ARGUMENTATION IN DOCTOR-PATIENT CONSULTATIONS IN EKEGUSII: A PRAGMA-DIALECTICAL APPROACH

By

Nobert Ombati Basweti

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Supervisor: Professor Marriana Visser

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DECLARATION

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ABSTRACT

This dissertation investigates the argumentative discourse of (Eke)Gusii doctor-patient consultations in Kenya using the framework of the extended pragma-dialectical theory of argumentation. The study particularly investigates how Gusii doctors and Gusii patients strategically manoeuvre in resolving differences of opinion through the analysis of simulated medical consultations in (Eke)Gusii. The data for the research constituted transcripts of audio recordings of twelve consultation simulations conducted in (Eke)Gusii involving Gusii doctors and Gusii simulated patients with already diagnosed cases of HIV and AIDS, diabetes or cancer at The Kisii Teaching and Referral Hospital, a public hospital in Kenya. The analysis conducted employed the pragma-dialectical method which entailed the interpretation, reconstruction and evaluation of the dialogues. Utilising the model of critical discussion, the study also assessed the display of communication accommodation and attitudinal aspects of evaluative language use in strategic manoeuvring in doctor-patient consultations. This multiperspective study establishes that the interplay of the macro contextual exigencies of contemporary western medicine and the traditional Gusii sociocultural belief system concerning illness, which determine the nature and properties of strategic manoeuvring in the (Eke)Gusii doctor-patient consultation give rise to a hybrid of genres of consultation and persuasion. Displaying explicit and invoked evaluative language, the Gusii doctors and Gusii patients continually exploit linguistic and psychological convergence or divergence in their choice of presentational devices to accommodate the institutional constraints of the two institutions and realising the composite institutional point. The study identifies and characterises the prototypical pattern of argumentation in the Gusii medical consultation, as one in which Gusii doctors and Gusii patients employ pragmatic argumentation as the main argumentation to defend a desirable effect of a prescriptive standpoint. The findings of the study indicate that symptomatic argumentation or other pragmatic arguments entail the support argumentation pattern for both parties but with diverse sources of authority. The sociocultural, macro and discursive contextual circumstances of the Gusii medical consultation determine the supporting argumentation and responses to the critical questions of pragmatic arguments. The study concludes that argumentation in the (Eke)Gusii medical consultation presents empirical evidence for the enhancement of the strategic manoeuvre design of the extended pragma-dialectical theory with elements of evaluative language use and communication accommodation.

OPSOMMING

Hierdie proefskrif ondersoek die argumentasie diskoers van (Eke)Gusii dokter-pasiënt konsultasies in Kenia binne die raamwerk van die pragma-dialektiese teorie van argumentasie. Die studie ondersoek, in die besonder, hoe Gusii dokters en Gusii pasiënte strategies maneuvreer in die resolusie van verskille in opinie deur analise van gesimuleerde mediese konsultasies in (Eke)Gusii. Die data vir die studie het die transkripsies en klankopnames behels van twaalf konsultasie simulasies gehou in (Eke)Gusii tussen Gusii dokters en Gusii pasiënte met reeds gediagnoseerde gevalle van HIV en VIGS, diabetes, of kanker by die Kisii Onderrig en Verwysings hospitaal in Kenia. Die analises wat gedoen is, het gebruik gemaak van die pragma-dialektiese metode wat die interpretasie, rekonstruksie en evaluering van die gesimuleerde dialoë behels. Met gebruikmaking van die model van kritiese bespreking, het hierdie studie ook die vertoon van kommunikasie-akkommodasie en gesindheid (houdings) aspekte van die gebruik van evalueringstaalgebruik beoordeel in strategiese maneuvrering in dokter-pasiënt konsultasies. Hierdie multi-perspektief studie toon aan dat die interaksie tussen die makro kontekstuele noodwendighede van kontemporêre westerse geneeskunde en die tradisionele Gusii sosio-kulturele oortuiging sisteem betreffende siekte, wat die aard en eienskappe bepaal van strategiese maneuvrering in die (Eke)Gusii dokter-pasiënt konsultasies, aanleiding gee tot ‘n hibriede genres van konsultasie en oorreding. In die vertoon van eksplisiete en beroepgedoende evaluerende taal, ontgin die Gusii dokters en Gusii pasiënte voortdurend linguïstiese en psigologiese konvergensie en divergensie in hulle keuses van aanbiedingsmiddele ten einde die institutionele beperkings te akkommodeer van die twee institusies en in die realisering van die saamgestelde institusionele raakpunt. Die studie identifiseer en krakateriseer die prototipiese patroon van argumentasie in die Gusii mediese konsultasie, as een waarin die Gusii dokters en Gusii pasiënte pragmatiese argumentasie as hoof argumentasie inspan ten einde ‘n gewenste effek van ‘n preskriptiewe standpunt te verdedig. Die bevindings van die studie dui daarop dat simptomatiese argumentasie of ander soorte pragmatiese argumente die ondersteuning argumentasie patroon behels vir beide dokters en pasiënte, alhoewel met verskillende bronne van outoriteit. Die sosiokulturele makro en diskursiewe omstandighede van die Gusii mediese konsultasie bepaal die ondersteunende argumentasie en response tot die kritiese vrae van pragmatiese argumente vir sowel die dokter en die pasiënt. Die studie kom tot die slotsom dat die argumentasie in die Gusii mediese konsultasie

empiriese bewys bied vir die uitbreiding van die strategiese maneuvrering ontwerp van die uitgebreide pragma-dialtektiese teorie, met elemente van evaluerende taalgebruik en kommunikasie akkommodasie.

IKISIRI

Tasnifu hii inatathmini mdahalo wa mashauriano kati ya madaktari Wakisii na wagonjwa Wakisii nchini Kenya kwa kutumia nadharia ya uchanganuzi wa kipragmatiki na mawasiliano huru ya majadaliano. Hususan, utafiti huu unachunguza jinsi madaktari Wakisii na wagonjwa Wakisii wanavyoweka mikakati ya kusuluhisha tofauti za kimaoni zinazojitokeza katika majaribio ya ushauri wa tiba kwa kutumia (lugha ya) Kikisii. Data ya utafiti huu ilitokana na nakala kumi na mbili zilizonasa sauti za majaribio ya mashauriano yaliyoendeshwa kwa lugha ya Kikisii. Waliohusishwa ni madaktari Wakisii na wagonjwa Wakisii ambao walikwishatambuliwa kuwa na magonjwa ya UKIMWI, kisukari au saratani kwenye Hospitali ya Umma ya Mafunzo na Rufaa inayopatikana nchini Kenya. Utafiti ulitumia mbinu ya mawasiliano huru iliyojumuisha ufasiri na uundaji upya wa midahalo. Kwa kutumia mfumo wa kuhakiki majadiliano, utafiti huu ulichunguza udhihirikaji wa maafikiano katika mawasiliano na kutathmini matumizi ya lugha katika kufaulisha midahalo yao ya lugha. Katika utafiti huu wa kutumia vipengele mbalimbali, ilibainika kuwepo kwa mgongano katika matumizi ya dawa za kigeni pamoja na imani na tamaduni za jamii ya Wakisii jinsi zinavyochangia katika matumizi ya mikakati ya kufaulisha mashauriano ya daktari na mgonjwa na yanavyoathiri matumizi ya uunganishwaji wa mbinu za mashauriano na ushawishi. Huku wakidhihirisha matumizi ya lugha bayana na ya kutathmini, madaktari Wakisii na wagonjwa Wakisii wanazidi kutumia maafikiano ya kilugha na kisaikolojia kufaulisha mawasiliano au tofauti katika uteuzi wa mbinu za uwasilishaji ili kufanikisha maelewano ya maslahi baina yao na kujengana na kuwa nguzo moja. Utafiti huu ulibainishwa na kutambulishwa na mipangilio mbalimbali ya kujadiliana katika mashauriano ya tiba ya Wakisii, moja ikiwa ni matumizi ya mawasiliano huru na vitendo kuwa nguzo ya mdahalo wao ili kuhalalisha makubaliano yao. Majadiliano juu ya dalili za maradhi au majadiliano mengine ya maradhi huhusisha utetezi wa kauli za daktari na mgonjwa kutegemea mitazamo na mazingira yao wote wawili. Mashauriano ya kimatibabu ya Wakisii baina ya mgonjwa na daktari mara nyingi hutegemea imani zao; huathiri jinsi mgonjwa atakavyojibu maswali yanayohitaji umakinifu wakati wa mashauriano. Utafiti huu wa mashauriano ya kimatibabu kati ya Wakisii yamedhihirisha kuwepo kwa ushahidi wa nadharia ya kuimarisha mbinu za mawasiliano huru na vitendo vinavyojumuisha tathmini ya matumizi ya lugha na maafikiano katika mawasiliano.

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LIST OF ABBREVIATIONS

AD	Alzheimer's disease
AU	African Union
CAM	Complementary and alternative medicine
CM	Complementary medicine
DTCA	Direct-to-consumer Advertisements
DTCA	Direct-to-consumer advertisements
eHealth	Electronic Health
GBD	Global Burden of Disease
GP	General Physician
HIV & AIDS	Human immunodeficiency virus and acquired immune deficiency syndrome
HL	Health literacy
KAIS	Kenya AIDS Indicator Survey
KTRH	Kisii Teaching and Referral Hospital
MARPs	Most-at-risk populations
mHealth	Mobile Health
NAAS	Nonverbal Accommodation Analysis System
NBM	Narrative-based medicine
NDCs	Non-communicable diseases
NM	Narrative medicine
NPI	Natural Products Industry
NUGL	New Updated Guthrie List
OTC	Over-the-counter
PCC	Patient-centred care
PLWHA	People living with HIV and AIDS
POA	Plan of Action
RECs	Regional Economic Communities
SDGs	Sustainable Development Goals
SDM	Shared decision-making
SP	Simulated (or standardised) patient
THPs	Traditional health practitioners

TM	Traditional medicine
T&CM	Traditional and complementary medicine
UHC	Universal health coverage
UNDP	United Nations Development Programme
USAID	United States Agency for International Development
WHA	World Health Assembly
WHO	World Health Organisation

CHAPTER ONE
INTRODUCTION

1.1 Introduction

This study sought to conduct a linguistic investigation of the argumentative discourse of (Eke)Gusii doctor-patient consultations employing the extended pragma-dialectical theory of argumentation. Taking a case of doctor-patient consultations in Kisii Teaching and Referral Hospital (KTRH), a public hospital in Kisii county, Kenya, the study explored the pragma-dialectical dynamics of the use of argumentation to resolve disputes in simulated medical consultation encounters in (Eke)Gusii. The (Eke)Gusii[1] language is a Bantu language spoken predominantly in the Kisii and Nyamira counties in south western Kenya (Basweti, Achola, Barasa & Michira, 2015). The simulated patients (SPs) in the study represented Gusii patients, who had been diagnosed with either non-communicable diseases (cancer or diabetes) or the HIV and AIDS pandemic considering the national and global attention[2] the medical conditions continue to elicit. The analysis of the audio recordings of the dialogic exchanges in the simulated consultations between doctors and patients involved a pragma-dialectic interpretation, reconstruction and evaluation of the dialogues. Exploiting the model of critical discussion (van Eemeren *et al.*, 2014: 534-535) the study investigated the argumentative manoeuvres in the resolution of differences of opinion in the treatment decision-making process. Because of the institutional macro contextual realities of the communicative activity type of the Gusii medical consultation, the analysis considered the theoretical value of communication accommodation in the strategic design of the argumentative process of resolving the differences of opinion. Exploring interpersonal considerations in the medical encounters between Gusii doctors and Gusii patients, the study analysed the attitudinal aspect of evaluative language use in their strategic manoeuvres when negotiating with the social identities of their interlocutors. The analysis identified the institutional preconditions which determine strategic manoeuvring and further characterised the prototypical

[1] (Eke)Gusii (JE42) is classified in the New Updated Guthrie List (NUGL) online alongside other Bantu languages like Logooli (JE41), Idaxo (JE411), Isukha (JE412) Kuria (JE43), Simbiti (JE431) and Tiriki (JE413) (Maho, 2009: 63).

[2] NDCs account for 27% of Kenya's deaths (WHO, 2014). Kenya AIDS Indicator Survey (2012) groups Kisii among the nine counties with approximately 65% of new HIV & AIDS infections.

argumentation patterns of the Gusii medical consultation for Gusii doctors and Gusii diabetics, cancer and HIV and AIDS patients.

1.2 Background to the study

Examining medical discourse, Mishler (1984) notes the conflict of interests in the medical consultation observing that whereas the doctor is interested in biomedical evaluation and the treatment process, the patient is bothered with personal anxiety, fears and his/her social "lifeworld" circumstance. This explains why the doctors sometimes find themselves focusing on their medical agenda while downplaying the patient's concerns which may at times be insightful in understanding the nature of their medical issue (Heritage & Mynard, 2006: 5). However intricate, the process of shared decision-making (SDM) in the medical consultation, because of the diversity of interests of the principal communicative partners, has proven effective for the management of long term or chronic conditions (Joosten, DeFuentes-Merillas, de Weert, Sensky, van der Staak, *et al.*, 2008: 224)

In the recent past, the SDM model has emerged as a major contributor to argumentation due to its collaborative problem solving ideal[3] and patient-centred character (Stiggelbout *et al.*, 2012; Lin & Fagerlin, 2014: 328; Kruk, Nigenda & Knaul, 2015: 431). Studies in doctor-patient interaction (Ong, DeHaes, Hoos & Lammes, 1995; Heritage & Mynard, 2006) point out that during healthcare encounters, doctors and patients share ideas in making decisions, and building mutual relations primarily through "talk" (Berry, 2007: 40). These collaborative efforts in the fight against chronic conditions (Ngutu & Nyamongo, 2015: 797) require an emphasis on the argumentation skills parameter by both doctors and patients because of the prolonged treatment and management.

While aiming for mutual agreement in the medical consultation, the SDM model emphasises information sharing, preferred treatment by the doctor and patient, and consensus-building on the best preferred of treatment option to adopt and self-management targets (Charles, Gafni & Whelan, 1997: 685–688; Coulter & Collins, 2011: 2). Incidentally other models do not give a chance to the patient to participate in the treatment decision-making (Charles *et al.*, 1997). For instance, in the *paternalistic model*, the doctor makes decisions without an attempt to solicit preferences. The

[3] See Baker (2009:130-131) whose idea can be adapted to the doctor-patient shared decision-making as an interactive argumentative situation.

doctor uses his professional expertise to diagnose and recommend clinical tests or preferable medication for a patient's medical condition (Charles *et al*., 1997: 683). On the other hand, the doctor, in the *informed model*, is the one with the technical and scientific knowhow to provide the available options and facts on treatments before the patient can choose one that suits his/her values. The information shared with the patient does not give him/her a chance to participate in the treatment decision making. By contrast, the *professional-as-perfect agent model* allows the doctor to make the decision based on the preferences of the patient without interfering with the patient's own preferences and values. Considering the values of the patient, patient autonomy and patient adherence, the *Shared Rational Deliberative Joint Decision model* is favoured in enhancing the SDM while retaining and improving the other models[4] (Sandman & Munthe, 2010: 62).

In the literature, however, little attention has been given to the burden of communication skills that the resolution of a difference of opinion imposes on doctors and patients (Zanini & Rubinelli, 2012: 165). The frame of critical discussion is foundational in unravelling the communication challenges in SDM. Based on the principles of critical discussion the SDM model faces five major challenges (Zanini & Rubinelli, 2012: 167). To begin with, the patient has the task of finding a doctor who is willing to participate in shared decision-making. Secondly, some doctors might not be willing to review their standpoints on for instance, treatment choice. Thirdly, the temptation to employ rhetorical persuasion to convince the patient might downplay the legal requirement by doctors to disclose some information to the patient. In addition, patient must be prepared to participate in the critical discussion. Lastly, the temporal nature of the medical consultation might not allow for the practicability of critical discussion. These challenges indicate a research gap in enhancing competencies of argumentation and critical thinking skills in medical training and patient literacy programs (Zanini & Rubinelli, 2012: 168).

At the global front, shared treatment decision-making has gained prominence (for example, see US' Patient Protection and Affordable Care Act, Sec 3506, 2010; UK's Right Care Shared Decision-Making Program, 2012) in making the patient the focal point of doctor-patient communication. Patient-Centred Care (PCC) studies in doctor-patient communication have

[4] Nevertheless Charles *et al.* (1997) has criticised some of these other SDM models such as the *Shared Rational Deliberative Patient Choice Model, Shared Rational Deliberative Paternalism Model, Professional Driven Best Interest Compromise Model* (Sandman & Munthe, 2010: 62)

indicated that the revelation of the patient's values, preferences, fears and opinions to the doctor provides an enabling platform for more collaborative and shared decision making (Levinson, Lesser & Epstein, 2010: 1311; Sanderman & Munthe, 2010:61,83). The study anchored the argumentation in the communicative manoeuvres of doctors and patients in the consultation room in the SDM model with all the institutional constraints it entails (Henselmans & van Laarhoven, 2018; Pilgram & Snoeck Henkemans, 2018; Snoeck Henkemans & Mohammed, 2012).

A medical encounter in a consultation room typically presents a healthcare professional and a patient, who engage in a dialogue. The healthcare professional can either be a clinician, general physician or a specialist (anaesthetist, paediatrician, oncologist and so on), nurse or psychologist. The study focused on doctor-patient consultations in which the doctor was mainly a general physician. During the consultation, the patient seeks professional or medical advice from a doctor normally about some health disorder, and the doctor provides befitting medical advice in the conversation. Whenever there is a difference in opinion, the dialogic exchanges necessitate an argumentative activity type (van Eemeren, 2010) of communication in the process. Argumentation in this case refers to the process of conversational exchanges between the doctor and the patient to resolve differences of opinion or at times some unclearly motivated resistance to treatment reasonably by presenting substantial support for the standpoints (van Eemeren & Grootendorst, 1984, 1992, 2004). Therefore, the doctor-patient consultation encounters are essentially punctuated with argumentative deliberations presented constructively mainly to resolve differences of opinion to settle on a treatment decision.

Medical consultation discourse has its conventions just like other forms of argumentative discourse such as the legal discourse in a courtroom, academic discourse in a lecture/seminar room or political discourse in a political setting, all of which employ argumentation (Feteris, 2002, 2016, Pilgram, 2009, 2015; van Eemeren & Garssen, 2009; Bigi, 2012; Labrie, 2012). The circumstance is such that the interaction between the doctor and the patient is carried out in an institutionalised communicative context. Within this setting there are rules governing the interpersonal communicative discussions between the doctor and patient. The argumentative context of the medical consultation has attracted the attention of research such as the study of the social communicative context of the Italian healthcare system (Bigi, 2012) using the model of the communicative context (Rigotti & Rocci, 2006: 170–171) . Examining the institutional context of

the medical encounters, Bigi (2012) explores the constraints of the medical consultation as a communicative activity type. Bigi (2012) examines how interpersonal and cultural dimensions of the Italian medical consultation constrain the institutional context of the communication activity type. Bigi's study demonstrates how an understanding of the institutional context qualifies the choice of argument schemes in strategic manoeuvres exhibited by both the doctor's and patient's premises in their arguments. On its part, the present study employed the pragma-dialectical theoretical model of argumentation to extrapolate the institutional-interpersonal dimensions of the communicative-argumentative discourse in the consultation room in a public hospital setting. The model adopts the "activity type" under the institutional dimension to identify the interaction schemes of argumentation within the social reality of the discourse with each of the parties involved taking different communicative roles as implementing subjects informed by the personal/professional/communal requirements.

The communicative context of the medical consultations takes a specific conventionalised manner. Most often the formal procedure involves presentation of the health complaint by the patient, a verbal or physical examination by the doctor before providing a diagnosis of the problem, a prescription and treatment explaining its suitability and implications. The doctor in this case is the technical expert who has both the medical knowhow and professional training to satisfactorily establish the health problem and accordingly advice or recommend medication for the patient (Labrie, 2013: 15; Sanford, Rivers, Braun, Schultz & Buchanan, 2018: 2). On the other hand, the patient is the expert on his/her illness history and experiences, values, expectations and sensitivities. The recognition of the diverse knowledge domains (Berry, 2007: 40) of the two parties implies that for doctors and patients to come to a shared decision during the consultation they must engage each other logically and rationally (Roter & Hall, 2006: 4; Labrie, 2016: 325; Mazzi, Rimondini, van der Zee, Boerma, Zimmermann, *et al.*, 2018: 1). The doctor, who takes charge of the consultation process, normally has many options at his disposal. An example is the likelihood of the doctor appealing to his professional and medical knowhow in signalling his medical counsel (Pilgram, 2015: 13) to authoritatively subject the patient into quickly accepting the doctor's desired treatment. In this case the doctor aims to be reasonable while effectively ensuring that his preferred treatment is acceptable to the patient. The doctor's argumentative move is referred to a *strategic manoeuvre* (van Eemeren, 2010:40) in the critical discussion towards resolving a difference in opinion in the pragma-dialectical theory of argumentation.

In contrast, the patient, relying on own knowledge and experience based on what he/she has discovered online or through other media or sources, such as direct-to-consumer advertisements (DTCA) (Wierda & Visser, 2012: 81; Wierda, 2015), may confront the doctor's opinion (*standpoint*). This may occur through an overt disagreement (mixed difference of opinion) or a covert hesitation (non-mixed difference of opinion) regarding the advice given. In pragma-dialectics, this occurs in the *confrontation* stage of the *model of critical discussion* (van Eemeren *et al.*, 2014: 529). The process of argumentation now ensues where the two participants engage in various *communicative activities*[5] limited to the medical discourse genre (Fairclough 1995:14). These activities form part of the interaction schemes (Rigotti & Rocci, 2006: 173) tailored towards resolving the differences in opinion, and settle on a treatment decision. These communicative activity types are classified as '*argumentative activity types*' in pragma-dialectics (van Eemeren *et al*., 2014:562).

In their interactions, the doctor and patient ought to convey their arguments freely without anyone stopping them. This conforms to the *Freedom Rule* in the pragma-dialectical theory of argumentation (van Eemeren & Grootendorst, 2004). To resolve their differences of opinion on merits, the doctor and the patient need to support their standpoints with argumentation for a number of reasons (Labrie, 2013: 18–19). First, legal regulations of medical practice (Roter & Hall, 2006: 110) require the *informed consent*[6] which compels the doctor to disclose relevant information about a patient's health condition before providing medical advice. Secondly, the *ethical code*[7] demands that both the doctor and the patient argue out their cases (Labrie, 2012: 178). The doctor needs to ensure patient-centeredness in approach and provide *evidence-based* medicine by building his arguments on explicit and valid medical evidence. Besides, the patient should be given the opportunity to logically deliberate with the doctor to come up with a shared treatment decision. Lastly, the doctor and patient are obliged to provide argumentation justifying their standpoints when trying to resolve their difference(s) in opinion(s) regarding a treatment or diagnostic

[5] For example, communion seeking - because of the interpersonal context of the medical consultation - negotiation and deliberation (van Eemeren *et al.*, 2014: 558-559).

[6] This is contained in the *Code of Professional Conduct and Discipline* (2012:35) which was developed from the Medical Practitioners and Dentists Board Act, Chap 253 of the *Laws of Kenya* (2012).

[7] This is spelt out in pages 32-43 of the *Code of Professional Conduct and Discipline* established by Cap 253 of the *Laws of Kenya* (2012).

decision. The commitment to defend themselves *(Obligation to Defend Rule)* is part of the rules of critical discussion (see section 3.2.4 of Chapter 3) in argumentation theoretical literature (van Eemeren & Grootendorst, 2004).

1.3 Rationale for the study

This study provided an opportunity for empirical linguistic research on the medical discourse in doctor-patient consultations in a Bantu language, EkeGusii, in a public hospital setting in Kenya. The analysis of strategic manoeuvring by Gusii doctors and Gusii patients in KTRH in resolving differences in opinion during medical consultations contributes to the contemporary linguistic debate in the argumentation theory. Following the establishment of the *argupolis*[8] at the Amsterdam School (van Eemeren, Morasso, Grossen, Perret-Clermont & Rigotti, 2009) most studies in doctor-patient argumentation have focused in European languages in European or western medical contexts and by researchers in schools of medicine, health and communication (Rubinelli & Schulz, 2006; Pilgram, 2009; Labrie, 2012; Rubinelli, Sarah & Henkemans, 2012; Wierda & Visser, 2012; Zanini & Rubinelli, 2012; Labrie, *et al*., 2015; Schulz & Rubinelli, 2015). Nevertheless, the literature on argumentation indicates some research activity in the study of argumentation in Chinese medical settings (Pan, 2017; Pan, Chen & Ju, 2018)

Besides, the study of argumentation in the Gusii doctor-patient consultations provided an opportunity for an empirical study on the patterns of argumentation in the medical consultation communicative activity type in the African context, one of the non-western cultural contexts. One of the two main objectives of the Argumentative Patterns Project, which is among the latest developments in the extended pragma-dialectical theory of argumentation is identifying institutional preconditions that determine the argumentative manoeuvring in the various communicative activity types in the different domains (van Eemeren, 2017a: 1,16). The second objective entails identifying and characterising the patterns of argumentation in the communicative activity types. The two objectives were integrated in the study's key objectives.

Whereas discourse studies have been carried out in the use of African languages and particularly Bantu languages in various professional contexts and genres (Jakaza, 2013; Kabugo, 2013;

[8] This is a doctoral research program which was established focusing on argumentation practices in different communicative contexts with experts from European universities.

Mugumya, 2013; Sabao, 2013; Nyanda, 2016) the literature review did not reveal a study in doctor-patient argumentative discourse in EkeGusii or any other Bantu or African language. Existing literature focusing on doctor-patient communication in Kenya investigated language as a barrier in communication in the ethnically heterogeneous and multilingual setting; the challenges of interpretation and miscommunication, and the role of ethnicity in the medical consultation (Miller, Booker, Mwithia & wa Ngula, 2010; Miller, Kinya, Booker, Kizito & wa Ngula, 2011; Waitiki, 2010).The study, however was unilingual focusing on the dominant EkeGusii speech community in the study setting.

As a first language speaker of EkeGusii, the language of the doctor-patient interactions under study, I understood the various values and beliefs systems of the AbaGusii. My Masters of Arts degree in Linguistics and African languages which focused on the morphosyntax of EkeGusii (Basweti, 2005) and other studies on (Eke)Gusii and the (Aba)Gusii (Basweti, Schroeder, Hamu & Omwenga, 2014; Basweti *et al.*, 2015; Mesman, Basweti & Misati, 2018; Omoke, Barasa & Basweti, 2018) affirmed my understanding and linguistic research experience in the Bantu language. In addition, the field research experience in healthcare research gained, as a research coordinator in a joint USAID-Government of South Sudan study, exposed me to healthcare practice in the horn of Africa and healthcare professionals' interactions with the most-at-risk populations (MARPs) regarding risk factors that predispose MARPS to HIV and AIDS (USAID/South Sudan, 2011). Besides, the over eight years of teaching and research experience in Communication Skills and Linguistics at the University of Nairobi, Kenya benefited the design and execution of the study.

1.4 Problem statement and research question(s)

In a medical consultation, doctors and patients often have different standpoints concerning treatment and management of the patient's health condition regarding the medical advice, recommendation on the medical regime or even the mode of medicinal administration. This is prevalent in treatment and management of long-term illnesses like non-communicable diseases (NDCs) like cancer and diabetes, and pandemics like HIV and AIDS. In such cases, argumentation comes in handy in building shared treatment decisions. During the consultation, either party resorts to attempting to effectively persuade the interlocutor while ensuring that they are doing this reasonably in resolving difference(s) of opinion(s) on merits. The contemporary debate in

argumentation in the medical domain is based on studies carried out in Europe and the West and marginally in Asia. This multi-perspective study investigated how Gusii doctors and Gusii patients exploit strategic manoeuvring in argumentation during their consultations in EkeGusii in KTRH, in Kenya, East Africa. It also explored how the choice of argument schemes in the strategic manoeuvres of both doctors and patients influences the adjustment of communicative behaviour and use of evaluative language in medical consultation simulations conducted in EkeGusii, a Bantu language, in a public hospital in the African setting.

The study was guided by the following *research question*:

How do Gusii doctors and Gusii patients strategically manoeuvre in resolving differences of opinion in simulated medical consultations in (Eke)Gusii?

To answer the research question, the following specific questions guided the study:

i. How do doctors and patients employ strategic manoeuvring in their argumentation in Gusii doctor-patient consultation simulations?
ii. What are the argument schemes in the argumentation structure of doctors' and patients' argumentation in resolving differences of opinion when making treatment decisions in Gusii doctor-patient consultation simulations?
iii. How does communication accommodation influence the choice of presentational devices by doctors and patients when strategic manoeuvring to resolve differences of opinion in Gusii doctor-patient consultation simulations?
iv. How does evaluative language use influence the choice of presentational devices in strategic manoeuvres of doctors and patients to resolve their differences of opinion in Gusii doctor-patient consultation simulations?
v. How does the macro contextual reality of the Gusii medical consultation affect the conventionalisation of the institutional preconditions which determine the process of strategic manoeuvring to resolve differences of opinion?
vi. What are the prototypical argumentative patterns exploited by doctors and patients in the (Eke)Gusii medical consultation?
vii. How is the study of argumentation in the doctor-patient consultation in EkeGusii informative in refining, extending and modifying the principles of the pragma-dialectical theory of argumentation?

1.5 Theoretical points of departure

This study employed a multi-perspective approach to investigation the simultaneous aspiration to achieve rhetorical and dialectical aims of argumentation in the Gusii doctor-patient consultation. In the investigation, the main theoretical framework the study employed was the extended pragma-dialectical theory of argumentation. To examine the macrocontextual dynamics of strategic manoeuvring in the Gusii medical consultation, the study incorporated elements of communication accommodation theory and appraisal theory.

1.5.1 Extended pragma-dialectical theory

In ascertaining how doctors and patients exploit strategic manoeuvres in the medical consultation, this multi-perspective study primarily employed the extended pragma-dialectical theory (van Eemeren, 2010; van Eemeren & Grootendorst, 2002a, 2002b). The theory introduces strategic communication consideration in the normative pragmatic study of argumentative discourse (van Eemeren, 2014: 552). According to this approach, the discussants in any real-life argumentative dialogue endeavour to convince the other party into accepting their point of view while simultaneously reasonably attempting to resolve their difference of opinion(s) on merits. The parties involved in the discussion can be said to be striving to achieve the dialectical goal of maintaining reasonableness, and the rhetorical aim of being effective.

To balance the rhetorical and dialectical aim, the discussants employ strategic manoeuvring. The parties basically formulate discussion moves in their arguments, which are focused on resolving the differences of opinion on merits while ensuring that their point of view is acceptable to each other. As discussed later in section 3.2.6 of Chapter 3, strategic manoeuvring developed through the incorporation of a strategic design in argumentation in what was called the extended pragma-dialectical theory of argumentation. It entails three components: the discussion participants concurrently selecting from the topic potential; trying to adapt their discussion to the audience demand and exploiting appropriate presentational devices to achieve the rhetorical and dialectical goals during the critical discussion (van Eemeren, 2010: 93-122; van Eemeren *et al*., 2014: 553-554).

Strategic manoeuvring in pragma-dialectics ought to be reasonable. This prerequisite informed the establishment of the rules of critical discussion (van Eemeren & Grootendorst, 1984: 151-189; 2004: 123-196) which ideally regulate how the discussion parties should resolve their differences in opinion(s) on merits. If the discussants violate any of the rules during their discussion, the very contributions become an obstacle to resolving the differences in a reasonable way and are therefore considered fallacious (van Eemeren & Grootendorst, 1992:102-106; van Eemeren, Garssen & Meuffels, 2009: 20-25). In pragma-dialectics, a fallacy is a speech act which can be said to violate either one or more of the rules of critical discussion.

In the end, evaluation of strategic manoeuvring in the medical consultation ought to start with the appreciation of the institutionalised context of the argumentative speech event. The communicative activity type in a doctor-patient consultation has its unique culturally established and institutionalised practices which are conventionalised in the extended pragma-dialectical metalanguage (van Eemeren, 2010: 139-145; van Eemeren *et al*., 2014: 557-563). The role of argumentation in such communicative activity type is thus of essence for it is in the argumentative discussion where one can detect the strategic manoeuvres.

The dialectical reasonableness of resolving the difference of opinion advanced by van Eemeren and Grootendorst (2004) has, however, been found to be problematic by some researchers in philosophy. Siegel and Biro (2008: 194-195) challenge the reasonableness of the problem validity and conventional validity of the rules of critical discussion by positing the possibility of discussants 'reasonably' resolving a difference in opinion through acceptance and ending up with a necessarily unreasonable belief or position. The notion of argumentation aiming at persuading a reasonable critic into accepting a standpoint (van Eemeren & Grootendorst, 2004: 3,12) brings the quality of argumentation into question. The quality of an argument is determined by its ability to either justify or refute a standpoint, and therefore ought to be treated independent of the reaction of the people involved in terms of its acceptability or otherwise (Siegel & Biro, 2008: 192-193). Siegel and Biro further have issues with van Eemeren and Grootendorst rejecting justificationism or positive justification (as does Karl Popper) for this makes the arguments meant to resolve the difference in opinions to lack epistemic worthiness (2008:199). This has not deterred the pragma-dialectic view of argumentation from its development as the claim can be classified under derailment in strategic manoeuvring in the model. However, Leal (2016:1-2) supports the pragma-

dialectical theory as a valid "analytical engine" with inferential development capacity, and ability to test hypotheses empirically based on a variety of real-time argumentative discourses.

To analyse the macro contextual exigencies of the Gusii medical consultation, the study incorporated two other theories in the framework of analysis: communication accommodation theory (CAT) and appraisal theory.

1.5.2 Communication accommodation theory (CAT)

Communication accommodation theory (CAT) originally conceived as speech accommodation theory (Giles, 1973; Giles & Powesland, 1975; Giles & Coupland, 1991;Williams, Giles, Coupland, Dalby, & Manasse, 1990) examines how communication partners adjust their communication behaviour to suit each other's communication needs (Dragojevic, Gasiorek & Giles, 2016). As discussed later in section 3.4 of Chapter 3, CAT accounts for the linguistic, social and psychological communicative behaviour people display when interacting among themselves (Coupland *et al.* 1988). It examines how social, objective and contextual parameters influence the multiple identities of an individual's communicative behaviour based on his/her motivation, identities, attitude or intentions (Jones *et al.* 1999:123-124).

Exploiting the explanatory potential of convergence, divergence and approximation, CAT has been exploited in examining how affective and cognitive communication processes affect the shared decision-making process in the doctor-patient consultations (Street, 1991; Watson & Gallois, 1998, 2002, 2004, 2007; Watson, Hewett & Gallois, 2012; Watson, Angus, Gore & Farmer, 2015). In exploring the communication processes involved in the improvisatory and adaptive nature of human interactions (Pitts & Harwood, 2015:89) in the Gusii medical consultation communicative activity type, the study employed CAT to explain how interlocutors' adjustment of their communicative behaviour according to their social roles and identities affect their strategic manoeuvring.

1.5.3 Appraisal theory

Exploiting the interpersonal metafunction, one[9] of the functions of languages Systemic Functional Linguistics (Halliday, 1985; Halliday and Matthiessen, 2004), the study employed Appraisal theory to examine the role of evaluative language use in the social context of the Gusii medical consultation. An evaluation of interpersonal meanings examined the choice of presentational devices used by communicators to express, naturalise or negotiate inter-subjective positions with their discussants or audience (Hood & Martin, 2005). To effectively carry out the appraisal, the three systems evaluative language uses that are considered: attitude graduation and engagement (Martin & White, 2005; Martin & Rose, 2003). As discussed, later, in section 3.3 of Chapter 3, attitude relates to the positive or negative positioning of communicators' feelings or opinions, graduation refers to the strength of expressing the feelings and opinions. In appraisal analysis, engagement relates to the way the communicators engage with the message to integrate or distance themselves from their interlocutors.

From the appraisal framework the study exploited the attitudinal system of evaluative language use by the Gusii doctors and Gusii patients in the strategic manoeuvring in the medical consultation communicative activity type. The communicator's attitudes to each other, things or states of being were assessed as positive or negative. The positive or negative attitudes were inscribed in the discussants' expression or simply implied in the social context of the argumentative discourse in the medical consultation. The analysis of evaluative language use employed three attitudinal semantic domains: affect, judgement and appreciation, for assessing doctors' and patients' feelings or opinions in their strategic manoeuvring as they negotiated with inter-subjective positions and social identities.

1.6. Research design and methods

The study was a *case study* of doctor-patient communication in simulated consultations at KTRH. Case study design provided an opportunity to interrogate argumentation in the Gusii medical consultation, which was under investigation within one unit and in this case, an urban public

[9] The other two functions of languages are the ideational metafunction based on one's sense of experience and the textual metafunction which relates to cohesion and coherence in producing and receiving text (Halliday 1985; Halliday and Matthiessen, 2004)

hospital in Kenya. Being a linguistic study, the synchronic data in the case study provided adequate insight into the subject of investigation (Houghton Casey, Shaw & Murphy, 2015: 13). The design was largely qualitative. Gusii doctors and Gusii nurses role-played the doctor-patient consultations, respectively, in (Eke)Gusii to bring out a reflection of their experiences with Gusii patients in their medical practice. Gusii medical practitioners were better placed to mirror the health and healthcare concerns and experiences of their regular patients and would attempt to emulate their expectations in a similar way including the communicative behaviour during the medical consultation (Miller *et al.*, 2010: 200).

The research design for the study is illustrated in the *figure 1.1* below:

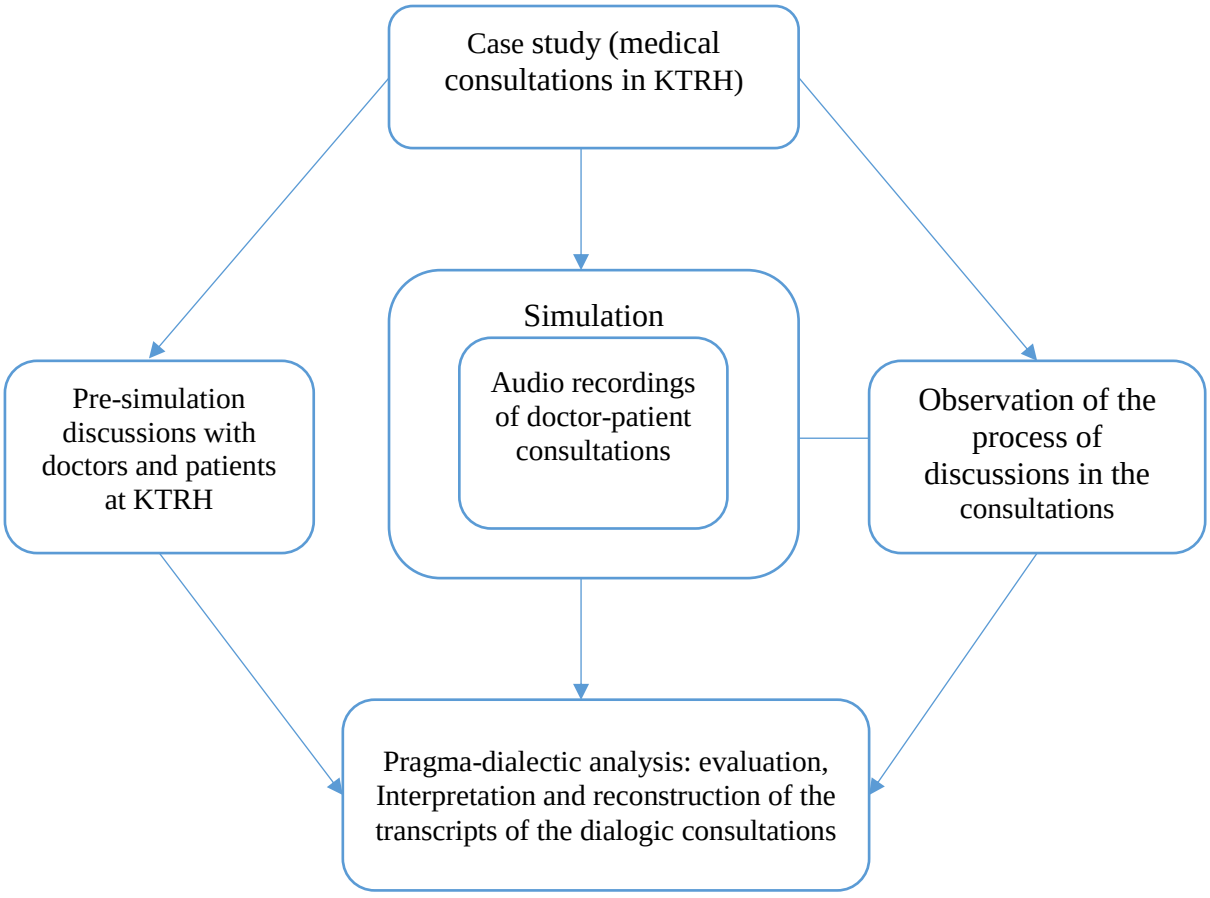


Figure 1.1 Representation of the research design of the study

The study examined doctor-patient dialogues in simulated medical consultations. Simulation has been used in medical training over the years (Nestel, Burn, Pritchard, Glastonbury & Tabak, 2011:

1028). This was an opportunity to investigate the doctor-patient argumentation and persuasion skills in the simulated medical encounters with eventual benefits to the two groups in future medical curricular or patient literacy programmes. The motivation for the simulated scenarios in the study was to bring out appropriate data which was not inhibited. The presence of a researcher in a real-life medical encounter was bound to result in an unnatural and artificial dialogue, which would compromise the subject under study. The focus of the study on two non-communicable diseases (NDCs) - cancer and diabetes - and the HIV & AIDS pandemic implied that some of the information could be private and quite sensitive to be shared freely by the patient in the presence of the researcher[10] which would have ethical implications.

A simulated or standardised patient (SP) originally referred to a programmed patient is an ordinary person, who enacts the role of either a patient or doctor, after undergoing some prior coaching, such that it appears as natural as possible (Barrows, 1993:443-444). The use of SPs has merits and demerits[11]. On a positive note, unlike real patients, SPs can be made available at a time of convenience; the use of SPs protects the real patients from mistreatment (Owen, 2012: 113) because they are compensated for simulation purposes; the SPs are like a stage in medical training before one moves onto the real patients, and the SPs can be manipulated for learning purposes. However, the use of SPs has demerits which, however, can be managed. The assumption that one needs a lot of time to prepare and train the SPs is a misperception as the SPs need to understand and bring out the health condition of the patient. The thought of the possibility of how much can be simulated is still open to interpretation. Due to the cost involved in the use of SPs or role-play, medical teachers should consider other "alternatives", which could benefit the learners depending on the circumstances (Lane & Rollnick, 2007).

Adopting the pragma-dialectic method (van Eemeren & Garssen, 2015:511-514), the study employed *three key research methods*: audio recordings of simulated doctor- patient consultations at KTRH; discussions with doctors and nurses, and observation of the consultations. The pragma-dialectical method is an empirical research method of investigating communication and critical regimentation of argumentative discourse in different communicative domains (van Eemeren &

[10] Confidentiality is one of the ethical code of professional conduct which empowers the doctor(s) or medical practitioners to protect a patient's information (Republic of Kenya, 2012a; 2012b:38).

[11] See Barrows 1993:444-445.

Garssen, 2015:508). A*udio recordings* of the simulated doctor-patient discussions during the consultations were the key method of data collection. This is because the study focused on analysing naturally occurring doctor-patient consultation dialogues data in consultation simulations in KTRH in Kenya. This was adopted as the main method because this data helped to address the main research question. To supplement the audio recordings of the consultations, the study conducted *discussions* with the Gusii doctors and Gusii nurses who were sampled to participate in the simulated consultations. The snowballing technique was used in sampling the doctors and nurses based on their availability during the working hours or during lunchtime or tea breaks. The discussions also included other doctors who treated Gusii patients at KTRH but who did not participate in the consultation simulations for varied argumentative experiences by Gusii patients, and to enrich the study. The pre-simulation discussions were considered preparatory and meant to bring out aspects which could inform the consultation simulations based on their experience and interactions with Gusii patients.

The discussion data were cross-checked with the consultation transcripts to see how the information corresponded and whether there were new insights. These transcripts provided insightful properties on argumentation and persuasion in medical practice, and how it is affected by patient literacy levels or programmes, if any. However, the discussion data was treated as background data for the doctor-patient simulated consultation dialogues which formed the primary data of the proposed study. Finally, the study employed observation mainly in the audio recording of the simulated consultations. Observation was important in the reconstruction and analysis of the data because it assisted the analyst to get a clear picture of the macro contextual realities of realising the institutional point in the Gusii medical consultation. In behavioural studies, observation is recommended for identification of nonverbal aspects of the dialogue which are important in the analysis and reconstruction stage (Kothari, 2004: 96).

Non-probability sampling was used to capture medical consultation discourse between Gusii doctors and Gusii SPs. Bernard (2006:147) asserts that cultural data requires non-probability sampling. The study site KTRH was sampled purposively because it is the major public referral heath facility in the larger Gusii region. Convenient sampling was used to recruit the doctors and nurses considering the schedules and availability of the participants. However, purposive and

stratified sampling was used in the role-plays by the SPs to reflect the different *demographics* of patients, who came to KTRH for consultations for cancer, diabetes and HIV and AIDS.

The *sample size* was 18: consisting of 5 Gusii doctors and 13 SPs, who were represented by Gusii nurses. This being a case study, the sample was sufficient for the study. The consultations were carried out with different SPs from different social demographics having different health problems. This wide array of possibilities in terms of the purposefully stratified nature of the simulated patients – fairly covering the different societal segments and suffering from cancer, diabetes or HIV and AIDS minimised both the sampling error and sampling bias. The ratio of doctors to patients is also partly informed by the representative statistics of doctor to patient ratio in Kenya[12].

The data collection entailed the use of three data collection tools. The process employed introductory notes tailor-made for the doctor(s) and the patient(s), key informant discussion guides, and a checklist for observation purposes especially for the doctor-patient consultation simulations. Fundamental to the data collection were the audio recorders, which assisted in capturing all the medical consultations and discussions. These tools and equipment were pilot-tested before the actual data collection. The pilot testing assisted in optimising the research tools and to get to understand the intricacies of the actual field work like the procedure and the time taken for discussions and consultations. The pilot test for the study was carried out at the Masimba Sub-County Hospital, Kisii County in Kenya because the hospital has a population with similar demographic characteristics as the one at the KTRH. This minimised bias due to exposure to the tools at KTRH before the research formally commences. The pilot test entailed two doctor-patient consultation simulations involving one doctor and a diabetic patient and a HIV and AIDS patient.

The *data analysis* employed the pragma-dialectic method of analysis and evaluation (van Eemeren, 2015: 521-542) which involved interpretation, analysis, evaluation and reconstruction of the transcripts of the argumentative discourse of the doctor-patient consultations. This process involved evaluating the adequacy of the process of reasoning of the doctors and patients in the

[12].It is reported that in 2000, the ratio of doctors to patients of 1: 25000 in Nairobi was the highest in any urban centre in Kenya with rural areas like Rachuonyo and Mandera Districts recording 1: 150,000 and 1:308,878, respectively (Mwaniki & Dulo, 2008: 27; Mwachaka & Mbugua, 2010). (See also Society for International Development, 2004)

arguments they presented in fulfilling the goal of resolving the difference in opinion based on the rules of critical discussion. In doing so, the pragma-dialectical analysis examined the role of communication adjustment and the evaluative language use in strategically manoeuvring by the doctors and patients. In the reconstruction of the argumentative discourse I determined the various kinds of argumentation schemes and argumentative patterns made when resolving the differences of opinion on merits. This way I was able to answer the research question of the study.

1.7 Organisation of the study

The chapter outline for the study is as follows:

Chapter One provides a roadmap for the study on the pragma-dialectics analysis of argumentation in doctor-patient consultations in (Eke)Gusii. It highlights the problem statement, research question, the theoretical points of departure, the research design and methods.

Chapter Two explores a review of literature on the argumentative context of the doctor-patient communication discourse/genre. The review of literature on doctor-patient communication and interactions explores literature in medical discourse, which has employed argumentation theory which was the main theoretical framework of the study. An exploration into traditional and complementary medicine (T&CM) which has a role in the study is also considered. Identifying some of the gaps the present study fills, the chapter also reviews some of the argumentation studies in the medical domain, which are relevant to the study. The chapter also explores literature on communication accommodation and use of evaluative language in the discourse of medical consultations in healthcare settings.

Chapter Three provides a comprehensive account of the theoretical framework of pragma-dialectical theory of argumentation which the study adopted. To supplement the main theoretical framework, the chapter employs two other theories, CAT and appraisal theory, to understand how the institutional macro contextual exigencies and intricacies influence doctors' and patients' strategic manoeuvring in the Gusii medical consultation.

Chapter Four investigates the structure of doctors' and HIV and AIDS patients' argumentation in their strategic manoeuvres in the Gusii medical consultation simulations. In doing so, the pragma-dialectic analysis incorporates aspects of evaluative language use using the attitudinal semantic

paradigms and communication adjustment in the strategic design of the argumentation process to determine the patterns of argumentation.

Chapter Five, examines strategic manoeuvres, argument schemes and patterns in dialogues between doctors and diabetics patients in the Gusii medical consultation simulations. The chapter further explores and discusses the display of attitudinal evaluation and communication attunement in the resolving of differences of opinion effectively and reasonably.

Chapter Six examines the strategic manoeuvring in the critical discussions to resolve differences of opinion between Gusii doctors and Gusii cancer patients in the simulated consultations. The chapter discusses the contribution of communication accommodation and use of evaluative language when strategic manoeuvring in the critical discussion of the simulations of the Gusii medical consultation communicative activity type.

Chapter Seven, the final chapter, provides a summary of the findings, conclusions and recommendations for medical practice and future research. The chapter reviews the contribution of argumentation in doctor-patient consultations in EkeGusii in terms of refining, extending or modifying the principles of the pragma-dialectical theory of argumentation.

1.8 Ethical considerations

Before data collection, all the necessary ethical review processes for the study were fulfilled. These included clearances from the Research Ethics Committee at Stellenbosch University (see appendix ix on page 389), and the Kenyatta National Hospital-University of Nairobi Ethical Review Committee in Kenya [KNH-ERC/A/453] (see appendix x on page 390). In Kenya, the study was approved through a research permit from the National Commission for Science Technology and Innovation of Kenya [NACOSTI/P/16/22737/12196] (see appendix xi and xii on page 393 and 381) and thereafter secured clearance by the Department of Basic Education, Kisii County (see appendix xiii on page 394) and the Department of Research, KTRH (see appendix xiv on page 395), where the actual field study site was carried out. The study observed all the codes of research ethics: ensuring that the informants signed the informed consent for voluntary participation and explaining to the informants on how confidentiality and anonymity were to be maintained during and after the study.

CHAPTER TWO
LITERATURE SURVEY ON THE ARGUMENTATIVE CONTEXT OF DOCTOR-PATIENT COMMUNICATION

2.1 Introduction

For an insightful reflection on the research question of the study, this chapter carries out a survey of literature on the argumentative context of the medical consultation. The survey explores the contextual parameters of the doctor-patient communication. The review explores the various elements of the medical consultation which influence argumentative nature of doctor-patient discourse. By analysing and discussing contributions from various scholars from different fields of study raging from medicine, communication, medical sociology, medical anthropology, linguistics and psychology, the review locates the essence of argumentation in the medical consultation. The chapter discusses various aspects of the medical consultation which has seen the communicative activity type appreciate the need for argumentation theoretical underpinnings in the contemporary legal and ethical institutional constraints such as patient-centred medicine, evidence-based medicine and informed consent. The exploration of other aspects like narrative-based medicine and traditional and complementary medicine which are attracting attention in contemporary medicinal practice and its influence on the discourse of the medical consultation is also considered. In pitching the present study, insights into argumentation in doctor-patient interaction, communication accommodation, and appraisal are also explored.

2.2 Contextualising doctor-patient communication in medical discourse

In analysing discourse, Jones (2012:36) notes the three approaches used in the examination of discourse analysis: Formal, functional and social. The formal approach examines the use of language above the clause of sentence level. The primary concern of this approach is to try to understand the process of combining clauses and sentences to produce texts. The functional approach on the other hand, conceives discourse as language in use. It is concerned with how people employ language to do things and how they decode other people's signals, whether spoken or written. Unlike the other two approaches, the social approach conceives discourse as social practice. The use of language in the context of the social approach is tantamount to hwo people

construct social identities and relationships be it in a group or institution. Examining medical discourse is multifaceted, borrowing aspects of the three approaches to the study of discourses

The discourse of doctor patient interaction fits into the larger realm of healthcare communication discourses which has attracted the attention of many researchers (Coulter, 2002; Heritage & Maynard, 2006; Bangeni, 2012; Stiggelbout *et al.*, 2012; Riedl & Schüßler, 2017; Basweti & Visser, forthcoming; Basweti, 2018a; 2018b). Discourse analysis in the healthcare settings borrows from the fields of medical anthropology and sociology, and cultural studies. These fields as Foucault (1976) points out are concerned with explanations on the causality of illness in different cultures, the way in which the health risk is embroidered in societal structure and the ideological perspective of the structure of biomedical discourse, respectively. The primary concern of a discourse analyst is the display of language use as a means of influencing social action (Jones 2015: 842). In the medical context, discourse analysis has been attributed to the desire to understand the meaning of medical care and how this is done discursively (Paugh & Izquierdo, 2009).

In his analysis of healthcare discourse, Jones (2015) points out some of the challenges which discourse analysts in the domain must bear with. First the power struggles and negotiations are commonplace because of the many discursive resources. A good example is the SDM which emphasises the centrality of the patient in the doctor-patient encounters (Charles *et al.*, 1997; Sandman & Munthe, 2010; Ishikawa, Hashimoto & Kiuchi, 2013). Secondly, the diversity of narratives and meanings on health and healthcare has resulted in the intersection of many voices which almost diffuse the process of communication in the medical consultation. Information from the traditional explanatory and belief systems, the myriad media sources of health information (Rubinelli, Schulz & Nakamoto, 2009; Adusei & Phillips, 2018) especially with the advent of eHealth (Kim & Xie, 2017) information sharing has created a heteroglossic[13]health communication system (Lupton, 2003).

The third challenge is the now broad conception of one's health to include personal experiences, emotions, perceptions on death and socio-political and economic aspects. This complex conception has made the work of discourse analysts an uphill task in deducing meaning out of the social action

[13] Attributed to Bakhtin (1981)

face of healthcare communication (Jones, 2013). Lastly, the biomedicine has become technologised to an extent that the patient's body is treated as an object of medical analysis. The obsession of medical professionals with the laboratory scans and tests from the body of the patient than the interpersonal communication with the patients has become discursive concern of medical discourse analysts (Atkinson, 1995, Iedema, 2003).

In the study of medical discourse, conversational analysis has been explored to understand the dynamics of talk in the medical consultation. Its focus has largely been on the chronology of the conversational talk of doctor-patient interactions and the actions associated to the medical talk (Heritage & Maynard, 2006, ten Have, 1991). The sequence of events in a medical consultation has a predeterminate structure: the opening stage, physical examination stage, the diagnosing stage, treatment and medical advice-giving stage and the closing stage (ten Have, 1989). The study of the power relations in the medical consultation talk through the interruptions, interviewing style and other verbal cues have been studied in the conversational analysis approach (Heritage, Robinson, Elliott, Beckett *et al*., 2007, Maynard, 1991). Supplementing the study of power struggles in the medical consultation is the approach of interactional sociolinguistics attends to issues of social identity in the doctor patient consultation.

The approach of interactional sociolinguistics examines how the two principal parties of the medical consultation negotiate their social identities with their interlocutors, the issues they are talking about or the social action of the groups they identify with (Jones 2013).Whereas conversational analysts are concerned with the systematic order of the reasoning of the doctor and the patient in the diagnosis or treatment advice-giving process in the consultation, interactional sociolinguists are keen on the identity of the communicators and the substance of their social actions (Sarangi, 2000, Tannen & Wallat, 1987). A discursive reconstruction of the different authorities or expertise in the medical consultation is part of the work of interaction sociolinguists. Some of the aspects identified in the analysis of the medical encounters include the use of implicit language, hedging and politeness for the sole purpose of interpersonal control. This perception closely relates to the use interpersonal control in communication accommodation as advanced by CAT proponents (Meyerhoff, 1998; Farzadnia & Giles, 2015; Dragojevic *et al.*, 2016). Incidentally, the approach of interactional sociolinguistics borrows some of the aspects of appraisal theory in the study of how interactants use language evaluatively in their attempt to negotiate with

their value positions and social identities (Gallardo & Ferrari, 2010; Armstrong, 2014; White, 2015).

2.2.1 Doctor-patient communication

In exploring medical discourse, the importance of effective doctor-patient communication has been emphasised as an essential dynamic in medical discourse. Effective communication in the doctor-patient encounters has direct implications in the healthcare outcome in terms of caring for the patient compliance to the doctor's treatment recommendations. In a multi-perspective study, Matusitz & Spear (2014) have conceptualised the 'ideal' doctor-patient communication begged on the conversational talk punctuated with active listening, building rapport and maximising on non-verbal communication signals. In the study, the doctor-patient consultation is anchored in shared understanding and the display of effective communicative skills. Through the display of effective communication, the doctor-doctor patient encounters can benefit from the ability to resolve issues which may arise thus increasing the level of satisfaction between the principal partners.

Examining patient centredness in provider-patient communication, Lambert and colleagues (1997) have conceptualised health in a patient centred theory. The theory perceives the patient to be at the centre stage in aligning the interpretation, identity and performance with the social, biological and psychological aspects of healthcare (Lambert et al 1997: 31). The patient-centred care framework is grounded on symbolic interactionism and social constructionism vis a vis culture and scientific practice (Blumer, 1969; Conrad & Schneider, 1992; Goffman, 1967; McCall & Simmons, 1978; Pickering, 1992, 1995;). Lambert *et al.* (1997:) calls for the need for communication training not just for health professionals and patients but also relatives, parents, friends if the goals of PCC can be achieved. The minimal attention on patient education to enhance their communicative competence will stabilise their health alignment in the medical encounters. Recent studies in argumentation have explored its role in PCC with further research on the pragma-dialectical theory in the enhancement of PCC especially in the breaking of badnews to pateints (Karnieli-Miller & Kroszynski, 2018; Snoeck Henkemans, Labrie & Pilgram, 2018; Wagemans, 2018) The present study explores the performance of the doctor and the patient in terms of the interactive stabilisation vis a vis the biological and sociopsychological considerations based on the patient's culture. The communicative competence and use of argumentation and effective persuasion skills by both the doctor and the patient is investigated.

The shift from the doctor-centred approach to the patient-centred approach is a culmination of the response to both the institutional codes of conduct of the medical practice and a desire to re-examine the roles of the doctor and the patient in the medical consultation. The traditional model favoured the doctor-centred model which was a one-sided approach to the doctor-patient consultation. This is because the medical practitioners may at times ignore the levels of understanding of the patients in conjunction to the treatment options which may be available (Silverman, Kurtz, & Draper, 1998). The demonstration of the same patterns of interation by general physicians across most of their consultations do not assist the spirit of shared understanding of the diversity of the patient experiences which may be unique to every consultation (Piccolo, Mazzi, Saltini, & Zimmermann, 2002). Inability to provide the patient with a chance to express themselvolo, es and taking all the time to express the thoughts about a disease by the doctor has been noted in doctor-centred approaches to the medical consultation Spending minimal time to elicit the personal concerns and desires of the patient through attentive listening is a lacking element for such physicians.

A qualitative study of the doctor-patient communication discourse which employs a multi-disciplinary approach to understand the Chilean medical consultation encounters explores the communicative activity type using interactional sociolinguistics (Cordella, 2004). The study explores the dialogic voices of the doctor and the patient in the Chilean system of healthcare. In trying to understand the level of symmetry between the doctors and the patients, the study explores the different voices demonstrated by the doctor and those of the patient. The exploration of the fellow human voice and educator's voice by the doctor in the discourse analysis study reveals the shifting stances of the doctor in the medical consultation (Cordella, 2004: 217).

In the ascertainment of the different social individualities of the patient, the Chilean-based study explored the patient's voices as an apologiser, complier, challenger, initiator and social communicator. Cordella (2004) concludes that the shifting voices of the doctor and patient indicate shifting social identities of the participants as they align themselves to the institutional settings associated to them. These shifts the study indicates the increasing or decreasing levels of communicative symmetries. This study affirms the reflection of the sociocultural ideology and values of the Chilean society in the doctor-patient communication based on the micro-linguistic representation of the doctor-patient relationship (Cordella, 2004: 218). The persuasive use of the

doctor's authority based on his professional expertise is a deliberate attempt to appeal the patient's understanding of the society in which both the doctor and the patient lives. Despite the different theoretical underpinning of the study, the present study explores the role of the sociocultural context of the medical consultation in trying to understand its correlation with the argumentative moves made by both the doctor and the patient. That, sociocultural factors influence the doctor-patient communication in the medial consultation, is a parameter which ought to be considered in the study medical consultation discourse.

The doctor-patient consultation can benefit from enhanced communication skills in the interpersonal relationship between the doctor and the patient. These communication skills inform a vibrant and fruitful healthcare encounters of doctor and patients which pays attention to the joint decision-making processes (Matusitz & Spear, 2014: 261). This assertion entails an understanding of the sociocultural and emotional aspects which affect the joint decision-making process in the medical consultation. Quality healthcare calls for quality interpersonal relations and communication in the doctors-patient encounters (Maguire & Pitceathly, 2002). In determining the quality of doctor-patient communication the present study delves into the significance of considering the macro contextual realities of the medical encounter to understand the micro contextual linguistic choices in the resolving disagreements between the doctor and the patient.

In the next section on narrative medicine, the medical consultation provides a context to have an experiential account of the doctor-patient encounter. Matusitz and Spear (2014:259) aptly point out that story telling offers an opportunity for human bodies, which experience the illness to express the human lives with all that is associated in terms of memories and scars.

2.2.2 Narrative-based medicine (NBM) in the doctor-patient consultation

In an awareness creation article on narrative-based medicine (NBM), Zaharias (2018a) defines NBM as the inculcation of the idea of narratives in medical practice. More precisely, the concept of NBM provides medical practitioners with interactive wisdom to enable them to comprehend the enduring struggles which patients go through in their illnesses while presenting them an opportunity to understand the challenges which face physicians when providing health care to their patients (Charon, 2006). Some of the critical skills important in the practice of narrative medicine

(NM) include a competence in the use of communication skills, reflective skills on, skills of neutrality, hypothesising and circular reasoning, imaginative skills (Zaharias, 2018a: 290)

Acknowledging that illness is a gamechanger in patient's life is the beginning to make doctor patient encounters and healthcare generally fruitful. As one of the key proponents of NBM, Charon (2006) points out the four divides which explain the inability of doctors to understand the patient in their provision of health care. The disconnect between the healthcare professionals and their patients relates to their perceptions on the relationship with death, the belief system on the causes of illnesses, contextual factors of illness and the fear, shame or stigma associated to illness. In all the four parameters, the worldviews of the doctor and the patient are diametrically in opposition. For instance, the assumption by doctors that illness is merely a natural and biological process is met with the effect of illness on a patient's life as a framework within which they perceive it. On the other hand, the fear of death or mortality in a patient's life implies that illness occasions an influx of emotions because it makes them relate with experiences in their lives. The doctor's perspective on death is not as personal as it is to the patient who is directly afflicted by the illness. The divergence of perceptions even on causality of illness also marks the divide. Whereas the patient may lack the medical knowhow of the doctors on the cause of his/her illness, the possibility to associate it with a given cause from a personal or eternal environment is high. The lack of openness by the doctor to ask some embarrassing or shameful questions does not make the patient's role in the medical encounter any better. Stigma, fear and even self-blame may bother a patient to the extent of not divulging important information which may be useful in the treatment and management if the patient's condition.

On the same vein, Kalitzkus & Matthiessen (2009) have carried out a systematic overview of NBM. Their study explores the different narrative genres and how they can be functional through research, theory and practice in the medical sector. Providing a reflective account of NBM, Kalitzkus & Matthiessen note the centrality of narrative in healthcare practice in the past but with the move towards the biomedical model which favoured 'facts and findings' saw the role of stories and narratives continually neglected (Kalitzkus & Matthiessen, 2009: 80). In the context of NBM medical practice distinguishes three key opportunities: 1. The desire to understand the perspectives of the patients and their care givers for purposes of research; 2 The need to understand the narrative structure in medical practice and narrative-based doctor-patient relationships, and 3.The place of

narratives as evidence for research in the social and medical sciences (Kalitzkus & Matthiessen, 2009: 80).

There is a remarkable shift from the physician narrative to the patient narrative (Zaharias, 2018b: 179). The doctor's biomedical report presented in a scientific manner has dominated modern medical narrative. Narratives are important in understanding personal accounts of patients' perceptions of the meaning of their illnesses. NBM provides an opportunity to the patient to give the personal perspective, meaning and the context of his/her medical problem (Greenhalgh & Hurwitz, 1998). This assertion is one of the merits of NBM that have been pointed out in research (Zaharias, 2018b: 179) Some of the merits Zaharias (2018b) enumerates demonstrate the critical role NBM plays in bridging the disconnect in the doctor patient relationship through the exploitation of storytelling to reconnect and empathise with each other's narratives for better care and management. First NBM strengthens the doctor patient relationship by creating an opportunity for striking rapport. Besides, NBM presents an opportunity for creating awareness to both the doctor and the patient. The therapeutic power of narratives to the patient may result in better healthcare outcomes. Getting a chance to express oneself and be heard enables a doctor to understand and empathise with the patient (Lewis, 2011). This way the doctor maximises the use of the power of reflection in the medical encounters. Research has further indicated the change of stance with the use of NBM (Charon, 2006). The problem solver tag of the doctor in the doctor-patient encounters is gradually replaced to an active listener who takes his time to reflect and understand issues in a patient's health (Kalitzkus & Matthiessen, 2009).

NBM researchers (Fioretti, Mazzocco, Riva, Oliveri, Masiero, *et al.*, 2016; Zaharias, 2018b) have the consensus the more research needs to be carried out on the modalities of incorporating the practice of narrative medicine in the contemporary practice. This will establish the critical competencies needed in the execution of the therapeutic effect of NBM for both the patients and the doctors in their encounters (Zaharias, 2018b: 179). This research in Narrative Medicine needs to be tailored on a needs assessment in medical practice to find out and draft specific protocols which will have far reaching impact of the use of narrative in healthcare provision and contribute to the improvement of the doctor patient relationship (Fioretti *et al.*, 2016: 8). Medical discourse analysts have explored the use of narrative in healthcare contexts by focusing on both what the patients say in their stories and trying to understand their social identities and how they are

informed by the different social contexts and circumstances (Jones, 2015:849). The conception of narrative based medicine closely builds on the enhanced SDM model (Charles *et al.*, 1997; Barratt, 2008; Sandman & Munthe, 2010). This forms a good basis for understanding some of the choices made by either doctors or patients in the critical discussion process amid the institutional constraints of the SDM process in the pragma dialectical analysis (Henselmans & van Laarhoven, 2018; Pilgram & Snoeck Henkemans, 2018; Snoeck Henkemans & Mohammed, 2012) which the current study explores.

2.3 The doctor-patient consultation

Writing on contemporary challenges of healthcare and the role of communication in health, Wright, Sparks & O'Hair (2008:9-10) highlight cultural diversity and tension between traditional and modern healthcare factors which have substantial influence on healthcare delivery. The ambivalence between cultural belief systems on illness and health and the conventional and mainstream healthcare greatly mars the provider-patient relationship.

The reluctance of healthcare providers to embrace new approaches to healthcare continues to destabilize healthcare provision. For instance, healthcare providers who were initially trained to use the biomedical model of medicine, which is evidence based and heavily reliant on scientific procedures for disease diagnosis, may not be open to new approaches which may for example consider psychosocial aspects of illness like cultural beliefs, patients' coping mechanisms and their day to day lifestyles. Instead of the curative methods of fighting disease like chemotherapy for cancer which may impact negatively to the patients' quality of life, homeopathic and more patient friendly and even palliative care are now more preferred (Wright, Sparks & O'Hair 2008:10-11).

Interpersonal communication problems in doctor-patient encounters are never one sided. During these encounters, the nature of communication between doctors and patients can improve the quality of the patients lives through fruitful healthy outcomes or due to poor handling, it can cause more problems to both the doctors and their patients. There is a considerable lack of emphasis on the critical role of communication skills in healthcare settings in the medical school curriculum which is more skewed to physical health aspects and the development of clinical skills (Wright, Sparks & O'Hair 2008:19).

Interrogating the linguistic aspect of doctor-patient communication in medicine, Patel (2018) has asserted that the way words are used reveals the thought patterns involved in the decision-making processes has profound impact on the healthcare system and the health of the patients (Patel, 2018: 342). On the choice of words in healthcare settings, Shuy (1993) identifies jargon or vocabulary, cultural differences and structure of discourse as the key barriers of effective communication in the medical consultation. The use of jargon (technical language) in the medical interview can cause ineffective communication. The use of jargon associated with one group, say an "in-group" in communicating with another group, an "out-group" is a challenge to the process of interpersonal communication. "Strategies for making the ingroup information available to the out-group are very complicated," (Shuy1993:18) partly because most professionals including doctors are not well equipped with how to put across key aspects of the treatment procedures to non-professionals. The doctors need to have at the back of their minds that their clients are patients whose interest is to be treated by remedying their health troubles and may not be keen to learn their jargon. However, some patients may have a unique social, regional or medical terminology which the doctor may be unfamiliar with. The solution to this can be the necessity for the doctor to develop a "receptive competence" to the patient's language by trying to understand what the patient is saying (Shuy 1993:19). This is a kind of convergence where the doctor tries to understand what the patient is saying while the patient tries to speak the language of the physician.

Cultural difference in medical consultations occurs when professional culture of the doctor clashes with that of the patient. The cultural belief systems of the patient are also bound to clash with the conventional medicine practice, and this can necessitate some element of social negotiation between the interactants. This can occur when the patient uses a substandard variety of a language while the doctor maintains the standard variety. Patients with the substandard variety of a language "consciously or subconsciously …tend to get worse treatment, wait longer for service; are considered ignorant, and are told what to do rather than asked what they would like to do" (Shuy 1993:20)

The uniqueness of the medical interview in the structure of its discourse is a barrier to effective information interchange. The doctor patient consultation does not take an ordinary conversation structure. It is an interview of a kind because one person asks questions while the other answers. Studying three medical histories of working-class women in tape recorded interviews which

conducted at Georgetown university hospital, Shuy (1993:22-29) analyses the discourse structure of the medical interview. Precisely, the analysis reveals four actions: introduction of the topic, response to the topic, recycling of the topic and cohesion/sequence marking. In introducing the topic, different consultations will cover different topics. There is a lack of control on the part of the patient. The medical interview "restricts communicative freedom of the respondents" (Shuy 1993: 24) For instance, the doctor normally has the leeway to be more conversational in interviewing the patient because he is desirous to tame the patient's anxiety thus making him/her more willing to give precise and complete information. If the doctor introduces a new topic in the interview, the expectation of the patient is to either pause, interject, seek clarification, agree or express an element of hesitation with little or no disagreement on the topic. Interruptions are normally made by either party to seek some more explanations. However, at times the doctor will allow the patient to give complete thoughts for the main reason of getting useful information for decision making. Cohesion in the medical interview is typically marked by an opening, transitions between the issues and closings between the topics.

The growth of doctor-patient communication discourse is attributed to the many settings where it is now practiced. These settings range from specialist clinics, homes of patients, general practice consultation rooms, hospices, delivery rooms, operation rooms and many others. Generally, primary care forms the most common and broad branch of medicare which is critical in doctor patient interactions. Heritage and Clayman (2010: 104) have distinguished four kinds of primary care visits: acute care, follow up, routine and well visits. The first type, acute care visit entails situations where a patient presents a new problem for the very first time to the doctor. On its part the follow up visit occurs when a patient goes back to the doctor to assess the process of treatment and/or progression of the disease. Thirdly, those periodic visits by patients mainly with chronic medical conditions like diabetes, cancer or hypertension so that the doctor can review their progress in terms of treatment are referred to as routine visits. Lastly, the well visit is an annual checkup visit where a patient presents himself/herself to a doctor to conform that there are no new health problems.

During the problem presentation stage of the consultation, acknowledgements in form of responses from both doctors and patients are distinguished. Acknowledgements which take the form of "uh huh" and "mm hm" are referred to as continuers (Schegloff 1982) while those which take the form

of "okey" or "right" are referred to as shift implicative acknowledgements (Beach 1993). In the medical interview, continuers indicate that a speaker is willing to forego an opportunity to take his or her turn thus signaling the other speaker to continue. It is an indication of an incomplete response from the other speaker. On the other hand, shift implicative acknowledgements are indicative of the intention by the speaker to move on to a new topic or even to a new speaker. These also indicate that a previous speaker has completed the submission and is ready for the shift. In a nutshell, acknowledgements are controlled by both the doctor and the patient in prompting, encouraging or curtailing the problem presentation which is a co-construction of the two parties (Heritage & Clayman 2010: 113).

In the healthcare domain, Street (1991) has examined the dynamics of the interpersonal communication in healthcare by examining the critical role of accommodation in the medical consultation. While underscoring the fundamental importance of the doctor-patient talk in the information sharing and ascertainment of understanding, Street (1991: 131) emphasises that the affective aspect of the doctor-patient encounters is key in relation building. Through talk the doctor and patient can synchronise both the verbal and nonverbal signals which are crucial in the shared decision-making process. Fruitful healthcare outcomes like patient compliance to medication and general satisfaction and healthcare uptake have been credited to information exchange and affective facets of doctor patient interactions.

Making a case for a communication theoretical framework to fully explicate the communicative process of the doctor-patient interaction, Street (1991: 132-134) provides a critique of existing theory and research in medical discourse. First, previous research in doctor patient communication was centred on the dominant player of the encounter, the doctor without considering the patient's communicative acts. These studies not only rubberstamped the paternalistic school of medicine, but they also did not focus on the patient as an equal partner and key player of the medical consultation. This implies that most post consultation studies whose objective was to examine patient compliance or satisfaction have relied on the patient's reaction to the focal point rather than focus on the patient's communicative behaviour or even the relationship between the two players in this encounter. Secondly, although some studies have focused on patient's perceptions of the doctor's actual or communicative behaviours few have focused on specific communicative behaviours of doctors. Finally, few studies have been conducted grounded on communication

theory to examine the doctor-patient interaction in its detail, safe for studies on doctor's verbal behaviours and responses to doctors and patients which have taken the medical communication behaviour framework.

However, critical discourse analysts[14] (Lupton, 1992) have delved into the dynamics of the medical consultation, ranging from the use of utterances by doctors and patients to demonstrate the power play and control to information sharing, and understanding; and the interactants' social and communicative roles in the consultation. Street (1991: 134) proposes that communication accommodation theory mediates between the doctor-patient communicative processes and the expected healthcare outcomes which previous theories and studies could not account for. This assertion integrates the verbal and nonverbal interactional behaviours and exchanges between the doctor and the patient with the understanding, compliance, satisfaction and maximum exploitation of healthcare service provision.

Two doctoral studies focusing on the discourse analysis approaches of appraisal, pragma-dialectical theory of argumentation and controversy analysis in the use Bantu languages in news reporting and parliamentary discourse in Zimbabwe have been carried out (Jakaza, 2013; Sabao, 2013). In his study, Sabao (2013) does a discourse analysis of Shona, Ndebele and English newspapers diachronically (2010-2012) using appraisal theory to determine the reporter's voice and objectivity in the reporting of controversial news. Of interest to the current study is the involvement of Shona and Ndebele which are Bantu languages in the data set for discourse analysis. The study establishes that the reporter's voice is evident in the three languages under study in the Zimbabwe news reporting. However, the study identifies the flouting of the objectivity ideal in news reporting through strategic impersonalisation (Sabao, 2013: 7–8,327) to express the authors evolutional attitudes. The present study explores further the displau of strategic maneuvering in EkeGusii during the critical discussions to achieve both the persuasive ideal and dialectical reasonableness in doctor-patient interaction, however with insights from appraisal and communication accomodation.

The second study (Jakaza, 2013) has employed an eclectic approach to analyse Zimbabwean parliamentary discourse and its representation in newspaper articles between 2009 and 2010.

[14] See also the work of Wodak (1997) on the critical discourse analysis of doctor-patient encounters and interactions.

Precisely the study employs the extended pragma-dialectical theory, appraisal theory and controversy analysis to carry out a linguistic analysis of speeches and debates in parliament and how these are reported in newspapers in English (*Newsday* and *The Herald*) and Shona (*Kwayedza*). The study concludes by noting the variation in attitudinal values of affect, judgement and appreciation in their manifestation in the text depending on the speech/debate (depending on the nature of the debate: divergent or consensus) or newspaper article (depending on the issue or theme under focus (Jakaza, 2013: 245). Whereas the parliamentary debates and their representations in the news reports, based controversy were explicitly dichotomised and evaluated the presidential speeches in the official opening of parliament were implicit in dichotomy and were implicitly evaluated. The conformation to the stages of critical discussion of the Zimbabwean parliamentary discourse and the exploitation of strategic maneuvering (Jakaza, 2013: 249) also form some of the key findings with a pointer towards a study of other discourses in different contexts and institutions and how probably argumentation is manifest in such. The identification of lexico- grammatical choices in Shona that inform the appraisal analysis in the study still brings into focus an extended pragma-dialectical investingation of argumentation in a Bantu language with the appraisal and controversy analysis perspectives.

In another doctoral research, the discourse of conflict in English and Runyankore-Rukiya newspapers in Uganda is analysed using genre and appraisal theoretical models diachronically (Mugumya, 2013). Besides establishing that hard news reports in English in Uganda emulate the Anglo-American architectural organisation, the writer notes the generic moves in Runyankore-Rukiya news reports like those in English. When one zeroes in on Runyankore- Rukiya news reports, the attitude-based meanings are expressed using "metaphors, token judgements, non-core lexis and occasional proverbs" (Mugumya, 2013: 284). Of interest to the current study which has an interpersonal perspective is the finding that proverbs are used to the interpersonal value of the locutions by the reporters. Whereas this study deals with a corpus of newspaper discourse, albeit in an African language in comparison with English, the present study explores an appraisal perspective in the process of a pragmadialectical analysis of resolution of differences of opinion in the medical discourse in Ekegusii.

On the same note, (Kabugo, 2013) explores decision-making and participation in spoken discourse in Luganda during community development meetings in Uganda using appraisal and genre

analysis theoretical designs. The study analysed audio recordings and transcripts of 15 Ugandan farmer group meeting discussions on a pre-tape-recorded seasonal weather forecast. Spontaneous, explicit and virtual decision-making styles punctuated with unstructured moderation to manage consensus building form some of the key findings of the study. Delving into professional spoken discourse and particularly seeking to understand the decision-making processes and patterns in Luganda, a Bantu language close to the language used in the context of the current study, provides useful insight. A quick parallel can be drawn in the decision-making process in a public meeting with many discussants engaged in negotiation in this study with the doctor patient discussion in a medical institutional context (Kabugo, 2013: 195) with two principal participants. The present study has insights of the SDM model in the critical discussion process, but which operates with distinct institutional preconditions applicable in the medical consultation (Henselmans & van Laarhoven, 2018; Pilgram & Snoeck Henkemans, 2018; Snoeck Henkemans & Mohammed, 2012).

2.3.1 The role of traditional medicine (TM) in the medical consultation

Traditional medicine (TM) plays a key role globally in healthcare solely or in complementing the mainstream healthcare delivery. In its complementary role TM has been referred to as complementary medicine (CM). Traditional medicine (TM) is defined by World Health organisation (WHO) as the:

> diverse health practices, approaches, knowledge and beliefs incorporating plant, animal, and/or mineral-based medicines, spiritual therapies, manual techniques and exercises applied singularly or in combination to maintain well-being, as well as to treat, diagnose or prevent illness (WHO, 2002:7).

Since acquiring global recognition[15], TM and CM, now formally referred to as traditional and complementary medicine (T &CM) by the World Health Organisation (WHO, 2013: 7), has asserted its critical role in healthcare delivery including in the medical consultation. In the developed world TM is referred to as complementary and alternative medicine (CAM) (Kasilo, Nikiema, Desta & Lona, 2018:4-5). Due to the its importance, availability in nearly every country

[15] In the year 2009, TM was adopted in the WHA resolution on Traditional Medicine (WHA 62.13)

and its growing demand, the WHO has reviewed the TM Strategy for the 2002-2005 decade in developing the current one runs for through the 2014-2023 (WHO, 2013: 7). The 2014-2023 T&CM strategy seeks to tackle the new challenges facing T&CM considering the progress in the operationalisation and regulation in its use among the member countries.

TM is decribed as the totality of the therapeutic practices which were in use before the founding of contemporary (also referred to as *modern, conventional orthodox* or *western*) medicine (Kasilo, Nikiema, Desta & Lona 2018: 1). Nevertheless, TM has a major role on the healthcare of the developing and developed world. In Africa, TM has been the predominant healthcare option for millions of Africa's populations before the advent of contemporary medicine (Abdullahi, 2011:116). Wendland and Jiao (2018) have noted that apart from the ease of access and affordability, TM is often associated with a community's overall belief system and an important part of day to day well-being This explains the substantial uptake of TM among African, Asian and Latin American populations to help meet healthcare needs with an increase in the usage of TM in developed countries (Wendland & Jiao, 2018: 52). Kasilo *et al*., 2018:35 have noted the deliberate efforts of collaboration and partnerships aimed at encouraging the complementarity between TM and contemporary medicine. For instance, ministries Health are collaborating with the ministries of Trade and Science and Technology and Trade and Industry in several African countries including Kenya, South Africa, Bukina Faso, Benin, Uganda, United Republic of Tanzania, Zimbabwe, Nigeria, Ghana, The Gambia, Rwanda, Mali and Senegal on ways of integrating the traditional and complementary medicine (Kasilo *et al*., 2018: 35). The growth of these collaborations working at the continental level have seen the African Union (AU) collaborating with the global body, WHO in conjunction with the regional Economic Communities (RECs) to see the implementation of the Plan of Action (POA) for the first Decade of Traditional African Medicine (2001-2010) and the declaration of the second Decade of African Traditional Medicine (2011-2020) (Kasilo *et al.*, 2018: 35-36). All the se efforts underscore the importance of the increasing recognition of T&CM in healthcare management in Africa and elsewhere. It is only through research and development (R&D) that safe, rational and effective TM practices, products and therapies can be identified and promoted to complement the contemporary medicine (Busia, 2018: 203)

On the local front, the Kenyan health care system is a pluralistic system in which sociocultural and historical factors have imposed a mutual coexistence of both the traditional and contemporary medicine (Ngetich, 2008: 25). The coexistence of these systems imply that legal mechanisms should be put in place to inculcate the mutual coexistence of the two systems of medicine. A proposed Natural Products Industry (NPI) draft policy paper recognises the anchorage of the indigenous and natural products the Constitution of Kenya 2010. The primacy of culture in the recognition and protection of indigenous knowledge and the protection of the products from the naturally occurring fauna and flora cannot be wished away. The prioritising of the NPI by the government which intends to develop the legal framework for the operationalisation of the industry is a plus to the recognition of the role of T&CM in healthcare provision in most parts of the world. The empirical data presented in the present study is proofs the situation as it is in the grassroots (Republic of Kenya, 2012:8). Herbal medicine plays a considerable role in health care provision in Kenya (Ondicho, Ochora, Matu & Mutai, 2015: 174).

Patients have alternative healthcare remedies during or even before they can consult their doctor. The alternatives remedies are available to lay people in the developing world such as the Gusii people of south western Kenya. Based on lay assessment of the effectiveness, patients will choose such alternatives as self-medication with OTC pharmaceuticals, use of home remedies, herbal medicinal treatments by traditional healers[16] apart from seeking care from healthcare facilities (Nyamongo, 2002: 377). Some patients opt not to go for any of the therapeutic interventions. Herbal preparations by traditional healers, who perform scarifications on patients or provide herbal treatments in the form of '*obosaro*'(the ash-like substance after burning herbs) which the Gusii patients have to prioritise before going for OTC medication (Nyamongo, 1998: 282, 2002). This affirms the assertion that herbal medicine together with essential oils are the most commonly used traditional, complementary, and alternative medicine therapy globally (Kasilo *et al*., 2018: 4).

A study on the evolving healthcare behaviour of malaria patients from the Gusii community in Kenya, Nyamongo (2002: 377) points out the determinants of the choice of medication for Gusii patients. These include level of knowledge and the prognosis of the time it takes to get well, patient's perception on the level of sickness and the estimated cost of treatment. In the analysis of

[16] Traditional healers form a whole rage of traditional diviver-healers who include traditional health practitioners (TPHs) or traditional medicine practitioners (See also Kasilo *et al*., 2018:4-5).

healthcare behaviour among the AbaGusii of south western Kenya, Nyamongo (1998:54) has underscored the role of infrastructural, structural and superstuctural forces. Infrastructural factors relate to the access to health care facilitie in terms of transport and communication. These parameters explain the healthcare behaviour of the AbaGusii when they attend to issues of illness. The sociocultural belief system which forms part of the superstructure forces which have an effect on the medical consultation involve the belief in witchcraft attributed to quarrels or cowife rivalry (Levine, 1962: 39)

Ondicho and colleagues (2015) conducted a cross-sectional study in Gucha district among a purposively sampled 167 (Aba)Gusii patients, who use herbal medicine in herbal clinics, exploring factors for their electing for that choice. The findings from the semi-structured questionnaires administered in the study indicate an herbal medicine uptake rate of 68.9% with 67% occasionally seeking modern contemporary medicine. Incidentally, the respondents attribute the preference to the efficacy of herbal medicine as compared to the contemporary medicine in a ratio of 88% to 27.5%. The study concludes that the belief that herbal medicine can maintain good health informs the positive attitude towards the safety and efficacy of herbal medicine (Ondicho, Ochora, Matu & Mutai, 2015). These findings are very core to informing the macro context of the present study whose interpretation of its corpus of data brings to the fore the traditional Gusii sociocultural belief on illness as an institution which influences the evaluative decisions and argument schemes of Gusii patients in the medical consultation.

In a similar study focusing on the complementarity and supplementary relationship between traditional medicine and modern medicine, Matlala, Nel & Chebali (2015) have explored confidentiality concerns of patients of TM experts who also consult with contemporary western medical providers. Using in-depth interviews, the study sought to understand the considerations of confidentiality among its participants following the lack of a structured referral system between the TM&C western medicine. The 12 clients of practitioners of traditional medicine who were at concurrently consulting contemporary western medical doctors consisted of Sepedi, Tswana and Sotho speakers from South Africa. Using the open coding method, a thematic analysis of the data revealed that the clients sought their right to confidentiality respected by both the traditional healers and the contemporary western medical providers. The propensity to use traditional medicine or contemporary western medicine puts patients in a precarious situation as to how to go

about their consultations with either practitioners in terms of the level disclosure of the healthcare need they are receiving from either party (Matlala, Nel & Chebali, 2015: 195). The traditional African belief system takes consultation confidentiality very personal and cases of western medical practitioners who take issue with such patients who simultaneously consult traditional healers erode the complementarity gains in healthcare provision and uptake in Africa.

The Interim Traditional Health Practitioners Act number 22(2007) of the South African constitution protects the people of South Africa in their use of the services of traditional medicine practitioners. The act promotes quality and comprehensive practice of healthcare by the traditional health practitioners. This means that patients seeking healthcare services from these traditional healers and practitioners just like from the contemporary western medical practitioners has their right to confidentiality protected in law (Constitution of the Republic of South Africa,1996, South African Nursing Council Regulations (2004, Clause 5, p. 8). In either institution, the cultural sensitivity of the patients or client's health care choices during consultations need to be respected through the protection of the confidentiality of their healthcare encounters with the healthcare practitioners. Trust and respect of the culture and values of the patient is a key ingredient of building positive healthcare practitioner-patient relationship and a major contributor to healthcare provision. Matlala, Nel & Chebali (2015:200) call for restraint and tolerance by contemporary western medical practitioners by developing a positive attitude and demonstrating "cultural sensitivity and cultural competence" in their healthcare encounters with patients and caregivers. The cultural competence of the contemporary healthcare providers helps in the practice of the medical consultation with the cultural sensitivity it deserves by being able to work with the patients by respecting their cultural preferences (Spector, 2004).

Although patients may feel that both the traditional and contemporary systems of healthcare are beneficial to their healthcare, the two may have antagonistic ailment causation (Matlala, Nel & Chebali 2015:196). The danger posed by the concurrent usage of drugs from both systems may prove to be counterproductive to the health of the patient. Non-disclosure of information on the herbal or traditional medicine usage to the nurses and doctors may lead to prolonged treatments due to complications arising from these drug to drug interactions and reactions putting more pressure on the resources of the family (de Beer, Brysiewicz, & Bhengu, 2011). Healthcare provision in African societies, who have an established social cultural belief system of traditional

medicine, can benefit if the contemporary western medical practice appreciated the existing traditional medical practice. This calls for mechanisms of aligning the institutional constraints of the two institutions which at times bring about antagonistic relationships in the contemporary medical consultations. Positive or constructive feedback from contemporary healthcare practitioners encourages patients disclose more information of their encounters with traditional medicine encounters and other therapies they may be using which is beneficial to the shared decision-making (Mpofu, Peltzer & Bojuwoye, 2011). The current study explores empirically how the T&CM and contemporary western medicine interact in the medical consultation in the Kenyan public hospital context.

2.4 Argumentation in doctor patient communication

The institutional context of the medical consultation makes the medical interview to operate under the dictates of the ethical code of medical practice. The code has provided legal and ethical institutional preconditions which govern the practice of the medical consultation. With the enhanced SDM process of conducting argumentation to support treatment decisions, diagnosis and medical advice, the patient engages with the doctor like an expert on his/her illness, with values, preferences and even a story associated with the illness (Sandman & Munthe, 2010). Therefore, differences of opinion evoke argumentation which operates under the informed consent, evidence-based medicine and patient-centred care (Weston, 2001; Bickenbach, 2012; Schulz & Rubinelli, 2015b; Snoeck Henkemans, Labrie & Pilgram, 2018)

2.4.1 Characterising argumentation in the medical consultation

A number or argumentation researchers have explored the process of argumentation in the medical consultation (Korsch & Harding, 1997; Wirtz, Cribb & Barber, 2006; Bigi, 2011; Labrie *et al.*, 2015). Rubinelli (2013) situates argumentation in doctor-patient communication by establishing its link with persuasion and further exploring the challenges of exploiting argumentation in the medical consultation with insights of how they can be overcome. Rubinelli traces the link between persuasion and argumentation in Aristotle's '*Rhetoric*' where he sees argumentation as a key tool for realising reasoned persuasion in his definition of rhetoric. Apart from Aristotle's devotion to encouraging students of rhetoric to exploit argumentation in their persuasion by constructing different argument schemes, better understanding of the linkage can be traced by the

conceptualisation of persuasion. In attributing the critical role of argumentation in persuasion, Rubinelli (2013) following O'Keefe's (2002, 2012) conceptions of the term, persuasion is a communication enterprise which is aimed at influencing the mental state and behaviour change of the intended person or audience. O'Keefe (2012) building on O'Keefe's (2002) view on persuasion that people's attitude determines their behaviour, posits that argumentation provides the mechanism of challenging the belief which influences one's attitude. Therefore, arriving at a rational persuasive nature of argumentation in its ability to influence one's belief system to an extent of changing it towards a desired train of thought.

Rubinelli (2013) makes a case for the role of argumentation in the contemporary socio-relational context of doctor-patient communication. As a reaction to the traditional paternalism model which has been accused of limiting participation of the patient in decision-making process, there has been a shift towards giving the individual patient the responsibility of his/her good health. Healthcare communication researchers have converged on the need to provide the patient with all available treatment choices in the treatment process (Edwards & Elwin 2009, Heritage & Maynard, 2006). This is also confounded in the ethical and legal requirement to provide the patient with enough information for them to be able to engage in the doctor-patient interaction (Collins, Britten, Ruusuvuori & Thompson, 2007). This is the informed consent requirement for all medical professionals in medical encounters. This autonomy gives the patient a chance to exercise his or her 'right to self-determination regarding medical treatment because it enables the patient to be also a partner on making decisions regarding his or her health (Rubinelli 2013: 553)

However, Zanini & Rubinelli (2012) differ with the critics of the paternalistic model which allows the doctor take centre stage in acting like a guardian to the patient (Roter & Hall, 2006; Taylor, 2009) because they ignore the non-deliberative delegators (Flynn, Smith & Vanness 2006) who are patients who prefer their doctors make decisions on their behalf (Shneider, 1998, Fraenkel, 2011). These critics do not see the patient-centredness of the approach in this respect. For the deliberative autonomists, however, who want to discuss and have a final say in their treatment decision (Flynn, Smith & Vanness 2006), Emmanuel and Emmanuel (1992) recommends the SDM and the informative models. The SDM model allows for joint communicative roles for both the doctor and patient in the decision-making process while the informative model calls on the doctor to disclose all relevant information on the alternatives, benefits and side effects of treatment

decisions before the patient comes up with the final decision (Deber, 1996; Charles, Gafni & Whelan 1997, 1999; Wirtz, Cribb & Barber, 2006). The central role of the key players in the medical encounter is thus appreciated in the two models. Exploiting argumentation, the doctor's and patient's knowledge, expertise and experience provide a repository of tools for engagement in decision making.

Another study by Roosmarlyn Pilgram characterises the argumentation process in the doctor-patient consultation. The study has explored the characterisation of the pragma-dialectical concept of communicative activity type to understand how the doctor-patient consultation exploits argumentation in the argumentative reality (Pilgram, 2015). The characterization of the communicative activity type informs pragma-dialectician's analysis and assessment of actual recorded doctor-patient consultations extracted from a compilation from the *Netherlands Institute for Health Services Research* database. This strategic move calls for an understanding of the contextual features to pay attention to in the analysis and evaluation of argumentative discourse in the doctor-patient consultation (Pilgrim, 2015:19).

At the heart of pragma-dialectical analysis and evaluation or argumentation discourse lies the concept of *argumentation activity type* also referred to as *communication activity type* (van Eemeren and Houtlosser, 2005, 2006; van Eemeren, 2010) especially when looked at from the genre of communicative activity where the argumentation takes place. In the different genres of communicative activity types, there is a unique and deliberate way of carrying out communicative practices established by the tradition and culture of any genre. These genres can be the legal, parliamentary/political, medical or academic. These culturally determined communicative activity types can be said to be institutionalised and conventionalised in the different domains. Van Eemeren (2010:138-143) distinguishes the conventionalised communicative activity types in the different communicative genres. To manage the process of argumentation the different communicative genres for instance the communicative activity types of arbitration of a court case or deliberation of a parliamentary debate, the preconditions for the actualisation of each of the communicative activity types is constrained by institutional preconditions[17] (van Eemeren, 2010:152-158). In this sense, the communicative activity type limits the strategic manoeuvring of

[17] For more on institutional preconditions see subsection 3.2.6, Chapter 3

arguers in their aiming to effectively convince each other, and reasonably resolve the difference of opinion on merits in the argumentative reality (van Eemeren & Houtlosser, 2006:385).

Exploiting the institutional preconditions which govern the doctor-patient communicative activity type Pilgram (2015: 20) examines the medical consultation as an argumentative activity type with institutionalised and conventionalised practice. The examination of the the communicative activity type enables an exploration of both the role of argumentation and the evaluation of the argumentation in the medical consultation. The nerve centre of the medical consultation is essentially communication because of its positive relation to quality health care outcomes during and after the consultation, doctor-patient satisfaction and the all-important patient adherence to the treatment regime (Brown, Stewart & Ryan, 2003:141-155). With a focus on the critical role of the doctor in the consultation, Pilgram (2015) does an evaluative assessment of argumentation in the medical consultation beyond the importance of argumentation in the consultation which several studies (Jenicek & Hitchcock, 2005; Murphy, 1997; Patel *et al*., 2009; Labrie & Schulz, 2014) have focused on.

In contextualising argumentation in the medical consultation using the extended pragma-dialectical theoretical (van Eemeren and Houtlosser, 2002a, 2002b; van Eemeren, 2010) lens, Pilgram (2015: 20) illustrates the means of evaluation of argumentative discourse in the medical domain. Arguers in the argumentative reality are always aiming at achieving the dialectical aim of reasonably resolving a difference of opinion on merits while simultaneously rhetorically striving to have their argument accepted by the other party. Van Eemeren (2010:40) affirms that strategic manoeuvring entails trying to get a balance of the pragma-dialectic aims in argumentation. A valid evaluation of strategic manoeuvring in the doctor-patient consultation ought to establish the character of the communicative activity type and significance of argumentation in the argumentation activity type (Pilgram, 2015:20). This is because the interactants' strategic manoeuvring is determined by the communicative activity type in which it occurs.

The medical consultation communicative activity type is a conventionalised communicative practice, which occurs in an assigned location in a health care setting involving primarily a doctor and a patient (Pilgrim, 2105:20). The conventionalisation of the communicative practice implies that the medical consultation operates under institutionalised regulations expressly spelt out in the ministry or departments of health or medical practitioners' professional bodies. In characterising

the medical consultation, Pilgram (2015) goes ahead to provide the conventional order of carrying out of a medical consultation. A typical medical consultation will involve an initial inquiry of the doctor about the patient's general health signaling the patient to explain his/her health concern and thus allow the doctor to suggest a diagnosis, the possible prognosis and/or treatment or medical advice about the concern. This is the point where the doctor carries out a physical examination of the patient and based on the findings uses his medical expertise to diagnose and advise on the treatment options available or recommendation and provide the prognosis of the medical condition (Pilgram 2015:20). The professional background of the doctor enables him to reassure the patient in his advice by even giving other relevant details related to the health problem to manage the anxiety of the patient. The level of formality of the medical consultation because of the conventions of its practice constrain the levels of interaction between the doctor and the patient in the medical discourse (Pilgram, 2015:21).

Pilgram (2015) further highlights why argumentation may be beneficial to the doctor and the patient in the medical consultation. From the doctor's perspective, the assumption that the patient is uncertain about a medical advice or recommendation may influence his need to use argumentation to support his advice or treatment choice. Sometimes for legal reasons, the doctor may provide argumentative support for decisions he makes during the consultation mainly to minimise the professional liability. From the patient's point of view, the hesitation from the patient about the doctor's diagnosis, advice or recommendation may be informed from what he/she has learnt online with the unlimited levels of medical information available. This consultation can be a performing confirmatory role to the patient, so the doctor may have to convince the patient by providing reasons for his judgement or advice which at times may be contrary to what the patient has gathered or learnt elsewhere (Pilgram, 2015:21). Nevertheless, any doubts expressed by the patient are a reason for the doctor to exploit argumentation during the consultation. Argumentation is very central in the medical consultation as a communicative activity type because it provides the doctor and the patient a chance to express their thoughts or doubts and, defend or justify them (Pilgram, 2015:21).

Employing both qualitative and quantitative approaches, Labrie (2013) has examined the purpose, the character and influence of the institutional requirements for argumentation for doctors in support of their advice in the medical consultation. The doctoral study examines doctor-patient

communication in the general patient consultation using the argumentation theoretical framework. Using the extended pragma-dialectical theory of argumentation Labrie (2013) analyses the doctor's argumentation in the general patient consultations. The study advances three reasons which justify the use of argumentation by doctors and patients in defending their standpoints while resolving differences of opinions (Labrie, 2013: 17–18). To begin with, the doctor is legally under the obligation to provide enough and relevant information relating to both the patient's illness and the medical advice given to the patient. The legal requirement of informed consent in medical consultations implies that the doctor provides the merits and demerits of treatment options to enable the patient to have the autonomy to make an informed decision on the most appropriate treatment for his or her health condition. Secondly, the general principles of social discursive conventionalisation of the medical consultation predispose the doctor and the patient to argue out their cases by defending and justifying positions they take in aiming to resolve the differences of opinion. Consensus building regarding a diagnosis, treatment procedure or medication regime requires willing and concerted reasonable efforts by each of the parties in the critical discussion to resolve any disputes on merits. This is the obligation-to-defend rule in the pragma-dialectical critical discussion process which requires arguers to come-up with arguments to defend their standpoints (van Eemeren & Grootendorst, 2004). Thirdly, the patient-centred and evidence-based medicine ethical ideals call for the doctor and the patient to present arguments to support their standpoints (Labrie, 2012: 178; Ishikawa *et al.*, 2013). Rational deliberation in the shared decision-making process between the doctor and the patient supports the patient-centred ideal. This is connected to the doctor's ethical constraint of providing overt medical evidence as the basis for the diagnostic process or for giving treatment advice (Barratt, 2008).

The multidisciplinary, empirical study fills the quantitative research gap in argumentation research in doctor-patient communication, specifically, in the medical consultation communicative activity type (Labrie, 2013). In a systematic review of literature on the use of argumentation in the medical domain, the study explores the parameter of argumentative discourse analysis in the social interactive context of the medical settings, argumentation in the field of medical informatics, the ethical ideal of argumentation in the medical context and argumentation in the process of critical discussion in the medical domain (Labrie & Schulz, 2014: 998). The study provides an in-depth understanding of the communication processes which go on in the medical consultation and

inculcates the institutional preconditions which influence the practice of medicine to explicate the dynamics of the doctor patient relationship.

Labrie (2013) explores the growing literature which explores the critical discussion process of resolving the disputes in the medical consultation, using the argumentation theory. The pragma-dialectical theory of argumentation theory examines the medical consultation as argumentative activity type in which through the ideal model of critical discussion, the doctor and the patient engage each other as experts in their own way in a rational discussion where differences of opinion are resolved on merits (Pilgram, 2009, 2012; Labrie, 2012; Rubinelli, Sarah & Henkemans, 2012). The differences of opinion could be related to the diagnostic process or medical advice on treatment or the kind of medication that the doctor recommends (Rubinelli & Schulz, 2006).

Through strategic manoeuvring of the doctor and the patient, the difference of opinions can be resolved effectively and reasonably (Van Rees, 2006; Pilgram, 2008; van Eemeren, 2010; Labrie, 2012, 2016; Schulz & Rubinelli, 2015). Studies in argumentation in the medical consultation point the linkage between the shared decision-making model and the ethical institutional precondition of informed consent (Sandman & Munthe, 2010; Bickenbach, 2012; Labrie, 2012; NHS, 2012; Rubinelli, Sarah & Henkemans, 2012; Schulz & Rubinelli, 2015). The legal requirement empowers the patient in as far as getting information from the doctor is concerned for him/her to make informed choices regarding his/her health. In the analysis, interpretation and reconstruction of argumentative discourse in the medical consultation, the theory of pragma-dialectics provides a resourceful tool which has been applied in exploring both the descriptive and normative aspects or argumentation in other domains (Labrie & Schulz, 2014: 1002).

Arguing in support of conversation analysis as an approach to analysing doctor patient interactions, a study examined excerpts of American and Finnish consultations focusing on how doctors exploit argumentation in justifying their diagnostic procedures (Drew, Chatwin & Collins, 2001). The study concluded that the approach provides the analyst a chance to understand the doctor's choices in the medical consultation and their effect on the interaction in the medical consultation (Drew *et al.*, 2001: 69). The study emphasised that an open presentation of the supporting evidence of the doctor's decisions regarding the treatment and consultation process will empower the patients and encourage them to contribute substantively in the consultations for better healthcare outcomes.

Other researchers have supported the conversational analytical approach to analysing doctor-patient communication (Perakyla, 1997; Jackson, 2012).

In addition, an examination of doctor-patient interaction using rhetorical and narrative approaches reveals the logical ways employed by patients when trying to present their state of health cases to the doctors and seeking care (Segal, 1994, 2007; Knight & Sweeney, 2007). The doctor, on the other hand, always purposes to convince the patient on the medical advice he/she gives concerning treatment or medication. In emphasising the role of rhetoric analysis or accounts in the medical consultation, one ought not to look at it as a rival of biomedical evidence rather one needs to look at illness in its entirety as argumentation (Segal, 2007: 240).

Philosophical and legal aspects of the decision-making models used in the medical consultation been deemed patient-centred have received criticism. Despite their patient-centred approach, informed decision-making, SDM and interpretative decision-making, Wirtz, Cribb, and Barber (2006) have pointed out the weakness of these contemporary models of decision-making in the doctor-patient consultation as missing a reasoning element. A reawakening to policy makers in healthcare to reengineer the doctor-patient relationship and re-evaluate the SDM ideal which does not necessarily take the centredness to the patient without any accountability of their choices while allowing the doctor (professional) on his/her own will try to solve the problem (Wirtz *et al.*, 2006: 122–123).

However, the SDM model has received a lot of attention and enhancement to give the two parties a fair chance of engagement (Sandman & Munthe, 2010). Despite the enhancement of the model and appreciation by pragma-dialectical researchers (Henselmans & van Laarhoven, 2018; Labrie, 2012; Pilgram & Snoeck Henkemans, 2018; Snoeck Henkemans & Mohammed, 2012; Snoeck Henkemans, 2011; Zanini & Rubinelli, 2012), who have looked at the parallelism between the SDM and the critical discussion process, insights of argumentation have not received the medical attention they deserve among the practitioners (Labrie, 2013: 51; Labrie & Schulz, 2014: 1005). Appreciating the normative and descriptive dimensions of the critical discussion employed in the pragma-dialectical theory, Labrie (2013) acknowledges the importance of argumentation not just to the medical research but also in other professional domains. While acknowledging that the objectives or analysing the discourse of doctor-patient communication from the perspectives of argumentation theory, medical informatics, discourse analysis and medical ethics will differ, there

is consensus that the discourse ought to be patient-centred and rational (Labrie & Schulz, 2014: 1005).

Whereas most of the literature on the argumentative discourse of doctor-patient communication exploits qualitative approach, the motivation for any meaningful research in argumentation ought to be the ability to exploit the insights gained in the argumentation research in the contemporary argumentative reality of the medical consultation grounded in a strong methodological foundation (Labrie, 2013: 55–56). This motivates the next aspect of the review which examines the strategic argumentative moves of general practitioners in establishing common ground for the initiation of the process of treatment decision-making employing qualitative research methods. In the study Labrie explores the need of having dialectical profiles in the opening stage of the critical discussion to aid in the strategic manoeuvring process to resolve the difference of opinion. Procedural starting points should be distinguished as the norms or rules which dictate the conduct of a communicative activity type such as the institutional preconditions, while material starting points are the situational premises upon which discussants build their cases in the discussion (van Eemeren, 2010). This distinction and a clear agreement on some of the starting points facilitates the process of the opening of the critical discussion (Labrie, 2013: 73).

The starting points can include values (institutional or personal), norms, truths, facts, facts, suppositions or value hierarchies (Labrie, 2013: 74). Establishing these is tantamount to creating dialectical profiles especially if the discussants can establish the common points of disagreement (van Eemeren and Grootendorst, 1992). Dialectical profiles help to point out dialectical moves which may be relevant in the opening stage of the critical discussion. Establishing these is an advantage to the discussants as they can identify the opportunities for argumentative manoeuvring for their pragma-dialectical benefit in the discussion. Using the dialectical profile as an analytical tool, Labrie (2013) proposes the use of a favourable proposition which has a rhetorical role while the shared starting point has the dialectical role in the strategic manoeuvring.

In characterising the argumentative activity type of the medical consultation, the study explores use of the observational content analysis in unpacking the linkage between the communicative contextual features of the general patient consultation and the general physicians (GPs). Labrie's study explores the advantages of the quantitative method of observational content analysis in investigating argumentation within the context of the GP consultation. Using a randomised-

controlled experiment, Labrie (2013) demonstrates the connection between the provisions for reasonable argumentation of the GPs in supporting their medical advice and the GP consultation outcomes. Whereas Labrie (2013) focuses on the strategic manoeuvring in the doctor-patient communication, her study predominantly has its focal point as the doctor in the medical consultation. The current study examines the strategic manoeuvres employed by both the doctor and the patient in the argumentative context on the medical consultation communicative activity type. Worth noting is the methodological choice of observational content analysis as a quantitative method for analysing the causality between the requirements of reasonable argumentation and the outcome of the consultation. The present study employs a qualitative research design in the analysis of transcripts of audio recorded data from doctor-patient consultation simulations in a public hospital setting. In terms of the theoretical framework the present study employs the extended pragma-dialectical theory of argumentation while incorporating communication accommodation and appraisal theories in unravelling the process of strategic manoeuvring in the dual institutional interaction peculiarities of the discourse of Gusii doctor-Gusii patient consultation.

Other studies dedicated to argumentation in the healthcare provision within the medical domain analyse medical advertisements (Wierda & Visser, 2012; DeLeon-dowd, 2017; Henkemans, 2017). One such a study dedicated to the pragma-dialectical analysis of authority argumentation in direct to consumer (DTC) medical advertisements has underscored the hybridity[18] in the communicative activity type (Wierda, 2015). The communicative activity type of DTC medical advertisements presents a communicative activity which involves the promotion of a medical product and a medical consultation on how the patient's health problem can be resolved by that medicinal product. Such a communicative activity type is said to have a composite institutional point aiming to achieve the two aims of promotion and consultation (Wierda, 2015: 32). Although the present study is limited to the medical consultation, the idea of hybridity in the DTC medical advertisement communicative activity type manifests itself in the Gusii medical consultation consisting the genres of consultation and persuation (see section 6.5.1 of Chapter 6).

[18] See van Eemeren (2010, pp. 174-187) on hybridity in advertorials.

2.4.2 Strategic manoeuvring the medical consultation

The medical consultation presents a typical communictive activity type where argumentation must be carried out in accordance to the set institutionalised preconditions. These legal guidelines govern the process of strategic manoeuvring to realise the institutional point of the medical consultation. Pilgram (2015) analyses the preconditions which make it possible for the discussants to strategically manoeuvre during argumentation in the doctor-patient consultation, having characterised the communicative activity type. The extended pragma-dialectical theory of argumentation (van Eemeren, 2010: 152-158) presents a matrix of four preconditions which are applicable to the argumentative activity types. These include the initial situation of the activity type, the starting points, the means of argumentation available in the communicative activity type and the possible outcomes.

The preconditions are in line with the four stanges of the ideal model of a critical discussion in which the strategic manoeuvring occurs. First, the manifestation of a difference of opinion regarding a diagnosis, medical advice, a treatment or medication recommendation demonstrated by some form of hesitation by the patient. The difference of opinion can mean that the patient is opposed to the doctor's position or it can be implicit in the discourse. Secondly, the starting points of the medical consultation presents the doctor as the leader of the discussion thus he/she exerts a lot of influence in determining the direction of the argumentation to resolve the lack of consensus is dealt with.

On the same notch, argumentation in the medical interview is also determined by procedural and material starting points. van Eemeren and Grootendorst (2004: 60) distinguish material and procedural starting points in the opening stage of the critical discussion. The discussion rules and regulations together with the division of the burden of proof constitute the procedural starting points. These procedural starting points can be implicit such as the unwritten rule that the doctor taking a leading role in the consultation and his obligation to get the patient to agree with his advice or decisions. On the contrary, explicit procedural starting points include the legal aspects of conducting medical consultations, which are enshrined in the law. Such requirements as evidence-based medicine and informed consent entail institutional preconditions of strategic manoeuvring in the communicative activity type of the medical consultation. The elected argument schemes and other presentational devices which the interactants may employ in their argumentation constitute

the material starting points. Some starting points may not be established during the consultation for instance medical discoveries being introduced by the doctor to the patient regarding his/her health problem (Pilgram, 2015: 22).

Thirdly, the argumentative means of the doctor and patient in defending their standpoints can be internal or external to the set material starting points. More specifically, the doctor and patient may present argumentation presented by the doctor and the patient must be reliant on the understanding of concessions based in biomedical evidence. Finally, the way forward on the patient's health problem is the aftermath of the argumentation process. This point of the discussion involves an agreement on the state of the illness of the patient by both parties and in a shared decision they decide how to proceed. The patient can at this point decide on whether to seek a second opinion if the patient was just seeking advice based on the shared agreement they already achieved with the doctor or proceed with the treatment process (Pilgram, 2015: 24).

In a study by on how informed consent has revolutionalised strategic manoeuvring in the medical consultation, Schulz and Rubinelli (2015b) have tried to integrate the traditional approaches to studying the medical consultation with the pragma dialectical approach of argumentation theory. Exploiting argumentation in the medical consultation, they conceptualise the doctor patient encounters as an info-suasive dialogue which relies on the precondition of informed consent. The article also explores the inherent challenges of not reconciliating the rhetorical and dialectical facets of the doctor's information due to the asymmetrical nature of the encounters in terms of status. Research into the institutional preconditions governing the SDM process in resolving differences of opinion in the medical consultation communicative activity type (Henselmans & van Laarhoven, 2018; Pilgram & Snoeck Henkemans, 2018; Snoeck Henkemans & Mohammed, 2012) has seen the SDM process transformed from the information seeking to an info-suasive dialogue (Schulz & Rubinelli, 2015b: 484). The information given by the doctor to the patient in compliance with the institutional precondition of informed consent normally involves a persuasive appeal to the patient about his/her medical condition which he may or may not be having based on the doctor's examination. The present study is, however, not limited to the precondition of informed consent but other preconditions of strategic manoeuvring that add to the ethical ideal such as evidence-based medicine and PCC are considered in the pragma-dialectical resolution of the differences of opinion. This is in addition to the considerations of communication

accommodation and evaluative language use in the choice of presentational devices when strategically manoeuvring.

2.4.3 Authority in the doctor's argumentation in the medical consultation

In a typical medical consultation, the doctor is expected to provide professional advice about his/her assessment of a patient's health concern. To this end, the doctor, who is the leader of the consultation usually endeavours to offer the patient a diagnosis, treatment advice or a prognosis according to the insights he draws from the consultation or after a physical examination of the medical condition of the patient (Pilgram 2015:11). It is not always the case that the patient will agree with the doctor's diagnosis or treatment advice or even prognosis. Nevertheless, the doctor will always try to exhibit his technical and professional training in communication skills and experience in handling patients to try and convince the patient on a preferred treatment decision or advice. Based on the institutional operational procedures, the doctor will at times provide a referral to another medical expert in the same hospital or another on how to go about remedying the medical concern of the patient (Pilgram 2015:11). As a rule, consensus building, between the doctor and the patient, during and up to the end of the consultation is imperative.

Pilgram (2015) points out that patients can either express opposition to doctor's proposed treatment advice or simply express doubt in their standpoint (11). This scenario provides an opportunity for the doctor to exploit his medical expertise and knowhow to try and effectively convince the patient into accepting the proposed advice. In the pragma-dialectical theory of argumentation (van Eemeren and Grotendorst, 1984, 1992, 2004) the doctor and the patient find themselves in a situation where they must engage in an argumentative discussion during the medical consultation. This discussion is a unique discussion because it is a doctor-patient communicative activity type, which operates in the institutional preconditions of the medical domain of argumentative discourse. The doctor's strategic exploitation of one of his or her argumentation schemes facilitates the discussion towards resolving the difference in opinion. One such means at the doctor's disposal is an argument from authority in which the medical professional appeals to his technical knowledge and expertise to signal the acceptability of his professional advice (Pilgram, 2015:11).

The argument from authority assists the doctor not to just convince the patient about his judgment or medical advice but also assert his authority in the medical consultation (Pilgram, 2008, 2012).

The mere fact that the patient comes to the consultation room to seek treatment is a sign of the patient ascribing to the authority of the doctor. Any advice or recommendation by the doctor is treated with the importance it deserves because the patient understands the technical role of the doctor in the medical consultation. At the end of the day, the patient expects a favorable health outcome from the consultation - o resolve his/her medical condition by suggesting a treatment or a way forward. In pragma-dialectical terms, the exploitation of the argument from authority is a strategic manoeuvre (van Eemeren, 2010:40) in the sense that it is not just a reasonable means of resolving a difference in opinion in the decision-making process, but it has its way of making sure the patient accepts the doctor's recommended medical counsel or treatment choice. The use of the argument from authority by the doctor is a strategic manoeuvre thus because by this move, the doctor aims at resolving the difference in opinion reasonably and effectively. The present study explores the strategic role of the authority in the docto's argumentation with insights into the patient's use of authority argumentation in the process of resolving differences of opinion in the Gusii medical consultation.

2.4.4 Patterns of argumentation in the medical discourse

Research in pragma-dialectics has embarked on a stage where the study of argumentation focuses on the stereotypical patterns of argumentation in the legal, medical, political and academic domain (Akkermans, Snoeck Henkemans, Labrie, Henselmans & van Laarhoven, 2018; Feteris, 2016, 2016; Garssen, 2016, 2017; Kunneman, Gärtner, Hargraves & Montori, 2018; Snoeck Henkemans, 2016, 2017, 2017a, 2017b; Wagemans, 2016). The medical domain has seen pragma-dialecticians explore the prototypical patterns of argumentation in general doctor-patient consultations and those which occur in over-the-counter medical advertisements (Snoeck Henkemans 2016, 2017, 2017a, 2017b). A substantive amount of literature takes into consideration the role of institutional preconditions of contemporary medical practice and the institutional constraints governing the local social cultural belief system regarding the illness and use medicine and affiliated beliefs. Argumentation moves occur in the strategic manoeuvring of arguers in the argumentative reality.

The argumentative reality of medical discourse may involve a wide range of scenarios. It may include the very basic doctor-patient consultations, consultations between the medical professionals, which can mean a team of consultants engaged in a critical discussion or simply between a doctor and a nurse in the treatment room, a consultation between a doctor, patient and

a caregiver, and the language use in over-the-counter advertisements. Contemporary studies of strategic manoeuvring take an empirical approach with the focus of argumentation in context (Akkermans *et al.*, 2018; Pan, Chen & Ju, 2018; Snoeck Henkemans 2016, 2017). The study of how doctors and their patients aim to achieve both effectiveness while remaining reasonable by use of sound argument schemes is examined under the institutional restrictions which constrain the practice of such a communicative activity type. Therefore, the pragma-dialectic analyst examines the different ways of strategic manoeuvring in the doctor-patient consultation communicative activity type as consequences the institutional preconditioning of the argumentative discourse.

In the doctor-patient communicative activity type, Pan, Chen and Ju (2018) have carried out an investigation on the argumentative discourse of Chinese medical consultations. The primary object of this study in the medical communicative genre is to identify the prototypical argumentative patterns the Chinese medical consultation. Of great consideration to the study is the preference of the principal partners in the consultations in terms of drugs, treatments or cultural belief systems and fork wisdom on the understanding of illness of medical procedures. This consideration in the analysis complements the institutional preconditions of the medical consultation (Pan, Chen & Ju, 2018:37).

The study of the prototypical argumentative patterns of the Chinese consultation, which forms part of the minimal literature by argumentation theory scholars in the medical domain in non-western settings. From the study, however, the realisation of the composite institutional point in the Chinese medical consultation communicative activity type presents a hybrid of genres of promotion and consultation (Pan *et al.*, 2018: 39). The present study explores a macro contextual setting with a composite institutional point because of the complexity in the two institutional systems involved in the Gusii consultation: the traditional Gusii sociocultural belief concerning illness system and that of contemporary medicine.

2.5 Accomodation in doctor-patient communication

Resources of communication accommodation have been applied in the study of medical consultations by a number of scholars (Street, 1991; Hewett, Watson, Gallois, Ward & Leggett, 2009; Hewett, Watson & Gallois, 2015; Bylund, Peterson & Cameron, 2012; Farzadnia & Giles,

2015; Agostino & Bylund, 2017; Basweti, 2018a, 2018b). The studies explore the various aspects of the medical consultation. The interpersonal communication accommodation between the doctor and the patient is an ingredient of beneficial healthcare outcomes in the encounters. Different writers have interrogated communication accommodation in the medical consultation. Substantive emphasis on the interpersonal communication in the doctor-patient consultation is essential in healthcare delivery because of the significance of talk and the affective aspect in the exchange of information and ascertaining understanding between the interlocutors in the encounter (Street, 1991: 131).

Giles, Bonilla & Speer (2012) addressing immigrant groups have extrapolated the issue of intergroup contact, communication accommodation and group vitality in applied and theoretical cultural research studies. Intergroup contact brings about a convergence of linguistic and cultural differences which usually is a recipe for "miscommunications, misattributions and misunderstandings" Giles, Bonilla & Speer (2012: 244). This mostly happens when the in and out groups is view each other either as outsiders versus insiders or us versus them simply because either group is presumed to be trying to challenge either the status quo or the veracity of the system (Dandy and Pe-Pua 2010). In the present study the doctors and the patients represent the ingroup and outgroups influencing the levels of accommodation between the institutional systems whose preconditions have to be adhered to for the realisation of the composite institutional points.

An exploratory study has analysed the nonverbal accommodation in oncology medical consultations (Agostino & Bylund, 2017). Using the Nonverbal Accommodation Analysis System (NAAS) the study analysed the nonverbal communication behaviour in 45 specialist consultations between doctors and cancer patients. The findings of the study reveal the joint convergence between doctors and patients rated higher with asymmetrical patient convergence following closely. Asymmetrical physician convergence was characterised with laughter, eye contact and gesticulations. The study findings emphasise the importance of communication accommodation in the healthcare provision of patient-centred healthcare (Agostino & Bylund, 2017: 572). Patient-centered care has a lot to benefit from a healthcare system which realises the importance of accommodation behaviour (Agostino & Bylund, 2017: 565).

Whereas the theory of CAT has been applied in a variety of interpersonal settings to understand the role of communication accommodation, literature reveals little to show on the critical role of

accommodation in medical interactions and the resultant impact on the outcomes of patient-centered care (Agostino & Bylund, 2017: 572). The present study serves to contribute to the exixting literature on accommodation in doctor-patient communication in healthcare settings involving HIV and AIDS, diabetes and cancer.

2.6 Appraisal in doctor-patient communication

A search through the literature does not reveal much of the use of evaluative resources of appraisal theory in the medical consultation. The search reveals that attitudinal assessments in doctor-patient communication is limited to the perceptions of satisfaction in the medical encounters (Agostino & Bylund, Blodt *et al*., 2018; 2017 Norfolk, Birdi & Walsh, 2007; Street, O'Malley, Cooper & Haidet, 2008.). In the medical domain, however a qualitative study in Latin America has employed the appraisal theoretical resources in understanding the perceptions of doctors about their health and medical practice (Gallardo & Ferrari, 2010). It is in the interest of the present study to note that the setting of the study was a Spanish speaking community. The study corpus of the Gullardo and Ferrari research involved texts obtained from discussions with doctors about their health and the professional practice of medicine. The study objectives targeted an attitudinal assessment of the working conditions in terms of the risk involved to own health; an assessment of their professional practice of medicine; the positive and negative evaluation of the discussions held at workplace; the object of evaluation in the discussions; and the evaluation of the party responsible for the prevailing situation from patients to colleagues to the healthcare system.

Using the semantic attitudinal parameters of judgement, affect and appreciation, the analysis revealed a negative attitude of the medical professionals' assessments in all the parameters. The findings also revealed that the professionals' negative judgements of social esteem and social sanctions of their personal health and the healthcare system, respectively. The medical professionals also evaluated their profession as challenging and distressful in terms of engagement but the expressions they used indicated that they never had a problem with that because their target audience probably understood the situation well (Gallardo & Ferrari, 2010: 3184–3186). Apart from proofing that the appraisal framework provides useful resources for atitudinal evaluations within the medical settings, the study was an intragroup assessment. The current study which explores the use of the appraisal resources (see subsection 3.3 of Chapter 3) in the assessment of the doctor-patient strategic choices of linguistic resources in argumentation presents both an

intergroup and intragroup evaluation (see subsection 4.3 of Chapter 4, subsection 5.4 of Chapter 5, and subsection 6.3 of Chapter 6). The attitudes of the Gusii patients about Gusii Doctors based on their strategic manoeuvres present atypical intragroup and intergroup evaluative setting. The common denominator of Gusii sociocultural background makes it an intragroup assessment and the layman/women versus medical professional qualifies the evaluation to take an intergroup evaluation.

2.7 Summary

This chapter has reviewed relevant studies and contributions, which reinforce an understanding of the argumentative context of the medical consultation. The review has explored various elements of the medical consultation discourse, which in effect, justify the growing interest in the study of argumentation in the context of doctor-patient communication. Through the exploration of traditional and complementary medicine and narrative-based medicine as some of the issues gaining attention of medical researchers due to their influence on the discourse of the medical interview has helped a foundation for understanding of some of the gaps that the current study intends to fill. The chapter analyses some of the studies, which have been carried out in the medical domain using argumentation theory indicating the contribution and how the present study interacts with them. Lastly, the chapter has provided insights into the application of appraisal and communication accommodation theories in the medical context as a way of indicting the relevance and significance of the aspects of the theories which the current pragma-dialectical theory-based empirical study incorporates. The next chapter carries an indepth exploration of theoretical literature of the three theories that guide the analysis of the data for the study.

CHAPTER THREE

THEORETICAL LITERATURE REVIEW

3.1 Introduction

This chapter explores a literature review of the theoretical framework of the study to augment the survey of literature explored in Chapter 2. The chapter examines both the main theoretical framework of the study, which is the pragma-dialectical theory of argumentation, and the complementing theories: appraisal theory and communication accommodation theory. Whereas the main theory squarely provides the principles and tools of investigation for the study of argumentation in the medical domain, the supportive theories are useful in handling the intricate issues of strategic manoeuvring in the Gusii medical consultation which benefit the main theoretical framework. The chapter thus explores the key aspects of the theories mapping out the elements of the supporting theories which are relevant to the present study. The review explores the possibilities of integrating some of the aspects of communication accommodation and appraisal in the pragma-dialectical framework of argumentation in the medical consultation.

3.2 Background to the pragma-dialectical theory of argumentation

The theory of pragma-dialectics was developed by Frans van Eemeren and Rob Grootendorst in the 1970s. Using the communicative aspect of the pragmatic circumstance of the speech act theory, and the rational criticism that guide dialectical aspects of discourse analysis, argumentation is defined as "a verbal, social and rational activity aimed at convincing a reasonable critic of the acceptability of a standpoint by putting forward a constellation of prepositions justifying or refuting the proposition expressed in the standpoint" (van Eemeren & Grootendorst, 2004:1). Pragma dialectical theory of argumentation was a culmination of the desire to account for the production, analysis and evaluation of argumentation which is part and parcel of everyday communication whether it is oral or written.

The importance of argumentation led van Eemeren and Grootendorst to come up with the theoretical framework in which they could progressively demonstrate how to improve the abstract ideal of argumentation to deal with the empirical reality of argumentation discourse. The two leading theorists of the theory conceived the multidisciplinary approach to the development of

argumentation theory. Building on insights from logic, philosophy, linguistics, communication and psychology, van Eemeren and Grootendorst carefully and systematically to set up a framework which enjoined critical normativity and pragmatic description (van Eemeren *et al*., 2014: 518). The theoretical and philosophical account of argumentation theory by van Eemeren and Grootendorst in *Speech Acts in Argumentation Theory* in 1984 lay a foundation for their development of a model for evaluation and analysis of argumentation in *Argumentation, Communication, and Fallacies* (1992a). Later, in 1993, working with Sally Jackson and Scott Jacobs, the proponents produced a monograph: *Reconstructing Argumentative Discourse* which showcased the pragma dialectical theoretical application on argumentative discourse in its contextual sense.

Despite the death of Rob Grootendorst, van Eemeren went ahead to further publish more texts with him. The first one, *Argumentation: Analysis, Evaluation & Presentation* delves into the pragma dialectic rigour of analysis, evaluation and presentation of argumentation with of selected real-life examples (van Eemeren, Grootendorst & Henkemans, 2002). The other one, *A Systematic Theory of Argumentation, the Pragma-Dialectic Approach* provides an overview of the three decades of the development of the pragma dialectical theoretical framework for analysing argumentative discourse jointly conceptualised and developed by the two argumentation theorists (van Eemeren & Grootendorst).

Ground-breaking qualitative and quantitative empirical studies have greatly contributed to the momentum of the development the pragma dialectical theory of argumentation. Partnering with Peter Houtloser and Francisca Snoeck Henkems, van Eemeren published *Argumentative Indicators in Discourse* after an empirical qualitative research on argumentation reality (van Eemeren, Houtloser & Henkemans, 2007). On the same breath, *Fallacies and Judgements of Reasonableness* is culmination of a qualitative experimental research on the acceptability or pragma dialectical standards of determining the reasonableness of argumentative discourse (van Eemeren, Garssen & Meuffels, 2009).

The process of the advancement of the pragma dialectical theory saw the introduction of a strategic component to argumentation by the work of van Eemeren and Peter Houtloser. This component revolutionised the theoretical framework to become the extended pragma dialectical theory in which interactants employ strategic manoeuvring in argumentative discourse by aiming for

rhetorical effectiveness while at they remain dialectically reasonable. The publication of *Dissociation in Argumentative Discussions* (van Rees, 2009) and *Strategic Maneuvering in Argumentative Discourse* (van Eemeren, 2010) pioneered the critical role of the notion of strategic manoeuvring in different communicative domains of argumentative discourse. Further research on the extended pragma-dialectic research was now focused on the different communicative domains of argumentation which included the medical, legal, academic and political domains.

