International Journal of Research in English
www.englishjournal.net
Online ISSN: 2664-8725; Print ISSN: 2664-8717
Received: 06-05-2019; Accepted: 07-06-2019; Published: 14-06-2019
Volume 1; Issue 3; 2019; Page No. 21-27

Conversational maxims in doctor-patient verbal interactions at university college hospital, Nigeria, Nigeria

Adewale Kazeem Ayeloja[1], Taofeek Olanrewaju Alabi[2]
[1] Department of English Faculty of Arts University of Ibadan Ibadan, Nigeria
[2] General Studies Department Federal Polytechnic, Ado-Ekiti, Ekiti State, Nigeria

Abstract
Conversation is a rule-governed behaviour. So, interlocutors either consciously or unconsciously obey some rules in the process. So, for any conversation to be effective, specific conversational etiquettes must be adhered to. Conversational maxims refer to the four rules which were proposed by H.P. Grice to ensure effective communication. This study, therefore, investigates the ingredients of effective communication in relation to medical practice by examining the extent of compliance with the Gricean conversational maxims by doctors during consultation with patients. The conceptual framework adopted for the study is the Gricean pragmatic concept of conversational maxims. One hundred tape recordings of doctor-patient conversations were made at the University College Hospital, Ibadan, Nigeria, in 2017. Twenty-five of the interactions were randomly selected for the study. The data were subjected to qualitative analysis. Violations of the conversational maxims of quantity and relation characterize the interactions. This takes tolls on the communication as the doctors either hold back some pieces of important information or deviate from the object of discussion to talk about irrelevances. Effective observance of the conversational maxims will impact positively on doctors' communication with patients as it will make the patients understand their medical conditions better and also encourage them to be cooperative during clerking and treatment. Therefore, effective observance of the conversational maxims is crucial to engendering effective communication between doctors and patients.

Keywords: conversational maxims, maxim of quantity, maxim of manner, verbal interactions

Introduction

Conversation is a form of interactive communication involving two or more people. Contributions to a conversation are response reactions to what has been previously said. They are essentially of an interactive nature (Conklin and Mary, 1912: 21-32) [4]. Conversation plays a crucial role in medicine as it is the medium by which doctors and patients investigatel the health challenges of patients and talk about treatment or management plans.

During clinical interviews, the medical practitioners play host to the patients. Therefore, doctors and patients must be able to understand each other so that the medical practitioners might be able to diagnose the patients' diseases appropriately and proffer apposite medical solutions to them, thereby achieving the objectives of medical practice.

A lot of research has been done in medical communication, and some of the recent works in this direction are: Odebunmi (2003) [10] that examines the pragmatic features of English usage in hospital interactions in South-West Nigeria; Odebunmi (2006) that examines locutions In medical discourse in Southwestern Nigeria; Ogunbode (1991) [12] which carries out a study on effective communication in the medical sciences in relation to teaching and learning in medical classes; Faleke and Alo (2010) that study mutual contextual beliefs in doctor-patient verbal interactions. Similarly, Adegbite (1991) [1] studies the features of language use in Yoruba traditional medicine, and Ayeloja (2017) that examines discourse devices and communicative functions in doctor-patient verbal interactions in two federal teaching hospitals in Nigeria. However, none of these studies has investigated conversational maxims in doctor-patient verbal interactions with a view to enhancing medical practitioners' communication skills. This study will fill this gap in order to assist doctors attain the objectives medicine i.e.: accurate diagnosis, treatment, patient recall, compliance and ultimately, patient wellbeing. Pragmatics is not included in the curriculum of Medicine but doctors use the conversational maxims intuitively. So, this study investigates the extent to which doctors comply with the Gricean conversational maxims during clinical interviews with patients.

A lot has been written on communication skills in academic journals as well as in introductory texts for medical students. These studies can be grouped into two: the relatively few which are predicated on natural or authentic language data and the larger group that uses indirect or intuitive data. Numerous questionnaire based works are available on nurse-patient verbal interactions. Bremhaar *et al*. (1996), Henderson and Chien (2004) made use of questionnaires to obtain information about patient perspectives on quality of care. In a similar vein, a number of textbooks underscore the importance of communication but very few offer examples of what make up effective communication.

