CHAPTER ONE

INTRODUCTION

1.0 Background to the study

This is a study situated within the framework of discourse analysis that focuses on interaction between receptionists and patients at the reception of public health facilities and private hospitals in Kisumu County, Kenya. Hewitt (2006) posit that receptionist attend to patients exclusively through the spoken and written means. This is juxtaposed to doctors and nurses whose work to patients involves verbal, physical and technical examination. Using a tape recorder at one public health facility and one private health facility in Kisumu County, Kenya, the study comparatively explored the verbal structure of frontline interface between patients and receptionists, describing recurrent transactional and relational patterns and variations in their enactment in the two health facilities in Kenya. The study also examined roles and identities which are constructed by receptionists and patients as they pursue their discourse goals in the two hospitals. Lastly, this study sought to consider how knowledge on front line interface discourse patterns can be used in receptionists training.

1.1 Interaction and communication

Merritt (1976) reported in Hewitt (2006), describes an episode between a receptionist and a patient at the front desk of a general hospital as a form of service encounter. He talks of an instance of face-to-face interaction between a server who is officially posted in some service area and a customer who is present in that service area and, the interaction being oriented to the satisfaction of the customer who is present in that service area. He further states that the interaction being oriented is to the satisfaction of the customer's presumed desire for some

service and the server's obligation to provide that service. Therefore, both the transactional and interactional functions of service encounters, respectively expressing content and social relations and personal attitude have been the subject of detailed critical attention (Hewitt, 2006). Therefore, the interest of this study in service encounters in public and private health facilities in Kenya was stimulated by the work of Hewitt (2006), who looks at the co-occurrence of transactional and relational talk in client encounters with hairdressers and instructors. However this study emphasises on the importance of interpersonal dynamics, which Hewitt (2006), Labov (1997) and Sarangi (1996) largely ignore in their work and who have all analysed language used by receptionists in institutional discourse. Vision 2030 on service delivery which is a long term development plan in Kenya, is also cited as key to communication strategy used by receptionists.

Another study by Hewitt (2001) investigates encounters between bus drivers and passengers. She found that while bus drivers and passengers collaborated in the pursuit of transactional goals, the driver's dual role as both provider of the service and the gatekeeper or controller of passenger access influenced the relational structure of the talk. The gatekeeping role of the bus driver therefore is similar to that of receptionists in mainly stationary environments. Therefore, there being a substantial body of work not only on service encounters but also on both gatekeeping and power relations in institutional discourse, this study comparatively explored this discourse further in one tier 3 public health facility and one tier 4 private facility in Kisumu County, Kenya. The goal of easy access to medical services has become an important one for the Ministry of Health throughout Kenya and is one of the Millennium Development Goals (MDGs) and is in line with Vision 2030, which is a national long-term development blue-print that aims to transform Kenya into a

newly industrialising, middle income country providing a high quality of life to all its citizens by 2030 in a clean and secure environment. Receptionists are very vital to the process of facilitating access for patients who need medical attention hence achieving quality life envisioned in Vision 2030.

The Vision 2030 comprises three key components which include the economic, social, and political pillars. This study was based on the social pillar which aims at investing in the people of Kenya, in order to improve the quality of life for all Kenyans by targeting a cross-section of human and social welfare projects and programmes specifically education, and training, health, environment, housing and urbanization, gender, children and social development ,and youth and sports. Under health, Vision 2030 has a flagship of projects which include human resource strategy and training. Therefore this study of receptionists and patients was anchored in the Vision 2030 specifically on training of receptionists and the expectations of patients in both public health facilities and private hospitals. In addition it strives to achieve better, fairer access to services and to improve communications and break down barriers.

Receptionists play a critical role in healthcare delivery yet their training has been neglected by policy formulators in both public and private health facilities. Their training normally include introduction to filing systems, health and safety, and very little on customer care. Therefore, many level 5 (currently tier 3) public health facilities receptionists receive no formal training and this is also the case in private health facilities (currently tier 4) where medical receptionists have no formal training in customer care but are given in house training by the human resource department. However, compared to public hospitals, private hospitals are well structured at the

reception. This is at variance with service charters of public health facilities which strive to provide innovative human resource services for specialised quality healthcare. Kenya's Vision 2030 intends to correct this inconsistency. In addition the findings of this study are intended to be used in receptionist training programmes in line with public hospitals' charters and vision 2030.

A review of relevant literature review reveals that the need to provide receptionists with better training was also seen as pressing because according to Wenger (1998), many public receptionists were doing work with serious implications for clients without fully understanding the procedures. In addition, Bolanakis (2004) argues that it is important that the repeat prescribing process in health facilities is both safe and efficient. Receptionists and clerks play a significant role in this process yet the training they receive is often unsatisfactory. Moreover, the medical training of both doctors and nurses has developed to include communication skills; the training of receptionists has remained a low priority in both government and private health facilities. In addition, Cicourel (1999:127) posits that "the clinical process begins with the discourse practices of personnel not trained in healthcare services". This study therefore investigates medical receptionists in Kenyan health facilities, who are the first point of contact for the majority of patients seeking their services.

It also emerged that, despite the growing interest in health care communication, with the exception of Cicourel (1999) who used linguistic analysis of appointment-making by receptionists in a paediatric clinic to further sociological understanding of structural and processual aspects of health care delivery, there had been no specific studies of interaction involving analysis of linguistic and interpersonal dynamics of receptionists. In the light of all

these points, it seemed that this was a context in which research findings about receptionist-patient interaction might be of some value.

Therefore, having established a substantial body of work on service encounters but also on linguistic encounters, the study explores this discourse further in a context which will bring out the linguistic and relational dynamics which eventually might be of value. The study became aware that the goal of easy access to services by patients had become an important one for the Kenyan government and it had been included in a policy statement (Muga, 2010). According to Muga (2010) receptionists were singled out as important to the process of facilitating access for patients. Moreover, it had recently been proposed that health be subject to monitoring by introduction of in-service training for all health personnel that would ensure that they maintained certain standards in all areas of their work, including performance of receptionists both trained and untrained (Ndavi, 2009).

1.2 Background of Kenya health framework

Muga (2010) states that the government of Kenya (GOK) approved the Kenya health policy framework (KHPF) as a blueprint for developing health services. It spells out the long-term strategic imperatives and the agenda for Kenya's health sector. To operationalise the document, the Ministry of Health (MOH) developed the Kenya health policy framework implementation action plan and established the health sector reform secretariat (HSRS) to spearhead and oversee the implantation process. The above policy initiatives aimed at responding to among many constraints such as inadequate management skills and training. This therefore led to the development of the first health sector strategic plan (NHSSP-I: 1999-2004) which was a follow

up to the Ministry of Health's efforts to translate the policy objectives into an implementable programme. The NHSSP-I was evaluated in September 2004 by an external team of independent consultants (Muga, 2010). It was found that among many weaknesses that there were weak management systems and low personnel morale at all levels.

As a result, the efforts made under NHSSP-I did not contribute towards improving Kenyans' health status and management and training of employees such as receptionists. Under the NHSSP-I organization of health care system consisted of national referral hospitals which provide sophisticated diagnostic, therapeutic, and rehabilitative services. The two national referral hospitals in Kenya are Kenyatta National Hospital in Nairobi and Moi Referral and Teaching hospital in Eldoret. The equivalent private referral hospitals are Nairobi Hospital and Aga Khan Hospital in Nairobi.

Provincial hospitals act as referral hospitals to their district hospitals. They also provide very specialized care. They oversee the implementation of health policy at the district level, maintain quality standards, and coordinate and control all district health activities. District hospitals concentrate on the delivery of health care services and generate their own expenditure plans and budget requirements based on guidelines from headquarters through provinces. The network of health centers provide many of ambulatory health services. Health centers generally offer preventive and curative services, mostly adapted to local needs. Dispensaries are meant to be the system's first line of contact with patients, but in some areas, health centers or even hospitals are effectively the first points of contact (Muga, 2010). Therefore because of the shortcomings of NHSSP-I and in an effort to improve healthcare sector, the second health sector strategic plan (NHSSP-II: 2005-2010) was developed. This was a renewed effort to improve

health service delivery and management in line with Vision 2030. This plan proposes to improve service delivery by using the following levels of care delivery:

Level 1, the community level, is the foundation of service delivery priorities. Once community is allowed to define its own priorities and once services are provided that supports such priorities, real ownership and commitment can be expected. Village health committees (VHC) will be organized in each community through which households and individuals can participate and contribute to their own health and that of their village. Level 2 and 3 (dispensaries, health centers, and maternity / nursing homes) will handle Kenya essential package for health (KEPH) activities related predominantly to promotive and preventive care, but also various curative services.

Lastly, level 4-6 (primary, secondary and tertiary hospitals) will undertake mainly curative and rehabilitative activities of their service delivery package. They will address to a limited extent preventive/promotive care (Muga, 2010). This study of the interaction between receptionists and patients therefore analysed the discourse realised in one level 5 (tier 3) health facility in Kenya and then did a comparative analysis with a private health facility in Nyanza (tier 4). In an effort to align health goals with Vision 2030 and global commitments, the government of Kenya developed Kenya Health Sector Strategic and Investment Plan (NHSSIP: 2012 – 2018).

1.3 Organisation of health service delivery around a four tiered health system

The health sector strategic and investment plan (July 2012 – June 2018) proposes a four tier system in service delivery. This is a departure from the second health sector strategic plan (NHSSP – II: 2005 – 2010) that divided health service delivery into level system. The tiers of

system will be community, primary care, primary referral and tertiary referral services. Community services will focus on creating appropriate demand for services, while primary care and referral services will focus on responding to this demand. This study therefore adopted a tier system with regard to both public and private health facilities by analysing former level 5 district hospital in Kisumu County, currently tier 3 and a private referral health facility, currently tier 4.These tiers include:

Firstly, the community services will comprise of all community based demand creation activities organised around the comprehensive community strategy defined by the health sector. Secondly, the primary care services will comprise all dispensaries, health centers and maternity homes of both public and private providers. Their capacity will be upgraded to ensure they can all provide appropriate demanded services. Thirdly, the County referral services will include hospitals operating in, and managed by a given county. This is made up of all the former level 4 and district hospitals in the county government, and private. Lastly, the national referral services will include the service units providing tertiary / highly specialized services including high level specialist medical care, laboratory support, blood product services, and research. The units include the former provincial general hospitals, and national level semi autonomous agencies, and shall operate under a defined level of self autonomy from the national health ministry, allowing for self governance. This study therefore analyses tier 3 and tier 4 health facilities in Kisumu County of Nyanza region in Kenya.