3.2.1 The research program of normative pragmatics

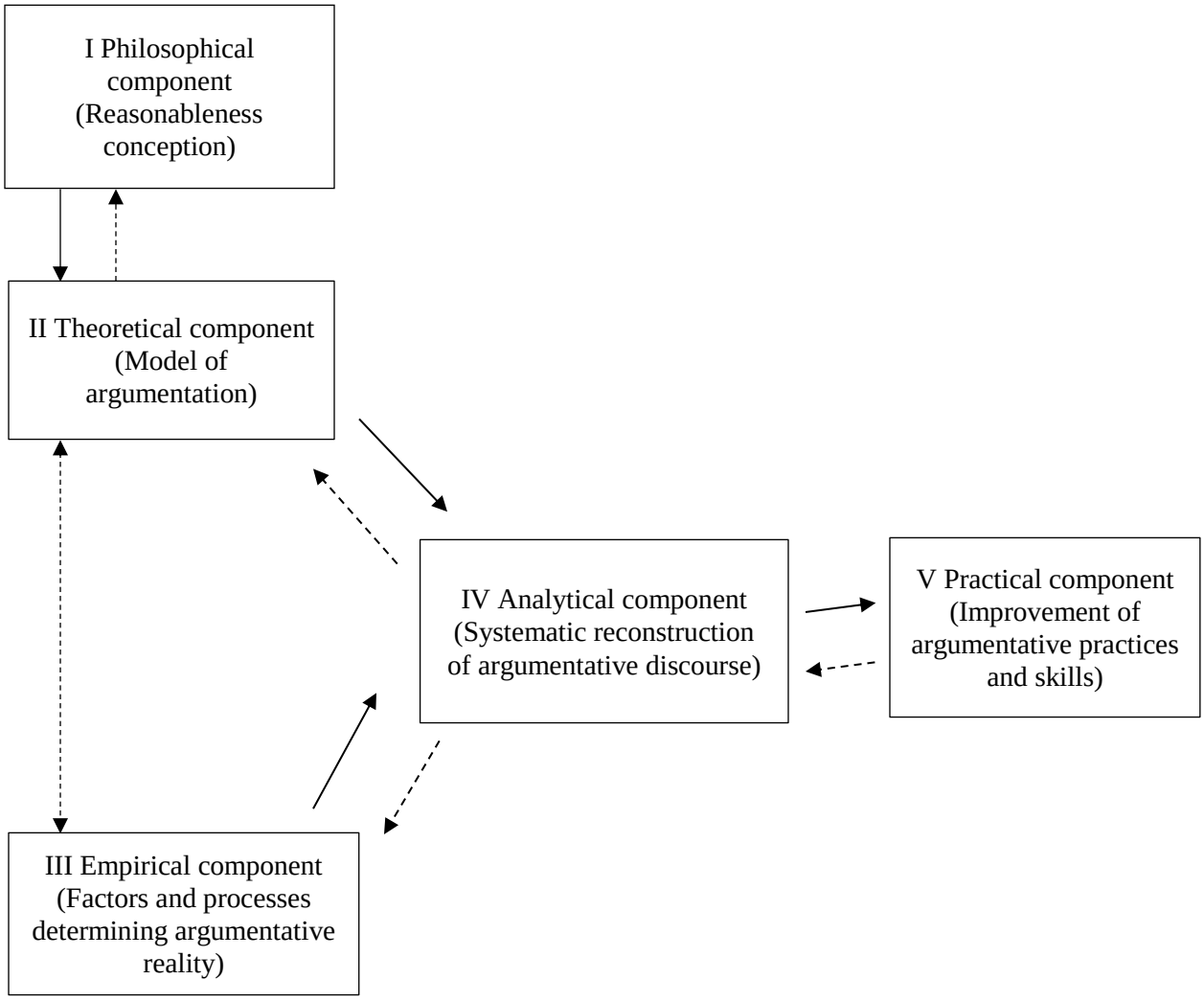


Figure 3.1 Components of the research program of argumentative theory (van Eemeren et al. 2014: 10)

Normative pragmatics was conceived by van Eemeren (1986, 1990) as an argumentative program which contextualised the social event where differences of opinion between a protagonist of a standpoint and an antagonist are resolved on merits. In this program, pragmatics entails the study of argumentative discourse as a communicative event or product of interaction between two parties. Building on this view, the resolving of differences of opinion on merits and reasonably so to the eyes of a critic forms part and parcel of dialectic which entails the study of regimented dialogues.

In the pragma-dialectical theory of argumentation, van Eemeren and Grootendorst systematically link descriptive pragmatics and normative dialectics in argumentative discourse. In linking the two, an understanding of the comprehensive research program or argumentative theory comprising of five interrelated components (van Eemeren & Grootendorst, 2004: 9-11; Van Eemeren *et al.*, 2014: 520-523) illustrated in *Figure 3.1* above is necessary.

The interconnections of the five components are centred at the analytical component as the focal point for its role in providing the parameters for integrating the descriptive pragmatic dimension and the normative dialectical dimension of argumentative discourse. Reasonableness in argumentative discourse is a reserve of the philosophical component. In trying to determine what qualifies to be reasonable, Toulmin (1976) distinguishes three conceptions: anthropological, geometric and critical reasonableness. An anthropological conception of reasonableness is one whose starting point is considered reasonable by the speech community. If argumentation is founded on indisputable basis and presented in a logical manner, then this is regarded as geometric reasonableness. Critical reasonableness, on the contrary is one where argumentation id justified by testing the acceptability of all argumentative moves systematically. Whereas rhetoricians adopt the anthropological thinking for its rhetorical role in persuasive argumentative discourse, dialecticians prefer the critical thinking which allows for the testing of standpoint acceptability based on a set of rules of procedure for a dialectical discussion (van Eemeren *et al*., 2014: 10-11). Pragma-dialectics takes a critical rationalist philosophical orientation where reasonableness is credited to the resolving of differences of opinions on merits methodologically by subjecting standpoints at issue to a regimented critical discussion using regulated procedures (van Eemeren & Grootendorst, 1984; 1994).

The second component is the theoretical component which hosts the model of critical discussion (van Eemeren, 1984; 2004). The model is a conceptual framework for argumentative discourse which qualifies the philosophical standard of reasonableness by specifying the various stages of resolving a difference in opinion on merits. The theoretical model brings out the argumentative moves in speech acts under a set of rules which outline the soundness conditions which need to be observed in the argumentation process. The communicative nature of the argumentative interactions which take a critical discussion procedure qualify the model to be referred to as a pragma dialectic framework with "heuristic, analytic, and critical functions" (van Eemeren *et al*., 2014: 521) in analysing and evaluating argumentative discourse synchronically.

On a related note, the empirical component examines the real-life occurrence, interpretation and evaluation of argumentative discourse in different contexts. The process is motivated by factors which are relevant to the model of critical discussion in the theoretical component. Through qualitative and quantitative empirical research, an argumentative discourse analyst can capture unique characteristics of argumentative discourse and/or test positions associated with how the discourse is presented, interpreted or evaluated respectively. Pragma dialectically, qualitative research precedes quantitative research mainly to give better insight on how interactants resolve differences in opinion on merits in the augmentative reality.

The focal point of the research program is the analytical component which is responsible for reconstructing argumentative discourse by linking the argumentative ideal in the theoretical model with the argumentative reality in pragma-dialectical research terms (van Eemeren & Grootendorst, 1990;1992a; van Eemeren *et al*. 1993). The argumentative reality of the pragmatic exchange of actual argumentative moves is dialectically aimed at the resolving of differences in opinion systematically using the theoretical model of critical discussion. While carrying out any analytical reconstruction, focus is given to the argumentative moves which are crucial to the resolution of the difference in opinion on merits (van Eemeren *et al*., 2014: 522). The final component is the practical component which is an evaluative and reflective component of the research program. It centres on the productive, analytic and evaluative skills requisite for argumentative competence of interactants. By focusing on the nature of the moves by arguers in a variety of contexts of argumentative reality and how it differs from the theoretical ideal, practical interventions for

review of specific pragma dialectic evaluative, analytic and productive competence of arguers (van Eemeren *et al.*, 1993; van Eemeren *et al.*, 2002a).

3.2.2 Meta theoretical starting points

Argumentation in pragma dialectics is founded on four premises on which the actual theorising is anchored. These premises influence the methodological orientation of the theorising in pragma-dialectical argumentation. In a set of four meta-theoretical starting points, these premises define the process of integrating the aiming which is innate in the pragmatic and dialectic dimensions of the argumentation theory. To achieve this integration in regimented critical argumentative interaction, the discourse ought to undergo *functionalisation, socialisation, externalisation* and *dialectification* (van Eemeren & Grootendorst, 1984).

As a meta-theoretical starting point, *functionalisation* assists pragma-dialecticians to assess how language use or speech acts are employed to perform specific communicative purposes during interaction (van Eemeren *et al*., 2014: 524). The very purpose for argumentation will deliberately come up with argumentative moves and lines of justification so that they can achieve their purpose of resolving a difference in opinion by managing the disagreement space (Jackson, 1992: 261). Functionalisation can be realised by exploring the performance of speech acts in the pragmatic context of argumentative discourse. By identifying how speech acts create a difference in opinion, equivalent standpoints at issue can also be identified from which the interactional and communicative functions of the resultant speech act aimed at coming up with a resolution can be ascertained (van Eemeren *et al*., 2014: 524). The identity conditions and correctness conditions of the identified functions of the speech acts can then qualify the argumentative moves made in the discourse (van Eemeren & Grootendorst, 1992: 30-31). This view makes pragma dialectics move away from formal and informal approaches to logic which rely heavily on logical influences or derivations without apportioning a functional role in the argumentative discourse (see also Fisher, 2004).

The second meta-theoretical starting point *socialisation*. This starting point is begged on the premise that argumentation occurs in an overt or covert communicative context where two or more parties will have differences in opinion and make deliberate efforts to resolve it. It does appreciate the fact that argumentation is part of a dialogic exchange where there will be standpoints put forth by both the ‘antagonist’ and ‘protagonist’ in their roles as opponents and proponents of claims and

counterclaims presented methodically to try and resolve the differences in opinion just like in formal dialectic (cf Barth & Krabbe, 1982). Indeed, pragma-dialectics borrows from dialogue theory and discourse analysis to acknowledge the need of socialisation when handling the subject matter of argumentation. The socialised approach to argumentation which emphasises its cooperative communicative and interactional roles of discussants and how they generate argumentative moves is a deviation from the product-oriented approach to argumentation which articulated the epistemic function of justifying standpoints as products of individual thought processes to establish truth in statements (Johnson, 2003: 48).

Thirdly, *externalisation*, a meta-theoretical starting point built on speech act theory, implies that parties involved in an interactive exchange are committed and accountable to their expressions within the discourse. The commitments are externalised based on the implications, implicatures and suppositions of the communicative activities of the interacting parties in the discourse, what they are saying and with the assumptions understood in the discourse. In characterising, argumentative commitments, speech acts which denote disagreeing or accepting can be externalised either as an opposing critical discussion or providing a favourable response to an arguable act (van Eemeren *et al*., 2014: 526). Externalisation moves away from the non-externalising and psychologising school of argumentation which was interested in the rhetorical appeal to the feelings of the arguers and their audiences. With this starting point, arguers present standpoints implicitly or explicitly for others or the public to scrutinise that way being held accountable to the commitments they externalise.

Finally, *dialectification* is a pragma-dialectic meta-theoretical starting point which requires a normative approach with the 'etic' perspective to the critical assessment of the resolving of differences in opinion in argumentative discourse. This moves away from the 'emic' perspective employed in descriptive approaches embraced by new rhetoricians, conversational and discourse analysts (van Eemeren, 2010: 137-138). With dialectification, pragma dialecticians ensure that argumentation is part of the critical testing process where standpoints at issue are subjected to a well-regulated critical discussion while maintaining standards of reasonableness in the resolution of differences in opinion on merits. This critical testing of standpoints has insights from the 'critical rationalist' model of reasonableness (Popper, 1972; 1974). As per the dialectical procedure of critical discussion, the quality of argumentative moves, is guided by the objective validity of the

rules – in resolving the difference in opinion- and intersubjective validity- in a conventionally acceptable manner to the interactants (Barth & Krabbe, 1982: 21-22; Van Eemeren *et al*., 2014: 3.7&3.9)

3.2.3 The model of critical discussion

The pragma dialectical theory of argumentation aims to resolve a difference of opinion on merits in argumentative discourse. At the heart of this theory is an ideal model of critical discussion which distinguishes the key stages of resolving a difference in opinion with their equivalent speech acts. A critical discussion is in the pragma dialectical approach an avenue to reasonably subject standpoints and value judgements to an acceptability testing process. The discussion is imbued with critical rationalist (see Albert, 1975: 44) understanding of the dialectical ideal of reasonably resolving differences in opinion. Beginning from common starting points the parties try to establish some form of consensus by testing the acceptability and tenacity of the standpoints at issue to arrive at a resolution at the end. This resolution in argumentative discourse means that there is agreement between the interactants "on whether or not the standpoint at issue is acceptable" (van Eemeren *et al*., 2014: 528).

The model of critical discussion in a pragma-dialectical sense reflects theoretical idealisation of the process of systematically resolving a difference in opinion on merits through argumentation. As a critical tool of reflecting upon argumentative discourse, the model indicates the points of reference in analysing, evaluating and producing oral or written discourse. This way the pragma dialectic model assists in analysis of the production of argumentative discourse as a 'heuristic and analytical' tool and in reconstructing discourse and determining roles of various speech acts towards practically ascertaining how to improve argumentative practices. van Eemeren & Houtlosser (2015: 115-156) points out that the process of resolving the difference in opinion should not be equated to resolving a dispute but a process which involves the parties involved agreeing on whether a disputed standpoint is acceptable. The model of critical discussion has four distinct stages through which argumentative discourse must go through in the process of resolving a difference in opinion reasonably. The stages are: the "*confrontation*", "*opening*", "*argumentative*" and "*concluding*" stages. In the argumentative reality, the discourse may not be out rightly organised in the order of the stages in the model.

The *confrontation stage* is the point where a difference in opinion occurs initiating a critical discussion between two parties. The difference in opinion can manifest itself through some doubt or unacceptance of the standpoints by one of the interactants (van Eemeren, 2002a, Chap 1). On its part, the *opening stage* of the critical discussion is a point in the discussion where the interactants assume their discussion roles either as protagonists or antagonists of the standpoints at issue. In terms of the commitments for these roles, the protagonist is obligated to defend the standpoints while the antagonist undertakes the obligation to critically interrogate to the protagonist's defense of the standpoints. In the discourse, itself, the common starting points for the parties involved in the discussion are manifest at this stage. The third stage in the model of critical discussion, and perhaps the most crucial, is the argumentation stage. In this stage, the protagonist and the antagonist engage each other in defending the standpoints at issue and counter argumentation ensues respectively. The protagonist wages more multiple, subordinatively and coordinatively compound argumentation depending on the critical reactions by the antagonist (Henkemans, 1992, van Eemeren & Grootendorst, 1992a, 73-89). In the argumentative reality, the parties may present their arguments explicitly after a critical appraisal of the argumentation will mean that they resolve the difference of opinion on merit or not.

The concluding stage marks a point of determining if the protagonist's defence of the standpoints and critical reactions by the antagonist have led to the resolving of the difference in opinion. This aftermath is reached by either the protagonist retracting doubts cast by the antagonist and the resolution favouring the protagonist, or the protagonist withdrawing his/her standpoints and the resolution favouring the antagonist (van Eemeren *et al*., 2014:530). As this critical discussion comes to an end, the parties involved will try to sum up their results to try to resolve the difference in opinion before embarking on yet another round or resolving a difference of opinion between themselves or with other parties.

In the various stages of the critical discussion, participants may employ a range of speech acts implicitly or explicitly. Assertives, directives, commissives, expressives and declaratives are instrumental in the process of resolving a difference of opinion on merits. Assertives normally claim, state, suppose, assure, opine, deny or concede whereas directives order, recommend, challenge, beg or forbid. Commissives generally promise, accept, reject, agree or undertake. On the other hand, expressives reveal speakers' feelings about something such as showing regret,

thanking someone, commiserating, greeting, condoling or apologising sincerely. Lastly declaratives call states of affairs into being such as to define, amplify or explicate (Searle, 1979: 1-29).

3.2.4 Pragma-dialectical rules of critical discussion

The pragma-dialectical process of resolving a difference of opinion represented in the theoretical model of critical discussion involves interaction of speech acts between the antagonist and protagonist. This interaction is meant to facilitate the dialectical process of persuasion in the critical discussion. The desire for a regulated argumentative process of a critical discussion influenced dialectical argumentation experts to develop rules of critical discussion. The totality of these rules constitutes a discussion procedure which creates the probability to resolve a difference of opinion (problem valid) and is acceptable to the discussants (conventionally valid) (van Eemeren & Houtlosser, 2015: 165; van Eemeren & Grootendorst, 2004: 134).

The critical discussion procedure aimed at resolving the difference of opinion through a logical inference of conclusions from a set of premises is ratified with a system of regulations governing the speech acts that are imperative in realising its goal (van Eemeren and Grootendorst, 2004). The rules of procedure therefore relate to each of the four stages of the critical discussion: confrontation, where the contradiction arises; opening, where material and procedural starting points are established; argumentation, where arguments are put forth by the parties; and conclusion, where the resolution is ascertained. The rules of critical discussion satisfy the problem validity criterion for making substantive contribution to problems which are unique to the different stages of resolving a difference of opinion on merit (van Eemeren & Houtlosser, 2015: 165). Observation of rules of procedure is necessary for the resolution of the difference of opinion. The focus of the rules on the interactants' speech acts implies that the rules regulate their behaviour in resolving the difference of opinion (van Eemeren & Grootendorst 2004: 135). In so doing, the rules delineate how and when discussants can perform some speech acts for the resolution of the difference of opinion. In their spirit, the rules indicate when and/if the interlocutors are either entitled or obligated to perform different kinds of speech acts (van Eemeren & Houtlosser, 2015: 164).

The application of the rules begins from the confrontation stage of the discussion because it is at this point where the parties involved must demonstrate their commitments to their standpoints

through their speech acts. At this point the externalisation of the difference in opinion ought to be optimal. The rules therefore provide the discussants the 'unconditional right' to present their standpoints and call into question that of the other discussant(s) (van Eemeren & Grootendorst 2004: 135). This right pervades the status of the discussants because it is the quality of the argument and ability to provide criticism that reins in a critical discussion. The discussion below examines the fifteen rules of critical discussion and where and how they apply in the resolution of the difference of opinion (van Eemeren & Grootendorst, 2004: 136-157).

Rule 1

a) *"Special conditions apply neither to the propositional content of the assertives by which a standpoint is expressed, nor to the propositional content of the negation of the commissive by means of which a standpoint is called to question.*
b) *In the performance of these assertives and negation commissives, no special preparatory conditions apply to the position or status of the speaker or writer and listener or reader."*

The rule, applicable to discussants involved in an argumentative discussion, empowers them with unconditional rights to express, or call into question any standpoint while allowing other discussants to equally do so. This implies that the discussants are obliged to cooperate in externalising every difference of opinion on merit for the process of its resolution to commence. Rule one forms a basis for the opening stage of the critical discussion process (van Eemeren & Grootendorst, 2004).

Rule 2

> "*The discussant who has called the standpoint of the other discussant into question in the confrontation stage is always entitled to challenge this discussant to defend his standpoint."*

This rule is an extension of Rule 1 in the sense that the unconditional right to call a standpoint into question is not limited to just that, rather the discussant can proceed to challenge any interlocutor on that (any) standpoint. However, the rule does not imply an obligation to challenge a standpoint. This means that once a discussant has accepted to take up a defensive role based on the challenge by an antagonist then a discussion ensues. But if the interlocutor rationally pulls out of the need to take up the challenge to defend their standpoint due to the idiosyncratic and unpredictable nature

of discussants then the discussion may be rendered superfluous and difficult (van Eemeren & Grootendorst, 2004). The unconditional right to challenge a standpoint gives rise to the obligation to defend Rule 3.

Rule 3

> *"The discussant who is challenged by the other discussant to defend the standpoint that he has put forward in the confrontation stage is always obliged to accept this challenge, unless the other discussant is not prepared to accept any shared premises and discussion rules; the discussant remains obliged to defend the standpoint as long as he does not retract it and as long as he has not successfully defended it against the other discussant on the basis of agreed premises and discussion rules."*

This rule implies that a discussant is obliged to defend a standpoint he/she has expressed using an assertive by providing enough supportive argumentation. The onus of proof in a discussion lies with the discussant who has put forward a standpoint and is therefore obliged to defend it. This obligation ends with a successful defence or retraction of the standpoint. However, this obligation to defend rule works hand in hand with the unconditional right to challenge already captured in Rule 2. This obligation to defend is in principle conditional. In argumentative practice, a reason or two may make it impractical to comply with the obligation. The discussants indicate their preparedness when they recognise the obligation to defend and accept the challenge of the interlocutor; and when the interlocutor equally agrees to the shared premises and discussion rules. In this case the goal of rule 3 is to externalise the willingness to engage in a discussion of interlocutors (van Eemeren & Grootendorst, 2004). Pursuant to Rule 3, Rule 4 focuses on the allocation of discussion roles to the interactants.

Rule 4

> *"The discussant who in the opening stage has accepted the other discussant's challenge to defend his standpoint will fulfil the role of protagonist in the argumentation stage, and the other discussant will fulfil the role of antagonist, unless they agree otherwise; the distribution of roles is maintained until the end of the discussion."*

The rule stipulates that the protagonist's role is taken by the discussant who defends the initial standpoint while the antagonist is the other one who challenges the standpoint. Rule 5 goes further to elaborate on these distinct roles (van Eemeren & Grootendorst, 2004).

Rule 5

> *"The discussants who will fulfil the roles of protagonist and antagonist in the argumentation stage agree before the start of the argumentation stage on the rules for the following: how the protagonist is to defend the initial standpoint and hoe the antagonist is to attack it, and in which case the protagonist has successfully defended the standpoint and in which case the antagonist has successfully attacked it. These rules apply throughout the duration of the discussion and may not be called into question during the discussion itself by either of the parties."*

This rule is concerned with agreements by the protagonist and antagonist to defend and attack respectively as per the shared rules of discussion. Once the interlocutors have expressed their readiness to carry out the discussion as per the rules, then the two get bound by these rules which then become conventions. Explicit agreement about these rules does happen in very externalised discussions and the parties involved are bound by the rules during the discussion (van Eemeren & Grootendorst, 2004).

Rule 6

a) *"The protagonist may always defend the standpoint that he adopts in the initial difference of opinion or in a sub-difference of opinion by performing a complex speech act of argumentation, which then counts as a provisional defense of this standpoint.*
b) *The antagonist may always attack a standpoint by calling into question the provisional content or the justificatory or refutatory force of the argumentation.*
c) *The protagonist and the antagonist may not defend or attack standpoints in any other way."*

From Rule 6, discussants can only attack or defend standpoints in a critical discussion either by the protagonist performing assertives in his/her argumentation, or the antagonist's use of commisives of accepting/declining the argumentation or through directives requesting new argumentation. This rule implies that discussion rules in the argumentation stage ought to clearly indicate when the protagonist's defence is successful and when the antagonist is obliged to accept

the defense by the protagonist. Following the rules of discussion, this is what will qualify the assertion of the protagonist ascertaining that he/she has successfully defended his/her standpoint failure to which then the antagonist will have successfully attacked the said standpoint (van Eemeren & Grootendorst, 2004).

Rule 7

a) *"The protagonist has successfully defended the propositional content of a complex propositional content of the of a complex speech act of argumentation against an attack by the antagonist if the application of the intersubjective identification procedure yields a positive result or if the propositional content is in the second instance accepted by both parties as a result of a sub-discussion in which the protagonist has successfully defended a positive sub-standpoint with regard to this propositional content.*
b) *The antagonist has successfully attacked the propositional content of the complex speech act of argumentation if the application of the intersubjective identification procedure yields a negative result and the protagonist has not successfully defended a positive sub-standpoint with regard to this propositional content in a sub-discussion."*

Intersubjective identification procedure in Rule 7 is the process in which the protagonist and antagonist jointly examine propositions called into question to find out if they are identical to their shared premises (van Eemeren & Grootendorst 2004).

Rule 8

a) *"The protagonist has successfully defended a complex speech act of argumentation against an attack by the antagonist with regard to its force of justification or refutation if the application of the intersubjective inference procedure or (after application of the intersubjective explicitisation procedure) the application of the intersubjective testing procedure yields a positive result.*
b) *The antagonist has successfully attacked the force of justification or refutation of the argumentation if the application of the intersubjective inference procedure or (after application of the intersubjective explicitisation procedure) the application of the intersubjective testing procedure yields a negative result."*

In the Rule 8, intersubjective inference procedure refers to the process of checking the logical validity of the protagonist's arguments that is checking the acceptability of the protagonist's inferences if the reasoning is fully externalised. Intersubjective explicitisation procedure on the other hand refer to a joint exercise by the antagonist and the protagonist to find out if the argument scheme applied is admissible by the two parties through reconstruction especially when the reasoning is not fully externalised I the argumentation. After the intersubjective explicitisation procedure, the protagonist and antagonist can, out of mutual consent, jointly conduct an intersubjective testing procedure which involves determining the admissibility and acceptability of the reconstructed argument scheme. This process involves a thorough scrutiny of both the argumentation and the proposition of the standpoint (van Eemeren & Grootendorst, 2004: 149-150).

Rule 9

a) *"The protagonist has conclusively defended an initial standpoint by means of a complex speech act of argumentation if he has successfully defended both the propositional content called into question by the antagonist and its force of justification or refutation called into question by the antagonist.*
b) *The antagonist has conclusively attacked the standpoint of the protagonist if he has successfully attacked either the propositional content or the force of justification or refutation of the complex speech act of argumentation."*

Rule 9 is built on rules 7 and 8 to emphasise on the protagonist's conclusive defense of a standpoint, and the antagonist's conclusive attack of the same standpoint.

Rule 10

> *"The antagonist retains throughout the entire discussion the right to call into question both the propositional content and the force of justification or refutation of every complex speech act of argumentation of the protagonist that the latter has not yet successfully defended."*

This rule serves as an extension of rule 6 by according the antagonist an opportunity to optimally exploit his/her right to attack for a conclusive resolution of the difference in opinion (van Eemeren & Grootendorst, 2004).

Rule 11

> *"The protagonist retains throughout the entire discussion the right to defend both the propositional content and the force of justification or refutation of every complex speech act of argumentation that he has performed and not yet successfully defended against every attack by the antagonist".*

Rule 12

> *"The protagonist retains throughout the entire discussion the right to retract any complex speech act of argumentation that he has performed and thereby to remove the obligation to defend it."*

Rule 13

a) *The protagonist and the antagonist may perform the same speech act with the same role in the discussion only once.*
b) *The protagonist and antagonist must in turn make a move of (complex) speech acts with a particular role in the discussion.*
c) *The protagonist and the antagonist may not perform more than one move of (complex) speech acts at once."*

Rule 14

a) *"The protagonist is obliged to retract the initial standpoint if the antagonist has conclusively attacked it (in the manner prescribed in rule 9) in the argumentation stage (and has also observed the other discussion rules).*
b) *The antagonist is obliged to retract the calling into question of the initial standpoint if the protagonist has conclusively defended it (in the manner prescribed in rule 9) in the argumentation stage (and has also observed the other discussion rules).*
c) *In all other cases, the protagonist is not obliged to retract the initial standpoints, nor is the antagonist obliged to withdraw his calling into question the initial standpoint."*

van Eemeren & Grootendorst (1992a) have proposed a code of conduct of a critical discussion for argumentative discourse after critical appraisal of the rules of critical discussion originally proposed by van Eemeren & Grootendorst (1984), and most recently reviewed as "the Ten Commandments" because of their manner of presentation as prohibitions in van Eemeren &

Grootendorst (2004: 190-196). This code of conduct consisting of ten simplified principles, which is an abridged version of the rules of critical discussion, is aimed at providing a basis for having augmentative discourse as a mode of resolving a difference of opinion on merits (van Eemeren et al 2013: 541-544). The Ten Commandments (van Eemeren & Houtloser, 2015: 166-168; van Eemeren et al., 2013: 541-544; van Eemeren & Grootendorst, 2004: 190-196) include the following:

Commandment 1. Discussants may not prevent each other from advancing standpoints or from calling standpoints into question (*Freedom Rule*).

Commandment 2. Discussants who advance a standpoint may not refuse to defend this standpoint when requested to do so (*Obligation to Defend Rule*).

Commandment 3. Attacks on standpoints may not bear on a standpoint that has not actually been put forward by the other party (*Standpoint Rule*).

Commandment 4. Standpoints may not be defended by non-argumentation or argumentation that is not relevant to the standpoint (*Relevance Rule*).

Commandment 5. Discussants may not falsely attribute unexpressed premises to the other party, nor disown responsibility for their own unexpressed premises (*Unexpressed Premise Rule*).

Commandment 6. Discussants may not falsely present something as an accepted starting point or falsely deny that something is an accepted starting point (*Starting Point Rule*).

Commandment 7. Reasoning that is in an argumentation explicitly and fully expressed and fully expressed may not be invalid in a logical sense (*Validity Rule*).

Commandment 8. Standpoints defended by argumentation that is not explicitly and fully expressed may not be regarded as conclusively defended by such argumentation unless the defense takes place by means of appropriate argument schemes that are applied correctly (*Argument Scheme Rule*).

Commandment 9. Inconclusive defenses of standpoints may not lead to maintaining these standpoints and conclusive defenses of standpoints may not lead to maintaining expressions of doubt concerning these standpoints (*Concluding Rule*).

Commandment 10. Discussants may not use any formulations that are insufficiently clear or confusingly ambiguous, and they may not deliberately misinterpret the other party's formulations (*Language Use Rule*).

The code of conduct has been deliberately developed for the practicality of resolving a difference in opinion through argumentative discourse because of the technicality of the critical discussion procedure as expressed in the rules of critical discussion (van Eemeren & Houtlosser, 2015: 166).

3.2.5 Analytical overview

In analysing data from the argumentative reality, the ideal model of critical discussion is supreme. However, argumentative discourse in real sense is not symmetrical with the model (van Eemeren, 2010). This means that the difference of opinion may not be always clearly delineated just like there will outright and explicit premises or standpoints which will need to be defended or refuted. To be able to work out material starting points, determine the protagonist, antagonist and other elements, an analytical reconstruction is inevitable. In carrying out this pragma dialectic reconstruction, the ability to analytically distinguish the four stages of the model of critical discussion to resolve the difference in opinion makes the model a sort of "heuristic" or "analytic" template (van Eemeren 2007: 17; van Eemeren *et al*., 2014: 535).

To systematically identify elements in the argumentative discourse which are relevant to the critical evaluation, specific analytic operations referred to 'reconstruction transformations' should be carried out. This reconstruction produces four different types of pragma dialectic transformations: 'deletion', 'addition', 'permutation' and 'substitution' (van Eemeren *et al.,* 1993: 61-86; van Eemeren & Grootendorst, 2004: 100-110). Deletion transformation ensures that all information which doesn't contribute to the resolving of a difference in opinion on merits such as repetitions, or irrelevant issues not devoted to the issue at hand are left out. On its part, addition transformation entails supplementing the given discourse by introducing elements which have been implied in the discourse such as unexpressed standpoints, premises or presupposed starting points which are instrumental to the process of resolving the difference in opinion on merits (van Eemeren *et al*., 2014:535; van Eemeren, Grootendorst & Henkemans, 2002: 49-51). The transformation of substitution occurs in the analysis when elements are paraphrased such that the discourse is clear for the resolution process. Finally, permutation reconstruction reorganises the

elements in the discourse such that the analytical overview order is supportive of the progressive stages of resolving the difference in opinion (van Eemeren et al 2014: 535-536).

The analytical overview requires that in the reconstruction, the transformations be carried out cyclically for communicative purposes. It needs to cover all the stages of the critical discussion: the establishment of the difference in opinion, the positions of the protagonist and antagonist together with their procedural and material premises, their argumentation schemes and structures, respective defences, criticism and justification, and the resultant outcome of the discussion. In the analytic overview, argument schemes and argument structures, which form the building blocks of argumentation, are significant. Argumentation has generally been defined as thus:

> "A verbal and social activity of reason aimed at increasing (or decreasing) the acceptability of a controversial standpoint for the listener or reader, by putting forward a constellation of propositions intended to justify (or refute) the standpoint before a rational judge" (van Eemeren *et al*., 1996:5).

The argumentative reality operates with the assumption that the interlocutors observe the principle of communication (van Eemeren & Grootendorst, 1992a) which has an epistemological relation with the Gricean Cooperative Principle (Grice, 1975). Interactants employ the standards like honesty, clarity, efficiency and relevancy of the Principle of communication to determine the levels of implicitness and explicitness of meaning in their discourse. Implicit elements in argumentative discourse like premises and standpoints remain unexpressed in the argumentation because of rules of communication, communication principles and basic principles of logic. The argumentative communication can identify such elements and reconstruct them (van Eemeren, Grootendorst & Henkemans, 2002: 49-58). Argumentation discourse analysts exploit "textual and contextual pragmatic factors" to understand how interlocutors engage each other in an argumentative discussion (van Eemeren *et al*., 1996:13). There is an implicit and explicit appeal to reasonableness in argumentative discussions in as much as it may be lacking in the argumentative reality. The most workable analysis must first trace the focal points of argumentative discussion and how they occur in the discourse. The difference in opinion normally implies a disagreement and the resultant argumentative discussion.

The ability to identify standpoints and reasons or the interlocutors is important in the analysis of argumentative discourse. Some of the verbal indicators which are normally employed in the

discourse to refer to standpoints and argumentation include: thus, therefore, so, for, because, since and many more in English. However, such discourse marking clues may not be always be present in the discourse. Some background information and context of the speech event, both verbal and non-verbal, can be important in getting clues of the standpoints or the argument in the discourse. Standpoints and reasons whether explicit or otherwise are functional units in the discourse which play a central role in resolving a difference in opinion. Standpoints are verbal utterances which serve to express a position where there is a difference in opinion while reasons are the verbal utterances in discourse which serve to defend a certain position where there is a controversial situation (van Eemeren *et al*., 1996: 13-14).

Examining the structure of argumentation from a holistic perspective gives insight into the external organisation of arguments. The study of the internal organisation of individual arguments in terms of premises in defense of standpoints shall later unearth argument schemes later in this chapter. Any understanding of complex argumentation needs to lay bare individual arguments and try to establish the relation between these arguments. Henkemans (2001: 127) equates 'single' or 'individual' arguments to reasons which together constitute complex argumentation. Single argumentation consists of the very basic structure of argumentation: "one argument pro or contra the standpoint" (Van Eemeren *et al*., 1996:16). A good example is: *You are corrupt, because you are a Kenyan*. The single argumentation presented in this utterance has one explicit premise (you are a Kenyan) and one unexpressed premise (Kenyans are corrupt).

In the classification of complex structured argumentation, three basic types of argument structures can be distinguished: subordinate argumentation (serial reasoning), coordinate argumentation (linked reasoning) and multiple argumentation (convergent reasoning) (van Eemeren *et al*., 1996 16-18; Henkemans, 2001:101; van Eemeren, Grootendorst & Henkemans 2002:63-66). To begin with, subordinate argumentation, an arguer presents a reason to support another reason, in other words, arguments are provided for other arguments. Normally, the arguer provides a defense for the initial standpoint layer after layer. The interlocutor keeps adding supportive arguments until the defense is conclusive. In this form of serial or chain reasoning, the weakest link influences the strength of the whole argument structure. An example is:

I cannot see you today

because

I have many appointments today

because

I have been on leave

because

I needed to secure my daughter a position in a good school

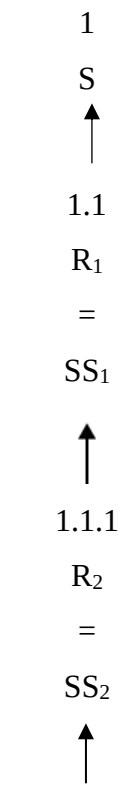
because

she did not perform very well in her national examinations

because

she has not been taking her schoolwork seriously.

Van Eemeren and colleagues (1996:19) refers the argument structure expressed in this sentence as a subordinately compound argumentation and presents the structure in figure 3.2 to represent it.



And so forth.

Where S = Standpoint,

R_1, R_2, R_n = Reasons (arguments)

Figure 3.2 Subordinate argumentation structure (Source: van Eemeren 1996:19)

In this kind of argumentation, the speaker always anticipates that a substandpoint part of his argumentation needs further defense ("subagumetation"). This "subargumentation" may contain a "subsubstandpoint" which is further defended with a "subsubargumentation" (Van Eemeren, Grootendorst & Henkemans, 2002: 66).

In coordinate argumentation, an interlocutor makes a deliberate attempt at defending a standpoint which consists of a combination of arguments which reinforce each other and therefore which must be taken together to consolidate the defense. The single arguments are connected in parallel (or dependent on each other) because each of the arguments could be too weak to substantively defend the standpoint or the objection of it. The second argument reinforces the first argument (Van Eemeren, Grootendorst & Henkemans, 2002: 65). An example:

> The party was exceptional, for the food was delicious and sufficient, the guests were overwhelmed at the hospitality, and the patrons celebrated all night.

The structure of such coordinate argumentation is illustratedin figure 3.3 below:

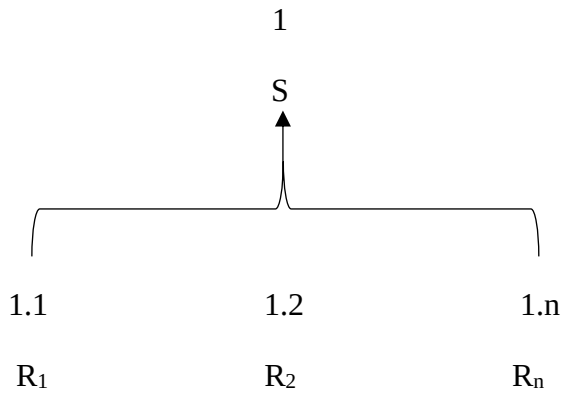


Figure 3.3 Structure of coordinate argumentation (source: van Eemeren et al., 1996: 18)

The third type of complex argumentation, multiple argumentation, consists of arguments that are not connected but are interdependent. The arguments presented are alternative defences of the standpoint, and they are of equal leverage. Diagrammatically, this can be seen in the figure 3.4. A good example of a complex argumentation with multiple argumentation is shown below:

> University education in Africa has greatly deteriorated. Apart from the fact that very few universities from Africa get fair ranking globally, many do not contribute to knowledge generation and very few, if any, have developed innovations which can solve Africa's problems.

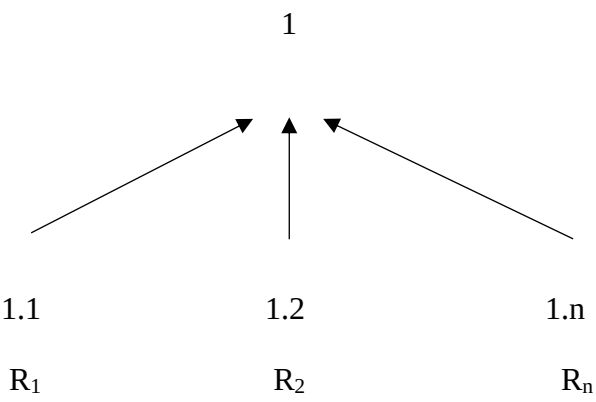


Figure 3.4 Structure of multiple argumentation (source: van Eemeren et al., 1996: 17)

In the example, the three arguments presented are stand-alone arguments, which are used to back up the standpoint. If you did away with any of them the remaining two arguments till will be presumed to be conclusively acceptable in defense of the standpoint. The defences are multiple but alternate at the same time.

In analysing complex argumentation, it may not be clear on the onset whether the argumentation one is dealing is subordinate, coordinate or multiple. There is also a possibility of having a more than one type of argument structure in in one compound argumentation. This warrants the exploitation of pragmatic and contextual factors and the distinguishing aspects of speech acts in the analysis (van Eemeren *et al*., 1996:18).

To unravel the internal structure of a single argumentation, the analysis of argument schemes is brought to the fore. Argument schemes underscore "the 'internal organisation' of individual single arguments, that is the principles on which these arguments rely in defending the standpoints at issue by means of the premises" (van Eemeren *et al*., 1996:19). The schemes establish the relation between the premises and the standpoints that a single argument intends to justify or refute. The criteria, principles and assumptions involved in the process of justifying or refuting a standpoint are accounted for in the discourse through the analysis of argument schemes. Argumentation schemes can be used to trace and evaluate argumentation besides being a basis for one's argumentative competence in a language (Garssen, 2001: 81). This is qualified by van Eemeren, Grootendorst & Henkemans (2002: 95) who posit that the ability to accurately employ argument schemes will influence the soundness of an argument.

There are three major categories of argument schemes each with a characteristic type of argumentation: *symptomatic, analogy and cause relation* (van Eemeren, Grootendorst & Henkemans 2002: 95-102). First, argumentation based on a symptomatic relation presents a scenario where an interlocutor defends a standpoint by citing a trait or distinguishing sign of what the standpoint claims. The presented trait is normally a symptomatic culmination or implication of another. Consider this example:

Jane is a feminist.

She cannot tolerate unfair treatment of women.

(Not tolerating unfair treatment of women is characteristic of being feminist)

The speaker presents a defense of the standpoint (Jane is a feminist) by presenting a distinct but symptomatic trait of what he/she thinks of feminists (not tolerating unfair treatment of women). The argument scheme for symptomatic relation can thus be presented as thus:

Y is true of X

Because: Z true of X

And : Z is symptomatic of Y

From the above argument scheme, these critical questions need to be asked:

Aren't there also other non-Ys that have the characteristic Z?

Aren't there also other Ys that do not have the characteristic Z? (van Eemeren, Grootendorst & Henkemans 2002: 97-98)

On its part, argumentation based on analogy is a case-based argument scheme whereby a standpoint is defended using a case referred to in the standpoint which resembles another case cited in the argumentation. Based on resemblance, a property in one case is presumed to be existent in another. Walton (2006: 96) outlines the argument scheme of an argument from analogy as follows:

SIMILARITY PREMISE: Generally, case C_1 is similar to case C_2

BASE PREMISE : A is true(false) in case C_1

CONCLUSION : A is true(false) in case C_2.

The assumption here is that the two cases C_1 and C_2 share all the features which are central to the argument. A critical question to be asked here is: Is there any significant difference between C_1 and C_2?

An example is:

> Raila Odinga might not be elected president of the Republic of Kenya because his late father, Oginga Odinga, never managed to become one.

The analogical argument presented here is one of comparing Raila Odinga (in the standpoint) and Oginga Odinga (in the argument), a son and his late father in as much as the two might not share all circumstantial and electability/leadership characteristics. Finally, when a standpoint is defended based on causality between an argument and the standpoint, the argumentation scheme that arises is one with a causal relation. For instance:

> James has cut his weight because he is going to the gym.
>
> (And going to the gym makes one cut weight)

The argument presents a situation where the defense is a sort of effect resulting from a certain cause, or as a means to an end. This can equally be reversed to a situation where the effect influences the cause. This argument scheme of causal relation is represented as follows:

> Y is true of X
>
> Because: Z is true of X
>
> And : Z leads to Y

A critical question to ask to assess whether the argumentation is conclusive is:

Does Z always lad to Y?

(van Eemeren, Grootendorst & Henkemans, 2002: 101)

For this to be established, it will of course need a verification process in the analysis. Under the causal relation argumentation lies *pragmatic argumentation* which is a kind of argument where the standpoint mentions by way of recommendation a given effect or course of action. For example:

> University lecturers in Kenya should have at least a PhD, because this improves the quality of university education.
>
> (And this is a good thing to improve the quality of university education).

3.2.6 Extended pragma-dialectics: strategic manoeuvring

The pragma-dialectical model of the argumentation theory in its development is anchored at the ability to convince persuade people into accepting a given view point as much as it is sound and done as per standards of argumentative discourse (van Eemeren & Houtlosser, 2002a: 131). The normative pragmatic enterprise, which accounts for the empirical and critical dimensions of argumentative discourse, is a harbinger of this development (Van Eemeren, 1990). Arguers, in written or spoken argumentative discourse, want to win the discussion while conducting it in a reasonable manner. The desire to entrench pragma-dialectics in the argumentative reality saw van Eemeren and Houtlosser (2002a) deduce a "strategic design" in the discourse. With this strategic design the standard theory of pragma-dialectics became the *extended theory of pragma-dialectics* to account for the now more elaborate and realistic process of analysing and evaluating argumentative discourse. Using argumentative discourse in context as the entry point, van Eemeren and Houtlosser integrated the dimension of effectiveness in argumentation with the already predominant dimension of reasonableness through the strategic design.

Arguers' rhetorical efforts to win over the discussion are simultaneously integrated in with dialectical underpinnings of resolving the difference in opinion on merits. This means that they strive to effectively convince their target audience while retaining the reasonableness standards of a critical discussion (van Eemeren *et al*., 2014: 553; van Eemeren & Houtlosser, 2002a: 135). To be able to maintain a delicate balance between aiming for effectiveness and remaining reasonable, arguers must exploit strategic manoeuvring. The strategic design therefore becomes an integral part of the theoretical tools of analysis and evaluation of argumentative discourse (van Eemeren, 2010: 89). A functional integration of rhetorical and dialectical approaches in the extended pragma-dialectical theory is made by

> "incorporating all those and those rhetorical insights in the pragma dialectical theorising that can play a constructive role as one wants to take the envisioned effectiveness of the

> strategic maneuvers made in argumentative discourse methodically into consideration, both in analysis and evaluation" (van Eemeren, 2010: 90).

This implies that in the model of critical discussion, any argumentative move made at whichever stage must aim at fulfilling the arguer's dialectical aim provided it achieves its rhetorical end in resolving of the difference in opinion. Therefore, strategic manoeuvring at the confrontation, opening, argumentation and concluding stages mitigates the tension resulting from the simultaneous pursuit of the dialectical and rhetorical aim.

In the argumentative reality, strategic manoeuvring manifests itself in the arguers' speech acts with inbuilt argumentative moves which can be systematically analysed and evaluated to pinpoint various aspects of the strategic function of these schemes in resolving a difference in opinion. A step by step examination of each of these aspects of strategic manoeuvring is necessary during the analysis and evaluation of argumentative discourse to unearth their distinct roles (van Eemeren, 2010: 93). Van Eemeren and Houtlosser (2002a) thus distinguished three aspects of this strategic function of manoeuvring associated with the different choices made by the interactants. Firstly, the "topic potential" provides a repertoire of relevant choices available to the arguer in making argumentative moves at a given point in the resolution process. This means that for every standpoint, the arguer can select a line of argumentation from the many such options at his/her disposal to defend himself/herself. The arguer can choose a symptomatic, comparison or causal relation argument scheme to pursue his/her line of defence (van Eemeren, 2010: 93-94; van Eemeren and Houtlosser (2002a 139-140; van Eemeren *et al.*, 2014: 555)

Secondly, the aspect of "audience demand" implies that the arguers come up with argumentative moves which complement the target reader reader's or listener's preferences or wishes for an optimal rhetorical effect at every stage in the resolution process. This further implies that the arguer should aim at creating the requisite "empathy or communion" sought by the audience at every stage (van Eemeren and Houtlosser, 2002a: 140). In pragma-dialectical language, arguers will comply with the audience demand when selecting the starting points by ensuring that they ininiate procedural and material points of departure congruent with what is acceptable to the audience or pleases them regarding the resolving of the difference in opinion on merits. The third and final aspect, 'presentational devices', calls for the stylistic choice of expressions to exploit to strategically serve the purpose of an argumentative move in the discourse. Arguers who

strategically manoeuvre tend to ensure that their standpoints and argumentative moves employ the most communicative words, phrases or expressions which benefit the process of resolving the difference in opinion at issue.

In pragma-dialectical lingua, an arguer can exploit his presentational devices to formulate a very reasonable and effective standpoint thus ending with a single or non-mixed argument scheme (van Eemeren, 2010: 94). To sum it up, van Eemeren and Houtlosser emphasise that "phrasing and stylistic framing of the moves should be systematically attuned to their discursive effectiveness exploiting the Gricean maxims of manner in a specific and deliberate way" (2002: 140). The three aspectual qualities of strategic manoeuvring are distinguished analytically but operate simultaneously in oral or written discourse. A writer or speaker involved in the argumentative reality forever endeavours to deliberately employ an argumentative strategy which sees his or her strategic manoeuvring converge at various stages of the resolution process when making choice of the topic potential, suiting the audience demand and selecting the presentational devise to utilise. van Eemeren & Houtlosser (2002: 141) see a totality of these argumentative strategies as a systematic design of schemes aimed at influencing the outcome of a critical discussion stage through coordinated and spontaneous utilisation of available opportunities for the benefit of the arguer.

The simultaneous interdependence of the three aspects is diagrammatically represented in the strategic manoeuvring triangle (van Eemeren (2010: 94-95; van Eemeren et al 2014: 554) shown in figure 3.5 below. The arrows show the interdependence of the three aspects of strategic manoeuvring. In analysing and evaluating written or spoken argumentative discourse, one needs to establish how the arguer makes choices on selecting the topic potential, meeting the audience demand and the presentational devices he or she exploits in each argumentative move in all the stages of the critical discussion in resolving the difference in opinion at issue (van Eemeren, 2010: 94-95). The argumentative reality for the current study take us to van Eemeren (2016:11-12) characterisation of the medical domain as the institutional preconditions, legal or otherwise, which constrain cases of strategic manoeuvring in various doctor-patient communication activity types and the resultant prototypical patterns of argumentation in doctor patient consultations. For example, the ethical requirement for doctors to provide sufficient information about the available

options and the risks of treatments and rationale for choosing medications is one among the preconditions doctors must pay attention to (Labrie, 2012).

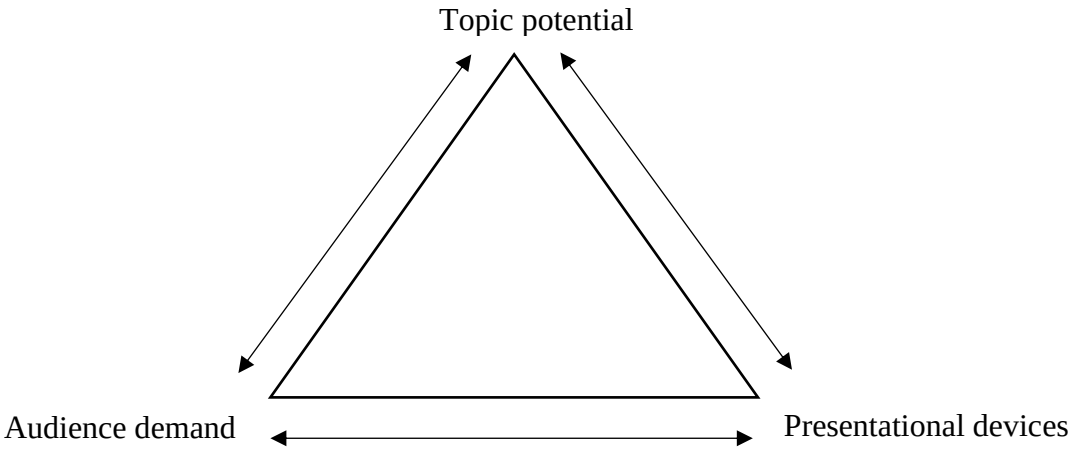


Figure 3.5 The strategic manoeuvring triangle (van Eemeren 2010: 95)

3.2.7 Studying effectiveness through reasonableness

The theoretical concept of strategic manoeuvring in the extended pragma dialectical theory opened an opportunity for empirical research in effectiveness and reasonableness in argumentation. The study of aiming for effectiveness of arguers and doing so in compliance with the standards of reasonableness gave rise to a project named "Pragma-Dialectical Effectiveness Research". In this research project van Eemeren, Garsen and Meuffels (2012a) aimed at empirically determining the persuasiveness of argumentative moves meant to convince other participants in argumentative discourse. In the study, Van Eemeren, Garsen and Meuffels formulate three hypotheses on the effectiveness of argumentative moves in the argumentative reality. The theorists analyse strategic manoeuvring in the context of the heuristic model of critical analysis of the pragma-dialectical theory of argumentation. The incorporation enables the extended pragma dialectical analysis to provide a succinct, detailed and evaluative interpretation of argumentative discourse in the different communication domains. The hypotheses thus emanate from an empirical interpretation of the strategic manoeuvring in the practice of argumentation (van Eemeren, Garsen and Meuffels, 2012a: 41-42, van Eemeren, 2016: 7; van Eemeren, 2015:136-137).

To begin with, hypothesis 1 says that ordinary participants are to some degree cognizant of the dialectical obligations of their contributions in the argumentative reality. The argumentative tendency of these participants in the discussion shows their commitment to standards of

reasonableness, which are not only equivalent to pragma dialectical standards but also account for their simultaneous aiming for rhetorical effectiveness with conformity to reasonableness. Secondly, hypothesis 2 proposes that ordinary discussants engage in argumentative discussions with the assumption that they are committed to common dialectical obligations. The shared assumptions on the dialectical standards of evaluating reasonableness of argumentative moves by interlocutors enable them to jointly link their aiming for effectiveness with their standards of reasonableness. Finally, hypothesis 3 suggests that ordinary discussants, just like their interlocutors, prefer to hold arguers accountable for any violation of the shared standards of reasonableness in a critical discussion. Discussants make sense of their strategic manoeuvring on the backdrop of an empirically observable standard, which permits discussants and their interlocutors to provide a prescriptive value of their reasonableness in their argumentative moves. Therefore, extended pragma dialectics has interwoven effectiveness and reasonableness of the argumentative moves. The conception of effectiveness in the empirical research borrows from the perlocutionary effect of the performance of an argumentative move as a speech act (van Eemeren, 1984: 22-29).

3.2.7.1 Prototypical patterns of argumentation

In the extended pragma-dialectical theory of argumentation, there are varied manifestations of the differences of opinion in the various communicative activity types in different communicative domains. The study of empirical study of effectiveness and reasonableness in strategic manoeuvring takes note of the deliberate argumentation moves made by arguers right from the confrontation stage of the critical discussion process where the difference in opinion manifests itself. Differences in opinion can be single nonmixed especially in a doctor-patient consultation or formal mixed difference in opinion in a legal case (van Eemeren, 2017:3). Out of the four differences of opinion van Eemeren, Grootendorst and Henkemans distinguish, the other two are the multiple mixed and the multiple nonmixed (2002: 8). It is noteworthy that the institutional preconditions in the specific communicative activities influence the process of critical argumentation. The preconditions override the basic parameters of argumentation such as the standpoints at issue, the difference in opinion and the material and procedural starting points (van Eemeren, 2017:4).

Argumentation researchers are embarking on an in-depth analysis of strategic manoeuvring in different communicative activity types in the different domains like medical, legal, political or academic (van Eemeren & Garssen, 2009; Wierda & Visser, 2012; Wierda, 2015; Henkemans, 2016; Nyanda, 2016; Feteris, 2017; Pan *et al.*, 2018). In the development of pragma-dialectic approach to argumentation, the focus on the analysis of the influence of institutional preconditions on strategic manoeuvring is taking precedence. Consequently, the studies now aim to identify characteristic or prototypical argumentative patterns because of the institution-based constraints, which shape the strategic manoeuvring (van Eemeren, 2016: 15).

In the critical discussion process, the argumentation stage provides the interlocutors an opportunity to exploit their strategic manoeuvres to achieve desired outcomes. This happens through the exploitation of specific argument scheme(s) which will bring out the desired outcome they aim to achieve in the equivalent communicative activity type(s) in the argumentative reality. However, strategic manoeuvring occurs in the communicative activity types which are regulated by the institutional exigencies of the macro context of the specific argumentative domain (van Eemeren, 2016: 9). For instance, the health professionals ought to comply with the institutional preconditions of doctor-patient consultations in the medical domain (Henkemans, 2011). It is a requirement that in the exploiting authority argumentation in the strategic manoeuvring, doctors must ensure that they adhere to the evidence based and informed consent obligations with sound arguments (Labrie, 2012; Pilgram, 2015). The stages of the ideal model of the critical discussion provides a regularised analytical parameter to justify a process of argumentative characterisation in the different communicative activity types of the various communicative domains (van Eemeren, 2010:146).

The characterisation of the argumentative moves in the different communicative activity types is equally constrained by both the primary and secondary institutional preconditions. Primary institutional preconditions are the formalised rules of procedure while the secondary institutional preconditions are the unwritten and informal but important rules in a given communicative domain (van Eemeren and Garssen, 2010). These formal and informal institutional preconditions affect the conventionalisation of the communicative activity types of the different communicative genres (van Eemeren, 2016: 9). For instance, the conventionalisation of the adjudication of a court case operates in a very formalised and explicit institutional point under regularised rules. The conventionalisation of deliberation of the political domain works on implicit and more

accommodative formal regulations while it can be reflective of established customs or simply informal in the interpersonal domain. The characterisation of the patterns of argumentation is additionally shaped by the character of the macro context of the communicative activity where the communicative practice occurs.

The conventionalisation of the communicative practice of a communicative activity is influenced by the institutional conventions which determine the institutional point in the argumentative reality of the communicative activity type (van Eemeren and Garssen, 2010). The characterisation of argumentative moves thus has ha direct correlation with the conventionalisation of communicative activity types to realise the institutional rationale of the communicative practice. Apart from serving the institutional needs, the conventionalisation of communicative activity types helps in implementing the argumentative activities in the various genres of communicative activity such as communion-seeking, adjudication, deliberation, consultation or negotiation. The empirical reality of the genres of communicative activities which are conventionalised in the multi-varied domains of communicative activity types with associated speech events in the argumentative reality offer an opportunity to culturally establish the institutional point (van Eemeren and Houtlosser, 2005).

Argumentative moves in the various communicative activity types are prototypes of the conventionalised and empirical reality of the argumentative activity types. The argumentation stage of the theoretical construct of the ideal model of the critical discussion applied in the empirical argumentation reality of the specific communicative activity types in equivalent communicative domains gives discussants a chance to employ different types of argument schemes to reach an intended outcome (van Eemeren 2017: 4). The use of some argument schemes requires strict observation of institutional preconditions in the specific communicative activity types. This implies that the critical questions underlying the argument schemes are part and parcel of the communicative activity type because they are tied to the institutional point of the communicative practice in that domain. This process arising from the discussants' attempts to defend a standpoint based on a given difference of opinion results in an empirically observable argumentative pattern. The use of argument schemes to defend a kind of standpoints in resolving a certain kind of difference of opinion in argumentative discourse in a given communicative activity produces an argumentative pattern. Van Eemeren (2017:4) defines the argumentative pattern as "*a particular constellation of argumentative moves in which, in dealing with a particular kind of difference of*

opinion, in defense of a particular type of standpoint, a particular argument scheme is used in a particular kind of argument structure".

In the argumentative reality of various communicative activity types in different domains, some argument schemes have emerged out as the prototypes of the defense system of the standpoints depending on the difference of opinion. Van Eemeren (2016: 14 & 2017: 5) highlights general examples of some of the argument schemes exploited in some of the communicative activity types in some argumentative domains. To begin with, the legal argumentative domain, a judge can justify a ruling in a court of law using symptomatic argumentation while pragmatic argumentation can be handy in making exceptions to the common law. These types of argumentation moves can be supported by other types of argumentation. Critical questions in legal argumentation are prevalent in cases where analogy and symptomatic argumentation are central in the strategic manoeuvring.

Additionally, the communicative activity of deliberation in political discourse normally takes centre stage of political argumentation especially in the parliamentary debates. Characteristically, speakers in parliamentary discourse exploit pragmatic argumentation in defending their standpoints followed by its subtype, causal argumentation, which is used to argue for the actions to be taken to realise a desirous outcome. The outcome can also be justified using symptomatic argumentation for effectiveness sake with appropriate critical questions for each of the argument schemes used in the deliberation process. The scientific discussion communicative activity type in academic discourse can also employ causal argumentation or its subtype to justify the acceptability of a scientific assertion at issue. The critical questions to be expected are those that relate to the argument scheme employed by the writer or speaker. In the various patterns in the various domains, the first level of defense forms the basic or main argument, but the analysis of argumentative discourse establishes other patterns of argumentation in the subsequent levels of defense with different degrees of complexity.

Ideally, the conventionalisation of the communicative activity type and the institutional point determine the kind of critical questions considered relevant and specified from the choice of argument schemes that the arguers are likely to anticipate in the argumentative reality (van Eemeren 2016: 14 & 2017: 5). Pragmatic, logical and contextual (micro, macro and meso and intertextual) considerations and the general background information of the communication activity

type are key in determining the pertinent and critical questions which need to be asked to be asked in evaluating the soundness of the argument schemes employed (van Eemeren, 2010:17–19). This is the case because the critical evaluation of the argumentation discourse required the pragma-dialectic analyst to establish the context-dependent precisations and transformations to the soundness standards in the specific communicative activity type and conditioned by the institutional constraints.

The predictability of the patterns of argumentation in the argumentative reality produces an archetypal manner of conducting argumentation in specific communicative activity types in the respective genres of communication. There is a possibility however that the occurrence of some of these argumentative patterns may be just incidental. Institutional preconditioning of strategic manoeuvring in argumentation in specific communicative activity types produces a predictable pattern of argumentation. The institutional preconditions qualify the occurrence of the prototypical patterns of argumentation in the communicative activity type. The argumentative patterns, which can be said to be prototypical of a specific (or a cluster of) communicative activity type(s), are a product of the different ways of strategic manoeuvring used by protagonists and antagonists in realizing of the institutional point. The arguers continually respond to the critical questions, which relate to the conventionalisation of the specific communicative activity type based on the institutional preconditions in appreciation of the institutional point of the communicative activity type (van Eemeren,2016:7, 2017:15).

Contemporary pragma-dialectical research has its focal point in the context-dependency of argumentation in the academic, political, medical and legal communicative domains. Pragma dialecticians are now engaged in the analysis of strategic manoeuvring with the intention of identifying prototypical argumentative patterns as consequences of the institutional constraints which govern the processes of strategic manoeuvring in specific communicative activity types of the various communicative domains. In the medical domain Pan, Chen & Ju (2018) has analysed argumentative pattern in Chinese consultations; Henkemans (2015) has examined argumentative patterns, which are characteristic of Over-the-Counter (OTC) medicinal advertisements.

In the legal domain, Feteris (2017) has explores the prototypical patters of argumentation used to justify the judicial decisions. Writing on the how pragmatic argumentation is exploited in the

justification process, Feteris (2016) has also analyses its role in the prototypical patterns of argumentation in the hard cases. In the political domain, Andone (2016) has explored how the European Parliamentary inquiry committee members use of pragmatic, and majority argumentation in recommending measures of action while ensuring the administration of the European Union constitution as an institutional requirement of the communicative activity type.

Of importance to the pragma-dialectical analyst is the dependency of the argumentative discourse on the context. The emergent empirical qualitative research findings of prototypical argumentative patterns in the different communicative activity types in the various argumentative domains indicates that the functionality of the modes of strategic manoeuvring is a product of the institutional preconditions, which are applicable to the respective communicative activity types. The pragma-dialectical theoretical typological classifications are the tools for disclosing and describing the constellation of prototypical patterns of argumentation which function in different communicative domains in the argumentative reality where they are manifest (van Eemeren, 2016: 15; 2017:7). Some of the typological classification instruments include the different kinds of: standpoints (descriptive, prescriptive, evaluative), differences of opinions (single non-mixed, multiple non-mixed, single mixed and multiple mixed), argument schemes (causation, symptomatic, comparison) and argumentation structures (single/multiple, coordinate/subordinate) (Van Eemeren and Grootendorst, 1992; van Eemeren, Grootendorst & Henkemans, 2002).

There is a likelihood of having many prototypical patterns of argumentation occurring in a communicative activity type or a cluster of the same in the argumentative reality. The need to document the diversity of institutional argumentative realities calls for the need to establish the independency or dependency of the argumentative context. In acknowledging the occurrence of both stereotypical and prototypical argumentative patterns in the practice or argumentation in the various argumentative domains, it is worth noting that the qualitative empirical research into argumentative patterns will need to be supplemented by a quantitative point of view of the argumentative reality.

Nevertheless, van Eemeren (2016:16) distinguished prototypical argumentative patterns from stereotypical patterns using the frequency parameter. Whereas prototypical patterns of argumentation products of strategic manoeuvring, which are responsible in the realization of the

institutional point of the specific communicative activity type, stereotypical patterns of argumentation are prototypical of the communicative activity type apart from occurring in a high frequency. In terms of the kind of research which produces these patterns of argumentation, stereotypical argumentative patterns can be determined through qualitative research while prototypical argumentative patterns are products of qualitative empirical research. In the present study, identifying and characterising the prototypical argumentation of the Gusii doctors and Gusii patients in the medical consultation (see sections 5.6 and 6.5 of Chapters 5 and 6, respectively) contributes to the ongoing debate in the development of argumentative theory

3.3 Appraisal theory

The appraisal framework is expressly developed from Systemic Functional Linguistics (SFL) (Halliday, 1994, Martin, 1992b, Matthiessen, 1995) to provide resources for analysing the language of evaluation and ascertaining the function of language. SFL identifies three facets of the social function of language: Ideational (use of language to represent the world of experience); interpersonal (language as a vehicle for assigning social roles and relationships) and textual (the rhetorical fluency and contextual validity of texts). The proponents of appraisal theory were motivated by their work which involved the development of literary programs which were genre-based under the field of educational linguistics in Australia (Iedema *et al.*, 1994, Christie & Martin, 1997, Martin, 2000). Appraisal theory develops and extrapolates the interpersonal facet by exploring the functionality of speakers and writers in their use of language. In this context, the theory seeks to underscore the various motivations of the language use through which speakers or writers construct and assign social roles and identities either as speakers/writers and the listeners/readers.

3.3.1 Evaluative language use in the Interpersonal metafunction

Exploiting the interpersonal metafunction, one[19] of the functions of languages Systemic Functional Linguistics (Halliday 1985; Halliday and Matthiessen, 2004), the study examines the role of evaluative language in the social context of the medical consultation. An evaluation of

[19] The other two functions of languages are the ideational metafunction based on one's sense of experience and the textual metafunction which relates to cohesion and coherence in producing and receiving text (Halliday, 1985; Halliday and Matthiessen, 2004)

interpersonal meanings examines the choice of presentational devices used by communicators to express, naturalise or negotiate inter-subjective positions with their discussants or audience (Hood and Martin, 2005). To effectively carry out the appraisal, three systems evaluative language use are considered: attitude graduation and engagement (Martin and White, 2005; Martin and Rose 2003). Whereas attitude relates to the positive or negative positioning of communicators' feelings or opinions, graduation refers to the strength of expressing the feelings and opinions. In appraisal analysis, engagement relates to the way the communicators engage with the message to integrate or distance themselves from their interlocutors

Within the interpersonal metafunction of appraisal, Martin (1997) the evaluative resources operate under a dual interpersonal system. There are those resources of communication the discussants, interactants or writers or speakers will display when responding, advising, asserting, recommending, commanding and promising. On the other hand, there are communicative resources which exhibit varying degrees of involvement by the interlocutors on terms of the meanings they want to pass across such as the use of hedging, use of different registers in the different professional fields or use of informal language normally attributed to social networks or even intimacy such as the use of slang or coded language(White, 2015: 2)

3.3.2 Attitude

From the appraisal framework the study exploits the attitudinal system of evaluative language use by the doctors and patients in the strategic manoeuvring in the medical consultation communicative activity type. The communicator's attitudes to each other, things or states of being can be assessed as positive or negative. The positive or negative attitudes can be inscribed in the words used by discussants or simply implied in the social context of the argumentative discourse in the medical consultation argumentative activity type. The appraisal framework has classified speakers' or writers' feelings or opinions into three attitudinal semantic domains: Affect, judgement and appreciation.

3.3.2.1 Affect

The central semantic domain of affect is concerned with the display of emotional response to an event, incident, person, object or state of affairs. It can be exhibited in discourse using adjectives, verbs or adverbs which express emotion or through nominalisation (Xinghua & Thompson

2009:5). Martin &White (2005: 42) define this semantic resource as the "emotive dimension of meaning". For example, one dichotomy of affect can be captured in terms of feelings such as happiness or sadness, interestedness or boredom, confidence or anxiety, (Martin & White, 2005: 42). The expression of sensations and feelings can be classified into three categories: un/happiness

- Un/happiness: Constituting emotions to do with happiness, sadness, love, annoyance
- In/security: Constituting emotions such as confidence, trust, fear or anxiety.
- Dis/satisfaction: constituting emotions related to goal-oriented behaviour such as contentment, frustration, weariness

Communicators/writers attribute affective emotions to a person, group of people or state of affairs to evoke emotional responses by another communicator/audience/reader which may bias the positive or negative assessment of the person, object or state of affairs. The appraisal theoretical framework has classified the attitudinal evaluation of affect relying on six factors (Martin 1997, 2000; White, 2011): *1)* A classification of the intensity of the emotions ranking them from low to high; *2*) Whether the emotions target some specific response to stimuli or just represented as affecting a general or undirected mood; *3*) The classification of emotions into the three main sets of the positive and negative dichotomy regarding un/happiness, dis/satisfaction and in/security(cf Martin& White, 2005). This is a factor that constitutes the affective feelings of the heart such as sadness, happiness, anger or love, all which relate to un/happiness, emotions that relate to the pursuing set goals such as displeasure, respect or curiosity, all relating to dis/satifaction and feelings which affect one's economic and social well-being such as anxiety, confidence or fear, all relating to in/security; *4)* A contrast of the cultural conception of feelings as being enjoyable or otherwise; *5*) Whether the feelings expressed are intentional in terms of a happening (realis) or a yet to happen stimulus (irrealis); and *6)* whether the emotions display a physiological or psychological effect or are manifested using paralinguistic expressions or paralinguistic expressions such as crying or trembling.

3.3.2.2 Judgement

Judgement refers to the attitudinal assessment of the behaviour of human subjects either positively or negatively, using the accepted social norms, rules or morality as the yardstick. This assessment

can lead one to either gaining admiration or criticising behaviour. Judgement, as an attitudinal assessment, has two major classes: social esteem and social sanction.

The classification of social esteem is further subdivided into the following:

- Normality: Assesses how a person's behaviour is unusual (For instance standard, fashionable, unlucky, unfortunate, eccentric etc.)
- Capacity: Assesses the competence or capability of a person (For instance insightful, powerful, skilled, clumsy, weak, uncoordinated etc.)
- Tenacity: Assesses a person's resolve or how dependable he/she is (For instance reliable, strong-willed, dependable, brave, cowardly, despondent, lazy, rash etc.)

The social sanction judgement is also subdivided into the following:

- Veracity: Assessment of a person's truthfulness/honesty (For instance credible, truthful, frank, genuine, fake, deceptive, dishonest etc.)
- Propriety (Assessment of how ethical a person is (For instance considerate, sensitive, virtuous, law-abiding, unjust, unfair, brutal, corrupt etc.)

The social sanction classification of the attitudinal assessment of judgement relate with the codification of sets of rules or procedures in a given society. The set of rules range from moral to legal or religious. On the other hand, social esteem judgements entail the evaluative assessments of which either raise or lower a person's esteem in a group or community without necessarily having any legality or moral consequences. Thus, the dichotomy of negative and positive assessments of judgements needs to be looked at as merely appropriate versus inappropriate values of human behaviour (White, 2011).

3.3.2.3 Appreciation

Appreciation denotes those resources used in the aesthetic assessment of either natural or semiotic phenomena - such as tangible objects, entities or even abstract constructs like policies and so forth - with respect to the value attributed to them or not in a field. It is worth noting that even human beings, when viewed as entities, can be evaluated using appreciation for example 'a dominant figure'. The attitudinal evaluation criteria of appreciation involve the assignment of value to objects or things in discourse. Appreciation forms the mainstay of aesthetics. White (2011) notes

that the framework of appraisal subclassifies appreciation into the attitudinal assessment of how human beings react to things or issues (distinguishing whether the response is positive or negative); the composition of the artefact or thing in terms of whether it is complex or balanced, and the value of something. Some of the examples of values of the appreciation assessment can include: the relevancy, effectiveness, significance, innovativeness, state of health and so on.

Generally interpersonal meanings can be subjected to a continuum of the interactive system of appraisal which intertwines the three components of affect, judgement and appreciation. Central to the system is the affectual response to either judgement or appreciation which have become institutionalised in social exchanges (Martin and White 2005: 45). Judgement predisposes human beings to appropriate their feelings towards the generally accepted code of conduct as propositions on how people should behave or not. These propositions get formalised into community values as rule and regulations in society which are implemented by the state. On the other hand, appreciation relooks at feelings as schemes on the aesthetics or social valuation/worth of things. Society later validates this value into charges, prizes, awards etc.

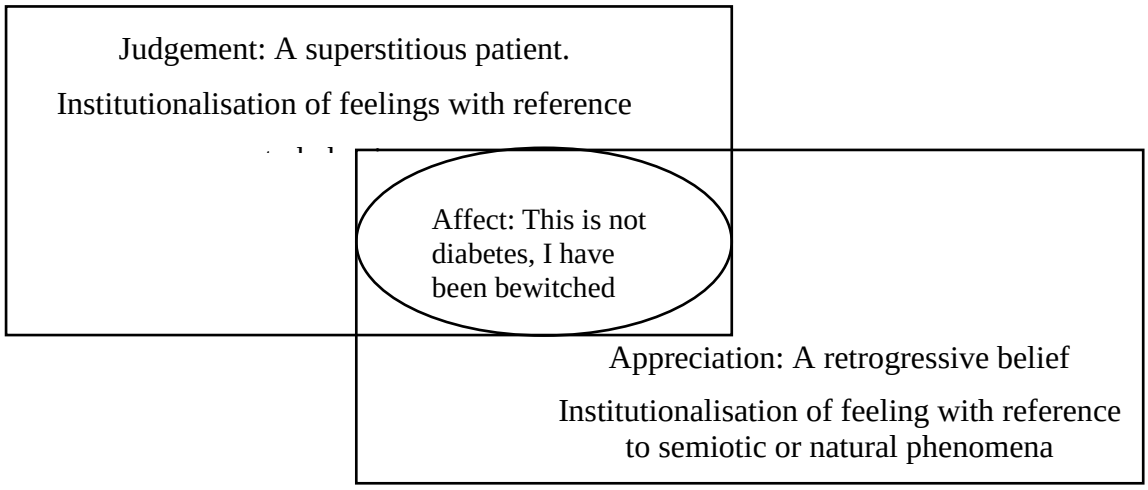


Figure 3.6 Pragmatic Attitudinal valuations (adopted from White 1998: 108)

3.3.3 Graduation

This refers to "values which act to provide grading of scaling either in terms of the interpersonal force which the speaker attaches to an utterance or in terms of the preciseness or sharpness of focus with which it exemplifies a valeur relationship' (White 2015: appraisal website). The two graduation resources are force and focus. Force is used to refer to those resources which are used

to demonstrate the varying scaling of intensity. Examples of these expressions are intensifiers such as adverbs used to express intensity, for instance: rather, very, a bit, completely etc. The graduation of force is linked to the attitudinal meaning attached to a point along a scale of low to high intensity.

On the other hand, focus is used to qualify attitudinal meanings to what can be attributed to as vague language. It is a scale which will show the extent of sharpening or blurring of a category member by either narrowing or broadening its meaning. 'Hedging' language is also covered by this resource. An example is "a true friend, pure folly" (White, 2015).

3.3.4 Engagement

This is a semantic paradigm of evaluative language use in which communicators, discussants, writers or speakers exploit intersubjective resources in positioning themselves in the discourse. This deliberate adoption of a variety of stances in terms of attitudinal advancement of standpoints is referred to dialogistic engagementin appraisal terms(White, 2015: 4). Writers or speakers can deliberately take positions which show their non-committal attitudes thus offering opportunities for other interlocutors to either challenge them or simply engage in a debate. Under engagement therefore one voice in the discourse signals an attitudinal engagement with other voices. These voices will angage with the textual voice as alternative voices which take a whole range of new positions. The current study however does not engage the semantic parameters of engagement or graduation.

3.4 Communication accommodation theory

The communication accommodation theory (CAT) is a framework which is employed in understanding the motivation, manner and social repercussions of adjusting communicative behaviours by interlocutors involved in interpersonal and intergroup interaction. In communicative encounters speakers tend to adapt their talk/speech to other interactants consciously or subconsciously. These speakers will verbally and nonverbally manipulate the "speech rate, volume, pitch, lexical choices, and even syntax to be more (or less) like *the* interlocutors" (Dragojevic, Gasiorek & Giles, 2016: 1).

The more than four decades old framework initially referred to as speech accommodation theory (SAT) was used as a prism for understanding the motivation behind speakers/writers adapting their

use of language in different circumstances when interacting with other people/readers (Giles, 1973). The SAT early studies on speakers' accommodation of each other bringing about speech variability focused more on the audience rather than the context. The contextual speech adjustments were linked more to the interpersonal communication accommodation pointing towards the centrality of the addressee of the message as the determinant of the modes of the speaker's adjustments.

The study of the communicative attunements (Giles & William, 1992) which involved the communicator's adjustment of language use to influence the discourse brought new insights into the study of speech accommodation to include nonverbal and discursive aspects of interaction. This led to the birth of the new code for the framework: communication accommodation theory (CAT). The theoretical framework has undergone several refinements and developments conceptually after its use in both inter/intracultural and inter/intragenerational communication contexts over time (Giles, Willemyns, Gallois & Anderson, 2007). CAT is now multi-disciplinary as it has been embraced in social psychology, sociology, linguistics, marketing, medicine, tourism and communication in the study of human interaction. Some of the applied context where CAT has been applied include medical and health communication, organizational, and mediated contexts which encompass video chatting, short message services, voice mails, e-mails among others (Giles & Soliz, 2014).

The conscious and at times involuntary communicative adjustment in day to day interactions between interlocutors has driven communication accommodation theory researchers to envisage and understand how interlocutors perceive, evaluate and respond to the attunements. In other disciplines, communication attunement has adopted such codes as linguistic style matching, audience/recipient design, mimicry and so forth. Communication accommodation has greatly contributed to the development of theories of ethnolinguistic identity, bilingualism and even intergenerational relations (Dragojevic, Gasiorek & Giles, 2016:1). Currently, the focus of CAT is intergroup and interpersonal communication (Gallois and Giles, 1998). A good percentage of empirical studies on CAT has been quantitative but in the recent past interpretive research on the theory has attracted a lot of attention. Dragojevic, Gasiorek & Giles (2016: 2) sums up that a third of the published empirical CAT based studies have utilized discourse analysis or the qualitative approach.

According to CAT, one's personality, social history and worldview influences how he/she "talks, listens and responds" in his/her communicative encounters with other people (Hehl & McDonald, 2014: 467). The adjustment in the communication between any two-people involved in any social interaction is random and is determined by circumstantial, personal or perceived factors. CAT posits that in trying to keep a positive social identity, speakers adapt their communicative behaviours depending on their appraisal of the defining communicative features of their fellow interactants (Dragojevic, Gasiorek & Giles, 2016: 3). Speakers involved in a two-way communication be it face to face or through or other media always want to maintain their social and personal identity. Due to this urgent need to keep a personal and unique identity, a speaker normally evaluates the other person's social identity based on his own perception of this proceeds to adjust his communicative ploys to suit the other party. In this case, the subsequent interactions are determined by the social identities established by each of the interlocutors in the present communicative encounter.

From the onset, interactants will approach each other with their preliminary orientation and perception based on their previous intergroup and interpersonal engagements and the existing sociohistorical context. This forms the basis for adjustments of communicative behaviour of for instance doctors and patients based on the evaluations of each other's personal communicative characteristics and the desire for each of these interlocutors to preserve a positive personal and social identity, as above.

3.4.1. Attunement strategies

While ensuring that communicators align and adapt their communicative behaviour to adapt to that of their partners, the product of their communication choice varies between covergence, divergence and complementarity. Convergence accommodation refers to the adjusting of communicative behaviors of communication partners to afford a similar communicative behaviour. Through such variables as accent, language, pitch or speed of talk convergence can exhibit itself in communicative contexts. Ordinarily interlocutors normally will try to adapt their talk so that it looks and sounds as similar or accommodative as possible.

Divergence, on the other hand entails the deliberate attempts by speakers or communicators to accentuate communication differences be they verbal or nonverbal. The intent of this kind of

accommodation is to make the language to be as dissimilar as possible for a desired effect. Studies have been carried out which demonstrate how communicators will maintain their social class without attempting to mix with others in terms of linguistic choices such as the use of Welsh and English case study which saw the identity emphasis based on the accents of the users of the two languages (Bourhis and Giles,1977). Discussants may deliberately prefer to display maintenance in their communication by consistently sticking to their default manner style of communication (Dragojevic *et al.*, 2016: 4). Maintenance is also referred to as complementarity. Street (1991: 135) has described complementarity as a communication accommodation strategy which entails the mutual maintenance of social differences and steady interactions.

3.4.2 Accommodation strategies

Communication accommodation or non-accommodation can be determined by four strategies of communication accommodation. These include: interpersonal control, approximation, discourse management, and interpretability (Jones, Gallois, Callan & Barker, 1999; Gasiorek & Giles, 2013; Dragojevic *et al.*, 2016). The present study explores the accommodation strategies of interpretability, discoursemanagement and interpersonal control to understand the way doctors and patients display their strategic manoeuvring through communicative adjustment (see section 4.4 of Chapter 4, section 5.5 of Chapter 5 and section 6.4 of Chapter 6).

i. Interpersonal control

The accommodative behaviour of interactants relative to the social relations in terms of role, status or power determines levels of interpersonal control in communication accommodation. Convergence or divergence in communication can be influenced by role relations of the interactants. Depending on one's discretion the level of communication adjustment can grow or reduce to suite the roles of each other (Gallois *et al*., 1988). Depending on the relations of members or groups, the strategy of interpersonal control can be exhibited for positive or negative effects. On a positive note, when used in between group members with clearly defined shared roles and identities, it is devoid of any uncertainties because everyone knows the roles of each other person. Similarly, in intergroup interactions, where roles can be set aside, and people have the freedom to express themselves in terms of communicative behaviour, it can have positive effect. On a negative note, however, interpersonal control in communication accommodation can be used to undermine

another person through use of linguistic resources to shift a person's role for control purposes (Giles & Coupland, 1991).

ii. Approximation

Approximation is a conversational accommodation strategy which involves the response to the communicative performance of a speaker in terms of his/her verbal behaviours. One can attune himself/herself to another person's accent or posture for acceptability in terms of communication. Approximation strategies of communicative accommodation may entail the deliberate attempts to align communication patterns in terms of language use to be more similar or dissimilar (Gasiorek & Giles, 2015; Dragojevic *et al.*, 2016).

Some of the approximation strategies include the convergence of adaption to another person's communicative behaviour which may include the speech rate or pauses including non-verbal communication cues. In addition, on can exhibit divergence accommodation of the other party by laying emphasis on the differences in their communication to achieve his/her communicative intentions. On the same note, a communicator can deliberately maintain the communicative behaviour without aligning it with his/her audience (Jones *et al.*, 1999: 124). In cases where the communicators have power or some roles, they may decide to establish a complementary relationship in their communicative accommodation of each other's style. Engaging each other in a dissimilar fashion reflects the differentiation of the powers or roles of each of them. This maintenance of social differences of interactants is called complementarity in CAT and it has been distinguished from divergence (Dragojevic *et al.*, 2016).

iii. Interpretability

The sociolinguistic strategy of interpretability involves an accommodative response to an interactant's capability to understand. Through interpretability, interlocutors' linguistic choices and style of communication is attuned to the level of comprehension of each other (Gallois et al., 2005). A discussant can attune his/her language to an overtly expressed inability to understand or perceived conversational need of the other party's ability to comprehend issues under discussion. Interpretability strategies therefore call for interactants to consider their partner's comprehension inadequacies and respode through adjusting their language to accommodate them.

Effective communication accommodation with regard to ensuring that there is inclusive and cohesive interactions calls for interpretive competence for communicators or interactants to understand each other when engaged in conversations. Giles and Coupland (1991) points out that one's interpretive competetence can be determined through the definition of the cultural or group or social network memberships based on ethnicity, profession or gender or any other parameters. A critical look at the competetence in the interpretability competence will involver a range of factors which are both stylistic, linguistic and extralinguistic(Farzadnia & Giles, 2015). The kind or presentational device choices are a consideration in classifying the interpretive competence in the language of the pragma-dialectics of critical discussions. The communicative behaviourial choices in trying to establish common ground for ease of interaction with the audience such as the nonverbal behavior choices; adherence to social norms, the selection of topics of discussion or the kind of lexical ites the person displays can determin the person's ability to integrate or imply the need to attune each other's communication (Jones *et al.*, 1999: 125).

iv. Discourse management

Exploiting discourse management as a strategy of communication discussants can evaluate and perceiver each other's conversational needs discursively. The display of discourse management occurs when the discursively decide on the decision makers in a conversational setting in terms of the content of their discussion. The centrality of discourse management among the accommodation strategies has been emphasised by Coupland et al. (1988) when they distinguish the mode, the field and the tenor as its key elements. The mode of discourse management refers to the manner of allocating turns in a conversational setting by structuring it in a manner that has meaning. On the other hand, field has been attributed to the ideational structure of the talk, such as the choice of the topics. Tenor in discourse management relates to the nonverbal aspect of communication of face and position management to achieve a desired effect in the context of the interaction. Face management can be used as a strategy to correct communication breakdown. Some cues can signal a desire for maintenance in communication by invoking responses targeting a reversal of incoherent messages or mitigating the social consequences of a breakdown in communication.

3.4.3 Other forms of accommodation

Convergence and divergence accommodation may take different forms (Gallois & Giles 1998). A distinction is made between upward and downward convergence or divergence accommodation. Another classification distinguishes psychological from linguistic accommodation (Thakerar *et al.,* 1982). Psychological accommodation relates to the intention or motivation to attune communication behaviour to suit another party whereas the actual choices of words and expressions form linguistic accommodation. Other recent developments of communication accommodation include the difference between productive and receptive accommodation (Pitts & Harwood, 2015). Productive accommodation entails the sending a message while receptive accommodation entails interpreting the message. In other words, communicators will exploit productive accommodation when they use their language to converge or diverge for desired outcomes. On the other hand, receptive accommodation entails the ways in which a person perceives the convergence or divergence in the communicative behaviour of his or her interlocutor.

Giles and colleagues (2007) have formulated a set of six guiding principles of accommodation in trying to map out the directions of CAT. First, the decrease in a speaker's perceived adjustment inevitably reduces the apparent social distance leading to shared understanding and healthy interactions and a fair assessment of interactants. Secondly, interactants will continually nonaccommodate to patterns of communicative behaviour which are associated to their partners by trying to increase the social distance between themselves as individuals or as a group. These interactants will do so by limiting the level understanding of their interlocutors. Third as a fundamental of interaction, communication accommodation aims to promote coherent interaction and manage the social distance between people and individual members of group. Fourth, due to the functional element of accommodation in terms of motivation and the expected outcomes, perceived nonaccomodation gradually dims interactional fulfilment increasing the social distance between communicators. This form of underaccomodation has the negative effect of hampering mutual satisfaction. Fifth, personal idiosyncratic preferences, the sociohistorical context, intergroup and interpersonal histories shape the expectations of what qualifies to be labelled appropriate accommodation in context. Lastly there is a tendency of communicators accommodating communicative patterns of those they wish to associate with at a personal or group lever with more clarity.

3.5 Summary

This chapter has presented the general background and developments of the theoretical framework of the extended pragma dialectical theory of argumentation. The review lays bare the pragma-dialectical resources of analysing the data for the study whose results and discussion are presented in the next chapters (Chapter 4, 5 and 6). The exploration reviews the latest developments of argumentation theory which is now focused on the process of identifying prototypical patterns of argumentation in which stems from argumentation in context. The chapter also discusses the theory of CAT and appraisal whose elements complement the process of investigating the strategic manoeuvres exhibited by doctor and patients in the Gusii medical consultation. In understanding the argumentative encounters between Gusii doctors and Gusii patients, the evaluation resources of attitude which the study utilises in trying to unravel the strategic design in the communicative activity type are explored in the review. Lastly, a review of the various accommodation strategies which also presents another perspective in understanding the motivation for the linguistic and stylistic choices in a medical consultation that displays the interplay between the institutions of traditional Gusii sociocultural belief system concerning illness and western contemporary medicine.

CHAPTER FOUR
STRATEGIC MANOEUVRING IN ARGUMENTATION IN MEDICAL CONSULTATIONS INVOLVING DOCTORS AND HIV & AIDS PATIENTS

4.1 Introduction

Having explored the theoretical grounding of the study in Chapter 3, where the pragma dialectical framework of argumentation is presented, together with the supplementing appraisal and communication accommodation theories, this study embarks on the first analysis chapter. Chapter 4 analyses the strategic manoeuvres involved in the argumentation processes in resolving differences of opinion which manifest themselves in the Gusii medical consultation involving HIV and AIDs patients. In doing so, section 4.2 explores the doctor's and patient's argumentation schemes in a difference of opinion on the use of contraceptives and stigma. Section 4.3 examines the role of the attitudinal assessment in language use in the strategic manoeuvring by the doctor and the patient in argumentative cultural intricacies of the supernatural *ebibiriri* 'evil eyes' and HIV stigma in discordant couple. An investigation on the role of discourse management, interpersonal control and interpretability in the communication adjustment in the strategic manoeuvres by the two consultation partners occurs in section 4.4. Sections 4.5 and 4.6 examine the argumentation structure of the medical consultation and the influence of the competing institutional preconditions in the strategic manoeuvring, respectively.

4.2 The pragma-dialectics of the medical consultation involving the doctor and HIV & AIDS patients

In the augmentative reality of a medical consultation involving a doctor and a HIV positive patient, differences of opinion occur in the process of shared decision-making. Some of the differences may be related to the adherence to antiretroviral therapy (ART), care to avoid either reinfection or infecting a partner or other people or simply on the disclosure of HIV status to partners or family. The pragma dialectical theoretical model of argumentative discourse can be exploited to empirically reconstruct the normative and descriptive aspects of the argumentative reality of the

medical consultation in an analysis aimed at resolving such differences of opinion on merits (van Eemeren & Grootendorst 1992:3-12; Van Eemeren *et al*. 2014:527-533; Van Eemeren & Houtlosser 2015:154-159). The theory of argumentation, discussed in Chapter 3 section 3.2, provides the analyst with the tools of reconstruction, interpretation and evaluation of argumentative discourse. The point of departure for a critical discussion is the confrontation stage where the opposition to a given standpoint by the interlocutor creates a difference of opinion (van Eemeren & Houtlosser, 2015:156). The disagreement evokes the argumentation process to resolve the difference reasonably. Example 1 below presents a situation where there is a contradiction, which offers a doctor a point of confronting a 20 to 23-year-old HIV positive female patient during a consultation (HIV and AIDS 1 [see appendix xv]).

(1) [1] Doctor: *Mogendererete kororana kemobere?*

Are you still intimate?

[2] Patient: *Ee*

Yes

[3] Doctor: *Ngotumia more ekondomu?*

Do you use the condom?

[4] Patient: *Yaya*

No

[5] Doctor: *N'omosani oyo oo inee, nabwa…opimirwe gose nere nigo…*

And this friend of yours, does he have… or has he gone for the test or is he also…

[6] Patient: *Nantebetie ng' opimirwe korende tindagenda nere gopimwa.*

He told me he went for the test, but we have not gone with him for it.

[7] Doctor: *Mm. Igo onye timorapimwa… korende teri mang'ana… nki keragere ororane n'omomura naye kore positive? Tobwati borendi nonya mboke?*

Mm. If you have not gone for the test … but never mind …why will you see a man and you are positive? Don't you have any care at all?

[8] Patient: *Igo nkwoboa komotebia ng'a igo nde positive*

I fear to disclose to him that I am positive.

[9] Doctor: *Eh, nomocharetie?*

Eh! Do you care for him?

[10] Patient: *Ee ntagete anywome.*

Yes, I want him to marry me.

[11] Doctor: *Bono onye komocharetie notakeire ritang'ani omanye gose nabwate oborwaire gose tabobwati erinde erio naye omorende.*

Then if you care for him you need to know his HIV status so that you don't infect him if he is HIV negative.

[12] Patient: *Na tagtari gakomanya nga igo nde positive tagontiga?*

And won't he abandon me if he knows my HIV status?

In example 1, the patient makes an assertion (turn 6) in a standpoint claiming her non-confirmation of the boyfriend's HIV status, in response to the doctor's inquiry on the patient's knowledge of the boyfriend's HIV status. The doctor reacts by confronting the patient's standpoint with a declarative challenging the patient why she will see the boyfriend without protection, yet she knew her status. The inquiry whether they use a contraceptive for protection from infection (turn 3 and 5) forms a basis for the doctor's challenge of the patient's standpoint. The institutional preconditions of contemporary medical practice accord the doctor the authority to ascertain very personal aspects of the patient's life. The subsequent disclosure by the patient of unprotected sex without determining the HIV status of the partner is a manifestation of a difference of opinion (turn 4 and 6). The revelation marks the point, where the two discussants agree on both material and procedural commitments for a critical discussion normally carried out in a regimented argumentative procedure. The opening stage sees the doctor assume the antagonist position challenging the patient who is the protagonist in the critical discussion. Using pragmatic argumentation, the patient quickly resorts to amplification in declarative speech acts explaining why she cannot afford to disclose her status to the boyfriend.

In argumentative discourse, discussants can express their standpoints and premises explicitly or implicitly. Unexpressed elements refer to elements in the discourse, which remain implicit because they are indirectly expressed unlike their explicitly expressed counterparts (van Eemeren Grootendorst & Snoeck Henkemans, 2002:49-59). Pragma-dialectic analysts can identify and reconstruct these implicit elements in their analysis and interpretation of argumentative discourse as discussed in section 3.2.5 of Chapter 3. In the argumentation stage of the critical discussion of the medical consultation argumentative activity type, in example 1 above, the patient presents two

pragmatic arguments with unexpressed premises in the consultation: i) If I tell him I am positive, I fear he will leave me (turn 8 and 12), and ii) I do not want to tell him my status because I want him to marry me (turn 8 and 10). Figure 4.1 below shows a schematic representation of the structure of the patient's argumentation from the consultation.

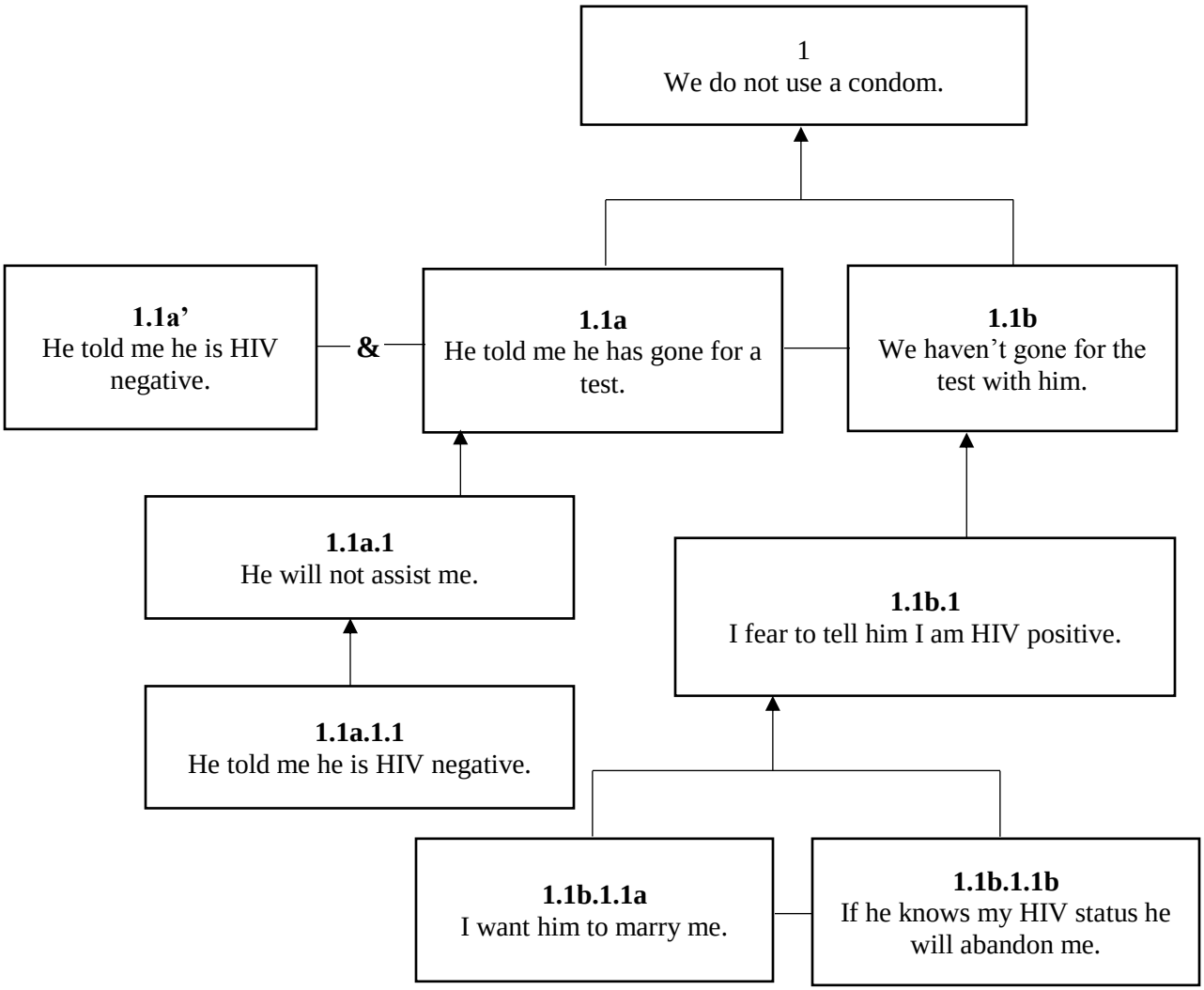


Figure 4.1 Schematic representation of patient's pragmatic arguments in a disagreement due to stigma in use of contraceptives

The two pragmatic argument schemes, which are a subtype of causal argumentation, are used by the patient to provide justification of her standpoint. These arguments are presented in figure 1 above as coordinative arguments **1.1a** and **1.1b** and the supportive second level subordinative arguments in **1.1a.1**, **1.1b.1** and the third level arguments 1.1a.1.1 (subordinative), and **1.1b.1.1a** and **1.1b.1.1b** (coordinative). The first implied premise also can be classified as a 'fear appeal'

argument in which the patient uses fear to legitimise her not disclosing her HIV status to the boyfriend. The affective aspect of choice of presentational devices where fear is an emotional parameter of evaluative language use is examined in the next section of this chapter which conducts an appraisal of the argumentative discourse in the medical consultation. Indeed, the two reasons presented by the patient might be qualified as unintentionally unreasonable forms of persuasion by the patient to justify her standpoint (Rubinelli, 2013).

Unreasonable persuasion happens when the premises of an argument do not support the conclusion provided. Unreasonable persuasion is fallacious in orientation. In example 1, the arguments seem convincing but on a critical evaluation they are fallacious because of the flaws in the reasoning. The intent might be positive, but the argument is unreasonable (Rubinelli, 2013). The patient expects to convince the doctor by using these arguments to justify her standpoint. The patient exploits the argumentation activity of persuasion in the communicative activity type of the medical consultation through a negative version of pragmatic argumentation to try and effectively and reasonably resolve the difference in opinion with the doctor.

The doctor's directive in example 1 above recommending that she needs to know the HIV status of the boyfriend to avoid infecting him if he is HIV negative (turn 11) has the refutation force of a doctor's authority. The institutional precondition of contemporary medicine empowers the doctor to exploit argument from authority in strategically manoeuvring as one of the primary prototypical argument schemes the doctor exploits in the medical consultation communicative activity type (Henkemans, 2011; Labrie,2012; Pilgram, 2015). In complying with this institutional requirement in his role as doctor, he quickly asserts his position by recommending that the patient needs to find out the HIV status of the boyfriend to avoid infecting him should he turn out to be negative.

In refuting the patient's argument, the doctor in the (Eke)Gusii excerpt in example 2 below drawn from the same HIV and AIDS 1 consultation (see appendix xv) employs symptomatic relation argumentation.

(2)

[1] Doctor: *Onye kagwanchete takogotiga.*

If he loves you, he won't leave you.

[2] Patient: *Mm*

Mm.

[3] Doctor: *Ee ase oborwaire obwo. Onye nere kabobwate mokonyane. Obwo nabwo obwanchani.*

Yes, should he turn out to be positive then you can find a way of managing your condition together. That is what love is all about.

[4] Doctor: *Nche ndoche ng'a tagonkonya*

I think he will not help me.

[5] Doctor: *Igo nigo bwoboete…*

So, you fear…

[6] Patient: *Egekogera nantebetie ng'a igo are negative.*

Because he had told me that he is negative.

[7] Doctor: *Onye kagwanchete boronge takogotama. Igo nario oramanye gose nagwanchete boronge.*

If this gentleman really loves you, he will not reject you. In fact, this will be the best opportunity to test his love for you.

[8] Patient: *Mm*

Mm.

[9] Doctor: *Ee.* ***Igo neganeirie*** *amanye gose nabobwate gose tabobwati, nario moramanye nchera ki mokororana kemobere. N'onye mogokora* ***goika motware*** *ekondomu, n'eriogo ogenderere konywa buna egwenerete. N'ore naende na mochando onde rero?*

True. **It is imperative** to know the status of this gentleman so that you can decide on how you engage in sexual intercourse. And when you do, you **must always have** a condom, and you should continue to take your medicine as required. Do you have any other issue?

Using the medical consultation discourse in the excerpts in examples 1 and 2, the doctor's argumentation structure is represented in Figure 4.2. In the consecutive assertions, the doctor exploits the argument scheme of authority to refute the patient's claim that she will leave him if he knows her HIV status. The doctor further uses the symbol of his authority to assert the acceptance of his pragmatic argument that if the test turns out to be positive then they can find a way of managing the HIV condition jointly (**1.1.1a**). Employing pragmatic argumentation, the doctor tries to persuade the patient to either disclose her status to the boyfriend or have both go for

HIV Testing and Counselling (HTC) together for better care, and management of the condition depending on the outcome of the test results.

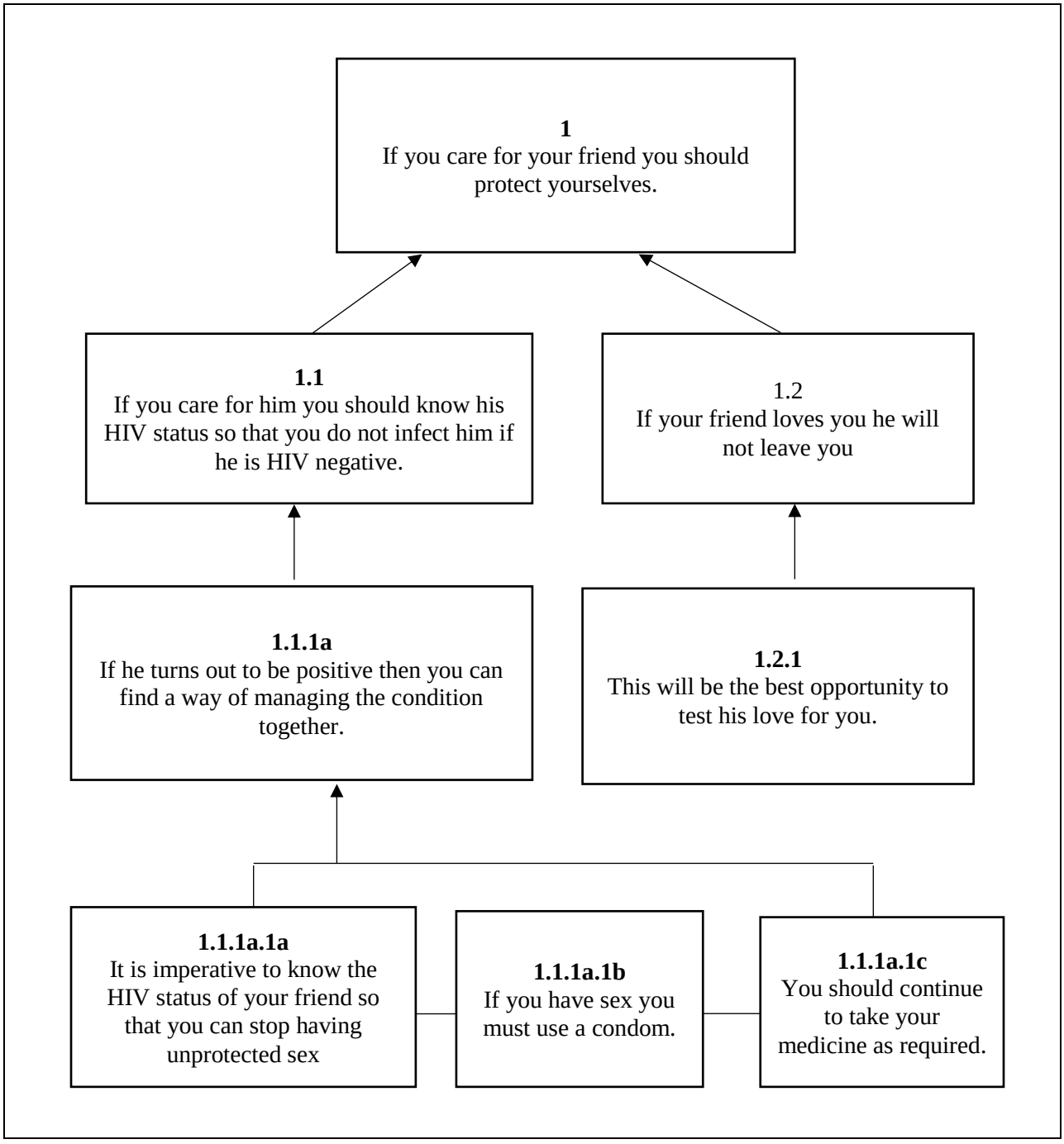


Figure 4.2 Argument structure of the doctor's pragmatic and symptomatic argumentation in difference of opinion on use of contraceptives

This is a strategic manoeuvre by the doctor in trying to appeal to the patient in the management of stigma, which seems to inform her unwillingness to disclose her HIV status unreasonably unaware of the devastating effect of her action. Using an assertive, the patient tries to justify her negative pragmatic argument by claiming that the boyfriend will not assist her because he had initially informed her that he was negative (turn 6, example 2). The patient's causal relation argumentation does not convince the doctor because of the evidence based institutional and legal requirement of the practice of medical consultation. This argument motivates the doctor to prepare the ground for the conclusion where the issue is resolved using his authority as the medical professional and leader of the medical consultation.

It is the final thrust of the doctor's argumentation, which resolves the difference of opinion. Exploiting pragmatic argumentation reliant on his authority and professional experience the doctor assertively assures the patient on the opportunity the boyfriend will have to demonstrate his love for her without necessarily having to abandon her (turn 7, example 2; also see 1.2 and 1.2.1 in figure 4.2). This argument prepares the doctor to exploit his privileged professional position to proceed to execute the final argument in the process of resolving the difference of opinion on merits. The doctor proceeds to employ the strategic manoeuvre of argument from authority by decisively using declaratives to issue directives to the patient using such expressions as *"igo neganeirie"* (It is imperative), *"goika motware"* (you must have). The doctor challenges the patient to establish the status of the boyfriend and orders her to stop having unprotected sex. He further directs her to ensure they use a condom and to take her ARV medicine as required. This might sound paternalistic limiting the patient's autonomy, but it is in the institutional precondition that empower the doctor by granting him authority to reasonably advice the patient as a professional by consensually giving requisite treatment recommendations (Labrie, 2012; Pilgram, 2015; van Eemeren, 2015).

From the argument structure in Figure 2, the doctor's argumentation can be characterised into pragmatic argumentation and authority argumentation. Exploiting the two argument schemes, which are subtypes of causal argumentation and symptomatic argumentation, respectively, the doctor and the patient resolve the difference of opinion effectively and reasonably to bring the critical discussion to a conclusion. Whereas the patient exploits the negative version of pragmatic argumentation, the doctor has exploited the positive version of pragmatic argumentation exploiting

the medical training and professional experience he has acquired in her interactions with HIV and AIDS patients. Section 3.2.5 and 3.2.6 of Chapter 3 have discussed both pragmatic and authority argumentation

4.3 The language of evaluation in doctor patient consultation

As discussed in Chapter 3 Section 3.3, discussants can exploit the semantic paradigms of affect, judgement and appreciation in their choices of presentational devices in expressing, naturalising and negotiating interpersonal subjective positions in a communicative situation (Hood & Martin, 2005). In resolving differences of opinion in consultations involving HIV and AIDS patients, the evaluation of the expression of positive and negative emotions and opinions by the doctors and patients in their strategic manoeuvring can help understand how the two communicators aim for rhetorical effectiveness while maintaining dialectical standards of reasonableness.

In the excerpt in example 3 below from HIV and AIDS 2 medical consultation (see appendix xvi on page 412) involving a HIV positive patient who is in a discordant couple, a difference in opinion manifests itself when the patient reveals that she may not get infected because they occasionally have unprotected sexual intercourse but because of the discordance, she thinks that "he is safe". This is the manifestation of the difference in opinion where the patient is the antagonist while the doctor is the protagonist.

(3)

[1] Patient: *Onye ndiria are kobonyora anga obonyorire*.

If he was getting it, he would have gotten it.

[2] Doctor: *Obonyorire.*

He would have gotten it.

[3] Patient: *Torochi rende nigo are safe?*

Don't you see he is safe?

[4] Doctor: *Obuya obotuki nabwo bogotoraa.*

The good thing, we are guided by research.

[5] Patient: *Mm.*

Mm.

[6] Doctor: *Boria bwakorirwe.*

Which has been done.

[7] Patient: *Mm.*

Mm.

[8] Doctor: *Tari aiga seito Gusii oka gose Kenya yoka.*

Not here in our Gusii home alone or Kenya alone.

[9] Patient: *Mm.*

Mm.

[10] Doctor: *Nkera ase.*

It is everywhere.

[11] Patient: *Mm.*

Mm.

In responding to the antagonist's stand, the doctor begins with an argument by authority by insisting that the medical practice is "guided by research". The expression "guided by research" evokes an evaluative statement by the doctor which touches on the judgement of the decision-making process during a medical consultation. The social sanction of this process is evidence-based. This is both a legal and ethical requirement in the medical profession where the doctor is expected to provide evidence-based medicine. The doctor's evaluation here is that this act is both a "moral" and "law-abiding" act. In terms of the evaluation of the social esteem, the doctor demonstrates the "standard" practice of the custom (normality) of the evaluation of the patient's condition; the "skilled" capacity in managing the consultation and engaging the patient in the treatment decision-making process, and the doctor's tenacity of being "reliable" and "dependable" (White 2011: 23).

The doctor authenticates the medical practice of evidenced based medicine when he says that their decision-making procedures and judgements are "guided by research which has been done" "everywhere" beyond the Gusii or Kenyan locality. In terms of the social sanction, the veracity of the doctor's advice can this be evaluated as being "authentic and honest". The doctor's use of such expressions such as, "*tari aiga seito Gusii oka"* (not here in Gusii alone) and "*gose Kenya yoka"*

(or Kenya alone) as a self-assessment of the studies have been carried out but "everywhere" in emphasizing the credible veracity of the evidence-based medicine in the argument from authority for the health of the discordant couples in HIV and AIDS consultations (turn 8, example 3). By the expression "*nkera ase"* (it is everywhere everywhere) the doctor evaluates the population basis of research findings which form part of the premise of his argument using the composition and valuation parameters of appreciation (turn 10, example 3). This means that the source of the findings "everywhere" denotes profound research(valuation) and representativeness of the research findings(composition).

Using the language of evaluation in the medical consultation, the doctor can strategically exploit his professional communication skills of argumentation to pragma-dialectically resolve a difference of opinion. In cases where the traditional Gusii sociocultural belief on illness system comes in the way of the contemporary medicine system, strategic manoeuvres consist of a careful exploitation of appraisal resources in the effective and reasonable resolution of disputes in the medical consultation communicative activity type. In an excerpt from HIV and AIDS 5 consultation (see appendix xix on page 519) in example 4 below, a HIV positive mother with a child with signs of HIV infection disagrees with the doctor during a treatment decision-making process. In line with the contemporary medical institutional precondition of evidence-based medicine, the doctor recommends a clinical investigation through tests to scientifically and professionally establish if the child could be having malaria (turns 1 and 3) especially because the Gusii region of Western Kenya has a high prevalent rate of malaria. Nevertheless, the patient expresses her doubts that the child may be having malaria (turn 4 and 6) and goes ahead to self-diagnose the child's illness to as being "*ebibiriri*" (turn 8).

(4)

[1] Doctor: *Mbuya tware koramorenga.*

It is good to carry out some tests on him.

[2] Patient: *Mm.*

Mm.

[3] Doctor: *Torore gose malaria abwate.*

We see if he has malaria.

[4] Patient: *Ah rakini bono rende ntware korarigereria... orarigereria ebinto binde?... okoba nabo erabe teba mareria… enchera egocha. Nigo riberera riaye rigocha rire igoro mono.*

But then couldn't we first check, check for other things? … because it might turn out not to be malaria… the way it manifests itself. It is his fever which is quite high.

[5] Doctor: *Mm.*

Mm.

[6] Patient: *Bono tinkagereti gose nenyare koba nga malaria.*

Now I don't think that it can be malaria.

[7] Doctor: *Aye ng'o orengereretie nki omwana abwate?*

In your thoughts, what is bothering the baby?

[8] Patient: *Ndoche ng'a nebibiriri asiareire.*

I see that the baby has been infected by 'ebibiriri'

[9] Doctor: *Ebibiriri?*

'Ebibiriri'?

[10] Patient: *Mm.*

Mm.

[11] Doctor: *Mmh …nki gekoorokia ase omwana …aye buna oroche nki gekoorokia?*

Mm … What shows on the baby… from your observation what shows?

[12] Patient: *Ekiagera bono riberera igo rire igoro mono*

Because now the fever is too high.

[13] Doctor: *Ah ebibiriri ase Gusii yaito tibiri gocha neriberera.*

Ah 'ebibiriri' in our Gusii backyard do not come with fever.

[14] Patient: *Mm.*

Mm.

[15] Doctor: *Omwana igo are korera?*

Was the baby crying?

[16] Patient: *Mm.*

Mm.

[17] Doctor: *Buna nkoigwa, igo akorera?*

From what I hear, the baby cries.

[18] Patient: *Mm.*

Mm.

[19] Doctor: *Tarigotwara iberera.*

He does not have fever.

[20] Patient: *Mm yaya ekobwati mbare bakorera naende riberera rire aroro*

Mm … No, it depends, there are those who cry and have fever at the same time.

[21] Doctor: *Ee.*

Yes.

[22] Patient: *Ee.*

Yes.

[23] Doctor: *Rakini asengencho tore ase malaria eichire…*

But because we stay at a region where malaria is predominant…

[24] Patient: *Mm.*

Mm.

[25] Doctor: *Malaria nero nabo egocha buna buna gwatebire igo.*

Malaria also has the same symptoms you have just said.

[26] Patient: *Mm.*

Mm.

[27] Doctor: *Igo ntobwati… kende nkeiyo togoita*

So, we don't have … there is nothing we are killing.

The choice of presentational devices, topic potential and the audience demand in the process of linguistic choices in the argumentation process brings to play the interpersonal functioning of the social identities the interlocutors exploit in the argumentative reality. The positions taken by the patient and doctor are informed by the socially determined values positions controlled by the institutional systems under which they operate. Whereas the doctor is aligned to achieving the institutional point of contemporary medicine, the patient aligned to the traditional Gusii sociocultural illness belief system while engaging the doctor in the medical consultation.

At the confrontation stage, the patient expresses her dissatisfaction with the doctor's clinical investigation intentions to find out if the child has malaria. In the discourse the patient gives a negative assessment of the doctor's recommendation to check for malaria (turn 4 and 6) as odd (normality/social esteem-judgement) because according to her, the symptoms of the child indicate the possibility of a supernatural cultural condition called *ebibiriri (turn 8).* The doubts cast on the doctor's recommendation also indicate the patient's suppressed affect feeling of fear, if the doctor is to proceed to carry out the tests. The traditional Gusii sociocultural illness belief associated with *ebibiriri* is that if a child has the condition then they should not be injected because they will automatically die. This belief makes the patient to quickly inform the doctor that this could be the

condition because of the assumption that the doctor understands the local traditional Gusii sociocultural illness belief. This implies that the patient has a negative assessment of the appreciation of *ebibiriri* because of its disastrous effect on the mortality of the child than her appreciation of effect malaria as suggested by the doctor. Armed with the material and procedural starting points, the opening stage sees the doctor taking the protagonist position against the patient who is the antagonist against the clinical investigation by the doctor. The difference of opinion literally brings the two institutions represented by the two discussants at loggerheads. However, the doctor being a Gusii speaker with understanding of the traditional Gusii sociocultural illness beliefs, and a medical professional, is quick to lead the critical discussion in resolving the difference of opinion on merits.

The argumentation stage of the critical discussion process involves a careful exploitation of the evaluative language resources in simultaneously aiming for a rhetorical and dialectical refutation of the patient's standpoint. Being a Gusii medical professional, the doctor exploits argument from authority in refuting the patient's assertion. In doing so, the doctor exploits the evaluative language of affect through the expression of emotional surge when he says, "*omwana igo akorera*" (the child cries) when he has been infected with *ebibiriri* (turns 15 and 17) as shown in Table 4.1 below. In these words, where he expresses his knowledge based on experience, the doctor indirectly provides a positive assessment of the judgement of his social esteem in skilled capacity and social sanction of a truthful and credible veracity. The evaluative aspects of his choice of presentational devices are meant to assert his position as the medical expert and leader of the consultation who understands the details of the medical process of establishing the illness of the child. However, the patient considers the crying and fever as distinct symptoms which may manifest themselves from one case to another (turn 20) in her pragmatic argumentation. However, the doctor uses his wealth of medical knowledge and experience to challenge the reliability of the information in the patient's argumentation.

Further in refuting the patient's argument, the doctor uses the argument from authority relying on expert opinion (turns 23 and 25). In presenting the argument, the doctor uses various social parameters of judgement in reinforcing the social identity of his position as an experienced professional. A positive evaluative expression of the doctor's judgement reveals his deployment of the evidence-based precondition of strategic manoeuvring in the communicative activity of the

medical consultation. His insistence that the region has a prevalence of malaria cases (turn 23) and the possibility that the symptoms the patient indicates (turn 25) automatically pointing to his interest in carrying out confirmatory clinical tests on the child to check for a probable malaria infection. The doctor's use of presentational device presents his positive assessment of his social esteem and social sanction in judgement terms. In terms of social esteem, the doctor presents himself as insightful and skilled (capacity), resolute (tenacity) and keen on following standard clinical procedures in the process of malaria diagnosis in the region (normality). On the other hand, in terms of social sanction the doctor is honest (veracity). Both the doctor and the patient retain their social identities in the argumentation stage employing every possible evaluative language in their choice of presentational devices in the consultation.

Table 4.1 Attitudinal assessment of affect for presentational device choices for the doctor and patient in consultations involving HIV & AIDS patients (after White, 2011)

Attitudinal evaluative language for affect	**Positive**	**Negative**
Patient: "… *igo toramoe omochakano chintetere echio chieriberera alafu toramotige igo torore buna akoba*" (… let's give him tablets for the fever then we leave him and see how he fairs on).		Fear/anxiety
Doctor: "*Buna nkoigwa, igo akorera"* (From what I hear, the baby cries.)		Crying

In example 5 below, in the following excerpt from HIV and AIDS 5 consultation (see appendix xix on page 522), the doctor and the patient exploit pragmatic argumentation informed based on the authority bestowed to them by their institutional leanings: the contemporary western medicine and the traditional Gusii sociocultural illness belief system respectively.

(5)

[1] Doctor: *Nabwate chisigns chikoorokia nabo aratware malaria.*
He has signs which show he may have malaria.

[2] Patient: *Mm.*
Mm.

[3] Doctor: *Igo tigango toramopima.*

So, let us first carry out the tests.

[4] Patient: *Mm.*

Mm.

[5] Doctor: *Ee tomanye komoa amariogo.*

Yes, then we can give him medicine.

[6] Patient: *Yaya bono egento torakore igo toramoe omochakano chintetere echio chieriberera alafu toramotige igo torore buna akoba*

No then, let's give him tablets for the fever then we leave him and see how he fairs on.

[7] Doctor: *Ogopima… tari ogopima mbosa.*

The testing… it is not that testing is free.

[8] Patient: *Mm.*

Mm.

[9] Doctor: *Na riberera tari borwaire.*

And fever is not a disease.

[10] Patient: *Mm.*

Mm.

[11] Doctor: *Riberera igo rikoretwa n'oborwaire*

Fever is caused by an infection.

[12] Patient: *Mm.*

Mm.

[13] Doctor: *Igo natomoa echi chieriberera onye ntoramoa echio oborwaire…*

So even if we give him the ones for fever, if we have not given those for the disease…

[14] Patient: *Mm.*

Mm.

[15] Doctor: *Bado ntorakonya mwana oyo.*

We would not have saved your child.

[16] Patient: *Mm.*

Mm.

[17] Doctor: *Omwana oyo nabwate oborwaire bokogera riberera eri riche. Tiga toramopima gatoranyore ng'a tabwati malaria, ntokomoa echia malaria. Gatoranyore malaria nerororo, nabo tokomoa echia malaria amo nechieriberera. Igo riberera ndiri gocha bosa. Yaya, igo rigocha rire noborwaire.*

This child has a disease which causes the fever. Let's carry out the tests, should we find out that he does not have malaria, we wouldn not treat him for malaria. If we find

that he has malaria, we will treat him for malaria and the fever. So, fever never comes just like that. No, it comes with an infection.

[18] Patient: *Noborwaire.*

With an infection.

[19] Doctor: *Noborwaire.Tiga tonyore oborwaire tomoe amariogo.*

With an infection. Let us establish the disease and give him medicine

In the doctor's commitment to the institutional precondition of evidence-based medicine, his choice of presentational devices denotes his positive appreciation of the medical procedures for diagnosing illnesses of his patients. In his exploitation of pragmatic argumentation, the doctor relies on his experience and training in using physical examination and history taking to recommend clinical testing to check for malaria and any other infection the child may be having (turns 1,3, 5 and 7). The doctor's commitment shows his positive evaluation, the judgement of his law-abiding (propriety) social sanction, by exploiting his skilled capacity in the practice of the standard (normality) procedures of contemporary medicine that assert his social esteem. In a surprise strategic argumentative move, the patient decides to do a self-prescription *"toramo*[*a*] *omochakano chintetere echio chieriberera alafu toramotige igo tororе buna akoba"* (to give him tablets for the fever then we leave him and see how he fairs on [turn 6]).

In the pragmatic argumentation move, the patient seems to negatively evaluate the appreciation of the doctor's recommendation and therefore contemporary medicine as worthless. Inscribed in the words of the patient, is her positive evaluation of the traditional Gusii sociocultural illness belief system as profound. The patient's argument attempts to positively evaluate the appreciation of the Gusii belief associated with *ebibirir*i as deep. Nevertheless, to the doctor, the negative attitudinal assessment of the patient's eccentric (normality), inconsiderate (propriety) and undependable (tenacity) argumentative move is inevitable in his contemporary western medicine worldview. Besides, inscribed in the argument is the negative evaluation of affect emotional surge of fear of the patient of losing the child in any presumptive injection in case the child has been infected by the supernatural condition already alluded to above. The fear invoked in her presentational devices in the patient's argument demonstrates the exploitation of the affect semantic domain as shown in Table 4.1. The institutional systems associated with the doctor and the patient accord them the authority from which they anchor their pragmatic arguments meant to realise the institutional points of the institutions: to see the child regain normal health.

However, as the leader of the medical consultation the doctor quickly refutes the argument of the patient with another pragmatic argument asserting that "*riberera igo rikoretwa n'oborwaire*" (fever is symptom of an infection [turn11]). He thus uses an argument from authority to negatively evaluate the appreciation of the argument from the patient as unfounded as they *"ntorakonya mwana"* (would have not saved the child [turns 9, 11, 13 and 15]). The doctor is determined to realise the institutional point of the medical consultation in his positive appreciation of the life of the child which he evaluates as invaluable human life which must be saved (turn 15). He goes ahead to strategically exploit another pragmatic argument asserting that the child has a disease which is responsible for the fever (turn 17) and it deserves medical attention (turn 19).

The doctor's attitude in the pragmatic argument, can be positively evaluated in terms of judgement to show his commitment to standard (normality) medical procedures thus law abiding (propriety). Inadvertently, in dealing with related cases involving children with similar symptoms pointing towards the possibility of having malaria, the judgement of the doctor's experience can be positively assessed as skilled (capacity), considerate (propriety) and dependable (tenacity). In terms of appreciation, the doctor negatively assesses malaria as acute and dangerous and capable of taking the life of the child if the condition is not checked and treated.

Table 4.2 Attitudinal assessment of judgement for presentational device choices for the doctor and patient in consultations involving HIV & AIDS patients (after White, 2011)

Doctor/patient evaluative language	**Positive**		**Negative**	
	Social esteem	Social sanction	Social esteem	Social sanction
"tigango toramopima" (let us first carry out the tests) *"tomanye komoa amariogo"* (then we can give him medicine)	Skilled (capacity); Standard (normality)	Law-abiding (propriety)		
"... igo toramoe omochakano chintetere echio chieriberera alafu toramotige igo torore buna akoba" (… let's give him tablets for the fever then we leave him and see how he fairs on)			Eccentric (normality)	Inconsiderate (propriety); Inconsiderate (tenacity)

"Riberera igo rikoretwa n'oborwaire" (Fever is caused by an infection).	Standard (normality)			
"... omoiseke nare ocha nka aria korwa buna amobwatete agasoa buna arwete igo aroro akagenda, omwana oyio akaimoka riberera. Namang'ana aye nakumete nka ng'a tari monto muya n'omonto ogosiara ebiriri" (… there is a lady who came at home and held the child and immediately she left, the baby developed fever. And the reputation of the lady is known at home that she is not a good person… she is a person who infects others with "ebibiriri")	Honest (veracity)	Honest (tenacity)		
"Gatoranyore malaria nerororo, nabo tokomoa echia malaria amo nechieriberera. Igo riberera ndiri gocha bosa. Yaya, igo rigocha rire noborwaire" If we find that he has malaria, we will treat him for malaria and the fever. So, fever never comes just like that. No, it comes with an infection.	Skilled (capacity)	Dependable (tenacity); Considerate (propriety)		

In example 6 in the excerpt below, from HIV and AIDS 5 consultation (see appendix xix on page 523), the patient goes ahead to defend her pragmatic argument using an argument from public opinion using an anecdote of a lady with the history of infecting people in the village with *ebibiriri* (turn 3). Discussants can use arguments with a variety of logical relations based on the premises they relate (Macagno & Walton, 2015: 37). The patient exploits the argument of popular opinion reliant on the authority of her believe in the Gusii illness belief system to defend her earlier pragmatic argument.

(6)

[1] Patient: *Mwana oyo iga tana gotwara riberera erio.*

This child has never had that kind of fever.

[2] Doctor: *Mm.*

Mm.

[3] Patient: *Korwa korwa gesa aiboretwe. Rakini omoiseke nare ocha nka aria korwa buna amobwatete agasoa buna arwete igo aroro akagenda, omwana oyio akaimoka*

riberera. Namang'ana aye nakumete nka ng'a tari monto muya n'omonto ogosiara ebiriri. Mm.

Since he was born. But there is a lady who came at home and held the child and immediately she left, the baby developed fever. And the reputation of the lady is known at home that she is not a good person… she is a person who infects others with "ebibiriri". Mm.

[4] Doctor: *Tiga nainche nagotebia iga…*

Let me also tell you this…

[5] Patient: *Mm.*

Mm.

[6] Doctor: *Malaria.*

Malaria.

[7] Patient: *Mm.*

Mm.

[8] Doctor: *Tari egento kegocha enya gokoria kera ngo'rango'ra baka eche goikera. Negento kegocha rimo. Ee omoiseke oyio nachete rakini igo toramanya ng'a n'eumbu nero nereo bono iga buna egotwa chiumbu nchiimogete. Malaria nere igoro ase ebinyoro. Nabo oranyore ase kwamobegete nonya mogaso eumbu nabo yamoromete otamanyeti gose otarochi. Igo nagotebi onye… ngopima tore. Ogopima mbosa na riberera eri ndigocha bosa, riberera abwate igo rire igoro mono, ndigocha bosa ritabwati oborwaire. Mbuya tware komopima ogopima mbosa torore gose nabwate malaria.*

Is not something which comes and starts infecting you slowly until it gets to a point. It is something that comes once. Yes, that lady came but you haven't known that a mosquito was also there, especially now that it is a raining, they are in plenty. Malaria cases are high now in the villages. It is possible that where you had placed the child even during the day, he had a mosquito bite without your knowledge. So, I told you if…we will carry out the tests. Doing the tests is free and this fever cannot be baseless, the fever he has is too high; it cannot be without a disease. It is better we examine him through tests. Tests are free… so that we see if he has malaria.

[9] Patient: Mm.

Mm.

[10] Doctor: *Nagotebia tindagokania gose tabwati ebibiriri rakini ebirririri nabirobio, riberera eri iga tokogenda ase omonyamete gose omonto bw'ebiriri ng'a achi komoa eriogo rieriberera. Eriogo rieriberera ntwe togoko … togokoa nyagitari. Igo mbuya kware egento tware gopima malaria nero nabo egocha buna oroche iga. Naende nabo eranyarekane ng'a omwana oyo nabwate malaria. Igaa ngusii tomanyete Gusii malaria nigo ere igoro sana. Nechinyagitari chiamalaria nochimanyete baba?*

I told you that I haven't denied that he does not have "*ebibiriri*" but then with this kind of fever, you can't visit a herbalist or a person who treats "*ebibiriri*" so that he/she so that he gives him medicine for this fever. The medicine for fever, it is us who give you

at the hospital. So, it is good if we could examine him through a malaria test because it has the symptoms you can see here. And it is possible that this baby has malaria. This is Gusiiand we know that Gusii reports high prevalence rates of malaria. And do you know the hospitals for malaria?

[11] Patient: *Ee ninchimanyete.*

Yes, I know them.

The argument further cements the patient's value position in the traditional Gusii sociocultural illness belief system by trying to positively judge her belief as credible through the honest narrative (tenacity). The use of the anecdote about the lady who allegedly infects the child can be associated to her positive attitudinal assessment of the appreciation of the Gusii sociocultural belief system as being unique with its intricate way of transmitting the peculiar illness she personally diagnoses as *ebibiriri*. In his further refutation, the doctor strategically employs symptomatic argumentation demonstrating his in-depth knowledge of the elaborate details of the causation, spread and symptoms of malaria.

Using both the informed consent and evidence-based medicine institutional preconditions for strategic manoeuvring the doctor goes ahead to show the prevalence rates for malaria in the region: "*Malaria nere igoro ase ebinyoro"* (Malaria cases are high now in the villages [turn 8]) as he seeks consent from the patient for the clinical test. The doctor demonstrates an attitudinal evaluation of his judgement of his professionalism in his duties as caring (propriety) genuine, honest (veracity) in executing the standard (normality) medical procedures. The doctor in presenting his argumentation in a more persuasive and reasonable on merit he captures the contextual weather conditions when he mentions *n'eumbu nero nyareo bono iga buna egotwa chiumbu nchiimogete* (a mosquito was also there, especially now that it is a raining, they are in plenty [turn 8]). In the presentational devices, the doctor negatively evaluates appreciation of the malaria transmitting mosquitoes as unwelcome and deadly. Inscribed in the words of the doctor is his negative attitudinal assessment of the appreciation of the rainy season as predisposing.

Armed with the contemporary western medication knowledge and training, the doctor goes ahead to challenge the patient using comparison and contrast argument scheme to understand the role of the contemporary western medication as compared to the traditional herbal medicine in treating the high fever state of the child (turn 10). The doctor intentionally poses the challenge using symptomatic argumentation knowing very well that his value position is implicitly persuasive in

making the patient appreciate his value position. An attitudinal assessment of the doctor's appreciation of the traditional herbal medicine in the medical condition of the child reveals its insignificant role in the treatment of the sick child. On the other hand, the doctor presents a positive assessment of the appreciation of the contemporary western medicine at the hospital as being valuable and remedial. In the strategic manoeuvres the doctor and patient advance in justifying their standpoints tailored to realising the institutional point of the medical consultation, the two discussants are involved in persuasive efforts meant to align the contemporary western medicine with the traditional Gusii sociocultural illness belief institutional system.

