delays a no-implied response "hmm:: nothing much". This second utterance, though offers a response to the question, still projects a dispreferred second due to the design of the turn. As enunciated by Sidnell (2010), delays are dispreferred responses in terms of "inter-turn gap and turn-initial delay" (2010: 78). Thus, when turns are constructed or designed as in line 07, the current speaker has declined to accomplish a projected activity. Here, the patient has obviously visited the doctor's office for a purpose and she is expected to have a reason for visiting, which should be explicitly stated. However, she responds to the initial question with silence, and further declines to state a reason for her visit. Schegloff (2007) states that the design of the first-pair part and its projected action determines the preference system. Thus, a turn may solicit two preferences – having a "cross-cutting preference" (2007: 76-77). Preferences, then, are "action-based" and "design-based"

(Sidnell 2010: 86). For instance, a polar question is designed to prefer a "yes/no" response and when asked as an offer, a polar question proffers an acceptance of the offer. Thus, when making an offer, a polar question has cross-cutting preferences for either a "yes/no" response or a "yes" response depending on the interactional context. Consequently, it is always important to be analytically clear about the preference structure that is being examined. In extract 2-4, the questions examined are Wh-questions that call for extended kinds of telling, based on their design – the questions' design solicit information that may have to do with reason, extent or justification, from the answerer. The preference system, therefore, is "structural, rather than psychological … a force that pushes the participants in one direction or another irrespective of their own wishes, desires, predilections and best intentions" (Sidnell 2010: 93).

2.1.4   Sequence

A sequence is composed of one or more adjacency pairs. Thus, sequences have "considerable complexity and length" (Sidnell 2010: 95). A first pair-part and second-pair part of an adjacency pair are referred to as a "base-pair part sequence", which may be pre- and post-expanded, with possible insertion sequences. Extract 2-5 illustrates the organisation of a greeting sequence in an HIV consultation.

Extract 2-5: *Sequence Structure in a d-p Consultation*
```
01   Doc: epele ma
          greetings madam
02        bawo lara yin
          how is your health↓
03        seko rera pupoju
          i HOPE you are not too ill?
04   Pat: olorun o ni je   ko po
          god will not allow me to be TOO ill
05   Doc: ki lo n sele o:
          what is happening o:?
06   Pat: <<p> AH? gbogbo ara  lo n dun mi:>
          AH? my whole:: body aches:
07        <<p> mi o le rin dada pelu ese yi>
          i can't walk properly with this leg
```

Here, the doctor and patient converse in Yorùbá and they exchange a Yorùbá greeting routine/culture which is normatively composed of multi-unit turns (see Odebunmi 2013; Olaoye 2017). In line 01, the doctor initiates the first pair-part greeting, which is expanded by another turn

about the patient's health (line 02), and the third turn about her medical health (line 03). The patient eventually orients to the previous turns as a greeting routine by responding with a statement of fineness "God will not allow me to be too ill" (line 04). This greeting routine is established before the participants move on to the core business of the consultation (lines 05-07). The greeting routine evidence that in consultations in Yorùbá, a second pair-part greeting may not be immediately followed by a first-part part – other turns may expand the greeting before the occurrence of a second pair-part. This example has shown how a sequence occurs within an adjacency pair. However, sequences may be expanded beyond the adjacency pair, to include insertions, pre-expansions and post-expansions of the base pair, all of which work towards establishing actions in interactions.

2.1.5 Repair

A repair is understood in terms of problems that occur during interactions. These problems involve speakers' "troubles of hearing, speaking and understanding" (Sidnell 2010: 110). Sidnell further describes these problems as follows:

> troubles of speaking arise, for instance, when a speaker uses the wrong word or cannot find the exact word they want. Troubles of hearing arise when a hearer cannot make out what the speaker has said. Troubles of understanding arise… such as when the hearer does not recognise a particular word, does not know who or what is being talked about, or cannot parse the grammatical structure of an utterance (2010: 110).

To fix these interactional problems, speakers may self-initiate repairs. Repairs may also be other-initiated or initiated at a third-turn position. In extract 2-6 for example, the doctor offers an other-initiated self-repair (line 03) when the patient refuses to take a turn at line 02.

Extract 2-6: Other-Initiated Self-Repair in a d-p Consultation (Cf. extracts 2-1 and 2-4)
```
01   Doc: madam KILO seyin tefi fe ri DOCtor?
          madam WHY do you want to see a DOCtor?
02   Pat: ((silence))
03   Doc: (to an attendant nurse) <<all> won o DAhun o>
                                      she isn't resPONDing o
04   Nur: <<ff> esoro: -->
                talk:
05        a be won ki won to dayin lohun ni i:
          we PLEADED with the doctor to meet with you
06   Doc: ani KILO se yin:
          i say WHAT is the matter with you:
```

```
07    Pat: <<p> hmm:: ko si pupo>
                hmm:: nothing much
```

The silence at line 02 indicates a trouble source though it is not clear if the trouble is a problem of speaking, hearing or understanding. To accomplish the current action (soliciting the patients' complaints), the doctor's "I say what is the matter with you?" (line 06) offers another other-initiated self-repair, to which the patient eventually responds "hmm:: nothing much" (line 07). The doctor's repair initiators are produced with question words that indicate the particular part of the trouble source that needs to be repaired. With the use of the pronoun "what?", the doctor has indicated that a response to the solicited information is required. As enunciated by Sidnell (2010), repair mechanisms maintain intersubjectivity (2010: 111). It also ensures that a projected action is continuously checked by participants, in order to maintain understanding in interactions.

2.1.6 Question Designs

Question designs play a vital role in contextualizing participants' domain of knowledge and assumptions of knowledge. Since this study examines the interactional negotiations of adherence, it becomes necessary to examine how participants jointly orient to questions that project these interactional trajectories. This inquiry is necessary because patients' adherence is a major concern for both the medical practitioner and the patient. Hence, it is important, not only to examine question-answer sequences as a feature of participants' joint accomplishment of interactional trajectories but also to see how questions contextualize the types of answers it elicits as a next turn proof of this joint accomplishment. It is first important to lay an empirical foundation for discussing question designs by reviewing how researchers have underpinned the arguments on what constitutes questions or questioning in both mundane and institutional interactions. Answers or responses are not discursively relevant without its first pair part. Thus, it is necessary to discuss the literature on how questions have been established as normatively "doing" something or asking for various responses in interactions. The following discussions briefly examine the existing literature on what constitutes the act of questioning in mundane and institutional interactions.

In CA research, a question has been established as a means by which social actions are produced through question-answer adjacency pair sequences in ordinary and institutional interactions (see Wardhaugh 1985; Heritage 2002a; Heritage & Clayman 2010; Heritage & Clayman 2010; Hayano 2013). The question-answer adjacency pair "obeys" the adjacency pair

description (see section 2.1.2, P. 22/23). Thus, by its sequential location, a question functions as the first pair part of a question-answer adjacency pair which operates within "intersubjectivity" (Heritage & Clayman 2010: 22) in the question/answer sequence. The realization of both actions (questions and answers) depends on how they are verbalized in connected speech. Its putative action-oriented function suggests that a question should typically produce an answer from a different speaker and drive interactional trajectories in the turn-taking system (Sacks, Schegloff, & Jefferson 1978: 13). When questions "crave" a verbal or other semiotic response e.g. a nod, social actions (such as giving off a subordinating attitude from the questioner to the responder) are produced (Bolinger 1957: 4). Hayano (2013) proposes that for questions to be defined in Bolinger's (1957) descriptive terms and other terms, they must depend on factors such as "how they are designed, who is asking them and the social and sequential context within which they are asked" (2013: 395). This, he states, brings about "diverse interaction consequences" (2013: 395) for questions. Therefore, the central arguments for the role of questions in both ordinary and institutional interactions are its constitution and interactional consequences.

Wardhaugh (1985)[2] further describes the domain of questions and questioning as a joint conversational behaviour between interlocutors in mundane interactions. When conversations begin, speakers question each other's motives mentally, and then verbally, such that the ways by which each person topicalizes their interests (through questions or statements) at the start of a conversation, "offer us a key to his or her personality" (1985: 25). Essentially, Wardhaugh (1985) considers questioning from two perspectives: the mental and verbal questioning which are interdependent. By questioning, individuals observe the language and personal behaviour of others and themselves through their "acting, doing, behaving and talking" (1985: 30). By "doing" a question, a speaker may employ this to set an agenda for discussion, state factual communication and equally "self-create" his or her feelings, interests and a variety of other things (1985: 30).

The interactional constitution of questions has further been studied by researchers in more recent times. For instance, as proposed by Stivers, Enfield & Levinson (2010), questions have three constituents across all languages: grammar, prosody and epistemic asymmetry. Hayano (2013) reinforces this assertion by stating that in English, some questions are grammatically marked as calling for answers rather than merely giving statements or making assertions. An

---

[2] In Wardhaugh's (1985) book titled "How Conversation Works", the researcher considers the social and contextual factors of talk and how interactants judge characteristics of speech in interpreting what happens in conversations.

example is polar (*yes-no*) questions, which are commonly marked with question particles across various languages. However, in English, a single proposition can be questioned in three different ways: an inverted interrogative (e.g., Did he come?), a negative interrogative (e.g., Didn't he come?) and a tag question (e.g., He came, didn't he?). These characteristics presuppose that interrogatives may not necessarily be "doing" questioning while a non-interrogative might be questioning. For example, the tag question: "He came, didn't he?" suggests that the speaker already has some awareness about the person who came. Hence, the questioner may not be requesting for an additional information but may merely be requesting for a confirmation of awareness. Likewise, a non-interrogative question format may be marked for questioning in the context of talk. If speaker A says to speaker B "I wonder if it's raining?", speaker A has made an assertion but only in a "limited degree of commitment to the possibility that it is raining", as opposed to the higher degree of certainty that comes with the assertion "It's raining" (Heritage & Stivers 2013: 371). This same principle applies to Yorùbá (the predominant language in South-west Nigeria), the language in which the interactions for the current chapter takes place. In Yorùbá, the tag question: *ó wá, àbí béèkó?* (He came, didn't he?), is characteristically accompanied with a *béèni* (yes) / *'béèko'* (no) response, despite the possibility that the questioner may already be knowledgeable about the preferred positive response *béèni* (yes), and might merely be requesting for confirmation. Let us consider extract 2-7 to exemplify this phenomenon. Here, the doctor identifies the patient as someone whom he had met the previous week at the outpatient clinic. His statement question *"Ó dà wípé èmi ni mo attend síiyín last week* (I think I attended to you last week) (line 03) merely seeks to confirm what he already knows to be true from the patient's medical records. Hence, he only requests for the preferred positive response: *béèni* (yes) (line 04).

Extract 2-7: "I think I attended to you last week"
```
01    Doc: e n le ma o epele
           greetings o madam hello
02    Pat: yes: sir
           thanks sir
03    Doc: o da wipe emi ni mo attend siyin last week
           i think i attended to you last week
04    Pat: beeni
           yes
```

In view of these possibilities, a few researchers assert that owing to its ambivalence in framing knowledge, the constitution of questioning in English and across several other languages, may not be fully accountable for linguistic or grammatical criteria (Bolinger 1957; Pomerantz 1980;

(Heritage 2012a, Heritage 2013). Nevertheless, the typology of questioning in Yorùbá provides various lexical distinctions for asking questions, each with its own interactional consequences. To cite another example, Yorùbá provides possibilities for various wh-question formats. In the context of extract 2-8, *sé* (is there?) is a request for information. Others include *kí* (what?), polar questions in a tag question format e.g., *àbí béèkó* (isn't it?), and positively-situated complaint solicitation format *sé kòsí* (hope there isn't anything?). Let us consider another example to foreground this argument – in extract 2-8, the questioner (doctor) asks the responder (patient) about the possibilities of medical problems, though the questions are framed as an expectation that the patient will not present problems.

Extract 2-8: *"Sé kòsí n kankan?"*
```
01    Doc: se kosi n kankan (.)
           hope there is no issue
02         se kosi iyonu
           hope there is no problem
03    Pat: rara oyi kan n ko mi ni
           no   i just feel dizzy
04    Doc: ok
```

In lines 01 and 02, the questions: *Sé kòsí n kankan? Sé kòsí ìyonu?* are polar questions which demand a yes/no response. However, the final translation strands hold deeper meanings, with contextual implications. When the doctor asks these questions, he means: "Hope there is no issue or problem?". Within the context of the encounter, the questions indicate that the doctor positively situates the patients' problems as being non-existent. Though the patient initially offers a preferred negative response, *rárá* "no", she eventually states a problem with mitigation, within the same turn *òyì kàn n kó mi ni "*I just feel dizzy*"* (line 03). Note that her response is designed with mitigation because she orients to the implication of the question in calling for a "no" response. Hence, questions in Yorùbá offer less ambiguity in its meaning and functions when communicated to a speaker of the language.

Another contributing factor which constitutes questioning is prosody. For example, in English, German and Yorùbá languages, a polar question should characteristically be asked with a rising intonation. However, as Hayano (2013: 396) reiterates, "it is misleading to treat prosody as strongly indicative of polar questions" (cf. Selting 1992; Stivers 2010; Couper-Kuhlen 2012).

The third contributing factor which has been largely substantiated to constitute the act of questioning is "epistemic asymmetry". Epistemic asymmetry refers to "territories of knowledge".

It describes individuals' knowledge about social realities, how interlocutors manage information, and also how they recognize the epistemic background from which their utterances or questions arise (see Heritage 1984a; Maynard 2003; Heritage 2013; Heritage 1984a). Labov and Fanshel (1977) developed and classified interactional knowledge base into five categories namely: A-events: Knowledge known to A, but not to B; B-events: Knowledge known to B, but not to A; AB-events: Knowledge known to both A and B; O-events: Knowledge known to everyone present and D-event: Knowledge that is disputable. This categorization evidences that question designs, i.e., the way questions are asked, can determine the actions that each question performs. It also prescribes the speakers' degree of latent knowledge. For example, when the information solicited by speaker B is known to speaker B and not to A (e.g., "Isn't this writing too technical to be translated?"*)*, the questioner may only be requesting to confirm an information he already knows to be true. But when speaker A hears speaker B's utterance as a question rather than a request for confirmation, the sort of knowledge displayed here is "recipient-titled" (Stivers & Rossano 2010). Pomerantz (1980) re-categorizes A and B events as Type 1 knowledge (first-hand knowledge e.g., directly experienced) and Type 2 knowledge (i.e., derivative knowledge, known only by hearsay or other indirect means).

Probably a more functional research on the role of epistemic asymmetry in conversation is offered by Heritage (2010; 2012a; 2013; cf. Heritage & Clayman 2010; Heritage & Raymond, 2005; 2012). The scholars make a distinction between *epistemic status* and *epistemic stance*, which suggest that only first-hand information and access to knowledge drive conversations. When individuals exhibit their epistemic status by, for instance, asking questions, this is not only concerned with their state of knowledge, but it also involves their right to possess and articulate their knowledge (Stivers, Mondada, & Steensig 2011a). Taking a cue from questions and answer sequences, Heritage and Clayman (2010) propose the term "epistemic gradient" to unravel talk participants' degree of knowledge:

> When persons ask questions in ordinary conversation, they normally commit to a number of basic propositions about themselves, their recipients, and the topic of the question. In addition to the social right to ask the question, they claim to be unknowing about the state of affairs they are asking about relative to the recipient. We will represent this as the "K−" claim of a questioner. Simultaneously, they establish the recipient as relatively knowledgeable about the matter, which we will represent as "K+". Thus, they establish an "epistemic gradient" between questioner and respondent (2010: 24-25).

Here, Heritage and Clayman suggest that speakers have their own specific territories of knowledge (i.e., K+/K- gradients) which show their epistemic status. The more knowledgeable and informed speaker makes K+ claims while responding to questions and the less informed exhibits K- claims while asking questions. Talk participants' knowledge base differ and are gradable but as information is disseminated by the more knowledgeable to the less knowledgeable, the domain of knowledge equalizes between them. Besides the domain of knowledge, epistemic gradients also elicit speakers' assumptions regarding their expectations towards one another. For example, in education, a teacher has the K+ gradient but he may assume the role of a less knowledgeable speaker by making K- claims in order to know if a pupil is K+ too.

In the literature, epistemic gradient is the most well-grounded resource that constitutes questioning in interactions, although the gradients cannot be accessed without relying on grammar and prosody as contextualization cues. Despite the speakers' epistemic gradient, questions can first be grammatically categorized as a first step in identifying their grammatical functions. Hence, this study will examine how question-answer sequences are produced by talk participants in tandem with grammatical rules. It will examine recurrent features and forms of questions and their second pair part answers as a next turn proof procedure for eliciting the actions performed by questions. This makes it possible to distinguish recipients' responses in line with either the grammatical markings of the question(s) or their epistemic gradients. Consequently, the present study discusses the role of grammar, epistemic gradient and preference organization for categorizing and analysing question designs.

2.2   Thematic Research Areas in Medical Conversation Analysis (MCA)

The CA methodology has come to be interdisciplinary in nature. Though primarily based within the domains of sociology, its methods have been adopted across several disciplines including linguistics, anthropology and pragmatics. As part of its wide appreciations across many disciplines, the CA approach has received considerable readership and scholarship amongst many social scientists whose interests are based on how social interactions work in various human settings. Particularly, the CA method stands out in the study of MCA. As Roter (2006) states, "conversation analysts have made notable contribution to the literature on medical communication by taking the reader through the examination room door to the heart of medical dialogue" (2006: xi). Hence, MCA, as Roter further states, is primarily concerned with "authentic dialogue from patients and

physicians as it unfolds, thus capturing the social and medical dynamic within which medicine is practiced" (2006: xi).

The pioneering research on d-p communication was published by Byrne and Long in 1984. Their book: *Doctors Talking to Patients,* anatomized the three levels of analysing medical conversations in primary care interviews as follows: (1) the overall structure of the primary care visit, (2) the sequence structures through which its particular component activities and tasks are realised, and (3) the designs of the individual turns at talk that make up those sequences. A typical example of this interrelatedness of analytical levels is the adjacency pair sequence which features in all medical encounters. In the d-p consultations from the present study, a significant adjacency pair sequence in the history-taking activity explains this phenomenon. Let us consider the following extract to exemplify this. In extract 2-9, the negotiation of patients' adherence entails the adjacency pair sequence – accusation: justification. Here, the doctor typically investigates the patient's history of adherence to treatment recommendation by taking a presumptive stance that she has not been adherent, and thereafter, reproaching her – he accuses her of not having taken the CD4 count test.[3]

Extract 2-9: "Madam you have not done CD4 since 2013"
```
06   Doc: madam you have not done cee dee four since 2013
07        true or false?
08   Pat: (.) it should be::
09   Doc: [true: or false ma?    ]
10   Pat: [it should be last year]
11   Doc: which time last year madam?
12        what time last year
13        the last cee dee four i am seeing here
14        is september 2013
15        the one ((test form)) they gave you last year (.)
16        it is empty (.) you didn't do it
17   Pat: i--
```

The doctor asserts "Madam you have not done CD4 since 2013" (line 06) to convey his communicative intention. This accounts for a next turn initiation of a consequent action (justification) from the patient "It should be:: last year" (lines 08 and 10). Notice that the doctor

---

[3] CD4 count (or T-cell count) are white blood cells that show how well the immune system is functioning, in terms of being able to fight infections. The more the CD4 count cells, the more quantity of white blood cells a person has to fight infections and live a healthy life. The doctors report that a healthy person has a CD4 cells of about 500-1,500. These healthy cells are targeted for destruction by the HIV virus, but the CD4 cell count increases as the HIV virus is controlled with effective ART. However, if the HIV infection progresses, the quantity of these healthy cells reduces and a reduction below 200 white blood cells means that an infected person receives an AIDS diagnosis.

purposefully topicalizes the patient's nonadherence to CD4 count testing. Giving the location of turn design features within paired sequences of actions in an interactional activity, the point is made that in both primary (acute) and chronic routine visits, the organisation of interactions and actions depend largely on how interactional activities are organised in various medical settings. In physician-patient interactions in the outpatient settings, for example, there are organisations of interactional actions in activities such as problem presentations (Heath 1981; Robinson 1998), diagnosing illnesses (Peräkylä 2002), and treatment recommendations (Robinson 2001a; Stivers et al. 2017). The present study advances the existing literature because it examines the interactional activities in a chronic routine context i.e., encounters between doctors and female HIV-positive patients. This study accesses the localized sequence designs of composite interactional actions and goals for the medical visits. With a focus on how interactions are opened and followed-up with subsequent activities, the study aims to adopt the MCA analytical approach to examine the interactional behaviour of the research participants. In the following sections, I discuss the thematic research areas of MCA that specifically relate to doctor/patient consultations – the focus of this study.

2.2.1   Interaction Structures and Activities

Levinson (1992) describes activity types (AT) as "any culturally recognized activity, whether that activity is coextensive with a period of speech or indeed whether any talk takes place in it at all […] provided these activities have a structure and style" (1992: 69). Based on the activity within which they are used, words or utterances may entail meanings beyond their literal meanings. In other words, in various human activities, utterances are assigned interactional functions based on their real-life functions. Equivalent terms to AT in the field of sociology and anthropology include "speech events" and "episodes" (Hymes 1972). However, the notion of AT distinguishes between institutional and ordinary conversations. In setting apart the basic features of AT, Levinson (1992) describes the terms of participants' orientations within the institutional context. Within this context, he suggests three things. First, that institutional interaction is normally informed by goal orientations of a relatively restricted conventional interactional form (cf. Drew and Heritage 1992: 22). Second, that institutional interaction may often involve special constraints on what one or both participants will treat as allowable contributions to the business at hand. Third, that institutional interactions may be associated with inferential frameworks and procedures that are to

specific institutional contexts. Levinson's (1992) focal argument is that activities do exist in human interactions and they have four major types of constraints: their goal, structure, allowable contributions and inferences. The structure, which includes episodes or subparts, is guided by norms governing how turns are allocated. The structure, therefore, dictates the realization of the other three constraints. Further reflections on the notion of interactional structure in medical encounters suggest a "co-construction" and "co-orientation" of interactional activities where physicians and patients jointly manage the actions that unfold during medical interviews. These co-constructed interactions dictate the "discernible overall structures" of medical activities (Heritage & Maynard 2006: 363) which are punctuated by procedural sequences. Beside the possibility of locating theme specific interaction structures of medical encounters such as adopting it to access patients' level of participation,[4] the normatively ordered structure of activities include progressions from opening sequence to problem presentation, history-taking, physical examination, diagnosis, treatment recommendations and a closing sequence (Heritage & Maynard 2006; Robinson 2003). As Heritage and Maynard (2006: 363) state, encounters in chronic routine interactions (such as in the context of HIV) are co-oriented by participants. However, the institutionalized nature of chronic routine encounters depends largely on what constitutes the institutions in question. As Drew and Heritage (1992) conjecture, "institutional contexts are manifested in, and in turn shape, the particular actions of both professional and lay interactants" (1992: 24). This study examines the structural constraints that guide the verbal contributions and inferences relative to interactional activities in doctor/patient encounters in the Nigerian context. Thus, this study discusses the systematic or methodological organisation of interactions in HIV consultations in order to show how this organisation constitutes the institutional nature of the consultations.

2.2.2   Opening Questions

In MCA research, opening questions have been extensively examined. The main arguments dwell on the ways by which doctors' opening questions are accountable for: first, proffering constraints on patients' preferred responses and determining patient's participation; second, implementing social actions during interactions, such as setting interactional agendas, and third, establishing

---

[4] Robinson (2003) discusses the interaction structure of medical activities during acute visits in relation to the notion of patients' participation.

interactants' relational traits through their knowledge claims i.e., superior epistemic stance. In describing patients' preferences for responses and participation, researchers make a distinction between open and close-ended opening questions. Physicians' use of open- rather than close-ended questions such as the "What can I do for you today?" and "What's been going on?" to solicit patients' concerns, establish patients' satisfaction with clinic visits and encourage proper diagnosis and treatment (see Robinson & Heritage 2005; Heritage & Robinson 2006). Physicians are, therefore, faced with a choice to adopt context-sensitive questions and adequate lexical choices in soliciting patients' concerns in order to ensure proper diagnosis and treatment. In a study of the practical work of optometrists in seven different UK optometric settings, Webb et al. (2013) likewise foreground the importance of question designs in optometrists' solicitation of clients' concerns in routine-timed visits. They report that when concerns are solicited with the word "problem", this lexical choice constitutes a problem because clients (patients) can either report a problem, report no problem or downplay their problems. Probably a more detailed study on the interactional role of question designs in implementing social actions is Robinson's (2006c) research on primary care and community-based clinic visits. The author suggests that "subtle difference occur in how physician's question designs can change the action that questions perform" and that "the distinction between open- and close-ended questions is not enough to capture these differences" (2006c: 23). He identifies four types of reasons: acute care, follow-up, routine and well-visits, which determine "medical goals and activities" as well as "interactional trajectories for visits" (2006c: 23). Essentially, the reason for the visit determines how opening questions are designed. Giving that patients visit clinics on a routine basis and might also have new concerns, the question format "What's new?" he states, addresses both issues by allowing patients to first present new concerns which will be dealt with before interactions move on to routine concerns.

Opening questions also encourage patients to present their concerns as being doctorable, in that questions "represent resources through which physicians can exert agenda-based constraints on the substance and extent of patients' responses" (Robinson 2006c: 91). In line with this argument, other researchers report that opening questions leading to history-taking and physical examination sequences can solely be controlled by the physician's initiative, leaving patients to become "constrained by a course of physician questioning that is physician-centred and driven by a more medical–technical agenda" (2006c: 89). Since questions make responses conditionally relevant, question recipients may prefer answers (Stivers & Robinson 2006) over non-answer

responses (Clayman 2002b). Preference organization goes on to include preferences for affirmation over non-affirmation (Pomerantz 1984a), type conformity over non-conformity (Schegloff & Lerner 2009) and selected speaker to answer over the non-selected speaker (Sacks, Schegloff & Jefferson 1974; Stivers & Robinson 2006). These "aspects of preferences are mobilized through questions – through their design and the actions they implement" (Hayano 2013: 408).

Furthermore, epistemic relations between doctor and patients, exhibited through questions designs "can have significant impact on the ensuing medical interaction" (Hayano 2013: 400). For example, when a doctor asks a patient a question with interrogative K- claims such as the Wh-question "Why have you not done your CD4 Count?", this suggests that the doctor is less knowledgeable (at least about the reasons for patients' nonadherence to recommendations of regular CD4 count tests. With this question, the doctor invites K+ claims from the patients though the question indicates that the patient did not do the CD4 count test as recommended (as a presupposition basis for reproach). Hence, the doctor is not completely ignorant about the patients' medical condition – he does have some partial knowledge, but he employs K- claims to justify his next action. Conversely, when a doctor uses polar questions which are constructed as a declarative question e.g. "There is no problem, right?" this presupposes that both speakers know the information which is solicited from the patient. However, being a "B-event", i.e., the recipient has primary epistemic rights to this information (Heritage & Raymond 2005), the doctor invites the patient, "who have superior rights to the matter, to provide minimal confirmation so they move on to the next agenda item" (Hayano 2013: 400).

Researchers have shown the importance of question designs in accounting for interactional consequences (including social actions and preferred responses) but little attention has been paid to question designs prevalent in chronic-routine visits, specifically in the context of HIV. In line with this assumption, the present study contributes to the existing research on the discursive role of opening questions and its interactional consequences in medical encounters. I focus particularly on the HIV context because question-response designs may play a crucial role in understanding what activities the interactants perform with their utterances in the opening stages of the interactions and how this may account for the trajectory of the encounters and participants' orientations to the interactional goals. In the analytical section, I use the term "Follow-up Questions" (FUQs) (see chapter 5). The term describes questions which relate back to the opening

questions by content. FUQs also take a certain stance towards the answer (action-like), while contributing to the action performed by the opening question. All activities after the opening questions may entail FUQs but I only describe their trajectories in the opening phases because this is where they present the most relevant adherence-related trajectories for the encounters. Thus, this study examines the way in which adherence/nonadherence is addressed in the opening stages of the interactions in order to understand how the doctor/patient relationship is shaped.

2.2.3   Treatment Discussions

The literature on treatment discussions in medical encounters suggests that when patients take the initiative to negotiate physicians' treatment recommendations, they have scaled the many factors responsible for low level of participation. Such factors include interaction-based structures of visits (Robinson 2003) and passive communication (Perakyla 1995) which can initiate non-willingness for shared decision making. However, more recent studies assert that patients have begun to assert their communicative roles in medical encounters (see Heritage & Robinson 2006) and "co-construct" medical activities (e.g. manage affective experiences and reactions, Maynard 2012). Such findings have shown the ways by which medical conversation analysts react to this possibility, to discuss the circumstances which lead to patients' participation, and in which contexts. In this study, I will hinge my discussion on the effects of physicians' presumptive stance on patients' adherence to the medical recommendation, to treatment prescription and negotiation in the HIV encounters.

2.3   Socio-cognitive Theory

In their review of health behaviour theories, Munro et al. (2007) state that few medical interventions to promote treatment adherence have drawn from the proposals of health behaviour theories. Meanwhile, these theories are beneficial for enhancing behaviour change across different health settings because they seek to understand patients' attitude towards long-term treatment adherence for chronic infections like HIV and tuberculosis. The theories also propose theoretical interventions that aid patients' treatment adherence. As part of their review, Munro et al (2007) discuss five main theoretical perspectives related to treatment adherence: biomedical, behavioural,

communication, cognitive and self-regulatory. From these five perspectives, the present study focuses on the cognitive approach to treatment adherence.

The cognitive approach, including the socio-cognitive theory (SCT), explains how human cognition contributes to behaviour change through an examination of individuals' attitudes, beliefs, expectations of future events and treatment outcomes. The SCT theory maintains that individuals will only embrace a health behaviour that promises the most positive treatment outcome. It proposes that there is a "reciprocal interplay between self-regulatory and environmental determinants of health behaviour… thus, it is a socio structural determinant of health as well as the personal determinants" (Bandura 2004: 623, cf. Bandura 1994; Armitage & Conner 2000; Bandura 2007). To ensure behaviour change, the SCT model proposes the following factors: knowledge of health risks, benefits of change, self-efficacy, expectations of treatment outcomes, and facilitators and barriers to treatment adherence. Individuals must possess a knowledge of health risks and the benefits of a changed behaviour, which can be recovered when they utter statements such as "I know what HIV disease and CD4 count test is", and "Taking the ARV drugs will improve my CD4 count". Furthermore, individuals must possess the personal desire and ability to produce an intended result (self-efficacy). This shows with expressions such as "I can take my ARV drugs". Health behaviour change is also facilitated with a projection of positive and negative treatment outcomes, as evidenced in a statement like "If I take my ARV drug, my health will improve". When alternative treatment options besides the recommended ones are sought, for instance, individuals can only embrace change when they can ascribe the appropriate types of result to each treatment option. Therefore, the SCT model suggests that behaviour change is achieved when there is an understanding of facilitators and barriers to treatment (recovered from statements such as "It is easy/difficult to take my medication" – behaviour change is primarily self-directed. However, "to achieve this self-directed change, people need to be given not only reasons to alter risky habits but also the behavioural means, resources, and social supports to do so" (Bandura 1994: 25). A social support may mean that people's beliefs are subscribed to.

The SCT theory has been criticised as having a "wide-ranging focus", which may make it "difficult to operationalise, and often used only in part" hence, "raising questions regarding its applicability to intervention development" (Munro et al 2007: 16). Nevertheless, the SCT theory is suitable for the present research, first because it is the most developed theory of health behaviour

(Redding et al. 2000). Second, because unlike other theories of health behaviour, "it offers predictors of adherence and guidelines for its promotion". In the present research, the HIV disease is still highly stigmatised in Nigeria and from observations at the outpatient clinics, patients tend to embrace treatment or medication options that promise to heal, regardless of the current incurable nature of the HIV disease. The SCT model is beneficial for discussing patients' attitudes toward adherence to medical recommendations and how adherence can be promoted.

2.4   Summary

In summary, conversation analysts use the basic CA structures to empirically describe the salient features or properties of interactions. The structures inform an interactional mechanism for understanding human social behaviour, and its application to different interactional contexts across any language that will be examined. The CA method is not without its criticisms. Some scholars criticise CA as adopting a restricted database i.e., recordings of naturally occurring interactions while neglecting other data sources like interviews. Hence, that CA has its limitations which result in a neglect of the participants involved in each interaction regarding their social identity and other social variables such as age, gender, class-structures, backgrounds, experiences, and certain important contexts (Cicourel 1981). However, as asserted by ten Have (2007), these criticisms only show that the CA approach is empirical because it allows the data to drive its findings. It validates the methodological dictate of CA which examines the minute details of conversations as a representation of social life and social structures. These basic structures will repeatedly feature in the present study.

Having briefly discussed the basic methodological approaches to understanding medical interactions (MCA and SCT), and their applicability to examining patients' health-related behaviours, it has become clear that there is a research dearth on the CA examination of medical interactions in the Nigerian HIV context, specifically regarding participants' interactions about patients' adherence to treatment regimen. The present study fills this research gap through empirical observations of communicative activities in both doctor/patient interactions and its relation to the analysis of participants' interviews. A closely related term to this approach to ethnographic methods is Maynard's (2005) notion of "limited affinity". He proposes the so-called "limited affinity" which abstracts away from other approaches such as "mutual affinity", thus arguing that every expression in discourse has the potential for indeterminateness and may need

41

the social experience of participants for a deeper understanding of the occurrence of speech i.e., speakers' intended contextual implication. Maynard asserts that this method of data and analytical collaboration enables "systematic and rigorous attention to the fullness of participants' spoken sociality and its generic structuring" (2005: 70). Though the researcher proposes this sort of affiliation in his study of diagnostic news delivery, his propositions are relevant for the present study, which seeks to understand the relationship between the content of medical interactions, and the views of doctors, counsellors and HIV patients about adherence. These objectives are pertinent for unravelling the implications of medical practice on patients' health-related behaviours.

3   Nigeria: HIV/AIDS Patients and Health Care Practices in the South-west Region

"Nigeria is a Fast-Track country and its response is guided by the National Strategic Framework 2017–2021, which aims at ending AIDS by achieving zero new infections, zero AIDS related deaths and zero discrimination. Elimination of mother-to-child transmission of HIV is a priority. Stigma and discrimination is a major challenge, especially towards key populations and people living with HIV" (UNAIDS, HIV/AIDS in Nigeria, 2016).

"In our centre, here at Ekiti state, we have received a very positive review on how we treat patients. Our services, we are told, have been highly commendable. Patients chose this hospital for referral, especially when they want to avoid the stigmatization in other clinics within and outside the state" (A doctor's report on stigma in an outpatient clinic in south-western Nigeria).

This chapter discusses the medical situation of HIV-positive patients in Nigeria, and the healthcare practices in outpatient clinics in the South-west region, where this study was conducted. In Nigeria, the HIV disease is normatively perceived as a gendered disease, as validated by researchers and international organisations (see Ajala & Olabisi 2008; Adeneye et al. 2009; Mbonu et al. 2010; Avert 2014). Avert (2014) report states that the HIV prevalence rate is higher among women in Nigeria and from my observations at the HIV clinics in south-western Nigeria, this report appears to be credible because more women populate the clinics for routine medical check-ups and for antiretroviral treatments. Although, this is not to say that the population of women in the clinics mean that the incidence rate of HIV among men is not high. For instance, when I interviewed a male HIV-positive patient (who also doubled as a coordinator of people living with HIV/AIDS in one of the South-western states I visited), he asserts that international organisations receive their statistics on HIV prevalence in Nigeria from local and national action committees against HIV/AIDS. Consequently, the reports only indicate the information received from the Nigerian organisations which are not really the true situation (see sections 3.2 and 3.4 for more discussion on this phenomenon). However, at least going by what is immediately observable at the outpatient clinics, women may have more reasons to visit the clinic than men do. Therefore, the following are the rationale for selecting women as the subjects of the present study:

(i)   reports of international health organisations about higher HIV/AIDS prevalence and contraction rates among women

(ii)   a higher population of women at outpatient clinics

(iii)   the gendered stereotype of HIV and stigmatisation of female HIV-positive patients

Hence, this study focuses on the female experiences of living with HIV, as a homogenous group of people who live in the same geographical region, with similar socio-cultural experiences. This study is focused on examining the role that medical interactions play in shaping and managing the female experiences of living with HIV in South-western Nigeria. The following sections briefly introduce the geographical location and language distribution of Nigeria's south-western geopolitical zone. This information elucidates the linguistic codes adopted at the outpatient clinics. Furthermore, the chapter describes ethnographic accounts on healthcare practices at the select HIV outpatient clinics in south-western Nigeria (including the spatial settings at the outpatient clinics) in order to exemplify how HIV consultations, take place. Finally, the chapter reports relevant information from the secondary materials gathered at the outpatient clinics as well as information from international health organizations and interviews with members of the association of PLWA (People Living with HIV/AIDS). These data include printed sensitization materials such as handbills, posters and fliers that inform HIV patients and the public about the importance of adherence to drug use, risk-controlled lifestyles (such as abstinence) and the effects of stigmatization. Information from international and local organizations include reports from organizations such as NACA (National Agency for the Control of AIDS), LACA (Local Action Committee against AIDS) and UNAIDS (The Joint United Nations Programme on HIV/AIDS) on the contraction, prevalence and adherence ratios of female HIV patients in South-western Nigeria. This information grounds this thesis within the framework of comparatively accessing locally provided data with reports from international organizations regarding the medical situation of HIV patients within the region of study.

3.1   HIV/AIDS in Nigeria: The Prevalence Ratios

Table 3-1 exemplifies the UNAIDS 2016 report on the HIV situation in Nigeria. The UNAIDS "Country fact sheet on HIV and AIDS estimates" shows the statistics for PLWA (People Living with AIDS). I indicate only sections of the fact sheet that are relevant for the present study.

Table 3-1: UNAIDS HIV/AIDS Estimates for PLWA in Nigeria

PLWA	Population and Percentage (%)
Number of people living with HIV	3.2 Million
Women aged 15 and over living with HIV	1.6 Million
Men aged 15 and over living with HIV	1.4 Million
Women aged 15 to 49 HIV prevalence rate	3.3%
Men aged 15 to 49 HIV prevalence rate	2.6%
Women aged 15 and over newly infected with HIV	91 000
Men aged 15 and over newly infected with HIV	87 000
HIV prevalence among young women	1.6%
HIV prevalence among young men	1.0%
Prevalence of recent intimate partner violence among women aged 15-49	10.9%
Knowledge about HIV prevention among young women aged 15-24	22.3%
Knowledge about HIV prevention among young men aged 15-24	27%
Percentage of adults (15-49) who responded No to the question: Would you buy fresh vegetables from a shopkeeper or vendor if you knew that this person had HIV?	46.8%

Source: UNAIDS 2016 "HIV and AIDS in Estimates, Nigeria"*. Retrieved. http://www.unaids.org/en/regionscountries/countries/nigeria. 13.01.2018. 02:00 am.*

With an estimated population of 186 million people in Nigeria in 2016, 3.2 Million live with HIV. Table 3-1 shows a general prevalence rate of 3.3% among women aged 15-49 and 2.6% among men of the same age group. The prevalence rate among women continues to increase when compared to the reports from previous years. For example, UNAIDS Global Report (2012: 11) states that Nigeria occupies a "stable" status, whose HIV "incidence rate changes less than 25% up or down", while other countries such as Kenya, Cameroon and South Africa have experienced

between "26-49% decrease in the occurrence of HIV/AIDS" especially among women. Thus, it is not surprising that the UNAIDS 2016 report estimates that 1.6 Million Nigerian women live with HIV while women become newly infected with HIV than men. The study also shows that women experience intimate partner violence and less knowledge about HIV prevention. Finally, 46.8% of respondents answer questions in a way that suggests that HIV patients are still highly stigmatized. The UNAIDS (2016) report validates Ajala and Olabisi's (2008) study. Meanwhile, there was conflicting information on the prevalence rates of HIV in the south-western states I visited for the current study. Although it is evident that UNAIDS's report gives a statistical background of the whole country (and it has been established that the prevalence rate is higher in the Northern region that in the South-western region), I still find that the medical personnel I interviewed did not have a unified perspective on the prevalence rate in their respective states. For example, while UNAIDS predicts a general 3.1% prevalence rate of HIV among adults aged 15-48 as at 2015, and 3.3% among women in 2016 (see table 3-1), the doctors and PLWA manager I interviewed did not report a unified statistic on the prevalence and adherence ratios of HIV patients within their respective states. One of the doctors I interviewed (Doctor Gideon; all names are pseudonyms) implies that due to competent staff services, low stigmatisation and patients' positive adherence behaviours, there is a decreasing incidence rate in his state and a decreasing incidence rate at his HIV centre:

> In our centre, here at Ekiti state, we have received a very positive review on how we treat patients. Our services, we are told, have been highly commendable. Patients chose this hospital for referral, especially when they want to avoid the stigmatization in other clinics within and outside the state. Concerning patients' adherence to clinic visits, 95% of our patients have been adherent and we encourage them to prioritize adherence to this medical recommendation beyond their personal plans, e.g. to travel. As for drug adherence, what we use as an index in this clinic is majorly patients' CD4 count. We can't live with them in their homes to enforce this though we have a social worker here who follows up on this. But from their CD4 count, we can tell the level of adherence. In our clinic, here, patients have been improving also, maybe not up to 95%. Concerning attitudes, some people still believe that HIV is a myth and can't be contracted, and this is a problem.

Doctor Gideon's report posits that there has been much improvement on patients' adherence, hence, implying a decrease in the incidence rates of the disease, at least within the south-western states in which he works (Ekiti state). Within the same state, a PLWA manager states that the prevalence rate is increasing due to lack of government intervention:

Before now (2015), the prevalence rate in Ekiti state was 1.4% but at the last surveillance rate that was conducted, the prevalence rate has increased to 2.8%. So, even though Ekiti state has one of the lowest prevalence rates in Nigeria, second only to Lagos state, we have still managed to attain double prevalence rates, and this prevalence ration is recorded mostly among women within the state. The LACA knows about this but they don't freely discuss this because they will not want to admit that the money issued by the world bank for intervention purposes was not properly utilized… I think the prevalence rate is increasing because the government is not monitoring the spread of the infected persons. The government has stopped the budget for PLWA which was previously used to empower infected persons and help them live self-sufficient lives so that they will no longer live carelessly and continue to be affected by stigma.

Another doctor (Doctor Maria), who also doubles as the manager for the Local Action Committee against AIDS (LACA) at Ondo State also reports a higher adherence ratio. I asked her what her opinions were, about the adherence and prevalence ratios of HIV-positive patients and she submits that from her experience, she will attribute reasons for the higher prevalence rate to political crisis:

It's because the state has withdrawn financial assistance that used to be given to Network of People Living with AIDS (NPLWA) members i.e., the monthly stipends in Ekiti state. How can people control themselves and adhere to drug use if they are not adequately provided for, financially? The country itself is in economic crises now so there is no stability in any program in Nigeria. But it's not like that in Ondo state. Whatever money comes for the program goes to the program and that is why the prevalence rate of HIV in Ondo state is only 2.8%.