Pragmatics is vital to effective communication, and it is an essential source for discourse analysis. A basic knowledge of pragmatic phenomena is a precondition required to analyze any discourse, and the various ways in which the pragmatic phenomena act and interact are also important. Somehow, there is an interconnection between Pragmatics and semantics. So, in a very simple way, it could be explained that if semantics is considered as the area of study covering the truth-conditional meaning of utterances, then Pragmatics deals with all the other types of meaning. This is a very broad definition and is

comparable to the one given by Morris in 1938 considered to be the first modern definition of the term (Alba-Juez, 2010). Levinson (1983:108), however, observes that Morris' definition of Pragmatics as "dealing with all the psychological, sociological and biological phenomena which occur in the functioning of signs" is much wider than the scope of the work that is currently labelled as pragmatic. Agreeing with Levinson, Morris' definition of Pragmatics has taken Pragmatics beyond language use. Levinson explains that the term Pragmatics was subject to successive thinning of scope and the definitions which were finally influential were those making reference to the users of the language.

Several scholars have defined Pragmatics in various ways, and these definitions present elements like: context, meaning beyond literal meaning, speech acts, deixis, understatement or implicature as key components of this discipline. Levinson (1983:15) argues that "the notion of meaning not covered in semantics certainly has some cogency". Leech (1983:6): opines that both Semantics and Pragmatics are concerned with meaning, but the difference between them lies in two different uses of the verb "to mean"

[1] What does X mean? [2] What did you mean by X?

Semantics would deal with [1] and Pragmatics with [2]. Therefore, semantic meaning is dyadic and has to do with words or expressions in a given language regardless of particular situations, speakers or hearers, while pragmatic meaning is triadic and is defined with respect to a speaker or user of the language.

Georgia Green's (1989:2) definition of Pragmatics is as broad as that of Morris:

Linguistic pragmatics as defined here is at the intersection of a number of fields within and outside of cognitive science; not only linguistics, cognitive psychology, cultural anthropology, and philosophy (logic, semantics, action theory), but also sociology (interpersonal dynamics and social convention) and rhetoric to contribute to its domain.

In addition, one of Levinson's (1983) definitions of Pragmatics as "the study of utterance meaning" equates it to Schiffrin's (1994:190) definition of Discourse Analysis. But, Alba-Juez (2009)[2] queries whether Pragmatics and Discourse Analysis are the same, and Schiffrin (1994: 190) counters by saying that the scope of Pragmatics is wide and "faces definitional dilemmas similar to those faced by Discourse Analysis".

In this study, Pragmatics is viewed as one of the main sources and approaches to Discourse Analysis, thus we consider Discourse Analysis as a broader discipline that draws from the principles of Pragmatics but includes other perspectives within its scope. The implication of this is that we regard Pragmatics in a narrower sense.

The focus of this study is to examine the extent of doctors' compliance with the conversational maxims as propounded by H.P. Grice (1975) [5] to ensure effective communication. It is therefore imperative to examine the concept here and what other scholars have said about it.

Gricean Cooperative Principle and the Theory of Implicature

As Horn *et al* (2004:9) note, "the landmark event in the development of a systematic framework for pragmatics was the delivery of Grice's (1967) William James Lectures". One of the basic concepts in Gricean Pragmatics is speaker meaning. Grice makes a distinction between speaker meaning, which is devoid of intentionality, and non-natural meaning (meaning-nn), which deals with intentional communication. There is a second intention which is implicit in the definition of meaning-nn, i.e. the recognition, on the part of the addressee of the speaker's communicative intention. Thus, if a child says: "I like that dress" to her mother, the meaning -nn would be that she wants her mother to buy that dress for her (and therefore she expects her mother to recognize her "hidden" intention or wish of having that dress). This type of meaning is closely connected to another of the central concepts in Gricean Pragmatics: the notion of conversational implicature, which is considered to be one of the single most important ideas in pragmatics. This notion has provided linguistic analysts with an explicit account of how it is possible to mean more than what is actually "said". Normally, what a speaker intends to communicate is far richer than what s/he says or directly expresses, and thus, s/he exploits pragmatic principles that the hearer can invoke in order to bridge the gap between what is said (the literal content of the uttered sentence, determined by its grammatical structure) and what was meant (i.e. what was really communicated).