Table 4.3 Attitudinal assessment of appreciation for presentational device choices for the doctor and the patient in consultations involving HIV & AIDS patients (after White, 2011)

Doctor/patient evaluative language	**Positive**	**Negative**
'Bado ntorakonya ***mwana oyo***" We would not have saved **your child**	Invaluable	
"Tiga toramopima gatoranyore ng'a tabwati malaria, ntokomoa echia ***malaria****. Gatoranyore malaria nerororo, nabo tokomoa echia malaria"* .(Let's carry out the tests, should we find out that he doesn't have malaria, we would not treat him for **malari**a. If we find that he has malaria, we will treat him for malaria and the fever.)		Dangerous/killer
"Igo tigango ***toramopima****"* (So, let us first **carry out the tests**)	Significant	
"... igo toramoe omochakano chintetere echio chieriberera alafu ***toramotige igo torore buna akoba****"* (… let's give him tablets for the fever then **we leave him and see how he fairs on**)	Profound (of the traditional Gusii sociocultural illness belief system)	Illogical; flawed; shallow (of the patient's reasoning)
"... ***omoiseke nare*** *ocha nka aria korwa* ***buna amobwatete*** *agasoa buna arwete igo aroro akagenda,* ***omwana oyio akaimoka riberera****. Namang'ana aye nakumete nka ng'a tari monto muya…* ***n'omonto ogosiara ebiriri.****"* (… **there is a lady** who came at home and **held the child a**nd immediately she left, the **baby developed fever.** And the reputation of the lady is known at home that she is not a good person… she is a person who **infects others with ebibiriri)**	Unique; inimitable	
*"****Nabwate chisigns*** *chikoorokia nabo aratware malaria. Igo* ***tigango toramopima****. Ee tomanye* ***komoa amariogo****"* (**He has signs** which show he may have malaria. So, let us **first carry out the tests**. Yes, then we can **give him medicine)**	Logical; scientific (of contemporary western medicine)	

*"... rakini igo toramanya ng'a **n'eumbu** nero nereo bono iga buna egotwa chiumbu nchiimogete"* (…but you haven't known that a mosquito was also there, especially now that it is a raining, they are in plenty)		Dreaded; deadly
"Nagotebia tindagokania gose tabwati ebibiriri rakini ebiririri nabirobio, riberera eri iga tokogenda ase omonyamete gose omonto bw'ebiriri ng'a achi komoa eriogo rieriberera." (I told you that I haven't denied that he does not have "ebibiriri" but then with this kind of fever, you can't visit a **herbalist or a person who treats "ebibiriri**" so that (s)he so that he gives him medicine for this fever)	Insignificant	
"Eriogo rieriberera ntwe togoko ... togokoa nyagitari" **(The medicine for fever**, it is us who give you at the **hospital.)**	Valuable; remedial	
*"... rakini igo toramanya ng'a n'eumbu nero nereo bono iga **buna egotwa** chiumbu nchiimogete"* (…but you haven't known that a mosquito was also there, especially now that **it is a raining**, they are in plenty)		Predisposing

Through their evaluative language presented in Tables 4.1, 4.2 and 4.3, the doctor and the patient exploit both the negative and positive attitudinal assessments of their and their partner's choice of presentational choices in the strategic manoeuvring in the argumentative reality. The doctor and patient are constantly reasserting their social roles and functions based on their spheres of experience and knowledge in their interpersonal argumentative moves meant to resolve the difference of opinion to allow for the shared decision making in the consultation.

The section has explored the various ways the primary discussion parties in the medical consultation communicative activity type appraise each other under the semantic domain of attitude. The analysis has demonstrated how the doctor and the patient use the positive and negative assessments of the social norms (judgement) associated with the macro-context of the Gusii medical consultation involving HIV patients. The attitudinal assessment has seen the two parties also explore how positive and negative assessments of their personal emotions (affect) and values of objects, systems, incidences or state of affairs (appreciation). Using the three evaluative language parameters, the analysis interrogates the interlocutors' strategic argumentative moves in the critical discussion processes involved in the realisation of the institutional points of the contemporary western medicine institution and the traditional Gusii sociocultural illness belief institutional system. The next section examines the sociolinguistic aspects of communication accommodation in the pragma dialectic process of the argumentation reality of the consultation encounters between doctors and HIV and AIDS patients.

4.4 Communication accommodation in argumentation in medical consultations with HIV patients

This section analyse show communication accommodation influences the pragma-dialectics of argumentative discourse in the communicative activity of the medical consultation involving Gusii doctors and HIV patients. The analysis examines the sociolinguistic strategies of communication adjustment in argumentative resolution of differences of opinions during the doctor-patient consultations. As introduced in section 3.4 of Chapter 3, interlocutors in social interactions are constantly engaged in communication adjustments to adapt to each other. The examination explores the different objective and subjective adjustment strategies employed by doctors and patients using the communication parameters of convergence, divergence and maintenance. In their strategic manoeuvres, the doctor and the patient explore ways of preserving their social identities especially looking at the two discussants from the perspective of an intergroup encounter. On that account, the doctor is aligned to the institutional preconditions of the contemporary western medicine while the patient is aligned to and tries to comply with the traditional Gusii sociocultural illness belief system on illness. Nevertheless, the doctor and the patient share the Gusii sociocultural background and are embroiled in the culture apart from their trust in the contemporary western medication, which has occasioned the medical consultation communicative activity type.

4.4.1 Communication adjustment through interpretability in argumentation

The choice of presentational devices by either the doctor or the HIV and AIDS patient in the medical encounters has fundamental communication adjustment. The accommodation is meant to propagate the intergroup identities (Giles, Howard & Soliz, 2014) based on individual perceptions of each other's argumentative moves, psychologically or their intentional linguistic accommodation moves aimed at resolving the difference of opinion. In so doing, the discussion parties employ the sociolinguistic accommodation strategies in their argumentative discourse. Exploring the communication accommodation strategies of interpretability, interpersonal control and discourse management (Farzadnia & Giles, 2015; Gasiorek & Giles, 2015), the following analysis investigates strategic manoeuvring in the argumentative data of the medical consultation communicative activity type. Interpretability in communication accommodation relates to the

communication partners' implicit or explicit ability to understand and follow a conversation. In the medical consultation, either party may perceive or express their understanding of the issues(s) under consideration during the consultation. In the argumentation process, disputes that may arise during the consultation, interpretation comes in handy in seeking to resolve such disputes persuasively and on merits. In exploring how interpretability as an adjustment strategy is employed in the argumentation process in the consultation, the (Eke)Gusii excerpt in example 7 below drawn from HIV and AIDS 5 consultation (see appendix xix from page 525) is examined.

(7)

[1] Doctor: *Ee nomanyete ng'a riberera ngocha rire na malaria?*

Yes, do you know that fever comes with malaria?

[2] Patient: *Ee ngocha rire.*

Yes, it does come.

[3] Doctor: *Nomanyete ogosaa ngocha kore na malaria?*

Do you know that diarrhoea comes with malaria?

[4] Patient: *Yaya ekio timanyeti*

No, I don't know.

[5] Doctor: *Bono ogosaa, enda koroma, omotwe kogwatia, ebio bionsi nabo bigocha na mala…*

Now diarrhoea, stomach pains, headache, all those come with mala...

[6] Patient: *Malaria.*

Malaria.

[7] Doctor: *Na malaria nakio gekogera abana bonsi bogocha agaiga. Naacha aa gaiga omwana akoroka na gosaa goika toramopima torore gose malaria yagera oroka kago…*

With malaria, that is why all the children come here. Even if a child comes here vomiting and with diarrhoea, we must carry out a malaria test to establish if it is the cause for the vomiting and diarr…

[8] Patient: *Kagosaa.*

Diarrhoea.

[9] Doctor: *Osaa. Omwana ogocha onde bwensi ogocha neriberera, mbuya tomopime, torore ng'a malaria nerororo? Igo riberera tari malaria yoka ekorireta. Amarwaire nande akoreta riberera. Nabo omwana akonyora abwate oborwaire ase enchera y'amache tokoroka UTI rikoreta ribere.*

Diarrhoea. Any child who comes with fever, it is good to check if (s)he has malaria. Therefore, malaria is not the only cause of fever. There are other diseases, which cause

high fever. You can get a child with a disease in the urine passage, what we call a urinary tract infection (UTI) causing fe...

[10] Patient: *Riberera*

Fever.

[11] Doctor: *Riberera*

Fever.

[12] Patient: *Igo riberera eri ndiri gocha bosa. Oborwaire mbore bokogera riberera riche.*

Therefore, this fever does not just come. There is a disease, which causes it.

[13] Doctor: *N'egento ekenene pi ase tomenyete seito Gusii gekoreta riberera, malaria. Toramopima. Kerabe tabwati malaria naende nabo tokorigereria binto binde biragere atware riberera. Twaigwananire?*

In addition, the most important thing, where we stay here in Gusii, the major cause of fever is malaria. Let us carry on the test. If it turns out he does not have malaria, we will carry out further examination to find out what is making the child to have fever. Are we in agreement?

[14] Patient: *Ee. Igo bono malaria yoka aranyare koba kagotwara? Borwaire bonde mboiyo bochererete obwo?*

Yes. So, does it mean it is malaria he can only be having? Is there any other disease related to that one?

Having established the idiosyncratic preferences, interpersonal and intergroup histories (Dragojevic *et al.*, 2016: 17) of the patient based on the sociohistorical context of the patient's willingness to converge to the contemporary western medical procedures, the doctor attempts to adjust his communication using the strategy of interpretability. The doctor exploits the strategy to reduce the social distance between the two of them and between the two institutional systems involved in the difference of opinion they are trying to resolve in the critical discussion. Demonstrating the informed consent institutional constraint, the doctor moderates the social distance by using the authority of his medical knowledge and professional experience to quickly do a checklist of the patient's knowledge of the signs of infection of malaria or causes of high fever among children (turns 1, 3, 5 and 7). This is an implicit application of interpretability using pragmatic argumentation to make the patient understand the causation and signs and symptoms of malaria infection. The admission by the patient that she does not understand that diarrhoea may be a sign of malaria infection (turn 4) is a convergence accommodation, which allows the doctor to educate her on all the signs of infection of malaria in his psychological and linguistic convergence.

An examination of the doctor's choice of presentational devices shows his dedication to not only informed consent but also evidence-based medicine, which are ethical preconditions of the medical consultation communicative activity type. The communicative decision to explain to the patient the role of tests to confirm the cause of different signs and symptoms of infection (turn 7) is a convergence adjustment attempt to make the patient appreciate the doctor's idiosyncratic preference in his linguistic convergence. The strategic move implicitly affirms the doctor's commitment to the institutional requirement of evidence medicine for the contemporary western medicine, which is the host of the consultation. For the patient to shift her ground on the need to have the child undergo the malaria test, the doctor goes to the extent to explore other causes of fever in a child's health (turns 9,11 and 13). The doctor's strategic manoeuvre based on argument from authority allows the patient to adjust her thoughts and communication from the traditional Gusii sociocultural illness belief system to accommodate the doctor's proposal. The subsequent affirmation that fever does not just come about without a cause signals the symmetrical convergence between the doctor and the patient in the resolving of the difference of opinion.

4.4.2 Communication adjustment through discourse management in argumentation

In resolving differences of opinions in doctor-patient communication, the communication partners adjust their communicative behaviour to suit each other by carefully assessing and responding to each other's conversational needs (Coupland *et al*., 1988). The technical term given to the deliberate adjustment of communication due to the apparent conversational needs of the interlocutor is 'discourse management'. Examining some of the linguistic pitfalls in the practice of medicine, Patel (2018: 242) urges the discussants to recalibrate the presentational devices for what he calls "semantic precision". This can in effect minimise the risk of ineffective decision-making processes, which may have undesirable effects on the health of people affected by such decisions. In pragma-dialectic theoretical terms, when strategic manoeuvring through discourse management communication partners exploit both psychological and linguistic accommodation by responding to the audience demand for the equivalent convergence or divergence communication adjustment through the choice of presentational devices. As the leader of the discussion in the medical consultation, the doctor can exploit his communication skills to manoeuvre strategically depending on the nature of communication accommodation of the patient regarding the information shared on in the process of attempting to resolve a difference of opinion.

Using discourse management in the (Eke)Gusii excerpt drawn from HIV and AIDS 3 consultation (see appendix xvii on page 437) with a sixteen-year-old HIV positive high school female student in Example 8 below, the doctor considers a scenario where the patient inevitably adjusts her communicative behaviour in her strategic manoeuvring in the critical discussion.

(8)

[1] Patient: *Ee naende tintageti gokwana igoro yenyamoreo nka seito.*

Yes, and I do not want to talk about HIV and AIDS at our home.

[2] Doctor: *Nonya?*

At all?

[3] Patient: *Mm.*

Mm.

[4] Doctor: *Bono Moraa tiga ngotebie. Egento nkere tokoroka disclosure. Disclosure n'ekero buna nyoko moke amanyete igoro ya HIV. Igere egento kia maana saana omoibori oo komanya igoro yestatus yao ya HIV. Moibori takogweita gse gokra gento kente kebe esengencho anyorire obwate eburusi ebio. Naseki ingotebera igo?*

Now Moraa, let me advise you. There is something called disclosure. Disclosure is like when you got to know about your HIV status. You know it is very important for your parent to know your HIV status. A parent cannot commit suicide or do anything bad because you are HIV positive. Why do I say so?

[5] Patient: *Mm.*

Mm.

[6] Doctor: *Ee ekiagera, totebe rero kwanyorire TB.*

Yes, because let us say today you contract TB.

[7] Patient: *Ee.*

Yes.

[8] Doctor: *Ntoigwanaine?*

Are we together?

[9] Patient: *Ee.*

Yes.

[10] Doctor: *Onyore TB na nyoko moke nachiete esabari.*

You develop TB, and your aunt had travelled on a journey.

[11] Patient: Ee.

Yes.

[12] Doctor: *Nyoko achiche. Nomanyete botambe omwana karwarire ng'o ogochia komoberisia nyagitari.*

Your mother comes. You know normally if a student gets sick who stays with her at the hospital.

[13] Patient: *Gose ng'ina.*

It is the mother.

[14] Doctor: *Ng'ina. Tari bo?*

The mother, isn't it?

[15] Patient: *Ee.*

Yes.

[16] Doctor: *Bono omanyete ase chingaki chinyinge abana baito kobare nyagitari, omosista nabo arakagere ng'a ng'ina omwana namanyete igoro yendwari y'omwana oye, tari bo?*

You know when our children are admitted in hospital, the nurse might think that the mother knows about the status of her child, isn't it?

[17] Patient: *Ee.*

Yes.

[18] Doctor: *Erio bonyorane na sister oyore egasi ase ewadi. Mm?*

Then they meet with the nurse on duty at the ward. Mm?

[19] Patient: *Ee.*

Yes.

[20] Doctor: *Agende atebie nyoko. Bono erio aye nigo oraire, ore omorwaire…TB mbora nomanyete buna egokora omonto oba omorwaire mono. Tari bo?*

She proceeds at ask your mother while in your sleep at the hospital bed. You know how TB makes someone very sick. Is that right?

[21] Patient: Ee.

Yes

[22] Doctor: *Nyoko nao are abwo akoberisetie. Rituko erimo sister otakomanyeti achiche aborie nyoko, "Mama Moraa, ng'ai amariogo aria y'ebirusi are? Ng'ai amariogo aria y'evirusi Moraa akonywa are?" Ntebiengo ng'aki erabe?*

You mother is there taking care of you. One day without informing you, she asks your mother, "Where are the ARV drugs? Where are the ARV drugs that Moraa takes?" Tell me how this will be?

[23] Patient: *Abwo igo erabe akong'u. Korende nche tagitari naye otamanyeti*

That will be difficult. However, doctor you do not know something….

The manifestation of linguistic divergence in the presentational devices employed by the patient presupposes a psychological divergence in her reluctance to disclose her HIV status to close family members (turn 1). The linguistic and psychological divergence explains her refutation of the doctor's convergence in her argumentation. In enlightening the patient on the importance of disclosure, the doctor decides to use an argument from example regarding the possibility of her getting infected with TB, one of the opportunistic infections associated with HIV and AIDS (turns 4 and 6). The argumentative move makes the discourse patient-centred and appealing to her discursively, the doctor paints a picture where the patient is admitted, and is unable to control the flow of information on issues related to her treatment including the ARV therapy to a caregiver at the hospital bed, who could turn out to be the mother (turns 10, 12, 14, 16, 18, 20 and 22). Through the discourse management strategy, the doctor's argument is discursively persuasive, and it signals a symmetrical convergence accommodation from either party. Relying on his expertise, the strategic manoeuvre of the doctor influences the adjustment of the patient's divergence accommodation regarding the disclosure of her HIV status to her parents, to convergence accommodation, which is beneficial to the patient.

In exploiting discourse management between communication partners, adjustment of the communication behaviour can occur because of persuasive justification of one of the parties. The (Eke)Gusii excerpt in example 9 below, drawn from HIV and AIDS 3 consultation (see appendix xvii on page 455) with a sixteen-year-old HIV positive lady, demonstrates how discourse management brings to a conclusive end a critical discussion on HIV counselling and testing (HTC) that affects both the patient and the work of the doctor. HTC is one of the strategies the Kenya government has adopted in the fight against the spread of HIV and AIDS through initiatives which involve "door-to-door" and "community-based testing"(Omondi, Mbogo & Luboobi, 2018: 2) .

After gathering enough information on why it is necessary to go for HTC together with the boyfriend, the patient concedes to the doctor's refutation of her noncommittal standpoint of not disclosing her HIV status to her sexual partner. In the convergence accommodation move, the patient takes over the topic of how she is willing to go for HTC with her partner in an implicit pragmatic argument in her concession strategic manoeuvre.

(9)

[1] Patient: *Igo ngocha komotebia December.*

I will tell him in December.

[2] Doctor: *Totageti komotebia. Nki gwachorera December?*

You don't want to tell him. Why did you choose December?

[3] Patient: *December.*

December.

[4] Doctor: *Mm.*

Mm.

[5] Patient: *Ekero tokare erusa entambe*

When we shall be on long holidays.

[6] Doctor: *Mm.*

Mm.

[7] Patient: *Nario ndamotebi. Ngocha are ong'ira etaro iga rende.*

That is when I can tell him. He normally comes and takes me out at least.

[8] Doctor: *Mm.*

Mm.

[9] Patient: *Nario ndamotebie tochie topimwe na tari aiga Gusii.*

Thats when I can tell him we go for the test and not here in Gusii.

[10] Doctor: *Ehee.*

Okay.

[11] Patient: *Yaya.*

No.

[12] Doctor: *Ehee*

Okay

[13] Patient: *Togende nonya Kisumu.*

We go even to Kisumu.

[14] Doctor: *Abwo igo orakore buya. Eyio ngokoa tu chingaki. Nimanyete nakong'u gokwana igoro ya HIV yao gochia ase omonto onde.*

That will be good. Then I give you the time. I know it is difficult to disclose your HIV status to another person.

[15] Patient: *Igo mbuya*

That is good.

[16] Doctor: *Igo onye gwanchire buna nDecember mm ... igo torabe tokobwatia igoro yao tomanye gose kwamotebirie mokogenda etaro eyio. Motebie toba n'obwoba. Kegosinya, aye ochiche. Ochiche otoerese ng'a igo gwasinyetwe pi komotebia.*

Then if you have agreed that its December… we will be following your case we get to know if you have convinced him for that outing. Tell him not to be afraid. If it is impossible, you just come. Come and explain to us that you couldn't manage to tell him.

[17] Patient: *Mm.*

Mm.

[18] Doctor: *Nabo tokomoikera.*

We can get him.

[19] Patient: *Igo?*

Like that?

[20] Doctor: *Oyio tari omonto oranyare gotebia nkobe gochia nyagetari?*

Is that not someone you can tell to escort you to hospital?

[21] Patient: *Ee*

Yes.

[22] Doctor: *Igo agocha, toigwanane, tomopime.*

He will come, we agree with each other, and test him.

[23] Patient: *Igo mbuya.*

That is good.

The patient convinces the doctor on the most appropriate time to get the sexual partner to accept to go for HTC together (turns 1, 3, 5, 7, 9 and 13). In her pragmatic argument, she indicates clearly the town where the point of disclosure-cum-HTC for both would take place. In the convergence accommodation move the patient gives the reason for her preference in an argument from causal relation in which she implicitly reveals the stigma associated with HIV and AIDS. This explains the preference to go to the distant town Kisumu for the disclosure and HTC (turns 9, 11 and 13). In a supportive and accommodative move the doctor uses argument from authority of his experience to assure the patient that in case there is a problem in the process of the disclosure, the hospital team was willing and trained to handle the process (turn 14 and 16). Based on the training and the strategic manoeuvring institutional precondition of informed consent, the doctor is swift to realise the conversational need to the patient especially with the level of stigma associated to disclosure of HIV status or HTC. The doctor, thus, uses the communication accommodation strategy of discourse management to give the patient a strategy to have the sexual partner come with her to hospital and where they can exploit their HTC skills to have him get to know their HIV status (turns 20 and 22).

On the contrary, the convergence accommodation strategic manoeuvre by the patient to concede to the doctor's standpoint in agreeing to undergo HTC with the boyfriend (turns 1, 3, 5,7 and 9), in example is built on the authority which comes with interpersonal control (discussed in 4.4.3 below) as a strategy of communication adjustment. The knowledge of the HIV status is one of goals of the UNAIDS 90-90-90 target, which seeks to suppress HIV by 90% through ensuring that 90% of the PLWHA have undergone HTC to know their HIV status, and that 90% of all the people diagnosed with HIV and AIDS to continually be under anti-retroviral therapy, by the year 2020 (UNAIDS,2014). Communication accommodation in medical encounters especially between doctors and PLWHA is an opportunity for the doctor to contribute to the care of the new unrecruited people in the ART program. The care for PLWHA is directly linked to the initiation and sustained ART (Page-Shipp et al., 2018:2) in addition of recruitment of people with new infections of HIV such as the boyfriend to the patient. In example 9 above, the patient has a key role in the consultation because at the conclusion stage of the critical discussion she promises to

convince the friend for the HTC, which will initiate other processes such as possible recruitment into the ART program. In a convergence accommodation strategic move the patient uses her status as the one with the authority to facilitate the process of establishing the HIV status of the boyfriend by agreeing to go for the HTC together with her friend for mutual support and care of their lives and other people's. This communication adjustment move is demonstrated in her choice of pragmatic argument as the appropriate presentational device in her strategic manoeuvring. The next section explores the role of the communication accommodation strategy of interpersonal control in the process of strategic manoeuvring aimed at resolving differences of opinion in a communication activity type of the medical consultations involving HIV patients.

4.4.3 Communication adjustment through interpersonal control in argumentation in the medical consultation

As already explained in Section 3.4.2 of Chapter 3 and alluded to in Section 2.5 of Chapter 2, discussion partners have a tendency of attuning their communicative behaviours to suit those of others because of their power, status or the beliefs and stereotypes associated with different individuals (Gasiorek & Giles, 2013; Farzadnia & Giles, 2015; Watson, Gallois, Watson & Gallois, 2017). The communication accommodation strategy of interpersonal control exploits the interactional roles of the discussion parties in a communicative activity type depending on their status to determine the extent of attunement in how they choose their presentational devices in their strategic manoeuvring. Building on the communication adjustment strategy of discourse management, the doctor explores the possibility of exploiting interpersonal control in the resolution of his difference of opinion with the patient on disclosure of her HIV status to close family members. The doctor reminds the patient of her role and status as a student still under the care of her parents, who needs to exploit that susceptible position to disclose her HIV status to the parents for easier management of her HIV status. As a medical expert and leader of the medical consultation, the doctor exploits his role in his strategic manoeuvring to convince the patient in the excerpt drawn from HIV and AIDS 3 consultation (see appendix xvii) with a sixteen-year-old HIV positive high school student in Example 10 below

(10)

[1] Patient: *Nche esukuru ngosoma Nyabururu Girls, nenational school.*

I study in Nyabururu Girls, a national school.

[2] Doctor: *Mm*

Mm.

[3] Patient: *N'omanyete chibesa irenga togwakana aroro?*

Do you know how much we pay there?

[4] Doctor: *Ninkoigwete.*

I get you.

[5] Patient: *Omoibori ang'akanere chibesa echi chionsi erio amanye ng'a n' HIV, omonto agokwa pi!*

A parent pays for me all that money and then (s)he knows about the HIV status, someone will die completely!

[6] Doctor: *Mm.*

Mm.

[7] Patient: *Oroche ningenderere gosomigwa?*

Do you think I will continue being supported in my studies?

[8] Doctor: *Igo oragenderere naende mono kegima.*

Of course, you will continue to get real support.

[9] Patient: *Gochia bono mbuya amanye kinde nyagitari ewodi korende nche tinkomotebia.*

I will rather she knows when am admitted in the hospital ward but personally I won't disclose to her.

[10] Doctor: *Bono oraisa komoreta rende tomotebie onye gwasinyirwe. Omanyete ntwe nabo tokonyara. Enchera nere torakwane n'abaibori tobaerese.*

Now, what if you brought her for us to disclose to her if you are not able to. You know we can do it. There is a way we can talk to your parent and explain to them.

[11] Patient: *Bono naki gose oramotebie? Ng'ai togochia na ninki togochia gokora? Mbora nyagetari togochia. Takomboria, "nkai orwarete?*"

Surely what can you tell her? Where are we going and what are we going to do? We are going to hospital…she will ask me, "Where are you not feeling well?"

[12] Doctor: *Mbora igo okomotebia toigweti omotwe buya otagete akoire nyagetari. Aye okomoreta ekiriniki giaito toteme komokwanera tomotebie.*

You just tell her that you have a headache and you ask her to take you to hospital. You bring her to our clinic we try to explain to her.

[13] Patient: *Aye igo otagete tingorerwa nonya n'eyanga.*

You want me to risk not being bought even a dress.

[14] Doctor: *Chianga nogorerwe naende buya mono Moraa. Korende nomanyete ase ensemo yaito ase nyagetari negento kieng'encho omoibori komanya igoro yokorwara kwao kwa HIV. Aye nigo oroche ng'a ekio n'egento otatageti goteba korende ninganetie orengererie boori agare…orengerie mono. Ekiagera nyoko moke takoba naye bogima bwao bwonsi.*

You will be bought clothes and very well so, Moraa. But you know on our part as doctors it is a very important for your parent to know about your HIV status. You may take this as some secret you want to keep but I want you to think deeply, think hard because your aunt is not going to be with you all your life.

[15] Patient: *Abwo tagitari gwakwanire buya, korende bono*

You have spoken well doctor, but…

[16] Doctor: *Mm.*

Mm.

[17] Patient: *Tiga ngende gose ntebie makomoke, ache kobatebia. Inche gaaki tindochi gose ninyare goatoka erieta erio*

Or let me go and tell my aunt to come and tell them. Please I do not see if I am able to utter that word.

[18] Doctor: *Ee nyokomoke, gwatebire buya. Nyokomoke nabo akomotebia atebie mam'omino, nyokomoke karasinywe gotebia mamomono tiga bache bonsi babere nyagetari tobasemie igoro ya HIV. Twaigwananire?*

Yes, your aunt, you have put it well. Your aunt can tell your mother. If your aunt finds it challenging to tell your mother, they can both come to the hospital we educate them about HIV and AIDS. Are we together?

[19] Patient: *Ee ninteme.*

Yes, I will try.

[20] Doctor: *Ee tema naende orengererie naende okore omokia gaaki. Mbuya gotebia nyoko, ee?*

Yes, try to think about it and make efforts please. It is good to tell your mother, isn't it?

[21] Patient: *Ee nabo*

Yes, it is true.

In her attempt to convince the doctor why she cannot disclose her HIV status to her parents, the patient uses an argument from authority based on her status as a student in a national school (turn 1). The patient exploits an interpersonal control move justifying her divergent accommodation of the doctor's standpoint by making the patient-centred argument, which can be perceived as being individualistic. For her, the cost of education at a national school affirms her reluctance to divulge the HIV status to parents because of the financial burden and possible psychological torture on them (turn 3, 5 and 7). To the patient, studying in a national school where they pay a lot of money gives her the higher negotiation status and interactional role which she uses for her psychological divergence as demonstrated in her choice of presentational devices.

Due to the stigma associated to HIV and AIDS (Treves-kagan, El, Audrey, Macphail, Twine, *et al.*, 2017; Atujuna, Newman, Wallace, Eluhu, Rubincam, *et al.*, 2018; Omondi *et al.*, 2018), the patient's argument is meant to convince the doctor on her desire not to stress her parents on the disclosure of her HIV status because of the psychological effect it may have on the family especially because of their financial sacrifice on her education. Nevertheless, the doctor employs a strategic manoeuvre of an argument from analogy to refute the patient's argument while mitigating the personal fears of the patient of her losing her support for her studies or upkeep (turn 4 and 14).

Using an analogy of a headache (turn 12) the doctor uses his role as a trained and experienced medical professional with the skills to disclose the HIV status to the parents with relative ease (turn 10). The convergence accommodation move not only affords the doctor an interpersonal control of the thoughts of the patient, but it also triggers an equivalent convergence adjustment in the conclusive concession by the patient to agree to request her aunty to assist in disclosing her HIV status (turns 17, 19 and 21). Through the sociolinguistic strategy of interpersonal control, the doctor now uses the power of his position and status in the medical consultation communicative activity type to formally get informed consent from the patient on the need to disclose her HIV status to the parents even if it means the parents and the aunt accompanying her for a counselling session (turn 18 and 20).

In a medical consultation communication activity type involving HIV and AIDS patients in the Gusii setting, argumentation moves to resolve differences of opinion regarding disclosure of the

HIV status are closely associated with adherence with the ARV therapy. The (Eke)Gusii excerpt in example 11 below drawn from HIV and AIDS 3 consultation (see appendix xvii on page 457) demonstrates how the two principal discussion partners exploit interpersonal control in communication accommodation to resolve a difference of opinion regarding a review of the drug regimen because of the size of one of the ARV drugs.

(11)

[1] Doctor: *Igo twatebire rero onywe eriogo n'echinsa. Oenekie ng'a kwagorire ensa y'okoboko ogende nero esukuru. Tari bo?*

So, we have said you take your medicine in the required times. Ensure that you have bought a wrist watch and go with it to school. Isn't it so?

[2] Patient: *Mm.*

Mm.

[3] Patient: *Na nchera ende gaki tagitari teiyo moranchencherie eriogo eri?*

And there is no other way you can change for me this drug?

[4] Doctor: *Gaaki ntokonyara gochenchia riogo. Obuya bw'eriogo eri nabo okoribuna omere.*

Please we cannot manage to change for you the drugs. The advantage of this drug is you can break it and swallow.

[5] Patient: *Ndibune gose…*

I break it or…

[6] Doctor: *Ee nabo onye gwasinyirwe konywa eri rire iga.*

Yes, you can if you are not able to take the way it is.

[7] Patient: *Ee.*

Yes.

[8] Doctor: *Nabo okoribuna.*

You can break it.

[9] Patient: *Bono eri nario eriogo ndabe nkonywa obogima bwane bwonsi buna rire rinene iga?*

Now is this the drug I will be taking for the rest of my life as big as it is?

[10] Doctor: *ARVs igo togochinywa obogima bwaito bwonsi pi. Twaigwananire?*

We take ARVs all through our lives. Are we together?

[11] Patient: *Ee.*

Yes.

[12] Doctor*: Korende otanyweti eriogo riao buya, bono ig' okonywa eriogo ria ARV rikorokwa first line. Ayande nareo akorokwa second line, n'ayande third line.*

But if you don't adhere to your uptake of medicine, now you are doing the first line type of ARV drugs. The others are called second line and third line.

[13] Patient: *Ah.*

Okay

[14] Doctor: *Otanyweti eri first line buya…*

If you don't take your medicine well…

[15] Patient: *Ee.*

Yes.

[16] Doctor: *Nkai togochakera, egento nkere tokoroka failure. Kogofail amariogo aya iga amatang'ani igo togokoira ase aya second line. Kwarorire ekio togosingerera? Ikomereri onywe first line. Onye nogofail, tiga ofail as'engencho eriogo riafail. Korende tofail as'engencho tonyweti riogo buya. Omanyete bono igo ekoba n'emechando emenge.*

Where do we begin from… there is something we called failure; if you fail in the first line medicine, we will put you on the second line ones. Can you see why we are insisting? Force yourself to take first line. Should you fail then let it be that it is the medicine that have failed. But do not fail because you didn't take your medicine well. You know now that will bring more challenges.

[17] Patient: *Ninywe eriogo tu daktari.*

I will just take the medicine doctor.

After the confrontation of the doctor on the desire to change one of the drugs because of its size (turn 3), the doctor refutes the divergence accommodation move with a symmetrical divergence accommodation strategic manoeuvre. Employing argument from authority the doctor defends the

drug regimen as the approved one in the ARV therapy for fight against the HIV and AIDS. In the strategic manoeuvre, the doctor exploits his role as the expert with the medical and professional knowhow on the treatment of HIV and AIDS. However, in the presentation of his refutation argument, the doctor uses the power of his authority to gain the psychological convergence in explaining to the patient about the option of breaking the dug before taking it in case she cannot take it the way it is (turn 4, 6 and 8). The doctor further demonstrates his expert opinion argument to strategically try to persuade the patient against her reluctance to adhering to the ART. Emphasising that the ARV therapy is a lifetime mission, the doctor chooses presentational devices in his strategic manoeuvring which portray his authority as the leader of the medical consultation communication activity type and the professional who understands the treatment process of HIV and AIDS (turn 10).

It is the doctor's final strategic manoeuvre which convinces the patient to withdraw her standpoint and accept to continue using the medication as advised by the doctor. In the strategic manoeuvring, in the communicative activity type of the medical consultation, the institutional precondition of informed consent guides the argumentative activity types the doctor chooses to use. The ethical precondition provides the doctor an opportunity to at last exploit a pragmatic argument in which he exploits the interpersonal control strategy of communication accommodation pegged on the power of his role in the medical encounter with his patient to demonstrate the danger of not using the medicine as per the doctor's guidelines. In a convergence accommodation argumentative move, the doctor explains the details of the successive lines of ART lines of medication which can result if the patient does not adhere to her medication accordingly. Using the sub-argument scheme of causal relation argumentation, the doctor professionally explains the risks involved on the health of the patient in case of the failure of the first line of medication (turns 12, 14 and 16). The doctor's strategic manoeuvre results in a convergence accommodation move from the patient when she agrees to adhere to her medication accordingly (turn 17) after the doctor's authoritative pragmatic argumentation. This is the concluding stage where the difference of opinion has been resolved effectively and on merits.

Whenever it suits the audience demand, in the process of strategic manoeuvring, the doctor and the patient exploit the communication accommodation strategy of interpersonal control in their choice of presentational devices. When resolving a difference of opinion, the discussion parties of

the communication activity type of the medical consultation go through a back and forth argumentation process, which involves divergence, and convergence communication adjustment until the problem is finally resolved effectively and on merits. The next section analyses the structure of the argumentative moves the doctor employs in his argumentation.

4.5 Argumentation structure for argument schemes employed by doctors when consulting HIVand AIDS patients

To evaluate the argumentation discourse, the structure below provides an insight into the kind of arguments or schemes of arguments innate in the process of the interlocutors trying to resolve the difference in opinion reasonably and effectively. The excerpt below in example 12 drawn from HIV 2 consultation (see appendix xvi on page 411-412) demonstrates how the doctor and patient attempt to effectively resolve a difference of opinion reasonably on merits. Figure 4.3 demonstrates the argument schemes employed by the doctor in the argument structure. It is possible to see the kind of patterns of argument schemes, which emerge at the end after the reconstruction and schematic argument structure building. Laying bare the structure of complex argumentation is useful not only in understanding how interlocutors justify their positions but also in the evaluation of the reasonableness and effectiveness of their argumentation (Henkemans, 2001: 101). In this kind of difference of opinion, the doctor and patient are not trying to come up with a treatment decision as such, but they endeavour to resolve a difference of opinion, which comes up in the process of the consultation.

(12)

[1] Patient: *Bono nsa chinde buna twabeire nere ase emiaka eyio.*

Now at times we have been with him for those years…

[2] Doctor: *Mm.*

Mm.

[3] Patient: *Na tanya konyora*

In addition, he has never gotten

[4] Doctor: *Mm.*

Mm.

[5] Patient: *Igo nabo ekonyarekana tanyora.*

Therefore, it is possible he will not get

[6] Doctor: *Mm.*

Mm.

[7] Patient: *Igo nsa chinde gotumia amang'ana ayio ya protection.*

So, at times using those issues of protection

[8] Doctor: *Mm.*

Mm.

[9] Patient: *Kero kende igo agoteba ng'a bono rinde rionsi tiga togenda igo…*

Sometimes he says that now whatever the case let us proceed without...

10 Doctor: *Mm.*

Mm.

[11] Patient: *Onye ndiria nare kobonyora anga nabonyorire.*

If I was getting it, I would have gotten it.

[12] Doctor: *Nabonyorire.*

I would have gotten it.

[13] Patient: *Torochi rende nigo ere safe?*

Don't you see he is safe?

[14] Doctor: *Obuya obotuki nabwo bogotoraa.*

The good thing, we are guided by research.

[15] Patient: *Mm.*

Mm.

[16] Doctor: *Boria bwakorirwe.*

Which has been done

[17] Patient: *Mm.*

Mm.

[18] Doctor: *Tari aiga seito Gusii oka gose Kenya yoka.*

Not here in our Gusii home alone or Kenya alone.

[19] Patient: *Mm.*

Mm.

[20] Doctor: *Nkera ase.*

It is everywhere.

[21] Patient: *Mm.*

Mm.

[22] Doctor: *Igo bokworokia ng'a onye kore discordant tebwati 100% security. Igo okoba discordant obogima bwao bwonsi.*

It shows that if you are (discordant), it does not have 100% security. You remain discordant all your life.

[23] Patient: *Mm.*

Mm.

[24] Doctor: *Iiga rende*

You see.

[25] Patient: *Mm.*

Mm.

[26] Doctor: *Goika ngaki gete tokomanyereria. Na nagotebirie igoro y'obotuki bwa Nairobi.*

Up to a certain time, you may not know. In addition, I have told you about the research in Nairobi.

[27] Patient: *Mm.*

Mm.

[28] Doctor: *Obotuki obwo …ninkoe amasakara nkagete ninyabwate aiga ase e file.*

That research …I will give you the findings, I think I have the article here in the file.

[29] Patient: *Mm.*

Mm.

[30] Doctor: *Igo okogenda osome ng'ora ng'ora ko bono n'egesongo kerabe n'amang'ana oya otaigwe korende…*

> You will go and read slowly although it is English which may have some terminologies you may not understand but…

In the schematic argumentation structure, representing the whole process of the critical discussion of resolving of one difference in opinion in an excerpt from HIV 2 consultation the doctor presents a blend of various types of argumentation. The difference of opinion, which necessitates the critical discussion, arises when the HIV patient presents a scenario where her husband is discordant. In the excerpt, turns 1-12 present material starting points for the critical discussion. The point of confrontation occurs in turn 13 where the patient uses an assertive to provide an evaluative opinion on her husband's safety from infection of the HIV virus. The presentation of the standpoint in turn 13 by the patient is immediately brought into doubt by the doctor, who seeks to guide the patient through a reasonable and acceptable process based on argument from authority as an expert in the medical profession.

The patient's proposition in turn 13 presents a case of a single non-mixed difference in opinion because it involves the patient who is committed to defending a standpoint in the argumentative reality (van Eemeren, 2015: 529; van Eemeren, Grootendorst & Henkemans, 2001:8). The difference of opinion in this case is in its elementary form a positive evaluative standpoint as proposed by the patient to the doctor but which in real sense is negative. Van Eemeren (2015: 529) regards the difference of opinion here as an evaluative standpoint because the patient literally presents her judgmental proposition of the discordant husband. For the analytical overview, we reorganise the discourse through a dialectical permutation in the argumentation discourse in the ideal critical discussion process of resolving the difference in opinion on merits. This sees the doctor's response in turn 26 become the protagonist's proposition in refuting the antagonistic position staken by the patient. The reconstruction permutation in this context involves the rearrangement of a section of the discourse; like in this case turn 26 forms part of the opening stage as a befitting standpoint refuting the patient's proposition thus forming the basis for the doctor's argumentation. The rearrangement of elements in this example is a case of a resolution-oriented normative reconstruction transformation, which involves linking the argumentation reality with the ideal theoretical model of critical discussion (van Eemeren, 2015: 286; van Eemeren *et al*., 2014: 535-536).

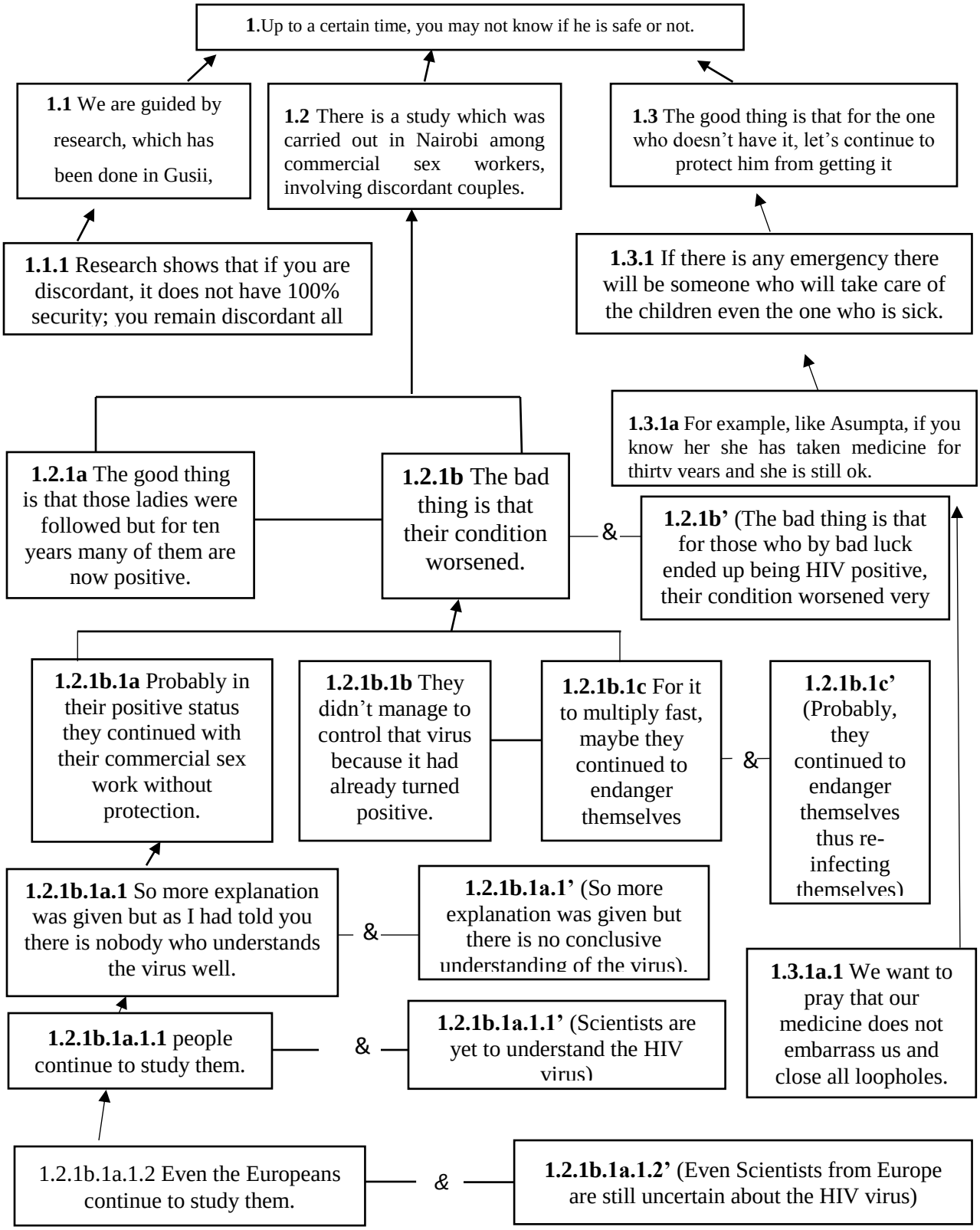


Figure 4.3 Complex argumentation structure of the doctor's argumentation in consulting with a HIV patient

The complex argumentation structure in figure 4.3 above demonstrates the argumentation stage of the critical discussion process where the exchange of critical reactions and arguments occur (van Eemeren 2015: 351). The schematic representation of the argumentation structure of arguments presented by the doctor to justify the refutation of the patient's standpoint has assumed a combination of different types of argumentation. From the onset, the complex argumentation structure has multiple, subordinative and coordinative argumentation. The multiple argumentation by the doctor consists of three alternative but systematic defences all aimed at defending his standpoint **1** (line 26). As is the character of multiple argumentation, three these defences (**1.1**, **1.2**, **1.3**), represented in the argumentative reality in HIV 2 excerpt, have equal refutation force that is they are not dependent on each other. Van Eemeren (2001: 65-66) argues that in the argumentation process, each defence, in theory, is adequate in the defence of a standpoint.

The justification for such multiple defence system by the doctor is his possible anticipation that one defence may not be effective enough in convincing the patient on her proposition. It is worth noting that at this point, the protagonist is not just addressing the patient's persona, but she is representing a 'heterogeneous' kind of interests, which in this case include the husband's and the children's interests as presented in the discourse. Therefore, the doctor has employed a multiple argumentation with defences meant to address this audience manifest in the patient's cosmology and to ensure that each of these defences is reasonable, successful and acceptable (van Eemeren, 2015: 535). The obligation to defend rule equally requires the doctor to get the agreement/consent of the patient as an institutional precondition of the communicative activity type of the medical consultation.

The doctor deliberately sums up his defence in three lines of argumentation organised in such a way as to strategically resolve the difference in opinion. Van Eemeren & Grootendorst (1992:73) have referred to this combination of single argumentations as complex argumentation, which we now analyse as multiple argumentation. In the first line of argumentation, **1.1**, the doctor begins from a global perspective by beginning with an argument from authority where he presents an argument in lines 14, 16 and 18. The evidence-based medicine requirement motivates the doctor's first line of argument, which culminates in a subordinative argumentation. Sub-argument **1.1.1** vertically connects with the defence argument **1.1**. The aim of sub-argument in turn 22 is to defend

the standpoint in the argument presented in turns 14, 16 and 18. This subordinative reasoning by the doctor provides layer by layer kind of reasoning aimed at strengthening the defence given (van Eemeren, Grootendorst & Henkemans, 2002: 65-66).

In a bid to achieve the rhetorical objective of strengthening his defence, the doctor has provided a "profusion of arguments" in the second line of his multiple argumentation, taking an incisive approach by employing an argument by example in a subordinative argumentation with six levels of arguments (van Eemeren & Grootendorst, 1992: 74). This decision is influenced by both the need to persuade the patient into understanding the past empirical dynamics of discordant cases, which compare to the current case and countering any possibility of objection to his standpoint. The argumentation is a mix of both subordinative and coordinative argumentation.

The main argument **1.2** presents an argument from authority in line 26: a symptomatic argumentation, which qualifies as independent line of defence of the standpoint **1** (van Eemeren & Grootendorst, 1992:160-161). The patient's acceptance of the doctor's account of the details of a reputed study in Nairobi, Kenya's capital involving discordant couples among commercial sex workers is not just guaranteed but it gives credibility of his refutation force of the patient's proposition. This kind of argument is indicative of the possibility of generalising the findings of such a study on couples or a population with discordant characteristics thus qualifying as a subtype of argumentation with features of relation of concomitance (van Eemeren & Grootendorst, 1992: 97).

The second level of the subordinative argumentation brings in two sub-arguments **1.2.1a** and **1.2.1b** conjoined in a coordinatively compound argumentation. These are single but related sub-arguments the doctor presents together as a well-rounded irrefutable defence of his standpoint (van Eemeren & Grootendorst, 1992: 76-77). In sub-argument **1.2.1a**, the doctor reveals the longitudinal nature of the study and in building the credibility test of generalizing its findings in as much as the women later turned HIV positive. On the other hand, in the coordinative sub-argument **1.2.1b** presented in line 34, exhibiting symptomatic argumentation the doctor underscores the negative aftermath of the lives of the women under study. Displaying three coordinative subsubarguments, the doctor proceeds to justify the negative outcome of the discordant women in the substandpoint in **1.2.1b**. The three subsubarguments have a relation of causation with the standpoint they try to justify (turns 42, 44 and 46). It is imperative to note here

that these reasons have direct implications to the patient who has a similar medical condition. At this point, the doctor is thus strategically trying to emphasise the need to use protection to reduce chances of infection of the husband, who has the discordant manifestations especially if he is still HIV negative.

In the argumentation structure, the doctor zeroes in on subsubargument **1.2.1b.1a** and to further defend its subsubstandpoint, he comes up with three more final layers of subordinative arguments in lines 48, 50 and 53. To strengthen his whole argument he thus comes up with an assertive in an appeal to popular opinion argument **1.2.1b.1a.1,** indicating that there is yet no conclusive understanding of the HIV virus in as much as some form of explanation was given in the study. On the same breath and to lay the base for his final line of argumentation and possibly the resolution in the argumentation process, the doctor adopts pragmatic argumentation in arguments **1.2.1b.1a.1.1** and **1.2.1b.1a.1.1.2,** where he asserts that scientists are still carrying out research on the virus both in the local and international scenes. This is meant to inspire hope for the infected patient and further to the husband with whom they are involved in this discordant case.

The third and final line of argumentation in the doctor's defence strategy after a buildup of the first and second lines of argumentation is a subordinative argumentation type with four layers of chain-reasoning. From the onset, the doctor in **1.3** gives a directive to the patient in a symptomatic argumentative move recommending the need to protect the husband who is currently HIV negative. The doctor takes his rightful role at this point to present an argument of authority as the professional, having given evidence-based argumentations expressing the realities of the current medical condition the couple finds themselves in. To support the standpoint in this argument, he goes ahead, in line 65, to present an argument from consequence in subargument **1.3.1**, where he brings the interests of the children to the attention of the patient. This is the subargument which sees the patient promising to take medicine properly forming part of the resolution of the difference in opinion on merits. Commissives such as this concession act by the patient can certainly be employed when a protagonist or antagonist in accepting argumentation or accepting of a standpoint (van Eemeren, 2014: 532).

To reinforce the justification process, the doctor singles out an argument from analogy by bringing in a case of an argument, which has a relation of similarity with the patient. The use of the case of renowned Asumpta, a Kenyan woman who defied the stigma associated with HIV & AIDS in the

1990s to declare publicly that she was HIV positive, enrolled in antiretroviral therapy, and has had to live with the condition normally for more than thirty years now, forms the basis of the doctor's analogy argumentation. The evidence-based institutional requirement influences the doctor's argumentative move. This subsubargument 1.3.1a is supportive of the acceptance argumentative response of the patient. The doctor concludes his defence in subsubsubargument **1.3.1a.1** to defend the subsubstandpoint of his previous argument. The doctor employs an expressive when he prays that the medicine does not embarrass the joint effort in their shared decision and an assertive when he assures the patient of closing all loopholes for the good health of her husband and herself, and the benefit of their children.

Before getting to the conclusion, the analyst notes the doctor's use of implied premises in the second line of argumentation. In argumentative discourse, discussants present their argument by leaving out certain elements. The communicators employ implied elements out of their fidelity to the communication principle, which spells out the basic rules of interaction. Speakers just like writers are constantly engaged in the violation of some of these rules of communication to achieve their rhetorical and logical import. To be able to resolve a difference in opinion pragma-dialectically, one should identify these implicit elements. The identification of these elements contributes to a move incisive evaluation of the argumentative discourse. Implicit premises for instance facilitate the acceptance of the explicit ones in the defence of standpoints in the discourse (van Eemeren et al., 2014: 17). In the doctor's second line of argumentation, there are unexpressed elements in the discourse. The doctor has used implied standpoints in the arguments presented in **1.2.1b'**, 1.2.1b.1c'**, 1.2.1b.1a.1', 1.2.1b.1a.1.1'** and **1.2.1b.1a.1.2'** to strategically manage his choice of presentational devices as this contributes in the resolution of the difference of opinion on merits. The suiting of his strategic manoeuvres to the audience demand necessitates that he leaves out some elements for a rhetorical and dialectical intent.

4.6 Strategic manoeuvring and institutional preconditions in doctor-patient argumentative encounters

The process of strategic manoeuvring in the communicative activity type of the medical consultation operates under strict institutional requirements (van Eemeren, 2010; Labrie, 2012; Schulz & Rubinelli, 2015b). These requirements are both legal and ethical. They are meant to

protect the susceptible position of the patient while at the same time ensuring that the practice of medicine follows the standard and ethical code. To achieve the institutional point of the medical consultation, a pragma-dialectical analysis needs to establish the macro context of the consultation. This acertainment of the formal and informal institutional preconditions will aid in unravelling the strategic manoeuvres in the doctor-patient consultation involving Gusii HIV-positive patients.

4.6.1 Institutional preconditions and Strategic manoeuvring in the doctor-patient consultation

Doctors, just like patients during the argumentative reality strive to appeal to each other's unique roles in the medical encounters. This appeal is not just the interpersonal acceptance based on how they relate with each other but also the urge to want to remain reasonable when trying to resolve any sort of difference in opinion. In argumentative discourse, the discussants are forever striving to concurrently attain the effectiveness and reasonableness goals in every move that they make (van Eemeren *et al*., 2014: 553). The deliberate attempt to strike this delicate rhetorical effectiveness within a dialectical standard of reasonableness in day-to-day argumentative discourse qualifies the extended pragma-dialectic conception of strategic manoeuvring (van Eemeren & Houtlosser, 2002a). A critical look at the strategic design in argumentation is fundamental in the analysis and evaluation of discourse in the various domains of argumentation.

The choices made by arguers in terms of argument moves during argumentation are each associated to distinct qualities of the three dimensions of strategic manoeuvring (van Eemeren, 2010: 93; van Eemeren & Houtlosser, 2002a). The interactants' choice of the 'topic potential', 'audience demand' and 'presentational device(s)' occurs simultaneously in every strategic move made in argumentative reality. It is at arguer's disposal to choose a part of the discourse and exploit it as a valid "topic potential" which will allow him/her to weave out his argument to defend a given standpoint. In example 13, from HIV and AIDS 4 consultation below (see appendix xviii), between a doctor and a HIV positive mother with a baby, a nonmixed difference in opinion emerges on the kind of food the mother gives the child. Normally, a nonmixed difference of opinion, which mainly involves only one proposition, is regarded as the "elementary form" or a single difference of opinion. Adopting a single standpoint, which is in this case called to doubt by the doctor makes the difference of opinion nonmixed (van Eemeren, Grootendorst and Henkemans, 2002:8).

(13)

[1] Doctor: *Nagendererete kogonka?*

Is she still breastfeeding?

[2] Patient: *Ee omwana nkogonka are.*

Yes, the child breastfeeds.

[3] Doctor: *Mm.*

Mm.

[4] Patient: *Korende kero kende ndoche ng'a nabo mbaise komoa akarongori.*

But, sometimes I see myself giving her some little porridge.

[5] Doctor: *Mm.*

Mm.

[6] Patient: *Ee*

Yes

[7]] Doctor: *Yaya*

No.

[8] Patient: *Gose… gose…erongori gose ebiasi. Eh?*

Or…or… porridge or potatoes. Eh?

[9] Doctor: *Nki gekogera otagete tomoe erongori? Nki gekogera otagete komorageria?*

Why do you want us to give her porridge? Why do you want to wean her?

[10] Patient: *Asengencho tagitari ndoche ng'a obeire omonene ake.*

It is because I see she is growing doctor.

[11] Doctor: *Mm.*

Mm.

[12] Patient: *Nimbwate ebiasara.*

I have some business.

[13] Doctor: *Mm.*

Mm.

[14] Patient: *Igo ngotiga omwana…*

So, I leave the child…

[15] Doctor: *Mm.*

Mm.

[16] Patient: *Nka.*

At home.

[17] Doctor: *Mm*

Mm

[18] Patient: *Bono ginkomotiga nka…*

Now if I leave her at home…

[19] Doctor: *Mm.*

Mm.

[20] Patient: *Tari konyora mabere aisaine.*

She does not get enough milk.

The doctor in line 1 strategically identifies the topical potential in breastfeeding of the infant from his expertise in handling HIV patients who have infants. Feeding of infants especially mixing breastmilk with other foods is an avenue for mother-infant HIV infection. At this point, the doctor proceeds to exploit presentational devices in the confrontation stage of the critical discussion with a strong commissive in turn 7 rejecting the patient's standpoint. The patient's use of an assertive stating that she intends to start weaning the infant with "*erongori gose ebiasi*" (some porridge, or potatoes) in turns 4 and 8 is the standpoint which makes her the protagonist of the argumentative exchange. Automatically the doctor becomes antagonist seeking to correct the misinformation in a bid to resolve the difference in opinion on merits. We later in the discourse discover that weaning the infant at the current age is against the institutional culture for HIV patients with infants of less than 6 months who are supposed to be exclusively breastfeeding. The doctor's confrontation of the patient in line 9 exploits the words "*nki gekogere*" (what is the reason) or (why) in the two consecutive questions he directs at the patient. This is pragma-dialectically a strategic manoeuvre, which seeks a sort of causal argumentative response, which informs the patient's intention. The doctor in the use of this presentational device is trying to achieve the dialectical objective of the

confrontational stage, which is a reasonable account of the difference in opinion. Simultaneously, the doctor seeks to attain the rhetorical optimum in the choice of this critical response to the patient. Discussants are continually engaged in strategic manoeuvring throughout the process of resolving a difference in opinion on merits in all the stages of the ideal model of critical discussion. This begins immediately the difference in opinion manifests itself and for this case, the doctor and the patient begin to exploit the strategic design in their argumentative moves with simultaneous dialectical and rhetorical aims (van Eemeren et al., 2014: 554-555).

The patient as the protagonist in the opening stage now takes it upon herself to provide her justification to defend her standpoint. In a multiple argumentation structure, the patient pursues two lines of argumentation as follows:

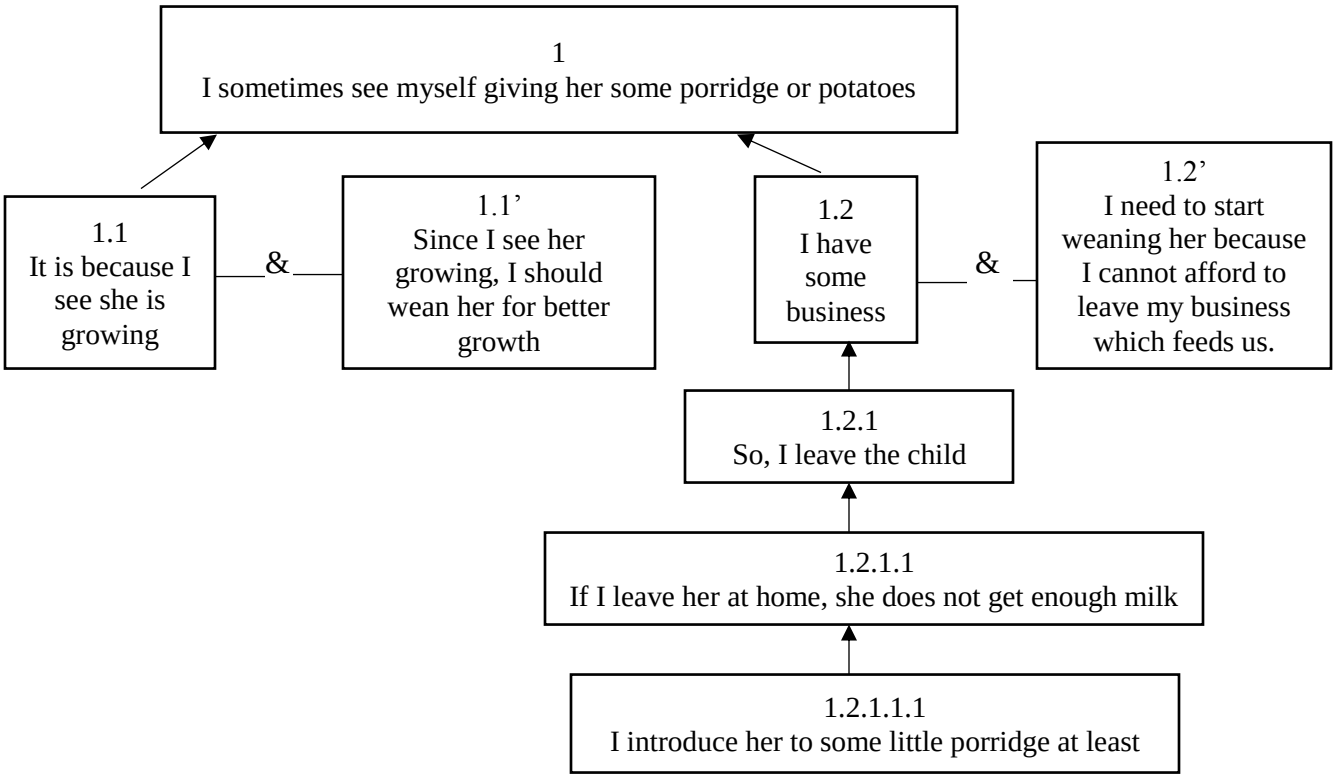


Figure 4.4 Schematic structure of HIV and AIDS patient's multiple argumentation

Presenting the first stand alone and main line of argumentation **1.1**, the patient undertakes in a commissive to explain, in a pragmatic argument, the reason why she thinks she should wean the infant by introducing some foods alongside breast milk (line 10). The patient's choice is a

pragmatic argument to justify her decision to wean her child. This is the argumentation stage of the ideal model of critical discussion. In the second line of argumentation, in line 12, the patient uses an assertive to provide a moral justification of his intentions to introduce other foods to her child in **1.2**. Using pragmatic argumentation, the protagonist explains why the socioeconomic circumstance makes her consider the business she has which is also important for the sustenance of the family. Employing subordinate augmentation, she further goes ahead to provide a chain of arguments - subargument **1.2.1**, subsubargument **1.2.1.1** and subsubsubargument **1.2.1.1.1** - where she employs assertives to build up her main argument in **1.2:** as demonstrated in Figure 4.4 above.

In the subordinative argumentation, which results from the patient's choice of the business idea as a topic potential, the patient tries to provide her new line of reasoning why she intends to introduce other foods to the child. In her argumentation, we notice the strategic manoeuvre of the audience demand as a response to her choice of topic potential. The social economic circumstance of the patient and that of her family which could be partly known to the doctor as his regular patient propels her to come up with the explanation to the doctor on why she has the weaning intentions. The patient's lines of argumentation employ pragmatic argument schemes where she explains the causal relation between the resultant weaning of her child and the family socio economic situation.

To reasonably and effectively come up with a strategic design on how to resolve the difference of opinion on merit, the doctor proceeds to further get more details on the nature of the business the patient is involved in, the place(s) of work and the distance from her home. This lifestyle inquiry is a strategic ploy by the doctor because after the patient reveals that she stays at Daraja, which is close to Daraja Mbili Market, one of the markets in her open-air market business apart from the days she will go to other distant markets in Nyakoe and/or Keroka, the doctor identifies a topic potential in her details. Let's see the doctor's strategic manoeuvring at this point in example 14 in the excerpt below from consultation HIV and AIDS 4 (see appendix xviii on page 464).

(14)

[1] Doctor: *Na gwatemire kobogoria omwana kera engaki ogokora emeremo anene mono ekero ogokora oboonchoreria?*

And have you tried to carry your child every time you are working especially when doing business?

[2] Patient: *Eyio tinkonyara tagitari.*

That, I am not able to do.

[3] Doctor: *Bono.*

Now.

[4] Patient: *Aa eyio igo erabe akong'u.*

Ah! That will be difficult.

[5] Doctor: *Bono* Eliza

Now Eliza

[6] Patient: *Ee.*

Yes.

[7] Doctor: *Noinyore togokora amasomo igoro y'obuya bw'okogonkia omwana?*

Can you remember our lessons on the advantages of breastfeeding?

[8] Patient: *Ee.*

Yes.

[9] Doctor: *Tari bo?*

Is that not so?

[10] Patient: *Ee.*

Yes.

[11] Doctor: *Togateba gokogonkia omwana emetienyi etano na rimo igo akonyora e faida ya…*

We said that if you breastfeed a child for six months she gets the benefits of

[12] Patient: *Ee.*

Yes.

[13] Doctor: *Amabere a ng'ina, tari bo?*

The mother's breast milk, isn't it?

[14] Patient: *Ee.*

Yes.

[15] Doctor: *Na togateba ng'a…*

And we said that…

[16] Patient: *Ee.*

Yes.

[17] Doctor: *Ekero okogonkia omwana…*

When you are breastfeeding a child…

[18] Patient: *Mm.*

Mm.

[19] Doctor: *Tekogwenereti koburukania n'echindagera chinde goika akore emetienyi erenga?*

You are not supposed to mix breast milk with other foods until the child is how many months old?

[20] Patient: *Emetienyi etano na rimo.*

Six months.

[21] Doctor: *Emetienyi etano na rimo na onye tokonyara…*

Six months and if you cannot manage…

[22] Patient: *Mm.*

Mm.

[23] Doctor: *Kogenderera komogonkia…*

To continue to breastfeed her…

[24] Patient: *Mm.*

Mm.

[25] Doctor: *Igo twatebete kogochaka komoburukaneria endagera n'amabere y'okogonkia...*

We said if you start mixing other foods with breast milk…

[26] Patient: *Ee.*

Yes.

[27] Doctor: *Igo akonyora ebiini.*

The child will be infected with the virus.

In the excerpt above, example 14, the doctor seeks to professionally see how the patient can minimise chances of infecting the child with HIV and AIDS even with the weaning by attempting to use informed consent constraint in his manoeuvring. Armed with the information from the

patient, the doctor makes an assertive inquiry strategically presupposing whether the patient has tried to carry the child to her workplace (turn 1). The doctor in this case presupposes the act of carrying the baby to work because he presumes it is the most workable possibility if the infant must continue depending on breastfeeding exclusively. Stalnaker (2002: 151) posits that a speaker presupposes a proposition "if the speaker is disposed to act as if he assumes or believes that the proposition is true, and as if he assumes or believes that his audience assumes or believes that it is true as well".

Presuppositions refer to those propositions a speaker makes with the assumption that their truth quality is informed by the mutual contextual common ground of the interlocutors. The doctor's presupposition is regarded to as pragmatic presupposition which is usually informed by presumptive reasoning by the speaker assuming that a proposition is not controversial because of the shared believe system and knowledge in the community or in the context of the dialogue informing the presupposition(Kecskes & Zhang, 2013: 376, Macagno & Bigi, 2017: 53–54)). The doctor's assertive expressed in the presupposition is an attempt aimed to have the defensive force of an argument form authority aimed at strategically convincing the patient to consider taking the infant with her to work. In the case in turn 1, the presupposed inquiry in the doctor's presumption is met with the patient rejecting the presupposition in strongly worded commisives in turns 2 and 4.

For rhetorical and dialectical effect, the doctor picks on reminding the patient on professional advice on the rules of breastfeeding already given to her in past clinics. The institutional precondition of informed consent informs the topic potential of the information on management of the child with exclusive breastfeeding to avoid infection. The doctor's argument resonates well with his patient, his primary audience especially in his choice of presentational device of using the argument from authority reliant on expert opinion (turns 7, 11, 13, 17, 19, 21, 23, 25). The doctor uses directives in reminding the patient on the benefits of exclusive breastfeeding of up to six months of age for a child (turn 7). He uses the word "*noinyore*" to mean "do you remember" (turn 7). In turns 11 and 15, he uses the word "*togateba*" to mean "we said" and in turn 25 he says "*igo twatebete*" to mean "we had said". He further uses a directive speech act in line 19 forbidding the patient from mixing breast milk with other foods by pointing out the grave repercussions of infection of the child with HIV and AIDS (turn 25). In the cautionary directives where the doctor

uses the argument from authority as his presentational device recommending that the patient should not mix breast milk with other foods for the infant, he employs the forbidding expression "*tekogwenereti*" to mean "you are not supposed to" in turn 19; and to express the dreaded aftermath of such mixing of infant feeding he uses the expression "*ntotageti*" to mean "we do not want" in line 31. These recommendations are the beginning of the concluding stage of the resolution process.

As part of his strategic manoeuvring, the doctor proceeds to exploit his authority as a thrust to give a directive recommending complete stoppage of the breastfeeding and only giving the infant food. The doctor's presupposition here is informed by his understanding of the Gusii cultural implications of moving up and about in the open-air market(s) and breastfeeding her child in public with all the 'evil eyes' out there. He therefore decides to give an agreeable reasoning for the recommendation he makes. He ideally establishes common ground in the shared decision-making process informed by the shared Gusii cultural context and believe system. As part of the resolution of the difference in opinion, the doctor cautions the patient in a directive where he uses the expressions *korende tomoirania* (but do not take her backlater in the discourse]) not to take back the child to the breast milk because of the danger of infection. Through this recommendation, the doctor presupposes that the patient affirms to it in appreciation of the Gusii sociocultural context and believe system. This implies that the doctor has been able to mitigate the option of breastfeeding the infant while at work and its cultural constraints by curtailing the act with this strategic manoeuvre. In this argumentative context, the doctor paints a picture of the financial situation of the family and the need for the patient to concentrate her energies on fending for his family by expressing his preference for the decision to stop breastfeeding the child and give her other foods.

In defending her proposition, the patient employs an argument from analogy as his presentational style to try and justify her standpoint at the beginning. Her topic potential this time is anchored on her experience with other business colleagues who are living with HIV and AIDS (PLWHA) and mothers with infants like hers. The patient's strategic manoeuvring is demonstrated in the counter argument in example 15 in the excerpt from consultation HIV and AIDS 4 (see appendix xviii on page 469) below.

(15)

[1] Patient: *Tindi korora abasani bane aria ase echiro…*

Don't I see my friends there at the market…

[2] Doctor: *Mm.*

Mm.

[3] Patient: *Mbare nkorora.*

There are some I see.

[4] Doctor: *Mm.*

Mm.

[5] Patient: *Tomanyaine tore positive.*

We know each other as being positive.

[6] Doctor: *Mm.*

Mm.

[7] Patient: *Na nkogamba tore.*

And we do talk.

[8] Doctor: *Mm.*

Mm.

[9] Patient: *Bono rende naigwete bagontebia…*

But then I heard them tell me…

[10] Doctor: *Mm.*

Mm.

[11] Patient: *Omwana oyo ntwamoete eriogo riria riesyrup*

We gave this kid that medicine in form of a syrup

[12] Doctor: *Mm.*

Mm.

[13] Patient: *Timanyeti gose ng'aki mokoriroka gose Nevirapine gose naki.*

I don't know what you call it, whether Nevirapine or something.

[14] Doctor: *Mm Nevirapine.*

Mm Neverapine.

[15] Patient: *Ntwamoete eyio teramokonya tagitari ninsa komoa nonya n'obokima*

We gave her but it hasn't assisted her even if I gave her *ugali*.

[16] Doctor: *Bono Elizabeth…*

Now Elizabeth…

[17] Patient: *Ee.*

Yes.

[18] Doctor: *Nevirapine.*

Nevirapine…

[19] Patient: *Ee.*

Yes.

[20] Doctor: *N'eriogo rigiya mono ase omwana.*

It is very good medicine for a child.

[21] Patient: *Ee.*

Yes.

[22] Doctor: *Noigwete?*

Do you get me?

[23] Patient: *Ee.*

Yes.

[24] Doctor: *Igo tokoa omwana korwa okoiborwa kwaye goika emetienyi etato.*

We give the child from birth up to three months of age.

In example 15 above, the patient uses an assertive to present a claim in form of an argument from analogy based on the shared experiences of PLWHA, who are colleagues at her work place (turns 1, 3, 5, 7). In her argument, the patient proceeds to explain the shared confessions of the PLWHA on how they gave their kids Nevirapine and mixed the breast milk with other foods (turns 9, 11, 13 and 15). The patient grounds her defence on the experience from other mothers in her circumstance to try and see if the doctor can agree to her intentions of weaning her child as he

continues to breastfeed her. The presupposition here is that the successful mixing of food and breast milk experience in the analogy will augur well and provide support which will convince the doctor her principal audience demand in this strategic manoeuvre. However, the doctor comes in to refute this analogical assertion using an argument from expert opinion to set straight the record by illuminating to the patient the role of Nevirapine and why it is given to the infant in the first three months of birth (turns 18, 20 and 24). As a professional he goes ahead to explain further in the discourse that in the first three months, the child takes the Nevirapine syrup because the mother's milk has the virus but if the mother eats well and the child is under exclusive breastfeeding then the medicine protects the child from infection. This expert advice given in lines 1, 3, 5 and 7 of example 16 in the excerpt below from HIV and AIDS 4 consultation (see appendix viii on page xx).

(16)

[1] Doctor: *Omwana igo akoegwa emetienyi etato asengencho emetienyi eyio neyengencho mono*

A child is given for three months because those months are very important.

[2] Patient: Mm.

Mm.

[3] Doctor: *N'amabere ya ng'ina omwana nigo are n'ebiini.*

And a mother's breast milk has the virus.

[4] Patient: *Mm.*

Mm.

[5] Doctor: *Na Nevirapine…*

And Nevirapine…

[6] Patient: *Mm.*

Mm.

[7] Doctor: *Nigo egokora egasi ekero ng'ina omwana akoragera buya na ekero omwana atari koburukanerigwa endagera.*

Works well when the mother to the child eats well and when the child is under exclusive breastfeeding.

[8] Patient: Mm.

Mm.

[9] Doctor: *Twaigwananire?*

Are we together?

[10] Patient: *Mm.*

Mm.

[11] Doctor: *Bono otabwateti machiko buna togoteba…*

Now if you do not follow these directions as we state them…

[12] Patient: *Mm.*

Mm.

[13] Doctor: *Na tomoa Nevirapine.*

Even if we give her Nevirapine.

[14] Patient: *Mm.*

Mm.

[15] Doctor: *Igo akonyora oborwaire.*

She will contract the disease.

[16] Patient: *Mm.*

Mm.

[17] Doctor: *Okoburukanerigwa gwoka igo akonyora oborwaire.*

Mixing the food alone will make the child contract the disease.

[18] Patient: Mm.

Mm.

[19] Doctor: *Na oinyore buna omwana oyo agendererete gokina…*

And remember as your child continues to grow…

[20] Patient: *Mm.*

Mm.

[21] Doctor: *Igo agendererete komenta koba enyamasi ere bweka omonyene.*

She continues to develop her own immunity.

The doctor's advice which is presented as an argument from authority, as bestowed on him because of the experience in handling patients with similar cases. His professional expertise and medical knowledge and the trust from the patient, makes his message to have the audience demand as its focal point. The patient at this level is keen at ensuring the child is secured from infection and will do anything to ensure the child remains HIV negative. The doctor's advice has the topic potential to complete the doctor's strategic manoeuvre at this argumentation stage. Having provided the patient with the information which is a legal requirement by the medical practice code of conduct, the doctor moves one notch higher in the authoritative hierarchy and invokes the institutional preconditions which requires the patient to follow the instructions to the latter (line 11) or risk the infection of the child even with administration of Nevirapine (lines 13, 15). In the administration of some drugs or treatments, there are prescribed instructions for the patients to adhere to for effectiveness of the treatment regimen.

In achieving the composite institutional point, the preconditions guiding the strategic manoeuvres of the doctor in the medical consultation literally interact with the socioeconomic and cultural circumstances of the patient's needs. Relative to the discussion in section 4.4, divergence accommodation occurs because the patient must prevent the infection of the child by adhering to the requirements of the drug regimen of Nevirapine and the feeding preconditions of the child. The doctor as the expert further gives his warning that the mixing of the foods even with the Nevirapine shall make the child susceptible to infection (lines 13, 15, 17). On the same note, the doctor encourages the patient by providing technical knowledge further that the immunity of the child continues to develop with age (lines 19, 21). This tactical manoeuvre is rhetorically acceptable to the patient but at the same time dialectically reasonable on merits. This is a case of convergence accommodation where the doctor gives hope to the patient while maintaining the dialectical standards of reasonableness.

Eventually, in the concluding stage of the critical discussion during the consultation, the doctor and the patient resolve the difference in opinion on merits. Using a commisive, the patient undertakes to follow the medical advice given by the doctor to protect the child from infection (line 1 in example 17 below which is an excerpt from HIV and AIDS 4 consultation [see appendix xviii on page 479]). This is a resolution which is appealing to the doctor, especially after having a long argumentative discussion with the patient. As a strategic manoeuvre, the patient has

employed an argument based on causal relation as her presentational device to justify her retraction of her initial proposition of intending to introduce other foodstuffs on top of breastfeeding her child. At the concluding stage of the ideal model of critical discussion for the acceptance or agreement to a shared decision between the doctor and patient.

(17)

[1] Patient: *Mbuya tagitari nche ndoche ng'a buna gwantebirie tiga mbwatie amaagizo ayio. Tintageti mwana one abe positive.*

It is okay doctor, I see what you have told me let me follow your pieces of advice. I do not want my child to be positive.

[2] Doctor: *Gaaki*.

Please.

[3] Patient: *Aisekoba positive…*

If he becomes positive…

[4] Doctor: *Mm.*

Mm.

[5] Patient: *Nonya ninche tinkonyara gokora meremo. Bono igo ndoche timbwatia amang'ana aria ngotebigwa aria echiro.*

Even me I won't manage to do my work. Now I see, I should not follow the information I am told at the market.

[6] Doctor: *Mm*.

Mm.

[7] Patient: *Tiga ngende mbwatie ogosemia kwomonyagitari nteme komogonkia.*

Let me go and follow the doctor's advice I try to breastfeed her.

[8] Doctor: *Mm.*

Mm.

[9] Patient: *Nindore gose ninyare nonya nokomobogoria gochia echiro gose kero kende nindore buna ndakore nonya nogokama amabere gose ntige emeremo eyio.*

I will see if I can manage to even carry her to the market or sometimes I see how to even express milk or I quit my job.

[10] Doctor: *Mmh.*

Mm.

[11] Patient: *Egere erio nonya n'emetienyi ebere ntige emeremo eyio omwana one agonke buya aike emetienyi etano na rimo erio nchake komoa endagera.*

Such that even for two months I leave that work and my child breastfeeds well until she gets to six months for me to start giving her food.

[12] Doctor: *Nagokire koigwa…*

I am happy to hear…

[13] Patient: *Mm.*

Mm.

[14] Doctor: *Ng'a nogonkie omwana.*

That you will breastfeed the child.

[15] Patient: *Mm.*

Mm.

[16] Doctor: *Korende onye kogotiga emeremo…*

But if you leave working…

[17] Patient: *Mm.*

Mm.

[18] Doctor: *Enekia ng'a n'obwate ase ande orabe gokonyora chibesa*

Ensure that you have another way of getting money.

[19] Patient: *Mm. Nabo.*

Mm. It is true.

[20] Doctor: *Totiga emeremo igo.*

Do not just leave working like that.

The culmination of the conclusion engages the topic potential and the audience demand in a medical consultation setting: a shared treatment decision arrived at with informed consent of the parties involved in the argumentative exchange. Informed consent in medical consultations is a legal requirement of medical practice which gves the doctor an obligation to ensure that the patient gets full information and clarification regarding any medical decision they have to arrive at during

the consultation (Weston, 2001; Bickenbach Jerome, 2012). Having tried to refute the patient's proposal by providing enough professional advice on the issue of feeding a child when the mother is HIV positive, the patient finally agrees to ignore misleading and unsubstantiated advice in the market place by fellow business women who are PLWHA (turn 5) and in a commissive agrees to follow the doctor's advice (turn 7). The patient accedes to either go to work with the baby, see if she can express milk for her while she is away at work (turn 9) with the option of even abandon her business for two more months for the sake of breastfeeding her child (turn 11). The extreme consideration of leaving her job for her child's sake (turn 11) has been pre-empted in an argument of causation where the patient does not want to contemplate her child turning HIV-positive (turn 3-5) because of exposing her to the risk of infection because of not following the doctor's counsel.

The patient's deliberate choice of securing the life of the child over her job is challenged by the doctor (turns 16, 18, 20) in a directive for her to find some income generating activity for the survival of her family whom she talks about in the discourse. This directive has the thrust of argument from authority by the doctor as a presentational style, and the presumption is the patient will consider the advice because it is in her interest as she argues earlier in the discourse. As the doctor appreciates the patient's retraction of her proposition, he still considers the topic potential of income for the sustenance of her family as something which is will capture the interest of his principal audience. The resolving of the difference in opinion by the doctor's and patient's strategic design is demonstrated in their deliberate coordination of the consecutive strategic manoeuvres in each stage of the critical discussion (horizontally) and ensuring that the strategic manoeuvres are audience motivated with stylistic choices befitting the topics chosen (vertically) (van Eemeren et al., 2014: 556). By so doing the constant aiming for rhetorical effectiveness and maintaining dialectical reasonableness is by design entangled in the shared treatment decision-making process in the critical discussion process of the medical consultation by resolving whichever differences in opinion, which arise in the process, on merits.

4.6.2 Strategic manoeuvring with formal and informal institutional preconditions doctor-patient consultations

In the analysis of strategic manouevring in the micro-context of doctor-patient consultations, it is imperative to account for the institutional environment as the macro-context of the communicative practices in the argumentative reality (van Eemeren 2016: 9). The communicative practices in the

doctor-patient consultation are the key to evaluating argumentative discourse in a medical hospital setting. Van Eemeren & Houtlosser (2005, 2006) regards these communicative practices by both doctors and patients as communicative activity types according them their unique quality of culturally established, conventionalised and institutionalised activity types. The conventionalization of the communicative activity types in the extended pragma dialectic theory sees them formalised in the various communicative genres for a more focused analysis (van Eemeren, 2014: 557). The genres, also regarded as communicative domains include the medical, legal, political, academic and other domains. The genre in this study is the medical domain whose communicative activity is one of a communion-seeking through the resolution of any differences in opinion on merits because of the interpersonal nature of the doctor-patient consultation.

Central to the success of doctor-patient consultations is the critical role of communication. On the same vein, reasonable argumentation is a critical aspect of ascertaining adequate healthcare outcome of the doctor-patient consultation (Pilgram, 2009: 156). The need to evaluate the reasonableness of the medical consultation as a communication activity type, has led to the assertion that the medical consultation is an institutionalised and conventionalised communicative practice which is carried out in medical facilities and under professional and institutional regulations (Pilgram, 2006: 157). Heath facilities or private doctor's practices ordinarily host the medical consultation, and this occurs in accordance to government and professional regulations which are have been established to ensure quality of healthcare. The conventional, cultural and institutional practice dictates interactant's deployment of strategic manoeuvring in their argumentation (van Eemeren, 2006: 385). Some of these formally or informally accepted communicative codes of conduct which have over time been institutionalized within the organisation, society, community, or profession should be subjected to the preconditional constraints for purposes of strategic manoeuvring in the argumentative activity of the medical consultation.

An exploration of the preconditions of strategic manoeuvring that pervade argumentative activity types reveals four parameters modelled on the pragma dialectic theory's model of critical discussion (van Eemeren & Houtlosser, 2005: 77; van Eemeren & Houtlosser, 2006: 384-386; Van Eemeren, 2010: 146). In the medical consultation communication activity type, these preconditions include: i) disagreement on a medical advice or on an issue during the doctor-patient

consultation serving as a confrontational trigger, (ii) the ascertainment of the material and procedural starting points, which accord the doctor the priviledge and responsibility of leading the consultation. The medical professional manages the discussion with the patient, and he/she must carry out his/her activities according to the legal code of the practice of medicine consisting informed consent and evidence-based medicine. iii) The doctor's or patient's discursive means during the argumentation such us adapting polite and cooperative face to face conversation for effective and reasonable resolution of difference in opinion on merits for a successful shared-decision making, and iv) an agreeable aftermath of the doctor- patient argumentative discussion on an issue or medical advice with an indication of a way forward on the issue including seeking another opinion from another doctor who could be a specialist or proceeding to come up with a shared treatment decision (Pilgram, 2009:158-163). In example (17) drawn from HIV and AIDS 5 of the data set for this study (see appendix xix on page 519), the excerpt below captures the confrontational trigger for the argumentative discussion between the doctor and patient.

(17)

[1] Doctor: *Mbuya tware koramorenga.*

It is good to carry out some tests on him.

[2] Patient: *Mm.*

Mm.

[3] Doctor: *Torore gose malaria abwate.*

We see if he has malaria.

[4] Patient: *Ah rakini bono rende ntware korarigereria, orarigereria ebinto binde?... okoba nabo erabe teba mareria… enchera egocha. Nigo riberera riaye rigocha rire igoro mono.*

But then couldn't we first check, you check for other things? … because it might turn out not to be malaria… the way it manifests itself. It is his fever which is exceedingly high.

[5] Doctor: *Mm.*

Mm.

[6] Patient: *Bono tinkagereti gose nenyare koba nga malaria.*

Now I don't think that it can be malaria.

In the excerpt, in example 17, the confrontational trigger for strategic manoeuvring manifests itself explicitly. The patient's mother openly differs with the doctor's advice of carrying out a malaria

test to establish if it is the cause of the high fever in line 4. The doctor employing the argument from authority tries to convince the patient's mother that the symptoms are indicative of a possibility of a malaria case (lines 1 and 3). At this point the doctor is implicity presenting a prototypical argumentative pattern because Gusii region, where the Kisii referral hospital is located, is a high-risk malaria region and therefore he goes ahead to suggest a malaria test for the child. Prototypical argumentative patterns are normally influenced by the institutional precondition which determines how arguers strategically manouevre in differerent communicative activity types (van Eemeren, 2016: 15). However, the mother to the ill child refutes the doctor's initial assessment based on his physical examination of the child.

The refutatory force of the mother's words in line 4, where she suggests in a rhetorical question "*rakini bono rende ntware korarigereria, orarigereria ebinto binde?*" (But then couldn't we first check, you check for other things?) The mother opines in this assertive that it is wise to properly ascertain that everything has been ruled out through physical examination before the move to carry out tests. In the same tone, the mother, assertively claims that "*Nigo riberera riaye rigocha rire igoro mono*" (It is his fever which is high [turn 4]) as if to further add her refutation force to her initial standpoint doubting the possibility of the child having malaria. This is a very strong disagreement with the doctor's advice and it is a counter argument from authority by the patient which equally fits in a prototypical argumentation paradigm in the Gusii macro-contextual setting of this communicative activity. In fact, the patient proceeds to perceptually rule out the possibility of the child having a malaria infection through an assertive denying the doctor's in initial assessment (turn 6). In this case the doctor chooses the biomedical establishment of the cause of the child's high fever by approaching systematically through evidence-based proposal which sets a stage for procedural and material starting points as the protagonist. The patient on the other hand comes out as an antagonist who is rejecting the doctor's advice. This is a typical case of the classification of Goodnight (2006: 79) which sees the doctor as the one who "proposes" thus a protagonist and the patient the one who "disposes" thus an antagonist.

Typically, this situation presents a case of two institutions whose preconditions are at loggerheads through a difference in opinion of its agents, the medical profession and the Gusii traditional belief system. The rhetorical question by the mother of the infant implicitly presupposes that the doctor knows these "other things" which the doctor should also check first even before carrying out the

test. In the argumentative discourse that follows, in example 18 from HIV 5 (see appendex xix on page 519) of the study data set, the doctor goes ahead to ask what else the mother suspects to be the cause of the high fever.

(18)

[1] Doctor: *Aye ng'orengereretie nki omwana abwate?*

In your mind, what is bothering the baby?

[2] Patient: *Ndoche ng'a nebibiriri asiareire.*

I see that the baby has been infected by '*ebibiriri*'

[3] Doctor: *Ebibiriri?*

'Ebibiriri'?

[4] Patient: *Mm.*

Mm.

[5] Doctor: *Mmh …nki gekoorokia ase omwana …aye buna oroche nki gekoorokia?*

Mm … What shows on the baby… from your observation what shows?

[6] Patient: *Ekiagera bono riberera igo rire igoro mono*

Because now the fever is too high.

[7] Doctor: *Mm.*

Mm

[8] Patient: *Mm.*

Mm

[9] Doctor: *Ah ebibiriri ase Gusii yaito tibiri gocha neriberera.*

Ah '*ebibiriri'* in our Gusii backyard do not come with fever.

[10] Patient: *Mm.*

Mm.

[11] Doctor: *Omwana igo are korera?*

Was the baby crying?

[12] Patient: *Mm.*

Mm.

[13] Doctor: *Buna nkoigwa, igo akorera?*

From what I hear, the baby cries.

[14] Patient: *Mm.*

Mm.

[15] Doctor: *Tarigotwara iberera.*

He does not have fever.

[16] Patient: *Mm yaya ekobwati mbare bakorera naende riberera rire aroro*

Mm … No, it depends, there are those who cry and have fever at the same time.

At this stage both the patient and the doctor try to come up with discursive means and ways of strategically manouevring to resolve the difference in opinion on merits. Both the doctor and the patient being AbaGusii who understand the cultural believe systems associated to illness represent the Gusii institutional belief system and its dictates and thus how they pervade to the medical macrocosm. Whereas the doctor is torn between the medical professional institutional preconditioning, he must strategically exploit his role as the professional and the leader of the consultation with the knowhow on how to synthesise the two competing institutional conventions in this scenario and carefully manage how the two parties interpret their "concessions in terms of medical facts and evidence" (Pilgram, 2009: 162). Thus, the argumentation presented by both the doctor and patient is reliant on the institutional preconditions of both the Gusii illness believe system and the medical health practice system.

The argumentative activity in this medical consultation communicative activity comprises of "institutionalised variants some of which are culturally established forms of communication" unique to the institution (van Eemeren & Houtlosser, 2005: 76). Each of these systems presents unique conventionalized argumentative and communicative activities at play in the medical consultation. Since the rhetorical dimension of strategic manoeuvring has a great impetus on the argumentation reality, a critical look at the situational context of the argumentation is beneficial to the evaluation and analysis of argumentative discourse (van Eemeren & Houtlosser, 2005:76).

In the spirit of shared decision-making, the doctor gives the patient a chance to literally diagnose her child's condition in line 1 of example 18 above. Kaldjian (2017: 84) emphasises the need for medical practitioners to recognize and appreciate diversity in believe and value system in doctor-patient communicative encounters because the differences "can lead to disagreements about what is good for a patient in a given circumstance, disagreements that manifest as questions about preferences, goals, and ethics that biomedical knowledge alone cannot answer". By allowing the patient to share her thoughts about the medical condition of her child, the doctor contributes to patient autonomy in shared decision making in doctor-patient communication. To the shock of

the doctor, the patient assertively claims that the child has been infected with "*ebibiriri*" to mean "evil eyes" (turn 2). The traditional Gusii sociocultural illness belief system preconditions the mother sees the child's high fever as a sign of infection by this '*ebibiriri*'.

To defend her standpoint, the patient strategically employs the argument from the sign. To talk of "fever is too high" (turn 6) is symptomatic in the defence of her standpoint. A sign in symptomatic argumentation is employed so that an arguer's standpoint can gain acceptability (van Eemeren, 1992: 97, Garsen, 1997: 8-14). In a way, this can be informed by her insight on the Gusii illness belief system, and qualify her pragmatic argumentation accorded to popular opinion/belief. The doctor strategically picks up the topic potential of Gusii illness belief system and challenges the patient's defence using a commissive rejecting her standpoint on the cause of "*ebibiriri*" among the Gusii (turn 9). He goes ahead to give his symptomatic argument based on his knowledge and popular culture (lines 13 and 15) stating that crying and not fever are the symptoms associated with '*ebibiriri*'. The doctor strategically employs argument from authority owing to his position in this argumentative context but also as a Gusii medical practitioner. Argument from authority as his presentational style is also informed by his Gusii cultural identity, understanding, and the experience he has in handling either similar cases in the sociocultural context of the hospital. The patient further defence of her standpoint is an argument from authority using her knowledge of the illness belief system (line 16). She assertively states by way of amplification that there are different manifestations of the infection of '*ebibiriri*'[20].

However, because of evidence based medicine and the informed consent requirement of medical practitioners, the doctor invokes argument from authority with its equivalent refutation force in lines 1 & 3 of example 19 from HIV and AIDS 5 consultation (see appendix xix on page xx) below. This contemporary medicine institutional preconditions influence the doctor's presentational device in his strategic manoeuvre in this case. It is out of his authority as an experienced medical practitioner in this hospital in the Gusii region which has accorded him with the knowledge that this is a high-risk malaria region (turn 1). This standpoint can be supported with evidence of the

[20] The patient has strategically manoeuvred with dissociation by distinguishing the doctor's interpretation of the cause of *ebibiriri* (term I) and with her amplification which brings in a new aspect of the interpretation (term II).

malaria infection statistics in western Kenya region[21] which is home to Kisii highlands (Wanjala et al., 2011: 2). The doctor uses this knowledge to assertively claim that malaria has the manifestations present in the child. This comes out as an argument of comparison and contrast in two competing institutional preconditions: the Gusii illness belief system heavily reliant onfolk wisdom informally recorded, and the contemporary evidence based medical practice which compels the doctor to seek informed consent in decision making.

(19)

[1] Doctor: *Rakini asengencho tore ase malaria eichire…*

But because we stay in a region where malaria is predorminant…

[2] Patient: *Mm.*

Mm.

[3] Doctor: *Malaria nero nabo egocha buna buna gwatebire igo.*

Malaria also has the same symptoms you have just mentioned.

[4] Patient: *Mm.*

Mm.

[5] Doctor: *Igo ntobwati… kende nkeiyo togoita*

So, we don't have … there is nothing we are killing.

[6] Patient: *Mm.*

Mm.

[7] Doctor: *Gose kende nkeiyo togosiria.*

Or there is nothing we are clearing.

[8] Patient: *Mm.*

Mm.

[9] Doctor: *Ase ogopima omwana malaria tomanye gose nero…*

In carrying out the malaria test to establish if it is the one…

[10] Patient: *Mm.*

Mm.

[11] Doctor: *Amang'ana y'ebibiriri…*

Issues of '*ebibiriri*'…

[21] Ingasia et al. (2016: 373) has classified the western highlands region as a malaria epidemic-prone region with a risk factor of between 5-20%.

[12] Patient: *Mm.*

Mm.

[13] Doctor: *Ebibiriri nyagitari ntobwati riogo toragotebi ng'a 'eri iga'.*

'*Ebibiriri*', at hospital we do not have the medicine we can tell you that 'here it is'.

[14] Patient: *Mm.*

Mm.

[15] Doctor: *Rakini nabo ntobwati eriogo rieriberera ntobwate eriogo ria malaria*

But we don't have medicine which can treat fever, but we have medicine for malaria.

The doctor exploits the ethical requirements which form the institutional preconditions of the medical consultation as conceived in contemporary western medicine to present his arguments in example 19 above from HIV and AIDS 5(see Appencix xix on page 522). Using both evidence-based medicine and informed consent, the doctor presents his pragmatic argument and argument from authority. The doctor exploits the argument from authority to demonstrate to the patient that in the treatment process their practice has parameters used to diagnose a disease. Using the signs of malaria present in the child after his preliminary examination the doctor already has preliminary evidence before he can do further clinical tests to establish the problem of the child. The doctor's strategic manoeuvre is informed by his experience even with similar cases of '*ebibiriri*', so, he comes up with the malaria test to try and dialectically persuade the patient into accepting his standpoint of carrying out the tests to establish the problem professionally (turn 9). The intervening traditional sociocultural illnesses believe system in the consultation informs the doctor's decision to use the informed consent requirement to try and critically convince the patient that malaria is prevalent in the region (turn 1). The doctor further uses pragmatic argumentation to inform the patient that they have medicine for fever or malaria at the hospital (turn 14) unlike *ebibiriri* which they do not have the medication (turn 13). It is worth noting that whereas the contemporary western medicine institution is very concerned about verifiable evidence, the traditional Gusii sociocultural illness belief system has a sort of evidence which may be supernatural and not quite verifiable, especially in the medical consultation room. Using his communication skills, the doctor can professionaly handle his experience with similar cases and his understanding of the Gusii illness belief system to resolve the difference of opinion on merits.

4.7 Summary

Chapter four has analysed the strategic manoeuvres exploited by the doctor and HIV patients in resolving differences of opinions that they are confronted with when in the medical consultation. The analysis has explored an array of the difference of opinions relating to the stigma associated with HIV and AIDS, challenges of discordant couples, manipulative self-diagnosis of patient conditions because of the ingrained institutional belief system of the Gusii, among others. The analyst has demonstrated the various pragma-dialectical operations involved in the resolution of these difference of opinions on merits. The process of resolving the difference of opinion is treated to the attitudinal semantic domains of affect, judgement and appreciation in the process of selecting the presentational devices which can suit either the doctor or the patient in the process of shared decision making. Using the communication adjustment strategies, the principal communication partners of the medical consultation can accommodate the complementary and competing institutional systems and preconditions when strategically manoeuvring to resolve difference of opinions on merits. The analysis also looks at the complex schematic argumentation structures showing the manoeuvres used by both the doctor and the HIV patient. In characterising the argumentative patterns which emerge in the strategic argumentative moves of the doctors in resolving the difference on opinion. In a difference of opinion regarding the challenge of discordance, the main argument for the doctor is argument from authority supported by argument from example, argument from popular opinion and pragmatic argumentation. On the other hand, in a difference of opinion on the risk of weaning the child before the appropriate time, the patient prototypically exploits the socioeconomic circumstance to present the main argument as a pragmatic argument which can be critically interrogated by the doctor who understands the socio-economic context of such patients from the local community. The support argumentation consists symptomatic argumentation using the argument from analogy. Overall, the prototypical argument employed by the doctor is authority argumentation while the patient exploits pragmatic argumentation informed by the sociocultural and economic circumstances and justified by symptomatic argumentation.

CHAPTER FIVE
ARGUMENTATION IN GUSII DOCTOR-PATIENT DIABETES CONSULTATIONS: EXPLORING COMMUNICATION ATTUNEMENT AND EVALUATIVE LANGUAGE

5.1 Introduction

This chapter analyses argumentative discourse in simulated consultations involving (Aba)Gusii doctors and diabetic patients at the Kisii Teaching and Referral Hospital (KTRH). The chapter explores both the dialectical and rhetorical efforts involved in resolving the differences in opinion on merits within the pragma-dialectical theoretical framework of argumentation. The analysis and discussion involve giving a representation of the reconstruction process of the dialogic moves in four (Aba)Gusii doctor-patient diabetes consultations (diabetes 1-4). Section 5.2 explores the stages of the ideal model of critical discussion process of resolving the differences of opinion between the doctor and the diabetic patient. Section 5.3 investigates how strategic manoeuvring influences the process of resolving differences in opinion and making shared decisions. The section analyses both the doctor's and the patient's argumentation, including questions relating to how each of their moves facilitates the pragma-dialectical process of argumentation in medical discourse. Section 5.4 explores evaluative language use in the doctor's argumentative discourse with diabetic patients. The section purposes to establish how the participants' social identities influence attitudes of interlocutors in managing the rhetorical and dialectical aims in strategic manoeuvring in their argumentation. In examining the role of communication adjustment in the choice of presentational devices relative to the macro contextual requirements of the Gusii medical consultation, Section 5.5 explores the effect of the convergence and divergence on the argumentative manoeuvres of the participants. The final section presents the prototypical argumentative patterns that characterise the Gusii doctor-patient diabetes consultation.

5.2 The pragma-dialectics of consultations between the doctor and diabetic patient

The pragma-dialectical framework of argumentation adopted in the analysis of the doctor-patient consultations invokes the parameters of interpersonal communication, which pervade the sociocultural, structural and legal aspects of the argumentative reality of the medical encounters. As demonstrated in the analytical overview in Chapter 3 section 3.2.5, the task of the pragma-dialectician is to exploit the linguistic resources at his/her disposal in understanding how the doctor and the diabetics patient maintain the delicate balance of ensuring persuasive communication and reasonable argumentation in the process of shared decision-making during the consultation. Instances of differences of opinion form key entry points the analyst is presented with when applying the theoretical framework of argumentation to the empirical reality of medical discourse.

In a study on the dynamics of shared decision making in doctor-patient communication concerning the therapeutic adherence of patients with the chronic condition of haemophilia, Río‑Lanza et al. (2016) adopted the Tates and Meeuswesen model which plays a pivotal role in a typical triadic doctor-parent-child communication, focusing on the relational, structural and linguistic aspects (2001: 840)[22]. The relational aspects relate to the patient's cognitive need to be informed and to understand and the emotional need to be appreciated and understood through the doctor's task-based and affective skills exhibited to achieve the goals of the consultation (Tates & Meeuswesen 2001: 840). On the other hand, Ervas et al. (2016: 98) posit that structural aspects apply to the differences in social positioning, freedom in the decision-making process and the responsibility of the players. The linguistic dimension refers to the interactional content of the consultation by either of the parties during the medical encounter based on their levels of knowledge, experience, cultural differences or beliefs, and how this affects how they interpret their communication signals (Rio-Lanza et al. 2016: 2). The pragma-dialectic theory of argumentation is invoked in this chapter in exploring this therapeutic doctor-patient communication about resolving differences of opinion on merits by considering such parameters. The relational aspect realised in the evaluative language

[22] Río‑Lanza et al. (2016) adopts the Tates & Meeuwesen three-dimensional model whose dimensions are inherently reflected in the pragma-dialectic theory of argumentation.

use in the dialogues is analysed using devices of appraisal theory discussed in section 3.3 of Chapter 3.

In resolving any difference of opinion, each of the stages of the ideal model of critical discussion, as demonstrated in section 3.2.3 in Chapter 3, entails all the aspects of strategic manoeuvring (see section 2.4.2 in Chapter 2). The interplay of the relational, structural and linguistic components in the context of pragma-dialectics encompasses the institutional point, institutional preconditions and choice of argumentative patterns, respectively. The three forms an ingredient which produces a medical encounter where the doctor gives reasons for a "therapeutic suggestion to the patient, giving intelligible information, explore advantages and disadvantages, negotiate with her/his actual expectations, values and way of life" (Ervas et al. 2016: 99).

Doctor-patient encounters in Eke(Gusii) involving diabetics patients constantly entail differences of opinion between the interlocutors. This calls for both reasonable and persuasive means of argumentation to resolve these differences on merits in the process of shared decision making on the treatment or management option.

Diabetes is a chronic medical condition which causes a set of illnesses due to the inability of the body to produce a hormone called insulin which regulates blood sugar (type I diabetes) or respond to the hormone (type II diabetes). However challenging, the disease can be managed through constant monitoring of one's blood glucose to ensure that it remains within the normal range by having health diets and regular bodily exercise (Robinson et al., 2010: 597; American Diabetes Association, 2017; Nathan, 2017). Research has indicated that early screening and sensitisation on lifestyle change for diabetic patients by stakeholders on how to develop a positive attitude on the management of the incurable condition have proven fruitful (Klein, Sheard, Pi-Sunyer, Daly, Wylie-Rosett, *et al.*, 2004: 2070; Basu & Garg, 2017: 74). However, diabetes still poses a great challenge as one of the deadly non- communicable diseases. The differences of opinion between diabetic patients and their doctors from the data on simulated dialogues examined relate to the administration of medication to manage the sugar levels, nutritional issues or those related to the causation of the disease due to the patients' traditional Gusii sociocultural belief system about illness

The ideal model of critical discussion as conceived by van Eemeren and Grootendorst (2015) was a deliberate attempt to develop an abstract step by step model concerning the intricacies of

argumentation in aiming to resolve a difference in opinion on merits in the argumentative reality (van Eemeren 2015: 129-131, van Eemeren & Grootendorst, 2014: 527-533). In the consultation between the Gusii doctor and the Gusii diabetic patient forming argumentative discourse data, the first stage of the critical discussion involves the manifestation of a difference in opinion. This is demonstrated in the (Eke)Gusii excerpt (1) in the diabetes 1 consultation (see appendix xx on page 534) below:

(1)

[1] Patient: *Bono mbwate ... nimbwate omochando. Omochando one ne…natemire korigia abana nkobwata oborito bwagwa. Bono timenyeti nki ndakore na ginkoboria abanto bantebia noborwaire obo naye nogendererete kong'a amariogo. Bono nki ndakore? Igo nkomenta konywa amariogo? Imente amange gose naroo okong'a.*

Now I have… I have a problem. My problem is…I have tried to look for children, when I get pregnancy, I miscarry. Now I do not know what to do and when I ask people they tell me that it is this disease and you have continued to give me the medicine. Now what will I do? Do I take more medicine? Add me more, I hope you have more to give me.

[2] Doctor: *Mm.*

Mm.

[3] Patient: *Ee. Omochando onde n'endagera; endagera igo mwantebetie ndie nke tindi gochia ng'igota!*

Yes. Another problem is food. You had told me to take a little food, but I do not even get satisfied!

[4] Doctor: *Aha!*

Ah!

[5] Patient: *Ee… bono timanyeti gose igo mogontebia mente ekewango…mong'e eriogo mente ekiagera abanto bande igo bakonywa esoda nche tindi konywa esoda.*

Yes … now I do not know if you will tell me to increase the portion…you also add me medicine because other people take soda, yet I do not.

[6] Doctor: *Aye oroche okonywa amache oka?*

You think you only take water?

[7] Patient: *Ee.*

Yes.

[8] Doctor: *Gose club soda.*

Or club soda.

[9] Patient: *Kende nkeiyo nkonywa!*

There is nothing I drink!

[10] Doctor: *Mm.*

Mm.

[11] Patient: *Ekiagera mwantebetie tinywa.*

Because you told me not to drink.

[12] Doctor: *Mm.*

Mm.

[13] Patient: *Naende nimbwate omochando onde.*

I also have another problem.

[14] Doctor: *Mm.*

Mm.

[15] Patient: *Omochando mbwate noyio bwamariogo ayio mogontebia ng'a nyetonge. Aah bono ntagete nchake eriokonywa bono tintageti eriogwetonga. Naende ntagete eriokonywa buna omosani one akonywa.*

The problem I have is about the medicine you tell me to inject myself. Aah, now I want oral drugs not injectable medicine. I want the oral one like my friend does.

[16] Doctor: *Bokong'u mboiyo. Nabo nkogokonya. Aye mbwoo ore, taribo?*

There is no problem. We can help. You are married, right?

In this case the patient takes the role of antagonist in turn 15 where the manifestation of the difference of opinion with the doctor occurs. In the follow up consultation the patient's non-acceptance to the doctor's standpoint advising her to inject herself marks the confrontation stage of the ideal model of critical discussion in this argumentative reality. The standpoints of the doctor and the patient appear to contradict each other signalling the difference in opinion (van Eemeren et al. 2014: 529).

In reconstructing the standpoint of the patient and the efforts made by the doctor to resolve it, closer attention to the micro-context, meso context, macro context and discursive context of the consultation is paramount (van Eemeren, 2010:16-19). The micro-context consists of the linguistic choices made by the Gusii interlocutors; the meso-context entails the situation of the speech event; the macro-context refers to the contemporary western medical institution, where the speech event occurs, and the discursive context entails the intertextual meanings of the argumentative moves in the speech event in a psycho-social perspective. These contextual realities inform the doctor's

reaction to the antagonistic standpoint where the patient seeks a review of the method of administration of her medicine from injectables to orals. The doctor exploits a deliberate logical attempt to answer the patient by strategically gathering information regarding the management of her medical condition thus exploiting pragmatic inferences, which provide the background information necessary in resolving the difference in opinion (van Eemeren *et al*. 2014: 538-539). The difference in opinion occurs in the context of the meso-context of the Gusii patient presenting her problem(s) during this clinical visit to the Gusii doctor. In turn 1, the patient expresses her confusion about her inability to bear children despite her multiple conceptions which are followed by miscarriages. The patient further proceeds to give her second problem which relates to her dissatisfaction about the doctor's recommendation on the quantity and type of food she should eat (turns 3 and 5). The difference in opinion lies in the patient's resentment to the self-injectable medicine to the orally administered one as she presents her third problem for the consultation.

As discussed in section 3.2.3 of Chapter 3, the opening stage of the critical discussion process involves the ascertainment of the discussion roles and the material and procedural commitments for both the protagonist and antagonist in the discourse (van Eemeren et al. 2014 :529). In the medical consultation, these roles are taken by the doctor and patient, respectively. While the doctor is procedurally expected to use his professional knowledge and experience in trying to resolve the difference in opinion, the patient presents her antagonistic view challenging the current treatment regime on which she is based on her preference and experience in the management of her medical condition. The (Eke)Gusii excerpt (example 2) below from the diabetes 1 consultation (see appendix xx on page 539) illustrate the material and procedural starting points for the two discussion parties.

(2)

[1] Doctor: *Aah igo tindengerereti ng'a echi n'echingaki ogwenerete obe n'echitang'utang'u asengencho bono iga n'amariogo ogendererete konywa.*

Aah, so I don't think that this is the time to have doubts because right now you are taking your medication.

[2] Patient: Ee.

Yes.

[3] Doctor: *Aa… na mbuya ogendererete koyanywa.*

Aa… and its good you continue taking them.

[4] Patient: *Mm.*

Mm.

[5] Doctor: *Aa.*

Aah.

[6] Patient: *Korende ntagete ong'oonchorerie.*

But I need you to change for me.

[7] Doctor: *Otagete goonchoreria aa... ngoika tore abwo. Oyio noro orenge omochando oo ogatato. Tokumia igo okare kogenda bwango mono. Igo egento togokora, tiga ritang'ani torakorana n'omochando oyo oo bw'okogwa kwoborito aa… totebe goikera bono esukari yao yabeire stable.*

You need to change, okay… we will get there. That was your third problem. Do not worry, you are moving so fast. So, what we do, let us first finish this problem of miscarriage… let's say your sugar level has now stabilised.

In the EkeGusii except (2) above, while the doctor is presenting a reason why the patient should not have any doubts about her present condition because she has been taking her medication correctly, he gives his argumentation based on a symptomatic relation in an assertive (turn 1). He proceeds to encourage the patient to continue taking her medication (turn 3) and this signals the point of ascertainment of the material and procedural starting points for the critical discussion. The patient seeks the substitution of the administration of her medicinal regime, literally antagonising the doctor's standpoint in turns 1 and 3. The patient presents this challenge in a directive targeted at the doctor's assumption that she will continue taking her medicine as is the current practice (turn 6). This confrontation reaffirms the patient's commitment to taking the role of antagonist in the discussion while the doctor takes the protagonist as he alludes in turn 7. This forms the opening stage of the resolution of the difference in opinion on merits.

On the same breath, *the argumentation stage* takes centre stage when the doctor comes to the patient's third problem in which the patient antagonises the status quo regarding the administration of her medicine. This is illustrated in the following excerpt (3) from diabetes 1 consultation (see appendix xx page 543-544):

(3)

[1] Doctor: *Omochando onde kwarenge noro noyio bweriogo riokwebeta, eriogo riokonywa, eriogo rigwetonga aa… ntagete ong'igwe buya. Oborwaire bw'esukari igo bore mara kabere. Mbore bwabana abake buna aye nimaete tori moke rakini emiaka yao …aaa… abana babwate emiaka buna eyao, na oborwaire bw'esukari mbore bw'abanto abagotu babo sokoro, torochi rende?*

Another problem you had was about the self-injectable medicine…orally administered medicine, injectable medicine…. Ah...I want you to get me well. There are two types of diabetes. There is one which affects young people like you, I know you are not as young but your number of years…aa… young people of your age, and the other type is for elderly people, the likes of grandfather, you see.

[2] Patient: Ee.

Yes.

[3] Doctor: *Igo eye y'abana abake anene mono chingaki chinyinge igo ekworokia nobwate omochando na insulin yao. Mobere oo tori konyara koroisia insulin esaine buna eria y'abant abagotu. Abanto abagotu nabo bokonyara koroisia insulin korende insulin eyio teri gokora egasi eria egwenerete. Ase igo amariogo abo nigo are amaao aaa… Eye nabo erabe eyokoondokia korende nabo ekonyarekana otumie chisindani ase engaki entambe onye tari obogima bwao bwonsi kobua baria abagotu aaa…Igo obwenerete kobeka amangana aya ase omotu oo, aa igo nario oranyare gwancherana…aa korende ningotome ase omonyagitari osomerete ebirengererio bi'obworwaire obo bwesukari. Buna nagotebia, oborwaire obo etokobwaterana, tari bwa monto omo bweka…Tindi kanyasae goka ase enyagetari eye, tari bo?*

So, this one for the young people most of the time, it means you have a problem with your insulin. You cannot produce enough insulin unlike the one for elderly people. The elderly can produce insulin, but the insulin is not giving the function it is supposed to, so their drugs are different aa… This might come as a shock but there is a high chance you will be doing injections for a long time if not forever as opposed to those other old people aa…. You just need to put your mind on it, aa that is how you can manage to accept it …aa... though I will still send you to a diabetic counsellor. Like I told you this disease we work together as a team it is not one man's show. I am not the only 'god' in this hospital, isn't it?

[4] Patient: *Mm*.

Mm.

[5] Doctor: *Igo togosanga n'abande. Ase ayio ningotome ase omosemia bw'oborwaire bw'esukari aaah… tona goichana tibori borwaire bw'ekerage nabo kwarengereria buya nakoeire pongezi ase ayio. Torochi rende?*

We involve other people. So, on that, I will send you to a diabetes counsellor aah… you don't need to worry it is not such a strange disease, and you thought it well I should congratulate you on that. You see?

In initiating the refutation of the patient's new standpoint of preferring a review of the mode of administration of her medication, as demonstrated in the EkeGusii excerpt (3) above, the doctor begins with a strong assertion assuring the patient by way of information about the two different types of diabetes (turn 1). In defending the patient's current self-injection as a method of drug administration the doctor deliberately exploits authority argumentation. In the pragma-dialectic theory of argumentation, authority argumentation is classified under symptomatic argumentation (van Eemeren & Grootendorst 1992: 160). This means that the authority in the argument scheme in the argumentation reality signals the acceptability of the standpoint in terms of symptomatic argumentation (Pilgram 2012: 36). Thus, an interactant who exploits authority argumentation in support of his argument is normally in agreement with the implicit authority in the standpoint as a sign of the truth and validity of the standpoint (van Eemeren & Grootendorst 1992: 163). We can reconstruct and further analyse the argumentative exchanges in example (3) above drawing from *Figure 5.1* below, which shows the schematic representation of authority argumentation.

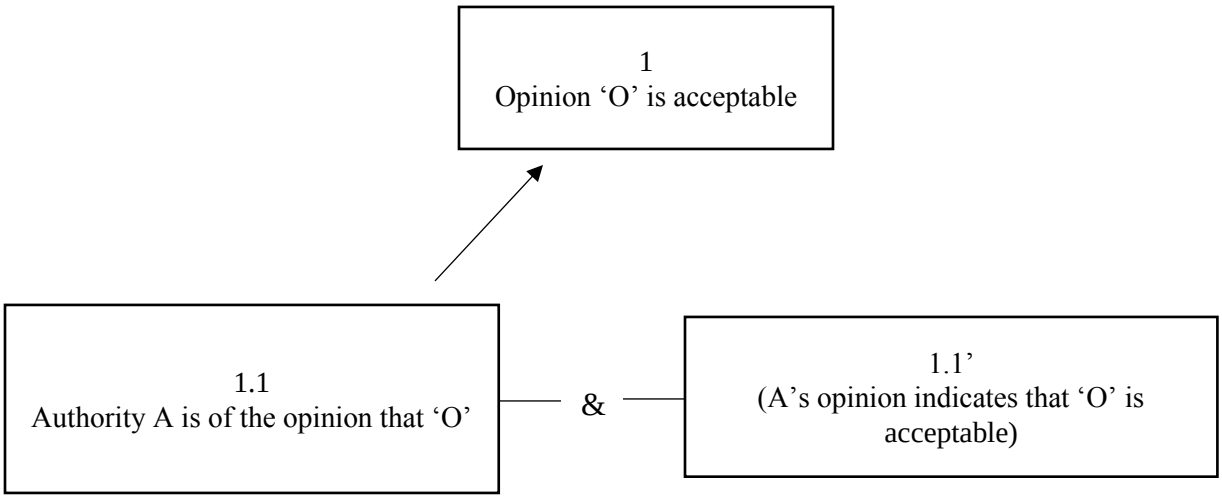


Figure 5.1 Schematic representation of argument scheme for authority argumentation

In this single argumentation schema above (Figure 1), standpoint 1 has two arguments, that is 1.1 and 1.1', which form the premises of the basic form of authority argumentation. In example 3, the doctor in turn 1 exploits authority argumentation in defending the current medical regime of the patient in three different ways. First the doctor exploits the legal authority which is bestowed upon him by the Hippocratic oath of the practice of medicine. This authority confounds in him the requirement to give evidence-based medicine especially having the knowledge of the patient's

informed consent legal requirement (Weston, 2001; Barratt, 2008). The doctor goes ahead to explain to the patient the two types of diabetes which have been discovered by medical researchers and how each of them targets either the young people or the elderly people (turn 1). The doctor further uses amplification to explains to the patient that hers is "*...bwabana abake..."* (one for the young people) because her body "*tori konyara koroisia insulin esaine buna eria y'abant abagotu"* (cannot produce enough insulin unlike the one for elderly people [turn 3]). The patient is armed with his informed consent card all this while and keenly listens to the doctor's advice. This is akin to say that because the doctor understands the treatment of the medical condition and therefore is the authority in this case, he can only be right thus his standpoint is acceptable according to Figure 5.1 above.

Secondly, the professional expertise and experience of the doctor gives him the authority on which he relies to give his counsel the thrust it needs in, for instance, in his precisation on the nature of diabetes which the patient is suffering from (turn 3). It is out of his experience and medical knowledge that he authoritatively stating that the patient may have to do the self-injecting medicine "*ase engaki entambe onye tari obogima bwao bwonsi*" (for a long time if not the whole of your life) because of her age and the nature of her medical condition (turn 3). Using this authoritative negotiating power of the doctor further recommends in a directive "*Igo obwenerete kobeka amangana aya ase omotu oo, aa igo nario oranyare gwancherana…"* (You just need to put your mind on it, aa that is how you can manage to accept it… [turn 3]). This means that the patient has no option but to accept the status quo regarding her medication. However, the doctor is quick to back up his directive with an institutional process which brings in other experts on the treatment and decision-making process in a medical consultation.

As part of the argumentation stage, the doctor has employed definition in a symptomatic relation in clearly defining the nature of the diabetes that the patient is suffering from and distinguishing it from the one which affects the elderly. Symptomatic argumentation can be applied in linking a standpoint with a reason through a definition (van Eemeren, Grootendorst & Henkemans, 2002: 98). The doctor says: "*Abanto abagotu nabo bokonyara koroisia insulin korende insulin eyio teri gokora egasi eria egwenerete. Ase igo amariogo abo nigo are amaao"* (The elderly can produce insulin, but the insulin is not giving the function it is supposed to, so their medicine is different [turn 3]). This definition is meant to demonstrate that the drugs administered to the elderly diabetic

patients are meant to serve a distinct task as opposed to those given to the young people because of the nature of their diabetes. Through comparison and contrast the doctor tries to dissuade the patient from her standpoint of a preference for orally administered drugs which are a reserve for the elderly because they can produce enough insulin.

The third perspective of the doctor's source of authority is demonstrated in the way he exploits symptomatic argumentation in the critical discussion, the institutional preconditioning of the medical consultation. The hospital infrastructural setting and the institutional rules of practice of medicine accords the doctor the authoritative position in the doctor- patient interaction. In this case the doctor gives a directive recommending the patient to his colleague, a diabetic counsellor "*ningotome ase omonyagitari osomerete ebirengererio bi'obworwaire obo bwesukari. Buna nagotebia, oborwaire obo etokobwaterana, tari bwa monto omo bweka"* (I will still send you to a diabetic counsellor. Like I told you this disease we work together as a team it is not one man's show" [turn 3]). This directive is issued to afford the doctor's authority and privileged position not to just make the decision alone but also involve a diabetic counsellor, a colleague who is a specialist, in the shared decision-making process. This speech act reinforces the authoritative argument of his move in assisting the patient have consent on the reason why she may have to continue with her previous administration of her medication. The doctor's expression, "*Buna nagotebia, oborwaire obo etokobwaterana, tari bwa monto omo bweka"* (Like I told you this disease we work together as a team it is not one man's show" [turn 3]), brings in the earlier argument from expert authority in the consultation which can be reconstructed using permutation as an argument from example to build on the doctor's defence using his argument from authority bestowed to him from the institutional preconditions of teamwork for effective medical practice. This argument which serves as an argument from example alluded in turn 3 of example (3) above can be seen in the (Eke)Gusii excerpt in example (4) also extracted from diabetes 1 consultation (see appendix xx page 541):

(4)

[1] Doctor: *Igo nkogotoma ase e gynecologist oyio ore omosani one sana. Gochi bono igo nkomwakera esimi otaragenda aroro. Nagokonye na kero kende erabe buya onye nkwagenda n'omogaka oo. Aa. na kero kende komwaigwananire amo nere nabo mokoarigania nyoko biara ase amangana buna aya aah egere tobeke… tobabeke buna e timu eyemo. Omaete nigo togwenerete korwania oborwaire obo bwe'esukari buna*

riboa erimo: nche buna omonyagetari oo, aye n'enka yao mobe buna etimu. Toise kobagekana ensemo ensemo…

I will send you to a gynaecologist who is my close friend. In fact, I will call him before you go there. He will assist you and maybe it will be good to go with your husband. Aa… and maybe once you agree with him you can invite your mother-in-law in the process…aah so that we put you in one team. You know we are supposed to fight this disease of diabetes as a team: myself as the doctor, you and your family as a team. If we get split into two….

[2] Patient: *Mm.*

Mm.

[3] Doctor: *To…toraise ko…igo to…tokobugwa, tari bo?*

We will lose, is that not so?

[4] Patient: *Mm.*

Mm.

[5] Doctor: *Abasongo ngoteba bare ng'a 'teamwork wins'. Nonya ninche torochi igo ngosanga n'omonyagetari onde.*

The English say, "teamwork wins". You see, even me I work with another doctor….

[6] Patient: *Mm.*

Mm.

[7] Doctor: *Oyio ore kemanyi ase amang'ana aya ya konyora abana kiagera ntagete tobe etimu.*

Who is a specialist in issues related to the female reproductive system because I want us to be a team.

[8] Patient: *Mm.*

Mm.

[9] Doctor: *Tokoba etimu enene. eeh.. ebwate ogosemerani nabo egokwanwa igo? Ebwate. ogotegererana na koigwanana tora. erio nario torabobue oborwaire naye buna ore omoke nabo okonyora abana ikomi gose batano batato oise kogania. Korende nimanyete kero kende igo oganetie abana batato gose babere eyio ere buya korende tinkorwa eira. Igo nkogotoma ase egynaecologist.*

When we are a big team…eeh…having consultations, is that how it is said? With understanding and agreement with each other, we can defeat this disease and being a young person, you can then be able to give birth to up to say fifteen children if you want. However, I know that you may want to get three or two which is okay though I can't make promises. So, I will send you to a gynaecologist.

[10] Patient: *Bono nankonye mbwate oborito?*

Now, will he assist me get pregnant?

[11] Doctor: *Ee amaboria onsi igoro y'ensemo eyio nakore obotuki ase ore erio akoe ogosemia na ekeene nakoe amachibu onsi.*

> Yes, all issues about that area, he will do some investigation on you then he will advise you, and of course he will give you all those answers.

In a subordinate argumentation move, the doctor, in turn 1 of example 4 above, alludes to an earlier argument in the discourse when employing a permutation transformation reconstruction on the argumentative discourse in the critical discussion process. As discussed in section 3.2.5 of Chapter 3, permutation transformations are employed in the reconstruction process of the analytical overview where the analyst rearranges elements so that they capture the systematic resolution process (van Eemeren et al. 2014: 535). The doctor suggests that he will send the patient to a gynaecologist, who will carry out more specialised investigations (turn 11) about her childbearing concerns (turn 10) as she undergoes diabetes treatment. The doctor emphasises the essence of teamwork in the decision-making process and the management of diabetes both at the hospital and family levels: "*Omaete nigo togwenerete korwania oborwaire obo bwe'esukari buna riboa erimo: nche buna omonyagetari oo, aye n'enka yao mobe buna etimu."* (You know we are supposed to fight this diabetes as a team: myself as the doctor, you and your family as a team" [turn1]). Apart from the support team of his medical team of specialists (diabetic counsellor, gynaecologist), the doctor recommends that close family members (husband, mother-in-law) should be part of the support group for her during the treatment process probably to manage the situational (meso context) and institutional (macro context) peculiarities of the treatment process.

A unique attribute that the Gusii doctor exploits is his understanding of the local Gusii sociocultural belief institutional system regarding illness and the challenge it poses to the family and how it involves the extended family relations in dealing with such a chronic condition. The exploitation of this presentational style is reliant on the argument from authority derived from his understanding of the Gusii sociocultural belief institutional system, psychologically appeals to the patient in articulating a common principle that speaks to the Gusii spirit of togetherness when faced with a challenge of a disease to the family unit. The doctor asserts, "teamwork wins" (turn 5). It is interesting to note how the informal institutional precondition of the traditional Gusii social cultural belief institutional system on illness and the formal institutional constraint of contemporary western medicine institutional system compares in terms of teamwork in the handling of chronic conditions such as of diabetes at the hospital. Deriving the authority of his

symptomatic argumentation from both diverse institutions. The doctor's critical challenge forms the ground for his refutation of the patient's standpoint on her medication.

Further still, to justify the teamwork in institutional rules and preconditions of medical practice, the doctor uses an argument from analogy when he claims in an assertive that he is "*Tindi kanyasae goka ase enyagetari eye"* (not the only "god'' in [the] hospital [turn 3, example 3]). The doctor invokes this argument to reinforce his refutation of the patient's initial standpoint. This means that if the patient listens to another professional in the hospital then this will make him appreciate the doctor's refutation of his stand. The institutional context also accords the doctor the authority to strongly assert that the patient has no option but rely on the self-administered injections option for a while and at this point the patient can only listen and appreciate the thrust the assertive signals. The doctor says, "*nabo ekonyarekana otumie chisindani ase engaki entambe onye tari obogima bwao bwonsi kobua baria abagotu"* (there is a high chance you will be doing injections for a long time if not forever as opposed to those other old people [turn 3, example 3]). The doctor proceeds to state authoritatively in a declarative categorically stating that the patient ought to begin to accept that she will continue with her medication for a while. He says, "*Igo obwenerete kobeka amangana aya ase omotu oo, aa igo nario oranyare gwancherana"* (You just need to put your mind on it, aa that is how you can manage to accept it [turn 3, example 3]). To gain a better insight on the application of the institutional preconditions in the medical consultation communicative activity type, the next section analyses the process of strategic manoeuvring in the consultations involving Gusii doctors and diabetic patients.

5.3 Strategic manoeuvring within institutional preconditions of the Gusii doctor - diabetic patient argumentative encounters

In the resolution of a difference in opinion, the strategic design comes in handy in the extended pragma dialectic theory. This strategic component conceives the process of resolving a difference in opinion between interlocutors in different scenarios: medical, academic, political or legal contexts of the argumentative reality. Strategic manoeuvring, as earlier clarified in section 3.2.5 of Chapter 3, was conceived by van Eemeren and Houtloser (2002a) with the purpose of broadening the theoretical basis of analysing and evaluating the empirical reality of argumentative discourse. Thus, the development from the standard theory of pragma-dialectics to the extended

theory of pragma-dialectics also meant a superior quality of argumentative discourse, be it oral or written and in whichever domain (van Eemeren, 2010). The strategic design thus contemplated an argumentative reality which aims at both effectiveness and reasonableness simultaneously. This means that interactants' argumentative moves must not only be acceptable to their audience but must be reasonable and in the confines of the rules of critical discussion (van Eemeren et al., 2014: 553).

The functional integration of the rhetorical and dialectical viewpoints of the argumentation theory is the basis of the strategic manoeuvring. The strategic manoeuvring triangle is a confluence of three focal points of rhetorical research which include style, audience adaptation and topical system. The process of utilising these kinds of strategic manoeuvres occurs in all the stages of the ideal model of critical discussion. All argumentative moves that discussants or writers employ are both dialectically and rhetorically aimed at resolving the difference on opinion on merits. In fact, for every argumentative move, strategic manoeuvring moderates the dialectical goal with its rhetorical analogue. In the medical domain, and more particularly, the doctor-patient argumentative reality, both the doctor and patient employ argumentative moves aiming for the resolution of any difference in opinion that may manifest in their consultation encounters. In so doing, they exploit the strategic design in this pursuit and each stage of the critical discussion in the process of resolving the difference in opinion. Examining data extracted from argumentative discourse in a consultation between the doctor and a mother with a diabetic child, in the EkeGusii excerpt in Example 5 drawn from diabetes 2 consultation below, the analysis explores how the doctor and the patient exploit the parameters of strategic manoeuvring to achieve the institutional point according to the institutional preconditions in the process of resolving differences of opinion on merits.

i. **Confrontation**

The manifestation of a difference in opinion occurs when the patient expresses doubt about the diagnosis of the first doctor who referred her to the KTRH. Normally, such manifestation will necessitate a confrontation by either party of the interactants. In the EkeGusii excerpt from diabetes 2 consultation (see appendix xxi on pate 555) in example 1 below, the patient expresses a non-acceptance of a medical standpoint from a previous doctor while consulting the doctor at the KTRH on the condition of her child. The previous doctor's investigation and diagnosis

notwithstanding, the patient comes with a mindset of disagreeing with the possibility of her child having diabetes and introduces an extraneous reason why she suspects the child is sick (turns1, 5 and 21). The disagreement space is motivated by the patient's preference and allegiance to the Gusii sociocultural belief system on illness which is in opposition to the doctor's fidelity to the contemporary western medical practice. The patient's standpoint is self-contradictory because she comes to the KTRH on a referral from another medical practitioner in another hospital and comes to seek medical review but with doubts based on her belief on the possible problem of the child's medical condition (turns1, 5 and 21). Some of the presentational devices the patient exploits in the confrontation stage include "*Korende tindochi*" (but I do not see) to strategically express her implicit doubt in the contemporary medical procedure and system.

(5)

[1] Patient: *Rakini nche tindochi*

But personally, I do not see.

[2] Doctor: *Ee*

Yes.

[3] Patient: *Mm.*

Mm.

[4] Doctor: *Torochi gose nkogwena are?*

You don't see the child recovering?