It is evident that due to several factors, the incidence of new HIV infections in Nigeria, especially among women is on the rise. In south-western Nigeria, such factors include political reasons, as well as some cultural and religious beliefs that make women more vulnerable to the disease than men. Without necessarily delving further into the political nuances regarding HIV/AIDS interventions in Nigeria, it is still worth mentioning that on the political sphere, the UNAIDS (2012) Fast-Track Targets had proposed to avert nearly 28 million new HIV infections and end the AIDS epidemic as a global threat by 2030. Regardless of this developmental strategy, however, there still exist some regional issues which threaten this goal and Nigeria is a typical example. Treatment coverage in Nigeria since 2012 has been only 20% with over 80% of patients not on Anti-Retroviral Treatment (ART) (57% of these are women). This is despite the increase in spending due to the provision of ARV drugs in Nigeria (UNAIDS 2012: 18).

Furthermore, there is currently a criminalization of persons in the lesbian, gay, bisexual and transgender (LGBT) community, organizations, activities, and people who support them.

47

There is therefore deep concern in the queer community, among whom there is a high percentage of HIV infection that access to ART would be limited (NBC news 2017). And, due to individual and cultural beliefs, non-LGBT HIV-positive patients are still predisposed to issues of stigmatization, faulty attitudinal disposition, religious sentimentality and nonadherence to (see Ajala & Olabisi 2008; Mbonu & Vries 2010). Female non-LGBT HIV-positive patients are victims of this situation because they are more prone to stigma due to the patriarchal society they find themselves – many have contracted the disease as victims of rape and sexual abuse in marriages, and detrimental sexual behaviours (see Folayan et al. 2014b; Ezechi et al. 2016; Ezechi & Agatha 2017; Rhine 2016). The rape victims hardly report assaults on them, and the less literate married women succumb often to unprotected sex with promiscuous husbands. And when the disease is contracted, these women usually receive the blame (Folayan et al. 2014a). Hence, a situation where most female HIV/AIDS patients desperately seek for medical attention and cure wherever their belief lies, even though there is yet no internationally approved cure for HIV/AIDS. They consult doctors, counsellors and herbal homes often and their actions are due to the need for constant reassurance that they can live a normal life free of stigmatization from the society, i.e., the stigma associated with living with HIV.

In South-western Nigeria, this consultation web between HIV-positive patients, doctors at ART clinics, counsellors at support group meetings, and herbal therapists is further necessitated by some cultural ethos associated with people who live in the geopolitical region. HIV is a social stigma. At ART clinics, many doctors see it as a taboo to refer to HIV/AIDS by name. They make "equivocal, concealing utterances" in referring to HIV/AIDS when relating with patients, which "takes into account, the socio-psychological security needs of clients and attends positively to clients' cultural expectations" (Odebunmi 2011: 619). Promiscuity and marital infidelity are also often considered as some of the leading causes of HIV contraction. With serodiscordant couples where women are the disease carriers, the level of social stigma is much worse for the female patients. Hence, female patients utilize the various healing interventions available to them to seek a cure from the disease and to avoid being stigmatized. Giving this situation in South-western Nigeria, the present study becomes relevant in that it focuses on female HIV patients' communication with doctors and counsellors, their interactional activities and patient's adherence behaviours in the bid to further access participants' accounts of the socio-cultural and socio-economic factors that influence their attitudes towards the disease. And, since the context and

success of language use in communication is culturally mediated (Duranti 2001: 1), the success of doctors and counsellors' aim in caring for HIV patients and the latter's goal at achieving wellness generally, requires an examination of the existing conversational organization and the "cultural fabric within which their utterances are shaped and meanings are produced" (2001: 1) during consultations. This factor determines the impact of medical therapy on patients and their willingness to adherence to orthodox medicine rather than opting for trado-medical options.

3.2 South-West Nigeria: The Location and Language Distribution

Nigeria's south-western geopolitical zone is one of the six geopolitical zones of Nigeria which consists of people with common culture, ethnic groups, historical backgrounds, languages and dialects. Faleyimu and Agbeja (2012) report:

> The area lies between longitude 20 311 and 60 001 East, and Latitude 60 211 and 80 371N (7), with a total land area of 77,818 km2 and a projected population of 28, 767, 752 in 2002 (2012: 2).

The South-western region includes the following states which make up the study areas for the present research: Lagos, Ekiti, Ondo, Ogun, Oyo and Osun (see Figure 3-1).[5] It consists majorly of the Yorùbá ethnic groups with an estimated population of 5.3 Million[6] who communicate in the many dialects of the Yorùbá language as well as English and Nigerian Pidgin English. The people who inhabit the South-west region of Nigeria communicate primarily in Yorùbá as their lingua franca although English is Nigeria's official language. In certain contexts, such as in the medical settings, people may adopt English, Igbo and pidgin when communicating with people from other ethnic groups who are not very fluent speakers of Yorùbá. These dynamic language choices are to be found also in the outpatient clinics, as per my experience. The linguistic codes adopted at the HIV clinics are majorly Yorùbá, Nigerian English, Igbo and Nigerian Pidgin English (NPE), in the following interactional contexts[7]:

- Yorùbá Doctor to Yorùbá patient – Communication in Yorùbá

- Yorùbá Doctor to Igbo Patient – Communication in English and/or NPE

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[5] Of the 6 six states, the study was specifically conducted in Lagos, Ekiti and Ondo states.
[6] Source: http://www.everyculture.com/wc/Mauritania-to-Nigeria/Yoruba.html
[7] This language choices are not representative of all consultations within the select clinics.

- Igbo Doctor to Yorùbá patient – Communication in English and/or NPE

- Igbo Doctor to Igbo Patient – Communication in English and/or Igbo

Figure 3-1: Map of Nigeria Showing the Study Area
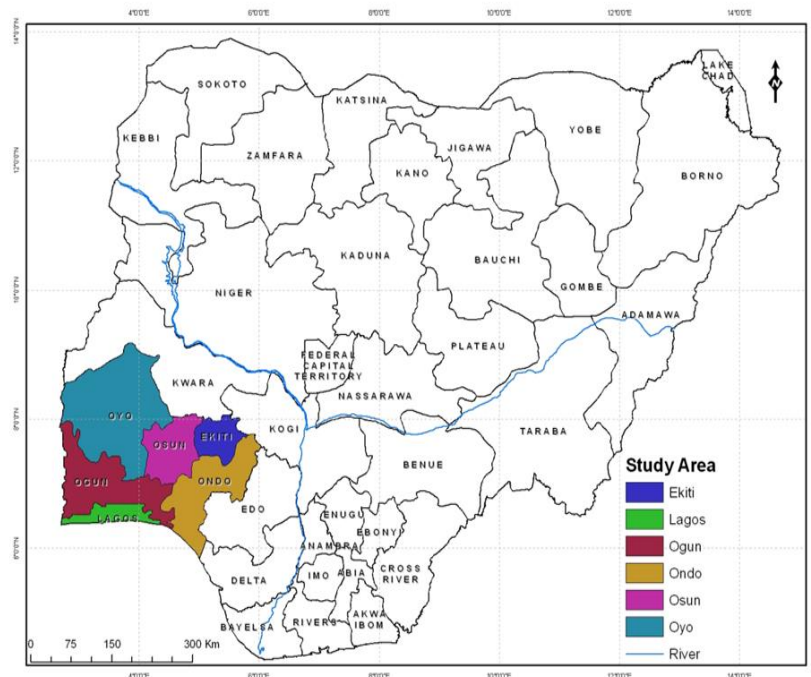
Source: Faleyimu and Agbeja (2012). http://article.sapub.org/10.5923.j.re.20120202.06.html.
Retrieved 11.08.2017, 13:33 PM

In some contexts, patients and doctors alternate or select codes (languages) due to cultural, institutional and linguistic "routines" (see Odebunmi 2013). However, the languages that were recovered at the select clinics exclude Igbo. Only English, Yorùbá, NPE, and code-mixing of any of the three languages were adopted. These language choices influence how consultations are shaped between the medical personnel and HIV patients.

3.3   Patients' (Non)Adherence to Treatment Regimen

Since its establishment as a concrete research domain, several scholars have extensively considered the discursive representation(s) of patients' adherence/nonadherence to medical

recommendation during medical interviews (Korsch & Negrete 1972).[8] Research in this domain focuses on factors responsible for patients' nonadherent attitudes and how patients interactively suggest this. Findings show that patients' decisions to adhere or not, are based on several factors, a major one being the notion of shared decision making. For instance, evidence in primary care visits supports the finding that patients positively orient to shared decision making about medications and vice versa (Stevenson et al. 2000). Although, when patients orient negatively to physicians' non-shared decision making regarding medications, physicians may sometimes defend their actions in cases where they (patients) have a mental disorder (Stewart et al. 2010). However, the importance of shared decision making cannot be undermined because when it is not practised, patients activate their general beliefs and perception of the typical physician-patient relationship which suggests the non-treatment of patients as equals. This "impact significantly on their decision to non-adhere to prescribed medication" (Stavropoulou 2011: 7).

To address this tendency, physicians have attempted shared decision on medication adherence by soliciting, for example, the joint access to EMR (Electronic Medical Records). However, this eventually results in unclear interactional conclusions, non-shared decision and lack of medication information to patients (Arar et al. 2005). In some cases, patients' adherence could also be influenced by doctor-patient communications and health-related beliefs of patients (Freidman et al. 2008) such as the use of TM (traditional medicine) and CAM (complementary and alternative medicine) e.g., OTCD (over-the-counter drug) (Shelley et al. 2009), and self-medication (Sleath et al. 2001). Patients may interactively communicate their tendencies for nonadherence by expressing aversion to medicines and resisting physicians' moral implications of linking their health status with own behaviour (Pilnick & Coleman 2003). Conversely, patients who adhere to medications show more alignment rates when physicians have used conversational strategies to encourage adherence (Smith et al. 2005). They equally show alignments with doctors' suggestions when they (patients) have favourable projected treatment outcomes by asking response-related questions (Hamilton et al 2006).

In the present study, patients' adherence to the medical recommendation is conceptualised differently from what is obtainable in the literature on d-p encounters. What is referred to as "adherence" or "nonadherence" originates from my observations of how medical practitioners

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[8] Korsch and Negrete's (1972) ground breaking research at the Children's Hospital of Los Angeles was based on observations of 800 paediatric acute care visits.

define patients' adherence status at the outpatient clinics. At the clinics, doctors and HIV patients have become familiar with the institutional relevancies. The predominant concern is patients' good medical health, which is expected to be achieved when patients visit the clinics for renewed drug prescriptions (intervals of two months), use their prescribed drugs daily and conduct CD4 count tests every three months. To ensure patients' optimal health, some of the clinics admit patients who have a combination of HIV and Tuberculosis (as an opportunistic infection), among other infections. Hence, acute medical complaints like a cough are related to HIV. Medications for non-HIV related complaints, like a headache, are also treated as a test of adherence to medications. Consequently, prescribed drugs at the clinics include HIV medications (ARV drugs) and non-HIV medications (prophylactic drugs and medications for acute complaints). Consequently, the term "adherence" relates to HIV and non-HIV medications. However, since medications can only be (freely) received when patients comply with other medical recommendations such as regular clinic visits, drug collection and CD4 count tests, nonadherence to these other recommendations is also generally treated as an indication of nonadherence to medical recommendations. Outpatients who visit the clinic to collect ARV drugs and other prophylactic drugs, often orient to the clinics' institutional tasks which involve documenting patients' regular CD4 count tests, as well as regular drug collection on clinic visit and checks for correct drug use. Patients take CD4 count tests quarterly, to check if their ART is working properly in terms of significantly reduced viral loads, although CD4 count tests are only done when patients regularly visit the clinics where they are registered (at the due time) for renewed drug prescriptions. Hence, adherence is not considered in relation to its one-dimensional interpretation (medication use) as found in the existing literature. Rather, it is defined in other terms – adherence issues surface in instances where doctors talk about these other medical recommendations. In this study, therefore, I prefer to talk about adherence to medical recommendations: regular drug collection, regular CD4 count tests, regular clinic visits and the regular use of prescribed HIV and non-HIV medications.

Research has tangibly shown the interactional strategies by which patients communicate adherence, and the possible factors responsible for their nonadherent attitudes. However, there is scanty research for interactions where these factors are not explicitly verbalized by patients, especially within the context of a routine medical encounter for a sensitive chronic illness such as HIV. Herein lies a problematization that validates the aim of the present study because the corpus shows that though HIV patients express nonadherence explicitly, there are instances where

patients' adherence attitudes can only be deduced through other indicators. This study, therefore, examines these interactional contexts, as well as the linguistic forms through which patients' disclosures of adherence are expressed, and the implications of these on medical practice in the HIV context.

3.4   Health Care Practices in Outpatient Clinics

3.4.1   Institutional/Interactional Tasks

This section examines the healthcare practices at the outpatient clinics and the efforts of medical practitioners regarding issues of HIV prevalence and adherence. At the clinics, two types of interactional tasks reveal two visit types for the HIV patients' consultations with the doctors. The first visit type makes specific provision for patients' medical complaints while the second is framed both for patients' medical complaints and other medical concerns. I will tag these visits Types I and II visits respectively. In Type I visits, patients routinely arrive at the clinic to collect the freely distributed ARV drugs. Clinic attendants locate their medical records while patients are counselled in groups by an intern, on several topics such as healthy living, good dental care, hygiene, dangers of self-medication, and the benefits of adherence to medical recommendations (see figure 3-2).

Figure 3-2: An Outpatient Clinic in South-west Nigeria

Source: The Guardian Online Newspaper. Retrieved. https://www.theguardian.com/global-development/gallery/2016/sep/26/sugar-the-pill-tackling-taboo-family-planning-nigeria-in-pictures-world-contraception-day. 14.08.2017, 10:35 am

Afterwards, nurses attend to patients for routine examinations such as blood pressure reading, temperature reading and weight and height measurements. Finally, patients queue to collect their ARV drugs and other drugs. Only patients who have new medical concerns (opportunistic infections) besides the already established one (HIV) can consult with a doctor. As shown in figure 3-2, it is typical for patients to be jointly addressed on clinic days, before consulting with the doctors (in type I visits). Furthermore, in Type I visits, patients and doctors are aware that their discussion is centred on presenting new medical concerns and when they present their concerns, the doctors take their medical histories while examining and counselling them if necessary. Finally, doctors renew ARV drug prescriptions as well as other prophylactic drugs if required. ARV drugs are labelled frontline drugs, second-line drugs and third line drugs. Frontline drugs are for first intervention. When patients do not adhere to these first intervention drugs, they are offered stronger brands of ARV drugs, and then a third line (brands with the most potent components), if they are still nonadherent. The reason for this is that patients' immune system may be resistant to the frontline drugs if they are not constantly ingested and this necessitates a second and third line drug intervention. Drug failure occurs when patients refuse to adhere to regularly taking the third line drugs. In Type II visits, patients also routinely arrive to collect their ARV drugs, but all are required to consult first, with a doctor, before receiving drugs. Again, doctors meet with patients to take their medical histories, listen to new concerns if there are any, conduct examinations, and renew prescriptions. In both Types I and II visits, however, doctors speak with patients based on the information available in patients' medical records. This information was taken in patients' previous visits by a medical staff or by the doctor who requested for the information at a previous routine appointment.

Two normative activities constitute the interactions in Types I and II visits: openings (introduced either with history-taking or problem solicitation) and treatment discussions. Other activities, such as patients' examination, may occur but not often. The visit types indicate that in the chronic-routine visits, doctors will first open the interaction either by taking the history of patient's adherence to drug use and regular clinic visits or by soliciting patients' concerns. Secondly, doctors will, as a matter of duty, renew prescription of ARV drugs and/or other drugs. The core objective of the patients' periodic visits, going by my data, is for drug renewal. But in the process, doctors are required to record patients' new medical concerns and histories of adherence to medical recommendations. Of the four hospitals visited, only one outpatient clinic

conducts voluntary HIV counselling and testing (VCT). For the tests, hospitals use the designated forms which are provided either by the state agencies for the control of AIDS or the national agency for the control of AIDS (NACA) (see figure 3-3). In some cases, this form also doubles as the HIV serology test and control form for patients who are have been diagnosed with HIV and are already visiting the outpatient clinics to collect the ARV drugs.

Figure 3-3: HIV Voluntary Counselling and Testing (HVCT) Form

Picture was taken by the researcher. Material received from an outpatient clinic in South-west Nigeria on 3rd December 2015 at 1:45 PM

In figure 3-3, we see that the HVCT form indicates patients' bio-data, the test result and information on the laboratory that conducted the test, and the hospital that requested the test. A typical doctors' office in outpatient clinics consists of at least three doctors seated either in make-shift cubicles or in an open-office arrangement. Sometimes, other medical staff such as nurses and clinic attendant (care and support staff) also share this consultation room. At other times, the nurses' station is located outside the consultation room. Prior to doctors' consultation with patients, nurses will have sorted patients' medical records and placed them on the doctors' tables. Doctors usually pre-examine these medical records and indicate to the nurses that they are ready to start attending to patients. Meanwhile, patients wait outside and are called into the consultation room according to their arrival times. In both visit types, conversations between doctors and patients begin with the core medical business, including preliminary greeting exchanges, problem solicitation and medical history-taking.

3.4.2   Sensitization Materials

At the outpatient clinics, efforts are on-going in the form of sensitization materials which are provided to inform patients and the populace about HIV, living with HIV and its prevention, and the consequences of living with HIV. These materials (handbills, billboards and posters) are designed by the HIV/AIDS Control Units in each South-western state, and the National Agencies, including ODSACA (Ondo State Agency for the Control of AIDS), LSACA (Lagos State AIDS Control Agency), EKSACA (Ekiti State AIDS Control Agency) and NACA. Materials are written in Yorùbá, English and NPE – the three languages adopted at the outpatient clinics in the South-west region. There are posters which give information about HIV prevention (see figures 3-4 and 3-5). In figure 3-4, the poster (in Yorùbá) synchronises the Yorùbá concept of *eèdì* "bewitchment" with eédì (AIDS), in order to pass the message that AIDS is associated with a situation of mystical captivity i.e., the mystical prowess of witchcrafts to bind an individual (*dè ó*) both physically and spiritually. Thus, AIDS has the ability to incapacitate and render an individual useless, as captured in the poster *eédì kò ní dèmí o,* I will not be bound by AIDS.

Figure 3-4: Poster in Yorùbá language on HIV prevention strategies

Picture was taken by the researcher. Material received from an outpatient clinic in South-west Nigeria on 3rd December 2015 at 2:00 PM

Little wonder that the AIDS figure in the poster looks sick and emaciated. To combat the disease, the poster advises that AIDS should be prevented through a first attack: *Kí àrun AIDS má ba dé o, yin íbon olóta méfà yí,* to prevent being bound by the AIDS disease, shoot this six-bullet gun. The disease should be prevented using six prevention mechanisms: refusing unscreened blood transfusions, avoiding needles and syringes, avoiding the sharing of skin piercing instruments, avoiding contact with other people's blood and serum, safe sexual practices, and faithfulness to a sexual partner, and the regular use of condoms. This poster reiterates how the HIV/AIDS disease is popularised in the South-west region and other regions in Nigeria. Emphasis is placed on the long-term effect of the HIV disease (AIDS), rather than HIV itself – engendering the assumption that the fear of AIDS is more important than HIV. It is assumed that anyone with HIV automatically has AIDS, a disease which is termed *aàrùn tí kò gbó ògùn*, an incurable disease. Therefore, the populace instinctively associates HIV with AIDS, though the serology of an HIV patient may still indicate healthy immune cells.

Figure 3-5 passes a similar message as figure 3-4 but the message is more detailed and communicated with the English language. The poster advises that individuals should know their HIV status and that the test is free in all government hospitals.

Figure 3-5: Poster in Nigerian English Language on HIV prevention strategies

Picture was taken by the researcher. Material received from an outpatient clinic in South-west Nigeria on 3rd December 2015 at 2:00 PM.

It also highlights sixteen basic facts about HIV for people's education. What is probably most notable in the poster is the picture of a woman embracing a man, both smiling into the camera.

The picture promotes heterosexual orientations and the need for safe sexual practices between a man and a woman (the LGBTQ community is not recognised). This sexual orientation shows that in Nigeria, the agencies for the control of HIV/AIDS mostly associate the incidence of HIV to sexual practices between people of the opposite gender only. Much more than other prevention mechanisms, sex is still regarded as the most important route of HIV transmission. At the outpatient clinics I visited, this mentality is foregrounded when women shared their views with me about the constant stigmatisation they suffer when people who know their HIV status immediately label them as promiscuous (in the sense of illicit sexual practices with men). Due to this stigma, many decide to leave certain businesses, to prove that they are not promiscuous. For example, when I asked patient Agatha (pseudonym) about her experience as a PLWA, she states:

> That is a very powerful question because my first husband and I separated over 10 years ago. He was the reason why I was initially depressed after I found out I was positive because I knew I wasn't promiscuous. Since we are no longer together, I don't know if he eventually got tested and I don't know if he infected me with the disease. But after being counselled severally about various means of HIV contraction and knowing that I also participate in some of those activities, such as hair fixing, I resigned to fate. This year, the pastor (Clinic Attendant, a clinic oddly) and I have discussed my new fiancée, how the relationship started and is progressing because one does not hide from the person who will bury him. I was wondering whether to reveal my status to my new man…

Agatha's view clearly shows the attitude of other people towards female HIV-positive patients. Besides implying that she separated from her husband over ten years ago due to depression from being stigmatised, she was also stigmatised and labelled promiscuous because of her contraction of the disease. Though Agatha is not sure if the disease was contracted from her previous husband (he did not get tested before their divorce), she still suffered from this stereotype, probably from the ex-husband, friends, in-laws and other people who knew her HIV status. Agatha's fear of stigma and depression was slightly lifted after several counselling sessions. However, the fear continues saliently because she is sceptical about informing her new man about her HIV status. Another HIV patient (Margret) reiterates:

> I used to sell beer. I owned a very big beer parlour in my area. But when I tested positive for HIV, I had to close my shop because people always think that a woman who runs a beer parlour is promiscuous. But I know that I have never cheated on my husband since the day I married him. We have been married for over 20 years.

From Margret's view, an HIV-positive woman must do everything possible to protect herself from stigmatisation. To the point that her business needed to be closed so that she could prove her

innocence to those who stigmatised her. Probably also due to the popularisation of HIV with certain information posters (see figure 3-5), the populace associates HIV with promiscuity and unfortunately, women bear more of the blame and stigma. At the clinics, doctors inform me that the disease is more easily contracted from a woman than from a man, due to the unique female physiology.

To stop HIV-positive patients from being stigmatised, the federal and state agencies for the control of HIV/AIDS frequently publish posters that discourage stigma. In figure 3-6, the poster advocates against the incidence of AIDS and the stigmatisation of HIV/AIDS patients. The poster is captioned with several exclamation marks that indicate the alarming rate of stigma, the discrimination against HIV/AIDS patients, and the seriousness of its message in advocating for a social reorientation in this regard. Interestingly also, there are several people holding the banner that reads: "Stop Stigma, Stop AIDS". This caption and, its people-representation signifies a joint and collective effort to combat stigma and discrimination.

Figure 3-6: Poster in Nigerian English on the negative effects of stigmatization.
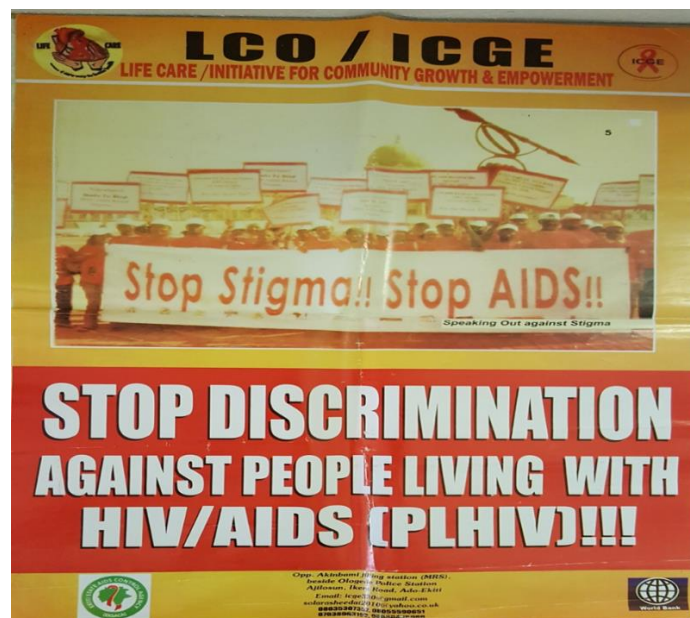
Picture was taken by the researcher. Material received from an outpatient clinic in South-west Nigeria on 3rd December 2015 at 2:00 PM

Sensitization materials at the clinics respond to the social construct of HIV in south-west Nigeria by addressing issues of stigma and lifestyle behaviours. Sensitization materials in Yorùbá, NPE, Igbo and English, condemn stigma and encourage voluntary counselling and testing. The materials

also educate the patients and the public about preventive measures for HIV, as well as treatment options and healthy lifestyle choices for the disease carriers. They educate the public about the health implications of living HIV while desensitizing people from the myths that have surrounded the HIV disease for several years. These messages exemplify the social construct of HIV, both from the victims' perspectives and from the public. A common message conveyed by these sensitization materials is that HIV/AIDS is negatively perceived and closely tied to the unpleasant consequences of living with the disease. Hence, it is not surprising that health care workers may constantly relate to this social construct when addressing nonadherent patients, to make them aware of the consequences of their behaviours.

3.5   Summary

The following are the concluding statements on the HIV/AIDS situation in Nigeria, and the health-care practices in outpatient clinics in the south-west region. First, adherence to the treatment regimen is a problem among HIV-positive patients (predominantly women). Thus, the populace reacts to HIV contraction from a stereotypically gendered perspective – women are often stigmatised because they are treated as the disease carriers and transmitters. Evidently, there are increasing incidences of the HIV disease among women in South-west Nigeria and this situation is revealed in the large influx of female patients at the clinics and in the reports from international and local organisations, though with some difference in statistical evidence. Second, the state, national and international agencies recognise this gendered social reaction to the disease. Thus, sensitization materials at the outpatient clinics are geared towards discouraging HIV contraction and stigmatisation – the materials show that living with the HIV disease has consequences on medical well-being, with negative perceptions from the populace. Third, interactions at the outpatient clinics are organized according to visit types (Type I and II visits), with varying linguistic codes: Igbo, Yorùbá, English, NPE and code-mixed languages, depending on participants' cultural backgrounds.

4   Data and Methods

> "First, utterances and actions are context shaped. Their contributions to an ongoing sequence of actions cannot be adequately understood except by reference to the context in which they participate" (Drew & Heritage 1992: 18).

> "By the conditional relevance of one item on another we mean: given the first, the second is expectable; upon its occurrence it can be seen to be a second item to the first; upon its non-occurrence it can be seen to be officially absent – all provided by the occurrence of the first item" (Schegloff 1968: 1083).

This chapter describes the data collection and data processing methods. For data triangulation, the study uses both primary and secondary data, which were collected for analysis. Primary data includes audio-recordings of d-p consultations while secondary data include interview data, field notes from participant observations, printed sensitization materials (flyers and posters), as well as information from international conventions, and state and national control units for the control of HIV/AIDS.

4.1   Sampling Technique

4.1.1   Scope of the Research

Due to limited time and resources, data for this thesis could only be recovered from three of six south-western geopolitical regions in Nigeria: Ondo, Ekiti and Lagos state, between August and December 2015. I conducted the study in four hospitals: one federal hospital in Ado-Ekiti, one federal teaching hospital in Ido-Ekiti respectively, a centre for infectious diseases in Yaba (a federal hospital in Lagos state) and a state specialist hospital in Ondo state. Five visits were collected from the federal hospitals while 5 visits were collected from the teaching and state hospitals (see table 4-1).

Table 4-1: Sampling Scope

States	Hospitals	Case Notes	D-P. Consultations	Interviews with Doctors	Interviews with Patients	Interviews with Counsellors	Interviews with Pat-Counsellors
Lagos	Lagos Mainland Hospital, Yaba	30	30	2	-	-	-
Ekiti	Ekiti State University Teaching Hospital, Ado-Ekiti	20	20	2	3	1	-
Ekiti	Federal Teaching Hospital, Ido-Ekiti	20	20	5	-	-	3
Ondo	State Specialist Hospital, Ikare	-	-	1	-	-	-
3	4	70	70	10	3	1	3

The four hospitals visited provide outpatient services for male and female HIV-positive patients whose HIV status had not yet developed into AIDS. Thus, the corpus is valid data only for consultations between doctors and female HIV-positive patients who were not yet admitted to the hospital. The hospitals were selected at the various locations based on their provision of HIV/AIDS clinics and heart to heart centres, and the large influx of HIV patients who visit the hospitals. Being gender biased, the study draws its analyses from seventy consultations, only between female patients and doctors – the main participants for the study. The female patients include serodiscordant couples, pregnant women, female sex workers and female injection drug users, whose case notes were also examined to confirm their occupation, social status and medical histories. The select HIV clinics observe two clinic days per week, where patients visit periodically to receive their freely distributed ARV drugs. Consultations mostly occur in offices where patients may either be counselled privately or in the presence of other HIV patients and doctors (see figure 3-2, P. 38). As previously mentioned, the predominant language in South-west Nigeria is Yorùbá. However, in situations where the participants are culturally diverse, they may also converse in

Nigerian English and NPE. Hence, some of the transcripts are translated from Yorùbá and NPE to standard British English.

4.1.2 Data Corpus

4.1.2.1 Audio Recordings

Seventy (70) audio recordings of d-p consultations were gathered for content analysis. The audio files were a total of 1, 750 minutes. The audio recordings were taken with audio recorders, which were placed on the consultation tables. The researcher was absent from the consultation room, to ensure that the participants' conversations were not influenced by the researcher's presence. The 17 participant interviews were also audio-recorded by the researcher (255 minutes in total). The number of d-p audio files exceeds the total number of audio files for semi-structured interviews due to the difficulty in interviewing the participants – they felt that the interviews were more intrusive than the audio recordings.

4.1.2.2 Semi-structured Interviews / Participant Observation

In-depth semi-structured interviews were used to collect supplementary data for the study. Data were collected using a two-part questionnaire which consists of participants' bio-data (except their names) and interview questions (see Appendix). Interviews were conducted with 17 interviewees, including doctors (n = 10), counsellor-patients (n = 3), non-counsellor patients (n = 3) and a counsellor (n = 1). The interview questions focused on patients' illness experiences, their relationship with the doctors, their impressions of the HIV disease i.e., whether it is curable or not, and steps they take to find a cure and improve their lives. Questions also cover their belief concerning the disease. Doctors and counsellors were asked to account for possible patients' attitudinal disposition towards the disease and the reasons behind the unreduced status of HIV/AIDS in Nigeria. However, for the present study, only responses that pertained to patients' adherence to medical recommendations were analysed using the method of inductive thematic analysis (ITA), as proposed by Virginia and Clarke (2008). Interviewees include male and female doctors, male and female counsellor/patients, a female counsellor, and three female HIV patients. The researcher also engaged in participant observation, to generally observe interactions at the research locations and take notes. Interview questions were guided by Kvale's (1996) guide to

qualitative research interviewing, which describes the dynamics of people's relationships with internal (personal) and external (environmental) factors. Kvale states that it is important to ask introducing questions, follow-up questions, probing questions, specifying questions, direct questions, indirect questions, structuring questions and interpreting questions. He also identifies the importance of silence during the questioning process because it allows the interviewees to reflect on the questions asked, after which they may break the silence with meaningful replies. For the present research, introducing questions and direct questions were asked, which then led to follow-up questions. These questions were the only question categories adopted. Semi-structured interviews were preferred to structured interviews due to the need to flexibly request for some sensitive questions.

4.1.2.3 Case Notes, Print media and HIV/AIDS Reports from International Organisations

Case notes of patients were accessed from doctors, for patients' details such as bio-data (except the names) and medical histories. This information is necessary because they may not feature in the consultations between doctors and patients. Print media such as handbills, posters, billboards and fliers that give information on adherence to drug use, abstinence and stigmatization, were collected at the outpatient clinics and counselling centres to examine the efforts of both state and federal HIV/AIDS control units in sensitizing the HIV-positive patients and the public on HIV prevention, Voluntary counselling and testing (VCT) and stigmatization. Furthermore, reports from international conventions such as UNAIDS amongst others were collected for current information on the status of HIV/AIDS patients in Nigeria.

4.2   Data Processing

4.2.1   GAT 2 (Conversation-Analytic Transcription System)

Audio recordings of consultations were transcribed using notations from conversation analytic model which focuses on natural unpremeditated discourse. Data were transcribed using the transcription convention provided by Gesprächsanalytisches Transkriptionssystem (Conversation-analytic transcription system) (GAT 2), a system for transcribing talk-in-interaction by German linguists, translated and adapted for English by Couper-Kuhlen and Barth-Weingarten (Selting et al. 2011; see Appendix). The analytical method used is CA (see section 2.1, P. 6).

4.2.2 ITA (Inductive Thematic Analysis)

The interviews were analysed using the method of Inductive Thematic Analysis (ITA) as proposed by Braun and Clarke (2008). ITA is described as a method for identifying, analysing and reporting patterns (themes) within data (2008: 79). The researchers state that ITA is a "theoretically flexible approach to analysing qualitative data" (Braun & Clarke 2008: 77) because it serves as a tool that accommodates various qualitative research or analytic methods. ITA distinguishes between data corpus, data set and data item. They state that within the dictates of ITA, "data corpus refers to all data collected for a particular research project, dataset refers to all the data from the corpus that are being used for a particular analysis, while data item is used to refer to each individual piece of data collected, which together make up the data set or corpus" (2008: 79). The data set is a collection of data selected to answer a research question or research questions. It consists of every instance where the research questions are mentioned.

Braun and Clarke (2008) argue that thematic analysis is beneficial because it is not tied to qualitative analytical methods that follow theoretical and epistemological positions (such as CA), interpretative phenomenological analysis (IPA), grounded theory, or narrative analysis. Rather, ITA is "essentially independent of theory and epistemology, and can be applied across a range of theoretical and epistemological approaches" (2008: 78). Therefore, ITA reflects both "reality and the surface of 'reality' (2008: 81). However, despite its flexibility, Braun and Clarke state that "it is important that the theoretical position of a thematic analysis is made clear" because "any theoretical framework carries with it a number of assumptions about the nature of the data, and what they represent in terms of the world" (2008: 81). Due to this flexibility, ITA has been criticised as lacking rigour (see Antaki et al. 2002). For the present research, ITA is preferred because the study discusses patients' social situations (see Silverman 1993) and its theoretical underpinnings. More so, ITA has a realist orientation which is closely related to the CA method in the data-driven approach. The ITA approach is objective because it lets the data dictate its findings. Its inductiveness and data-driven tendency mean that "themes identified are strongly linked to the data" and "may bear little relation to the specific questions that were asked of the participants… or the researcher's theoretical interest in the area or topic" (Braun & Clarke 2008: 83). The theoretical implication of the data analysis that was identified in the data (SCT) was only discussed after relevant latent themes were identified and analysed. Hence, like CA, it takes the form of a bottom-up approach. Furthermore, as Braun and Clarke (2008) argue, the ITA method involves a

"process of coding the data without trying to fit it into a pre-existing coding frame, or the researcher's analytic preconceptions (2008: 83). Themes from an ITA approach will not be guided by themes derived from the previous literature on the topic, but it will be data-specific. Latent themes were preferred because they go beyond what a participant has said, to identifying or generating interpretations of what has been said. The six phases of ITA include: "(i) familiarizing with the data for initial ideas, (2) generating initial codes, (3) searching for themes, (4) reviewing themes, (5) defining and naming themes and (6) producing the report" (2008: 87). In summary, ITA is a methodological approach that recovers the social situation guiding the verbal production of a speech activity. Basically, the approach is adopted to view how participants construct the speech activities and unravel their behavioural patterns on varying medical concerns regarding the care and treatment of HIV patients.

4.3   Analysis of the Data

The main method used for data analysis is CA while the interview data were subjected to content analysis. The study places d-p communication within the framework of an institution comprising patients who are bound by a common disease (HIV), and who are faced with similar societal constructs. Specifically, for female HIV patients, the HIV disease has come to interplay and define the social realities they experience individually and from the communities surrounding them. To examine this phenomenon, this study has adopted a first data collection technique, i.e. a conversation analytic observation of recorded, unpremeditated interactions between doctors and female HIV-positive patients. Attention was focused on the selection of interactional patterns and sequences of actions across the data (see Schegloff 1986; Drew & Heritage 1992). The CA methodology was used to observe speakers' different practices for doing an action, such as question formats. For the analysis of the interviews, participants' accounts were collected and analysed inductively, using the ITA method to generate linguistic observables with consequent social implications.

4.4   Ethical Considerations for the Study

Data collection for this study was officially approved by the local ethics and research committees of select clinics, while patients signed informed consents prior to the data collection. The approval

process lasted three months (i.e., August-October 2015). I was certified for the study with conditions to protect patients' rights and hospitals' rights through anonymity. I was issued two clearance certificates to conduct research at the hospitals, with certificate numbers ERC/2015/12/29/45B and EKSUTH/A67/2014/12/002. The ethics and research committees are composed of medical directors of the federal and teaching hospitals, who hold periodic meetings to decide on the credibility of proposals submitted for research.[9] The consent form states the purpose of the research and invites patients to either approve or disapprove of data collection. Only patients who signed their approval participated in the study. Participating patients were aware of being recorded and gave permission to publish the recordings. Following the specific ethical guideline of this study, the respondents are identified with pseudonyms in the analytical sections.

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[9] The internal ethics committees of both clinics in Ekiti state report that in the previous five years before the approval for the current study was granted, they had collectively approved about 400 proposals for research across various disciplines, while the clinic in Lagos state informed the researcher that they had approved about 150 proposals for research in previous years.

5   Opening Sequences

> "Questions are a powerful tool to control interaction: they pressure recipients for response, impose presuppositions, agendas and preferences, and implement various initiating actions, including some that are potentially face-threatening" (Hayano 2013: 395-396, cf. Brown & Levinson 1987).

> "As long as one is in the position of doing the questions, then in part they have control of the conversation" (Sacks 1995a: 54).

This chapter examines opening sequences in HIV consultations. It focuses on the preliminary questions and the main-business questions, which both entail the main concerns of the consultations. Hence, it discusses the formal and functional properties (social actions) of preliminary and main-business questions in the consultations (see section 2.1.6, P. 28, for a detailed review on the constitution of questioning in mundane and institutional interactions). It also discusses the consequences of the question designs on question-answer adjacency sequences in the opening phases of the consultations and shows how responses are accountably produced after the first pair part of the adjacency pairs, with its underlying implications for medical actions and goals in the HIV context. This chapter relates to the topic of adherence because as we will observe in the data analysis, opening sequences already constitute an adherence-related activity. In the following sections, the notion of "opening sequences" is operationalized. What follows is the data analysis and concluding thoughts on the findings.

5.1   Operationalizing "Opening Sequences"

Normatively, openings in medical encounters are designed to account for patients' presenting concerns as the reason for the visit (Robinson & Heritage 2005). However, these concerns are usually solicited (see Frankel 1995b) in diverse ways, including open-ended opening questions which limits patients' participation (Heritage & Robinson 2006), and those which encourage participation (Webb et al. 2013). For example, open-ended questions such as "What can I do for you today?" and "What's been going on?", establish patients' satisfaction with clinic visits and encourage proper diagnosis and treatment, as against close-ended questions such as "What is the problem?" Schegloff (1986) describes the general opening section of talk in ordinary conversations as when participants establish their identities and, in institutional settings, as when important organizational issues are addressed. In MCA research, opening sequences entail activities which

are influenced by several factors, including patients' visit types (Robinson 2006c). Thus, opening sequences may entail greeting routines (Heath 1981; Robinson 1998) and patients' presenting concerns (Robinson 2006a) among other concerns, and they establish a medically-oriented interaction.

Similarly, in the present study, opening sequences address patients' main reasons for seeking doctors' medical expertise. Therefore, this study operationalizes opening sequences as the start of the main interactional business in the consultations. The phrase "main business" refers to medically-relevant issues in the HIV patients' periodic visits which are evident in the preliminary parts and the first topic slot in the consultations – the opening sequences include preliminary talks which are also medically focused and part of the core encounter. Thus, opening sequences focus on health-related topics, including patients' health-related behaviour, well-being and medical problems. The opening questions occupy the sequential position after greetings and other preliminaries, like seat-taking, have already taken place. The data analysis will show how these "main business" questions are initiated at the start of the consultations by considering their grammatical and epistemic properties. The following specific research questions will be answered:

(i)   What opening question designs are obtainable in the select corpus (question types) and what are their formal properties?

(ii)   What are the grammatical features of the question types?

(iii)   What is the putative epistemic gradient(s) displayed in the contextual functions of the recovered question types?

To describe the prevalent grammatical features for the questions, the most common grammatical marking for "doing" questioning in English e.g. question particles and word order (Hayano 2013) will be discussed. This same principle applies to transcripts translated from NPE and Yorùbá, to English. The principle applies because the final free translations of data in the target language (English) will be used for the analysis. To describe the epistemic gradient and contextual functions of the questions, the analysis will show how questions perform various social actions.[10]

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[10] Due to background noises in the audio recordings, the analysis cannot, unfortunately, account for core prosodic differences in the questions' verbal production within individual consultations.

5.2   The Formal Properties of Opening Question Types

Opening questions are recovered from all seventy consultations (all seventy consultations have opening questions) and they are categorized into three types: Wh-questions, general inquiries ("How are you?" questions) and polar questions. In the corpus, 49% of question types are Wh-questions (n = 34), 44% are formatted as polar questions (n = 31) and 7.14% are "How are you?" questions (n = 5) (see figure 5-1).

Figure 5-1: Distribution of Question Types
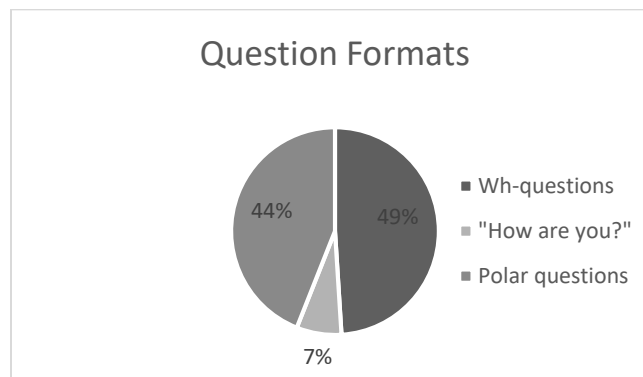
5.2.1   Wh-Questions

Wh-questions (as with all question types) are generally characterized by interrogative words which request information, which all languages are said to have (Dryer 2011b) There are different types of question words for Wh-questions (also referred to as content questions). Question words include "what?", "who?", "where?", "when?", "which?" and "how?" and they perform different interactional functions – "What?" asks for specific information, "Who?" asks about the subject (person or people) that performs an action, "Where?" asks about place or position, "When?" asks about time while "Which?" asks about choice. However, "How?" asks for various things. It may request about manner, condition or quality, extent or degree, distance, length, quantity, quantity, age, reason and confirmation. In the present study, Wh-questions ask "What?" questions about patients' previous CD4 count test results, hospital visits, general health and medical problems.

5.2.2 General Inquiries *("How are you?"* Questions)

"How are you?" questions are designed for diverse types of inquiries, hence the ambiguity in its formal characteristics and consequent interactional action(s). Due to its various uses in the present study, "How are you?" questions are designed for diverse types of inquiries, hence its functional ambiguity. Thus, "How are you?" questions are discussed separately.