1.4 Reception work in Kenya

In common with other countries, most patients in Kenya receive medical treatment through the Ministry of Medical Services and private hospitals. Although the use of private hospitals in

Kenya is on the increase particularly after the government introduced a comprehensive health care scheme for civil servants (GOK 2012) in January, 2012, private provisions remain low in the primary care sector. According to Cicourel (1999) the first point of contact for public hospitals for the majority of patients is through the. In fact, over 95% of medical encounters in general hospitals take place in primary care which is 'gatekept' by receptionists.

Not only do receptionists provide primary medical care but also through writing authorise access to specialist secondary care for patients. They also determine which patients should receive direct support from nurses. Receptionists therefore facilitate access to a whole range of services (Conrales 2004). Although their central role is the provision of healthcare, general receptionists can also be seen as administrators who function as gatekeepers of a social order (Sarangi and Slembrouk 1996).

A general medical team consists of all the other personnel in the fields of health. They include nurses and specialists. Clerical workers operate within the hospital administration (Muga, 2010). Receptionists are members of this latter group although distinct within it, in contrast with other administrative personnel, who only meet members of the public occasionally; they have regular direct contact with patients. Receptionist face-to-face work with patients includes registration, appointments, admission, and monitoring behaviour at the reception. In addition to ensuring that patients' records are updated and organised, receptionists process and file the various documents which come in and out of public health facility. These include registration, tests, results and letters to hospital personnel.

In effect, tier 3 public and tier 4 private health facility receptionists have a dual role. In their public role, they act as gatekeepers for health facilities. At the same time out of the public eye, they play a part in the documentation side. Thus, receptionists, despite being service purveyors rather than service providers, play an important part in ensuring the efficient management of patients' access. Their role is vital since they stand at the boundary at the point where private person becomes the institutional case.

1.5 Statement of the problem

This is a study of interaction between receptionists at tier 3 public and tier 4 private health facilities in Kisumu County, Kenya and patients at the front desk of these hospitals. It is clear from recent policy statements (Vision 2030) that improved patient access and better communication with the public will be central objectives in the future development of the national health service in Kenya. Approximately, ninety per cent of all medical consultations take place in primary care settings, where receptionists are the first point of contact for the majority of patients. Receptionists play a demonstrably important role in health care teams, but recent research into primary care services has shown that, although they often facilitate public access, receptionists may also impede or hamper effective communication. This possibility is at variance with public and private health facilities charters and Vision 2030. Language is the primary vehicle through which receptionists carry out their work and better understanding of the typical linguistic structures and interpersonal dynamics that emerge during this interaction will make it easier to identify reasons for communicative successes and failures. This study is therefore, an investigation into language and interpersonal dynamics that emerge between receptionists and patients in two contrasted public and private health facilities, in Kisumu

County, with a view of highlighting linguistic strategies and relational dynamics that interfere with communicative competence.

1.6 Research Questions

The study is guided by the following research questions:-

i) What are the linguistic patterns and interpersonal dynamics used by receptionists and patients at the two health facilities?

ii) How are the linguistic patterns and interpersonal dynamics used by receptionists and patients at the two health facilities?

iii) How do receptionists and patients enactment their discourse roles and identities?

iv) How do linguistic patterns and interpersonal dynamics influence the construction and orientation to institutional power?

1.7 Objectives

The objectives of this study are:-

i) Identify linguistic patterns and interpersonal dynamics used by receptionists and patients at the two health facilities.

ii) Analyse the linguistic patterns and interpersonal dynamics at two health facilities in Kisumu County, Kenya.

iii) Examine how receptionists and patients enact their respective discourse roles and identities

iv) Investigate the extent to which these linguistic patterns and practices are implicated in the construction and orientation to institutional power.

1.8 Justification of the Study

Despite the growing interest in health care communication, with the notable exception of the work of Cicourel (2001) who used linguistic analysis of appointment-making by receptionists in a pediatric clinic in Britain to further sociological understanding of the structural and processual aspects of health care delivery, Hewitt (2006) who studied transactional patterns between drivers and passengers and Ojwang' (2010) who analysed pragmatic practices between nurses and patients, there has been no specific study of discourse patterns and the emerging interpersonal dynamics between receptionists and patients. In the light of all these, it seems that the findings of this study about receptionists – client interaction might be of some value specifically in Linguistics, policy makers, literature review and methodology.

The discourse patterns through which reception work is accomplished at the two health facilities is found to consist of four levels. These are present in varying combinations in different activity types but are always enacted through predictable combinations of moves and realised through a range of speech routines and conversational acts. This is a contribution to linguistics with regard to speech routines used by receptionists and patients.

In addition in terms of policy makers who emphasise on improving the quality of life for all Kenyans and services in both public and private health care sector line with Kenya's Vision 2030, this study proposes ways of improving receptionists' communication through training thereby providing patients' satisfaction.

A review of relevant literature review revealed similarities with other service encounters in other contexts. However, this study makes contribution on the interpersonal dynamics that

emerge as a result of these linguistics patterns. Different choices of speech patterns encode differing levels and styles of face protection, which appear to be conditioned by factors such as the social environment of each health facility, the preferred relational choices of individual receptionist and level of imposition that an activity type entails. This is a contribution to the literature review with regard to the relationship between speech routines and interpersonal dynamics enacted by receptionists and patients.

In terms of methodology, this study has borrowed from other studies with similar settings especially in the health sectors. The study has borrowed Ojwang's (2010) research design, Silverman's (2001) qualitative data analysis techniques, Hewitt's (2006) speech categories and research ethic and Labov's (1997) analysis of speech routines in institutional discourse.

1.9 Area and scope of the study

The study focused on receptionists and patient interaction in one tier 3 public health facility and one tier 4 private health facility in Kisumu County, Kenya. However, the study did not analyse discourse realised between medical practitioners and patients. The focus of the study was on spoken discourse and how receptionists and patients construct their roles and identities through their spoken language. In addition, the study also analysed how receptionists enact their power by having authority to make decisions which affect the patients. Expert analysis of what receptionists actually say might make it possible to introduce new elements into training programmes, particularly in order to help them to deal with difficult situations. The two health facilities are located in Kisumu County, Kenya.

1.10 Theoretical framework

This study is based on Goffman's (2002) theory of roles and identities. Goffman, (2002), Sarangi and Slembrouk (1996) observe that subjects are always speaking from within one or other role and the essentialist idea of a unified social subject – role-less true self is lost. Goffman (2002) has made an influential contribution to the understanding of roles and positions which are taken in talk. His thinking covers three concepts: participation frameworks, footings and frames. The term participation framework captures the idea of the set roles open to speakers and hearers. This study analysed these positions which individuals within perceptual range of an utterance may take in relation to what is said.

Roles are developed as speakers assume footings. According to Goffman (2002), the alignments speakers and hearers take up present as expressed in the way they manage the production or reception of an utterance. He describes this as capacity of the dexterous because speaker jump back and forth hence keeping different circles in play. In keeping different roles, speaker recreate frames, the organisational and interactional principles by which situations are defined and sustained as experiences. Goffman (2002) further identified four speaker footings: animator, who produces the utterance, author, who determines what will be in it, principal or originator, who is responsible for it, and figure or character, the persona enacted in it.

Aspects of Goffman's (2002) theoretical framework have been suggestively used in this study of receptionists-patients talk. In the current study there entitlements and responsibilities associated with relational frames, so that failure to align to a frame or failure to sustain the appropriate footings will be noticeable and negotiation will take place. In addition, according to

Goffman (2002) speakers use frames or metastatements to signal their transactional as well as relational discourse goals: in other words goals in both getting things done and getting along.

An additional feature of Goffman's (2002) system is the 'key' which indicates a change of footings. He draws attention particularly to the keying effect of reporting forms (mentioned discourse, direct discourse and quoted discourse), lexical markers (real and hypothetical), verbs and particles, direct quotation, prosody, demonstratives and other deictic forms, also referred to as shifters. He makes a more general observation that changes of frame and footing are keyed through changes of register, demonstrating his point in a discussion of a consultation in a paediatric clinic, where he finds three observable registers, casual conversation, motherese and reporting, which are associated respectively with social encounter, consultation and examination frames.

Above all, according to Goffman (2002) in institutional environments in which specialists and lay persons interact, interactive frames can clash, since linguistic cues do not always work in the same way for every participant. His example is the word 'wheezing' which triggers a common sense interpretation in a mother (breathing sound) and a clinical one in a doctor (interruption in air passage).

In the current study, different roles are constructed through emergent participant identities, which are salient on the basis of fact as Goffman states that people are contingently sensitive to who they relevantly are, where they are, what they are attempting to do, and what is expected of them. He further proposes three forms of identity: discourse identities (such as speaker/hearer, questioner/answerer), which are a feature of the immediate organisation of talk; situated

identities (such as nurse/patient), which relate to the activity engaged in; and latent transportable identities (such as male/female), the physical or cultural attributes which move with individuals across situations and on which they are able to draw.

Goffman (2002) has therefore shown that a multiplicity of positions is open to speakers and listeners. In the institutional context, participants can draw both on their lay identities and their officially sanctioned roles. McElhinny (1995), for example, shows how female police officers attending scenes of domestic violence switch at boundary stage of encounters from their official identities, marked by long silences, the absence of backchannel comments and missing responses in adjacency pairs, to their gender ones, marked by a more affiliative style. The role thus allows for the expression of both these identity types. It is also open to lay participants to appropriate an institutional identity by using the language conventionally associated with it.

In addition, as Roberts and Sarangi (1999) point out, both groups can have particular identities ascribed to them. This is the case in an episode described by Hall, Sarangi and Slembrouck (1997), in which, by highlighting negative characteristics, social workers construct a deficit client, who lacks the necessary competence to act independently. This example is characteristic in that it is the institutional member who performs the identity ascription and provides support. Agar (1985) states that there is a diagnostic stage through which the institutional representative fits the client frame to the institutional frame.

Sarangi and Slembrouck (1996) find that institutional representatives have a strong tendency to impose routine procedures without attending to the client, seeing this as part of their rationally and efficiently managing the needs and wants emerging from the private domain. They posit

that both bureaucrat and client have pre-inscribed roles and that of the client is more limited on a number of counts. First, stories told by clients will be interpreted by bureaucrats in direct relation to the institutional agenda; second, non-relevant client moves are liable to be ignored as opt-outs from institutional routine and therefore suspicious; third, clients are obliged to comply with all routine stages before reaching their goals; fourth, the bureaucrat is assumed to be cooperative and trustworthy but the client has to prove credentials; fifth, clients are expected to answer questions but may not have their own question answered; sixth, bureaucrats can withhold information but, if they wish to achieve their goals, clients can not. In short there is power differential between institutional representatives clients, which results from their differing levels of knowledge and responsibility and leads both to an unequal distribution of speaking rights and limitation on the client's capacity for conversational manoeuvre.