[5] Patient: *Rakini naende tindochi gose nesukari eyio.*

But then I do not see that it is that diabetes.

[6] Doctor: *Ee.*

Okay.

[7] Patient: *Omaete nonya n'omosubati nare…*

You know there is this lady…

[8] Doctor: *Ee.*

Yes.

[9] Patient: *Twomanete nere nka.*

We stay with at home.

[10] Doctor: *Ee.*

Yes.

[11] Patient: *Agantebi ng'a n'ororе.*

She threatened me that "I will see".

[12] Doctor: *Ee.*

Yes.

[13] Patient: *Mm.*

Mm.

[14] Doctor: *Bono ntagete tokore iga…*

Now, I want us to do this…

[15] Patient: *Mm.*

Mm.

[16] Doctor: *Etokorigereria omwana*.

We shall examine the child.

[17] Patient: *Mm.*

Mm.

[18] Doctor: *Tomopime.*

We carry out the tests on her.

[19] Patient: *Mm.*

Mm.

[20] Doctor: *Tororе ng'aki arwarete.*

To establish the nature of her sickness.

[21] Patient: *Mompimere rende gaki mokonye rakini nche tindochi.*

You carry those tests on her please, but I personally don't see!

[22] Doctor: *Ee rakini amang'ana ayio y'omosubati oyio n'ebimoni ntagete totigane kabisa*

Yes, but I want us to avoid those issues of that lady and the cats absolutely.

In example 5 above, from the topical options at the patient's disposal with the potential to confront the doctor about her non- acceptance of the status quo, which is informed by the doctor's response to her expression of doubt, the patient chooses to give a reason why she thinks the sickness is due to a witchcraft (turns 7,9, and 11). The choice of topic potential links two aspects, which arrest the attention of the doctor, who is the primary audience of the patient. These are the diagnosis by the previous doctor, and the reason behind the doubt expressed by the patient during the consultation. The patient intentionally distinguishes between what she considers the real cause and the previous doctor's apparent diagnosis of her child's illness in her bid to challenge the contemporary western medical practice. The institutional system of the traditional (Eke)Gusii sociocultural belief system on illness informs the patient's expression of doubt of the causal factor of the illness identified by the doctor, who referred her to the hospital for further investigations. The simultaneous rhetorical and dialectical appropriation of the aim of the confrontational stage reaffirms the pragma-dialectical commitment of the interlocutors in the strategic manoeuvring. The choices made by the patient at this stage in establishing the disagreement space and the subsequent moves in the presentational devices, having elected on the topical potential and the rational link to the doctor as her audience lay a foundation for an effective and acceptable discussion process aimed at resolving the difference in opinion reasonably on merit.

ii. Opening

The strategic element of the pragma-dialectical argumentation in the opening stage sets a stage for establishing the material and procedural starting points for the parties involved in a critical discussion. In example 5 above, extracted from the diabetes 2 consultation, the doctor and the patient have both taken their respective discussion roles, and in their moves, asserted their material stating points clearly. The doctor assumes the role of the protagonist and in this position, he seeks to commit to undertake the examination of the sick child, carry out tests and ascertain a diagnosis of her sickness professionally (turns 16, 18 and 20). The surrogate patient (the mother), on the other hand takes the antagonist role expressing her doubt about the diagnosis by the previous doctor (turn 1 and 5). Her standpoint which is partly implicit reveals the reasoning behind her non-acceptance of the diagnosis and the current attempt to try and treat the child.

The roles taken by the interlocutors in their contrasting views of the medical process makes the doctor and the surrogate patient commit to their material and procedural starting points. The

doctor, as the protagonist, is promoting the conventional medical practice and culture in defending the biomedical ascertainment of the medical condition of the child, thus his role as a trained medical professional, who carries out his medical practice according to the medical institutional preconditions forms his material and procedural starting points. As a presentational style, the doctor has employed symptomatic argumentation, where he uses his authority as a medical doctor to issue a directive forbidding the patient from cultural believes which do not relate to the illness of the child (turn 22). The doctor further states, in an assertive, the medical procedures that he will follow in examining, testing and diagnosing the illness of child (turn 16, 18, 20). The surrogate patient, on the other hand, in her antagonistic role, comes to this consultation with her presuppositions informed by the institution of the traditional Gusii sociocultural belief system on illness, which in retrospect further influences her doubts about her child's diagnosis of diabetes (turns 1 and 5).

The doctor's standpoint and that of the surrogate patient are contradictory thus making their difference in opinion mixed. While the doctor objectively focuses on an evidence-based approach to the illness of the child (turn 22), the patient communicates her local beliefs (turns 7, 9 and 11) which implicitly challenges the doctor's commitment to establishing the right diagnosis for the child (turn 21). The topical potential choices for the protagonist and antagonist reaffirm their commitments to two institutions which are at cross-purposes in this consultation: the contemporary western medical practice which is evidence-based and the traditional Gusii sociocultural belief system on illness, which is based on the belief in the supernatural forces conditioned by fellow human beings to cause human illnesses. The audience demand is manifested in this consultation in the way the discussants from the same Gusii cultural background strategically manoeuvre with each. The doctor is left to pragma-dialectically manoeuvre with the patient's traditional Gusii sociocultural belief system with dissociation while making her understand the role of the contemporary western medical practice. Table 5.1 below shows some of the presentational devices used by the protagonist (doctor) and antagonist (patient) to entrench the institutional interlocutors in their argumentative exchanges.

Table 5.1 Presentational devices employed by the doctor(protagonist)and patient(antagonist)

Protagonist	**Antagonist**
Etokomorigereria (we shall examine her)	Tindochi (I do not see)
Tomopime (we carry out tests on her)	Tindochi gose nesukari eyio (I do not see if it is that diabetes)
Torore ngaki arwarete (We establish the nature of her sickness)	Omosubati nare…agantebia norore (There is a lady…. she threatened me that I will see)
Amangana ayio yomosubati oyio nebimoni totigane kabisa (I want us to avoid those issues to do with that lady and cats completely)	Mompimere rende…. korende tindochi! (Just carry the tests on her for me…. but I do not see!)

The presentational choices of the two discussion parties show the push and pull between the institution of contemporary western medical practice and threat of the Gusii traditional illness/alternative medical belief system, which replays itself in the argumentation stage. The parties test the acceptability of their standpoints through arguments they present to reasonably resolve the difference in opinion on merit thus facilitating the process of shared decision-making during the consultation.

iii. Argumentation

To demonstrate how the protagonist and antagonist exploit different strategic moves in the argumentation reality of the medical consultation and in resolving the difference of opinion, the (Eke)Gusii excerpt in example 6 extracted from the diabetes 2 consultation (Appendix xxi page 557), is considered. However, in the analysis of the argumentation in the argumentation stage of the model of critical discussion, as is the tradition, only relevant argumentative discourse is reconstructed from the argumentative reality. Thus, several segments of the discourse are omitted

while others undergo reconstruction transformations: permutation, deletion, addition and substitution. These analytic operations are aimed at providing the model of critical discussion which serves as an analytical tool or template for the resolution of differences of opinion on merit (van Eemeren et al., 2014: 534-536, van Eemeren *et al*., 2001: 17)

(6)

[1] Doctor: *Yaya omwana nache agwene, tobaise goteba igo… bono iga Nyasae.*
No, the child will get well, do not say that… now it is God.

[2] Patient: *Mm.*
Mm.

[3] Doctor: *Omwana nache agwene.*
The child will get well.

[4] Patient: Mm.
Mm.

[5] Doctor: *Rakini amang'ana aria anka ari.*
But those issues from home…

[6] Patient: *Mm.*
Mm.

[7] Doctor: *Gokogenderera konyegena mwana takogwena.*
If you continue to believe them the child will not get well.

[8] Patient: *Rakini rende naende nagenda ase.*
But then I went somewhere.

[9] Doctor: *Mm.*
Mm.

[10] Patient: *Omogaka gete n'omorwari sana.*
Some old man is a great medicine man.

[11] Doctor: *Mm.*
Mm.

[12] Patient: *Nantebi ng'a bori n'oborogi.*
Told me that it is witchcraft.

[13] Doctor: *Bono ekio naki ntatageti; ntagete toyatige isiko igaria.*
Now that is what I don't want; I want us to leave all that out there.

[14] Patient: *Mm.*

Mm.

[15] Doctor: *Kwaigure?*

Do you understand?

[16] Patient: *Mm*

Mm.

[17] Doctor: *Mang'ana a borogi taiyo.*

Issues of witchcraft are out of question.

[18] Patient: *Mm.*

Mm.

[19] Doctor: *Ee bono okwo n'okwegena gwekegusii korororo rakini borogi mboiyo.*

Yes, that is a Gusii belief which is there, but witchcraft doesn't exist.

[20] Patient: *Orwariri abanto omosubati onde. Ang'e nka iga namorwaria omwana ore kona gostuka stuka*.

He has cured people. Near my home he treated a child who used to have seizures.

[21] Doctor: *Ee.*

Yes.

[22] Patient: *Akamoa eriogo ogwenire.*

He gave her medicine and she has recovered.

[23] Doctor: *Esukari…*

Sugar...

[24] Patient: *Na kimoranyare gontebi ng'a esukari nero nabo akoba iga akorara akira kiri*

And if you can manage to tell me that diabetes also makes the child like thiswhen she sleeps she goes quiet?

[25] Doctor: *Bono aye tiga topime omwana.*

Now just let us carry out the tests on the child.

[26] Patient: *Mm.*

Mm.

[27] Doctor: *Tomoe amariogo.*

We prescribe her medicine.

[28] Patient: *Mopime rende gaki.*

Please go ahead and carry out the tests.

[29] Doctor: *Ee omwana nkomopima tore.*

Yes, we are carrying out the tests on the child.

[30] Patient: *Mm.*

Mm.

[31] Doctor: *Rakini bono ntotageti koburukani binto ebio tokomopima na komoa amariogo.*

But then we do not want to mix those things after the tests and prescribing medicine for her.

[32] Patient: *Mm.*

Mm.

[33] Doctor: *Ekegusii okogenda otigane kando.*

You go and leave Ekegusii alone.

[34] Patient: *Mm.*

Mm.

[35] Doctor: *Kwaigure*?

Do you understand?

[36] Patient: *Mm.*

Mm.

[37] Doctor: *Amang'ana y'ebimoni ebio ogende otigane orare chitoro marogoba.*

Those issues regarding the cats, leave them alone and be fast asleep in the evening.

[38] Patient: *Mm.*

Mm.

[39] Doctor: *N'amang'ana y'omosubati oyio tiga.*

And leave those issues regarding the lady.

[40] Patient: *Mm.*

Mm.

[41] Doctor: *Mwanyabanto tabwati nguru chiogokora binto buna ebio*

A human being doesn't have the power to do things like those.

Exploiting the tools of pragma-dialectics, discussed in sections 2.4.2 and 3.2.5 of Chapters 2 and 3, respectively, the structure of the doctor's argumentation, in his strategic manoeuvring in resolving the difference of opinion reasonably and effectively, in the argumentative discourse in example (6) above can be analysed as follows:

Doctor's argumentation

1.*We shall examine the child and carry out tests to establish the nature of her sickness.*

1.1 I want us to avoid issues to do with that lady and the cats completely

1.1.1a I want us to leave all that out there. Issues of witchcraft are out of question.

1.1.1a.1a Yes, that is a Gusii belief which is there, but witchcraft is not there.

1.1.1a.1b Those issues regarding those cats leave them alone and be fast asleep at night and leave those issues regarding the lady.

1.1.1b But, if you continue to believe those issues from home, the child will not get well.

1.1.1b.1 A human being does not have power to do such things.

1.2 After the tests we shall give the child medicine and she gets well.

1.2.1a We do not pre-empt anything until we have done everything according to the required procedures.

1.2.1b We are carrying out tests, but we do not want to mix those things after the tests and prescribing medicine for her.

1.2.1b.1a She cannot take alternative Gusii medicine and mix with the ones from hospital

1.2.1b.1b You go and leave Gusii thoughts completely.

1.2.1c If you listen to the doctors' advice, the child will get well and grow like other kids

1.3 Now it is God…the child will get well.

(**1.3'**) (Now you have to trust in God so that you child gets well.)

1.3.1a But, those issues from home, if you continue to believe them the child will not get well

1.3.1b Provided you follow our instructions, the child is going to get well.

1.4 Yes, the doctor who carried out tests on your child with the things he used is a good doctor and it looks like he got the diabetes diagnosis.

1.4.1a We have diagnosed diabetes, and it is not complicated. Now, these drugs we shall give her so that they can reduce the sugar level

1.4.1b And, that believe you have, now know that the child is suffering from diabetes.

1.4.1c We shall call the expert who will teach you on how you will feed your child.

1.4.1d The medicine we shall give you is free and the measuring instruments

Figure 5.2 Pragma-dialectical representation of the structure of the doctor's argumentation

In the argumentation stage of a doctor-patient argumentative communicative activity as discussed in section 2.4 2 in Chapter 2, the antagonist exploits a series of argument schemes to refute a standpoint advanced by the protagonist who equally tries to defend his/her standpoint (see also section 3.2.3 in Chapter 3). These roles can be taken by either of the two principal parties. In this case the doctor who takes the role of a protagonist is out to defend his standpoint "*We shall examine the child and carry out tests to establish the nature of her sickness"* (turns 25, 27, 29 and 31*)* which is a culmination of a confrontation by the patient who does not seem to trust the medical system of treating her sickly child. The doctor, whose fidelity to the contemporary medical practice summons his *obligation to defend rule* of critical discussion (see section 3.2.4 of Chapter 3) to set the record straight on the biomedical process of history taking, then examination, carrying out tests and ascertaining a diagnosis which has a medical basis.

The analytic overview of the structure of the doctor's argumentation, as *Figure 5.2* demonstrates reveals a case of multiple argumentation with four substandpoints as alternative defences of the main standpoint (**1.1, 1.2, 1.3** and **1.4**). These substandpoints reveal the doctor's manoeuvring strategy both in terms of topic potential, presentational style and audience demand. The deliberate decision to exploit various argument schemes in these substandpoints inform the presentational style of defence of the doctor. The use of the subset of symptomatic argumentation of authority argumentation attributed to different sources point towards the prototypical argumentative pattern in the doctor's strategic design, discussed later, in section 5.6 of this chapter. The sources of the authority in the argumentation include the doctor's medical professional training (**1.1** and **1.2**), his understanding of the traditional Gusii sociocultural belief system on illness (**1.1**) and the belief in Christianity (**1.3**).

Using the medical professional knowledge as his authority, the doctor asserts in a coordinative argumentation (**1.1.1a**, **1.1.1b**) with defences challenging the traditional Gusii sociocultural belief system (turns 5, 7, 13 and 17, example 6). The intention of the doctor is to defend the certified

medical and professional procedure of ascertaining the cause of the illness of the child which is his main standpoint. Thus, he chooses to relate the threat of the lady, who threatens the mother of the sick child, and the cats with the traditional Gusii sociocultural belief of witchcraft given that the doctor and the patient share a common Gusii cultural background. However, the doctor dissociates himself from this belief partly through his association with the contemporary medical practice which is evidence based and practical. This line of defence is influenced by its topic potential as a strategy to try to effectively dissuade the patient from the witchcraft which he agrees is a Gusii belief, but which he states is non-existent (turn 19, example 6) to rhetorically and dialectically find a resolution to the difference in opinion on merit.

Primarily, the doctor strategically employs the assumption that the audience demand is tied to his patient's belief that since the doctor is Gusii, he appreciates the Gusii sociocultural beliefs better, making the doctor to agree that the Gusii have a belief of witchcraft but which he quickly disowns as unfounded in his argument. This is a divergence accommodation move where the doctor has employed the sociolinguistic accommodation strategy of discourse management (see also section 3.4.2, Chapter 3) to tackle the conversational need of the patient in his strategic manoeuvring. The doctor uses a directive to forbid the mother from being bothered with the cats and treat them as a normal occurrence while forgetting about this lady's threats to focus on how the child can get proper medical attention (turns 37 and 39, example 6). This forms the basis for the coordinative argument **1.1.1b** whose argument scheme is symptomatic since the doctor understands the danger of ignoring the biomedical way of diagnosing the child's problem of putting the child on treatment for her to regain normal health (turns 5 and 7, example 7).

The doctor reaffirms authoritatively that human beings do not have the power to cause such an ailment to others (turn 19, example 7). The doctor's choices of expressions, in *Table 5.2* below all drawn from Example 7, as presentational devices are a thrust on the authority of the doctor on the patient in the doctor's strategic manoeuvring in his first line of defence of the contemporary medical practice. The refutation force in the words is rhetorically persuasive given the position of the doctor in the doctor- patient argumentative communication encounter.

Table 5.2 Presentational devices used by the doctor to assert his authority in his argumentation

Presentational device	**Gloss**
Nakio ntatageti	What I don't want
Ntagete toyatige isiko	I want us to leave out
ayio taiyo	That is out of question
Borogi mboiyo	Witchcraft doesn't exist
Ogende otigane	Leave them alone
Tiga	Leave
Tabwati nguru	He does not have power
Gokogenderera konyegena…. Takogwena	If you continue to believe…she will not get well

The symptomatic argumentation based on the authority of the expertise of the professionally trained medical personnel who handles patients in contemporary medicine constitutes the basis for the fourth line of defence (**1.4**) for the doctor as the protagonist in this argumentative reality. The relevant examples of the argumentative discourse reconstructed for this line of argumentation are drawn mainly from the excerpt in example 7 below. The patient's antagonism is literally curtailed when the doctor using a comparison and contrast argument scheme reaffirms the previous doctor's diagnosis after his own examination and tests on the patient (turn 1, example 7). The discovery of the medical condition in itself is the basis of the symptomatic argumentation because the treatment process of the child is assured in the subsubstandpoints in support of the argumentation: the problem is clear and the medial regime to put the child on assured (later in the discourse in example 7); the patient now understands the problem of the child (turn 29 example 7); the doctor promises to refer her to a nutrition specialist for management of the food intake and the assurance that the

hospital offers patients the measuring instruments of the sugar level and the medicine for free (later in the discourse in Example 7).

The doctor's authority in this fourth line of argumentation in the schematic structure in *Figure 5.2* has the refutation force which rhetorically and dialectically resolves the difference in opinion because herein lies the resolution. The experience of the doctor influences his choice of topical potential, one after the other especially after the confirmatory results indicating that the child suffers from diabetes. This gives him the authority to understand the psychology of the patient-audience demands and how to reveal the results, the reference to a diet specialist and thereafter, the prescription of medicine. The thrust of the doctor's defence is strengthened by the presentational devices which emphasise teamwork of the medical practitioners, as an institutional precondition. After the diagnosis, the doctor uses the expressions in Table 5.3 below drawn from three out of the four subsubstandpoints (in the discourse after the excerpt in, example 7):

Table 5.3 Institutional metalanguage for teamwork

Presentational device	**Gloss**
togochia gokoa	we shall give
igo tokoa omwana	we shall give the child
twanyorire oborwaire	we have diagnosed
nkorangeria tore	we shall call

The teamwork presentational device choice by the doctor in the *Table 5.3* also demonstrates the authority of the doctor's recommendation derived from a team of medical professionals involved in the treatment decision making procedures. These devices demonstrate the teamwork in the process and the accommodation process in the shared decision making and thus they perform a rhetoric function in the resolution process.

In the **1.2** substandpoint of the schema in Figure 5.2, the doctor exploits pragmatic argumentation which is a subtype of argumentation by causal relation where the argument denotes a "favourable consequence" of what the substandpoint acclaims (van Eemeren, Grootendorst & Snoeck Henkemans, 2002: 101). In line with pragmatic argumentation and its use in the defence of policy standpoints (van Eemeren, 2016: 14), such as the substandpoint **1.2**, in support of the main standpoint 1, the doctor goes ahead to seek the acceptance of his argument by indicating why the ethical procedure is key in medication (1.2.1a). He expressly indicates why the contemporary medical regime they shall recommend cannot be mixed with the local belief in alternative medicine (turns 29, 31 and 33, example 2; turn 23, example 7) and assuring the patient in an assertive, the benefit of considering the doctor's advice on her child's recovery (turns 13 and 15, example 7).

The move by the doctor to go for the institutional practice and culture at the hospital verses the Gusii alternative medicine and cultural leaning of the patient has both the topic potential and audience demand locus because he can come out with the favourable consequence through his pragmatic argumentation. It is, however, important that the doctor has employed authority argument schemes in his **1.2.1b.1a** and **1.2.1b.1b** coordinative arguments in support of subsubstandpoint **1.2.1b**. This authority is derived from the power the doctor has as the Gusii medical expert with the experience of handling patients in this hospital and thus he has the audacity to judge the value of the patient's belief in Gusii traditional medicine or sociocultural system in this case. The use of directives as the doctor's preferred speech acts to forbid the patient from the presupposition of mixing local Gusii medicine with the medicine prescribed in the hospital (turn 23, example 7) and discouraging her Gusii medically imprecise views (turn 33, example 6) as presentational devices is a strategic move meant to exploit his privileged position in the shared decision-making process to minimise the disagreement space with its pragmatic force.

As one of the ways of seeking to get acceptance of his standpoint, the doctor uses causal argumentation in the substandpoint he advances in **1.3** (Figure 5.2) where he exploits the religious aspect by challenging the surrogate patient to focus on the possibility of the healing power of God despite the long-term nature of the non-communicable medical condition of the child (turns 1 and 3, example 6). He derives a relation between the complete healing of the child and trust in God in the implied premise1.3. In qualifying this substandpoint the doctor cautions the patient against following the local belief system (turns 5 and 7, example 6) while at the same time promising the

medical stability of the child if the mother follows the guidelines of the doctor (turn 57, example 7). The doctor's understanding of the Gusii sociocultural belief system and how it relates with the Christian belief system of the Abagusii people informs his use of dissociation from the local Gusii belief system with the Christian belief system of his patients and the subsequent association with trust in God in his argumentation. The use of "*Nyasaye"* ("God") as a presentational device, thus, is a strategic device which has both a topic potential in this causal argumentation context relative to its audience demand and how it affects both the dialectical and rhetorical process of resolving the difference in opinion. The (Eke)Gusii excerpt below in example 7, under analysis together with example 6, also extracted from the diabetes 2 consultation (see appendix xxi on page 561):

(7)

[1] Doctor: *Ee bono omonyagitari omopimete n'ebinto biria amopimete n'omonyagitari omuya.*

Yes, the doctor who carried out tests on your child with the instruments he used is a good doctor.

[2] Patient: *Ee.*

Yes.

[3] Doctor: *Naende okororа esukari eyio nayenyorete.*

And it looks that he got the diabetes diagnosis.

[4] Patient: Mm.

Mm.

[5] Doctor: *Ee bono. Bono omwana oyo Esther igo arwarete esukari. Arwarete oborwaire bw'esukari bokorokwa diabetes.*

It is true. Now this child Esther has the sugar disease. This disease is called diabetes.

[6] Patient: *Ee.*

Yes.

[7] Doctor: *Ee bono. Bono naende…*

Yes. Another thing…

[8] Patient: *Ee.*

Yes.

[9] Doctor: *Oborwaire obo nkonyara bore koba controlled.*

This disease can be controlled.

[10] Patient: *Ee.*

Yes.

[11] Doctor: *Ee bono.*

Yes, it can.

[12] Patient: *Akonywa amariogo*.

She will take her medicine.

[13] Doctor: *Naende kogotegerera buna abanyagitari bakogotebia*

And if you listen to what the doctors will advise you.

[14] Patient: *Ee.*

Yes.

[15] Doctor: *Omwana nache na koba are buya*

The child will get well.

[16] Patient: *Ee*.

Yes.

[17] Doctor: *Na gokina buna abana bande.*

And grow like other kids.

[18] Patient: *Ee.*

Yes.

[19] Doctor: *Agende esukuru buna abana bande.*

She goes to school like other kids.

[20] Patient: *Ee.*

Yes.

[21] Doctor: *Rakini egento ntagete omanye.*

But what I want you to know.

[22] Patient: *Ee*.

Yes.

[23] Doctor: *Takonywa mariogo y'ekegusii naende aburukanie aya nyagitari.*

She cannot take alternative medicine from Gusii and mix with the ones from hospital.

[24] Patient: *Mm.*

Mm.

[25] Doctor: *Ee bono*

Yes.

[26] Patient: *Mm.*

Mm.

[27] Doctor: *Bono ogocha komoa amariogo aya nyagitari oka.*

Now you will give her these medicine from hospital alone.

[28] Patient: *Mm.*

Mm.

[29] Doctor: *N'okwegena okwo kwao bono manya omwana n'esukari arwarete.*

And that belief you have, now know that the child is suffering from diabetes.

[30] Patient: *Ee bono.*

Yes.

[31] Doctor: *Naende nache agwene kwaigure?*

And she will get well, you get me.

[32] Patient: *Rakini omosubati ori gose nomanyete naende tari konyara gokira. Igo akonya kondama naende nonya mbono iga namororire agoeta isiko abwo.*

But you know that lady never shuts up! She continues to abuse me and even right now I have seen her passing out there.

[33] Doctor: *Aye bono tigana nere narwarete eye n'enyagitari enene*.

Now leave her alone, she is sick. This is a big hospital.

On the other hand, after reconstruction of the doctor-patient argumentative discourse, the patient's argumentation can pragma-dialectically be analysed and represented as follows:

Patient's argumentation

1. *I do not see that this is that diabetes*

(**1'**) (I do not see that this is diabetes despite the diagnosis by the doctor who referred me here)

1.1 I do not know if the child could be having an Ekegusii instigated illness

1.1.1a There is this lady we stay with at home who threatened me that "I will see".

1.1.1b The fever comes at night and there are cats which cry outside my house at night.

1.1.1b 1a Some old man a great medicine man…told me that it is witchcraft.

1.1.1b.1a.1a He has cured people.

1.1.1b.1a.1b Near my home he treated a child who had seizures.

1.1.1b.1a.1c He gave her medicine and she recovered.

1.2 I really don't trust those drugs but let me have faith for Esther for only today I see what becomes of this child.

1.2.1 Please, she has troubled me.

(**1.2.1'**) Please, if the medical regime can heal my child and take away the trouble she has given me, then so be it.

Figure 5.3 Pragma-dialectical representation of the structure of the patient's argumentation

The following discussion puts Figure 5.3 in perspective. In refuting the previous doctor's diagnosis, the patient employs symptomatic argumentation by expressing her doubt on the medical procedure used to arrive at the diabetes diagnosis for the child's condition. For the patient, the signs from home are an indication of some other local influences on the sickness of the child. In her arguments in support of her substandpoint, the patient singles out cats meowing at night and a lady-neighbour who threatened her (turns 7,9 and 11, example 5). The patient further proceeds to defend her doubts with an argument from example as an argument scheme where she gives the example of a witchdoctor with a history of curing people with various ailments and who apparently alleges it is witchcraft (turns 20 and 22, example 6). The revelation by the patient of her decision to consult a sorcerer on the cause of the sickness of her child is a manifestation of lack of trust on the contemporary western medical practice. Nevertheless, the argument presented by the patient is

expected to be met with much refutation from the doctor, which indeed happens. The choice of the topic by the patient is informed by her worldview on the traditional Gusii sociocultural belief system concerning illness, which assists her to strategically present her argument which antagonises contemporary medical practice. The patient's choice of presentational devices, in which she uses the sign of cats meowing and a lady threatening her, and her subsequent consultation with a witchdoctor, one with a reputation of curing ailments in the locality, is aimed at appealing to the Gusii doctor, who is her primary audience such that it may influence his medical procedure in respect to the possibility of some supernatural interference with the health of the child.

However, when the doctor refutes her argumentation with a new diagnosis which agrees with that of the previous doctor, the patient in her second line of argument (**1.2**) in which she seems to throw in the towel on her belief that the problem was caused by witchcraft. In a symptomatic argument scheme, the patient promises to change her faith on the power of the medicine in assisting her child to get well, thus assisting her in overcoming the trouble she has had with the sickness (turns 9 and 13, example 8). The change in view by the patient to have some faith in the contemporary medical procedure is a product of rhetorical and dialectical attempt by the doctor to try and make the patient understand that her argument on the human hand in the child's illness is unfounded. Thus, in the end, the patient is persuaded to have the child undertake the treatment for diabetes as the doctor advises. Example 8 below demonstrates a section of the (Eke)Gusii excerpt drawn from the diabetes 2 consultation (see appendix xxi on page 565) where the difference in opinion is resolved marking the concluding stage of the critical discussion.

(8)

[1] Patient: *Igo omwana agocha korwara rioka rioka?*

Will the child be unwell every now and then?

[2] Doctor: *Yaya tari gocha kona korwara rioka rioka. Gakonywa amariogo nkoba are buya omwana onde.*

No, the child is not going to be sick every now and then. Once she takes medicine, the child will be get well.

[3] Patient: *Mm.*

Mm.

[4] Doctor: *Nere ogenda ochiesa buna abana bande.*

She also goes to play like other children.

[5] Patient: *Mm.*

Mm.

[6] Doctor: *Ogenda esukuru buna abana bande.*

She goes to school like other children.

[7] Patient: *Mm.*

Mm.

[8] Doctor: *Naende osoma buna abana bande egere ogocha gokina nere kaa ache gotwara abana baye.*

And she studies like other children such that once she is grown up can also have her own children.

[9] Patient: *Nche gaki tiga nkire amariogo ayio igo rakini tinyegeneti korende tiga ndaregena Esther rero rioka ndore omwana oyo gose ng'aki akombera.*

Please let me not say anything, I really don't trust those drugs but let me have faith for Esther for only today I see what becomes of this child.

[10] Doctor: *Nabo. Ayio naro bono twachakeire ig'abwo kogicha tobaise gochia koburukania mariogo aya.*

True. Those are the ones we have started with, provided you do not go and mix these drugs.

[11] Patient: *Ee.*

Yes.

[12] Doctor: *Naende okore buna togokweresa*

And you do as we instruct you.

[13] Patient: *Gaki onchandire.*

Please she has troubled me.

[14] Doctor: *Omwana nache abe buya*

The child will be fine.

[15] Patient: *Mm.*

Mm.

[16] Doctor: *Ee twara okwegena nabwene.*

Yes, have faith she will get well.

[17] Patient: *Mm.*

Mm.

[18] Doctor: *Ee bono.*

It is true.

[19] Patient: *Aya*.

Okay.

[20] Doctor: *Omwana nache agwene kabisa. Kwaigure?*

The child will fully recover. You get me?

[21] Patient: A*ya asanti gaki.*

Okay thanks please.

iv. Concluding stage

The conclusion of a critical discussion in a medical communication activity type of argumentative discourse is always directed at resolving a difference in opinion, which is critical in the shared decision-making process in the consultation. The simultaneous aiming for rhetorical effectiveness while maintaining dialectical reasonableness by both the doctor and the patient influences the process of resolving the difference in opinion. In this case, the disagreement space is mitigated in the presentational devices employed at the end by both the doctor and the patient. Whereas the doctor appeals to the patient to trust God and "*twara okwegena*" ("have faith" [see turn 16, example 8]) on the healing of the child, the patient resorts to have faith "*tiga ndaregena*" (let me have faith [see turn 9, example 8]) the drugs ability to help the child get well. These expressions imply that the doctor has been able to persuade the patient to accept his main standpoint of confirming diabetes diagnosis once more through an examination and testing procedure.

The use of symptomatic argumentation signalled by argument schemes of authority by the doctor mark the concluding stage. The moment the examination and test results are out, the doctor strategically exploits his legal authority to provide the patient enough information on the diabetes (turns 5,9,12,13,15,17,19 and 21, example 7) according to the ethical requirement of informed consent. The doctor further goes ahead to assertively authorise a prescription as the treatment for the child while dissuading the mother from her unfounded belief on her child's illness (turns 25 and 27, example 7). To further gain the acceptance of the treatment decision based on the diagnosis, the doctor goes ahead to demonstrate the institutional nature of the decision making and management of diabetes in the hospital in the manner of his presentational devices as already presented in Table 5.3 above.

The teamwork in the presentational devices rhetorically makes the doctor's argument more effective especially when he states that they will bring in a nutrition specialist to advise the mother of the child on the dietary requirements for the child. On the other hand, the governmental input is demonstrated when the doctor reveals that the hospital will provide medicine and testing equipment to the patient. The patient reluctantly accepts the doctor's submission, albeit reluctantly because of her 'little' faith in the contemporary western medicine (turn 9, example 8), especially because of the trouble the child has given her (turn13, example 8). The assurance and encouragement of the doctor on the recovery of the child and on her faith (turns 14, 16 and 20, example 8) makes her to formally agree to it (turns 9 and 21, example 8). Different argument schemes of symptomatic argumentation by both the doctor and the patient thus afford the critical discussion a resolution of the main difference in opinion in a rhetorically agreeable and dialectically reasonable manner.

Generally, this section has examined the strategic manoeuvres exploited by doctors and patients in the process of resolving differences of opinions on merits in the medical consultation communicative activity type based on the institutional preconditions. The next section explores questions on how the use of evaluative language in the medical consultation encounters influence the choices of presentational devices in the argumentative manoeuvres of the doctor and patient.

5.4 Appraisal in pragma dialectical argumentation

Appraisal theory makes a distinction between explicit versus implied assessments in the discourse through linguistic devices that White (2011: 17-18) refers to as inscribed evaluation verses invoked evaluation, respectively. As discussed in section 3.3 of Chapter 3, on appraisal theory, inscribed evaluation orexplicit assessment entails having positive/negative attitudinal vocabulary in the discourse. Conversely, implicit (invoked) evaluation implies that the analyst is not able to explicitly identify the words expressing these attitudes. In example 9 below, the excerpt drawn from diabetes 4 in a consultation between a doctor and a 45-50-year-old female diabetic patient (see appendix xxiii pages 587-588) suffering from diabetes, provides a segment of discourse from the argumentative reality of a medical consultation for analysing the use of evaluative language in examining the choice of presentational devices in the process of resolving differences of opinion on merits. The evaluation of the positive or negative attitudes of the doctor or patient in their

linguistic choices is meant to establish how the interlocutors interact with socially controlled value positions.

(9)

[1] Patient: *Ee amariogo nabo nkonyu botambe buna ntebiri n'omonyagitari*

Yes, I always take the medicine as advised by the doctor.

[2] Doctor: *Mm.*

Mm.

[3] Patient: *Mm.*

Mm.

[4] Doctor: *Epattern eye ya 20 ndiriri yachaka? Ekero esukari ere 20 irenga egocha yaba ekawaida yao?*

This pattern of 20 when did it start? When the sugar is 20, what is your usual level?

[5] Patient: *Ekawaida?*

Usual?

[6] Doctor: *Mm.*

Mm.

[7] Patient: *Bono nche omanyete e ngocha aa nyagitari.*

Now, you know I come to hospital.

[8] Doctor: *Mm.*

Mm.

[9] Patient: *Napimwa namanya komanya na ng'ai ng'aki ere gose riria naigure ng'a narwarire.*

I take the measure and I get to know how it is or when I feel like I am sick.

[10] Doctor: *Mm.*

Mm

[11] Patient: *Nacha nyagitari king'igwete ng'a omobere orwarire.*

I come to hospital when I am feeling my body is not unwell.

[12] Doctor: *Mm.*

Mm

[13] Patient: *Naende ekero nachire bantebi napima esukari. Nario ngochia namanya ekerengo kiaye.*

And when I come they tell me to test my sugar. That is when I get to know its level.

[14] Doctor: *Buna rero eri gwacha ere 20 ekworokia buna amariogo ogotumeka tari kogokonya gose ogwenerete togochencheri toragotema esindani. Gose bono naki oroche?*

Like today when you came the level of 20 shows that either the drugs you use are not effective enough or we need to change and try the injection. Or how do you see it?

[15] Patient: *Ah! Esendani ero yaya!*

Ah! An injection no!

[16] Doctor: *Mm. Nki okwangera esindani.*

Mm. Why do you refuse an injection?

[17] Patient: *Esindani?*

An injection?

[18] Doctor: *Mm.*

Mm.

[19] Patient: *A yaya gaki*

Ah, no please.

[20] Doctor: *Mm.*

Mm.

[21] Patient: *Nyakwebeta kera kera ri… sindani ero yaya!*

I inject myself every da… that injection no!

[22] Doctor: *Esindani nero engiya.*

An injection is better.

[23] Patient: *Mware gwancha momentere amariogo?*

Why can’t you agree to add me more drugs?

[24] Doctor: *Mm.*

Mm.

[25] Patient: *Aro nabo nkonywa.*

Those, I can take.

[26] Doctor: *Gose momanyete nkwaeresetwe igoro ya obobe bokoretwa namariogo aya?*

You know…were you given an explanation on the side effects of these drugs?

[27] Patient: *Ting'eresiri buya.*

I did not get a proper explanation.

[28] Doctor: *Mm… Gekogera gokoyanywa engaki entambe riogo rinde rionsi ngotwara rire obobe bwaye. Esukari kero ekoba controlled n'esindani igo egokonya mono kobua chintetere echio.*

Because if you take them for a long time, any type of medicine will have its side effects. When the sugar is controlled, the injection is normally more effective than those drugs.

[29] Patient: *Mm.*

Mm.

[30] Doctor: *N'echintetere echi kero ogochitumeka nchibwate obobe ase chinguru chiao buna omosubati chikorokwa 'libido'. Nkwaeresetwe?*

And when you use these drugs, they may affect your strength as a woman, what we call 'libido'. Did you get this explanation?

[31] Patient: *Neresetwe ng'a amariogo narororo akoirania okogania inse.*

I was told that there are drugs which reduce the libido.

[32] Doctor: *Mm. Bono nki otakoratemera esindani amatuko make torore naki esukari yao ekogenderera.*

Mm. Now why couldn't you try the injection for a few days we see how your sugar fairs on.

[33] Patient: *Rakini kwarenge gwancha omentere enchera nere oramente eriogo eri?*

But if you could have agreed to add me more, is there a way you can add me more of this medicine?

[34] Doctor: *Rakini torochi kwarachinyure amatuko amange sukari eyio etari koirana nse? Gose igotagete esukari enyakogenderera komentekana gochia igoro?*

But can you see that you have been taking these drugs for many days now without lowering your sugar level? Or do you want your sugar level to continue increasing?

[35] Patient: *Sindani… igo naki ndabe nkwebeta?*

Injection… so how will I be injecting myself?

[36] Doctor: *Mm. Nabo tokogosomia ase ogwenerete bwebete. N'enchera agostore eriogo erio maambia na marogoba.*

Mm. We can teach you where you are supposed to inject yourself. And the way you are supposed to store the medicine in the morning and evening.

[37] Patient: *Bono igo orang'erese.*

They you can explain to me.

Throughout the stages of resolving the difference in opinion, interlocutors make deliberate argumentative moves using linguistic choices, which not only have specific social functions of trying to resolve the dispute but are also loaded with attitudinal assessments of the social subjects in the context of their institutionally determined positions. In the argumentative reality of the diabetes 4 consultation in the (Eke)Gusii excerpt shown in example 9 above, the manifestation of a difference of opinion warranting a confrontation occurs when the diabetes patient has explained how she gets to know her low sugar level, which reveals a pattern of a reading of 20. Judging the veracity of the patient the responses reveal her social role in the consultation as honest/truthful (turns 1, 9, 11 and 13). This attitudinal assessment is in the responses which form part of the latest history taking section of the clinical consultation especially when the doctor seeks to understand the pattern of the low sugar levels of the patient (turn 4) which point towards the doctor as law-abiding in terms of the social sanction of propriety which demand informed consent.

The patient's use of expressions: "*ekero nachire*" (when I come), "*nario ngocha namanya*" (that is when I get to know) denoting the time she visits the clinic as the time she gets to know the level of her sugar (turn 13) brings out the patient's positive attitudinal assessment of honesty (veracity) and standard (normality). The same is demonstrated when the patient says she takes her medication "*botambe buna ntebiri n'omonyagitari*" (always according to the doctor's advice [turn 1]). The patient's attitude, however, comes out as law-abiding (propriety) because of her fidelity to the doctor's instructions. The evaluation of the veracity of the presentational devices here is partly inscribed in the expressions she uses, and holistically invoked. The confrontation by the doctor occurs when he issues his medical advice in his position as the expert in the consultation (turn 14). The authority inspired by the doctor's role as the leader of the consultation makes his proposition

of putting the patient on a new medical regime through the administration of an injection to portend a positive judgement. The doctor's act qualifies as standard (procedural normality) and he presents himself as dependable (tenacity), law-abiding, sensitive (propriety) and insightful (capacity). His preferred proposal makes him dependable because of his professional intuition and experience in handling other diabetes patients in the same hospital. The doctor is law-abiding in his loyalty to the informed consent precondition in the practice. This marks the confrontational stage of the ideal model of critical discussion.

The confrontational proposal reveals the doctor's positive attitude of sensitivity by providing the patient an opportunity to express her opinion or preference on her healthcare when he asks "*Gose bono naki oroche*?" (Or how do you see it?). The doctor's capability and expertise reveal his capacity to make the insightful directions on how to improve the health of the patient which indeed is a standard procedure for people with the similar medical condition. This question also implies that right from the confrontational stage, the doctor is keen on a shared decision-making process. The social esteem and social sanction attitudinal assessments of the judgement of the doctor in the discourse in the argumentative reality above play a pivotal role in his symptomatic argumentation in the confrontation. This is because they validate the doctor's argument in his loyalty to the contemporary medical institutional preconditions which enthrone the doctor as the centre of professional authority in the medical consultation. The doctor's scientific knowledge and medical experience is perceived as superior to that of the patient's - however integral - while signalling the need for acceptance from the patient, whose chronic medical condition is at stake in the consultation.

The patient's rejection of the proposition by the doctor in the recommendation for the change of drug administration marks the beginning of the opening stage of the process of resolving the difference in opinion. This rejection is signalled by the affectual attitudinal evaluations of her words (turns 15,19 and 21) which are an indication of her fear and anxiety over injections. The exclamations in turns 15 and 21 at the mention of the injection affects the patient's attitude all over a sudden: "*Ah! Esindani ero yaya!*" (Ah! Not an injection!); *"Nyakwebeta kera kera ri… sindani ero yaya!"* (I inject myself every day…that injection no!). This inevitably establishes a disagreement space among the two interactants with the doctor maintaining his protagonist position and the patient the antagonist in the argumentative communicative context. The affectual

attitude has a role in the entrenchment of the material and procedural starting points for this argumentative exchange. The usurped authority of the patient based on her negative affective feelings of fear and anxiety or preferences in her argument is quickly countered by the doctor's reassuring and confident tone in the insightful (capacity) and truthful (veracity) argument (turn 22) where he defends the administration of medicine by an injection.

Using the argument scheme of comparison and contrast, the doctor exploits the veracity and capacity of his social position to champion the value position entrusted in his office as a social sanction. As an experienced medical practitioner his words "*esindani nero engiya*" (an injection is the good one) in turn 22 implicitly invoke his loyalty to the legal requirement of providing evidence-based medicine (propriety) thereby adding more authority in his locutionary act meant to refute the patient's affectual rebuttal of his proposition. Argumentation, the third stage of the process of critical discussion, is therefore brought to bear in the doctor's symptomatic argumentation move to try and convince the patient to understand what informs the doctor's preferred treatment option.

In the same breath, the doctor employs an argument from expert opinion by asserting that the drugs taken over a long time have side effects (turns 26,28 and 30). In doing so, the doctor seeks to know if the prescribing doctor had explained to the patient on these side effects. This inquiry, where the doctor uses the expression "*nkwaeresetwe*?" (Were you given this explanation?), not only reveals the doctor's propriety in carrying out his medical practice according to the ethical principles of informed consent (law-abiding) but also the capacity accorded to him by his professional expertise and experience. The caring aspect of the doctor's attitudinal propriety inscribed in the judgement of the expression is meant to seek the patient's acceptance of the doctor's standpoint. Revisiting the argument scheme of comparison and contrast, the doctor's propriety in demonstrating his understanding of the management of diabetes, in his attempt to defend his proposition argues that in the management of the sugar level, "*esindani igo egokonya mono kobua chintetere*" (an injection is more effective than the tablets). This comparative expression invokes a positive composition and valuation appreciation of the doctor's considered and valuable quality, respectively, of the administration of insulin by injection (turn 28).

In the final argument by the doctor, he exploits pragmatic argumentation to try and convive the patient to agree to his proposal. Using the expression "*nki otarekoratemera esindani?*" (Why

couldn't you try the injection?) in a rhetorical question, the doctor uses a directive challenging the patient to consider the injection and see the effects on her sugar level (turn 32). An evaluation of the attitudinal judgement of the doctor's stylistic choice of language in terms of tenacity of his social esteem and the ethics of his social sanction depicts his move as reliable and considerate, respectively. The doctor further exploits the subtype of causal relation argumentation to show the negative attitudinal appreciation of the alarming and dangerous effect of the patient's long use of drugs without any remarkable change of lowering the sugar level (turn 34). In a rhetorical question the doctor appeals for the acceptance of his proposition: "*Gose igotagete esukari enyakogenderera komentekana gochia igoro?*" (Or do you want your sugar level to continue increasing?). The appreciation and judgement invoked by the rhetorical question is rooted in the overall insightful value of the doctor's symptomatic argumentation imbued by his privileged social position in the medical consultation. The doctor, as the medical expert and argumentation leader in the consultation, achieves the rhetorical and dialectic role of gaining the acceptance of the patient to use the injection administration of medicine procedure in her treatment.

On her part, the patient acceding to not getting enough information on the drugs she is taking (turn 27) brings out her veracity as honest. Perhaps, this assessment explains her argument from her limited understanding when she insists in her plea to the doctor to add more drugs for her (turns 23 and 33). This is rebutted by the doctor's symptomatic argumentation on the side effects associated with the drugs.

The use of doctor's authority in his symptomatic argumentation in this process of critical discussion is seen to violate the Relevance Rule (4) especially the exploitation of his positive assessments of his integrity, honesty and fairness in getting his standpoint accepted by the patient. This violation creates ethotic (ethical) fallacies. On the other hand, the patient can be accused of violating the same Relevance Rule (4) for using negative emotions such as fear of injecting herself- to appeal to the doctor to maintain her drugs administration or add her more. This also violates the rule to create pathetic fallacies (van Eemeren et al., 2014: 546). The concluding stage of the critical process of decision-making in the argumentative medical discourse sees the patient's acceptance of the doctor's proposal to resolve the difference in opinion on merits. The doctor's fidelity to the medical practice and the institutional preconditions is clearly demonstrated in his use of language as argued above in the various attitudinal evaluations using the appraisal parameters of affect,

judgement and appreciation. The assessments of these attitudes have in one way or another assisted in the establishment of the social identities of the interlocutors thus contributing to the rhetorical and dialectical facets of strategic manoeuvring in argumentation in the process of resolving the difference of opinion on merits through shared decision-making during the medical consultation.

The next section explores the role of communication accommodation strategies in the strategic manoeuvring process to resolve the differences of opinion in the medical consultation involving the diabetic patient.

5.5 Strategic manoeuvring with communication accommodation

As noted in Section 2.4.2, Chapter 2, the communicative activity type of a medical consultation is guided by the institutional preconditions which constrain the argumentative manoeuvres of participants in the argumentative activity during the consultation (van Eemeren, 2016: 9–10, 2017b: 5). The consultation between the Gusii doctor and the Gusii patient with diabetes condition presents a situation in which two institutions operate in a complementary manner. The two institutions which influence the argumentative reality of the medical consultation include the traditional Gusii sociocultural belief system concerning illness and contemporary western medicine. Whereas the doctor is inclined to championing and promoting the institutional point of the contemporary western medicine, the viewpoints of the Gusii patient are constantly torn between the traditional Gusii sociocultural belief system, and the contemporary western medicine system. As discussed in section 2.3.1 in Chapter 2 the two institutions form part of the alternatives available for the patient's healthcare.

When there are instances of differences of opinion during the medical consultation the two institutions present a scenario in which the discussants strategically manoeuvre to achieve the joint institutional points. The operationalisation of the extended pragma-dialectic theory of argumentation in such cases calls upon the analyst to establish how the doctor and the patient strategically manoeuvre while accommodating the two institutions based on the mutually exclusive constraints that are associated with the institutions. Communication accommodation in the strategic manoeuvring the doctor-patient consultation in the choice of presentational devices

facilitates the process of realising the composite institutional point[23]. The institutional points of the communicative activity type of the doctor-patient consultation has a mix of two genres that is the consultation and persuasion. The consultation provides a communication accommodation opportunity in the realisation of the complementary institutional points. The doctor and the patient are engaged in the very formal medical consultation but at the same time strategically persuading each other about the acceptability of their standpoints. The positions the two primary participants take are informed by either the institutional preconditions of the practice of the contemporary medicine or preference for TM. Attributing the cause of the medical condition to some supernatural powers also counters the contemporary western medicine position. The institutional preconditions influence the communication convergence in the strategic manoeuvres of the doctor and the patient in the medical consultation communicative activity type.

Notably, asymmetrical accommodation occurs in the doctor-patient treatment decision-making process, especially arising from a difference of opinion which has to do with the interlocking institutional preconditions. In intergroup communication discussants are often "sidestepping sensitive topics" with a tendency of a minimal reciprocity partly due to the differential social status and power between speakers even during convergence or divergence accommodation (Dragojevic *et al.*, 2016: 4). Power and social status may inform the unidirectional shift in the convergence or divergence in communicative or argumentative accommodation in the Gusii doctor and Gusii patient consultation. The level of formality of the contemporary western medical practice with its stringent institutional preconditions empower the doctor in his interaction and negotiation with the patient, who is quick to hold onto the informal institutional preconditions of the traditional Gusii sociocultural illness belief system. This circumstance informs the asymmetrical accommodation, which occurs in the argumentative reality of the Gusii doctor-patient consultation.

Exploiting the accommodation strategies proposed by CAT (see section 3.4.2 of Chapter 3), this pragma-dialectical analysis puts the argumentative reality of the medical consultation activity type involving the Gusii doctor and a Gusii diabetic patient in perspective. The communication adjustment strategies such as interpersonal control, approximation, discourse management, and interpretability (Coupland et al., 1988; Farzadnia & Giles, 2015; Giles, Gasiorek & Soliz, 2015;

[23] The hybridity of communication activities implies that the institutional point is composite such as the display of promotion and consultation in realising the composite institutional point of DTCA (Wierda & Visser, 2012: 82)

Dragojevic, Gasiorek & Giles, 2016:5-6;) have a practical influence in the strategic manoeuvring of the two principal discussants in the medical consultation. To elucidate the adjustment strategies, interpersonal control reawakens the social status roles of the discussants in a communicative encounter. Approximation, on the other hand, involves the verbal and nonverbal adjustment behaviours in convergence or divergence of interlocutors thus making the language of each other either more similar or dissimilar. During a discussion, interlocutors find themselves exploiting discourse management in their deliberate shifts of topics based on their mutual concern and on each other's macro conversational requirements. Lastly, interpretability in communication accommodation entails the clarification of issues by use of accessible syntactic structures and lexical choices (Farzadnia & Giles, 2015: 19; Dragojevic *et al.*, 2016: 5–6).

5.5.1 Strategic manoeuvring using interpretability in communication accommodation

While resolving a difference of opinion in the doctor patient consultation involving a patient suffering from diabetes, there are instances when either the doctor or the patient need to clarify certain issues or concepts. The clarification serves not just as a communication accommodation strategy but a strategic manoeuvre in the medical consultation communicative activity type. The interpretability strategy of CAT performs a major role in the argumentation activity in the communication activity type of the doctor -patient consultation. The interpretability adjustment, which occurs in the strategic manoeuvring in the extended pragma-dialectical terms, is meant to achieve the simultaneous aiming for rhetorical appeal and dialectical reasonableness. The (Eke)Gusii excerpt in Example 10 below drawn from the diabetes 3 consultation between a Gusii doctor and a 40-50-year-old Gusii female diabetes patient (see appendix xxii on page 588) demonstrates how interpretability influences the argumentation moves of the argumentative stage of the ideal model of critical discussion.

(10)

[1] Patient: *Nyakwebeta kera kera ri… sindani ero yaya!*

I inject myself every day… that injection no!

[2] Doctor: *Esindani nero engiya.*

An injection is better.

[3] Patient: *Mware gwancha momentere amariogo?*

Why can't you agree to add me more drugs?

[4] Doctor: *Mm.*

Mm.

[5] Patient: *Aro nabo nkonywa.*

Those, I can take.

[6] Doctor: *Gose momanyete nkwaeresetwe igoro ya obobe bokoretwa namariogo aya?*

You know…did you get an explanation on the side effects of these drugs?

[7] Patient: *Ting'eresiri buya.*

I did not get a proper explanation.

[8] Doctor: *Mm… Gekogera gokoyanywa engaki entambe riogo rinde rionsi ngotwara rire obobe bwaye. Esukari kero ekoba controlled n'esindani igo ekoba more effective kobua chintetere echio.*

Mm…because if you take them for a long time, any type of medicine will have its side effects. When the sugar is controlled, the injection is normally more effective than those drugs.

[9] Patient: *Mm.*

Mm.

[10] Doctor: *N'echintetere echi kero ogochitumeka nchibwate obobe ase chinguru chiao buna omosubati chikorokwa 'libido'. Nkwaeresetwe?*

And when you use these drugs, they may affect your strength as a woman, what we call 'libido'. Did you get this explanation?

[11] Patient: *Neresetwe ng'a amariogo narororo akoirania okogania inse.*

I was told that there are drugs which reduce the libido.

[12] Doctor: *Mm. Bono nki gaaki nki otakoratemera esindani amatuko make torore naki esukari yao ekogenderera.*

Mm. Now why can't you please try the injection for a few days we see how your sugar fairs on.

[13] Patient: *Rakini kwarenge gwancha omentere enchera nere oramente eriogo eri?*

But if you could have agreed to add me more, is there a way you can add me more of this medicine?

[14] Doctor: *Rakini torochi kwarachinyure amatuko amange sukari eyio etari koirana nse? Gose igotagete esukari enyakogenderera komentekana gochia igoro?*

But can you see that you have been taking these drugs for many days now without lowering your sugar level? Or do you want your sugar level to continue increasing?

[15] Patient: *Sindani… igo naki ndabe nkwebeta?*

Injection… so how will I be injecting myself?

[16] Doctor: *Mm. Nabo tokogosomia ase ogwenerete bwebete. N'enchera agostore eriogo erio maambia na marogoba.*

Mm. We can teach you where you are supposed to inject yourself. And the way you are supposed to store the medicine in the morning and evening.

[17] Patient: *Bono igo orang'erese.*

Then you can explain to me.

[18] Doctor: *Mm.*

Mm.

[19] Patient: *Egere manye ng'a naki ngotumia eriogo erio gekogera nche nanya kwebeta esindani.*

So that I know how to use that medicine because I have never injected myself.

[20] Doctor: *Nkwana kwebetwa esindani? Korende abarwaire ebakobetwa.*

You have never injected yourself? However, patients are injected.

[21] Patient: *Ee, nkorora nde bakobetwa nonya n'ekero narenge e ward mbare barenge kobetwa.*

Yes, I normally see people being injected and when I was in the ward there were some who were being injected.

The excerpt above is part of a consultation between a doctor and a diabetic patient who have a difference of opinion regarding the need to change the administration of medicine from orally administered drugs to a self-administered injection. As the protagonist, the doctor's standpoint is for the patient to accept the self-administered injection because that is the second line of treatment for the patient. However, the antagonistic position of the patient on her preference for more drugs is a divergence accommodation move which makes her exploit a persuasive strategy (turn 3). The patient's persuasion is informed by the folk wisdom of taking medicine, but the doctor seeks to change the line of medication based on the biomedical evidence on the medicine the patient has

been on. The doctor's argument is informed by the institutional preconditions of the contemporary western medicine, which allows for change of line of treatment regimen based on the progression of a disease or response to drugs.

The utilisation of interpretability in convergence accommodation in the doctor's strategic manoeuvre presents him a chance to exploit pragmatic argumentation in his refutation of the patient's standpoint. The inquiry on the patient's knowledge of the side effects of the drugs is a strategic manoeuvre of trying to provide information to the patient to mitigate the disagreement space through the convergence accommodation move (turn 6 and 8). The argument scheme he is displaying is symptomatic. The doctor's authority in the medical consultation serves as a sign of acceptance of his argument when he assertively tries to find out about the side effects of the drugs. The legal institutional precondition of contemporary western medicine of informed consent gives the doctor the authority to determine the level of knowledge of the patient about the drugs she is using for him to understand the patient's reasoning in the shared decision-making processes.

Table 5.4 Doctor's choice of presentational devices and argumentation moves based on interpretability

Presentational device	**Speech act**	**Type of argument scheme**
Gose momanyete... nkwaeresetwe igoro ya obobe bokoretwa namariogo aya? (Supposedly you know…did you get an explanation on the side effects of these drugs?)	Assertive	Authority
*Gekogera gokoyanywa engaki entambe riogo rinde rionsi ngotwara rire obobe bwaye (*Because if you take them for a long time, any type of medicine will have its side effects.)	Assertive	Causation
Esukari kero ekoba controlled n'esindani igo ekoba more effective kobua chintetere echio (When the sugar is controlled, the injection is normally more effective than those drugs).	Assertive	Comparison and contrast
N'echintetere echi kero ogochitumeka nchibwate obobe ase chinguru chiao buna omosubati chikorokwa 'libido' (And when you use these drugs, they may affect your strength as a woman, what we call 'libido').	Assertive	Authority
Bono nki gaaki nki otakoratemera esindani amatuko make torore naki esukari yao ekogenderera. (Now why can't you	Directive	Authority

please try the injection for a few days we see how your sugar fairs on).		
Rakini torochi kwarachinyure amatuko amange sukari eyio etari koirana nse? Gose igotagete esukari enyakogenderera komentekana gochia igoro? (But can you see that you have been taking these drugs for many days now without lowering your sugar level? Or do you want your sugar level to continue increasing?)	Directive	Causation
Nabo tokogosomia ase ogwenerete bwebete. N'enchera agostore eriogo erio maambia na marogoba. (We can teach you where you are supposed to inject yourself. And the way you are supposed to store the medicine in the morning and evening.)	Directive	Authority

In his strategic manoeuvring, the doctor resorts to the use of interpretability as a communication accommodation strategy in his convergence towards the patient in the process of resolving the dispute on merits and in an acceptable manner. The ethical institutional precondition of informed consent empowers the doctor with the authority of legally providing the patient with as much information as possible to enable the patient to make the right decision in the process of shared decision-making in the medical consultation. As indicated in *Table 5.4* above, the doctor goes ahead to reaffirm one of the side effects of the drugs in an argument from authority based on his professional knowledge (turn 10). Using causal relation argumentation, the doctor further uses his professional expertise to justify his standpoint by explaining the effect of the progression of her sugar condition without change of treatment regime (turn 12 and 14).

In his convergence, in the medical consultation communicative activity type, the doctor exploits persuasion in his expression to make the patient understand the negative effect of her not appreciating the use of an injection to monitor the sugar condition (turn 12). Using a rhetorical question, as a presentational device the doctor's convergence accommodation strategic manoeuvre challenges the patient regarding the possible effect of her persistence in the use of the same line of drugs without change (turn 14). The rhetorical question is a possible effect of the persistent taking of the drugs without any effect on lowering the sugar level. Causal relation argumentation entails the defence of a standpoint using a connection between the reason and the standpoint warranting the acceptance of the standpoint based on the reason (van Eemeren, Grootendorst & Snoeck Henkemans, 2002:100). The use of the argument from causal relation is a deliberate attempt by the doctor to try and make the patient understand the reason behind the recommendation to use the

injection in the administration of medication. This is an interpretability accommodation strategic manoeuvre sanctioned by the informed consent institutional precondition of the contemporary western medical practice. The move informs the patient's positive gesture of the acceptance of the doctor's standpoint who exploits his authority to further explain the willingness to train her on how to use the injection (turns 15, 17 &19). In the process of exploiting a variety of strategic manoeuvres in his argumentation, the doctor uses assertives and directives in his execution of his different argument schemes as indicated in *Table 5.4* above. The initiative by the doctor to exploit the informed consent precondition allows him to exploit interpretability in his strategic manoeuvring forming the basis for the resolution of the difference of opinion between the doctor and the patient.

5.5.2 Accommodation through interpersonal control in strategic manoeuvring

As illuminated in section 2.4.1 of Chapter 2, the role of persuasion in the argumentative reality of the medical consultation in its power to influence another person's belief or perception (O'Keefe, 2012a; Rubinelli, 2013). The communicative activity type of the medical consultation in the socio-cultural contextual setting of KTRH at the heart centre of Gusii operates under the conventionalised institutional preconditions of both the contemporary western medicine and the traditional Gusii socio-cultural belief system. The doctor and the patient are constantly engaged in using their social leanings to persuade each other in their attempt to influence each other's worldview with a possibility of gaining acceptance of their standpoints in the process of resolving any points of disputation. This communicative and argumentative process inevitably involves interpersonal and inter-institutional accommodation.

Through interpersonal control, either of the two primary discussants of the medical consultation can strategically pursue a convergence or divergence accommodative and persuasive goal to both reasonably and effectively resolve a difference of opinion. Interpersonal control sociolinguistic strategies involve the attuning of communicative behaviours of the discussants with the intention of maintaining their social identities based on their status, relational roles and sociocultural context (Farzadnia & Giles, 2015: 19,25; Dragojevic *et al.*, 2016: 6). The enactment of these social identities based on the foregoing belief system and stereotypes sees interactants exploit power to try and influence or manipulate the communicative behaviour of one another in the argumentative reality. The strategy of interpersonal control in communication accommodation in the doctor-

patient consultation communicative activity type may express itself in the competing beliefs and practices of the two institutional inclinations and constraints. The power and status of the doctor in the consultation predisposes his exploitation of interpersonal control in trying to influence the communicative behaviour of the patient. This may imply that there is limited accommodation from the contemporary western medical practitioners as compared to the patients who subscribe to the beliefs and practices of the traditional medicine practitioners. In example 11 below drawn from the diabetes 2 consultation (see appendix xxi on page 557), the doctor uses his privileged professional status to minimally accommodate the patient's doubtful believe in contemporary western medicine. Whereas the doctor exploits the arguments from authority, the patient uses arguments from example and analogy to support her standpoints.

(11)

[1] Patient: *Rakini naende tindochi gose nesukari eyio.*
But then I do not see that it is that diabetes.

[2] Doctor: *Ee.*
Okay.

[3] Patient: *Omaete nonya n'omosubati nare…*
You know there is this lady…

[4] Doctor: *Ee.*
Yes.

[5] Patient: *Twomanete nere nka.*
We quarrelled with at home.

[6] Doctor: *Ee.*
Yes.

[7] Patient: *Agantebi ng'a n'orore.*
She threatened me that "I will see".

[8] Doctor: *Ee.*
Yes.

[9] Patient: *Mm.*
Mm.

[10] Doctor: *Bono ntagete tokore iga…*
Now I want us to do this…

[11] Patient: *Mm.*

Mm.

[12] Doctor: *Etokorigereria omwana*

We shall examine the child.

[13] Patient: *Mm.*

Mm.

[14] Doctor: *Tomopime.*

We carry out the tests on her.

[15] Patient: *Mm.*

Mm.

[16] Doctor: *Erio torore ng'aki arwarete.*

Then we establish the nature of her sickness.

[17] Patient: *Mompimere rende gaki mokonye rakini nche tindochi.*

You carry those tests on her please, but I personally don't see!

[18] Doctor: *Ee rakini amang'ana ayio y'omosubati oyio n'ebimoni ntagete totigane kabisa*.

Yes, but I want us to avoid those issues of that lady and the cats absolutely.

[19] Patient: *Oo.*

Oh.

[20] Doctor: *Ee bono kwaigure?*

Yes, do you understand?

[21] Patient: *Ee*

Yes.

[22] Doctor: *Nkomopima tore.*

We are carrying out the tests on her.

[23] Patient: *Ee.*

Yes.

[24] Doctor: *Tomoe eriogo omwana ache agwene.*

We give the child medicine and she gets well.

[25] Patient: *Ee, nagwene rakini?*

Yes, can she really get well?

[26] Doctor: *Ee bono nache agwene.*

Yes, she will get well.

[27] Patient: *Gaki mbuya mono onye okogwena rakini tindochi!*

Please thanks if she is getting well although I don't see!

[28] Doctor: *Yaya omwana nache agwene, tobaise goteba igo… bono iga Nyasae.*

No, the child will get well, do not say that… now it is God.

[29] Patient: *Mm.*

Mm.

[30] Doctor: *Omwana nache agwene.*

The child will get well.

[31] Patient: *Mm.*

Mm.

[32] Doctor: *Rakini amang'ana aria anka ari.*

But those issues from home…

[33] Patient: *Mm.*

Mm.

[34] Doctor: *Gokogenderera konyegena mwana takogwena.*

If you continue to believe them the child will not get well.

[35] Patient: *Rakini rende naende nagenda ase.*

But then I went somewhere.

[36] Doctor: *Mm.*

Mm.

[37] Patient: *Omogaka gete n'omorwari sana.*

Some old man who is a great healer.

[38] Doctor: *Mm.*

Mm.

[39] Patient: *Nantebi ng'a bori n'oborogi.*

Told me that it is witchcraft.

[40] Doctor: *Bono ekio naki ntatageti; ntagete toyatige isiko igaria.*

Now that is what I don't want; I want us to leave all that out there.

[41] Patient: *Mm.*

Mm.

[42] Doctor: *Kwaigure?*

Do you understand?

[43] Patient: *Mm*

Mm.

[44] Doctor: *Mang'ana a borogi taiyo.*

Issues of witchcraft are out of question.

[45] Patient: *Mm.*

Mm.

[46] Doctor: *Ee bono okwo n'okwegena gwekegusii korororo rakini borogi mboiyo.*

Yes, that is an existing Gusii belief but witchcraft doesn't exist.

[47] Patient: *Orwariri abanto omosubati onde. Ang'e nka iga namorwaria omwana ore kona gostuka stuka.*

He has cured people. Near my home he treated a child who used to have seizures.

[48] Doctor: *Ee.*

Yes.

[49] Patient: *Akamoa eriogo ogwenire.*

He gave her medicine and she has recovered.

[50] Doctor: *Esukari…*

Sugar...

[51] Patient: *Na kimoranyare gontebi ng'a esukari nero nabo akoba iga akorara akira kiri!*

And if you can manage to tell me that diabetes also makes the child okay then when she sleeps she goes quiet!

[52] Doctor: *Bono aye tiga topime omwana*

Now just let us carry out the tests on the child.

[53] Patient: *Mm.*

Mm.

[54] Doctor: *Tomoe amariogo.*

We prescribe her medicine.

[55] Patient: *Mopime rende gaki.*

Please go ahead and carry out the tests.

[56] Doctor: *Ee omwana nkomopima tore.*

Yes, we are carrying out the tests on the child.

[57] Patient: *Mm.*

Mm.

[58] Doctor: *Rakini bono ntotageti koburukani binto ebio tokomopima na komoa amariogo.*

But then we do not want to mix those things after the tests and prescribing medicine for her.

[59] Patient: *Mm.*

Mm.

[60] Doctor: *Ekegusii okogenda otigane kando.*

You go and leave Ekegusii alone.

[61] Patient: *Mm.*

Mm.

[62] Doctor: *Kwaigure?*

Do you understand?

[63] Patient: *Mm.*

Mm.

[64] Doctor: *Amang'ana y'ebimoni ebio ogende otigane orare chitoro marogoba.*

Those issues regarding the cats, leave them alone and be fast asleep in the evening.

[65] Patient: *Mm.*

Mm.

[66] Doctor: *N'amang'ana y'omosubati oyio tiga*

And leave those issues regarding the lady.

[67] Patient: *Mm.*

Mm.

[68] Doctor: *Mwanyabanto tabwati nguru chiogokora binto buna ebio*

A human being doesn't have the power to do things like those.

In trying to resolve the difference in opinion regarding the patient's doubts about a previous doctor's diagnosis of her child's medical condition (turn 1), there is an argumentation tussle between the doctor and the surrogate patient (mother of the sick child). Throughout the excerpt above the patient on two occasions expresses her doubts of the contemporary western medication efforts to save her child from her condition (turn 17 and 27). Discursively, this not only emphasizes her deep-seated belief in the traditional Gusii sociocultural belief system concerning illness in her standpoint but justifies her concerted antagonism to the biomedical approach of examining the child and professionally determining the diagnosis and cause of her child's illness. Armed with the tools of strategic manoeuvring, the doctor and the patient defend and justify standpoints

effectively and on merits based on their knowledge and/or institutional belief, respectively. In pursuit of the institutional points of the two interlocking institutions, the two discussants strategically handle the argumentative reality with the strategic manoeuvring precision it demands due to the constraints of the conventionalisation's of the institutions. As antagonist, the patient expresses her dissatisfaction with contemporary western medicine and its procedures even though she brings the child to the diabetes clinic for check-up and to consult the doctor on a referral from a doctor in another hospital. Using persuasion in the consultation, the patient tries to defend her standpoint by alluding to the possibility of supernatural causes for the condition of the child.

The antagonistic position of the patient is informed by her strong belief in the traditional Gusii sociocultural belief system about illness. Her argumentation in defence of her standpoint is therefore a deliberate attempt to exploit her belief to try and control the doctor in the shared decision-making process. Using symptomatic argumentation, the surrogate patient gives her first line of defence on why she disapproves the diagnosis of her child with diabetes. By arguing from the sign of the lady with whom they quarrelled at home and that she issued a stern warning to her, the patient seems to suggest that probably the sickness of the child could be related to the warning (turns 3,5 and 7). The concomitance between the lady's warning signal and the surrogate patient's doubts about the diabetes diagnosis in her antagonistic standpoint makes her believe the doctor should consider this as he also tries to establish the cause of the illness of the child. The argument scheme for any argumentation based on symptomatic relation states as follows:

Y is true of X,

because: Z is true of X,

and: Z is symptomatic of Y.

(van Eemeren, Grootendorst & Snoeck Henkemans, 2002:97-98)

In evaluating the surrogate patient's argument, two critical questions must be asked: (1) aren't there other people who may have quarrelled with her who may have caused the illness? (2) Aren't there other neighbours whose quarrels or differences may not necessarily cause the child to become sick? The argument is appropriately evaluated by the doctor who is Gusii and understand the sociocultural illness belief system of the Gusii and its institutional point.

In another case of symptomatic argumentation, the surrogate patient still maintains her belief in the traditional Gusii sociocultural belief system regarding illness while trying to make an interpersonal appeal to the doctor's perception in the consultation. Using argumentation from example in her strategic manoeuvre, the patient gives an example of a traditional healer/seer who links the illness of the child to witchcraft (turns 37 and 39) and with a reputation of curing another child who had seizures (turns 47 and 49). In the convergence accommodation argumentative move, the patient seems committed to persuade the doctor about her believe that the illness may not get a credible contemporary medical diagnosis even though she is in the consultation to seek a solution to her child's health problem. Discursively, the patient is exploiting the institutional system of the traditional Gusii sociocultural belief system concerning illness to try and gain an interpersonal control of the doctor in his role as a gatekeeper and professional practitioner of the contemporary western medicine.

In the doctor's argument, the evaluation of the argument scheme of symptomatic relation provides him with the opportunity to exploit his authority and professional training to refute her arguments. Building his argument from the institutional preconditions of the medical consultation, the doctor exploits the argument from authority to defend the contemporary western medical procedure and ethical requirement of evidence-based medicine. The authority of his argument derives from the legal requirement of evidence-based medicine in the practice of medicine and the societal status he enjoys as the leader of the consultation. Using assertives, the doctor embraces a divergence accommodation move by ignoring the patient's desire to draw the doctor into the traditional Gusii sociocultural belief system in accounting for the cause of the child's illness (turns 10, 12, 14, 16). The institutional point of the consultation is clear, to establish the root cause of the child's illness through the required evidence-based medical procedure and agree on the most appropriate treatment decision with the surrogate patient through informed consent. The doctor has exploited the institutional constraints to try and control the interaction with the patient by maintaining his professional role and presenting his argument based on the professional code of the practice of medicine.

Even though the doctor, who is equally a Gusii speaker understands the local belief system, he does not submit to the surrogate patient's strategic manoeuvres in her divergence accommodation attempt to influence the doctor's decision-making process. In refuting the surrogate patent's belief

about the child's cause of illness and the possible misdiagnosis, the doctor presents another argument from authority informed by his professional leaning towards the contemporary western medical practice. The doctor uses a directive to authoritatively dissuade the surrogate patient from her belief in the lady and the cats or witchcraft as being responsible for the child's sickness (turn 18).

In reinforcing his argument, the doctor exploits a persuasive tone still with the authority of his social role in the consultation when he advices the patient that her belief in the traditional Gusii sociocultural belief system concerning illness, will have a negative effect on the healing process of the child (turns 32 and 34). In a dissociation move, the doctor agrees that witchcraft is a Gusii belief but "*borogi mboiyo"* (witchcraft does not exist) - (turn 44 and 46). The doctor uses the opportunity to use the argument from causation relation to dissuade the patient from the belief of a mere mortal able to cause an illness on a fellow human being (turn 68). Affirming the antagonistic nature of the interaction of the two institutions in the medical consultation, the doctor at the end uses another argument from authority to forbid the patient in an all-important directive not to mix the medicine with the traditional Gusii sociocultural practices related to illness at home (turn 58, 60, 62). To this divergence accommodation end, he uses his authority and status to give a directive forbidding the patient from issues regarding the lady or the cats at night as they have nothing related to her child's illness (turn 64).

The power of the doctor in trying to reject the attempt by the surrogate patient to influence him on the role of the local belief system and particularly witchcraft emphasizes his divergence accommodation of the patient's interpersonal control move. The contemporary western medicine institutional constraints provide him with the argumentation credentials to use his authority and power as a sign of acceptance of his standpoint. The switch between divergence and convergence accommodation in the surrogate patient's pleas to the doctor to consider the traditional Gusii sociocultural causes of the child's illness reveals her determination to use interpersonal control to convince the doctor to accept her standpoint.

Conversely, the doctor carefully exploits the power which his profession bestows upon him as leader of the discussion to interpersonally manoeuvre strategically guiding the patient using the institutional preconditions of contemporary western medicine. The doctor demonstrates his divergence accommodation with maintenance of the traditional Gusii sociocultural belief system

on illness (turn 60) to convince the surrogate patient how the child's condition will be professionally examined (turn 12), tests carried out (turns 14, 22 and 52) to establish the diagnosis (turn 16), and fully recover after taking the doctor's prescribed medicine (turns 24, 26, 28 and 30). In refuting the doubts of the patient further, the doctor uses a divergence accommodation strategic manoeuvre by exploiting an argument from analogy by appealing to the patient using the belief in the healing power of God (turn 28). The move to use the belief in God for the recovery process is a strategic move by the doctor to try and exploit persuasion to counter the traditional Gusii sociocultural belief system with Christianity which does not go hand in hand with the belief in witchcraft among the AbaGusii.

The social interactional roles of the doctor and the patient in the medical consultation influence their exploitation of the institutional preconditions in their argumentative manoeuvres. The communicative adjustment of the two discussants is manifest in their choices of presentational devices in divergence or convergence accommodation moves due to interpersonal control in the argumentative reality.

The next section investigates the role of discourse management as a communication accommodation sociolinguistic strategy at play in the process of strategically manoeuvring in resolving differences of opinion on merits. Exhibiting elements of discourse management presents the discussants with opportunities to strategically manoeuvre.

5.5.3 Discourse management as an accommodation strategy in strategic manoeuvring

The display of interpersonal control and interpretability as accommodation strategies in the medical consultation is complemented with strategic exploitation of discourse management in the doctor's and patient's argumentative manoeuvres. In the shared decision-making process of a medical consultation, the interlocutors are continually involved in the evaluation and assessment of each other's conversational needs and categorically responding to them. This deliberate adjustment of the communicative behaviour based on overt or covert conversational needs of the interlocutor(s) embodies discourse management strategies. The centrality of discourse management strategies in the argumentative reality of the doctor-patient consultation communicative activity type is best demonstrated by exploring the three key tenets of the strategic manoeuvring triangle: topic potential, audience demand and presentational devices. In resolving

any differences of opinion that may arise during the discourse, the doctor and the patient carefully provide argumentation and support for their standpoints in efforts to reasonably and effectively resolve the difference of opinion on merits. Their choices of issues to address (topic potential), patterns of arguments and the style of presentation (presentational devices) that befits the other party's requirement (audience demand) functions within the established conventionalised constraints (van Eemeren, 2010; Labrie, 2016). The institutional preconditions determine the levels of communication accommodation in the argumentative discourse management of the medical consultation. Cognizant of the institutional points of the two institutional systems at play in the consultation, the doctor and the patient strategically manoeuvre in the persuasion and consultation communicative activities targeted at resolving the differences in opinion which arise.

Both the doctor and the patient exploit the sociolinguistic strategy of discourse management in their argumentation during the medical consultation. Both parties exploit the strategy according to the institutional preconditions either during their pursuit of persuasion or consultation or both argumentative activities intended to resolve their differences of opinion on merits. In a difference of opinion regarding the change of the medication regime, the critical discussion which ensues in the (Eke)Gusii excerpt below drawn from diabetes 4 consultation (see appendix xxiii from page 588) makes the doctor protagonist while the patient takes the role of antagonist, as manifest in example 12.

(12)

[1] Doctor: *Esindani nero engiya.*

An injection is better.

[2] Patient: *Mware gwancha momentere amariogo?*

Why can't you agree to add me more drugs?

[3] Doctor: *Mm.*

Mm.

[4] Patient: *Aro nabo nkonywa.*

Those, I can take.

[5] Doctor: *Gose momanyete... nkwaeresetwe igoro ya obobe bokoretwa namariogo aya?*

I hope you know... did you get an explanation on the side effects of these drugs?

[6] Patient: *Ting'eresiri buya.*

I did not get a proper explanation.

[7] Doctor: *Mm… Gekogera gokoyanywa engaki entambe riogo rinde rionsi ngotwara rire obobe bwaye. Esukari kero ekoba controlled n'esindani igo ekoba more effective kobua chintetere echio*.

Because if you take them for a long time, any type of medicine will have its side effects. When the sugar is controlled, the injection is normally more effective than those drugs.

[8] Patient: *Mm.*

Mm.

[9] Doctor: *N'echintetere echi kero ogochitumeka nchibwate obobe ase chinguru chiao buna omosubati chikorokwa 'libido'. Nkwaeresetwe?*

And when you use these drugs, they may affect your strength as a woman, what we call 'libido'. Did you get this explanation?

[10] Patient: *Neresetwe ng'a amariogo narororo akoirania okogania inse.*

I was told that there are drugs which reduce the libido.

[11] Doctor: *Mm. Bono nki otakoratemera esindani amatuko make torore naki esukari yao ekogenderera.*

Mm. Now why can't you try the injection for a few days we see how your sugar fairs on.

[12] Patient: *Rakini kwarenge gwancha omentere enchera nere oramente eriogo eri?*

But if you could have agreed to add me more, is there a way you can add me more of this medicine?

[13] Doctor: *Rakini torochi kwarachinyure amatuko amange sukari eyio etari koirana nse? Gose igotagete esukari enyakogenderera komentekana gochia igoro?*

But can you see that you have been taking these drugs for many days now without lowering your sugar level? Or do you want your sugar level to continue increasing?

[14] Patient: *Sindani… igo naki ndabe nkwebeta?*

Injection… so how will I be injecting myself?

[15] Doctor: *Mm. Nabo tokogosomia ase ogwenerete bwebete. N'enchera agostore eriogo erio maambia na marogoba.*

> Mm. We can teach you where you are supposed to inject yourself. And the way you are supposed to store the medicine in the morning and evening.

Whereas the patient takes a divergence accommodation move persisting on her preference of the medication she has been having, the doctor seizes the opportunity to exploit both the legal and ethical precondition to defend a new and more effective treatment regime. Using the ethical requirement of informed consent, the doctor exploits the discourse management strategy to defend the change of the treatment regime for the diabetes patient to an injection administered by self. Thus, using the contemporary western medicine preconditions for strategic manoeuvring in the medical consultation communicative activity type, the doctor uses multiple argumentation in defending his standpoint. In a persuasive tone, the doctor explores a presentational choice of argumentation based on causal relation in linking the side effects of the drugs the patient has been taking. By this choice, the doctor uses the argument scheme of pragmatic argumentation to justify why the patient should at all costs avoid the fatal effect of using the drugs continuously without desired effects (turns 5 and 7). The pragmatic argumentation presented implies the positive outcome of the action expressed in the standpoint of the doctor (Garsen, 2001: 92). To support this argument, the doctor presents an argument from example when he asks the patient if she was told that the drugs may have a negative effect on her libido (turn 9).

The doctor's argumentation together with the subordinative argument have the power of the convergence accommodation because the doctor uses the defence opportunity to provide important information to the patient. The authority of the doctor derived from the informed consent communicative activity constraint in the practice of medicine allows his argumentative discourse to be patient-centred. This gives the doctor a chance to exploit the same discourse to resolve the difference of opinion through his strategic manoeuvres. In further reinforcing his argument, the doctor reassures the patient through use of symptomatic argumentation. In the strategic manoeuvre, the doctor uses the argument scheme of argument from authority. The doctor's authority in his argument is a sign of the truth and by extension the acceptance of his counsel on how they will train the patient on how to inject herself and store her medicine at home (turn 15) (Garsen, 2001: 92). The information the doctor gives to the patient in his argumentative moves is intended to attune the communication of the patient with his convergence accommodation. The resolution process yields the change of view by the patient after the doctor convinces her to accept

the change of her treatment regimen for the more effective self-injection regimen (see the discourse that follows the excerpt in example 12 in appendix xxiii page 595).

The use of discourse management strategies in communication accommodation may be helpful in resolving a difference of opinion arising because of the clashing institutional beliefs and/or procedures of the contemporary western medicine and the traditional Gusii belief system regarding illness. In example 13, in the (Eke)Gusii excerpt below, the doctor employs discourse management in his strategic manoeuvring in the argumentative reality of the diabetes 4 consultation (see appendix xxiii on page 595). The patient, taking an antagonistic position, implicitly inquires the possibility of the effectiveness of local Gusii TM to cure diabetes completely (turn 1 and 3). The patient's standpoint is supported by her argument from popular opinion based on what she has heard (turns 5, 13,15 and 17).

Appeal to common opinion or belief is an argument which is reliant on a generally accepted issue because majority of the people think so or it is merely common knowledge (Walton, 2006: 91). The patient presents her argument in a persuasive manner in her persistence on the existence of Gusii TM, which can cure diabetes although she does not have the evidence to back her argument (turns 5, 7, 9, 13, 15 and 17). The patient's position and implied preference in the implied premise of her argument is her belief in the power of Gusii TM to equally heal without the use of contemporary western medication. For the patient, the strategic argumentative move she makes tends towards divergence accommodation because of the implied cultural preference. The excerpt in example 13 below drawn from the diabetes 4 consultation further demonstrates how discourse management in communication accommodation influences strategic manoeuvring in the medical consultation:

(13)

[1] Patient: *Ee tindimanyeti rakini rende nkoigwa ng'a amariogo naroo y'ekegusii okonyu.*

Yes, I don't know it but then I hear that there are indigenous Gusii medicine one takes.

[2] Doctor: *Mm.*

Mm.

[3] Patient: *Yaani rikogwenia oborwaire bw'esukari pi*

So, it cures the sugar condition completely.

[4] Doctor: *Rakini omaete oborwaire bw'esukari igo bore ime ase omobere. Production ya insulin kero kende igo yagenda ekabanse. Gete omobere igo ogoproduce insulin rakini teri goisana. Bono kero ogotumeka amariogo aya aito a nyagitari nigo a goboost production ya insulin. Onye yarenge teisaini ase omobere amariogo aya anyebeka yaba effective. Ah amatuko aya a rero bado ngotumeka tore amariogo ekienyeji bori?*

But you know diabetes is inside the body. The production of insulin sometimes is not enough... It is the body that produces insulin, but it is not enough. Now when you use our medicine here at hospital, they assist to boost the production of insulin. If it wasn't enough in the body, then the medicine makes it to be effective. Ah these days, do we still use indigenous medicine really?

[5] Patient: *Nkoigwa ng'a...*

I hear that...

[6] Doctor: *Mm.*

Mm.

[7] Patient: *Amariogo naroo y'ekegusii onywe...*

There are indigenous Gusii medicine which if you take...

[8] Doctor: *Mm.*

Mm.

[9] Patient: *Nabo, nabo akogokonya. Nabo akogwenia asukari.*

True, they can help you. They can cure diabetes.

[10] Doctor: *Mm. Omonto oyio okogotebia boigo nogwenerete oramoboria research nakorete buya bori igoro y'omochando bwesukari eye.*

Mm. You should ask that person who tells you whether he or she has done proper research on this diabetes.

[11] Patient: *Ee gochia abwo timanyeti gose nakorete.*

Yes, towards that end I don't know if he did.

[12] Doctor: *Mm.*

Mm.

[13] Patient: *Tatiga igo tokoigwa ng'a...*

Only that we hear that...

[14] Doctor: *Mm.*

Mm.

[15] Patient: *Amariogo nare aroro y'ekegusii...*

There are indigenous Gusii medicines...

[16] Doctor: *Mm.*

Mm.

[17] Patient: *Oranywe rende ogwene.*

You can take and get cured.

[18] Doctor: *Eki imanyete amariogo anyagitari aiga nigo akoreire research. Abanto batemire, na goetera research baexperimentiri, bamanyire nare effective ase omobere ogo. Aya y'ekegusii neba kagotumeka gento nkeiyo gekoenekia, gekworokia how effective eriogo erio ri'emete riratumeke gocontrol esukari.*

What I know is that the medicine in hospital here are products of research. People have tried and through research they have experimented and have known that they are effective in your body. These indigenous Gusii ones even though they are being used, there is no proof that shows how effective the herbal medicine can be used to control diabetes.

[19] Patient: *Mm.*

Mm.

[20] Doctor: *Goetania chindagera, lifestyle change amo na'amariogo aya a nyagitari.*

Apart from diet or lifestyle change and the use of these medicine we give here in hospital.

The legal institutional preconditions of the practice of contemporary western medicine replicated in the medical consultation, in the (Eke)Gusii doctor-patient dialogue in example 13, provide the opportunity for the doctor to exploit discourse management to defend the contemporary western medicine treatment regimen. Informed consent gives the doctor the obligation to provide the patient with adequate information on a diagnosis or treatment options including side effects for the patient to choose the most appropriate treatment option (Bickenbach, 2012; Schulz & Rubinelli, 2015: 486–488). Evidence-based medicine, on the other hand, is an ethical precondition which requires the doctor to provide sufficient evidence which is based on findings of research or scientific studies in consulting with the patient. This informs the doctor's strategic manoeuvre in his use of symptomatic argumentation in expalaining to the patient what the diabetic condition is

all about. Using the argument from expert opinion, the doctor uses the authority of his professional and scientific knowledge to make the patient understand how the human body reacts with the production of insulin and how the insulin deficiency is supported when the hospital medication (turn 4). The doctor's argument from expert opinion is a convergence accommodation argumentative move meant to provide information to the patient regarding the treatment of diabetes in the human body. This strategic manoeuvre is a product of the institutionalised precondition of informed consent in the conventionalised medical consultation communicative activity type.

In the doctor's final rebuttal of the patients' argument, he uses argument from authority to question the kind of research the person who proposed that traditional Gusii medicine would cure diabetes (turn 10). Using the evidence-based medicine precondition, the doctor exploits the discourse management strategy to further inform the patient how the contemporary western medicine has been researched on, scientifically experimented and certified for their effectiveness for use in treatment purposes (turn 18). It is this basis that he uses to interrogate the ethical integrity of the proponents of the usage of the Gusii TM in the treatment of diabetes. The lack of proven evidence on the effectiveness of the traditional Gusii medicine deals a blow to the patient's standpoint on the feasibility of use of the medicine to try and cure diabetes (turn 18). The Gusii doctor uses convergence accommodation to strategically manoeuvre in his use of argument from authority in his critical evaluation of the use of Gusii TM. In his appreciation of the existence and use of Gusii TM, the doctor accommodates the patient's belief in traditional Gusii sociocultural belief system concerning illness but goes ahead to use the contemporary western medicine institutional preconditions to cross-examine the veracity of the medical usage of Gusii TM. Through discourse management, the doctor can strategically manoeuvre between the institutional preconditions of both the traditional Gusii sociocultural belief system regarding illness and the contemporary western medicine. Overall, the strategic manoeuvring with divergence or convergence accommodation effectively and reasonably resolves the difference in opinion on merits. The next section identifies a prototype of the argumentative patterns in the Gusii medical consultation involving the Gusii patient with the diabetic medical condition.

5.6 Prototypical argumentation patterns in medical consultations involving diabetic patients

This section explores the prototypical patterns of argumentation the Gusii doctor and the Gusii diabetic patient employs in the argumentative reality of the medical consultation communicative activity type. A pragma-dialectical analyst can recognise argumentative patterns in argumentative discourse and establish an empirical analogue of argumentative patterns which can be relevant in the resolution of differences of opinion in the theoretical model of a critical discussion (van Eemeren, 2017b: 6). As highlighted in Chapter 3, in section 3.2.6, pragma-dialectical research now focuses on context dependency of argumentative patterns, which are prototypical in the communicative activity types in the medical and other argumentative domains (van Eemeren, 2016: 15). The occurrence and identification of prototypical argumentative patterns in argumentative discourse is guided by the conventionalised institutional preconditions, which govern the strategic manoeuvring in a given communicative activity type where they are manifest (van Eemeren, 2010; van Eemeren & Garsen ,2014; Pilgram, 2015; Snoeck Henkemans & Wagemans, 2015; Snoeck Henkenams, 2016). In the analysis of the argumentative patterns in the Gusii medical consultation communicative activity type involving the doctor and the diabetic patient, the nature of the difference of opinion is linked with the argument scheme and argumentation structure employed by either of the two discussants. The differences in the resultant argumentative patterns is influenced by the type of difference of opinion, the kind of standpoints by the discussants, the material and procedural starting points and the institutional preconditions which regulate the specific communicative activity type (van Eemeren, 2017:4). The analysis of the prototypical patterns of argumentation also entails a critical evaluation of the argument schemes employed based on the institutional point, the exigencies of the communicative domain and the conventionalisation of the communicative activity type of the medical consultation (van Eemeren, 2017: 5).

5.6.1 Sociocultural effect on the Gusii medical consultation argumentative patterns

Culture has an effect in argumentation in the medical domain (Pan, 2017; Pan *et al.*, 2018). The nature of the Gusii medical consultation involving a doctor and a diabetic patient compares to the argumentative patterns in the Chinese medical consultation (Pan *et al.*, 2018), over the counter

(OTC) medical advertisements (Henkemans, 2016), and direct-to-consumer (DTC) prescription drug advertisements (Wierda & Visser, 2012, 2014) which have a hybrid communicative activity types. Even though the former is a medical consultation and the latter two entail the medical advertising communicative activity type, both communication activity types share a hybrid of promotion and consultation (Wierda & Visser, 2012, 2014; Henkemans, 2016; Pan *et al.*, 2018). The medical consultation involving the Gusii doctor with a Gusii patient suffering from diabetes typically portends a hybrid of persuasion and consultation. The Gusii medical consultation presents a situation of the competing influence of the traditional Gusii sociocultural belief system concerning illness on the contemporary western medicine institutional point. The cultural preferences of the patient based on the traditional sociocultural belief system of the Gusii on illness keeps intervening in the argumentative discourse influencing some of the differences of opinion with the doctor during the consultation. A good example is the belief in traditional herbal medicine, and supernatural causes of illness such as witchcraft.

The influence of the traditional Gusii sociocultural illness belief system has a direct effect on the institutional point of the communicative activity type of the medical consultation. The Gusii doctor and the Gusii patient constantly find themselves engaged in a twofold institutional point: attempting to persuade the patient to give the biomedical procedures of the contemporary modern medicine on the one hand and executing the medical consultation according to the legal requirements of informed consent and evidence-based medicine on the other. The persuasion aspect of the institutional point is necessary because of the sociocultural consciousness of both the doctor and the patient about the traditional Gusii sociocultural belief system on illness. Therefore, apart from the attempts made by the patient to try and persuade the doctor on attending to the cultural preferences in the consultation, the doctor, who is aware of the cultural beliefs, uses his professional knowledge and training in communication skills to strategically manoeuvre. The strategic moves by the doctor and the patient are determined by the institutional preconditions of the medical consultation communicative activity type as conceived by the contemporary western medicine. Nevertheless because of instances of difference of opinion because of the intervening traditional Gusii sociocultural institutional system concerning illness beliefs, the use of persuasion by either of the two discussants ensures that the critical discussion progressively moves towards a resolution.

5.6.2 Authority in the doctor's pragmatic argumentation

In the argumentative reality of a consultation involving the Gusii doctor and the Gusii diabetic patient, the discussion parties resolve their difference of opinions which characteristically arise because of cultural preferences or any other argumentative reality issue using characteristic augmentative patterns. As pointed out in section 3.2.6, Chapter 3, the different communication activity types, the characterisation of argumentative patterns are also referred to as prototypical argumentative patterns (van Eemeren, 2010: 146, 2016: 16–17). In figure 5.5 below the doctor's basic pattern of argumentation employed by the doctor in a difference of opinion regarding the belief in the supernatural causes of a diabetic child according to the mother, is pragmatic argumentation presented with the authority of the doctor. As a subtype of causal argumentation, pragmatic argumentation is used in an argumentative scenario where an action in a proposition ought to be (or not) carried out because of the desirable (or undesirable) outcome. The pragma-dialectical conception of pragmatic argumentation has both the positive and the negative variants: the positive variant provides support for the positive proposition ("Action X should be carried out") and the negative variant provides support for the negative proposition ("Action X should not be carried out"). The characterisation of the positive version of pragmatic argumentation is as follows:

1 Proposition: Action X should be carried out

1.1 Because Action X will lead to a positive result Y

(**1.1'**) And If an action of type X [such as X] leads to a positive result of type Y [such as Y] then it should be carried out (Eemeren, 2016b: 17).

In evaluating the soundness of pragmatic argumentation, van Eemeren (2016b) specifies the following three critical questions associated with the positive version of the argumentation:

1. Do actions of type X lead to results of type Y

2. Is result Y really possible (i.e. desirable)?

3. Does action X non-have any major negative (i.e. undesirable) side effects?

The context dependency of the strategic manoeuvring in the different communicative activity types allows for the expansion of the above critical questions according to the nature of argumentative

choices made by discussion parties (Eemeren, 2016b: 17–18). Applying the macro contextual exigencies of the Gusii doctor-patient consultation which operates formally under contemporary western medical consultation with an overriding institution of the traditional Gusii sociocultural belief system on illness, the following critical questions can add value in the evaluation of the argumentation:

4. Can there be another action which could help realise result Y?

To specify the question in the context of the Gusii doctor Gusii patient consultation may read as thus: Can dealing with in supernatural illness causing factors [i.e. a quarrel with a neighbour or cats crying at night] help realise result Y?

5. Can there be another action which can jointly be done with action X to realise result Y?

A more precise critical question in the argumentative reality will be: Should supernatural considerations or traditional belief be pursued jointly with action X (if this is the modern medicine prescription after biomedical diagnosis) to realise result Y?

In the Gusii medical consultation, *critical question 1* for the doctor's pragmatic argumentation "do actions of type X lead to results of type Y", the authority vested on the Gusii doctor even in terms of social status implies that the doctor's suggested recommendation to be taken seriously by the patient. There is a possibility the patient will have cultural explanations on the possible suspected cause but the authority of the doctor's pragmatic argumentation together with the supportive arguments from expert opinion or causal relation makes the doctor's argument sound. On the same tone, a discussion party may anticipate the *critical question 2* "is the result Y really desirable". Depending on the level of literacy or knowledge of the patient, the doctor should be able to convince him/her about the risk involved if the action X is not done to realise the full desirability of result Y. This is demonstrated in Figure 5.5 in premises **1.1.1a**, **1.1.1b** and **1.1.1c**; all supporting arguments meant to strategically manoeuvre between the two institutional systems which influence the process of critical discussion in resolving differences in opinion in the Gusii medical consultation.

Among the anticipated questions in *critical question 3* which poses: "Does action X have any major undesirable effects?" From *Figure 5.5* below, in bridging the supporting arguments from authority and pragmatic argumentation premises **1.1'1a** or **1.1'1a** and **1.1'1b** reaffirm all the

possible questions which may prevent the positive result out of action A. The strict observance of the ethical procedures employed by the doctor in the authority argumentation is demonstrated in the two versions of premise **1.1'1a**. On the other hand, a pragmatic argument delinks the surrogate patient's Gusii supernatural belief system with the medical procedures which can implicitly delay and derail the treatment process resulting in an undesirable outcome (**1.1'1b**).

The application of the competing institutional systems in the consultation room lead to the *critical question 4*, "Can there be another action which could help realise result Y". Part of the implicit option in the critical question regards the use of the traditional Gusii sociocultural illness belief system to try and assist heal the child. On the contrary, the doctor understands the place of traditional Gusii sociocultural belief system, and in one of the supporting subarguments (**1.1'1b.1a**) he exploits his scientific and professional knowledge to challenge the traditional illness belief system on its power to heal the sick child.

In the (Eke)Gusii medical consultation, the complementarity of the contemporary medicine system and the use of traditional medicine keeps occurring in the argumentative reality of the discourse. The cultural preferences are part and parcel of the argumentative discourse making the traditional Gusii sociocultural belief system on illness emerge as a potential option to the contemporary western medicine especially according to the patient. In the basic pattern, the patient's belief in the local traditional medicine and the mistrust in the initial diagnosis is relevant to *critical question 5*, "Can there be another action which can jointly be done with action X to realise result Y"? However, the doctor does not accede to the patient's traditional belief of the child's illness having discovered the illness biomedically. Nevertheless, the Critical question is relevant because in the premise **1.1'1c.1c**, the doctor recommends the patient to a nutrition specialist whose advice will hasten the realization of Action X.

In the schematic representation in *Figure 5.5*, the doctor's main argumentation is a pragmatic argumentation supported by different types of argument schemes. This is the character of prototypical pattern involving pragmatic argumentation supported by subordinatively and coordinatively linked argument schemes for the purpose of any anticipated critical questions and to fulfil the institutional constraints (van Eemeren, 2016: 18–19).This is also demonstrated in the argumentation subsection on doctor's argumentation as exemplified in *Figure 5.2* which is a schematic representation of the difference of opinion in the (Eke)Gusii excerpt in example 6 from

the diabetes 4 consultation. From the pragma-dialectical theoretical characterization of argument schemes, the argument scheme of authority states as thus:

1 X is acceptable.

1.1 Authority A is of the opinion that X.

1.1' A's opinion indicates that X is acceptable.

Figure 5.4 Argument scheme for authority argumentation

The acceptability of standpoint (**1**) in the scheme in Figure 5.5 above is supported by two premises: authority A's opinion (**1.1**) and A's opinion that X is acceptable (**1.1'**). These premises are presented as minor and major, respectively. When the doctor says, "we shall examine the child and carry out diagnostic tests to establish the nature of her sickness", the authority of the doctor's argument signified in his professional training and expertise provides sufficient ground for the soundness and therefore acceptability of the treatment recommendation X. In this case the doctor is himself a discussion party who exploits his position as the leader of the consultation and as a medical professional to authoritatively advise the patient in the resolution of the difference of opinion that arises from the surrogate patient's belief in supernatural causes of the child's illness. In the support arguments, the doctor speaks not just as a doctor but as a Gusii educated insider questioning the believe in supernatural forces in the illness of the child. In both cases the doctor does not expressly indicate his expertise, but he implicitly asserts that they will employ the requisite legal and professional procedures to establish the problem of the child. In so doing, the doctor has employed a strategic argumentative move, which complies with the institutional preconditions that help him realise the institutional point of the communicative activity type of the Gusii medical consultation.

Basic pattern: pragmatic argumentation as the main argument

1. We shall carry out diagnostic tests (X) to establish the cause of the child's sickness for us to treat the child and the child will regain her health again (Y).

1.1 For the treatment process to commence [the surrogate patient must avoid issues relating to supernatural causes of the sickness] for the child to get well (Y).

1.1' Medial procedures entail physical examination and diagnostic tests (X) which have no harm whatsoever on the patient [assuming there are no supernatural considerations] for a positive health outcome for the child (Y).

Probable extensions: supporting arguments which try to respond to some of the critical questions

A. Support for premise 1.1

1.1.1a To professionally establish the cause of the child's illness and save the child, we must first put aside the belief in supernatural powers and give the diagnostic tests a chance

[*Science based argument from expert opinion* which does not accommodate traditional sociocultural belief in supernatural powers]

And/or

1.1.1b It is true that the Gusii belief in supernatural powers [such as witchcraft] but witchcraft does not exist.

[*argument from authority as a Gusii medical professional*: Appreciating the belief in supernatural causes of illness but downplays its existence]

1.1.1c The patient has to trust in God for the child to get well

[*Argument from the authority of Christianity*: overriding the Gusii traditional sociocultural belief in supernatural powers]

1.1.1c.1a The more the patient continues to believe in supernatural powers, the more the process of recovery for the child is affected.

[*Pragmatic argument*: neglecting the treatment process for the child because of the belief that the supernatural power will not benefit the health of the child]

1.1.1c.1b Adherence to the doctor's instructions on the treatment regimen for condition X will see the child get well.

[*Argument from authority by the medical professional*, the doctor]

B. Support for bridging premise 1.1'

1.1'.1a That the doctor does not pre-empt anything until the diagnostic test results for establishing condition X are out.

[*Argument from the authority* of the ethical procedures of the consultation, examination and treatment process]

Or

1.1'.1a There is no link between supernatural causes (the lady and the cats) and child's illness.

[*Argument from authority* by a medical professional and expert after the biomedical tests]

1.1'.1b Continued believe in supernatural forces does not benefit the treatment and healing process of the child.

[*pragmatic argument*]

1.1'1b.1a Human beings do not have the power to influence the supernatural occurrence of illnesses on others.

[*Argument from authority* of a Gusii medical professional who understands the sociocultural belief system of his people]

1.1'1c The doctor who diagnosed condition A and referred you to this hospital knew that the hospital has a qualified medical professional.

[*Argument from comparison and contrast* with another medical process by another medical expert]

1.1'.1c.1a The establishment of the cause of the child's illness means the child will now be given treatment and to improve her health condition.

[*Argument from causation*]

1.1'1c.1b The patient needs to change the mindset and forget about the supernatural causes especially after the scientific diagnosis of the child's illness.

[*Argument from authority* by the medical professional]

1.1'1c.1c The doctor shall recommend a nutrition specialist to teach the patient on the nutritional requirements of the child to boost the recovery process.

[*Argument from expert opinion* by the doctor]

1.1'1c.1d The child shall get free medicine and the measuring instruments from the hospital free of charge.

[*Argument from authority* of the doctor as a government doctor]

Figure 5.5 Basic argumentative pattern of the Gusii medical doctor in a consultation involving a diabetic patient and its extensions

In the Gusii medical consultation, involving the diabetic patient, authority argumentation forms the one of the supportive arguments for pragmatic argumentation in the cluster of prototypical arguments. There are two variants of argument schemes relating to authority argumentation: argument by authority and argument from authority (Pilgram, 2015: 38). Argument by authority is the variant of the argumentation which is exclusively associated to the discussion party whose authority is referred to in the argumentative discourse while argument from authority refers to an authority who is an outside source from the discussion parties in the discourse. In Figure 5.5, above the different forms of authority argumentation are all arguments by authority of the doctor albeit from the different sources drawn from the two institutions for strategic manoeuvring which are manifest in the macro context of the Gusii medical consultation. From the pragma-dialectical characterisation of argument schemes, the argument scheme of authority argumentation states as thus:

1 X is acceptable.

1.1 Authority A is of the opinion that X.

1.1' A's opinion indicates that X is acceptable.

The acceptability of standpoint (**1**) in the scheme above is supported by two premises: authority A's opinion (**1.1**) and A's opinion that X is acceptable (**1.1'**). These premises are presented as minor and major, respectively. In Example 11, when the doctor says: *"Amang'ana y'ebimoni ebio ogende otigane*" (Those issues regarding the cats, leave them alone [turn 64])*; "N'amang'ana y'omosubati oyio tiga"* (And leave those issues regarding the lady [turn 66]) and *"Mwanyabanto tabwati nguru chiogokora binto buna ebio"* (A human being doesn't have the power to do things like those [turn 68]) in the patient's attempt to link supernatural causes (the lady and the cats) with the child's illness, the authority of the doctor's argument signified in his professional examination and diagnostic tests provides sufficient ground for the soundness and therefore acceptability of the assertion X. In this case the doctor is himself a discussion party who exploits his position as leader of the consultation and as a medical professional to authoritatively advise the patient in the

resolution of the difference of opinion that arises from the surrogate patient's belief in supernatural causes of the child's illness. In the support arguments, the doctor speaks not just as a doctor but as a Gusii educated insider strategically questioning the belief in supernatural forces as the cause of the illness of the child. In both cases the doctor does not expressly indicate his expertise, but he implicitly asserts that they will employ the requisite legal and professional procedures to establish the problem of the child. In so doing, the doctor is employing a strategic move which complies with the institutional preconditions to realise the institutional point of the medical consultation communicative activity type.

The pragma-dialectical theory classifies authority argumentation as a subtype of symptomatic argumentation (van Eemeren & Grootendorst, 1992: 163; Garssen, 1997:11). In argumentation by symptomatic relation, a discussion party cites in the argument a symptom or a distinguishing of what the standpoint claims. The general schematic representation of the symptomatic scheme, as discussed above in section 5.4. under the section on strategic manoeuvring with interpersonal control in communication accommodation, is presented as follows:

Y is true of X,

Because: Z is true of X,

And: Z is symptomatic of Y

From the symptomatic relation argument scheme (van Eemeren, Grootendorst & Henkemans, 2002: 97-98) two crucial critical questions to ask in the argumentative reality are: 1. is there a possibility that there is non-Y's with the characteristic Z? 2. Is there a possibility that there are other Y's without the characteristic Z? The distinguishing feature in authority argumentation is carried in the authority itself. A person's special position or know-how can pass for the distinguishing sign, which can warrant a proposition or standpoint attributed to him/her as acceptable. This is the case with a medical doctor in the doctor-patient consultation communicative activity type. For this argument to be employed in the defence of a standpoint the antagonist must recognise the authority for the argument to be sound (van Eemeren & Grootendorst, 1992: 161) Further still, an arguer ought to satisfy both the responsibility and sincerity conditions that he or she is truthful and is responsible in felicitously performing the assertive as an acceptable standpoint

(van Eemeren & Grootendorst, 2004, 77-94; Pilgram, 2015:35; Searle, 1969: 66-67). The accountability of the use of authority argumentation is attributed to the user of the argument because the assumption is that out of the context dependency of the strategic manoeuvre, the thrust of the opinion of the authority has the signal of the acceptability of a standpoint.

5.6.3 Pragmatic argumentation in patient's argumentation

The Gusii medical consultation typically presents a situation where the status of the doctor is held in high esteem. The interaction with the patient continuously sees the doctor's position elevated in terms of status in as much as he pays close attention to the patient's information on the medical condition or preferences in terms of treatment during the consultation. Grounded in the traditional Gusii sociocultural illness belief as institutional system, some patients express their reservations on the biomedical procedures used to establish the medical conditions. Such patients will prefer to justify the root cause of illness from the local community or environment including the supernatural forces. The analysis of the medical consultation argumentative discourse from the Gusii surrogate patient (mother) with a diabetic child presents a typical case of the Gusii patient's characteristic argumentative pattern and its supportive arguments. Exploiting the institutional preconditions of the medical consultation, and the overriding the institutional system of the traditional Gusii sociocultural belief concerning illness, the Gusii patient's strategic manoeuvring presents a basic pattern of symptomatic argumentation (see section 5.6.2 above). The characteristic pattern of argumentation for a diabetic patient in a Gusii medical consultation is demonstrated in figure 5.6 below.

Basic pattern: main argument is symptomatic

1 The child's illness (Y) is not ordinary (X)

1.1 Gusii supernatural powers (Z) can cause of the illness with such kind of symptoms (X)

1.1' Some people believe in the use of supernatural powers (Z) such as witchcraft to cause such kind of illness (Y).

Possible extensions: supporting arguments addressing critical questions for symptomatic argumentation

A Support for **1.1**

1.1.1a A quarrel at home with a malicious neighbour may threaten to retaliate with an illness such as X [*Argument from causal relation*]

And/or

1.1.1b Having fever at night with cats meowing outside my home at night is not ordinary (X) [*argument from authority* applicable in the traditional Gusii sociocultural belief system concerning illness]

Or: **1.1.1b** A great traditional medicine man links the strange illness(X) to witchcraft(Z).

[*argument from expert opinion* in supernatural power applicable in traditional Gusii illness belief system]

1.1.1a.1 The medicine man has cured people including a child who had seizures

[*argument from example* applicable in traditional Gusii illness belief system]

B Support for bridging premise 1.1'

1.1'1 There could be diseases which are just normal, and which can be treated.

[*pragmatic argument*]

Or

1.1'1 Using hospital drugs to treat this kind of illness will need lots of faith.

[*argument from authority* of the shifting belief from traditional Gusii sociocultural belief system to the institution of Christianity and its belief system]

Figure 5.6 Prototypical pattern of diabetic patient's argumentation

An argument is symptomatic if what it states has a relation of concomitance with what the standpoint expresses (van Eemeren & Grootendorst, 1992:97). The thrust of the argumentation is in the sign or symptom of what the standpoint states. The sign or symptom of the patient's argumentation is in the authority of her belief in the institutional system of the traditional Gusii sociocultural belief regarding illness. The basic pattern of symptomatic argumentation uses the authority of the patient in her belief system to challenge the contemporary western medicine recommendation using the supernatural causation of illness of the child. The argument from

authority implies that when a discussion party makes a claim, then there is truth in the claim (Garssen, 2001: 92). The patient also exploits argument from example to justify her supporting coordinative argumentation which employs pragmatic arguments in trying to conform to the evidence-based consultation precondition as influenced by the doctor's argumentation.

Using a subtype of causal argumentation referred to as pragmatic argumentation the patient interrogates the contemporary western biomedical procedure by linking the child's sickness to supernatural causes. As indicated in section 5.5.2 above, pragmatic argumentation is employed in defense of an action that should be carried out in a standpoint because of the expected result which is desirous of the discussion party (van Eemeren, 2016b: 17). The depiction of the basic prototypical pattern of argumentation of the patient in a difference of opinion based on cultural preferences derives from the argument structure of the patient argumentation represented in figure 5.3 developed from the consultation excerpt in example 7 in section 5.3 above. Using the schematic structure in figure 5.3 as an exemplary argumentative structure of the patient, the prototypical structure of the patient's argument presents a case of use of symptomatic argumentation as the main argument while exploiting pragmatic argumentation to justify the main standpoint in support argumentation. Other support arguments based on possible anticipated critical questions are argument schemes of example and argument from authority or expert opinion. The patient derives the authority and expertise from the institution of the traditional Gusii sociocultural belief system concerning illness. Nevertheless, there is an institution of Christian belief which comes in the concession that the patient must make for the difference of opinion to be resolved as the institutional belief is opposed to the belief in supernatural powers entailed in the traditional Gusii sociocultural belief system regarding illness.

5.7 Summary

Chapter 5 has examined the argumentative manoeuvres the Gusii doctor and the Gusii diabetic patient exploit in the medical consultation. The analysis first explored the pragma-dialectical process of resolving differences of opinions in the argumentative reality of the medical consultations involving Gusii diabetic patients and Gusii doctors. Using the empirical reality of the (Eke)Gusii medical consultation involving the interplay between the institutions of contemporary western medicine and traditional Gusii sociocultural belief system on illness, the investigation analyses the doctor's and patient's strategic manoeuvres. The process of strategic

manoeuvring is governed by the institutional preconditions of the two institutions influencing the medical dialogue. In ascertaining how the doctor and patient choose their presentational devices in the process, the investigation exploits the role of attitudinal assessment in the evaluative language use by each of the parties in their negotiation with their value positions and how this affects their argumentative moves. The analysis further interrogates the role of communication accommodation aspects of convergence and divergence in choice of presentational devices particularly explores how discourse management, interpretability and interpersonal control are exploited in the strategic manoeuvring. Subsequently, the analysis characterises the prototypical argumentative pattern of the Gusii doctor in consultation with a Gusii diabetic patient as one which exploits pragmatic argumentation as its main argumentation. The doctor's authority in his symptomatic argumentation which forms part of his support argumentation borrows from the institutions of western contemporary medicine and that of the traditional Gusii sociocultural belief system concerning illness. On the other hand, the analysis conceives the patient's prototypical argumentative pattern as one which is characterised by authority argumentation supported by pragmatic argumentation. The patient's authority on the other had is accorded by the traditional Gusii sociocultural belief system concerning illness and partly the institution of Christian belief.

CHAPTER SIX
ARGUMENTATION IN DOCTOR-CANCER PATIENT CONSULTATIONS

6.1 Introduction

This chapter presents an analysis of strategic manoeuvring in argumentation in simulated consultations between doctors and cancer patients in medical encounters at the Kisii Teaching and Referral Hospital (KTRH). Sub-section 6.2 explores the process of resolving differences in opinion between the doctor and a breast cancer patient rhetorically and reasonably to arrive at an agreeable shared treatment decision. An insight into the conventionalisation of the doctor-patient consultation discourse provides a basis for the analysis of the strategic manoeuvres by both the doctor and the cancer patient. Sub-section 6.3 explores the role of evaluative language in argumentative encounters between the doctor and the cancer patient. The section examines the how attitudinal assessments in argumentative moves affect the choice of presentational devices by both the doctor and cancer patient in the ideal model of critical discussion. Furthermore, sub-section 6.4 addresses the role of communication accommodation in the strategic manoeuvring process in the medical encounters between the doctor and the cancer patient. The analysis examines the significance of communicative accommodation strategies of interpretability, interpersonal control and discourse management in the strategic manoeuvres by both parties in the consultation. The last sub-section, 6.5, characterises the prototypical argumentative patterns of the doctors and cancer patients.

6.2 Strategic manoeuvring in the doctor-cancer patient consultation argumentative reality

The argumentative reality of a medical encounter between a Gusii doctor and a Gusii cancer patient is bound to have instances of disagreements regarding treatment procedures between the interlocutors. The chronic nature of cancer, and the myths associated to the patients' beliefs because of the terminal nature of the medical condition may influence some of the patients' preferences (Chewning, Bylund, Shah, Arora, Gueguen, *et al.*, 2012) which may cause some disagreements. The medical consultation itself may bring about conflict between the socio-cultural and macro-contextual factors due to the preferences of the cancer patient. The socio-cultural

beliefs of some of the cancer patients influenced by their level of understanding on the chronic condition can also cause misperceptions (Frerichs, Hahlweg, Muller, Adis & Scholl, 2016: 10) which may lead to protracted arguments on various issues related to the treatment process.

The educational backgrounds of patients and their general ability of understanding form important considerations by the doctor in trying to resolve some of the differences in opinion. The doctors, however, are quick to deploy their professional insights and intuitions in the use of requisite communication skills based on their assessments of a variety of patients in the consultation process. In the data investigated in this chapter, the common sociocultural Gusii background between the doctor and the patient makes is both beneficial and challenging to the process of resolving the differences of opinion. The trust levels between the two parties benefit the personalised engagements, especially in the case of cervical cancer, despite the institutionalised nature of the medical encounter. The challenge obtains when the patient assumes that the doctor, being a local Gusii doctor, must understand common positions which relate with the local Gusii social wisdom or cultural belief system. The medical training of the doctor in the practice of contemporary medicine together with the institutional preconditions (van Eemeren, 2016: 11–12, 2017a: 5) of the practice of medicine, both legal or procedural moderate his or her professional handling of the medical consultation. The argumentative reality of the doctor-cancer patient communicative activity thus presents both parties a chance to deploy strategic manoeuvring skills in resolving of the differences in opinion effectively and reasonably.

6.2.1 Conventionalisation of doctor- patient argumentative discourse

The hospital as an institutional point defines the macro-contextual requirements which influence the doctor's communication with patient in terms of the legal requirements associated with the doctor-patient consultation as a communication activity. The conventionalisation of the communicative activity type at the hospital-institutional point as a macro-context determines the analysis and reconstruction of doctor-patient augmentative discourse in the argumentative reality (van Eemeren & Garsen, 2015:483). Some of these institutional requirements also referred to as preconditions[24] in the research literature include the informed consent, which accords the patient

[24] The institutional preconditions are further classified into primary (official, formal and procedural) and secondary (informal but substantial) preconditions (see van Eemeren and Garssen, 2009, 2010, 2011).

the right to information in the shared decision-making process during the consultation (Schulz & Rubinelli, 2015b: 486–488; van Eemeren, 2016: 11). The informational needs for the patient may range from the causes of the disease, evidence-based research findings on the disease, choice of treatment regime and why one will be preferred over the other and the adverse effects of the treatment (Rao, Anderson, Inui & Frankell, 2007; Barratt, 2008; Labrie & Schulz, 2014).

The need to go beyond the ideal critical discussion and reconstruct the strategic moves by the doctor and the cancer patient calls for an analysis of the various communicative practices which have shaped the medical discourse genre (van Eemeren & Garsen, 2015:482). The communicative practices, which occur during doctor-patient encounters during the consultation, entail a communication activity type dictated by the institutional point. The communication activity types, as conceived in the extended pragma-dialectical thought, are those conventionalised communicative procedures normally carried out to perform the institutional modalities and requirements of the communicative paradigm (van Eemeren, 2010: 139-145). The conventionalisation of these communicative activity types may require a formal or informal process depending on the communicative domain. Whereas some communicative activities in some communicative domains are formal like the legal domain, those in the academic, medical and political domains have varying levels of formality with the interpersonal realm being less formal.

6.2.2 Strategic manoeuvring in the critical discussion process

The advent of strategic considerations in the analysis and evaluation of argumentative discourse meant that the requisite extended pragma-dialectics tools provide more profound and realistic output in the critical discussion (van Eemeren & Houtloser, 2002a). The key proponents of the strategic design in the reconstruction of argumentative discourse subsumed that in the argumentative reality aiming to be reasonable and aiming to be effective go hand in hand (van Eemeren, 2014 *et al.*, 553). In a typical doctor-patient consultation communicative activity, the doctor and the patient always want to understand each other by way of seeking approval and acceptance of each other's communication and this occurs through their urge to remain reasonable. This simultaneous aiming for persuasive acceptance and intent to attain this goal on the merits of the argumentative moves the discussants make implies constantly aiming to be reasonable. The rules of critical discussion therefore ensure that the shared decision-making process is a reasonable

undertaking as the doctors and patients seek to resolve incidences of differences of opinion during consultations.

Through the process of strategic manoeuvring, van Emeren and Houtloser foresaw a functional integration process of examining the rhetorical and dialectical processes of the argumentation reality (van Eemeren, 2010: 87-92). At the core of this integration process are the three parameters of strategic manoeuvring in argumentation as already explained in Chapter 3, section 3.3.6. First, the interactants are constantly faced with a choice of the available alternatives of ideas which make up the *topic potential* in the argumentative discourse. Secondly, the need to gain acceptance demands that an arguer adapts to the *audience demand* and this is both a rhetorical and reasonable appeal. The third and final parameter is the deliberate choice of *presentational devices* and the style of expressing oneself to achieve the intended purpose in the argumentation process (van Eemeren & Houtlosser, 2002a). These parameters are interdependent and permeate through all the stages of critical discussion.

The following (Eke)Gusii excerpt in example 1 drawn from the Cancer 1 consultation (see appendix xxiv on page 600) demonstrates how the doctor and the patient exploit the strategic design in the process of argumentation is a case where a breast cancer patient is opposed to the chemotherapy treatment recommendation by her doctor.

(1)

[1] Doctor: *Eriogo ndireo togwenerete gokoa na nigo rire chiseries encher' ende igokobwatia kwana gokorerwa korwa erimo gochi' erinde. Nobe ang'e gokorerwa eprocedure eyio okonyeke?*

There is some medicine we are supposed to give you, and it is in series, that is once you are done with one you proceed to another. Are you ready to go through the procedure for your own safety?

[2] Patient: *Eprocedure eyio ng'aki ekorokwa?*

What is that procedure called?

[3] Doctor: *Chemotherapy.*

Chemotherapy.

[4] Patient: *Nche gaaki chemotherapy eyio tingotaka gokorerwa! Tobwati riogo rinde gaaki?*

> Please I won't want to undergo that chemotherapy! Don't you have any other medicine, please?

In example (1) above, the manifestation of a difference of opinion occurs when the doctor's standpoint of having the cancer patient go through the chemotherapy treatment procedure is met with non-acceptance by the patient. This, therefore, signals the first stage of the critical discussion process where the patient immediately musters her presentation devices to confront her principal audience, the doctor. Dialectically, the discussants need to ascertain what is at stake in the difference in opinion, and rhetorically they employ linguistic resources, which are "most beneficial" to their argumentative intention (van Eemeren, 2010: 43). The patient's standpoint in which she presents her subordinative argumentation (see turn 4 in example 1 above) marks the *confrontation stage*. Figure 6.1 below shows a schematic representation of the standpoint.

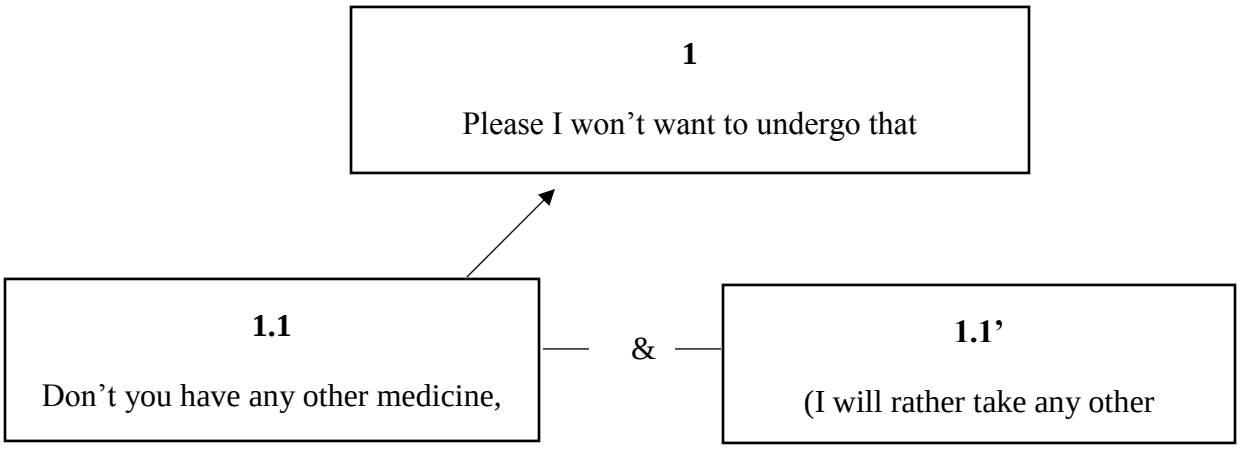


Figure 6.1 Cancer patient's confrontation subordinative argumentation schema

Presented in a single argumentation in the schema, in Figure 6.*1* above, the patient has an unexpressed premise (**1.1'**) where she indicates her preference as opposed to the doctor's proposal. In the confrontation, the patient practically aims for optimal rhetorical effectiveness within the confines of a dialectical intent. The patient demonstrates this simultaneous pursuit in her firm but appealing style in the way she has used her presentational devices. The use of the word "*gaaki*" (please) in both the main standpoint (1) and the substandpoint (**1.1**) in Figure 6.1 above confirms the argumentative strategy she has employed right at the beginning of this critical discussion

process (turn 4). The politeness of the use of the word "*gaaki*" conforms to the Principle of Communication in terms of the clarity, honesty, efficiency and precision of the non-acceptance standpoint (van Eemeren & Garsen, 2015: 473). The choice of presentational expression not only expresses the patient's submission to the privileged position of the doctor as the centre of authority party in the consultation, but it also appeals to the doctor's feelings. The tone the patient exudes using the pleading expression "*gaaki*" equally reaffirms the patriarchal set up of the shared decision-making process empowering the doctor as the gatekeeper of the doctor-patient communication process. Thus, the choice of presentation device in this case becomes a sort of intermediary between appealing to the audience demand and the topic potential of either accepting or rejecting chemotherapy in argumentative reality. The topic potential relates to vantage position the arguer takes when choosing an argumentative move (van Eemeren, 2010:96). The patient, therefore, settles at an angle where she does not want to antagonise the medical system but to try to have a negotiated decision based on her preference.

The second stage of the resolution process, the opening stage, sees the arguers establish the material and procedural starting points. Discussants dialectically establish a clear-cut point of departure by agreeing on the various aspects of conducting the discussion at this stage. These range from the premises of the discussion, which determine the material starting points and how the discussants share the burden of proof as part of the procedural starting points. On the other hand, each of the discussants will always aim for opportune rhetorical effectiveness by trying to ascertain the points of departure both materially and procedurally in a way that encourages effectiveness in the discussion (van Eemeren, 2010: 44). In the case of the consultation in cancer 1, in example 1 above the doctor assumes the role of protagonist and the patient takes the role of antagonist. These positions are loaded with the interests of the discussants in terms of engaging each other effectively in the process of resolving the difference of opinion critically on merits.

The third stage of the critical discussion process is the argumentation stage. In this stage, the discussants equally strategically manoeuvre with dialectical and rhetorical objectives. The interactants test the acceptability of each other's standpoints expressed right from the point of departure by either advancing argumentation or expressing critical doubt or vice versa. On the other hand, each of the interactants tries to use the most effective argumentative moves to either critically express doubt or argument schemes which can satisfy the other party until there is no

doubt (van Eemeren, 2010:44). In a doctor-patient consultation situation, such as the (Eke)Gusii excerpt in example 2 drawn from the cancer 1 consultation (see appendix xxiv on page 601) below, the protagonist and antagonist aim for the most effective means of critical argumentation which can satisfactorily remove doubts expressed by either party in defence or refutation of their standpoint till one of them convinces the other and a shared treatment decision is made.

(2)

[1] Doctor: *Kobwatekana buna toroche ase oborwaire bwao bwaikire,*

From what we see, based on the level of your disease,

[2] Patient: *Mm.*

Mm.

[3] Doctor: *Eye nero erabe enchera egwenerete as'ore.*

This will be the most appropriate for you.

[4] Patient: *Mm.*

Mm.

[5] Doctor: *Ee bun' omonyagetari oo…*

Yes, as your doctor…

[6] Patient: *Ee…korende tagitari ndoche ng'a tinkonyara okogwenigwa okwo ekiagera nararire obobe bwaye.*

Yes …but doctor, I don't think I will manage that treatment because I have seen its side-effects.

[7] Doctor: *Obobe mboreo korende tokoreng'ania e risk y'oborwaire n'obobe bweriogo eri. Ah mbuya ochore okorwarigwa goetera encher' eye erio egere omenye. Onye tari bo….*

The effects are there but you cannot compare the risk of the disease with the side effects of this medicine. It will be better to choose this way of treatment such that you live. If you will not….

[8] Patient: *Mm. Bono etuki' eye eraera neche komera naende ekero enchera eye y'okogwenigwa yaerire?*

Mm. Like if this hair gets finished will it grow again after this treatment process?

[9] Doctor: *Amatuko aya ntobwate nonya nechiweave. Echio nabo okobeka tu etukia teri mochando. Nonya n'abasubati amatuko aya nkogingira bare etukia naende bagenderera kororekana koba abanyakieni.*

These days we even have weaves. Those, you can put on, hair is not a problem. Even ladies these days trim their hair and they remain beautiful.

[10] Patient: *Korende nche tagitari tindaitaberana*

But I have not agreed.

[11] Doctor: *Nche buna omonyagetari oo, oyo gwacheire agosemie nigo ninganetie bwanche erinde togokonye. Bono oise kwanga oborwaire nigo bokogenderera bokomenta n'eprognosis echie koba enene.*

As your personal doctor, whom you have come to consult I wish you would agree such that we assist you. Now if you refuse this disease will advance and the prognosis will be bigger.

[12] Patient: *Mm.*

Mm.

[13] Doctor: *Ee, ase igo nigo nkogosaba yaani tu bwanche erinde togokonye. Ntokoganeretie amaya.*

Yes, therefore, I pray that you accept such that we assist you. We wish you well.

[14] Patient: *N'eyio ng'ai egokorerwa?*

And where is that done?

[15] Doctor: *Agaiga ase enyagetari yaito ntobwati korende nabo tokogotoma gochia ase enyagetari ekorwa eprocedure eyio yokorwaria oborwaire obo.*

Here at our hospital we do not have it but we can refer you to a hospital which offers that procedure of treating this disease.

[16] Patient: *Na kingokorerwa, ngaki eng'ana ng'aki ndaire kogwena?*

And once I undergo the procedure how long will it take for me to recover?

[17] Doctor: *Igo ekobwatekana buna omobere oo orareact gochia ase amariogo. Kera omonto igo akoreact ase chinchera ao ao. Korende eyio n'eprognosis. Igo ere buya okorerwe chemotherapy.*

It normally depends on how your body will react with the medicine. Every person reacts in different ways. However, that is a prognosis. It is better to undergo chemotherapy.

[18] Patient: *Nanchire nkorerwe eprocedure eyio.*

I agree to undergo that procedure.

In Example 2 above, the doctor is the protagonist while the patient is the antagonist. Exploiting the tools of pragma-dialectical analysis, the patient's and doctor's argumentation can be represented in the schematic structural reconstruction as demonstrated in *Figures 6.2* and *6.3* below.

Patient (antagonist)

1. Please, I do not want to undergo chemotherapy

1.1a Don't you don't have any other medicine, please

1.1a' (I will rather take any other medicine that you may recommend)

1.1b I do not think I will manage that treatment because I have seen its side effects.

1.1b.1a Like if I lose this hair will it grow again after this treatment process?

1.1c Where is that done? And if I undergo the procedure how long will it take for me to recover?

1.1c' (Does this hospital have the capacity to do chemotherapy?)

Figure 6.2 Structure of cancer patient's argumentation

Doctor (protagonist)

1. There is some medicine we are supposed to give you, and it is in series, that is once you are done with one you proceed to another. This procedure is called chemotherapy.

1.1a According to our investigations, based on the level of your disease this is the most appropriate.

1.1a.1a It has effects, but you can't compare the risk of the disease with the side effects of the medicine.

1.1a.1a.1a These days there are weaves you can put on, hair is not a problem.

1.1a.1a.1b Ladies these days trim their hair and remain beautiful.

1.1a.1b It is better to go for this kind of treatment such that you live.

1.1b As your personal doctor, whom you have come to consult I wish you would agree such that we help you.

1.1b' (As a professional and your personal doctor, whom you have come to consult, I wish you would agree so that we help you before it is too late.)