5.2.3 Polar Questions

Polar questions topicalize patients' general health, medical problems and regular CD4 count tests. The questions are designed for a *yes* or *no*-answer and they make either a *yes*-answer or *no*-answer relevant (see Boyd & Heritage 2006; Raymond 2003; Heritage & Clayman 2010; Heritage 2010). Much more than Wh-questions, they constrain responses by inviting the respondent to affirm or disaffirm a "candidate proposition about a matter, thus, setting the terms within which the response should be constructed" (Lee 2013: 423; cf. Heritage & Raymond 2012). Citing the vast research on questions in interactions, Hayano (2013) states:

> Polar questions typically display the speakers' preference for one of *yes, no* answer and answers that converge with that expectation are preferred over those that do not (2013: 405).

Invariably, polar questions work within the preference system which set "binary possibilities for what their recipients do in response" (Hayano 2013: 404). Specifically, it prefers affirmative over dis-affirmative responses. In the present study, polar questions generally request about patients' health, though with varying lexical choices and topic focus. Linguistic forms for asking the questions include "*Any X?*" questions and statement questions. In terms of topic/content, questions may be either be "Health-Oriented" or relate to patients CD4 count tests. Table 5-1 shows the distribution of polar question categories and their grammatical constructions, as proposed by Heritage (2010).[11]

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[11] The polar questions are specific to the present study. However, I have adopted Heritage's (2010) terminologies for describing their grammatical constructions.

Table 5-1: Grammatical Construction of Polar Questions in HIV Consultations

Polar Question Types	Social Actions	Sample Questions	Grammatical Construction	Preference Organization
"Health- Oriented" Questions	Well-being question	"Are you healthy this morning?	Positively Formulated "Straight" Interrogatives.	Preferring "yes/no" answers
"Any X?" Questions	Problem-oriented question	"Any Problem?"	Positive Interrogative + Negative Polarity Item "Any".	Preferring "yes/no" answers
Statement Questions	Problem-oriented question	"Hope there is no problem?"	Positive Assertion + Positive Polarity Item: "Hope".	Preferring "no" answers
CD4 Count Questions	Health behaviour-related question	"Have you done your CD4 count test?"	Positively Formulated Straight Interrogative.	Preferring "yes/no" answers

The table shows how each question type is grammatically designed to solicit unknown information in the select consultations by establishing preferences for a yes or *no*-answer (Heritage 2010).

5.3 The Functions of Opening Questions

The three question types have four broad categories in terms of their social actions: health-behaviour questions, questions about patients' well-being, general inquiries and problem-oriented questions. Hence, question types may have similar social actions – the data analysis would focus more on these social functions of questions, than their form. The formal topic focus of the 70 opening questions are distributed into the following categories in terms of their social actions: health-behaviour questions (28.57%; n = 20), "well-being" questions (31.42%; n = 22), problem-oriented questions (32.85%; n = 23) and general inquiries "How are you?" questions (7.12%, n = 5). This distribution shows that problem-oriented questions are prioritized, giving its highest frequency. This ranking is followed by well-being questions, health-behaviour questions and "How are you?" questions (see figure 5-2). "How are you?" questions (7.14% of the corpus; n = 5) have dual functions: general inquiry and problem solicitation.

Figure 5-2: Distribution of Questions' Functions

▤ Frequency	General Inquiries	Health-behaviour questions	Well-being questions	Problem-oriented questions
	5	20	22	23
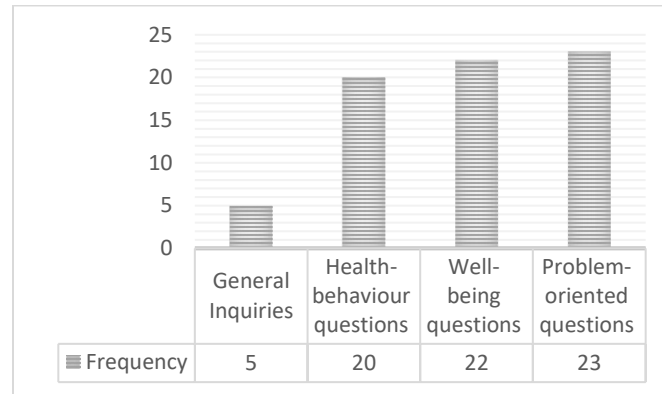
The functional properties of these question types often show participants' intersubjective actions that do not only raise the specific issues mentioned above (see Heritage 2003a, 2010) but also convey significant presupposition features in consultations. Besides generally requesting and obtaining information, questions are designed in such a way that when consultations open, doctors and patients work to establish latent presuppositions about doctors' expectations from patients regarding their chronic illness (HIV). These presupposition features, therefore, inform how opening questions start to set agendas that focus on core concerns for the chronic routine patients' visits. I will discuss the questions' functions in turn.

5.3.1 Up-dating about Health-Related Behaviour

In the consultations, Wh-questions up-date about patients' health-related behaviour by requesting information on patients' medical histories of CD4 count tests, clinic visits, drug-collection and drug use. The questions' topic focus will be discussed simultaneously because their realization in the data are interdependent: from my observations at the select research locations, and as evident in the data, HIV patients who visit the clinic to collect ARV drugs and other prophylactic drugs, often orient to the clinics' institutional tasks which involve documenting patients' regular CD4 count test results, as well as regular drug collection on clinic visits, and checks for correct drug use. In other words, patients habitually do CD4 count tests to check if their ARV drugs have been used correctly in terms of significantly reduced viral loads. However, CD4 count tests are only done when patients regularly visit the clinics where they are registered, at the due time, for renewed drug prescriptions. Thus, discussions on opening questions which border on CD4 count tests

cannot be isolated from opening questions on "visit-times", drug collection and drug use. These topic foci are often initiated with the question word "When?" and they solicit similar types of response designs. The consultations typically begin when doctors address the main business of the visit by observing patients' medical records and soliciting other types of information about their medical histories with the adjectival phrase "When last?", for example, Extract 5-1. Here, the consultation starts when the doctor invites the patient to sit and calls her name (X) (line 01). This is followed by a nonverbal action (writing), after which the doctor self-selects a turn, calls the patient's name again (X) and produces the opening question (line 02).

Extract 5-1: *"When last did you do CD4 Count?"*
```
01    Doc: sit down X (.)
02         <<writing> X? when last did you do cee dee four count>
03    Pat: (.) like::: last year (unintelligible, appr. 2 sec)
04         (--)
05    Doc: who tell you make you no do cee dee four count  ← FUQ 1
           who told you not to do cee dee four count
06    Pat: (         )
07    Doc: hm :::
08         (0.2)
09         <<pp> so na dat time you go do am>
                 so it that time you went did it
                 so that was when you did it
10         so na which time you come here last  ← FUQ 2
           so it which time you come here last
           so when last were you here
```

The opening question "When last did you do CD4 count?" (line 02) is grammatically set to interrogate, especially since it explicitly foregrounds the question particle "When?". It starts a history-taking activity by asking about the specific dates of the patient's previous CD4 count tests. When the patient responds (in line 03), she provides the solicited information with audible and inaudible responses. However, in subsequent turns, the doctor continues the history-taking activity by asking follow-up questions (in the following: FUQ) at lines 05 and 10; up-taking on the patient's response (in line 03) and confirming the initially solicited information on her previous CD4 count tests. The FUQs relate to the opening questions by content and they also contribute to the action performed by the opening question. Thus, at FUQ 1, the question "Who told you not to do CD4 count?" asks about a third party who may have influenced her decision not to have done the CD4 count test as recommended. FUQ 1 indicates that the patient may have stated a specific time when her last CD4 count test was done, hence, it suggests the content of the patient's inaudible response.

FUQ 1 is followed by another inaudible response and an elongated assessment by the doctor. After a 0.2 seconds break (line 08), during which the doctor is again, probably studying the medical record, he utters a declarative statement which expands his assessment of the patient's inaudible response at line 06. In line 10, the doctor, yet again, asks an information question "So when last were you here?" – a reformulation of the opening question.

Giving its turn design, sequential organisation and organisation of actions in proceeding sequences, the opening question, though formally structured as an information question, appears to be rhetorical. First, the doctor asks the opening question immediately after probably reading her medical record (the short pause at line 01) and writing his observations (line 02). This suggests that he already had prior knowledge of her history of CD4 count tests before asking the question – recommendations for CD4 count tests at previous visits are usually recorded in patients' medical records. Thus, the question appears to confirm the already accessible information from the medical record because the doctor's subsequent turn with FUQ 1 "Who told you not to do CD4 count?" (line 05) precisely shows that CD4 count tests have not been taken in more recent times, suggesting that the patient has been nonadherent to recommendations of regular CD4 count testing. Usually, CD4 tests are recommended to be taken every six months (not visible in the encounter) but the patient here, had done it "last year" (at least eight months before this consultation). FUQ 1 also suggests that the patient has transferred her personal responsibility to maintain adherence to a someone else. Further evidence of the opening question's epistemic gradient (regarding the patient's possible nonadherence) is located at the turn design of FUQ 1. With the patient's silence at line 04, the doctor has the initiative floor to ask more questions. Therefore, he pursues his topical interest by framing FUQ 1 with the question word "who?", to initiate a repair which is targeted at fixing and resolving the patient's silence. The question word indicates which part of FUQ 1 may be responded to and repaired by the patient. Consequently, FUQ 1 challenges and accuses the patient – it pursues the topic focus of the opening question by suggesting that a third party had influenced the patient's decision not to adhere to medical recommendations. It also discloses an explicit orientation towards adherence, in contrast to the opening question.

Following FUQ 1, the patient's response to it (line 06), and the doctor's assessment of her response with a recipient signal (line 07) and reassurance question (line 09), the doctor continues to pursue the topical agenda for the opening question with an uptake – he uptakes the patient's response to his assessments as a cue for reformulating another question that borders on the same

solicited information (FUQ 2, 10). His uptake suggests that what appears to be an initial solicitation of unknown information with the opening question does not align with what the doctor subsequently does with FUQ 1 and 2. By uttering the FUQs, the opening question served to update about a health-related behaviour though the patient's response suggests that she takes it to be a genuine request for information. Stivers and Rossano (2010) refer to this situation as a "recipient-titled" knowledge where speaker A may hear speaker B's utterance as an information question rather than a request for confirmation. Also, the opening question relates to health behaviour by showing that the doctor and patient are socially distant. For example, the doctors' no-offer for mutuality and informality may be evident from the start of the consultation and this suggests that they present interests on medically-relevant topics. The directive at line 01 and the opening question at line 02 suggest that when doctors up-date about health-related behaviour, they may do so in the service of assuming a business-like stance, especially giving the specific question that was asked in extract 5-1 and the way it was asked i.e., simultaneously and subsequently with the action of writing on the patient's medical record.

This same semantics of questioning, in up-dating about health-related behaviour through "recipient-tilted" orientation of opening questions is evident in other examples in the corpus. While Extract 5-1 suggests that the opening question requests confirmation of an already known information from the patient, Extract 5-2 presents a more overtly stated request for confirmation.

Extract 5-2: *"When last did you do CD4 Count?"*
```
01   Doc: good morning madam are you mrs x?
02   Pat: yes
03   Doc: you can sit down ma
04        when last did you do CD4 count?
05   Pat: ehm:::i was doing ( )
06   Doc: madam you have not done CD4 since 2013
07        true or false?            ←—— FUQ
08   Pat: (.) [it should be:::  ]
09   Doc:     [TRUE or false ma?] ←—— repeated FUQ unit
10   Pat: it should be last year
```

Here, the consultation begins with greetings and a "recognitional reference" (Sidnell 2010: 124) "Good morning madam, are you Mrs X?" (line 01). The patient responds affirmatively and is invited to take a seat. With the first topic slot "When last did you do CD4 count?" (line 04), the doctor begins to initiate a history-taking activity by asking about the dates of her previous CD4 count tests. And at line 05, the patient begins to respond to his question by first, "doing thinking"

with an elongated hesitation marker "ehm :::" and thereafter, producing an account that ends with an inaudible utterance "I was doing…". The doctor subsequently uptakes on her response "Madam you have not done CD4 since 2013, true or false?" (FUQ in lines 06 and 07) before the patient eventually responds to the opening question in line 10. The FUQ offers suggestions on how the opening question may be contextualized: the patient is directly accused, through an affirmative statement (line 06), of not taking her CD4 count test in the last 2 years prior to this consultation. This accusative action is first evidenced (in line 01) by the greeting sequence and "person-reference" (Sidnell 2010: 124) which shows that the doctor has read the patient's medical history (he refers to her by name to confirm that she is the next person on the queue to see the doctor)[12] and asks the opening question to confirm the information annotated in it.

Thus, before the opening question, the doctor already had access to her medical history and he displays this knowledge of her identity and medical history by initiating a FUQ (lines 06 and 07) and repeating the second unit of the base first pair part of the FUQ (line 09). The second evidence of the accusative action performed by the opening question is informed by the turn design of the FUQ – the FUQ is an assertion that already responds to the opening question, hence, its function as a rhetorical question. The function (as the main job of the turn) is thus an accusation, not a question (or a request for information). Furthermore, the repeated second unit of the FUQ "true or false ma?" projects the patient's delay (in line 08) as a repair mechanism for uttering a dispreferred response. The repeated unit also "challenges the adequacy, accuracy or plausibility" (Sidnell 2010: 130) of what the patient had previously said. Consequently, the doctor's utterance overlaps the patient's response in order to pursue his request for an answer and disagree with the projected dispreferred turn. The third evidence for the function of the opening question is located in the patient's response designs. The patient's elongated "ehm:::" (line 05), delay and elongated turn ending "it should be:::" (line 08), and repetition of turn component (line 10) are all indicators of the patient's self-initiated self-repair which identifies the opening question as a trouble source which must be properly understood and contextualised before an appropriate response is stated. This response is designed to offer a stative explanation using the modal auxiliary verb "should"

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[12] In Type II clinics settings (as discussed in section 3.4.1, P. 53) all patients are required to consult with the doctors regardless of having new medical complaints. In this scenario, nurses and other medical personnel who conduct preliminary examinations before patients see the doctors, will normally take patients' attendance and pile up their medical records on the tables of doctors on duty. Since patients must queue and take turns to see the doctors, the latter sometimes call patients by their names before proceeding with the consultation.

i.e., "It should … be last year (lines 08 and 10). What is probably more interesting is that the patient does not shift the direction of her response despite being interrupted by the doctor's accusation. This response design indicates that the more explicit the accusative action (a form of reproach) on the doctor's path, the more explicit the defensive action by the patient (a form of justification). It also evidences that the doctor employs this strategy i.e., an explicitly accusative request for affirmation, to dissociate the patient from a more passive response to his questions. The opening question, therefore, engenders the prototypicality of its design as up-dating about a health-related behaviour for this encounter because the patient's response displays some troubles, which explicitly comes through in the next sequence.

Note that like extract 5-1, the opening question here shows that doctors and patients establish social distance. The doctor does not allocate turns to the patients after the first greeting. Furthermore, the opening question poses an overtly stated superior institutional authority on the path of the doctor. The doctor displays what I term "professional hierarchy". First off, he wields the informative power accessible to him from her medical records and establishes himself with the superior authority to ask about her medical history, particularly her previous CD4 count tests. With a louder and raised pitched utterance "true or false ma?" (lines 09 and 07 respectively), he further invites her to attest to the truth value of the information he is already knowledgeable about. These culminate into the vivid possibility that the opening question, with its attendant accusative statement, establishes the doctor's power and authority to request information from the patient. It further reveals that the sequential activities which surround the opening question place a conflicting social and institutional role on the patient, who is rather misplaced on how to relate with the doctor. The patient's responses to the opening question are quite interesting for analysis. From my observation of doctor-patient relationship in South-western Nigeria, the doctors habitually display their professional hierarchy, both to establish their professional authority, and to engage patients in taking more active roles in assuming responsibility for their general wellness. Hence, the doctors' professional authority is already oriented to by the participants. This reinforces how they manage their social and institutional relationships.

Another evidence for the function of Wh-opening questions in up-dating about health-related behaviour is observed when the questions request for information about a patient's previous dates of drug-collection from the clinic. By asking about dates for drug-collection, the doctor is implicitly asking about a previous clinic visit because drugs are only collected when patients visit

the clinics regularly for the routine check-ups. Thus, these consultations show that the health-related behaviour questions direct the focus of consultations to the expectation that patients should visit the clinics regularly for drug collection. This evidence is premised on doctors' requests for the last time a patient collected her ARV drugs. In extract 5-3, for example, the doctor starts by inviting the patient into the consultation room and offering her a seat (line 01). After a 0.5 seconds break (line 02), the opening question and its subsequent turns show that both doctor and patient orient to the association between visit-times and drug collection – the doctor first uses the adjectival phrase "When last?" (Cf. Extract 5-1 and Extract 5-2) to ask the patient about the last time she collected her drugs (line 03).

Extract 5-3: *"When last did you collect drugs?"*
```
01    Doc: just come in and sit
02         (0.5)
03         when last did you collect drugs?
04    Pat: about two months ago
05    Doc: so any problem?
06    Pat: i feel ehm:: tired
07         the thing will be hurting me
08         small small small small
09    Doc: ok
```

In this example, the patient's response is satisfying for the doctor in terms of adherence / adequate health management; so, he goes on with history-taking without accusing the patient. Following the opening question, he solicits the patients' complaints with a complaint solicitation question (line 05). The question appears to be another history-taking question which is problem-focused (rather than focused on health-related behaviour like in line 03). It shows that the doctor focuses on the patient's problems after having checked if there is an adherence problem. It also addresses the main concern for the visit. Thus, at line 02, he had read her medical record (0.5 seconds break) before beginning the next question with "so", an inferential marker (Blakemore 1998) which infers from her first response as a basis for the complaint-solicitation question. Evidently, the opening question is asked after a 0.5 seconds' break (line 02) where the doctor should probably be going through the patients' medical records. This break separates the activity that occurs in line 01, (i.e., the doctor inviting the patient into the interaction floor/consulting room) from the start of the main business. By its sequential embedding, the opening question indicates the first topic slot that proffers the first topic of interest for consultation, which will be followed by the second part of the core interactional concern i.e., the second complaint solicitation question. However, both questions

at lines 03 and 05 depict the two main sources for addressing the core purpose for clinic visits, and both questions strategically ask the patient about the core medical aspects of the consultations (the interactional functions of the polar question "Any problem?" will be treated in more detail in proceeding subsections of this chapter). In response to the drug-related interrogative question, the patient offers an explanation that borders on her drug collection (line 04). Responding to the complaint-solicitation question, she states a medical concern (lines 06-08) and the opening sequence ends with the doctor's minimal assessment "ok" (line 09).

Extract 5-4 shows the same question resource for topicalizing a health-related behaviour regarding specific dates. The opening question is asked after a 0.3 seconds' break (line 04) which indicates the end of the preliminary part of the consultation (lines 01- 03) and the introduction of a first topic slot. Here, the opening question implicitly relates to a health behaviour.

Extract 5-4: *"When did your drug finish?"*
```
01   Doc: where is your file=
02        =where is your weight
03        <<all> drop it sit down>
04        (0.3)
05        when did your drug finish
06   Pat: what happened is that they wrote:::
07        it's been a while
08        i will collect another one
09   Doc: where is it              ←─ FUQ
10   Pat: it is finished
```

Note that the opening question is prefaced by preliminary questions in multiunit turns – while establishing his agenda, the doctor does not leave allowance for the patient to respond to his questions about her medical file and weight[13] before moving on to the core concern for the visit i.e., her previous visit-times. The patient responds by offering an account on what had occurred with an elongated turn ending "What happened is that they wrote:::" (line 06), only to abandon the account in favour of stating previous visit-times and her intention to collect another prescription from the doctor "It's been a while… I will collect <u>another one</u> (i.e., <u>another prescription</u>) (line 07-08). And, when he asks when her drug finished (line 05), both participants do not engage in a thorough interactional work[14] to orient to the doctor's history-taking agenda. This tendency for no-

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[13] The institutional task at the select clinics does not usually involve a direct contact of the patients with their medical records (see section 3.4.1, P. 53).

[14] What may further account for this no-interaction work is that both the doctor and patient are working with a shared epistemic status about the patient's state of health and medical history. When the doctor requests for her medical file (medical records) and weight, and asks her to drop it and sit down, his utterances show that sometimes the patients

interaction work engenders the assumption that the visit-time question also requests to confirm already known information because it holds the patient accountable for the use of HIV and non-HIV prescribed medications.

Notably, the participants display their understanding of institutional roles by uttering conforming responses to the opening questions. In this extract, the doctor asks closed, narrow-focused questions in a repetitive way (in lines 01-03) before the opening question (line 05). Afterwards, the patient starts to respond to the opening question and finishes her turn with a lengthening "What happened is that they wrote:::", after which she immediately abandons her statement in favour of another attempt to respond "It's been a while I will collect another one" (lines 05- 06). Her reference to "they" (line 04) refers to the clinic's pharmacy where patients routinely queue to collect their ARV drugs and other drugs after it has been prescribed by the doctors. Both interlocutor locally manages this reference i.e., "they" without any communication breakdown: by the opening question, the patient orients to the doctor's set interactional agenda as a request for information concerning the last time she visited the clinic to receive her drug prescription and collect her ARV drugs from the pharmacy. Interestingly, at lines 09 and 10, the participants' anaphoric "it" means different things. The doctor's turn "Where is it?" (line 09) is an uptake on the patient's expanded explanation for his opening question. Since she does not immediately answer his question about when her drug finished but begins to talk about a prescription from the pharmacy, the doctor asks about "it" (the prescription), while the patient now responds to the opening question "It is finished" (line 10). This buttresses how the participants locally manage the referents and presuppositions from their interaction.

Another practice for topicalizing a health-related behaviour occurs when a doctor asks a patient when she last saw a doctor as in extract 5-5. Here, the consultation begins with person-reference (line 01), which ensures that the patient's name tallies with the name on her medical records. After the patient utters an inaudible response, she is invited to take a seat (line 03). At line 04, the routine business of taking the patient's history opens the core medical purpose of the encounter. The opening question interrogates the patient's previous visit to the doctor's. The same phrase that was examined in extracts 5-1 to 5-3 "When last?" resurfaces here once more – the question asks for statistical details of the patient's last visit to see a doctor.

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can also access their medical records and probably observe its contents. Hence, both participants have access to the same information from the medical records.

Extract 5-5: *"When last did you see a doctor?"*
```
01   Doc: what's your name ma
02   Pat: ( )
03   Doc: ok have a seat ma
04        when last did you see a doctor
05   Pat: on the 8th
06   Doc: 8th of when    ←—— FUQ
07        (.)
08        ehn?
09   Pat: last month
```

The first question (line 01) displays non-knowledge about the recipient. It starts a preliminary sequence that checks for the patient's identity as a precondition to begin the consultation. After the preliminary sequence, we may observe that the opening question is uniquely designed by its lexical choice. The indefinite article "a" referring to "a doctor", initially suggests non-specificity about a doctor because it may refer to any doctor at an outpatient clinic, who may have been consulted by the patient in the recent past. However, it is common knowledge between the participants that patients cannot visit an outpatient clinic where they have not been registered (not shown in the extract). Hence, "seeing a doctor" is contextualized as visits to this specific clinic, to see a doctor for follow-up visits. Thus, giving its recipient design, the opening question is specific in its reference to a medical practitioner because both participants orient to the knowledge that the patient is HIV-positive and is registered for care at this specific clinic. Responding to the opening question, the patient produces a visit-oriented response "On the 8th (line 05). Subsequently, the FUQ (line 06) expands the patient's reply by soliciting a more specific response. More interestingly, the FUQ is followed by a minimal pause in which the patient is silent and does not take a turn. Projecting a trouble source in the patient's silence, the doctor produces a minimal open-class repair initiator "ehn?" (line 08) which "does not locate any particular repairable component" (Sidnell 2010: 117) because the patient can easily identify the repairable item as the FUQ. In line 09, she responds to the FUQ in more detail "last month". Evidently, the participants could parse the function of the opening question as a request for confirmation, giving that it asks about the patient's specific previous visit-times despite the shared knowledge that this information has been pre-recorded in the medical records.

As previously examined, Wh-questions that topicalize patients' visit-times and CD4 count testing, orient to a health-related behaviour. Similarly, polar questions may up-date about health-related behaviour when it asks about patients' regular CD4 count testing. The question is grammatically constructed as positively formulated straight interrogative, referring yes/no

answers. In extract 5-6, for example, the consultation begins with greeting sequences (lines 01 and 02), followed by the patient's presenting concerns (lines 03 and 04), person-reference question (lines 05-06) and a pause (line 08) before the doctor turns to business (line 09). The person-reference and information question "Are you not the one who was admitted but discharged against medical advice?" prefaces the opening question and submits a strong contextualization force for the opening question.

Extract 5-6: *"Have you done your CD4 count test?"*
```
01   Doc: good morning
02   Pat: good morning
03        <<pp> please doctor=
04        =i want to: complain about this cough>
05   Doc: are you not the one who was admitted
06        but discharged against medical advice
07   Pat: yes i am the one
08        (0.6)
09   Doc: have you done your cee dee four count test
10   Pat: yes i did it the last time i came
11        they said the test result is ready
12   Doc: ok
```

Intersubjectively, the opening question is an uptake on preceding sequences in lines 01-08 because the doctor clearly asks about the CD4 count tests due to the presupposition that the patient is nonadherent to drug use. It posits opposite interactional trajectories when compared with Wh-questions on CD4 count tests (see extract 5-1 & 5-2). The opening question is not produced for confirmative requests but to investigate the patients' adherence status – after all, it has been established that she discharged herself against the doctors' advice. Thus, here, the question functions for information solicitation purposes. The doctor may be kin to recover the patient's reasons for deciding to discharge herself from the hospital without taking the proper permissions to do so. Hence, when she presents a concern about a cough, the opening question launches the doctor's interest in discovering whether she has now become responsible towards ensuring her own wellness or not. This interactional trajectory (i.e., up-dating about health-related behaviour) is made relevant to the patient who produces a *yes*-answer and an additional information about test results (line 11). The extract shows that polar questions are interactionally relevant in highly contextualized consultations, where doctors request information on patients' adherence to treatment recommendation. Giving the characteristics of the question in preferring a *yes*/no

answer, the extract also indicates that the question provides affordances for the patient to account for her actions, at least when she initiates a turn to do so.

In summary, extracts 5-1 to 5-6 show that opening questions are information solicitors and they function to up-date about patients' health-related behaviour in the opening phases. This observation is made evident by the sequential location of the opening questions, their turn designs, patients' response designs and the intersubjective actions of the proceeding FUQs in subsequent turns. The questions are preceded by a person-reference or a pause after greeting sequences, which indicate that the doctor had access to the patients' medical records and its information before opening the main business. Furthermore, the opening questions are often followed by at least one FUQ which pursues and enforces the opening question's agenda – suggesting that patients' initial responses to the opening question may not be satisfactory and is disagreed with, in some cases. Lastly, patients respond to the opening questions and subsequent FUQs with either silence, delays at turn initials or with prolonged turn endings, suggesting that the opening questions (as in extracts 5-1 and 5-4), the FUQ (as extract 5-5) and a combination of the opening question and the FUQ (as in extract 5-2) are trouble sources that required other-initiated repairs. Alluding to this phenomenon, Sidnell (2010) states: "repair mechanisms are a digression from the action that that talk otherwise implements" (2010: 114). Thus, patients' response designs stall the current action from taking place when opening questions were accusative and "potentially face-threatening" (Hayano 2013: 395-396).

5.3.2 Soliciting Information on Well-Being

Wh-questions which focus on patients' health engender a different type of interactional function – they solicit information on patients' well-being. Patients orient to these well-being questions, either as starting the main interactional business or as part of the greeting sequences. I observed some noticings when opening questions explicitly focus on patients' well-being. The first observation is that the sequential organisation of the question contributes to how it is oriented to. Secondly, when this question type is framed with the direct question on health i.e., "How is your health?", it accommodates different orientation for the patients as against when it is indirectly framed as "How do you feel?". Thus, the lexical choices for the well-being questions are instructive for analysis.

To discuss the first observation, when "How is your health?" is asked immediately after greeting sequences, the patient may orient to it as a "How are you?" greeting as is obtainable in the context of mundane interactions. In extract 5-7, for example, the greeting sequences at lines 01 - 02 present the first activity, which sets off the consultation on an informal basis.

Extract 5-7: *"How is your health this morning?"*
```
01   Doc: good morning o:
02   Pat: good morning doctor
03   Doc: how is your family
04        how is your health this morning
05   Pat: fine
06        but i usually have aches in my side
```
At line 01, the doctor greets the patient "Good morning o". This mode of greeting features the Nigerian English usage where the greeting and its discourse marker "o" function as phatic communion, a phenomenon which (Enyi 2015) refers to as "constituting the beginnings and endings of conversation" in Nigerian English usage and "functioning to secure attention, agreement and solidarity with the listener" (2015: 47-48). The doctor offers greetings, while the patient responds accordingly with a second pair part of the greeting sequence "Good morning doctor" (line 02). At line 04, the doctor sets an agenda for the consultation with multiunit turns which ask the patient about her family and her health. In response, the patient states "fine" (line 05) and proceeds to state her complaints with a subordinating conjunction "but" (line 06), which "links the talk it prefaces to an earlier line of talk and connects to the immediately preceding unit" (Mazeland 2013: 482). After the opening question in line 04, the consultation progresses in a way which establishes that the opening question offers mutuality to the patient (especially since it is asked in the same sequential environment with the greeting sequences) and requests about the patient's medically-relevant state of health. However, the patient orients to it as a greeting for enquiring about her general well-being. An indication of these varying orientations is the multi-unit turn "how is your family, how is your health this morning*?"* (lines 03 and 04) which simultaneously functions as an extended greeting "how is your family?" and as the first pair part of the main business question "how is your health this morning?" The main business question is designed with specificity "this morning" in its request for the patients' medical health, but the patient responds with "fine" (line 05) to both questions. Then, she proceeds to contrast her condition of fineness with a "pro-forma agreement" (Sidnell 2010: 79) which states a medically-

relevant complaint "fine but I usually have aches in my side" (lines 05-06). Her response attributes a dual function to the question i.e., both as a greeting and complaint solicitation.

In extract 5-8, we see another example of varying orientations for "How is your health?" opening questions. The question solicits information about the patient's health, although the patient interprets it differently. Here, the doctor opens the consultation by initiating the first pair part of a greeting sequence with a greeting question "How is your home?" (line 01) and immediately proceeds with a health-related question within the same turn "How is your health?" (line 01). Giving that no turn is allocated for the patient to respond to the first greeting question before the next question is asked, the patient responds to both questions as a Yorùbá greeting routine (cf. extract 5-6). Hence, her "very well" (line 02) response is the second pair part of the greeting sequence.

Extract 5-8: *"How is your health?"*
```
01    Doc:  ile nko
             how is your home
02          bawo lara
             how is your health
03    Pat:  alaafia
             very well
04    Doc:  se kosi ti e fi bewa wo o
             is there a reason you have come to see us
05          ki lo n sele
             what is happening
06    Pat:  mo nya igbe
             i have diarrhoea
07          = mo legbo lenu
             i have sore in my mouth
08          mi o le jeun
             i can't eat
09          ara tun n ro mi eti n yun mi
             my body aches and my ears itch
```

However, the doctor re-asserts his topical interest at the third turn with reformulated opening questions "Is there a reason why you have come to see us?" "What is happening?" (lines 03 – 04). These double question forms solicit new information and begin the main business and in response to these FUQs, the patient states her medical complaints (lines 05-09).

Extract 5-9 further expatiates on how the participants mean different things in their interpretation of well-being questions. In line 01, the doctor asks the opening question with the same interrogative format and sequential positioning as extract 5-8 while the patient, likewise, offers a minimal affirmative response "It is good" (line 02).

86

Extract 5-9: *"How is your health?"*
```
01    Doc: ile nko bawo lara
           how is your home how is your health
02    Pat: dada ni
           it is good
03         (.)
04         sir nkan ti mowa ri yin fun ni wipe
           sir what i came to see you for is that
05         atigba ti moti ni miscarriage
           since i had miscarriage
06         mi ori period mi mo
           i did not see my period anymore
```

The opening question is designed differently in this case: the doctor refrains from either taking another turn or constructing further interaction work to establish the purpose of the opening question. Both doctor and patient observe a break (line 03), after which the patient self-selects a turn that orients to "How is your health?" as a solicitation of her state of health and, in lines 04 – 06, she states her complaints.

In contrast to what occurs in extract 5-7 to 5-9, extract 5-10 shows a marked distinction between the greeting sequences in lines 01 and 02 and the first topic slot for the main business of the visit (line 03). The patient responds to the doctor's greeting with the second pair part of the greeting sequence "Good morning thank you sir" (line 02) and, at line 03, the doctor opens the main business by soliciting her health-status: "How is your health this morning madam?". This temporal specification explicitly contextualizes the institutional function of the question.

Extract 5-10: *"How is your health?"*
```
01    Doc: epele ma
           greetings madam
02    Pat: ekaro ese sir
           good morning thank you sir
03    Doc: bawo lara yin leni madam
           how is your health today madam
04    Pat: o fair sir
           it is fair sir
```

Extract 5-11, likewise, distinguishes between the greeting sequences (lines 01 - 05) and the first topic slot (line 06). The separation between greeting sequences and the first topic slot sets a distinct interactional agenda for the "How is your health?" question and equally clarifies the agenda for the patient's response. After the opening question is asked, the patient takes a turn, which explicitly states that she has come to the clinic because she has complaints "I have come because I have complaint" (line 07*).*

Extract 5-11*: "How is your health?"*
```
01   Doc: ekaro
02        good morning
03        (.)
04        eku ise
          greetings to you
05   Pat: ekaro
          good morning
06   Doc: bawo lara
          how is your health
07   Pat: moni complaint naa mi mosewa
          i have come because i have complaint
```

More interestingly, she specifically refers to her health – her statement at line 07 presupposes that she is not in good health because if she was, she would not be at the clinic. Hence, the participants orient to cordial institutional and personal roles: the greeting sequences are formatted for ordinary conversations and the interlocutors leave allowance for the each other, to take a turn at the adequate TRP. This sequential positioning for "How is your health?" opening questions, therefore, establishes the argument that it plays a significant role in providing constraints for how patients orient and respond to it, either as a solicitation of health status or as part of the greeting sequence. Since the patient does not return the "How is your health?", it suggests the institutional asymmetry of the greeting initiative.

As earlier mentioned, "How do you feel?" opening questions equally solicit information on patients' health status. However, the questions are oriented to, more specifically as a request for medically-relevant concerns. In extract 5-12, the consultation begins with greeting sequences (lines 01-03) after which the doctor proceeds to confirm the patients' identity (lines 04-05). Subsequently, the "How do you feel?" question occupies the next turn unit and receives an explicit response from the patient "That is why I came" (line 07).

Extract 5-12: *"How do you feel?"*
```
01   Pat: e n le sir
          greetings sir
02   Doc: e n le ma
          greetings ma
03   Pat: epele sir
          well done sir
04   Doc: oRUko YIN  madam
          YOUR  NAME madam
05   Pat: (X)
06   Doc: BAWO le se n feel?
          HOW do you feel
```

```
07    Pat:  <<p> nkan to gbe mi wa niyen>
             that is why i came
08    Doc:  o:k
```

The patient's response to the well-being question suggests that she orients to the question as a solicitation of her complaint, or at least, of her state of health. This is probably due to the lexical choice "feel" which attributes more to bodily feeling than the more general and diverse "health term" (Robinson 2006a). In the Yorùbá lexicon, the word '*health*' translates as '*body*' and posits the right of ownership, a bodily existence that touches on several issues, including morality and privacy. Therefore, the state of the *body* in the Yorùbá socio-cultural space is a sensitive cultural issue which others may not readily gain access to and can only be accessible to its owner. Her orientation to the question is also premised on its sequential positioning – it is clearly distinguished from the first topic slot because it occurs after the greeting routines in lines 01-03 and the identification question and response in lines 04 and 05 are already completed. This orientation is consistent in other examples in the corpus. In extract 5-13, the phatic communion sequences at lines 01 - 06 are also sequentially separated from the first topic slot (line 08). Here, both participants locally manage their interaction: each participant takes a turn at their appropriate TRPs. At the 10 seconds' pause, the doctor is probably looking through her medical records to briefly study her illness history before turning to the main business for the consultation.

Extract 5-13: *"How do you feel?"*
```
01    Doc:  e n le ma o epele
             greetings o madam hello
02    Pat:  yes: sir
             thanks sir
03    Doc:  o da wipe emi ni mo attend siyin last week
             i think i am the one who attended to you last week
04    Pat:  beeni
             yes
05:   Doc:  ile nko o
             how is your home
06    Pat:  gbogbo eyan wa
             everyone is fine
07          (0.10)
08    Doc:  bawo lese feel
             how do you feel
09    Pat:  daada ni sir
             well sir
10    Doc:  iyen naa da
             that's good
11          (.)
```

```
12        and your drugs?
13   Pat: they are here with me
```

The patient treats the pause at the end of the greeting sequences as an indication that a new turn or topic has started and therefore orients her "well sir" (line 09) as a response to the main-business question. At line 10, the doctor jointly accomplishes the complaint solicitation action of the main-business question by offering a "good" assessment of her "well" medical condition. Note that this assessment is only exclusively offered after the main-business question and not for the greeting questions that preceded it. What follows in lines 11 to 13 evidence that the main business continues when the doctor pauses to probably read her medical record (line 11), and ask about her drugs, while the patient responds, "they are here with me" (line 13). By responding this way, the patient gives an indirect proof of adherence, i. e. that she has the drugs with her – another example that shows how patients orient to adherence talk in the opening phases.

When polar questions solicit information on patients' well-being, the data shows that these questions focus on their general welfare and HIV 'health'. Extract 5-14 situates this context. Here, the opening question (line 01) does not immediately elicit a "yes" response from the patient. Rather, the patient gives an account of having Malaria (line 02). Afterwards, the doctor's minimal next turn "ok" (line 3) shows that he understands her response as an opportunity to present her complaints.

Extract 5-14: "*Are you healthy this morning?*"
```
01   Doc: se  ara yin  mokun laaro yii
          is  body-NOM your healthy-COMP morning this
          are you healthy this morning
02   Pat: uhm:::  malaria yii  nikan ni
          malaria-NOM    this only it-APP is-AUX
          it is only this Malaria
03   Doc: ok
```

On the agenda for the question, the doctor's lexical choice "healthy" in the opening question "Are you healthy this morning?" (line 01) requests information about both the patient's health and medical problems or complaints. However, the term entails a larger scope of presupposition in that the patient is expected to be healthy and has not visited the clinic with medical problems or complaints. Responding to the opening question, the patient orients to this expectation by mitigating the severity of her complaint when she designs it as an "*only*-compliant" (Webb et al. 2013) "It is only this Malaria" (line 02). Her response further orients to the presupposition and social action conveyed by the opening question, which is especially marked by the adjective

"only".[15] By adopting an "only-response" the patient does not state problems but instead, gives an account of the problem. Apparently, she states a complaint but engages some interaction work to overcome the problem with responding (Drew 1997; Stivers & Hayashi 2010) by providing an aligned response, which relates to her well-being. This well-being question, therefore, suggests that patients subscribe positively to lexical items that posit a negative face to the existence of medical problems. With her response, the patient states her complaints in such a way as to locally manage a disorientation to a medical health problem – she states her complaints by delaying an immediate "yes" response in favour of an account. Giving that her chronic illness is already somewhat problematic, she prefers to express the problematic nature of the medical concern as "only" being a bit significant. The question further evidence that preferences conveyed by this grammatical formulation may be more complex and "cross-cutting" (Pomerantz 1984a; Schegloff 2007b) – requiring more interaction work to be realized.

In summary, opening questions in extracts 5-7 to 5-14 solicit information on patients' well-being. The questions are highly contextualised by their sequential embedding and turn design. Based on its sequence organisation, "How is your health?" questions accommodate different orientations for patients' responses, depending on their actions as greetings or information solicitors. On the other hand, "How do you feel?" questions are located at the sequential position after preliminary sequences have been completed, and they orient to a more specific request for information about patients' medical health.

5.3.3   Making General Inquiries

In the foregoing, we have discussed the functions of question types, as used in types I and II visits, to up-date about health-related behaviour and solicit information on patients' medical well-being. These actions have been established as being implicit, despite the formal characteristics of the Wh-questions and polar questions that inform the said actions. Similarly, "How are you?" projects interactional actions that are antithetical to its formal characteristics. In its grammatical sense, "How are you?" questions are structured as AVO (adverb-verb-object) word order where "How*"* functions as an adverb which may preclude any of the following meanings: way, manner, condition, physical/mental state, extent or degree. The verb "are" is existential; it reflects a state

---

[15] Stivers and Hyashi (2010) refer to this type of response as a *transformative* response type which is designed to adjust to the question and which may also alter the agenda.

of being. "How are you?", therefore, poses the principal meaning: "In what physical and mental state are you?" From this literal purview, the questions presuppose a genuine request for information from the askance: the essence of the question touches on what Pomerantz (1980) refers to as a type B event i.e., information that can only be provided by the respondent and not deducible by the questioner or a third party. In the present corpus, "How are you?" questions do different things. They present different activities, either as asking for the patient's well-being or as phatic communion, as consistent with the rituals of mundane/social interactions (see Heritage & Clayman 2010 for the role of phatic communion in medical encounters). In the following extracts, I will discuss how the question performs divergent functions.

First, "How are you?" questions may open the medical core part of the encounter. Extract 5-15 presents this first possibility. Here, the participants open the consultation with greeting exchanges (lines 01 and 02), a sequence which is proceeded by a 0.7 seconds' pause (line 03). Following this, the doctor asks the patient "How are you?" (line 04) and she responds with "fine" (line 05). Afterwards, the consultation moves on to other businesses – the doctor takes a history of the patients' clinic attendance (lines 06 to 10).

Extract 5-15: *"How are you?"* (Organized sequentially in the *position after greeting* exchanges)
```
01   Pat: good morning doctor
02   Doc: good morning
03        (0.7)
04   Doc: how are you?
05   Pat: fine
06   Doc: since we gave you drugs
07        you have not come back
08   Pat: ( )
09   Doc: i didn't hear you o?
10   Pat: i came
```

The sequential location for the "How are you?" question is especially instructive for understanding the action it performs. First, the question is asked after greeting exchanges had already taken place and after a pause. This implies that the greeting ritual had already been completed while the pause paves the way for other types of activities and actions to take place. The pause also indicates that the "How are you?" is not part of the greeting anymore but more the opening of the medical core part of the encounter. It elicits a minimal response "fine" (line 05), which allows the participants to move on to the "businesses of the interaction" (Heritage & Stivers 2013: 668). Therefore, the

pause indicates one possibility for action[16]: the doctor is probably reading the patient's medical record and getting ready to address core concerns for the visit. Also, the "How are you?" question is followed by a statement which ties intersubjectively with the action it performs. The patient's "fine" response, at first posits "wellness" since it presents itself as the canonical response for a "How are you?" question. However, the doctor's statement on her clinic visit (lines 06 and 07), coupled with his demand for an explanation (line 09) when her utterance was inaudible (line 08), makes the patient's "fine" culpable. It appears that the statement uptakes on the "fine" in an accusative way because consequent upon her claims of *"fineness",* the doctor's "I didn't hear you o" (a Nigerian version of the British English expression: "I can't understand you") performs an other-initiated self-repair which addresses the preceding inaudible turn as a trouble source and reinforces the pursuit of the accusative action. Though a statement, the repair is marked for questioning since it ends with a rising tone and is emphasized with the discourse marker "o" (we have previously considered the interactional function of the discourse marker "o" in extract 5-6). Apparently, the patient's inaudible response informs the doctor's subsequent request for more explanation on her medical well-being. Thus, the opening question addresses the medical core part of the encounter, but the patient responds to it as a greeting, probably because she does feel fine.