Hence in the present study, health facilities receptionists are in the role of bureaucrats and patients are the clients. In addition the status of receptionists within the organisation which they represent is low and their remit is to serve patients by facilitating their access to the free health care to which they are entitled. There is thus potential in the frontline interface between receptionists and patients not only for foregrounding of different aspects of participants identities but also for negotiation of authority and power.

1.11Research methodology

1.11.1 Introduction

Although, like all cultural representations, research studies are constructs which are shaped to some extent by the current interest, theories and methods of the researcher (Hewitt, 2006), this does not preclude the systematic analysis of the structure and patterns through which action and

interaction are encoded. This study is qualitative in the sense that it is an attempt to identify the patterns and meanings which underlie naturally occurring episodes of interaction, but it also aims to meet the rigorous standards necessary to ensure the validity, reliability and objectivity of the findings. Denzin and Lincoln (1994) state that, first, internal validity is the degree to which findings correctly map the phenomenon in question; second, external validity is the degree to which findings can be generalised to other settings similar to the one in which the study occurred, third, reliability the extent to which findings can be replicated, or reproduced, by another inquirer; and lastly, objectivity is the extent to which findings are free from bias. Therefore, this section analysed the research design, the area of study, the study population, sampling procedures, data collection procedures and data analysis techniques used in the study.

1.11.2 Research design

A design is the arrangement of conditions for collection and analysis of data in a manner that aims to combine relevance to the research purpose with economy in procedure (Kothari, 2003). This study is based on a case study which is an in-depth study of an individual, groups, institution, organisation or programme. The study is also qualitative in the sense that it attempted to identify the patterns and meanings which underlie naturally occurring episodes of interaction between receptionists and patients in one tier 3 public health facility and one tier 4 private health facility in Kisumu County. It also aimed to meet the rigorous standards necessary to ensure the validity, reliability and objectivity of the findings which have already been earlier.

1.11.3 The area of study

The investigation was carried out in one tier 3 public health facility and one tier 4 private health facility in Kisumu County, Kenya, after obtaining permission to carry out the research. In order to capture the area of study it was necessary to analyse the following: ethnography,

contextualisation, then seek institutional authorisation to carry out the research in these areas. It was felt that it would be useful to collect information on the health facilities setting to ensure that the verbal interaction would be properly understood. The following section contains a summary of the information about the two health facilities where recordings were made. It hasbeen collated from a variety of sources including observation and field notes, research diary, interviews and the patient questionnaire.

Before data could be collected, authorisation had to be obtained from the health facilities under study. Their permission was to ensure that the research would not pose any risk to their institutions or to their patients and to ensure that the results could be of practical value to staff and patients. The process of making contacts within the health facilities, of building up working relationship and developing mutual understanding, was, as predicted by others working in unfamiliar institutional environments, a slow one which demanded both patience and determination. At this stage, and indeed throughout the period of the study, the researcher was dependent on the goodwill of individuals already working in the ministry of health and these health facilities and consequently always felt that it was important to make the best possible impression on the people encountered. This was an illustration of the point made by Hammersly and Atkinson (1983) that people are often more concerned with what kind of person the researcher is than with the research itself. The researcher's first contact was with an experienced hospital administrator within the ministry of medical services, who had been involved in research and training for many years, and with the director of basic health care within the ministry of health who is involved in promoting primary health care in the ministry of health in Kenya. Through them the researcher was introduced to several health administrators who supported the study by facilitating contact with health facilities in Kisumu County.

1.11.4 Study population

The target population of the study consisted of seven receptionists in tier 3 public health facility and tier 4 private health facility and ten thousand patients who visited these facilities for a period of one month. Patients were recruited by self-selection, that is, by opting in if attending the hospital while the study is in progress. As Table 1 shows, the two health facilities differ in the number of patients who visit these facilities.

Table 1: Information about the health facilities

Facility code	Number of receptionists.	Approximate number of patients per day.	Socio-demographic profile.
A	2	700	Urban, Lower class.
B	5	300	Urban, Middle class.

1.11.5 Sampling procedures

A sample is the group of participants whom the researcher actually examines in an empirical investigation (Dorney, 2007). He goes on and says that in linguistic research, a data range of between one per cent to ten per cent of the population is usually mentioned as the magic sampling fraction, with a maximum of about 100 participants. Milroy (2002) further posits that linguistic samples are usually too small to ensure that the set of persons selected is representative of the population as a whole, in the sense that findings can be extrapolated from the sample to the population within measurable and statistically specifiable confidence limits.

1.11.5.1 Recruitment of patients

To answer the research questions satisfactorily, it was essential to obtain examples of naturally occurring interaction from the reception discourse of the two health facilities in Kisumu County. The study refers to talk which is not the product of experimental conditions but would occur in some form regardless of the presence of a researcher or recording equipment. Therefore, this study used iteration and saturation when selecting the patients in the two hospitals in Kisumu County.

The researcher selected patients until that point when additional data by the patients do not seem to develop the concepts any further but simply repeat what previous patients have already revealed. In other words, saturation was achieved at one hundred patients.

1.11.5.2 Selection of health facilities

A total of ten health facilities in Kisumu County were approached individually and asked if they would be willing to host the research. If the response was positive, contact was made with the health facility and the administrators and a letter sent to receptionists explaining the nature and scope of the study. This was done to ensure that the research would only be carried out if there was still consensus that it should go ahead after all the potential participants had been informed about the research method.

As mentioned earlier, these health facilities had a different social and demographic profile which was required in order to provide a broad based sample. The two health facilities where recordings were made were accordingly chosen partly because of their contrasting social profiles, willingness to take part in the research, the number of patients visiting these facilities,

and accessibility to the facilities' administrators. Therefore their sampling technique was purely purposive in nature. Therefore, each hospital administrator of the two facilities chosen was sent a letter designed to explain the aim of the research, the research method, and what the research would entail the receptionists. The response of each health facility was slightly different. The administrator at the public health facility (thereafter A) held a meeting at which the latter was shown to all receptionists, who immediately agreed to participate in the research. The manager at the private health facility (thereafter B) agreed that face to face interaction at the reception could be recorded subject to the unanimous approval of receptionists, which was subsequently given.

1.11.6 Data collection techniques.

1.11.6.1 Tape recording

Recording of face-to-face interaction between receptionists and patients procceeded very smoothly at all the two health facilities. The tape recorder was always placed next to the receptionists' work stations while the researcher monitored the flow of patients a couple of metres away. There are a total of approximately 48 hours of tape recording: 24 hours from health facility A, and 24 hour from health facility B. Recordings were carried out at different days at each of the health facilities. There were two and a half hours of recordings at each facility for ten days each spread in one month. In addition to the receptionists-patients interaction, recordings include periods of silence as well as conversations between receptionists and other members of staff or visitors to the health facilities who are not patients, and comments made by receptionists to the author and the research assistants. As mentioned above, recordings of telephone interaction was less successful. At the health facility A there were no telephones at the reception desks while at the health facility B, there were telephones at the reception but the

telephone system was too complex and it was therefore decided to abandon this aspect of research.

1.11.6.2 Interview schedules

There are two receptionists at health facility A, all of whom are not permanent employees and five receptionist at health facility B who are all permanent employees. All the receptionists at all the two health facilities consented to be recorded but recordings were only obtained of four receptionists, two at facility A coded RA1 to RA2 and two at facility B, coded RB1 to RB2, because the researcher had to alternate between the two facilities at intervals. These recordings were only done when these receptionists were on duty and therefore the researcher had to adjust hid diary according to the availability of these receptionists. The researcher obtained information about receptionists and their work in three ways: through semi structured interviews, which were conducted in the facilities before recording began, through observation and note taking and through listening to interaction between receptionists which was captured on audio tape.

1.11.6.3 Questionnaires

In contrast with receptionists, patients were only informed about the research as they arrived at the health facilities on the day of recording. If they were willing to take part, they were asked to hand in a consent form to a receptionist when they got to the reception and also complete the four point questionnaire which asked information about age, gender and attendance to the health facilities. Those who failed to consent to the study were mainly on the grounds of haste or from people who simply wanted directions to different hospital departments and did not think their

participation worthwhile. Details of the consent patterns for patients at the two health facilities per day have been shown below.

Table 2: Consenting patients

Facility.	**Female.**	**Male.**
A	70	30
B	65	35
TOTAL	135	65

Although consent rates varied slightly from facility to facility, at all the two there was a higher rate for females than males. This corresponded with the higher attendance rates for females at all facilities. Questionnaires were completed by 70% of consenting patients at health facility A, and by 60% at health facility B. Findings from the questionnaires indicate that females outnumber males in all patient age groups. The largest single group in both facility A and B is of females between the ages of 26 and 40. The numbers for males increase through the first two age bands, remain stable between ages 41 and 60 and the decline. Answers to the questions about attendance to the health facilities have not been collated because most patients were often uncertain. However; they have been used to explain the discourse patterns between receptionists and patients.

1.11.7 Data analysis

Data analysis involves sifting, organising, summarising and synthesising the data so as to arrive at the results and conclusions of the research (Seliger and Shohamy 2011). This study employed qualitative data analysis technique. Silverman (2001) asserts that the five most important techniques in qualitative data analysis include: analytic induction, the use of constant comparative method, the search for deviant cases, comprehensive data treatment and using appropriate tabulation. Using these methods the researcher approached the data with a general idea having generated the research questions, tested these questions repeatedly on all the data generated, assigned the data consistently to categories, identified deviant cases, that is, cases which the research questions did not account for, reviewed the questions in terms of the underlying conceptual framework in order to account for the deviant, or negative, cases. This approach will also allow the researcher to use appropriate tabulation i.e. to create a comprehensive taxonomy and to count instances of phenomenon.

Therefore, the qualitative approach does not have to be seen as the antithesis of a quantitative one since as Hammersley (1992:163) points out "we are not faced with a stark choice between words and numbers, or even between precise and imprecise data, but with a range from more to less precise data. These were the analytic methods that were used for this study. Frontline interface activities were identified, and classified into groups until all instances had been accounted for. Both recordings and transcripts were also subjected to continuous review as new categories emerged. The theoretical framework was then applied to each category and discourse patterns identified and accounted for.