Alba-Juez (2009:48) [2] observes that conversational implicatures are a kind of inference that can be derived from an utterance in order to work out the "meant" from the "said", and they are related to what Grice called the "Cooperative Principle" and its "Maxims". Given the fact that our talk exchanges do not normally consist of a succession of disconnected remarks (and would appear irrational if they did), the remarks are characteristically cooperative efforts and each participant recognizes in them a mutually accepted direction. It is assumed that speakers cooperate and follow these maxims, which are reproduced below:

A) The Cooperative Principle

Make your contribution such as is required, at the stage at which it occurs, by the accepted purpose or direction of the talk exchange in which you are engaged.

1) The Maxim of Quantity

i) Make your contribution as informative as required (for the purposes of the exchange).
ii) Do not make your contribution more informative than is required.

2) The Maxim of Quality

Try to make your contribution one that is true, specifically:

i) Do not say what you believe to be false.
ii) Do not say that for which you lack adequate evidence.

3) The Maxim of Relation

i) Be relevant.

4) The Maxim of Manner

Be perspicuous, and specifically

i) Avoid obscurity of expression.
ii) Avoid ambiguity.
iii) Be brief (avoid unnecessary prolixity).
iv) Be orderly. (Grice, 1975:45-46) [5]

Grice (ibid) explains people sometimes do flout these guidelines, and here is where conversational implicatures play their parts. In

the event of a violation of one of the maxims, the listener assumes that the speaker is nevertheless trying to be cooperative and looks for the meaning at some deeper level. By so doing, s/he makes an inference, namely a "conversational implicature".

3. Methodology

Doctors' verbal interactions with patients were tape-recorded at the University College Hospital, Ibadan, Nigeria, in 2017. A total number of 5 doctors, and 20 patients were used for this study. One hundred interactions were recorded out of which only 25 were randomly selected for this study. The conceptual framework adopted for this study is the Gricean pragmatic concept of conversational maxims. An ethical approval was obtained for the data collection. This involved making some payments and submitting a research proposal.

Equally important, the research was conducted in a multilingual setting, only the contributions of Yoruba and English languages speakers formed the data. In situations where the doctors and patients conversed in Yoruba and Pidgin English, or engaged in alternate code-mixing of either of the two codes, their contributions were translated into English, while contributions rendered in English were retained.

4. Data Analysis and Discussions

This section offers a discussion of the pragmatic features of hospital verbal interactions. This involves a study of the observance of the conversational maxims in the doctor-patient discourse. The pragmatic features discussed here were achieved mainly orally.

The study of the conversational maxims has been carried out here in relation to the violation of the Gricean conversational maxims. According to him, interlocutors should be as brief as possible, be truthful, avoid ambiguity and also avoid obscurity in their contributions. A careful study of the data revealed that only two maxims – those of quantity and relation were violated. Quality and manner maxim were not violated at all. The implication of this is that the doctors totally avoided falsehood and obscurity in their contributions. We shall examine the violation of the two concerned conversational maxims and the extent of the violations.

4.4.1. Quantity Maxim

The quantity maxim is the more violated of the two concerned maxims. Its violation in the Doc.-Pt. interaction was about 65%. Let us consider the following:

Extract 1 (Interaction 1)

Doc.: Do you take sweet:
Pt.: That was before.
Doc.: So, you don't take it again. What about coke.
Pt.: I take it occasionally.
Doc.: How many times do you clean your teeth in a day?
Pt.: Once.
Doc.: How do you brush?
Pt.: I use toothbrush.
Doc.: How? In which direction?
Pt.: Anyhow. All around.
Doc.: Do you brush up and down?
Pt.: Up and down.
Doc.: Ok.