This phenomenon is further buttressed in extract 5-16. Here, the "How are you?" opening question is not sequentially separated from greeting sequences. The question is not distinguished from the normal everyday greetings because it co-occurs with the second part of the greeting sequences within a single turn (lines 02 and 03) and elicits a similar response "fine" (line 04).

**Extract 5-16: *"How are you?"* (In the same sequential environment with the second-pair part of a greeting exchange*)*

```
01    Pat: good morning
02    Doc: good morning
03         how are you?
04    Pat: fine
05    Doc: fine?
06         everywhere is fine: sure?
07    Pat: yes
08    Doc: why are you here then?
09    Pat: <<:-)> i'm just trying to::: ( )>
```

---

[16] At the clinics, I observe that a break after a patient's response during history-taking indicates two possibilities. Firstly, the doctor may be addressing other doctors, nurses or medical staff. Secondly, both interactants may be silent, during which the doctor pays close attention to the content of the patient's medical record to make deductions from it and use his deductions to set agenda for the interaction.

At lines 05 and 06, the doctor pursues another relevant action with an upshot of the previous turn. His "fine?" (line 04) constitutes a question-intoned repeat which treats the preceding turn as a trouble source and initiates a repair that reinforces the function of the opening question as a "real" question and not for general inquiry. Subsequently, the doctor's next turn is initiated and completed with a meta-communicative comment "everywhere is fine, sure?" This meta-comment further indicates that the doctor and patient are "doing" different things with the opening question. The question aligns with another action – the action of "asking a medically-relevant state of being" instead of the action of greeting but the patient responds to it as a greeting. Hence, her "fine" is treated as accountable, not only because it specifies a trouble source but also because it produces an account (line 09). We may observe that the patient's initial affirmation of fineness is met with disagreement while the doctor continues to establish the relevant action for the opening question.

This consultation and other similar examples in the corpus suggest that doctors orient to an expectation of patients' medically-relevant complaints on clinic days. Since this is most often the case, the doctors habitually set interactional agenda on complaint solicitation. The "How are you?" opening question, therefore indicates that it was not intended to ask about the patient's general welfare – it presupposes an illness-specific question. Nevertheless, patients may maintain their orientation to the questions while doctors will uptakes on this with, for example, a reformulated FUQ "Why are you here then?" (extract 5-16, line 08). In this context, however, the patient's response to the reformulated question "I am just trying to:: (line 09) "co-implicates" (Sidnell 2010: 28) the doctor into a mutual understanding about the function of the opening question. Implicitly, she concedes to an understanding of the interrogative function of the question in the later part of the opening sequence. By her response with a smiling voice (line 09), she orients to a clear understanding of the doctor's expectation of her illness and a probable justification for that expectation. Hence, her non-verbal action of smiling orients to the same epistemic gradient with the doctor about her medical history, which negates her initial "fine" response. Consequently, she eventually orients to the "How are you?" opening question as a core medical question but this knowledge is only made evident when the doctor rearranges knowledge to ask a more specific illness-oriented question with the meta-pragmatic comment (lines 05 and 06) and FUQ (line 08).

In other examples in the corpus, "How are you?" opening questions function more as greetings and establishes phatic communion purposes by its sequential location and the response designs it solicits. In extract 5-17, the question is inserted at a sequential location for initiating

greeting sequences i.e., the first sequences for naturally establishing identification, which characterizes other consultations that we have examined above. The opening question co-occurs with the history-taking question "Where do you live?" (line 01) within the same turn. [17]

Extract 5-17: *"How are you?"* (Co-Occurring with History-Taking)
```
01   Doc: how are you? where do you live?
02   Pat: ( )
03   Doc: sorry because of that child
04        you gave birth to the baby right?
05        we will send you to pmtct hospital
06        they will take care of you (.) you hear?
07        you are supposed to be on drugs but the child too
08        the child must be taken care of
09        are you breastfeeding?
10   Pat: yes
```

Following both questions, the patient (a pregnant woman) is not allocated a turn to respond before the doctor refers the patient to a prevention of mother to child transmission (PMTCT) hospital for the prevention of the HIV virus to her unborn baby (lines 03-09). Further evidence for the function of "How are you?" as a general greeting in this example, is recovered from the doctor's response turns in lines 03-09. His responses suggest that he had some pre-information on the patients' identity and medical/health status. Hence, the "How are you?" in line 01 neither establishes nor starts the medical core part of the encounter. When he asks the polar question "You gave birth to that child right?" (line 04), he makes a K+ claim, a positive statement with a negative tag (Heritage 2010) which orients to a B event (knowledge available to only the patient). Further to this, he receives no response to the question before recommending treatment "We will send you to MTCT hospital. They will take care of you, you hear?" (lines 05-06). He also proceeds to display his K+ epistemic status about her health condition "You are supposed to be on drugs but the child too, the child must be taken care of" (lines 07-08). The doctor's no-turn allocation for a response to the "How are you?" question, therefore, indicates that the question does not require a response because it only prefaces the start to a more serious interaction on the patient's current health status. The FUQ at line 09 "Are you breastfeeding?" is the only question to which the patient responds, though minimally with a "Yes" (line 10).

---

[17] I observe that the patient is a new mother and she already had a prior check-up with the nurses and other medical staff. Thus, when she arrives for consultation, the doctor's opening questions addresses the report he received from the medical staff about her health. Thus, setting his interactional agenda as a preface to the core concerns for the visit.

In extract 5-18, the "How are you?" opening question (line 01) equally functions as a greeting and a preface to sequences that project core medical questions. The question receives an inaudible response from the patient (line 02) after which the doctor issues a double "Any X?" problem-oriented question "Any complaints, any problem?" (lines 03 and 04), to solicit her complaints. The patient complains about itching (line 05) while both discuss the medical problem (lines 06-07).

Extract 5-18: *"How are you?"* (Projecting ambiguous actions)
```
01   Doc: how are you?
02   Pat: (unintelligible, appr. 0.02)
03   Doc: any complaints=
04        =any problem?
05   Pat: my body was itching me (.)
06   Doc: your body was itching (0.04)
07        your body was itching you::
```

Due to the patients' inaudible turn in line 02, the function of "How are you?" opening question is not evident. However, the doctor solicits her complaints with multiunit turns at line 03 and due to this, we may assume possible actions for the opening question – it may function either as a complaint solicitation which was reformulated at line 03 or as phatic communion. Fox et al. (2013) allude to this possibility by positing that research in CA has resulted in linguists actively seeking to re-conceptualize traditionally understood linguistic categories and units in terms of interactional practices and action. This suggestion submits that multiunit questions may fulfil several actions in different contexts. In this regard, Levinson (2013: 118) submits that a turn can contain more than one action and turns can be composed of more than one turn-constructional unit (TCU), each performing a main action. Robinson (2013) also alludes to this multi-functional interactional trajectory for the question when he asserts that "How are you?" may "accomplish an entirely different action – depending on its location within openings" (2013: 264). For extract 5-18, the doctor's binary FUQ (lines 04 & 04) fulfil one overt action i.e., requesting for information about well-being. Thus, the joint questions make other possibilities for the opening question's action relevant i.e., making general inquiries.

In contrast with the most frequent use in mundane and institutional interactions where greeting sequences are employed for establishing interactional mutuality (see Heritage and Clayman 2010), the consultation here does not evidence exchange of greeting routines as a first sequential activity between the participants. For the norms of social interaction, a second person's

greeting is understood as a "return" (Heritage 1984b) which transforms the context of an interactional exchange to what Heritage and Clayman (2010: 62) refer to as "recognizing the other person". They state that "greetings are often intertwined with the identification/recognition process because issuing a greeting can be a way of claiming to have recognized the other person" (2010: 62) and establishing "sociability rather than instrumental tasks" (2010: 63). The social norm of greeting, therefore, presupposes that one who enters a room or interactional space should naturally greet first, to recognize the other person and establish mutual acceptance for the greeting and subsequent interaction. Therefore, the patient should initiate greetings because, at this interactional setting (the clinic), they file in to see an already seated doctor for consultations. And the doctors should equally bear the responsibility to welcome patients into the consultation room after the latter may have gone through preliminary routine examinations by the medical staff. Rather, the patient enters the consultation room without offering to greet nor "returning" one but to accept the agenda for the interaction which was immediately initiated by the doctor at the start of the encounter. From this, we may infer that the doctor is hierarchical towards the patient and he is also pursuing a business-purpose consultation. We can probably allude this to the institutional tasks at this clinic which saddles the doctors with a responsibility to generally consult with all patients before renewing their ARV prescription. Hence, they may be overwhelmed by the high number of patients they must consult with per clinic day. It is also possible that when patients come in for consultation, doctors do not feel obliged to welcome them since they have already been previously welcomed by the medical staff during preliminary health observations. Giving this scenario, doctors should naturally exchange greetings with patients but here, the doctor declines greetings for an outright turn to "official business" (Drew & Sorjonen 1997: 93).

5.3.4   Soliciting Medical Problems

Polar questions also solicit patients' medical problems. For this purpose, "*Any X?"* questions are prominent in consultations where doctors solicit patients' concerns and prioritize this as the interactional agenda. This opening question category is probably the most significant in the polar question corpus, being that it accounts for the largest percentage of the polar question category (51.61%; n = 16). The question specifically refers to a noun phrase designed to accommodate possibilities of noun choices (X) which are semantically symmetrical with the notion of "problem". In the data, the category X include words such as "problem", "issue" and "complaints". These

nouns collocate with the adjective and negative polarity item "Any" while the phrases produced by the collocation fulfil parallel functions in all contexts where they are used. In the literature, "*Any X?"* question has not been fully developed but it fulfils one of Heritage's (2010) description of grammatical categories for polar questions i.e., Positive interrogatives + negative polarity items, '*Any*' which prefers *yes*-answers. However, in the present study, "*Any X*?" questions may prefer either a "yes" or "no" answer – the question is contextually framed to for types I and II visits i.e., patients' presenting concerns and general routine visits, hence, its medically-oriented relevance within the institutional context where it occurs. Essentially, the questions are context-sensitive: they are employed for questioning patients who had either pre-indicated interests in consulting with the doctors for complaints presentation purposes or not. Taking a cue from extracts 5-19 and 5-20, the doctors open the consultations with the opening question "Any Problem?"

Extract 5-19: *"Any Problem?"*
```
01    Doc: how old are you?
02    Pat: thirty six
03    Doc: okay what is your weight?
04    Pat: ( )
05    Doc: yeah <<sigh>> any problem?>
06    Pat: the only problem i have is i go to toilet
             to purge so many times a day
07    Doc: ok
```

Extract 5-20: *"Any Problem?"*
```
01    Doc: how old are you
02    Pat: ( )
03    Doc: forty
04         (.)
05         how are you
06    Pat: fine
07    Doc: any problem
08    Pat: nothing apart from cough and itch
09    Doc: ok
```

In their sequential environments, the main-business questions occur as the third question. They are asked after other history-taking questions, seemingly more preliminary but already part of the main business. In both extracts, the consultations begin with preliminary questions which feature often in the corpus.[18] At lines 05 and 07, the doctors pose the question "Any problem?"; in extract 5-19, the question is produced with vocalization: the doctor sighs while asking the question. His

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[18] As we have previously observed above; see for example, extract 5-8, P. 86

vocalization is probably typical of the routine context of the consultation, justifying reasons for the question's predominance in the data: the action presupposes either physical tiredness or boredom with what seems to be a routine type of question. And, in extract 5-20, the patients' "fine" (line 06) orients to "How are you?" as a general inquiry. Thus, the doctor's next turn shifts to the main business for the consultation (line 07). As previously mentioned, this opening question characteristically presents a B-event but with a preference for a *yes/no* response. Unlike "well-being" questions whose response is delayed (as in extract 5-14, P. 75), the patients here, produce immediate answers but with distinctive designs. They produce an *only*-response which uptakes on the presupposition conveyed by the questions: the questions presuppose that the patients, without doubt, have a problem to state and they should state "*any*" of the problems they want to complain to the doctors about. Thus, the patients' *only* problems are diarrhoea (extract 5-19), and "cough and itch" (extract 5-20). However, while *only*-response performs a transformative function in the former, it orients to a different kind of response design in the latter – the latter accounts for a problem after denying that a problem existed. "Nothing apart from cough and itch" (line 06). Nevertheless, both responses show that patients are held accountable for indeed, uttering a problem whether they orient their accounts to the lexical choice "problem" or not.

Likewise, in extract 5-21 and 5-22,[19] the patients design their responses by prefacing them with "just": "no I just feel dizzy" (line 02), "I just came for my drugs" (line 06), respectively.

Extract 5-21: *"Is there any issue?"; "Is there any problem?"*
```
01    Doc: se kosi n kankan se kosi iyonu
           is there any issue is there any problem
02    Pat: rara oyi kan  n ko mi ni
           no i just feel dizzy
03    Doc: ok
```

Extract 5-22: *"Any issue?"*
```
01    Doc: how are you what's your weight
02    Pat: ( )
03    Doc: ehn ehn –
04         you said your weight is seventy:
05         any issue
06    Pat: i just came for my drugs?
```

---

[19] In extract 5-22, the doctor's opening inquiry and question about weight "How are you?", "What's your weight?" (line 01) receives an inaudible response from the patient. However, the "How are you?" question occurs in the same sequential environment as the second question, and within the same turn. As previously observed in extract 5-17, P. 95, when "How are you?" question co-occurs with a history-taking question or within greeting sequences, its action is ambiguous. Hence, in extract 5-22, the doctor's "Any issue?" (line 05) orients more to the main-business question for this interaction.

```
07   Doc: ehn you will have told them now
08        that you just came for your drugs
             (unintelligible, appr. 5 sec)
```

Raymond (2003) describes these response designs as embodying type-conformity over nonconformity in their preference structure. The researcher further states that while type-conforming answers contain yes or no answers and are preferred, non-conforming answers convey affirmation or disaffirmation and they are dispreferred. Non-conforming answers are produced 'for cause' i.e., to contend with the presuppositions of the question. Furthermore, Webb et al. (2013) state that when the word problem is used to solicit patients' concerns, patients' responses have the tendency to downplay the seriousness of the problem. Here, patients limit their concerns to the existence of a mild problem (extract 5-21) or a no-complaint (extract 5-22). However, when a complaint is uttered, this admission is elicited in such a way that the patient works to mitigate the severe nature of the illness by alluding to the word "problem". This response design occurs despite the question's double forms in extract 5-21. Though the initial opening question is reformulated with another question within the same turn "Is there any problem?" (line 01), the patient orients still, to the semantic import of the lexical items "issue" and "problem" by mitigating her complaints.

Another variant of category X in the "Any X?" grammatical formation is the noun *"complaint"*. "Any complaint?" opening question aligns or disalign with the questions' presupposition. In contrast to "Any problem?" questions, "Any complaint?" questions tend to "prefer affirmation over disaffirmation". In extract 5-23, for example, the doctor moves to the main interactional business with the opening question "Is there any complaint?" (line 04).

Extract 5-23: *"Is there any complaint?"*
```
01   Doc: good morning
02        how is everything?
03   Pat: good morning
04   Doc: is there any complaint?
05   Pat: no
06   Doc: how about your drugs↓
07   Pat: i am using it
```

The patient does not delay her *no*-response (in line 05) but directly responds to the question at her allocated turn. A further question about her drug intake (line 06) is equally met with an immediate, no-hedged and non-delayed response "I am using it" (line 06). This consultation displays an antithetical interactional trajectory with the "Any Problem?" opening question. While the former

is *problem*-centred, the latter is *complaint*-centred. However, extract 5-23 represents the hypothetically unideal response type for the grammatical construction of "Any X?" questions: the question design prefers a positive *yes*-answer rather than the *no*-responses as suggested in the literature (see Raymond 2003; Heinemann 2005). This difference in preference structure is probably due to the visit type in the present study – the questions are used in type I and II visits. Thus, the reason for the visit and the doctoring styles are displayed in the question's preference structure. Moreover, patients' responses establish some dynamism, depending on the different terminologies that refer to their medical concerns i.e., "Problem" or "Complaint".

Extract 5-24 reveals more of this dynamism in preference systems for "Any X?" opening questions. Sequel to the routine greeting sequences (lines 01-03), the interactants observe a 15 seconds' break after which the doctor requests to know the patient's medical concerns "Any Complaints?" (line 05).

Extract 5-24: *"Any complaint?"*
```
01   Pat: good morning sir
02   Doc: how are you
03   Pat: fine
04        (0.15)
05   Doc: any complaints?
06   Pat: i have complaints (.)
07        i have cough
08   Doc: [Unintelligible, appr. 0.03)]
09        [ok                         ]
```

She responds directly "I have complaints" (line 06), pauses a little and eventually states her complaint "I have cough" (line 07). The problem presentation sequences are concluded with the doctor's affirmation of understanding "ok" (line 09). Notably, the patient has uttered a direct response to the opening questions by affirming complaints without delays.

In the corpus, statement questions also solicit medical complaints, but with a preference for a "no" answer. Its grammatical construction (positive assertion + positive polarity Item: "hope") does not feature in Heritage (2010) classification of polar questions. Nevertheless, it is realizable from the data as a contextual derivation from consultations which primarily occur in Yorùbá. Besides the consultations occurring in Yorùbá, another prominent noticing in consultations where statement questions are used is that an additional lexical item is added in the final free translation. This is so because the negative marker *(not-NEG)* supposedly negates the

occurrence of a problem. Hence, it presupposed the belief and 'hope' that the patient has not come with a problem. These questions are asked with such a narrow focus that patients' responses orient to their preference structure. In extract 5-25 for example, the original transcript of the doctor's opening question in Yorùbá connotes the word '*hope'* which appears in the free translation. This is not apparent in the interlinear gloss because it is a contextual derivation from the current consultation. With the opening question "So hope there is no problem or complaint?" (line 01), the patient aligns with this seemingly positive presupposition for the question i.e., expressing a "hope" that she is complaint-free – establishing the questions' design-based preference structure for "no" answer (Sidnell 2010: 87).

Extract 5-25*: "Hope there is no problem or complaint?"*
```
01    Doc: so se kosi problem tabi complain kan kan
           so is not-NEG Problem or complain at all
           so hope there is no problem or complain
02    Pat: rara ko si problem (.)
           no not-NEG problem
           no problem at all
03         ulcer yen naa ni moni ulcer
           ulcer that it is i have ulcer
           it's just that i have ulcer
04         motun ni awon complain kekeke kan
           i also have some complain small small some
           i also have some small complaint
05    Doc: iru complain wo
           type complain what
           what type of complain
06    Pat: ise agbara ni mo nse
           work strenuous it i am doing
           i do a strenuous job
```
In lines 02 and 03, she responds with multiunit turns which initially disaffirms a problem "No problem at all" but eventually, she mitigates a problem "It's just that I have Ulcer" and states an additional concern "I also have some small complaints". Due to the preference structure of the statement questions, she disorients to the existence of *"problems"*, orienting instead to mild complaints "It's Just" (line 02). Her use of multiunit turns is instructive: researchers have attributed possible sequential function of multiunit turns as a way for which actions such as defending oneself against a possible complaint or accusation may be implemented (see Schegloff 1988a: 118-31). Hence, the multiunit turns defend her presentation of problems. While stating her complaints, she mitigates its severity by associating the complaint within the context of *just* a little complaint even though she proceeds to state other concerns (lines 03 and 05). Following this, the doctor's request

about her specific problem (line 05) gives off additional problem stating "I do a strenuous job" (line 06). This shows that she indeed has more than one complaint, but the complaints are presented it in such a way that it avoids accusations from the doctor.

When compared with "Any X?" *problem*-centred questions, the analysis here shows that patients' tendencies to associate *"problem"* with negativity is a consistent finding. Patients prefer not to state problems after the problem-centred questions have been asked. And, when they do state concerns, they structure their responses within multiunit turns – prefacing the problems with a *no*-problem response, probably to avoid being accused of having problems. Asides this preference organisation, patients' responses probably also connote a culture/religious-bound phenomenon. The Yorùbá people consider "health and illness" as "two opposing phenomena which underly the Yorùbá philosophy" (Jegede 2005). To be healthy is to be sick from time to time and wholesome at other times. But illness or "not being well" is constituted as "*Aisan",* a physical and/or mental problem (2005:10) resulting in *wahala* (a problematic situation) which can only be controlled by the spiritual entities greater than the ordinary man.[20] For them, the notion of "problem" embodies a greater dilemma than what they consider as simple illnesses. A "problem" is that which can only be resolved by powers or entities greater than themselves (such as the Supreme being or traditional gods) or other humans, including doctors. These "problems" include pathological illnesses and incurable diseases such as madness and incurable diseases respectively. This religious and socio-cultural orientation may further account for why problems are constantly reduced to lesser problems (i.e., complaints). In the extracts, it appears that the participants orient to this understanding due to the shared knowledge of the cultural/spiritual implication surrounding the notion of "problems".

Problem-oriented questions have been established as being context-sensitive, both in instituting interactional agenda and in constraining "cross-cutting" preferences. Specifically, the institutional setting is contextualized by how patients display their understanding of the purpose for the question: the questions are asked in consultations where the patients either supposedly have a complaint to report (type I visit) or not (type II visit). Responses to the question can be answered with "no", after which the sequence closes (e.g. extracts 5-22 and 5-23). Whereas, a "yes" answer

---

[20] Jegede (2005) reiterates that the Yoruba people descended from Odùduwà (an ancestor of the Yoruba origin) and they are predominantly traditional worshippers who worship various gods and deities. They believe in a supreme being known as Olódùmarè (God) who is the controller of vital forces both on earth and in terrestrial spaces. Many problems caused by natural factors are usually attributed to supernatural or preternatural causes (2005: 10).

needs to be expanded with problem presentations (see extract 5-24) or mitigated problem presentations (see extracts 5-18 – 5-21). This preference structure suggests that the questions may be interpreted as K- questions which implement the social action of "requesting". Thus, responses to "Any X?" questions are bi-polar – they are visits-based and have a "twin preference structure" (Sidnell 2010: 88) based on their designs. The analysis reveals that patients' response designs are consequent upon latent presuppositions for the question. Direct and non-contentious responses are produced for *complaint*-centred questions and vice versa for *problem*-centred questions. In other words, instead of preference organisation, the lexical choice for the 'X' category is the most significant contextualisation cue for how responses for "Any X" opening questions are designed.

5.3.5 Summary

It is evident from the analysis that health-related behaviour questions and well-being questions introduce medically-relevant topics when the following turn properties are considered:

- lexical choices (the question particles)
- sequential embedding (occurring after a brief pause or person-reference)
- intersubjective responses (preliminary and follow-up questions)
- no-interaction work (shared background knowledge between the participants)

The questions specifically utilize the question word "when?" but especially combined with the adverbial "last". Thus, the phrase "when last?" presupposes an initial preference for a medical-history account from the patients, on issues regarding their CD4 count testing, hospital visits and drug use. However, we have shown that this topic focus does not solicit new information because it either surface after a break within preliminary turns in the opening sequences or act as an embedded opening question. Furthermore, the opening questions that utilize the question word "when?", ask statistical questions about times and dates of CD4 count testing, hospital visits and drug use. These foci seem to have a special function besides openings. As the analysis of the trajectories show, they elicit information accessed according to patients' adherence to the medical recommendation. When answers show that patients have been adherent, such as attending the clinics regularly, the doctor still shifts to topics or questions about time perspectives (perspectives shift from before to now), to ascertain that answers were given correctly, according to the information from medical records (for example, extracts 5-1 and 5-4). And, if patients admit to not

having adhered sometimes (or often), sanctions follow (for example, extracts 5-1 and 5-2). Consequently, Wh-opening questions that up-date about health-related behaviour, as used in the present study, are rhetorical. Although the questions initially appear to solicit unknown information, the contextual organisation of actions in preceding and proceeding turns evidence that they are used to confirm already accessible and known information.

On the other hand, opening questions that solicit information on patients' health and medical problems tend to genuinely seek medical information from patients. For "Health" interrogative opening questions, indirect question framing, and sequential location offers the two main loci for which the interactional function of the opening question is oriented to within the question-answer adjacency pair sequences. Both opening question designs for "Health" interrogatives occur in consultations which offer mutuality to the patients. Despite this informal ambience, it does not reflect on how the questions differ in providing constraints for patients' responses. Direct questions on patients' "health" offer binary alternatives for orientation on the path of the patient who may consider it as part of greeting sequences, especially if the opening question is not prioritized for a new turn. Conversely, when questions about patients' health are indirectly framed as a request for patients' "feelings", the analysis shows that greeting sequences are clearly segmented into their appropriate sequential locations. With this sequential arrangement, and with the different lexical choice, patients directly relate to the question as a request for their medical state of health.

For polar questions on patients' health, the opening questions solicit new, unknown information, with varying degree of preference systems especially due to their sequential embedding (i.e., occurring after a brief pause and/or information questions). However, as per patients' orientation to the questions, the following turn properties of the opening questions are instructive:

- lexical choices (alignment with the word "health')
- context-sensitivity (visit types)

Except for statement questions which prefer a "no" answer", all other polar question categories prefer "yes/no" answers". This phenomenon constitutes what Sidnell (2010: 89) refer to as "twin preference structure". Sidnell reiterates that responses may be "organized in relation to two sometimes conflicting and sometimes convergent preferences" (2010: 90). Though this observation refers to the research on references to persons, Sidnell's (2010) submission accounts

for the possibility of having convergent preference structures for the first pair part of action-related adjacency pairs as it is the case with the polar questions that we have observed in the analysis.

"How are you?" questions are ambivalent when we consider the different expectations it engenders for patients' responses. In extract 5-15 for example, the patient orient to them as phatic communion regardless of a clear difference in its sequential locations from the greeting exchange. However, following the "How are you?" opening questions, the doctors either make recourse to the patient's medical problems that presuppose and negates the patient's testament of fineness (as in extract 5-13) or outrightly display a preference for disaffirmation of fineness (as in extract 5-14). This suggests a probable reformulation of "How are you?" questions which function as requests for HIV-related health. In extract 5-15 and 5-16, the question functions more in terms of greetings but as the consultations unfold, the interactional function of the question is not clearly deducible. Generally, the sequential embedding for the "How are you?" question is the most important contextualization cue for how it is interpreted. Also, the "fine" response is the dispreferred response because patients must account for their fineness. In summary, opening questions occur in interactional contexts where social distance and institutional roles are established between doctors and patients. This justifies reasons for the medically/formally-oriented activities which underlie the interactional functions of the questions: up-dating about health-related behaviour, soliciting problems, asking about well-being and making general inquiries.

5.4   Question Types for Visit Types

This chapter started with the argument that question types are context-sensitive and that they have presupposition features that distinguish their forms from their functions. At this juncture, it is expedient to systematically account for the differences between question types that feature in visit types I and II, as recovered in the data analysis.

5.4.1   Type I Visits

In the data analysis, polar questions on patients' health-related behaviour (see table 5-1) is mostly used in type I visits. This question functions for information solicitation purposes in situations where patients have come to present medical problems. The questions are produced with the following sequential properties:

- asked after medical records are checked
- "cross-cutting" preferences
- no FUQs
- no accusations
- responses lead to sequence closure

Even though they are asked after medical records are checked, there are no subsequent FUQs that seek to divulge more information from patients. Furthermore, their preference structure is binary, and patients' responses are neither treated as questionable nor do they lead to accusations. Rather, patients' responses lead to sequence closure. Consequently, the sequential properties show that the question solicits new and unknown information, which saliently seek to recover patients' disposition to adherence to regular CD4 count testing. Thus, the questions are produced with the least presupposition. As evidenced in extract 5-6 (P. 83), the patient orients to the questions purposes when she produces a yes-answer and an additional information about the test results.

5.4.2 Type II Visits

Asides polar questions that focus on CD4 count tests, all other question types are used in type II visits. Doctors produce Wh-questions on patients' CD4 count tests, visit-times, and health, with more presupposition features due to a lower epistemic access (institutionally-fixed knowledge) – the doctors display an already existing knowledge about the information that is solicited. Thus, though there are different access to knowledge between the participants, the interactional display of such knowledge directs the trajectories for the encounters. Questions in Type II visits have the following sequential properties:

- asked after medical records are checked
- "cross-cutting" preferences
- FUQs in subsequent turns
- accusations
- responses lead to more history-taking questions

As earlier discussed in the analysis, these Wh-question designs and their trajectories are typical of type II clinics settings where patients do not need to report additional medical concerns before seeing the doctor, and where other issues besides patients' complaints may be addressed. Turns

leading up to, and after the opening questions show that the questions were asked after the medical records were checked, and with binary preferences for responses. However, subsequent FUQs suggest that the questions seek to confirm the information in patients' medical records. And, when patients' responses do not tally with the medical records, the responses become questionable and call for sanctions in the form of accusations. Hence, the participants do not need interaction work to orient to the topical agenda set by the opening question types, as contextualized by the adjectival phrase "When last?". Patients' responses show that they orient to the medically-relevant agenda of the questions and the clinic's expectations regarding their adherence to medical recommendations. Although the questions initially appear to solicit new information, the shared epistemic gradient between the participants' regarding patients' medical records and medical health, lead to an adoption of the topical agenda for the opening question. Therefore, when questions on CD4 count, hospital visits, drug collection and drug use are initiated in the opening phases, the participants locally manage the interactional agenda for the questions, their implicit actions, and "cross-cutting" preference structure.

In type II visits, some other opening questions are produced with a lower epistemic access (e.g., "well-being" and general inquiry questions). These questions have the following sequential properties:

- asked after medical records are checked
- "cross-cutting" preferences
- no FUQs in subsequent turns
- no accusations
- responses lead to sequence closure

These questions are also asked after medical records are checked and with binary preference structures. However, they differ from other questions in type II visits because there are no FUQs in subsequent turns or accusative actions. Patients' responses lead to sequence closure. For example, Wh-questions which solicit patients' medical health status are produced with lower epistemic access. They are produced with two different lexical choices: "health" and "feel", which directly relate to the question as a real request for patients' medical state of health. Consequently, patients respond to them as specifically requesting for their medical-health status and these "health"-focused questions justifiably elicit various response designs because their actions are not contextualised by patients' presentation of specific medical complaints. Furthermore, "How are

you?" questions and polar questions (asides polar questions on CD4 count) project the reason for the visit while patients' responses establish some dynamism, depending on the different terminologies that refer to their medical concerns i.e., "Problem" or "Compliant". Also, "Any X?" questions are context-sensitive, both in instituting interactional agenda and constraining "cross-cutting" preferences.

5.4.3 Summary

The distinctions in the question types adopted for each visit type makes provision for how questions are contextualized by the interactional settings: visit types provide a basis by which we may critically examine why some question types are preferred over others. For example, we can infer that CD4 count polar questions are preferred for type I visits because it has been ascertained that patients have new medical complaints. Thus, it is expedient for the doctor to ask about previous CD4 count tests in other to know the true status of blood test results. In extract 5-6, P. 83 is a case in point: the patient presented a new medical complaint. However, since she was also established as once having had a more chronic form of the HIV illness (AIDS), the doctor requests to know her current medical health, before proceeding to examine her or prescribing medications for her current complaints. Thus, the question is contextualised by how knowledge is interactionally negotiated between the participants. Conversely, questions on patients' CD4 count, visit-time and health are produced in type II visits where patients share equal epistemic gradient about the latter's medical health and medical records. This is because the doctor has reasons to believe (from the medical records) that patients have been nonadherent to medical recommendations, even though they have not purposefully visited the clinic to present new medical complaints. Hence, when patients' responses do not reflect the medical records, doctors refer to the case notes, to accuse patients of presenting inaccurate information about their adherence. "Any X?" problem-oriented polar questions and some "How are you?" questions are also used in type II visits – where participants interactionally negotiate knowledge about patients' medical health. Thus, in these situations, patients are not presumed to be nonadherent.

This chapter has shown concretely, how opening questions are structured for, and by visit types. Secondly, some question types are highly contextualized by presupposition, such as shared-epistemic access in type II visits, which are largely guided by presupposition on patients' nonadherence – making the social action of "request" for confirmation relevant.

5.5   Concluding Discussion

Hayano (2013) alludes to the complexity of "questions" in institutional and mundane interactions when he asserts thus that "a question that has no simple answer, for the form a question takes is quite diverse" (2013: 396). In the same vein, this chapter has extensively discussed the interactional consequences of opening questions in the context of HIV consultations. The data analysis reveals three question types: Wh-questions, "How are you?" questions and polar questions, with their attendant interactional actions and consequences. This chapter relates to patients' adherence because opening sequences already entail adherence-related activities.

First, the analysis shows that all question types are closed-ended. This points expressly to their use in a routine type of interaction. The institutional framing of the opening questions ranges from medical history-taking activities (regular CD4 count testing, hospital visits and drug use) to solicitation of patients' medical concerns, and general health. Wh-questions perform agenda-setting functions by up-dating about health-related behaviour, soliciting patients' health status and soliciting patients' complaints/concerns. Polar questions also solicit patient' complaints, solicit no-complaints, and request specifically about patients' medical history of regular CD4 count testing. These interactional trajectories define what constitutes the main business of the consultations, within the ambience of two visit types which I have labelled types I and II visits. The data analysis shows that the questions differ in terms of forms and functions. All question types initially appear to be information questions that solicit new information but functionally, most question types and categories are either rhetorical or marked as greeting questions.

For most polar questions, participants interactionally negotiate knowledge on patients' medical health though occasionally guided by presuppositions on patients' nonadherence. This engenders the social function of polar questions as "requests for information". However, the recovered polar questions with their attendant grammatical constructions are designed differently – they are designed to accommodate "extended telling" from patients, who respond by expressing their concerns where necessary. Patients also offer diagnostic claims while giving extensive explanations about their concerns. The typology of Yorùbá polar questions in the data is specifically insightful for discussion. Statement questions, which are designed as "Hope there is no problem?" and "Hope there is no complaint?" requests have question particles with the inserted lexical item "hope". This is transposed as the subject of the clause. Statement questions are equally timed as the first sequential activity (see extract 5-25, P. 102) – transforming the constraints it

110

provides for patients' responses. With the lexical item "*Hope*", the polar question makes a *no-*answer relevant even when patients have new concerns. Schegloff (1988a) refers to possibilities for this phenomenon as a "structure-based preference for a *no*-type response" in the context of routine visitations. Patients' responses to statement questions (in the polar question category) also take a cultural/religious dimension, like constraints provided by "Any X?" polar questions. The analysis suggests that patients display high sensitivity to questions which solicit their concerns, yet still show that doctors are business-minded and positively disposed to the existence of 'problems'. This is especially so when the words "problems", "complaint" and "issue" are used. I find that doctors use these labels to mean concerns relating to opportunistic infections, but patients relate to them differently. From a cultural/religious standpoint, patients allude to the notion of "problems" as the incurableness of the HIV disease. They mostly deny having problems by stating the purpose of their visit for only drug renewal or for other minor illnesses which the doctor is professionally capable to resolve. The serious problematic nature of the disease is also downplayed before concerns are stated. Conversely, when doctors deviate from the expectation that they have problematic illnesses, patients' uptake on this by showing that they are willing to participate more actively and openly in the consultations. When doctors "hope" that patients are "healthy", this expectation projects patients' willingness to state their concerns, much more beyond the immediate relevance of such concerns to the consultations. In this case, interactants jointly manage their understanding of the unproblematic nature of the HIV disease. This situation may then further generate patients' willingness to expose subjective religious beliefs about healing. Moreover, the opening questions reinforce the participants' institutional roles i.e., the doctor as the questioner and the patient as the responder or complainer. When patients respond to doctors' opening questions, the participants' roles are evident, for example, when patients comply with the doctors' requests and are willing to respond to interrogation (e.g., extract 5-1, P. 74).

Findings from this chapter suggest a range of practical implications for healthcare practice for female HIV-positive patients. The subjects live in the south-western geopolitical zone of Nigeria, an environment where there is a rise in the incidence of new HIV infections among women (UNAIDS 2016). The social construct of HIV disease in this region is problematic in that it has been labelled "incurable" and considered a "taboo" in many quarters (Odebunmi 2011: 619). Female HIV patients particularly, are stigmatized due to the cultural expectation that victims must either be promiscuous or engage in marital infidelity. The findings suggest, therefore, that when

doctors open consultations with patients in a less hierarchical way, mutuality can be established with the patients. This may encourage them to speak more about their medical conditions, especially when doctors do not orient to the societal and structural construction of the personality of female patients and the problematic nature of the HIV disease. Moreover, opening questions explicitly relate to doctoring styles and interactional trajectories in the encounters. In type II visits, opening questions which are produced with shared epistemic access may not foster adherence to medical recommendations because they accuse and threaten patients' face. However, when opening questions solicit unknown information, accusative actions do not take place. Consequently, institutional roles are better managed between doctors and patients while they also maintain better social relationships. Ultimately, besides setting interactional agendas, opening questions indicate that the doctors seem ready to assume nonadherence and take a paternalistic accusative doctoring style, to which the patients react in a defensive manner. It is suggested that when doctors address less defensive patients, they can then also access patient's subjective and/or religious theories of healing, and their attributions of the "supernatural" control of the diseases. Doctors' access to this information is crucial so that they can provide patients with the right counsel on profitable lifestyle and coping mechanisms for living with HIV.

6 Adherence-Related Negotiations in Medical History-Taking

"Adherence to medications is the process by which patients take their medication as prescribed, described by three quantifiable phases: initiation, implementation, and discontinuation" (Vrijens et al 2012: 691).

"Concerning patients' adherence to clinic visits, 95% of our patients have been adherent and we encourage them to prioritize adherence to this medical recommendation beyond their personal plans, e.g. to travel. As for drug adherence, what we use as an index in this clinic is majorly patients' CD4 count. We can't live with them in their homes to enforce this though we have a social worker here who follows up on this. But from their CD4 count, we can tell the level of adherence" (A doctor's report concerning HIV-positive patients in a South-western Nigerian Clinic).

In chapter five, I examined the interactional consequences of opening questions. Important findings show that questions are shaped for, and by visit types and this provides a basis by which we may critically examine the actions that questions perform in the consultations. In type I visits, patients only consult with doctors when they have medical complaints. Thus, opening questions in this visit type solicit information about patients' current medical health. In type II visits, patients consult with doctors due to recurrent screening reasons. These various reasons for attending the consultation reflect in the different opening questions, highlighting either acute concerns or routine reasons for visiting the doctor's office. Chapter five further shows that adherence negotiations are already indicated in the opening phases of the consultations. In the present chapter, I research further on these consultations, specifically what occurs during the history-taking activity. By "negotiation", I refer to the ways by which adherence-related issues are interactionally made relevant in the consultations. The history-taking activity is worth focusing on because it presents striking adherence-related concerns as a trajectory. Also, the adherence-related consultations occupy a substantial part of the corpus (34 of 70 encounters). This chapter, therefore, investigates the organisation of history-taking sequences in the consultations, but with specific reference to the adherence-related questions that surface in the activity. It discusses how patients' adherence status are implicitly or explicitly topicalized, and the implications on doctoring styles, patients' expertise, and patients' accountability for their health management.

6.1   Finding out about Adherence Through Medical History-Taking Questions

6.1.1   History-taking Questions: Asking about Past Health-Related Behaviour

In the opening phases and subsequent phases of type II visits, doctors' questions verbalize adherence-related trajectories when they explicitly or implicitly talk about (past) medical recommendations. The measure of directness is not binary (indirect or direct) but a gradient from really explicit, to implicit/optional relation to adherence. As we will show in the following sections, these explicit/implicitly-framed adherence-related questions are contextualized by the previous examination of patients' medical records, and this pre-medical record examination is consequential for the questions, patients' responses, the local organization of interactional sequences, and subsequent actions. By the terms "explicit" and "implicit", I borrow from Maynard's (2005) concept of allusive talk which "purposely avoids explicit formulation" and directness in naturally occurring interactions (2005: 69; cf. Gallardo 2005; Barth-Weingarten 2011; Betz, 2015; Mondada 2015; Jenkins & Reuber 2015). Clayman and Romaniuk (2013) allude to this phenomenon by stating that the measurement of directness is in the "absence of various practices that embody an indirect or cautious stance toward the question" (2013: 324). Hence, the character of allusiveness is shown to eschew directness and therefore, necessitates more inferences from the interaction, to determine participants' communicative intentions. The following sections discuss the structure of history-taking sequences in the consultations that feature adherence-related negotiations. What follows is a description of the sequence organizations, their underlying social actions, and the concluding thoughts on the analysis.

6.1.1.1 Explicit Questions on Past Health-Related Behaviour

In the opening phases of type II visits, doctors explicitly ask adherence-related questions when patients' medical records indicate certain information that is consequential for the proper use of medication. Such information includes previous and/or current medical complaints, and poor medical health. The medical record may also reveal that patients visited the clinic irregularly or failed to conduct the necessary medical tests. In these circumstances, doctors make relevant the respective information from patients' medical records by asking about a past adherence-related behaviour. Doctors also assess patients' responses while patients agree or disagree with this assessment. Extract 6-1 exemplifies this sequence organisation: in lines 01-07, the doctor asks the

patient about her drug use and medical health status. The patient offers a minimal response particle "yes", to both questions (lines 02, 05 and 07).

Extract 6-1: *"Are you using your drug well?"*
```
01   Doc: are you using your drug well
02   Pat: yes
03        (0.5)
04   Doc: so are you using your drug well
05   Pat: yes
06   Doc: so are you in good health?
07   Pat: yes
08   Doc: but your record states that you complained=
09        =aBOUT cough the last time you came here
10        <<l> did you take the cough medicine>?
11   Pat: <<l> when i came>
12        (.)
13        a drug for cough was prescribed>
14        and i was told to go get it
15        where we actually get drug
16        (.)
17        when i got there
18        the pharmacy said
19        the drug is not available
20        (.)
21        <<f> but i am thankful>
22        that the cough is totally stopped now
23   Doc: ok::?
24   Pat: yes
```

The opening phase consists of three question-answer adjacency pair sequences. In the first sequence (line 01-02), the doctor's "are you using your drug well?" asks about the frequency of drug use in its recommended dosage. The patents "yes" is a minimal response that confirms appropriate drug use and closes the first sequence. What follows is a 0.5 seconds break at which time, the doctor should be reading her medical records.[21] In the second sequence (lines 04-05), the doctor self-selects a turn by repeating his "drug-use" question and prefacing it with "so", which is an "appositional beginning" or a "pre-start" (Sacks, Schegloff and Jefferson 1974: 719). According to Sacks, Schegloff and Jefferson (1974), such turn beginnings are only turn-entry devices which do not necessarily require that the speaker conditions his turn beginning in any specific way. Thus, the question seems only to re-emphasize the doctor's interest in the patient's drug use. The repeated question also appears to be a means of repairing a trouble source that was disagreed with. The "so"

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[21] The doctor is probably reading her medical records throughout the interaction, to gather more information that will aid further questions.

is a practice to indicate a restart after having been "out of talking" – the doctor's once again, self-selected turn, is prefaced with the appositional beginning "so" while the patient responds for the third time, with a minimal contribution "yes". Again, the patients minimal "yes" closes the second sequence. At this point, there is yet no reference to the type of drug being requested before the third sequence digresses to ask about the patients' medical health (lines 06-07). However, it is not surprising that the first two sequences that topicalize the patient's drug use are tied to issues of medical health because, as previously mentioned, clinicians associate patients' medical health to several factors, one of which is appropriate drug use. Subsequently, in lines 08-10, the doctor's multiunit turns are produced with fast and low pitch registers. He starts, in a fast pace, by post-expanding the immediately preceding turn which assesses and negates the patient's previous "yes" response: "but your record states that you complained about cough the last time you came here" (line 08). This assessment simultaneously functions as a low-pitched produced start of a third sequence – the drug-use explicit adherence-related question "did you take the cough medicine?" (line 10). Thus, in lines 08-10, the doctor refutes her claims of fineness (good medical health) by recalling her previous complaint of a cough and asking if she took the prescribed cough medication. Here again, the patients' medical well-being is tied to a previous complaint about a cough and medications for a cough. In response to this third history-taking question, however, the patient responds with an account which initially starts with a low-pitch (lines 11-13) and ends with a louder voice tempo (lines 21-22). The account is a dispreferred second because the patient didn't straightforwardly answer yes or no. Instead, she projected the question on cough medication as investigative, and takes a turn, based on this projection, by accounting for her actions. As enunciated by Schegloff and Lerner (2009), this response type does not inhabit the preceding turn and is therefore not a straightforward response. In lines 11-22, the patient re-affirms her medical well-being by stating that though the previously prescribed medication for a cough was not used, the cough has subsided. This is an account that resolves the contradiction between the good well-being and the information on the patient's record, to account for not having taken the cough medication. Finally, in line 23, the doctor's elongated "ok" minimally responds to the patients' account while the patient's "yes" agrees with this response (line 24).