1.12 Ethical considerations

Hewitt (2006) states that ethical issues underpin all relationships between researchers and researched. Therefore in the Kenyan context and specifically in Kisumu County, all research work done at the health facilities is subject to strict ethical control and must be approved by research ethics committees of respective health facilities. These committees ensure that both patients are protected and that the research complies with healthcare ethics. Since it was proposed to conduct this research in health facilities in Kisumu County, a request for ethical approval was made to the hospital administration sub-committees on ethics of the two health facilities which deal with application to carry out research in primary care settings. Approval of the research was granted in the tier 3 public health facility upon the researcher appearance before the hospital administration but the approval in the private health facility was granted on the understanding that several additional points were included in the research design, notably:

i) The researcher should not be able to overhear interviews for which consent had not been granted

ii) Patients should be advised that withholding their consent would not affect the treatment which they receive. Approval came from the tier 3 public health facility in June 2012 and from the private health facility one month later.

To conclude, therefore, the research ethics committees of these facilities ensured that requests to carry out research were given careful scrutiny, covering issues such as scientific responsibility, informed consent, confidentiality and anonymity for participants. Hence it was within the ethical considerations described above that the research methods were formulated and implemented.

1.13 literature review

1.13.1 Introduction

How data are to be analysed is partly determined by the desired relationship to other studies while awareness of relevant or related studies both helps the researcher to avoid analytical traps and makes it possible for the findings to be used to inform and develop knowledge within existing model (Antaki 2002). This study was situated within the broad institutional context of research into the delivery of health care but its main relationships are with studies of institutional discourse in general, service encounters and institutional gatekeeping. Therefore, in this chapter, the study reviewed studies of the institutional contexts of reception work. The researcher also examines the main frameworks adopted in studies of encounters involving institutions and lay participants. Detailed reviews of the forms in the two institutions in Kenya with regard to frontline interface are then provided: service encounters, gatekeeping encounters and doctor patient encounters. Finally the study then outline studies which have been adopted with regard to the use of naturally occurring data to inform training programmes for health facilities receptionists.

1.13.2 The healthcare discourse in Kenya

The encounters between receptionists and patients who were considered in this study took place in one tier 3 public health facility and one tier 4 private health facility, which are part of the healthcare system in Kenya. The structure and the ethics of these health institutions affect the behaviour of both the receptionists and patients. Moreover the front desks of these institutions have their own distinctive beliefs and practices. Therefore in this section the study outlines issues of health care before analysing studies of the work of receptionists.

Hyden and Mishter (1999:185) commented that "the health field has become a contested space where alternative conceptions of illness and treatment compete with the dominant tradition of scientific medicine" The dominant tradition is captured by Ojwang's (2010) view that there is an unwritten contract between physician and patient: the physician's technical expertise entitles them to the institutionally ratified role of healer while the patient has an accepted sick role, whose characteristics include exemption from normal social responsibility and the obligation to seek technically competent help in order to achieve the goal of recovery. While the most notable features of the medical role are objectivity, effective neutrality and technical competence, those of the sick role are helpless dependence, emotional involvement and technical incompetence.

According to Lawton (2003) there has been a shift of a patient being a dependent outsider towards an increase in lay involvement in medical decision-making and an acknowledgement of the value of the individual's subjective experience of illness. In this interpretation, the sick role has been superseded by the health role in which the individual assumes responsibility for health maintenance through appropriate lifestyle choices, thereby further reducing the centrality of the physician. In addition, there has been an increasing influence of corporate managers on medical agendas, for example through media campaigns. They are required to work in bureaucratically organised institutions under a new cadre of managers. In Kenya, Kenyatta National Hospital, a government institution is currently managed by a non-medic CEO which was not previously the case (Ndavi, 2009).

In Kenya, the trend towards increased lay involvement was reflected by the introduction in 2009 of the patient's charter (Ministry of Medical servicers strategic plan, 2008 – 2012), a document which was designed to redress the clinical balance in favour of patients and involve them in

medical decision making at all levels. The trend towards centralised corporate management has also been reflected in changes to the administrative structure of the ministry of Medical Services. Historically, Kenya has had a centralised approach to health care systems decision making (MOH 2012). Centralised functions at the headquarter level in the ministry of Health (MOH) include policy formulation, coordinating activities of government and non-governmental organizations, managing implementation of policy changes regarding government services such as user charges, and monitoring and evaluating the impact of policy changes (MOH, 2012).

Hence, as Hyden and Mishler suggest, a mixture of attitudes and approaches is likely to be found. While the influence of central decision-making cannot be denied (Ndavi, 2009) there is still also a place for what Williams and Calnan (1969:7) described as the "preferred self-image of the medical world as a scientific morally neutral and value-free institution, predicated upon an altruistic concern for both patient and community welfare." Similarly, although in some situations, patients may be active participants both in health care and health maintenance, in others, as Shilling (2002: 635) reminds us "the traditional parsonian approach towards the sick role may continue to retain some value for analysing the medical relationships of those who are unable to access, or are alienated from the proliferation of health related information".

Changes in attitude and outlook have an impact on communicative style. Ojwang (2010) suggested that, by putting serious time constraints on doctors and removing the incentive of competition, the nationalisation practice had led to the development of a communicative style, the bureaucratic format, which was impersonal, highly controlled and relatively uninformative. Ojwang (2010) also points out that it pays doctors to be polite to the great mass of patients

because the financial positions, prestige and degree of self-control of professional as a whole are under direct political management.

Although Ojwang (2010) was thinking primarily of the communicative approaches of physicians, it's anticipated the divergent views of health care provision will also be reflected in the discourse positioning of receptionists and patients and may influence their construction and understanding of the interaction, as will the primary care experiences of the two groups and their attitudes to one another.

1.13.3 Receptionists and discourse

Hewitt (2006) reports that Copeman and Zwanerberg (1988) were interested in the attitudes and experiences of receptionists. Copeman and Zwanerberg (1988) interviewed 70 receptionists from 20 hospitals. Respondents were asked what they considered to be their most important function and without exception their responses concerned the patients and the services the patients need. The same point is made again by Eisner and Britten (1999) in their survey of receptionists' thoughts and feelings about their work: "…receptionists gain satisfaction from helping patients." (1999: 105).

Hewitt (2006) goes ahead and posit that the low status of receptionists in health facilities is among the points raised in several papers. Gosling (2002) found an economic reflection of low status in the discovery that receptionists who were promoted to the post of practice manager from within a hospital earned much less than those who were recruited to the job from outside. On training that only 10% of receptionists had received any formal training and were inadequately trained and excluded from decision–making processes (Ndavi, 2009). This was a

source of difficulty for them, exacerbating the already high level of stress which they experienced. There are a number of papers in which proposals are made for remedying this situation through further training. Hewitt (2006) cites studies by Essex and Bate (1991) which demonstrate that the competence of receptionists could be extended to include audit of achievement of practice goals in their job descriptions, and Patterson et al (2000) and Coward (2003) who describe training schemes which would allow receptionists to take additional responsibility for patient assessment.

Hewitt (2006) reports that one of the reasons for high stress levels among receptionists may be the disparity between their low status and the high level of responsibility vested in them particularly through their control of the allocation of appointments. The gatekeeping role of receptionists was investigated by Arber and Sawyer (1985). They found that patients are more likely to experience the receptionist as a gatekeeper when they interfere in medical affairs which are not seen as their legitimate province when formalised roles which lead to inflexibilities are introduced to manage a mismatch between patients needs and the number of appointments available, and when patients particularly young adults and the mothers of young children are typified as over-demanding.

Gatekeeping by receptionists is also the focus of a number of subject studies. Hallman (1993) who used a postal survey to canvas the opinions of patients in four hospitals on access to doctors by telephone found that receptionists were regarded as obstructive. Gallagher et al (2001) demonstrated how receptionists control access to appointments and Offredy (2002) pointed out that over-zealous gate keeping can also lead to infringement of the patient's rights

to privacy. Patches et al (2001) reveal how receptionists often fail to maintain confidentiality for patients who are HIV positive.

Hewitt (2006) says that frontline is often used to refer to the situation of receptionist. Hewitt emphasises that receptionists are always on the frontline.She goes on and postulates that one of the difficulties of receptionists being on the frontline is that they are the first point of call of services and sometimes they aren't able to deliver what patients expect.

Being on the frontline can also mean being in the firing line. Heuston et al (2001) outlines the problems faced by receptionists when dealing with substance abusing patients. Naish et al (2002) discover that receptionists are the group most likely to face aggression from patients. Dixton et al (2004) find that over two thirds of the receptionists had experienced some form of verbal abuse over the previous twelve months. Threatening or abusive behaviour was the most common reason given to Munro et al (2004) by general hospital receptionists for removing patients from their lists with almost half of instances involving verbal abuse towards receptionists. The picture which emerges from studies described above is of a group of workers who, though well-meaning, often find themselves interacting with clients who have generally negative attitudes towards them in situations which they lack either authority or training to deal with. These findings were also looked at in this study through interviews and observations of the receptionists, as well as by informal discussion with many health service users.

1.13.4 Discourse frameworks

Psathas (1995) reports that interlocutors in institutional and lay worlds like receptionists and patients tend to develop standard practices to manage the duties of their encounters. Due to this

discourse structures develop which are characterised by a task related shape and with a predictable ordering of stages and recurrent structures. Therefore participants in discourse are aware of these patterns.

Several discourse frameworks have therefore been analysed. Conversational analysts such as Zmmerman et al (1991) are interested in the turn by turn construction of talk by saying that it is only within these talks that institutions are talked into being. However, this study goes deep to analyse the emergent relational patterns of interlocutors. However, one of the main breakthroughs of conversational analysis has been the demonstration of how conversational participants place themselves to the activities in which they are involved and develop these discourse strategies based on these set up.

Another discourse framework developed by genre analysts, aim to identify the rules which combine to create a genre. This was developed by Bhatia et al (1993) at it includes a series of obligatory patterns which in turn are constructed from predictable moves and also include roles for interlocutors. However, according to McCarthy (2000) the genre model which is based on transactional goals cannot account for interpersonal dynamics even if such talk may appear to be unmotivated. McCarthy (2000) concludes by saying that there has been a shift to interest in the relational features as opposed to transactional features only. Therefore this study intends to pursue these interpersonal dynamics further by analysing receptionists and patients in health facilities in Kenya through Goffman's (2002) roles and identities theory.

Ventola (1989) works with another model called systemic functional perspective. He creates a comprehensive taxonomy of classroom interaction, accounting for both macro and micro levels

of discourse organisation in a rank scale model. This consists at its highest level of lessons and continues through transactions and exchanges to the micro organisation of individual moves and speech routines. However according to Hasan (1990), the rank scale model privileged the sequence of discourse elements over global text structures and failed to include individual optional elements and various conventions of how relational patterns sequence the elements.