In the above extract, Doc asked Pt. whether he took sweet. Pt. responded that he had taken it in the past. Then, Doc. asked again whether Pt. took coke as well. Pt responded he took it occasionally. Next, Doc. inquired from Pt. the number of times he brushed his teeth daily, and Pt. answered he brushed his teeth once in a day. Here, Doc flouted the quantity maxim by being inadequately informative. One, he did not explain to Pt. that sugary things (coke and sweet inclusive) could damage the teeth when taken without caution. In addition, he did not tell Pt. to stay away from sugary things to enjoy good oral health. This fact is attested to by the Doc. in (Interaction 1). See below.

Extract 2 (Interaction 1)

Doc.: But don't you think you should leave sweet for children considering your age and the fact that sweet is not good for the teeth? Research has shown established it that sweet things expose the teeth to bacterial attacks.
Pt. (Laughs) Yees. I try hard to stop it but I'm too used to it. I use mouthwash.

Two, in response to Doc's question, Pt. explained he brushed his teeth only once daily but Doc. did not explain to Pt. that teeth should be brushed at least twice in a day - morning and night - for good oral hygiene as explained by the Doc in Interaction 8. See below.

Extract 3 (Interaction 1)

Doc.: You should be cleaning your mouth two times daily. What did I say?
Pt.: Two times daily.
Doc.: In the morning before breakfast and in the evening the last thing. Also make sure you use toothpastes containing fluorided.
Pt.: Ok, ma.

In response to Doc.'s question on what Pt. used to clean his teeth, Pt. said he used a toothbrush. Doc. also sought to know how he carried out the brushing. Pt. explained he brushed ''all round''. Doc was satisfied and remarked ''Ok''. Yet, Doc still flouted the quantity maxim again by not telling Pt. how often he should change his toothbrush and the type of toothbrush and toothpaste he should use as recommended by the Doc. in Extract 4. See below.

Extract 4 (Interaction 1)

Doc.: Not at all. How many times do you brush in a day?
Pt.: Twice - morning and night.
Doc.: Yes. The right thing to do is to brush in the morning and night. Do you use toothbrush or chew stick?
Pt.: Brush.
Doc.: How do you brush? Can you demonstrate it?
Pt.: I brush it up, down, the corners.
Doc.: Good. Ok. So, what kind of toothbrush do you use now? Is it soft or very soft?
Pt.: Very soft brush.
Doc.: Were you told to buy soft toothbrush? Or do you know the name of the toothbrush?
Pt.: No.
Doc.: So, when you are buying a toothbrush, check the packet to ensure 'medium' is written on it.
Pt.: Ok. Thank you.

Doc.: Next time when you are buying a toothbrush, make sure you look at the inscription on the packet because we have soft, medium and hard. Always use the medium one. It's the best for you. The soft is for children while the medium is for adult. Don't use the hard one because it damages your teeth. It scrapes off part of your teeth. In addition, you should change your toothbrush every three months.
Pt.: Thank you.

Extract 5 (Interaction 2)
Pt.: Francis 'M' School.
Doc.: Frances 'M' School. Where is your school? Is it in Ibadan?
Pt.: Yes. Agbowo.
Doc.: Francis 'M' School in Agbowo. Do you take all these sugar?
Pt.: I don't like sugar.
Doc.: But you like sweet things a lot, abi?
Pt.: Sometimes.

Pt. had apicaperiondotitis. So, Doc. asked him whether he liked sugary food items, and Pt. responded in the affirmative. Doc. flouted the quantity maxim here too because he did not tell Pt. to stay away from them because of the peril they pose to dental health. There is, therefore, the tendency that Pt. will continue taking sugary things that could eventually damage his teeth.