Notably, the patient's account is punctuated by several short pauses (line 12, 16 and 20), at which time the doctor does not interrupt her but delays his response till her account ended. The accounts detail her previous visit to the clinic for drug prescription "when I came a drug for cough

was prescribed" (lines 11-13), her referral to the clinic's pharmacy[22] "and I was told to go get it where we actually get drug" (lines 14-15), reports about what transpired at the pharmacists' "when I got there the pharmacy said the drug is not available" (lines 17-19) and gratitude about her healing from the cough "but I am thankful that the cough is totally stopped now" (lines 21-22). The patient reports that though the cough medication could not be retrieved from the pharmacist, she no longer had complaints about a cough. Finally, the doctor's elongated "ok" (line 23) minimally expands the patients' account and legitimizes her account – he indicates a change of state regarding the B event ("drug use") by saying "ok" and legitimizing (at the same time) the patient's account, while the patient's "yes" accedes to this "ok" response.

The extract shows that the history-taking sequence is organised in such a way that the patient's medical health is associated with her drug use and medical complaints. Hence, when the doctor asks about her drug use, especially in the second sequence, he is explicitly asking about adherence to drug use, which he treats as necessary for the patients' medical health. However, the 0.5 seconds break before the second, repeated sequence suggests that the "so" preface is not only an appositional beginning but it also doubles in function as an inferential marker (Blakemore 1998) which contextualises the action performed by the question.[23] The question marks some sort of inference, in this case, an inference to the doctor's previous non-verbal communication with the patient's medical record. The opening question is repeated with the "so" discourse marker, occurs after a short pause and is followed by another opening question on the patient's health. With this sequential organisation, the doctor is re-affirming the patient's account of regular drug use. This re-affirmation suggests that he initiates a topic on the patient's history of drug use, and associates this concern with her actual, present health status. She is interrogated about her adherence to medical recommendations, and her responses show that she orients to the doctor's principle of cooperation in fulfilling this specific task. The doctor asks about an information on drug use that only the patient has knowledge about and this question is then repeated for further re-confirmation. It also links with a question on medical health that should already be visible in the medical record. So, the doctor explicitly questions her correct use of drugs, giving the fact that she had earlier complained about a cough. Consequently, the patient's medical record and previous health play a

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[22] In South-western Nigeria, HIV patients freely receive ARV drugs and drugs for HIV-related illnesses. In certain cases, however, the clinics may run out of these drugs, hence the patients must purchase them on their own.
[23] See Schiffrin (1987) and Blakemore (1988) for other roles of discourse marker "so" in interactional contexts.

prominent role in contextualising the idea that the patient's adherence to medical recommendation may have been questionable. And, as though the doctor hints that adherence could be a topic, the patient's account shows that the cough drugs were indeed, not ingested. Since the patient is not found to be nonadherence, subsequent actions are not accusative. In this history-taking sequence, the explicit question is about a medication-related behaviour. The patient orient to the adherence topic by accounting for not having taken the meds. (She does not simply say: "No, I haven't taken the medicine"). There are two things coming through: (1) The doctor links well-being with adherence to medication (2) The question about drug use is oriented to as having a moral dimension: Not having used the drugs has to be accounted for.

Similarly, in extract 6-2, an explicit history-taking question on past health-related behaviour asks about the patient's drug-use after the patient complains of ill health, and after the doctor reads her medical records. The consultation begins with first and second greeting exchanges (lines 01-02). This opening (greeting) sequence is followed by a 0.5 seconds' break (line 03), and a second (question-answer) sequence (lines 04-05).

Extract 6-2: "Are you using your drugs?"
```
01    Pat: good morning
02    Doc: good morning
03         (0.5)
04         yes (.) what is the problem?
05    Pat: in::: on monday, i came in ( )
06         i wasn't feeling fine (.)
07         so i said let me see a doctor
08    Doc: so, if you were feeling fine (.)
09         you wouldn't have come (.)
10         the last time you saw a doctor was in 2009
11    Pat: NO O? the last time was last year (.)
12         you spoke to me last year
13    Doc: oh, inside a consulting room?
14    Pat: yes
15    Doc: hh? the last time you saw a doctor was last year
16    Pat: yes, in december
17    Doc: six months ago=
18    Pat: =december last year
19    Doc: six months ago
20    Pat: yes
21    Doc: how many children do you have now
22    Pat: none
22    Doc: none (.)
23         i thought you said
24         you were pregnant the other time
25    Pat: <<f> no o>
26    Doc: are you using your drugs?
```

```
27   Pat: yes
28        (-)
29        but it's a different one that i started with
30        this was changed recently ( )
31        and i am beginning to see some rashes on my skin
32   Doc: this rash
33        do you have it somewhere else asides your face?
34   Pat: all my body =
35   Doc: =did you change your drugs?
36        asides the one you are using
37        are you using any other drugs?
38   Pat: no
39        though they ((pharmacy)) changed my drugs
40        from the former one to this one
41        and i complained at the pharmacy
42        that this is not the same colour of drug
43        that i usually use
44   Doc: yes ok
45        <<pp> we will see about that>
```

In the second sequence, the first pair-part elicits the first question – a complaint solicitation question, while the patient offers a second pair-part answer – a complaint of "not feeling fine" during a previous visit has prompted the current repeat visit (lines 05-07). The subsequent sequence is instructive for our discussion in this chapter. The doctor starts a third sequence with an uptake on the patient's response to the second sequence. With an unmodalized statement about a past health behaviour (the last time you saw a doctor) (lines 08-10), he assesses this previous response using multiunit turns which explicitly accuses the patient of not having visited the clinic since 2009 (six years before this consultation). The patient, however, offers a downgraded second assessment by accentuating and pitching her turn initial "NO O" and adopting the same lexical choices with the doctor "the last time" (line 11). With this turn design, the patient re-asserts that the doctor's assumption was wrong and that he had, in fact, spoken to her "last year" (line 12). This preference structure agrees with Pomerantz (1984a) who states that second assessments of the same or lower value are usually accompanied by disagreement. Following the completion of the third sequence, the doctor starts the fourth sequence – a FUQ which is prefaced with "oh" (a change-of-state marker; Heritage 1984a) that changes the doctors' epistemic status from "not-knowing to knowing" (Sidnell 2010: 105) "Oh, inside a consulting room?" (line 13). In response to this FUQ, the patient offers a minimal agreement "yes" (line 14). The complaint solicitation sequence is completed with a fifth sequence – an assessment sequence (line 16-20), prior to the initiation of other concerns (line 21-25). In this final assessment sequence, the doctor re-states his

new knowledge with an affirmative statement, a base first pair part of the assessment sequence: "The last time you saw a doctor was last year" (line 15). The patient agrees by starting a devalued assessment that repairs the time frame of her previous clinic visit "Yes, in December (line 16). What follows are affirmations and re-affirmations of the time frame in dispute: "six months ago" (line 17), "December last year" (line 18), "six months ago" (line 19). The patient's "yes" establishes the base second pair part which minimally agrees with the preceding turn.

Subsequently, drug-use question surfaces "Are you using your drugs?" (line 26), to which the patient responds in the affirmative "yes" (line 27). After a short pause, where the doctor does not immediately take a turn, the patient self-selects a multiunit turn (lines 29-31) which uptakes on the previous "yes" response with a "pro-forma agreement" (Sidnell 2010: 79). She complains of some rash on her skin, probably because she was prescribed a different brand of ARV drug that she did not normally use. What follows are questions about the local spread of the rash on her skin (lines 32-34) and negotiations about drug prescriptions (lines 35-45). Notably, the doctor repeats his drug use question to confirm the relationship between her ARV drugs and the complaint about rash (lines 36-37). However, the patient displays a good understanding of how ARV drugs work with the human immune system and its possible side effects, specifically on her body, when different brands of ARV drugs are ingested over a period. She also shows that she adheres to medical recommendations. This probably accounts for contributory shared decision making on drug prescription between the participants. Having established her adherence status to be true, the patient responds affirmatively to interrogations on drug use and suggests what drugs should be prescribed to suit her health needs. Tarn et al. (2006) support this notion with their finding that patients may not take new medications because of fear of interactions with other medications or adverse effect. This suggestion further shows that a patient with such understanding recognized the importance of medications and adhering to medications. Nevertheless, here, the doctor still accuses the patient of not having visited the clinic at the due time because her history of clinic visits is linked with her presentation of medical complaints – transforming the initial complaint solicitation to an actual investigation of the patient's medical history. It is evident here that presumptions about the patient's nonadherence lead to a different type of sequential organisation. Though the doctor read her medical record (as it is most cases), he first initiates a greeting sequence and follows this with an information question that solicits her medical complaints. Only after the information question was not satisfactory, does sanction follow. Hence, the opening (complaint

solicitation) question already starts on a note that the patient's adherence status was somewhat questionable, prompting an investigation of drug use and previous clinic visits in the history-taking activity.

From this consultation, we may submit that interactional goal as evidenced in the history-taking activity dictates the overall structures of interactions that feature adherence-related negotiations. The patients' adherence was targeted as an interactional goal in the opening phases of the encounter, even though her nonadherence was an unmarked expectation. However, the patient is indeed found to be adherent even after being accused of nonadherence in the beginning. Hence, in the consultation, explicit adherence-related questions inform questions-answer sequences.

In another instance, explicit drug-use questions take the form of information questions – in extract 6-1, this is one practice to begin adherence-related negotiations in the history-taking phase. Furthermore, in extract 6-3, the doctor starts the consultation by asking about the patient's identity (line 01). She offers her identity "X" (line 02) and completes the first question-answer sequence. Afterwards, the doctor uses the person reference in a question about currently having her drugs with her during the consultation (line 03). The patient offers a minimal "yes" and closes the second sequence. In a third sequence, the doctor assesses her response by confirming her statement of assurance about her drugs "You still have your drugs" (line 03).

Extract 6-3: "When last did you take them ((drugs))?"
```
01    Doc: what is your name
02    Pat: (X)
03    Doc: X do you have your drugs
04    Pat: yes
05    Doc: you still have your drugs=
06         =when last did you take them
07         so you've come to collect drugs
08    Pat: <<pp>  hm>
09    Doc: are you taking drugs too
10    Pat: <<pp> hm:: yes>
11    Doc: i'll give you ( ) right?
12         what are you waiting for
13         do you see us taking deliveries here?
14         (.)
15         how many people have you heard
16         that said oh: i delivered at X clinic
17    Pat: ok yes
18         the drugs
19         (.)
20         the one i have will last
```

```
21   Doc: it will last till::
22        till july
23        so: you will go to:
24        where do you stay?
25   Pat: i stay at XY
26   Doc: so (.) no complaint?
27        so your dee dee four is still normal
29        keep it that way
30        adhere to your drugs
31        and feed well
```

After confirming that she still has her drugs, he explicitly asks an adherence-related drug-use question "When last did you take them?" (line 06). Surprisingly, the doctor does not wait to receive a response to the information question before confirming the purpose of her visit (drug collection) "So you've come to collect drugs". The patient produces a yes-like response "Hm" (line 08). It appears that while asking these information questions, the doctor is busy flipping through her medical record and may not really be soliciting a response but may be merely making the conversation on-going. This may also be because the patient has neither indicated any medical complaint nor shown any evidence of ill health. It may also be because her medical record shows that she has complied with the various medical recommendations (her medical status shows in the subsequent turns). In the fourth sequence, the doctor asks about her intake of "other drugs" (line 09) besides the ARV drugs and she responded with another elongated assessment "Hm:: yes" (line 10). Subsequently, the doctor offers an elongated assessment that confirms that the patient is pregnant and is due to deliver soon. In lines 12-16, the doctor recommends that she go to the clinic for delivery. Afterwards, both participants negotiate treatment by jointly sharing the decision about the quantity of ARV drugs that she will receive before re-visiting the clinic for another prescription. In summary, extract 6-3 shows two explicit adherence-related questions (lines 06 and 09). These questions suggest that nonadherence may have been suspected by the doctor in the history-taking phase. However, when the patient's responses show that she is adherent, there are no further indications that she is accused of nonadherence. Rather, the interaction proceeds with other concerns.

In type II visits (as shown in extracts 6-1 to 6-3) doctors explicitly ask adherence-related questions when they topicalize drug-use. In other cases, however, explicit questions surface when previous medical recommendations are talked about in the history-taking activity. In these consultations, patients' medical records also play a role in contextualising presumptions about patients' adherence status. In extract 6-4 for example, the patient is invited to take a seat and

afterwards, asked about her previous CD4 count tests. As enunciated in chapter 5, this opening question type (though initially functioning as an information question), are rhetorical questions which refer to patients' medical record and proffer medically-relevant topic for discussion. In the beginning, the doctor asks the patient about her previous CD4 count test (line 02) and receives a responding false-start "like:::" (line 03), which is not due to a self-initiated self repair that indicates a misunderstanding of what CD4 means, but an attempt to accurately remember when last her CD4 counts test was done.

Extract 6-4: *"When last did you do CD4 count?"*
```
01   Doc: sit down X (.)
02        <<writing> X? when last did you do cee dee four count>
03   Pat: (.) like::: last year (unintelligible, appr. 2 sec)
04        (--)
05   Doc: who tell you make you no do cee dee four count
          who told you not to do cee dee four count
06   Pat: (          )
07   Doc: hm:::
08        (0.2)
09        <<pp> so na dat time you go do am>
              so that was when you did it
10   Doc: your drug expired two months ago
11        (-)
12        he finish but you suppose come april
          it's finished and you ought to have come in april
13        so why you no come april
          so why didn't you come in april
14   Pat: i came in april
15   Doc: they give you medicine?=
          =were you given any drug?
16        <<all> how many months?>
17        your drug suppose remain pass like that X
          your drug ought to remain more than that X
18   Pat: ( )
19   Doc: when is your next appointment?
20   Pat: it's today
21   Doc: today is your next appointment
22        ok o:::
23        (--)
24        (0.9)
25        see (.)
26        i'll write your drugs for you
27        just go and wait <<pp> alright>
```
Having supposedly read the patients' medical record, the doctor begins the next history-taking sequence with a self-selected turn that asks about the person who influenced her decision not to take the CD4 count test (line 05). Unfortunately, the patient's response at line 06 is inaudible.

However, from subsequent turns, we may deduce that she offers an account of the CD4 count test which responds to the doctor's question. This response is evidenced when the doctor utters an elongated assessment of the inaudible response "Hm::: (line 07), pauses shortly (line 08) and eventually re-states the content of the inaudible response, which is a confirmation that her medical tests were conducted at the recommended time "So that was when you did it" (line 09). What follows are assessments of the patients' drug-use "Your drug expired two months ago" (line 10), "It's finished, and you ought to have come in April" (line 12), and evoking an account about nonadherence to clinic visits "So why didn't you come in April?" (line 13). The patient then asserts that she had visited the clinic at the recommended time (line 14). What follows are negotiations about the previous drug-use (line 15-18), next appointment (lines 19-23) and drug prescription (lines 25-27).

As earlier mentioned, HIV-positive patients are expected to be adequately aware of their medical condition, while also regularly monitoring CD4 count volumes every three months. However, the patient here does not fulfil this expectation because she had taken the test "last year", at least eight months before this consultation (not shown in extract). Thus, her response shows that she was nonadherent to recommendations of regular CD4 count tests. Consequently, in the next sequence, the doctor's "Who told you not to do CD4 count" (line 05) is an accusation which is made by the rhetorical reference to a third-party. The third-party reference suggests that the patient had not taken responsibility for her medical condition because a certain person had influenced her decision not to take the CD4 count test. The extract shows that when the doctor reads and writes on the patient's medical records (line 01-02), the information gathered from the record prompted the medical history-taking question (on CD4 count). Consequently, when the patient shows that she was nonadherent to this recommendation, sanctions follow in the form of an accusation (line 05).

In this consultation, nonadherence is directly targeted as a trajectory in the opening phases of the consultation. The opening question is rhetorical because it is asked with a background knowledge of the patient's medical record, which may have suggested that the patient has been nonadherent. Another possibility is that he checks his knowledge (to test whether the record is not complete). Consequently, he charges the patient with a series of accusations (with an interrogative format) that ranges from irregular CD4 count testing, irregular clinic visit, non-drug collection and non-drug use. He even tests her rectitude in keeping true to her real appointment times. With these

questions, the doctor asks about the patient's adherence to medical recommendations, thereby making adherence relevant as a moral order and treating nonadherence as accountable. Thus, the sequences are organized in such a way that suggests that there are presumptions from the patients' medical records. The recursive explicit adherence-related questions and accusation sequences within history-taking are followed by treatment prescription sequences. With a louder voice and fast continuous speech, the doctor questions her about the longevity of the drugs she had previously received and asserts that she ought to have leftover drugs (line 17). He further requests to know if she had indeed come to the right appointment. These questions appear to ask for a subsequent appointment, but the participants orient to an understanding that only the questioner could issue the next appointment. That being the case, the patient upholds her position, that going by her medical records, the present appointment she has come for is her indeed her next one "It's today" (line 20). The doctor then offers a repeat question about a next appointment, to again, investigate her clinic visits. And, the patient once more, defends her adherent status. The doctor accepts her response with an "ok" and an elongated Nigerian discourse marker "Ok o:::" (line 22), which indicates a resignation to accept the patient's testimony and defence. Ultimately, drugs are prescribed (line 25-27).

To sum up the analysis of extract 6-4, we may observe that by its turn design and sequential embedding, the opening question here is rhetorical because it asks about an information that should already be visible in the medical record. The utterance also doubles as an accusation in an interrogative format (form: interrogative, function/action: accusation), which leads to a justification from the patient. In subsequent history-taking sequences, explicit drug-use questions surface, as well as question-answer sequences on other medical recommendations. The extract evidence that interrogatives in the history-taking activity may not be an information question but an accusation, depending on the context, the content, and also proffered by the design: A "why"-interrogative requests for an account.

Similarly, in extract 6-5, the consultation begins with the first pair part of a greeting exchange (lines 01). After a short pause (the doctor reads the medical record, line 02), the doctor confirms the patients' identity (line 03) and invites her to take a seat (line 05).

Extract 6-5: *"When last did you do CD4 count?"*
```
01   Doc: good morning madam
02        (.)
03        are you mrs x?
```

```
04    Pat: yes
05    Doc: you can sit down ma
06         when last did you do cee dee four count?
07    Pat: ehm::: i was doing ( )
08    Doc: madam you have not done cee dee four since 2013
09         true or false?
10    Pat: (.) it should be::
11    Doc: [true: or false ma?     ]
12    Pat: [it should be last year]
13    Doc: which time last year madam?
14         what time last year
15         the last cee dee four i am seeing here ((medical record))
16         is september 2013
17         the one ((test form)) they gave you last year (.)
18         it is empty (.) you didn't do it
19    Pat: i --
20    Doc: it's true now madam (.)
21         <<all> see it now >
22         there's no result on it
23         it did not even get to your hand (.)
24         [so::                              ]
25    Pat: [the one ((test form)) that i have]
26         i am coming next week
27    Doc: ok::: come and do madam
```

He proceeds by asking about her previous CD4 count test "When last did you do CD4 count?"
(line 06). In response, the patient begins to utter a hesitation "ehm:::", followed by an account that
ends inaudibly "I was doing …" (line 07), which projects and indicates a dispreferred response.
What follows is the doctor's instructive uptake on her account. His assertion "Madam you have
not done cee dee four since 2013" (line 08) appears to disagree with the patient's account – it
asserts that the last test was conducted two years before this consultation. Thus, it directly accuses
the patient of nonadherence. It also transforms the function of the opening question as an
accusation of nonadherence to medical recommendations because it shows that the question is a
test question, and not an information question. The assertion is a confronting statement because it
is produced without any epistemic modalization (e. g. "I believe you have not done CD4 since
2013"). So, the doctor displays a certain epistemic stance towards this piece of information he has
asked about one sequence before. The repeated true or false is also a confronting way of asking,
like an interrogation at the police or at the court. He "forces" her to respond quickly and compares
her responses with what is documented in the record. Following the assertion, the doctor goes
further to complete his turn with a question which challenges the patient to deny the assertion "true
or false?" (line 09). In line 10, the patient hesitates still, with a pause and what seems to be a

statement of uncertainty "It should be::" The doctor then restates his challenge: "true or false ma?" (line 11) before the patient finally completes the base pair sequence by overlapping her response to the CD4 count question – "It should be last year" (line 12). Her repair at the prolongation of the turn initial (line 07) and turn ending (line 10) suggests that she hesitates from uttering a dispreferred response. Wilkinson (2007) asserts that prolongation of utterances delays the ongoing progressivity of a current turn and may initiate a repair attempt. Her hesitation, therefore, evidences that she could not sufficiently confirm her regular visits to the clinic to conduct the recommended CD4 count tests. Following this response, the doctor's multiunit turns constitute two repeated FUQ "which time last year … madam" (lines 13 and 14) that challenges the accuracy of the patient's prior turn, in reference to the medical records. He explicitly states that by her medical records, the patient's last visit to the clinic and CD4 count test was two years before this consultation (lines 15-18): "You didn't do it" (line 18). Once again, the patient hesitates, and the doctor produces evidence of his accusation (line 20-24). However, when the patient utters an intention to act in a certain way (I am coming next week) (line 26), the doctor uses this statement of intention to utter advice/instructions in a strong deontic fashion with an imperative "Ok come and do madam" (line 27).

This extract shows that the consultation topicalizes adherence because the doctor makes an explicit reference to the patients' medical records and infers from it to assert that the patient has been nonadherent. Adherence and respectively nonadherence is something the doctor seeks to know about. Consequently, he uses the history-taking activity to explore the patient's past health-related behaviour. The test questions, the comparing patients' responses with the record, the accusations, show that the doctor has some "nonadherence bias", a presupposition that patients are not adherent. Thus, the relationship between the doctor and patient is characterized by this presumption. The extract shows that the history-taking question-answer adjacency pair sequences interrogate the patient's adherence to CD4 count tests, especially because her CD4 count tests are topicalized as a first question or as a follow-up question to complaint solicitation questions. The consultation presents an overt evidence to support the assertion made earlier that when doctors presume that patients have been nonadherent to the medical recommendation, they would have habitually interacted with patients' medical records before patients are called in for consultations. Though sometimes their presumptions are wrong, the doctors pursue this agenda by directly accusing the patient of nonadherence to medications, while talking about other medical

recommendations that the patient did not comply with. As shown in extract 6-5, the doctor uses the explicit adherence-related question to request confirmation of the case record, as evidenced in the repeated medical history-taking sequences that follow the question. After confirming her suspicion, the doctor does not designate turns to address the patient's concerns regarding treatment prescriptions though the latter does not actually initiate or propose those turns – engendering less participation and shared decision making. Her action in prescribing drugs is instructive because she affirms that the patient needs to be monitored closely and a further decision needs to be taken on her return visit (lines 37-39).

Furthermore, doctors ask explicit adherence-related questions in the history-taking phase when patients show signs of ill health. As earlier mentioned, in some of the clinics, patients are admitted, who have a combination of HIV and Tuberculosis (as an opportunistic infection), among other infections. Hence, a cough is related to HIV. In extract 6-6, the doctor asks the patient to cover her nose and mouth with a handkerchief, so as not to transmit the airborne TB disease to others in the clinic. The patient had come into the consultation room coughing (line 01) and this prompts a complaint solicitation question "What is the matter with you?" (line 02).

Extract 6-6: *"When last did you do your CD4?"*
```
01   Pat: ((coughs))
02   Doc: <<p> what is the matter with you>
03   Pat: i cough a lot
04   Doc: <<all> use your handkerchief use your handkerchief>
05   Pat: ( )
06   Doc: since when have you been coughing
07   Pat: it's up to a week now
08   Doc: it's up to a week or a month
09   Pat: ehn
10   Doc: [a month?]
11   Pat: [that i  ] have been coughing?
12   Doc: hmm:::
13   Pat: it's once a [while]
14   Doc:             [it's ]once a while
15        do you have catarrh with it?
16        (.)
17        do you have catarrh with it?
18   Pat: no
19   Doc: when last did you do your CD4?
20   Pat: -- hmm[::: ]
21   Doc:        [hmm?]
22        (.)
23        <<all> i can't hear you o>
24   Pat: -- in august
25   Doc: august last year
```

```
26          (.)
27          and you don't know you ought to do another one?
28    Pat:  i wanted to:::
29          they stole the thing:::((lab form))
30          where we submitted the form (.)
31          the form was stolen
32    Doc:  <<ff> AH> you are on your own o
33          you are your own (.)
34          from 149$^{24}$ (.) you have dropped to 98$^{25}$
35    Pat:  i am sorry
36    Doc:  you are not helping us=
37          =you are not helping yourself
38          now (.) your cee dee four count is dropping
39          and you were told to do it at a point
40          you didn't do it::: you didn't do it (.)
41          <<ff> its NOT good o>
42          this is bad behaviour (.)
43          this is a very bad behaviour
44    Pat:  you will just forgive us and have mercy
45    Doc:  i should have mercy (.)
46          i told you to do test;
47          you said i should have mercy
48          what other mercy do i have to offer
49          than to ask you to go and do test?
```

With the complaint solicitation question, the doctor asks an information question that topicalizes the patient's medical health. Subsequent turns show that the patient's ill health serves as an indicator of nonadherence to medications. The doctor offers ostensive cues with the complaint solicitation question (line 02), to aid the patient's understanding of its topic focus and to establish the severity of her complaints about a cough (line 06). When the patient responds to the duration of her cough in line 07, the doctor immediately reformulates the question at his next TCU (line 08) – he establishes the accuracy of her response (due to what he is currently observing from her medical records) and diagnoses its severity (lines 06-17). Again, by comparing the patient's response with the record, he corrects the patient's response with his own knowledge from the documentation. Thus, he orients to her complaint about cough as an opportunistic infection, maybe as an onset of Tuberculosis, because he asks if the cough has been persistent (going by the fact that most patients here have both HIV and TB). The patient initially responds affirmatively to the persistence of the cough for over a month, with the discourse fragment "ehn", which presupposes

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[24] Here, the patient has a CD4 cell count of 149, which is considered a weak immune system.

[25] The doctor complains that an already weakened immune system of 149 CD4 count cells has further decreased to 98. This means that the patient's ill-health from HIV and TB is justifiably due to the decrease in the quantity of immune (white blood) cells.

an affirmative "yes" in the Yorùbá interactional context (line 09). She responds further in the negative about experiencing catarrh with the cough (line 18). The Yorùbá expression "ehn" may not be directly accepted by the respondents as a statement of acceptance, probably because the expression only gives an assessment of acceptance and not an actual acceptance of a proposition. In some interactional contexts, Yorùbá people use it to avoid being sanctioned or held accountable for a direct response. "Ehn" may also occur in contexts where its speakers use it as a constant interruption during conversations (Crowther 1852). Thus, to receive further information regarding the patient's health, one question leads to the other (lines 10-18) but at line 19, the doctor asks an explicit adherence-related question on CD4 count tests "When last did you do your CD4?". This sequential closeness suggests that this question is in service of finding out the reason for the cough. The patient hesitates and drawls "- - hmm:::" (line 20) while the doctor offers a question intoned repeat "Hmm?" (line 21). When the patient still does not take a turn (line 22), the doctor offers an other-initiated self-repair that addresses the problem of hearing the previous turn. His statement is structured as an interrogation at the police "I can't hear you o" (line 23) (implying "say it quickly!") The patient finally responds to the question (line 24). Afterwards, the doctor assesses her response (line 25) before asking another question (line 27).

The interrogative format "and you don't know you ought to do another one?" (line 27) is instructive because the patient is accused of not taking the responsibility to conduct the necessary CD4 count test. The accusation is a negative assertive format focusing on the patient's state of mind and operating as an implicit accusation. The patient orients to this action quality and accounts for not having done the CD4. The accounts make it easier/ more aligning for the doctor to utter direct accusations in the following sequence. Thus, the format generates an account. However, her explanation about the laboratory form being stolen from the clinic (lines 28-31) did not suffice even though she tendered this explanation to exonerate herself from the doctor's accusation. Following this, the doctor exclaims and declares her on her own (lines 32-33).[26] This response admonishes and accusing the patient of bad (= nonadherent) behaviour. He further casts blame on the patient for her decision not to adhere to the medical recommendation regarding CD4 count testing. He informs her, that her CD4 count volume is dropping (line 34-38) and finally declares her behaviour as bad with an explicit accusation in the form of negative assessment of health-

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[26] This expression is a Nigerian English expression for what will probably be stated in Standard British English as: "I am not in support of your decision and in case any problem arises, I will not be held accountable for your actions."

related behaviour (lines 41-43). Meanwhile, the patient pleads that he excuses her behaviour (lines 35 and 44) but her pleas are not accepted as credible (lines 45-49).

In summary, extract 6-6 shows a unique kind of adherence-related negotiation. It shows that patients' ill health may prompt an explicit health-behaviour question and this phenomenon is not surprising. An HIV-positive patient with a failing health is presumed to have a weakened immune system which is a consequence of either irregular drug use or drug failure. In this consultation, the patient's nonadherence is made explicit in the history-taking question, especially since she offered (dispreferred) accounts of her nonadherence. Hence, the doctor's negative assessment of her behaviour and accusations are justifiable.

In another consultation (extract 6-7), the doctor explicitly accuses a patient of nonadherence when he requests to know the last time she took her CD4 count test (lines 08). Prior to this explicit adherence-related question, the participants had exchanged greetings in a first sequence (lines 01-02) and the doctor had read the patients' medical records (line 03). After these preliminaries, he asks a current-state, "initial-inquiry" (Sidnell 2010: 49) "How are you?" question, which receives a "fine" response and completes the second sequence. In a third sequence, he asserts that her clinic visits have been inconsistent since the last time she received drugs, using an unmodalized (epistemic access) statement about the patient's behaviour as one practice to initiate or (re) engage in adherence negotiations and to perform accusations (lines 06-07). This assertion then prompts the CD4 count question (line 08).

Extract 6-7: "When last did you do your CD4?"
```
01   Pat: good morning doctor
02   Doc: good morning
03        (0.7)
04        how are you?
05   Pat: fine
06   Doc: since we gave you drugs
07        you have not come back
08   Doc: when did you last do your cee dee four count?
09   Pat: ( )
10   Doc: EHN?
11   Pat: it's here sir ((shows test result))
12   Doc: i want you to tell me
13   Pat: that was   [ehn::: in::         ]
14   Doc:           [have you done again]
15        (.)
16        this year at all?
17        you have not seen doctor this year at all
18        <<p> you have not seen doctor this year at all>
```

```
19          when i saw you in february (.)
20          i said you should do CD4 count
21   Pat: yes now,   [I DID IT        ]
22   Doc:            [HAVE you done it?] go and collect it
23          (10.0)((patient leaves the room and returns after 10 mins))
24   Doc: sit down madam (.) so, WHAT HAPpened
25   Pat: mr::: X((lab attendant))
26          said that he cannot find it ((CD4 test result))
27   Doc: ⁻he said he can't [find it]
28   Pat:                   [yes    ]
29   Doc: and you are sure you did the test
30   Pat: yes
31   Doc: what is your weight now
32   Pat: se:venty::: seventy eight
33   Doc: <<pp> ok>
```

The patient's response to the question is inaudible (line 09) but after the open-class repair initiator "ehn?" (line 10), which pressures her for a response, she attempts to show him the test result (line 11). However, she is requested to produce a more recent test result (lines 12-16). The doctor's "Have you done again?" (line 14) overlaps her hesitated response in line 13. Again, in lines 17-18, the doctor uses an unmodalized statement about past health behaviour as a practice of accusation. Furthermore, her loudly uttered defensive, declarative turn "I did it" (line 21) responds to the accusation that she has not visited the clinic to see a doctor since February (lines 16-20).[27] The doctor then repeats his overlapped question in the vicinity of the patient's incomplete turn "Have you done it" (line 22). Evidently, while the patient pursues a justification with her affirmative statement "Yes now" (yes, of course) and loudly uttered "I did it" (line 21), the doctor pursues his interrogation in line 22. The interrogation is made more relevant with the doctor's metapragmatic comment "and you are sure you did the test?" (line 29), which makes her justification questionable. During the 10-minute break (line 23) the patient had visited the clinic's laboratory to collect the new CD4 count test result. Eventually, she returns to inform the doctor that the lab attendant has misplaced her CD4 count test result (lines 25 - 26). Afterwards, the doctor reconfirms the patient's report of a missing lab test result by repeating the report with an other-initiated other-repair that sustains his understanding of the information "He said he can't find it (line 26). The patient offers a minimal "Yes" response (line 28). However, she is re-interrogated again with a nonadherence

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[27] This interaction was recorded in November of the same year, approximately nine months after her alleged last visit to the clinic.

bias which appears through suspicions "And you are sure you did the test" (line 29) before the consultation proceeds to other routine concerns (lines 31-33).

In this consultation, it is evident that the doctor aligns with the patient's defence because has not shown signs of opportunistic infections, other illnesses, or reduced CD4 count cells. This occurrence resounds the argument in the previous extracts that where doctors establish the presence of an opportunistic infection, patients' irregular clinic visits and reduced CD4 count cells, the patient is made responsible for her adherence to medical recommendations and general health. Despite evidence that might point to the clinic's operational laxities, if patients fall severely ill, their accounts become dispreferred and ignored. Thus, when the patient has not complained about any critical illness, her accounts are assessed, is more believable, and is validated.

In summary, explicit-adherence related questions, as examined in extracts 6-1 to 6-7, request for information (on adherence). However, the questions explicitly project nonadherence as a trajectory in the history-taking sequences, hence their functions as accusations, with consequent justification from patients. The questions' sequential properties are as follows:

- asked after medical records are read
- leads to sequence closure or more adherence-related questions

Patients' responses with accounts show that these accounts are dispreferred responses and they often indicate nonadherence to medical recommendations. Reproach, in the form of accusations, are optional when patients are found to be adherent to medical recommendations.

6.1.1.2 Implicit Questions on Past Health-Related Behaviour

In type II visits, implicit questions on past health-related behaviour (adherence-related questions) occur in different circumstances but the questions' links to adherence are optional and not apparent in the question itself or in the patient's responses – the questions are used as indicators/aspects of adherence or nonadherence. One instance is when patients are experiencing stigmatization. In extract 6-8, for example, the consultation begins with a first pair part greeting (line 01), after which the doctor requests to know if the patient was just arriving (line 02), and from which location (line 04). The doctor asks these questions because the patient arrived late at the clinic (not shown in the extract). Meanwhile, the patient confirms her later arrival (line 03) and where she travelled from (line 05).

Extract 6-8: *"So what drug are you using?"*
```
01   Doc: good morning ma
02        are you just coming
03   pat: yes
04   Doc: from where
05   Pat: from kogi
06        (0.6)
07   Doc: so what drug are you using
08   Pat: the drug from the pharmacy
09   Doc: ok
10        any other drug?
11   Pat: no o:: its just that one
12        i use it regularly
13        (1.0)
14   Doc: why do you come from so far
15   Pat: AH:: doctor
16        people know me too much there
17        if they know, i will just die
18        they must not know
19   Doc: i see
20   Pat: ehn:: ah
          yes:: ah
```

What follows the first two sequences is a 0.6 seconds' break, at which time, the doctor should be reading her medical records. Afterwards, his information question "So what drug are you using?" (line 07) begins a third sequence that seeks to know what drug the patient is currently using. The question is adherence-related (to check whether the patient knows about the medication – medical literacy as an indicator of adherence). The question is designed with the same "so" preface, an inferential marker as observed in extract 6-1. The patient responds by stating that her drugs (ARV drugs) are the normally recommended ones from the clinic's pharmacy. Afterwards, the doctor responds with a sequence closing third, a minimal response "ok" (line 09), which is immediately followed by another sequence initiation, a FUQ "any other drug?" (line 10). In response to the FUQ, the patient's "No o, it's just that one (lines 11) uptakes on the projection that the FUQ investigates her use of self-medication. Hence, she designs her response with a negative marker and an elongated discourse marker "No o::", which defends against a possible accusation and asserts that only the recommended drugs are ingested "It's just that one" (line 11). Her turn is completed by a statement of reassurance – she reassures the doctor that she uses her drugs regularly "I use it regularly" (line 12).

Note that the patient did not present any medical complaints or adverse reactions to an existing ARV drug that normally should warrant these drug-use questions. Nevertheless, the doctor requests to know, maybe as part of the normal concerns of the routine encounters, and maybe also

because there are reasons (from her medical record) to question the patient's appropriate drug use. An evidence of this is that after a 1.0-minute break (line 13) (the doctor is still scrutinizing her medical record), he asks another information question "Why do you come from so far?" (line 14). The patient responds with multiunit turns – she first exclaims loudly "AH::" and proceeds to state the reason why she needed to travel several miles (from Kogi to Ekiti state) for consultations (lines 15-18). Apparently, due to stigmatization, she needed to travel several hours from her state of residence, Kogi (a state in the north-central zone of Nigeria) to Ekiti state (a south-western state), for consultations. She declares that if people know she is HIV-positive, she will commit suicide. What follows is an assessment of this declaration "I see" (line 19) and a positive confirmation to the assessment "Yes:: ah" (line 20). Consequently, having confirmed a severe case of stigmatisation, the doctor takes her medical history of drug-use, after which he eventually confirms the effects of stigma on her medically-related choices (distant travels for consultations). Here, the consultation shows that implicit adherence-related question feature questions-answer sequences. However, the patient is not found to be nonadherence. Thus, there are no accusations of nonadherence in subsequent sequences.

In type II visits, implicit drug-use questions may also inquire about patients' use of alternative treatments. For instance, in extract 6-9, the doctor introduces the first sequence by soliciting the patients' medical complaints. This is done on the presumption that she may have a complaint and may not be healthy because she had not visited the clinic as required.

Extract 6-9: "*What drug are you on at the moment?*"
```
01   Doc: madam hope there is no complaint?
02   Pat: no doctor
03   Doc: you feel healthy?
04   Pat: yes doctor
05   Doc: ok o::: --
06        when is your expected date of delivery?
07   Pat: <<pp> ( )>
08   Doc: and you have not started receiving health care
09        for your condition?
10        that is not good enough
11        (0.4)
12        that is not good enough --
13        so what drug are you on at the moment?
14   Pat: the two drugs
15   Doc: EHN?
16        WHAT TWO?
17   Pat: ( )
18   Doc: what two are you talking about
```

```
19   Pat: <<p> the ones given to me at ile alagbo>
                       ((traditional herbal center))
20   Doc: what are you doing there?
21        (.)
22        you want to give birth
23        at the traditional herbal enter?
24   Pat: THAT is where i have been receiving care
```

Here, the patient is pregnant and has not been receiving care at the Prevention of Mother to Child Treatment (PMTCT) centre (we assume, as is the norm, that the doctor already knows this from her medical record before the consultation starts even though one can see from the doctor's behaviour (statements as in line 08) that he knows something about the patient's history.). Hence, when the doctor solicits her complaints with a question designed with an assertion and an expression of hope "Hope there is no complaint?", and the patient states no problem (line 02), he reformulates his initial opening question with the first pair part of a second sequence, to emphasize her medical health status with an assertive question "You feel healthy?". The patient responds affirmatively "Yes doctor" (line 04), while the doctor offers a minimal sequence closing third and an elongated discourse marker "Ok o:::" (line 05). In chapter 5, we examined the function of the discourse marker "o" as "constituting the beginnings and endings of conversation" in Nigerian English usage and "functioning to secure attention, agreement and solidarity with the listener" (Enyi 2015: 47-48). Hence, with the "Ok o::", the doctor offers an agreement that is designed to seek attention, or draw attention to an ongoing talk. Implicitly, it indicates an agreement offered with some reservation, especially when it reacts to an addressee whose epistemic access is not shared with the questioner – only the patient can ascertain whether she is healthy or not. Giving the current situation, i.e., not having started the PMTCT clinic, the doctor starts another sequence with a question that seeks to know her expected date of delivery (EDD) (line 06).

From this consultation, it is evident that the pregnant patient is yet to begin the routine check-ups and has no obvious medical complaints. However, in soft speech, she reveals some alternative drugs taken outside the clinic settings – the traditional herbal centre (THC). When the doctor interrogates her about this by questioning and criticizing her behaviour through repeating and explicating what she has said before (lines 22-23), she offers the needed information explicitly "That is where I have been receiving care" (line 24). As an unlearned Yorùbá woman, the patient may not be informed about how herbal medicines may contra-indicate with ARV drugs (not shown in the extract). However, it is noteworthy that the patient states her treatment options, in response to the implicit drug-use question. This probably necessitates the doctor's non-accusative treatment

of her alternative medical options. The patient offers a very soft inaudible response while the doctor proceeds to assess her response. His assessment is started with a coordinating conjunction "and" which connects with the current nonverbal action of scrutinizing her medical record. He utters a confirmation of the information accessible to him "and you have not started receiving health care for your condition" (lines 08-09) and a negative assessment "That is not good enough" (line 10). After a 0.4 seconds break (he is still reading her medical records), he repeats the negative assessment (line 12). Subsequently, the next sequence asks a question on drug-use which is prefaced with the "so" inferential marker "So what drug are you on at the moment?" (line 13). Note that the turn ending features a prepositional phrase "at the moment" which relates to the current state of drug use i.e., "right now". This turn design orients to the patients' current well-being in the light of her non-registration a the PMTCT clinic. Eventually, the patient states that she is using "The two drugs" (line 14) that were given to her at the THC (line 19). The doctor further requests to know why she had visited this herbal centre (line 20-23) and she confirms that they have been providing her with antenatal care "That is where I have been receiving care (line 24).

Notably, the patient's medical history of clinic visits occurs only after the doctor presumes a problem: though the patient has not presented any medical complaints, her non-registered status with the clinic is an important indicator of nonadherence. This is not obvious on the surface of talk because what is visible is that the questions and doubts her past health behaviour. However, we have previously integrated 'attendance at health centres' in our conception of adherence (see section 3.3, P. 50) – this is an important aspect of the way doctors conceptualize adherence in the clinics. Thus, we may deduce that the doctor uses the information in the patient's medical record, to ask about the consistency of her hospital visits and alternative treatment options. Since the statement in line 08 hints at a past recommendation which first assesses the patient's health behaviour, the question-answer sequences are followed by a negative assessment, reproach (accusations about nonadherence to medical recommendations) and subsequent justification. In sum, the extract showed that reference to a past health-related behaviour may be implicit when patients are suspected to have been noncompliant to the institutional requirements.