Brown and Levinson (1987) came up with an influential model of politeness, which divides face into negative wants, the want of every competent adult member and that his actions be unimpeded by others, and positive ones, the want of every member that his wants be desirable to at least some others. According to Brown et al (1987) limitation of either of these wants is perceived as a face threatening act, in which face saving strategies can be used. Negative wants demand linguistic enactments of formality, deference and social distance while positive ones call for shows of informality, camaraderie and solidarity.

However, while the importance of politeness model has been widely acknowledged, it has been recognised by the proponents themselves (Brown and Levinson, 1987) that there are shortcomings in their Universalist, speaker centered system. That the degree of attention to face varies between genders, cultures, nations, setting, individuals and social set up. Hickey et al (2005) observe that interactional accomplishment emerge in talk rather than drives it. Therefore in this understanding, politeness model cannot be evaluated without contextual information and that no utterance encodes a specific face meaning and both speaker and hearer are important in the enactment of face behaviour. This study therefore intends to bridge this gap by analysing the emergent linguistic and relational behaviuor of both receptionist and patients in different environments or contexts.

Therefore in the models described above, the problem can be said to have arisen due to use of different frames by interlocutors and therefore they had divergent interpretations of their roles. Like in other institutional- lay encounters, the roles and identities of receptionists and patients are pre determined by their duties and objectives but they may also find themselves in situations where a choice is possible, for example, between institutional and lay roles or between medical and life world identities. Hence this study uses Goffman's (2002) roles and identities to analyse the linguistic patterns and interpersonal dynamics that emerge between receptionist and patients in health facilities in Kenya. This has not been analysed by the preceding frameworks.

1.13.5 Discourse encounters

Lamourex (1988) has demonstrated that the service encounter is a speech genre which involves a complex process of rhetorical adjustment, with the result that mastery of it can cause difficulty for certain groups while Goffman (1983) chose the service encounter to exemplify and demonstrate his understanding of micro-constitution of social order. Goffman (2002) concentrated on routinisation, the presence of relationship rituals and the contextual combination of local determinism and externally-based attributes, all themes which have been taken up by others. Although Boxer (2002), following Tracy (1997), claims that there is a distinction between service encounters and institutional ones, on the ground that the money changes hands in the former but not in the latter, a receptionist-patient encounter matches the definition of service encounter by Merritt (1976).

The first significant work on service encounters, Mitchell (1975) studied the patterns of interaction during street trading to create what McCarthy (2000:85) describes as "seminal account of staging and sequencing of extended spoken events. From this Hasan (1985:64) used

the "generic structure potential to map the total range of optional and obligatory elements in their order", while Ventola (1987) developed flow-chart to account for the occurrence of repetition and recursion in service encounters, focusing on the stages which must, or might, occur before a transaction is completed. Earlier, in a study of encounters recorded in shops on a university campus, Merritt (1976) had analysed the individual moves and turns from which the service encounter is built. She anatomised the exchange structures exemplified by adjacency pairs, insertion sequences and other two or three part units of interaction in microscopic detail.

Merritt (1976) drew heavily on the ideas of Goffman (1983), as well as those of conversation analysts, whose insights she applied and developed. Jefferson and Lee (1981, 1992) also use conversation analysis (CA) techniques to dissect the genre clash between a service encounter and a trouble-telling, and document the types of constraint inherent in both the form and the content of the genre.

According to Hewitt (2006), there has been a move in service encounters studies away from interest in the distinctive shaping of the exchange structures towards the construction of interpersonal dynamics. McCarthy (2000:90) is typical in his view that the relational side of discourse in geners, is of equal relevance to the achievement of goals as the transactional staging of predictable elements. Using communication accommodation theory (CAT) as the basis of their interpretation, Ylanne-McEwen and Coupland (2000:190) show how speakers in a travel agency reduce linguistic or communication differences between themselves and their speaking partners as they bid to make their communication more effective. Kuiper and Flindall (2000:184) suggest that although participants make use of rituals and routines because there is

little room for free and unconstrained linguistic performance in many situations, there is nevertheless room for individually idiosyncrasy and even for a small measure of creativity.

Hewitt (2006) states that linguistic politeness is one of the main tools of the relational side of service encounters and has generated wide interest among researchers interested in cultural variation. Bailey (1997), Mayes (2004) and Ryoo (2005) all discover differing norms for the expression of politeness in the speech of different cultural groups in the United States, while at the other end of the politeness spectrum, Buttny and Williams (2000) discuss narratives of disrespect in inter-racial discourse. In an Asian context, Kong (1998) shows that politeness norms can vary according to the type of encounter, or the anticipated length of service provider/service user relationship, Pan (2000) posit that the differences in norms can also arise when the same type of encounter takes place in different social settings and Chan et al (2004) states that although Chinese and Filipino participants in service encounters have different attitudes to rapport promotion, in both cases the client is dependent on the good will of the provider. In South America, Marquez-Reiter and Placencia (2004) find differing norms of politeness displayed between providers and clients in large stores in the capital cities of Uruguay and Ecuador while, in an earlier study, Placencia (2001), found less respect shown for marginalised social groups than economically strong ones.

There have been only a small number of discourse studies of service encounters involving receptionists. Schneider (1988) was among the first to recognise the strategic use of small talk in his examination of the language of hotel receptionists. Kidwell (2000) has shown how sequential and institutional contexts provide support for non-native speakers in their interaction with a receptionist at a language school and Channel (2000) has engaged in linguistic

consultancy work in an attempt to help town hall telephonists to provide a better service. In the health context Bastos (1996) analysed face to face receptionist-client interaction at a health insurance office, finding that linguistic markers of power and solidarity were used differently with receptionists by speakers from different social backgrounds and with differing levels of knowledge of institutional practice. She also noted that clients allowed themselves to be patronised by attendants but not the reverse although, in contractual talk in particular, clients claimed power by attributing requests to authority figures and demonstrating knowledge of administrative procedures or office working practices. Bastos found that the most difficult encounters were those involving middle employees of accredited medical services. These clients did not accept the asymmetry in the receptionist's favour whereas low-status clients did. Bastos concludes that her study is consistent with the assumption that individuals manipulate to their own benefit emotional and personal connections of discourse.

1.13.6 Gatekeeping discourse

Hospital receptionists are gatekeepers to registration, appointment and repeat prescription services. Erickson and Schultz (1982: xi) define institutional gatekeeping encounters as "brief encounters in which two persons meet, usually as strangers, with one of them having the authority to make decisions which affect the others' future". The essence of gatekeeping work is the legitimisation of membership credentials. Following the lead of Sacks (1992) in his analysis of telephone calls to a suicide prevention centre, conversation analysts have shown in great detail how, when negotiating these claims, both gatekeepers and clients orient to typification ofevents and cases. For example, Zimmerman and his collaborators (1990) have shown communicative frames are used and claims shaped in calls to various emergency services.

Predictable sequences which they identify are epistemological display in which callers categorise problems and explain how they came to know of the events in question and interrogative series in which call-receivers elicit all the information necessary for the emergency centre to react to the call. Additional studies of emergency calls include the work of Perez-Gonzalez (1998) who refers to the findings of Whalen et al (1988) but adopts a framework which owes more to the theories of Halliday (1961) and Sinclair and Couther (1975). In his close analysis of a call for emergency assistance he shows how the clash between the action-orientation of a caller's turns (the wish for immediate action to be taken) and the knowledge-orientation of the call-taker's stance (the need to elicit essential information from the caller) in the service bid stage impedes successful communication between the two participants (c.f Ventola, 1987).

According to Erickson and Shultz (1982:25) "suspicion is institutionalised as part of the official role" which means that clients must demonstrate their entitlement to access. Linell and Fredin (1995:303) who have shown how this is achieved in a social welfare office suggest that conflict may develop because "…these verbal exchanges between professionals and clients often develop into arguing from two different positions, the norms and categorisations of the social welfare and the rationalisation of the client's everyday life world. They go on to point out that it may be that the social worker as a person embodies a negotiation between different identities of his or her self or between different voices within his or her own mind, speaking at one moment in the voice of the lifeworld, at another, as the voice of the institutional system.

Zimmerman's (1971) insight that rules are always indeterminate, with no neat fit to reality, they argue that abstract categories have to be contextually interpreted through a negotiation of

definitions and interpretations, which may even lead to modification of rules and categories because of the inherent reflexivity between language and its situated use. The more of an outsider the client, the more difficulty this type of negotiation is likely to present. Many of the most influential studies of the working of gatekeeping practices deal with the cultural barriers which obstruct legitimisation and access. In their work on interviews between academic adviser and students, Erickson and Schultz (1982) have demonstrated how co-membership is constructed on the basis of cultural compatibility, suggesting that the gatekeeping game is rigged in favour of those individuals whose communication style and social background are most similar to those of the interviewer. They think it possible that behavioural regularity, especially rhythmic regularity, may be prima facie evidence of shared interpretive frameworks and arrhythmia a sign of social disjunction. Gumperz (1997) has also created an extensive body of reports of gatekeeping encounters, showing how the use and interpretation of linguistic and paralinguistic cues, which vary according to one's first language or cultural background, lead to miscommunication and misunderstanding.

These insights have been applied in the healthcare context by Sarangi and Roberts (1999) who have analysed interviews for admission to membership of Royal College of General Practitioners in a bid to determine why minority ethnic candidates who had trained abroad were consistently assessed less positively than their white and ethnic minority counterparts who had trained in Britain. They have found that one has to manage to talk like a legitimate participant in order to become accepted in the inner circle, which is characteristic of most gatekeeping encounters. The problems faced by patients who are non-native speakers are discussed by Cameron and Williams (1997) who, using a relevance theoretical approach, consider the

importance both of professional knowledge and the capacity to make inferences for the successful pursuit of instrumental and communicative goals.

The issue of patient access is the focus of Jean's (2004) study of gatekeeping (termed intake screening) practices of receptionists (termed front-office workers) involved in appointment making in Ophthalmology and oncology clinics. Jean concentrates on the variations in interactional styles between restrictive screening practices which are associated with the rationing of services and inclusive screening which is associated with appointment making. In the former, a narrow range of information is considered whereas in the latter the format is open-ended. Jean observed that front - office workers typically juggle many tasks simultaneously and that there is pressure on them because they are accountable for the decision which they make. Cicourel (2004:35), who was interested in aspects of way levels of medical expertise can influence health care delivery, has also studied the working practices of receptionists in specialist medical clinics. He concludes that receptionists frequently experience cognitive overload resulting either from routine problems and interruptions or the mismatch between experience, expertise, temperaments, and the details of a task in hand and the demands of supervisory personnel and obliged to address patient irritation at the mismatch between appointment needs and the lack of personnel to fulfill them.