1.1b.1a Now if you refuse this disease will advance and the prognosis will be bigger.

1.1c Here at our hospital we do not have it but we can refer you to a hospital which offers the that procedure of treating this disease

1.1d It normally depends on how your body will react with the medicine. Every person reacts in different ways. However, that is a prognosis. It is better to undergo chemotherapy.

Figure 6.3 Structure of doctor's argumentation in a consultation involving a cancer patient

The argumentation structures in Figure 6.2 and 6.3 demonstrate strategic manoeuvres of the doctor and the patient, for a difference of opinion, which does not relate to the interplay between the institutions of the western contemporary medicine and the traditional Gusii sociocultural belief system regarding illness. The main arguments of both the Gusii doctor and the Gusii cancer patient employ pragmatic argumentation supported by symptomatic argumentation. The authority in the patient's and doctor's pragmatic and symptomatic arguments comes from the knowledge levels on cancer and the technical and professional expertise, respectively. Both structures present complex argumentation structures composed of multiple, subordinative and coordinative argumentation structures with argument schemes aimed at effectively resolving the difference of opinion within the reasonable standards.

The next section investigates how the use of evaluative language in the medical consultation influences argumentative moves of the doctor and the patient in their strategic manoeuvring to resolve differences of opinion in the shared decision-making process.

6.3 The language of evaluation in the argumentative discourse of doctor-cancer patient consultations

This section explores the role of positive and negative assessments of the argumentative moves by the doctors and patients in their attempts to resolve the differences of opinion in the medical encounters. The two principal interactants are continually involved in evaluative assessment of their interpersonal engagements in the argumentative discourse in the process of shared decision-

making in the medical consultation. The linguistic choices of the interactants is influenced by how they negotiate their identities and social roles in their relationship in the communicative activity (Dvorak, 2015: 96; White, 2015: 2). The presentational devices in the doctor-patient interaction reflect the deliberate thoughtful and evaluative social positioning of the two parties. This is reflected in the they manage their levels of involvement in the argumentation moves in the consultation dialogue based on each other's interpretation and response to the attitudinal meanings of their utterances.

6.3.1 Attitudinal assessment in argumentative manoeuvres in the critical discussion

In examining the resolution of differences of opinion in the communicative activity of the medical consultation, the analyst investigates the role of the three attitudinal assessment parameters as discussed in section 3.3 of Chapter 3: affect, judgement and appreciation. As already elaborated, affect relates with the positive or negative valuation of the participants' emotional reactions. On the other hand, judgement is associated with assessment of human behaviour with reference to conventionalised social norms (Dvorak, 2015: 97; White, 2015: 2). On its part, appreciation entails the evaluation of objects, phenomena, processes or states of affairs and according them positive or negative values with reference to social salience, aesthetic qualities, significance in a certain field or potential to cause harm (Martin & White, 2005: 36; Dvorak, 2015: 98; White, 2015: 2). An analysis of the strategic design in the interactants' argumentative moves is bound to benefit from the evaluation of language use in terms of affect, judgement and appreciation. The assessments of attitudes of arguers' meanings either explicitly expressed or inscribed in the language implicitly. A reconstruction and interpretation of the argumentative discourse must unearth these evaluative aspects of language use in the choice of presentational devices as the interlocutors negotiate with their social identities in the interpersonal engagement in the medical consultation.

A close analysis of the process of strategic manoeuvring during a critical discussion in the process of resolving a difference in opinion offers a novel opportunity to examine the taxonomy of the subtypes of attitudinal assessments of the arguers. The (Eke)Gusii excerpt in example 3a below extracted from the cancer 2 consultation dialogue (see appendix xxv) shows the argumentative reality of a doctor-patient consultation where the two make deliberate attempts to resolve is a difference in opinions on merits.

(3a)

[1] Doctor: *Ah, ndoche nobwate omochando aiga ekiagera timbwati mang'ana maya.*

Ah, I see you have a problem here because I do not have good news.

[2] Patient: *Mm.*

Mm.

[3] Doctor: *Ekworokia ng'a nabo eranyarekane…*

It shows that it is possible…

[4] Patient: *Mm.*

Mm.

[5] Doctor: *Korende chitest nchire togochagokora nario toraeneki…*

But there are tests we shall carry out to confirm …

[6] Patient: *Mm.*

Mm.

[7] Doctor: *Buna nabo eranyarekane*

That it is possible.

[8] Patient: *Mm*

Mm

[9] Doctor: *Obe na cancer.*

For you to have cancer.

[10] Patient: *He! Tagitari! Kansa?*

What! Doctor! Cancer?

[11] Doctor: *Ase mm chinsemo chia nsoni, ase omorangu oria okoigoka gochia ase enyomba y'omwana.*

In your…mm private parts, at the entrance to the uterus…

[12] Patient: *Bono igo inaki gose ekare? Igo ngochagokwa gose inaki? Ntebi nche amatuko ane aerire bono nche ng'ende kwearigania gaaki. Tobaise kong'ainakoranche.*

So, what does that mean? Will I die or what now? Tell me my days are finished so that I go prepare myself please. Do not lie to me please.

[13] Doctor: *Omongina naki gwantebia okorokwa?*

Madam what did you tell me your name is?

[14] Patient: *Nche Risper nkorokwa.*

I am Risper.

[15] Doctor: *Asante, nainche naki nkorokwa?*

Thank you, and what is my name?

[16] Patient & Doctor: *Daktari*

Doctor

[17] Doctor: *Eh… ndi ngocha gokwa*?

Eh…when will I die?

[18] Patient: *Tagitari bono ninkamanyete.*

Doctor, now how can I tell.

[19] Doctor: *Aseki?*

Why?

[20] Patient: *Aye rende otarwareti (amaseko).*

But then you are not sick (laughter).

[21] Doctor: *Ker'omonto nabwate rituko riaye.*

Everyone has his day.

[22] Patient: *Mm.*

Mm.

[23] Doctor: *Omanyete enseye intwe twensi nabaeti.*

You know, in this world we are all passers-by.

[24] Patient: *Mm.*

Mm.

[25] Doctor: *Abanto mbare bamenyire na HIV emiaka ne miaka batana goku.*

There are people who have stayed with HIV and AIDS who have never died.

[26] Patient: *Mm.*

Mm.

[27] Doctor: *Moisonde ebus yaita abana besukuru.*

The other day a bus killed school kids.

[28] Patient: *Ah tagitari!*

Ah doctor!

[29] Doctor: *Gokwa tikobwati ororeria.*

Death doesn't have a genealogy.

[30] Patient: *Gose nkoigwa ng'oborwaire obo ngoita bore abanto, obogoita abanto.*

I hear that this disease is a killer, it kills people.

[31] Doctor: *Omonto ekero...*

When a person....

[32] Patient: *Mbobwati riogo.*

It does not have a cure.

[33] Doctor: *Omonto ekero akoiboru…*

When a person is born

[34] Patient: *Mm.*

Mm.

[35] Doctor: *Ninki naende aganyete? Ase ense eye?*

What else does he/she wait for? In this world?

[36] Patient: *Ah tagitari yaya bono rende nararire nonya n'abachokoro iga bane gose abachokororia?*

Ah, no doctor, have I seen at least even my own grandchildren or great grandchildren?

The manifestation of a difference in opinion in the consultation in example 3a above which triggers the argumentation occurs when the doctor is disclosing the results of the laboratory tests to the patient. During a doctor-patient consultation, sometimes the doctor deliberately tries to hide sensitive and disappointing diagnostic news normally in the interest of the patient, and present the information in a manner, which gives hope to the patient risking distortion of the message (Gillotti,

2003:163). In the argumentative reality of the medical consultation in example 3a above, the doctor tries to comply with the ethical code of medical practice by handling the disclosure in a very cautious manner. He uses the expression "*nabo eranyarekane*" (it could be possible) [turn 3 and 7]), example 3a. The deliberate use of the assertive to state the professional interpretation of the results is a product of the doctor's careful attitudinal assessment of the content of the results. In this expression, the three parameters of evaluative language come to play. In the first place, the doctor has exploited the affectual aspect in the sense that using his professional skills; he intends to reduce the emotional and psychological effect of the news of the cancer infection on the patient. In mitigating the effect of fear, anxiety and other emotional effects of the disclosure the doctor prefers to give his predictive expression which minimises the possibility of the occurrence of the terminal condition in the cancer patient.

Secondly, in terms of judgement evaluation, the doctor's linguistic choice is meets two aspects of human behaviour which subscribe to social esteem and social sanction. In terms of social esteem, the doctor's language demonstrates that he has the communication skills necessary for disclosure of bad news to a patient. The 'skilled' positive attitudinal assessment lies under capacity, one of the attitudinal subclasses under social esteem (White, 2011: 23). On the social sanction subclass of propriety, the linguistic choice accords him the positive attitudinal attribute of sensitive and law abiding. This is in line with the informed consent ethical code of medical practice which requires the doctor to provide information to the patient to enable the patient to make any decisions (Rubinelli & Schulz, 2006; Labrie & Schulz, 2014: 996; Schulz & Rubinelli, 2015b). Regarding the third parameter, the doctor's choice of presentational device embodies the positive attribute of the value of human life vis a vis the infection of a chronic condition like cancer.

Therefore, in terms of appreciation the doctor carefully handles the process of ascertaining whether indeed the patient has the cancer infection by indicating that it could be possible that they need to carry more tests to confirm the preliminary tests (turn 5). The value of the life at stake is expressed positively and optimistically by the doctor. The doctor elects to use symptomatic argumentation through the argument scheme of comparison and contrast as his presentational device (turn 5). In his assertive stating that there are some requisite confirmatory tests reveals his positive attitudinal assessment in his judgement. The standard procedure of carrying out other tests before ascertaining the infection of a disease fully is a conventionalised and institutional procedure. The expression,

"*chitest nchire totakeire tokore nario toraeneki*" (there are tests we are required to do so that we can confirm [turn 5]) shows the doctor's positive attitude of the standard hospital custom reaffirming the social esteem of his position as a professional. In addition, the revelation of this standard procedure presents his positive attitudes (honesty in terms of his veracity and law abiding/moral in terms of propriety) which reinforce social sanction subclass of judgement. Inscribed in the words is a positive attitude of affect, which shows the doctors intention to allay any fears of the disclosure. This assertion is made in anticipation of a reaction from the patient and indeed the revelation that she may have cancer (turns 3, 5, 7, 9) warrants the patients confrontation in the discourse.

The confrontation stage sees the patient present a standpoint in which she seeks to confirm that she has cancer and the implication whether it is a death sentence for her. The patient uses the words "*igo ngochagokwa...?"* (will I die...?) "*Ntebi amatuko ane aerire..."* (Tell me my days are over [turn 12]). Inscribed in these presentational devices are twin attitudinal assessments. There is the negative emotional feeling of fear, which shows how the patient is struggling with the affect attitudinal aspect after the disclosure of the contents of the test results. The patient further presents an appreciation evaluative assessment of a negative value of her life because of the possibility of infection of the chronic condition. She further goes ahead to apply judgement evaluation in appealing to the doctor's veracity in his honesty about her condition whether she will die or not. She does this in a directive begging the doctor, "*Tobaise Kongaina koranche"* (Do not lie to me please [turn 12]). The directive complies with the audience demand because it puts the doctor on a mission to set the record straight on the topic at hand based on his professional experience and medical knowledge.

In a critical discussion, the opening stage sets the substantive and procedural starting points clear. In this stage, the protagonist and antagonist agreed on the roles each of them should take in the discussion. In the argumentative reality in question, the patient has already taken the position an antagonist. Her standpoint presupposing that the cancer diagnosis is a death sentence for her warrants the doctor to take up the role of a protagonist with argumentation, which refutes the patient's position. As protagonist, the doctor has an obligation defend the process of disclosure and ensure that the patient has a clear understanding of the test results. The doctor also needs to explain the implications of the cancer diagnosis and if possible prognosis. On the other hand, the

patient in her antagonistic role is to provide critical responses to the doctor's standpoints in the discussion until the difference in opinion is resolved.

The argumentation stage opens with the doctor exploiting a rhetorical question as a presentational device, "*ndi ngocha gokwa?*" (when will I die?) [turn 17]. In another assertive, the doctor assures the patient using an argument from authority, "*kera omonto nabwate rituko riaye*" (everyone has his day- turn 21). This assertive expresses the doctor's positive appreciation assessment of human life whose length is beyond human cognition. In the expression "*mbare bamenyire na ukimwi emiaka ne miaka bana gokwa*" (there are people living with HIV & AIDS for many years who have never died) [turn 25], the doctor employs analogy argumentation using an argument scheme of comparison and contrast. The doctor does this to refute the patient's standpoint about her fears about death because of the cancer diagnosis. The statements of the doctor express his positive attitudinal assessment of the affect parameter. The doctor's presentational device choice inspires hope in the patient (his key audience) by mitigating fear in his comparison of the long lives of people living with HIV & AIDS with the patient's.

To reaffirm his refutation of the patient's standpoint, the doctor also employs argument from example. In the example "*ebasi yaita abana besukuru*" (a bus killed school children -turn 27) an accident involving a school bus takes the lives of many school children at three days earlier. The doctor's choice of presentational devices shows his negative assessment of the accident, which caused the deaths of the children because of the fear and sadness it brings about (affect). However, this attitudinal assessment is backed by his assertion that death is an unfortunate (negative) occurrence which is like an everyday human standard (positive evaluation of normality judgement). The doctor uses this argument by strategically manoeuvring through the ambiguity of the attitudinal assessment of the normality of death (judgement), and the harm it causes rendering human life valueless (appreciation) in critically appealing to the patient to accept his standpoint. In addition, the doctor employs argument from analogy to add on the thrust of his standpoint that the preliminary cancer diagnosis is not a death sentence for the patient. Through the doctor's assertion stating that, "*ogokwa nkobwati roreria*" (death does not have a genealogy); the doctor positively evaluates death as a standard occurrence (judgement) which affects everyone (turn 29). The doctor intends to effectively make the patient understand the inevitability of death but also the chance she has for surviving the diagnosis of cancer.

On her part, the patient elects to employ an argument from popular opinion. The relatively limited literacy level of the patient influences the patient's choice of presentational style. In her assertive she claims, "*nkoigwa ng'oborwaire obo ngoita bore abanto*" (I hear that this disease kills people [turn 30]). An attitudinal assessment of these words reveals a negative feeling of fear (affect) inspired by cancer. Inscribed in the words is the negative value of cancer because of the devastating effect on human life (appreciation). The target of this argument is the doctor who is the authority and the medical professional who is the default leader of this discussion. The patient further says that cancer "*mbobuati riogo*" (does not have a cure [turn 32].) These words have inscribed negative assessments of affect and appreciation due to the fear they inspire and the chronic nature of the disease respectively.

The doctor and the patient employ symptomatic argumentation in defending their standpoints. In both cases there is the strategic use of metaphor with inscribed attitudinal assessments targeted at these two principal discussants. For instance, the doctor chooses to employ a rhetorical question: "*omonto kaiboirwe ninki naende aganyete ase ense eye?*" (When a person is born, what else is he/she waiting for in this world [turns 33 and 35]). This rhetorical choice enables the doctor to express his negative attitude on the value of human life (appreciation) because of the inevitability of death immediately after birth because ultimately human beings do not have control over their lives. Employing judgmental evaluation, this is a standard (positive) of human existence which human beings must appreciate. On the other hand, the patient uses an equivalent rhetorical device to refute the doctor's argument. She poses, "... *bono rende narorire nonya n'abachokoro iga bane gose abachokororia*?" (... now have I seen at least even my own grandchildren or great grandchildren? [turn 36]). The assertion implicitly shows that death can deny the patient a chance to see her grandchildren and great grandchildren. Inscribed in the rhetorical expression is the positive evaluation of the elderly (appreciation) due to their ability to enjoy the interaction with their grandchildren and great-grandchildren. However, the expression has the negative assessment of possible death due to the cancer diagnosis which can deny the patient a chance of seeing her offspring due to its terminal nature. As a continuation to the dialogue in example 3a extracted from the cancer 2 consultation (see appendix xxv on page 620), the (Eke)Gusii excerpt in Example 3b below further demonstrates how the doctor's and patient's choices of presentational devices help them interpersonally negotiate with their value positions (Dvorak, 2015: 96) in their strategic manoeuvres.

(3b)

[1] Doctor: *Rakini…*

But…

[2] Patient: *Mm.*

Mm.

[3] Doctor: *Ah tobaise kwoboa…*

Ah, never fear…

[4] Patient: *Mm.*

Mm.

[5] Doctor: *Ebinto otamanyeti.*

Things that you do not know.

[6] Patient: *Mm*

Mm

[7] Doctor: *Kwaigure?*

Have you heard?

[8] Patient: *Mm.*

Mm.

[9] Doctor: *Ee.*

Yes.

[10] Patient: *Bono inki gekoboreta gaaki buna nakagota iga?*

Now surely what causes it the way I am now this old?

[11] Doctor: *Korende eseng'encho twachakire korora cancer chinyinge.*

But because we have started to see different types of cancers.

[12] Patient: *Mm.*

Mm.

[13] Doctor: *Obotuki obonge mbogenderete gokorwa.*

Lots of research is still being done.

[14] Patient: *Mm.*

Mm.

[15] Doctor: *Ah chisababu nchiroo babegete buna theories.*

There are reasons which they have come up with like theories.

[16] Patient: *Mm.*

Mm.

[17] Doctor: *Korende mbana gotwara esababu eratebe n'eye ekogera*

But they have never established the root cause.

[18] Patient: *Mm.*

Mm.

[19] Doctor: *Rakini ebirusi mbirooroo biatokire.*

However, there is a virus which has been discovered.

[20] Patient: *Mm.*

Mm.

[21] Doctor: *Ekorokwa ng'a human papilloma.*

It is called human papilloma.

[22] Patient: *Mm.*

Mm.

[23] Doctor: *Nero bakagerete ekoreta oborwaire obo.*

It is the probable cause of this disease.

[24] Patient: *Mm.*

Mm.

[25] Doctor: *Anene…*

Broadly…

[26] Patient: *Bono ebirusi ebio nkai bigotoka?*

So where is this virus found?

[27] Doctor: *Ebigotoka ase ense eye. Ebiatongetwe na Nyasae gose bono saitani toratebe?*

The virus is on this earth. They were created by God or should we say satan?

[28] Patient: *Eh.*

Eh.

[29] Doctor: *Korende kerokende nabo okonyora omosacha gakwambokeria omosubati.*

However, at times it is possible to get a man contaminating a woman.

[30] Patient: *Mm*

Mm.

[31] Doctor: *Gose bwacha igo buna oratware oborwaire bonde bwonsi.*

Or you can develop it like that just like any other disease.

[32] Patient: *Mm.*

Mm.

[33] Doctor: *Buna rikuba.*

Like flu.

[34] Patient: *Mm.*

Mm.

[35] Doctor: *Nabo egocha tu.*

It can just come.

[36] Patient: *Mm.*

Mm.

[37] Doctor: *Bono igo ogocha koyeigwa ekero yarentire cancer tayari.*

You get to feel it when it has already developed [...] already.

[38] Patient: *Mm.*

Mm.

[39] Doctor: *Igo egento ekemo etotakeire tokore chitest chinde nario toraeneki oborwaire obo tokagerete.*

So, one thing we need to do further tests to confirm the diagnosis.

[40] Patient: *Mm.*

Mm.

[41] Doctor: *Igo tokumia. Egento kende…*

So, don't be worried. The next thing.

[42] Patient: *Mm.*

Mm.

[43] Doctor: *Tori gochi gokwa mambia.*

You are not dying tomorrow.

[44] Patient: *Mm.*

Mm.

[45] Doctor: *Ah korengana nekerengo oborwaire bwaikire nabo togokobwenia pi…*

Ah depending on the state, we can completely cure it…

[46] Patient: *Mm.*

Mm.

[47] Doctor: By doing an operation.

Goetera ase okobarwa.

[48] Patient: *Mm.*

Mm.

[49] Doctor: *Nabo togokobara.*

We can operate on you.

[50] Patient: *Mm.*

Mm.

[51] Doctor: *Na korusie obobe bwensi tokore cancer yonsi korwa asore.*

And remove all the infection and you will be free of cancer.

[52] Patient: *Mm.*

Mm.

[53] Doctor: *Yonsi pi.*

Completely.

[54] Patient: *Gaaki mbuya mono ase amaereso ayio. Onde bwensi nabo akwoboa amakweri*

Please thanks for that advice. Anyone can fear death.

[55] Doctor: *Igo aye tobaise kwoboa nonya nonya ng'ake. Omonene nare amo naye.*

Ah so don't fear at all at all. God is with you.

In the (Eke)Gusii excerpt in example 3b above which is an extension of the dialogue in example 3a extracted from the cancer 2 consultation (see appendix xxv on page 617), the doctor justifies his standpoint through a strategic manoeuvre using an argument from authority with a directive challenging the patient "*tobaise kwoboa ebinto otamanyeti*" (do not fear things you do not know) [turns 3 and 4]. The doctor defies the attitudinal assessment of fear (affect), and implicitly assures the patient with a positive assessment of value in her life (appreciation). Besides, the expression also demonstrates the doctor's negative evaluation of the patient's relatively limited literacy level on cancer (appreciation). As if this is a trigger, the patient employs the argument of causal relation to seek a better understanding of the propositional content of the doctor about the disease (turn 10). Legally, the doctor has an obligation to provide informed consent to his patient during the medical consultation. The doctor, therefore, takes this chance to carefully exploit the presentational devices at his disposal to conclusively defend his position.

To begin with, the doctor strategically exploits mainly the argument from expert opinion, argument from causal relation, and argument from analogy (comparison and contrast). These presentational device choices help the doctor in making the patient understand the nature of the virus, which

causes the disease, its transmission and the prognosis. Using argument from expert opinion, the doctor gives evidence-based information when he talks about the occurrence of many cancers, which have encouraged a substantive amount of ongoing studies, which have come up with theories to explain the chronic condition (turns 11, 13 and 15). The evaluation of the attitude of the doctor in the presentational devices he chooses to employ in the expression, "*eseng'encho twachakire korora cancer chinyinge obotuki obonge mbogenderete gokorwa*" (because we have started to see different types of cancers lots of research is still going on) [turns 11 and 13], reveals his positive assessment of his ethical and credible conduct (judgement) as a medical professional. Evidence-based medicine and informed consent are some of the social sanctions (propriety and veracity) which accord the doctor his role in the communicative activity type of the medical consultation a positive assessment (appreciation).

The doctor employs argument from causal relation to further explain that in as much as the root cause of the disease has not been established, research has established that the human *papilloma* virus is responsible for causing and transmitting cancer (turns 17, 19, 21, 23 and 25). Employing the analogy of flu, the doctor argues that cancer just develops because the human *papilloma* virus is found on earth like other disease-causing micro-organisms. Cancer can develop naturally like any other disease or be transmitted from one person to another like the case of cervical cancer and one just discovers it when it has already developed (turns 27, 29, 31, 33, 35 and 37).

The concluding stage of the critical discussion involves the withdrawal of the standpoint of the antagonist after the protagonist successfully defends his standpoint (van Eemeren *et al*. 2014: 530). The doctor uses authority argumentation based on his experience to give hope for the patient with a directive recommending confirmatory tests to establish the level of the cervical cancer such that they can operate and remove the infection (turns 39,45,47,49, 51 and 53). Inscribed in the doctor's expression, "*koreng'ana nekerengo oborwaire bwao baikire nabo togokobwenia pi*" (depending on the level of your disease we can cure it completely) [turn 81] is his positive attitudinal assessment of the cancer screening process at the hospital (appreciation). Projected in the statements, is the positive assessment of the skilled capacity of the doctor (judgement) to remove the cancer from the patient completely. This attitudinal evaluation is echoed in "*nabo togokobara na korusia obobe bwensi tokore cance yonsi korwa asore*" (we can operate on you and remove all the infection and you will be free of cancer) [turn 49 and 51]. The presentational device reveals

the positive evaluation of his role as an honest and dependable medical professional (judgement). The doctor's ability to contribute in the process of sustaining human life also reveals his positive assessment of the value of human life (appreciation).

The final refutation force of his assertive assuring the patient not to worry or fear because she is not dying yet and that the Lord is with her (turns 41, 43 and 55). In his words, "*tobaise kwoboa nonya ngake...omonene nare amo naye*" (do not fear at all... the Lord is with you) [turn 55], the doctor makes a positive assessment of two affective feelings: courage and hope in overcoming and surviving the cancer infection. These words also indicate a positive attitudinal assessment (appreciation) of both human life and the power of God. This attitudinal assessment and appreciation from the patient contributes to some extent in the process of resolving the difference in opinion.

On the other hand, the patient as the antagonist withdraws her doubts of her survival chances expressing her appreciation to the doctor's advice. She thus contributes to the resolution of the difference in opinion with her argument from public opinion that makes anyone have the fear of death (turn 54). The positive attitudinal evaluation of the doctor's advice and medical knowledge (appreciation) in the expression, "*mbuya mono ase amaereso ayio*" (thanks for that advice) is key in the concluding argumentation. The conceding assertion that "*ondebwensi nabo akoboa amakweri*" (anyone can fear death - turn 54) reveals the patient's negative attitudinal assessment of the public opinion about fear of death (affect and appreciation). This informs the patient's fear for the cancer diagnosis while appreciating the window of hope in the doctor's prognosis which will make her a cancer survivor. Tables 6.1 and 6.2 present in summary some of the choices of presentational devicesrelative to the attitudinal evaluation in the strategic manoeuvring of the doctor and the patient.

Table 6.1 Attitudinal evaluation of doctor's choices of presentational devices when strategic manoeuvring

Presentational device(metaphor/expression)	**Affect assessment**	**Judgement assessment**	**Appreciation assessment**
"*nabo eranyarekane*" (it could be possible)	Positive mitigation of fear	Skilled (social esteem); sensitive and law-abiding (social sanction)	Positive value of human life
"chitest nchire totakeire tokore nario toraeneki" (there are tests we are required to do for that we can confirm	Positive hope	Professional (social esteem/capacity); standard (custom); Honesty (veracity); Law-abiding(propriety)	Positive value of human life
"kera omonto nabwate rituko riaye" (everyone has his day	Positive mitigation of fear	Standard (custom/normality)	Negative evaluation of human life
"*ogokwa nkobwati roreria*" (death does not have a genealogy	Positive mitigation of fear	Standard (custom/normality)	Negative evaluation of human life
"*tobaise kwoboa nonya ngake...*" (do not fear at all...)	Positive assessment of courage and hope	Standard (custom/normality)	Positive value of life
"*...omonene nare amo naye*" (the Lord is with you)	Positive assurance of hope	Standard (custom/normality)	Positive assessment of the power of God
"*korengana nekerengo oborwaire bwao baikire nabo togokobwenia pi*" (depending on the level of your disease we can cure it completely	Positive instilling of hope	Skilled(capacity); standard (custom/normality)	Positive assessment of the cancer screening process at the hospital
"*eseng'encho twachakire korora cancer chinyinge obotuki obonge mbogenderete gokorwa*" (because we have started to see different types of cancers lots of research is still going on	Positive Instilling hope	Law-abiding (propriety) Honest (vecacity) Reliable (tenacity)	Positive evaluation of the value of medical research on cancer. Positive evaluation of human life
"*tobaise kwoboa ebinto otamanyeti*" (do not fear things you do not know)	Positive Management of fear	Frank/genuine (veracity)	Positive evaluation of optimism in human life
"*omonto kaiboirwe ninki naende aganyete ase ense eye?*" (when a person is born, what else is he/she waiting for in this world	Positive Facing the reality of human life	Standard (custom/normality) Truthful (veracity)	Negative evaluation of human life
"*mbare bamenyire na ukimwi emiaka ne miaka bana gokwa*" (there are people living with	Positive assurance of hope	Truthful and frank (veracity)	Positive evaluation of hope among PLWHA

HIV & AIDS for many years who have never died			Positive evaluation of human life Positive evaluation of adherence to ARV therapy
"*nabo togokobara na korusia obobe bwensi tokore cance yonsi korwa asore*" (we can operate on you and remove all the infection and you will be free of cancer)	Positive assurance of hope	Honest and dependable(veracity) skilled/Professional (social esteem/capacity);	Positive value of life

Table 6.2 Attitudinal evaluation of the patient's choices of presentational devices when strategic manoeuvring

Presentational device(metaphor/expression)	**Affect assessment**	**Judgement assessment**	**Appreciation assessment**
"*Tobaise kongaina koranche"* (Do not lie to me please)	Positive desirous of hope	Honest/Diect (veracity) sensitive (propriety)	Positive evaluation to honest disclosure
"bono rende narorire nonya n'abachokoro iga bane gose abachokororia?" (... now have I seen at least even my own grandchildren or great grandchildren?)	Negative (fear)	Standard (custom /normality) Frank (veracity)	Positive assessment of human life /procreation/family
"*igo ngochagokwa...?"* (will I die...?)	Negative (fear)	Sensitive (propriety) Direct (veracity)	Negative assessment of human life
Ntebi amatuko ane aerire...(Tell me my days are over)	Negative (fear)	Direct (veracity) Impatient (normality)	Negative assessment of human life due to mortality
"*nkoigwa ng'oborwaire obo ngoita bore abanto*" (I hear that this disease kills people)	Negative(fear)	Honest/direct (veracity)	Negative assessment the danger of cancer on human life
"*mbobuati riogo*" (does not have a cure	Negative (fear)	Truthful (veracity) Sensitive (propriety)	Negative assessment of the danger of cancer
"*mbuya mono ase amaereso ayio*" (thanks for that advice)	Positive (gratitude)	Sensitive (propriety)	Positive assessment of the doctor's advice
"*ondebwensi nabo akoboa amakweri*" (anyone can fear death	Negative association of death with fear	Honest/franc (veracity)	Negative assessment of the public opinion about death

6.4 Communication accommodation in strategic manoeuvring in doctor-cancer patient consultations

An insight into the display of communicative accommodation in the behaviour of doctors and patients when resolving differences of opinion can demonstrate their pragma-dialectical aims. The striving to achieve the composite institutional point of the Gusii medical consultation inevitably demands the convergence and divergence in the communicative behaviour of the two parties because of the contextual complexity of the communicative activity type of the Gusii medical consultation.

6.4.1 Introduction to communication accommodation and strategic manoeuvring

Having examined the role of evaluative language appraisal devices in the choice of presentational devices when strategic manoeuvring in the argumentation reality, this section investigates other presentational dynamics of speech accommodation of the interlocutors. In examining speech or communication accommodation, the section explores the management of the rhetorical asymmetry between the intergroup aspects of the medical consultation. The interaction between the doctor and the patient in their attempts to resolve differences in opinion during the consultation unearths the gap between the traditional Gusii sociocultural belief system concerning illness and the contemporary medicine. To bridge this gap, the interlocutors are constantly engaged in "trying to speak with the other's voice" (Bonnin, 2014:141) or converge, maintaining their unique communicative social identities or simply adapt communicative behaviour that emphasises the difference between that of the other party (Street, 1991:134-135). As argued in Chapter 3, section 3.4, communication accommodation theory is grounded in psychology, communication and linguistics therefore offers the analyst theoretical principles to further understand the presentational choices made by interactants in the argumentation reality.

The intersection of communication accommodation and strategic manoeuvring in the effective resolution of differences in opinion on merits in the medical consultation is the strategic design. The extended pragma-dialectic theory of argumentation reinvigorated the model of critical discussion with the discussants' strategic designs. Every move by discussants is inherently contains the three elements of strategic manoeuvring: presentational devices, topic potential and audience demand. These elements are conceived as the strategic manoeuvring triangle in pragma-

dialectic terms. The moves made by the discussants right from the confrontation stage through to the concluding stage of the critical discussion are all richly equipped with these elements of strategic manoeuvring. This section attempts to underscore the dynamics of communicative accommodation in the choice of presentational devices by the doctor and the patient in resolving differences in opinion on merits.

6.4.2 Attunement strategies in the critical discussion

When confronted with a difference in opinion, the doctor and the patient in a shared decision-making process try to find the most effective way of reasonably resolving it amicably. An attempt to unpackaging the "process" of communication and "explicating" the doctor-patient communicative activity (Street, 1991:133-134) is necessary in appreciating the interactants' motivations for choice of presentational style and the imprints of such choices based on their intentions. The verbal communicative behaviour, which partly represents the argumentation moves of the interactants, is complemented by nonverbal cues. This section examines the role of communication of communication accommodation in resolving the difference in opinion during the medical consultation. The exploration of how the doctors and the patient manage their communicative behaviour in terms of maintaining, increasing or decreasing the social distance during the consultation complements the pragma-dialectic resolution of differences in opinion which occurs. How the doctor or patient attunes his or her message to accommodate his or her interlocutor or otherwise is dependent of the interpersonal control, approximation, discourse management, and interpretability (Dragojevic, Gasiorek & Giles, 2016:5-6). The presentational stylistic choices made in the argumentative discourse are thus pegged at these accommodation strategies.

A parallel is drawn in the relation between the strategic manoeuvring triangle and the four accommodation strategies. Whereas the centrality of the presentational devices takes precedence in the accommodation process, the accommodation strategies relate with the topic potential and the audience demand. For instance, the interpersonal control in the medical consultation sees the doctor take his professional and privileged position affecting how he relates with his audience. On the other hand, discourse management is determined by the doctor because of his leadership role of the consultation in determining which topics to handle during their interaction. As the consultation leader, the doctor will always employ interpretability to suit his message to the

audience and this is determined by the subject of discussion which may at times determine the difference in opinion. Strategic manoeuvres by either party will also determine their approximation moves in their management of both verbal and nonverbal communication moves that is to converge, maintain or diverge from each other's interlocutors.

Communication accommodation or non-accommodation in the argumentative reality is manifest immediately when a difference in opinion occurs in the medical consultation. Using the three parameters of accommodation, convergence, divergence and complementarity, this analysis examines the interplay between argumentation and accommodation. In the argumentation reality of a consultation between a doctor and a cervical cancer patient (see the (Eke)Gusii excerpt in example 4 drawn from cancer 3 consultation, appendix xxii on page 628), a difference of opinion regarding radiotherapy as a possible treatment procedure manifests itself.

(4)

[1] Doctor: *Ee na kansa ngosumbua ere ase ogopima korende konye twaigwananire togateba nochiche erinde tokore a staging. Tari boigo?*

Yes, I know cancer is quite bothersome when testing but we had agreed you will come so that we can do staging. Is that right?

[2] Patient: *Nabo.*

That is right.

[3] Doctor: *Nario toramanye gose ne'operation togokora gose togotome ogende osambwererigwe n'esitima gose onywe amariogo a chemotherapy.*

That is when we can know whether we need to do an operation, or we send you to undergo electric shockwave treatment procedure or you take the [chemotherapy] medicine.

[4] Patient: *Eh! Nsambwererigwe n'esitima nche?*

Eh! I get electric shocks, myself?

[5] Doctor: Ee.

Yes.

[6] Patient: *Yaya tagitari.*

No doctor.

[7] Doctor: *Ee.*

Yes.

[8] Patient: *Nki ndakwere n'abana bane…*

Why will I die yet my kids…

[9] Doctor: *Bare bake.*

Are so young.

[10] Patient: *Eerende.*

Of course.

[11] Doctor: *Korende eyio tokoroka ogosambwererigwa n'estima igo ekorokwa radiotherapy. Eyio nigo egokonya gokora kansa, tari mobere egosamba. Na tari ogosamba ase ogotumia omorero ng'a gose oyie. Yaya.*

But the one we refer to getting burnt by electricity is called radiotherapy. That assists to clear cancer, it does not burn the body. And not burning like using fire such that you burn. No.

[12] Patient: Mm.

Mm.

[13] Doctor: *Igo bagokobeka tu ase emachine n'emachine ende yasoigwa korwa nse ase enchera y'oroiboro egere yakora kansa eyio yatiga komentekana.*

They put you in a machine and another machine is placed at the cercical entrance so that it clears the cancer and stop it from progressing.

[14] Patient : *Ai! Tagitari, eyio yaya! Riorio bono n'eba amariogo ake ake.*

Ai! That one no, doctor! I will rather medicine in bits.

[15] Doctor: *Yaya.*

No.

[16] Patient: *Mm.*

Mm.

[17] Doctor: *Bono igo ere iga, eh? Nomanyete kera oborwaire mbore n'enchera yaye y'okorwarigwa. Tari bo?*

Now it is this way, eh? You know every disease has its own way of treatment. Is that not so?

[18] Patient: *Ee nabo.*

That is true.

[19] Doctor: *Tokonywa eriogo riegekuba korwaria malaria. Kera ekemo nkere n'enchera yaye. Tari bo?*

You cannot take medicine meant for the chest to treat malaria. Each has its own way. Isn't it?

[20] Patient: *Ee nabo.*

That is true.

In example 4 above, the confrontation stage of the critical discussion sets a stage for a resolution process. The doctor's material starting points present a convergence accommodation move which is faced with a divergence accommodation move by the patient. A strategic exploitation of the communication accommodation strategy of interpretability as a means of attempting to select the presentational devices relevant in convincing the patient in the process of shared decision-making cum resolving the difference in opinion is the doctor's best attempt. The next section explores how interpretability as a sociolinguistic strategy of accommodation can be useful in strategic manoeuvring in the medical consultation communicative activity type.

6.4.2.1 Interpretability in accommodation and strategic manoeuvring

In Chapter 3 section 3.4.2, it was stated that one of the approaches which discussion parties employ when involved in any communicative activity type to augment or minimise shared understanding is the strategic use of language. Through this approach referred to as interpretability, interlocutors make linguistic and stylistic choices in attunement to each other's level of comprehension (Gallois *et al.*, 2005). As an interactional strategy, the communication accommodation calls for the interpretive competence of discussants in attuning to each other's conversational requirements. The communication attunement through definition aiming for rhetorical and dialectical goals as a manifestation of interpretability has been exploited in cross cultural argumentative accommodation in parliamentary argumentative discoursestudies (Hoinărescu, 2018) In the doctor-patient communicative context, in the intercultural context of the institutional systems involved in the study, linterpretability is dependent upon the interactants' "perceived or expressed ability to understand" the content of the discussion in the consultation (Farzadnia & Giles, 2015: 19). The ideal model of critical discussion in the doctor-patient consultation provides the pragma-

dialectic analyst an intriguing avenue to examine how doctors and patients utilise interpretability in their strategic design when confronted with a difference in opinion. Because of their level of interaction, the doctor and patient get to perceive each other's levels of understanding, and this comes in to play during the consultation. In establishing the preferences of the patient, the doctor can employ "constructive *engagement*" to assist the patient understand and choose from available alternatives (Elwyn, Cochran & Pignone, 2017:1239). For instance, in a follow up medical consultation involving a cervical cancer patient (example 4), the doctor suggests the two options the patient may have to undergo once they establish the stage of her cervical cancer (turn 1):

> "*Ogende osambwererigwe n'esitima gose onywe amariogo a chemotherapy"* (to undergo electric shock wave treatment procedure or you take the chemotherapy medicine [turn 3]).

The patient's reaction is a trigger for a critical discussion afterwards. Using a rhetorical question "*Nsambwererigwe n'esitima nche?"* (I get electric shocks, myself?) the patient confronts the doctor's standpoint (turn 4). Right at this *confrontation stage*, communication accommodation comes to play. The doctor's treatment options available for the patient call for further clarification. The patient's presentational device posed in a rhetorical question in a rebuttal response is a divergence accommodation move. The strategic manoeuvre by the patient in this divergence communication move relies on her level of knowledge and understanding of her medical condition. The symptomatic argumentation relies on the patient's own knowledge and interpretation of the doctor's standpoint. Writing on shared decision-making with patients with the chronic condition of Alzheimer's disease (AD), Bronner (2016:1) argues that it is in the interest of the patient if they can have access to information about their medical condition and its prognosis for better planning especially when they are able to do so. The patient's strategic manoeuvre in terms of her choice of presentational devices is limited to her knowledge level about cervical cancer, its treatment and prognosis. The topic potential is equally limited to her literacy level on her medical condition. This equally applies to the capacity to package the message to suit her target audience, the doctor. For accommodation sake during the consultation between the doctor and the cancer patient, the doctor's continual assessment of interpretability levels of the patient influences his degree of convergence or divergence or complementarity. This assessment has a direct effect on the process of resolving the difference in opinion.

The *opening stage* of the ideal model of the critical discussion sees the protagonist and antagonist assume their roles in the argumentative process. In the argumentative reality of the consultation, in example 4 above, the doctor as the protagonist is committed to explaining to the patient why radiotherapy can be a viable option of treatment for cervical cancer. Through shared decision-making doctors and patients can reasonably discuss how to manage any problem during the consultation: explicit evidence-based comparisons should be carried out with clarifications on the benefits and the side effects. (Elwyn, Cochran & Pignone, 2017:1239). In the spirit of shared decision-making, the patient on the other hand adopts the role of antagonist rejecting the possibility of subjecting herself to the "electric shockwaves" (turn 4 and 6). This is the first argumentative move of the *argumentation stage*. In terms of her understanding, the patient adopts a complementarity accommodation mode when she employs an argument from causation with the refutation force against the doctor's standpoint "*nki ndakere n'abana bane*" (why will I want to de yet my kids… [turn 8]). Incidentally, as part of his convergence accommodation, the doctor strategically offers to complete the expression for the patient (turn 9): "*bare abake*" (are so young). The choice of the doctor's presentational device in this case builds on his experience with Gusii patients and understanding the concerns and anxieties of mothers with such chronic conditions. This forms part of interpretability in communication adjustment in the doctor's attempt to understand the concerns of the patient and what he needs to know further.

Exploiting authority argumentation, the doctor exploits the communication accommodation strategy of interpretability to strategically justify his standpoint to the patient. The doctor thus uses convergence by clarifying what the procedure is exactly for the patient to understand. He explains: "*...eyio tokoroka ogosambwererigwa n'estima igo ekorokwa radiotherapy. Eyio nigo egokonya gokora kansa, tari mobere egosamba. Na tari ogosamba ase ogotumia omorero…*" (the one we refer to getting an electric shock-wave is called radiotherapy. That one assists to clear cancer, it does not burn the body. And not burning like using fire [turn 11]). The strategic manoeuvre in the doctor's advice lies in the prepositional content of the words he has used. The authority in the prepositional content of the doctor's assertion in which he explains to the patient the meaning of what the electric shock wave in medical terms provides a justificatory force for his standpoint. In pragma-dialectic theory, the argument scheme of argumentation by authority is a subtype of symptomatic relation argument scheme (van Eemeren & Grootendorst, 1992: 160, Garsen, 1997: 11). The medical knowledge level of the doctor is a distinguishing sign of authority in this

argument scheme based on symptomatic relation (van Eemeren, Grootendorst & Henkemans, 2002:96-97). The intention is to critically justify the stand the doctor takes by making the patient to reasonably get to understand the interpretation of the radiotherapy expression.

The initiative by the doctor to explain to the patient what happens during the radiotherapy procedure is a strong demonstration of his convergence accommodation (turn 13). The doctor's accommodation drive in this case is interpretability. He exploits the thrust of this authority argumentation to provide justification for the acceptance of his standpoint on why the patient can opt for radiotherapy if the doctor's investigations lead to its recommendation. Of interest to this analysis is the doctor's choice of presentational device, "*Igo bagokobeka tu ase emachine n'emachine ende yasoigwa korwa nse ase enchera y'oroiboro egere yakora kansa eyio yatiga komentekana* (they put you in a machine and another machine is placed at the cervical opening so that it clears the cancer and stop it from advancing). The explanation of how exactly it is done by painting a picture of exactly how it happens is a way of appealing to the patient on the importance of the procedure by indicating the effect of minimising or curtailing the progression of the cancer.

Table 6.3 Cancer patient's choice of presentational devices in divergence accommodation in argumentation

Presentational device	**Argument scheme**
Nsambwererigwe n'esitima nche? (I get electric shocks, myself?)	symptomatic
Nki ndakwere n'abana bane… (Why will I die yet my kids…)	Causation
Tagitari, eyio yaya! Riorio bono n'eba amariogo ake ake (That one no, doctor! I will rather medicine in bits)	comparison and contrast

The antagonistic stand taken by the patient is consistent with her divergence accommodation as demonstrated in Table 6.3 above. Oncology consultations are associated with "managing possibilities of dying as well as other challenging, delicate, and highly emotional moments" mainly because of the terminal nature of the cancer medical condition (Beach, 2014: 459). The choices

the patient makes in her strategic manoeuvring to enhance the refutation force of her symptomatic and causation argumentation to defend her standpoint, which is opposite to that of the doctor's treatment options available for her treatment. However, it is these choices which bring about the underlying divergence with convergence as far as her consultation with the doctor. The doctor employs the sociolinguistic strategy of interpretability in communication accommodation to strategically manoeuvre in the critical discussion. His choice of presentational devices is intertwined with the topic potential of the treatment choice and procedures he needs to clarify to the patient, as demanded by the argumentative consultation circumstance.

Employing his authority and the ethical requirement of informed consent, the doctor exploits symptomatic argumentation (see Table 6.4 below*)* to try and defend his standpoint in the consultation. The interpretation mainly focuses on the elaboration of what radiotherapy entails and what the doctor means by the choice of the words he uses in the consultation. Beach (2014: 459) captures the emerging social order in oncology consultations where the doctors is working towards giving hope by focusing on the betterment and sustenance of patients' health and promoting good news by downplaying bad news during the consultations. In trying to make the patient gain understanding, the doctor has exploited his expert medical knowledge to make the patient appreciate the procedure of radiotherapy as a helpful treatment procedure for cervical cancer. The doctor endeavours to simultaneously attain both the objectives of effectiveness and reasonableness of the argumentative communicative exchange in inspiring hope and changing the attitude of the patient.

Table 6.4 Doctor's choice of presentational devices in convergence accommodation based on interpretability

Presentational device	**Speech act**	**Type of argument scheme**
*"ogende osambwererigwe n'esitima gose onywe amariogo a chemotherapy" (*to undergo electric shock wave treatment procedure or you take the chemotherapy treatment*)*	Assertive	Authority
"…eyio tokoroka ogosambwererigwa n'estima igo ekorokwa radiotherapy. Eyio nigo egokonya gokora kansa, tari mobere egosamba. Na tari ogosamba ase ogotumia omorero…' (the one we refer to getting an electric shock-wave is called	Assertive	Authority

radiotherapy. That assists to clear cancer, it does not burn the body. And not burning like using fire)		
"*Igo bagokobeka tu ase emachine n'emachine ende yasoigwa korwa nse ase enchera y'oroiboro egere yakora kansa eyio yatiga komentekana* (they put you in a machine and another machine is placed at the cercical opening so that it clears the cancer, and stop it from advancing)	Assertive	Authority

The presentational choices by the patient and the doctor above which reveals the convergence-divergence relationship of the doctor-patient interaction, respectively, show a likelihood of an elusive accommodation stance between the interlocutors. However, it takes "social and communication competence" to accommodate the contrasting social and cultural identities (Pitts & Harwood, 2015: 93) of the doctor and the cancer patient in the current scenario. In cases of non-accommodation because of the intergroup challenges occasioned by competing identities of interlocutors, the next communication accommodation strategy of interpersonal control comes in handy to the discussion parties.

6.4.2.2 Strategic manoeuvring and interpersonal control in communication accommodation

Accommodation in the doctor-patient consultation communicative activity occurs within the institutional setting of a doctor's consultation room. The conventionalised communicative activity of a medical consultation has its typical rules of engagement (Pilgram, 2015: 1527). Interpersonal control is deals with the way interlocutors adjust communicative behaviours to maintain their social identities founded on the relational roles, social status or cultural beliefs in a communicative encounter (Farzadnia & Giles, 2015: 25). In the doctor-patient argumentative discourse, interactants attune their communicative behaviours in their strategically manoeuvre by exploiting their social identities and the power or status that comes with them to try and accommodate each other in the shared decision-making process.

In the argumentative reality of a medical consultation, a doctor can strategically use of symptomatic argumentation building on the authority of his position as the leader of the consultation. The doctor can try to control the patient in his choice of presentational devices in an asymmetrical convergence to achieve a desired end. The interpersonal control can manifest itself when the doctor wants to assert his standpoint to facilitate the ongoing consultation discussion. For instance, in the excerpt in example 4 above drawn from the consultation between the doctor

and a cancer patient, after a series of divergence accommodation strategic moves by the patient the doctor assertively summons his status in his privileged role to give a directive to the patient (turn 17). He authoritatively tells the patient how things ought to be: "*Bono igo ere iga, eh? Nomanyete kera oborwaire mbore n'enchera yaye y'okorwarigwa."* (Now it is this way, eh? You know every disease has its own way of treatment). This argument by the doctor puts a thrust on his initial interpretability strategy of making the patient understand that he is the professional with medical training and the experience to lead in advising how every disease has its unique treatment. The patient indeed has no option but for the first time she agrees with the doctor's argument in a convergence accommodation gesture (turn 18).

Using argument from analogy, the doctor further enhances his justification of his standpoint by maintaining his convergence accommodation through interpersonal control (in the same example 4). He does this by giving an example of the patient taking the wrong medication to cure a disease it is not intended to treat "*Tokonywa eriogo riegekuba korwaria malaria. Kera ekemo nkere n'enchera yaye. Tari bo?"* (You cannot take medicine meant for the chest to treat malaria. Each has its own way. Isnt't it?) The affirmative response (turn 20) by the patient to the doctor's assertion in turn 19 above is a convergence accommodation move. This means that the analogical argument further reinforces the strategic manoeuvring by the doctor's symptomatic argumentation, justifying his standpoint further.

Employing a combination of interpretability and interpersonal control as accommodation resources, the doctor locates the patient in the macro context of the consultation situation in the hospital. The doctor's perceptual assessment of the patient's level of understanding informs his attempts to make the patient understand his linguistic choices thereby adjusting his communicative behaviour to suit the patient. The interpersonal control is in the sense of interlocutors responding to the social identities based on the roles and status of the doctor and patient and trying to converge symmetrically towards each other. For instance, in example 5 (drawn from cancer 3 consultation, appendix xxii), below, the doctor explains that the third stage of cancer (turn 1) may call for the radiotherapy procedure: "*Nero eyio y'ogosambereriga korende tari ogosamba omaete igo ngotumia eng'ana eyio erio egere toigwane. Onye tari bo nigo ekorokwa radiotherapy. Tari bo?"* (It is the one of being burnt but not in the sense of being burnt, you know I use that term so that we can understand each other. Otherwise it is called radiotherapy) [see turn 3 of the same example

below]. As a strategic manoeuvre, the doctor thus has effectively used argument from causation to justify the need for the radiotherapy procedure. In so doing, the doctor has demonstrated that through interpersonal control, an interlocutor may exploit interpretability as a joint accommodation strategy for a desired rhetorical effectiveness and reasonableness in argumentative discourse. The control in this sense is influenced by the cancer literacy demands of the patient which in effect make the doctor to exploit his training in communication skills to come to the level of the patient (audience demand) for effectiveness in his strategic manoeuvre.

(5)

[1] Doctor: *Korende onye yaikire estage ya gatato…*

But if it is at stage three…

[2] Patient: *Mm.*

Mm.

[3] Doctor: *Eyio bono nero torakore. Nero eyio y'ogosambereriga korende tari ogosamba omaete igo ngotumia eng'ana eyio erio egere toigwane. Onye tari bo nigo ekorokwa radiotherapy. Tari bo?*

That is what we can do. It is the one of being burnt but not in the sense of being burnt, you know I use that term so that we can understand each other. Otherwise it is called radiotherapy. Isn't it?

[4] Patient: *Ee nabo.*

Yes, it is.

A doctor's authority normally derives from not just the crucial role he plays in a medical consultation but also his or her status in society and in the hospital institutional setting. This social identity gives the doctor an advantage in the critical discussion process of resolving any difference in opinion which may arise. In the (Eke)Gusii excerpt from the cancer 3 consultation (appendix xxii on page 629-630), in example 6 below, the doctor exploits his social identity in the conventionalised institutional setting of the hospital to give direction and further counsel to his cervical cancer patient during the consultation. As a matter of interpersonal control, the doctor uses argument from authority to guide the patient on the procedures they ought to follow before the actual treatment (turns1, 3 and 5). The doctor has at his disposal the power to decide on the

issues to address (topic potential), he knows what the patient needs to know at this argumentation stage of the critical discussion process (audience demand) and, he makes a careful choice of words (presentational devices).

(6)

[1] Doctor: *Korende totaraika abwo ase ogoteba, eki torakore igo totakeire tokore staging. Mm.*

However, before we get to what you are saying, what we need to do now is staging. Mm.

[2] Patient: *Mm.*

Mm.

[3] Doctor: *Ritang'ani tokore staging tomanye estage ki ore. Bono oborwaire obo mbobwate amachiko aye. Onye n'estage, igo bagoteba chistage goikera inye. Tari bo?*

Let's first do staging to establish the stage you are in. Now this disease has its own rules. If it is the stage, they talk of up to stage 4. Okay?

[4] Patient: *Nabo.*

True.

[5] Doctor: *Onye kere estage entang'ani gose eyakabere eyio nigo ere abwo tu ase enchera y'oroiboro.*

If it is the first or second stage, then it is at the cervical entrance.

[6] Patient: Mm.

Mm.

[7] Doctor: *Eyio nero togokorera eoperation. Igo tokorusia rirara mori n'ecervix eyio abwo ase kansa ere*

That is the one we carry out an operation. We remove uterus and the cervix where the cancer is.

[8] Patient: Mm.

Mm.

[9] Doctor: *Ekero twayerusirie bono eyio nigo togoteba kwagwenigwe kegima. Eyio igo ekorokwa okogwena kw'emia ase emia. Ee rende?*

Once we have removed it then we say you have been healed. That is called getting healed a hundred percent. Okay?

[10] Patient: *Igo ningwenigwe?*

So, will I be healed?

[11] Doctor: *Onye kere e stage entang'ani na…*

If it is at the first stage and…

[12] Patient: *Gose eyakabere.*

Or the second stage.

[13] Doctor: *Gose eyakabere. Ee rende?*

Or the second stage. Isn't it?

[14] Patient: Mm.

Mm.

[15] Doctor: *Korende onye yachire aake yaikire e stage ya gatato gose yaikire estage ya kane, eh? Estage ya gatato enchera ende yasoire ase chinsemo chinde korende tu abwo ang'e n'ecervix. Kero kende nigo etarerete chinsemo chiamakere.*

But if it has advanced a bit to stage three or four, eh...stage three means that it has moved to other parts but around the cervix. At times it may be attached to the abdomen.

[16] Patient: Mm.

Mm.

[17] Doctor: *Yaseretire abwo. Eyio natokora eoperation.*

It has developed a nest there. That one even if we operate.

[18] Patient: *Mm.*

Mm.

[19] Doctor: *Gose estage ya kane engencho yaye yaetananire yaikire ase amaa gose omotwe ntokonyara koyegwenia. Iga rende.*

Or the fourth stage which means it has reached the lungs or the head, we cannot cure it. You see.

The presentational choices of devices by the doctor in example 6 above can be analysed as strategic manoeuvres which exploit the authority argumentation through such speech acts as directives or assertives in compliance to the institutional requirements of the medical consultation communicative activity type. An analysis of the speech acts

employed by the doctor in each of the argument schemes in the excerpt in example 6 is presented in table 4 below. Each of the presentational choices by the doctor is identified with the equivalent speech act and argument scheme.

Table 6.5 The doctor's interpersonal control idiom in strategic manoeuvring with convergence accommodation

Presentational device	Speech act	Argument scheme
"Korende totaraika abwo ase ogoteba, eki torakore igo totakeire tokore staging…" (However, before we get to what you are saying, what we need to do now is staging…)	Directive	Authority
"Ritang'ani tokore staging tomanye estage ki ore. (First, we do staging to establish the stage you are in...)	Assertive	Authority
"Bono oborwaire obo mbobwate amachiko aye. Onye n'estage, igo bagoteba chistage goikera inye..." (...Now this disease has its own rules. If it is the stage, they talk of up to stage 4...)	Assertive	Authority
"Onye kere estage entang'ani gose eyakabere eyio nigo ere abwo tu ase enchera y'oroiboro". (If it is the first or second stage, then it is at the cervical entrance)	Assertive	Authority
"Eyio nero togokorera eoperation. Igo tokorusia rirara mori n'ecervix eyio abwo ase kansa ere" (That is the one we carry out an operation. We remove uterus and the cervix where the cancer is)	Assertive	Authority

The presentational devices, which the doctor employs in the argumentation stage, affirm the asymmetry of information between the interlocutors. The strategy of interpersonal control in the medical encounter reveals an information need on the part of the patient, as demonstrated in *Table 4* above. The argumentative manoeuvres with the convergence accommodation strategy of interpersonal control by the doctor not only serves the informed consent precondition of the medical consultation but it also gives the patient chance to try and understand her medical condition and the possibilities of regaining normal health (Schulz & Rubinelli, 2015: 484). The strategic moves by the doctor are meant to fill in the information need gap which caused the misunderstanding and the difference in opinion in the first place.

The domineering symptomatic argumentation by the doctor in his justification of his standpoint provides factual medical knowledge on cervical cancer. This prototypical argumentative pattern

gives the doctor a chance to use his advantaged position in the discussion to try and win over the patient on the need to undergo the treatment procedures once the staging of her cancer condition is established (Schulz & Rubinelli, 2015: 484). The use of interpersonal control in the shared decision-making process in the excerpt presents the doctor's patient-centred approach to assist the patient understand the dynamics of her medical condition for a better decision making and resolution of the difference in opinion. The doctor's strategic manoeuvring with interpersonal control in the excerpt in example 6 above can be reinforced when used with the accommodation strategy of discourse management, discussed in the next section, to serve the information needs to the interlocutor in the shared decision-making process while resolving differences of opinion on merits.

6.4.2.3 Strategic manoeuvring and discourse management for accommodation

Supplementary to interpretability and interpersonal control is the communication accommodation strategy of discourse management. Interlocutor's conversational interests can influence the strategic argumentative moves by interactants in the process of resolving differences in opinion. Discourse management is devoted to discussants' shifting focus to topics and issues of mutual concern for adjustment purposes (Dragojevic, Gasiorek & Giles, 2016:6; Farzadnia & Giles, 2015: 19). The issues of concern worth accommodation in the discourse can be either macro-contextual or those the discussants may perceive to be of interest to each other. Discussion parties in involved in an interactive encounter constantly evaluate and respond to each other's perceived conversational needs. In the argumentative reality of the medical consultation, interlocutors are continually involved in choosing topics which demand acceptable presentational resources to suit the audience needs.

The argumentation stage of the ideal model of critical discussion gives interactants a chance to exploit every possible argumentative move to either defend their standpoint or refute one another's position and vice versa. In a resolving a difference of opinion with a cervical cancer patient, who is considering the use of herbal medicine before embarking on the use of contemporary medical staging procedures, the doctor initially accommodates her thoughts. The convergence accommodation move is a part of his strategic manoeuvring through discourse management, his elected communication adjustment strategy. The patient's preference to use herbal medicine ahead of the cervical cancer staging is informed by local cultural practice in the treatment of ailments.

The doctor and the patient both understand the place of herbal medicine in the traditional Gusii sociocultural illness belief system. Thus, the doctor's strategic move of convergence accommodation of the patient's proposal lays the ground for his later rebuttal of the standpoint in preference of contemporary medical practice.

In a dissociation move, the doctor thus adopts convergence accommodation to appreciate the patient's preference to be using herbal medicine before possibly embarking on the conventional medicine and treatment procedures. In the critical discussion process, in the excerpt in example 7 below, the patient, as protagonist, justifies her standpoint using an argument from example. Argumentation using an example is classified under argumentation based on symptomatic relation (van Eemeren, Grootendorst & Henkemans, 2002:98). As demonstrated in Chapter 3, symptomatic argument scheme is represented as follows:

Y is true of X,

because: Z is true of X,

and: Z is symptomatic of Y

The cervical cancer patient applies this general argument scheme of symptomatic relation using one example of a patient, who has used herbal medicine and recovered (turn 1 & 2, example 7 below, from the cancer 3 consultation, appendix xxvi on page 635). Subjecting the patient's argument to a critical question on her pragmatic argument reveals her inability to proof this claim in the consultation room or to generalise the single case to other cervical cancer patients. The distinguishing mark or sign in the justification argument by the patient is the assumption of the healing effect of the herbal medicine based on the information she has regarding the person who used the medicine and recovered. The argument by the patient undergoes a critical appraisal by the doctor who exploits legal resources at his disposal as a medical practitioner to respond to the argument. Worth noting is the extent to which this argument influences the doctor's counter argument which at first takes a convergence accommodation direction before resorting to divergence accommodation.

(7)

[1] Patient: *Noroche omoamate one aria nka*

You see a neighbour at home.

[2] Doctor: Mm.

Mm.

[3] Patient: *Nareo oyatumia na nigo agoteba ng'a ogwenire.*

Is there who used them, and she says that she has recovered.

[4] Doctor: *Ogwenire. Nakio nkogotebia ng'a riboti eyio nche ntimbwati timanyeti, tinkonyara asengencho chisemi mbwate bono iga…*

She has recovered. That is why I am telling you that I do not have, and I don't know that report; I cannot because the knowledge I now have…

[5] Patient: *Mm.*

Mm.

[6] Doctor: *Tingoyetumia kogosemia gokora gose mamincha*

I cannot use it to advice to do contrary.

[7] Patient: *Mm.*

Mm.

[8] Doctor: *Torochi rende? Korende ekio ndagotebie nkeria ng'a kobwatekana nainche n'obwate obosibore bwo'okonacha onye gotagete bo ko bono igo nkogosaba tu egento ekemo.*

You see? But what I will tell you is that according to me you should feel free to decide if that is what you want only that I have one request.

[9] Patient: *Mm*

Mm.

[10] Doctor: *Obe gokogenderera gocha e kiriniki onye kogotumia emete eyio. Nagotebirie emekubio ebere kegoeta oirane naende, nkogosaba tomocha gocha. Ase ogwancha kwao eh?*

You continue attending the clinic as you use the herbal medicine. I have told you after two weeks you come back again, please do not miss to. As you wish, eh*?*

[11] Patient: *Mm.*

Mm

12] Doctor: *Nario naintwe togopima twarora buna ogendererete nonya buna ogendrerete gotumia emete eyio. Kero kende omonyagetari oyio bw'emete nagotebie buna orabe gokoirana ase are akorigererie, korende bono n'ase obuya bwao.*

For us to also examine you to monitor your progress as you continue using those herbs. At times the herbalist may tell you to see him to examine you, but it is for your own good.

[13] Patient: *Mm.*

Mm.

[14] Doctor: *Mbuya bono akorigererie nainche boigo nkorigererie buna bono onye kogochia gocha buna chinsa echi gwachire, omotienyi gokoera naende oirane naende torore buna kansa eyio egendererete asengencho nkoiteka ore emetienyi, amanyinga ao nkewango ki ang'ana? Tari bo?*

It is better he examines you and I also examine you if you will come the same time as you have today, after a month you come back we see how the cancer is progressing because of the menstruation flow we see the level of your blood. Okay?

[15] Patient: *Ee nabo.*

It is true.

[16] Doctor: *Emete eyio nigo egoserwa ase amani.*

Those herbs are processed in the liver.

[17] Patient: *Mm.*

Mm.

[18] Doctor: *Torore amani ao naki emete eyio ekoyakora buna chingaki chigoeta. Oise gocha torore ng'a egento nkere gekageire koretwa n'amariogo ayio, na togosemie. Ningotebie ng'a eriogo eri riarorekanire riakorire amani ao arose mono gose riakorire kansa egenderere gose ekee, korende okwo n'ogwancha kwao.*

We check the effect of the herbs on your liver over time. If you come and we notice any side effect of that medicine, we will advise you. I will inform you any indication of the overworking of your liver or the increase or reduction of cancer, but that is your choice.

Informed consent and evidence-based medicine are institutionalised and conventionalised constraints in the practice of contemporary western medicine. In a typical case, where the traditional Gusii sociocultural illness belief system regarding illness forms a basis for interrogating contemporary western medical practice, or vice versa, the doctor and the patient reassess their argumentative engagement. This assertion is grounded on the formal guidelines applied in contemporary medical practice *vis a vis* the informal guidelines or wisdom which informs local

traditional Gusii sociocultural illness belief system about illness. Employing pragmatic argumentation, the doctor adopts a divergence accommodation position to try and refute the patient's position albeit in a very veiled sense (see example 7 above). Pragmatic argumentation is a form of causal relation argumentation whereby the argument captures the consequence of what the standpoint recommends (van Eemeren, Grootendorst & Henkemans, 2002: 101). The doctor admits to the recovery of the patient on herbal medication but because it is not scientifically proven or reported he cannot accede to the patient's claim (turn 4). The doctor further explains that the patient's unreported claim cannot form a basis for his evidenced based approach to advise her (turn 6). The doctor's pragmatic argumentation in this case reinforces his antagonistic stand and it is for this reason he advises against his use of the patient's claim as evidence of his/their shared decision-making process. In so doing, the patient has been able to influence his discourse to consider her preference informed by hearsay or her knowledge.

As a strategic manoeuvre, the doctor decides to exploit the informed consent legal requirement as the source of his authority argumentation. Thus, arguing from a professional point of view the doctor dissociates himself from having to force the patient to go contrary to her preference. In a convergence with maintenance move, the doctor gives the patient the freedom to decide on the use of herbal medicine but requests her to be attending her clinics for review of her condition (turn 8 and 10). The doctor's move accommodates the foregoing believe on the role of herbal medicine in the traditional Gusii sociocultural illness believe system but alongside the freedom to choose the doctor maintains the critical role of the clinics for the contemporary routine monitoring of her condition. In addition, the doctor elects to employ argumentation by comparison and contrast by encouraging the patient to continue visiting the clinic so that the doctor can monitor the progression of her cancer even as the herbalist also monitors it (turn 12 and 14). A critical evaluation of the doctor's argument already reveals the weakness in the patient's electing to see the herbalist who may not have equipment for screening the cervical cancer. This is also a distinguishing mark in this argumentation based on a symptomatic relation, which sees the doctor slowly pointing a weakness on the patient's standpoint. The doctor's is a strategic manoeuvre of slowly exploiting the discourse management strategy to build a case of his refutation agenda albeit in an effective way, through carefully dissociating himself with the local Gusii belief system concerning illness.

The argumentative manoeuvre in the doctor's use of the symptomatic argumentation through his experience and medical knowledge especially in his use of presentational devices is meant to challenge the patient to evaluate the decision she wants to make. The institutions of the contemporary medicine and the traditional Gusii sociocultural belief system which accord the doctor and the herbalist respectively the authority in the symptomatic argumentation presented by the doctor gives him a comparative advantage especially when it comes to screening because the hospital has machines and other experts who work with him. Compared to the herbalist in the patient's argument, the doctor demonstrates that he understands other processes associated to the cervical cancer treatment in terms of timing and screening (see turn 14 below).

> *Mbuya bono akorigererie nainche boigo nkorigererie buna bono onye kogochia gocha buna chinsa echi gwachire, omotienyi gokoera naende oirane naende torore buna kansa eyio egendererete asengencho nkoiteka ore emetienyi, amanyinga ao nkewango ki ang'ana? Tari bo?* (It is better he examines you and I also examine you if you will come the same time like you have today, after a month you come back we see how the cancer is progressing because of the menstruation flow we see the level of your blood. Okay?)

The doctor's assertion in the argument from comparison and contrast in turn 14 above strategically shows his intent to accommodate the interest of the patient. Nevertheless, exploiting his deep understanding on the human bodily functioning, the doctor goes ahead to shed light on the effect of the herbal medicine on the liver apart from the possible medicinal quality on the cervical cancer. Courtesy of discourse management, this is a convergence accommodation move, which is at the core of the doctor's strategic manoeuvring. The choice of the topic potential of the side effect of the herbal medicine on the liver (turn 16) and the role of the screening process by the doctor to monitor the effect over time (turn 18) appeals to the patient, his key audience. The doctor provides his professional advice to the patient after an informational needs assessment of the patient. He presents it through argumentation from authority owing to his professional expertise and experience.

In terms of the doctor's strategic manoeuvring resources, he further exploits the informed consent obligation to the patient to express his refutation of the patient's resolve. He does this by exploiting an argument from comparison and contrast to relate the freedom to come to hospital with the freedom to use herbal medication (see turn 1 and 3, in the excerpt in example 8 below, from the cancer 3 consultation too, appendix xxvi on page 637). By making the patient understand the freedom of choice between the herbal treatment and the contemporary medicine treatment at her

disposal, the patient feels empowered, especially with her affirmative responses (turn 4 and 6). This is a product of discourse management in convergence accommodation in the strategic manoeuvring of the doctor in the medical consultation communicative activity type.

(8)

[1] Doctor: *Tari buna omonyagetari otebire erasima oiche aiga*

Not that the doctor has said that you must come here.

[2] Patient: *Ok.*

Ok.

[3] Doctor*: Ekiagera nonya n'emete eyio onde tari okogotebia ng'a n'erasima oyatumie. Naye omonyene.*

Because even those herbs nobody tells you that you must use them. It is yourself.

[4] Patient: *Ninche naamuire.*

I have decided.

[5] Doctor: *Kwaamuire, tari bo?*

You have decided, isn't it?

[6] Patient: *Mm.*

Mm.

[7] Doctor: *Ee ko nabo bono orende eh? Asengencho abanyamete mbabwati research eisaine, tari bo?*

Okay but be careful, eh? Because herbalists do not have enough research, isn't it?

[8] Patient: *Nabo*

True.

[9] Doctor: *Nakio okonyora bakogotumia buna engurue.*

That is why they use you like a guinea pig.

[10] Patient: *Mm.*

Mm.

[11] Doctor: *Nigo batagete rituko erimo batebe nga nonya n'omong'ina oria nagwena.*

They want to say one day that even that lady got well.

[12] Patient: *Mm.*

Mm.

[13] Doctor: *Kabere nonya n'omoamate oyio ogoteba ng'a nagwena, tobwati bomaene bonde bwonsi gose ekeene nagwena.*

Secondly, even if the neighbour you talk about recovered, you do not have any proof that indeed she truly got well.

[14] Patient: *N'maene.*

It is true.

[15] Doctor: *Aye nigo kwaigwa abanto bagokwana. Tari bo?*

You just heard people say, is that not so?

[16] Patient: Nabo.

It is true.

[17] Doctor: *Na buna orabe kogocha buna bono nagotebia ochiche omotienyi koerire ntobe tokogokorera counselling. Tari bo?*

Since you will be coming as I already told you to come after a month, we shall be giving you counselling. Okay?

[18] Patient: *Ee.*

Yes.

[19] Doctor: *Tokogokorera counselling ase chingaki gete nonyore ng'a nonya n'enkoro yao yaororobire goikera bwanche togokorere staging na tokore okorwarigwa kogwenerete kobwatekana n'estage eria twanyorire. Tari bo?*

Once we counsel you for a while you will get your heart softening so that we do staging for you and give you the right treatment as per the stage we will establish. Isn't it?

[20] Patient: *Ee kobwatekana buna kwang'eresire.*

From your how you have explained to me

[21] Doctor: *Mm.*

Mm.

[22] Patient: *Tiga tu nteme.*

Let me just try.

[23] Doctor: *Mm*

Mm.

[24] Patient: *Erinde erio ng'irane. Tinkomocha tincha.*

Then I can come back. I can't miss to come back.

A strategic use of discourse management by the doctor in convincing the cervical patient on the need to do staging, enables the doctor to exploit his strategic manoeuvres to have the patient make a more beneficial decision. Using an argument from analogy, the doctor makes the patient understand the operational procedures of the traditional herbal medication in a divergence accommodation move. The doctor uses the analogy of use as guinea pigs partly because of their medical practice which could be illegal because they have not done enough research, endangers the life of the patient whom the herbalist wants to use an example to her clients (see turns 7, 9 and 11). In this argumentative move the doctor exploits the institutional precondition of evidence-based medicine to challenge the practice of the herbalist whom the patient seems to trust. The divergence accommodation refutation strategy of the doctor is also informed by the informed consent precondition of the practice of contemporary western medicine.

Using the argument from authority the doctor uses his position to further still challenge the credibility of the recovery of the patient's neighbour who is using the herbal medicine (turn 13). This divergence accommodation reproach by the doctor assists him to rebut the patient's loyalty to the Gusii traditional medicine when the doctor uses his authority to assert that through the clinical visits the counselling services and teaching will enable her to see the need for staging of her condition for determination of its treatment (turns 17 and 19).The positive response from the patient (turns 20, 22 and 24) in the argumentative discourse is indicative of the workability of the communication accommodation strategy of discourse management in strategic manoeuvring. When exploited carefully by discussion parties, discourse management provides argumentative manoeuvring communicative accommodation opportunities useful in resolving any difference of opinion with their interlocutors even in a situation with competing institutional systems as is the case with example 8 above. Having discussed the role of the different sociolinguistic strategies of communication accommodation in strategic manoeuvring in the medical consultation

communicative activity type, the next section explores the characteristic argumentative patterns used by both doctor and cancer patients in the argumentative reality.

6.5 Prototypical argumentative patterns in consultations between doctors and cancer patients

The previous section addressed the critical role communication accommodation plays in the process of strategic manoeuvring to resolve the difference of opinion on merits in the communicative activity type of the medical consultation. This section highlights some of the prototypical patterns of argumentation employed by Gusii doctors and Gusii cancer patients in the communicative activity type of a medical consultation. Having explored the various analytical operations of the argumentative reality in the Gusii doctor-patient consultation communicative activity type, as discussed in Chapter 3 under section 3.2.5, the analysis further attempts to use the identify the argumentative patterns which are prototypical of the Gusii medical consultation. An introduction to the current developments of the context-dependency of prototypical patterns of argumentation is also discussed in section 3.2.6.1 in chapter 3. The pragma-dialectical theoretical program has an overall research objective of identifying prototypical argumentative patterns based on the stringent *institutional preconditions* which govern the possible means of strategic manoeuvring the various communicative activity types in individual argumentative genres (van Eemeren, 2016: 11; van Eemeren, 2017:20). The study of the argumentation in consultations involving Gusii doctors and Gusii patients, classified under the medical genre of argumentative activity, provides empirical data for the identification of the prototypical patterns of argumentation as arising from realisation of the institutional point of the doctor-patient communicative activity type as per the institutional preconditions.

6.5.1 The institutional and sociocultural context of the Gusii doctor-patient consultation

When a difference of opinion manifests itself occurs during the consultation, the Gusii doctor and the Gusii cancer patient engage each other in an argumentative encounter which operates under the constraining requirements of both the institutional precondition of a medical consultation and the traditional Gusii sociocultural illness belief system regarding illness. The patient's preference influenced by the Gusii sociocultural belief system concerning illness shapes the doctor's strategic manoeuvring. The doctor, who has an obligation to the institutional preconditions of contemporary

western medical practice, strategically manoeuvres using argumentation patterns which accommodate the Gusii sociocultural belief system concerning illness while ensuring that the communicative activity type realises the institutional point. A pragma-dialectical account of the patterns of argumentation in the communicative activity type of the Gusii doctor-patient consultation explores the convergence of the institutional preconditions of the contemporary western medicine institution and the Gusii social cultural belief system. To understand the argumentation patterns involved in the medical consultations involving Gusii doctors and Gusii patients, an insight into the local Gusii believe system is important.

The use of different types and subtypes of argument schemes normally entrenched in the context-dependent prototypical patterns of argumentation (van Eemeren 2017:20) by Gusii doctors and Gusii patients in the medical consultation communicative activity type is directly constrained by the very formal institutional preconditions of contemporary medicine, and the informal Gusii socio-cultural believe system. Van Eemeren has emphasised the context-dependency of argumentative patterns in various domains when he argues that in determining the kind of argumentative patterns which can be typical in a certain communicative activity type, pragma-dialecticians must ascertain the institutional point resulting from the conventionalisation of the institutional constraints of the activity type (van Eemeren, 2017:23). As discussed in Chapter 2, section 2.4.2, the institutional preconditions governing the medical consultation communicative activity in the communicative genre of the medical domain function alongside other macro, meso and micro contextual realities. Whereas there is substantial research which have been carried out in the domain of medicine, a good percentage are western-based studies with minimal percentage emanating from non-western settings.

The context of the Gusii medical consultation involving the Gusii doctors attending Gusii cancer patients presents a complex situation which involves the institutional preconditioning of the argumentation process with the local cultural preferences based on the local Gusii socio cultural belief system. As discussed in Chapter 2, section 2.3.1, the acknowledgement of traditional medicine benefits the medical consultation communicative activity type because of the complementary role it plays in the medical consultation. This medical consultation communicative activity type presents scenario which has a mix of consultation and persuasion by interrogating the local beliefs relating to illness and medicine.

Research in the medical domain in both western and non-western societies has demonstrated evidence on the occurrence of a hybrid genres of communicative activity types (Wierda & Visser, 2012; Henkemans, 2016; Pan *et al.*, 2018). The common communicative activity type in studies on argumentation practices in advertisements on direct-to-consumer(DTCA) prescription drugs (Wierda & Visser, 2012; Wierda, 2015), argumentative patterns in advertisements in OTC medicine (Henkemans, 2016), and argumentation in the Chinese medical consultations (Pan *et al.*, 2018) consists a hybrid of the genres of consultation and promotion. It is important to note that the influence if the cultural preferences based on the individual ethnic groups in China and the general cultural attitudes and beliefs about healthcare among the Chinese as illuminated in Chapter 2 section 2.4.4, is the reason behind the "consultation room marketing" (Pan *et al.*, 2018: 39). The institutional point in the medical consultations in the simulations between Gusii Doctors and Gusii patients is to typically carry out communicative activity type of the doctor-patient consultation and use the ethical requirement of giving evidence-based medicine and informed consent to reason out with the patient preferences based on his or her Gusii sociocultural beliefs related to the treatment and healing of the medical condition.

6.5.2 Pragmatic argumentation in the consultation between the doctor and the cancer patient

The Gusii medical consultation involving the cancer patient, as happens in the argumentative reality of the encounters with the other patients with the chronic conditions of diabetes, demonstrates the use of pragmatic argumentation in differences of opinion linked with cultural preferences. The traditional Gusii socio-cultural illness believe system brings to the medical interview a new paradigm of local explanations and belief system of disease causation to an extent of almost subsuming the role of the medical doctor in the consultation process. While the doctor will try to use the biomedical process of professionally and scientifically investigating the cause of the medical condition, the patient is quick to drag the doctor to a socio-cultural cause where supernatural powers are responsible for the illness of the patient. Nevertheless, the doctor being a Gusii medical professional exploits his communication skills in the medical consultation to not only strategically manage the argumentative activity in cases of a dispute but also exploit the precondition of informed consent and evidence-based medicine to educate the patient in trying to resolve the dispute on merits.

Characteristically the process of trying to resolve the difference of opinion normally regarding the disease causation results in a pattern of pragmatic argumentation as the main arguments for both the patient and the doctor. The reliance of pragmatic argumentation which has a leaning towards the two institutional systems of the discussion parties exploits both the positive and negative variants of pragmatic argumentation. It is the critical questions of pragmatic argumentation which differentiate the reasonableness in the application of the overall argument scheme of causal argumentation used by the two discussion parties

As a prototype of the Gusii medical consultation, pragmatic argumentation forms the first line of defence that forms the basic argumentation pattern for both the doctor and the patient. On the one hand, the doctor finds himself attempting to use the subtype of causal argumentation to explain a how a disease like cancer is caused, and how one can professionally use a recommended treatment to produce a desired result of improving one's health (see example 9). On the other hand, some patients will try to relate their illness to some supernatural causes as already mentioned above. Pragmatic argumentation is a subtype of causal argumentation which presents a scenario in which a standpoint proposing a specific action to be carried out is defended by noting the desirability of its aftermath. Pragma-dialectically, van Eemeren (2016b:17) defines the positive variant of pragmatic argumentation as follows:

> 1 Action X will be carried out because
>
> 1.1 Action X will lead to a positive result Y, and
>
> 1.1'if action of type X [such as X] leads to a positive result type Y [such as Y], then that action should be carried out.

The negative variant of the subtype of causal argumentation which defends a negative standpoint is represented as ("Action X should not be carried out"). Taking both variants of the sub-scheme of pragmatic argumentation, van Eemeren (2016b) prefers an evaluation of argumentation which exploits the strategic manoeuvre using a set of critical questions which can be relevant to the specification of the causal argumentation argument scheme. The questions include the following though depending on the nature and complexity of the argumentation more critical questions can be anticipated:

a) Do actions of type X lead to results of type Y?
b) Is result Y really positive (i.e., desirable)/negative (i.e., undesirable)?
c) Does action X not have any major negative (i.e., undesirable)/positive (i.e., desirable) died effects?

(van Eemeren, 2016:17)

The (Eke)Gusii excerpt in example 9 below drawn from cancer 3 consultation (see appendix xxvi on page 642) between a Gusii doctor and a Gusii cervical cancer patient presents a typical case where the two variants of pragmatic argumentation are exploited in the argumentative reality of a medical consultation communicative activity type.

(9)

[1] Patient: *Omorisia nakare…*

There is a church elder…

[2] Doctor: *Mm.*

Mm.

[3] Patient: *Okare goteba ng'a n'ebaise koba oborogi*

Who tells me that it might be witchcraft.

[4] Doctor: *Ehee!*

What!

[5] Patient: *Naende agateba ng'a nabo agonsabera.*

And he said that he can pray for me.

[6] Doctor: *Mm.*

Mm.

[7] Patient: *Aye ng'aki oroche tagitari?*

What do you think, doctor?

[8] Doctor: *Ahaa omanyete buna gwantebia igoro y'emete nagania komanya mono ng'a ninki ekerenga kieyio. Aah kansa teri gocha asengencho y'oborogi.*

Ah! You know the way you told me about the herbs and I wanted to know more, what is the objective for that? Aah, cancer is not caused by witchcraft.

[9] Patient: *Mm.*

Mm.

[10] Doctor: *Noroche rende?*

You see?

[11] Patient: *Ee.*

Yes.

[12] Doctor: *Kansa n'ebwate chinchera chiaye chikoyereta na nkagerete ase e kiriniki keria kende nkwamboretie okoboria buna oko: Tagitari ninki gekogera mbwate kansa? Tagitari nche tindarara isiko, tagitari tindakora eke. Chinchera n'echinyinge chire echio obotuki bokworokia ng'a nabo chikoreta kansa.*

Cancer has its own causes and I think in the last clinic you asked this kind of question: why do I have cancer doctor? I have not slept out doctor; I have not done this doctor. There are many causes of cancer, which research has shown.

[13] Patient: *Mm.*

Mm.

[14] Doctor: *Igo bagoteba ng'onye gwachagete kororana kemobere n'abasacha kore ekegori egeke, buna bono aye ogoteba kwanywometwe kore n'emiaka ikomi n'ebere. Eh? Igo onye gwachagete gokora obonyaka kore omoke, kabere onye kwaiboire abana abange na gatato onye omogaka tararokigwa. Ase igo chisababu n'echinyinge. Borogi ritang'ani tibomanyiri ng'a ngento ki. Nimanyete aiga Gusii ase tomenyete ntobwate okwegena okwo mono ase oborogi.*

They say that if you started having sexual intercourse at a very early age, like now you say you got married at an early age of twelve years, eh? So, if you started engaging in fornication as a young person, secondly if you have given birth to too many children, and third, if your husband is not circumcised. So, there are many causes. (Witchcraft in the first place is not known what it really is. I know here in Gusii where we stay we have lots of believe in witchcraft.

[15] Patient: *Mono.*

So much.

[16] Doctor: *Korende…*

However, …

[17] Patient: *Ritang'ani omoamate oria one*

To begin with, my neighbour….

[18] Doctor: *Ehee, igo agokorigereria n'amaiso amabe*

Yes, she looks at you with bad eyes.

[19] Patient: *Amaene ntori koigwana nonya.*

Honestly, we do not get along at all.

[20] Doctor: *Bono eyio nigo eragokorekanie naboigo ekero ore n'okwegena okwo ngokorentere ebirengererio ebikorekanu naboigo ekero gwakorekanigwe ochake gotiga konywa amariogo. Naboigo ekero kaa ogochaka gotumia amariogo gose gokorerwa e operation igo okonyora kansa yachire aare mono tokorigererie togotebie mama titokonyara kogokonya. Igo eyio nigo ekogosareria chinsa ekogera onyorwe anene mono okogwenigwa na nigo orabe ase abe mono ekiagera kero kende nigo ore e stage entagani yoka. Keria oganetie n'eoperation yoka obe buya, ogende korenda abana bao. Korende bono igo ogosaria chinsa kogenda ase omobasta oyo na mambia yaye otebigwe n'omosani bwomobasta nakare Mombasa origie chibesa chiokogenda Mombasa. Rituko rinde otebigwe ooh Loliondo nekare Tanzania onache etigiti y'echiribu ikomi kogenda Loliondo. Echio n'echinsa ogosaria. Kansa eyio nigo egendererete gosuka. Noroche rende.*

Now that will confuse you and when you have that believe, it will bring you confusing thoughts to an extent of abandoning the uptake of medicine. Similarly, when you will start to use medicine or undergo an operation the cancer will have advanced a lot, and we will look at you and tell you mummy we are not able to save you. So, that only wastes your time because if you delay a lot it will be challenging to be cured because maybe you are just at stage one. You just need an operation and you will get well, you go to take care of your kids. But now you are wasting time going to that pastor, and the following day you are told that there is a friend of the pastor in Mombasa look for the fare to travel there. Then another day you are told oh there is a Loliondo in Tanzania get a ticket of ten thousand to travel to Loliondo. That is time wasting, this cancer is progressing. You see now.

[21] Patient: *Bono buna gwantebirie…*

Now that you have told me

[22] Doctor: *Mm.*

Mm.

[23] Patient: *Narorire.*

I have seen.

[24] Doctor: *Mm.*

Mm.

[25] Patient: Onkorere staging

You can now do staging for me.

[26] Doctor: *Mbuya ah! Ehee.*

Nice ah! Okay.

Applying the pragma-dialectical argumentative tools of analysis to determine how the doctor and patient resolve the difference of opinion manifest in the medical consultation simulation dialogue. In the excerpt above, the following argumentation structures can be generated.

Patient's argumentation

Patient's argumentation as protagonist

1 There is a church elder who tells me that it might be witchcraft,

1.1a He says he can pray for me and my cancer will be healed.

1.1b To begin with, we don't get along at all with my neighbour.

1.1b' There is likelihood that my neighbour must be the one bewitching me.

Figure 6.4 Cancer patient's argumentation structure

Doctor's argumentation

Doctor's refutation as antagonist

2 Witchcraft does not cause cancer

2.1a The way you told me about the herbs and I wanted to know more, what is the objective for that church elder's advice? (example)

2.1a' Praying for the witchcraft will not heal the cancer.

2.1b Cancer has its own causes. There are many causes of cancer, which research has shown.

2.1b.1a They say that if you started having sexual intercourse at a very early age, like now you say you got married at an early age of twelve years, eh? So, if you started engaging in sexual activities as a young person;

2.1b.1b If you have given birth to many children [you may risk a cervical cancer infection]

2.1b.1c If your husband is not circumcised [you may risk a cervical cancer infection]

2.1c Witchcraft in the first place is not known what it really is.

2.1c.1a I know here in Gusii where we stay we have lots of believe in witchcraft.

2.1c.1b Now that will confuse you and when you have that believe, it will bring you confusing thoughts to an extent of abandoning the uptake of medicine.

2.1c.1b.1a Similarly, when you will start to use medicine or undergo an operation the cancer will have advanced a lot, and we will look at you and tell you mummy we are not able to save you.

2.1c.1b.1b So, that only wastes your time because if you delay a lot, it will be challenging to be cured because maybe you are just at stage one. You just need an operation and you will get well, you go to take care of your kids.

2.1c.1b.1c But, now you are wasting time going to that pastor, and the following day you are told that there is a friend of the pastor in Mombasa look for the fare to travel there.

2.1c.1b.1d Then another day you are told oh there is a Loliondo in Tanzania get a ticket of ten thousand to travel to Loliondo. That is time wasting, this cancer is progressing. You see now.

Figure 6.5 Doctor's argumentation structure with pragmatic argumentation as the main argument

In the argument structure in figure 6.4, the patient exploits pragmatic argumentation as the basic argumentative pattern in a multiple difference of opinion. The patient's standpoint echoes two propositions: that the church elder thinks her problem is caused by witchcraft and that he will pray for her and she will get well. This is technically referred to as a multiple dispute or difference of opinion (van Eemeren, Grootendorst & Henkemans 2002: 9; van Eemeren & Grootendorst 1992: 17).

Applying the primary critical questions highlighted by van Eemeren (2016b) to the patient's argument which not only embraces the traditional Gusii sociocultural illness system but also the

religious believe in Christianity associated with the power to outwit witchcraft and magic (turns 1, 3 and 5). The Gusii doctor (figure 6.7 and Gusii cancer patient (figure 6.6) argumentation structures below

Patient's argumentation:

Basic pattern: pragmatic argument as the main argument

1. A church elder says that witchcraft is the cause of the cancer.

1.1a He says a religious remedial prayer X will have beneficial effect Y on the cancer patient.

1.1a' If a religious remedial prayer X will have beneficial effect of type Y on the cancer patient's health then the patient should go for the religious remedial prayer.

1.1b There is likelihood that my neighbour must be the one bewitching the patient

Figure 6.6 Basic pattern of the Gusii cancer patient's argumentation with pragmatic argument as main argument

Doctor's argumentation:

The doctor's basic pragmatic argumentative pattern

2 Remedial prayers X will not cure cancer patients because it is not caused by witchcraft.

2.1a'Accepting remedial prayers X will lead to undesirable effects Y on the cancer patient's health.

2.1a If accepting remedial prayers X will have undesirable effects Y on the cancer patient's health then the patient should not accept remedial prayers X

2.1b Cancer has its own known causes which can be treated but not through remedial prayers X

(A*rgument from expert opinion*)

2.1b.1a If one starts having sexual intercourse at an early age she risks infection of cervical cancer

2.1b.1b If one gives birth to many children may be at risk of having cervical cancer.

2.1b.1c If one's husband is not circumcised she may be at risk of cervical cancer infection

2.1c Remedial prayers X prescribed by the church elder because of witchcraft are unfounded because cancer has it known causes. (*Argument from expert opinion*)

2.1c.1a There is substantive belief in witchcraft among the (Aba)Gusii (*Argument from public opinion deriving authority from traditional Gusii sociocultural belief system*)

2.1c.1b Patient's belief in witchcraft and remedial prayers X will bring confusion on how to manage the cancer problem (*Pragmatic argument*)

2.1c.1b.1 The confusion may affect a patient's adherence to medication

2.1c.1b.1a Delay to take medication because of remedial prayers X will make the cancer to advance too fast to save the patient. (*Argument from expert opinion*)

2.1c.1b.1b Remedial prayers X will be a waste of time.

2.1c.1b.1b.1 An operation may just cure the cancer if it is detected and done in good time.

2.1c.1b.1c The likelihood to be lured by a friend about another pastor healer in a neighbouring city is high (*Argument from example*)

2.1c.1b.1d At a different time a friend convices the patient to pay so much to travel to Loliondo for some healing potion in Loliondo in Tanzania - a time-wasting venture as cancer advances. (*Argument from analogy*).

Possible extensions: support arguments to respond to critical questions emanating from pragmatic argument

Support for premise 2.1

2.1.1a To get the undesirable effect Y on the cancer patient will mean deterioration of the health of the cancer patient (*Pragmatic argument*)

And/or

2.1.1b Remedial prayers X by a church elder purporting to link cancer to supernational causes (witchcraft [W]) will only make the patient's condition worse (*Causal sociocultural belief argument*)

Or **2.1.1b** Remedial prayers will X will not medically cure a cancer patient (*Science based argument*)

Figure 6.7 Doctor's basic pragmatic argumentation pattern

6.5.3. Characterising argumentative patterns resulting from strategic manoeuvring in the medical consultation

The process of identifying argumentative patterns in the Gusii medical consultation involving the cancer patient ought to also focus the differences in opinion which have no extraneous considerations (see section 6.2.2). There are cases of prototypical patterns of argumentation employed by both the patient and the doctor in resolving the difference of opinion, which emanate from the soul of the treatment consultation process especially regarding the intricacies of the chronic illness. The argumentation structures (see *Figures 6.2* and *6.3*) for the argumentative discourse in example 2 drawn from the dialogue in the cancer 2 consultation, forms the basis of the patterns of argumentation identified in this section. Using the argumentation structures, the following Figures 6.8 and 6.9 present the basic argumentation patterns for a Gusii cancer patient and Gusii doctor, where personal preference rather than cultural preference influences the strategic manoeuvring.

Patient's strategic manoeuvring

Basic argumentative pattern: main argument is a negative version of a pragmatic argument

1 The patient does not agree to undergo treatment procedure X

1.1a Since treatment procedure X may bring about side effects Y the patient prefers a different form of treatment

1.1a' If undergoing treatment procedure X has side effects such as Y then the patient should request for a different form of treatment

1.1b There is minimal information on the whether the side effects associated with treatment procedure X are reversible.

1.1c Getting enough information on the length of medication and where the procedure will be carried out will determine if the patient accepts treatment procedure X

Possible extensions of the basic argument based on the critical questions

Support arguments for premise 1.1a

1.1a.1 Accepting treatment procedure X will have the negative effect of side effects Y such as the patient has seen on other cancer survivors. (*Pragmatic argument*)

And/or

1.1a.1 Treatment X has health benefits with undesirable side effects Y (*Pragmatic argument*)

Or **1.1a.1** If there is another treatment option with minimal side effects then the patient can go for it (*Comparison and contrast argument*)

Or **1.1a.1** Unless treatment procedure X can be undertaken alongside another treatment to minimise the side effect Y, then the patient will not accept it (pragmatic argument)

Figure 6.8 Basic argumentative pattern of a Gusii cancer patient consulting a Gusii doctor

Doctor's strategic manoeuvring

Basic pattern: Main argument is pragmatic

1. A patient suffering from cancer should accept treatment procedure X

1.1 The acceptance to undergo the treatment procedure X will bring about positive health outcome Y in the cancer patient's health.

1.1' If undergoing treatment procedure X has health benefits such as Y in cancer patients, then the patient should undergo treatment X

Possible extensions: supporting arguments answering critical questions in pragmatic argumentation

Support for premise 1.1

1.1.1a The desirable outcome Y will be possible especially because of the level of the cancer (*Pragmatic argument*)

And/or

1.1.1b Treatment procedure X can save the life of a cancer patient (*Expert opinion argument*)

Or: **1.1.1b** Treatment procedure X may have side effects but they are bearable compared to the risk of cancer (*Expert opinion argument*)

1.1.1b.1a If the patient loses hair she can get a weave.

1.1.1b.1b Ladies still trim hair and remain beautiful

B Support for bridging premise 1.1'

1.1'.1 At the level of cancer on the patient, treatment procedure X is the scientifically proven treatment option with minimal side effects (*Expert opinion argument*)

1.1'.1.1 The cancer patient needs to accept to undergo treatment procedure X so that she lives as this is the patient's personal doctor's recommendation. (*Authority argument*)

Or

1.1'.1 The treatment procedure X is carried out in medical facilities with the machines and experts where the cancer patient is referred to (*Authority argument*)

Or: **1.1'.1** The treatment procedure X clears the condition, but it differs from one patient to another, depending on how their bodies react to it. (*Expert opinion argument*)

Figure 6.9 Basic argumentation structure for a Gusii doctor in a medical consultation with a Gusii cancer patient

The exemplary illustration in section 6.2.2 for the basic argumentative structure of the doctor and the patient above presents a typical case of the sociocultural circumstance of the cancer patients in the local Gusii community. The arguments presented in the pragmatic arguments which form the main arguments for the two principal partners of the communicative activity type form a basis for critical questions which apply to all pragmatic arguments. Three questions associated with the characterisation of pragma-dialectical argument scheme of pragmatic argumentation include:

1. Do actions of type X lead to results of type Y?

2. Is result Y truly positive (i.e desirable)?

3. Does action X have any major negative (i.e., undesirable) side effects?(van Eemeren, 2016: 17)

In the support arguments for the doctor and patient, the patient's preference implied that two more critical questions are added to the list for the western contemporary medical institution for their strategic manoeuvres:

4. Are there better treatment procedures of realising result Y which do not have side effects?

5.To minimise the side effects, is it possible to carry out treatment procedure X in combination with another one?

As protagonist the doctor can employ critical question 4 and 5 to defend her prescriptive standpoint. On her part the patient can use the questions to further defend her antagonism to the doctor's standpoint based on her personal fears and treatment preferences. The fears of the patient because of the side effects of the treatment procedure of chemotherapy such as losing hair form the substance of her pragmatic argumentation. The disagreement space is managed by the doctor effectively and reasonably through concerted pragmatic and symptomatic argumentative patterns to try and have the patient withdraw her standpoint in agreement to undergo the procedure to save her life. Incidentally, even applying the critical questions normally used to interrogate pragmatic arguments, the patient's strategic manoeuvres are weakened because of the knowledge levels in terms of information on cancer prognosis and treatment procedures or even management. Nevertheless, the doctor exploits his professional scientific and medical knowledge to fill the information gap in his strategic manoeuvring. Clarifying and providing sufficient information for the patient to make an informed decision regarding her treatment is part of the institutional preconditions of the contemporary western medicine for the communicative activity type of a medical consultation.

6.6 Summary

This chapter has analysed the findings of the strategic manoeuvring of the Gusii doctor and Gusii cancer patient in a medical consultation. The analysis has presented the schematic argument structures for both the Gusii doctor and Gusii cancer patients showing their exploitation of the strategic design in aiming for rhetorical effectiveness and dialectical reasonableness in resolving their difference of opinion on merits. In appreciating the interaction between the traditional Gusii sociocultural illness belief system concerning illness and the contemporary western institutional systems, the analysis explored the role of evaluative language use and communication

accommodation in the choice of presentation devices. It has examined the pragma-dialectical process of resolving medical disputes related to the sociocultural preferences of some of the Gusii cancer patients while paying attention to the sociolinguistic strategies of communication accommodation. Finally, the investigation has established the prototypical argumentative pattern of a Gusii doctor and a Gusii cancer patient in a medical consultation communicative activity type. In the characterisation, the study has demonstrated the positive and negative versions of pragmatic argumentation and how the doctor and the patient exploit the subtype of causal argumentation in resolving their difference of opinion. The patterns reveal the main argument as being a pragmatic argument of both discussants and the supporting arguments are supplemented by either authority argumentation or other pragmatic arguments. The supporting arguments for the premises of the main pragmatic arguments present a case of responses to critical questions which are associated to pragmatic argumentation but the analysis tailors them to the sociocultural meso and macro context of the Gusii medical consultation.

CHAPTER SEVEN
CONCLUSION

7.1 Introduction

This chapter presents a summary and synthesis of the key findings in respect to the research questions that the study set to investigate. The chapter also presents the opportunities for future studies in the field of argumentation in the medial domain in non-western societies, especially in the African context which has not received attention in the *arguopolis* research programme pointing to some of the limitations of the study. It also highlights the contribution of the study in the pragma-dialectical research of argumentation and in linguistics and medical communication research, more generally.

7.2 Main Findings

In resolving differences of opinions, the strategic manoeuvres of the Gusii doctors and Gusii patients in the communicative activity type of the (Eke)Gusii medical consultation operates in a hybrid/combination of two genres of consultation and persuasion. Although persuasion is closely linked to argumentation in the conventional sense, which relates the influence of one's attitude with the means of arousing emotions, its relation to the argumentation ought to be qualified in terms of the means a speaker exploits in realising a communicative end (O'Keefe, 2012b: 31–32). The process of persuasion is an intentional communicative process with the objective of successfully influencing a discussant's mental state (O'Keefe, 2002: 5; Rubinelli & Rubinelli, 2013: 552) in medical consultation encounters. In attempting to realise the institutional point of the communicative activity type of the medical consultation, the doctor and patient are constantly entangled between the discourse genres of consultation and persuasion.

The hybrid genres of consultation and persuasion have a direct correlation with the interplay of the macro contextual exigencies of the two institutions which determine the strategic manoeuvring in the (Eke)Gusii doctor-patient consultation. The interaction between the institutions of the contemporary western medicine and the traditional Gusii sociocultural belief system concerning illness moderates the argumentative manoeuvres exhibited by the Gusii doctor and the Gusii patient who is HIV positive, diabetic or has a cancer infection. Displaying explicit and invoked

evaluative language, the doctors and patients continually exhibit linguistic and psychological convergence or divergence in their choice of presentational devices to accommodate the established and/or procedural requirements of the two institutions. The occurrence genre combination in the (Eke)Gusii medical consultation compares with the communicative activity investigated in research in the medical domain of both western and non-western societies has shown empirical evidence of a hybrid genres of communicative activity types (Wierda & Visser, 2012; Wierda, 2015; Henkemans, 2016; Pan *et al.*, 2018). Incidentally the Gusii medical consultation closely compares with the Chinese medical consultation, which demonstrates a mix of the genres of consultation and promotion[25] because of the sociocultural preferences.

Unsurprisingly, the choice of argumentation moves in the intertwined consultation and persuasion communicative activity type of the Gusii consultation presents the typical social interdependence. The choice of argumentation espouses a shared decision-making process which calls for accommodation and integration of the diverse preferences and institutional commitments (Kaldjian, 2017: 85–86) in the relationship between the Gusii doctor and the Gusii patient. This intricate pragma-dialectical process entails the Gusii doctor and the Gusii patient exploiting communication accommodation and attitudinal evaluation linguistic resources to negotiate their intersubjective standpoints with their interlocutors in the intertwined institutional discourse to achieve the composite institutional point[26].

The Gusii doctor has an obligation to conform to the professional and legal constraints of the institution of contemporary western medicine such as *informed consent*, being *patient-centred* and offering *evidence-based medicine*, in his/her strategic manoeuvring. Nevertheless, his/her knowledge and insight keep reminding him/her of the traditional Gusii sociocultural belief system concerning illness, which he needs to consider. This intrapersonal relationship replays itself in the assumptions in the patient's argumentation in some of the differences of opinion in the Gusii medical consultation simulations. In a similar manner, some of the Gusii patients seek to get their

[25] This sort of 'consultation room marketing' involves the culture of patients anticipating medical recommendation or advice on medication from the available options for patients to signal some element of doctor-patient care and sincerity (Pan *et al.*, 2018: 39)

[26] This institutional point is composed of two aims for both communicative activity types, which in this case is aiming to persuade either party based on their belief systems while at the same time aiming to carry out a medical consultation (Wierda, 2015: 32).

health concerns addressed in the medical consultation room while entrenched in the wisdom of institution of the traditional Gusii sociocultural belief system concerning illness to the extent of being sceptical of the contemporary medical procedures. The institution of traditional medicine contains a set of informal conventionalised preconditions,[27] which inform the Gusii patients' strategic manoeuvring, yet as one of the key stakeholders in the communicative activity type; they are subject to the institutional preconditions of the contemporary western medical institution in the shared decision-making process of resolving any disputes on merits.

The strategic manoeuvring of the doctors and patients in the (Eke)Gusii medical consultations is influenced by the nature of the differences of opinion. The differences of opinions can be classified in two areas: i. Those which bring the institution of contemporary western medicine, and the traditional Gusii sociocultural belief institutional system on illness into cross purposes, and as such, mixed, and ii. those which arise from the medical meso context of the illness and as such are nonmixed. In the two cases, argumentation plays an important role of effectively managing the gap between the presentation of doctor's advice and reasons for the advice and the actual effect on the patient (Rubinelli & Schulz, 2006: 357) in the foregoing macro contextual circumstances.

For the mixed differences of opinion, which result from the interlocking institutional preconditions of the contemporary western medicine system, and the traditional Gusii sociocultural belief regarding treatment of illness as an institutional system, the strategic manoeuvres of the Gusii doctor and the Gusii patient are motivated by the affiliation to these respective institutions. The macro context of the communicative activity of the Gusii medical consultation impacts on the doctors' and patients' strategic manoeuvring. The constraints deriving from the formal conventionalisation of the institution of contemporary western medicine, and informal conventionalisation of the traditional Gusii sociocultural belief concerning illness treatment as an institutional system govern the argument moves of the Gusii doctors and the Gusii patients who have been diagnosed with HIV and AIDS, diabetes or cancer. Out of necessity, the argumentative manoeuvres are determined by the mutually interdependent institutional preconditions, which arecentral in realising the institutional point. In the rhetorical and dialectical commitments of the

[27] The conventionalisation of the institutional exigencies of the traditional Gusii sociocultural belief system regarding illness contains unwritten and informal, only known to the AbaGusii as practices, which exist in the cosmology of the speech community as part of its folk wisdom. The informal conventionalisation is likened to that of the interpersonal domain where common-seeking relies on established practices (van Eemeren, 2017a: 14).

two principal arguers, agreeing on the interaction of institutional preconditions and the joint institutional point(s) they establish their starting points in the critical discussion (van Eemeren, 2017b: 23).

For the non-mixed differences of opinion, the strategic manoeuvres of the Gusii doctor and the Gusii patient in medical consultations involving HIV and AIDS, cancer and diabetes patients are influenced by the institutional preconditions of contemporary western medicine. The legal requirements of informed consent and evidence-based medicine have a direct impetus in the nonmixed differences of opinion. The use of authority argumentation, a subtype of symptomatic argumentation by the doctor forms the main argument of the doctor in his strategic manoeuvring as he/she exploits informed consent to clarify medical information relating to the process of treatment. For instance, the doctor exploits the precondition of informed consent and obligation to defend in defending his recommendation for change of the medical regime from oral administration of medicine to self-injection for a diabetic child.

Exploiting the meso, macro and discursive contextual realities of the Gusii medical consultation, the doctor employs argument from expert opinion, a subtype of symptomatic argumentation as the main argument in critically trying to have his standpoint regarding the change of medical regime accepted by the patient. Through the argument scheme of expert opinion, the doctor clarifies to the patient what the diabetic condition entails and how it affects the health of the child. As part of the support argumentation, the Gusii doctor's authority argumentation derives its thrust from the common precondition of "*teamwork*" in the team of medical professionals (diabetes counsellor, gynaecologist and the doctor himself), and the team of family members (parents, parents-in law, brothers and sisters) in the management of the chronic disease. Despite the nonmixed nature of the difference of opinion, the pragma-dialectical process of resolving this difference of opinion borrows the procedural precondition of teamwork, which formally and informally pervades both the institution of contemporary western medicine, and the traditional Gusii sociocultural belief institutional system about illness, respectively.

The Gusii doctor's strategic manoeuvring in a mixed difference of opinion regarding the possibility of supernatural causes for a doubtful case of diabetic child, exploits a dialectical route of a prototypical pragmatic argumentation structure. This is a difference of opinion in which the protagonist and antagonist adopt opposing views about a proposition (van Eemeren, Grootendorst

& Snoeck Henkemans 2002:9). The commitment of the doctor to the institution of contemporary western medicine informs his exploitation of a hybrid of sources of authority in supporting the main lines of his prototypical pragmatic argumentative pattern which arises from the process of resolving this difference of opinion. In his attempts to critically persuade the patient to accept his standpoint of carrying out biomedical tests on the child to establish the cause of the illness some of the sources of the supporting authority argumentation he employs include his medical professional training, his understanding of the traditional Gusii sociocultural belief system on illness and the belief in Christianity (see Section 5.3, Chapter 5). On the other hand, in defending her standpoint, which is grounded in the institutional system of traditional Gusii sociocultural belief on the possibility of the child's illness having supernatural causes, the patient employs symptomatic argumentation supported by argument from example. Deriving her authority mainly from the institutional system of traditional Gusii sociocultural belief, the patient withdraws her standpoint after being persuaded to believe in the possibility of managing the child's condition using contemporary western medication procedures.

The study investigates and characterises the argumentation manoeuvres in the doctor-cancer patient consultations, *for a difference of opinion, which does not relate to the interplay between the institutions* of the western contemporary medicine and the traditional Gusii sociocultural belief system regarding illness. The main arguments of both the Gusii doctor and the Gusii cancer patient exhibit pragmatic argumentation supported by symptomatic argumentation. The authority in the patient's pragmatic and symptomatic arguments emanates from the level of her knowledge of cancer. On the other hand, the doctor's pragmatic and symptomatic argumentation is a product of his/her professional expertise and medical knowledge. The structures of the doctor and patient's argumentation are presented in complex argumentation structures composed of multiple, subordinative and coordinative argumentation structures.

In their strategic manoeuvring to resolve differences of opinions, which relate to emotional responses in the medical consultation simulations with Gusii doctors, Gusii diabetics, cancer and HIV-positive patients explicitly/implicitly express arguments with attitudinal evaluative language use. The patients' choice of presentational devices shows an activation of the affect semantic domain of attitudinal evaluation exploiting a variety of expressions as demonstrated in each of the medical conditions. The emotional responses expressed in the patient's standpoints are occasioned by: i. Stigma of going for HIV testing and counselling (HTC) or disclosure of HIV-positive status,

size of the antiretroviral (ARV) drugs or hair loss and other side effects associated with chemotherapy in cancer treatment; ii. Worry and anxiety of being abandoned by a spouse or boyfriend because of disclosure of HIV status or of not getting children because of diabetes or iii. Fear of death for injecting a child with '*ebibiriri' (*evil eyes) or because of the terminal nature of the non-communicable diseases (NDCs), for self-injections especially for diabetics' patients. In their strategic manoeuvres, patients use the affect attitudinal evaluation when presenting negative version of pragmatic argumentation normally supported by symptomatic argumentation relying on their knowledge levels of the medical condition or the local traditional Gusii belief system. Through persuasion and consultation, they exploit communication accommodation to strategically manoeuvre with the patients' emotionally imbued arguments.

Similarly, doctors' strategic manoeuvres exploit symptomatic argumentation exhibiting the presentational devices inscribed with social esteem and social sanction parameters of their judgement in effectively and reasonably bridging the disagreement space. While preserving their social identity, the Gusii doctors exploit argument schemes of authority and expert opinion in their symptomatic argumentation in accordance with the institutional ethical constraint of informed consent to rhetorically and critically resolve differences of opinion on merits. The attitudinal paradigm of appreciation traverses the evaluation of the institutional systems and processes at work in the medical consultation for both the patients' and doctors' argumentation. While exhibiting convergence and divergence accomodation appropriately, the doctors and patients constantly acknowledge the positive and negative value of each other's belief systems and institutional procedures and preconditions in their strategic manoeuvres to resolve differences in opinion on merits in all the consultations involving the Gusii patients with HIV and AIDS, diabetes and cancer.

The prototypical patterns of argumentation in the Gusii doctor-Gusii patient consultations are a product of the interaction between the traditional Gusii sociocultural belief institutional system concerning illness and the contemporary western medicine institutional system. The complementary relationship between the two institutions plays a key role in the characterisation of the argumentative patterns. This is because the strategic manoeuvres of Gusii doctors and Gusii patients are a product of the conventionalisation of the two institutional systems and the mutual institutional preconditions determines how the composite institutional point is realised. With or

without the sociocultural preference in the medical consultation, the Gusii doctor and the Gusii patient employ pragmatic argumentation as their main argumentation where they defend the desirable effect of a prescriptive standpoint. The sociocultural, macro and discursive contextual circumstance of the Gusii medical consultation determines the supporting argumentation which entails responses to the critical questions of pragmatic arguments for both the doctor and the patient. The support argumentation mainly employs symptomatic or other pragmatic arguments. The primacy of pragmatic and symptomatic argumentation is now concern of argumentation study in the over the counter medicine advertisements albeit being a different communicative activity type from the medical consultation in the current study (Snoeck Henkemans 2017a, 2017b). Worth noting, however, is the composite institutional point in both argumentation in over the counter medicine advertisements and the Gusii doctor-Gusii patient medical consultation which take the hybrid communicative genres of promotion and persuasion respectively on top of the common denominator, medical consultation.

Whenever the Gusii doctor employs symptomatic argumentation as the main argument or as supporting argument, the doctor's authority is reliant on his/her medical expertise and professional and scientific knowledge but minimally borrows from his/her understanding of the traditional Gusii sociocultural belief system regarding illness. On the other hand, the Gusii patient exploits the authority of the traditional Gusii sociocultural belief system regarding illness, from prevailing public opinion or from the Christianity belief system. The findings affirm the typology of argument schemes advanced by both the standard and extended versions of the pragma-dialectical theory of argumentation which entail symptomatic, causal and argument scheme based on comparison (van Eemeren, 1992:94-102; van Eemeren & Grootendorst, 2004: 4; van Eemeren 2010: 12). The evaluative questions criteria for argument schemes proposed by van Eemeren & Grootendorst (1992: 158-168) accounts for the instances of fallacious argumentation in the use of inappropriate argument scheme or the incorrect use of an appropriate argument scheme. The fallacies in the resolution process resulting from the two-dimensional criteria relates mainly to pragmatic and authority argumentation, subtypes of causal and symptomatic argumentation respectively (Hitchcock & Wagemans 2011: 190) .in the Gusii medical consultation communicative activity type.

In the schematic representation of the prototypical argumentative patterns of the Gusii doctor and Gusii patient, complex argumentation is manifest with multiple, subordinative and coordinative argumentation structures for the three medical conditions. Nevertheless, the argumentative structure for the Gusii doctor is more complex with multiple lines of defence in grappling with the institutional constraints of informed consent, evidence-based medicine and patient-centredness with the sociocultural preferences of the Gusii patients in the shared decision-making process. Apart from characterising the prototypical argumentative patterns of both the Gusii doctor and the Gusii patient, the study of argumentation in the (Eke)Gusii medical consultation presents empirical evidence for the enhancement of the strategic design of the extended pragma-dialectical theory. By analysing the argumentative discourse in speech communities where the traditional cultural belief system regarding illness influences the strategic manoeuvring in the medical discourse such as in the African medical settings, the pragma-dialectical theoretical research ought to account for evaluative language use and communicative accommodation. To mitigate the rhetorical and critical dimensions of the interaction between the traditional Gusii sociocultural belief institutional system and the contemporary western medical institutional system, a pragma-dialectician needs to consider factors relating to communicative accommodation and attitudinal evaluation resources to effectively analyse discussants' choices of presentational devices.

7.3 Areas for further study

The study of argumentation in the Gusii medical consultation is still largely an unexplored domain in the African linguistic and cultural context. This assertion is not limited to the unilingual context of study of the medical consultation, such as the present study which focused on Gusii doctor's and Gusii patients. Argumentation study in the medical consultation in the African context is yet to explore the multilingual and interpretational meso contexts in Kenya and other countries where different doctors from different linguistic bacgrounds and cultures work in hospitals in regions with dissimilar cultures. Further macro contextual challenges of the institutional interactions in such multilingual settings especially involving local indigenous languages, say national or official languages, which might involve interpreters to the consultation room still need to be explored.

7.4 Interventions for medical practice

The study proposes the expansion of the communication skills training programs of doctors with argumentation and critical thinking skills. Interventions involving trainings on argumentation and communication skills for doctors and coaching of patients with chronic illnesses on communication of shared decision-making have produced positive outcomes in enhancing patient-centred care through improving doctor-patient communication (Epstein, Duberstein, Fenton, Fiscella, Hoerger, *et al.*, 2017: 98, Karnieli-Miller & Kroszynski, 2018; Snoeck Henkemans, Labrie, & Pilgram, 2018; Wagemans, 2018).

The enhancement of the health literacy (HL) levels of patients on chronic conditions will not only improve the healthcare of the patients but it will improve their interactions with doctors during clinical visits and other medical encounters. While appreciating and acknowledging the sociocultural diversities and power relations, implementation of health literacy (HL) programmes will not only to ensure positive uptake of healthcare services delivery but also improve both the levels of acceptance and the realisation of desired effects interventions (Tang, Health, Smith, Adler-milstein, Delbanco, *et al.*, 2016: 4; Adusei & Phillips, 2018: 47) to manage the effect of non-communicable diseases such as cancer and diabetes, on the one hand, and HIV and AIDS on the other. The local county government in conjunction with the national government can prioritise such HL or health promotional programmes to reach out to the people at the grassroots in local languages which they best understand such as EkeGusii. In what is now referred to as the democratisation of the delivery of healthcare, the study porposes the use of resources which can integrate and accommodate the linguistic and cultural diversity while establishing partnerships with local community for ownership of the health literacy campaigns (Tang *et al.*, 2016: 4).

Health literacy at the grassroot level will promote the principle of universal health coverage (UHC) because it will minimise the financial burden in the end. Consequently, the access to health information on various diseases will reduce the last minute curative measures while promoting preventive health One of the Sustainable Development Goals (SDGs) is the realisation of UHC and the realisation of the health goal propels the other SDGs targets (UNDP, 2017). UHC means access to information on safe and effective healthcare and services with minimal financial hardship (WHO, 2015: 41). The health literacy programmes will contribute to the stigma mitigation interventions especially among the PLWHA. The programmes will equally mitigate the

information gap on chronic conditions and the stigma associated with some cancers such as cervical cancer (Ngutu & Nyamongo, 2015: 795–796). Apart from enhancing argumentation skills of patients in the medical consultations these programmes are bound to improve the management of the terminal illnesses. The literacy campaigns will empower patients with important information on sustainable healthy lifestyles and when they have encounters with doctors they will be able to engage the doctors from a point of information even in whichever socio-cultural context. This way they will be able to argue out their cases appreciating the role of contemporary western medicine alongside the traciional and complementary medicine (T&CM).

The acknowledgement of the role of traditional and complementary medicine in the Gusii medical consultation in Kenya, as is the case in Africa generally where there is an increase in the use of herbal medicine due top its affordability, accessibility and effectiveness will contribute in improved healthcare of the population. The onus is on the government to provide enforceable regulatory framework and funding for promotional programs and research and development, in addition to sustained education of some of the traditional medicine practitioners (Busia, 2018: 205) and the medical students about the role of traditional and complementary medicine because of the propensity of most patients to try out the medicine alongside contemporary medicine. This will create a better understanding in the shared decision-making process in the critical discussions arising from misunderstandings between the local traditional sociocultural institutional system and that of the contemporary medicine.

The study also proposes the use of mHealth and eHealth applications even in local African languages as part of the measures of empowering patients on long-term illnesses and chronic conditions. The mHealth and eHealth field is emergent in its role in supplementing healthcare research. Use of mobile telephony, computer tablets and other computer applications can assist patients with chronic conditions enhance the management of their medical conditions. Studies have shown the potential of the Mhealth applications in improving the information sharing, education and self-management of long-term and chronic conditions especially with recommendations from the medical professionals (Oreskovic, Huang & Moon, 2015; Gabarron, Arsand, & Wynn, 2018; Grazia & Bigi, 2017; Kim & Xie, 2017; Sheon, Bolen, Callahan, Shick & Perzynski, 2017). The

growth of the mobile telephone and social media industry in Kenya[28] can be exploited to empower the patients with information on their healthcare and this will have an impact in their communicative and ergumentative engagement with their doctors in the medical consultation.

7.5 Contribution of the study

This study has contributed to the existing literature in the field of argumentation in healthcare discourse studies. Specifically, it has provided empirical insights in the application of the pragma-dialectical theory of argumentation in the analysis of the (Eke)Gusii medical consultation communicative activity type in an African public hospital, a non-western healthcare setting. Due to the intricate micro-contextual, meso-contextual, macro-contextual and discursive contextual (van Eemeren, 2010:16-19) realities of discourse in the (Eke)Gusii doctor-patient consultation, the study proposes the incorporation of the communication accommodation and appraisal resources in strategic design of the extended pragma-dialectical theory of argumentation.

This study has also contributed to the existing literature on health communication. The findings of the study can inform the Kisii Teaching and Referral Hospital (KTRH) medical researchers and practitioners on ways of strengthening the communication skills of the doctors and patients especially suffering from the HIV pandemic or the non-communicable diseases (NDCs) (cancer and diabetes). The appreciation of the local belief system regarding illness in the medical consultation will see better healthcare outcomes for the hospital and other facilities in similar healthcare settings. In line with the recognition of the traditional and complementary medicine (T&CM) by World Health Organisation (WHO) on the critical role it plays in the healthcare process in majority of the countries formally or informally, the study acknowledges the interplay of the institution of contemporary western medicine with that of the traditional Gusii sociocultural belief system regarding illness. The complementarity of the conventionalisation of the two institutions has beneficial effect in the process of strategic manoeuvring in the African medical settings because of the role of traditional and complementary medicine (T&CM) and other sociocultural beliefs associated to illness.

[28] Howard and Parks (2018:361) note the moderate to high levels of internet use in Kenya, among other countries with the potentioal to use of social media in creating a narrative for social change.

7.6 Limitations

The findings of this study are limited in terms of the source of data and may only be generalised within the case study, Kisii Teaching and Referral Hospital (KTRH) and hospitals within the larger AbaGusii community where the doctors and patients are (Eke)Gusii speakers. The use of simulations to collect the audio recorded dialogues of the doctor-patient consultations in the research design is also limiting in terms of the argumentative data one could have expected in a situational and sociocultural context of a Gusii doctor and Gusii patient who is HIV positive or infected with either of the two chronic conditions: cancer or diabetes. The training of the simulated patients (SPs) who were enacted by Gusii nurses, and the doctors in the pre-simulation interviews was also pre-emptive making the data lack the authenticity of free flowing and natural conversations in a consultation room with all the affective and social circumstantial details. This may have affected the realtime micro linguistic aspects of the medical consultation simulations which provided the corpus of data for analysis. The audio recording equally had its limitations in terms of the inability to capture the nonverbal aspects of the doctor-patient consultation which may affect the analyst's perception of some of the argumentative moves by either party in the medical consultation communicative activity type. Despite the ethical challenges, video recordings of medical consultations can be richer in exploring more details of the interpersonal linguistic and communicative behaviour which may affect the argumentation process in one way or another.

7.7 Conclusion

This study of argumentation in medical consultation simulations in (Eke)Gusii within the framework of the pragma-dialectical theory presents innovative research in argumentation theory studies in the medical domain in the African setting. Focusing on the argumentation of Gusii doctors and Gusii patients with cancer, diabetes and HIV and AIDS infections, the study has established the strategic manoeuvres of the principal participants in the medical consultation communicative activity type. The study has acknowledged the interaction between the institutions of the traditional Gusii sociocultural belief system concerning illness and the contemporary western medical system in the pragma-dialectical analysis in the process of resolving disputes in the Gusii medical consultation on merits. Employing the hybrid communication genres of persuasion and consultation, the Gusii doctors' and Gusii patients' strategic manoeuvres benefit

from communicative accommodation through evaluative language use to realise the composite institutional point without which care for the patient will be compromised due to the diversity of institutional belief systems (Charon 2006, 2009). Despite the constraining institutional preconditions for strategic manoeuvres by the two institutions, the Gusii doctor and Gusii patient resolve their differences of opinions on merits. The prototypical pattern of pragmatic argumentation and/or symptomatic argumentation supported by other pragmatic arguments and/or other symptomatic arguments characterise argumentation in the Gusii doctor-Gusii patient medical consultation communicative activity type.

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APPENDICES

Appendix i: Informed consent

UNIVERSITEIT•STELLENBOSCH•UNIVERSITY
jou kennisvennoot • your knowledge partner

STELLENBOSCH UNIVERSITY

CONSENT TO PARTICIPATE IN RESEARCH

Argumentation in doctor-patient consultations in EkeGusii: A pragma-dialectical approach

You are asked to participate in a research study conducted by *Nobert Ombati Basweti*, from the *Department of African Languages* at Stellenbosch University. The results of this research will be contributed in a PhD dissertation in African Languages. You were selected as a possible participant in this study because of your experience as a Gusii community member/medical professional in Kisii Teaching and Referral Hospital and can contribute much to this study.

1. PURPOSE OF THE STUDY

This study examines how doctors and patients effectively exploit argumentation and persuasion skills in simulated consultations in EkeGusii. It explores the use of argument styles and patterns by doctors and patients in simulated consultations in EkeGusii, a Bantu language spoken in Western Kenya, in a public hospital setting.

2. PROCEDURES

If you volunteer to participate in this study, we would ask you to do the following things:

Invitation criteria

You are invited to take part in this discussion because of your experience as a Gusii community member/medical professional in Kisii Teaching and Referral Hospital, you can contribute much to this discussion. During this discussion, however, we do not wish you to tell us your personal experiences but give us your opinion on the questions that we will pose to you, based on your personal experiences with Gusii patients and/or doctors and your experience regarding effective persuasion and communication between doctors and patient at Kisii Teaching and Referral Hospital.

Participation

If you do not wish to answer any of the questions, you may say so, and keep quiet. The entire discussions and consultations will be tape-recorded but you will not be identified by name on the tape. The research team consisting of the researcher and an assistant researcher will be present in the discussion/consultation room.

Length of time for participation

The discussions may last between 10 to 15 minutes, and the simulated consultations may also last between 15 to 20 minutes.

Location/Time of the discussions/consultations

The discussions will be held in the hospital preferably in your office while the simulated consultations will be conducted in the doctors' consultation rooms especially at lunch hour or at a time of convenience for both the doctor and the nurses.

3. POTENTIAL RISKS AND DISCOMFORTS

There is a slight risk that you may share some personal or confidential information with the research team by chance, or that you may feel uncomfortable talking about some of the topics. However, we do not wish this to happen, and you may refuse to answer any question, if you feel they are personal. If you feel that any question or concern touches on an issue you may be uncomfortable with you are free to point it out and we shall avoid such issues.

4. POTENTIAL BENEFITS TO SUBJECTS AND/OR TO SOCIETY

There will be no direct benefits to you. But your participation is likely to help in ascertaining the effective arguing and persuasion skills necessary for decision making in doctor-patient interactions in managing the long term non-communicable diseases, particularly cancer and diabetes and the HIV and AIDS pandemic. The medical practice is bound to benefit from the outcome of the study for the findings and recommendations. Patients and society, generally, could benefit from the results especially in establishing the need for probably patient literacy programs which will empower them with persuasion skills.

5. PAYMENT FOR PARTICIPATION

There is no plan to pay participants in the study, but we shall provide a token of Ksh.500 for lunch per participant after the simulated consultations between doctors and simulated patients. However, this will be in consultation with the administration of KTRH. This is because of the possibility of having the consultations during lunch breaks probably because of the busy schedule of the doctors and nurses in the simulated consultations.

6. CONFIDENTIALITY

Any information that is obtained in connection with this study and that can be identified with you will remain confidential and will be disclosed only with your permission or as required by law. Confidentiality will be maintained by means of ensuring anonymity in the data collecting and reporting of the findings. As a participant you are free to review your information at any stage in the study process or even withdraw. If information from our discussion with you is used in publication or reports, we will not refer to your identity in any way.

All data will be kept strictly confidential. We will contact you first, to book an appointment for the discussion and second, to inform you about the date and venue to share with you the findings of the study. Additionally, the information recorded is considered confidential, and no one else except the research team will have access to the tapes. Once we are through with them we will erase all the information from the audio recorders. All data will be only accessed and kept in safe custody by the principal investigator and supervisor using password safeguarded electronic format until the destruction date as per the regulations of the Research and Ethics policy of Stellenbosch University.

7. PARTICIPATION AND WITHDRAWAL

You can choose whether to be in this study or not. If you volunteer to be in this study, you may withdraw at any time without consequences of any kind. You may also refuse to answer any questions you don't want to answer and still remain in the study. The investigator may withdraw you from this research if circumstances arise which warrant doing so. Such unforeseeable termination of participation may be as a result of any conflict of interest or based on the conduct of the participant regarding the integrity of the study.

8. IDENTIFICATION OF INVESTIGATORS

If you have any questions or concerns about the research, please feel free to contact Nobert O. Basweti (20619537@sun.ac.za; +254723743927 or +27 62 679194), the principal investigator, and Prof. Marianna W. Visser (mwv@sun.ac.za; +27 21 8082106), the Supervisor.

9. RIGHTS OF RESEARCH SUBJECTS

You may withdraw your consent at any time and discontinue participation without penalty. You are not waiving any legal claims, rights or remedies because of your participation in this research study. If you have questions regarding your rights as a research subject, contact Ms Maléne Fouché [mfouche@sun.ac.za; 021 808 4622] at the Division for Research Development.

SIGNATURE OF RESEARCH SUBJECT OR LEGAL REPRESENTATIVE

The information above was described to [*me/the subject/the participant]* by [*name of relevant person]* in [*Afrikaans/English/Xhosa/other]* and [*I am/the subject is/the participant is]* in command of this language

or it was satisfactorily translated to [*me/him/her*]. [*I/the participant/the subject]* was given the opportunity to ask questions and these questions were answered to *[my/his/her]* satisfaction.

[I hereby consent voluntarily to participate in this study/I hereby consent that the subject/participant may participate in this study.] I have been given a copy of this form.

_____

Name of Subject/Participant

_____

Name of Legal Representative (if applicable)

_____ _____

Signature of Subject/Participant or Legal Representative Date

SIGNATURE OF INVESTIGATOR

I declare that I explained the information given in this document to _____ [*name of the subject/participant]* and/or [his/her] representative _____ [*name of the representative].* [He/she] was encouraged and given ample time to ask me any questions. This conversation was conducted in [**English/*EkeGusii*] and [*no translator was used/this conversation was translated into* _____ by _____].

_____ _____

Signature of Investigator Date

Appendix ii. Discussion guide for doctors

Introduction

My Name Nobert Ombati Basweti, a PhD student at Department of African Languages, Stellenbosch University, South Africa. I am currently doing a study on effective persuasion and arguing skills in doctor–patient communication in simulated consultations in EkeGusii. The purpose of the study is to understand how doctors and patients can convince each other in coming up with shared treatment decisions.

In this regard I would like to ask you a few questions regarding this. The discussion will take a few minutes. Because my study is a linguistic study focusing on EkeGusii I purposely selected Gusii doctors and Gusii nurses (as patients) for this study. That is how you have been chosen. If you agree, I would like to ask you some questions on your persuasion and arguing skills during doctor-patient consultations.

Your participation is entirely voluntary. If you do not want to be part of this discussion, you are free to say no. If you do not take part now you are still welcome to participate in our other discussions in the coming days.

Do you have any questions at the moment?

Please sign for me the consent form as a confirmation of your acceptance (*Should sign after fully explaining the full contents in the consent form*-Appendix i).

Initials of discussion leader……Date…….

Staff designation……..

Sex…….

Number of years in this position……

As trained medical professionals, you have skills on how you persuade Gusii patients and argue out your case during consultations.

1) What kind of scenarios do you face during consultations with patients (*probe for those diagnosed with Diabetes, Cancer, HIV & AIDS*); in terms of the need to persuade patients based on some preferences them may have?