Extract 6 (Interaction 3)
Doc.: So, what have you done about the eyes?
Pt.: I use chloramphenicol eye drop.
Doc.: And it has not changed anything.
Pt.: Yes.
Doc.: Does anybody in your family have eye problem.
Pt.: Yes. My parents.

Pt. felt pains in the eyes and came to see Doc. for treatment. Doc. asked Pt. the measures he had taken to treat the condition, and Pt. explained he had applied chloramphenicol eye drop in his eyes but the condition persisted. Doc. flouted the quantity maxim here because he failed to educate Pt. on the dangers of self-medication. Instead, he went ahead to seek information about Pt.'s family history (FH). As we can see in the extract above, despite the use of chloramphenicol by Pt., his condition remained unchanged. Therefore, it is medically wrong for a non-physician to administer drugs not recommended by a physician.

A look through all our data also revealed that every doctor in our data violated the quantity maxim in relation to drugs side effects. The doctors recommended drugs of various kinds but never mentioned any of the side effects of any of the drugs. As stated in the Literature Review in the main work, there is no single drug without a side effect; some are mild while some are severe. Explanation of the side effects of the prescribed drugs would have greatly engendered compliance with the prescribed treatment and assisted patients to prepare for any unusual developments. Therefore, there is the fear of possible stoppage of the use of the prescribed drugs when patients experience any adverse reactions after taking the drugs, and this may defeat the treatment agenda.

4.4.2 Quality Maxim

As evident in the data, the quality maxim was observed 100% in the interactions as the doctors made their contributions very truthful. The doctors presented explanations on diagnosis medical advice very truthfully. The implication is that the patients were able to understand and believe the doctors. At the level of compliance with medical prescriptions and advice, the truthful contributions of the doctors are believed to enhance patients' cooperation. The following extracts further prove the above assertions.

Extract 7 (Interaction 13)
Pt.: Then, I also experience itching.
Doc.: Did you ever have it before?
Pt.: Yes.
Doc.: Where do you feel the itching?
Pt.: In my palms.
Doc.: [Checks patient's case note] Bilateral itching on both palms.
Pt.: Yes.
Doc: This type of itching has nothing to do with the liver. The kind of itching that the liver problem causes is on the skin. It is generalized. It is not restricted to any part. What could be causing itching on your palm could be some kind of allergies. Probably you come in contact with something that irritates your palm and then itching results. That might be an allergic thing. But if you are talking about a disease, it will affect the whole system - systemic- not just localized.
Pt.: So, with this kind of situation now, should I - since I started coming here, I have stopped having any sexual contact with my wife just to know my fate because I don't want her to catch the infection.
Doc: Ok. The thing about hepatitis B is that it can actually be sexually transmitted the same way HIV is transmitted. In addition, if one gets a blood product from an infected person or if one shares a sharp object with an infected person, one could have - needles, blades etc. In fact, it has been said that the virus in hepatitis B stays longer on objects than that in HIV. May be about 30 minutes, the HIV virus will have died but that of hepatitis B can stay alive for months. So, it's better to have your own clipper, blade etc.
Pt.: That's another area.

In the extract above, Pt. had itching and hepatitis B. In the doctor's effort to educate Pt. on the sicknesses, he was very truthful based on his medical knowledge of the ailments. So, in Doc.'s first emboldened contribution in the extract, he explained to Pt. very clearly and honestly that the itching he felt was not due to a liver problem but a mere reaction arising possibly from an allergy because it was localized. Two, he explained to Pt. again, clearly and honestly, that hepatitis B is truly sexually transmitted, just like HIV. He also moved a step further to educate Pt. on other ways of contacting the hepatitis B virus: getting a blood product from an infected person or sharing an infected sharp object. Relying on the researcher's common knowledge of the ailments, the doctor's explanations are true, and this is very likely to enable Pt. have a good knowledge of the concerned ailments and consequently be better informed about the ailments.