1.13.7 Medical personnel-patient communication

Hewitt (2006) states that receptionists-patient interaction is part of the broad field of health care communication. This assertion is backed by other scholars such as Candlin (2000), Sarangi and Roberts (1999) and Silverman (1997). The view from the consulting room has in the past dominated the field of discourse analysis and as mentioned above, in its concern with discourse

patterns, the construction of participant roles and the discovery of asymmetries, medical personnel-patient is the most relevant to this study.

Paul (2001) suggests that the study of consultation as a genre is one of the two main topics of interest in studies of doctor patient interaction. According to Hewitt (2006) Byrne and Long (1976) ,who were first to record and transcribe a large number of consultation, found repeated sequences of events, which they classified into six phases, some obligatory and others optional. Their findings are corroborated by those of Have (1989) himself, who also identified a basic format consisting of six stages. The typical turn-by-turn structure of these stages has received close attention form conversation analysts. Heath (1981), for instance, provides an influential account of the use of topic initiators in the opening phase of consultation while, in a more recent study, in keeping with the trend towards patient involvement, Gafaranga and Britten (2003) have shown how alignment is achieved, or not, in the joint construction of the first stage of consultation, and how this relates to the goal of shared decision-making.

According to Have (1989), the second main topic of interest in doctor-patient talk is discourse style, which is one of the main indicators of participants' understanding of their roles. Strong (1979) detailed analysis of the role formats used in a large number of consultations in diverse settings is a classic example of this approach. Drawing heavily on the ideas of Goffman, he identifies four formats, or styles of surface ceremony, which participants routinely use. The bureaucratic format which, according to Strong (1979) is dominant in most health facilities, and distinguished on the one hand by impersonality and medical dominance, and the other, by medical gentility, an idealisation of patient's personal competence, is contrasted with private, charity and clinical formats, which are present elsewhere. Anticipating Sarangi's (2000)

identification of interactional hybridity in the context of genetic counseling consultations, Have (1989) notes that discourse formats such as therapeutic talk and troubles-tellings, can clash or combine with the dominant clinical one during consultations.

Role formats are interactionally achieved through changes of frame and footing. Coupland and Coupland (2000:225) who have worked extensively on multi-party consultations in which elderly patients are accompanied by their relatives or carers make the point that "…roles and alignments are not definitely given by institutional and intergenerational structure of the encounters themselves, although normative configurations are apparent. Non-normative frames can be actively proposed and in some cases resisted". Although frame shifts are a norm of doctor-patient encounters, they may lead to interactional trouble, as Silverman (1987) points out in his demonstration of how teenagers attending a cleft-palate clinic are cast uneasily between everyday and clinical roles as a result of the alternation of consumerist and technical-medical discourse.

Underlying much of this research is the question of asymmetry between clinician and client. Writing of dyadic consultation, Byrne and Long (1976) noted that in ninety five percent of all consultations studied it may be safely argued that the doctor is in charge of the how of that consultation as well as what. Many subsequent studies have concentrated on the mechanisms by which this apparent asymmetry is brought about. Taking a functional approach, Mishler (1984) drew on Schutz's (1962) contrast between natural and scientific attitudes and Haberman's (1984) distinction between symbolic and rational-purposive interaction to demonstrate how personal concerns, the voice of the lifeworld, are often stifled by clinical ones, the voice of medicine.

Hewitt (2006) goes ahead and states that Fisher and Todd (1983) and West (1984) also find evidence of medical dominance, particularly when the physician is male and the patient female. Specific features which might be thought to construct asymmetry have also received attention. For instance, Stirling (1999), using data recorded in 1980, shows how if-clauses are mainly used directively in hospital consultations, in contrast with their predominantly optative use in other conversational sites, while Shuy (1976) reveals how too great a use of the voice of medicine, in the form of specialist vocabulary, causes problems for patients.

Such views have also been challenged and contested. Meehan (1981) found that problems with medical terminology could be resolved interactionally through repair sequences and Street (1991) posits that the degree of accommodation in consultations depended on social as well as institutional factors. Frankel (1990) and Maynard (1991) demonstrate how medical dominance is jointly constructed by physicians and patients, illustrating Have's (1995:254) point that "it is best to see doctor-patient interaction as a strategic game played in an asymmetrical format, an asymmetry which is constituted collaboratively by both physicians and patients". However, Have (1995) also conceives of consultations as a service encounter, in which patients pursue clear service goals through forms of participation which they adopt, while Hak (2004) proposes that any asymmetry which occurs will be the product not of interactional factors but external, structural discrepancies in knowledge and power.

Hewitt (2006) states that some of these studies were done some time ago and it is probably true to say that, in line with the changes in attitudes to health and illness described earlier, asymmetry in medical consultations has decreased over the years, as lay participation in decision making has become greater and the individuality of the patient better attended to. This

is also in line with Kenya's Vision 2030 which strives to achieve better, fairer access to service and to improve communication and break down barriers.

However, although research on the use of less clinical communicative styles has shown how they can both improve health care and make the patient more comfortable, it is apparent that a socially interactive posture may also be exploited as an alternative route to medical control and that negative evaluations of patients can be constructed using relational discourses (Silverman, 1987). In addition, physicians may still find it difficult to accept patients involvement in decision making with the result that the prototypical patterns of interaction, at least in primary in Kenya, still appears to be one identified by Skelton (2002) in his concordancing analysis of the use of first person pronouns :"patient: I suffer. Doctor: I think. We will act".

Although they serve very different purposes, as will be seen in this study, there are many parallels between doctor-patient and receptionist-patient encounters, both in the structure of the individuals stages, as pointed out to me by director of primary health care in the Ministry of Public Health and Sanitation who commented on the findings of my research, and the asymmetrical positions which are often adopted.

1.13.8 Research discourse and training

One of the primary reasons for conducting this study was the realisation that there was little research on reception-patient interaction in general and no studies of front desk discourse in the healthcare sector in Kenya. It had also been noted that training opportunities for receptionists tend to be limited. This led to the intention to explore how findings from this study might be used to inform receptionist training which is also in line with Kenya's Vision 2030. However,

the question of whether and how discourse analytical data can or should be used for the training of institutional members has been subject to discussion. These different conclusions which have been reached will be reviewed in this section.

Sarangi and Roberts (1999) describe the two main possibilities for the use of discourse research. They posit that research studies are irreducible and should not be boiled down for practical use. They add that research must be done first then the boiling down can follow. Sarangi and Candlin (2003) draw attention to the difficulties faced by the discourse researcher who is asked to act as an impartial and distant observer but simultaneously to be consultant, evaluator and assessor, pointing out that expert findings are always uncertain and should not therefore be applied directly to practice. This is particularly so because of the analyst's status in healthcare contexts which, Candlin and Candlin (2003) suggest, may limit insider knowledge and reduce understanding of professional practice unless there is full collaboration from the researched group.

However, corroboration may lead to an additional problem: the exploitation of the analyst in the name of managerial and bureaucratic agendas. Fairclough (1992) also warns against these risks, suggesting that discourse technologisation is a resource for cultural and social engineering, while Cameron (2000) shows how over-prescriptive approaches to training develop because of a widespread belief among managers that linguistic regulation can be used systematically as an instrument of culture change and control over people.

Fairclough (1992) nevertheless accepts that research can be used to inform training and proposes that, instead of being used for top-down enculturation into new discourse practices,

specialist knowledge be used to facilitate change from below through teaching of critical language awareness (CLA). Candlin (2000) adopts similar position in her recommendations for training of nurses in order for them to develop a critical and explanatory awareness of the power potential of discourse. Erickson and Schultz (1982) also support the use of authentic examples, suggesting that they can be used to raise critical awareness of the effects of particularistic features. However, they recognise that generic good and bad styles cannot be clearly defined and that, when research does lead to training, the latter must not be over-prescriptive but responsive to the interactional environment. Hyden and Mishler (1999) exemplify this point in their demonstration of the ineffectiveness of medical training based on generalisations while Silverman (1992) shows how the use of real-life examples helps to prevent the pitfalls of anecdotalism and over abstraction.

It is also recognised that, in situations where there is gatekeeping or institutional-lay contact, knowledge based on authentic data can be particularly useful. For instance, Kaspar (1990) sees the importance of observing cultural variations especially in gatekeeping encounters as one precaution against discriminatory practice. He proposes the use of discourse strategies such as an increased amount of small talk to promote co-membership. Gumperz (1982) in addition, has\ used his research on cultural variations and conventions behind the use of contextualisation cues as the basis for programmes which increase awareness of cultural differences.

Ventola (1990) has made comparisons of her service encounters data with textbook examples to introduce language learners to complexity of real-life communication, increasing attention, for example, to strategies which increase rapport and thus decrease the discomfort of participants

greatly by decreasing social distance. Aston (1995) says, that teaching does not need to focus not only on underlying regularities of sequential structure, but also on the ways in which things can be worked out when the instantiation of those scripts is problematic for participants in the talk.

The inductive method has been successfully been applied in a number of disciplines. In English language training, Carter and McCarthy (1997, 2000) have produced textbooks using only attested examples. In medical training, Roberts et al (2003) have used their findings on the differences between the discourse styles of undergraduate medical students as the basis for a proposed new teaching framework. Togher et al (2004) have used research findings to device a training scheme designed to improve communication between police desk officers and clients who have suffered traumatic brain injury. Finally in civic administration, Channel (2000) has created a discourse-based awareness raising programme for town hall receptionists, with the aim of increasing both their efficiency and their customer relations skills.

In sum therefore, although there are difficulties resulting from conflicts between the research goal of objectivity and the need for evaluation or from the risk of exploitation by institutional members, there are a number of reasons for using the findings from discourse analysis for training. These include the avoidance of over abstraction or idealisation and the raising of awareness, both of cultural variation and the complexity of naturally occurring interaction.

CHAPTER TWO

LINGUISTIC PATTERNS AND INTERPERSONAL DYNAMICS OF DISCOURSE ENCOUNTERS

2.0 Introduction

According to Scollon (2001) the reception area of health facilities is known as site of engagement for majority of patients. He adds that it is an institutional environment which provides a framework for understanding of talk which occurs at the reception. Cicourel (1999) observes that the interaction at the reception of health facilities by both patients and receptionists assume a world known in common and taken for granted. Thus, most patients are aware that when a receptionist is stationed at the reception of a health facility, the receptionist is likely to be in a position to offer them services to which they are entitled while receptionists assume that when patients approach the reception they do so with the specific goal of gaining access to medical services, the legitimacy or urgency of which they will be required to ascertain. This leads to some form of frontline encounter between the receptionists and patients. One of the goals of this study therefore, is to analyse the underlying linguistic patterns of this frontline interface between the receptionists and patients in two contrasted tier 3 public health facility and tier 4 private health facility in Kisumu County, Kenya.