2) What are the level of ignorance/knowledge of patients (*probe for those diagnosed with Diabetes, Cancer, HIV & AIDS*)?
    - ✓ What is the link between the level of ignorance/knowledge and patient's ability/inability to either present his or her case or wish/preference in terms of treatment or challenge/persuade the doctor or his position?
3) What kinds of questions do patients ask(a) Diabetes patients b) Cancer patients, c) HIV &AIDS patients) regarding either the doctor's prescribed medicine or treatment regime or advice?
4) What are the kinds of reservations/objections/doubts to treatment do patients raise? How do you go about convincing them on the more appropriate treatment for instance?
5) Do patient literacy levels have anything to do with their differences probably in opinion with doctors during consultations (*Probe for any unique questions from those diagnosed with Diabetes, Cancer, HIV & AIDS*)? How does this affect their deliberation or persuasion skills?
    - ✓ What kinds of knowledge bases do they attribute their strong positions/preferences to? (Probe for self-knowledge, from friends, views from other medical experts, advertising, formal patient literacy programs, reading from the internet, traditional customs or believes etc.)
6) What kinds of persuasion styles or how do you argue out your case as a professional in managing such differences in treatment decision making? *Probe for any unique persuasion mechanisms targeting those diagnosed with Diabetes, Cancer, HIV & AIDS.*
7) What is your overall assessment of Gusii patients in terms of persuasion during the doctor patient communication?
    - ✓ What do you think about their level of awareness of their rights even to information during consultations during their encounters with doctors?
    - ✓ What do you think about their ability to express what they think should be their preferred treatment option? Or even appreciate professional advice from doctor in efforts towards coming up with treatment decisions? (For *each probe for any unique scenarios for those diagnosed with Diabetes, Cancer, HIV & AIDS*).
8) Is there anything else you wish to add?

Appendix iii. Discussion guide for patients(nurses)

My Name Nobert Ombati Basweti, a PhD student at Department of African Languages, Stellenbosch University, South Africa. I am currently doing a study on effective persuasion and arguing skills in doctor–patient communication in simulated consultations in EkeGusii. The purpose of the study is to understand how Gusii doctors and Gusii patients are able to convince each other in coming up with shared treatment decisions.

In this regard I would like to ask you a few questions regarding this. The discussion will take a few minutes. Because my study is a linguistic study focusing on EkeGusii I purposely selected Gusii doctors and Gusii nurses (as patients) for this study. That is how you have been chosen. If you agree, I would like to ask you some questions on your persuasion and arguing skills during doctor-patient consultations.

Your participation is entirely voluntary. If you do not want to be part of this discussion, you are free to say no. If you do not take part now you are still welcome to participate in our other discussions in the coming days.

Do you have any questions at the moment?

Please sign for me the consent form as a confirmation of your acceptance (*Should sign after fully explaining the full contents in the consent form*-Appendix i).

Signature: ……Date:…….

Initials of discussion leader……Date…….

Staff designation……..

Sex…….

Number of years in this position……

As Gusii patients who have been diagnosed with Diabetes, Cancer, HIV & AIDS, you have skills on how you persuade your doctors and argue out your case during consultations. Over time because of the nature of your medical conditions you can be said to be skilled in arguing or persuasion.

1) What kind of scenarios do you face during consultations with doctors (*probe for those diagnosed with Diabetes, Cancer, HIV & AIDS*); in terms of the opinions of the doctors and the need to persuade doctors based on some preferences you may have?
2) How do you express your concerns about treatment decisions based on your level of ignorance/knowledge of patients (*probe for those diagnosed with Diabetes, Cancer, HIV & AIDS*)?
    - ✓ What is the link between ignorance/knowledge and ability/inability to either present your case or wish/preference in terms of treatment or challenge the doctor's position or advice?
3) What kinds of questions do you (a) Diabetes patient b) Cancer patient, c) HIV & AIDS patient) ask a doctor regarding either the doctor's prescribed medicine or treatment regime or advice?
4) Do you raise any reservations/objections/doubts to treatment do you raise to doctors? How do you go about it to persuade the doctor to listen to you?
5) As a patient do you think your literacy level has anything to do with your ability to deliberate with a doctor when you have a different opinion on what you think is your preferred position or treatment with doctors during consultations and subsequent persuasion (*Probe for any unique questions from those diagnosed with Diabetes, Cancer, HIV & AIDS*)?
    - ✓ What kinds of knowledge bases do you rely on for your strong positions/preferences or differences in opinion with the doctor? (Probe for self-knowledge, from friends, views from other medical experts, advertising, formal patient literacy programs, reading from the internet, traditional customs or believes etc.)
6) What kinds of persuasion styles or how do you argue out your case as a Gusii patient in managing such differences in treatment decision making? *Probe for any unique persuasion mechanisms targeting those diagnosed with Diabetes, Cancer, HIV & AIDS; resorting to religion?*
7) What is your overall assessment of Gusii doctors in terms of persuasion during the doctor patient communication?
    - ✓ Do you think about their creation of awareness on patients' rights even to information on the disease and preferred treatments decisions during consultations during their encounters with doctors?

- ✓ What do you think about their ability or willingness to persuade you on what they think should be their preferred treatment option? Or even provision of professional advice/evidence in efforts towards coming up with shared treatment decisions? (For *each probe for any unique scenarios for those diagnosed with Diabetes, Cancer, HIV & AIDS*).

8) Is there anything else you wish to add?

Appendix iv. Simulated consultation guide for the doctor

My name is Mr. Nobert Ombati Basweti. I am a student at Stellenbosch University, South Africa, at the Department of African Languages, where I am pursuing a PhD in African Languages. I am carrying out a study on *Argumentation in doctor–patient consultations in EkeGusii: A pragma-dialectical approach.* The research setting of this study is Kisii Teaching and Referral Hospital.

You (Gusii doctor) are a doctor at Kisii Teaching and Referral Hospital (KTRH). A Gusii patient who has been diagnosed with *cancer/diabetes/HIV & AIDS* has come for a consultation in your consultation room. Can you engage this patient through the process of the consultation as though it were real? Please try to bring out the experiences you have with Gusii patients who come for medication for the same medical condition or ailment during your day to day encounters with Gusii patients in this hospital. During the consultation it is not always the case that you will agree with the patient in everything. There are such points where you may disagree with the patient or the patient may not agree with your advice or prescription. This is normally so because nowadays it is possible to get some patients who have been exposed to literature and information about their medical condition or ailment and thus they come for consultations armed with their own knowledge, preferences, values or fears.

I would like to follow how you (would) professionally engage the patient ***in EkeGusii*** *and most important how you iron out these the differences of opinion with the patient which may probably arise in the process until you are able to settle on an acceptable and shared treatment decision.* I will audio record this dialogic discussion and observe to be able to capture the process of the discussion with the patient during the consultation and how the decision-making process unfolds.

Through the findings of this and similar studies, we hope that doctors and patients shall benefit in the design of future programs on effective communication skills during their interactions.

Your participation is entirely voluntary. If you do not wish to be part of this consultation, you are free to say no. If you do not take part now you are still welcome to participate in our other consultations in the coming days.

Do you have any questions at the moment?

Please sign for me the consent form as a confirmation of your acceptance (*Should sign after fully explaining the full contents in the consent form*-Appendix i).

Signature: ……Date:…….

Appendix v. Simulated consultation guide for the patient (nurse)

My name is Mr. Nobert Ombati Basweti. I am a student at Stellenbosch University, South Africa, at the Department of African Languages where I am pursuing a PhD in African Languages. I am carrying out a study on *Argumentation in doctor–patient consultations in EkeGusii: A pragma-dialectical approach.* The research setting of this study is Kisii Teaching and Referral Hospital.

You (Gusii patient) have been diagnosed with *cancer/diabetes/HIV & AIDS*. You decide to seek medical advice at Kisii Teaching and Referral Hospital. You get to hospital and you get this Gusii doctor. Can you go through the process of the consultation as though it were real? Please try to bring out the experience you have about/with Gusii patients who come for medication for the same medical condition or ailment in this hospital. During the consultation it is not always the case that you will agree with the doctor in everything he/she tells you. This could be based on your exposure to information about your medical condition or ailment or just preference, values or what you have been told by friends or other medical professionals before. There are such points where you disagree with the doctor on his/her advice or the doctor may not agree with your position based on his/her professional knowledge or experience.

I would like to follow how you present your case or engage the doctor in ***a discussion in Ekegusii*** *during the treatment decision making process until both of you resolve such difference(s) in opinion(s) and jointly settle on a treatment decision.* I will audio record this dialogic exchange and observe to be able to capture the process of the discussion with the doctor during the consultation and how the decision-making process unfolds.

Through the findings of this and similar studies, we hope that patients and doctors shall benefit in the design of future programs on effective communication skills during their interactions.

Your participation is entirely voluntary. If you do not want to be part of this consultation, you are free to say no. If you do not take part now you are still welcome to participate in our other consultations in the coming days.

Do you have any questions at the moment?

Please sign for me the consent form as a confirmation of your acceptance (*Should sign after fully explaining the full contents in the consent form*-Appendix i).

Signature: ……Date:…….

Appendix vi. Observation sheet

Date/ Time	Consultation No.	Disease	Observation remarks

Appendix vii. Communication to the Chief executive officer, KTRH

Nobert O. Basweti, 20619537-2016

Department of African Languages
University of Stellenbosch
STELLENBOSCH 7600 South Africa
Tel: +27 626769194

Email: 20619537@sun.ac.za or nobert.ombati@uonbi.ac.ke
1st February 2016

The Medical Superintendent,

Kisii Teaching and Referral Hospital

P O Box 92- 40200, KISII

Dear Sir,

RE: **Inquiry on a Proposed Study of Doctor-Patient Communication in EkeGusii: An Extended Pragma-Dialectic Approach**

This is to inquire about the possibility of working with the doctors and nurses at Kisii Teaching and Referral Hospital for my doctoral study whose proposal I am currently working on with my supervisor.

I am a Kenyan enrolled for a full time Phd program in African Languages at the University of Stellenbosch, South Africa. My registration number is 20619537-2016. I have proposed Kisii Teaching and Referral Hospital as my research site.

The proposed is a linguistic study which shall employ the argumentation theory in assessing the use of persuasion and argumentation in the consultations involving Gusii doctors and patients (to be represented by nurses in the simulation) at the hospital. Specifically, the study design may involve i) simulations of shared doctor - patient decision making about treatment, and ii) interviews with Gusii doctors and nurses about their communication with Gusii patients. The study will involve mainly Gusii speaking personnel: +/- 5 doctors and 5-10 nurses during the actual field study and/or data collection sometime in August 2016 when the proposal shall have probably been approved by the Graduate School of Arts and Social Sciences at the university.

This inquiry serves as a starting point as we conceptualise the study with my supervisor, Prof. Marianna Visser. Once the study is approved we shall follow the required procedures involved in getting clearance for the study formally.

Thanks.

Yours faithfully,

Nobert Ombati Basweti

Appendix viii. Communication from Chief executive officer, KTRH

MINISTRY OF HEALTH

Telegramme "medical" Kisii
Telephone: (058) 31310 Kisii
Email:kisiihospital@gmail.com
Web: www.kisiihospital.org.ke

CHIEF EXECUTIVE OFFICER
THE KISII TEACHING & REFERRAL HOSPITAL
P.O. BOX 92
KISII

REF: D.1/54/2016/VOL.II/11

Date: 7th March, 2016

Norbert Basweti
Department of African languages
University of Stellenbosch
STELLENBOSCH 7600
South Africa
Tel: +27626761994

RE: APPROVAL OF STUDY

This is to confirm that the Kisii Teaching & Referral Hospital has no objection to the study of "Simulated Doctor and Patient Communication: an Extended Pragma-dialetic analysis of Ekegusii."

This will be subject to necessary ERB approvals from a recognized institution.

Thank you.

THE CHIEF EXECUTIVE OFFICER
THE KISII TEACHING &
REFERRAL HOSPITAL
P. O. Box 92, KISII.

DR. E. ONDARI
CHIEF EXECUTIVE OFFICER
KISII TEACHING & REFERRAL HOSPITAL

Appendix ix. Ethical clearance (Departmental ethics committee, Stellenbosch University)

UNIVERSITEIT·STELLENBOSCH·UNIVERSITY
jou kennisvennoot • your knowledge partner

13 June, 2016

TO WHOM IT MAY CONCERN

RE: Ethical Clearance for PHD Fieldwork and Data Gathering Research for Mr. Nobert Ombati Basweti -Reg No. 20619537

I hereby confirm that the PhD(African Languages) research proposal of Mr. Basweti has been approved by the Faculty Admissions Committee. The title of the proposal is **Argumentation in doctor-patient consultations in EkeGusii: A pragma-dialectical approach.** This proposal included a detailed overview of the filedwork and data gathering that the candidate needs to conduct for his research in Kenya.

The specific ethical clearance application of the candidate has been considered by the Departmental ethical screening committee of the Department of African Languages in accordance with the ethical clearance procedures of the University of Stellenbosch, South Africa. This screening Committee approved of the candidate's ethical procedures in conducting his fieldwork and data gathering for his PhD research.

M Visser

Prof Marianna Visser
(Supervisor)

Departement Afrikatale
Privaatsak X 1, Matieland, 7602
Tel: 021 – 808 2210
Faks: 021 – 808 2171

Department of African Languages
Private Bag X1, Matieland, 7602
Tel: 021 – 808 2210
Fax: 021 – 808 2171

Appendix x. Ethical clearance (KNH-UON Ethics review committee, Kenya)

UNIVERSITY OF NAIROBI
COLLEGE OF HEALTH SCIENCES
P O BOX 19676 Code 00202
Telegrams: varsity
Tel:(254-020) 2726300 Ext 44355

KNH-UON ERC
Email: uonknh_erc@uonbi.ac.ke
Website: http://www.erc.uonbi.ac.ke
Facebook: https://www.facebook.com/uonknh.erc
Twitter: @UONKNH_ERC https://twitter.com/UONKNH_ERC

KENYATTA NATIONAL HOSPITAL
P O BOX 20723 Code 00202
Tel: 726300-9
Fax: 725272
Telegrams: MEDSUP, Nairobi

KENYATTA NATIONAL HOSPITAL APPROVED 21 NOV 2016 KNH/UoN-ERC P.O. BOX 20723-00202 NAIROBI

Ref: KNH-ERC/A/453

21st November 2016

Nobert Ombati Basweti
Student No.20619537/2016
Department of African Languages
Stellenbosch University
Private Bag XI
Matieland, 7602, South Africa

Dear Nobert

REVISED RESEARCH PROPOSAL- ARGUMENTATION IN DOCTOR-PATIENT CONSULTATIONS IN EKEGUSII: A PRAGMA-DIALECTICAL APPROACH (P475/06/2016)

This is to inform you that the KNH- UoN Ethics & Research Committee (KNH- UoN ERC) has reviewed and **approved** your above revised proposal. The approval period is from 21st November 2016- 20th November 2017.

This approval is subject to compliance with the following requirements:

a) Only approved documents (informed consents, study instruments, advertising materials etc) will be used.
b) All changes (amendments, deviations, violations etc) are submitted for review and approval by KNH-UoN ERC before implementation.
c) Death and life threatening problems and serious adverse events (SAEs) or unexpected adverse events whether related or unrelated to the study must be reported to the KNH-UoN ERC within 72 hours of notification.
d) Any changes, anticipated or otherwise that may increase the risks or affect safety or welfare of study participants and others or affect the integrity of the research must be reported to KNH- UoN ERC within 72 hours.
e) Submission of a request for renewal of approval at least 60 days prior to expiry of the approval period. (*Attach a comprehensive progress report to support the renewal*).
f) Clearance for export of biological specimens must be obtained from KNH- UoN ERC for each batch of shipment.
g) Submission of an *executive summary* report within 90 days upon completion of the study.

Protect to discover

This information will form part of the data base that will be consulted in future when processing related research studies so as to minimize chances of study duplication and/ or plagiarism.

For more details consult the KNH- UoN ERC website **http://www.erc.uonbi.ac.ke**

Yours sincerely,

Appendix xi. Fieldwork research approval (NACOSTI P/16/22737/12196)

NATIONAL COMMISSION FOR SCIENCE, TECHNOLOGY AND INNOVATION

Telephone:+254-20-2213471,
2241349,3310571,2219420
Fax:+254-20-318245,318249
Email:dg@nacosti.go.ke
Website: www.nacosti.go.ke
when replying please quote

9th Floor, Utalii House
Uhuru Highway
P.O. Box 30623-00100
NAIROBI-KENYA

Ref. No. NACOSTI/P/16/22737/12196

Date: 12th July, 2016

Nobert Ombati Basweti
Stellenbosch University
SOUTH AFRICA.

RE: RESEARCH AUTHORIZATION

Following your application for authority to carry out research on ***"Argumentation in doctor-patient consultations in Ekegusii: A pragma-dialectical approach,"*** I am pleased to inform you that you have been authorized to undertake research in **Kisii County** for the period ending **12th July, 2017.**

You are advised to report to **the County Commissioner, the County Director of Education and the County Coordinator of Health, Kisii County** before embarking on the research project.

On completion of the research, you are expected to submit **two hard copies and one soft copy in pdf** of the research report/thesis to our office.

BONIFACE WANYAMA
FOR: DIRECTOR-GENERAL/CEO

COUNTY COMMISSIONER
KISII COUNTY

Copy to:

The County Commissioner
Kisii County.

Authorized
27/7/16

The County Director of Education
Kisii County.

KISII COUNTY GOVERNMENT
COUNTY HEALTH DIRECTOR
P. O. Box 92 – 40200
KISII.

27/7/16
Noted and approved
C.E.O Dr ondari

The County Coordinator of Health
Kisii County.

Noted & Approved
27/7/2016

Appendix xii. Fieldwork research permit (NACOSTI P/16/22737/12196)

CONDITIONS

1. You must report to the County Commissioner and the County Education Officer of the area before embarking on your research. Failure to do that may lead to the cancellation of your permit
2. Government Officers will not be interviewed without prior appointment.
3. No questionnaire will be used unless it has been approved.
4. Excavation, filming and collection of biological specimens are subject to further permission from the relevant Government Ministries.
5. You are required to submit at least two(2) hard copies and one(1) soft copy of your final report.
6. The Government of Kenya reserves the right to modify the conditions of this permit including its cancellation without notice

REPUBLIC OF KENYA

National Commission for Science, Technology and Innovation

RESEARCH CLEARANCE PERMIT

Serial No. A 10094

CONDITIONS: see back page

THIS IS TO CERTIFY THAT:
MR. NOBERT OMBATI BASWETI
of STELLENBOSCH UNIVERSITY, 0-100 NAIROBI,has been permitted to conduct research in *Kisii County*
on the topic: *ARGUMENTATION IN DOCTOR-PATIENT CONSULTATIONS IN EKEGUSII: A PRAGMA-DIALECTICAL APPROACH*
for the period ending: *12th July,2017*

Permit No : NACOSTI/P/16/22737/12196
Date Of Issue : 12th July,2016
Fee Recieved :Ksh 2000

Applicant's Signature

Director General
National Commission for Science, Technology & Innovation

Appendix xiii. Approval by Department of Education, Kisii County

REPUBLIC OF KENYA

MINISTRY OF EDUCATION

Telegram: "EDUCATION"
Telephone: 058 – 30695
When replying please quote
E-mail: cdekisii@gmail.com

COUNTY DIRECTOR OF EDUCATION
KISII COUNTY
P.O. BOX 4499 - 40200
KISII.

Ref: CDE/KSI/RESECH/19

DATE: 27th July, 2016.

STATE DEPARTMENT OF BASIC EDUCATION

Nobert Ombati Basweti
Stellenbosch University
SOUTH AFRICA.

RE: RESEARCH AUTHORIZATION.

Following your research Authorization vide your letter ***Ref. NACOSTI/ P/16/22737/12196,*** to carry out research in Kisii County, this letter refers.

I am pleased to inform you that you can carry out your research in the County on "***Argumentation in doctor-patient consultations in Ekegusii: A Pragmadialectical approach in Kisii County, Kenya."*** I am pleased to inform you that you have been authorized to undertake research in Kisii County for a period ending **12th July , *2017.***

Wish you a successful research.

COUNTY DIRECTOR OF EDUCATION
KISII COUNTY
27 JUL 2016
P.O. Box 4499 - 40200, KISII.

RICHARD CHEPKAWAI
COUNTY DIRECTOR OF EDUCATION
KISII COUNTY.

Appendix xiv. Approval by Department of Research, The Kisii Teaching and Referral Hospital

MINISTRY OF HEALTH

Telegramme "medical" Kisii
Telephone: (058) 31310 Kisii
Email:kisiihospital@gmail.com
Web: www.kisiihospital.org.ke

DEPARTMENT OF RESEARCH
THE KISII TEACHING & REFERRAL HOSPITAL
P.O. BOX 92
KISII

REF. NO.

DATE: 27th July, 2016

BASWETI NOBERT OMBATI

RE: DATA COLLECTION

This is to inform you that the research department of Kisii Teaching and Referral Hospital has reviewed your proposal titled

"Argumentation in Doctor-Patient Consultation in Ekegusii: a Pragma-Dialectical Approach."

The following are our comments.

1) You have been authorized to proceed with data collection upon payment of KShs.5,000/- (five thousand shillings only).
2) Ensure confidentiality for your study subjects.
3) Ensure data collected is used for academic purposes only.
4) Ensure a copy of the final report is submitted to this office for retention and use.

DR. E.B. MASANTA -MBCHB (UoN), MPH (Epidem) (JOOUST), PGDPM (KIM) Applied Epidem & Bio (UoN).
FOR: CHIEF EXECUTIVE OFFICER
KISII TEACHING AND REFERRAL HOSPITAL

THE KISII TEACHING AND REFERRAL HOSPITAL
27 JUN
P. O. ... KISII
SIGN.....

Appendix xv. HIV and AIDS 1 Consultation

Doctor: *Zipporah karibu nyagitari.*

Welcome to hospital Zipporah.

Patient: *Asante daktari.*

Thanks doctor.

Doctor: *Mochando ki obwate rero?*

What is your problem today?

Patient: *Rero omochando ondeta aiga nori ng'a risankwa riane ndibwate omochando mokeigo*.

Today the problem which brought me here is my skin which has a slight problem.

Doctor: *Buna ndoche aiga igo ore HIV positive.*

I can see from our records you are HIV positive.

Patient: *Ee*

Yes.

Doctor: *Nkonyu ore amariogo?*

Are you taking your medicine?

Patient: *Ee*

Yes

Doctor: *Buya buna gwatebetigwe?*

The way you were advised?

Patient: *Rero mbuya nayatumia korende amatuko ande tindi koyanywa, ekero nkogenda korora omosani one tindi kogenda n'amariogo ayio.*

Today, I took my medicine but sometimes I have to skip some days without taking the medicine especially when I go to see my friend because I do not carry my medicine.

Doctor: *Komorora omosani oo engecho yaye naki?*

What do you mean by going to see your friend?

Patient: *Omosani one omomura.*

My boyfriend.

Doctor: *Oo*

Okay.

Patient: *Mm*

Mm.

Doctor: *Mogendererete kororana kemobere?*

Are you still intimate with him?

Patient: *Ee*

Yes

Doctor: *Ngotumia more ekondomu?*

Do you use the condom?

Patient: *Yaya*

No

Doctor: *N'omosani oyo oo inee, nabwa..opimirwe gose nere nigo.....*

And this friend of yours, does he have… or has he gone for the test or is he also…

Patient: *Nantebetie ng' opimirwe korende tindagenda nere gopimwa.*

He told me he went for the test, but we have not gone with him for it.

Doctor: *Mm. Igo onye timorapimwa... korende teri mang'ana... nki keragere ororane n'omomura naye kore positive? Tobwati borendi nonya mboke?*

Mm. If you haven't for gone for the test, … but never mind, …why will you see a man and you are positive? You don't care at all?

Patient: *Igo nkwoboa komotebia ng'a igo nde positive*

I fear to disclose to him that I am positive.

Doctor: *Eh, nomocharetie?*

Eh! Do you care for him?

Patient: *Ee ntagete anywome.*

Yes, I want him to marry me.

Doctor: *Bono onye komocharetie notakeire ritang'ani omanye gose nabwate oborwaire gose tabobwati erinde erio naye omorende.*

Then if you care for him you need to know if his HIV status so that you don't infect him if he is HIV negative.

Patient: *Na tagtari gakomanya nga igo nde positive tagontiga?*

And won't he abandon me if he knows my HIV status?

Doctor: *Onye kangwanchete takogotiga*

If he truly loves you he won't leave you.

Patient: *Mm*

Mm.

Doctor: *Ee ase oborwaire obwo. Onye nere kabobwate mokonyane. Obwo nabwo obwanchani.*

Yes, should he turn out to be positive then you can find a way of managing your condition together. That is what love is all about.

Doctor: *Nche ndoche ng'a tagonkonya*

I think he will not cooperate with me to assist me.

Doctor: *Igo nigo bwoboete…*

So, you fear…

Patient: *Egekogera nantebetie ng'a igo are negative.*

Because he had told me that he is negative.

Doctor: *Onye kagwanchete boronge takogotama. Igo nario oramanye gose nagwanchete boronge*.

If this gentleman really loves you, he will not reject you. In fact, this will be the best opportunity to test his love for you.

Patient: *Mm*

Emh.

Doctor: *Ee. Igo neganeirie amanye gose nabobwate gose tabobwati, na mokore, yaani okororana kemobere. N'onye mogokora goika motware ekondomu, n'eriogo ogenderere konywa buna egwenerete. N'ore naende na mochando onde rero?*

True. It is imperative to know the status of this gentleman so that you can decide on how you engage in sexual intercourse. And when you do, you must always use a condom, and you should continue to take your medicine as required. Do you have any other issue?

Patient: *Ee risankwa riane ndibwate omochando na nigo nkona kweyagia aiga ase okoboko.*

Yes, I have an issue with my skin, I keep scratching it especially on my arms.

Doctor: *Ee ndi riachagete?*

When did it start?

Patient: *Goikera bono omokubio oerire.*

It is now a week.

Doctor: *Kwarorekanire na monyagetari gose, akoe amariogo?*

Have you seen any doctor for medication?

Patient: *Yaya ndero nachire.*

Not really. That's why I came today.

Doctor: *Oo*

Okay.

Patient: *Mm*

Mm

Doctor: *Iga rende. Tiga ngopime erinde ndore kerokende gose n'eriogo rikare koreact gose kende. Amariogo ande nare orabe gokare gotumia buna ayegenka?*

Okay then. Let me check if it's the medicine which could be reacting with your skin or something. Could you be using any other medicine at home like herbal medicine?

Patient: *Ee ayegenka neyagete korende tingweneti.*

Yes, I have applied some herbs, but it hasn't healed.

Doctor: *Ninki gekogera ogotumia amariogo yegenka? Tibwegeneti ayaito?*

Why do you apply herbal medicine? You don't trust our medicine?

Patient: *Igo natebetigwe korwa nka nyatumie.*

I was advised to use them at home.

Doctor: *Mm? Nabo gwatebetigwe igo korwa nka?*

Mmh? Is that what you were advised at home?

Patient: *Ee igo makomoke antebetie ng'a namanyete eriogo rikogwenia ngachia gotumia tinagwena.*

Yeah you know my auntie assured me that she knows the cure but I haven't recovered after using it.

Doctor: *Tochieti kogwena?*

You did not recover?

Patient: *Mmh*

Mmh!

Doctor: *Bono nakio nkogotebia ng'a amariogo ayio yegenka tari maya ase engencho tarakorerwa obotuki. Buna bono ayaito akoreirwe obotuki akamanyekana erinde akaba nse y'oboteneneri. Timanyeti gose ayio ande…*

Now that is why I am telling you that those herbs that you take at home are not desirable because they are not products of scientific analysis. Like our medicine here is scientifically proven and certified and distributed formally. I don't know if those other …

Patient: *Korende abande mbareo aeire amariogo ayio naborobwo bakagwena.*

But there are some patients she has given the same herbs and they have recovered fully.

Doctor: *Ee nabo okogwena korende nkogotebia ng'a mariogo ayio tarapimwa. Nab' abaise gosaria omobere oo, akoretere emechando yende. Igo tari maya.*

It is possible someone can get healed but there is no scientific research or evidence to show that. They might harm your body and bring about other complications. They are not good.

Patient: *N'ase ki atara…atarareta emechando ase abande abanyatumiire?*

Why… and yet they haven't caused any problems to others who have used this medicine.

Doctor: *Ker' omonto igo akoreact ase enchera ao ao n'amariogo ayio, igo nabo ekonyarekana akoumise oyonde tamoumisa. Korende naki nkogotebia ng'a tarapimwa boronge na kobekwa nse y'obotenenerи buna ayaito. Igo nigo ogwenerete kwegena ayaito. Aya yegenka tari maya moono.*

People react differently to that type of medicine; It is possible to have adverse effects to one person while to others it may not. That is why I am telling you that the medicine has not been analysed scientifically and certified like our drugs. So, you need to tryst our drugs. The local herbs are not recommended as such.

Patient: *N'omochando oyo bwerinsankwa n'oborwaire obo bokoyoreta gose?*

And is this skin problem caused by the disease?

Doctor: *Ee oborwaire obo nigo bobwate emechando emenge eyemo yabo nase risankwa. Nabo borakoretere emechando gose kero kende n'eriogo toragochencherie onye erio tirikobereti buya.*

This disease exposes you to many opportunistic infections one of which has an effect on the skin. You might experience other problems, but we shall see if we can change the medicine for you if it is not reacting well with you.

Patient: *Mm*

Mm.

Doctor: *Ee.*

Yes

Patient: *Igo nse konywa amariogo buya omochando oyo noere?*

So, if I take my medicine well, will this problem clear?

Doctor: *Nakio nkogotebia... oise koyanywa buya n'onye mm kore. ntorigererie torore gose n'eriogo rigokoretera togochencherie.*

That is what I am saying … if you take your medicine as prescribed, I think … we shall see if we can change the medicine if it is the one causing this.

Patient: *Mm*

Mh

Doctor: *Ee Korende oise koyanywa buya aah obotindi bwoborwaire igo bogokeana na nigo emechando eyio yende ego…tekogotunyana.*

Yes, but if you take your medicine well, the severity of your disease will reduce, and other infections won't bother you.

Patient: *Na ndaisa konywa eriogo eri omochando bw'HIV noere? Nse korinywa buya?*

And if I take this medicine will I get cured of HIV & AIDS? If I take the medicine as required?

Doctor: *Ee korinywa buya tiko… tari… oborwaire obo nigo bore ase obogima bwao bwonsi.Tari borwaire bokogwenigwa.*

Taking this medicine does not… this disease is with you for your lifetime; it is not a curable disease.

Patient: *Bono rende nki ndanywere eriogo kera rituko kera rituko ritagwenia?*

So why should I take this medicine every other day if it cannot help me recover from this condition completely?

Doctor: *Nakio nkogotebia bono tari buna n'okogwenigwa korende ogokeania obororo naboigo komenta ekworiti y'obogima. Igo oramenye ase engaki entambe okeanie obotindi bwoborwaire naende omente ekworiti y'obogima. Totakeiri gotiga.*

That is why I am telling you that we are not trying to cure the disease but managing the pain and improving the quality of life. You can live long and be able to reduce the severity of the disease thus improving the quality of life. You are not supposed to stop.

Patient: *Nkorora abande igo bakonywa amariogo omoerio bakwa.*

Normally, I see other patients on medication end up dying.

Doctor: *Eh kera omonto nkoika are okwa. N'engaki yao egoika.*

Every human being has his last day to live. It only that your day has not reached.

Patient: *Kera omonto ore na enyamoreo??*

You mean every person infected with HIV & AIDS?

Doctor: *Nonya n'abanto bande batabwati HIV ngocha bare bakwa. N'echingaki chiao tu gochiaikire igo ogokwa korende ngoteba oise gotumia eriogo, aah obotindi bwoborwaire igo bogokeanigwa, omenye ase amatuko amange, n'ekworiti y'obogima emente. Naki ere engencho enenene otumie amariogo aya.*

Even those not infected with the virus still die. Even when your time comes you cannot stop it. But I am saying if you use the medicine you can manage the disease and you can live longer and the quality of your life will increase. It is very important for you to use the drugs.

Patient: *Omosani one onde nare ontebia ng'a ere igo agotumia amariogo aya ande korende tari konywa septrine.*

A friend told me that she uses these other drugs, but she doesn't take septrine.

Doctor: *Igo aroche akonywa amariogo a HIV korende takonywa septrine?*

She decided to take the other drugs for HIV without taking septrine?

Patient: *Mm*

Mm

Doctor: *Igo septrine eyio ogoitaa, tiga totebe, tomanyeti prophylaxis? Enchera ende kwerenda tonyora borwaire bonde bwa…*

So, the septrine you ask about is a form of prophlaxis? In other words, a preventive measure against getting another disease….

Patient: *Korende nonya nere mbuya are. Borwaire bonde tiboiyo bwamocheire.*

But she is also okay. She has not been infected by any disease.

Doctor: *Naboigo. Abande igo bakobonyora bande tibakobonyora. Igo oise konywa erio eh nabo igo rigotanga tonyora oborwaire. Gwasanekire gose nobwate koboria konde?*

It is possible. Some people may get infected while some may not. So, if you do the medicine you it may prevent infection.

Patient: *Okoboria konde noko…*

Another question is …

Doctor: *Eriogo twaigwanaire noritumie buya?*

We have agreed that you will take your medicine as required, right?

Patient: *Ninteme korinywa kera rituko. Korende bon'omosani one omomura tinkomotebia.*

I will try to take my medicine every day. However, I may not disclose to my boyfriend.

Doctor: *Bono. omosani oyio oo omomura komotebia goika ebetererie moikaranse nse mokwane onye komocharetie.*

You must sit down and talk about this with your friend if you care for him.

Patient: *Nimocharetie nakio gekogera ntatageti komotebia. Igo abaise gontiga.*

I care for him that is why I don't want to disclose my status to him because I do not want to lose him.

Doctor: *Bono onye tabobwati, erio omanye komwambokeria obwo n'obwanchani bori?*

If it happens that you have infected him will you call it love?

Patient: *Ko bono tintageti komotiga.*

But I don't want to leave him.

Doctor: *Nakio nkogotebia ng'a tebeterereti omotige, korende etakeire amanye nere gose nabobwate erio mokonyane.*

You do not have to leave him, but it is important that he knows his HIV status then you can know how to take care for each other.

Patient: *Gakomanya rende tagontiga?*

I fear if he knows he will abandon me.

Doctor: *Erinde agotige, aise kogotiga engencho yaye tagwancheti.*

Leave you … If he decides to abandon you then he does not love you.

Patient: *Korende nche nimwanchete.*

But I personally love him.

Doctor: *Toko… onye… teri mang'ana, ng'aki oranche omonto otagwancheti? Mbaiyo abande abagwanchete?*

Can't you… That is okay…. How can you love someone who does not love you? You do not other lovers?

Patient: *Onde nare bori orang'anche kimbwate HIV?*

Is there anyone who will love me with my HIV positive status?

Doctor: *Ee bono. Kore omosae n'omonyakieni. Bwanchani tibori buna mororane kemobere. Obwanchani n'ebint' ebinge. Onye kagocharetie takogotiga. Negwenerete omanye gose nabobwate gose tabobwati nere boigo.*

Yes. You are young and beautiful. Love does not mean that you must have to be intimate. Love is greater than that. If your boyfriend cares for you he will remain with you. You need to know his HIV status just like he needs to know too.

Patient: *Bono tagtari amariogo aya namanene. Mariogo ande taiyo oranchecherie ayio arabe amake gose ombete esindani?*

The tablets are really big. You don't have smaller ones to substitute with these or you even give me an injection?

Doctor: *Amaene amariogo ayio okoboria nareo korende igo are ayerigori rinene.*

It is true we have the medicine you ask for, but they are very expensive.

Patient: *Mm*

Mm

Doctor: *Korende n' omanyete buna nagotebia n'oborwaire yaani borabe naye ase obogima bwonsi.*

But as I told you this is a lifelong medical condition you know.

Patient: *Mm*

Mm

Doctor: *Igo goika oyanywe kera rituko*

So, you must take the medicine daily.

Patient: *Mh*

Mh

Doctor: *Naende noganie eriogo kera rituko naboigo asengencho kobwatekana n'okonyara kwaino, ndoche yaani igo erababere obokong'u kogenderera korigora. Gotwara chibesa buna echio kera rituko buna bono echiokobetwa esindani.*

Since you will need to take the medicine each other day, the cost will be too high for your family. For instance, it will be very expensive for you to pay for a daily injection for the rest of your life.

Patient: *Mm*

Mm

Doctor: *Igo mbuya onywe ayio agokonye. Oyaikamerere onye kibwecharetie na onye notagete komenya ase engaki entambe eh yaani otumie. Omanyete tari ng'a nigo akare amaya koyamera. Chiria chinde chinene n'echindoro korende ekomererie.*

So, it is better to take that medicine for your dear life. You need to take the drugs if you are to live for long even if it's challenging to swallow them. I know the bigger ones are a bit bitter, but you need to persevere.

Patient: *Tokonyara kombeta nonya ndimo ase omokubio?*

Is it not possible to even have at least one injection in a week?

Doctor: *Nabo yaani nabo ekonyarekana korende gokobetwa ayio, Engencho yaye ne.yaani ona gotongwa rioka rioka… nechio n'echibesa chinyinge,*

It can be done but what this will mean is that you will be having injections continuously… and that is a lot of money.

Patient: *Mm*

Mm

Doctor: *N'erigori rinene.*

And the cost will be high.

Patient: *Mm*

Mm

Doctor: *Eyio oroche erabe egurube ase inwe* .

This will be a heavy burden to you.

Patient: *Mm*

Mm

Doctor: *Na nigo erabe yaani igo erarabokie enka yaino ase ensemo y'echibesa.*

It will strain your family's finances.

Patient: *Mm*

Mm

Doctor: *Igo mbuya aya iga twakoeire.*

So, these drugs we have given you are better.

Patient: *Mm*

Mm

Doctor: *Egekogera aya iga mbora igo okonyora ng'a nigo ogochia koyaira tu korwa aria bosa.*

Because these drugs are given for free.

Patient: *Ee*

Yes

Doctor: *Igo bagokorikera tu. Torochi mbosa?*

They just write for you. You see they are free?

Patient: *Mm*

Mm

Doctor: *Ee igo mbuya ogenderere naya kobua aria yechibesa chinyinge.*

So, continue with these drugs instead of those expensive ones.

Patient: *Mm*

Mm

Doctor: *Ee*

Yes

Patient: *Igo mbuya*

That's good.

Doctor: Igo twaigwananire buna ah nonywe eriogo

So, we have agreed you will take your drugs.

Patient: Mm.

Mh.

Doctor: *Buya.*

Good.

Patient: *Ee.*

Yes.

Doctor: *Aa n'omosani oo omomura twaigwananire no oteme origie enchera yo'komotebia buna bwemanyete. Naboigo mochiche naende moche mopimwe mwensi.*

Eh… and your boyfriend, we have agreed you will try to convince him so that you can come for a HIV test together.

Patient: *Onye togocha gopimwa nere tomotebia ng'a ninde positive. Igo togocha gopimwa buna, nyekore ng'a nche timanyeti gose nimbobwate.*

Please don't don't reveal my status to him. We shall come for the VCT then I pretend that I don't know my status.

Doctor: *Ee mogocha engaki eyio nario orarore. Tobakwanere mwensi.*

Yes, we shall see when you will come. We shall counsel both of you.

Patient: *Mm*

Mm

Doctor: *Ee naye buna tomanyete igoro yao ntorigererie eyaye eri' egere tomanye buna tora toragenderere gochia bosio kobakonya. Naki esukuru?*

Of course, now that we know your status we shall check his then we can see how to progress in assisting you. Otherwise, how is school?

Patient: *Esukuru mbuya ere n'amasomo. Ningendererete kobeka omokia.*

School is good. I am working hard in my studies.

Doctor: *Borwaire obo tibori kogosumbua ebirengererio gose?*

This disease is not bothering you at all?

Patient: *Yaya*

No.

Doctor: *Na nore, yaani omwegenwa ase omosani oyo oo oyomo omomura?*

And are you faithful to your boyfriend?

Patient: *Ee*

Yes.

Doctor: *Gose n'obokabara boria bwesukuru obwate?*

Or do you have the mischief of school life?

Patient: *Yaya nere bweka tu.*

No, he is the only one.

Doctor: *Mbora nomanyete teri buya gokora obokabara obwo erio bwambokerie abande.*

I hope you know that you should avoid any mischief so that you don't infect other people.

Patient: *Ee*.

Yes.

Doctor: *Igo mbuya ore?*

So, you are okay?

Patient: *Ee*

Yes

Doctor: *Tobwati mechando ase amasomo?*

You don't any problem related to your studies?

Patient: *Yaya tindi na mochando ase amasomo.*

No, I do not have any academic issue.

Doctor: *Nobwate mochando onde oyio oraganie nkokonye?*

Do you have any problem still which you will want me to solve?

Patient: *Yaya*

No, I don't.

Doctor: *Igo gwaisanekire?*

So, you are satisfied.

Patient: *Ee*

Yes

Doctor: *Naboigo*

That is it.

Patient: *Mbuya mono tagitari*

Thanks doctor.

Appendix xvi. HIV and AIDS 2 consultation

Doctor: *Mbuy'ore baba?*

How are you mummy?

Patient: *Mbuya.*

Fine.

Doctor: *Karibu.*

Welcome.

Patient: *Asanti.*

Thanks.

Doctor: *Ah aye nigo okongokia mono kegima.*

Ah, you make me very happy.

Patient: *Mm.*

Mm.

Doctor: *Buna gwachaka gocha ekiriniki tikwana komocha.*

Since you started coming to the clinic you have never missed.

Patient: Ee.

Yes.

Doctor: *Bono ntagete ritang'ani onye ndiria nare konyara nkoe ekeegwa asengencho gwanchire ekiriniki giaito.*

Now I want first if I could manage to give you a present because you like our clinic.

Patient: *Mm.*

Mm.

Doctor: *Na gwachorire ng'a eye nero erabe enchera erabe gekogokonya.*

And you have chosen that this is the way to help you.

Patient: *Ee.*

Yes.

Doctor: *Tari bo?*

Is that not so?

Patient: *Mm.*

Mm.

Doctor: *Ase ayio ngokoa pongezi mono.*

I commend you a lot for that.

Patient: *Ee asante.*

Yes thanks.

Doctor: *Nka ng'aki bare?*

How is everyone at home?

Patient: *Mbuya bare.*

They are fine.

Doctor: *Omogaka?*

Your husband?

Patient: *Omogaka mbuya are.*

My husband is fine.

Doctor: *Mm.*

Mm.

Patient: *Nkona koboka tore.*

We keep waking up.

Doctor: *Igo gwantebetie abana mbarenga obwate?*

Did you tell me how may kids you have?

Patient: *Mbatato mbwate.*

I have three.

Doctor: *Batato?*

Three?

Patient: *Mm.*

Mm.

Doctor: *Igo mbuya. Omonene ng'aki akorokwa?*

That is good. What is the name of the eldest?

Patient: *Akorokwa Mercy.*

She is called Mercy.

Doctor: *Mercy?*

Mercy?

Patient: *Mm.*

Mm.

Doctor: *Emiaka n'erenga abwate?*

How old is she?

Patient: *Ikomi n'etato.*

Fifteen.

Doctor: *Ikomi n'etato.*

Thirteen.

Patient: *Mm.*

Mm.

Doctor: *N'oyokomobwatia?*

And the one who follows her?

Patient: *Igo are emiaka etano n'etato.*

He is eight years old.

Doctor: *N'oyio onde?*

And that other one?

Patient: *Igo are n'emiaka etano nomo.*

He is six years old.

Doctor: *Abamura mbarenga obwate?*

How many boys do you have?

Patient: *Mbabere.*

They are two.

Doctor: *Babere?*

Two.

Patient: *Mm.*

Mm.

Doctor: *Aye igo rende tokoreti?*

So, have you not finished?

Patient: *Ee.*

Yes.

Doctor: *Hahaha! Haya karibu. Igo naki nkogokonya rero?*

Hahahah! Okay welcome. So how do I assist you today?

Patient: *Bono nagendereire konywa amariogo.*

I have continued to take the medicine.

Doctor: *Mm.*

Mm.

Patient: *Gotatiga omochando oyomo ngocha nyora.*

Except one problem which I normally get.

Doctor: *Mm.*

Mm.

Patient: *Bono buna twapimetwe…*

Now as we were tested…

Doctor: *Mm.*

Mm.

Patient: *Nche ngapimwa ngasoka nde positive.*

I was tested, and I turned positive.

Doctor: *Mm.*

Mm.

Patient: *Na bono buna emiaka eye etano n'etato yaetire nabeire nkonywa amariogo.*

And now like in the last eight years, I have been taking medicine.

Doctor: *Mm.*

Mm.

Patient: *Korende omogaka one igo are buya.*

But my husband is fine.

Doctor: *Mm.*

Mm.

Patient: Ere tabwati biini.

He is HIV negative.

Doctor: *Mm.*

Mm.

Patient: *Bono ngokumia ng'a n'ase ki kagopimwa akonyorekana igo naende tokoba igo tore n'ere bweka.*

Now I wonder why after being tested he turns out that way, yet we are with him alone.

Doctor: *Mm.*

Mm.

Patient: *Ere tana koba positive.*

He has never become positive.

Doctor: *Positive.*

Positive.

Patient: *Mm.*

Mm.

Doctor: *Na nchera ki mokoba nere ekiagera gwantebirie ng'a omwana oo omoke n'obwemiaka etano nomo.*

And how do you engage with him because you have told me that your little child is six years old.

Patient: *Asengencho…*

Because…

Doctor: *Na kwanyure amariogo ase emiaka etano n'etato.*

Yet you have taken medicine for eight years.

Patient: *Asengencho ya.. ki?*

Why is it so?

Doctor: *Mm.*

Mm.

Patient: *Ritang'ani buna napimetwe… nkaba ase emiaka ene ntana gopimwa.*

First, as I was tested… I stayed like four years without being tested.

Doctor: *Oo.*

Okay.

Patient: *Timotebetie buna nabo narenge igo.*

I never disclosed to him my status.

Doctor: *Mm.*

Mm.

Patient: *Asengencho rituko riria nachiete ekiriniki ki'omwana nario napimetwe.*

Because the day I went for the clinic for the baby that is when I tested my status.

Doctor: *Mm.*

Mm.

Patient: *Ngatebigwa.*

I was told.

Doctor: *Oyio o gatigati.*

The middle one?

Patient: *Ee ngatebigwa nabo nde igo.*

Yes, I was told about my status.

Doctor: *Mm.*

Mm.

Patient: *Bono ere bono.*

Now for him…

Doctor: *Ogakira igo.*

You kept quiet.

Patient: *Ngakira.*

I kept quiet.

Doctor: *Korende.*

But.

Patient: *Buna nakira tokagenderera n'amang'ana aito ekeene tinchieti komotebia…*

Since I kept quiet we continued with our affairs, honestly, I never told him…

Doctor: *Mm.*

Mm.

Patient: *Totumie protection.*

We use protection.

Doctor: *Mm.*

Mm.

Patient: *Bono ere kagenda gopimwa ekero konye napimirwe tokaba nere ase emiaka ene.*

Now, when he went for the test, we had been with him for four years.

Doctor: *Mm.*

Mm.

Patient: *Kogenda bono moisonde kogenda gopimwa ekero emiaka eyio ene yaetire akanyorekana are negative.*

Going for the test the other day after those four years he turns out to be negative.

Doctor: *Na bono negative are?*

And now is he negative?

Patient: *Na konye twachire nere mara aange.*

And we had been with him several times.

Doctor: *Mbuya mono.*

Thank you.

Patient: *Mm.*

Mm.

Doctor: *Tari mara aange korwa moumerana?*

Is it not many times, since you met?

Patient: *Kera ee bono.*

Yes always.

Doctor: *Ee.*

Yes.

Patient: *Korwa toumerana ekiagera oyio omotang'ani tinchieti komopima.*

Since we met because the first one I did not test her.

Doctor: *Nonya n'igoro?*

Even yesterday?

Patient: *Ee bono igo timanyeti.*

Yes, so I do not know.

Doctor: *Mbuya mono. Omanyete egento ndagotebie ekiagera ...gose kero kende kerabe technical mono.*

Thank you. You know what I will tell you because …or maybe it might be too technical.

Patient: Mm.

Mm.

Doctor: *Na n'obaise gosirerigwa ase gete gati kabere. Aah omanye ng'a ritang'ani e biini ebi bia HIV mbagendererete kobimanya.*

And you might get lost in between. Ah you need to know that first they are still trying to understand HIV.(*expert/authority*)

Patient: *Mm.*

Mm.

Doctor: *Kobisoma nonya n'abasongo.*

To study them, even Europeans.

Patient: *Mm.*

Mm.

Doctor: *Nkonya konyemanya bare. Monto tari omanyete buya.*

They continue to study it. Nobody knows it well.

Patient: *Mm.*

Mm.

Doctor: *Ekiagera obomanyi mbore tobwate ng'a n'evirus ya RNA ekogenda ase DNA y'ecell yao erio e cell yao nero… eyio nagosometie ase ekiriniki keria kende.*

Because there is information which we have that this the RNA virus which enters the DNA of your cell then your cell in turn….that I had taught in the previous clinic. (*Expert/Authority*)

Patient: *Mm.*

Mm.

Doctor: *Bono e cell yao nero ekogendererera koyeibora.*

Then your cell goes ahead to reproduce it

Patient: *Mm.*

Mm.

Doctor: *Tari bo?*

Is that not so?

Patient: *Mm.*

Mm.

Doctor: *Korende goikera rero nonya naiga Kenya .. naki ekorokwa? Eeh KEMRI.*

But up to date even here in Kenya….what is it called? Er..KEMRI…

Patient: *Mm.*

Mm.

Doctor: *Bado negendererete gokora obotuki.*

Is still engaged in research.

Patient: *Mm.*

Mm.

Doctor: *Korende obotuki mbore boria boke bakorire tayari.*

But there is the little research they have done.

Patient: *Mm.*

Mm.

Doctor: *Anene mono igoro y'amang'ana ayio gati y'omokung'u n'omosacha koba etabauti.*

Mainly on issues relating a husband and wife having different HIV status.

Patient: *Mm.*

Mm.

Doctor: *Timanyeti gose kwaigure obotuki boria bakorerete abang'ina baria ba Pumwani, Nairobi. Kero kende kwaigure nonya nase TV.*

I do not know if you have heard about the research that was carried out the Pumwani women in Nairobi. Maybe you have heard on TV.

Patient: *Mm.*

Mm.

Doctor: *Gose ase eredio.*

Or on radio.

Patient: *Mm.*

Mm.

Doctor: *Gose ase egaseti*.

Or in the newspaper.

Patient: *Mm.*

Mm.

Doctor: *Ng'a abang'ina mbakare bagokora obomaraya.*

That there are ladies who do commercial sex work.

Patient: *Mm.*

Mm.

Doctor: *Na nigo bagendererete gokora obonchoreria bwabo buna botambe.Ee omanyete aria Nairobi kero kende ngoteba bare kogotumia omobira n'erigori gete…*

And they continue to do their business as usual. You know in Nairobi, sometimes they say that if you use a condom it is a given cost…

Patient: *Mm.*

Mm.

Doctor: *Otatumieti n'erigori gete, n'abangina abwo babeire bagokora oboonchoreria obwo na tibana gotwara HIV.*

I you do not use, it is a specific cost, and those women have been doing their commercial sex work, but they have never become HIV positive. (*Affect/expert/Authority*)

Patient: *Mm.*

Mm.

Doctor: *Buna ase echimo chie chi theories echio bagendererete koenekia gose namaene neria ng'a abanto mbare batongire abwo chi cells chiabo chitabwati ebinto gete. Biagera e biini ebi tibigotarera.*

As one of the theories which they continue to proof is that there are people whose cells do not contain some things where the virus attaches… (authority)

Patient: *Mm.*

Mm.

Doctor: *Erio bisoe ime bikore abe na HIV. Tindi goteba ng'a omogaka oo nabo are igo korende nabo eranyarekane.*

So, that they can enter and make someone HIV positive. I am not saying that your husband is in this category but it is possible.

Patient: *Mm.*

Mm.

Doctor: *Iiga*

You see.

Patient: *Igo nabo erabe okay eyio n'eyemo.*

That is possible. Okay, that is one.

Doctor: *Mm.*

Mm.

Patient: *Eyio n'eyemo. Nenyarekane gose ng'a kero kende ogopimwa okwo nkore n'amamocho.*

That is one. Is it possible that maybe the testing itself could be having a mistake? (*ignorance*)

Doctor: *Amamocho… okay ogopimwa nonya noko gwapimirwe naye kwanyorekana koba nabwo.*

A mistake… okay clinical testing even the one that you underwent, and it turned positive…

Patient: *Mm.*

Mm.

Doctor: *Tari mamocho nkoboa bare chipercentages.*

Is not a problem; they give it percentages.(*expert*)

Patient: Mm.

Mm.

Doctor: *Ee igo ekogotebia obomaene goikera ekerengo ki.*

Yes, it tells you the truth up to a certain degree.

Patient: *Mm.*

Mm.

Doctor: *Korende chingaki echi technology tobwate aiga ase enyagetari eye yaito Gusii…*

But currently the technology we have here in our hospital in Kisii…

Patient: *Mm.*

Mm.

Doctor: *Gose nonya mbono, eyegotumeka mono goetania aria isiko ase chinyagetari chogokora ebinto egenka…*

Or even now the one we use more than out there in hospitals which do things traditionally….

Patient: *Mm.*

Mm.

Doctor: *Chinchera togotumia nigo chire gati ya 90 – 98%...*

The methods we use are between 90 to 98%...

Patient: *Mm.*

Mm.

Doctor: *Amaene.*

Sure.

Patient: *Mm.*

Mm.

Doctor: *Nakio gekogera togokora mara kabere. Nakio gekogera gwapimete eyeplastic*

That is why we do it twice; that is why you did a plastic test…

Patient: *Mm.*

Mm.

Doctor: *Naboigo ogapima eyerisakara chionsi rimo. Kwarore?*

And you did a paper test both at the same time. You see?(*Convergence/expert*)

Patient: *Mm.*

Mm.

Doctor: *Erinde egere eye ekoe obomaene bwaye bwa 98% ; eria ya 2% igo ere covered neye yende eyio nero egokoa 98%.*

Such that this gives you 98% truth; the 2% is covered by this one which will also give you 98%.(*expert/authority*)

Patient: *Mm.*

Mm.

Doctor: *Na onye tobwate chitang'utang'u nabo tokobeka eyagatato toisa gotwara esababu y'ogotwara chitang'utang'u…*

And in case you have a doubt we can put in a third and if you have a reason for a doubt...(*affect/accommodation*)

Patient: *Mm.*

Mm.

Doctor: *Nabo tokobeka eyagatato. Korende bono omogaka oo twabeire tokomobwatia ase emiaka etano nomo nonya mbono twachire aare ake. Twakorire Long-ELIZA test*

We can put in a third. But now we have been following your husband for six years; for him we have gone further. We have done the long ELISA test. (*expert/accommodation/appraisal*)

Patient: *Mm.*

Mm.

Doctor: *Iiga rende ase e test eyemo, buna mwanyabanto nonya nande onsi ase ense eyio nero e standard procedure. Ekero ogokora e test eyemo, igo otagete korusia chitang'utang'u. Nakio gekogera bagokora chitest ibere.*

Okay for one test its okay and as human beings even anywhere in the world that is the standard procedure. When you do one test, you want to rule out the doubt aspect of it. That's why they carry out two tests.

Patient: *Mm.*

Mm.

Doctor: *Na onye gotagete koba n'obomaene ng'a echi ibere chiang'orokirie obomaene, buna twakorerete omogaka oo; igo tokobeka eyagatato eyio egototebia oburukanie amachibu y'etest y'eye n'eye n'eye. Nomanyete ng'a omogaka oo test teiyo nonya n'eyemo ana kworokia kare positive?*

And if you want to proof that these two have shown me the truth, like we did for your husband; we will do a third and you add the result onto the other and previous test results. Do you know that for your husband, not even one of his tests have turned positive?

Patient: *Mm.*

Mm.

Doctor: *Chionsi chiabeire chikworokia negative na gokeania chitang'utang'u nonya neria entambe ekoira engaki entambe n'eyegokora e test ase oboikeranu naboigo ekaorokia kare negative. Igo goteba ng'a kero kende test teri na bomaene, nkagete eyio yashugurikeirwe. Onye ndiria konye twakorire e test eyemo yoka, rirorio nario tware gocha goteba ng'a ah tiga tu toteme eye n'eye n'eye n'eye.*

All have been showing negative and to minimize doubt even the long test which takes a longer period and is more accurate also confirmed his negative status. So, saying that sometimes the test does not have the truth, I think that has been taken care of. If we had done just one test, then we would have said let us try this and this and this and this.

Patient: *Mm.*

Mm.

Doctor: *Tari bo? Korende bono iga chitest nirenga twakorire? Nonya naye nomanyete*

Isn't it so? But then how many tests have we carried out? Even you yourself know.

Patient: *Mm.*

Mm.

Doctor: *Na mara karenga twairoreire?*

And how many times have we seen by ourselves?

Patient: *Mm.*

Mm.

Doctor: *Nonya n'omotienyi oria nao mwarenge nere.*

Even last month you were with him.

Patient: *Na twakorire.*

And we have done it.

Doctor: *Ng'iwete ng'a igo mwachiete mogatebia sister mokore naende.*

I hear that you proceeded to ask sister to do it again.

Patient: *Ee naende tokagenda ase ang'ao.*

Yes then we went elsewhere.

Doctor: *Mbuya mono.*

Very good.

Patient: *Gekaba ere nigo are negative.*

It turned out that he is negative.

Doctor: *Nabo antebetie ng'a Nairobi mware.*

He told me that you were in Nairobi.

Patient: *Mm.*

Mm.

Doctor: *Bono onye gwakorire igo rirorio bono chitang'utang'u igoro y'echitest strips…*

Now if you have done that then your doubts about the test strips…

Patient: *Mm.*

Mm.

Doctor: *N'eprocedure chiarusigwe aroro.*

And procedures have been cleared.

Patient: *Mm.*

Mm.

Doctor: *Igo eyio teri buya ona koyerengereria ekiagera nabo oretebie ng'a naye tori positive.*

So it is not good for you to be thinking about it because you may convince yourself that you are also not positive.

Patient: M*m.*

Mm.

Doctor: *Omanye korwoo otige amariogo!*

You then stop your medicine!

Patient: *Mm.*

Mm.

Doctor: *Ng'o ararere abana bao?*

Who will take care of your children?

Patient: *Onde.*

Nobody.

Doctor: *Torochi?*

Can't you see?

Patient: *Eriogo nkonywa nde.*

I take medicine.

Doctor: *Ee*

Yes.

Patient: *Korende kero kende konaikaransire iga nigo nkwerigereria.*

But sometimes when I sit down, I look at myself…

Doctor: *Mm.*

Mm.

Patient: *Nkwerigereria nasoa gweitia amang'ana aria y'echingaki chiria chia kare.*

I look at myself and start regretting my old ways.

Doctor: *Mm.*

Mm.

Patient: *Kero kende igo nkwoboa ng'a omogaka one nabo abaise gontiga.*

Sometimes I fear that my husband may even leave me.

Doctor: *Mm.*

Mm.

Patient: *Bono timanyeti. Ngoika nde natwara ebirerengererio buna ebio.*

Now I don't know. I normally develop such thoughts.

Doctor: *Ebirengererio…*

Thoughts…

Patient: *Mm.*

Mm.

Doctor: *Ebio kobitwara bobe tiboiyo. Tobaise gweitia. Tibweitia egekogera gwatwara ebirengererio buna ebio. Eyio n'ekemwanyamanto.*

Having those has no problem. Do not regret. Do not regret because you developed such thoughts. It is only human.

Patient: *Mm.*

Mm.

Doctor: *Ase enchera ende aye mwanyabanto buna abanto bande. Nonya ninche nare gocha koba aye… gose nonya mbono buna nde.*

In other words, you are human just like other people. Even me if I were you…Even me the way I am.

Patient: *Mm.*

Mm.

Doctor: *Nche gose omong'ina one ntobwate ogotaigwanana gwaito.*

My wife and I have our have our own misunderstanding.

Patient: *Mm.*

Mm.

Doctor: *Naende kero kende ngochande narengereria ng'a nabo arantige. Ase igo eyio n'ekenyamwabanto.*

And at times I think that she may leave me. Therefore, that is human.

Patient: *Mm.*

Mm.

Doctor: *Tari bo?*

Is that not so?

Patient: *Mm.*

Mm.

Doctor: *Ekio ogwenerete gokora botambe kamwomanire nonya n'igoro y'obokima botayieti…*

What you are supposed to do always, if you have quarreled even about ugali which is not well cooked…

Patient: *Mm.*

Mm.

Doctor: *Kegambe.*

Talk about it.

Patient: *Mm.*

Mm.

Doctor: *Tari bo?*

Is that not so?

Patient: *Mm.*

Mm.

Doctor: *Nonya ochire nka gatindete, mwomanire; mambia komokoboka gamba igoro yayio.*

Even if he is coming home drunk, you have quarreled; when you wake up talk about it.

Patient: *Mm.*

Mm.

Doctor: *Igoro y'omochando oyio.*

About that problem.

Patient: *Mm.*

Mm.

Doctor: *Natakeire amanye ng'a tarakogokia. Igo tomotiga igo tu erinde erio ogechigwe okire gose chingaki chiria obwate ebirengererio ng'a nkogotiga are.*

He needs to know that you are not happy. So do not leave then you get annoyed and keep quietwhen you have the thoughts of him abandoning you.

Patient: *Mm.*

Mm.

Doctor: *Okire ogende korora ng'a gose nkogotiga are. Yaya.*

You keep quiet to see if he will abandon you. No!

Patient: *Mm.*

Mm.

Doctor: *Ebirengererio ebio bigocha; mbuya obishugurikie mapema.*

Those thoughts which come; you better deal with them early.

Patient: *Mm.*

Mm.

Doctor: *Nonya mbono iga onye kobwate ebirengererio ebio kogoika nka…*

Even right now if you have hose thoughts, when you get home …

Patient: *Mm.*

Mm.

Doctor: *Genda motebie omwanchi one omaete rero riria nagenda e kiriniki narengereria ng'a nabo orantige.*

Go and tell him that my beloved husband when I went to the clinic I thought that you may abandon me.

Patient: *Mm.*

Mm.

Doctor: *Kabe bwango kogamba...*

Be fast to talk...

Patient: *Mm.*

Mm.

Doctor: *Igoro y'egento keria gekogochanda ebirengererio nere boigo. Onye gakorora ng'a aye igo ore positive nere tari positive na mwaiboire abana babere.*

About whatever that troubles your thoughts likewise to him.

Patient: *Mm.*

Mm.

Doctor: *Kore positive na bonsi bare negative.*

While you are positive and they are both negative.

Patient: *Mm.*

Mm.

Doctor: *Takonyara kogotiga. Enchera ende eyio nigo egwenerete gokoa ogosemeria. Kero kende ekero nonya n'ere akorora ng'a igo atagete kogotiga asengencho ya HIV yao egento ekiya nonya nere atebe egere moyakwane.*

He cannot manage to leave you. In other words, that should give you hope. Sometimes even him when he feels like he wants to leave you because of your HIV status, the best thing is for him to speak out so that you talk about it.

Patient: *Mm.*

Mm.

Doctor: *Igo agocha agotebie omwanchi one HIV eye yansumbuire omotwe nonya rero mambia saitani natema gontebia ngotige.*

He will come and tell you, my beloved wife, this HIV has bothered my head, even today the devil was telling me to leave you.

Patient: *Mm.*

Mm.

Doctor: *Ekero mokogamba igoro y'egento.*

When you are talking about something.

Patient: *Mm.*

Mm.

Doctor: *Igo mokogekora bwango. Korende ekero mogokira, igo gekogenderera koira emerio gochia ime yaba n'okobua okonene koba….*

That way you finish it fast. But when you keep quiet the issue becomes profound and a big deal…

Patient: *Bono nsa chinde buna twabeire nere ase emiaka eyio.*

Now at times we have been with him for those years…

Doctor: *Mm.*

Mm.

Patient: *Na tanya konyora*

And he has never gotten

Doctor: *Mm.*

Mm.

Patient: *Igo nabo ekonyarekana tanyora.*

So, it is possible he may not get

Doctor: *Mm.*

Mm.

Patient: *Igo nsa chinde gotumia amang'ana ayio ya protection.*

So, at times using those issues of protection

Doctor: *Mm.*

Mm.

Patient: *Kero kende igo agoteba ng'a bono rinde rionsi tiga togenda igo…*

Sometimes he says that now whatever the case let's proceed without...

Doctor: *Mm.*

Mm.

Patient: *Onye ndiria nare kobonyora anga nabonyorire.*

If I was getting it, I would have gotten it.

Doctor: *Nabonyorire.*

I would have gotten it.

Patient: *Torochi rende nigo ere safe?*

Don't you see he is safe?

Doctor: *Obuya obotuki nabwo bogotoraa.*

The good thing, we are guided by research.

Patient: Mm.

Mm.

Doctor: *Boria bwakorirwe.*

Which has been done

Patient: *Mm.*

Mm.

Doctor: *Tari aiga seito Gusii oka gose Kenya yoka.*

Not here in our Gusii home alone or Kenya alone.

Patient: *Mm.*

Mm.

Doctor: *Nkera ase.*

It is everywhere.

Patient: *Mm.*

Mm.

Doctor: *Igo bokworokia ng'a onye kore discordant tebwati 100% security. Igo okoba discordant obogima bwao bwonsi.*

It shows that if you are discordant, it doesn't have 100% security. You remain discordant all your life.

Patient: *Mm.*

Mm.

Doctor: *Iiga rende*

You see.

Patient: *Mm.*

Mm.

Doctor: *Goika ngaki gete tokomanyereria. Na nagotebirie igoro y'obotuki bwa Nairobi.*

Up to a certain time, you may not know. And I have told you about the research in Nairobi.

Patient: *Mm.*

Mm.

Doctor: *Obotuki obwo …ninkoe amasakara nkagete ninyabwate aiga ase e file.*

That research …I will give you the findings, I think I have the article here in the file.

Patient: *Mm.*

Doctor: *Igo okogenda osome ng'ora ng'ora ko bono n'egesongo kerabe n'amang'ana oya otaigwe korende…*

You will go and read slowly although it is English which may have some terminologies you may not understand but…

Patient: *Mm.*

Mm.

Doctor: *Obuya bwaye mbori ng'a abang'ina baria mbabete bakobwatigwa korende ase emiaka ikomi mbare abange ase egati yabo abwo bono iga bare positive.*

The good thing is that those ladies were followed but for ten years many of them are now positive.

Patient: *Mm.*

Mm.

Doctor: *N'egento ekebe nkeri ng'a nigo bamentete bwango sana.*

And the bad thing is that their condition worsened.

Patient: *Oo.*

Okay.

Doctor: *Iga rende.*

You see.

Patient: *Mm.*

Mm.

Doctor: *Baria ase e bahati embe bakorerete koba positive.*

Those who by bad luck ended being HIV positive.

Patient: *Mm.*

Mm.

Doctor: *Korende amaereso narwetwe.*

But an explanation was given.

Patient: *Mm.*

Mm.

Doctor: *Kero kende kobare positive nigo bagendererete n'oboonchoreria obwo bwabo tibachia gwetanga.*

maybe since they were positive they continued with their business without protection.

Patient: *Mm.*

Mm.

Doctor: *Gose mbachieti gotanga e virus eyio: konye yabeire positive.*

Or they didn't manage to control that virus: it had turned positive.

Patient: *Mm.*

Mm.

Doctor: *Tementekana bwango, kero kende bakagenderera kwebeka ase abe.*

For it not to multiply fast, maybe they continued to endanger themselves.

Patient: *Mm.*

Mm.

Doctor: *Igo amaereso ande narwetwe korende buna riria nagotebetie monto taiyo omanyete ebiini ebi buya.*

So more advice was given but as I had told you there is nobody who understands the virus well.

Patient: *Mm.*

Mm.

Doctor: *Abanto mbagendererete kobisoma.*

People continue to study them.

Patient: *Mbagendererete kobisoma.*

They continue to study them.

Doctor: *Mbagendererete kobisoma.*

They continue to study them.

Patient: *Nonya n'abasongo mbagendererete kobisoma?*

Even the Europeans continue to study them?

Doctor: *Mm.*

Mm.

Patient: *Igo tebwati koenekia ng'a onye tabobwati rero mambia takobotwara?*

So, there is no proof that if he doesn't have it today, tomorrow he will have it?

Doctor: *Mm.*

Mm

Doctor: *Nonya eyio igekoondokia.*

Even that is perturbing.

Patient: *Mm.*

Mm.

Doctor: *Tintageti bwoboe. Egento ekenene nkeri ng'a, omong'ina nabwate HIV omogaka tabwati.*

I do not want you to fear. The most important thing is that the wife has HIV and the husband doesn't.

Patient: *Mm.*

Mm.

Doctor: *Abana n'abake. Omonene nobw'emiaka ikomi netato.*

The children are young. The elder one is thirteen years old.

Patient: *Mm.*

Mm.

Doctor: *Oyonde n'emiaka etanemo. Egento ekiya nkeri ng'a oria otabwati tiga togenderere komorenda tanyora.*

The other one is six years old. The good thing is that for the one who doesn't have it, let's continue to protect him from getting it.

Patient: *Mm.*

Mm.

Doctor: *Gento kebe gikerabasokane omonto natoke orarende abana nonya noria omorwaire. Tari bo?*

If there is any emergency there will be someone who will take care of the children even the one who is sick. Is that not so?

Patient: *Ee nonya ninche. Nche nabo nkoyara. Nse konywa eriogo buya nabo nkomenya kabisa.*

Yes, even me. Personally, I can manage. If I take my medicine properly, I can live very long.

Doctor: *Eyio ntore n'amaene. Eyio nero ntobe ake tomanye korora . Ase engencho buna iga oria … timanyeti gose nomanyete Asumpta.*

That we are sure of. That too with time we shall get to know. Because for instance like that…I don't know if you know Asumpta.

Patient: *Mm nkomoigwande.*

Mm I hear about her.

Doctor: *Igo akoba ase egaseti.*

She is normally in the newspapers.

Patient: *Mm.*

Mm.

Doctor: *Onyure amariogo ase emiaka emorong'etato.*

She has been taken medicine for thirty years.

Patient: *Mm.*

Mm.

Doctor: *Eyio nero naende nomorora ase eTV nig' are buya.*

That is it, and if you see her on TV she is okay.

Patient: *Mm.*

Mm.

Doctor: *Eyio nero togosaba.*

That is what we pray.

Patient: *Mm.*

Mm.

Doctor: *Ng'a amariogo aito tagotosokia*

That our medicine will not embarrass us.

Patient: M*m.*

Mm.

Doctor: *Igo totagete gotuntuba chinsinyo chionsi.*

We want to close all loop holes.

Patient: *Mm.*

Mm.

Doctor: *Tari bo?*

Is that not so?

Patient: *Mm.*

Mm.

Doctor: *Igo totagete nonya naye…*

We would like even you…

Patient: *Mm.*

Mm.

Doctor: *Noganie omonto oragokonye gocha e kiriniki kwoyia amariogo.*

You need someone who will assist you to be coming to the clinic to collect your medicine.

Patient: *Mm.*

Mm.

Doctor: *Tari bo?*

Is that not so?

Patient: *Mm.*

Mm.

Doctor: *Gose nonya gokorema mogondo.*

Or if you are working in your farm

Patient: *Mm*

Doctor: *N'ere mbuya are nare n'chinguru igo okomotebia*

And he is fine and has the energy, you tell him

Patient: *Mm.*

Mm.

Doctor: *Rero genda tu e kiriniki naakeire e sisiter esimi namotebirie ninyorwe oetere aroro bwoyie amariogo.*

Today, go to the clinic, I have called Sister and informed her that I will be late you pass there to pick medicine.

Patient: *Mm.*

Mm.

Doctor: *Igo otagete abe n'echinguru?*

You want him to be strong?

Patient: *Mm.*

Mm.

Doctor: *Ntagete abe… totageti arware.*

I want him to… you don't want him to be unwell.

Patient: *Mm.*

Mm.

Doctor: *Tari bo? Igo nakio gekogera ntagete eyio ya protection mogenderere tu gotumia protection.*

Is that not so. So that is why I want to continue using protection going forward.

Patient: *Bono omwana oria onde oria bw'emiaka 6 kero kende ndengereria.*

Now the six-year-old child, sometimes I think…

Doctor: *Mm.*

Mm.

Patient: *Nabo abaise koba bosibore kegima…*

He might be have escaped…

Patient: *Mm.*

Mm.

Doctor: *Korwa ase ebiini ebio.*

From HIV infection.

Patient: *Mm.*

Mm.

Doctor: *Omanyete buna riria aiboretwe ntwakorete e test.*

You know immediately he was delivered we did a test.

Patient: *Nakoreretwe, ee nakoreretwe.*

He underwent, yes he underwent.

Doctor: *Tokamoa amariogo.*

We gave him medicine.

Patient: *Ee.*

Yes.

Doctor: *Tokamoa.*

We gave him.

Patient: *Agakorerwa.*

He underwent.

Doctor: *Gotanga naye okaba Nyasae akagosesenia ogachora gotamogonkia.*

To prevent….and you also were…God blessed you to decide not to breastfeed her.

Patient: *Mm.*

Mm.

Doctor: *Na buna gwaika omwaka oyomo togakora e test.*

And after one year we did the test.

Patient: *Mm.*

Mm.

Doctor: *Omwaka o kabere togakora e test. Omwaka o kane togakora e test.*

The second year we did the test. The fourth year we did the test.

Patient: *Mm.*

Mm.

Doctor: *Kobwatekana nainche ndoche ng'a bono iga oyio nagochia natotana gokwana amang'ana aye.*

From what I see, I think for that child we do not need to talk about his case.

Patient: *Mm.*

Mm.

Doctor: *Oyio Nyasae omorendire.*

That is God who has taken care of him.

Patient: *Mm.*

Mm.

Doctor: *Mbuya are.*

He is fine.

Patient: *Ee.*

Yes.

Doctor: *Ee.*

Yes.

Patient: *Ee naakire mbuya mono.*

Yes I say thank you so much.

Doctor: *Mm.*

Mm.

Patient: *Nonya nabo rende rero nche mbuyande.*

Even so, today I am fine.

Doctor: *Mm.*

Mm.

Patient: *Timbwati mechando menge.*

I do not have many problems.

Doctor: *Mm.*

Patient: *Igo natara tu kwagara amariogo ane rero.*

I came over to refill my medicine.

Doctor: *Na sister okoyaire tayari?*

And has sister already given you the medicine?

Patient: *Eeh naeirwe narora tiga.*

Yes, I have been given; I saw let…

Doctor: *Oetere tu?*

You pass by?

Patient: *Nkwane na daktari ake.*

I talk with the doctor a bit.

Doctor: *Tokwananie.*

We greet each other.

Patient: *Mm.*

Mm.

Doctor: *Aya n'omong'ina nere nkorantoma are ase ore rituko riria twaumeranete e supermarket.*

Okay and my wife normally sends me to you, that day we met at the supermarket.

Patient: *Mm.*

Mm.

Doctor: *Noinyorete?*

Do you remember?

Patient: *Mm.*

Mm.

Doctor: *Aah*

Ah.

Patient: *Mbuya are?*

How is she?

Doctor: *Antoma ngokwanie.*

She sends her greetings to you.

Patient: *Ee mbuya sana.*

Yes, that is very nice.

Doctor: *Ngontoma are tu neria timanyeti ndi arache.*

She sends me only that I don't know when she will come.

Patient: *Mm.*

Mm.

Doctor: *Sister one n'ere omanyete e diary yaino.*

My sister is the one who knows your diary.

Patient: *Eeh.*

Yes.

Doctor: *Korende okomisirie.*

But she has missed you.

Patient: *Mm.*

Mm.

Doctor: *N'eching'eni chiria kwamoreterete rituko riria.*

And you brought the vegetables that day.

Patient: *Mm.*

Mm.

Doctor: *Akagoka mono.*

She was very happy.

Patient: *Ee ntobwate ching'eni chinyinge mogondo. Kero kende omonyagetari oria okondigereria buya narora ng'a mbuya ndete gento geke moe.*

Yes, we have a lot of vegetables at the farm. Sometimes a doctor who treats me well, I feel like I should get something small and give them.

Doctor: *Hehehe!*

Hehehe!

Patient: *Ee nimbwate ching'eni chinyinge mogondo.*

Yes, we have a lot of vegetables at the farm.

Doctor: *Ntobange totare togore tu nonya ninkeigo.*

We shall plan we buy even a little.

Patient: *Aya mbuya mono.*

Okay than you so much.

Doctor: *Nkoonia ore gose n'echiao chiokoria?*

Do you sell or are they for your subsistence?

Patient: *Echinde nkoonia n'echinyinge.*

I sell others; they are a lot.

Doctor: *Aa mbuya*

Ah good.

Patient: *Ee.*

Yes.

Doctor: N*totare.*

We may visit.

Patient: *Asante.*

Thanks.

Doctor: *Haya asante.*

Okay thanks.

Appendix xvii. HIV and AIDS 3 consultation

Doctor: *Gesare mbuy'ore baba?*

Gesare, how are you dear?

Patient: *Mbuya mono tagitari.*

I am fine doctor.

Doctor: *Karibu ekiriki rero torore buna toragokonye. Naki ogenderete korwa ochicha aiga ekiriniki?*

Welcome to this clinic we see how we can be of help. How have you been from the last time you visited the clinic?

Patient: *Nche mbuyande korende amariogo nkonywa tindochi gose nkombera akare buya.*

I am fine, but I don't think that I am responding well to the medicine that I am taking.

Doctor: *Tiga ngo tochakere aiga. Mwasiekire esukuru?*

Let's start from here. Have you closed school?

Patient: *Ee*

Yes.

Doctor: *Ndi mwasiegete?*

When did you close?

Patient: *Etwasiegete omokubio oria oeta.*

We closed last week.

Doctor: *Mwasiegete omokubio oria oeta?*

You closed last week?

Patient: *Ee.*

Yes.

Doctor: *Inwe morabanga gosamba esukuru buna abana bande be'chisukuru chinde?*

You have not planned to burn your school like the other students from other schools?

Patient: *Aa esukuru konye twabangire toyesambe!*

We had already planned to burn it!

Doctor: *Ee*

Eh!

Patient: *Korende omwarimu oito omonene.*

But our Principal

Doctor: *Ee.*

Yes.

Patient: *[Agatoikaransia, agatokwanera…*

[He sat us down and talked with us…

Doctor: *Ee*

Yes.

Patient: *[Akarangeria abaibori…*

[He called the parents…

Doctor: *Ee.*

Yes.

Patient: *[Tokagamba,*

[We deliberated…

Doctor: *Ee*

Yes.

Patient: *[Anene agakonya. Ko bono konye twabangire.*

Most important he saved the situation. But we actally had planned.

Doctor: *Ee*

Yes

Patient: *[N'amaguta tu konye ... amatuko abere tu ngocha koreterwa tware. Nonya naintwe anga tosambe esukuru eyio.*

Its only petrol that… we were to recieve it in two days. We would have burnt that school.

Doctor: *Bono anga. Timosamb' esukuru. Inwe ninki mogosamber'esukuru? Ee? N'echisimi mobwate?*

Now you could have… Dont burn the school. And why do you burn your school? Eh? And do you have phones?

Patient: *Ee bono esimi n'erasima. Nereo*

Of course, a phone is a must! We have.

Doctor: *Y'okobisa gose eyo…?*

One you hide or one for….

Patient: *Igo tokobisa*

We hide.

Doctor: *Igo mokobisa*

You hide

Patient: *Ee*

Yes

Doctor: *Igo mwancheire kobogoria esimi gochia esukuru.*

So, are you allowed to carry a mobile phone to school?

Patient: *Ntwancheiri korende … esimi.*

We are not allowed but …. mobile phones.

Doctor: *Ee.*

Yes.

Patient: *[Abana abange mbabwate chisimi.*

[Many students have mobile phones.

Doctor: *Abana…*

Students…

Patient: *Igo tokochibisa ekero ekero tore ekerasi twarimia twachibeka ase egetanda... chimaturesi.*

We normally hide them when in class and put them in our beds…matresses.

Doctor: *Ase chimaturesi?*

In the matresses?

Patient: *Ee morogoba tocha twagenderera.*

Yes, then we resume in the evening we continue.

Doctor: *Inwe ngosibwa more. Obee! Ngosibwa more! Ganya inwe tu. Obe! Bono igo gwateba ng'a riogo tiriri gokobera buya?*

You risk arrest. Oh my God! You will be arrested! Just wait! Now you said that you are not responding well with your medicine?

Patient: *Ee*

Yes.

Doctor: *N'ase ki ritari gokobera buya?*

Why are you not responding well?

Patient: *Eriogo ndire nkonywa. Timanyeti ngocha koritiga.*

These is some medication am taking. I don't know whether I should abandon it.

Doctor: *Ase ki?*

Why?

Patient: *Eriogo eri Efavirenz eri ria yiero.*

The yellow drug Efavirenz.

Doctor: *Ee.*

Yes.

Patient: *Bono nche tindochi nki motang'ere eriogo buna… omaete amatuko aria, ekero nachagete iga, mokang'a amariogo abere.*

I really cannot see why you cannot give me drugs like… You know when i started you gave me two types of drugs.

Doctor: *Ee.*

Yes.

Patient: *Ndireo rirabu n'erio ria yiero.*

There is white one, and the yellow one.

Doctor: *Ee.*

Yes.

Patient: *Bono eri ria yiero ndoche ng'a n'erinene mono.*

This yellow one i think its too big.

Doctor: *Rinene?*

Big?

Patient: *Rinene mono! Ninsa konywa bono omonto igo akomboria, anene mono abana. Rituko ndire abana bamboretie ng'a ndiogo ki eri okonywa rinene iga. Ngasinywa koiraneria ekiagera eri rinde rirabu igo bakorikagera koba Panadol.*

Too big! If I took it someone will wonder especially fellow students. One time, my classmates sought to know the kind of drugs I was taking considering their big size. I could not answer them because the other white drug, they always assume it is panadol.

Doctor: *Ee.*

Yes.

Patient: *Mbari na kiambori nario.*

They dont have issues with it.

Doctor: *Ee.*

Yes.

Patient: *Bono erio nario eriogo ndoche ndache ntige.*

So, I think I may have to stop taking that particular drug.

Doctor: *Ah yaya totiga eriogo Verah. N'oroche eri rikorokwa Efavirenz? Ntoigwanaine?*

Ah! Please do not stop taking the medicine. Do you see this one called Efavirenz? Are we together?

Patient: *Ee.*

Yes.

Doctor: *Eriogo erio nigo rire yiero na nigo rire chisize. Kera esize nere n'esababu.*

This medicine is yellow in colour and it in different sizes. Each size has its reason.

Patient: *Ee.*

Yes.

Doctor: *Mm… esaisi eye n'ebwate esababu. Nebwate esababu gekogera ebwate erangi ya yellow n'esababu y'esize enene iga. Otanyweti entetere eye ntokogokonya.*

Mm …This size has a reason. It has a reason why it is yellow in colour and why it hs a bigger size. If you do not take this drug we will not help you.

Patient: *Ee*

Ee.

Doctor: *Buna bone ore esekondari, omaete esecondari nigo mwanchete gotumatuma … nechinsa irenga ogocha kwanywa chintetere?*

Now that you are in high school; I know in high school students like to play aabout…. What time do you really take your medicine?

Patient: *Amariogo ayio nigo nkoyanywa tu morogoba buna twakorire koragera iga.*

I take my medicine in the evenings after supper.

Doctor: *Morogoba chinsa irenga?*

What time in the evening?

Patient: *Tinkomanyereria buya. Timbwati simi. Ensa eye nabwate igo yaibetwe. Korende riria twakorire tu koragera nario nkwonya.*

I cannot tell exactly. I dont have a phone. My watch was stolen. But I normally take my medicine immediately we are done with supper.

Doctor: *Mm.*

Mm.

Patient: *Koria indagera.*

Eating food.

Doctor: *Mm.*

Mm.

Patient: *Nario nkonywa narara.*

That is when I take the medicine before I sleep.

Doctor: *Igo tori konywa riogo riao buya?*

This means you dont take your medicine well.

Patient: *Gose nanywa namanya kogenda ekerasi.*

Or at times I take before I go to class.

Doctor: *Mm ... Igo nigo okonywa eriogo riao nsa chinde chionsi.*

Mm… So, you take your medicine at any time?

Patient: *Yaya nigo nkonywa eriogo chinsa igoro igoro buna twakorire koragera kera rituko.*

Not really, I always take my medicine immediately we are done with our meals every day.

Doctor: *Kera rituko igo tomanyeti nonya chinsa irenga.*

Every day but you dont know at what time.

Patient: *Ee. Korende eri ndiri nkonywa chinsa chiria tu twakorire koragera.*

Yes. But i take this one when we are through with our meals.

Doctor: *Mwana onde taiyo oraborie ng'a n'echinsa irenga?*

You dont have a classmate from whom you can inquire the time?

Patient: *Yaya bono ginkoboria omwana onde ker'ensa mbakoba bakomboria ng'a nki gekogera koyabeire mogoroba gose mambia, okoboria ng'a n'echinsa irenga.*

Not really, if i asked every other time the students will be suspicious about my inquiring about the time every morning and evening.

Doctor : *Ee.*

Yes.

Patient : *Tindi koboria binto bun'ebio.*

I dont ask such things.

Doctor : *N'omwarimu namanyete ng'a nkonyw'ore eriogo ?*

And does the teacher know that you take medicine ?

Patient : *Yaya. Monto taiyo omanyete ng'a nkonywande eriogo.*

No. Nobody knows that I take this medicine.

Doctor : *Na toratebia nyoko na iso bakogorere ensa?*

And you have never told yourmum or dad to buy you a watch?

Patient : *Nche enyamoreo eye timanyeti ase nayenyorete ekiagera nonya n'abaibori bane mbamanyeti.*

I actually dont know where I got this HIV & AIDS from because evem my parents do not know.

Doctor : *Mm.*

Mm.

Patient : *Nche oyomanyete igoro ya HIV eye makomoke.*

The only person who knows about my problem is my auntie.

Doctor : *Mm.*

Mm.

Patient : *Korende makomoke oyo nigo are aare ake, ase igo acha teiyo ase engencho mbakomboria igoro y'ensa gekogera nabwo bangorerete ensa naiche nkayesiria.*

But my auntie stays far away ; so there is no need to ask them because they will wonder how i lost the one they had bought me.

Doctor : *Mm*

Mm

Patient : *Riorio bono kero kende ndusie chibesa chiane moguko…*

Unless i get the cash from my pocket money…

Doctor : *Mm*

Mm.

Patient : *[Ngore ensa eyio*

[I buy that watch.

Doctor : *Bono Gesare ndoche ng'a tori konywa riogo riao buya. Ekio naki' egento egetang'ani.*

Now Gesare I see you are not taking your medication well. That is the first thing.

Patient : *Aseki? Teri boigo ekiagera kera rituko morogoba buna twakora koragera iga*

Why? That is not correct because every evening after supper…

Doctor : *Mm.*

Mm.

Patient : *[igo nkonywa eriogo. Maambia togokora konywa echae nanywa eriogo.*

[I normally take my medicine. In the mornings I take my medicine immediately after breakfast.

Doctor : *Noroche, eriogo ria ARV nigo okonywa n'echinsa. Onye togoteba n'echinsa ibere, chibe chinsa ibere. Ekiagera rero nabo okonywa echae ensa eyemo, mambia onywe echae ensa eyemo n'enusu. Oroche twabwatirie chinsa abwo?*

You see the dosage of anti retroviral drugs goes with time. If we say 8.00 a.m we man 8.00 a.m. It is possible you have your breakfast today at 7.00 am and tomorrow you have it at 7.30 a.m. Do you think we are following the time ?

Patient : *Obe! Yaya.*

Oh! No.

Doctor : *Torochi tori kobwatia chinsa?*

Cant you see that you do not follow the prescibed time ?

Patient : *Mm.*

Mm.

Doctor : *Nabo oraragere endagera ya morogoba…omanyete nonya ninche narenge esekondari. Eh? Nonya ninche tinchieti esukuru?*

You can have your supper…You know I also went to high school. Eh? Don't you think I have gone to school?

Patient : *Ee.*

Yes

Doctor : *Engaki nere, anene mono engaki y'amatemu*

There are times especially during exams…

Patient : *Mm.*

Mm.

Doctor : *[Buna ekengere kiabugigwa iga mogende koragera. Torochi igo okoratigara nyuma ake iga buna chitageka emerongo ebere?*

As soon as the bell rings you will go to eat. Don't you see you end up delaying like for twenty minutes.

Patient : *Mm.*

Mm.

Doctor : *[Kwagenda koria endagera ya mogoroba*

You proceed to have your supper.

Patient: *Abwo kwang'inyoirie naende engaki y'amatemu*

Now you remind me about the examination period.

Doctor : *Ee*

Yes.

Patient : *[Igo bago… togochaka..omanyete…. buna intwe ebirasi mbire bigochaka buna bono twachakire amatemu.*

You know they…we begin…Some of the classes will be first like now we have started writing exams.

Doctor : *Mm*

Mm.

Patient: *[Barobwo batang'ana koragera, abande twamanakoragera…*

They will be be first to eat before the rest can serve…

Doctor & Patient : *Kobakorire.*

[Once they are done

Doctor: *Ee.*

Yes.

Patient: *Korende nche goika nywe eriogo gotwakorire konywa echae.*

But I always make sure I have taken my drugs once we are though with taking tea.

Doctor : *Igo matuko tanya kobwekana. Nonya kero kende echae teri konyorwa konywegwa?*

This means each day is unique. Is it not possible that tea will be served late at times?

Patient: *Nkonyorw' ere.*

Yes, it does come late.

Doctor: *Igo bono engecho yaye neri ng'a riogo tori korinywa ase chinsa chigwenerete. Nekio n'egento egetang'ani. N'ekero twachagete gokoa ogosemia igoro ya ARVs nigo twatebete eriogo rinywegwe n'echingaki.*

That means that you are not adhering to the rimelines of your uptake of medicine. That is the first thing. And when we started educating you about ARVs we said that the drugs must be taken with strict observation of time.

Patient: *Ee.*

Yes.

Doctor: *Chinsa nakwo ogoteba ng'a onye n'enchinsa ibere chibe chinsa ibere, onye n'echinsa isato chibe chinsa isato n'onye n'ensa eyemo n'enusu ebe ensa eyemo n'enusu kera rituko.*

Time implies that if its 8 .00 a.m let it be 8.00 a.m, if its 9.00 a.m let it be 9.00 a.m, amd if it is half past seven then it should be half past seven every day.

Patient: *Ee.*

Ee.

Doctor: *Igo gwanchire ng'a riogo erio tori korinywa buya kera rituko. Tori korinywa n'echinsa! Kero kende kobwatekana naye igo oroche nkorinyw' ore buya.*

So you are in agreement that you are not taking your drugs as required every day. You do not follow the time when taking your drugs! According to you you probably think you are taking them as required.

Patient: *Ee.*

Yes

Doctor: *Korende ase ensemo yaito buna abanyagetari, riogo eri tori korinywa buya. Igo rigwenerete konywegwa n'echinsa. Twaigwananire?*

But on our part as medical professionals, you are not taking your drugs well. The drugs are supposed to be taken according to the stipulated time. Are we together?

Patient: *Buya kegima.*

That is right.

Doctor: *Bono aseng'encho gwateba ng'a nyoko moke nere omanyete igoro yao na oborwaire obo bwokimi…*

Now since you indicated that it is your auntie who knows about your HIV status…

Patient: *Ee.*

Yes.

Doctor: *Tema komotebia akogorere ensa.*

Try and convince her to buy you a watch.

Patient: *Ns' ero tagitati timbwati bokong'u.*

A watch is not a problem doctor.

Doctor: *Ee.*

Okay.

Patient: *Ensa nabo nkorusia chibesa moguko ngore.*

I can use part of my pocket money to buy a watch.

Doctor: *Ogore.*

You buy.

Patient: *Mm.*

Mm.

Doctor: *Ndi orayegore?*

When will you buy it?

Patient: *Nabo nkogora ginkogenda.*

I can buy when I go back.

Doctor: *Tosiegeti esukuru?*

Haven't you closed school?

Patient: *Ee ginkogenda esukuru.*

Yes when I go back to school.

Doctor: *Na bono nk' omenyete?*

And do you stay at home?

Patient: *Mm.*

Mm.

Doctor: *Bono nki ogotumia kweinyoria chinsa?*

Now what do you use to remind you about the time?

Patient: *N'eyio tu buna botambe. Togokora koragera tu nanywa.*

Its the same routine. Once we are done with mealss I take my drugs.

Doctor: *Igo twaigwananaire nochake gotumia ensa?*

So we have agreed that you will start using your watch?

Patient: *Ee, korende nka ntobwate ensa y'enyasi.*

Yes but atleast we have a wall clock at home.

Doctor: *Y'enyasi.*

The wall one?

Patient: *Mm.*

Mm.

Doctor: *N'echinsa irenga otagete konywa eriogo?*

What time do you want to be take your drugs?

Patient: *Bono iga nigo tokoruga chinsa isato. Igo chinsa isato.*

Now, we cook at 9.00 p.m. So at 9.00 p.m.

Doctor: *Bono omanyete kogochaka konywa chinsa isato nka, gokogend' esukuru n'echinsa isato.*

Now you know if you start taking your drugs at 9.00 p.m at home, when you go back to school you need to keep it 9.00 p.m.

Patient: *Ee.*

Ee.

Doctor: *Igo*

That is it.

Patient: *Mm.*

Mm.

Doctor: *Rero morogoba.*

Today in the evening.

Patient: *Ee.*

Yes

Doctor: *Igo okorigereria kegoika chinsa isato iga, eh?*

Be vigilant such that when it clocks 9.00 pm, uh

Patient: E*e.*

Ee.

Doctor: *Oenekie ng'a kwanyure eriogo chinsa isato igoro.*

You ensure that you take your drugs at exactly 9.00 pm.

Patient: *Ee*

Doctor: *Chisukuru chikoigora…*

When schools open…

Patient: *Ee.*

Yes.

Doctor: *Buna chikoigorwa iga…*

As soon as they open…

Patient: *Ee.*

Yes.

Doctor: *[Oenekie ng'a kwagorire ensa yao y'okoboko. Tari bo?*

Ensure that you buy a wrist watch, will you?

Patient: *Nabo*

Yes i will.

Doctor: *Na boono?*

And now?

Patient: *Mm.*

Mh.

Doctor: *Buna monto onde taiyo nka omanyete ng'a nkonyw' ore eriogo eri…*

Since nobody at home knows you are taking these drugs…

Patient: *Ee* .

Ee.

Doctor: *[Igo ng'aki okonywa eriogo?*

So how do you take your drugs?

Patient: *Nche eriogo*

For me the drugs…

Doctor: *Ng'ai okorinywera?*

Where do you take the medicine from?

Patient: *Eriogo igo rikobera ase erumu yane yokorara.*

I keep my drugs in my bedroom.

Doctor: *Monto taiyo ona gocha erumu yago aburikanie ebinto gose ebahati embe erinde erio anyore chintetere chia'ARV?*

Nobody has ever come to your room and mixed up your things and maybe by bad luck come across your ARV drugs.

Patient: *Yaya omanyete nche tagitari….*

Not really, You know doctor…

Doctor: *Mm.*

Mm.

Patient: *[Ekero naetwe eriogo eri….*

When I was given this medicine…

Doctor: *Mm.*

Mm.

Patient: *[Enachiete nkagora ebaasa.*

I bought an envelope.

Doctor: *Mm.*

Mm.

Patient: *Nkabeka amariogo ayio ane ime.*

And i transfered my drugs there.

Doctor: *Mm.*

Mm.

Patient: *Nkabeka eburifukesi yane ime.*

And safely kept it in my briefcase.

Doctor: *Mm.*

Mm.

Patient: *Abwo nao nkobeka eriogo erio*

Thats where i keep my medicine.

Doctor: Mm.

Mm.

Patient: *Nche gaaki nkonywa nde eriogo riane buya.*

Actually I have been taking my medicine well.

Doctor: *Mm.*

Mm.

Patient: *Nainche makomoke gocha komanya igoro ya HIV yane, mwaye namenyete…*

And for my Auntie to know about my HIV status, I used to stay at her place…

Doctor: *Mm.*

Mm.

Patient: *Igo ngachaka korwara*

And I started getting sick

Doctor: *Mm*

Mm

Patient: *Akang'ira nyagetari…*

And she took me to hospital.

Doctor: *Mm*

Mm.

Patient: *Ekero napimwa nkanyora nokimwi*

When tested HIV positive…

Doctor: *Mm*

Mm

Patient: *Nkamotebia totebia monto onde…*

I told her not to tell anyone else…

Doctor: *Mm.*

Mm

Patient: *Igo ntobwate obobisi obwo gati yane nere.*

So we keep that secret between me and her.

Doctor: *Nere. Na nobwate moroberio bwokobatebia abaibori?*

With her. And do you have any plans of informing your parents?

Patient: *Ah! Bono yaya.*

Ah! Not now.

Doctor: *Totageti nonya?*

You dont want at all?

Patient: *Nche ndoche ng'a abaibori bane igo barabaise kong'ita.*

I am afraid my parents might kill me.

Doctor: *N'ase ki oroche igo?*

Why do you think so?

Patient: *Gose beite!*

Or they kill hemselves!

Doctor: *Gose beite?*

Or theu kill themselves?

Patient: *Igo babwate enkoro enke.*

They are so temperamental.

Doctor: *Kwanyatema kobakwanera igoro ya oborwaire bwokimi orore.*

Have you ever seen how they react if you tried to talk to them about HIV & AIDS?

Patient: *Obe! Yaya!*

Oh! No!

Doctor: *Orore buna barairanerie?*

You see how they will respond.

Patient: *Eyio tagitari tindakora*

That, I won't do, doctor.

Doctor: *Eyagosinyire mono?*

Is it very difficult?

Patient: *Ee naende tintageti gokwana igoro yenyamoreo nka seito.*

Yes, and i do not want to talk about HIV & AIDS at our home.

Doctor: *Nonya?*

At all?

Patient: *Mm.*

Mm.

Doctor: *Bono Moraa tiga ngotebie. Egento nkere tokoroka Disclosure. Disclosure n'ekero buna nyoko moke amanyete igoro ya HIV. Igere egento kia maana saana omoibori oo komanya igoro yestatus yao ya HIV. Moibori takogweita gse gokra gento kente kebe esengencho anyorire obwate eburusi ebio. Naseki ingotebera igo?*

Now Moraa let me advice you. There is something called disclosure. Disclosure is like when you got to know about your HIV status. You know it is very important for your parent to know your HIV status. A parent cannot commit suicide or do anything bad because you are HIV positive. Why do I say so?

Patient: *Mm.*

Mm.

Doctor: *Ee ekiagera, totebe rero kwanyorire TB.*

Yes, because lets say today you contract TB.

Patient: *Ee.*

Yes.

Doctor: *Ntoigwanaine?*

Are we together?

Patient: *Ee.*

Yes.

Doctor: *Onyore TB na nyoko moke nachiete esabari.*

You develop TB, and your aunt had travelled on a journey.

Patient: *Ee.*

Yes

Doctor: *Nyoko achiche. Nomanyete botambe omwana karwarire ng'o ogochia komoberisia nyagitari.*

Your mother comes. You know normally if a student gets sick who stays with her at the hospital.

Patient: *Gose ng'ina.*

It is the mother.

Doctor: *Ng'ina. Tari bo?*

The mother, isn't it?

Patient: *Ee.*

Yes.

Doctor: Bono omanyete ase chingaki chinyinge abana baito kobare nyagitari, omosista nabo arakagere ng'a ng'ina omwana namanyete igoro yendwari y'omwana oye, tari bo?

You know when our children are in admitted in hospital, the nurse might think that the mother knows about the status her child, isn't it?

Patient: *Ee.*

Yes.

Doctor: *Erio bonyorane na sister oyore egasi ase ewadi. Mm?*

Then they meet with with the nurse on duty at the ward. Mm?

Patient: *Ee.*

Yes.

Doctor: *Agende atebie nyoko. Bono erio aye nigo oraire, ore omorwaire…TB mbora nomanyete buna egokora omonto oba omorwaire mono. Tari bo?*

She proceeds at ask your mother….while in your sleep at the hospital bed….You know how TB makes someone very sick. Is that right?

Patient: *Ee.*

Yes

Doctor : *Nyoko nao are abwo akoberisetie. Rituko erimo sister otakomanyeti achiche aborie nyoko, "Mama Moraa, ng'ai amariogo aria y'ebirusi are ? Ng'ai amariogo aria y'evirusi Moraa akonywa are?" Ntebiengo ng'aki erabe?*

You mother is there taking care of you. One day without informing you, she asks your mother, "Where are the ARV drugs? Where are the ARV drugs that Moraa takes?" Tell me how this will be?

Patient : *Abwo igo erabe akong'u. Korende nche tagitari naye otamanyeti*

That will be difficult. However, doctor yu do not know something….

Doctor: *Mm.*

Mm.

Patient: *Nche esukuru ngosoma Nyabururu Girls, nenational school.*

I study in Nyabururu Girls, a national school.

Doctor: *Mm*

Mm.

Patient: *N'omanyete chibesa irenga togwakana aroro?*

Do you know how much we pay there?

Doctor: *Ninkoigwete.*

I get you.

Patient: Omoibori ang'akanere chibesa echi chionsi erio amanye ng'a n' HIV, omonto agokwa pi!

A parent pays for me all that money and then he/she know about the HIV status, someone will die completely!

Doctor: *Mm.*

Mm.

Patient: *Oroche ningenderere gosomigwa?*

Do you thinki will continue being supported in my studies?

Doctor : *Igo oragenderere naende mono kegima.*

Of course you will continue to get real support.

Patient : *Gochia bono mbuya amanye kinde nyagitari ewodi korende nche tinkomotebia.*

I will rather she knows when am admitted in the hospital ward but personally I wont disclose to her.

Doctor : *Bono oraisa komoreta rende tomotebie onye gwasinyirwe. Omanyete ntwe nabo tokonyara. Enchera nere torakwane n'abaibori tobaerese.*

Now, what if you you brought her for us to disclose to her if you are not able to. You know we can be able to do it. There is a way we can talk to your parent and explain to thems.

Patient : *Bono naki gose oramotebie? Ng'ai togochia na ninki togochia gokora? Mbora nyagetari togochia. Takomboria, "nkai orwarete?"*

Surely what can you tell her? Where are we going and what are we going to do?.... We are going to hospital…she will ask me, "where are you not feeling well."

Doctor : *Mbora igo okomotebia toigweti omotwe buya otagete akoire nyagetari. Aye okomoreta ekiriniki giaito toteme komokwanera tomotebie.*

You just tell her that you have a headache and you ask want her to take you to hospital. You bring her to our clinic we try to explain to her.

Patient : *Aye igo otagete tingorerwa nonya n'eyanga.*

You want me to risk not being bought even a dress.

Doctor : *Chianga nogorerwe naende buya mono Moraa. Korende nomanyete ase ensemo yaito ase nyagetari negento kieng'encho omoibori komanya igoro yokorwara kwao kwa HIV. Aye nigo oroche ng'a ekio n'egento otatageti goteba korende ninganetie orengererie boori agare…orengerie mono. Ekiagera nyoko moke takoba naye bogima bwao bwonsi.*

You will be bought clothers and very well so, Moraa. But you know on our part as doctors it is a very important for your parent yo know about your HIV status. You may take this as some secret you want to keep but I want you to think deeply ….think hard because your aunt is not going to be with you all your life.

Patient : *Abwo tagitari gwakwanire buya, korende bono*

You have spoken well doctor , but…

Doctor : *Mm.*

Mm.

Patient : *Tiga ngende gose ntebie makomoke, ache kobatebia. Inche gaaki tindochi gose ninyare goatoka erieta erio*

Or let me go and tell my aunt to come and tell them. Please I do not see if I am able to utter that word.

Doctor: *Ee nyokomoke, gwatebire buya. Nyokomoke nabo akomotebia atebie mam'omino…nyokomoke karasinywe gotebia mamomono tiga bache bonsi babere nyagetari tobasemie igoro ya HIV. Twaigwananire?*

Yes your aunt, you have put it well. Your auntie can tell your your mother ….. if your aunt finds it challanging to ell your mother, they can both come to the hospital we educate them about HIV & AIDS. Are we together?

Patient : *Ee ninteme.*

Yes i will try.

Doctor : *Ee tema naende orengererie naende okore omokia gaaki. Mbuya gotebia nyoko, ee?*

Yes, try to think about it and make efforts please. It is good to tell your mother, isn't it?

Patient : *Ee nabo*

Yes, it is true.

Doctor : *Na nigo gwateba ng'a tomanyeti ase kwaruseti HIV. Tari bo?*

And you said that you dont know how you contracted HIV. Is that right ?

Patient : *Ee.*

Yes.

Doctor : *N'obwate omosani omomura?*

Do you have a boyfriend?

Patient : *ee nimbwate omosani korwa kinde kerasi isano na isato.*

Yes I have had a friend since I was in class eight.

Doctor : *Kerasi isano na isato*

Class eight.

Patient: *Igo tochakerete kerasi isano na isato.*

We started in class eight.

Doctor: *Kerasi isano na isato?*

Class eight?

Patient: *Mm*

Mm.

Doctor: *Na nere more nere goikera bono?*

And are with him till now?

Patient: *Goika bono*

Up to now.

Doctor: *Omosani oyomo omomura?*

One boyfriend?

Patient: *Oyomo bweka, nche tinanya gotwara babere.*

Just one, I have never had two.

Doctor: *Ngosom' are?*

Does he go to school?

Patient: *Ee ngosom' are e national school ya Western.*

Yes he is a student in a national school in Western.

Doctor: *Ya Western?*

In Western?

Patient: *Mm.*

Mh.

Doctor : *Bono ndi mogocha mwaumerana?*

So when do you normally meet ?

Patient: *Anene mono engaki y'erusa buna bono nkomo nare nere.*

Mostly during holidays like now I was with him.

Doctor: *Mm.*

Mm.

Patient: *Ankooba ong'ikia aiga.*

He escorted me up to here.

Doctor: *Mm.*

Mm.

Patient: *Nao anganyete etaoni.*

He is waiting for me in town.

Doctor: *Mm. N'omogusii?*

Mm. Is he Gusii?

Patient : *Ee.*

Yes.

Doctor: *Ooh. N'amanyete igoro ya HIV yao?*

Oh okay. Does he know your HIV status?

Patient: *Ayie! Oyio bono nere ntatebie nonya ekiagera aise komanya.*

What! That one is the one I will never tell because if he knows…

Doctor: *Mm.*

Mm.

Patient : *Tagontiga?*

Wont he leave me?

Doctor : *Bono totebe, mbora nomanyete ng'a HIV n'egento…nkororana more kemobere?*

Now lets say, you know that HIV and AIDS is something… are you intimate?

Patient : *Ee ngokora tore.*

Yes we are.

Doctor : *Ngotumia more ekondomu?*

Do you use the condom?

Patient : *Rimo igo.*

Once in a while.

Doctor : *Once in a while?*

Doctor & Patient: Rimo igo

Once on a while…

Patient : Korende ekero twachagete…

But when we started…

Doctor : *Ehee.*

Okay.

Patient : *Ntwarenge gotumia ekondomu.*

We never used to use the condom.

Doctor : *Nonya ?*

At all?

Patient : *Togaika gati agachaka gontebia kero kende nimbaise kobwata oborito.*

We got to a point he started to tell me maybe I may conceive.

Doctor : *Mm.*

Mm.

Patient : *Ekero amatuk' ane atari safe.*

When my days are not safe.

Doctor : *Mm.*

Mm.

Patient : *Igo togotumia ekondomu.*

We use the condom.

Doctor : *ekondomu.*

Condom.

Patient : *Igo togotumia ekondomu.*

We use the condom.

Doctor : *Mm.*

Mm.

Patient : *Korende onye kinde safe…*

However, if I am safe…

Doctor : *Mm*

Mm.

Patient : *Ndioka igo.*

Just like that.

Doctor : *Ooh. Bono Moraa torochi buya bw'ogotebia omosani oo omomura igoro yao n'ere ache gopimwa?*

Oh. Now Moraa can't you see the benefit of informing your boyfriend about your status so that he can come for the test?

Patient : *Nche yaya tinkomotebia ekiagera bint'ebi ngosomigwa tore esukuru. Nere tiga aechorere erebweka agende apimwe, korende tintageti tokwane mang'ana a HIV.*

No, me I can't tell him because these things we are taught in school. Let him decide and go for the check up but I do not want us to discuss about HIV & AIDS issues.

Doctor : *Nonya?*

At all ?

Patient : *Ee.*

Yes.

Doctor : *Okey nche ndoche mbuya omokwanere igoro ya HIV nonya totageti komotebia ye hali yao.*

Okay, I think it is good to talk to him about HIV & AIDS even if you do not want to disclose your HIV status him.

Patient : *Ee.*

Ee.

Doctor : *Omotebie agende apimwe ebirusi gose mogende amo mopimwe ebirusi bia HIV.*

Tell him to go and check his HIV status or you can go together for the HIV test.

Patient : *Araisa konyora.*

And what if he gets….

Doctor : *Ehee!*

Eh!

Patient : *Araisa konyora nimbwate e virusi.*

If he gets i am HIV positive.

Doctor : *Ehee!*

Eh !

Patient : Na tanya gotwara mosani onde moiseke.

And he has never had any other girlfriend.

Doctor : Mm.

Mm.

Patient : *Ng'aki gose erabe?*

How will it be?

Doctor : *Omaete bono abwo ebinto nabo bigokong'a. Mm?*

You know hat will be a difficult situatuation. Mm.

Patient: *Inaki erabe.*

How will it be?

Doctor: *Nabo ekoba akong'u. Nabo ekoba akongu. Nabo ekonyarekana mogende nomosani oo mopimwe onyore abe negative naye positive; nabwo ntomanyeki ngaki torakore. Na ngakiende nabo arapimwe anyore kare positive atebe naye kwamoete ebirusi. Nabo araganie kogotiga gose mogenderere koba nere.*

It can be difficult. It can be difficult. It is possible you go with your boyfriend and you test and he turns out negative and you positive; and there we don't know what we will do. And at times he can do the test and he turns out to be positive and he accuses you for infecting him with HIV & AIDS. He may decde to leave you or you still contitue to be with him.

Patient: *Na monto torikomanya ngaki araire amachibu ayio.*

And you can't tell how he can react to the results.

Doctor: *Mono*

So much

Doctor: *Korende igere buya omosani oyooo amanye gose nabwate ebirusi gose tabwati kobua gotamanya. Omanyete nabo aranyore gose nakabwate omosandi onde nonya Western oyo bakoumerana gose ekero bachire noya nemechieso.*

But it is better for your friend to know if he is HIV positive of not than not knowing at all. You know you may find that he is having another friend even in Western who they meet maybe when they have gone for sports.

Patient: *Oria nanyare bori gotwara omonto onde? Amaene nigo mwegenete. Nkorengereia ng'a igo mwegenete.*

Can he really have another person? Honestly, I trust him. I think I trust him.

Doctor: *Nomanyete nomwegenete kegima?*

You know you trust him completely?

Patient: *Mm.*

Mm.

Doctor: *Omanyete buna ore aiga Moraa eh?*

You know Moraa as you are here, eh?

Patient : *Mm*

Mm

Doctor : *Omosani oo omomura nao are aiga.*

Your boyfriend is around.

Patient : *Mm.*

Mm.

Doctor : *Ekero kierusa kobakare sobo ntomanyeti gose nakabwate omoiseke onde.*

During holidays when they are at home we dont know if he has another girl.

Patient : *Ee.*

Yes.

Doctor : *Ntomanyeti, okwo nogokagera toranyare tu gokonya. Omanyete nonya komanyete estatus yao mbuya nere amanye eyaye mokonye ekenyoro.*

We do not know, that is just suspiscion so as to assist. You know even if you know your status, he also needs to know his status so that you can secure the local community.

Patient : *Ee.*

Yes.

Doctor : *Tiga totebe gose onye obonyorire nere onye kabwate omosani omoiseke onde naboigo abomoe, igo mbuya bori? Gose monyorane amatufo are bosio monyuomane naende onyore omwanna oo nere onyorire ebirusi. Mbuya erabe oroche?*

Lets assume he is infected and if he has another girlfriend he also infects her, is it really good? Or let's say you meet later on and marry you get blessed to a baby who also probably gets infected. Will it be okay?

Patient : *Yaya tekoba buya.*

No that wont be okay.

Doctor : *Aye ng'aki oroche?*

How do you see it?

Patient : *Teri buya.*

It is not good.

Doctor : *Omanyete kero kende nabo egokong'a nonya niche. Kero kende ntobwati kende ekio torakore, mm ? Korende mbuya omotebie buna omogesangio oo apimwe. Omanye konyora nka sobo otebirie abanto bamwabo bamanyire ng'a aye omosani oye, tari bo?*

You know at times it assists even me. At times we dont have anything that we can do, mm ? But it is good to tell him as your peer he goes for the test. You may find that in his home he has told this family and they know that you are his girlfriend, isnt it ?

Patient : *Ee.*

Yes

Doctor : *Ere obeire infected na totebe obeire infected na HIV.*

He has been infected and let's say he is infected with HIV & AIDS.

Patient : *Ee.*

Yes.

Doctor : *Anyore TB or meningitis akwe atamanyeti gose nabwate ebirusi.*

He gets TB and meningitis and passes on without establishing the HIV status.

Patient : *Mm.*

Mm.

Doctor : *Nonyigwete?*

Do you get me?

Patient : *Mm.*

Mm.

Doctor : *Tana komanya status chiaye, okure na meningitis. Abanto nka sobo bamanye Moraa n'ere omosani omoiseke bweka abeire nere. Aye oroche enka yabo naki erakoire koba ? Ng'o oratigare nere?*

He has never known his HIV status, he has died with menengitis. At his home, people get to know that Moraa was his only girl friend he has been with. How do you think his family will take you to be ? Who will you remain with ?

Patient : *Abwo nebe akong'u.*

That will be difficult.

Doctor : *Ng'o oratigare nere?*

Who will you remain with?

Patient : *Abwo nebe akong'u.*

That will be difficult.

Doctor : *Torochi yachire gokobetereria ogende korigia omosani omomura onde.*

You see now you will have to look for another boyfriend.

Patient : *Igo nkorigia oyonde.*

I will look for another one.

Doctor : *Erio?*

Then?

Patient : *Korakini nche tintageti korigia oyonde...*

But I dont want to look for another one.

Doctor : *Mm.*

Mm.

Patient : *[Egekogera riria nachagete gocha ekiriniki natebetigwe.*

[Because when i started attending clinic i was told….

Doctor : *Mm.*

Mm.

Patient : *[Ng'a titotwara abasani abamura abange.*

[That we should not have multiple partners.

Doctor : *Eeh*

Eh.

Patient : *Mbe n'oyomo bweka.*

I be with just one.

Doctor : *N'oyomo.*

With one.

Patient: *Naboigo totumie ekondomu. Igo n'erituko riria rinde agantebia ng'a tiga ntotumia tobe igo.*

And that we should use a condom. So, it is the other day he told me that we should not use one.

Doctor: *Mm.*

Mm.

Patient: *Ngasinywa komokania.*

I was not able to stop him.

Doctor: *Mm.*

Mm.

Patient: *N'abwo omochakano ngotumia twarenge ekinga.*

From the beginning we used to protect ourselves.

Doctor: *Bono rende torochi. N'omanyete igo ore sexually active ee?*

You see now. You know you are sexually active, right?

Patient: *Ee*

Yes

Doctor: *Ekinga n'erasima totumie*

We must use protection.

Patient: *Mm.*

Mm.

Doctor: *Twaigwananire?*

Are we in agreement?

Patient: *Ee.*

Yes.

Doctor: *Kabere tema komotebia agende apimwe n'onye totageti komotebia status, genda amo mopimwe HIV.*

Secondly, try to concince him to go for a test even and if you do not want to disclose your status to him, go for the HIV test together.

Patient : *Mm.*

Mm.

Doctor : *Ekeene kwarorire buna ekoba.*

Surely, you have seen how it happens.

Patient : *Ee.*

Yes.

Doctor: *Gakonyora TB akwe enka yaye igo egoteba ninwe mobwate e virusi na ninwe mwambokeretie omomura obo naboigo agakwa asengencho ya HIV nonya bamanyete ng'a HIV teri goita.*

If he gets TB and passes on, his family will accuse you.. for infecting their son causing the death even if they know that HIV does not kill.

Patient : *Ee. Nimanyete teri goita.*

Yes. I know it doesnt kill.

Doctor : *Egento kende tumia family planning. Ninki otarachakera gotumia family planning?*

Another thing is you need to use family planning. Why have you not stared using family planning?

Patient : *Bono onye twachagete nere emiaka eye yonsi…*

Now if we began being with him all these years…

Doctor : *Mm.*

Mm.

Patient : *Korwa kerasi isano isato.*

Since I was in class eight.

Doctor : *Mm.*

Mm.

Patient: *Na bono igo'nde form 3 na tinanakobwata borito. Igo oroche ng'a nche n'omoriri?*

And now I am in form three and I have never conceived. So you see I am studip ?

Doctor : *Mm.*

Mm.

Patient : *Nche n'omong'aini mono.*

I am very wise.

Doctor : *Aye n'omong'aini kegima.*

You are wise indeed.

Patient: *Ee bono nimanyete ng'aki ngokora egento ekio.*

Yes, I know how do that thing.

Doctor : *Nonya komanyete, ngaki ende nere egoika…*

Even if you know, a time comes…

Patient : *Mm*

Mm.

Doctor : *[Esako egoika yachenchi'ere. Nomanyete bo?*

You know that the cylce changes. Do you know that?

Patient : *Ngochenchi'ere?*

Does it change?

Doctor : *Esako bak'echenchie. Onye komanyete kobara esako yao buya, nabo okorora engaki amanyinga y'omotienyi agocha ngaki gete na ngaki ende anyorwa. Ngaki ende acha mapema ngaki ende acha chingaki echimo. Bono oise kobara chitariki bobe….*

The cycle has to change. If you know how to count your cycle well, you will note that there are times the menses comes at a particular time and at times it delays. At times it comes earlier and at times it occurs at the same dates. Now if you happen to countyour dates wrongly…

Patient : *Abwo aro emechando yasoire.*

There indeed problems will come.

Doctor : *Torochi igo okoba morito ?*

You see you will conceive?

Patient : *Gaaki nche tindi omoke gochaka gotumia family planning?*

But am I not too young to start using family planning?

Doctor : *Yaya family planning nabo egochaka koreng'ana buna ore sexually active, gochakera emiaka ikomi n'etano. Monto taiyo orakorine family planning. Amatuko aya ebinto biachenchirie Moraa.*

No family planning can begin when one becomes sexually active, from fifteen years. Nobody will deny you family planning. These days things have changed Moraa.

Patient : *Bono buna birebi ?*

Now like what ?

Doctor : *N'oroche buna bono igo togokoira e rumu ya family planning, kwaegwa ogosemia igoro y'echinchera chionsi. Korende asengencho aye n'omoiseke omoke…*

You see like now we will take you to the family planning room and you will be advised on all the methods. But because you are a young girl…

Patient : *Mm.*

Mm.

Doctor : *Igo togotumia chinchera chiria chi'engaki enke yaani short term family planning. Yaani oise gotiga gochitumia nabo okobogoria oborito kegima.*

We will use those short term methods in other words short term family planning. This means if you stop using them you can conceive immediately.

Patient : *Buna ereri eye?*

Like which one?

Doctor: *Buna gotumia chintetere chi'epill.*

Like the use of the pill tablets.

Patient : *Epill tari eriogo ngochia konywa buna aya.*

The pill is not medicine you will take like these ones.

Doctor : *Ee.*

Yes.

Patient : Nkonywa ?

I take ?

Doctor : *Ee.*

Yes.

Patient : *Yaya ayio.*

That no.

Doctor : *Totageti konywa ?*

You dont want to take ?

Patient: *Yaya.*

No.

Doctor : *Korende mbora nigo akonywa erimo rioka.*

But you just take only one.

Patient : *Erio yaya pi.*

That one not at all.

Doctor : *Aseki otatakereti konywa ?*

Why don't you want to pertake?

Patient : *Naende mente abe atato?*

I again add to make them three?

Doctor : *Mm.*

Mm.

Patient : *Eria kane?*

The fourth one?

Doctor : *Eria kane.*

The fourth one.

Patient : *Yaya.*

No

Doctor : *Toritageti?*

You dont want it ?

Patient : *Erio yaya.*

That one no.

Doctor : *Esindano ya DEPO nereo.*

There is a DEPO injection.

Patient : *Nagochi bono rirorio esindano.*

I will rather an injection then.

Doctor : *Ee okobetwa kera emetienyi etato. Korende bono eyio nigo eragokore onyorwe konyora omwana ekero oraike engaki eria y'okonyora omwana.*

Yes you get an injection every five months. However, that will make you delay from giving birth when you will want to.

Patient : *Eyio yaya bono nainche.*

I dont want that one then.

Doctor : *Mm.*

Mm.

Patient : *Tari buna nanywomirwe.*

Not that I am married.

Doctor : *Mm.*

Mm.

Patient : *N'omonto tokororana…*

It's someone we see each other…

Doctor : *Mm.*

Mm.

Patient : *[Rimo…*

[Once…

Doctor : *Mm.*

Mm.

Patient : *[Totebe gatato.*

[Lets say three times.

Doctor : *Mm.*

Mm.

Patient : *Ebinto bun'ebio yaya.*

Such things no.

Doctor : *N'omanyete tobaise koba gokonywa contraceptive eria ekorokwa emergency pill. N'omanyete emergency pill nigo egokora omonto otwara complications chi'enda y'oroiboro.*

And you know do not be taking that contraceptive called the emergency pill. You know the emergency pill makes someone to develop complications in the uterus.

Patient : *Eyio ngochande nanyetumia kero kende.*

I normally use that one at times.

Doctor : *Epill eyio yaya. E pill eye tari nchera y'okobanga oroiboro. Eyio n' emergency togotumia ase abanto bakururirwe. Tomanyeti ogokururwa?*

That pill is inappropriate. This pill is not recommenced for family planning. It is an emergency pill we use for people who have been raped. Don't you know rape?

Patient : *Eriogo erio…*

That medicine…

Doctor: *Mm.*

Mm.

Patient: *Inche nkonywa gose ndiria ogotumia chinsa 78 chitaraera?*

Am I the one to take it or is it the one you use before 78 hours expire?

Doctor: *Mm*

Mm.

Patient: *Erio ngotumia nde.*

I use that one.

Doctor: *Erio oritumie mono n'onyore emechando y'enda y'oroiboro. Kwaigure?*

If you use that medicine for long you will have problems in the uterus. Do you hear?

Patient: *Buya mono.*

Very well.

Doctor: *N'ereo e implant tokobeka aiga. Korende eyio n'eyengaki entambe.*

There is one which is an implant we put here. But that is long-term method.

Patient: *Gaaki igo indagania kobeka eyio y'engaki entambe egeka kaa ngokora high school ngende eyunibasiti.*

Please I will need to put that long term one to cover all this time till I finish high school and proceed to university.

Doctor: *Mm.*

Mm.

Patient: *Erio manye konywomwa. Tirikorankonya?*

Then I can get married. Will it not have helped me?

Doctor: *Ndigokonye. N'erigiya ase engaki entambe korende obokong'u mboria ng'a tokonyora mwana bwango kegima.*

It will help you. It is a good in the longrun but the problem is you wont give birth immediately afterwards.

Patient: *Ndibwate omochando.*

It has a problem.

Doctor: *Gwatebigwe? Mm igo eyio naende ntwancheti ritumeke ase omonto oria otana konyora mwana nakio oroche togotebera ing'a enchera engiya n'gotumia pills. Nche ntagete oikaranse nse orengererie.*

Have you been told? Mm… so we also do not recommend it for someone who has not given birth, that is why we are saying that the best method is to use pills. I want you to sit down and think.

Patient: *Ee bono*

Okay.

Doctor: *Orengererie, mbuya korengereria. Tingokobetereria korende orengererie n'ekero kia beene ochake kobanga oroiboro. Tonyora oborito obwo otarabangera. Torochi ngwantebia nigo ore enational school?*

You think, it is good to think. I cannot force you but let you to think and at the right time you start family planning. You do not need to get a pregnancy you have not planned for. You see, you told me you are in a national school.

Patient: *Ee.*

Yes.

Doctor: *Omanye konyora oborito.*

Then you get pregnant.

Patient: *Ah oborito naborobwo tagitari.*

Ah…just pregnancy doctor…

Doctor: *Onyore oborito obwo…*

You get that pregnancy…

Patient: *Ninyerendete mono.*

I am very careful.

Doctor: *Mbwerendete?*

Are you taking care?

Patient: *Ee.*

Yes.

Doctor: *Mono?*

Very?

Patient: *Mm.*

Mm.

Doctor: *Korende rengereria kobanga oroiboro mapema.*

But think of family planning early.

Patient: *Eyio nimotebie.*

That I will tell him.

Doctor: *Oyio oyomo.*

That one?

Patient: *Nimotebie omosani oyio one ndore gose nanche.*

I will tell my boy friend i see if he will agree.

Doctor: *Igo mbuya.*

That is good.

Patient: *N'egento nkere gwantebia igoro y'oyo gopimwa.*

And there is something you told me about being tested.

Doctor: *Ee*

Yes

Patient: *Tinkoramotebia bwango iga.*

I won't tell him soon.

Doctor: *Mm.*

Mm.

Patient: *Igo ngocha komotebia December.*

I will tell him in December.

Doctor: *Totageti komotebia. Nki gwachorera December?*

You dont want to tell him. Why did you choose December?

Patient: *December.*

December.

Tagitari: *Mm.*

Mm.

Patient: *Ekero tokare erusa entambe.*

When we shall be on long holidays.

Doctor: *Mm.*

Mm.

Patient: *Nario ndamotebi. Ngocha are ong'ira etaro iga rende.*

That is when i can tell him. He normally comes and takes me out at least.

Doctor: *Mm.*

Mm.

Patient: *Nario ndamotebie tochie topimwe na tari aiga Gusii.*

Thats when i can tell hime we go for the test and not here in Gusii.

Doctor: *Ehee.*

Okay.

Patient: *Yaya.*

No.

Tagitari: *Ehee*

Okay

Patient: *Togende nonya nKisumu.*

We go even to Kisumu.

Doctor: *Abwo igo orakore buya. Eyio ngokoa tu chingaki. Nimanyete nakong'u gokwana igoro ya HIV yao gochia ase omonto onde.*

That will be good. Then I give you the time. I know it is difficult to disclose your HIV status to another person.

Patient: Igo *mbuya.*

That is good.

Tagitari: *Igo onye gwanchire buna nDecember mm ... igo torabe tokobwatia igoro yao tomanye gose kwamotebirie mokogenda etaro eyio. Motebie toba n'obwoba. Kegosinya, aye ochiche. Ochiche otoerese ng'a igo gwasinyetwe pi komotebia.*

Then if you have agreed that its Deceember… we will be following your case we get to know if you have convinced him for that outing. Tell him don't be afraid. If it is impossible, you just come. Come and explain to us that you couldn't manage to tell him.

Patient: *Mm.*

Mm.

Doctor: *Nabo tokomoikera.*

We can get him.

Patient: *Igo?*

Like that?

Doctor: *Oyio tari omonto oranyare gotebia nkobe gochia nyagetari?*

Is that not someone you can tell to escort you to hospital?

Patient: *Ee*

Yes.

Doctor: *Igo agocha, toigwanane, tomopime.*

He will come, we agree with each other, and test him.

Patient: *Igo mbuya.*

That is good.

Doctor: *Igo twatebire rero onywe eriogo n'echinsa. Oenekie ng'a kwagorire ensa y'okoboko ogende nero esukuru. Tari bo?*

So, we have said you take your medicine in the required times. Ensure that you have bought a wrist watch and go with it to school. Isn't it so?

Patient: *Mm.*

Mm.

Patient: *Na nchera ende gaki tagitari teiyo moranchencherie eriogo eri?*

And there is no other way you can change for me this drug?

Doctor: *Gaaki ntokonyara gochenchia riogo. Obuya bw'eriogo eri nabo okoribuna omere.*

Plese we cannot manage to change for you the drugs. The advantage of this dru gis you can break it and swallow.

Patient: *Ndibune gose…*

I break it or…

Doctor: *Ee nabo onye gwasinyirwe konywa eri rire iga.*

Yes, you can if you you are not able to take like this one.

Patient: *Ee.*

Yes.

Doctor: *Nabo okoribuna.*

You can break it.

Patient: *Bono eri nario eriogo ndabe nkonywa obogima bwane bwonsi buna rire rinene iga?*

Now is this the drug I will be taking for the rest of my life as big as it is?

Doctor: *ARVs igo togochinywa obogima bwaito bwonsi pi. Twaigwananire?*

We take ARVs all through our lives. Are we together?

Patient: *Ee.*

Yes.

Doctor: *Korende otanyweti eriogo riao buya, bono ig' okonywa eriogo ria ARV rikorokwa first line. Ayande nareo akorokwa second line, n'ayande third line.*

But if you don't adhere to your uptake of medicine, now you are doing the firstline type of ARV drugs. The others are called secondline and thirdline.

Patient : *Ah.*

Okay

Doctor: *Otanyweti eri first line buya…*

If you don't take your medicine well…

Patient: *Ee.*

Yes.

Doctor: *Nkai togochakera, egento nkere tokoroka failure. Kogofail amariogo aya iga amatang'ani igo togokoira ase aya second line. Kwarorire ekio togosingerera? Ikomereri onywe first line. Onye nogofail, tiga ofail as'engencho eriogo riafail. Korende tofail as'engencho tonyweti riogo buya. Omanyete bono igo ekoba n'emechando emenge.*

Where do we begin from… there is something we called failure. If you fail in the firstline medicine, we will put you on the sesondline ones. Can you see why we are insisting? Force yourself to take firstline. Should you fail then let it be that it is the drugs that have failed. But do not fail because you didn't take your medicine well. You know now that will bring more challenges.

Patient: *Ninywe eriogo tu daktari.*

I will just take the drugs doctor.

Doctor: *Tagoteba ng'a nonywe tu. Ntagete oamue ng'a norinywe buya mono.*

Do not say that you will just take the drugs. I want you to decide that you will adhere to the uptake of your medicine.

Patient: *Buya mono.*

Very well.

Doctor: *Ntoigwanaine? Oise konywa buya n'onya n'omobere igo okonara. Omanyete nchera ende teiyo torakore mm?*

Are we in agreement. If you take your medicine well even the body will get used. You know there is no other way we can use…mm?

Patient: *Ee*

Yes

Doctor: Totiga konywa eriogo Moraa.

Do not stop taking the medicine Moraa.