In another consultation, extract 6-10, the doctor opens the consultation with the first sequence, a multiple turn with a double form questions that ask about the patient's medical record and weight (lines 01-02). Subsequently, during the 0.3 seconds' break, the doctor reads her medical

record before he asks the implicit drug-use adherence question in a second sequence "When did your drug finish?" (line 04).

Extract 6-10: *"When did your drug finish?"*
```
01   Doc: where is your file where is your weight
02        drop it <<all> sit down>
03        (0.3)
04        when did your drug finish
05   Pat: what happened is that they wrote:::
06        it's been a while
07        i will collect another one
08   Doc: where is it
09   Pat: it is finished
10   Doc: <<all> if you don't answer my ques[tion,>]
11   Pat:                                  [AH?  ]
12        this is what it remains
13   Doc: <<all> i also will not answer yours as well>
14   Pat: okay↓
15   Doc: the one (CD4 count test result) brought the last time
16        was okay now=
17   Pat: =ehn::: seven something
18   Doc: yes you are improving
19   Pat: thank you doctor
20        you attended to me
21        the first time i came here
22   Doc: hmm:
```

Her response, though indirect, offers an extended explanation on what she considers the most relevant of the three requests, i.e., an account of what happened to her drugs (lines 05-07). In line 06, she offers a direct response and in line 07, she orients to the doctor's expectations of responsible health-related behaviour by explicating intentions to act. Her response also reveals the principle of closeness which often occurs in mundane talk: If you ask three questions, you get a response for the last one. In the next sequence, the doctor re-states his question "Where is it?" (line 08) and in line 09, she declares that her drugs are finished. The consultation immediately shifts to turns that address the patients' indirect responses (the account). Through a fast, connected speech, the doctor uses a very confrontational and dissenting utterance – a pronouncement of non-cooperation which threatens not to respond to her requests or concerns if she also failed to respond directly to his questions on drug use (lines 10 and 13). In-between his threat, the patient exclaims "AH" (line 11), before offering a different response about her drugs "This is what it remains" (line 12). The participants then move on to other businesses when they begin a topical shift to the patient's CD4 test results (lines 15-22). The doctor treats the patient's response as primarily

evasive because she gives an account that does not reveal her knowledge about her drug use. He then pressures her for directness with a commissive act (lines 10 and 13) that reinforces his institutional authority as the knowledgeable questioner and the patient, as the less authoritative answerer within the context of the consultation. This probably necessitates his use of threats and interrogation to commit the patient to openness. Evidently, his methods proved effective in pressurizing her to offer information about her drug-use routines.

In this consultation, the doctor adopts requests for an explanation in a way that suggests that he has prior knowledge that her drugs already finished before she visited the clinic. Patients are normally expected to renew their prescriptions at the clinics before their drugs are exhausted because this is the only way to ensure that the ARV drugs are taken daily and often. Hence, this background knowledge is jointly managed by the participants who orient to the implicit drug-use question as information-seeking. This background knowledge is also probably consequential on the patient who does not respond to the question as though it were face threatening. Instead, she purposively aligns with doctor's explicit request for information about her drugs. The interactional trajectory of the consultation is particularly insightful. It shows that in certain contexts, implicit adherence-related (drug-use) questions may be efficiently adapted for patients with a hidden truth or opinion that directly affects their health. It may also mean that drug-use questions are oriented to by patients as pointing to adherence: She accounts for being out of medicine instead of just saying: they finished two months ago. Hence, there may be some familiarity between both interactants that allows for an authoritative-laden consultation and allows the doctor to threaten the patient for information even when she has not shown the usual signs of nonadherence. Thus, since the patient appears to be nonadherent, the adherence question is followed by dispreferred answers (accounts), a negative assessment and more adherence-related questions on CD4 count tests.

Drug-use questions may also establish the institutional dimension of the encounter, specifically in the context of its interactional goal. Let us again consider extract 6-11. Sequel to inviting her to come in and take a seat (line 01) and reading the patient's medical records (the

pause at line 2),[28] the doctor designs his history-taking question in a way that suggests that her previous clinic visit for drug collection was questionable.

Extract 6-11: *"When last did you collect drugs?"*
```
01   Doc: just come in and sit
02        (5.0)
03        when last did you collect drugs?
04   Pat: about two months ago
05   Doc: so (.) any problem?
06   Pat: i feel ehmm… tired (.)
07        the thing (gestures to her stomach)
08        will be hurting me small small (.)
09        small small
10   Doc: after taking the drugs?
11   Pat: ehn::: after taking the drugs
12   Doc: don't worry (.)
13        you'll be okay
14   pat: but ehm::
15        since ( )
16        do i request to do another CD4 again?
17   Doc: when was the last time you did CD4
18   Pat: in february
19   Doc: february (.)
20        ehn:: you did one in March
21   Pat: okay in march
```

The history-taking question topicalizes and questions about adherence (it is not really suggesting nonadherence on the surface) – the doctor asks when last she collected her drugs (line 03) and the patient completes this first sequence by responding that she collected her drugs about two months ago (line 04). Thus, by asking when last she collected her drugs, this doctor asks the question based on the assumption that her last clinic visit for drug collection is questionable. However, the patient responded that she has been adherent because she visited the clinic at the recommended time – "two months ago" (line 04). It is evident that the opening question justifiably topicalizes a history of the patient's clinic visits and this is completed before the doctor continues to solicit her present complaint "So any problem?" (line 05).

This conversational indirectness is more observable with the doctor's apparent interest in the patient's immediate medical complaints when he emphasizes on drug collection and drug use in the first and third sequences (lines 03/04 and 10/11 respectively). Note that the interactional

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[28] It is standard procedure at the clinics that patients record their complaints with the nursing staff before consulting with the doctors. The nursing staff inputs these complaints in the patients' medical records before passing them on to the doctor on duty to observe, and afterwards consult with the patients.

goal is evidenced at these two crucial sequential positions (sequence 1 and 3) – the doctor prioritizes the patient's clinic visits while indirectly investigating her adherence to drug collection and consequently, drug use. Therefore, the consultation is organized to scrutinize the patient's adherence to regular clinic visits, because it appears the doctor presumes, before the drug-use question, that the patient was nonadherent. However, it is notable that with this indirectness, comes a seemingly informal atmosphere for the consultation to take place: by quickly dispelling with the drug-collection question to request about her state of health, the consultation progresses with a presentation of medical complaints. Here, the patient is found to be adherent. Hence, question-answer sequences are not followed by accusation and the sequence proceeds to other medical concerns.

Implicit adherence-related questions may also be relevant when it asks about patients' previous visits to the doctors'. In extract 6-12, the rhetorical function of the implicit question "When last did you see a doctor?" (line 05) stems from an examination of the patients' medical records. Here, the patient reports nonadherence to medical recommendations on the excuse that the clinic or medical staff has some laxities – she states that her nonadherence is in related to certain weaknesses in the way the hospital staff conduct their tasks.

Extract 6-12: "*When last did you see a doctor?"*
```
01   Doc: what's your name ma
02   Pat: ( )
03   Doc: ok, have a seat ma
04        sit down there ma
05        when last did you see a doctor
06   Pat: on the 8th
07   Doc: two years have passed
08        you have not seen doctor
09        two years have passed
10        you have not done cee dee four.
11   Pat: i've come  [to:::        ]
12   Doc:            [before today]
13        when did you do your cee dee four?
14   Pat: i USED to come to (.) they say:::
15        i should call them on phone that they
16        there is no::: ehm syRINGE
17   Doc: ehn ehn:::?=
18   Pat: =they no get [extra  ]
19   Doc:             [there's] no sy [RINGE]
20   Pat:                             [no   ]
21   Doc: <<pp> ok>
```

The doctor initiates the first topic slot by identifying the patient (lines 01-04) before interrogating her on clinic visits (lines 05-06). When her responses do fit the institutional relevancies, he declares her nonadherent by accusing her of irregular clinic visit and CD4 count testing with an unmodalized statement as an accusation (lines 07-10). To justify her actions, the patient informs the doctor that her efforts to obey the clinic's expectations concerning adherence has failed due to the clinic's operational laxities. With a speech overlap from the doctor (line 12), she responds by starting to offer an account of what has transpired (line 11). Using a drawled lexeme at the clausal end of her turns (lines 11 and 14), she states that tests could not be taken at the clinic because the lab technicians complained of the insufficient syringe at the clinic laboratory (line 15 and 16) – her account accuses somebody else. The doctor responds with an assessment token "ehn ehn:::?" (really?) (line 17), reconfirms her information (line 18 and 19) and then produce a sequence closing third "ok" (line 21). Evidently, the patient offers new information regarding the irresponsibility of medical practitioners. With his assessments and repetitive turns, the doctor, at least, suggests that he is ignorant about her "new" information. In this context, the patient has abstracted away from being responsible for nonadherent behaviours. And, since this is not contested, it may suffice to say that she has successfully got the doctor informed of her positive disposition towards adherence to medical recommendations.

In summary, as examined in extracts 6-8 to 6-12, the formal and functional properties of implicit-adherence related questions show that they are rhetorical questions which request for confirmation of patients' adherence according to the medical records that show what transpired in previous clinic visits. The rhetorical questions may also be asked after patients show physical evidence of ill health. However, the questions implicitly project nonadherence as a trajectory in the opening phases. The sequential properties show that they are asked after medical records are read and they lead to more health-related/adherent-related questions.

6.1.2   Supposing Nonadherence Through Accusations

In the corpus, there are practices of accusation that relate to adherence. These practices are noticeable when asked after the explicitly-framed health-behaviour question "(When last) Have you done X" is asked. Accusations are recovered as rhetorical questions, epistemically unmarked statements and negative assessments of health-related behaviour.

6.1.2.1 Rhetorical questions

As earlier mentioned, HIV-positive patients are expected to be adequately aware of their medical condition, while also regularly monitoring CD4 count volumes every three months. Thus, when patients do not fulfil this expectation, the doctors may ask questions that relate to this expectation, although, responses to these questions may be visible in the medical record. In extract 6-13 for example, the patient does not fulfil the expectations of regularly conducting CD4 count tests. The doctor invites her to take a seat and asks about the last time she took the CD4 count test (line 01-02). Apparently, she had taken the test "last year", at least eight months before this consultation (line 03).

Extract 6-13: *"Who told you not to do CD4?"* (Cf. Extract 6-4, P. 123)
```
01    Doc: sit down X (.)
02         <<writing> X? when last did you do cee dee four count>
03    Pat: (.) like::: last year (unintelligible, appr. 2 sec)
04         (--)
05    Doc: who tell you make you no do cee dee four count
           who told you not to do cee dee four count
06    Pat: (       )
07    Doc: hm:::
08         (0.2)
09         <<pp> so na dat time you go do am>
                 so that was when you did it
```

Her response shows that she was nonadherent to recommendations of regular CD4 count tests. Consequently, in the next sequence, the doctor's "Who told you not to do CD4 count" (line 05) is an accusation which is made by the rhetorical reference to a third-party. The third-party reference suggests that the patient had not taken responsibility for her medical condition because a certain person had influenced her decision not to take the CD4 count test. Unfortunately, the patient's response at line 06 is inaudible. However, it appears that she eventually states a time when the test was conducted because in a next turn, the doctor offers an assessment by "doing" thinking with the marker "hm::" (line 07), and afterwards observing a two seconds break before confirming this information (line 09). The consultation shows that when the doctor reads and writes on the patient's medical records (line 01-02) and accesses the information gathered from the medical record, he is prompted to ask rhetorical questions that may already be apparent in the medical record.

6.1.2.2 Epistemically Unmarked Statements

In another situation, practices of accusation are realised through epistemically unmarked statements. In extract 6-14, the doctor's assertion "Madam you have not done CD4 since 2013" (line 08) is epistemically unmodalized – it asserts that the last test was conducted two years before this consultation. Hence, the doctor displays a certain epistemic stance towards this piece of information he seeks to know.

Extract 6-14: *"You haven't done CD4 since 2013"* (Cf. Extract 6-5, P.125/126)
```
08   Doc: madam you have not done cee dee four since 2013
09        true or false?
10   Pat: (.) it should be::
11   Doc: [true: or false ma?    ]
12   Pat: [it should be last year]
13   Doc: which time last year madam?
14        what time last year
15        the last cee dee four i am seeing here ((medical record))
16        is september 2013
17        the one ((test form)) they gave you last year (.)
18        it is empty (.) you didn't do it
19   Pat: i --
20   Doc: it's true now madam (.)
21        <<all> see it now >
22        there's no result on it
23        it did not even get to your hand (.)
24        [so::                                  ]
```

The repeated true or false is also a confrontational format that interrogates the patient by providing evidence that obligates her to respond to the accusations. The accusation is further completed in the next turn with a question that challenges the patient to deny the assertion "true or false?" (line 09). In line 10, the patient hesitates with a pause and a statement of uncertainty "It should be::" The doctor then restates his challenge: "true or false ma?" (line 11) before the patient finally completes the base pair sequence by overlapping her response to the CD4 count question – "It should be last year" (line 12). Her repair at the prolongation of the turn initial (line 07) and turn ending (line 10) suggests that she hesitates to utter a dispreferred response and this is an evidence that she could not sufficiently confirm her regular visits to the clinic to conduct the recommended CD4 count tests. Following this response, the doctor utters repeated FUQ "which time last year … madam" (lines 13 and 14) and refers to the medical records. He explicitly states that by her medical records, the patient's last visit to the clinic to take a CD4 count test was two years before this

144

consultation (lines 15-18): "You didn't do it" (line 18). Again, the patient hesitates, and the doctor produces evidence to validate his accusation (line 20-24). This extract shows that the consultation topicalizes nonadherence because the doctor makes an explicit reference to the patients' medical records and infers from it to assert that the patient has been nonadherent.

Similarly, in extract 6-15, the doctor uses an unmodalized, epistemically unmarked statement about a past health behaviour as a practice of accusation. In lines 17 and 18, he accuses the patient with a repeated assertion "You have not seen doctor this year at all" and proceeds to account for his assertion with an explanation "When I saw you in February I said you should do CD4 count" (lines 19-20).

Extract 6-15: *"You have not seen doctor this year at all"* (Cf. Extract 6-7, P. 131/132)
```
17          you have not seen doctor this year at all
18          <<p> you have not seen doctor this year at all>
19          when i saw you in february (.)
20          i said you should do CD4 count
21    Pat: yes now,   [I DID IT       ]
22    Doc:           [HAVE you done it?] go and collect it
23          (10.0)((patient leaves the room and returns after 10 mins))
```
His accusations are based on an explicitly expressed epistemic stance about the patient's previous visit, his recommendations for a CD4 count and the knowledge that patient was nonadherent to this recommendation. However, with a loudly uttered defensive and declarative turn "I did it" (line 21), the patient's response to the accusation was that she was adherent. The doctor then repeats his question with an overlapped turn "Have you done it?", which is completed with an instruction to go collect the test result (line 22).

In another instance in the corpus, the doctor accuses the patient of nonadherence to recommendations of regular clinic visits with an epistemically unmarked statement. In extract 6-16, this accusation is contextualised by the assertion that she has not seen a doctor since 2009 (six years before this consultation). The patient responds by downgrading the accusation with a loudly pitch second assessment "NO O, the last time was last year" (line 11).

Extract 6-16: *"The last time you saw a doctor was in 2009"* (Cf. Extract 6-2, P. 118/119)
```
10          the last time you saw a doctor was in 2009
11    Pat: NO O? the last time was last year (.)
12          you spoke to me last year
13    Doc: oh, inside a consulting room?
14    Pat: yes
```

```
15    Doc: hh? the last time you saw a doctor was last year
16    Pat: yes, in december
17    Doc: six months ago=
18    Pat: =december last year
19    Doc: six months ago
20    Pat: yes
```

By her response, the patient asserts that the doctor's accusation was wrong because he spoke to her "last year" (line 12). Following this response, the next turn "Oh, inside a consulting room?", informs the doctor and changes his epistemic access from "not-knowing to knowing" (Sidnell 2010: 105) (line 13), which the patient agrees with "yes" (line 14), while the doctor re-states his new knowledge with an affirmative statement that repairs the problem of understanding "The last time you saw a doctor was last year" (line 15). The patient agrees "Yes, in December (line 16) and her turn is followed by affirmations of the time frame in dispute: "six months ago" (line 17), "December last year" (line 18), "six months ago" (line 19). Finally, the patient's "yes" agrees with the preceding turn.

6.1.2.3 Negative Assessments of Health-Related Behaviour

Practices of accusation are also realised through negative assessments of health-related behaviour. In extract 6-17, this practice is evident when the doctor establishes that the patient was nonadherent (not shown in extract) and responds to this behaviour by stating that she is on her own (lines 32-33).[29]

Extract 6-17: *"This is Bad behaviour" (Cf. Extract 6-6, P. 128/129)*
```
32    Doc: <<ff> AH> you are on your own o
33         you are your own (.)
34         from 149[30] (.) you have dropped to 98[31]
35    Pat: i am sorry
36    Doc: you are not helping us=
37         =you are not helping yourself
38         now (.) your cee dee four count is dropping
39         and you were told to do it at a point
40         you didn't do it::: you didn't do it (.)
41         <<ff> its NOT good o>
42         this is bad behaviour (.)
```

---

[29] This expression is a Nigerian English expression for what will probably be stated in Standard British English as: "I am not in support of your decision and in case any problem arises, I will not be held accountable for your actions."

[30] Here, the patient has a CD4 cell count of 149, which is considered a weak immune system.

[31] The doctor complains that an already weakened immune system of 149 CD4 count cells has further decreased to 98. This means that the patient's ill-health from HIV and TB is justifiably due to the decrease in the quantity of immune (white blood) cells.

```
43        this is a very bad behaviour
```

The doctor accuses the patient of nonadherence and this accusation is further contextualised by an account that justifies the accusation. In line 34, the doctor states that the CD4 count cell volume has dropped from 149 to 98, dangerously putting the patient at risk of falling critically ill. The patient is apologetic (line 35) but she is further accused with more negative assessments (lines 36-37). With another immediate turn, the doctor further justifies his accusations with an account – he states that her CD4 count volume is dropping because she didn't conduct the test (line 38-40). Finally, he declares her behaviour as bad with an explicit accusation in the form of negative assessments of health-related behaviour (lines 41-43).

Similarly, in extract 6-18, the doctor asks about a left-over drug (line 01) and the current result of the patients CD4 count test (line 03).

Extract 6-18: "You are Not Doing Well Aunty"
```
01   Doc: how about the remaining drugs
02        (.)
03        so what do you say your cee dee four is?
04   Pat: 221[32]
05   Doc: 221
06        you are not doing well aunty
07   Pat: hmm:::
08   Doc: you are not doing well at all aunty
```

The patient offers the requested information "221" (line 04), which is then repeated for confirmation (line 05). Based on the evaluation of the CD4 test result, a negative health behaviour is implied by the negative assessment "You are not doing well aunty" (line 06). The patient's "hmm" does not contest this negative assessment, especially because she orients to the purpose of the question as an accusation that ARV drugs may not have been ingested correctly – implicitly referred to in line 01. In line 08, however, the doctor repeats the negative assessment, to ensure that the patient understands its purpose as a negative evaluation of her health-related behaviour.

6.2   Discussion

The sequential embedding of explicit adherence-related questions and intersubjective actions are insightful for examining their functions in the encounters. While they occur in question-answer

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[32] A CD4 cell count of 221 is considered a weakened immune system.

adjacency pair sequences, subsequent actions are based on patients' second pair part responses to the questions. Furthermore, when questions are followed by preferred responses, the current history-taking activity either closes (see extract 6-2 and 6-3) or proceeds to other concerns (see extracts 6-5 and 6-6). Conversely, when responses are followed by (dispreferred) accounts, the next steps are accusations (reproach), and subsequent justifications are followed by more adherence-related questions. These occur whether the patients were found to be adherent or not (see extracts 6-1, 6-4 and 6-7). These consultations have the following action sequencing: question-answer, reproach-justification, questions-answers. When patients disclose accounts for nonadherence in an explicit, non-allusive way, they orient to doctors' requests as investigations of adherence and they respond in line with this orientation, to declare their adherence/nonadherent status. Thus, patients' orientations to their disclosures of adherence are contextual interactional resources which crucially determine how their responses are locally managed. It is observed that patients know the implications of disclosing nonadherence. As Saiki and Lobo (2011) assert, patient disclosure is "the act of seeking care by revealing personally significant information that exposes the bearer to the risk of rejection or negative judgment" (2011: 2719). This definition relatively points to the ways by which patients may state their concerns or reveal sensitive health information, with or without risking judgment. It stems from Mishler's (1984) recommendations that researchers should look beyond mere descriptions of the asymmetrical context of doctor-patient interactions but to hear patients' strong voice by developing methods to hear it and theories to analyse it. Hence, research on patient disclosure, within the medical settings, have focused on patient-centeredness and the role of patients as the sole initiator of interactive (verbal and non-verbal) accounts on diverse medical concerns (for further research on patient disclosures, see; Parsons & Shils 1962; Fisher & Groce 1990; Peräkylä & Silverman 1991; Wertsch 1998; Frankel 2001; Duggan & Parrott 2001; Drew 2001, Sarangi 2004; Beach et al. 2005; Epstein et al. 2005; Floyd et al. 2005; Birkner 2006, Heritage & Maynard 2006; Kremer and Ironson 2006; Piccolo et al. 2007; Freidman et al., 2008; Jangland et al. 2009; Siebold 2011; Bergen & Stivers 2013; Koller et al. 2016). Thus, doctors' uptake on patients' responses is primarily constrained by accounts which they consider either contestable or not. For accounts with contested truths (extracts 6-1, 6-4 and 6-7), doctors' communicative stance is accusative and to this, patients respond with justification. Conversely, with shared background knowledge that is acceptable to the participants,

the functions of questions are interactionally ratified by the participants (see extracts 6-2, 6-3, 6-5 and 6-6).

The sequential embedding of implicit adherence-related questions and intersubjective actions show that the questions are rhetorical. They project sequences that are organised around the presumptions that patients have been nonadherent to regular clinic visits, drug use and CD4 count tests. Occasionally, after posing the questions, doctors subsequently refer to information from the record which is contradicting to the patients' response, e. g. when patients maintain that the attended the clinic regularly are healthy. However, it is rather striking that despite patients' defence, accusations still occur. This suggests that questions may operate as test questions, making explicit nonadherence negotiations possible. As shown in the analysis, patients react to sanctions with a defence while doctors reinforce the projection of the current talk with more adherence-related questions. Like explicit adherence-related questions, when patients disclose accounts for nonadherence in an explicit, non-allusive way, they orient to doctors' requests as investigations of adherence and they respond in line with this orientation, to declare their adherence/nonadherent status. Thus, patients' orientations to their disclosures of adherence are contextual interactional resources which crucially determine how their responses are locally managed although doctors' uptake on patients' responses are not constrained by accounts which they consider either contestable or not. Whether patients' accounts show that they were adherent or not, subsequent sequences continue to interrogate patients and establish their adherence status. The following summarises the noticings in these consultations:

- adherence is not a one-dimensional concept (use of medication). Rather, it is approached in relation to compliance with other medical recommendations, and other health-related behaviour e.g. regular attendance at the clinics and drug collection.
- adherence-related questions may be explicit or implicit.
- doctors' history-taking questions display the presumption that adherence could be a problem
- by giving accounts, patients orient to explicit and implicit adherence-related questions as a test to disclose their adherence status

One practice of making adherence come through as a topic in the consultations is through the explicitly adherence-related questions: "Are you using your drugs?" and explicit question about

health management (as an indicator for adherence or as an aspect of a broader concept of adherence). It asks about the time of the last CD4 whereas the first question "Are you using your drugs" is most explicit about adherence. "When last did you do CD4 count?". With these questions, doctors assume adherence from patients' drug-use and clinic visits. Thus, patients' adherence can occur at various levels. In the present study, it is not only about medications (a one-dimensional concept in health studies) but adherence topics are more complex, and this broadens the concept of adherence in the literature. However, even when these questions do not refer to medications, they ask about medications by requesting about other things (CD4 count test), though this is not obvious on the surface of the talk. Thus, explicit-adherence questions are pseudo-question or rhetorical questions which explicitly accuse patients of nonadherence. While producing these accusations, doctors sometimes disclose explicitly that they are asking for adherence. Thus, in these consultations, there exists epistemic access. The epistemic access is lower in the accusation because doctors display knowledge that the patient has been nonadherent. However, they seem to "play" on these epistemic accesses because the initial purpose of the question was for information, which he may already know about. Thus, arguing with their epistemic access may be somewhat vague because they look at the records and although they have the information, they still ask for the information. So, these are like test questions.

When patients disclose accounts for nonadherence in an explicit, non-allusive way, they orient to doctors' requests as investigations of adherence and respond in line with this orientation to declare nonadherence in the following contexts: (a) when reporting a medical complaint (b) when offering information about clinic laxities (c) when informing about alternative herbal medicine use. These contexts show that patients' orientations to their disclosures of adherence are contextual interactional resources which are locally managed. Conversely, with shared background knowledge that is acceptable to the interlocutors, accounts may be justifiable when the truth value of their adherence disclosures are questioned by the doctors.

Conversely, implicit adherent-related questions are marked by patients' orientation to the second purpose of the question – they orient to the purpose of the question as adherence-related, and not just for information solicitation purposes though this did not come out so explicitly in the analyses. For these questions, doctors fulfil the subtle task of generating disclosures from the patients through interrogations and compliant solicitations. However, for the doctors, some factors lead them to suspicions about patients' nonadherence. These include patients' statements about

third-party influences and stigmatization. In these contexts, patients produced all accounts, sequel to turns which are allocated for them to respond to questions about general health issues or solicitations of specific complaints. Besides this, patients will mostly show that they were cautious in revealing sensitive information that would "expose them to judgments" (Saiki and Lobo, 2011: 2713). They showed this when turns are hedged through interactional features such as hesitations, delays in responses, nervous laughter and pitch change. With these features, patients oriented to the understanding that the questions solicit for adherence which may or may not be "medication-related" (Bergen & Stivers 2013: 222).

6.2.1   Implications on Participants' Orientations to Adherence

Adherence topic features in different sequential environments, and in different activities – History-taking vs. treatment discussions (chapter seven examines treatment discussions). The sequence structure presented here proposes that in consultations with HIV patients, when opening sequences or history/taking activity consist of utterances which border on patients' history of nonadherence to medical recommendations, adherence-related questions make accusations possible, with subsequent history-taking questions. Adherence-related questions may be a normal part of the history-taking sequence, and they may either be followed by accusations and justifications or not. It is important to note that this structure applies only to encounters where adherence related topics are initiated with history-taking questions. These history-taking questions are normatively prioritized as the core medical concern for the visits (even when the consultations begin with complaint solicitation sequences). Furthermore, the sequence structure only occurs in type II visits. It does not deal with visits where patients present new medical problems (Robinson 2003: 30)[33] or medical symptoms (Burbaum 2010; Sarangi 2004). Nevertheless, when these consultations feature in the opening questions to the consultations, the questions are contextualized by certain lexical choices.

Some lexical choices play a huge role in this scenario. I found out that little items in the history-taking questions establish causal, contradictory relations to the previous talk and play a role in building up the preconditions for uttering an accusation. One example is the subordinating

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[33] Robinson (2003) categorizes medical concerns to include requests for vaccinations, paperwork, repeat prescriptions, and family planning advice. Medical symptoms are categorized to include rash, shoulder pain, and ear pain while routine problems include monitoring high blood pressure.

conjunction "but" which signals a contrary opinion to a preceding discourse. In extract 6-1, the doctor states "but your record states that you complained about cough the last time you came here (lines 03 and 04). To portray this contrariness, the patient equally uptakes on her understanding of the significance of this lexical item, to contribute to the discussion by contradicting the doctor's assumptions about her state of health "but i am thankful that the cough is totally stopped now" (lines 21 and 22). This shows that this lexical item possesses a certain quality in contextualizing both the interactional direction of these turns and how the other speaker (the patient), receives the action (apparently as an investigation) upon which the use of the lexical item is based within the context of this encounter. Another example is the use of the lexical item "so", which Blakemore (1998) refers to as a marker for inference. In extract 6-2, when the patient complains about rashes, the doctor responds "So if you were feeling fine you wouldn't have come, the last time you saw a doctor was in 2009" (lines 08-10). Here, "so" functions as a contextualization cue that conditions the patient's complaint as a cause and effect phenomenon. In response, the patient utters a loud retort "NO O? the last time was last year, you spoke to me last year" (lines 11-12). Her response, as expected, follows the interactional direction. Although the latter has a greater force of admonishment purposes than the former, both lexical items, among other contextualization cues in the opening phases of the consultations, are highly consequential upon doctors' inferences from patients' medical records. This allows for very little self-initiated contributions from patients: the topics brought forth by the doctors make the patients accountable for their adherence to medical recommendations, and makes them answerable, only in defence of this expectation. Hence, we find that patient's contributions reveal that they are aware of this, and they attempt to defend their positions regarding adherence. Thus, in this chapter, I specifically refer to certain lexical choices in the consultations, that cue patients into conversational inferences – signalling what, where and when they may contribute to the consultations. This occurs both in the history-taking phases of the consultations.

The opening phases, which is mainly characterized by history-taking sequences and close-ended complaint solicitation questions are first, a useful signal for the patients to take a TCU, state their complaint and progress through other sequences. After the initial question-answer adjacency pairs have been minimally completed, then comes the next action sequences: accusation-justification. This sequential arrangement shows that when doctors investigate patients' history of nonadherence to the medical recommendation, they may not only do so in the service of

authoritatively taking a presumptive stance that patients have not been adherent to medical recommendations but to also accuse them. The interactional strategies for completing the act of accusing include assertive utterances and inferential markers. As enunciated by Drew and Heritage (1992), utterances and actions are "context shaped" and "context renewing". The environment within which utterances occur is largely consequential upon the contextual frameworks that guide the consultations in question. In other words, utterances, as they occur in various interactional contexts, follow an observable methodological process which can be deduced from how sequences of actions and turns are progressively designed to make up the institutionality or ordinariness of the interactions that were examined.

So far, I have based my arguments on a central objective – that consultations focused on patients' adherence to medical recommendations are structured by their goal orientation and inferential frameworks. The history-taking activity where they occur specifically contextualized the doctors' agenda for the consultations: investigating and establishing the status of patients' adherence to medical recommendation(s). The activity, therefore, can be termed an act of investigation that is preoccupied with the social action of questioning for information solicitation purposes – the history-taking activity is realized as an interrogative investigation. Within this conversational activity, two paired actions (with their various turn designs) may be observed as its sequential structure: history-taking questions-answers and accusation-justification, but sometimes, patients orient to the hidden purpose of the question by giving accounts directly as a response to the question. For the history-taking activity, sequence structures are important for assessing the interactional goals and other interactional constraints such as allowable contributions and inferences (Levinson 1992). Hence, the crucial nature of sequential structures in defining human activities cannot be overstated. In the adherence-related consultations as examined above, interactional goals are evident from the history-taking sequences. And if one sequence opens the consultations, this comes with possibilities for the second sequence and third sequence to occur. These possibilities are jointly managed, coordinated and oriented to by the interlocutors. The history-taking sequence structure, therefore, suggests that doctors' pre-encounter and in-encounter perceptions patients' attitude towards adherence to drug use and active involvement in clinic visits, relates to the sequence structure of the consultations. Consequently, doctors' dispositions towards patients are oriented to, when s/he already has had access to patients' history from her medical record. In this case, doctors may either initiate the interaction by "offering to serve" (Robinson

2003: 35) through open-ended problem solicitation questions or through a direct request on patients' health status. Studies on physician's open questions (see Robinson & Heritage 2005; Heritage 2006; Frankel 1995b) find that open-ended questions establish patients' satisfaction with clinic visits and encourage proper diagnosis and treatment. These consultations, which are structured with adherence-oriented history-taking sequences do not leave allowance for patient satisfaction, let alone concerns about the treatment of a potential medical complaint. Rather, accusations are continuously foregrounded.

6.2.2   Implications on Patients' Expertise

The consultations show that doctors do not prioritize patients' biographic/body knowledge – patients are expected to just do what the doctors recommend (no responsibility to decide and no participation in the decision). This may be because patients tend not to know the names of the medication (low medical literacy). However, the medical staff is charged with the responsibility to ensure that patients adhere to doctors' rules while patients are expected to recognize the importance of these rules in relation to their HIV health. While patients are aware of the clinics' expectations concerning their HIV health, the interactants deal with these expectations by placing the authority for its execution with the doctors and other medical personnel. Therefore, the doctors use certain linguistic resources to investigate patients' nonadherent attitudes to medical recommendations. These resources include accusations through assertions and offering knowledge about the purpose of the adherence questions. Thus, the doctors use these questions to fulfil both the interactional and professional tasks of caring for the HIV patients.

With this understanding, I find that patients do not challenge doctors' authority or discretion in employing whatever interactional means possible, to investigate and ensure their HIV health. This is different from mundane interactions where accusations might be considered as face-threatening, especially when the accusation is based on a false testimony. accusations are treated differently in adherence-related consultations because the interactants orient to the general goal of the consultations, which is to ensure their HIV health. For example, in extract 6-6, the patient is accused of not attending the clinic regularly, even though the accusations are eventually, proven to be false. The patient's response, though defensive, does not connote that she considers the doctor's accusations to be offensive. She does not show emotions of anger, disappointments or sharp retorts. Rather, she defends herself, only in simple responses to correct the doctor's

impression concerning her supposed nonadherence. Though the latter's explanations are aggressively met with more accusations from the doctor, the patient ultimately submits to the doctor's authority "you will just forgive us and have mercy" (line 44). She submits to the fact that the doctor has the interactional task and professional authority to pursue his interactional goal to whatever extent possible, and that she might not have much say in this possibility. From all these, we may deduce that the interactions are primarily set to be investigative. While interrogating patients, the doctors take different stances: they may either make patients answerable for what they presume is a case of nonadherence or establish suspicions of nonadherence from the patients' responses. Inferences are ultimately made to the patient's medical histories though the doctor sometimes allows for intuitive responses from the patients. With these interactional features, the issue of nonadherence has been concretized in this chapter, as a valid discourse that requires an in-depth discussion. Though patterned differently, the individual interactional contexts, as we have examined in the corpus, all qualify these interactions as conducting different ways of establishing the same trajectory: tropicalizing patients' nonadherence to medical recommendations.

6.2.3   Implications on Doctoring Styles

This chapter has shown the interaction work that comes with eliciting both implicit and explicit health-related behaviour questions – underlying the contexts of soliciting information about patients' nonadherence within the d-p encounters. Importantly also, findings have revealed the doctoring style of an extreme form of paternalism, which necessitates patients' responses which are unique in the sense of having some sort of narrative or salient justification for nonadherence to medical recommendations. Without a doubt, nonadherence does exist as a behavioural pattern among the patients as reported in the literature (see Ekama et al. 2012; Igwegbe et al. 2010) and the doctors have shown their ability to elicit its disclosures through various interactional means. Findings from the chapter show that history-taking sequences in the HIV consultations are characterized by physicians' questions which pave the way for disclosing the patient's adherence. Thus, patients' adherence or nonadherence is predicated on the overall agenda of the activity i.e., investigating their health-related behaviours to medical recommendations. However, responses are organized differently in the select encounters – necessitating different responses to explicit and implicit questions on adherence. For both question categories, there are varying sequential

locations and contexts, but patients orient to their underlying moral expectation. As we have examined, the interrogative doctoring style may not enable patients to express the freedom to disclose concerns or behaviours of nonadherence. As Stevenson et al. (2000) and Stavropoulou (2011) assert, it is important to discourage the perception of the typical physician-patient relationship which suggests non-treatment of patients as equals and de-emphasizes patients' expertise because this may "impact significantly on their decision to non-adhere to prescribed medication" (Stavropoulou 2011: 7). Moreover, if the clinical practice of medicine were to be considered as the gradual process of care and understanding of patient' needs, then, their responses should be understood in the various interactional and medical contexts where they occur.

6.3   Conclusion

In conclusion, the adherence-related consultations (as analysed in extracts 6-1 to 6-12) show how patients' adherence is topicalized during the medical history-taking activity. This chapter also examined its implications on patients' responses and doctoring styles. The adherence-related questions that feature in the consultations are either explicitly or implicitly framed and they are initiated by doctors within the context of investigating patients' adherence to drug use, regular CD4 count testing, regular clinic visits and regular drug collection at the clinics. Consequently, the questions infer from patients' medical records – suggesting that the doctors seek evidence from patients' medical records to presume their nonadherence to medical recommendations. It also suggests that prior to asking the nonadherence questions, the doctors are already working with a presumption that patients have been indulging in nonadherent behaviours. Further evidence for the questions' functions is provided in their sequentially embedding: the questions are located after a brief pause, after patients' complaints may have been solicited and stated or after doctors realise that the patients are ill. Therefore, these adherence questions are used to utter suspicions about patients' nonadherence to medical recommendations. Findings further show that it is typical for doctors to presume, at the beginning of the consultations, that patients have been nonadherent. Thus, adherence plays such a dominant role in the beginnings, sometimes explicitly and sometimes more implicitly. Doctors address it in the beginning but refer to very different things: taking cough medicine as well as attending regularly at the clinic, doing a CD4, etc. And, they address it in a unique way, such that nonadherence is the unmarked expectation which leads to, or embodies the action of accusations, with subsequent justification from patients (see extracts 6-13 to 6-18).

Beyond the obvious motivation to 'do' questioning, patients orient to the purpose of the questions as a test to know their adherence status.

7   Ensuring Adherence During Treatment Discussions

"Poor adherence can lead to treatment failure, evolution of drug resistance, and subsequent immunological and clinical failure" (Olowookere et al. 2008: 369; cf. Machtinger & Bangsberg 2005).

"Physicians' medical authority, specified as their epistemic and deontic authority to diagnose and prescribe, creates an asymmetry that may be presumed to exist between physician and patient. When physicians recommend treatment, they adopt a position of greater epistemic and deontic authority relative to the patient" (Stivers et al. 2017: 9).

In chapter six, I examined adherence-related negotiations in medical history-taking sequences. Important findings show that doctors find out about adherence and suppose nonadherence during medical history-taking. These practices "comes through" during medical history-taking because the activity itself is structured as an interrogation which is produced with explicit and implicit questions on patients' health-related behaviours, and practices of accusations. In the present chapter, I research further on these special adherence-related consultations, with a specific focus on treatment discussions. This treatment discussion phase is worth focusing on because as we will see in the analysis, they show how doctors re-topicalize patients' health-related behaviours, to ensure that medical recommendations are adhered to. In this phase, speaking practices are realized as instructions, explanations about the importance of taking CD4 count tests, and planned sequences of next appointments. I will take these practices in turn.

7.1   Instructions

In the consultations, adherence-related treatment discussions are initiated by doctors who exercise their deontic authority to explicitly instruct patients about future adherence-related behaviours. In extract 7-1 for example, the participants begin the treatment discussion phase after having completed the medical history-taking phase – the patient affirmed that she has no medical complaint (the bridge between the previous activity and the current, as represented in line 26).

Extract 7-1 "*Adhere to your drugs*"
```
26   Doc: so (.) no complaint?
27        so your CD4 is still normal
28        keep it that way
29        adhere to your drugs
30        and feed well
31   Pat: ok
```

The patient's apparent good medical health is evidenced in lines 26-31 where the doctor confirms that she has no complaints and has a normal CD4 count. Hence, the doctor establishes the normalcy of the patient's CD4 count (line 27) and instructs that she "Keep it that way" (line 28). Subsequently, she is instructed to adhere to her drugs and feed well (lines 29 and 30). The doctor's instructions are an explicit practice to topicalize (future) health-related behaviour. Notably, he uses the verb "adhere", an imperative format which implies that the patient should take an already decided direction. With this lexical choice, and with the imperative framing of the other instructions, the doctor does not appear to be advising the patient but issuing an order. Hence, his directive does not pursue a response from the patient as something to be negotiated or jointly decided because his instructions are uttered in multiunit turns, with no turn allocation for the patient's response. When she responds with a minimal token "ok" (line 31) and a statement of gratitude "thank you doctor" (line 32), the patient shows that she orients to the deontic force of the doctor's instructions by accepting these instructions without attempting to contest it.

The imperative format in adherence-related treatment discussions is also evident in extract 7-2. Here, the doctor describes what the patient will do in the future, concerning conducting a CD4 count test (test description not shown in extract). As shown in the extract (line 01), the doctor specifies with a deictic phrase "this test", and in line 02, she instructs "you will go and do it". After a short break (line 03), the patient offers a reason why the doctor's instructions may be difficult to obey.

Extract 7-2: *"You will go and do it"*
```
01   Doc: this test (.)
02        you will go and do it
03        (3.0)
04   Pat: please ma that test
05        (.)
06        i wont be able to
07        because i don't have money
08   Doc: its not the type you pay for
09        this one is free
10   Pat: ok
```

The patient's turn is designed with the lexical choice "please" in the turn initial, and an honorific term "ma", which suggests that she appeals to the doctor about a possible decision to disobey the instruction about the said test. This prefacing is followed by an account that stipulates a financial

problem (line 07). However, the doctor clarifies the financial implication of the test when she informs that the test is free (lines 08-09). Thus, she eliminates the projected dispreferred turn by offering accounts that support the possibility of obedience to the instructions. Also, by stating that the test is free, the doctor pursues the imperative-implication of her instruction, while the patient orients to the projected action (instruction) by agreeing to comply with the stipulated action, with "ok" (line 10). The patient's responses show that in the event of a refusal to align with the actions projected by the doctor's instructions, her refusals are not designed as an affront to the doctor's deontic authority. Rather, her refusals are hedged through an appeal to the doctor's face. This places her in a subordinate role as the receiver of an action, who has not much choice but to obey the doctor's instructions.

Extract 7-3 evidence another paternalistic way of negotiating treatment discussions on the path of doctors. Here, it is observed that the pregnant patient indulges in receiving alternative care at the traditional herbal centre (THC) (not shown in extract). Consequently, the doctor initiates a treatment discussion by stating "Madam we are going to start you on drugs" (line 30), an action type which Stivers et al (2017) refer to as "pronouncements".

Extract 7-3: *"You must not give birth at the THCs"*
```
30    Doc: madam we are going to start you on drugs
31         but you must not give birth at the local THCs
32         – ehn?
32    Pat: <<pp> ( )>
34    Doc: it's because of your child o
35         you wouldn't want your child
36         to also be affected or infected with the virus
37         we don't take deliveries here=
38         = where do you live?
39    Pat: ( )
((1 min. omitted, discussions about PMTCT centres))
```

With this pronouncement, the doctor recommends that patient starts to receive her drugs at the designated HIV clinic. However, his pronouncement is followed by an instruction not to give birth at the THC (line 31), and a question marker "ehn?" *(ok?)* (line 32)*. Unfortunately, the patient's next turn is inaudible. However, giving the turn design of the doctor's pronounced instruction, specifically giving with the question-intoned marker, the doctor appears to leave the patient with no choice but to obey his instructions. Although he offers an explanation that accounts for his instructions (lines 34-37), the patient is still offered no opportunity to share in the decision-making

process about recommended treatments. Note that she is not allocated a response turn to react to the doctor's explanations before the interaction moves on to other routine concerns (lines 38-39).