Administrative processes vary slightly from health facility to health facility however, in all the two reception desks where recordings were made, patient actions, such as checking in, making appointments or making enquiries, and receptionist ones, such as dealing with administrative duties and confirming the identity of patients, are achieved through routinised episodes of talk which are task related (Drew and Heritage 1992). Like other goal directed institutional activity

types, each of these encounters types consists of several stages, each of which includes an exchange, or series of exchanges, which is in turn constructed from a sequence of verbal actions. These actions are accomplished through discursive moves consisting of one or more speech episodes.

In this chapter the researcher will analyse the organisation of the data, categorisation of interaction and discourse patterns through which reception activities are accomplished, and in so doing answer the first and second research questions:

i) What are the linguistic patterns and interpersonal dynamics used by receptionists and patients at the two health facilities?

ii) How are the linguistic patterns and interpersonal dynamics used by receptionists and patients at the two health facilities?

2.1 Organisation of data

The data on which the analysis would mainly be based were the 24 hours of audio recording at each of the two facilities. Before the analysis could begin, these raw data had to be shaped into a form which made them accessible since as Hewitt (2006) observes that, recordings are essential tools in discourse research, but are not sufficient by themselves for systematic examination of interaction. She goes ahead and states that it is simply impossible to hold in mind the transient, highly multidimensional, and often overlapping events of an interaction as they unfold in real time. Therefore, recordings were first transcribed and then grouped according to their information content.

2.1.1 Transcription

All transcription involves a process of selection and omission which reflects the objectives, attitudes and preferences of the transcriber. Ochs and Schieffelin (1979) remark that transcriptions are the researcher's data while Gumperz and Berenz (1993) are even more explicit observing that transcription is an integral part of an overall process of interpretative analysis. It therefore follows that transcriptions cannot be theory neutral or without bias (Edwards, 1993), instead it is the duty of the transcriber to make explicit the theoretical considerations which have caused specific choices to be made. The broad theoretical aim of this transcription is in the words of Gumperz and Berenz (1993) to reveal the functioning of communicative signs in the turn by turn interpretation of talk. There is also an underlying practical goal, namely, to combine faithfulness to the original interaction on which the transcriptions are based with readability and clarity. In other words as Ehlich (1993:124) puts it "the transcript should be so constructed as to facilitate the process of increasing understanding, providing good visualisation of interaction and interactional dynamics"

Therefore the practical aims is the overall goal of producing a transcription which is internally consistent and which, adhering to the precepts outlined by Edwards (1993), uses categories which are systematically discriminable in the sense that for every case in the data it is clear for every category whether or not it applies. The transcription used in this study is supplemented by additional information about vocal and contextual features which are considered significant. Transcribed features which are regarded as significant include the mechanisms through which speaker turns are ordered and constructed, marked aspects of intonation, pauses and non standard usage. The transcription also included transcriber intervention in the form of coding,

contextual information and free translation. Extract 2.1 exemplifies most of the transcription practices which are described below.

Extract 2.1

(Facility B, Tape 2, episode 3)

1. PB5:hello.I've got an appointment at.eh.the <u>radiology</u> for (.) two o'clock

    I-1PS   have-PRF-PRS

2. RB1: (5) what is your name?

    What-DET   is-COP   your-2PS

3. PB5: Mary Atieno

4. RB1: Mary Atieno?

5. PB5: right

6 RB1: ye:s they will do ECG {PB5: right} just go in the radiology and you will be given directions//

    They-DET   will-AUX   the-ART   you-2PS

7. PB5: it's room?

8. RB1: // just behind yo:u

    You-2PS-OBJ

9. PB5: // behind me?. right.hh hh.right.thank you

i .Speaker turns.

One of the first choices which must be made when transcribing verbal interaction is how to represent speaker turns. The study has adopted a vertical layout since this seems to capture the turn by turn, joint, sequential construction of talk by the speaker in the data. Each new speaker

turn begins on a new line. Most of the interaction in the data is orderly and dyadic, meaning that there are few cases in which it is difficult to determine who is holding the conversational floor. When there is competition for the floor, it sometimes gives rise to overlapping talk which is marked by double vertical strokes (//) placed at the point in the turn of each speaker where the overlap begins (e.g. Extract 2.1, lines 6-9).

The end of overlapping talk is not marked when one participant subsequently cedes the floor to the other but a new line is used if the speaker who has ceded the turn subsequently regains the floor. Latching, the absence of the standard pause beat between the end of one turn and the beginning of the next one is another feature which results from participants' judgments about the content and intent of current speaker's turn (Gumperz and Berenz 1993). It is represented by single equal signs (=), which are paced both at the end of the turn of the last speaker and the beginning of the turn of the next one. There are also occasions when there are one or two word utterances by a second speaker during pauses between intonation units in first speaker turns, the so called backchannels or continuers, which Schegloff (1981:77) describes as "bits of talk extracted from what becomes ongoing talk by another". These appear in curly brackets (e.g. {right} in Extract 2.1, line 6) and are distinct from one or two word turns which appear on separate lines (e.g 'right' in Extract 2.1, line 5).

ii .Intonation

Each speaker turn consists of one or more intonation units, prosodic units which, according to Chafe (2001:675) "provide a useful way of segmenting speech and are profitably viewed as expressing constantly changing foci of consciousness". Intonation units or in Gumperz and Berenz's (1993) terms of informational phrases or rhythmically bounded, prosodically defined

chunks are separated by time breaks only a fraction of a second long. These are transcribed here as full stops both preceded and followed by single spaces, as illustrated by line 1 of Extract 2.1:hello.i have got an appointment at the radiology. for two o'clock. Since intonation is not the main focus of this study, variations in pitch and register within intonation units are only broadly acknowledged in the transcription.

The exception to this are marked choices which are measured in relation to a natural speaking level which listeners are able to recognise (Couper-Kuhlen 1986; Crystal 1975). Rising intonation is indicated by the use of a question mark (?) and exclamatory intonation by the use of an exclamation mark (!).Emphatic stress is shown by underlining (e.g. radiology in Extract 2.1, line 1), prolongation by colons, with each additional colon indicating additional length (e.g. 'yo: u' in Extract 2.1, line 8).Non verbal noises, such as sighs and coughs are described using italicised comments in brackets (*sighs*) and, in another modification of a system devised by Jefferson (1985), [h] is repeated or combined with different vowel symbols to give an idea of the duration and quality of laughter (e.g. 'hh hh in Extract 2.1, line 9).

iii.Pauses.

Speaker production takes place against a background of silence, which includes cessation of the ongoing talk, varying duration from fractions of a second to minutes or hours, and serving a whole range of communicative functions (see Jefferson 1989, Tannen and Saville-Troike 1985). In this data of interaction between receptionists and patients in Kenya, there are mainly silences of short duration which can be characterised as pauses, hesitations mainly from patients or silences from receptionists, depending on the context and the communicative function which they appear to serve. These include indications of:

i) communicative strain or high rapport

ii) the degree of conversational synchrony in an interaction

iii) additional processes, including those related to planning of utterances and the coordination of turns

iv) speakers orientation towards the ongoing conversational interaction

Several forms of pauses have been transcribed. Those of less than one second are shown as full stops in brackets (e.g. (.) in Extract 2.1, line 1.), those of more than one second, with the number of seconds in brackets (e.g. (5) in Extract 2.1, line 2). When a pause occurs between speaker turns, the co-text is used to determine whether it should be attributed to one or other participant or entered on a separate line with no participant identification. Filled pauses are marked in the transcript in different forms according to their realization by speakers (e.g. 'eh' in Extract 2.1, line 1). Another type of pause, truncation, occurs when a speaker makes a false start and breaks off abruptly to repair the utterance and take a new direction in the production of a word or phrase. Truncations are identified and measured "not against normative notions of clause completeness but against the speaker's presumed projection for the current intonation unit" (Du Bois et al 1993:47). They are marked with a dash placed without spacing immediately after the last word before the truncation (e.g. 'wiya-' in Extract 2.2, line 2).

Extract 2.2

(Facility A, Tape 1, episode 22)

1,RA2: koro? anyalo konyi?

Koro-DET-BE-1PS can-AUX you-1PS

(*how are you? can I help you*?)

2. PA22: ber.atimo gima rach.Wiya-.Wiya owil gi (.) yath momiya gi daktar!

atimo-SBJ-1PS wiya-1SP gi-ART momiya-PTCP daktar-OBJ

(*fine.I have done something bad.I have-.have forgotten the medicine given by the doctor!)*

Iv .Non-standard usage.

Extract 2.3

(Facility A, Tape 1, episode 4)

1.RA1: amosi?

amosi-DET-BE-1PS

(*how are you*?)

2. PA4: ber ahinya

Ber-1PS ahinya-ADV

(*i'm very fine*)

3. RA1: ithi nade?

Ithi-DET nade-COP-PTCP

(*how is everything?)*

4. PA4: *i'm going well*

I-1PS-SBJ going-PTCP well-ADV

(*i'm doing fine*)

Another production feature of potential significance is deviation from standard phonological, lexical and grammatical forms. Many participants in this study speak a vernacular dholuo language spoken in western Kenya, which is exemplified by direct translation from dholuo to English (e.g. 'I'm going well' in Extract 2.3, line 4). Macaulay (1991) suggests that it is only

worth using non-standard spelling where variation has some effect on meaning while Preston (1985) has shown that the use of literary transcription or eye dialect can trivialise participants' utterances by conjuring up pejorative stereotypes. It was therefore important to indicate when dholuo translations were used because as Gumperz and Berenz (1993) themselves point out that stylistic variation can reveal significant differences along the formality/informality dimension from which inferences can be made regarding participants' categorisation of an interaction. In this study no attempt has been made to represent features of dholuo pronunciation because it was not the focus of the study.

v. Transcriber intervention.

The transcriber text has been annotated in a number of different ways with contextual comments. First, free translation has been provided below the recorded episodes. This was done partly for practical reasons so that episodes could easily be understood. Secondly, in order to ensure the anonymity of all participants, a system of codes has been adopted, using the letters P for patients, R for receptionists and in combination with the letters A and B to denote the two health facilities.