Extract 8 (Interaction 14)
Doc.: Do you feel abdomin- stomach pain.
Pt.: Yes. During Ramadan fast.
Doc.: Is it a mild stomach ache?
Pt.: No. It's always very painful.
Doc.: And you don't break the fast.
Pt.: No. Ramadan Fast is a must for every true muslim.
Doc.: Madam, as a fellow muslim, I know The Quran exempts the sick from fasting. So, it is not right to fast when you are sick, when it affects your health negatively like you explained. God knows more than we do about everything concerning us, even our health. It is allowed in the Quran to provide food for those fasting if your health does not permit you to fast.
Pt.: I didn't know this before. Thank you.

In Extract 8, Pt. suffered from abdominal pain as a result of ulcerative conditions but Pt. continued to observe the Ramadan Fast in spite of the fact that it is contraindicated in ulcerative conditions. In the emboldened contribution, Doc., therefore, in an attempt to assist Pt. have a good health explained truthfully told the Muslim patient that Islam permitted abstinence from the Ramada Fast where it affected people's health. He added that those that could not observe the Ramadan Fast might provide food items to those observing the fast as an act of worship. The truthfulness of Doc.'s explanations gladdened Pt. and he consequently, remarked: "I didn't know before".

Extract 9 (Interaction 20)
Doc.: Kinni nwon so pe o je? [What was the reading?]
Pt.: 140/100.
Doc.: Ah! 140/100. Iyen ga. [Ah. That's high.] A o le je ki e lo ile bayi. [We can't allow you to go home now.] Se e ti gbo? [Have you heard me?]
Pt..: Mo ti gbo nyin.. [I have heard you.]
Doc.: Kii se pe e maa sun si hospital. [Not that you will be admitted.] E kan maa sun die nibi ni ki ifunpa nyin le wale. [You will only take some rest here to enable your blood pressure come down]. E lo lexotan tablet miran bayii. [Take another tablet of lexotan now.]
Pt.: Eyo kan? [One tablet.]
Doc.: Beeni. (Yes.)

In Extract 9, Pt. had an abnormally high blood pressure. As evident in Doc.'s first emboldened contribution in the extract, he knew it was dangerous for Pt. to be allowed to leave the hospital without her BP brought down. So, he told Pt. she had to rest for some time there to force down her elevated BP before she left the hospital. Doc. probably sensed Pt. thought she would be put on a long admission, so he took his time to explain truthfully to Pt. that she would only be asked to stay in the hospital for a few moments after taking a lexotan tablet to bring down her blood pressure. In Extract 7 – 9, the doctors were very honest in all they told the patients. So, their observance of the quality maxim was 100%.

4.4.3 Manner Maxim

As our data revealed, the manner maxim was observed 100% in the Doc.-Pt. verbal interactions as the doctors did not use medical jargons during consultation with the patients. They used simple expressions that the patients could understand. The implication is that the patients were able to understand the doctors very well. This, in turn, enabled the patients to also contribute meaningfully to assist the doctors arrive at appropriate diagnoses and at the same proffer appropriate medical solutions to the patients' medical challenges. The accompanying extracts further clarify the above assertions.

Extract 10 (Interaction 4)
Doc.: What kind of pain do you feel? Is it sharp or is it a severe pain? Is it a mild pain? What kind of pain?
Pt.: The pain is just there. It is not very sharp. It's just paining me any time I am talking.
Doc.: Does it come and go?
Pt.: It is always there. I feel the pain anytime I am eating

Extract 11 (Interaction 5)
Doc.: What are your complaints?
Pt.: I have a pain here (Pointing to his mouth).
Doc.: Is it your upper or lower jaw?
Pt.: Lower jaw. I have done a test (Shows doc. an X-ray).
Doc.: No problem. The X-ray is different. The X-ray - I will look at it. But then I need to ask you some questions and you have to like – give me the honest answers so that I can make my own impressions and I will look at the X-ray and I can tell you ---- do you understand. So, I'm sorry I'm going to start asking you questions afresh.
Pt.: Ok.
Doc.: You say you have pain in your teeth. Where?
Pt.: The lower jaw?
Doc.: The lower jaw. When did it begin?
Pt.: Ammmh. I think about two or three weeks ago.
Doc.: Two or three weeks ago. Has it been constant? Or, It has been coming and going?
Pt.: Constant.