In another context, instructions are given concerning tests and other prophylactic drugs when the patient is not thriving or doing well medically. In extract 7-4, the patient had complained about a stomach ache, and her CD4 count is low (not shown in extract). In the beginning, the doctor diagnoses the cause of her stomach ache to be probably caused by the patient's indulgence in taking painkillers (Alabukun and Ibucap). Then, he instructs her to stop taking them "so you will stop using it" (lines 01-10).

Extract 7-4: *"Make Sure You take it and Use It Every day"*
```
01   Doc: do you use ibucap?³⁴
02   Pat: no
03   Doc: you don't use ibucap?
04        do you use alabukun?³⁵
05   Pat: yes, i use it very well
06   Doc: you use it very well
07        okay:::
08        maybe that is what is responsible
09        for your stomach aches
10        so you will stop using it
11   Pat  ( )
12   Doc: so you will go and repeat the chest x-ray
13        don't run away o
14        you hear?
15   Pat: where do i do it?
((2 mins. omitted discussions about CD4 test and x-ray test locations))
16   Doc: you will go and buy drugs
17        you cannot collect drugs for now
18        not until you bring your test results
19        then we will know the type of drug
20        to prescribe for you
21        (.)
22        and give you
((1 min. omitted, discussions about good diet))
23   Pat: so if i do all these
24        i'll be better
25   Doc: by god's grace=
26        =do you have septrin³⁶
27   Pat: [yes]
28   Doc: [you] still have a lot
```

---

[34] Ibucap is used for treating diverse types of pain.

[35] Alabukun is an indigenous brand, produced and distributed widely in Nigeria. Often purchased by most Nigerians as an over-the-counter drug, it is a mild analgesic that works effectively for several purposes such as migraine, toothache, and sore throat among many others.

[36] Septrin is an antibiotic that is used to treat infections caused by bacteria. At the HIV clinics, it is recommended as a part of the treatment regimen in all stages: first line, second line and third line drugs.

```
29          make sure you take it
30          and use it every day
```

With the "so" discourse marker, he prefaces another turn with an instruction to conduct a chest x-ray (line 12), and not abscond (line 13). These instructions are substantiated with the doctor's self-initiated self-repair that addresses the problem of hearing when the patient does not immediately respond "you hear" (you understand?). In a next sequence, the patient is instructed to buy drugs because her tests need to be ready before she begins to receive the freely distributed drugs at the clinics (lines 16-22). The patient responds by requesting a statement of assurance about her future wellness if she adhered to the doctor's instructions (lines 23-24). The doctor assures her by inclining towards a religious reference "by god's grace" (line 25), and he immediately proceeds in a new sequence, with a question about Septrin (line 26). After confirming that she has this drug (lines 27-28), the doctor offers a final instruction "Make sure you take it and use it every day" (lines 29-30).

Furthermore, in extract 7-5, the doctor uses the imperative formats to explicitly address adherence-related concerns. In lines 47-48, he asks about the previously prescribed ARV drugs and subsequently instructs her to use the drugs (line 49).

Extract 7-5: *"Make Sure You Take the Drugs Prescribed"*
```
47   Doc: what about the drug
48        that the doctor prescribed for you?
49        make sure you take the drugs prescribed
50        you didn't buy any drug
51        that looks as if its water inside?
52   Pat: that is usually inside water
53   Doc: hmm:::
54   Pat: i didn't buy it
55   Doc: i will write it for you now
56        go and buy it
57   Pat: yes (.) write it [for me     ]
58   Doc:                  [yes i have] written it
59        go and buy it and use it
60   Doc: i hope you are using septrin?
61   Pat: ehn::: i use septrin
62   Doc: okay (.) you use septrin?
63        make sure you use it always o--
```

We may observe that he requests to know about another type of drug that she may have bought (lines 50-53). When the patient responds in the negative (line 54), an instruction follows "I will write it for you now, go and buy it" (lines 55-56). In response, the patient is very cooperative, as she accepts this prescription and consents to follow the doctor's instructions "Yes, write it for me"

(line 57). However, the doctor again, repeats his instruction "Go and buy it and use it" (line 59). Subsequently, he offers a statement of "hope" that the patient has been taking her Septrin, to which he receives a positive response, prefaced with an elongated "Ehn:::" (yes) (line 61). The treatment discussion phase closes with a question-intoned repeat (line 62) and a final instruction "Make sure you use it always o" (line 63). As we already observed in chapter 5, the discourse marker "o" secures the recipient's attention. Thus, by the doctor's final turn design, his instruction calls for agreement, albeit, a non-negotiated agreement. The patient shows by her responses, that these instructions are not an advice or suggestions that require a jointly formulated decision-making sequence. Rather, she explicitly submits her expertise and patient rights to the doctor by agreeing to his instructions on the treatment regimen.

This same submission of patient rights through an agreement to instructions about treatment regimens is portrayed in extract 7-6. Here, the same turn design as extract 7-5 is used to open the treatment discussion phase. In lines 01-02, the doctor asks about a previously prescribed drug. In response, the patient states that she has bought the drugs (lines 03-04).

Extract 7-6: *"Make Sure You take the Drugs Prescribed"*
```
01    Doc: what about the drug=
02         =that the doctor prescribed for you?
03    Pat: the drug that was prescribed yesterday
04         i have bought it
05    Doc: you have bought the drugs?
06    Pat: i have gone to buy it
07    Doc: did you take injection yesterday?
08    Pat: no
09    Doc: you took the tablet equivalent
10    Pat: yes i did
11    Doc: make sure you take the drugs prescribed.
```

What follows is a question-intoned repeat that locates a specific part of the previous turn as a trouble source that needs to be clarified in terms of understanding "You have bought the drugs?" (line 05). The patient confirms her compliance "I have gone to buy it" (line 06) but to pursue another aspect of an adherence-related issue, the doctor asks about a previously prescribed injection and receives a positive response (lines 07-10). In a final turn, the instruction on drug use is repeated (line 11). This extract shows that the instructions are used to direct the course of a future event relating to adherence to medical recommendations, and these instructions are designed as already situational upon the need to enforce compliance on the path of the patient. In return, the

patient does not contest the doctor's deontic authority but accepts these instructions in a way that ascribes the doctor with medical authority.

In another situation, instructions may be given as pronouncements in a sequential environment that offers an extended explanation for the instructions. In other words, instructions may be mitigated by the doctor's account. In extract 7-7, the doctor offers a pronouncement "We will give you drugs for a week and see how it goes" (line 01 and 02). After pausing briefly (line 03), he explicitly instructs that she must adhere to drug use "you must adhere strictly to the time and days of intake" (line 05-06). Afterwards, he begins an extended explanation about the importance of adhering to drug use (lines 08-26).

```
Extract 7-7: "You Must Adhere Strictly to the Time
              and Days of Intake"
01    Doc: we will give you drugs for a week=
02         =and see how it goes
03         (.)
04         about the drugs
05         ((clears throat)) you must adhere strictly=
06         =to the time and days of intake
07         (.)
08         take your time to think about=
09         =when to start taking the drugs
10         you see:
11         it's better not to start
12         than to start and stop –
13         or be unfaithful with the intake=
14         = because we don't have so much drugs to work with
15         so if you now start one
16         and you drop it along the way
17         it would be ineffective
18         or you change your drugs
19         from chloroquine to fansidar³⁷
20         camoquin lonart etc
21         (.)
22         so when you start
23         you don't stop
24         (.)
25         so if you are not ready to start
26         you go and think about it and let us know
27    Pat: i am ready
28         i have been coming for a long while
29    Doc: so you are ready
30         (.)
31         you are ready
32         it's not everyone that we place on drugs o
```

---

³⁷ Fansidar, Chloroquine and Lonart are antimalaria drugs.

```
33   Pat: i am ready
34   Doc: go and buy this one ((a drug))
35        for the others
36        they ((pharmacists)) will tell you about the drugs
37        so after one week
38        you'll come back
```

In his explanation, he suggests that she think about starting the treatment regimen (lines 08-09). Subsequently, he accounts for his instructions by prefacing his explanations about the importance of drug use with a preface "you see" (line 10), and then, the extended account takes place with multiunit turns. During this account, the patient orients to the doctor's trajectory by not offering a turn that interrupts the ongoing action but instead, she takes a turn at the end of the explanation when she is asked if she is ready to begin treatment "I am ready, I have been coming for a while now" (lines 27-38). To be sure that the patient's affirmation is processed epistemically, the doctor repeats her information "so you are ready" (lines 29 and 31), after which he pursues a proper understanding of his suggestion with a relevant uptake of his suggestion "It's not everyone that we place on drugs o" (line 32). Eventually, the patient reaffirms her readiness to start treatment, and is instructed to buy a certain drug (line 34), visit the pharmacist for more instructions (lines 35-36), and return after a week (lines 37-38). In this treatment discussion phase, it is evident that the patient consents to the doctor's deontic authority to prescribe the needed drugs. However, the doctor here mitigates the deontic force of his instructions by offering an explanation that makes his instructions accountable.

Furthermore, in extract 7-8, we see another evidence of instructions that are mitigated by explanations. In the beginning, the doctor formulates his treatment offers with a pronouncement (line 01).

Extract 7-8: "Still Take Them"
```
01   Doc: i will likely change your drug
02        that drug that you use
03        because it seems that the drug is not okay for you
04        i want to be sure
05   Pat: ( )
06   Doc: these two drugs
07        give them at the lab
08        do your tests
09        and let me see you next week
10        i want to see you next week
11   Pat: you want to see me?
12        what about these ones ((shows previous drugs))
13   Doc: still take them
```

He proceeds by offering an explanation that orients to his pronouncement to an epistemically modalized initiative about the inappropriateness of the patient's previous drugs. With his "It seems …" (line 03), he orients towards the knowledge that the previous drug was inappropriate and needed to be changed. On this premise, he specifies the new drugs "these two drugs" (line 06), instructs her to get them at the pharmacist' laboratory (line 07) and requests to see her the following week (lines 09-10). Subsequently, the patient identifies his instruction as a trouble source with a question-intoned repeat (line 11). Furthermore, she asks about the previous drugs (line 12) while the doctor responds with an instruction "Still take them" (line 13).

Similarly, in extract 7-9, the doctor describes a future event for the patient with regard to drug intake. At the beginning of the treatment discussion phase, he explicitly instructs her with a strong deontic force "These are the drugs you will ingest" (line 05), "Buy them at the pharmacy" (line 06).

Extract 7-9: *"These are the Drugs You Will Ingest"*
```
05   Doc: awon  ogun  tie      ma   lo  niyi
          these are the drugs you will ingest
06        era won ni pharmacy
          buy them at the pharmacy
07        mo de  tun  ti prescribe awon ogun imi
          i have also prescribed   some other drugs
08        ti  won   ma   fun  yin ni clinic ibi yii
          that you will be given at this clinic
09   Pat: ejo:
          please:
10        (.)
11        mi o mu      owo wa    ni sin yii
          i didn't come with money at the moment
12   Doc: EHN:: nigba kigba ti eba ni   owo   elo raa
          WELL:: go and buy it whenever you have money
```

On the surface, one may posit that nonadherence has not been made relevantly complete and cannot be established from this consultation. However, note that in response to being given prescription slips with the instruction for its use, the patient announces a possible rejection of the instruction by prefacing her turn with a "please" (line 09) and after a short pause, uttering dispreferred turn (line 11). This action is contextualized and constituted by how the instruction is oriented to. The patient's action is a direct response to the directive at line 06 "Buy them at the pharmacy". Hence, her treatment of the preceding turn as an instruction which obligates her financially. Following the adjacency pair rule, directives, as a social action, (in this case, an order) may be minimally completed when its recipients concede to the requested action without any verbal response (see

(Stevanovic & Peräkylä 2015). Here, however, the patient starts to utter a dispreferred response by offering a politeness cue with the lexical item "please" and hesitating before announcing her financial status – rendering her statement of financial disposition as being existential and progressive. On the doctor's path, he aligns with her announcement, although prefacing his response with an elongated assessment "Ehn" (Well) …go and buy it whenever you have money (line 12).

7.2   Explaining the Importance of CD4 Count Cell Tests

In the consultations, adherence-related treatment discussions are also initiated when doctors explain the importance of CD4 count cell tests to patients. This is quite seldom in the data; however, such consultations still evidence authoritative/paternalistic doctor styles that pursue patients' understanding. In extract 7-10, line 25 indicates the boundary between treatment proposals and the doctors' account. In lines 26-33, the doctor accounts for why she should take her CD4 count test.

Extract 7-10: "It's only CD4 Count that will Show…"
```
25   Doc: ok::: come and do madam
26        but hope you know (.)
27        that it's only CD-4
28        that will show whether your drugs are working or not
29        so (.)
30        if you are swallowing drugs for up to two years
31        and you don't do test (.)
32        you don't know whether the drug is working or not
33        so:::
34        (0.6)
35   Pat: by god's grace next week
36   Doc: ok o::: ma
```

This explanation is in the function of ensuring adherence, but it appears it threatens the patient and does not leave much choice for a rejection "Come and do (CD4 count test) madam" (line 25). The explanation states a consequence of nonadherence to treatment – in lines 30-32, the doctor explicitly states that only tests can indicate how medically well the patient is. Consequently, no-tests mean no knowledge of well-being and the risk of illness. The patient's turn at line 35 is instructive – she states that she will take the new test by God's grace, to which the doctor responds with an "ok" and a prolonged discourse marker, and an honorific term "o::: ma" (line 36). The doctor's "ok" is not designed to accept the patient's statement as credible or as a true statement of

intent. The elongated discourse marker that follows the "ok" i.e., "o:::" is attitudinal when considered in the Yorùbá social context – it alters the meaning of "ok" from being an acceptance of the patient's statement to a resignation. At this sequential location, it is indeed ambiguous to ascertain if the patient's statement about God is an inherent belief in God or merely ritualistic in terms of simply offering a response. However, it is an evidence of a certain religious or personal belief that may have guided or is still currently guiding the patient's actions and subjective orientations concerning her HIV ailment. This notion will be discussed in detail, in chapter eight. What is evident, however, is that the patient's reference to God weakens the commitment for the plan to come the following week for the CD4 count test. She does this by delivering the responsibility to attend the clinic to "God's grace". What is also evident is that the doctor offers an explanation that accounts for the need for adherence.

7.3   Planning Next Appointments

In the consultations, adherence-related treatment discussions are initiated when doctors plan next appointments to make sure patients visit the clinics on the required dates and times. As already enunciated in chapter 3, medications can only be (freely) received when patients adhere to other medical recommendations such as regular clinic visits, drug collection and CD4 count tests. Thus, nonadherence to these other recommendations is also taken as an indication of nonadherence to medication because drugs can only be received when patients visit the clinics regularly. In other words, patients take CD4 count tests quarterly, to check if their ARV drugs are working properly in terms of significantly reduced viral loads. Hence, when doctors offer patients the next appointment, they are ensuring adherence to the treatment regimen. In extract 7-11, for example, the treatment recommendation phase is closed with a plan for the next appointment.

Extract 7-11: *"I'm Going to Give You Drugs for Only One Month"*
```
37   Doc: i'm going to give you drugs for only one month
38        so when you come and do
39        we'll now know what we will do
40        you can go ma
41   Pat: thank you
42   Doc: alright ma
43        ((sighs)) OH DEAR
```

In line 37, the doctor pronounces "I'm going to give you drugs for only one month", after which he explains the reasons for this plan (lines 38-40). The patient responds with a statement of gratitude and acceptance "Thank you" (line 41), while the doctor offers a sequence closing third "Alright ma" (line 42) and closes the encounter with a sighed utterance "Oh dear" (line 43). A one-month drug implies that the patient should visit the clinic in the next four weeks. Hence, the doctor uses his planned appointment as a strategy to monitor the patient's well-being in terms of good CD4 count cell volume and drug prescription. Evidently, the patient shows that she reserves her rights to contest the times given for the next clinic visit.

In another consultation, next appointments are planned with pronouncements. In extract 7-12, the doctor offers to give the patient drugs for two months (line 56) because she had expressed concern that she had started to take a different drug (seemingly another brand of ARV drug) before it was changed to the one she currently uses. Consequently, she notices that she has reacted to this change in the form of rashes all over her skin and body (not shown in extract), and this necessitates her visit to the clinic besides her current valid appointment for the present consultation.

Extract 7-12: "Come Back Next Week"
```
56   Doc: okay? let me give you two months
57   Pat: i still have these drugs
58   Doc: okay
59        (.)
60        this one will finish in one month
61        okay
62        (.)
63        get it changed
64        (.)
65        and you see me::: ((writes))
66        you will give the pharmacist this paper
67   Pat: ( )
68   Doc: yes
69        (0.5)
70        this thing shouldn't spoil your skin o
71   Pat: ehn::
72        that's why i came quickly to complain
73   Doc: you know what will happen
74        (.)
75        you can come back by next week
76        (0.12)
77        come back by next week
78        after you must have used
79        a substantial amount of the drug
80        let me see what happens
81        (.)
82        go and see the pharmacist
```

Here, the patient displays a good understanding of how ARV drugs work with the human immune system and it's possible side effects when varied brands of ARV drugs are ingested over a period. She also reveals that she understands the importance of adhering to medical recommendations. Nevertheless, the consultation does not account for contributory shared decision making on drug prescription between the participants. Having established her adherence status to be true, the patient responds confidently and affirmatively to interrogations on drug use and suggests what drugs should be prescribed to suit her health needs. Tarn et al (2006) support this notion with the finding that patients may not take new medications because of fear of interactions with other medications or adverse effects. This further suggests that a patient with such understanding recognizes the importance of medications and adhering to medications. In this encounter, we may submit that adherence was targeted as a trajectory.

Similarly, in extract 7-13, adherence is ensured through pronouncements of next visit times. In line 01, the doctor states explicitly, "I'll give you drugs for two months". With his next turn, he performs an understanding check that relates to the implications of his pronouncement.

Extract 7-13: *"I'll give You Drugs for Two Months"*
```
01   Doc: i'll give you drugs for two months
02        (.)
03        are you happy=
04        =you didn't say thank you o
05   Pat: thank you
06   Doc: in fact
07        i will not give you for two
08        i'll give you for one month
09   Pat: OH god bless you
10        <<ff> AH don't give me for one month o>
11   Doc: are you eating well?
12   Pat: ( )
13   Doc: so i'll see you in two months time
14   Pat: <<p> thank you>
```

When he states, "Are you happy? You didn't say thank you o" (lines 03-04), he calls the patient's attention to the fact that she is privileged to receive a two-month appointment. The patient responds with "thank you" (line 05) and afterwards, the doctor humorously pretends to change his mind by making another pronouncement that reduces the quantity of recommended drugs to one month (lines 06-08). The patient orients to this utterance as being marked for a joke – she responds with an exclamation "ah!", in the environment of a loudly produced turn that states that she is grateful for the extended two-month appointment for the next visit (line 10).

Furthermore, in extract 7-14, the doctor uses a pronouncement to plan the patient's next appointment. In line 01, his pronouncement "I will give you two months" stipulates a next visit for regulating the intervals between her drug collection times at the clinic. As evident in the data, a two-month appointment time is a norm in several of the HIV clinics, whereas, appointments for a month may indicate that the patient needs more close monitoring for adherence check and tests for regulating the C4 count volume among other routine medical concerns.

Extract 7-14: "I Will Give You Two Months"
```
01    Doc: i will give you two months
02         (.)
03         so::: ((hands over her medical record))
04         you can see that you are better now
05    Pat: yes indeed
06         i was so slim then
07         we thank god
```

Thus, the doctor here validates his assessment of the patient's well-being, both by offering the two-month appointment and accounting for this planned next visit with a justification "You can see that you are better now" (line 04). As expected, the patient agrees with this evaluation because it establishes her current medical well-being (lines 05-07).

In the corpus, extract 7-15 features the only deviant case where the patient proposes the next appointment. Rather than wait for the doctor to fulfil this routine expectation, she pleads to receive drugs for three months based on a planned future trip (lines 14-16).[38]

Extract 7-15: "I Will Give you for Two Months"
```
14    Pat: <<f> please madam(.)>=
15         =give me a three months appointment
16         because i WANT to travel
17    Doc: i will give you two months
18    Pat: please ma
19    Doc: it's not me (.)
20         the clinic only gives two months maximum
21    Pat: ok
22    Doc: take this to the pharmacy
23    Pat: ok
```

---

[38] At the study location, clinic visits are follow-up visits for further consultation drug prescription. Patients receive ARV drugs which would be sufficient for three months at a stretch after which they must visit the clinic for drug renewal. This is to monitor patients' adherence to drug use. In some cases, doctors may access some patients as being adherent to medical recommendations and therefore give such patients an earlier appointment. In other words, drug prescription is not necessarily a strict process – they are largely contextual upon the doctors' perception of the patient's medical well-being.

However, the doctor agrees to give only two months (line 17) – he rejects her request by citing the clinic's standard procedure on drug prescription (lines 19-20). Subsequently, his refusal is accepted with a minimal "ok" (line 23), followed by the doctor's instruction about the prescription (line 22), and a closing statement of appreciation "Ok, thank you doctor" (lines 23-24). It is evident here that a proposal of next appointments is rarely initiated by the patient, probably because it may be rejected – as shown in extract 7-15. Hence, the deontic authority of the doctor is seldom "put to the test" by patients.

7.4   Conclusion

This chapter has shown that asides from the opening phases and medical history-taking phases, adherence-related trajectories are also made relevant in the treatment discussion phase. This phase is characterised by practices of giving instructions, explaining about CD4 count cell tests and planning next appointments. As shown in the analysis, these practices are often initiated by the doctors, in the service of ensuring patients' adherence. With utterances mostly structured as imperatives and pronouncements, doctors orient to a deontic force in their production of directives for the patient's future health-related behaviour. When responding, patients parse this deontic force and the doctor's authority by submitting their rights to shared decision-making on treatment plans. However, in rare situations, patients contest or propose prescriptions for ARV drugs[39] though their proposals are often rejected.

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[39] In HIV/AIDS clinics in South-west Nigeria, doctors prescribe ARV drugs and drugs for HIV-related opportunistic infections to be used for a certain period, mostly two months. Patients must then return to the clinic for renewal of the ARV drugs, and to state existing medical complaints. This stipulated interval between visits is to ensure that patients use their drugs regularly, while also monitoring their adherence and ensuring their general wellness.

8   Patients' Social Situations as Adherence Indicators

> "I wanted a dialogue to begin between us but in her 'own terms'. The problem was how to recognize what her 'own terms' were… [Consequently] .... I sought by a series of exercises to 'clear myself out of the way" (Goode 1994: 24).

> "…we can do ethnographic interviewing in a way that incorporates what we have learned about the impact of the interviewer/interviewee relationship on the co-construction of knowledge" (Heyl 2001: 370).

In chapter seven, findings reveal that doctors ensure patients' adherence during treatment discussions. This goal is established through practices of instructions, explaining the importance of CD4 count tests and planning next appointments. These practices are produced as directives (imperatives) and pronouncements, that display the deontic force of doctors' authority and patients' submission of their rights to joint decision-making on treatment plans. Giving that some patients were indeed found to be nonadherent to medical recommendations, this chapter discusses factors responsible for patients' nonadherence to medical recommendations. It researches further on the findings in chapters five, six and seven by discussing the views of doctors and counsellors on the indicators of patients' nonadherence in the d-p encounters, and what they do when this behaviour is noticed. It also discusses patients' views on possible reasons for nonadherence and the influence of doctoring styles and institutional tasks in influencing their adherence behaviours. To do this, I take a cue from Goode's (1994) approach to ethnographic interviewing which involves putting oneself in the "interviewer's shoes" – while conducting the interviews, I assured the research participants that I was not merely interested in academic research but also personally interested in their medical and social realities. By doing this, I cleared my personal misgivings "out of the way" (1994: 24) to encourage the participants to speak in an unreserved way about their medical conditions and their lifestyle choices. The present study critically examines participants views by adopting a qualitative research method (in-depth interviews) to the research enquiry. This chapter is guided by the following three research questions:

(i)   how do doctors suspect patients' nonadherence and consequently investigate this behaviour during the d-p encounters?

(ii)   what are the views of doctors and counsellors about the factors responsible for patients' nonadherence?

(iii)   what do patients disclose as adherence or nonadherence factors?

To answer these research questions, individual in-depth interviews were conducted with 17 research participants using semi-structured questionnaires, to encourage flexibility in the respondents' views, and to also enable a "co-construction of knowledge". As Heyl (2001) puts it, successful ethnographic interviewing in all fields should involve a co-construction of knowledge between interviewer and interviewee when the interviewer does the following:

> (1) listen well and respectfully, developing an ethical engagement with the participants at all stages of the project, (2) acquire a self-awareness of his role in the co-construction of meaning during the interview process, (3) is cognizant of ways in which both the ongoing relationship and the broader social context affect the participants, the interview process, and the project outcomes and (4) recognizes that dialogue is discovery and only partial knowledge will ever be attained (2001: 370).

This submits that doing ethnographic interviewing is not only about asking questions and receiving answers but working together with the interviewees to generate the actual social meaning that they ascribe to their utterances. Interviews were audio-recorded and transcribed. Interview questions were researcher-designed, following Kvale's (1996) guide to interview investigation with appropriate questions (See Appendix and chapter 4).[40] Results of the analysis answer the research questions for the present chapter. For the analysis of data, the interview transcript was studied for its content and thereafter, coded, using the method of ITA**.** ITA is a bottom-up approach to thematic analysis which proposes that the analysis of data (in this case, interviews) be data-driven (Braun & Clarke 2008), as against a more theoretical background to thematic analysis which is driven by data sorting according to an existing theory. Thus, the sorting and analysis of data here are guided by the research inquiry on patients' adherence in HIV encounters – latent themes are derived from the data corpus, to derive the data set. Findings from the study were discussed in line with the theoretical implications of the socio-cognitive theory of health behaviour. This methodological approach was adopted because it is closely related to the CA approach in terms of objectivity and inductiveness in the analysis of data. The data analysis is structured into three major parts which answer the three research questions raised above. Section 8.1.2 answers the first research questions, section 8.1.3 answers the second research question while section 8.1.4 answers the third research question. Following the ethical guideline of this thesis, the respondents gave

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[40] Probing questions were excluded.

informed consents and are identified with pseudonyms in the data analysis. In the following sections, I discuss the results of the study and conclude with reflections on the findings.

8.1 Results

8.1.1 Participants' Characteristics

The data corpus consists of responses from 17 interviewees: doctors (n = 10), counsellor-patients (n = 3), non-counsellor patients (n = 3) and a counsellor (n = 1). Few participants participated because the interviews were thought to be more intrusive than the audio recordings. Most patients, especially, did not wish to be interviewed. Counsellor/patients are HIV patients who work at the outpatient clinics and double as adherence counsellors. The interviewees were stratified randomly per their gender. Though there is a larger percentage of female patient-respondents, this stratification is necessary because one male counsellor-patient was interviewed (see table 8-1). This stratification ensures a cross-gendered distribution of respondents' perspectives on the semi-structured questionnaire that was used to conduct the study. Asides the gender stratification, participating patients had been attending the HIV clinic for a longer time. Importantly also, the medical personnel (i.e., doctors and counsellors) are not specialists on HIV care – they are mostly GPs on call at the outpatient clinics. However, the patients who participated have had a long-term HIV infection (ranging from 5-7 years of being on ART) at the time of the interviews.

Table 8-1: Participants' Identity and Gender Distribution (M = Male, F = Female)

Identity	Sex	Number	Total
Doctor	M	5	10
	F	5	
Counsellor-Patient	M	2	3
	F	1	
Counsellor	F	1	1
Patients	F	3	3

This long-term infection is advantageous because it ensures that patients' responses can be assessed based on their long-term experience of living with HIV. By their medical records, the three female patients have social circumstances that present an interesting opportunity to view

their perspectives on how they cope with adherence, especially the use of alternative therapeutic options (ATO) and alternative herbal medicines (AHMs).[41]

8.1.2 Mentions of Evidences of Patients' Nonadherence in the D-P Encounters

To generate evidence of patients' nonadherent behaviours in the d-p encounters, the doctors and counsellors reported differing views on how they suspect, and consequently investigate these nonadherence indicators (see table 8-2). Their reports include evidence such as the following themes: patients' irregular clinic visits, Low CD4 count, complaint types, unimproved health and use of ATOs and AHMs.

Table 8-2: Mentions of Evidences of Patients' Nonadherence in the D-P Encounters

Evidence	Frequency of Reports	Total
Irregular Clinic Visits	Doc. (n = 2)	2
Low CD4 count	Doc. (n = 1)	1
Complaint Types	Coun. (n = 1)	1
Unimproved Health	Doc. (n = 2); Coun. (n = 1)	3
ATOs and AHMs	Doc. (n = 1); Coun. (n = 1)	2

Table 8-2 shows the limited number of reports for each evidence. There are ten doctors and four counsellors so not every interviewee mentions an evidence.[42] However, evidence of patients' unimproved health and ATOs and AHMs received the reports of both counsellor and doctor, indicating that both agreed that patients' health status and their indulgence in ATOs and AHMs are indicators for suspecting nonadherent behaviours.

8.1.2.1 Evidence 1: Irregular Clinic Visits

When I interacted with doctors to recover their opinions on how they suspect patients' nonadherent behaviours during the routine consultations, two doctors reported patients' irregular clinic

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[41] AHMs refer to herbal medicines while ATOs are other treatment options besides herbal medicines, including off-the-counter drugs and spiritual interventions. Occasionally, ATOs may include positive lifestyle choices such as safe sexual practices and healthy diets. However, patients often display ATOs which pre-supposes negative life style choices.

[42] Braun and Clarke (2008) allude to this tendency for limited quantity of themes by emphasizing that not all respondents may provide reports or accounts that are crucial and related to the research inquiry.

attendance as the first evidence. For instance, I asked D. G. (Doctor Gideon) what his experiences have been with patients who indulged in unapproved ATOs for their HIV treatment and how he investigates this. He had this to say:

> Yes, definitely. But they (patients) won't voice that out (to doctors) … We detect their use of alternative therapies when first, they don't come to the clinic regularly (**D.G.1).**

Doctor Gideon affirms that patients do indulge in ATOs. He suggests that patients are characteristically reluctant to state other treatment options. However, due to evidence from their medical records which show irregular attendances at the clinic, doctors consequently suspect nonadherence. The thinking is that when a patient doesn't come to the clinic to receive to ARV drugs and other drugs regularly, then she must have alternative treatment options.

8.1.2.2 Evidence 2: Low CD4 Count

For Doctor Evelyn (D.E.), an indicator of nonadherence may also entail detecting a pathologically depressed patient who has a low CD4 count and is determined to infect others with the virus:

> Some people have the mind of vendetta. They want to go ahead and infect others with the disease… it's implied. When someone whom you expect her CD4 count to be high, has a low CD4 [sic] etc.., doesn't come regularly to the clinic and says she has a manfriend and doesn't like to use a condom, the assumption is expected. That female knows the right thing to do but doesn't do it. These things are revealed gradually during consultations (**D. E. 1)**

She reiterates the opinion of doctor Gideon about irregular clinic visits as a clear indicator of nonadherence. However, she adds that this may have a psychological implication because this attitude shows tendencies for seeking revenge (vendetta) and wanting to infect others with the HIV disease. This is especially so in cases where patients with low CD4 counts refuse to attend the clinic regularly and equally express aversions to safe sexual practices. Strange as this may seem, she suspects that the patient has chosen to be sicker in order to infect others.

8.1.2.3 Evidence 3: Complaint Types

Counsellor Esther (C.E.), she suspects patients' nonadherent behaviours when, during counselling, they complain about the side effects of other unapproved medicines such as herbs:

> We also know because when they come to the clinic, they don't come with the drugs (the herbal drugs) most times but complain about the effect of the drugs (**C. E. 1)**

Her opinion clearly shows that other alternative treatment options interact badly with the approved, ARV prescriptions. Furthermore, the side effects of using ARV drugs presents itself differently from the side effect of the counter-interaction of simultaneous orthodox and traditional medicine use (not shown in the extract). Since the doctors and counsellors are knowledgeable about this differentiation, they are quick to suspect that patients have been nonadherent.

8.1.2.4 Evidence 4: Unimproved Health

Another evidence for suspecting patients' nonadherence is their unimproved health. Doctor Gideon had earlier stated that the patients' irregular clinic visit is an evidence of nonadherence (see D.G.1). He reiterates this further by stating that nonadherent patients are bound to have unimproved health especially when they have low CD4 counts:

> We detect their use of alternative therapies when … second… they are given drugs regularly but are not responding adequately to treatment. As for drug adherence, what we use as an index in this clinic is majorly patients' CD4 count. We can't live with them in their homes to enforce this though we have a social worker here who follows up on this. But from their CD4 count, we can tell the level of adherence **(D. G. 2)**.

Counsellor Esther and doctor Evelyn corroborate this opinion. Esther states that she believes patients use alternative treatment options, which can sometimes have fatal consequences, especially when such patients do not disclose this preference for alternative treatments.

> Yes, I believe patients use alternative treatment options but sometimes they don't reveal their preference for alternative therapy while attending to them. Such patients get worse and sometimes they die **(C. E. 2)**.

Doctor Evelyn equally asserts that unimproved health (illness) is an evidence of nonadherence to regular drug use and CD4 count testing.

> Those who attend clinic regularly adhere to drug use and have a high CD4 count. Those who don't adhere and don't come regularly to the clinic, fall ill often **(D. E. 2)**.

These opinions establish the views that nonadherence is intricately linked to other medical recommendations asides medication use.

8.1.2.5 Evidence 5: ATOs and AHMs

The fifth evidence of doctors' suspicion of patients' nonadherence is patients' use of ATOs and AHMs. Doctor Gideon reiterates:

178

> We detect their use of alternative therapies … third during interacting with them, they mention the regular church attendances and the *aajo* (tradio-medical alternative medicine) they make to find a solution to their problems **(D.G. 3)**.

For counsellor Esther, also, patients tend not to reveal alternative therapies during consultations. But, they (the medical personnel) suspect their use of other medicines when they mention these alternative drugs they feel may help resolve their medical problems:

> Some combine ARV drugs with other drugs and sometimes, they tell us at the hospital but sometimes they don't. They say oh, someone introduced this drug or herb to me and that it is good. At times, we discourage them but most of them still go ahead to use the drugs. It's a problem because Nigerian made drugs are not controlled. The drugs complicate matters for patients. **(C. E. 3)**.

Esther states that patients may still indulge in taking alternative medicines despite being told that these drugs are unhealthy and unstandardized as most indigenously produced drugs in Nigeria are. More so, patients complain about the effects of other types of drugs besides the familiar side effects of ARV drugs. This, indeed, constitutes a problem for caregivers and the patients themselves because the ATOs and AHMs may counter-interact with the prescribed ARV medications, resulting in worse medical health.

8.1.2.6 Summary

The interviewees' opinions clearly show the indicators that lead to suspicions about patients' nonadherence. These indicators include: (a) Irregular Clinic Visits (b) Low CD4 count (c) Complaint Types (d) Unimproved Health and (e) ATOs and AHMs. The doctors and counsellors state these indicators as evidence which helps them divulge more information from patients on what influences or accounts for their nonadherent behaviours. ATOs are clearer to understand when patients explicitly state them (see D.G.3 and C.E.3). However, where patients do not clearly state them, then all other verbal evidence points to nonadherence through ATOs.

8.1.3   Attributions of Patients Nonadherence to Social Situations

When doctors and counsellors were asked about their perceptions of patients' adherence to drug use and other medical recommendations, they reported six major social situations as factors which are hindrances to patients' adherence. These include financial status, educational status, lack of family support, stigma, cultural/religious beliefs and hostile medical staff (see table 8-3) – these

social situations were reported as being premised on three perceptions: nonadherence as a product of patients' personal behaviour (self-inflicted behaviour), stigmatisation, the prevailing cultural

Table 8-3: Attributions of Patients Nonadherence to Social Situations

Perceptions of Social Situations	Social Situations	Frequency of Reports	Total
Self-Inflicted Behaviour	Financial Status	Doc (n = 2); C-P (n = 1)	3
	Educational Status	Doc (n =1)	1
	Lack of Family Support	C-P (n = 1); Coun (n = 1)	2
Stigmatization	Stigma	C-P (n = 2); Coun (n = 1)	3
Cultural Norms	Cultural/Religious Beliefs	Doc (n = 4); Coun (n = 4)	8
Hostile Medical Staff	Hostile Medical Staff	Doc (n = 2); C-P (n = 1)	3

Doc = Doctor; C-P = Counsellor/Patient; Coun. = Counsellor

norms among the Yorùbá people of South-western Nigeria and hostile medical staff at the outpatient clinics. More reports (n = 8) were recovered from the doctors, on the factor of cultural/religious beliefs as being the prevalent social situation leading to patients' nonadherence.

8.1.3.1 Self-Inflicted Behaviour

The first attribution of patient's nonadherence to social situations is patients' self-inflicted nonadherent behaviour which is premised on their report of inadequate financial status. To understand how and why this type of account is stated, we will refer to a counsellor's opinion about the interconnectedness between patients' socioeconomic status (financial status), self-inflicted behaviour, and nonadherence. Counsellor-Patient Peter (C-P P), explains that patients' financial status is a cogent reason for nonadherence. He also attributes this status to a lack of the necessary family support that should ease their financial burden and problems of stigmatization:

> I think it is due to lack of money to visit the clinic. Some also genuinely forget because they lack the support of family members due to secrecy. The family members who should remind them of their dates and drug use are not even aware of the HIV status (**C-P P 1**).

He suggests that patients' financial status is self-inflicted, especially because family members that should ease their financial burdens are unaware of their HIV status. Thus, secrecy leads to worse financial difficulties, which may contribute to patients' inability to visit the clinics at the due time. Another medical personnel (doctor Paul), reiterates C-P P's position with a little caveat. Doctor Paul (D. P.) equally defends the position that patients' financial status is inextricably linked with nonadherent behaviours, though issues of stigma and poor educational background are the stronger underlying consequences of patients' financial status.

> It depends on their educational status and if they've had a bad experience. Those with poor educational background will usually come with poor financial status. And with poor financial status, they have stigmatization problems **(D. P. 1).**

Invariably, a poor patient from a lower economic class already suffers the consequences of being economically downturned and this may lead to a low sense of self-worth and stigmatisation from others. From D. P' s perspective, the factors of poverty, education and stigma determine patients' behavioural patterns and of course, determine the poorly-decided personal choices they make concerning their health. He justifies his argument further by again, attributing poverty to people's (consequently, patients') personal/cultural beliefs. Specifically, he states that poverty engenders gullibility, religiosity and high sentimentality, with its consequences on quests for hope in alternative therapeutic options that patients use, not only to seek comfort for their HIV illness but also to resolve problems of poverty:

> The average Nigerian is gullible, religious and highly sentimental… this makes the patients believe anything or anyone that promises them healing. The high rate of poverty in the country also make people quest for hope very desperately. They ruggedly believe that when there is life, there is hope. So, people tend to keep hope alive through any means possible. This is all about people's psychology and the notion of healing. It's a purely mental health issue **(D. P. 2).**

The point is made that poverty breeds tendencies for self-gratification, all of which are intrinsically connected with patients' identity, other social behaviours and specifically, nonadherence to medical recommendations. So, we return to the main question: why do patients explicitly report inadequate financial status as an excuse for nonadherent behaviours? From the point of view of the medical personnel interviewed, there are salient socio-economic situations behind this nature of explicit interactions, including no-family support due to secrecy, old age, stigmatization, poor educational background, religious sentimentality and mental health. Hence, when patients are non-

allusive in their declaration of a low financial status, they do so, not merely in the service of explicitly portraying themselves as victims of their poor economic situation, but also showing that their behaviour is self-initiated and self-inflicted.

8.1.3.2 Stigmatisation

Counsellor-patient Peter states that the problem of stigma leads to nonadherence to the medical recommendation. This problem is especially noticeable when female patients lack the family support that should normally be a support mechanism for appropriate drug use:

> I take surveys of women who are not adherent to drug use and I try to follow them up. None of these women has ever mentioned family support as their remembrance strategy. When I ask them what efforts they make to take their drugs at the due time. Most mention alarm clocks, others mental alarm and wrist watches. People who come from far distances, who are avoiding stigma, also fall victim to nonadherence. The stress of journeying from one state to another determines how often they can make it to the clinic (**C-P P 3**).

Stigma also results in patients choosing to journey through distant states to register at a clinic for the routine consultations. Peter is sure that such a journey will affect how often patients can make it to their clinics for drug collection and other necessary medical examinations. As earlier mentioned, Peter has reiterated that patients avoid stigma at the clinics as well:

> They (patients) are most likely running away from being stigmatized (*at the clinic, emphasis mine*). When I was diagnosed with HIV, I had to leave Lagos for Ekiti because the attitude of Lagosians and their clinicians in the HIV/AIDS clinics is very bad. They still hold on to their opinion of HIV being a death sentence (**C-P P 2**).

His experience as a patient in a Lagos outpatient clinic was unfavourable because he was stigmatised. According to him, the problem of stigma transcends the attitude of the public – stigma also occurs within the clinics and among the medical staff because some of them still hold on to the belief that HIV is a death sentence. Peter's opinion affirms that stigma is indeed a barrier to patients' adherence.

8.1.3.3 Cultural Norms

My interview with counsellor-patient Thatcher indicates that patients' fears and expectation of stigmatization from family members, may result in nonadherence to the medical recommendation. Thatcher believes that serodiscordant couples have a higher possibility of having threatened marriages especially if the husband has tested negative for HIV while the wife has tested positive.

As a counsellor, she encourages female patients to convince their spouses to be tested and if negative, to "protect" their spouses from contracting the disease in every way possible – except that this so-called "protection" does not entail revealing their HIV status. Her reason for this approach is that men's reactions to such news is unpredictable and may be negativity received. Hence, she affirms that it is the patient's decision to either disclose her status or not. When I questioned her further about the possibility of preventing the non-infected spouse from being infected, she states:

> Well, it depends on the situation. For instance, I am HIV-positive while my husband is not. I always convince my husband to come regularly for a further check-up and pre-contraction counselling even though he doesn't know my status. My boss at the clinic encouraged him to use Septrin to protect himself, but unknown to him, to protect himself from me. It's my duty to keep encouraging him to take the Septrin and I tell him that the drug I use it for my constant headache. You see, I can't just open up to him like that if he still has a negative attitude and impression about HIV. Until this change, I can't stand this risk of breaking my home (**C-P T 1**).

Her opinions show that as a counsellor, she also has a spouse who is ignorant of her HIV status. This sheds light on the nature of counselling that patients may receive within the clinic setting – secrecy and intact marriages are prioritized over the risk of infecting spouses due to fear of stigmatization and depressions that may arise from broken marriages. And, if such behaviour is excusable from the clinic staff, the fear of stigma is obviously, deeply ingrained within the socio-psychological fabric of the health institutions and within the individual patients themselves. This sense of fear may promote more nonadherence because the sole purpose of adherence is to be healthy and live a less-infectious life.

Doctor Gideon also had this to say concerning the role of cultural norms in influencing patients' nonadherence:

> during interacting with them, they mention the regular church attendances and the *aajo* (trado-medical alternative medicine) they make to find a solution to their problems (**D. G. 4, cf. D.G. 3**).

He suggests that due to personal and traditional beliefs, patients may become nonadherent. He states further:

> Concerning attitudes, some people still believe that HIV is a myth and can't be contracted and this is a problem (**D.G. 5**).