Patient: *Mm.*

Mm.

Doctor: *Tari bo?*

Okay?

Patient: *Ee.*

Yes.

Doctor: *Bono tiga tororane omokubio ogocha.*

Now lets meet next week.

Patient: *Mm.*

Mm.

Doctor: *Enekia ng'a kwabangire komotebia omosani oo omomura igoro yao na HIV, ogopimwa. Tema boigo n'abaibori bamanye. Twaigwananire?*

Ensure that you have planned to disclose your HIV status to your boyfriend and the test. Try and inform your parents too. Are we in agreement ?

Patient: *Gaki mbuya mono tagitari. Gwankwaneire buya. Kero kende ekero ngocha ekiriniki, gaki abanyagetari bande igo bagonkwanera bobe nagechigwa.*

Please thanks a lot Doctor. You have told me well. Sometimes when i come for clinic some doctors do not talk to me well, so i normally get annoyed.

Doctor: *Kwagechigwa.*

You get annoyed.

Patient: *Ninki gekogera batana gontebia mang'ana aya onsi?*

Why have they not told me all these information?

Doctor: *Bono rero kwamanyire.*

Now today you know.

Patient: *N'eriogo n'eriamatuko arenga okong'a?*

And you will give me drugs for how many days?

Doctor: *Ekiagera okogenda esukuru, tiga nkoe eri'emetienyi etato.*

Since you will be going back to school, I will give you for five months.

Patient: *Etato?*

Five?

Doctor: *Ee.*

Yes.

Patient: *Mbuya mono.*

Thank you.

Doctor: *Nario ase ogocha kwao konde topime viral manyinga y'okoboko.*

So that when you will come we will the viral load of your blood from your arm.

Patient: *Ee.*

Yes.

Doctor: *Iiga rende. Oike buya?*

Yes. Travel well?

Patient: *Ee.*

Yes.

Doctor: *Orore eriogo abwo e pharmacy.*

Pick the drugs at the pharmacy.

Patient: *Ee gaaki asante.*

Yes, please thanks.

Appendix xviii. HIV and AIDS 4 consultation

Doctor: *Elizabeth*

Elizabeth

Patient: *Ee!*

Yes!

Doctor: *Naki ogoteba?*

How are you?

Patient: *Mbuya mono tagitari.*

Very fine doctor.

Doctor: *Nao ore buya?*

You are fine?

Patient: *Mbuya nde kegima.*

I am quite fine.

Doctor: *Naki ogendererete rero?*

How are you doing today?

Patient: *Mbuya ngendererete.*

I am doing well.

Doctor: *Eh.*

Okay.

Patient: *Nonya n'omwana torochi omentire chikiro?*

Even the baby you see has added more kilos?

Doctor: *Ee nabo ndoche mbuya sana gwakorire.*

Yes, I see you have done well.

Patient: *Ee ee.*

Yes, yes.

Doctor: *Nagendererete kogonka?*

Is she still breastfeeding?

Patient: *Ee omwana nkogonka are?*

Yes, the child breastfeeds.

Doctor: *Mm.*

Mm.

Patient: *Korende kero kende ndoche ng'a nabo mbaise komoa akarongori.*

But sometimes I see myself giving her some little porridge.

Doctor: *Mm.*

Mm.

Patient: *Ee*

Yes

Doctor: *Yaya*

No.

Patient: *Gose… gose…erongori gose ebiasi. Eh?*

Or…or… porridge or potatoes. Eh?

Doctor: *Nki gekogera otagete tomoe erongori? Nki gekogera otagete komorageria?*

Why do you want us to give her porridge? Why do you want to wean her?

Patient: *Asengencho tagitari ndoche ng'a obeire omonene ake.*

It is because I see she is is growing doctor.

Doctor: *Mm.*

Mm.

Patient*: Nimbwate ebiasara.*

I have some business.

Doctor: *Mm.*

Mm.

Patient: *Igo ngotiga omwana…*

So I leave the child…

Doctor: *Mm.*

Mm.

Patient: *Nka.*

At home.

Doctor: *Mm*

Mm

Patient: *Bono ginkomotiga nka…*

Now if I leave her at home…

Doctor: *Mm.*

Mm.

Patient: *Tari konyora mabere aisaine.*

She doesn't get enough milk.

Doctor: *Mm.*

Mm.

Patient: *Torochi rende.*

You see now.

Doctor: *Mm.*

Mm.

Patient: *Mochakie nonya n'akarongori iga*

I introduce her to some little porridge at least.

Doctor: *Na bono.*

And now

Patient: M*m.*

Mm.

Doctor: *Emeremo eye ogokora, ng'ai omenyete?*

This work you do, where do you stay?

Patient: *Nche?*

Myself ?

Doctor: *Ee.*

Yes.

Patient: *N'aria Daracha menyete.*

I stay there at Daraja.

Doctor: *N'emeremo ng'ai okonyekorera?*

And where do you work from?

Patient: *Emeremo igo nkoyekorera ase chichiro.*

I work at the markets.

Doctor: *Ase chichiro.*

At the markets.

Patient: *Na igo ekobwatia rituko ri'echiro.*

So, it depends on the day of the market.

Doctor: *Mm.*

Mm.

Patient: *Kero kende nagenda Nyakoe.*

Sometimes I go to Nyakoe.

Doctor: *Mm.*

Mm.

Patient: *Keroka.*

Keroka.

Doctor: *Mm.*

Mm.

Patient: *Kero kende aiga Daraja.*

Sometimes here in Daraja.

Doctor: *Ooh.*

Ooh.

Patient: *Ee.*

Yes.

Doctor: *Na gwatemire kobogoria omwana kera engaki ogokora emeremo anene mono ekero ogokora oboonchoreria?*

And have you tried to carry your child every time you are working especially when doing business?

Patient: *Eyio tinkonyara tagitari.*

That, I am not able to do.

Doctor: *Bono.*

Now.

Patient: *Aa eyio igo erabe akong'u.*

Ah! That will be difficult.

Doctor: *Bono Eliza…*

Now Eliza…

Patient: *Ee.*

Yes.

Doctor: *Noinyore togokora amasomo igoro y'obuya bw'okogonkia omwana?*

Can you remember our lessons on the advantages of breastfeeding?

Patient: *Ee.*

Yes.

Doctor: *Tari bo?*

Is that not so?

Patient: *Ee.*

Yes.

Doctor: *Togateba gokogonkia omwana emetienyi etano na rimo igo akonyora e faida ya…*

We said that if you breastfeed a child for six months she gets the benefits of

Patient: *Ee.*

Yes.

Doctor: *Amabere a ng'ina, tari bo?*

The mother's breastmilk, isn't it?

Patient: *Ee.*

Yes.

Doctor: *Na togateba ng'a…*

And we said that…

Patient: *Ee.*

Yes.

Doctor: *Ekero okogonkia omwana…*

Whey you are breastfeeding a child…

Patient: *Mm.*

Doctor: *Tekogwenereti koburukania n'echindagera chinde goika akore emetienyi erenga?*

You are not supposed to mix breastmilk with other foods until the child is how many months old?

Patient: *Emetienyi etano na rimo.*

Six months.

Doctor: Emetienyi etano na rimo na onye tokonyara…

Six months and if you cannot manage…

Patient: *Mm.*

Mm.

Doctor: *Kogenderera komogonkia…*

To continue to breastfeed her…

Patient: *Mm.*

Mm.

Doctor: *Igo twatebete kogochaka komoburukaneria endagera n'amabere y'okogonkia...*

We said if you start mixing other foods with breastmilk…

Patient: *Ee.*

Yes.

Doctor: *Igo akonyora e biini.*

The child will be infected with the virus.

Patient: *Igo twa…*

So we…

Doctor: *Tari bo twatebete?*

Is that not what we said?

Patient: *Ee tagitari nainyoire.*

Yes doctor, I remember.

Doctor: *Ntotageti onyore ebiini.*

We dont want her to get infected with the virus.

Patient: *Ee.*

Yes.

Doctor: *Bono onye koroche ng'a emeremo igo ekogochanda kogonkia omwana mm…*

Now if you see that your work is a bother to your breastfeeding the child mm…

Patient: *Mm.*

Mm.

Doctor: *Nabo okomotigia komogonkia kabisa.*

You can stop breastfeeding her completely.

Patient: Oh.

Oh.

Doctor: *Omoe endagera.*

You give her food.

Patient: Endagera.

Food.

Doctor: *Korende tomoirania ase orobere.*

But do not take her back to the breast.

Patient: *Ooh bono tagitari…*

Oh now doctor…

Doctor: *Mm.*

Mm.

Patient: *Nimotige komogonkia emetienyi enne?*

Can I stop breastfeeding her at four months?

Doctor: *Bono omanyete ntobwati eki torakore.*

Now you know there is nothing we can do.

Patient: *Mm.*

Mm.

Doctor: *Mm? Ekiagera enchera eyemo…*

Mm ? Because one way…

Patient: *Mm.*

Mm.

Doctor: *Riorio omotige komogonkia omwana kegima omoe endagera*

Unless you stop breastfeeding your child completely, and start giving her food.

Patient: *Mm.*

Mm.

Doctor: *Ekiagera emeremo yabeire emekong'u.*

Because of the challenge of work.

Patient: *Mm.*

Mm.

Doctor: *Torochi emeremo igo okogenda korwa echiro gochia eyende?*

Can't you see your work involves moving from one market to another?

Patient: *Mm.*

Mm.

Doctor: *Chibesa tari abana okorigeria?*

Arent you looking for money for your kids ?

Patient: *Mm.*

Mm.

Doctor: *N'oyo n'omwana oo ogatato.*

And this is your third-born child.

Patient: *Mm.*

Mm.

Doctor: *Otakoreti bo bono abande…*

If you do not do so then the others…

Patient: *Mm.*

Mm.

Doctor: *Ng'ai bagochia konyora endagera? Tari bo?*

Where will they get food? Isn't it so?

Patient: *Mm.*

Mm.

Doctor: *Kabere,…*

Second,…

Patient: *Mm.*

Mm.

Doctor: *Onye kore n'okobua gw'okomobogoria…*

If you decide to carry her…

Patient: *Mm*

Mm.

Doctor: *Kogenda echiro.*

To the market.

Patient: *Mm.*

Mm.

Doctor: *Mbuya.*

Its fine.

Patient: *Mm.*

Mm.

Doctor: *Bogoria omwana oo omogonkie.*

Carry your child and breastfeed her.

Patient: *Mm.*

Mm.

Doctor: *Acha teiyo kobogoria gotiga omwana nyomba.*

There is no point of leaving your child at home.

Patient: *Mm.*

Mm.

Doctor: *Mm?*

Mm ?

Patient: *Mm.*

Mm.

Doctor: *Aegwe erongori.*

She is given porridge.

Patient: *Mm.*

Mm.

Doctor: *Aegwe endagera buna ebokima…*

She is given foods like ugali…

Patient: *Mm.*

Mm.

Doctor: *Amatoke erinde morogoba gwacha kwamogonkia.*

Bananas then in the evening you come to breastfeed her!

Patient: *Mm.*

Mm.

Doctor: *Igo torabe twachakire koburukania erio onyore ebiini na titotageti omwana akorerwe egento gekorokwa mixed food*

We will have started to mix and she ends up getting the virus, and we do not want the kid to have what is called "mixed food".

Patient: *Korende tagitari…*

But doctor…

Doctor: *Mm.*

Mm.

Patient: *Tindi korora abasani bane aria ase echiro…*

Don't I see my friends there at the market…

Doctor: *Mm.*

Mm.

Patient: *Mbare nkorora.*

There are some I see.

Doctor: *Mm.*

Mm.

Patient: *Tomanyaine tore positive.*

We know each other as being positive.

Doctor: *Mm.*

Mm.

Patient: *Na nkogamba tore.*

And we do talk.

Doctor: *Mm.*

Mm.

Patient: *Bono rende naigwete bagontebia…*

But then i heard them tell me…

Doctor: *Mm.*

Mm.

Patient: *Omwana oyo ntwamoete eriogo riria riesyrup.*

We gave this kid that medicine in form of a syrup.

Doctor: *Mm.*

Mm.

Patient: *Timanyeti gose ng'aki mokoriroka gose Nevirapine gose naki.*

I don't know what you call it, whether Nevirapine or something.

Doctor: *Mm Nevirapine.*

Mm Neverapine.

Patient: *Ntwamoete eyio teramokonya tagitari ninsa komoa nonya n'obokima*

We gave her but it hasn't assisted her even if I gave her ugali.

Doctor: *(amaseko) Bono Elizabeth…*

(laughter)Now Elizabeth…

Patient: *Ee.*

Yes.

Doctor: *Nevirapine.*

Nevirapine…

Patient: *Ee.*

Yes.

Doctor: *N'eriogo rigiya mono ase omwana.*

Is very good medicine for a child.

Patient: *Ee.*

Yes.

Doctor: *Noigwete?*

Do you get me?

Patient: *Ee.*

Yes.

Doctor: *Igo tokoa omwana korwa okoiborwa kwaye goika emetienyi etato.*

We give the child from birth up to three months of age.

Patient: *Mm.*

Mm.

Doctor: *Torochi rende?*

You see now?

Patient: *Mm.*

Mm.

Doctor: *Korende Nevirapine…*

But Nevirapine…

Patient: *Mm.*

Mm.

Doctor: *Oroche twaeire omwana korwa okoiborwa goika emetienyi etato*

You see we have given the child since she was born up to three months.

Patient: *Mm.*

Mm.

Doctor: *N'omwana oo nemetienyio erenga abwate?*

And how many months does your child have?

Patient: *Emetienyi enne.*

Four months.

Doctor: *Oetanirie emetienyi etato.*

She is past three months.

Patient: *Mm.*

Mm.

Doctor: *Omwana igo akoegwa emetienyi etato asengencho emetienyi eyio neyengencho mono.*

A child is given for three months because those months are very important.

Patient: *Mm.*

Mm.

Doctor: *N'amabere ya ng'ina omwana nigo are n'ebiini.*

And a mother's breastmilk has the virus.

Patient: *Mm.*

Mm.

Doctor: *Na Nevirapine…*

And Nevirapine…

Patient: *Mm.*

Mm.

Doctor: *Nigo egokora egasi ekero ng'ina omwana akoragera buya na ekero omwana atari koburukanerigwa endagera.*

Works well wen the mother to the child eats well and when the child is under exclusive breastfeeding.

Patient: *Mm.*

Mm.

Doctor: *Twaigwananire?*

Are we together?

Patient: *Mm.*

Mm.

Doctor: *Bono otabwateti machiko buna togoteba…*

Now if you do not follow these directions as we state them…

Patient: *Mm.*

Mm.

Doctor: *Na tomoa Nevirapine.*

And you do not give her Nevirapine.

Patient: *Mm.*

Mm.

Doctor: *Igo akonyora oborwaire.*

She will contract the disease.

Patient: *Mm.*

Mm.

Doctor: *Okoburukanerigwa gwoka igo akonyora oborwaire*

Patient: *Mm.*

Mm.

Doctor: *Na oinyore buna omwana oyo agendererete gokina…*

And remember as your child continues to grow…

Patient: *Mm.*

Mm.

Doctor: *Igo agendererete komenta koba enyamasi ere bweka omonyene.*

She continues to develop her own immunity.

Patient: *Mm.*

Mm.

Doctor: *Ntoigwanaine?*

Are we together ?

Patient: *Mm.*

Mm.

Doctor: *Bono igo ebetereretie…*

So, in the worst-case scenario...

Patient: *Mm.*

Mm.

Doctor: *Onache ebirengererio aye bweka.*

You make up your mind alone.

Patient: *Mm.*

Mm.

Doctor: *Nche igo nkogosemia ng'a…*

I advice you that…

Patient: *Mm.*

Mm.

Doctor: *Mbuya kogonkia omwana ase emetienyi etano na rimo.*

It is better to breastfeed a child for six months.

Patient: *Ee.*

Yes.

Doctor: *Amabere ayio'ka.*

That milk exclusively.

Patient: *Ee.*

Yes.

Doctor: *Asengencho…*

Because…

Patient: *Ee.*

Yes.

Doctor: *Y'obuya bw'amabere y'okogonkia.*

Of the value of breastmilk.

Patient: *Mm.*

Mm.

Doctor: *Omwana takoba kagosaa achachi, koroka, takoba gakoba morwaire achachi.*

A child won't diarrhoea at all, vomit; she wont get sick at all.

Patient: *Mm.*

Mm.

Doctor: *Ekiagera akonyora obuya mono kobua omwana oria otigigwe kogonkigwa mapema.*

Because she gets more benefits than one who stops breastfeeding at an early age.

Patient: *Mm.*

Mm.

Doctor: *Amaene otigie kogonkia omwana nigo torabe tokonyorana naye aiga ase e ward.*

Honestly if you stop breastfeeding your child we will be meeting here at the ward.

Patient: *Mm.*

Mm.

Doctor: *Kera rituko omwana igo agosaa, rinde onyorire pneumonia tari koragera buya.*

Every day a child diarrhoeas, at times she gets pneumonia and doesn't eat well.

Patient: *Mm.*

Mm.

Doctor: *Onyorire kwashiorkor.*

She has gotten kwashiorkor…

Patient: *Mm.*

Mm.

Doctor: *Kwamotiga nka tomanyeti gose orageire buya.*

You leave her at home and you do not know if she has eaten well.

Patient: *Mm.*

Mm.

Doctor: *Omanyete abanto togotigera abana ntomanyeti gose nkobaa bare endagera. Tari bo?*

You know the people we leave our kids with we do not know whether they give them food. Is that not so?

Patient: *Mm.*

Mm.

Doctor: *Igo ase ensemo y'ekiriniki mbuya kogonkia omwana ase emetienyi etano nomo.*

So, on the part of the clinic it is better to breastfeed a child for six months.

Patient: *Mm.*

Mm.

Doctor: *Korende mbare togwanchera. Mbare emeremo yabereire emekong'u. Igo togotema gosanga ebirengererio.*

But there are those we allow. There are those whose work is quite challenging. We try to share ideas.

Patient: *Mm.*

Mm.

Doctor: *Toigwanane ng'aki egocha koba. Tari bo?*

Let us agree on how it should be. Isn't it?

Patient: *Mm.*

Mm.

Doctor: *Gekonyarekana tema buna okonyara obogorie omwana.*

If it is possible, try as much as you can and carry your child.

Patient: *Mm.*

Mm.

Doctor: *Genda nere emeremo, tema ogonkie omwana ase emetienyi etano na rimo ekiagera obuya igo bore obonge kobua omwana oria ochakeirwe endagera n'erongori mapema omanya gotigigwa emetienyi etano na rimo etaraera.*

Go with her to work, try to breastfeed your child for six months because the advantages are more than that child who is weaned early with food and porridge and is stopped from breastfeeding before six months elapse.

Patient: *Tagitari nakoigure buya na nararire ogosemia oko kwao…*

Doctor, I have gotten you well, i see your advice…

Doctor: *Mm.*

Mm.

Patient: *Nokuya…*

Is good.

Doctor: *Mm.*

Mm.

Patient: *Korende…*

However…

Doctor: *Mm.*

Mm.

Patient: *Kero kende tagitari mwaba mogototegerera.*

Sometimes doctor you need to listen to us.

Doctor: *Mm.*

Mm.

Patient: *Ebiasara ebi biane…*

This business of mine…

Doctor: *Mm.*

Mm.

Patient: *Oyo n'omwana one.*

This is my child.

Doctor: *Mm.*

Mm.

Patient: *Ogatato. Torochi?*

The third-born. You see?

Doctor: *Mm.*

Mm.

Patient: *Oria onde ekero nachete ekiriniki kinde positive eh?*

The other one when I came for clinic wheni was positive, huh?

Doctor: *Mm.*

Mm.

Patient: *Oria onde.*

The other one.

Doctor: *Mm.*

Mm.

Patient: *Na nigo namoete endagera.*

And I gave him food.

Doctor: *Mm.*

Mm.

Patient: *Emetienyi enne.*

Four months.

Doctor: *Mm.*

Mm.

Doctor: *Eh.*

Eh.

Patient: *Na bono igo are negative.*

And now he is negative.

Doctor: *Mm.*

Mm.

Patient: *Ee.*

Yes.

Doctor: *Mm.*

Mm.

Patient: *Bono korende nararire ogosemia okwo. Ninteme mono.*

Now nevertheless I have seen your advice. I will try hard.

Doctor: *Mm.*

Mm.

Patient: *Korende naboigo tagitari kero kende mobe mokorigereria momanye.*

But also, doctor sometimes try to be vigilant to know.

Doctor: *Mm.*

Mm.

Patient: *Buna togotema.*

How we try.

Doctor: *Naigure.*

I have heard.

Patient: *Ekiagera omwana oria onde igo arenge … igo nare komoa endagera na komogonkia nainche erio kinde positive*

Because the other child was…I used to give him food while I breastfeed him while I am positive.

Doctor: *Mm.*

Mm.

Patient: *Na bono igo are negative.*

And he is negative now.

Doctor: *Mm. Igo nigo ogoteba ng'a igo kware komoa endagera kogendererete komogonkia engaki eyemo.*

Mm. So you are saying that you used to give him food as you breastfed him at the same time.

Patient: *Ee akaba negative.*

Yes, he became negative.

Doctor: *Akaba negative.*

He became negative.

Patient: *Nonya n'oyo tinkomoa endagera?*

Can't I give even this one food?

Doctor: *Yaya.*

No.

Patient: *Ee.*

Yes.

Doctor: *Titogokora igo okoburukania okwo kw'endagera n'amabere kware gokora abwo kare.*

We cannot do that mixing of food and milk you used to do in the past.

Patient: *Ee.*

Yes.

Doctor: *Igo kware amamocha. Oria okoete …igo enga buna tikwaetwe gosemia buya.*

Was a mistake. Whoever gave you…it is like you never got wise counsel.

Patient: *Mm.*

Mm.

Doctor: *Titori koburukania mabere y'orobere n'endagera.*

We do not mix breastmilk with food.

Patient: *Ooh.*

Oh.

Doctor: *Na onye obete negative ekio negekone ekenene mono kegima. Twaigwananire?*

And if he became negative that is quite a miracle indeed. Are we together?

Patient: *Mm.*

Mm.

Doctor: *Korende ase bono...*

But for now…

Patient: *Mm.*

Mm.

Doctor: *Obotuki bwakorirwe buya.*

More refined research has been done.

Patient: *Mm.*

Mm.

Doctor: *Na bwanyorire ng'a…*

And it has found out that…

Patient: *Mm.*

Mm.

Doctor: *Gokoburukania endagera n'amabere gokogonkia omwana kogasaine komorageria*

Patient: Mm.

Mm.

Doctor: *Amaene goika anyore ebiini. Eyio goika anyore ebiini. Abwo kende tikeri togokwana. Twaigwananire?*

Patient: *Mm.*

Mm.

Doctor: *Kero kende engaki eria tikware kogonkia mono.*

Maybe that time you were not breasfeeding too much.

Patient: *Ee.*

Yes.

Doctor: *Igo kware komoa endagera mono kobua buna kware komogonkia. Korende oburukanie bono obe gokomoa erongori kogendererete gokomogonkia amaene goika anyore ebiini.*

You were giving him more food than you breastfed him. However, now if you give him porridge while you continue breatfeeding him, he will surely contract the virus.

Patient: *Mbuya tagitari nche ndoche ng'a buna gwantebirie tiga mbwatie amaagizo ayio. Tintageti mwana one abe positive.*

It is okay doctor, I see what you have told me let me follow your pieces of advice. I do not want my child to be positive.

Doctor: *Gaaki.*

Please.

Patient: *Aisekoba positive…*

If he becomes positive…

Doctor: *Mm.*

Mm.

Patient: *Nonya ninche tinkonyara gokora meremo. Bono igo ndoche timbwatia amang'ana aria ngotebigwa aria echiro.*

Even me I won't manage to do my work. Now I see I should not follow the information I am told at the market.

Doctor: *Mm.*

Mm.

Patient: *Tiga ngende mbwatie ogosemia kwomonyagitari nteme komogonkia.*

Let me go and follow the doctor's advice i try to breastfeed her.

Doctor: *Mm.*

Mm.

Patient: *Nindore gose ninyare nonya nokomobogoria gochia echiro gose kero kende nindore buna ndakore nonya nogokama amabere gose ntige emeremo eyio.*

I will see if I can manage to even carry her to the market or sometimes I see how to even express milk or I leave that work.

Doctor: *Mmh.*

Mm.

Patient: *Egere erio nonya n'emetienyi ebere ntige emeremo eyio omwana one agonke buya aike emetienyi etano na rimo erio nchake komoa endagera.*

Such that even for two months I leave that work and my child breastfeeds well until she gets to six months for me to start giving her food.

Doctor: *Nagokire koigwa…*

I am happy to hear…

Patient: *Mm.*

Mm.

Doctor: *Ng'a nogonkie omwana.*

That you will breastfeed the child.

Patient: *Mm.*

Doctor: *Korende onye kogotiga emeremo…*

But if you leave working…

Patient: *Mm.*

Mm.

Doctor: *Enekia ng'a n'obwate ase ande orabe gokonyora chibesa.*

Ensure that you have another way of getting money.

Patient: *Mm. Nabo.*

Mm. It is true.

Doctor: *Totiga emeremo igo.*

Do not just leave working like that.

Patient: *Mm.*

Mm.

Doctor: *Twaigwananire?*

Are we together?

Patient: *Ee nabo.*

Yes, we are.

Doctor: *Ee gonkia omwana. Onye gokonyara gokama…*

Yes, breastfeed the child. If you can manage to express milk…

Patient: *Ee.*

Yes.

Doctor: *Otige…*

You leave…

Patient: *Ee.*

Yes.

Doctor: *Nyomba.*

At home.

Patient: *Ee*

Yes.

Doctor: *Bono eyio nebe akong'u asinini.*

Now that will be a bit difficult.

Patient: *Ee.*

Yes.

Doctor: *Omaete omwana oria…*

You know that child…

Patient: *Ee.*

Yes.

Doctor: *Gwachire buna bono echiro Rongo…*

You have gone to say Rongo market…

Patient: *Ee.*

Yes.

Doctor: *Rituko rigima…*

The whole day…

Patient: *Ee.*

Yes.

Doctor: *Gwakamire echuba eyemo…*

You have expressed one bottle…

Patient: *Ee.*

Yes.

Doctor: *Noroche echuba eyemo?*

You see one bottle?

Patient: *Ee.*

Yes.

Doctor: *Eyio neisaine omwana goika morogoba?*

Is it enough for a child until the evening?

Patient: *Tekomoisana.*

It can't be enough.

Doctor: *Tekomoisana*

It can't be enough.

Patient: *Mm.*

Mm.

Doctor: *Bono igo ekobetereria…*

Now it will force you…

Patient: *Mm.*

Mm.

Doctor: *Ogosemia okuya okwo ndakoe…*

The best advice I can give you…

Patient: *Ee.*

Yes.

Doctor: *Ira omwana mogende echiro. Eyio kegosinya kegima*

Go with your child to the market. If that becomes very impossible…

Patient: *Ee.*

Yes.

Doctor: *Kegima, kegima, kegima…*

Very, very, very…

Patient: *Ee.*

Yes.

Doctor: *Eh?*

Eh?

Patient: *Ee.*

Yes.

Doctor: *Tiga komogonkia.*

Stop breastfeeding her.

Patient: *Nabo.*

True.

Doctor: *Ekiagera omwana oyo gakonyora ebiini…*

Because when this kids gets the virus…

Patient: *Mm.*

Mm.

Doctor: *Igo erabe eng'ana. Tari bo?*

It will be devastating. Isn't it?

Patient: *Ee.*

Yes.

Doctor: *Bono ng'aki ogendererete konywa eriogo riao?*

Now how are you going on with your medicine?

Patient: *Mbuya nkonywa eriogo tagitari.*

I take my medicine well, doctor.

Doctor: *Buya enchera yaye igo naki?*

What do you mean by 'well'?

Patient: *Tindi komocha konywa riogo.*

I never miss taking medicine.

Doctor: *Mm.*

Mm.

Patient: *Ee buna mokong'a eriogo riane nche nkorinywa nde*

Doctor: *Chinsa irenga okorinywa?*

What time do you take it?

Patient: *Amariogo ane aria mwang'ete.*

My medicine which you gave me.

Doctor: *Mm.*

Mm.

Patient: *Maambia*

Early in the morning.

Doctor: *Mm.*

Mm.

Patient: *Na marogoba.*

And in the evening.

Doctor: *Mm.*

Mm.

Patient: *Ee timanyeti ng'aki eriogo eri rikorokwa korende igo mokoring'a chichuba ibere.*

Yes, I don't know what this other medicine is called but you give it to me in two bottles.

Doctor: *Mm.*

Mm.

Patient: *Echuba eyemo nanywa marogoba. Echuba ende nanywa mambia na marogoba amo na septrine.*

One bottle, I take in the evening. The other bottle I take in the morning and in the evening together with septrine.

Doctor: *Na septrine. Aya nkwabogoria echuba y'amache rero?*

With septrine. Okay, did you carry the water bottle today?

Patient: *Echuba y'eriogo?*

A bottle for medicine?

Doctor: *Mm.*

Mm.

Patient: *Tagitari igo neba.*

Doctor, I forgot.

Doctor: *Mm. Tobogoretie rero?*

Mm. You didn't carry today?

Patient: *Timbogoreti.*

I did not carry.

Doctor: *Bono Elizabeth tiga nkworokie amariogo ao.*

Now Elizabeth let me show you your medicine.

Patient: *Eh.*

Eh.

Doctor: *Aya naro amariogo ao. Tari bo?*

These are your medicine. Isn't it?

Patient: *Ee.*

Yes.

Doctor: *Eye n'echuba entang'ani.*

This is the first bottle.

Patient: *Ee.*

Yes

Doctor: *Eye n'echuba yakabere. Torochi rende?*

This is the second bottle. You see now?

Patient: *Ee.*

Yes.

Doctor: *Echuba entang'ani…*

The first bottle…

Patient: *Mm.*

Mm.

Doctor: *Igo ogwenerete konywa entetere yao mara rimo rituko.*

You are supposed to take your tablet once in a day.

Patient: *Mm.*

Mm.

Doctor: *Torochi rende?*

You see now ?

Patient: *Mm.*

Mm.

Doctor: *N'echuba eye yakabere eye enke oroche aiga. Mm?*

And this second bottle, this small one you can see here. Mm?

Patient: *Mm.*

Mm.

Doctor: *Igo okoyenywa…*

You take it...

Patient: *Mm.*

Mm.

Doctor: *Mara kabere rituko.*

Twice a day.

Patient: *Mm.*

Mm.

Doctor: *Twaigwananire?*

Are we together?

Patient: *Ee tagitari.*

Yes doctor.

Doctor: *Bono n'echuba eye enene…*

And now this big bottle…

Patient: *Mm.*

Mm.

Doctor: *Igo gwateba okoyenywa… eriogo riao igo rikorokwa ?.. Ntobwate Nevirapine…*

You said you take it…your medicine is called…? We have Nevirapine…

Patient: *Mm.*

Mm.

Doctor: *Na Tenova tab…*

And Tenova tab…

Patient: *Ee.*

Ee.

Doctor: *Eriogo eri ri'echuba enene igo gwateba chinsa nirenga ogocha kwarinywa?*

This medicine in the big bottle what time did you say you take it normally?

Patient: *Echuba eye enene igo nkonywa marogoba.*

This big bottle I take in the evening.

Doctor: *Chinsa irenga?*

What time?

Patient: *Igo nkonywa buna saa moja saa mbili iga.*

I take it at around seven or eight thereabout.

Doctor: *Saa moja saa mbili.*

Around seven or eight thereabout.

Patient: *Ekero narure echiro.*

When I am back from the market.

Doctor: *Mm.*

Mm.

Patient: *Mm.*

Mm.

Doctor: *N'echuba eye enke ng'aki okorinywa?*

And the small bottle how do you take it?

Patient: *Erio nigo nkonywa ensa eyemo mambia ntarasoka kogenda emeremo.*

I take that one at seven in the morning before I go to work.

Doctor: *Ensa eyemo mambia rioka?*

Only at seven in the morning?

Patient: *Ee.*

Yes.

Doctor: *Mm ninki ogotumia gokoinyoria chinsa?*

Mm what do you use to remind you about time?

Patient: *Bono omaete tagitari narenge nealarm korende bono ase asimi.*

Now you know I had an alarm but on the phone

Doctor: *Mm.*

Mm.

Patient: *Korende esimi egasira.*

But the phone got lost.

Doctor: *Esimi egasira.*

The phone got lost.

Patient: *Mm.*

Mm.

Doctor: *Igo bono iga tobwati egento kiogokoinyoria.*

So now you do not have anything to remind you.

Patient: *Egento giokong'inyoria… kero kende mambia.*

Something to remind me… unless in the morning.

Doctor: *Mm.*

Mm.

Patient: *Ginkorora risase gose kero kende etwani gekobuga….*

When I see the sun or sometimes when the cock crows…

Doctor: *Mm.*

Mm.

Patient: *Namanya ng'a bono chinsa chi'okonywa eriogo chiaikire.*

I know that now it is time for taking medicine.

Doctor: *Nobwate eredio?*

Do you have a radio?

Patient: *Ee nimbwate eredio.*

Yes, I have a radio.

Doctor: *Ngotegererore eredio?*

Do you listen to the radio?

Patient: *Kero kende ngotegererande.*

Sometimes I listen.

Doctor: *Tari kera engaki?*

Not every other time?

Patient: *Tari kera engaki.*

Not every other time.

Doctor: *Ooh.*

Oh.

Patient: *Mm*

Mm.

Doctor: *Bono Elizabeth…*

Now Elizabeth…

Patient: *Mm.*

Mm.

Doctor: *Amariogo aya a ARV goika anywegwe n'echinsa.*

These ARV medicine must be taken in strict timelines.

Patient: *Mm.*

Mm.

Doctor: *Otanyweti riogo riao n'echinsa…*

If you do not take your medicine in time…

Patient: *Mm.*

Mm.

Doctor: *Noinyorete engaki entang'ani twasomete igoro ya CD4 na viral load?*

Do you remember the first time we learnt about CD4 and viral load?

Patient: *Ee tagitari.*

Yes doctor.

Doctor: *Ekero otari konywa aeriogo riao buya…*

When you do not take your medicine well…

Patient: *Mm.*

Mm.

Doctor: *Ekerengo ki'ebiini ase omobere igo gekomentekana ase obonge. Ntoigwanaine?*

Your viral load in your body will radically increase. Do we understand each other?

Patient: *Mm.*

Mm.

Doctor: *Gekoba enyinge ase omobere…*

When it becomes to much in the body…

Patient: *Mm.*

Mm.

Doctor: *Afya yao igo ekogenda nse.*

Your health will deteriorate.

Patient: *Mm.*

Mm.

Doctor: *Kwanyora amarwaire buna TB, Menengitis.*

You contract diseases like TB, meningitis.

Patient: *Mm.*

Mm.

Doctor: *Nayio namarwaire agoita omonto.*

And those are killer diseases.

Patient: *Mm.*

Mm.

Doctor: *Twaigwananire?*

Are we together?

Patient: *Ee tagitari.*

Yes doctor.

Doctor: *ARVs namariogo agokonya e kinga yao y'omobere ebe igoro naye boigo obe na afya.*

ARVs are drugs which assist to increase the immunity of your body, and to also enhance your health.

Patient: *Mm.*

Mm.

Doctor: *Goetania abwo…*

In addition to that…

Patient: *Mm.*

Mm.

Doctor: *Ekero ebiini biachiire igoro na togenderere kogonkia omwana igo akonyora ebiini nonya konye onyure Nevirapine.*

Once the viral load is high and we continue to breastfeed the child she will be infected even if you have been taking Nevirapine.

Patient: *Ooh.*

Oh.

Doctor: *Twaigwananire?*

Are we together?

Patient: *Ee.*

Yes.

Doctor: *Egento egetang'ani ochake gotegerera eredio.*

The first thing you start to listen to the radio.

Patient: *Mm.*

Mm.

Doctor: *Omonto nare nka omanyete igoro ya HIV yao?*

Is there someone at home who knows about your HIV status?

Patient: *Ee omogaka one.*

Yes, my husband.

Doctor: *Omogaka oo.*

Your husband.

Patient: *Mm.*

Mm.

Doctor: *Omogaka oo nabwate esimi?*

Does your husband have a mobile phone?

Patient: *Omogaka one nabwate esimi.*

My husband has a mobile phone.

Doctor: *Igo ogotumia esimi y'omogaka.*

You use the mobile phone of your husband.

Patient: *Nabo.*

That is true.

Doctor: *Igo ogotumia esimi y'omogaka goset ealarm. Ntoigwanaine?*

You use the mobile phone of your husband to set the alarm. Are we together?

Patient: *Mm.*

Mm.

Doctor: *Eriogo eri rikonywegwa ara rimo rituko…*

This medicine which is taken once a day…

Patient: *Mm.*

Mm.

Doctor: *Echuba eye enene gwateba okonywa ensa eyemo gose ibere.*

This big bottle you said you take at seven or eight.

Patient: *Ee.*

Yes.

Doctor: *Tari bo?*

Isn't it ?

Patient: *Mm*

Mm

Doctor: *Chinsa irenga ogocha kwagenda echiro?*

What time do you go to the market ?

Patient: *Igo ngosoka mambia.*

I leave in the morning.

Doctor: *Chinsa irenga?*

What time ?

Patient: *Ensa eyemo nenusu gose ibere nasokire korwa nyomba.*

At half past seven or eight I have left the house.

Doctor: *Gwasokire?*

You have left ?

Patient: *Mm.*

Mm.

Doctor: *Bono ntagete ochore chinsa chiria aye oigwete onywe eriogo eri riechuba enene.Chinsa irenga orabe kogocha kwanywa?*

Now I want you to choose the time you feel you should take the medicine in the big bottle. What time will you be taking it?

Patient: *Buna ikomi na ibere chia mambia igo chirabe buya.*

Like at six in the morning will be okay.

Doctor: *Chinsa ikomi na ibere chia mambia.*

At six in the morning.

Patient: *Ee.*

Yes.

Doctor: *Goika onywe ikomi na ibere.*

You must take at six.

Patient: *Ee.*

Yes.

Doctor: *Igo okoira esimi y'omogaka…*

So you will take your husband's phone…

Patient: *Ee.*

Yes

Doctor: *Oset ikomi na ibere chia mambia. Noroche rende?*

You setit at six in the morning. You see now?

Patient: *Ee.*

Yes.

Doctor: *Echuba eye enke…*

This small bottle…

Patient: *Ee.*

Yes.

Doctor: *Igo ekonywegwa mara kabere.*

Is taken twice.

Patient: *Ee.*

Yes.

Doctor: *Torochi nonya n'echirangi tichibwekaini?*

You see even the colours are different.

Patient: *Mm.*

Mm.

Doctor: *Igo okonywa mara kabere.*

You take it twice.

Patient: *Mm.*

Mm.

Doctor: *Torochi rende?*

Now you see?

Patient: *Mm.*

Mm.

Doctor: *Ekiagera eri okonywa chinsa ikomi na ibere mambia.*

Because this one you will take it at six in the morning.

Patient: *Mm.*

Mm.

Doctor: *Eri igo ogocha konywa ikomi na ibere chia mambia*

This one you will take it at six in the morning.

Patient: *Mm.*

Mm.

Doctor: *Na ikomi na ibere chia marogoba.*

And at six in the evening.

Patient: *Bono tagitari.*

Now doctor.

Doctor: *Mm.*

Mm.

Patient: *Nche… amariogo aya!*

Me…these drugs!

Doctor: *Mm.*

Mm.

Patient: *Ai! Tagtari amariogo aya n'amange!*

Huh! Doctor these drugs are too many!

Doctor: *Mm.*

Mm.

Patient: *Ee.*

Yes.

Doctor: *Amange nchera ki?*

Many in which way?

Patient: *Ginkonywa ndire eri nkonywa mara kabere.*

When i take, there is one i take twice.

Doctor: *Mm.*

Mm.

Patient: *Neri mara rimo*

And this once.

Doctor: *Mm.*

Mm.

Patient: *Tagitari…*

Doctor…

Doctor: *Mm.*

Mm.

Patient: *Asengencho eri ria mara kabere.*

Because this one of twice a day.

Doctor : *Mm.*

Mm.

Patient: *Igo nkweba eriogo eri riokonywa mara kabere ase rituko.*

I normally forget this medicine taken twice a day.

Doctor: *Mm*

Mm.

Patient: *Torochi?*

You see.

Doctor: *Mm.*

Mm.

Patient: *Ginkonywa mambia…*

If I take in the morning…

Doctor: *Mm.*

Mm.

Patient: *Riria ria marogoba ginkare echiro kwearigania gosieka erio nchiche nka…*

The one for the evening when I am in the market preparing to close and come back home…

Doctor: *Mm.*

Mm.

Patient: *Eriogo eri ginkoirana ndosete n'omwana oyio okorera mogonkie tindaragera.*

This medicine, when I come back I am tired, the child is crying I breastfeed her, I haven't eaten.

Doctor: *Mm.*

Mm.

Patient: *Eriogo eri ria mara kabere ase rituko…*

This medicine taken twice in a day…

Doctor: *Mm.*

Mm.

Patient: *Igo nkweba.*

I forget.

Doctor: *Igo okweba eria marogoba.*

You forget the evening dose.

Patient: *Bono nche igo nkweba, ee igo nkweba eria marogoba.*

Now I forget, yes, I forget the evening dose.

Doctor: *Mm.*

Mm.

Patient: *Korende mambia igo nkonywa buya.*

But in the morning, I take my medicine well.

Doctor: *Mm.*

Mm.

Patient: *Bono nche ndoche tagitari….*

Now, I see doctor…

Doctor: *Mm.*

Mm.

Patient: *Omanyete enchera abanto bande bagokora...*

You know the way other people do…

Doctor: *Mm.*

Mm.

Patient: *Eriogio eri ria mara kabere…*

This medicine taken twice…

Doctor: *Mm.*

Mm.

Patient: *Nywe rionsi amo.*

I take both together.

Doctor: *(amaseko)*

(laughter)

Patient: *Nywe rionsi amo, nywe rionsi amo*

I take both doses together, I take all of it together.

Doctor: *Mm.*

Mm.

Patient: *Egere marogoba tintwara riogo nkonywa.*

Such that in the evening I do not have any medicine to take.

Doctor: *Tonywa…*

You do not take…

Patient: *Ee nywe rionsi mambia, nkorane n'amag'ana ayio.*

Yes, I take both doses in the morning, I get done with those issues.

Doctor: *Bono ekio n'ekerengererio ekiya…*

Now that is a good idea…

Patient: *Mm.*

Mm.

Doctor: *Korende…*

But…

Patient: *Mm.*

Mm.

Doctor: *Eye Nevirapine.*

This is Nevirapine.

Patient: *Mm.*

Mm.

Doctor: *Tokonywa ibere rimo.*

You cannot take two at the same time.

Patient: *Mm.*

Mm.

Doctor: *Igo torabe twakorire eoverdose…*

We will have done an overdose…

Patient: *Mm.*

Mm.

Doctor: *Y'eriogo.*

Of the medicine.

Patient: *Mm.*

Mm.

Doctor: *Na tokoverdose eriogo…*

And if we overdose medicine…

Patient: *Mm.*

Mm.

Doctor: *Tiriri gokora egasi ase omobere.*

It will not work in the body.

Patient: *Ee.*

Yes.

Doctor: *Naende nabo orasinywe kogenda emeremo mambia.*

You may also not manage to go to work in the morning.

Patient: *Mm.*

Mm.

Doctor: *Ase engencho y'echiside effects. Twaigwanaire?*

Becayse of side effects. Are we together?

Patient: *Ee tagitari.*

Yes doctor.

Doctor: *Igo erio oinyore konywa eriogo riao magoroba.*

Therefore, remember to take that medicine in the evening.

Patient: *Mm.*

Mm.

Doctor: *Risakara ndire ngokoa.*

There is a paper I will give you.

Patient: *Mm.*

Mm.

Doctor: *Mambia chinsa ikomi na ibere gokoboka…*

In the morning at six when you wake up…

Patient: *Mm.*

Mm.

Doctor: *Kwarusia entetere eyemo aiga ase echuba eye enene.*

You take one tablet from this big bottle.

Patient: *Mm.*

Mm.

Doctor: *Kwarusia entetere eyemo ya Nevirapine. Torochi?*

You take one tablet of Nevirapine. You see?

Patient: *Ee.*

Yes.

Doctor: *Korwa ase echuba eye ya Nevirapine.*

From the bottle of Nevirapine.

Patient: *Ee.*

Yes.

Doctor: *Kwanywa. Septrine chinsa irenga okonywa? Igo okoyenywa mambia gose mogoroba?*

You take. What time do you take septrine? Do you take it in the morning or evening?

Patient: *Mambia.*

In the morning.

Doctor: *Mambia igo nigo okorusia eriogo erimo ase eye ya TTF?*

So, in the morning you take one drug from this TTF?

Patient: *Mm.*

Mm.

Doctor: *Kwarusia erimo ria Nevirapine.*

You take one Nevirapine.

Patient: *Mm.*

Mm.

Doctor: *Kwarusia Septrine eh?*

You take neptrine, eh?

Patient: *Mm.*

Mm.

Doctor: *Kwanywa. Kwarusia nevirapine ya magoroba…*

You take them. You remove nevirapine for the evening dose…

Patient: *Mm.*

Mm.

Doctor: *Kwabeka risakara.*

You place it in the paper.

Patient: *Mm.*

Mm.

Doctor: *Nkorora ore abang'ina baria bechinchugu?*

Do you aee thole ladies who sell groundnuts?

Patient: *Mm.*

Mm.

Doctor: *Buna bagosiba amasakara abo, eh?*

The way they fold their satchets, eh?

Patient: *Mm.*

Mm.

Doctor: *Okobeka eriogo riao ime kwabogoria.*

You put your drug in and carry it.

Patient: *Mm.*

Mm.

Doctor: *Omanyete kore echiro ogokora oboonchoreria ng'o omanyete ng' a nkonywa ore ARVs?*

You know when in the market doing your business, who knows that you are taking ARVs?

Patient: *Eh! Tagitari abwo goika abanto bandore. Erio bandore bamanyete ng'a igo nde positive.*

Eh! Doctor people will see me. They will see and know that I am positive.

Doctor: *Eh!*

Eh!

Patient: *Tinkobogoria eriogo gochia echiro!*

I cannot carry medicine to the market!

Doctor: *Eh.*

Eh.

Patient: *Igo otagete tagitari ebiasara biane bigwe?*

So, do you want my business to go under?

Doctor: *Eh (amaseko)*

Eh(laughter)

Patient: *Abanto bakomanya ng'a nche igo nde positive…*

If people know that I am positive…

Doctor: *Eh.*

Eh.

Patient: *Tibagocha kogora ebinto biane ase echiro.*

They won't come to buy my goods in the market.

Doctor: *Eh.*

Eh

Patient: *Bono tagitari abwo nche ndoche tinkonyara kobogoria eriogo.*

Now there doctor I don't see myself carrying medicine.

Doctor: *Bono.*

Now.

Patient: *Ee.*

Yes

Doctor: *Eriogo eri ria nevirapine…*

This medicine, nevirapine…

Patient: *Mm.*

Mm.

Doctor: *Ekero okobogoria eriogo echiro…*

When you carry medicine at the market…

Patient: *Mm.*

Mm.

Doctor: *Monto taiyo oramanye nki okonywa.*

Nobody will know what you are taking.

Patient: *Ee.*

Yes.

Doctor: *Mbarenga echiro omanyete barabaise…kwanakorora bare na ARVs?*

How many do you know might…have you ever seen with ARVs?

Patient: *Tindarora tagitari.*

I have not seen doctor.

Doctor: *Monto onde ona kogotebia nachire … nkonywa ore ... omanyete nindusia eriogo eri, oroche nevirapine igo rire rirabu.*

Has anyone ever told you, I have gone…Do you take…you know even if I remove this tablet, you see nevirapine is white.

Patient: *Mm.*

Mm.

Doctor: *Eh?*

Eh?

Patient: *Mm.*

Mm.

Doctor: *Gokoribeka iga torochi igo rikoba buna hedex?*

If you put it like this, do you see it looks like hedex?

Patient: *Mm.*

Mm.

Doctor: *Emeremo eria y'echiro omogaso okobara…*

The work at the market once the sight is shining…

Patient: *Ee.*

Yes.

Doctor: *Nabo ogwatigwa n'omotwe.*

You can have headache.

Patient: *Ee.*

Yes.

Doctor: *Gwateba tiga ndusie*

You say let me remove…

Patient: *Mm.*

Mm.

Doctor: *Tiriri rirabu buna panadol?*

Is it not white like panadol ?

Patient: *Ee.*

Yes.

Doctor: *Ng'o oramanye ng'a nkonywa ore ARVs?*

Who will know that you are taking ARVs?

Patient: *Ee.*

Yes.

Doctor: *Engaki yoka abanto baramanye ng'a nkonywa ore ARVs nekero orabatebie ng'a nkonywa ore ARVs.*

The only time people will know that you are taking ARVs is when you tell them that you are taking ARVs.

Patient: *Korende tibakumia inaki ngwatigwa n'omotwe kera rituko.*

But won't they wonder how I have headache everyday?

Doctor: *Egento giakabere…*

The second thing…

Doctor: Ekiagera kero kende tikwanywete mache botuko.

Because you never took water at night.

Patient: *Mm.*

Mm.

Doctor: *Egento gia kabere nabo orasoke ake igo otigere omonto ebiasara otebe…echiro tebwati echo?*

The second thing you can excuse yourself and you ask someone to hold brief for you and say…is there no toilet at the market?

Patient: *Mm.*

Mm

Doctor: *Otebe n'echoo ogochia.*

You say you are going to the toilet.

Patient: *Mm.*

Mm.

Doctor: *Kwagenda kwanywa eriogo riao. Nkogosemia…*

You go and take your medicine. I advice for you…

Patient: *Mm.*

Mm.

Doctor: *Eriogo eri.*

This medicine…

Patient: *Mm.*

Mm.

Doctor: *Ng'a abanto nkomanya bare ng'a nkonywa ore; omaete abanto igo bamanyete asengencho aye n'omorwaire ore n'ebiini. Twatebire otanyweti amariogo marwaire ki okonyora?*

That people get to know that you are taking the medicine; you know people know because you are HIV positive. We have said if you do not take your drugs which diseases will you get?

Patient: *Nkonyora TB,*

I get TB,

Doctor: *Okonyora TB.*

You get TB.

Patient: *Meningitis…*

Meningitis…

Doctor: *Mm.*

Mm.

Patient: *Pneumonia eria embe.*

Acute pneumonia.

Doctor: *Pneumonia eria embe.*

Acute pneumonia.

Patient: *Ee*

Yes.

Doctor: *Na kwana korora omonto ore na TB?*

And have you ever seen someone with TB?

Patient: *Nayebwate.*

I used to have it.

Doctor: *Mm.*

Mm.

Patient: *Nkamanya gocha go gochaka ekiriniki ngachaka amariogo.*

Before I came for the clininic and enrolled for drugs.

Doctor: *Eh buya mono.*

Eh that is very good.

Patient: *Ee.*

Yes.

Doctor: *Ekero kwabwate TB naki kware koigwa?*

When you had TB how were you feeling?

Patient: *Igo nare koigwa ng'a ngokwa nde.*

I used to feel like I am going to die.

Doctor: *Buna ngokwa ore.*

Like you are going to die.

Patient: *Ee.*

Yes.

Doctor: *Kwana korora omonto onyorire meningitis.*

Have you ever seen anyone who has gotten meningitis?

Patient: *Ee kinde eward nkorwarigwa TB.*

Yes whe I was in the ward being treated for TB.

Doctor: *Mm.*

Mm.

Patient: *Naroche omorwaire onde orenge na meningitis.*

I saw another patient who had meningitis.

Doctor: *Orenge na meningitis.*

Who had meningitis.

Patient: *Ee*

Yes.

Doctor: *Ng'aki kwaroche are?*

How was the person?

Patient: *Oyio tagitari nigo akwete.*

That one doctor passed on.

Doctor: *Akwete.*

He passed on.

Patient: *Ee mbuya mono asengencho tare konywa mariogo aye buya.*

Yes thank you… because he was not taking his medicine well.

Doctor: *Kero kende n'omonto opimetwe ebiini…*

Sometimes it is a person who tested for HIV…

Patient: *Mm.*

Mm.

Doctor: *Akanga konywa eriogo riaye buya.*

He refused to take his medicine well.

Patient: *Mm.*

Mm.

Doctor: *Ekinga ekagenda nse.*

The immunity went down.

Patient: *Mm.*

Mm.

Doctor: *Erio amarwaire acha buna meningitis.*

Then diseases like meningitis come.

Patient: *Mm.*

Mm.

Doctor: *Egento gia kabere.*

The second thing.

Patient: *Mm.*

Mm.

Doctor: *Oria orenge eward…*

The one who was in the ward…

Patient: *Mm.*

Mm.

Doctor: *Abairi baye, bamura na basubati bamwabo…*

His relatives, brothers and sisters…

Patient: *Mm.*

Mm.

Doctor: *Buna omanyete eker'obwate na meningitis tori kwenyara.*

Like you know when you have meningitis you become helpless.

Patient: *Mm.*

Mm.

Doctor: *Omanyete intwe buna abanyagitari ntore n'obosibore bw'ogotebia abairi ng'a nore n'ebiini. Abwo nao ekenyoro ekegima gekomanyera ng'a nobwate HIV.*

You know, as doctors we have the freedom to inform your relatives about your HIV status. That is when the whole village gets to know that you are HIV positive.

Patient: *Obe obe obe! Tagitari eyio tintageti ebe bo!*

Oh, my God! I do not want it to be that way doctor!

Doctor: *Mm.*

Mm.

Patient: *Nche gaaki tiga inywe eriogo, ning'inyorete buna TB yanchandete.*

Let me take my the medicine, I remember how TB troubled me.

Doctor: *Mm.*

Mm.

Patient: *Tintageti gokwa ntige abana bane!*

I do not want to die and leave my children !

Doctor: *Ng'ai orabatige?*

Where will you leave them?

Patient: *Ntagete ndore abana bane*

Doctor: *Mmh.*

Mm.

Patient: *Korende tagitari ntagete onkonye.*

But I want you to assist me doctor.

Doctor: *Mm.*

Mm.

Patient: *Erio nywe eriogo eri buya.*

Such that I take this medicine well.

Doctor: *Mm.*

Mm.

Patient: *Nkorora omogaka one…*

I see my husband…

Doctor: *Mm.*

Mm.

Patient: *Nere ochire ekiriniki.*

Has also gone for clinic.

Doctor: *Mm.*

Mm.

Patient: *Ngochia are e kiriniki korende aria ase agokora emeremo…*

He goes for clinic but where he works…

Doctor: *Mm.*

Mm.

Patient: *Ere eriogo riaye igo akonywa n'echuba eyemo akonywa rimo.*

For him, he takes his medicine in one bottle which he takes once.

Doctor: *Mm.*

Patient: *Bono gaaki tagitari otagonkonya onchencherie ong'e buna erio riomogaka?*

Now doctor, can you please assist me change my medicine and give me like that of my husband.

Doctor: *Buna erio riomogaka.*

Like that of your husband.

Patient: *Ee.*

Yes.

Doctor: *Titogokora igo.*

We cannot do that.

Patient: *Mm.*

Mm.

Doctor: *Omanyete…*

You know…

Patient: *Mm.*

Mm.

Doctor: E*kero togochakia omonto ART…*

When we start someone on anti retroviral therapy…

Patient: *Mm.*

Mm.

Doctor: *Aye ekero kwanyorete ebiini ritang'ani…*

When you contracted HIV for the first time…

Patient: *Mm.*

Mm.

Doctor: *Ogapimwa.*

You were tested.

Patient: *Mm.*

Mm.

Doctor: *Eri nario eriogo 1st line yao twachagete naye chingaki echio togochaka eriogo.*

That is when we put your on the first line of medicine at that time.

Patient: *Mm.*

Mm.

Doctor: *Twaigwananire?*

Are in agreement?

Patient: *Mm.*

Mm.

Doctor: *Nere chingaki echi bono…*

For him this time…

Patient: *Mm.*

Mm.

Doctor: *1st line yaye nero eye aetwe.*

His first line is the one he was given.

Patient: *Mm.*

Mm.

Doctor: *Bono titokonyara kogochencheria torusie eri togotebie ng'a onywe eri. Eyio igo eragere eriogo tirikora egasi buya. Twaigwananire? Igo nevirapine eye ekobetereria obogorie eriogo riao gochia ase ogokora emeremo.*

Now we cannot manage to substitute your medicine and tell you to take this. That will make the medicine not work properly. Are we together? So this nevirapine will force you to carry your drugs to your work place.

Patient: *Ee nabo.*

Yes that is true.

Doctor: *Nario otebe….*

Then you say…

Patient: *Ee.*

Yes.

Doctor: *Koraganie nabo nkogokonya amasakara aria y'okobogoria.*

If you want I can give you the the carry bags.

Patient: *Mm.*

Mm.

Doctor: *Ebe raisi kwabeka eriogo ribe rire richenu.*

It will be easy for you to carry your clean medicine.

Patient: *Mm.*

Mm.

Doctor: *Ekero okororа chinsa ikomi na ibere chiabeire abang'ina baria timori kogamba nabwo*.

When it is approaching six, don't you talk with those ladies?

Patient: *Mm.*

Mm.

Doctor: *Obaborie, ''chinsa nirenga chiabeire?''*

Ask them, 'what is the time' ?

Patient: *Mm.*

Mm.

Doctor: *Bagotebie n'echinsa ikomi na ibere…*

They tell you it is six oclock…

Patient: *Mm.*

Mm.

Doctor: *Otaratare ogende onywe eriogo riao korende otware obwoba bw'okonywa eriogo riao, igo bakomanya ng'a nkonywa ore eriogo ria ARVs na bamanye ng'a nigo okwebisa asengencho otagete konywa eriogo. Twaigwananire?*

Patient: *Twaigwananire tagitari. Mbuya mono gwankoyire.*

We are together doctor. Thanks for the assistance.

Doctor: *Mm.*

Mm.

Patient: *Eriogo eri tinare konywa buya*

Doctor: *Mm.*

Mm.

Patient: *Buna nonya ndiria nagotebetie…*

Like I had told you…

Doctor: *Mm.*

Mm.

Patient: *Kero kende tinare konywa marogoba.*

Sometimes I wasn't taking in the evening.

Doctor: *Mm.*

Mm.

Patient: *Kero kende nanywa riria rikonywegwa rimo.*

Sometimes I take the one taken once.

Doctor: *Mm.*

Mm.

Patient: *Ekero ngwenerete konywa 1*2*

When I am supposed to take 1 times 2.

Doctor: *Mm.*

Mm.

Patient: *1*2 ndireri tagitari?*

Which one is taken 1 times 2 doctor?

Doctor: *Echuba eye.*

This bottle.

Patient: *Echuba eye enke eria mambia na magoroba…*

The small bottle for the morning and evening…

Doctor: *Ee.*

Yes.

Patient: *Igo nare konywa kabere.*

I used to take twice.

Doctor: *Mm.*

Mm.

Patient: *Nigo nare konywa chintetere ibere mambia.*

I used to take 2 tablets in the morning.

Doctor: *Mm.*

Mm.

Patient: *Nario marogoba ntanywe.*

So, that I do not take in the evening.

Doctor: *Otanywe.*

You do not take.

Patient: *Ntanywe.*

I do not take.

Doctor: *Mm.*

Mm.

Patient: *Na onye tindanywa igo tinare konywa.*

And if I hadn't taken then I would not take.

Doctor: *Mm.*

Mm.

Patient: *Bono tagitari nararire.*

Now doctor I have seen.

Doctor: *Mm.*

Mm.

Patient: *Ee bono namanyire, tiga ing'ende ndigererie…*

Yes, now i know, let me go and think…

Doctor: *Mm.*

Mm.

Patient: *Inywe eriogo buya.*

I take my medicine properly.

Doctor: *Mm.*

Mm.

Patient: *N'omwana nere…*

And the child also…

Doctor: *Mm.*

Mm.

Patient: *Tiga ngende nteme ekiagera tintageti mwana one abe positive gaaki.*

Let me go and try because I do not want my child to become positive please.

Doctor: *Oteme tari bo?*

You try, isn't it?

Patient: *Ee.*

Yes.

Doctor: *Igo erabe bobe amaene ekero omwana arabe positive.*

It will be bad for sure if the child becomes positive.

Patient: *Ee.*

Yes.

Doctor: *Ritang'ani korwania komoa amariogo kagoika emiaka ikomi akoboria mama eriogo eri nki rikoruari?*

First to fight to give her drugs when she is ten she asks, mummy what does this medicine treat?

Patient: *Mm.*

Mm.

Doctor: *Nomotebie ng'a n'asthma?*

Will you tell her that it is asthma ?

Patient: *Mm.*

Mm.

Doctor: *Tokomotebia; nabo ekobetererie omotebie n'ebiini*.

You will not tell her, it may force you to tell her it is HIV.

Patient: *Eyio nebe akong'u.*

That will be difficult.

Doctor: *Tari bo?*

Is that not so?

Patient: *Nkorora aria enka y'omoko one…*

I normally see at home at my in-law's…

Doctor: *Mm.*

Mm.

Patient: *Nabwate omwana ore positive.*

She has a child who is positive.

Doctor: *Mm.*

Mm.

Patient: *Gaaki yabeire akong'u ase omwana oyo.*

Indeed it has become difficult for this child.

Doctor: *N'omoibori boigo, tari bo?*

Same to the parent, isn't it?

Patient: *Ee igo agochandeka.*

Yes, she will suffer.

Doctor: *Omwana gakogenda esukuru atari konywa eriogo buya gakoba omosae igo agochandeka.*

When the child goes to school without medicine well, when she is a teenager she suffers.

Patient: *Mm.*

Mm.

Doctor: *Korende aye n'obwate ribaga bono riogokonya omwana tanyora ebiini. Tari bo?*

However, you have the opportunity to safeguard your child from contracting HIV, Isn't it?

Patient: *Mm.*

Mm.

Doctor: *Igo eriogo kanywe buya.*

So, take your medicine well.

Patient: *Mm.*

Mm.

Doctor: *Twaigwananire?*

Are we in agreement?

Patient: *Mm.*

Mm.

Doctor: *Oenekie ng'a kwanyure eriogo ria TDF 1*1 rimo ase rituko chinsa ikomi na ibere. Ntoigwanaine igo?*

Ensure that you take TDF 1 times 1(once in a day) at six. Are we in agreement?

Patient: *Ee tagitari.*

Yes doctor.

Doctor: *Na nevirapine.*

And nevirapine.

Patient: *Mm.*

Mm.

Doctor: *Igo okonywa chinsa ikomi na ibere chia mambia na marogoba. Ng'aki orainyore eria mambia? Omogaka igo agokoinyoria chinsa. Tari bo?*

You take it at six in the morning and in the evening. How will you remember the one for the morning? Your husband will remind you the time. Is that not so?

Patient: *Nabo tagitari.*

It is true doctor.

Doctor: *N'eriamarogoba nki twateba togokora?*

And the evening dose what did we say we do?

Patient: *Igo tokobogoria.*

We carry it.

Doctor: *Igo tokobogoria eriogo gochia se togokora emeremo. Tari bo?*

We carry the drug to our work place, isn't it?

Patient: *Ee.*

Yes.

Doctor: *Igo okoribeka ase arabu. Twaigwananire?*

You place it in a clean place. Are together?

Patient: *Ee tagitari.*

Yes doctor.

Doctor: *Omwana omorende buya.*

Take care of the child properly.

Patient: *Mm.*

Mm.

Doctor: *Gonkia omwana.*

Breastfeed the child.

Patient: *Mm.*

Mm.

Doctor: *Oinyore komoa septrine.*

Remember to give her septrine.

Patient: *Mm.*

Mm.

Doctor: *Torochi rende?*

Can you see?

Patient: *Ee tagitari.*

Yes doctor.

Doctor: *Rero ndoche omentire oborito.*

I see today the child is a little bit heavier.

Patient: *Mm.*

Mm.

Doctor: *Ochake komoa 10 mls.*

Strart giving her 10mls.

Patient: *Ee nabo.*

Yes, it is true.

Doctor: *Igo tware komoa 5mls ase igo gochakera rero igo tokomoa 10 mls ekiagera ndoche omentire oborito buya. Tari bo?*

We were giving her 5mls so from today we shall be giving her 10 mls because i see she has added weight well, isn't it?

Patient: *Nabo.*

True.

Doctor: *Bono genda buya.*

Okay go well.

Patient: *Ee.*

Yes.

Doctor: *Tororane omotienyi ogocha eh?*

Let us meet next month, eh?

Patient: *Ee. Mbuya mono tagitari.*

Yes. Thank you doctor.

Doctor: *Haya.*

Okay.

Patient: *Ee.*

Yes.

Appendix xix. HIV and AIDS 5 consultation

Doctor: *Karibu Cecilia*

Welcome Cecilia.

Patient: *Mm*

Mm.

Doctor: *Naki ogendererete amatuko amange?*

How have you been… many days.

Patient: *Mbuyande.*

I am fine.

Doctor: *Mm.*

Mm.

Patient: *Ee.*

Yes.

Doctor: *N'omwana naki agendererete?*

And how is the baby fairing on?

Patient: *Omwana nere obwate omochando moke.*

The baby has a little problem.

Doctor: *Mm.*

Mm.

Patient: *Ee nabwate omochando… ndoche ng'a tabwato afya ngiya.*

Yes, he has a problem…. It is like he does not have good health.

Doctor: *Mm.*

Mm.

Patient: *Mm.*

Mm.

Doctor: *Nki kiagera gwachicha?*

What exactly made you come?

Patient: *Ok, igo ng'igwete ng'a nabwate riberera ike.*

Okay, I feel he has some fever.

Doctor: *Mm.*

Mm.

Patient: *Naki gekogera namoreta aiga nyagitari.*

That is why I brought him to hospital.

Doctor: *Kwaariganigwe mono.*

You are most welcome.

Patient: *Mm.*

Mm.

Doctor: *N'eriberera rioka?*

Just the fever?

Patient: *Ee korende okorora ng'a igo akoigwa ana korerarera.*

Yes, but it is like that he feels like crying all the time.

Doctor: *Mm.*

Mm.

Patient: *Mm akorwara botuko.*

Mm he gets sick at night.

Doctor: *Mm.*

Mm.

Patient: *Korende tindamanya omochando oye ninki.*

However, I have not discovered what his problem is.

Doctor: *Mm.*

Mm.

Patient: *Ee.*

Yes.

Doctor: *Kwaariganigwe.*

You are welcome.

Patient: *Mm, mbuya mono.*

Mm, thanks a lot.

Doctor: *Aa… Ndi achagete korwara?*

Ah... When did he start feeling unwell?

Patient: *Mm korwa moisonde.*

Mm since yesterday but one.

Doctor: *Korwa moisonde?*

Since yesterday but one?

Patient: *Ee*

Yes.

Doctor: *Kwamoeire mariogo ande?*

Have you given him any medicine?

Patient: *Yaya.*

No.

Doctor: *Mm.*

Mm.

Patient: *Bado tindamoa.*

I haven't given him yet.

Doctor: *Nonya nayogosunyunta nimanyete toramoa.*

Even the local herbs I know you haven't given him.

Patient: *(amaseko) Yaya tindamoa amariogo ayio.*

(Laughter) No I haven't given him that medicine.

Doctor: *Mm.*

Mm.

Patient: *Okoba tinare gochakera koramoira ase emete alafu manye komorenta nyagitari.*

Because I could not begin with herbs then I bring him to hospital.

Doctor: *Ooh ok.*

Oh okay.

Patient: *Mm.*

Mm.

Doctor: *Nkokorora are?*

Does he cough?

Patient: *Yaya tari gokorora.*

No, he doesn't.

Doctor: *Tari gokorora?*

He does not cough?

Patient: *Mm.*

Mm.

Doctor: *Ee mbora nomaete nobwate oborwaire bwa HIV?*

Yes, don't you know that you are HIV positive?

Patient: *Mm.*

Mm.

Doctor: *Naki mbuya okonywa amariogo?*

Do you take your medicine properly?

Patient: *Mm amariogo aro nkobwatia nde.*

Mm. For medicine I take as required.

Doctor: *Mm.*

Mm.

Patient: *Buna ogontebia.*

The way you tell me.

Doctor: *Nomwana nere mbuya okomoa amariogo aria aye?*

And the baby, do you give him his medicine properly?

Patient: *Ee omwana… nkomoa nde.*

Yes, the baby… I do give him.

Doctor: *Ok.*

Ok.

Patient: *Mm.*

Mm.

Doctor: *Tigango toramorigereria.*

Let us examine him.

Patient: *Mm.*

Mm.

Doctor: *Ee ekororekana omwana oyo nabo aratware signs chia malaria.*

Yes, it looks as though this baby has signs of malaria.

Patient: *Mm.*

Mm.

Doctor: *Signs chia malaria. Ngosaa are?*

Signs of malaria. Does he diarrhoea?

Patient: *Yaya tari gosaa.*

No, he does not diarrhoea.

Doctor: *Tari gosaa?*

He doesn't diarrhoea?

Patient: *Mm.*

Mm.

Doctor: *Mbuya tware koramorenga.*

It is good to carry out some tests on him.

Patient: *Mm.*

Mm.

Doctor: *Torore gose malaria abwate.*

We see if he has malaria.

Patient: *Ah rakini bono rende ntware korarigereria, orarigereria ebinto binde?... okoba nabo erabe teba mareria… enchera egocha. Nigo riberera riaye rigocha rire igoro mono.*

But then couldn't we first check, you check for other things? … because it might turn out not to be malaria… the way it manifests itself. It is his fever which is quite high.

Doctor: *Mm.*

Mm.

Patient: *Bono tinkagereti gose nenyare koba nga malaria.*

Now I don't think that it can be malaria.

Doctor: *Aye ng'o orengerereti nki omwana abwate?*

In your thoughts, what is bothering the baby?

Patient: *Ndoche ng'a nebibiriri asiareire.*

I see that the baby has been infected by 'ebibiriri'

Doctor: *Ebibiriri?*

'Ebibiriri'?

Patient: *Mm.*

Mm.

Doctor: *Mmh …nki gekoorokia ase omwana …aye buna oroche nki gekoorokia?*

Mm … What shows on the baby… from your observation what shows?

Patient: *Ekiagera bono riberera igo rire igoro mono.*

Because now the fever is too high.

Doctor: *Ah ebibiriri ase Gusii yaito tibiri gocha neriberera.*

Ah 'ebibiriri' in our Gusii backyard do not come with fever.

Patient: *Mm.*

Mm.

Doctor: *Omwana igo are korera?*

Was the baby crying?

Patient: *Mm.*

Mm.

Doctor: *Buna nkoigwa, igo akorera?*

From what i hear, the baby cries.

Patient: *Mm.*

Mm.

Doctor: *Tarigotwara iberera.*

He does not have fever.

Patient: *Mm yaya ekobwati mbare bakorera naende riberera rire aroro.*

Mm … No, it depends, there are those who cry and have fever at the same time.

Doctor: *Ee.*

Yes.

Patient: *Ee.*

Yes.

Doctor: *Rakini asengencho tore ase malaria eichire…*

But because we stay at a region where malaria is predominant…

Patient: *Mm.*

Mm.

Doctor: *Malaria nero nabo egocha buna buna gwatebire igo.*

Malaria also has the same symptoms you have just said.

Patient: *Mm.*

Mm.

Doctor: *Igo ntobwati… kende nkeiyo togoita.*

So, we don't have … there is nothing we are killing.

Patient: *Mm.*

Mm.

Doctor: *Gose kende nkeiyo togosiria.*

Or there is nothing we are eliminating.

Patient: *Mm.*

Mm.

Doctor: *Ase ogopima omwana malaria tomanye gose nero…*

In carrying out the malaria test to establish if it is the one…

Patient: *Mm.*

Mm.

Doctor: *Amang'ana y'ebibiriri…*

Issues of 'ebibiriri '…

Patient: *Mm.*

Mm.

Doctor: *Ebibiriri nyagitari ntobwati riogo toragotebi ng'a 'eri iga'.*

'Ebibiriri', at hospital we do not have the medicine we can tell you that 'here it is'.

Patient: *Mm.*

Mm.

Doctor: *Rakini nabo ntobwati eriogo rieriberera ntobwate eriogo ria malaria.*

But we don't have medicine for fever, but we have medicine for malaria.

Patient: *Malaria.*

Malaria.

Doctor: *Egento acha aa nakio ekenene.*

What brought him here is what is important.

Patient: *Mm.*

Mm.

Doctor: *N'eriberera nario riakoreta.*

And it is fever which brought you.

Patient: *Mm.*

Mm.

Doctor: *Na buna imoroche…*

And as I can see him…

Patient: *Mm.*

Mm.

Doctor: *Nabwate chisigns chikoorokia nabo aratware malaria.*

He has signs which show he may have malaria.

Patient: *Mm.*

Mm.

Doctor: *Igo tigango toramopima.*

So, let us first carry out the tests.

Patient: *Mm.*

Mm.

Doctor: *Ee tomanye komoa amariogo.*

Yes, then we can give him medicine.

Patient: *Yaya bono egento torakore igo toramoe omochakano chintetere echio chieriberera alafu toramotige igo torore buna akoba.*

No then what we can do, let's give him tablets for the fever then we leave him and see how he fairs on.

Doctor: *Ogopima… tari ogopima mbosa.*

The testing… it is not that testing is free.

Patient: *Mm.*

Mm.

Doctor: *Na riberera tari borwaire.*

And fever is not a disease.

Patient: *Mm.*

Mm.

Doctor: *Riberera igo rikoretwa n'oborwaire.*

Fever is caused by an infection.

Patient: *Mm.*

Mm.

Doctor: *Igo natomoa echi chieriberera onye ntoramoa echio oborwaire…*

So even if we give him the ones for fever, if we have not given those for the disease…

Patient: *Mm.*

Mm.

Doctor: *Bado ntorakonya mwana oyo.*

We would not have saved your child.

Patient: *Mm.*

Mm.

Doctor: *Omwana oyo nabwate oborwaire bokogera riberera eri riche.Tiga toramopima gatoranyore ng'a tabwati malaria,ntokomoa echia malaria.Gatoranyore malaria nerororo,nabo tokomoa echia malaria amo nechieriberera. Igo riberera ndiri gocha bosa.Yaya,igo rigocha rire noborwaire.*

This child has a disease which causes the fever. Let's carry out the tests, should we find out that he doesn't have malaria, we wouldn't treat him for malaria. If we find that he has

malaria, we will treat him for malaria and the fever. So, fever never comes just like that. No, it comes with an infection.

Patient: *Noborwaire.*

With an infection.

Doctor: *Noborwaire.Tiga tonyore oborwaire tomoe amariogo.*

With an infection. Let is establish the disease and give him medicine.

Patient: *Mm.*

Mm.

Doctor: *Ayoborwaire amo nayeriberera.*

For the disease and the fever.

Patient: *Noroche egento nkogoteberia igo.*

Can you see what I am telling you really?

Doctor: *Mm.*

Mm.

Patient: *Mwana oyo iga tana gotwara riberera erio.*

This child has never had that kind of fever.

Doctor: *Mm.*

Mm.

Patient: *Korwa korwa gesa aiboretwe. Rakini omoiseke nare ocha nka aria korwa buna amobwatete agasoa buna arwete igo aroro akagenda, omwana oyio akaimoka riberera. Namang'ana aye nakumete nka ng'a tari monto muya n'omonto ogosiara ebiriri. Mm.*

Since he was born. But there is a lady who came at home and held the child and immediately she left, the baby developed fever. And the reputation of the lady is known at home that she is not a good person… she is a person who infects others with "ebibiriri". Mm.

Doctor: *Tiga nainche nagotebia iga…*

Let me also tell you this…

Patient: *Mm.*

Mm.

Doctor: *Malaria.*

Malaria.

Patient: *Mm.*

Mm.

Doctor: *Tari egento kegocha enya gokoria kera ngo'rango'ra baka eche goikera.Negento kegocha rimo.Ee omoiseke oyio nachete rakini igo toramanya ng'a n'eumbu nero nyareo bono iga buna egotwa chiumbu nchiimogete. Malaria nere igoro ase ebinyoro.Nabo oranyore ase kwamobegete nonya mogaso eumbu nabo yamoromete otamanyeti gose otarochi. Igo nagotebi onye… ngopima tore. Ogopima mbosa na riberera eri ndigocha bosa,riberera abwate igo rire igoro mono,ndigocha bosa ritabwati oborwaire.Mbuya tware komopima ogopima mbosa torore gose nabwate malaria.*

Is not something which comes and starts infecting you slowly until it gets to a point. It is something that comes once. Yes, that lady came but you haven't known that a mosquito was also there, especially now that it is a raining, they are in plenty. Malaria cases are high now in the villages. It is possible that where you had placed the child even during the day, he had a mosquito bite without your knowledge or without you noticing. So, I told you if…we will carry out the tests. Doing the tests is free and this fever cannot be baseless, the fever he has is too high; it cannot be without a disease. It is better we examine him through tests. Tests are free… so that we see if he has malaria.

Patient: *Mm.*

Mm.

Doctor: *Nagotebia tindagokania gose tabwati ebibiriri rakini ebirириri nabirobio,riberera eri iga tokogenda ase omonyamete gose omonto bw'ebiriri ng'a achi komoa eriogo rieriberera. Eriogo rieriberera ntwe togoko.. togokoa nyagitari. Igo mbuya kware egento tware gopima malaria nero nabo egocha buna oroche iga. Naende nabo eranyarekane ng'a omwana oyo nabwate malaria. Igaa ngusii tomanyete Gusii malaria nigo ere igoro sana. Nechinyagitari chiamalaria nochimanyete baba?*

I told you that I haven't denied that he does not have "ebibiriri" but then with this kind of fever, you can't visit a herbalist or a person who treats "ebibiriri" so that he/she so that he gives him medicine for this fever. The medicine for fever, it is us who give you at the hospital. So, it is good if we could examine him through a malaria test because it has the symptoms you can see here. And it is possible that this baby has malaria. This is Gusiiand we know that Gusii reports high prevalence rates of malaria. And do you know the hospitals for malaria?

Patient: *Ee ninchimanyete.*

Yes, I know them.

Doctor: *Nochimanyete.*

You know them.

Patient: *Mm.*

Mm.

Doctor: *Ee nomanyete ng'a riberera ngocha rire na malaria?*

Yes, do you know that fever comes with malaria?

Patient: *Ee ngocha rire.*

Yes, it does come.

Doctor: *Nomanyete ogosaa ngocha kore na malaria?*

Do you know that diarrhoea comes with malaria?

Patient: *Yaya ekio timanyeti.*

No, I dont know.

Doctor: *Bono ogosaa, enda koroma, omotwe kogwatia, ebio bionsi nabo bigocha na mala…*

Now diarrhoea, stomach ache, head ache, all those come with mala...

Patient: *Malaria.*

Malaria.

Doctor: *Na malaria nakio gekogera abana bonsi bogocha agaiga. Naacha aa gaiga omwana akoroka na gosaa goika toramopima torore gose malaria yagera oroka kago…*

With malaria, that is why all the children come here. Even if a child come here vomiting and diarrhoea, we must carry out a malaria test to establish if it is the course for the vomiting and diarr…

Patient: *Kagosaa.*

Diarrhoea.

Doctor: *Osaa. Omwana ogocha onde bwensi ogocha neriberera, mbuya tomopime, torore ng'a malaria nerororo? Igo riberera tari malaria yoka ekorireta. Amarwaire nande akoreta riberera. Nabo omwana akonyora abwate oborwaire ase enchera y'amache tokoroka UTI rikoreta ribere.*

Diarrhoea. Any child who comes with fever, it is good to check if he/she has malaria. So, fever is not only caused by malaria. There are other diseases which cause high fever. You can get a child with a disease in the urine passage, what we call a urinary tract infection (UTI) causing fe...

Patient: *Riberera*

Fever.

Doctor: *Riberera*

Fever.

Patient: *Igo riberera eri ndiri gocha bosa. Oborwaire mbore bokogera riberera riche.*

Therefore, this fever does not just come. There is a disease which causes it.

Doctor: *N'egento ekenene pi ase tomenyete seito Gusii gekoreta riberera, malaria. Toramopima. Kerabe tabwati malaria naende nabo tokorigereria binto binde biragere atware riberera. Twaigwananire?*

And the most important thing, where we stay here in Gusii, the major cause of fever is malaria. Let's carry on the test. If it turns out he doesn't have malaria, we will carry on further examination to find out what is making the child to have fever. Are we in agreement?

Patient: *Ee. Igo bono malaria yoka aranyare koba kagotwara? Borwaire bonde mboiyo bochererete obwo?*

Yes. So, does it mean it is only malaria he can only be having? Is there any other disease related to that one?

Doctor: *Nakio nagotebia ng'a.*

That is what I am saying that

Patient: *Mm.*

Mm.

Doctor: *Tari malaria yoka ekoreta.*

It is not malaria alone which brings

Patient: *Mm.*

Mm.

Doctor: *Ayande.*

Others.

Patient: *Mm.*

Mm.

Doctor: *Rikuba onye ndiri abwate rikuba kanga ngwateba ng'a ogokorora amo n'amamiri goeta ayio gwateba tabwate egento kiamosumbua mono nenda ekomoroma amo neriberera.*

Flu, if she had flu then you could have talked of coughing and a running nose and apart from that you said she didn't have anything which has troubled her more, safe for the stomach ache and fever.

Patient: *Rakini n'omonwa noro nomoriete.*

But she also has the 'mouth'.

Doctor: *Omonwa*

The mouth.

Patient: *Mm.*

Mm.

Doctor: *Omonwa nabo tokorigereria.*

We can examine the mouth.

Patient: *Mm*

Mm.

Doctor: *Aye gikwarora korwa nka monwa ki kwarora orenge? Emenwa nere etabauti.*

Since you observed from home, what kind of 'mouth' was it? We have different types of 'mouths'.

Patient: *Igo yare buna amaote iga korwa ime.*

It was as if it has wounds from inside.

Doctor: *Amarabu arenge gose namabariri?*

Were they whitish or reddish?

Patient: *Amarabu.*

Whitish.

Doctor: *Amarabu.*

Whitish.

Patient: *Mm.*

Mm.

Doctor: *Ase omwana, amaote amarabu oyio n'omonwa okorokwa oral thrush.*

For a child, whitish wounds on the mouth can be a mouth disease referred to as oral thrush.

Patient: *Mm.*

Mm.

Doctor: *Oral thrush n'oborwaire bokoretwa n'ebiini bire e fungus. Ase ekegusii, etokoboroka omo. Omonwa.*

Oral thrush is a fungal infection. In Ekegusii, we call it the 'mouth'.

Patient: *Omonwa.*

The mouth.

Doctor: *Omonwa. Igaa nyagitari omonwa oyo ekero tokonyorigereri eyio n'efungal infection ekorokwa candidiasis. Eh?*

The mouth. Here in hospital when we examine it, that one is a fungal infection referred to as candidiasis. Eh?

Patient: *Mm.*

Mm.

Doctor: *Eyio nero. Tiga toramorigereri. Ekemaene nabwate?*

That is, it. Let's examine her. Is it true she has it?

Patient: *Nabwate.*

She has it.

Doctor: *Ekemaene nabwate. Na omwana oyo nkomogonkia ore?*

True she has it. And do you breastfeed her?

Patient: *Ee bono.*

Yes, I do.

Doctor: *Nomaete estatus yao. Ee. Omwana orwarire omonwa. Ekero okomogonkia nabo eranyarekane omwambokeri oborwaire bwa HIV. Igo omonu oyo norororo ee asengencho y'eriberera eri arwarire naborirarete omonwa. Nakio nakoboreria ritang'ani konya mwamoeire mariogo ande y'ekienyeji.*

You know your HIV and AIDS status. Yes. The child has been infected with oral thrash. It is possible to infect her with HIV when breastfeeding her. So, this oral thrash is there, yes because of this fever it may cause oral thrash. That is why I first asked you if you had already given her any of the traditional medicine.

Patient: *Yaya rakini mwang'ete amariogo korwa igaa nyagitari ayankomoa.*

No but you had given me medicine from here at hospital which I give her.

Doctor: *Amariogo aya twakoete*.

This medicine that we gave you.

Patient: Mm.

Mm.

Doctor: *Aro tari gochia tari gotanga omonu gose tari kogwenia monu oyo*

They do not, they do not prevent oral thrash or even cure this oral thrash

Patient: *Mm.*

Mm.

Doctor: *Aya n'amang'ana …amariogo torakoe.*

These are issues…we shall give you medicine

Patient: *Mm.*

Mm.

Doctor: *Gaki igo ngosaba, aiga Gusii ntonarete kogenda twanyora amariogo y'ekienyeji. Aya y'ekienyeji tari gocha gokonya egekogera naende igo aragere omwana atware amarwarwaire ande achake gosaa nonya tare gosaa. Amariogo nareo anyagitari ay'omonw' oyo.*

Please I pray, here in Gusii we like to go and get traditional medicine. These traditional medicines do not help because they can even cause other illnesses, cause diarrhoea even if she did not have diarrhoea. There are hospital medicines for this child.

Patient: *Mm.*

Mm.

Doctor: *Tokomoa amorwarie omonwa okore ki?*

We give her to trat the oral thrash so that?

Patient: *Oere*

It clears it.

Doctor: *Oere. Naende asengencho omanyete estatus yao genderera komoa amariogo aya.*

It clears it. And because you know your status, continue to give her these medicines.

Patient: *Mm.*

Mm.

Doctor: *Naye mbora nkonywa ore ayao. Naye totiga ayao. Totiga na ay'omonwa erinde ntochia komwambokeria ebirusi bia HIV.*

And I hope you are taking your medication. Do not leave yours. Do not leave the child's too such that we do not transmit the HIV virus to her.

Patient: *Iga bono omwana oyo nache agwene pi?*

So now will this child recover fully?

Doctor: *Omwana?*

The child?

Patient: *Ginkomoa amariogo aya y'oborwaire obo, mbonyare koba bogochenchi boa be HIV negative?*

Since am giving her the medicine for this disease, is it possible for it to change and be HIV negative?

Doctor: *Ase omwana twamotigire.*

For the child we have left her.

Patient: *Mm.*

Mm.

Doctor: *Ntwamopimete riria twachagete. Ntwamopimete emetienyi sita. Eye yonsi igo arenge negative.*

We carried out tests when we started. We carried out tests on her again after six months. All these tests were showing her negative status.

Patient: *Mm.*

Mm.

Doctor: *Twakweresire buna ogwenerete komogonki twakoeresire namariogo aye buna agwenerete koyanywa. Ee ebi bionsi igo togokora erinde omwana oyo to taba HIV positive. Ee naende igo togosaba omwana oyo omoerio neba n'obwate HIV tomwambokeri. Nakio gekogera naye tokogotebi onywe amariogo ebirusi bibe nse pi. Ekero bire nse naende okonywa amariogo buya mbikorwa ase ore bigende ase omwa…*

We have explained to you how you are supposed to breastfeed her; we have explained how you she is supposed to take her medication. We do all this so that this child does not get HIV positive. We also pray that this child, even if you are HIV positive, you do not infect her. That is why we advise you to take your medication such that the viral load to be very low. When they are low, and you take your medicine properly, they cannot be transmitted from you to the chi…

Patient: *Ase omwana.*

To the child.

Doctor: *Naki gekogera tokogotebia omwana karwarire tiga kona kogenda ogende ochie gotumia alternative medicine erororo ase ekenyoro kero kende emete. Mbuya oche nyagitari buna gwachire iga. Amariogo aya tokomoa nyagitari nabo akomokonya. Nabo okomokonya tomwambokeri ebirusi bia HIV. Ninde n'okwegena koratumie amariogo buna tokogotebia na tosabe na Nyasae, mwanoo tagotwara birusi.*

That is why we are telling you that when the child gets sick do not get used to going for alternative medicine in the village, including herbs. It is better to come to hospital just like you have come here. The drugs we give her at hospital can help her. You can help her so that you do not infect her. With the HIV. I believe that if you use your medication according to our advice, and we pray God, your child will not be infected.

Patient: *Igo bono omwana oyo nachenchi igo achi koba HIV negative chingaki gochiaetire gochi bosio?*

So now will this child to change and become HIV negative after some time going forward?

Doctor: *Omwana ne HIV negative are.*

The child is HIV negative.

Patient: *Mm.*

Mm.

Doctor: *Riorio onye kende kiabeire gati aa keragere omwambokeri.*

Uness something has happened in between here which can make you infect her.

Patient: *Mm.*

Mm.

Doctor: *Omwana nabo agotigara koba HIV negative. Nimanyete abana abange baiborwe n'abang'ina babwate HIV buna aye rakini bairwe amariogo, barendirwe buya. Bono iga buna togokwana iga abana mbare aba mama omwabo agonkete rakini bare HIV.*

The child can remain being HIV negative. I know many children have been born by women mothers who are HIV positive like you, but they have been given medicine and been taken care of properly. Right now, as we speak there are children who were breastfed by the mother, but they are HIV

Patient: *Negative*

Negative

Doctor: *Negative. Igo naye noyoo nabo arabe oyomo ase baria gicha obwati amachiko amo n'amariogo okore ki …onywe buna togotebeti, n'omwana oyo am very sure nkoba are HIV negative.*

Negative. So, yours can be one of those provided you follow the rules and the medicines you do what…you take them according to our guidelines am very sure this child is going to be HIV negative.

Patient: *Mm.*

Mm.

Doctor: *Ee*

Yes.

Patient: *Ndire naro okonyora amariogo aya nyagitari aika bono nonye twanyora chenchi teiyo. Kwana konyu rioka rioka rakini chenchi teiyo. Bono ekobetereri ng'a oranyu nonya n'emete orasunyunta meke onywe nario orachenchie. Nkobere buya.*

Sometimes you get that these hospital medicine get to a point when there is no change at all. You continue taking on and on without any change. Now it forces you to consider the preparing even some little herbal remedy for at least some change. It gets better.

Doctor: *Ee ense yaramokirie.*

Yes, the world is waking up.

Patient: *Mm.*

Mm.

Doctor: *Chingaki twagatumiire emete igo chiaerete kare. Kero ore esabari, esabari igo okogenda gochia motwe tori koirana gochia magega Ee kero tore esabari igo okogenda gochia motwe tari okoirana magega. Emete engaki yaye nere yakabeire. Bono iga ntobwate amariogo nyagitari. Nase oborwaire ntobwati riogo rimo. Ntobwate eriogo ase ogochakera. Ndire eriogo ndirororo eri kiriasinya nkogenda tore eri rinde. Gikwarora ng'a tobwati chenchi gwatumiire amariogo aya amatuko abere atato eriakane torochi na nobwate echenchi nchu nyagitari. Kigwachire nyagitari naende nabo togokorenga torore ng'a noborwaire bori bori obwate gose obonde mboroo bw'akorire ki bwasoire ekiagera otatwara echenchi. Korwa abwo nabo tokogochencheria amariogo. Riogo ntobwati rimo nyagitari. Eh?*

The times we used to use herbal medicine have long passed. When you are travelling on a journey you keep going further not backwards. Herbs used to have their own time. Now we have hospital medicines. And for a disease we do not just have one medicinal remedy. We have the first line medicine, there is the second line medicine which we move to if this other one fails. Once you notice that you do have any change after using the medicine for two, three days, the fourth one there is no change, come to hospital. When you have come to hospital we will clinically examine you and establish if the same disease you have or if there is a new infection which may be responsible for the resistance to the treatment. From there we can review your medication. We do not just have one kind of medicine at hospital. Eh?

Patient: *Mm.*

Mm.

Doctor: *Igo, egento nkogotebi emete nemiya yakarenge rakini chingaki chiaye chiakorire ki? Chiaerire.*

So, what I am telling you herbs used to be good, but their time has done what? Has elapsed.

Patient: *Chiaerire.*

Has elapsed.

Doctor: *Nyagitari aiga nigo tore aroro. Gatwakoa eriogo naende nkogotebia tore ng'a gotaigwe buya irana togochencheri.*

Here in hospital we are available. Once we have given you medicine we inform you to come back if you do not see any change.

Patient: *Mm.*

Mm.

Doctor: *Igo tari riogo rikare aroro. Tari bo?*

So, it is not that its medicine that is there. Isnt it?

Patient: *Mm.*

Mm.

Doctor: *Nobwate iswari rinde toraragotoma ochie korengwa?*

Do you have any other question before we send you to go for the tests?

Patient: *Yaya bono ayane aerire. Mbuya kegima.*

No, I have exhausted mine. Thanks a lot.

Doctor: *Karibu sana.*

Very welcome.

Appendix xx. Diabetes 1 consultation

Doctor: *Karibu mummy. Naki rituko?*

Welcome mummy. How is the day?

Patient: *Mbuya mono.*

Very well.

Doctor: *Ah… gwakorire buya gocha ekiriniki.*

Ah…You have done well to come for clinic.

Patient: *Ee.*

Yes.

Doctor: *Aye nkwanya komocha clinic.*

You have never missed clinic.

Patient: *Ee.*

Yes.

Doctor: *Aye n'omorwaire omuya.*

You are a good patient.

Patient: *Mm.*

Mm.

Doctor: *Nka naki ere?*

How is home?

Patient: *Mbuy' ere.*

It is fine.

Doctor: *Karibu. Ayaa. ntebi bono.*

Welcome. Okay tell me then.

Patient: *Bono mbwate … nimbwate omochando. Omochando one ne…natemire korigia abana nkobwata oborito bwagwa. Bono timenyeti nki ndakore na ginkoboria abanto bantebia noborwaire obo naye nogendererete kong'a amariogo. Bono nki ndakore? Igo nkomenta konywa amariogo? Imente amange gose naroo okong'a.*

Now I have… I have a problem. My problem is…I have tried to look for children, when I get pregnancy, I get a miscarriage. Now I do not know what I will do and when I ask people they tell me that it is this disease and you have continued to give me the medicine. Now what will I do? Do I take more drugs? Add me more, I hope you have more to give me.

Doctor: *Mm.*

Mm.

Patient: *Ee. Omochando onde n'endagera ; endagera igo mwantebetie ndie nke tindi gochia ng'igota!*

Yes. Another problem is food. You had told me to take a little food but i do not even get satisfied!

Doctor: *Haha.*

Haha.

Patient: *Ee… bono timanyeti gose igo mogontebia mente ekewango…mong'e eriogo mente ekiagera abanto bande igo bakonywa esoda nche tindi konywa soda.*

Yes … now I dont know if you will tell me to increase the portion…you also add me medicine because other people take soda yet I do not.

Doctor: *Aye oroche okonywa amache oka?*

You think you only take water?

Patient: *Ee.*

Yes.

Doctor: *Gose club soda.*

Or club soda.

Patient: *Kende nkeiyo nkonywa!*

There is nothing I drink!

Doctor: *Mm.*

Mm.

Patient: *Ekiagera mwantebetie tinywa.*

Because you told me not to drink.

Doctor: *Mm.*

Mm.

Patient: *Naende nimbwate omochando onde.*

I also have another problem.

Doctor: *Mm.*

Mm.

Patient: *Omochando mbwate noyio bwamariogo ayio mogontebia ng'a nyetonge. Aah bono ntagete nchake eriokonywa bono tintageti eriogwetonga. Naende ntagete eriokonywa buna omosani one akonywa.*

The problem I have is about the medicine you tell me to inject myself. Aah, now I want oral drugs not injectable medicine. I want the oral one like my friend does.

Doctor: *Bokong'u mboiyo. Nabo nkogokonya. Aye mbwoo ore, taribo?*

There is no problem. We can help. You are married, right?

Patient: *Ee.*

Yes.

Doctor: *Aah.*

Okay.

Patient: *Mm.*

Mm.

Doctor: *Emiaka erenga bono kwabeire bwoo?*

How many years have you been married?

Patient: *Emiaka etano ntaranyora mwana.*

Five years without getting a baby.

Doctor: *Emiaka etano. Bono iga emiaka erenga obwate?*

Five years. Now how old are you?

Patient: *Bono iga emerongo ebere na etano.*

Now I am twenty-five.

Doctor: *Aye egwatamete koru nkaa gose chiombe chiairirwe?*

Did you elope from home or have the cows been taken?

Patient: *Chiombe mbaraira asengencho tindanyora mwana.*

They haven't taken the cows because of I haven't given birth to a baby

Doctor: *Igo aye igo kwanywometwe kore 20, 19 gose 18?*

So, you got married at twenty, nineteen or eighteen?

Patient: *Ekero nare emerongo ebere.*

When I was twenty.

Doctor: *Ebere?*

Twenty?

Patient: *Eeh.*

Yes.

Doctor: *Aah iiga. Igo ase emiaka emerongo ebere kwarwanirie konyora omwana na…*

Ah I see. So, in twenty years you have struggled to get a baby and …

Patient: *Yaya ase emiaka yaetire etano.*

No for five years now.

Doctor: *Yaya pole pole, mbuya mono ase... bono… korwa enywomo... korwa emiaka emerongo ebere goikera bono gwatemire konyora omwana.*

No slow down, Thanks for... now... since marriage...from twenty years up to now you have tried to get a baby.

Patient: *Eeh*

Yeah.

Doctor: *Naende igo gwantebia ng'a oborito bwao bwabeire bokogwa?*

And you have told me that you have been having miscarriages?

Patient: *Ee.*

Yes.

Doctor: *Mara karenga?*

How many times?

Patient: *Mara gatato.*

Three times.

Doctor: *Ndi eriomoerio riare?*

When was the last time?

Patient: *Eyarenge omotienyi o kianda.*

It was in September.

Doctor: *Omotienyi o kianda omwaka oyo oerete?*

September last year?

Patient: *Ee.*

Yes.

Doctor: *Pole nonya nabo. Goika obe…*

Sorry for that. You must be…

Patient: *Ritang'ani nagotebirie ng'a igo yare omotienyi o gatato.*

First, I have told you that it happened in March.

Doctor: *Omotienyi o gatato? Goika okare omosubati omokong'u naende goika nkoe pongezi. Aah tari achachi komenya n'obosoku obwo okonyora gati y'abanto nonya n'ekanisa abanto ngokogenka bare. Ninde namaene nonya nyoko biara oansire ko… ebinto biria abagusii bagoteba.*

March? You must be a strong lady and I must commend you. Ah…it is not easy to stay with the shame which you get among people even those in church who may misadvice you. I am sure that even your mother in law has started to…those things that the AbaGusii say.

Patient: *Ee ngonteba are.*

Yes, she says.

Doctor: *Ochakire? Ochakire?*

Has she started? Has she started?

Patient: *Agotebia omogaka arête omong'ina onde.*

She tells my husband to marry another wifeDoctor: *Ochakire ..eeh ebinto buna ebio.*

She has started…eh… those kinds of things?

Patient: *Mm.*

Mm.

Doctor: *Bokong'u mboiyo.*

There is no problem.

Patient: *Mm.*

Mm.

Doctor: *Mm omaete titochieti kogopima borwaire obo bwao bw'esukari goikera bwango iga.*

Mm you know we have not run tests for your diabetes of late.

Patient: *Mm.*

Mm.

Doctor: *Obobe aah ogopimwa oko nigo gwakoretwe totebe omwaka oyomo gose ebere yaetire tari bo?*

The problem is such tests were done say one or two years ago.

Patient: *Ee.*

Yes.

Doctor: *Aah igo tindengerereti ng'a echi n'echingaki ogwenerete obe n'echitang'utang'u asengencho bono iga n'amariogo ogendererete konywa.*

Aah so I don't think that this is the time to have doubts because right now you are taking your medication.

Patient: *Ee.*

Yes.

Doctor: *Aa… na mbuya ogendererete koyanywa.*

Aa… and its god you continue taking them.

Patient: *Mm.*

Mm.

Doctor: *Aah.*

Aah.

Patient: *Korende ntagete ong'oonchorerie.*

But I need you to change for me.

Doctor: *Otagete goonchoreria aa.. ngoika tore abwo. Oyio noro orenge omochando oo ogatato. Tokumia igo okare kogenda bwango mono. Igo egento togokora, tiga ritang'ani torakorana n'omochando oyo oo bw'okogwa kwoborito aa… totebe goikera bono esukari yao yabeire stable.*

You need to change, okay… we will get there. That was your third problem. Do not worry, you are moving so fast. So, what we do, let us first finish this problem of miscarrying… let's say your sugar level has now stabilised.

Patient: *Ee.*

Yes.

Doctor: *Na yabeire buna egwenerete gose ekero ore nka nkoror.. nkoraa.. nkoraepima ore nobwate emachine?*

And it is normal, when you are at home, I hope you test yourself, do you have the machine?

Patient: *Ee nimbwate emachine nkwepimera.*

Yes I have the machine which I use to test myself.

Doctor: *Yana kogenda igoro yanya goika ikomi gose ikomi gochi igoro?*

Has it ever gone up to ten or above ten?

Patient: *Riri' ekogenda igoro ngochande.*

When it goes up I come.

Doctor: *Mm.*

Mm.

Patient: *Mm.*

Mm.

Doctor: *Gwacha ase emergency bakorora naende kwagenda nka?*

You come to emergency they see you and you go back home?

Patient: *Eeh.*

Yes.

Doctor: *Mara karenga ase omotienyi oyo yaba..?*

How many times has it happened this month?

Patient: *Omotienyi oyo teraba igo.*

This month it has not happened.

Doctor: *Ee kiagera nonye nechirecords chire ase e computer chikooroki ng'a sukari yao tekari mbe*

Yes, because even your records in our computers show that your sugar level is not bad.

Patient: *Mm.*

Mm.

Doctor: *Ee nkorayecontrol ore.*

Yes you control it.

Patient: *Ee.*

Yes.

Doctor: *Naende amariogo aya ngokonya are.*

The medicine also helps.

Patient: *Ee.*

Yes.

Doctor: *Bono ngokoande rirube ...*

Now I will give you a letter…

Patient: *Mm.*

Mm.

Doctor: *Igo nkogotoma ase e gynecologist oyio ore omosani one sana. Gochi bono igo nkomwakera esimi otaragenda aroro. Nagokonye na kero kende erabe buya onye nkwagenda n'omogaka oo. Aa.. na kero kende komwaigwananire amo nere nabo mokoarigania nyoko biara ase amangana buna aya aah egere tobeke… tobabeke buna e timu eyemo. Omaete nigo togwenerete korwania oborwaire obo bwe'esukari buna riboa erimo: nche buna omonyagetari oo, aye n'enka yao mobe buna etimu. Toise kobagekana ensemo ensemo…*

I will send you to a gynecologist who is my close friend. In fact, I will call him before you go there. He will assist you and maybe it will be good to go with your husband. Aa..and maybe once you agree with him you can invite your mother-in-law in the process…aah so that we put you in one team. You know we are supposed to fight this disease of diabetes as a team: myself as the doctor, you and your family as a team. If we get split into two…

Patient: *Mm.*

Mm.

Doctor: *To..toraise ko…igo to…tokobugwa, tari bo?*

We will lose, is that not so?

Patient: *Mm.*

Mm.

Doctor: *Abasongo ngoteba bare ng'a 'teamwork wins'. Nonya ninche torochi igo ngosanga n'omonyagetari onde.*

The English say, "teamwork wins". You see, even me I work with another doctor…

Patient: *Mm.*

Mm.

Doctor: *Oyio ore kemanyi ase amang'ana aya ya konyora abana kiagera ntagete tobe etimu.*

Who is a specialist in issues related to the female reproductive system because I want us to be a team.

Patient: *Mm.*

Mm.

Doctor: *Tokoba etimu enene..eeh.. ebwate ogosemerani nabo egokwanwa igo? Ebwatee.. ogotegererana na koigwanana tora.. erio nario torabobue oborwaire naye buna ore omoke nabo okonyora abana ikomi gose batano batato oise kogania. Korende nimanyete kero kende igo oganetie abana batato gose babere eyio ere buya korende tinkorwa eira. Igo nkogotoma ase gynacologysist.*

When we are a big team…eeh…having consultations, is that how it is said? With understanding and agreement with each other, we can defeat this disease and being a young person, you can then be able to give birth to up to say fifteen children if you want. However, I know that you maybe want to get three or two which is okay though I can't make promises. So, I will send you to a gynecologist.

Patient: *Bono nankonye mbwate oborito?*

Now, will he assist me get pregnant?

Doctor: *Ee amaboria onsi igoro y'ensemo eyio nakore obotuki ase ore erio akoe ogosemia na ekeene nakoe amachibu onsi.*

Yes, all issues about that area he will do some investigation on you then he will advice you, and of course he will give you all those answers.

Patient: *Aye oroche nintware oborito?*

Do you think I will get pregnant?

Doctor: *Korende… ee kwabeire gokoba morito abwo magega aa… nabo obaise koba morito naende. Ekio totagete gokora ekiagera bono ntobwati chitang'utang'u ntori goteba ng'a omogaka igo agosokia amarumbe.*

But…yeah you have gotten pregnant before aa…you can easily get pregnant again. All we want to do…because we now have no doubts… we are not saying that your husband is not fertile.

Patient: *Mm.*

Mm.

Doctor: *Ng'a gose aye nda yao teri kobwata borito yaya. Bono ntomanyete ng'a mwensi monyare koibora. Igo totagete oborito obo bobeo ase enchera y'okorenda esukari na kero kende korwaria borwaire bonde bwonsi egynecologist eranyore na um…. Ekero bwarwarigwe bono igo tokomenta okobua kwao gwo'okonyora omwana oo. Ntagete ngotebie ntari n'echitang'utang'u ng'a abarwaire bane abange babeire morito buya naboigo bakoreire koibora. Igo koira eyio koba kirori, aa… nabo nkogotebia kinde n'obomaene ng'a twaisire goika abwo aa… tibwoboa. Tokwa omoyo. Genderera korwana. Oborwaire obo nobe nabwo kero kende ase obogima bwao bwonsi tari bo? Ntomanyeti egekogera kero kende Yeso nkogwenia arenge abanto ase okobaaka amate ase amaiso abo tari bo?... igo kende nabo kebaise gokorekana aande gati kabere. Igo… tobeke ogosemeria gwaito abwo tari boigo?*

Or that you are not able to get pregnant, no. Now we know at least both of you are fertile. We just want to sustain the pregnancy by controlling sugars and probably treating any other condition that the gynecologist might find. Once it is treated, now we increase your chances of getting your baby. I would say without a doubt and most of my patients who are diabetic and your age mates have gotten pregnant successfully, and given birth. So based on that evidence, aa…I can tell you with almost all surety that we are almost there aa.. don't panic. Don't give up. You just keep on fighting. You may have to probably stay with this disease for the rest of your life, is that not so? We don't know because maybe Jesus used to heal blind people by applying saliva on their eyes, is that not so?..so something could happen in between… we are not ruling it out so… let's just put our hopes there, okay?

Patient: *Ee.*

Yes.

Doctor: *Omochando onde kwarenge noro noyio bweriogo riokwebeta, eriogo riokonywa, eriogo rigwetonga aa.. ntagete ong'igwe buya. Oborwaire bw'esukari igo bore mara kabere. Mbore bwabana abake buna aye nimaete tori moke rakini emiaka yao …aaa.. abana babwate emiaka buna eyao, na oborwaire bw'esukari mbore bw'abanto abagotu babo sokoro, torochi rende?*

Another problem you had was about the self-injectable medicine…orally administered medicine, injectable medicine.aa..I want you to get me well. There are two types of diabetes. There is one which affects young people like you, I know you are not as young but your number o years…aa… young people of your age, and the other type is for elderly people, the likes of grandfather, you see.

Patient: *Ee.*

Yes.

Doctor: *Igo eye y'abana abake anene mono chingaki chinyinge igo ekworokia nobwate omochando na insulin yao. Mobere oo tori konyara koroisia insulin esaine buna eria y'abant abagotu. Abanto abagotu nabo bokonyara koroisia insulin korende insulin eyio teri gokora egasi eria egwenerete. Ase igo amariogo abo nigo are amaao aaa… Eye nabo erabe eyokoondokia korende nabo ekonyarekana otumie chisindani ase engaki entambe onye tari obogima bwao bwonsi kobua baria abagotu aaa…Tindi kanyasae goka ase enyagetari eye, tari bo?*

So, this one for the young people most of the time, it means you have a problem with your insulin. You cannot produce enough insulin unlike the one for elderly people. The elderly can produce insulin, but the insulin is not giving the function it's supposed to so their drugs are different aaa… This might come as a shocker but there is a high chance you will be doing injections for a long time if not forever as opposed to those other old people aaa…. You just need to put your mind on it, aa it's much easier when you accept it …aa... though I will still send you to a diabetic counselor …aa… like I told you this thing we do as a team it's not one man's show. I am not the only ''god'' in this hospital, isn't it?

Patient: *mm*

Doctor: *Igo togosanga n'abande. Ase ayio ningotome ase omosemia bw'oborwaire bw'esukari aaah… tona goichana tibori borwaire bw'ekerage nabo kwarengereria buya nakoeire pongezi ase ayio. Torochi rende?*

We involve other people. So, on that I will send you to a diabetes counselor aah… you don't need to worry it's not such a strange disease, and you thought it well I should congratulate you on that. You see?

Patient: *Bono eriogo ndire riegenka riatoka Migori rikorwaria buya mono tinkogenderera nario?*

There is some herbal medicine which was founded in Migori which treats very well, can't I continue with it?

Doctor: *Akai!*

What!

Patient: *Naboigo narenge …*

That's what I was…

Doctor: *Igo gwachakire koritumia?*

So, you have started to use it?

Patient: *Ntagete nchake koritumia.*

I want to start to use it.

Doctor: *Oo omaete gwantebirie ng'a nabo obaise kogenderera nario narengereria ng'a gwachakire.*

I see, you know you have said that that you might continue with it so I thought that you have already started.

Patient: *Ninchake igo nakoboria.*

I asked if I can start.

Doctor: *Oo.*

Okay.

Patient: *Ekiagera eriogo eri naigure oborwaire obo omaete n'abanto bakondigereria bobe.*

Because this medicine, I have heard this this disease is as a result of people looking at me with ill intentions.

Doctor: *Ehe.*

Okay.

Patient: *Tari borwaire obwane igo narogetwe.*

Not my disease, i was bewitched.

Doctor: *Bono aye ng'inyori erieta riao.*

Now remind me your name.

Patient: *Nkoroku Kemunto.*

I am Kemunto.

Doctor: *Kemunto, Kemunto aye emiaka erenga obwate.*

Kemunto, how old are you Kemunto?

Patient: *Emerongo ebere n'etano.*

Twenty-five.

Doctor: *Ngwasomete mbaka ekerasi gia karenga?*

You studied up to which class?

Patient: *naigete ekia gatato…*

I got to the third one…

Doctor: *Aye buna ore buya iga kia gatato tori kong'aina?*

The way you look nice, the third, you are not lying to me?

Patient: *Yaya.*

No.

Doctor: *Oo.*

Okay.

Patient: *Mm.*

Mm.

Doctor: *Gwa! Ngocha gonsokia kware mono kiagera birengererio buna ebio nebia abang'ina abakoro bari batasomete baria batari korora nonya ne TV.*

Alas! I was to be ashamed of you because such like thoughts are for old grannies who never went to school and who do not even watch TV.

Patient: *Rakini omonto nare ontebeti obwo n'oborogi tari…*

But there is someone who told me that this is witchcraft not…

Doctor: *Nimaete aye tiga karatiga. Omaete abang'ina bari abagotu abaiseke buna aye.*

I know wait first. Do you know old ladies, ladies like you ?

Patient: *Mm.*

Mm.

Doctor: *Korende omaete diabetis nere baka Bosongo.*

But you know diabetes exists even in Europe.

Patient: *Mm.*

Mm.

Doctor: *Bosongo abarogi mbaroo? Abagusii nkogenda bare aroro baminyoka botuko?*

Are there witches in Europe? Do AbaGusii go there for night running?

Patient: *Ee.*

Yes.

Doctor: Yaya. America?

No. America?

Patient: *Obee!*

Oh my!

Doctor: *Gose England? Gose Germany?*

Or England? Or Germany?

Patient: *Timaeti.*

I do not know.

Doctor: *Eeh, rakini mboroo mbaka aroro. Bagusii mbaiyo barogi mbaiyo. Igo abwo Germany ninki gekoboreta rende? Gose Finland?*

Yes, but it is there even there. The AbaGusii are not there, and witches are not there. So in Germany what causes it ? Or in Finland ?

Patient: *Nakanyeigure.*

I can't know.

Doctor: *Nomaete America? Minesota nomaete?*

Do you know America? Do you know Minesota?

Patient: *Mm.*

Mm.

Doctor: *Nobwate omoiri okaroo?*

Do you have a relative there?

Patient: *Yaya.*

No.

Doctor: *Borwaire obu …aa… omanyete abanto ao ao igo bagotwara okwegena ao ao tari bo?*

That disease …aa… you know different people have different beliefs, isn't it?

Patient: *Mm.*

Mm.

Doctor: *Korende oborwaire bw'esukari bwakoreirwe obotuki ase chilaboratories. Tari bo? Eeh obotuki mbogendererete na totebe ntomanyete nki gekoborenta. Buna nagotebia omobere oo tori gosoki insulin. Torochi rende?*

But diabetes has been studied even in laboratories, isn't it? Eeh research is still ongoing and at least we know what is causing it. Like I told you your body does not produce insulin. You see?

Patient: *Ee.*

Yes.

Doctor: *Riogo eri togokoa rieinsulin… noroche rende… yaani tari borogi tokorwari namariogo aya. Riakabere aye esukari yao yachakire gokoa naende emechando emeng'ao okogweria oborito kwaba n'esukari ekogenda nsa chinde igoro nsa chinde yacha yarwarigwa ase emergency aa.. igo ntobwati nsa togokora egosori na binto binde tari bo ?*

The insulin medicine we give you… you see.. means we are not trying to fight witchcraft with this medicine. Secondly, your sugar has started to give you other problems : miscarriages then your sugar fluctuating to high level and you for treatment at the emergency unit. So we do not have the luxury of playing around with other things, isn't it ?

Patient: *Mm.*

Mm.

Doctor: *Bono iga nigo totagete ko…ntagete ngotome ase egynecologyst erio egere togokonye obe morito na nigo arasarie pi oise gochaka komenta ebinto binde. Igo oratoiranie amabarato ikomi gochia nyuma twasuka amabarato abere bosio gwatoirania amabarato abere magega igo tori kogenda ande. Eeh ntagete ngotebi, ngosoma ore ebuku?*

Right now we want to… I want to send to a gynecologist so that they can assist you to get pregnant and you would you would mess everything up if now you start introducing other things. You will take us ten steps backwards and we move two steps ahead and you take us two steps behind so we are not moving anywhere. Yes, I want to tell you, do you read the Bible?

Patient: *Mm.*

Mm.

Doctor: *Ee genda aye kora amasabo. Soma ebuku …aa. Tobaise gwanchera ebirengererio ebibe gose ebinto bi'egenka abanto bagokwana bitagware obongo bwao. Aye n'omosubati omong'aini ore n'obogima obuya bwa bosio mm ... ebinto ebi biabagusii otagete koreta aiga ntagete oteme obirusie ase ebirengererio biao, torochi rende?*

Yes, you go and pray. Read your Bible… aa … Do not allow evil thoughts, traditional things, what people tell you to rule your mind. You are a sharp lady you have a bright future ahead of you mm… These things of the AbaGusii you want to bring here, I want you to try and remove them from your thoughts, you see?

Patient: *Mm.*

Mm.

Doctor: *Aa… goetania abwo amariogo ayio y'emete kwaigure chibesa irenga akoonigwa?*

Aa … beyond that have you heard the cost of those herbs?

Patient: *Chiribu chimia isano.*

Fife hundred thousand.

Doctor: *Arari aaria Tanzania gose Boganda gose Machakos?*

Where is that….Tanzania, or Ugannda or Machakos?

Patient: *Maasai.*

Maasai.

Doctor: *Maasai koru aa mbaka aroro chibesa irenga?*

How much do you pay to go to Masai?

Patient: *Bagokorenta.*

They bring you.

Doctor: *Mbaka nyomba?*

Up to the house?

Patient: *Mbaka bosongo.*

Up to Kisii.

Doctor: *Mbaka aiga Gusii?*

Up to here Gusii?

Patient: *Mm.*

Mm.

Doctor: *Naende omaete nki kebekire aroro?*

Do you know the contents?

Patient: *Timaeti.*

I do not know.

Doctor: *Ee rende omaete omonto arabase koo.. kobeka chisogisi chiaye chianga chia ime asungusie ache akorentere ng'a nemete aye oenane chibesa otamaeti nki kebekire ororo. Omaete amariogo aya togokoa chikontents chiaye chirikire ase echuba. Eyio y'emete nomaete nki kerororo?*

Yes, you know someone can bring you a mixture of one's socks and innerwear and bring you as medicine and you just pay without knowing the contents. You know the medicine we give you has its contents displayed on the bottle. Do you know what the herbs have?

Patient: *Yaya.*

No.

Doctor: *Omonto arabaise gokoa nonya ama.. ekwerende echo yaye (amaseko) Agotebi n'emete. Omaete binto buna ebio goika obibeke ase ebirengereri biao.*

A person can even give you even his faeces(*laughter*) and tell you that is herbal medicine. You know you need to put such things in your thoughts.

Patient: *Mm.*

Mm.

Doctor: *Tobase kogenda kwaegwa kende gionsi aye kwaira kera eng'ana okonyora. Yaringorie erinde aa.. tiga nkoe pongezi ekiagera kwayereta ekiagera abaibori abange igo bakoyekora bobisi isiko aaria na uum twacha konyora gotwanyorirwe ekero bagocha esukari yasinyire koirania nse, rini riabo riasoire koba rinene, amaiso abo asoire koba yellow nario okorora kwamanya koboria, uum.. kwana gotumia eriogo ri'egenka… nario agocha kogotebia. Igo tanga ebirengererio ebio. Kabe omoremereria nimanyete ayio gwaeteire okogwa kw'oborito nabo obaise kobabaika na kero kende oteme ebinto binde korende torigereria egori torochi rende?*

Do not be given anything…you take every information you receive, filter it and …aa… I will congratulate you because you brought it up otherwise most of my patients just do it secretly out there and mm we have come to find out very late when they come the sugar is not getting controlled, their liver is becoming big, their eyes are becoming yellow, and now it hits you then you ask mm have you ever used herbal medicine… that is when he/she tells you. So, avoid those thoughts. Be very patient I know with the situation you have been through: loss of pregnancy, you are bound to panic and probably try other things but don't lose focus of the goal, you see now?

Patient: *Ee.*

Yes.

Doctor: *Rigereria bosio na nigo nagotebia nga ntwe n'etimu eyemo naboigo twensi amo na tobue. Torochi rende?*

Look ahead and I told you that we are one team and together we shall win. You see now?

Patient: *Ee.*

Yes.

Doctor: *Mm… ee igo tiga nkoe rituko riokoirana. Ninkorore omotienyi gokoera. Mm echi nachio chicontact chiane kabe n'obosibore kong'akera esimi mogaso gose botuko. Ntebi onye kore na koboria konde n'ekero nkare aare ntanyare koimokia esimi inchwo ase e department yaito ya emergency omonto natoke oragokonye.*

Mm… yes so let me give you a day for your next visit. I will see you as the month ends. Mm… these are my contacts be free to call me during the day or at night. Tell me if you have any question, and if I am away from the phone and I am not able to pick you can come to our emergency department and someone will be there to help you.

Patient: *Nabo.*

True.

Doctor: *Torochi rende?*

You see now?

Patient: *Ee.*

Yes.

Doctor: *Mbuya mono.*

Thank you.

Appendix xxi. Diabetes 2 consultation

Patient: *Bwakire daktari?*

Good morning doctor?

Doctor: *Mbuya mono baba. Mbuy' ore?*

Good morning mummy, how are you?

Patient: *Mbuya nde korende nomwana otaigweti buya.*

I am okay, but it is the child who is not feeling very fine.

Doctor: *Nki ekebe?*

What is the problem?

Patient: *Omwana oyo gaaki igarwarete rioka rioka gaki monyare gonkoya?*

This child of mine is sickly always, can you please help me?

Doctor: *Nabo tokogokonya. Gose eyio nero egasi togokora aa.*

We can help you. Really that is the work we do here.

Patient: *Gaaki akona korwara, riberera kera rituko.*

She has been getting ill with fever every day.

Doctor: *Ee.*

Eh.

Patient: *Naende nkagenda enyagitari ende gochia aria Getare bagantebia…*

And I visited some hospital at Getare they told me…

Doctor: *Ee.*

Eh.

Patient: *Ng'a igo abwate oborwaire bw'esukari.*

That she has diabetes.

Doctor: *Ee.*

Eh.

Patient: *Bono gaki eyio nere buya bori?*

Now, is that fine at all?

Doctor: *Hey baby girl, omwana nere oyo?*

Hey baby girl, is this the child?

Patient: *Ee omwana nere oyo.*

Yes, this is the child.

Doctor: *Ee… naki ntebi ngo riberera eri ndi riachagete?*

Yes … how, tell me when did this fever start?

Patient: *Esther suka gochia ase omonyagitari ang'e akwerese.*

Ester move close to the doctor to explain to you.

Doctor: *Riberera ndi riachagete?*

When did the fever start?

Patient: *Riberera riarabeire amatuko.*

The fever has lasted for days.

Doctor: *Mm.*

Mm.

Patient: *Nche omwana oyo iga onsinyire.*

I can't understand this child!

Doctor: Mm.

Mm.

Patient: *Timanyeti nche gose omonyagitari omwana oyo iga gose n'ekegusii akarwarete.*

I do not know if doctor, this child could be could be ill in EkeGusii sense.

Doctor: *Ekegusii yaya Ekegusii tiga goteba Ekegusii titora tiga torapima omwana torore ng'aki arwarete. Buna gwateba n'eriberera rikomochanda?*

EkeGusii sense of illness, no Ekegusii, don't say Ekegusii, lets carry out tests on the child to establish what the problem is. Did you say that she suffers from high fever?

Patient: *Ee.*

Yes.

Doctor: *Nsaa ngapi rigocha mono?*

What time does the fever manifest itself?

Patient: *Rigocha botuko naende ebimoni mbire bikobuga mwane isiko.*

It comes at night and there are some cats which meow outside my house.

Doctor: *Ebiao gose ebiabande?*

Yours or another person's?

Patient: *Yaya timbimanyeti*

No, I do not know them.

Doctor: *Yaya karatigana bono n'ebimoni, karantebia ango ake igoro y'omwana.*

No, leave the cats alone, briefly tell me about the child.

Patient: *Mm.*

Mm.

Doctor: *Oyio ogotebi narwarete esukari naki agotebeti igo amopimete?*

The one who told you that she is suffering from diabetes, did he carry out any tests?

Patient: *Igo amopimete Getare aria.*

He tested her there at Getare.

Doctor: *Mm.*

Mm.

Patient: *Agantebi nchiche igaiga nyagitari eye ya bosongo.*

He referred me here at Kisii hospital.

Doctor: *Nki atumiete gopima?*

What did he use to carry out the test?

Patient: *Atumiete ebinto biria biabo babwate ebichanga iga.*

He used those their things with some wires like this.

Doctor: *Mm.*

Mm.

Patient: *Ee.*

Yes.

Doctor: *Agateba esukari er…*

He said the sugar is…

Patient: *Agateba esukari igo ere emerongo etato.*

He said the sugar level is at 30.

Doctor: *Er'emerongo etato?*

It is at level 30?

Patient: *Mm.*

Mm.

Doctor: *Nki bamokorerete?*

What did they do with the child?

Patient: *Mm igo bamobekerete amache.*

Mm they put her on a drip of water.

Doctor: *Ee.*

Yes.

Patient: *Arafu bakang'a n'amariogo.*

Then they gave me medicine.

Doctor: *Ee.*

Okay.

Patient: *Bakandikera...*

The prescribed for me...

Doctor: E*e.*

Yes.

Patient: *Ayande atarengeo.*

The ones that were not there.

Doctor: *Ok.*

Ok.

Patient: *Rakini nche tindochi.*

But personally, I do not see.

Doctor: *Ee.*

Yes.

Patient: *Mm.*

Mm.

Doctor: *Torochi gose nkogwena are?*

You don't see the child recovering?

Patient: *Rakini naende tindochi gose nesukari eyio.*

But then I do not see that it is that diabetes.

Doctor: *Ee.*

Okay.

Patient: *Omaete nonya n'omosubati nare…*

You know there is this lady…

Doctor: *Ee.*

Yes.

Patient: *Twomanete nere nka.*

We quarreled with at home.

Doctor: *Ee.*

Yes.

Patient: *Agantebi ng'a n'orore.*

She threatened me that "I will see".

Doctor: *Ee.*

Yes

Patient: *Mm.*

Mm.

Doctor: *Bono ntagete tokore iga…*

Now I want us to do this…

Patient: *Mm.*

Mm.

Doctor: *Etokorigereria omwana.*

We shall examine the child.

Patient: *Mm.*

Mm.

Doctor: *Tomopime.*

We carry out the tests on her.

Patient: *Mm.*

Mm.

Doctor: *Erio torore ng'aki arwarete.*

Then we establish the nature of her sickness.

Patient: *Mompimere rende gaki mokonye rakini nche tindochi.*

You Carry those tests on her please but I personally don't see!

Doctor: *Ee rakini amang'ana ayio y'omosubati oyio n'ebimoni ntagete totigane kabisa.*

Yes, but I want us to avoid those issues of that lady and the cats absolutely.

Patient: *Ooh.*

Oh.

Doctor: *Ee bono kwaigure?*

Yes, do you understand?

Patient: *Ee*

Yes.

Doctor: *Nkomopima tore.*

We are carrying out the tests on her.

Patient: *Ee.*

Yes.

Doctor: *Tomoe eriogo omwana ache agwene.*

We give the child medicine and she gets well.

Patient: *Ee, nagwene rakini?*

Yes, can she really get well?

Doctor: *Ee bono nache agwene.*

Yes, she will get well.

Patient: *Gaki mbuya mono onye okogwena rakini tindochi!*

Please thanks if she is getting well although I don't see!

Doctor: *Yaya omwana nache agwene, tobaise goteba igo… bono iga Nyasae.*

No, the child will get well, do not say that… now it is God.

Patient: *Mm.*

Mm.

Doctor: *Omwana nache agwene.*

The child will get well.

Patient: *Mm.*

Mm.

Doctor: *Rakini amang'ana aria anka ari.*

But those issues from home…

Patient: *Mm.*

Mm.

Doctor: *Gokogenderera konyegena mwana takogwena.*

If you continue to believe them the child will not get well.

Patient: *Rakini rende naende nagenda ase.*

But then I went somewhere.

Doctor: *Mm.*

Mm.

Patient: *Omogaka gete n'omorwari sana.*

Some oldman who is a great healer.

Doctor: *Mm.*

Mm.

Patient: *Nantebi ng'a bori n'oborogi.*

Told me that it is witchcraft.

Doctor: *Bono ekio naki ntatageti; ntagete toyatige isiko igaria.*

Now that is what I don't want; I want us we leave all that out there.

Patient: *Mm.*

Mm.

Doctor: *Kwaigure?*

Do you understand?

Patient: *Mm.*

Mm.

Doctor: *Mang'ana a borogi taiyo.*

Issues of witchcraft are out of question.

Patient: *Mm.*

Mm.

Doctor: *Ee bono okwo n'okwegena gwekegusii korororo rakini borogi mboiyo.*

Yes, that is a Gusii belief which is there but witchcraft doesn't exist.

Patient: *Orwariri abanto omosubati onde. Ang'e nka iga namorwaria omwana ore kona gostuka stuka.*

He has cured people. Near my home he treated a child who used to have seizures.

Doctor: *Ee.*

Yes.

Patient: *Akamoa eriogo ogwenire.*

He gave her medicine and she has recovered.

Doctor: *Esukari…*

Sugar...

Patient: *Na kimoranyare gontebi ng'a esukari nero nabo akoba iga akorara akira kiri!*

And if you can manage to tell me that diabetes also makes the child will be okay then when she sleeps she goes quiet!

Doctor: *Bono aye tiga topime omwana.*

Now just let us carry out the tests on the child.

Patient: *Mm.*

Mm.

Doctor: *Tomoe amariogo.*

We prescribe her medicine.

Patient: *Mopime rende gaki.*

Please go ahead and carry out the tests.

Doctor: *Ee omwana nkomopima tore.*

Yes, we are carrying out the tests on the child.

Patient: *Mm.*

Mm.

Doctor: *Rakini bono ntotageti koburukani binto ebio tokomopima na komoa amariogo.*

But then we do not want to mix those things after the tests and prescribing medicine for her.

Patient: *Mm.*

Mm.

Doctor: *Ekegusii okogenda otigane kando.*

You go and leave Ekegusii alone.

Patient: *Mm.*

Mm.

Doctor: *Kwaigure?*

Do you understand?

Patient: *Mm.*

Mm.

Doctor: *Amang'ana y'ebimoni ebio ogende otigane orare chitoro marogoba.*

Those issues regarding the cats, leave them alone and be fast asleep in the evening.

Patient: *Mm.*

Mm.

Doctor: *N'amang'ana y'omosubati oyio tiga.*

And leave those issues regarding the lady.

Patient: *Mm.*

Mm.

Doctor: *Mwanyabanto tabwati nguru chiogokora binto buna ebio.*

A human being doesn't have the power to do things like those.

Patient: *Mm.*

Mm.

Doctor: *Ee bono.*

It's true.

Patient: *Mm.*

Mm.

Doctor: *Bono tiga torapima Esther.*

Now let's carry out the tests on Ester.

Patient: *Ee gaaki nkonye.*

Yes, please help me.

Doctor: *Torore ase aigwete bobe.*

We see where she is not feeling well.

Patient: *Nkonyere Esther bono.*

Save Esther for me them.

Doctor: *Ee naende buna okoegwa amariogo ogende nka ochie omoe amariogo.*

Yes, and once you are given the medicine you go home and give her the medicine.

Patient: *Mm.*

Mm.

Doctor: *Chitariki chiokoirana naende oirane.*

And come back on your next clinic date.

Patient: *Ng'irane gocha aa omwana one gaki mware gonkonya gaki bono mokombeka e ward?*

I come back here again my child; please why would you not put me in a ward?

Doctor: *Ekero twapimire nario tokwamua.*

Once we have carried out the tests that is when we can decide.

Patient: *Mm.*

Mm.

Doctor: *Ntori goteba totarakora kera egento buna egwenerete.*

We do not preempt anything until we have done everything according to the required manner.

Patient: *Nkonyere bono omwana.*

Save the child for me then.

Doctor: *Ee bono.*

True.

Patient: *Mm.*

Mm.

Doctor: *Haya.*

Okay.

(Tests are carried out)

Doctor: *Bono bono Mama Esther.*

Now then Mama Esther.