Extract 12 (Interaction 6)
Doc.: He also has itchy eyes. Do you react to something like smokes?
Pt.: Sometimes.
Doc.: Do you react to dust? Do you have skin rashes?
Pt.: Yes.

In all the three extracts above, Docs. used very simple expressions that were very easy for the patients to understand to elicit information from them. There are medical jargons that the doctors could have used to describe the patients' conditions but they instead opted for simple words that the patients could understand easily. Consequently, the patients were able to understand the doctors.

In addition, it is encouraging to note that even when the doctors used medical terms that patients did not understand, they made efforts to explain what they meant. For instance, we may consider the following extracts:

Extract 13 (Interaction 6)
Doc.: I will examine your eyes. Then, you will go to the nurses. You will read a chart so we can see how well your eyes can see and then, we will know what next to do by the time I see your – we call it visual acuity.

Extract 14 (Interaction 7)
Doc.: Alright. You will take form to the nurses. I want us to do urinalysis. It will show if there is infection in your urine. If

there is evidence of infection in that test, then you will have to take another test. In addition, they will measure your height and weight. In fact, they should have taken all the vital signs before you came here. After that, I will take your blood pressure myself.

In Extract 13 (Interaction 6), Doc used the medical jargon 'visual acuity' towards the end of the extract but had explained what it means in the beginning of the extract. Doc. later used the medical term out of a desire to make Pt. know the name of that procedure, probably for the sake of information as Pt. was educated. Similarly, in Extract 14 (Interaction 7), Doc. used the medical jargons 'urinalysis' and 'vital signs' but also explained the meaning of each of them. This was done to enable Pt. know the terms for the procedures.

4.4.4 Relation Maxim

The relation maxim is the second violated maxim and its non-observance was about 35.2%. The non-observance of this maxim is, however, small when compared to that of the quantity maxim. The communicative implication of this phenomenon is that Docs. that were guilty of this misbehavior deviated from the subject being discussed to talk about triviality. We examine the extract below.

Extract 15 (Interaction 8)

Doc.: Is your firstborn a male or female?
Pt.: Male. He is a doctor too.
Doc.: So, the remaining two are females. Are they married?
Pt.: One of them is married while one is undergoing National Youth Service.
Doc.: How many children did the married female have?
Pt.: One.
Doc.: Girl or boy?
Pt.: Boy.
Doc.: How old?
Pt.: Seven months.
Doc.: Is she your youngest child?
Pt.: Yes.

Here, Doc. violated the relevance maxim because she asked Pt. the number of children Pt.'s only female child had whereas Pt.'s complaint is about a strange movement in her body. Using common sense, there is no way the number of one's grandchildren can have a biologic effect on one's health. Therefore, Doc's questions should have been centred on Pt.'s lifestyle.as this is what could have yielded insights into the possible cause of the strange movement in Pt.'s body.

Extract 16 (Interaction 9)

Bakannaa, e o maa ye abe bata nyin wo fun eso toripe to ba gun-un, o le se nyin lese. you. [Similarly, you should regularly inspect the soles of your shoes to ensure there are no nails in them as they could wound yoi.]. Atipe diabetes maa n baa won isan ese je ni debii pe ti nnkan gun eyan lese, ko nii mo. [In addition, diabetes is so debilitating to the extent that one may have an injury and yet not know. Ni afikun, e o maa wa losoosu fun itoju ati ayewo. [Youshould also come every month for examination and treatment.] To ba je pe owo lani k'e waa gba, e maa wa, bo je eemeji losu. [If we ask you to come to collect money, even twice in a month, you would come.] Tori naa. ilera se Pataki. [Therefore, good health is important] E o maa wa losoosu - eemejila lodun. [You will come to the hospital monthly–twelve times yearly] E o maa ra oogun nyin deede. [You are to buy your drugs regularly] Toogun nyin ba ti ku merin ni e ti maa wa sibi lati waa se ayewo. [Immediately you have four doses left, you should come here for aother test] Nigbati e ba n bo, eo nii jeun abi momi wa. [You will not take your breakfast or drink water when coming] Idi ti a ni lati se bayii ni ki sugar to wa lara nyin ti a n gbiyanju ati muwale ma baa lo soke. [The reason for this is to ensure your blood sugar level does not go up.]