Counsellor Esther agrees with this opinion:

… because they keep things secret from people close to them. Their friends and family members are not aware of the nature of their ailment, so they advise the patients to try various things or remedies for their ailment and due to desperation, they give in and abandon their ARV drugs. Besides their fear of stigma, the patients also have their own personal beliefs which are far away from the reality, and which encourages them to engage in alternative therapies **(C. E. 4)**.

For Esther, patients are equally susceptible to nonadherence due to fear of stigmatization from the society. Hence, as C-P peter had asserted (see C-P. P 1), they secretly hide their HIV status from family members and friends. This is because the Yorùbá culture still attributes HIV contractions to female patients' promiscuity. For Doctor Evelyn, these cultural norms make female patients susceptible to a feeling of desperation and on the quest to rid themselves of the HIV infection through any drug that may help cure the disease:

> …Culturally, people also have drugs that they feel can equally cure their ailment, so they go for those drugs and neglect their ARV drugs (**D. E. 1**).

Besides the feeling of desperation, their use of other drugs may also have a cultural undertone because, besides ARV drugs, patients also believe in traditional herbs that have been locally provided to treat various ailments within their cultural system. This belief, as stated by doctor Maria, stems from the Yorùbá socio-cultural milieu:

> Among the Yorùbá, there is a cultural belief that there is always a solution to every problem and the solution comes from God, deities and other things that people may believe in. People can't just accept a medical explanation that a solution to an ailment is impossible because they believe that with God, all things are possible. So, I usually encourage patients by supporting their belief alongside clinical evidence, else, the patients will never return to the clinics. We call this Medical Life Assurance. Patients react violently if their subjective beliefs are not used to soothe them (**D. M. 1**).

For doctor Paul, the Yorùbá culture also subjugates females to the male figures in their lives, especially, the vulnerable female HIV-positive patients who are already being stigmatized:

> Sometimes, women subject their actions, concerning their health to their husband or father's decision, generally the masculine figures in their lives. It's a cultural thing I believe (**D. P. 2**).

Counsellor-Patient Peter and counsellor Esther view the situation from a religious/spiritual perspective:

It won't work. They are just deceiving themselves. There are things that God can do but won't so. He'll leave it for medical practitioners. That's why the saying goes that doctors care, but God heals. It is possible to combine faith and fact (medical alternative) to health but it must not be one-sided (**C-P P 2**).

I think their beliefs are a bit extreme and sentimental. For instance, there is a pastor, an attendant who works here at the clinic. Female patients listen to him a lot, even to their own detriment. We, counsellors, have once had to rebuke a patient who listened to the pastor's instruction not to bother conducting laboratory tests at a certain time. We advise patients to listen and obey the doctors, and not clinic attendants with little knowledge of their medical condition **(C. E. 4)**.

8.1.3.4 Hostile Medical Staff

Counsellor-Patient Peter states that the medical staff at the hospital are likely to be nonchalant in their attitudes towards patients, with consequences on patients' nonadherent behaviours:

They (patients) are most likely running away from being stigmatized (*at the clinic, emphasis mine*). When I was diagnosed with HIV, I had to leave Lagos for Ekiti because the attitude of most Lagosian and their clinicians in the HIV clinics is very bad. They still hold on to their opinion of HIV being a death sentence. The clinicians in Lagos are very nonchalant and uncaring. My first wife died of the disease because she lacked adequate medical care. She was not given ARV drugs or Septrin, even after being diagnosed with HIV (**C-P P 2**).

Peter's opinion points to a typical trait of the medical staff, who still hold still to the societal beliefs about HIV, hence, a lack of professionality on the path of the clinicians. Asides the financial burden of undertaking such frequent trips, there are also possibilities that patients may lose trust in the medical system generally. Doctor Paul resonates with this argument when he states that doctors may sarcastically respond to less severely ill patients and focus more attention on the severely ill ones. He does not specifically state which type of medical staff perpetrate this nonchalant disposition, but he hints at doctors as part of the perpetrators. When I asked his opinion about patients who may opt for treatment at the hospitals as a last resort or only as an option, he had this further to say:

Maybe because the doctors are not friendly enough. That could be the case. Doctors can be really sarcastic. Sarcasm is an occupational trait. Doctors who overwork, mostly have this trait. In this scenario, they sarcastically respond to patients who are not seriously ill. They sometimes treat patients' complaints as no big deal and not being unique to them. So, they pay more attention to the chronically ill patients, those who are admitted to the clinic, before giving outpatients any attention. This could affect

patients' attitudes because they may feel that their pains or complaints are not understood and prioritized. The long waiting periods at the outpatient clinics attest to this (**D. P. 3**).

Being a doctor himself, his argues from familiar grounds. He asserts that sarcasm is an occupational trait of doctors and suggests that the concepts of pain and illness are dichotomized between patients and doctors. While outpatients may feel that they needed prioritization during consultations and for their medical care, the doctors usually consider the situation differently. For one, since consultations with outpatients are routinely based, the doctors may not give them any preferential treatment. Furthermore, outpatients who are eventually proven adherent, present obvious cases of sarcasm as a professional behaviour and other conditions such as suspicions about patients' nonadherence which is premised upon the operational inadequacies at the clinics.

8.1.3.5 Summary

Doctors and counsellors state that patients' social situations are factors militating against their adherence to medical recommendations. These factors are generally perceived in four categories: (a) self-inflicted behaviour (b) stigmatisation (c) cultural norms and (d) hostile medical staff. Their perceptions indicate that regardless of patients' social situations, nonadherent behaviours may either be self-inflicted or inflicted on them by the prevailing societal cultures and by the stigmatization they specifically experience from the medical staff at the outpatient clinics.

8.1.4   Patients' Views on Adherence

8.1.4.1 Alternative Herbal Therapies (AHTs)

When I interviewed a few patients about their tendency for indulging in AHTs, their responses were considered worthy of analytical interest because they offered a positive stance on their interest in alternative medicines. At first, patients were reluctant to emphatically state that they indulged in using AHTs, but they eventually admitted to doing this during the interviews. Patient Paula's interview is a case in point:

Interview Transcript 1: Interview with Patient Agatha (Res = Researcher; Pat = Patient)
01   Res: Do you believe HIV can be cured?
02   Pat: Yes, Madam
03   Res: Are you a Christian or Muslim?

04	Pat:	Christian
05	Res:	Do you take your ARV drugs?
06	Pat:	Oh yes, I do. Very well
06	Res:	Do you use Holy Water
07	Pat:	No o! All I use is my ARV drug, Sceptrin and Iron Capsules
08		To increase my blood supply.
09	Res:	And herbal bitters? Herbs?
10	Pat:	No o!
11	Res:	Not even for a headache or something else?
11	Pat:	No, not at all. But sometimes when some people hawk herbal medicine for Malaria
12		at my place of work, I sometimes buy it.

At lines 1-4, Paula confirms her religious allegiance and beliefs concerning HIV, especially the belief that though an incurable disease, HIV can still be cured. However, she denies using either spiritual waters or herbal medicines for healing (lines 5-9). When the researcher pressed further on this (line 10), she eventually admitted to occasional indulgences in herbal concoctions, hence stating her beliefs in herbs as a medical solution (lines 11-12). Patient Jane also indicates her occasional use of herbs and spiritual waters.

Interview Transcript 2: Interview with Patient Jane

01	Res:	You go to church to pray and you believe that the HIV disease can be cured?
02	Pat:	Yes
03	Res:	You go to prayer meetings etc.
04	Pat:	Yes, I do, I must.
05	Res:	Have you ever stopped using your drugs?
06	Pat:	No. I use my drugs at exactly 10 pm every day although when I first started taking
07		drugs, there were a few times I forgot to use it.
08		But now, since my husband is aware of my condition, he supports me by reminding me.
09		So now, I am more consistent with my drug use.
10	Res:	Do you use any alternative treatments? Sometimes?
11	Pat:	Yes. Sometimes I use spiritual water from church, for diseases and illnesses.
12		I also take some water solutions from my husband, it's water from a hill and I believe it's
13		not from a diabolical source especially because it's my husband who brings the
14		water and I cannot refuse to take something that he offers me.
15	Res:	What about herbs?
16	Pat:	If I will take herbs, I take them in the morning.

Jane declares her religious allegiance (lines 1-4) and adherence to ARV medications (lines 6-9). She also admits to using spiritual waters to support her beliefs about seeking a cure for her HIV disease, but she does not immediately list herbal medicines as another source of AHT (lines 11-14). When she does admit to this, however, she states that it as an occasional behaviour, using the "if" clause (line 16). This suggests that her use of herbal medicines only occurs under certain conditions. Hence, she neither categorically states that she uses herbal medicines nor deny it. Here

lies the curiosity regarding patients' reluctance to admit using herbal medicines while sometimes freely admitting to other forms of alternative treatments for HIV (such as spiritual concoctions). It is clear, however, that the patients embrace treatment options that align with their beliefs.

8.1.4.2 ATOs: Cultural/Religious Beliefs

Patient Agatha's narrative validates the link between cultural/religious beliefs and adherence. She mentions the concept of fate as it is believed in the Yorùbá socio-cultural system. Having separated from her first husband over 10 years before this interview, and being in a new relationship, Agatha is still "secret-full" because the new to-be husband is unaware of her HIV status, and neither does any of her family members (not stated in the transcript):

Interview Transcript 3: Interview with Patient Agatha

01	Res:	How long have you been on treatment?
02	Pat:	Over a year ago
03	Res:	Do you have any challenges in taking your medication
04	Pat:	No, I take all the prescribed drugs
05	Res:	How has life been since you discovered your status?
06	Pat:	Well, we just must thank God for all things. Although when I first got knowledge of this,
07		I thought the world is coming to an end for me, that there is no solution anymore.
08		But by coming to the clinic and seeing other people and being counselled, I realised that by
09		God's grace, nothing is impossible.
10	Res:	Is your husband also positive?
11	Pat:	That is a very powerful question because my first husband and I separated over 10 years
12		ago. He was the reason why I was initially depressed after I found out I was positive
13		because I knew I wasn't promiscuous. Since we are no longer together, I don't know if
14		he eventually got tested and I don't know if he infected me with the disease.
15		But after being counselled severally about various means of HIV contraction
16		and knowing that I also participate in some of those activities, such as hair fixing
17		I resigned to fate.
18		This year, the pastor (clinic attendant) and I have discussed my new fiancée,
19		how the relationship started and is progressing because one does not hide from the
20		person who will bury him. I was wondering whether to reveal my status to my new man.
21	Res:	Which of your family members know that you are HIV-positive?
22	Pat:	I didn't tell anyone
23	Res:	Why?
24	Pat:	Hm… truthfully said, the Yorùbá people say that only the hidden things are valued.
25		I don't know how they will react if I tell them.

Agatha's perspective hinges pertinently on the importance of saving face in stigma-laden circumstances (her HIV disease). For her, she sees the need to hide her medical situation from her spouse and family because she shares the same beliefs in the cultural norms guiding her immediate

society – she believes it is fate to be infected with a disease which has no cure (line 14). And with fate, comes a feeling of resignation and/or desperation to believe that her medical condition is real. Nevertheless, she still seeks for possible sources of cure. Having resigned to fate (the belief that she is destined to be HIV-positive), one of her coping mechanisms is to seek counsel from a clinic attendant whom she refers to as pastor (lines 18-20). The pastor is that sacred, religious individual who knows her medical condition and from whom she must not hide her secret, unlike her family members who must remain unaware of her condition. The question remains why Agatha chooses to conceal her medical condition from her family members and spouse and reveal it willingly to a non-family member. Probably because she understands her cultural background? It is evident that she conceals her HIV status to avoid stigma, discrimination and judgment. Though the pastor shares the same cultural orientations with her (being a Yorùbá man), Agatha believes that religion has set him apart from being judgmental. After all, pastors are there to preach salvation, protect other Christians and perform life-saving miracles. Here, we see a case of conflicting cultural norms that dictate discrepancies in the rules that govern openness and secrecy. Within the Yorùbá socio-cultural space, openness or truthfulness is allowed, to "one who will bury you" (i.e., the one who is trustworthy and has a measure of control over your life) and vice versa. It is surprising though, that Agatha's family and close relations are characterised as people who cannot be trusted and from whom valuable, hidden things (such as HIV disease) must not be exposed. However, she has stated very clearly that her actions regarding the ART and living with HIV are guided by cultural and religious beliefs.

8.1.4.3 Summary

The patients' interviews have shown evidence of their tendencies to be nonadherent to medical recommendations, i.e., they indulge in AHTs and ATOs. This evidence resonates with the finding that doctors suspect patients' nonadherence to medical recommendations when the latter presents lifestyle choices that may lead to non-medically approved alternative treatments options. It has been established that the issue of patients' nonadherence goes beyond their adherence to medical recommendations alone – patients who are not nonadherent may still be intertwined with several cultural/religious beliefs that may affect their stance towards medically-approved treatment options at the clinics. For instance, when patients believe in secrecy, herbal remedies, the cultural concept of fate, and religion, these beliefs already show that they seek solace in alternative

therapeutic remedies that transcends what the clinics offer i.e., ARV drugs, prophylactic drugs and drugs for acute medical complaints.

8.2   Concluding Discussion

This chapter was guided by the following research questions: (i) how do doctors suspect patients' nonadherence and consequently investigate this behaviour during the d-p encounters? (ii) what are the views of doctors and counsellors about the factors responsible for patients' nonadherence? (iii) what do patients disclose as adherence or nonadherence factors? To answer the questions, the chapter has adopted qualitative (key informant interviews) and quantitative methods (thematic coding) to the research enquiry. This chapter examined the perceptions of the research participants (doctors, counsellors and female HIV-positive patients) on patients' social situations and its influence on nonadherence. From the findings, doctors show that they believe patients are nonadherent when the following behaviours are noticed (a) Irregular Clinic Visits (b) Low CD4 count test (c) Complaint Types (d) Unimproved Health and (e) ATOs and AHMs. Furthermore, the reports of doctors and counsellors show that patients' social situations exist as factors militating against their adherence to medical recommendations. These factors are generally perceived in four ways: self-inflicted behaviour, stigmatisation, cultural norms and hostile medical staff. Their perceptions suggest that due to patients' social situations, nonadherence may either be self-inflicted or inflicted on patients due to the prevailing social cultures, and due to the stigmatization that patients experience from the medical staff at the outpatient clinics. Patients' interviews also indicate that they tend to indulge often in AHTs and ATOs.

So, what does this all mean for our interpretation of participants' perceptions of patient's nonadherence? First, the analysis of data shows that the term "social situation" adequately describes participants' lifeworlds. Silverman (1993) describes this term as the theoretical and empirical understanding of the subjects' life worlds by describing how they see it and not how the researcher sees it. Silverman exemplifies the role of an anthropologist in understanding how participants organize their world (1993: 60). The researcher further states that this ethnomethodological attempt "locates the skills ("artful practices") through which people come to develop an understanding of each other and of social situations" (1993: 60). Hence, by considering the social situations of ethnographic subjects, the researcher is making provisions for describing their world as they see it and not the other way around. Goode (1994) also referred to this when

describing how he "wanted a dialogue … between him and his research subjects, but in their 'own terms" (1994: 24). And in recognizing their 'own terms', various methods were adopted to rid the researcher of the temptation of subjectivity. From the analysis of participants' interviews, it is evident that attributions of patients' social situations to adherence behaviours is adequate for describing their experiences as PLWA because the interpretation of participants' views was analysed according to how participants express them (i.e., their lifeworlds).

Second, the data analysis exemplifies what the doctors and counsellors define as patients' nonadherent behaviours. Their definition of nonadherence transcends adherence to prescription/treatment recommendations alone. Nonadherence is treated as a multidimensional concept that incorporates medication use, as well as compliance with other medical recommendations: CD4 count test, regular clinic visit and drug collection. As exemplified in table 8-2, mentions of evidence of patients' nonadherence include irregular clinic visits, low CD4 count, patients' complaint types, unimproved Health, ATOs and AHMs. These factors show that patients' lifestyle choices and general health are key factors for determining adherent versus nonadherent behaviours – doctors and counsellors suspect that patients have been nonadherence to medical recommendations when the latter is either sick or presents lifestyle choices and socio-economic situations that may lead to non-clinically approved alternative treatments options. These may include cultural/religious beliefs, unsafe sexual practices, low educational status, financial problems and deluded experiences of illness (especially what the HIV disease entails medically). This finding presents a clearer perspective to understanding how and why doctors show expectations of patients' nonadherence in the interactions. It also explains why such adherence-focused encounters are interactionally structured the way they are, in the sense that a patient whose medical record shows adherent behaviours may still be accused of nonadherence in the interactions. The doctors and counsellors' views of nonadherence also justify their perceptions of patients' social situations as indicators of nonadherence, especially when they sometimes view patients' social situations as an influence of self-inflicted behaviours. Furthermore, it has been established from patients' interviews that the issue of nonadherence goes beyond their adherence to medical recommendations alone – patients who are adherent may still be intertwined with several cultural/religious beliefs that may affect their stance towards medically-approved treatment options (see D. M. 1). Thus, the notion of adherence is much more complex in the Nigerian HIV

context, than what is stated in the literature, and these findings resonate with the findings in chapters five, six and seven.

Participants' interviews support evidence from the consultations in that doctors and counsellors affirm patients' responses as concrete evidence of their real-life experiences. The participants expressed opinions on how patients carve out various identities in their actions – as also expressed in the d-p consultations. This may shed some light on why patients do not react to the doctors' instructions as face-threatening, but purposively align with doctors' interest in detecting some personal beliefs that they may have about HIV. Doctor Gideon reiterates that patients are sometimes aware that they are questioned for investigative purposes "We detect their use of alternative therapies when first…" (see D.G.2). Counsellor Esther also alludes to this as an effort to discourage unwanted behaviour: "At times, we discourage them but … the patients also have their own personal beliefs which are far away from the reality…" (see C. E. 2 and C.E.1). Patients accept that conversational strategies are predicated on the investigative agenda for the d-p consultations. Doctor Gideon and counsellor Esther corroborate this opinion (see D.G.1 and C.E.1) when they state that patients only reveal other treatment preferences when they mention the advice of people they closely relate with. This, they maintain, is an unarguable indicator of nonadherence whether the patient feels well or not. However, the real question, probably, is: "How do patients yield to clinicians' advice to live healthy lives when they (the clinicians) sometimes counsel patients to be secretive among other things?" For instance, a counsellor may counsel patients to practice safe sex, but this same counsellor keeps her HIV status a secret and preaches the same to patients in order to properly manage their medical condition. Furthermore, the medical staff encourage adherence but also stigmatise patients. Thus, how do patients cope with such prejudice when the medical staff are hostile towards patients? Hence, it is evident that sometimes, patients' health behaviours are inspired by the weaknesses of the medical staff. Unfortunately, no real conclusions can be drawn from patients' data because very few patients were willing to be interviewed. However, the few patients lend their voices on perceptions and experiences regarding adherence and living HIV.

Braun and Clarke (2008) state that the theoretical position of a thematic analysis must be established because "any theoretical framework carries with it a number of assumptions about the nature of the data and what they represent in terms of the world" (2008: 81). Thus, in applying the socio-cognitive, we may observe that participants' reports show that the factors contributing to

patients' adherence include facilitators and barriers, and patients' disposition to medication expectations. From the reports of counsellors and doctors, patients' social situations are barriers to behaviour change. These social situations include poor financial status, insufficient education, lack of family support, stigmatisation, cultural/religious beliefs and hostile medical staff. When these factors are perceived in the d-p encounters, then nonadherence is suspected. The few patients' reports indicate that they are driven by self-efficacy – they possess the personal desire and ability to produce an intended positive result. This is evidenced with expressions such as "All I use is my ARV drug" (Interview transcript 1), "I use my drugs" (Interview transcript 2). Thus, patients are motivated to take their ARV drugs because of expectations of positive treatment outcomes. Where clinicians consider ATOs and AHMs as barriers, for instance, patients see them as a facilitator for ensuring total health. The patients I interviewed state that they indulge in alternative herbal therapies and ATOs but they view this only as health enhancers and not an indication of nonadherence, because their ARV drugs are used together with these other treatment options. Meanwhile, the doctors maintain that such alternative medicines contraindicate with the ARV drugs and have the capacity to reduce patients' motivation to take the required drugs, follow the treatment plan or comply with other medical recommendations. Of the fourteen-medical staff interviewed, only one doctor share similar perspectives with the patients. The doctor states that patients' behaviour change can only be assured when their subjective beliefs are adhered to – a need for patients' medical life assurance. Thus, it appears that other sociocultural problems such as stigmatisation, hostile medical staff, financial and educational status and lack of family support are all intricately linked to patients' need for optimal treatment or positive medication outcomes (such as getting healed of the HIV disease and achieving a general well-being). Moreover, patients may not have control of these other social factors, but they do have control over the decision to be adherent. In summary, the analysis shows that patients' behaviour change concerning adherence may be encouraged when their subjective beliefs are subscribed to, and when medical practitioners continuously assure them of positive treatment outcomes for ARV drugs and alternative therapies. Probably, there may be some mechanisms for increasing the health benefits of these alternative treatment options if the medical practitioners do not view them as barriers, but as facilitators.

9 Summary and Conclusion

9.1 Summary of Major Findings

This study examined the interactions between female HIV-positive patients and doctors/counsellors in outpatient clinics covering Nigeria's south-western geo-political zone. It asks four research questions which were answered by specifically examining three interactional activities in the doctor/patient consultations: openings, medical history-taking and treatment discussions. It also discussed participants' (doctors, counsellors and patients) views about patients' adherence behaviours. The research questions for this study were to first, recover how the consultations were opened, hence a study of the trajectories and interactional consequences of opening sequences (including preliminary sequences and main-business questions that were all a part of the main reasons for the medical consultation). Furthermore, it discussed adherence-related negotiations in the history-taking sequences. This question accounts for how adherence-related question designs set the interactional goals of the consultations and how participants orient to these interactional goals. Third, it discusses how doctors ensured adherence in treatment discussions. Lastly, this study discussed the opinions of the research participants regarding patients' nonadherence to medical recommendations. Thus, this study examined the socio-cultural fabric which shapes the attitudes and beliefs of doctors, counsellors and female HIV-positive patients towards HIV/AIDS, as they negotiate adherence-related talks during, and outside the routine consultations.

To answer the first research question, findings from chapter five reveal that while doctors make provision for solicitation of patients' medical concerns while opening the encounters, the doctor/patient consultations are majorly contextualized by one central objective: doctors' expectations of patients' nonadherence to medical recommendations. The chapter showed that preliminary sequences such as greeting routines and person-reference for identity purposes were part of the main medical concerns of the visits. The main business is introduced with three question types: Wh-questions, "How are you?" questions and polar questions. These questions are close-ended, pointing expressly to their use in a routine type of interaction, and they perform four agenda-setting functions: up-dating about health-related behaviour, soliciting patients' well-health status and soliciting patients' medical complaints. These interactional trajectories constitute the semantics of questioning while participants conduct the main business of the consultations, within

the ambience of two visit types which I labelled types I and II visits. All question types initially appear to be information questions that solicit current information but functionally, most questions are a test of adherence. This test is an unmarked expectation that informs the interactional trajectories on addressing patients' nonadherence.

Findings in chapter six respond to the second research question. This chapter showed that adherence-related trajectories were projected in the medical history-taking activity. Participants oriented to these trajectories as they negotiate adherence-related topics, with its implications on patients' responses and doctoring styles. The adherence-related questions that feature in this activity are explicitly and implicitly framed, and they are initiated by doctors within the context of investigating patients' adherence to drug use, regular CD4 count testing, regular clinic visits and regular drug collection. However, there is evidence that the history-taking questions infer from patients' medical records – suggesting that the doctors seek evidence from patients' medical records to presume their adherence status. Another evidence of the questions' functions is provided in their sequentially embedding: the questions are located after a brief pause, after patients' complaints may have been solicited and stated, or after doctors realise that patients are ill. These evidences suggest that prior to asking the nonadherence questions, the doctors are already working with a presumption that patients have been indulging in nonadherent behaviours. Thus, it is typical for doctors to presume, at the beginning of the consultations, that patients have been nonadherent – an indication that adherence issues play a dominant role in the beginnings, sometimes explicitly and sometimes more implicitly. Doctors address it in the beginning but refer to very different things: taking cough medicine as well as attending regularly at the clinic, doing a CD4, etc. And, they address it in a unique way, such that nonadherence is the unmarked expectation which leads to, or embodies the action of accusations, with subsequent justification from patients. Patients' responses show that beyond the obvious motivation to 'do' questioning, they orient to the purpose of the history-taking questions as a test of adherence.

Chapter seven answers the third research question. The chapter shows that doctors ensure patients' adherence in the treatment discussion phase. Doctors achieve these trajectory with practices of giving instructions, explaining the importance of conducting regular CD4 count tests and planning next appointments for future routine check-ups, drug collection and medical examinations. In this activity, doctors display a strong deontic force in their practices. Hence, they

display a strong medical authority and paternalism in their relationship with the patients. Patients, on the other hand, submit their rights to shared decision-making on treatment regimens.

To answer the fourth research question, chapter eight examined interview data that were recovered from HIV-positive patients, and doctors and counsellors at the outpatient clinics. Results from the analysis of interview data show that doctors and counsellors constantly work with the beliefs expressed during the doctor/patient consultations, that patients' nonadherent behaviours do exist, but can only be attributed to their social situations (life worlds or social realities). Thus, doctors expect that patients have been nonadherent, consequently investigate this behaviour during the d-p encounters. However, this expectation of nonadherence is perceived as a product of patients' social situations – an underlying factor in nonadherent behaviours. Furthermore, patients disclose alternative therapeutic options as a facilitator for healing, rather than a barrier. Doctors believe that patients have been nonadherent when the following behaviours are noticed (a) Irregular Clinic Visits (b) Low CD4 count test (c) Complaint Types (d) Unimproved Health and (e) ATOs and AHMs. All of which point to one underlying denominator for suspecting patients' nonadherence, i.e., their indulgence in alternative therapeutic options (ATOs) due to social situations such as self-inflicted behaviour, stigmatisation, cultural norms and hostile medical staff. These perceptions clearly show that due to patients' social situations, nonadherent behaviours may either be self-inflicted or inflicted on them by the prevailing societal structures and by the stigmatization they experience from the medical staff at the outpatient clinics. Moreover, the patients' interviews show evidence of their indulgence in AHTs and ATOs.

In the present study, adherence is analysed from the perspective of medical recommendations. This is because, at the outpatient clinics, adherence is treated as a multidimensional concept that incorporates medication use, as well as compliance with other medical recommendations: CD4 count test, regular clinic visit and drug collection. Thus, the notion of adherence is much more complex in the HIV context, than what obtains in the existing literature. Furthermore, from the theoretical position of the thematic analysis, patients' accounts of nonadherence are perceived as facilitators for wellness, a subjective belief about healing from the HIV disease – though there is yet, no cure. This perception takes a different position from the doctors who perceive that alternative treatment options are barriers to adherence and positive behaviour change. Thus, factors such as financial status, educational status, lack of family support, stigmatisation, cultural/religious beliefs and hostile medical staff are perceived as evidence of

nonadherence. Conversely, patients report that they possess the personal desire and ability to indulge in positive behaviour change of their subjective beliefs are subscribed to.

9.2   Theoretical Contribution

In their review of health behaviour theories, Munro et al (2007) state that few medical interventions to promote treatment adherence have drawn from the proposals of health behaviour theories. Meanwhile, these theories are beneficial for enhancing behaviour change across different health settings because they seek to understand patients' attitude towards long-term treatment adherence for chronic infections like HIV and tuberculosis. Health behaviour theories also propose theoretical interventions that will aid patients' treatment adherence. In line with this assertion, the present study contributes to the discourse on patients' health behaviour by applying the dictates of SCT to Nigerian medical consultations. It specifically contributes to an understanding of the notion of "self-efficacy" and "knowledge of treatment outcomes" and its application, not only to medication use but to other medical recommendations that can aid medication use. So, these concepts need to be expanded to account for treatment use, as well as other medical recommendations, especially in the context of chronic-routine doctor/patient visits.

The study also contributes to the global discourse on MCA. As a methodological approach, MCA focuses on the interactional co-construction of aspects of doctor-patient interaction and sees participants' social situation primarily as generated in situ (in individual and case-by-case interactions). Hence, it systematically examines the interaction-inherent factors that engender participants' social actions. However, most MCA studies about doctor-patient encounters focus on settings and institutions in western countries like England, Germany and the United States. Studies in other countries practising biomedical care like it is the case in Nigeria, as well as comparative studies, are still rare (see Odebunmi 2003; Adegbite & Odebunmi 2006). Thus, in Nigeria, there is scant literature on the activity structure and social actions in Nigerian doctor/patient encounters, significant as they are to the understanding of the context of medical consultations in the country. This study contributes to the discourse on doctor/patient interactions from this fresh perspective by examining the role of participants' interactional activities/actions, and participants' opinion samples in addressing a specific patients' health-related behaviour (adherence).

9.3 Practical Implications

The results from this study contribute to the development of research in d-p interactions in Nigeria, especially the nature of consultations in chronic-routine visits. The study has shown the impact of cultural ethos in understanding how patients' adherence behaviours are managed in the consultations between doctors/counsellors and female HIV-positive, and its implications for the increasing prevalence of the HIV disease within the south-western region of Nigeria. By discussing the prevalent communicative trajectories of the consultations as well as the communicative skills needed by doctors/counsellors to manage consultations with female HIV patients, this study has revealed utterances which show communication failure, hence, suggestions on managing discourse of this nature and interpersonal relations within the HIV clinics. This, then, will be of benefit to doctors and counsellors who are currently involved in medically managing female HIV patients. In turn, this would help in the process of fostering trust between female HIV patients and their doctors/counsellors, thus merging the perspectives of doctors and patients on alternate therapeutic options. Results from the research will also be useful for policymakers in the Nigerian government as they will be enlightened on, for instance, the consequence of low treatment coverage of HIV patients and inadequate provision of CD4 count testing laboratories within the clinics, which encourages patients' nonadherence. There is also the need to consider trained and accredited experts in the care of HIV/AIDS patients in south-western Nigeria, rather than general practitioners who currently attend to them. In addition, the study will be of relevance to linguistic anthropologists as well as researchers who focus on medical communication.

In terms of health care practice, the subjects live in the south-west geopolitical zone of Nigeria, an environment where there is a rise in the incidence of new HIV infections among women (UNAIDS 2015). The social construct of HIV disease generally in this region is problematic. It has been labelled as "incurable" and a "taboo" in many quarters (Odebunmi 2011: 619). Female HIV patients particularly, are stigmatized due to the cultural expectation that they contracted the disease because they are promiscuous. Therefore, when doctors open consultations with patients in a less hierarchical way, mutuality needs to be established. This may encourage patients to speak more openly about their medical conditions, especially when doctors do not orient to the societal and structural construction of the personality of female victims and the problematic nature of HIV disease. Consequently, institutional roles are better managed between doctors and patients while they also maintain better social relationships. Moreover, more patient-minded opening questions

tend to make patients less defensive, who can then provide more information about their personal lives, their fears of stigmatization and fears about their general state of health. When doctors address less defensive patients, then they can then also access patient's subjective experiences and subjective and/or religious theories of healing and the "supernatural" control of their diseases. Doctor's access to this information is crucial such that the right counsel on profitable lifestyle and living with HIV as female victims can be provided.

9.4 Future Directions

Future research may wish to consider a few pertinent research questions which were not addressed in this thesis. First, researchers may wish to consider in more detail, the role of female HIV patients' illness narratives in understanding their expression of victimhood as a factor of nonadherence to medical recommendations. Second, CA researchers may wish to consider how the d-p encounters are closed, with the view to identifying the prescription recommendation phases of the encounters and how this phase may be influenced by doctors' suspicions of patients' nonadherence. Finally, future ethnographic research may wish to consider how language choices at the HIV clinics may influence patients' response designs. This will show if responses to questions are due to cultural differences or a genuine orientation to interactional agendas.

9.5 Conclusion

In conclusion, findings showed that first, opening questions come with its interactional consequences – it focuses more on patients' medical concerns and their nonadherence to medical recommendations. The questions are jointly oriented to, by both doctors and patients as either investigative actions or general inquiries, and are responded to, based on these orientations. Second, patients respond to both explicit and implicit requests for adherence behaviours, which may or may not show that they orient to their behaviours as nonadherent. Third, participants have unique definitions for what they consider as adherence – adherence is generally treated as compliance to medical recommendations. Patients' social situations are taken as proof of nonadherence, especially when their accounts for nonadherence present unique narratives which justify their behaviours. Ultimately, this study shows that consultations between female HIV-positive patients and doctors/counsellors in South-west Nigeria are highly influenced by concerns

centred on patients' adherence to medical recommendations, and the interactional strategies they adopt for addressing this behaviour.

Moreover, the research participants have a sense of agency in managing consultations, both in the d-p encounters and during counselling sessions. Though doctors and counsellors have the higher authoritative roles as per the content and interactional trajectories of consultations and counselling sessions, patients equally "have a say" on how they chose to respond to interactive agendas. While nonadherence is the overriding concern, several other issues militate against the idea that patients' behaviours are solely constitutive of their nonchalant decisions. The Yorùbá sociocultural milieu dictates that every (medical) problem has a solution. Thus, alternative treatment options are one of the ways of seeking a solution to the HIV medical menace. In both the CA and interview (discourse) analysis approaches, participants' verbal actions on adherence are influenced by the specific institutional relevancies and the culture within which they operate.

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Appendixes

Appendix 1: (GAT 2) Transcription Conventions

[ ] [ ]	overlap and simultaneous talk
(.)	micropause, estimated to 0.2 sec. duration
(--)	intermediate estimated pause of approx. 0.8 sec. duration
(0.5) / (0.2)	measured pause of appr. 0.5/2.0 sec. duration
( )	unintelligible passage
→	refers to a line of transcript relevant in the argument
=	fast, immediate continuation with a new turn or segment
:	lengthening, by about 0.2-0.5 sec.
::	lengthening, by about 0.5-0.8 sec.
:::	lengthening, by about 0.8-1.0 sec.
,	rising to mid
;	falling to mid
<<surprised> >	interpretive comment with indication of scope
?	smaller pitch upstep
SYLlable	focus accent
?´	smaller pitch upstep to the peak of the accented syllable
<<pp> >	pianissimo, very soft
<<p> >	piano, soft
<<l> >	lower pitch register
<<all> >	allegro, fast
<<ff> >	fortissimo, very loud
<<f> >	forte, loud
↑	smaller pitch upstep
↓	smaller pitch downstep
<<:-)> so>	smile voice
((coughs))	non-verbal vocal actions and events
((laughs))	description of laughter
((unintelligible, appr. 3 sec))	unintelligible passage with indication of duration
((...))	omission in transcript

Appendix 2: Consent Form for Doctors, Counsellors and Patients

Dear Sir/Madam,

I am a PhD student of University of Bayreuth, Germany. The data collected would be transcribed and sent to the doctors in charge for consent before further work is done on the study. The data would be treated with utmost confidentiality and names of the patients and doctors will be excluded from the study. You are kindly requested to indicate your acceptance for the collection of the data, and sign afterwards. Thank you for your cooperation.

I AGREE ☐

SIGNATURE

Appendix 3: Questionnaire for Interview with Doctors and Counsellors

Dear Sir/Madam,

The following interview questions have been drafted to elicit information from doctors and counsellors concerning their relationship with HIV-positive patients. The information provided will help to understand the communicative strategies used by participants during interactions.

The questions below are strictly for academic and research purposes. The data would be treated with utmost confidentiality and names of the doctors, counsellors and patients will be excluded from the study. Kindly answer the questions as objectively as possible. Thank you for your co-operation.

Section A

(Please tick where applicable)

Bio Data

(i) Age range: 16 -25☐   26-35☐   36-45☐   46-55☐   55 and above☐

(ii) Gender: Male ☐   Female ☐

(iv) Job Description: _____

(v) Ethnic Group: _____

(vi) Religious Affiliation: _____

(vii) Educational background: _____

Section B

Introducing Question

1) Can you tell me about yourself and your experiences so far, as a doctor or counsellor attending to HIV patients living in this south-west region?

Direct and Follow-up Questions
2) The incidence of new HIV/AIDS contraction is still at an unreduced status in Nigeria. What do you believe is responsible for this?
3) What is your impression of beliefs held by female HIV patients in south-western Nigeria concerning the disease?
4) Are your impressions of patients' beliefs influenced by patients' socio-ethnic background or the medical and political milieu in Nigeria?

5) Are female HIV patients more prone to new infections than male or vice versa?
6) Do you find that female HIV patients in Nigeria are more prone to stigmatization and why?
7) Do female patients that you attend to adhere to drug use and or seek alternative therapies? If yes, can you estimate the percentage of patients you regularly attend to, who adhere to drug use?
8) Do female patients sometimes use linguistic devices (complaining, digression, joking, silence, arguing, lamenting etc.) to either give information or refrain from divulging information during consultations?
9) During consultations, do you sometimes allow patients to speak without necessarily being asked a question?
10) Do you expect the patient to already possess some basic information about their ailment such as CD4 count, viral load, stage of the viral infection etc. before coming for consultation? Is this always, less often or never the case?
11) Do you often encourage patients to respond to a discussion by asking for their opinion?
12) Do you usually give patients more than enough time to express themselves?
13) Do you perceive that most female patients fully or do not fully understand the nature of their illness? Why?
14) Do patients' dispositions during consultation include one or more of the following; excitement, enthusiasm, sorrow, pessimism, glee, optimism or any other?
15) Are there language barriers (cultural differences) between you and the patients that inhibit communication? How do you usually handle such cases?
16) During counselling, do the patients readily agree with your suggestions? If yes, at what point (i.e., during drug prescriptions, advice on lifestyle, food intake, etc.)?

Appendix 4: Questionnaire for Interview with Patients

Dear Sir/Madam,

The following interview questions have been drafted to elicit information from you on your experiences as an HIV-positive patient. The information you provide will help us to understand the nature of communication between you and the doctors/counsellors at the outpatient clinics.

The questions below are strictly for academic and research purposes. The data would be treated with the utmost confidentiality and names of the doctors and patients will be excluded from the study. Kindly answer the questions as objectively as possible. Thank you for your co-operation.

<u>**Section A**</u>

<u>**(Please tick where applicable)**</u>

<u>**Bio Data**</u>

(i) Age range: 16 -25 ☐   26-35 ☐   36-45☐   46-55☐   55 and above ☐

(ii) Gender: Male ☐   Female☐

(iv) Job Description: _____

(v) Ethnic Group: _____

(vi) Religious Affiliation: _____

(vii) Educational background: _____

Section B

Introducing Question

1)   Can you tell me about yourself and your experiences so far, as an HIV patient living in this south-west region?

Direct and Follow-up Questions

2)   You have tested positive for HIV but do you believe the disease is real?

3)   Do you believe the disease is curable? If yes, why?

4)   What has been your experience and relationship with family members and healthcare providers since you protracted the HIV disease?

5)   Have you tried to seek a cure for the disease besides orthodox medicine? If yes, what has been your experience of cure with alternative therapies, do they prove more effective than ARV drugs?

6) Do you disclose that you seek alternative therapies to doctors? If no, why and how do you avoid telling the doctors this even when asked?
7) Do you believe alternative therapies are more effective than ARV drugs?
8) Do you feel free to relate with people who know you are HIV-positive?
9) Does having the disease deprived you of certain social benefits such as getting a reputable job?
10) Are you placed on isolation when admitted to the clinic? How does that make you feel?
11) Do you feel free to communicate with doctors without any language barriers?
12) Do you believe doctors are sympathetic towards you?
13) Do you feel stigmatized or castigated by health care providers and family members? How do you cope with this?

Appendix 5: Research Permit 1

FEDERAL TEACHING HOSPITAL
IDO-EKITI
P.M.B. 201, IDO-EKITI. Tel: 030-251723, 251110

Our Ref:............................ Your Ref:............................ Date:............................

ETHICS AND RESEARCH COMMITTEE, FEDERAL TEACHING HOSPITAL, IDO-EKITI

CLEARANCE CERTIFICATE

PROTOCOL NUMBER: ERC/2014/12/29/45B

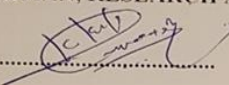PROJECT TITLE: Discourse Features of Language Usage in Doctor-Patient

Encounters in HIV/AIDS Clinics in Southwestern Nigeria.

PRINCIPAL INVESTIGATOR(S): Boluwaduro, Eniola Olamide

DEPT/INSTITUTION: Department of English, University of Ibadan, Nigeria.

DATE CONSIDERED: 07/12/2015   DECISION OF COMMITTEE: APPROVED

ACTING CHAIRMAN, RESEARCH AND ETHICS COMMITTEE: Dr Durowade K. A.

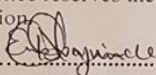SIGNATURE..   DATE........08/12/15........

DECLARATION BY INVESTIGATOR(S)

PROTOCOL NUMBER:(Please quote in all enquiries/correspondence) ERC/2014/12/29/45B

To be completed in three copies and returned to the Secretary, Ethics and Research Committee of Federal Medical Centre, Ido-Ekiti, Ekiti State, Nigeria.

I/ We fully understand the conditions under which I am/we are authorized to conduct the above mentioned research and I/ we guarantee that I/we will ensure compliance with these conditions. Should any changes or departure be contemplated from the research procedure as approved, I/we undertake to re-submit the protocol to the Ethics and Research Committee for consideration and approval.

NB: The Committee reserves the right to conduct compliance visit(s) to your research site(s) without prior notification.

Signature(s)..   Date....15/12/2015....

Phone Number....08034 966 407....   E-mail Address....adedoyine@gmail.com....

219

Appendix 6: Research Permit 2

EKITI STATE UNIVERSITY TEACHING HOSPITAL
ADO-EKITI, NIGERIA.
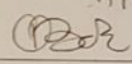
ETHICS AND RESEARCH COMMITTEE

CLEARANCE CERTIFICATE

PROTOCOL NUMBER: EKSUTH /A67/2014/12/002

PROJECT TITLE: DISCURSIVE PATTERN AND CONTEXTUAL FEATURES OF LANGUAGE USAGE IN DOCTOR-PATIENT ENCOUNTERS IN HIV\AIDS CLINICS IN SOUTH WESTERN NIGERIA .

INVESTIGATOR(S):BOLUWADURO,ENIOLA OLAMIDE.

SUPERVISOR(S): PROFESSOR SUSANNE MUEHLEISEN AND DR ODEBUNMI.

DEPARTMENT: ENGLISH.

INSTITUTION: UNIVERSITY OF BAYRENTH, BAYRENTH, GERMANY AND UNIVERSITY OF IBADAN, IBADAN NIGERIA.

DATE CONSIDERED:18\12/2014.

DECISION OF COMMITTEE: | APPROVED |
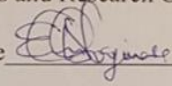
CHAIRMAN: Dr. Obitade S. OBIMAKINDE   SIGNATURE & DATE: _____

DECLARATION BY INVESTIGATOR/PRINCIPAL INVESTIGATOR
PROTOCOL NUMBER (Please quote in all enquires) EKSUTH /A67/2014/12\002

To be completed in three copies and two copies returned to the Secretary; Ethics and Research Committee, University Teaching Hospital, Ado-Ekiti, Nigeria.

I/we fully understand the conditions under which I am/we are authorise to conduct the above-mentioned research and I/we guarantee that I/we will ensure compliance with these conditions. Should any departure be contemplated from the research procedure as approved, I/we undertake to resubmit the protocol to the Ethics and Research Committee.

Signature _____   Date: 29/12/2014

NB: Any erasure, cancellation or alteration renders this certificate invalid.