Patient : *Mm.*

Mm.

Doctor: *Twapimire omwana.*

We have carried out tests on the child.

Patient : *Ee.*

Yes.

Doctor: *Ee bono omonyagitari omopimete n'ebinto biria amopimete n'omonyagitari omuya.*

Yes, the doctor who carried out tests on your child with the things he used is a good doctor.

Patient : *Ee.*

Yes.

Doctor: *Naende okorora esukari eyio nayenyorete.*

And it looks that he got the diabetes diagnosis.

Patient : *Mm.*

Mm.

Doctor: *Ee bono. Bono omwana oyo Esther igo arwarete esukari. Arwarete oborwaire bw'esukari bokorokwa diabetes.*

It is true. Now this child Esther has the sugar disease. This disease is called diabetes.

Patient : *Ee.*

Yes.

Doctor: *Ee bono. Bono naende…*

Yes. Another thing…

Patient : *Ee.*

Yes.

Doctor: *Oborwaire obo nkonyara bore koba controlled.*

This disease can be controlled.

Patient: *Ee.*

Yes.

Doctor: *Ee bono.*

Yes it can.

Patient : *Akonywa amariogo.*

She takes her medicine.

Doctor: *Naende kogotegerera buna abanyagitari bakogotebia.*

And if you listen to what the doctors will advise you.

Patient : *Ee.*

Yes.

Doctor: *Omwana nache na koba are buya.*

The child will get well.

Patient : *Ee.*

Yes.

Doctor: *Na gokina buna abana bande.*

And grow like other kids.

Patient : *Ee.*

Yes.

Doctor: *Agende esukuru buna abana bande.*

She goes to school like other kids.

Patient : *Ee.*

Yes.

Doctor: *Rakini egento ntagete omanye.*

But what I want you to know.

Patient: *Ee.*

Yes.

Doctor: *Takonywa mariogo y'ekegusii naende aburukanie aya nyagitari.*

She cannot take alternative medicine from Gusii and mix with the ones from hospital.

Patient : *Mm.*

Mm.

Doctor: *Ee bono.*

Yes

Patient : *Mm.*

Mm.

Doctor: *Bono ngocha komoa amariogo aya nyagitari oka.*

I will now give her these drugs from hospital alone.

Patient : *Mm.*

Mm.

Doctor: *N'okwegena okwo kwao bono manya omwana n'esukari arwarete.*

And that believe you have, now know that the child is suffering from diabetes.

Patient : *Ee bono.*

Yes.

Doctor : *Naende nache agwene kwaigure?*

And she will get well, you get me.

Patient: *Rakini omosubati ori gose nomanyete naende tari konyara gokira. Igo akonya kondama naende nonya mbono iga namororire agoeta isiko abwo.*

But you know that lady never shuts up! She continues to abuse me and even right now I have seen her crossing out there.

Doctor: *Aye bono tigana nere narwarete eye n'enyagitari enene.*

Now leave her alone, she is sick. This is a big hospital.

Patient : *Mm.*

Mm.

Doctor : *Igo nyagitari acha.*

It means, she came to hospital.

Patient : *Oo.*

Okay.

Doctor : *Kwaigure?*

You understand ?

Patient : *Ee.*

Yes.

Doctor: *Bono igo tokoa omwana… twanyorire oborwaire bwesukari.*

Now we shall give the child….we have discovered diabetes

Patient : Ee.

Yes.

Doctor: *Naende obuya mbori complicated.*

And the good thing it is not complicated.

Patient : *Ee.*

Yes.

Doctor: *Bono amariogo aya iga tokomoa…*

Now, these drugs we shall give her…

Patient : *Ee.*

Yes.

Doctor: *Egere airanie esukari nse.*

So that they can reduce the sugar level.

Patient : *Ee.*

Yes.

Doctor: *Nkorangeria tore oria ogochia kogosomia buna ogochia korageria omwana.*

We shall call the expert who will teach you on how you will feed your child.

Patient : *Ee.*

Yes.

Doctor: *Naende enamba yao y'esimi kera egento ngototigera ore.*

And your phone number and everything, you will leave with us.

Patient: *Ee.*

Yes.

Doctor: *Togenderere kobwatia buna omwana agenderete.*

We continue to follow the progress of your child.

Patient: *Ee.*

Yes.

Doctor: Amariogo igo togochia gokoa bosa.

The medicine that we shall give you is free.

Patient : *Ee.*

Yes.

Doctor: *Ebinto bi'ogopima.*

And the instruments for measuring.

Patient : *Ee.*

Yes.

Doctor: *Kagicha obwati amaagizo aito omwana nkoba are buya.*

Provided you follow our instructions, the child is going to get well.

Patient : *Timbwati namba ya simi ntabwati simi; ng'ai ngochi konyora enamba y'esimi?*

I don't have a phone number; where will I get a phone number?

Doctor: *Nkorora tore buna togokora.*

We shall see what to do.

Patient : *Mm.*

Mm.

Doctor: *Nabo tokonyora nonya nenamba yechifu nka gose omoiri rero chisimi nchirararoro.*

We can get even your area chief's or a relative's number, these days there are phones.

Patient : *Ee.*

Yes.

Doctor: *Ntomanyete buna togochia gokora. Nabo ngotema torore buna tokonyara.*

We know how we will handle that. I will try we see how we shall manage

Patient: *Mm.*

Mm.

Doctor: *Tobe in touch.*

We keep in touch.

Patient : *Moche moche?*

Will you come ?

Doctor: *Ntoche nkorora tore buna togokora. Naende egento kende…*

We will see what we shall do. And another thing…

Patient : *Mm.*

Mm.

Doctor: *Obwati amaagizo aito.*

Follow our instructions.

Patient : *Oo.*

Okay.

Doctor: *Naende tobaise kwoboa koirana gochia nyagitari.*

Patient : *Ee.*

Yes.

Doctor: *Nabo ogocha nyagitari etageka ende yonsi oroche onye omwana oigure bobe.*

You can come to hospital any time you notice the child is unwell.

Patient: *Igo omwana agocha korwara rioka rioka?*

Will the child be unwell every now and then?

Doctor: *Yaya tari gocha kona korwara rioka rioka. Gakonywa amariogo nkoba are buya omwana onde.*

No the child is not going to be sick every now and then. Once she takes medicine, the child will be get well.

Patient : *Mm.*

Mm.

Doctor: *Nere ogenda ochiesa buna abana bande.*

She also goes to play like other children.

Patient: *Mm.*

Mm.

Doctor: *Ogenda esukuru buna abana bande.*

She goes to school like other children.

Patient : *Mm.*

Mm.

Doctor: *Naende osoma buna abana bande egere ogocha gokina nere kaa ache gotwara abana baye.*

And she studies like other childrens such that once she is grown up can also have her own children.

Patient: *Nche gaki tiga nkire amariogo ayio igo rakini tinyegeneti korende tiga ndaregena Esther rero rioka ndore omwana oyo gose ng'aki akombera.*

Please let me not say anything, I really don't trust those drugs but let me have faith for Esther for only today I see what becomes of this child.

Doctor: *Nabo. Ayio naro bono twachakeire ig'abwo kogicha tobaise gochia koburukania mariogo aya.*

True. Those are the ones we have started with provided you do not go and mix these drugs.

Patient: *Ee.*

Yes.

Doctor: *Naende okore buna togokweresa.*

And you do as we instruct you.

Patient: *Gaki onchandire.*

Please she has troubled me.

Doctor: *Omwana nache abe buya.*

The child will be fine.

Patient: *Mm.*

Mm.

Doctor: *Ee twara okwegena nabwene.*

Yes have faith she will get well.

Patient : *Mm.*

Mm.

Doctor: *Ee bono.*

It is true.

Patient: *Aya.*

Okay.

Doctor: *Omwana nache agwene kabisa. Kwaigure?*

The child will fully recover. You get me?

Patient: *Haya asanti gaki.*

Okay thanks please.

Doctor: *Ee bono.*

Yes.

Patient: *Mm.*

Mm.

Doctor: *Bwatia amachiko y'omonyagitari.*

Follow the guidelines of the doctor.

Patient: *Ee.*

Yes.

Doctor: *Oenekie nga onyure n'amariogo.*

Ensure that she takes the drugs.

Patient: *Oo.*

Okay.

Doctor: *Ee bono.*

True.

Patient: *Mbuya mono.*

Thank you.

Doctor: *Haya karibu naende.*

Okay welcome again.

Appendix xxii. Diabetes 3 consultation

Doctor: *Karibu naki ogoteba?*

Welcome, how are you?

Patient: *Mbuya mono*

I am fine.

Doctor: *Ee.*

Yes.

Patient: *Yah.*

Yeah.

Doctor: *Aa gwasirire mono sana.*

Eh you have been lost.

Patient: *Yaya, nao nde tu.*

No, am just there.

Doctor: *Chingaki chiria chinde nkagotebia ochiche.*

The other time I told you to come.

Patient: *Aa*

Ah.

Doctor: *Tigwacha ekiriniki kemo.*

You missed one clinic.

Patient: *Aa.*

Ah.

Doctor: *Rero naende ndoche gwachire chitariki chitari chiao.*

Today you have come on the wrong date.

Patient: *Ee.*

Eh.

Doctor: *Gose ng'aki yare? Nki kiabete tigwacha?*

Or what happened? Why didn't you come?

Patient: *Enanyorete omochando moke nka.*

I got a little problem at home.

Doctor: *Mm.*

Mm.

Patient: *Okagera tinachicha.*

It made me not to come.

Doctor: *Aa aye n'omosae omoke mochando ki kwanyorete nka?*

Ah…you are a young person, what problem did you get at home?

Patient: *Amatanga twabwate.*

We had a funeral.

Doctor: *Pore gaaki, ng'o osirete.*

Sorry please, who had passed away?

Patient: *Ntata.*

My dad.

Doctor: *Mochando ki orenge?*

What was the problem?

Patient: *Igo arenge omorwaire.*

He was sick.

Doctor: *Ere ng'aki arwarete?*

How was he sick?

Patient: *Ere n'omorwaire orenge.*

He was quite sick.

Doctor: *Mm.*

Mm.

Patient: *Korende tari nyagitari igaa arenge.*

But he was not hospitalised here.

Doctor: *Oh.*

Oh.

Patient: *Mm.*

Mm.

Doctor: *Ng'ai arenge omorwaire? Toteba n'esukari buna eyio yao.*

Where was he sick? Don't say he was diabetic like you.

Patient: *Aa ere tabwate sukari.*

No, he did no have diabetes.

Doctor: *Oo.*

I see.

Patient: *Malaria tu yarenge.*

It was just malaria.

Doctor: *Haya karibu.*

Okay welcome.

Patient: *Mbuya mono igo tagitari omochando one nori…*

Thank you doctor, the problem is that…

Doctor: *Mm.*

Mm.

Patient: *Okonyora ng'a ekero ng'ikaransete nyomba igo nkoigwa nde omorosu nkoroosa.*

Normally, when I am seated in the house I feel like i am so tired.

Doctor: *Mm.*

Mm.

Patient: *N'amariogo ningendererete konywa korende tindochi eki agokora.*

And I am still taking my medication but am not seeing any change.

Doctor: *Mm.*

Mm.

Patient: *Ee aki.*

Yes, for sure.

Doctor: *Nkoboria…*

I ask…

Patient: *Mm.*

Mm.

Doctor: *Nkwaetwe emachine y'ogopima esukari.*

Were you ever given the machine for measuring your sugar level?

Patient: *Emachine naetwe.*

I was given the machine.

Doctor: *Nkwaetwe?*

Were you given?

Patient: *Ee aki.*

Yes, for sure.

Doctor: *Na okaegwa n'eriogo gose esindani y'ogwetonga.*

And were you also given medicine and the self-injecting needle.

Patient: *Naetwe na…*

I was given with…

Doctor: *Esindano.*

The needle.

Patient: *Y'ogwetonga*

For self-injection.

Doctor: *Y'ogwetonga?*

For self-injection?

Patient: *Ee.*

Yes.

Doctor: *Haya na ngaki ki okoigwa okorosa okwo?*

Okay, when do you feel the tiredness?

Patient: *Anene mono chinsa chi'amorogoba iga.*

Mostly during the evenings.

Doctor: *Mm.*

Mm.

Patient: *Ekero nakorire emeremo yane yakera rituko.*

After I have done my everyday work.

Doctor: *Aa.*

Aah.

Patient: *Kingochia korara.*

When I am going to sleep.

Doctor: *Na kwanya gopimwa esukari yao ekero kwaigure ore omorosu?*

And have you ever measured your sugar anytime you feel like you are tired?

Patient: *Ee nonya ndero nepima.*

Yes even today I took the reading.

Doctor: *Mm.*

Mm.

Patient: *Ee.*

Yes.

Doctor: *Na kwanyora irenga.*

And what was the reading?

Patient: *Igo yarenge ikomi na isano.*

It was fifteen.

Doctor: *Ikomi na isano.*

Fifteen?

Patient: Ee.

Yes.

Doctor: *Na nogendererete gotong' eriogo?*

And are still injecting yourself with the medicine?

Patient: *Eriogo ngwetonga nde.*

I do inject myself with the medicine.

Doctor: *Iiga rende.*

Oh i see.

Patient: *Ee.*

Yes.

Doctor: *Omanyete ikomi na isano n'igoro mono.*

You know fifteen is quite high.

Patient: *Ee.*

Yes.

Doctor: *Ng'aki okogacha eriogo riao?*

How do you keep your medicine?

Patient: *Igo nkoribeka enyongo ime.*

I keep it in the pot.

Doctor: *Enyongo?*

A pot?

Patient: *Ee.*

Yes.

Doctor: *Aye n' omogusii?*

Are you a Gusii ?

Patient: *Nche n'omogusii.*

I am a Gusii.

Doctor: *Igo okobeka ase enyongo?*

So, you put it at the pot.

Patient: *Ee ase enyongo nao nkobeka.*

Yes, I put it at the pot.

Doctor: *Enyongo eria mokorugera gose eye mokobeka amache ayio okonywa?*

The cooking pot or the one you use for storing water?

Patient: *Eria y'amache okonywa.*

The one for drinking water.

Doctor: *Ee.*

Yes.

Patient: *Ee bono.*

Very true.

Doctor: *Kwanyebeka goch'ime gose gochi maate gose ase ensemo iga.*

You put it into, in or just nearby?

Patient: *Nkonyebeka ase agansemo iga.*

I put it just nearby.

Doctor: *Ee.*

Yes.

Patient: *Mm.*

Mm.

Doctor: *N'enyongo eye nkai mokonyebeka? Ndiko gochi chikoni gose neero?*

And this pot where do you put it? In the kitchen or in the sitting room?

Patient: *Aa neero ase nse noo ere.*

Ah in the floor of the sitting room, that's where it is.

Doctor: *Mm.*

Mm.

Patient: *Ee bono.*

Yes.

Doctor: *Aa as'omogaso okare gose?*

Ah, could it be near sunlight?

Patient: *Yaya mogaso toiyo.*

No there is no sunlight.

Doctor: *Mm.*

Mm.

Patient: *Nasakenderete.*

It is a cold place.

Doctor: *Mm.*

Mm.

Patient: *Ee.*

Yes

Doctor: *Aa nonyare… kwanya… ekero okonyetumia…*

Ah can you…have you ever… when you use it…

Patient: *Mm.*

Mm.

Doctor: *Naki okonyesungusi?*

How do you shake it?

Patient: *Nkoyesungusi iga ndora ere endabu ime.*

I shake it like this I see it white inside.

Doctor: *Aa.*

Ah.

Patient: *Mm.*

Mm.

Doctor: *Igo yanya goonchoreria e rangi?*

So, has it ever changed its colour?

Patient: *Yaya teraonchoreria.*

No it has not changed.

Doctor: *Naende omosister nakworoki buna okoyesungusi.*

The sister will again show you how to shake it.

Patient: *Ee.*

Yes.

Doctor: *Iga bokong'u tiboiyo.*

So there is no problem.

Patient: *Ee.*

Yes.

Doctor: *Ee aya ekororekana edosi ogotumia n'enke.*

Eh… looks like the dose that you are using is small.

Patient: *Ee.*

Yes.

Doctor: *Nabo nkomenta edose ake igo egere…*

I can increase your dose so that…

Patient: *Ee.*

Yes

Doctor: *Tororе ng'aki eragokonye.*

We see how it will assist you.

Patient: *Oo.*

Okay.

Doctor: *Naende chisteps nchireo torakoe.*

And there are steps we can give you.

Patient: *Ee bono.*

Yes indeed.

Doctor: *Mm.*

Mm.

Patient: *Mm.*

Mm.

Doctor: *Bono bono egento giakabere…*

Now now, the second thing…

Patient: *Mm.*

Mm.

Doctor: *Mm… omochando onde noreo gotatiga okorosa okwo?*

Mm… is there any problem apart from that fatigue?

Patient: *Omochando onde n'amaiso.*

The other problem is eyes.

Doctor: *Mm.*

Mm.

Patient: *Ngotema korigereria narora korwa aare.*

When I try to look, I see from afar.

Doctor: *Mm.*

Mm.

Patient: *Nkorora ebinto bire aare tindi korora buya.*

I see but I don't see the things that are far clearly.

Doctor: *Mm.*

Mm.

Patient: *Mm.*

Mm.

Doctor: *Korwa ririri?*

Since when?

Patient: *Korwa bono omokubio oerire.*

It has been a week since.

Doctor: *Mm na mochando onde noreo kero kende … otebe yonsi amo egere ngokonye rimo?*

Mm and could there be any other problem … you say all of them such that I can assist you once.

Patient : *Aa… anene mono n'eyio.*

Ah… mainly, those are the ones.

Doctor : *N'echio ibere tu chi'amaiso.*

It is just those two eye issues.

Patient : *Amaiso?*

The eyes?

Doctor : *Iiga rende.*

I see.

Patient : *Mm.*

Mm.

Doctor: *Eye y'amaiso.*

This one of the eyes.

Patient: *Mm.*

Mm.

Patient: *Ngokorikera ogende ororе omonyagitari bw'maiso.*

I will give you a referral and see an optician.

Doctor: *Mm.*

Mm.

Patient: *Achie agopime.*

And he can carry out tests.

Patient: *Mm.*

Mm.

Doctor: *Omaete oborwaire obo bw'esukari.*

You know this sugar medical condition.

Patient: *Mm.*

Mm.

Doctor: *Igo bokogenda ker'ase ase omobere oo.*

Is one which affects every part of your body.

Patient: *Mm.*

Mm.

Doctor: *Korwa ase amagoro mbaka ase amaiso.*

From the legs up to the eyes.

Patient: *Ee bono.*

Yes, true.

Doctor: *Aya nainde chicomplications nchiroo chiratoke kerase ase amagoko.*

And by the way there are complications, which may occur all over your hands.

Patient: *Ee.*

Yes

Doctor: *Ee buna okogenderera ko kogorwara.*

Yes as you progress with the condition.

Patient: *Ee.*

Yes.

Doctor*: Ogochi koexperience kera eke kera ekemo.*

You will experience it in every organ.

Patient: *Ee.*

Yes.

Doctor: *Ee nabo eratoke bono iga n'amaiso atwarire chicomplications echio.*

Yes it may be that for now it is the eyes which have developed the complications.

Patient: *Ee.*

Yes.

Doctor: *Rakini tari rasima.*

But it is not a must.

Patient: *Ee.*

Yes.

Doctor: *Nabo ogotwara oborwaire b'wamaiso omonto ondebwensi nabo agotwara oborwaire bw'amaiso tari diabetic boka.*

You can have an eye problem, anyone can develop an eye problem, not just diabetics.

Patient: *Ee nabo ere.*

Yes, it is true.

Doctor: *Tari boigo?*

Is it not so?

Patient: *Ee.*

Yes.

Doctor: *Aa nabo omonyagitari bw'amais' agocha kogokonya.*

Here an optician will help you.

Patient: *Ee.*

Yes.

Doctor: *Akorigererie n'emasini.*

He examines you with a machine.

Patient: *Ee.*

Yes.

Doctor: *Arigereri buya goch' ime.*

He properly examines the inside.

Patient: *Mm.*

Mm.

Doctor: *Akorikere amariogo.*

He prescribes you medicine.

Patient: *Mm.*

Mm.

Doctor: *Nainde agotebi ekero agocha koirana.*

And he tells you when you will come back.

Patient: *Mm.*

Mm.

Doctor: *Bono ribori ndireo ntagete gokoboria.*

Now there is a question which I want to ask you.

Patient: *Mm.*

Mm.

Doctor: *Kwana konyora omochando ekero ogwetonga gose ekero ogotumia eriogo? Bwoba mbore okoba nabwo gose mochando onde bwonsi bw'ogwetonga gose aye mbuy'ore tu?*
Have you had a problem when you inject yourself or when using the medicine? Are there Any fears that you normally have or any problem in the self-injection or are you just Okay.

Patient: *Omochakano nagatwarire emechando.*
At the beginning I used to have problems.

Doctor: *Mm.*
Mm.

Patient: *Nakabeire n'obwoba gwetonga.*
I used to have a problem with injecting myself.

Doctor: *Nki gwakorete mbaka obwoba bokaera okanara?*
What did you do until I overcame the fear.

Patient: *Omanyete igo yabeterereti ekiagera namanyete nchera ende teiyo ndetonge.*
You know it was inevitable because I knew there is no other way I could inject myself.

Doctor: *Mm.*
Mm.

Patient: *Goika ngaika nkanara.*
Until I got used.

Doctor: *Mm.*
Mm.

Patient: *Bono tindi na bwoba bonde bwonsi.*
Now I do not have any fear.

Doctor: *Mm.*
Mm.

Doctor: *Mm. Mwaka ki ore ase e university? Gwaisire gose kwabeire aang'e kograduate?*
Which your are you at the university? Are you almost or nearing graduation?

Patient: *Omwaka o gatato nde.*
I am in my third year.

Doctor: *Omwaka o gatato?*

Third year?

Patient: *Mm.*

Mm.

Doctor: *Riboria rinde ndireo ntagete nkoborie naende.*

There is another question I want to ask again.

Patient: *Mm.*

Mm.

Doctor: *Naki oboamate bwao bore? Nobwate mosani moiseke? Abaiseke mbakwoboete*

How is your social life? Do you have a girlfriend? Do ladies fear you?

Patient: *Ee ngochande narigereria omobira, nimbwate omosani omoiseke,*

Doctor: *Eseng'encho obwate diabetes, ngosok'ore n'abasani? Nkogenda ore chiclub? Nkorigereria ore omobira?*

Now that you have diabetes, Do you go out with friends ? Do you go to clubs ? Do you watch football?

Patient: *Mm. Omochando bw'oka nori ng'a…*

Mm. The problem is that…

Doctor: *Mm.*

Mm.

Patient: *Igo nkoboa kogenda out.*

I fear to go out.

Doctor: *Mm.*

Mm.

Patient: *Ee bono ekero gi'iesukari.*

Yes when i have the sugar imbalance

Doctor: *Mm.*

Mm.

Patient: *Naende igo natebigwa nagenda n'eriogo.*

And I was told I go with my medicine.

Doctor: *Mm.*

Mm.

Patient: *Tingwenereti konywa ebinyugwa.*

I am not supposed to take drinks.

Doctor: *Buya mono.*

Very nice.

Patient: *Ee.*

Yes.

Doctor: *Omosister nagosomi ayio onsi.*

The sister taught you all that.

Patient: *Ee.*

Yes.

Doctor: *Aa tari binyugwa bioka.*

Ah...not just drinks.

Patient: *Ee.*

Yes

Doctor: *Na gentoki naende? Ebinyuwa ... igo oganetie goteba amarwa tari bo?*

And what else? Drinks ... you need to say alcohol, is that not so?

Patient: *Ase amarwa...*

For alcohol...

Doctor: *Na Delmonte*

And Delmonte

Patient: *Amang'ana aya y'esukari...*

This sugar issues...

Doctor: *N'esoda.*

And soda.

Patient: *Eye ebwate esukari.*

The one with sugar.

Doctor: *Ee.*

Yes.

Patient: *Nero tingwenereti nyenywe.*

I am not supposed to take it too.

Doctor: *Ekio n'egento kende egekogera tegwenereti egotange asengencho obwate oborwaire bw'esukari igo tomenyeti obogima bwa botambe.*

That is another thing which is not supposed to prevent you, because you have diabetes you not to have your usual lifestyle.

Patient: *Mm.*

Mm.

Doctor: *Igo ogwenerete komenya buna mwanyabanto onde bwensi.*

You are supposed to live like any human being.

Patient: *Mm.*

Mm.

Doctor: *Tari bo?*

Isn't it?

Patient: *Nabo.*

True.

Doctor: *Egento ogwenerete omanye nkeri ng'a n'obwate e condititon eye.*

What you need to know is that you have this condition.

Patient: *Mm.*

Mm.

Doctor: *Igo ore special akeigo.*

You are fairly special.

Patient: *Mm.*

Mm.

Doctor: *Ekero abande bakare konywa chibeer chiabo gose chichuice chia Delmonte gose chisoda.*

When others are having their beer or their Delmonte juices or their soda...

Patient: *Mm.*

Mm.

Doctor: *Aye nabo okonywa amache y'echuba.*

You can have bottled water.

Patient: *Mm.*

Mm.

Doctor: *Ekeene, buna okonywa amache amange buna erakobere buya.*

True, the more the water you take the better it gets for you.

Patient: *Mm.*

Mm.

Doctor: *Aa nki nkende oranyare kwegokia nakio?*

Ah... What else can you manage to entertain yourself with?

Patient: *Mm.*

Mm.

Doctor: *Nabo ogosoka bwegokie ekero Manchester yabuire.*

You can go out and you have fun when Manchester has won.

Patient: *Mm.*

Mm.

Doctor: *Arsenal ekero yaitirwe na Liverpool iga rende.*

When Arsenal has been defeated with Liverpool, you see.

Patient: *Mm.*

Mm.

Doctor: *Ekiagera aye igo ore omoikeranu kegima.*

Because you are very okay and normal.

Patient: *Mm.*

Mm.

Doctor: *Aye nabaria bande obauti teiyo.*

There is no difference between you and those other people.

Patient: *Mm.*

Mm.

Doctor: *N'omoiseke oo omosani nagwenerete amanye erinde erio mosirane.*

And your girlfriend needs to know such that you support each other.

Patient: *Mm.*

Mm.

Doctor: *Torochi rende?*

You see ?

Patient: *Mm.*

Mm.

Doctor: *Ee naende nagokigwe n'enchera kwamanyire komenya n'econdition.*

And she will be happy to know the way you have managed to live with your condition.

Patient: *Ee.*

Yes.

Doctor: *Igo mbuya goikera abwo tiga ngotige ogende nka.*

It's okay, Now let me let you go home.

Patient: *Mm.*

Mm.

Doctor: *Aa echi nachio chinamba chiane chi'esimi nabo ogontebia kende geise koba.*

Ah this is my phone number, you can reach me in case there is an issue.

Patient: *Ee.*

Yes.

Doctor: *Na koranche ontebie gose kwanyorire emechando ende yonsi ebe n'eyoboamate.*

And please tell me if you have any problem even in your relationship.

Patient: *Ee.*

Yes.

Doctor: *Teba n'emechando y'amaiso oka gose esukari yoka.*

Not just problems with your eyes or your sugar.

Patient: *Mm.*

Mm.

Doctor: *Ekero kwanyorire omochando bw'ekeboamate koranche ntebi nkorore ase emetienyi ebere.*

When you have a problem in your relationship please tell me I see you in two months.

Patient: *Ee.*

Yes.

Doctor: *Korende nabo ogocha mapema kende geise kobasokana.*

But you can come early in case of any emergency.

Patient: *Ee asanti.*

Sure thanks.

Doctor: *Naakire mbuya mono.*

I say thank you so much.

Patient: *Mbuya mono.*

Thanks a lot.

Doctor: *Aya aye genda buya.*

Okay, you can go well.

Patient: *Ee.*

Yes.

Doctor: *Aa gaki tiga tokwane rende.*

Ah please let's keep talking.

Patient: *Ee naakire mbuya mono.*

Yes Thanks.

Appendix xxiii. Diabetes 4 consultation

Doctor: *Naki bwairire omong'ina?*

How is the afternoon mum?

Patient: *Bwairire buya daktari.*

Good afternoon doctor.

Doctor: *Mm esukari yao irenga yarenge ekemambia?*

Mm what was your sugar level this morning?

Patient: *Mambia igo yarenge 20.*

It was 20 in the morning.

Doctor: *20, igo ngwapimwa naende ekero kwanywa amariogo?*

20, so did you take the measure after taking medicine?

Patient: *Tindapimwa.*

I haven't measured.

Doctor: *Mm.*

Mm.

Patient: *Asengencho timbwati egento ngopimera*

Because I do not have something to use in measuring.

Doctor: *Ah eglucometer eye twabatebirie ng'a mogore naye n'omonto osomete tomanyete ng'a ogwenerete otware eglucometer naki otaranyegora?*

Ah… we have told you to buy this glucometer, and you are an educated person that we know should be having one, how come you haven't bought it?

Patient: *Nechibesa… igo ekogorwa chibesa chinyinge.*

Its money...It costs a lot of money.

Doctor: *Mm, tokogacha omosaara nonya ndimo iga ogore e glucometer?*

Mm, can't you save your salary even once so that you buy a glucometer?

Patient: *Bono omanyete ntobwate abana bare chisukuru baganetie chibesa.*

Now you know we have children in school who need the money.

Doctor: *Mm.*

Mm.

Patient: *Bono gaaki ntorikonyara kogacha erio togore eglucometer.*

Now please we never manage to save so that we can buy the glucometer.

Doctor: *N'enyagitari ere ang'e na ase omenyete agadispensary nkaiyo? Gose ey' omonyene?*

And the nearest hospital to your home, is there a mini dispensary? Or even a private one?

Patient: *Agadispensary nkarororo rakini masini echio nchiraikoo.*

There is a mini dispensary, but those machines have not gotten there.

Doctor: *Nchiraika aroro?*

They haven't gotten there?

Patient: *Mm.*

Mm.

Doctor: *Ekero esukari yao yatirire rende ng'aki ogocha gwakora?*

When your sugar has risen what you normally do?

Patient: *Ntwasometigwe igaiga ng'a ekero esukari yakinire...*

We were taught here that when the sugar level has risen...

Doctor: *Mm.*

Mm.

Patient: *Chisaini nchirororo okorora.*

There are signs, which you see.

Doctor: *Mm.*

Mm.

Patient: *Ee.*

Yes.

Doctor: *Ng'eresengo nke chiria oinyorete.*

Can you explain the ones you recall?

Patient: *Chiria ng'inyorete neria bagototebia ng'a igo okorosa.*

The ones I recall them telling us is that you you get so tired.

Doctor: *Mm.*

Mm.

Patient: *Naende okona kominyoka gochia isiko.*

And you are always going out.

Doctor: *Mm.*

Mm.

Patient: *Mara aange.*

Several times.

Doctor: *Mm.*

Mm.

Patient: *Naende okonywa amache amange.*

And you take lots of water.

Doctor: *N'amariogo mbuya okonyatumeka?*

And the medicine, do you use them as presribed?

Patient: *Ee amariogo nabo nkonyu buna ntebiri n'omonyagitari.*

Yes, I take the medicine as advised by the doctor.

Doctor: *Mm.*

Mm.

Patient: *Mm.*

Mm.

Doctor: *Epattern eye ya 20 ndiriri yachaka? Ekero esukari ere 20 irenga egocha yaba ekawaida yao?*

When did this pattern of 20 start? When the sugar is 20, what is your usual level?

Patient: *Ekawaida?*

Usual?

Doctor: *Mm.*

Mm.

Patient: *Bono nche omanyete igo ngocha aa nyagitari.*

Now, you know I come to hospital.

Doctor: *Mm.*

Mm.

Patient: *Napimwa namanya komanya na ng'ai ng'aki ere gose riria naigure ng'a narwarire.*

I take the measure and I get to know how it is or when I feel like I am sick.

Doctor: *Mm.*

Mm.

Patient: *Nacha nyagitari king'igwete ng'a omobere orwarire.*

I come to hospital when I am feeling unwell.

Doctor: *Mm.*

Mm.

Patient: *Naende ekero nachire bantebi napima esukari. Nario ngochia namanya ekerengo kiaye.*

And when I come they tell me to test my sugar. That is when I get to know its level.

Doctor: *Buna rero eri gwacha ere 20 ekworokia buna amariogo ogotumeka tari kogokonya gose ogwenerete togochencheri toragotema esindani. Gose bono naki oroche?*

Like today when you came the level of 20 shows that either the drugs you use are not effective enough or we need to change and try the injection. Or how do you see it?

Patient: *Ah. Esendani ero yaya!*

Ah! An injection no!

Doctor: *Mm. Nki okwangera esindani.*

Mm. Why do you refuse an injection?

Patient: *Esindani?*

An injection?

Doctor: *Mm.*

Mm.

Patient: *Ah yaya gaki.*

Ah no please.

Doctor: *Mm.*

Mm.

Patient: *Nyakwebeta kera kera ri… sindani ero yaya!*

I inject myself every da… that injection no!

Doctor: *Esindani nero engiya.*

An injection is better.

Patient: *Mware gwancha momentere amariogo?*

Why can't you agree to add me more drugs?

Doctor: *Mm.*

Mm.

Patient: *Aro nabo nkonywa.*

Those ones, I can take.

Doctor: *Gose momanyete nkwaeresetwe igoro ya obobe bokoretwa namariogo aya?*

You know…did you get an explanation on the side effects of these drugs?

Patient: *Ting'eresiri buya.*

I did not get a proper explanation.

Doctor: *Mm… Gekogera gokoyanywa engaki entambe riogo rinde rionsi ngotwara rire obobe bwaye. Esukari kero ekoba controlled n'esindani igo ekoba more effective kobua chintetere echio.*

Because if you take them for a long time, any type of medicine will have its side effects. When the sugar is controlled, the injection is normally more effective than those drugs.

Patient: *Mm.*

Mm.

Doctor: *N'echintetere echi kero ogochitumeka nchibwate obobe ase chinguru chiao buna omosubati chikorokwa 'libido'. Nkwaeresetwe?*

And when you use these drugs, they may affect your strength as a woman, what we call 'libido'. Did you get this explanation?

Patient: *Neresetwe ng'a amariogo narororo akoirania okogania inse.*

I was told that there are drugs which reduce the libido.

Doctor: *Mm. Bono nki otakoratemera esindani amatuko make torore naki esukari yao ekogenderera.*

Mm. Now why can't you try the injection for a few days we see how your sugar fairs on.

Patient: *Rakini kwarenge gwancha omentere enchera nere oramente eriogo eri?*

But if you could have agreed to add me more, is there a way you can add me more of this medicine?

Doctor: *Rakini torochi kwarachinyure amatuko amange sukari eyio etari koirana nse? Gose igotagete esukari enyakogenderera komentekana gochia igoro?*

But can you see that you have been taking these drugs for many days now without lowering your sugar level? Or do you want your sugar level to continue increasing?

Patient: *Sindani… igo naki ndabe nkwebeta?*

Injection… so how will I be injecting myself?

Doctor: *Mm. Nabo tokogosomia ase ogwenerete bwebete. N'enchera agostore eriogo erio maambia na marogoba.*

Mm. We can teach you where you are supposed to inject yourself. And the way you are supposed to store the medicine in the morning and evening.

Patient: *Bono igo orang'erese.*

They you can explain to me.

Doctor: *Mm.*

Mm.

Patient: *Egere manye ng'a naki ngotumia eriogo erio gekogera nche nanya kwebeta esindani.*

So that I know how to use that medicine because I have never injected myself.

Doctor: *Nkwana kwebetwa esindani? Korende abarwaire ebakobetwa.*

You have never injected yourself? However, patients are injected.

Patient: *Ee, nkorora nde bakobetwa nonya n'ekero narenge e ward mbare barenge kobetwa.*

Yes, I normally see people being injected and when I was in the ward there were some who were being injected.

Doctor: *Mm.*

Mm.

Patient: *Ee*

Yes

Doctor: *Nobwate mosani ore ang'e bari mogocha nabarobwo ekiriniki ogotumia esindani?*

Do you have any friend around among those you come with to the clinic who uses the injection?

Patient: *Ee nimbwate abasani.*

Yes, I have friends.

Doctor: *Mm. Naki bakogotebi ritang'ani ase ekerengo kiobuya goetera ogotumia chintetere gose ogotumia esindani?*

Mm. What do they tell you first on the level of goodness from their usage of the drugs of the injection?

Patient: *Ee ebagoteba ng'a esindani mbuya.*

Yes, they say that the injection is better.

Doctor: *Mm.*

Mm.

Patient: *Gotatiga rende n'okwebeta oko rende oroche kona kwebeta kera rituko.*

However, it is this injecting, considering you have to keep injecting yourself every day.

Doctor: *Nakwo kore omochando.*

Is the one which has a problem

Patient: *Nakwo kore omochando.*

Is the one which has a problem

Doctor: *Torakoa omosista omuuya okogosomi rende igoro y'okobeta esindani?*

If we give you a good sister who teaches you how you administer an injection?

Patient: *Ogonsomi igaiga gose?*

One who teaches me here?

Doctor: *Okogosomi igaiga ekero twakorire buna okwebeta esindani naende akobundise buna okonyegacha. N'obwate e fridge nyomba gose?*

Who will teach you here once we have finished how to inject yourself and to train you on how to store it. Do you have a fridge in the house?

Patient: *Efridge?*

A fridge?

Doctor: *Mm.*

Mm.

Patient: *Ee abana mbangorerete efridge.*

Yes, the children have bought me a fridge.

Doctor: *Mm. Nabo okogacha aroro korende igo baragosomi naki okwebeta esindani.*

Mm. You can keep there but then they should teach you first how you inject yourself.

Patient: *Ee bansomi buna nkwebeta.*

Yes, they will teach me how to inject myself.

Doctor: *Rakini rende egwenerete otware emasini eria egopima esukari tokoroka eglucometer nero nario okomonitor esukari ekero ogotumia insulin.*

But then you are supposed to have that machine which measures sugar we refer to as a glucometer such that you can monitor your sugar when using insulin.

Patient: *Mm.*

Mm.

Doctor: Mm.

Mm.

Patient: *Bono ekero chibesa chiratoke.*

Then when the money will be available.

Doctor: *Mm.*

Mm.

Patient: *Riorio nabo ndagore.*

Then I can buy.

Doctor: *Na endagera ero ediet yao naki okonyeri?*

And food in your diet how do you eat?

Patient: *Endagera?*

Food?

Doctor: *Mm.*

Mm.

Patient: *Inkoragera buna bagotosomi igaiga.*

I eat the way they teach us here.

Doctor: *Mm.*

Mm.

Patient: *Ebagototebi ng'a twaria obokima bw'obori mono.*

They told us that we eat ugali cooked from millet.

Doctor: *Mm.*

Mm.

Patient: *Obokima bw'obori, ee rende okori obokima okori kwari n'eching'eni chinyinge ase esani yao.*

Ugali made from millet, yes you eat the ugali with more vegetables in your plate.

Doctor: *Mm.*

Mm.

Patient: *Ogwenerete kori ching'eni chinyinge obokima bwaba oboke.*

You are supposed to eat more vegetables with a little portion of ugali.

Doctor: *Nkonyara ore komaintain koria endagera buna eyio?*

Do you manage to maintain that kind of diet?

Patient: *Bono omaete nabo ekoba akong'u kobua mono buna ching'eni echio.*

Now you know it can be difficult especially like those vegetables.

Doctor: *Mm.*

Mm.

Patient: *Ching'eni echio bono echi chitakeire chinyinge nachirochio bono nchiri gotoka.*

Those vegetables now needed in high quantities, are not even available.

Doctor: *Mm.*

Mm.

Patient: *Bono naende n'obokima obo iga obosinini tindi koigota.*

Now again this little portion of ugali I never get satisfied.

Doctor: *Igo goetania koria obokima obwo oboke mwaeresetwe buna mogwenerete korenda erinde esukari tegenda nse? Buna koria ebinto ao ao ng'ora ng'ora, ebigwango ebike ase kera chingaki chinke.*

So beyond eating that little food, were you advised oh how to monitor so that your sugar does not go down? Like eating different things slowly, in small quantities in short durations?

Patient: *Ee ntwatebetigwe ng'a…*

Yes we were told that…

Doctor: *Mm.*

Mm.

Patient: *Etogwenerete gotara n'ebitamuntamu omobuko.*

We are supposed to walk with some sweets in our pocket.

Doctor: *Mm.*

Mm.

Patient: *Ee erinde ekero kwaigure ng'a esukari nkogenda ekare nse gwa…*

Yes so that when you feel that the sugar is going down you…

Doctor: *Rakini bono ekwerende koria obokima obo oboke n'eching'eni chinyinge gwateba tori koigwa gose ngochi bore kwaigota. Oraisa gotema rende koragera kera engaki ase rituko korende ase ebipimo ebike?*

But now eating a little portion of ugali and higher quantity of vegetables, you said hat you never get satisfied. What if you try eating many times in a day but in small quantities.

Patient: *Ee naki kwabori naende?*

Yes, what did you ask again?

Doctor: Endagera eye.

This food.

Patient: Mm.

Mm.

Doctor: Okori nke nke ase chingaki chinke.

You eat a little in a short duration.

Patient: *Mm.*

Mm.

Doctor: *Rika riokoganya mbaka chiike nsa mocha nario ogocha koragera rimo.*

Instead of waiting until it is seven when you will eat once.

Patient: *Naragera gati kabere… aa.*

I eat in between…aah.

Doctor: *Kwaragera gati kabere iga ebipimo ebike ebike.*

You eat in between in small quantities.

Patient: *Mm.*

Mm.

Doctor: *Rakini bibe regular.*

But they should be regular.

Patient: *Mm.*

Mm.

Doctor: *Mm.*

Mm.

Patient: *Ok ebinto ebike ebike buna birebi bono gati aa?*

Ok small quantities of what kind of things now in between here?

Doctor: *Mono mono bono buna endagera eye nabo okoyebaga otebe onye kwaragera ekemaambia kwanywa erongori eye y'obori.*

Moreso you can divide such kind of food say if you eat in the morning you eat porridge from sorghum.

Patient: *Mm.*

Mm.

Doctor: *Mobaso iga nabo ogotwara chislice ibere chiomogati oyo brown noro.*

In the afternoon you can have two slices of brown bread too.

Patient: *Mm.*

Mm.

Doctor: *Gati igabwo iga morogoba naro nabo onyore erongori eyio n'omogati chislice nonya n'ibere.*

In between there in the evening too you get porridge and even two slices of bread.

Patient: *Mm.*

Mm.

Doctor: *Oche koganyera supper eyio.*

As you wait for supper.

Patient: *Ok.*

Ok.

Doctor: *Mm.*

Mm.

Patient: *Ee nabo ndateme.*

Yes, I can try.

Doctor: *Mm*

Patient: Mm

Doctor: *Tekoba buya.*

Won't that be okay?

Patient: *Nabo ekoba buya.*

It will be alright.

Doctor: *Mm.*

Mm.

Patient: *Otatiga ntagete koboria ee teri raisa gotumeka eriogo ria ri'ekegusii?*

Although I want to ask...eh...isnt it easier to use indigenous Gusii medicine?

Doctor: *Mm.*

Mm.

Patient: *Kogwenia oborwaire obo bw'esukari?*

To cure this condition of diabetes?

Doctor: *Ndiogo ki eri ri'ekegusii erio otagete gochi gotumia? Togotobundisa naintwe abanyagitari?*

Which indigenous Gusii medicine is that you want to go and use? You can teach us as Doctors too.

Patient: *Ee tindimanyeti rakini rende nkoigwa ng'a amariogo naroo y'ekegusii okonyu.*

Yes, I don't know it but then I hear that there are indigenous Gusii medicine one takes.

Doctor: *Mm.*

Mm.

Patient: *Egere yaani rikogwenia oborwaire bw'esukari pi.*

So that it cures the sugar condition completely.

Doctor: *Rakini omaete oborwaire bw'esukari igo bore ime ase omobere. Production ya insulin kero kende igo yaenda ekabanse .. Gete omobere igo ogoproduce insulin rakini teri goisana. Bono kero ogotumeka amariogo aya aito a nyagitari nigo a goboost production ya insulin. Onye yarenge teisaini ase omobere amariogo aya anyebeka yaba effective. Ah amatuko aya a rero bado ngotumeka tore amariogo ekienyeji bori?*

But you know diabetes is inside the body. The production of insulin sometimes is not enough... It is the body that produces insulin, but it is not enough. Now when you use our medicine here at hospital, they assist to boost the production of insulin. If it wasn't enough in the body, then the medicine makes it to be effective. Ah these days, do we still use indigenous medicine really?

Patient: *Nkoigwa ng'a...*

I hear that...

Doctor: *Mm.*

Mm.

Patient: *Amariogo naroo y'ekegusii onywe...*

There are indigenous Gusii medicine which if you take...

Doctor: *Mm.*

Mm.

Patient: *Nabo, nabo akogokonya. Nabo akogwenia asukari.*

True, they can help you. They can cure diabetes.

Doctor: *Mm. Omonto oyio okogotebia boigo nogwenerete oramoboria research nakorete buya bori igoro y'omochando bwesukari eye.*

Mm. You should ask that person who tells you that whether he or she has done proper research on this diabetes.

Patient: *Ee gochia abwo timanyeti gose nakorete.*

Yes, towards that end I don't know if he did.

Doctor: *Mm.*

Mm.

Patient: *Tatiga igo tokoigwa ng'a...*

Only that we hear that...

Doctor: *Mm.*

Mm.

Patient: *Amariogo nare aroro y'ekegusii...*

There are indigenous Gusii medicines...

Doctor: *Mm.*

Mm.

Patient: *Oranywe rende ogwene.*

You can take and get cured.

Doctor: *Eki imanyete amariogo anyagitari aiga nigo akoreire research. Abanto batemire, na goetera research baexperimentiri, bamanyire nare effective ase omobere ogo. Aya y'ekegusii neba kagotumeka gento nkeiyo gekoenekia, gekworokia how effective eriogo erio ri'emete riratumeke gocontrol esukari.*

What I know is that the medicine in hospital here are products of research. People have tried and through research they have experimented and have known that they are effective in your body. These indigenous Gusii ones even though they are being used, there is no proof that shows how effective the that herbal medicine can be used to control diabetes.

Patient: *Mm.*

Mm.

Doctor: *Goetania chindagera, lifestyle change amo na'amariogo aya a nyagitari*

Apart from diet or lifestyle change and the use of these medicine we give here in hospital.

Patient: *Bono buna eriogo eri ri'esindani gwantebiri.*

Now like this injection medicine you have told me.

Doctor: *Mm.*

Mm.

Patient: *Irenga riko... ng'aki rikogorwa?*

How much does it...How is it bought?

Doctor: *Ase enyagitari igaiga, ase ogochakera nigo okoegwa e dose ere complete ere free, korwabwo ekero ogocha e kiriniki nabo okoba prescribed for ekero control y'esukari ekworokia ng'a n'irenga chiaikire.*

In this hospital, to begin with you are given a free complete dose; from there when you come for the clinic visits the doctor prescribes for you controlling your sugar level based on what it has gotten to.

Patient: *Mm.*

Mm.

Doctor: *Korwabwo twagoprescribe alafu rende ne chikwerende…chifacilities orabe gokonyora…*

From there we prescribe for you and the things…the facilities you will be getting…

Patient: *Ndabe nkonyora bosa gose…*

Which I will be getting free or..

Doctor: *Neba ase rigori tekoba igori inene mono.*

Even in the cost it can be that much expensive.

Patient: *Narenge komanya ng'a ng'aki rikoonigwa.*

I couldn't know how it is sold.

Doctor: *Mm rakini rende ...*

Mm but then...

Patient: *Gekogera....*

Because...

Doctor: *Amariogo aya....*

These drugs...

Patient: *Gekogera nkoigwa abanto bande bagoteba ng'a eriogo erio ng'a erikoonigwa gose mia tano.*

Because I hear other people saying that medicine is sold around five hundred.

Doctor: *Mm.*

Mm.

Patient: *Naende okwaneta gose ne wiki eyemo yaerire.*

And he said this like one week ago.

Doctor: *Rakini rende oroche obo n'obogima bwao n'ebesa?*

But then this is about your life and money.

Patient: *Ee tokoboreng'ani tatiga rende bono eriogo erio nabo rigokonya obogima naborobwo ebesa erabora pi ririorio okogora ngaki aro orabe?*

Yes you cannot equate it but then that medicine can assist the life, if there no money at all for buying how will you be ?

Doctor: *Mm yaya teraikera abwo ase ekobora.*

Mm no it has not gotten to the extent of lacking.

Patient: *Mm.*

Mm.

Doctor: *Mmh? Teraikera ase ekobora. Eria enke obwate nero okorachakera.*

Mmh? It has not gotten to where it is not there. The little you have is what you begin With.

Patient: *Mm.*

Mm .

Doctor: *Oranyora edose entang'ani eracontrol sugar korwabwo nabo okorora ng'aki egokoira onye rigori nario omochando, origie enchera ende.*

If you get the first dose which can control the sugar from there you can see how you progress with it and if the cost is the problem then you try some other means.

Patient: *Mm. Ok sawa sawa.*

Mm. Okay okay okay.

Doctor: *Mbuya mono.*

Thank you.

Appendix xxiv. Cancer 1 consultation

Patient: *Naki tagitari?*

How are you Doctor?

Doctor: *Mbuya mono naye oratebe?*

Very fine, how are you?

Patient: *Nche mbuyande, korende orobere rwane oromo ndore n'omochando.*

I am fine but one of my breasts has a problem.

Doctor: *Mochando ki oyo?*

What kind of problem?

Patient: *Mm ngatebigwa nkore chitest echio nareta ngaaka chibicha nkareta erio mogantebia timanyeti gose nkansa.*

Mm I was told to carry out some tests which I brought, I took the scans and brought them and you told me I don't know if its cancer.

Doctor: *Igo mbaenegetie ng'a nobwate kansa?*

So, did they confirm that you have cancer?

Patient: *Mbaenegetie.*

They confirmed.

Doctor: *Mm.*

Mm.

Patient: *Ee erio bagantebia nchiche rero.*

Yes then they told me to come today.

Doctor: *Igo… mm… kwarora oche rero. Nore n'amachbu ayio ndayarigereria rende?*

So, mm you decided to come today. Do you have those results I look at them?

Patient: *Ee, ninde n'amachibu.*

Yes, I have the results.

Doctor: *Igo, encher' ende mbaenegetie kegima ng'a nobwate kansa. Ee?*

So in other words they confirmed that you have cancer, Is it?

Patient: *Mm.*

Mm.

Doctor: *Igo ningwenerete nkoe obosemia.*

So, I need to give you advice.

Patient: *Buna orasome ebicha eye.*

Depending on how you will interpret this scan.

Doctor: *Igo rende gose igo nganeirie nkoe ogosemia igoro ya cancer eye, tari bo?*

So, I am supposed to give you advice on this type of cancer, isn't it?

Patient: *Ee gaaki,*

Yes please.

Doctor: *Amangana aya ndoche namakong'u asinini.*

These issues are a bit difficult.

Patient: *Ntebi aye gaaki naba amakon'gu*.

Let me know please even if it is difficult.

Doctor: *Igo ekero bakoete amachibu mbagotebetie igoro y'okogwenigwa kwoborwaire?*

So, when they gave you the results did they tell you about the treatment of the disease?

Patient: *Mbantebeti*.

They never told me.

Doctor: *Igo onye e... kansa eye nigo yachire are. Chinchera chinyinge nchireo kobwatekana n'ase yaikire.*

So, if this cancer has advanced a bit. There are many ways depending on its level.

Patient: Mm.

Mm.

Doctor: *Igo eye yao nigo yachire are. Ntokogania ng'a erusigwe.*

So, this one is so advanced. We won't need it to be removed.

Patient: *Mm.*

Mm.

Doctor: *Eriogo ndireo togwenerete gokoa na nigo rire chiseries encher' ende igokobwatia kwana gokorerwa korwa erimo gochi' erinde. Nobe ang'e gokorerwa eprocedure eyio okonyeke?*

There is some medicine we are supposed to give you, and it is in series, that is once you are done with one you proceed to another. Are you ready to go through the procedure for your own safety?

Patient: *Eprocedure eyio ng'aki ekorokwa?*

What is that procedure called?

Doctor: *Chemotherapy.*

Chemotherapy.

Patient: *Nche gaaki chemotherapy eyio tingotaka gokorerwa! Tobwati riogo rinde gaaki?*

Please I won't want to undergo that chemotherapy! You don't have any other medicine?

Doctor: *Kobwatekana buna toroche ase oborwaire bwao bwaikire,*

From what we see, based on the level of your disease,

Patient: *Mm.*

Mm.

Doctor: *Eye nero erabe enchera egwenerete as'ore.*

This will be the most appropriate for you.

Patient: *Mm.*

Mm.

Doctor: *Ee bun' omonyagetari oo…*

Eh, as your doctor…

Patient: *Ee…korende tagitari ndoche ng'a tinkonyara okogwenigwa okwo ekiagera nararire obobe bwaye.*

Yes …but Doctor, I don't think I will manage that treatment because I have seen its side effects.

Doctor: *Obobe mboreo korende tokoreng'ania e risk y'oborwaire n'obobe bweriogo eri. Ah mbuya ochore okorwarigwa goetera encher' eye erio egere omenye. Onye tari bo….*

The effects are there but you cannot compare the risk of the disease with the side effects of that this medicine. It will be better to choose this way of treatment such that you live. If you will not….

Patient: *Mm. Bono etuki' eye eraera neche komera naende ekero enchera eye y'okogwenigwa yaerire?*

Mm. Like if this hair gets finished will it grow again after this treatment process?

Doctor: *Amatuko aya ntobwate nonya nechiweave. Echio nabo okobeka tu etukia teri mochando. Nonya n'abasubati amatuko aya nkogingira bare etukia naende bagenderera kororekana koba abanyakieni.*

These days we even have weaves. Those, you can put on, hair is not a problem. Even ladies these days trim their hair and they remain beautiful.

Patient: *Korende nche tagitari tindaitaberana.*

But I have not agreed.

Doctor: *Nche buna omonyagetari oo, oyo gwacheire agosemie nigo ninganetie bwanche erinde togokonye. Bono oise kwanga oborwaire nigo bokogenderera bokomenta n'eprognosis echie koba enene.*

As your personal doctor, whom you have come to consult I wish you would agree such that we assist you. Now if you refuse this disease will advance and the prognosis will be bigger.

Patient: *Mm.*

Mm.

Doctor: *Ee, ase igo nigo nkogosaba yaani tu bwanche erinde togokonye. Ntokoganeretie amaya.*

Yes, therefore I pray that you accept such that we assist you. We wish you well.

Patient: *N'eyio ng'ai egokorerwa?*

And where is that done?

Doctor: *Agaiga ase enyagetari yaito ntobwati korende nabo tokogotoma ochia ase enyagetari ekorwa eprocedure eyio yokorwaria oborwaire obo.*

Here at our hospital we do not have it but we can refer you to a hospital which offers the that procedure of treating this disease.

Patient: *Na kingokorerwa, ngaki eng'ana ng'aki ndaire kogwena?*

And once I undergo the procedure how long will it take for me to recover?

Doctor: *Igo ekobwatekana buna omobere oo orareact gochia ase amariogo. Kera omonto igo akoreact ase chinchera ao ao. Korende eyio n'eprognosis. Igo ere buya okorerwe chemotherapy.*

It normally depends on how your body will react with the medicine. Every person reacts in different ways. However, that is a prognosis. It is better to undergo chemotherapy.

Patient: *Nanchire nkorerwe eprocedure eyio.*

I agree to undergo that procedure.

Doctor: *Imbuya sana, igo eragokonye mono kobwena.*

Thanks a lot. It will assist your recovery process a great deal.

Patient: *Mbuya tagitari gwantebirie igoro y'okogwenigwa kwa nyagetari korende naigure igoro y'amariogo yegenka akogwenia buya.*

Thanks doctor for telling me about medication at the hospital but however, I have heard about community herbal medicine which treats well.

Doctor: *Amariogo aito igo akoreire obotuki n'abasayansi ase engaki entambe, agakorerwa chitest, nabwate ogosemeria na nigo abwate chiside effect chireo chimanyekanete kobua aya y'egenka, atarapimwa akoumisa omobere mono. Igo teri buya ase omobere oo egekogera nigo erabaise gokoa emechando yende. Igo mbuya mm aya akoreirwe chitest agakorerwa obotuki agancherwa naro arabe buya kegima kobua ayegenka.*

Our medicine have been scientifically analysed for a long time, they have undergone tests, they give hope and they have side-effects which are known than these community herbal medicine which have not been certified and which hurt the body the more. So they are not recommended for your body because it may bring other complications. So it is better...mm these which have undergone tests, scientifically analysed and certified for use will be better than the local herbs.

Patient: *Korende tagitari inee, amariogo tari koroisigwa korwa ase emete?*

But if I may ask, doctor, are drugs not made from herbs?

Doctor: *Ee, amariogo nkoroisigwa are korwa ase emete naki gekogera nkogotebia naro ayio. Korende aya akoreirwe obotuki, chitest chiedose na kera egento. Na atemirwe na*

kororekana gokora egasi emanyekanete kobua aya ande tu are iga tu atamanyekaneti na ayarabaise gokoretera emechando yende.

Yes, drugs are made from herbs that is why I am telling you they are there. However, these ones have undergone research and tests for the dosage and everything. and they have been tried and proven to work more effectively than these others whose effectiveness in still unknown and which may even bring about other complications.

Patient: *Chemotherapy eye gwateba chibesa irenga ekoira?*

How much does this chemotherapy cost?

Doctor: *Kera enyagetari n'ebwate chibesa echio ekogania. Ig' ekobwatia ng'a nereri gwachora erio egere omanye koboria ng'a nirenga bogochia gotaka.*

Every hospital has its own cost. It depends on the one you will choose then you can ask how much they will need.

Patient: *Korende natebigwa ng'a enyagitari enene ya Kenyatta igo babwate rigori igoro. Ribaga erio rende ntingotwerwa eriogo riemete?*

But I was told that Kenyatta National Hospital has a higher cost. Instead of that, why can't I go for herbal medicine?

Doctor: *Namaene nabo ere igoro korende buna nagotebia bono totakeirie korengereria igoro yechibesa. Igo egwenerete orengererie igoro ya afia yao n'okogwena. Naende nagotebirie igoro y'obobe bwamariogo aya yegenka, tari maya.*

It is true it is high but as I advised you, now you are not supposed to think about the money. You are supposed to think about your health and your recovery. And I have told you about the adverse effects of the local herbal medicine, they are not good.

Patient: *Korende nche gaaki timbwati meremo na tindi na nchera ende ekondetera chibesa. Na NHIF tera…tindarikwa na serikari. Bono ng'ai nkorusia chibesa kiagera kogoteba igoro yechibesa, besa chinyene tinchimbwati.*

But please I do not have a job and I have no other means of generating income. And NHIF has not…I have not been employed by the government. Now where do I get the money because if you talk about money, I do not have it.

Doctor: *Bono onye kere igo, goika ekobetererie otebie abanto banka erio torore buna toragokonye.*

Now if that is the way it is, then you may have to inform folks from home so that we see how we can assist you.

Patient: *Igo mbuya tiga ngende ngo nteme.*

That is nice; let me go then and try.

Patient: *Bono tagitari mwantebirie buna eye nkansa korende aria nka* ***omosubati*** *nare twateranete totari koigwanana buya. Ee ekero naiborete omwana one, gikogonkia, igo are kona komaeria ase orobere rwane. N'ekero nakorete nario nachagete gotwara omochando oyo. Igo nkagete omochando nigo ochakerete nka.*

Now doctor you have told me that this is cancer, but back at home there is a lady who is a neighbour we are not in good terms with. When I delivered my child, while breastfeeding,

she was always stealing glances at my breast. And afterwards that is when I began having this problem. So I tend to think this problem started from home.*(Gusii traditional health belief verses the Contemporary medicine model at loggerheads.)*

Doctor: *Igo mochando ki ochakerete nka ogoteba?*

So which problem started at home, you are saying?

Patient: *Oyo o kansa.*

This one of cancer.

Doctor: *Oo, bono onye….*

Okay, now if…

Patient: *Ee mwantebia ng'a nkansa korende nche ndoche ng'a n'omonto okondoga.*

Yes, you told me that this is cancer but from what I see it is someone bewitching me.

Dcotor: *Omonto ogokoroga?*

Someone bewitching you?

Patient: *Ee.*

Yes.

Doctor: *Oborogi, ritang'ani n'obwegenete?*

Witchcraft, first do you believe in it?

Patient: *Ee mboroo. Tikwana koboigwa?*

Yes, it exixts. You haven't heard of it?

Doctor: *Kobwatekana nobotuki bwaito omochando oyo o kansa tari ng'a n'oborogi, omonto ogokoroga. Ebinto n'ebinge bikorenta kansa eye obwate, nakio gekogera kwanyorekanire nero… tari buna n'oborogi …eh… omanyete kansa y'orobere nigo ekorentwa n'ebinto ebinge buna bono korwa ase ororeria, chindagera omonto akoria, eriogo, igo n'ebinto ebinge ebio biakoreirwe obotuki bikanyorekana koba ng'a nabio bikorenta kansa igo… ee nase chisababu echio borogi tiboiyo. Ee naye nigo ogoteba mbwegenete oborogi.*

From our investigations, this problem of cancer is not associated to witchcraft where a person bewitches you. There are many causes of this cancer which you have, which is why you have been diagnosed with it, not that it is witchcraft…eh…you know breast cancer has many causes, for instance it could be genetic, the foods one eats, drugs, so research has revealed that many things are causal agents of cancer …yes among those witchcraft is not part of them. Er and you say that you believe in witchcraft.

Patient: *Korende korwa gesa nchaka korwara igo yarenge ekero konye twarure kogosana n'omoamate oyio one na korwa erio ngasoa korwara.*

Rted gettBut since I began to get ill, it was after we had been at loggerheads with that neighbor of mine and from then I became sick.

Doctor: *Ee ogosemia kwane nkori ng'a tari borogi bokoreta borwaire obwo. Eyio nigo erabe omobasokano tu.*

Yes my advice is that it is not witchcraft which causes this disease. That can only be just a coincidence.

Patient: *Ah korende nindengererie buya.*

Ah..i will think about it properly.

Doctor: *Ee igo mbuya.*

That is good.

Patient: *Igo gwantebia ng'a ngende chemotherapy korende nonya Nyasae nkogwenia are nonya naba bakogenda chemotherapy nkobagwenia are.*

So you advised me to go for chemotherapy but then even God heals, even those who go for chemotherapy He heals them.

Doctor: *Mm.*

Mm.

Patient: *Igo nche nigo nyegenete Nyasae ngochia nde kogwena na pastor one nansaberete.*

So I still believe my God I am going to be fine and my pastor prayed for me.

Doctor: *Amaene Nyasae naroo nonya ninche ninyegenete ng'a Nyasae naroo naboigo nkogwenia are korende naende nateba ng'a kera oborwaire mbobwate eriogo riaye. Igo eri nario tokogotebia eriogo rioborwaire obo. Igo naye nabo ogosaba omosabe Nyasae oo akogwenie korende oyatumie amariogo aya erio agokonye kogwena.*

It is true God is there and even me I believe in God's existence and he makes us believe but I said that every disease has its medicine. So, this is the medicine we are prescribing for you for this disease. But then you also need to pray God to heal you but you must use these drugs so that they assist you get well.

Patient: *Korende tari Nyasae oete abanyagetari chisemi echi chionsi?*

But isn't it not God who gave the doctors all this knowledge?

Doctor: *Ee nere otoete.*

Yes, He is the one who has given us.

Patient: *Bono rende inki atangwenerie kimwegenete ng'a nere okorwa chisemi echio?*

Now then why will he not heal me now that I believe that he is the one who gives that knowledge?*(Rhetorical question_ presentational device)*

Doctor: *Ee gose nakio nkogotebia, Nyasae nkogwenia are korende obekire amariogo yokogwenia aroro, naro aya mm otoeire chisemi echi chi'amariogo erio egere tochitumie tobakonye mogwene.*

Yes that is what I am telling you, that God heals but He has made the medicine which facilitate the process available, these ones…mm… he has given us the medical knowledge for us to use in assisting you regain your normal health.

Patient: *Bono omonyagetari twaigwananire onye gwatebire erio nario rirankonye, nanchire ng'a nabo ere igo. Tiga ngende korigia chibesa rituko erio ngocha konyora nario nkogenda*

nyagitari. Bono nasinyirwe ninki ndabe ngotumia? Gose mbe igo goikera rituko erio ria chemotherapy?

Now doctor we have an agreement if you have told me that this is what will assist me, I agree that it is so. Let me go and look for money and when I will find the cash then I will go to hospital. Now I wonder what will I be using? Or I just stay like that until the day of chemotherapy?

Doctor: *Ekiagera tobwati chibesa enchera yoka toranyare kogokonya. Ok ritang'ani korarigia chibesa buya ekiagera oborwire obwo nigo bokona komenta. Otanyoreti okogwenigwa koria koganeirie nario bokogenderera koba bobe mono. Korende ase bono tiga nkorikere amariogo aya iga abere ayio aragokonye gotanga oborwaire tibogenderera komenta. Amariogo abere, erimo nigo oraritumie rimo rioka, kera maambia, ah erinde nigo oraritumie mara gatato rituko. Eriogo eri rinde….naki oroche eri? Nario riragokonye kogendererete.*

Because you don't have money, the only way we can assist you… okay, first look for the money properly because this disease keeps advancing. If you don't get required treatment then the disease becomes worse. However, for now let me prescribe for you these two drugs to assist you prevent the disease from advancing further. Two kinds of medicine, the first you will take once a day, every morning, ah the other one you will use three times a day. This other medicine...how do you see it? It will be the one to assist you going forward.

Patient: *Bono rende gaaki buna gwatebire ng'a amariogo aya nabo agotanga oborwaire obwo tibogenderera komentekana, nabono rende ndaisa rende gochaka konywa ayio abere abere rika ria eyemo eyemo erinde erio chibe chinyinge ase o mobere chinkonye timba....*

Now that you have said that these drugs can control this disease from advancing further, now then what if I begin taking drugs in pairs instead of just one at a time such that they are many in my body to assist me not to...(*difference of opinion*)

Doctor: *Ritang'ani nagotebia ng'a amariogo aya tari gotenenia korende gokeania ekewango kioborwaire.*

First, I told you that these drugs do not stop but minimize the level of the disease.

Patient: *Mm.*

Mm.

Doctor: *Ee bono. Tari buna nigo rikobotenenia. Kabere gokonywa eriogo rinyinge nomanyete ng'a teri buya. Ekerengo kiaye nkereo gekogera rigokonya. Gokomenta goetania ekerengo nigo rirakobere bobe. Igo teri buya konywa rinyinge goetania buna omonyagetari akorikeire.*

Yes. Not that they stop the disease. Secondly, if you take an overdose of the medicine, you know it is not good. There is its required dosage which makes it useful. If you add more than the right dosage it will be counterproductive. So it is not good to take more than prescribed by the doctor.

Patient: *Ninchinywe n'endagera gose ekero nakorire koragera?*

Can I take them with food or after I have had a meal?

Doctor: *Echio nabo ogochinywa otararagera nayande nekero kwarageire.*

Those ones, you can take before meals and these ones after your meals.

Patient: *Amariogo tari kobua abanto chinguru?*

Doesn't medicine weaken people?

Doctor: *Ee mbare aroro akobua kobwatena n'obotuki. Igo mbuya oyaburukanie amo nendagera, otararagera gose ekero kwarageire.*

Yes there are some the medicine can overpower from research. So it is good to mix them with food, either before or after meals.

Patient: *Nenyarekane amariogo aya akwangana nechindagera chinde?*

Is it possible for these drugs not to work with some foods?

Doctor: *Ake mono.*

In the very least.

Patient: *Mm.*

Mm.

Doctor: *Ee onye ndiri yare koba boigo anga nagotebia ng'a ndagera ki na ki chitari koigwanana naro.*

Yes if that were to be the case I could have told you the particular foods they are not compatible with.

Patient: *Na ning'inyore korinywa gatato rituko bori?*

And will I remember to take it thricea day?

Doctor: *Nabo ogotebia omonto buna bono omonto ore ang'e naye akoinyorie gose nabo okobeka e alarm ase chisimi echi chiacha….*

You can tell someone like someone who is near to remind you or you can use an alarm of these phones which are commonplace...

Patient: *Nonya nsimi timbwati.*

I don't even have a phone.

Doctor: *Igo ekio orakore nogotema koinyora n'omonto oria ore ang'e naye naboigo omotebie akoinyorie onywe amariogo ao.*

So, what you can do is to try to remember and inform anyone who is close to you to remind you to take your medicine.

Patient: Ee bono.

Yes.

Doctor: *Bono amariogo aya nokorikera oyaire korwa epharmacy yaito abwo onye mbabwati bagotebi origore isiko. Tingotebeti buna oraritumie?*

Now you can collect these drugs I prescribed for you from our pharmacy but if you miss they will refer you to buy from out there. Have I not told you how you will use them?

Patient: Mm.

Mm.

Doctor: *N'obuya bwa chemotherapy eyio. Gokonyora chibesa iga, ochiche togobook. N'ekero okogenda gotumia amariogo aya ntobe togokorora eclinic ororekane kera emekubio ebere otaranyora chibesa torore buna toragokonye.*

And the advantage of that chemotherapy? Once you get the money come we book you. And as you continue taking these drugs we will be seeing you in the clinic every two weeks before you get the money we see how we can help you.

Patient: *Buya kegima. Mbuya mono. Korende igo gwateba nchiche aiga mombook?*

Very nice. Thanks a lot. But you said I should come here you book me?

Doctor: *Ee.*

Yes.

Patient: *Nabo*

True.

Doctor: *Kera emekubio ebere*.

Every two weeks.

Patient: *Mm.*

Mm.

Doctor: *Na ntobe tokorigereria buna ogotumia eriogo n'ekero oranyore chibesa iga ochiche tokobeke chemotherapy.*

And we shall be monitoring how you are taking the medication and once you have money you come and we put you on chemotherapy.

Patient: *Mbuya mono.*

Thank you.

Doctor: *Nore na koboria konde?*

Do you have any other question?

Patient: *Timbwati koboria.*

No I don't.

Appendix xxv. Cancer 2 consultation

Doctor: *Naki bono Risper?*

How is it Risper?

Patient: *Mbuya nde.*

I am fine.

Doctor: *Karibu.*

Welcome

Patient: *Asante.*

Thanks.

Doctor: *Inaki obeete iga? Seka akeigo.*

How come you are so sad? Laugh a little.

Patient: *Ee (amaseko) tagitari gaaki nonyare goseka ...gose igo tokwete… togotara tokwete!*

Yes(laughs) doctor, please you cannot manage to laugh…we are dead…we walk while dead!

Doctor: *Ayie! Aye igo kwana korora omonto okwete?*

Huh! Have you ever seen a person who is dead?

Patient: *Toteba gaaki.*

Do not say please.

Doctor: *Nkobeka are eyanga buna eye?*

Does he/she put on such a dress?

Patient: *Ee gaaki tagitari chianga echi igo tokobeka twatuba obobe.*

That's true doctor, we dress like this so that we can hide the badness.

Doctor: *Yaya.*

No.

Patient : *Yaya ?*

No ?

Doctor : *Nka mbuyere?*

How is home ?

Patient : *Mbuy'ere.*

It is fine.

Doctor : *Abana?*

The kids?

Patient : *Abana mbuya bare.*

The kids are fine.

Doctor : *Chimbori?*

And the goats?

Patient : *Chimbori…*

The goats …

Doctor : *Ebimoni?*

The cats ?

Patient : *Ahahah! (amaseko)*

Ahahah! (laughter)

Doctor : *Nabo etakeire igo.*

That is what is needed.

Patient : *Ee.*

Yes.

Doctor : *Omanyete ense eye ebwate emechando yaye.*

You know this world has its problems.

Patient : *Mm.*

Mm.

Doctor : *Nonya niche kingoseka iga…*

Even if i am laughing like so…

Patient : *Mm.*

Mm.

Doctor : *Tomanyeti nainche nabo ndatware emechando yane ?*

Dont you know I equally may have my problems ?

Patient : *Aro nabo tagitari.*

Thats true doctor.

Doctor : *Tobaise gokumia.*

Do not worry.

Patient : *Mm.*

Mm.

Doctor : *Nonya n'ase ematatu…*

Even in a matatu…

Patient : *Mm.*

Mm.

Doctor : *Ekero okorina ematatu*

When you board a matatu.

Patient : *Mm.*

Mm.

Doctor : *Abanto mbarenga bakoba ase ematatu?*

How many people normally board a matatu ?

Patient : *Abange.*

Many.

Doctor : *Ee, aye n'obwate emechando yao. Nomanyete omontereba ninki agoetera ase obogima bwaye?*

Yes, you have your problems. Do you know what the driver goes through in his life?

Patient : *Yaya.*

No.

Doctor : *Igo ker'omonto nabwate emechando yaye.*

So everyone has his own problems.

Patient : *Mm.*

Mm.

Doctor : *Kwaraseka gaaki.*

You can laugh please.

Patient : *Mm.*

Mm.

Doctor : *Ee. Nabo erakomente amatuko ase ense eye.*

Yes. It can add you more days in this world.

Patient : *Nabo aro tagitari (amaseko) mm.*

It is for sure doctor (*laughter*) mm.

Doctor : *Ah bono naki nkogokonya?*

Now how can I assist you ?

Patient : *Tagitari buna nde iga…*

Doctor, the way you see me…

Doctor : *Mm.*

Mm.

Patient : *Nimbwate omochando*

I have aproblem.

Doctor : *Mm*

Mm.

Patient : *Ase chinsemo chia nsoni.*

In my private parts.

Doctor : *Mm*

Mm.

Patient : *Obochabu mbor' oo bokorwa aroro.*

There is some dirt that is coming from there.

Doctor : *Ee..*

Okay

Patient : *Bwansinyire !*

I cant handle it !

Doctor : *Ee*

Yes.

Patient : *Tagitari rero tindi gotarere abanto nonye nachire igaiga nyagitari.*

Doctor, these days I do not visit people even if I have come here in hospital.

Doctor : *Ehee*

Okay.

Patient : *Nigo nasinyirwe gaaki. Konye igo ngosinywa gotara.*

I am defeated please. Previously, I was not able to walk.

Doctor : *Kwana kogenda kiriniki korigererigwa?*

Have you ever gone for check up at the clinic?

Patient : *Kiriniki yaya, gose tagitari igo tokwoboa kogenda kiriniki bono.*

Not at all, we actually fear going to the clinic, doctor.

Doctor : *Kwana gopimwa?*

Have you ever been tested?

Patient : *Tinanyagopimwa.*

I have never been tested.

Doctor : *Igo ndero gwacha aa ritang'ani?*

So is today the first day you came here ?

Patient : *Ee mbono nachire aa ritang'ani.*

Yes now is the first time I have come.

Doctor : *Oo.*

I see.

Patient : *Ee.*

Yes.

Doctor : *Igo mbana gokora chitest chiria chia cervical cancer gose naki. Nonya namanyinga*.

So they have never done the cervical cancer tests or what is it ? Even blood.

Patient : *Ari tokogenda tagitari twasabwa chibesa chinyinge.*

When we go there they ask for a lot of money.

Doctor : *Ee.*

Yes.

Patient : *Bono onye ntobwati abang'ina buna ntwe ng'ai tokorusia?*

Now, if we dont have, where will old ladies like us find it?

Doctor: *Okay.*

Okay.

Patient: *Kwairana nyomba gwatimoka.*

You go back to the house and relax.

Doctor: *Okay.*

Okay.

Patient : *Bono bono ekero …*

Now, now when…

Doctor : *Aye obwate chimbori, ching'ombe, chingoko, ebimoni…*

You have goats, cattle, chicken, cats…

Patient : *Chimbori n'echiane gose n'echiabamura ?*

Do the goats belong to me, they belong to the sons.

Doctor: *Ahaha (amaseko)*

Ah ah! (*laughter*)

Patient: (amaseko) *Tagitari. Nche nigo mbarenderete.*

(*laughter*) Doctor, I only take care for them on their behalf.

Doctor: *Yaya n'ebiao.*

No, they are yours.

Patient: *Yaya mbiri biane.*

No they are not mine.

Doctor: *Imbuya.*

It is okay.

Patient : *Ee.*

Yes.

Doctor: *Egwateba kwabeire nobochabu obo ase engaki eng'ana ng'aki ?*

How long have you said you have had this dirt ?

Patient : *Ange emetianyi etano nomo.*

Almost six months.

Doctor : *Ase emetienyi eye etanonomo nkwachiete nyagitari ?*

In these six months, did you go to hospital ?

Patient: *Ee*

Yes.

Doctor : *Ah aa bono.*

Okay, now…

Patient : *Mm.*

Mm.

Doctor : *Omanyete, omochando oyio bwogoetia obochabu…*

You know, that problem of passing dirt…

Patient : *Mm.*

Mm.

Doctor : *Ekworokia ebinto ebinge.*

It shows many things.

Patient : *Mm.*

Mm.

Doctor : *Nabo erabe ng'a kwanyorire einfection gete.*

It might be that you have gotten a particular infection.

Patient : *Mm.*

Mm.

Doctor : *Tari bo?*

Isn't it ?

Patient : *Mm.*

Mm.

Doctor : *Nabo erabe ebacteria yasoire.*

It can be a bacterium that has entered.

Patient : *Mm.*

Mm.

Doctor : *Ekoreta omochando. Gose onyore nomogaka ochiete ande akairana nomochando oyo.*

That brings this problem. Maybe you may find that your husband went somewhere and came back with this problem.

Patient : *Kemaene*.

True.

Doctor: *Tari bo?*

Is it not so ?

Patient: *Ee.*

Yes.

Doctor: *Ah… Gose ngentoki kende? Aye kwanya koigwa gento kende keranyare koreta omochando oyio bwogoetia amache amachabu?*

Ah…Or what else? Have you ever heard of anothe cause for this problem of passing out dirt?

Patient: *Tagitari teba intwe ntomanyeti.*

Tell us doctor, we do not know.

Doctor: *Korende inki kwaigure aye aria nka?*

But what have you heard at home?

Patient : *Inka etokoigwa abanto bagoteba ng'a oisekoba noborwaire bwokweyagia korwa inse, nabo erabe einfection.*

At home we hear people saying that if you have a disease of scratching your groin, it can be an infection.

Doctor: *Oo.*

I see.

Patient : *Ee.*

Yes.

Doctor : *Bono tiga ngotome elab.*

Now let me send you to the lab.

Patient : *Mm.*

Mm.

Doctor : *Gose genda…*

Or go…

Patient : *Mm.*

Mm.

Doctor : *Mm… bairere rirube eri, okore chitest bamanyegokoa amachibu ondetere.*

Mm … give them this letter, you do the tests then you bring me the results they will give you.

Patient : *Mm*

Mm

Doctor : *Sawa sawa?*

Okay?

Patient : *Asante gaaki*

Thanks please.

Tagitari : *Mm.*

Mm.

After the lab.

Doctor: *Yaya yaya yaya, ing'a amachibu ao.*

No no no… just give me your results.

Patient: *Tagitari gose narentire amachibu.*

Doctor, I have brought the results.

Doctor: *Igo mbuya.*

That is good.

Patient: *Mm.*

Mm.

Doctor: *Amachibu naro aya, ah. Imbuya. Bono…*

Are these the results? Ah. Ok. Now...

Patient: *Mm.*

Mm.

Doctor: *Chitest chiria twakora chiamanyinga, amasinyoro na kera egento…*

All those tests we did for blood, urine, and everything…

Patient: *Mm.*

Mm.

Doctor : *Twanyorire amachibu.*

We have the results.

Patient : *Mm*

Mm

Doctor : *Ah, ndoche nobwate omochando aiga ekiagera timbwati mang'ana maya.*

Ah, I see you have a problem here because I do not have good news.

Partient : *Mm.*

Mm.

Doctor : *Ekworokia ng'a nabo eranyarekane…*

It shows that it is possible…

Patient : *Mm.*

Mm.

Doctor: *Korende chitest nchire togochagokora nario toraeneki…*

But there are tests we shall carry out to confirm …

Patient : *Mm.*

Mm.

Doctor : *Buna nabo eranyarekane*

That it is possible..

Patient : *Mm*

Mm

Doctor: *Obe na cancer.*

For you to have cancer.

Patient: *He! Tagitari! Kansa?*

What! Doctor! Cancer?

Doctor: *Ase mmm chinsemo chia nsoni, ase omorangu oria okoigoka gochia ase enyomba y'omwana.*

In your…mmm private parts, at the entrance to the uterus…

Patient: *Bono igo inaki gose ekare? Igo ngochagokwa gose inaki? Ntebi nche amatuko ane aerire bono nche ng'ende kwearigania gaaki. Tobaise kong'aina koranche.*

So what does that mean? Will I die or what now? Tell me my days are finished so that I go prepare myself please. Do not lie to me please.

Doctor: *Omongina naki gwantebia okorokwa?*

Madam what did you tell me your name is?

Patient: *Nche Risper nkorokwa.*

I am Risper.

Doctor: *Asante, nainche naki nkorokwa ?*

Thank you and what is my name?

Patient & Doctor: *Daktari*

Doctor

Doctor: *Eh… ndi ngocha gokwa*?

Eh…when will I die?

Patient: *Tagitari bono ninkamanyete.*

Doctor, now how can I tell.

Doctor: *Aseki?*

Why?

Patient: *Aye rende otarwareti (amaseko).*

But then you are not sick(laughter).

Doctor: *Ker'omonto nabwate rituko riaye.*

Everyone has his day…

Patient: *Mm.*

Mm.

Doctor: *Omanyete enseye intwe twensi nabaeti.*

You know, in this world we are all passers by.

Patient: *Mm.*

Mm.

Doctor: *Abanto mbare bamenyire na HIV emiaka ne miaka batana goku.*

There are people who have stayed with HIV & AIDS who have never died.

Patient: *Mm.*

Mm.

Doctor: *Moisonde ebus yaita abana besukuru.*

The other day a bus killed school kids.

Patient: *Ah tagitari!*

Ah Doctor!

Doctor: *Gokwa tikobwati ororeria.*

Death doesn't have a genealogy.

Patient: *Gose nkoigwa ng'oborwaire obo ngoita bore abanto, obogoita abanto.*

I hear that this disease is a killer, it kills people.

Doctor: *Omonto ekero ...*

When a person….

Patient: *Mbobwati riogo*.

It doesnt have a cure.

Doctor: *Omonto ekero akoiboru…*

When a person is born

Patient: *Mm.*

Mm.

Doctor: *Ninki naende aganyete? Ase ense eye?*

What else does he/she wait for ? In this world ?

Patient: *Ah tagitari yaya bono rende nararire nonya n'abachokoro iga bane gose abachokororia?*

Ah, no doctor, have I seen at least even my own grandchildren or great grandchildren?

Doctor : *Rakini…*

But…

Patient : *Mm.*

Mm.

Doctor : *Ah tobaise kwoboa…*

Ah, never fear…

Patient : *Mm.*

Mm.

Doctor : *Ebinto otamanyeti.*

Things that you do not know.

Patient : *Mm*

Mm

Doctor : *Kwaigure ?*

Have you heard?

Patient : *Mm.*

Mm.

Doctor : *Ee.*

Yes.

Patient : *Bono inki gekoboreta gaaki buna nakagota iga ?*

Now surely what causes it the way I am now this old ?

Doctor : *Korende eseng'encho twachakire korora cancer chinyinge.*

But because we have started to see different types of cancers.

Patient : *Mm.*

Mm.

Doctor : *Obotuki obonge mbogenderete gokorwa.*

Lots of research is still being done.

Patient : *Mm.*

Mm.

Doctor : *Ah chisababu nchiroo babegete buna theories.*

There are reasons which they have come up with like theories.

Patient : *Mm.*

Mm.

Doctor : *Korende mbana gotwara esababu eratebe n'eye ekogera*

But they have never established the root cause.

Patient : *Mm.*

Mm.

Doctor : *Rakini ebirusi mbirooroo biatokire.*

However, there is a virus which has been discovered.

Patient : *Mm.*

Mm.

Doctor : *Ekorokwa ng'a human papilloma.*

It is called human papilloma.

Patient : *Mm.*

Mm.

Doctor : *Nero bakagerete ekoreta oborwaire obo.*

It is the probable cause of this disease.

Patient : *Mm.*

Mm.

Doctor : *Anene..*

Broadly

Patient : *Bono ebirusi ebio nkai bigotoka?*

So where is this virus found?

Doctor : *Ebigotoka ase ense eye. Ebiatongetwe na Nyasae gose bono saitani toratebe?*

The virus is on this earth. They were created by God or should we say satan?

Patient : *(Amaseko) Eh.*

(laughter) Eh.

Doctor : *Korende kerokende nabo okonyora omosacha gakwambokeria omosubati.*

However, at times it is possible to get a man contaminating a woman.

Patient : *Mm*

Mm.

Doctor : *Gose bwacha igo buna oratware oborwaire bonde bwonsi.*

Or you can develop it like that just like any other disease.

Patient : *Mm.*

Mm.

Doctor : *Buna rikuba.*

Like flu.

Patient : *Mm.*

Mm.

Doctor : *Nabo egocha tu.*

It can just come.

Patient : *Mm.*

Mm.

Doctor : *Bono igo ogocha koyeigwa ekero yarentire cancer tayari.*

You get to feel it when it has already developed cancer already.

Patient : *Mm.*

Mm.

Doctor : *Igo egento ekemo etotakeire tokore chitest chinde nario toraeneki oborwaire obo tokagerete.*

So, one thing we need to do further tests to confirm the diagnosis.

Patient : *Mm.*

Mm.

Doctor : *Igo tokumia. Egento kende…*

So, don't be worried. The next thing

Patient: *Mm.*

Mm.

Doctor: *Tori gochi gokwa mambia.*

You are not dying tomorrow.

Patient: *Mm.*

Mm.

Doctor: *Ah korengana nekerengo oborwaire bwaikire nabo togokobwenia pi…*

Ah depending on the state, we can completely cure it…

Patient: *Mm.*

Mm.

Doctor: By doing an operation.

Goetera ase okobarwa.

Patient: *Mm.*

Mm.

Doctor: *Nabo togokobara.*

We can operate on you.

Patient: *Mm.*

Mm.

Doctor: *Na korusie obobe bwensi tokore cancer yonsi korwa asore.*

And remove all the infection and you be free of cancer.

Patient: *Mm.*

Mm.

Doctor: *Yonsi pi.*

Completely.

Patient: *Gaaki mbuya mono ase amaereso ayio. Ondebwensi nabo akwoboa amakweri*

Please thanks for that advice. Anyone can fear death.

Doctor: *Igo aye tobaise kwoboa nonya nonya ng'ake. Omonene nare amo naye.*

Ah so don't fear at all at all. God is with you.

Patient: *Korende bono gaaki ng'aki ogochagokora obotioku obo rende? Inche ntagete obotioku obo borasira.*

But now please what will you do about this smell? I want this smell to disappear first.

Doctor: *Botioku mbobwati bokong'u.*

The smell does not have a problem.

Patient: *Mm.*

Mm.

Doctor: *Ngokoande amariogo.*

I am giving you medication.

Patient: *Mm.*

Mm.

Doctor: *Naende ntogenderete gokorora ase ekiriniki.*

And we continue to observe you at the clinic.

Patient: *Mm.*

Mm.

Doctor: *Enagotebia ochogende okore chitest chinde buna goaka ebicha.*

I told you about the further tests you will need to do like doing a scan.

Patient: *Mm.*

Mm.

Doctor: *Escan.*

A scan.

Patient: *Mm*

Mm.

Doctor: *Kera egento ntopime tomanye ekerengo kioborwaire tomanye kogotebia egekobwatia. Neserekari bono iga ngwatebigwa nga yakeirie rigori riokorwarigwa.*

We will screen everything to determine the level of your disease then we shall tell you what follows. And you were told that the government has reduced the cost of medication.

Patient: *Mm.*

Mm.

Doctor: *Bono iga enyagitari enene buna eye yaito okonyora…*

Now a big hospital like this one of ours you get….

Patient: *Mm.*

Mm.

Doctor: *Igere rigori rike bobua kare ekero abanto barenge kogenda baka India.*

It is a lot cheaper than in the past when people used to go to India.

Patient: *Mm.*

Mm.

Doctor: *Igo tobaise gokumia.*

So, you don't need to worry.

Patient: *Mm.*

Mm.

Doctor: *Eria gatato…*

Thirdly…

Patient: *Mm.*

Mm.

Doctor: *Tobaise gotwara ebirengererio ng'a n'oborogi.*

Do not harbour thoughts that it is witchcraft.

Patient: *Mm.*

Mm.

Doctor: *Yaya. Mbori borogi.*

No. It is not wichcraft.

Patient: *(Amaseko)*

(Laughter)

Doctor: *Igo tobaise komocha gochia clinic.*

So never miss clinic attendance.

Patient: *Mm.*

Mm.

Doctor: *Ase engencho gwachire gotumeka amariogo aya yekegusii.*

Because you have started using the local Gusii herbs.

Patient: *Mm.*

Mm.

Doctor: *Gose ng'aki bono, gwachire goetanana ase omote gete mara gatano…*

Or what do you think, have you gone round some tree five times…

Patient: *(Amaseko).*

(Laughter).

Doctor: *Nario oragwene.*

For you to get healed.

Patient: *Ee gaki tagitari, gose abanto nabo bakorigia emete.*

Yes indeed doctor, people do look for herbs.

Doctor: *Gose naki gose ngwachakire konywa emete?*

Or what are you saying, have you started taking herbs?

Patient: *Mm.*

Mm.

Doctor: *Yaya.*

No.

Patient: *Mm.*

Mm.

Doctor: *Aye twara omorembe.*

You be in peace.

Patient: *Mm.*

Mm.

Doctor: *Kanya gocha e clinic tokore chitest echio nagotebia korende naye ogende okore chitest aya nkokorikera ase e card yao.*

Continue with the clinic attendance as we carry out our tests but you also go and carry out the tests I will prescribe for you on your card.

Patient: *Mm.*

Mm.

Doctor: *Ah ekero ogocha omokubio oyomo gose ebere korwa bono…*

Ah once you come after one or two weeks…

Patient: *Mm.*

Mm.

Doctor: *Torore amachibu ayio manye kogotebia buna togokorwaria.*

We see the results then tell you how we shall proceed with your treatment.

Patient: *Ooh.*

Oh.

Doctor: *Rakini oborwaire obo mbobwate amariogo aye naende chioperation nchiroo togochi gokora.*

But this disease has its medicine and there are other operations we shall carry out.

Patient: *Mm.*

Mm.

Doctor: *Chigokonye.*

Which will assist you.

Patient: *Ee. Asante tagitari.*

Yes. Thanks doctor.

Doctor: *Ee igo nagokire.*

Yes I am very happy.

Patient: *Mm.*

Mm.

Doctor: *Genda buya.*

Go well.

Patient: *Ee mbuya mono tagitari.*

Doctor: *Naende ekero ogocha gocha ondeteranie agatwani gose chinsaga iga.*

And when you will come you can bring me a cockerel or even ‘chinsaga’.

Patient: *Ee mbuya mono tagitari.*

Sure thanks doctor.

Doctor: *Naende gwaseka.*

You also need o laugh.

Patient: *Osesenigwe.*

Be blessed.

Doctor: *Aaya*

Okay.

Appendix xxvi. Cancer 3 consultation

Doctor: *Karibu baba. Naki ogoteba?*

Welcome mum. How are you?

Patient: *Mbuya mono tagitari.*

Thanks doctor.

Doctor: *Ehee.*

Okay.

Patient: *Mm.*

Mm.

Doctor: *Naki ogendererete?*

How are you doing?

Patient: *Mbuya.*

Fine.

Doctor: *Tokarorana engaki eri ende ngakorwaria n'amariogo ngakoa. Bono ng'aki oigwete?*

We had met last time, i treated you and gave you medicine. Now how are you doing?

Patient: *Ah ndoche tindarora chenchi.*

Ah, i think i haven't had any change.

Doctor: *N'omochando oria obwate?*

You still have the same problem?

Patient: *Nimbwate omochando oria rimisu ribe rianchandire aiga.*

I still have that problem; the bad smell is still bothering me.

Doctor: *Ee.*

Ee.

Patient: *Mm.*

Mm.

Doctor : *Korende konye nagotebirie ng'a omochando oo nkansa.*

But i had told you that your problem is cancer.

Patient: *Ee.*

Yes.

Doctor: *Ase enchera y'oroiboro.*

Of the cervix.

Patient: *Ee ngwantebeti.*

Yes, you told me.

Doctor: *Ee na kansa ngosumbua ere ase ogopima korende konye twaigwananire togateba nochiche erinde tokore a staging. Tari boigo?*

Yes, I know cancer is quite bothersome when testing but we had agreed you will come so that we can do staging. Is that right?

Patient: *Nabo.*

That is right.

Doctor: *Nario toramanye gose ne'operation togokora gose togotome ogende osambwererigwe n'esitima gose onywe amariogo a chemotherapy.*

That is when we can know whether we need to do an operation, or we send you to be burnt by electricity or you take the chemotherapy medicine.

Patient: *Eh! Nsambwererigwe n'esitima nche?*

Eh! I get burnt by electricity?

Doctor: *Ee.*

Yes.

Patient: *Yaya tagitari.*

No doctor.

Doctor: *Ee.*

Yes.

Patient: *Nki ndakwere n'abana bane…*

Why will i die yet my kids…

Doctor: *Bare bake.*

Are so young.

Patient: *Ee rende.*

Of course.

Doctor: *Korende eyio tokoroka ogosambwererigwa n'estima igo ekorokwa radiotherapy. Eyio nigo egokonya gokora kansa, tari mobere egosamba. Na tari ogosamba ase ogotumia omorero ng'a gose oyie. Yaya.*

But the one we refer to getting burnt by electricity is called radiotherapy. That assists to clear cancer, it does not burn the body. And not burning like using fire such that you burn. No.

Patient: *Mm.*

Mm.

Doctor : *Igo bagokobeka tu ase emachine n'emachine ende yasoigwa korwa nse ase enchera y'oroiboro egere yakora kansa eyio yatiga komentekana.*

They put you in a machine and another machine is placed at the cercical entrance so that it clears the cancer and stop it from progressing.

Patient : *Ai ! Tagitari, eyio yaya! Riorio bono n'eba amariogo ake ake.*

Huh! That one no, doctor! I will rather medicine in bits.

Doctor: *Yaya.*

No.

Patient: *Mm.*

Mm.

Doctor: *Bono igo ere iga, eh? Nomanyete kera oborwaire mbore n'enchera yaye y'okorwarigwa. Tari bo?*

Now it is this way, eh? You know every disease has its own way of treatment. Is that not so?

Patient: *Ee nabo.*

That is true.

Doctor: *Buna malaria n'ebwate amariogo aye akoyerwaria. Tari bo?*

Like malaria has its medicine which treats it. Is that not so ?

Patient : *Ee nabo.*

That is true.

Doctor : *Tokonywa eriogo riegekuba korwaria malaria. Kera ekemo nkere n'enchera yaye. Tari bo ?*

You cannot take medicine meant for the chest to treat malaria. Each has its own way. Isnt't it?

Patient : *Ee nabo.*

That is true.

Doctor : *Korende totaraika abwo ase ogoteba, eki torakore igo totakeire tokore staging. Mm.*

However, before we get to what you are saying, what we need to do now is staging. Mm.

Patient : *Mm.*

Mm.

Doctor: *Ritang'ani tokore staging tomanye estage ki ore. Bono oborwaire obo mbobwate amachiko aye. Onye n'estage, igo bagoteba chistage goikera inye. Tari bo?*

Let's first do staging to establish the stage you are in. Now this disease has its own rules. If it is the stage, they talk of up to stage 4. Okay?

Patient: *Nabo.*

yes.

Doctor: *Onye kere estage entang'ani gose eyakabere eyio nigo ere abwo tu ase enchera y'oroiboro.*

If it is the first or second stage, then it is at the cervical entrance.

Patient: *Mm.*

Mm.

Doctor : *Eyio nero togokorera eoperation. Igo tokorusia rirara mori n'ecervix eyio abwo ase kansa ere*

That is the one we carry out an operation. We remove uterus and the cervix where the cancer is.

Patient: *Mm.*

Mm.

Doctor : *Ekero twayerusirie bono eyio nigo togoteba kwagwenigwe kegima. Eyio igo ekorokwa okogwena kw'emia ase emia. Ee rende?*

Once we have removed it then we say you have been healed. That is called getting healed a hundred percent. Okay?

Patient: *Igo ningwenigwe?*

So, will I be healed?

Doctor: *Onye kere e stage entang'ani na…*

If it is at the first stage and…

Patient : *Gose eyakabere.*

Or the second stage.

Doctor : *Gose eyakabere. Ee rende?*

Or the second stage. Isn't it?

Patient : *Mm.*

Mm.

Tagitari : *Korende onye yachire aake yaikire e stage ya gatato gose yaikire estage ya kane, eh ? Estage ya gatato enchera ende yasoire ase chinsemo chinde korende tu abwo ang'e n'ecervix. Kero kende nigo etarerete chinsemo chiamakere.*

But if it has advanced a bit to stage three or four, eh...stage three means that it has moved to other parts but around the cervix. At times it may be atached to the abdomen.

Patient : *Mm.*

Mm.

Doctor : *Yaseretire abwo. Eyio natokora eoperation.*

It has developed a nest there. That one even if we operate

Patient : *Mm.*

Mm.

Doctor : *Gose estage ya kane engencho yaye yaetananire yaikire ase amaa gose omotwe ntokonyara koyegwenia. Iga rende.*

Or the fourth stage which means it has reached the lungs or the head, we cannot cure it. You see.

Patient : *Iiga.. Bono nche tiga bankonye.*

I see. Now let them assist me.

Tagitari : *Korende onye yaikire estage ya gatato…*

But if it is at stage three…(cause effect)

Patient: *Mm.*

Mm.

Doctor : *Eyio bono nero torakore. Nero eyio y'ogosambereriga korende tari ogosamba omaete igo ngotumia eng'ana eyio erio egere toigwane. Onye tari bo nigo ekorokwa radiotherapy. Tari bo?*

That is what we can do. It is the one of being burnt but not in the sense of being burnt, You know I use that term so that we can understand each other. Otherwise it is called radiotherapy. Isn't it?

Patient: *Ee nabo.*

Yes, it is.

Doctor : *Na nigo togotumia brachytherapy engencho yaye ng'a n'emachine ekobekwa goetera enchera yao y'oroiboro egere kegwokigwa, kansa eyio ere ang'e abwo yakora ki?*

And we use brachytherapy meaning a machine is inserted through the cervix and once its put on, all the cance that is around there des what?

Patient: *Yasambwa.*

Gets burnt.

Doctor : *Yayia. Ee tari okoyia buna tokomanyete, yagwenigwa.*

It gets burnt. Not the literal burning, it gets cured.

Patient: *Mm.*

Mm.

Doctor : *Korende igo ekogwenigwa n'esitima asengencho rieta riekegusii tiriyo ndanyare gotumia nakio togotebera ogosambwa. Korende tari ogosambwa buna bono oigwe omerero gose oyie. Aye tokomanya nonya ng'a ninki.*

But it is cured by the electricity because we do not have an equivalent word in EkeGusii, that is why we say "to be burnt". But it is not being burnt like feeling the fire or being burnt. You may not know at all what it it.

Patient: *Mm.*

Mm.

Doctor : *Tokoigwa kende nonya. Aye nigo ogotebigwa ng'a emachine yokigwe. Ogenderere gosoma egaseti korwa abwo erimigwe otebigwe emachine yakorire. Mambia yaye naende otebigwe buna orabe gokoirana gokorerwa igo. Korende tori koigwa iberera.*

You do not feel a thing. You just get told that the machine has been switched on. You continue reading your newspaper and then the machine will be switched off and you are told that it is through. The following day you will again be told how you will be coming for that procedure. But you do not feel the heat.

Patient: *Mm.*

Mm.

Doctor : *Gose riberera gose obokendu, yaya. Emasini nigo erabe kegokora egasi yaye aye otamanyeti ninki kegendererete. Na kansa negendererete korigererigwa torore buna egendererete ko bono ekero ere estage ya gatato. Bono estage ya kane onye yachire aare nario riorio bono gosamba natosamba tikogokonya. Korende bono iga ase twaikire nche naye ritang'ani tokore staging eyio.*

Or hotness or coldness, no. The machine will do its work without knowing what is going on. And the cancer is being monitored to see how it is progressing but when it is in stage three. If it has gone to stage four, then even we do the burning may not help. However now where we have reached we will do staging.

Patient: *Mm.*

Mm.

Doctor: *Ee rende ? Nabwo nao konye twaikire gokwana korwa riria toumerana. Etakeire ochiche togotebie rituko riria ogocha kogenda theatre erinde omanye ng'a ase e theatre nao omonyagetari agochia gopima n'okoboko na nigo aragopime koraire. Ee rende?*

Is that not so? That is where we had reached in our discussions since we last met. You need to come we tell you the day you will go to theatre so that you may know that it is here where the doctor will investigate using his/her hand and he will do so while you are asleep.

Patient: *Mm.*

Mm.

Doctor: *Eyio nigo ekorokwa okorigererigwa kobekeire eriogo riamagandi. Gakorire koyekora namanye gose nigo ere ase e cervix oka gose yasukire gochia ase ebimo binde amakere ao, ensemo ya inse yenda.*

That is called examination while you are on an anaesthesia. Once he/she will be through he/se will know whether it is at the cervix or it as advanced to other parts in the abdomen or the lowerpaty of the stomach.

Patient: *Mm.*

Mm.

Doctor: *Korwa abwo nario torachake gokwana igoro y'okogwenigwa koria otakeire okore. N'ase obweng'e tu nakio nare kogotebia igoro ya staging korende bono aye ntomanyeti estage yao.*

From there we can now start talking about the kind of treatment for you. And in short that is why i was telling you about staging but we do not know your stage yet.

Patient: *Mbuya mono tagitari ase ogonsemia.*

Thanks doctor for educating me.

Doctor: *Mm.*

Mm.

Patient: *Bono namanyire.*

Now i know.

Doctor: *Mm.*

Mm.

Patient: *Korende nigo ngosaba.*

But I pray.

Doctor: *Mm.*

Mm.

Patient: *Onye ndiria nagenda ntumie, omogaka nareo ong'a emete.*

If I could go and use, there is an oldman who gave me some herbs.

Doctor: *Mm.*

Mm.

Patient : *Ngende ntumie ake.*

I go and use them a bit.

Doctor: *Mm.*

Mm.

Patient: *Imanye koirana.*

Then I come back.

Doctor : *Mm.*

Mm.

Patient: *Torore gose nstage ki yaikire.*

We see which stage it has reached.

Doctor : *Ah, gwakorire buya gonsaba ribaga. Abarwaire abange tibari gosaba ibaga. Ah timanyeti igo bagokora nse y'amache bonkunyunkunyu.*

Ah, you have done a good thing to request my permission. Many patients do not ask for permission. Ah, i dont know they do it very secretively.

Patient : *Mm.*

Mm.

Doctor: *Omoerio kwaigwa ng'a ooh nyarebe tacheti asengencho agotumia amariogo korende aye gwantebirie. Na onye gwantebia igo ekworokia ng'a ase enkoro yao ensemo nere etagete nkoe ogosemia.*

At the end you hear that so and so did not come because he/she is using some local medicine but atleast you have told me. And if you have told me it shows that in your heart you need some advice on something.

Patient: *Mm.*

Mm.

Doctor: *Gose okwo nokonacha okuya gose okobe tinkogotebia ng'a mbobe gose mbuya. Okwo nokonacha kwao.*

That it is a good decision or a bad one I can not tell you it is good or bad. That is your decision.

Patient: *Mm.*

Mm.

Doctor: *Ekiagera nonya n'amariogo aya ane onye buna bono gintagete kogenda gokora staging ase e theatre, goika ong'e ribaga. Tinkogosiba engori ngotebie togende theatre gokora staging. Yaya.*

Because even with my this my medicine, if like now if i need to go and do staging in the theatre, you must give me permission. I cannot tie you with a rope and take you to the theatre to do staging. No.

Patient : *Mm.*

Mm.

Doctor: *Ase kera egetambokero goika ong'e ribaga riao naboigo nore nobosibore bw'okomanya gose nchera ende nereo ndanyare gokoa goetania eyio. Tari bo?*

In every step you must give me permission and you are free to know if there is another option apart from that one. Is that not so?

Patient: *Ee nabo.*

It is true.

Doctor: *Bono aye omonyene gwatumiire obosibore obwo bwao kwenachera ng'a ase bono nigo otagete gokora iga ribaga ria iga.*

So you have personally exercised that your freedom to decide that for now you want to do this instead of this.

Patient: *Mm.*

Mm.

Doctor: *Buna nagotebirie obwo bwonsi n'obosibore bwao.*

As i have told you, all that is your freedom.

Patient: *Ee*

Yes.

Doctor: *Obokong'u mbwate bokogera tinyara gokoa ogosemia igoro y'amariogo ayio mbori ng'a timbwati riboti ende yonsi. Tindarora botuki bakorire igoro ya cancer n'emete eyio, igo mbate ogosemia ogoke. Igo timbwati gosemia konde gwensi igoro y'emete eyio ndanyare kogosemia.*

The problem I have which prevent me from advising you about that medicine is that I do not have any report. I have not seen any research on cancer and those herbs, so I have limited information. Therefore, I do not have any information on those herbs to be able to advise you.

Patient: *Nomanyete ekio gekogera nkogotebia igo?*

Do you know why I am telling you that?

Doctor: *Ehee.*

Okay.

Patient: *Noroche omoamate one aria nka …*

You see a neighbour at home …

Doctor: *Mm.*

Mm.

Patient: *Nareo oyatumia na nigo agoteba ng'a ogwenire?*

Is there a person who used them, and she says that she has revovered?

Doctor : *Ogwenire. Nakio nkogotebia ng'a riboti eyio nche ntimbwati timanyeti, tinkonyara asengencho chisemi mbwate bono iga…*

She has recovered. That is why I am telling you that I do not have, and I don't know that report; I cannot because the knowledge I now have…

Patient : *Mm.*

Mm.

Doctor : *Tingoyetumia kogosemia gokora gose mamincha.*

I cannot use it to advice to do contrary.

Patient : *Mm.*

Mm.

Doctor : *Torochi rende ? Korende ekio ndagotebie nkeria ng'a kobwatekana nainche n'obwate obosibore bwo'okonacha onye gotagete bo ko bono igo nkogosaba tu egento ekemo.*

You see ? But what I will tell you is that according to me you should feel free to decide if that is what you want only that I have one request.

Patient : *Mm*

Mm.

Doctor : Obe gokogenderera gocha e kiriniki onye kogotumia emete eyio. Nagotebirie emekubio ebere kegoeta oirane naende, nkogosaba tomocha gocha. Ase ogwancha kwao eh?

You continue attending the clinic as you use the herbal medicine. I have told you after two weeks you come back again, please do not miss to. As you wish, eh?

Patient : *Mm.*

Doctor: *Nario naintwe togopima twarora buna ogendererete nonya buna ogendrerete gotumia emete eyio. Kero kende omonyagetari oyio bw'emete nagotebie buna orabe gokoirana ase are akorigererie, korende bono n'ase obuya bwao.*

For us to also examine you to monitor your progress as you continue using those herbs. At times the herbalist may tell you to see him to examine you, but it is for your own good.

Patient: *Mm.*

Mm.

Doctor: *Mbuya bono akorigererie nainche boigo nkorigererie buna bono onye kogochia gocha buna chinsa echi gwachire, omotienyi gokoera naende oirane naende torore buna kansa eyio egendererete asengencho nkoiteka ore emetienyi, amanyinga ao nkewango ki ang'ana? Ee rende?*

It is better he examines you and I also examine you if you will come the same time like you have today, after a month you come back we see how the cancer is progressing because of the menestration flow we see the level of your blood. Okay?

Patient : *Ee nabo.*

It is true.

Doctor: *Emete eyio nigo egoserwa ase amani.*

Those herbs is processed in the liver.

Patient : *Mm.*

Mm.

Doctor: *Torore amani ao naki emete eyio ekoyakora buna chingaki chigoeta. Oise gocha torore ng'a egento nkere gekageire koretwa n'amariogo ayio, na togosemie. Ningotebie ng'a eriogo eri riarorekanire riakorire amani ao arose mono gose riakorire kansa egenderere gose ekee, korende okwo n'ogwancha kwao.*

We check the effect of the herbs on your liver over time. If you come and we notice a side effect of that medicine, we will advise you. I will inform you any indication of the overworking of your liver or the increase or reduction of cancer, but that is your choice.

Patient: *Mm.*

Mm.

Doctor: *Tari buna omonyagetari otebire erasima oiche aiga.*

Not that the doctor has said that you must come here.

Patient: *Ok.*

Ok.

Doctor: *Ekiagera nonya n'emete eyio onde tari okogotebia ng'a n'erasima oyatumie. Naye omonyene.*

Because even those herbs nobody tells you that you must use them. It is yourself.

Patient: *Ninche naamuire.*

I have decided.

Doctor: *Kwaamuire, tari bo*

You have decided, isn't it

Patient : *Mm.*

Mm.

Doctor: *Ee ko nabo bono orende eh ? Asengencho abanyamete mbabwati research eisaine, tari bo?*

Okay but be careful, eh? Because herbalists do not have enough research, isn't it?

Patient: *Nabo*

True.

Doctor: *Nakio okonyora bakogotumia buna engurue.*

That is why they use you like a guinea pig.

Patient: *Mm.*

Mm.

Doctor: *Nigo batagete rituko erimo batebe nga nonya n'omong'ina oria nagwena.*

They want to say one day that even that lady got well.

Patient: *Mm.*

Mm.

Doctor : *Kabere nonya n'omoamate oyio ogoteba ng'a nagwena, tobwati bomaene bonde bwonsi gose ekeene nagwena.*

Secondly, even is the neighbour you talk about recovers, you do not have any proof that indeed she truly got well.

Patient: *N'maene.*

It is true.

Doctor: *Aye nigo kwaigwa abanto bagokwana. Tari bo?*

You just heard people say, is that not so?

Patient: *Nabo.*

It is true.

Doctor: *Na buna orabe kogocha buna bono nagotebia ochiche omotienyi koerire ntobe tokogokorera counselling. Tari bo?*

Since you will be coming as I already told you to come after a month, we shall be giving you counselling. Okay?

Patient: *Ee.*

Yes.

Doctor : *Tokogokorera counselling ase chingaki gete nonyore ng'a nonya n'enkoro yao yaororobire goikera bwanche togokorere staging na tokore okorwarigwa kogwenerete kobwatekana n'estage eria twanyorire. Tari bo?*

Once we counsel you for a while you will get your heart softening so that we do staging for you and give you the right treatment as per the stage we will establish. Isn't it?

Patient : *Ee kobwatekana buna kwang'eresire.*

Doctor : *Mm.*

Mm.

Patient : *Tiga tu nteme.*

Let me just try.

Doctor : *Mm*

Mm.

Patient: *Erinde erio ng'irane. Tinkomocha tincha.*

Then I can come back. I can't miss to come back.

Doctor : *Ee.*

Yes.

Patient: *Ekiagera gwansomirie buya.*

Because you have educated me well.

Doctor : *Ehee*

Okay.

Patient: *Tiga ngende tu nteme.*

Let me go and try.

Doctor : *Ehee.*

Okay.

Patient: *Erinde ng'irane naye boigo ontebie buna ngendererete.*

Then i come for you to tell me how i am progressing.

Doctor: *Ee ningoke ko bono anga nagoka mono onye ngwancha tokore staging nario nonya nekero ogotumia ariogo erio…*

I will be happy but I would have been happier if you could have accepted for us to do staging such that when you use that medicine…

Patient: *Mm.*

Mm.

Doctor : *Tomanye nstage ki kware ekero kwarichagete eriogo erio na onye gotagete gotiga eriogo tomanye ng'a igo kwaritiga kore stage ki. Tobaisa konywa eriogo bosa igo. Naboigo toba n'obwango bw'okominyokera eriogo ase omobwekano bono iga kwamboririe ogosemia.*

We know which stage you were when you started using that medicine ans if you want to stop using the medicine we know that you stopped using when you are in a particular stage. Do not just take medicine like that. And do not be fast to rush into hebal medicine, for instance, just now you have asked me for advice.

Patient: *Mm*

Mm.

Doctor : *Tari bo?*

Is it not so?

Patient: *Nabo.*

True.

Doctor : *Aya na konya otaracha aiga konye kwaboririe osemigwe n'omoamate oo. Gwasemigwe n'abanto babere. Ninganie oire chingaki ritang'ani osemigwa korwa chinsemo ao ao. Tonacha ekerengererio ekemo tu ase engencho omonto oyio gwakagera kogwena na toraboriaboria osemigwe. Toragenda omanye ng'aki agwenete nonya n'omong'ina oyio torokwana nere. Noroche?*

Okay and before you came here, you had asked for advice from your neighbour. You have been advised by two people. I will need you to take your time and get advice from different places. Do not make a decision because the person you assumed had recovered you haven't asked around to get the right information. You have not gone to know how she recovered, let alone talking to that lady. You see

Patient : *Ee.*

yes.

Doctor: Taragotebia gose amaene ogwenigwe gose taragotebia gose igo agwenete asengencho y'emete eyio. Gose kero kende n'eriogo ria nyagetari arenge gotumia gose neoperation akoreretwe. Ntoigwanaine?

She hasn't told you whether she has been healed nor has she told you if she she got healed because of the herbal medicine, or maybe it is medicine from hospital she was using, or she underwent an operation. Are we together?

Patient : *Mm.*

Mm.

Doctor : *N'oganetie chisemi chinyinge. Ase igo nigo nkogosaba eh?*

You need more information. Therefore i request you, eh ?

Patient : *Mm.*

Mm.

Doctor: *Torwa aiga na gochaka gotumia eriogo erio rero.*

Do not get out of here and start using that medicine today.(graduation force)

Patient: *Mm.*

Mm.

Doctor : *Toayerera, Tari bo?*

Take your time, isn't it ?

Patient: *Mm.*

Mm.

Doctor : *Ira chingaki. Irana okwane n'omoamate oyio oo eh ? Kiagera torakwana nere, genda omoborie ng'a naigure chinkwana ng'a kwagwenire kansa na tori na bomaene gose n'obwate kansa nonye nabo. Konye ochire nyagetari buna aye gwachire? Opimirwe n'omonyagetari? Namanyekanete nstage ki arenge? Manya kera egento. Nimanyete aye n'omong'aini nonya torasoma mono korende nobwate chisemi gete.*

Take time. Go back and talk to that neighbor of yours, eh? Because you haven't talked with her, go and ask her that you have heard rumours that she recovered from cancer and you are not sure if she had cancer in the first place. Hash she been examined by a doctor? Does she know the stage she was? Know everything. I know you are clever, even if you have not studied much but you have some knowledge.

Patient: *Mm.*

Mm.

Doctor: *Tari bo? N'obwate chisemi chinke; tumia chisemi echio chiao gwekonya. Genda okwane n'omoamate oyio oo timanyeti nchera ki ogochia gotumia. Korende motebie tu ng'a ninde n'omochando. Ngapimwa nkanyorekana na kansa na nkaigwa abanto bagokwana ase achiro gose ekanisa buna nkwabwate omochando buna oyo, bono nyigwete ng'a kwagwenire. Naki gwakorete okagwena? Noroche rende?*

Is that not so? You have some little knowledge; use that knowledge to save yourself. Go and talk to your neighbour, I don't know how. But tell her that I have a problem. I was examined and found to have cancer and I heard people talking at the market or at church

that you had a problem like this one and now you have been recovered. What did you do to get healed? You see?

Patient: *Ee.*

Yes.

Doctor: *Erinde erio ekero akworokererie na kogotebia nki akorete, agotebie ritang'ani gose n'oborimo. Amatuko aya nonya n'abanto mbari goteba ng'a nyarebe nabwate ukimwi ekero atabwati?*

She can then show you and explain to you what she did, she tells you first if those are lies. These days don't you find people claiming that so and so is HIV positive when the person is not?

Patient : *Mm.*

Mm.

Doctor : *Kero kende n'oborimo. Bono torwa aiga ogende ase omogaka oyio ogende kwoyia amariogo ekiagera amatuko aya abanto igo bagokora oboonchoreria.*

Maybe it is a lie. So do not get out of here and go for medicine from that old man because these days people do business.

Patient : *Mm.*

Mm.

Doctor : *Oranyore ng'a nigo agasimegete emete y'emekindori agokooneria chiribu ikomi ekero nche ndagokorere kero kende chiribu ibere okore staging, n'eribu eyemo ekore e test. Onyore ng'a ase chiribu echi ikomi gwatigairie e change y'okogora endagera nyomba.*

You may get that he has planted emete y'emekindori and he sells to you at ten thousand when i will charge you maybe two thousand for staging and and one thousand for a test. Out of your ten thousand, you still end up getting change to buy food to take home.

Patient : *Endagera.*

Food.

Doctor : *Bono okorwa aiga okominyokera ani omonto oberirie chisogisi chiria abegete igoro n'eyanga yaye ya ime agotebie ng'a kanywe erio n'eriogo ria kansa! Ebikone biamatuko aya timanyeti nki saitani atokoreire ase ense eye! Tominyokera amariogo ayio buna omouko. Kora obotuki ekiagera nobwate chisemi. Kora obotuki erinde ekero kwanachire ekerengererio ng'a rero nachakire konywa emete eyio, onyore n'ekerengererio nonya n'omoyo oo oitabire ng'a nakorire obotuki bwane nkamanya eriogo eri ndinkonye. Torochi rende?*

Now when you leave here you will rush to someone who has boiled a pair of socks he was putting on yesterday together with his panties and he tell you take this its cancer medicine! The strange happenings of these days, I don't know what the devil has done to us in this world! Do not rush into those herbs as a blind person. Do your research because you have knowledge. Do research such that when you decide that today I have started to

take these herbs, you get that your sould approves of that decision that I have done my research and known that this medicine will assist me. You see?

Patient: *Ee nabo. Egento kende nkoboria…*

That is true. Another thing I want to ask…

Doctor: *Mm.*

Mm.

Patient: *Omorisia nakare…*

There is a church elder…

Doctor: *Mm.*

Mm.

Patient: *Okare goteba ng'a n'ebaise koba oborogi*

Who tells me that it might be witchcraft.

Doctor: *Ehee!*

What!

Patient: *Naende agateba ng'a nabo agonsabera.*

And he said that he can pra for me.

Doctor: *Mm.*

Mm.

Patient : *Aye ng'aki oroche tagitari?*

What do you think, doctor?

Doctor: *Ahaa omanyete buna gwantebia igoro y'emete nagania komanya mono ng'a ninki ekerenga kieyio. Aah kansa teri gocha asengencho y'oborogi.*

Ah! You know the way you told me about the herbs and i wanted to know more, what is the objective for that? Aah, cancer is not caused by witchcraft.

Patient : *Mm.*

Mm.

Doctor: *Noroche rende?*

You see?

Patient : *Ee.*

Yes.

Doctor: *Kansa n'ebwate chinchera chiaye chikoyereta na nkagerete ase e kiriniki keria kende nkwamboretie okoboria buna oko: Tagitari ninki gekogera mbwate kansa? Tagitari nche tindarara isiko, tagitari tindakora eke. Chinchera n'echinyinge chire echio obotuki bokworokia ng'a nabo chikoreta kansa.*

Cancer has its own causes and I think in the last clinic you asked the this kind of question : why do i have cancer doctor ? I have not slept out doctor, I have not done this doctor. There are many causes of cancer, which research has shown.

Patient: *Mm.*

Mm.

Doctor: *Igo bagoteba ng'onye gwachagete kororana kemobere n'abasacha kore ekegori egeke, buna bono aye ogoteba kwanywometwe kore n'emiaka ikomi n'ebere. Eh ? Igo onye gwachagete gokora obonyaka kore omoke, kabere onye kwaiboire abana abange na gatato onye omogaka tararokigwa. Ase igo chisababu n'echinyinge. Borogi ritang'ani tibomanyiri ng'a ngento ki. Nimanyete aiga Gusii ase tomenyete ntobwate okwegena okwo mono ase oborogi.*

They say that if you started having sexual intercourse at a very early age, like now you say you got married at an early age of twelve years, eh? So, if you started engaging in fornication as a young person, secondly if you have given birth to many children, and third, if your husband is not circumcised. So there are many causes. Witchcraft in the first place is not known what it really is. I know here in Gusii where we stay we have lots of believe in witchcraft.

Patient: *Mono.*

So much.

Doctor: *Korende…*

However…

Patient: *Ritang'ani omoamate oria one*

To begin with, my neighbour….

Doctor: *Ehee, igo agokorigereria n'amaiso amabe*

Yes, she looks at you with bad eyes.

Patient : *Amaene tari koigwana nonya.*

Honestly we do not get along at all.

Doctor: *Bono eyio nigo eragokorekanie naboigo ekero ore n'okwegena okwo ngokorentere ebirengererio ebikorekanu naboigo ekero gwakorekanigwe ochake gotiga konywa amariogo. Naboigo ekero kaa ogochaka gotumia amariogo gose gokorerwa e operation igo okonyora kansa yachire aare mono tokorigererie togotebie mama titokonyara kogokonya. Igo eyio nigo ekogosareria chinsa ekogera onyorwe anene mono okogwenigwa na nigo orabe ase abe mono ekiagera kero kende nigo ore e stage entagani yoka. Keria oganetie n'eoperation yoka obe buya, ogende korenda abana bao. Korende bono igo ogosaria chinsa kogenda ase omobasta oyo na mambia yaye otebigwe n'omosani bwomobasta nakare Mombasa origie chibesa chiokogenda Mombasa. Rituko rinde otebigwe ooh Loliondo nekare Tanzania onache etigiti y'echiribu ikomi kogenda Loliondo. Echio n'echinsa ogosaria. Kansa eyio nigo egendererete gosuka. Noroche rende.*

Now that will confuse you and when you have that believe, it will bring you confusing thoughts to an extent of abandoning the uptake of medicine. Similarly, when you will start to use medicine or undergo an operation the cancer will have advanced a lot, and we will look at you and tell you mummy we are not able to save you. So, that only wastes your time because if you get delay a lot it will be challenging to be cured because maybe you are just at stage one. You just need an operation and you will get well, you go to take care of your kids. But now you are wasting time going to that pastor, and the following day you are told that there is a friend of the pastor in Mombasa lookf for the fare to travel there. Then another day you are told oh there is a Loliondo in Tanzania get a ticket of ten thousand to travel to Loliondo. That is time wasting, this cancer is progressing. You see now.

Patient : *Bono buna gwantebirie…*

Now that you have told me

Doctor: *Mm.*

Mm.

Patient : *Narorire.*

I have seen.

Doctor: *Mm.*

Mm.

Patient: *Onkorere staging.*

You can now do staging for me.

Doctor: *Mbuya aah! Ehee.*

Nice ah! Okay.

Patient: *Kogokora gokora staging…*

Once you are done with staging…

Doctor: *Mm.*

Mm.

Patient: *Mbora gwantebirie ningederere n'amariogo.*

You told me I can continue with medicine.

Doctor: *Mm.*

Mm.

Patient : *Naboigo nabo nkogend'ase oria bw'emete.*

I can also go to the herbalist.

Doctor: *Mm.*

Mm.

Patient : *Erio nkoirana…*

Such that when i return…

Doctor: *Mm.*

Mm.

Patient : *Manye nkai nde.*

I know where i am.

Doctor: *Ok ah mbuya kiagera eyio ekworokia twasukire bosio.*

Okay, ah it is good because that shows we will have made a step.

Patient : *Mm.*

Mm.

Doctor: *Buna bono gwanchire tokore staging igo egokorwa korwa ase ensemo gochi' eyende. Okoigwa ng'a gwasukire nonya n'einch igo mbuya.*

Like now you have agreed we do staging, it is done in stages. If you feel like you have moved even an inch then that is good.

Patient : *Mm.*

Mm.

Doctor: Bono aye genda okwane n'omosister

Now go and talk to the nurse.

Patient : *Mm.*

Mm .

Doctor: *Omoirere rirube eri egere agotebie rituko riria toragobook; rituko riria torakore staging. Na buna torakore staging buna oragenderere gocha, ntogenderere gokwana naye nogenderere komboria amaswari.*

Take her this letter so that she can tell you the day we can book you; the day when we will do staging. And once we do staging as you will continue coming we will continue advising you and you should continue asking more questions.

Patient: *Mm.*

Mm.

Doctor: *Rero twasukire nonya kere asinini. Eyio ekworokia ekerenga ekiya na buna oragenderere gocha ekiriniki togenderere gokwana. Ntogenderere gosuka egekogera ayio onsi nase engencho y'okogokonya. Tari bo?*

Today we have progressed even if it is a bit. That is a good sign and as you will continue coming for clinic we shall continue this discussion. We will continue to progress because all that is because of wanting to assist, isn't it?

Patient: *Ee gaki.*

Yes please.

Doctor: *Ee buna bono gokogwena ning'o okogoka?*

Like now once you get gell who will be happy?

Patient: *Gose ninche.*

It is me.

Doctor: *Ee, nonya n'omonyagetari nagoke atebe, aah omorwaire one okanyekire.*

Even the doctor will be happy and he will say…aah my patient has recovered

Patient: *Mm.*

Mm.

Doctor: *Korende oyoranyore obuya bwonsi naye, tari bo?*

But the one who will have all the benefit is you, isn't it?

Patient : *Mm.*

Mm.

Doctor : *Igo ayio onsi togokora tari ng'a n'oboonchoreria, ng'a gose nkoonerie emete y'echiribu ikomi*

So all that we do is not business, like I sell you herbs at ten thousand….(*example*)

Patient: *Mm.*

Mm.

Doctor: *Erinde erio ngende ngore e prado eh… naye kogendererete koumia. Kogocha ngontebie ribaga ri'ebikombe bitato bono kanywe ebikombe sita. Naende omanye komenta chiribu chinde emerongo ebere na cancer yao kegendererетekomenta. Bono kwarorire.*

Such that i go and buy a Prado eh… as you contintinue to suffer. When you come I tell you that instead of three cups, now take six. Then you add another twenty thousand and the cancer keeps inceasing. Now you see.

Patient : *Iiga.*

Sure.

Doctor: *Aye manya ng'a chikiriniki echi ogocha n'ebinto ebi bionsi togokwana n'ebiokogokonya. Torochi rende?*

You need to know that all the clinic visits and all that we disuss is to help you. You see?

Patient: *Ee.*

Yes.

Doctor: *Twensi pi nonya n'omosister oyio ore isiko abwo ogopima pressure, twensi nigo tokobokera aiga mambia kera rituko gocha aiga ase engencho yao gose omorwaire oito. Gokogwena nomanyete omosara oito nooria ogwene togwena na tari monge. Torochi abanyagetari amatuko aya obogima bwaito bwabeire buna onde bwensi, nonya abanto*

mbareo bamenyete buya kobua abanyagetari. Kero kende igo tokomoiraneria Nyasae mbuya mono egekogera twarorire amachibu aito. Oise gocha aiga kore n' obororo osoke kogogete igo tokogoka. Tari bo?

All of us including the nurse out there, who took tested your pressure, we all wake reprt here early because of you as our patient. When you get well you know our salary is the same even if you recover or not and it is not much. You see these days the lives of doctors is quite ordinary, there are people who live better than doctors'. If you come here with with pain and you leave while happy we also feel happy.

Patient: *Nabo*

It is true.

Doctor: *Igo torora ng'a igo twakorianania. Nonya n'ekiriniki chibesa irenga kwarwa rero? Ekadi n'echisiringi emerongo ebere. Korende ase omogaka oyo oo bwe'emete chibesa irenga oraakane ase okomorora gwoka?*

So, do not think that we took advantage of you. Even for the clinic, how much did you pay today? The card costs twenty shillings. But how much would you have paid even to see your herbalist?

Patient: *Komorora rimo n'echiribu isato.*

It is a thousand to see him once.

Doctor: *Aya na kagokoboria emete egarani eyemo y'echirita emerongo ebere?*

And then after charging you for a twenty-litre gallonful of herbs?

Patient: *Igo chikoba chinyinge.*

It will be a lot.

Doctor: *Aya rero kwaakanire chisiringi emerongo ebere yoka.*

Okay today you have paid only twenty shillings.

Patient: *Ebere yoka.*

Only twenty.

Doctor: *Torochi?*

You see ?

Patient: *Mm.*

Mm.

Doctor: *Igo aye manya ng'a aiga igo togocha ase engencho yao. Na buna eserekari yatebire ng'a amatuko aya abang'ina mbarwarigwe bosa baibore batari gwaakana. Engencho yaye nonya nkansa eserekari yebange buya nabo moraanse korwarigwa bosa. Torochi abwo faida teiyo?*

So you need to know that we are here because of you. And the government has said that these days ladies will receive free maternity care. This means even cancer, if the government plans well, you can get free treatment. You see there is no benefit there.

Patient : *Narorire.*

I have seen.

Doctor : *N'omorwaire bweka okonyora efaida. Taribo?*

It is the only the patient who benefits, isn't it?

Patient : *Mm. Mbuya mono tagitari.*

Mm. Thanks doctor.

Doctor : *Mm.*

Mm.

Patient : *Gwankonyire.*

You have helped me.

Doctor : *Mm.*

Mm.

Patient: *Mbuya mono ase ogontebia ekio ntamanyete.*

Thanks for telling me what I did not know.

Doctor: *Mm.*

Mm.

Patient: *Na nigo ngosaba ogenderere kobatebia abande bamanye.*

And I pray you continue to tell many others.

Doctor: *Aya*

Okay.

Patient: *Mbare baria basireire ase abaganga kera ase. Tiga Nyasae ankonye ndore gose ningwene.*

There are those who have been lost in witchdoctors all over. Let the Lord help me I see if I will get well.

Doctor: *Aya, aye tiga tororane omokubio ogocha.*

Okay, lets see each other next week.

Patient: *Mm.*

Mm.

Doctor: *Sister nagotebie rituko riria torakore staging.*

Sister told you the day when you will come for us to do staging.

Patient: *Ee.*

Yes.

Doctor: *Togokora staging ntogenderere gokwana.*

Once we determine the stage, we shall continue to talk.

Patient: *Mm.*

Mm.

Doctor: *Kero Kendo gochi bwanche togokorere eoperation eyio ogende nka otabwati kansa.*

Maybe you accept we do that operation and you go home cancer free.

Patient: *Igo ndakonyeke mono kegima.*

I will have been helped a lot.

Doctor: *Tari bo?*

Is that not so?

Patient : *Mm.*

Mm.

Doctor: *Aya bono.*

Okay then.