In the extract above, Doc. was counselling Pt. on the 'dos' and 'donts' of diabetes but suddenly went off track to condemnably insinuate that Pt. was not serious with her health. This is communicatively unacceptable as Doc. had gone too far making such a damaging comment, thus violating the relation maxim. This is especially bad as the Pt. was an adult.

5. Conclusion

This study constitutes a pioneering effort at studying medical discourse by applying the Gricean conversational maxims to doctor-patient communication for the purpose of enhancing the communicative competence of doctors in medical settings, using discourse analysis.

Additionally, violations of the conversational maxims of quantity and relation characterized the interactions. These took tolls on the communication as the doctors either held back some pieces of important information or deviated from the object of discussion to talk about irrelevances.

Lastly, the present study has covertly stressed the importance of incorporating some elements of Pragmatics, particularly the Gricean conversational maxims, into the medical curriculum in view of their immense communicative benefits. Effective communication is sure to impact positively on doctors' communication with patients as it will make the patients understand their medical conditions better and also encourage them to be cooperative during clerking and treatment. Therefore, effective observance of the Gricean conversational maxims by both doctors and patients is crucial to engendering effective doctor-patient communication.

References

1. Adegbite W. Some features of language use in Yoruba traditional medicine. Unpublished Ph.D. Thesis: Department of English, University of Ibadan, 1991.
2. Alba-Juez L. Perspectives on Discourse Analysis: Theory and Practice. London: Cambridge Scholars Publishing, 2009.
3. Cassell EJ. Making the Subjective Objective: Communicating with Medical Patients. Eds. Stewart M. Roter & D. Newsbury Park: Sage Publications, 1989, 13-51.
4. Conklin, D. and Mary, G. Conversation: What to Say and How to Say it. New York and London: Funk & Wagnalis Company, 1912.
5. Grice HP. Logic and Conversation in Syntax and Semantics. Eds. Peter Cole and Perry Morgan Lee. New York: Academia Press, 1975, 3.
6. Studies in the Way of Words. Cambridge, Massachussets: Havard University Press, 1979.
7. Levinson DA. A Guide to the Clinical Interview. Philadelphia: Saunders, 1987.

8. Levinson SC. Activity Types and Language. Linguistics. 1997; 17:365-399.
9. Mishler EG. The Discourse of Medicine: Dialectics of Interviews. Norwood, NJ. Ablex, 1984.
10. Odebunmi SA. Pragmatic Features of English Usage in Hospital Interactions Amongst Medical Practitioners and Patients in South-Western Nigeria. Thesis. English. Arts. Obafemi Awolowo University, 2003, i:87.
11. Odebunmi A. Pragmatic Strategies of Diagnostic News Delivery in Nigerian Hospitals. Linguistik Oonline. 2008; 36(4):21-37.
12. Ogunbode O. Effective Communication in the Medical Sciences. Effective Communication in Teaching and Learning: Basic Principles Ed. Adegbija E. Ilorin: University of Ilorin GNS Division, 1991, Xx-33.
13. Oloruntoba-Oju T. Aspects of Communication in the Medical Class. English Language and Communication Skills. Eds. Adegbija and Ofuya. Ilorin: The English Language Outer Circle, 1996, 187-201.
14. Schiffrin D. Discourse Markers. Cambridge: Cambridge University Press, 1987.
15. Searle J. Speech Acts: An Essay in the Philosophy of Language. Cambridge: Cambridge University Press, 1969.
16. Stubbs M. Discourse Analysis: The Sociolinguistic Analysis of Natural language. Oxford: Blackwell, 1983.