The first patient to be recorded at health facility A is thus PA1, the first receptionist RA1, and so forth. In addition, where applicable, information from the questionnaires is placed at the head of each interaction episode. For instance, the code **F/20-30/lm/esm** indicates that the patient is female, aged between 20 and 30, last attended the health facility during the previous month, on average, attends it every six months. In addition in this study personal names are occasionally used and when this happens, they are either reduced to initials or when a section of text is

discussed in detail, represented by pseudonyms, which permit the reader to get a more clear impression of who the participants are (Du Bois et al 1993).

2.2 Categories of interaction

There are four categories of talk involving receptionists and patients at the two health facilities in Kenya:

i) face to face interaction with patients relating to health facilities business

ii) face to face interaction with patients relating to their interactions with receptionists

iii) interaction with other members of the health facilities

iv) interaction with members of the research team

The first categories of interactions have been transcribed in full whereas interaction from the latter two groups has been noted but not analysed in full. This is because it is not directly relevant to the research objectives and questions and therefore plays only a tangential part in the analysis.

Interaction with patients relating to health facilities business

Organisation of the interaction relating to the health facilities business was straightforward since episodes could be grouped into categories according to the frontline activity which was being carried out in them. The only exceptions to this rule were episodes in which more than one activity type occurred. This was the case, for example when a patient who was making inquiries also made appointment.

The most frequent activity type at the two health facilities was seeking treatment though there is less checking in for treatment at health facility B, which is more expensive and private compared to facility A, a public health facility. Patients also sometimes make appointments at the front desk, especially at health facility B. There are several registrations at the health facility A, where patients are required to buy registration books at the billing office. Appointments and inquiries between them account for the bulk of interaction in the recordings, including the prescription queries especially at health facility B, which outnumber all other queries together. There is a comprehensive list of face to face activity types in the recordings in Table 3.

Table 3: Reception activities.

Activity.	**Facility A**	**Facility B**	**TOTAL**
Treatment.	90	50	140
Appointments	-	55	55
Registration.	80	40	120
Prescription query.	20	60	80
TOTAL	190	205	395

Receptionists-patients interaction

Two activities related to the conduct of the research occur in the recordings. These are dealing with consent forms and dealing with questionnaires, both administered to the patients. In most cases receptionists combine these activities and integrate them into either the opening or closing phase of other in the manner of Extract 2.4 in which it is dealt with at the end.

Extract 2.4

(Facility B, Tape 2, episode 5)

1. RB1: hello

hello-DET

2. PB1 :(.) hi

hi-DET

3. RB1:*hi.kindly//fill for me this consent form and questionnaire*

hi-DET kindly-ADV this-DEM consent form-INS questionnaire-INS

4. PB1:*// that's okay with me and thanks. my name is Martine Otieno to see Dr Omondi*

that-DEM is-COP my-DET name-SUBJ Martine Otieno-SUBJ COMP

Extract 2.5

(Facility B, Tape 2, episode 4)

1. RB2://hello

hello-DET

2. PB2://Onyango.came for check-up

Onyango-SUBJ check-up-OBJ

3. RB2: *good (.) and do you have your (3) yes. Good.*

do-AUX have-PRF

4. PB2: *what do you want? do you want it to be filled?* (*Consent form*)

what-DET do-AUX

5. RB2:*yes.i want it filled {PB2:okay.okay} and you can take that* (*questionnaire*).*thank you very much.*

I-1PS-SUBJ filled-PTCP you-2PS can-AUX that-DEM

6. PB2: thank you too.

Patients sometimes question receptionists directly about consent forms, questionnaires and the study. As mentioned earlier, the recordings also included two types of interaction which have not been analysed. They include the following:

i) IT1: Interaction between members of the health facilities

ii) IT2: Interaction between receptionists and members of the research team

The incidences of these interaction activity types varied from facility to facility as indicated in Table 4.

Table 4: Activities not used in analysis.

Facility	IT1	IT2	TOTAL
A	10	20	30
B	15	35	50
TOTAL	25	55	80

The table shows that there was considerably more talk between the receptionists and other members of the health facilities. Interaction was also noted between the receptionists and members of the research team. The interaction between members of staff includes inter-receptionist talk and talk between receptionists and doctors, nurses, facility administrators and clerical officers. Holmes and Stubbe (2003) posit that it is not generally possible to parcel out meaning into neat packages of referential or transactional meaning on the one hand and social or

affective meaning on the other and that talk is inherently multifunctional. Contrary, the study has been able to distinguish three types of talk between members of staff which include: on the task talk, in which work issues are dealt with directly, work related talk, which is occasioned by the work environment but social in nature, and talk which is purely social.

Table 5: Interaction between members of facilities' staff

Facility	**A**	**B**
On - task	10	20
Work related.	2	3
Social	4	-
TOTAL	16	23

The interaction between members of staff at the two facilities was dominated by on task exchanges, most of them very short. Subject matter included appointments, medical insuarance, enquiries, patients' registrations and files. There was general cooperation over work issues at both health facilities. At health facility A most of the work centered interaction resulted from one receptionist asking for clarifications, help and advice, while at health facility B most of the interaction took the form of clarifications addressed to the reception supervisor concerning patients' medical insurance cover.

Receptionists also sometimes spoke to members of the research team. As table 6 shows, receptionists at health facility A appeared to be more inclined to engage in this form of talk than those of B. This was true both of research-related interaction and conversation on general issues.

Table 6: Interaction between receptionists and research team

Facility	A	B
Research related	20	14
Social	30	5
TOTAL	50	19

Research-related interaction at the two health facilities consisted mainly of short exchanges about research procedures to be used when dealing with consent forms and questionnaires for the patients at the two facilities and the provision of information about health facilities' procedures. At both facilities A and B, there were discussions about the positioning of my research assistants, who were recruiting patients to the study and asking for their consent. Social talk ranged from offers of refreshments to the locally embedded topics which as Schneider (1988) has shown are typical of talk between speakers who do not know each other well such as local politics, comments about the weather and other topics arising from the immediate environment such as personalities of different patients. At facility A, for example, there were also long conversations about the health of a receptionist with a persistent cough and emaciated health.

Jakobson et al (1960) suggest that there are two forces underlying discourse, the common sense purposes of interactants and the need to build human relationships. That is, interactants simultaneously pursue both transactional and relational goals, each of which generates distinctive linguistic patterns (c.f 1.1). While it is impossible to separate the transactional and relational function of discourse, some patterns can be associated with interactants common sense purposes and others with their construction of relationships. In this chapter the researcher

dwells on how discourse patterns are used in the two health facilities to accomplish transactional purposes and in chapter 5, on how the discourse patterns are used for relationship building in the tier 3 and 4 health facilities in Kisumu County, Kenya.

2.3 Transactional patterns

Patients' task of engaging in interaction with receptionists can be achieved through a number of transactional stages. The researcher found that there are three types of activity carried out by patients at the reception when they attend the health facilities: requesting, claiming and reviewing. When making appointments, collecting prescription and registration encounters, patients are requesting services. In problem solving ones they are both requesting and reviewing services, and when checking in or collecting prescription, they are claiming services which have already been arranged. All these activity types have a maximum of four stages which include service orientation, information check, confirmation and resolution.

The researcher also found that because of the possibility of non verbal communication in the two health facilities under study, and the use of existing documentation by the receptionists, there is not always verbal enactment of all the four stages. For example, during the activity of checking in, if the receptionist is already aware of a patient's name or sees it written in the appointment schedule, the service orientation stage may be left out, while the information check may be ellipted entirely when patients provide all the necessary information as part of the service orientation. Information check also applies during prescription collection because receptionists are required to confirm the bio data of patients before issuing prescriptions. This was very common at the health facility B during the study.

The researcher built up each stage up through the use of distinctive exchange patterns. Table 7 indicates that the stages are constructed from two part exchanges. In the service orientation and resolution stages the receptionist initiates the interaction and the patient responds whereas in the information check and confirmation stages either receptionist or the patient may initiate the interaction.

Table 7: Stages of interactions

Stages	Speaker	Action
Service orientation	receptionist patient	signal availability bid for service
Information check	receptionist/patient patient/receptionist	seek information provide/not provide info
Confirmation	receptionist/patient patient/receptionist	seek confirmation confirm/not confirm
Resolution	receptionist patient	inform/instruct accept/reject

For service orientation, the moves involve signals and bids for services. Information check and confirmation, requests or elicitations followed respectively by provision or non provision and confirmation or non confirmation of the information. For resolution, there is informing or instructing about services followed by either acceptance or rejection. The researcher found that sometimes there are a few variations to these patterns. On some occasion the first move of a stage is ignored by hearer, leading to omission of the second pair part of interaction.

In both health facilities A and B it was found that all encounters begin with service orientation, the point at which the agenda is set by the patient, and continue with one or more additional stages. The pattern for check in and prescription collection encounters is shown below with optional stages in brackets.

Procedure for checking in and prescription

Service orientation

(Information check)

(Confirmation)

Resolution

At the health facility B the researcher found that in check in encounters, service orientation is followed by information check at the reception. However at health facility A, check ins have only two stages which include service orientation and resolution. At the facility B, the remainder stages that include confirmation and resolution follow. During prescription collection, which was only noted at the health facility B, information check follows service orientation in well over 50% of encounters between receptionists and the patients at the reception. The researcher also noted that patients from outside but having medical covers, prescription collections move straight from service orientation to resolution.

Hasan (1978) and Ventola (1987) observe that the ordering of stages in appointment making encounters as well as the whole range of problem solving encounters is complex, variable and recursive, as is typical in service encounters. They add that confirmation is more likely to follow service orientation during appointment making and that there are large numbers of

information checks in both these encounter types. Both also have an interim resolution stage in which a proposed appointment time or problem solution is given and provisionally accepted or rejected. Further information checking and confirmation then typically follows before the final resolution stage which like in checking in and prescription collection marks the close of almost all encounters. The typical procedure is as follows:

Procedure for appointment making and problem solving

Service orientation

(Confirmation)

Information check

Resolution

Information check

(Confirmation)

Resolution

How all this can work in a health facility is shown in Table 8, in a turn by turn analysis of an appointment making encounter at health facility B (Facility B, Tape 2, episode 10, F/26-40/lm/om)

Table 8: Appointment making encounter

(R = receptionist RB1; P = patient PB10)

Stage		Action	R/P	Text
Service orientation	1 2	Signal availability Bid for service	R P	Good afternoon I wanted to make an appointment with a resident gynecologist?
Resolution 1	3 4 5 6	Inform Inform Accept inform	R R P R	Let me confirm . O:h (.) just a moment (.) the doctor will be available at three o'clock= =ok . I'll be there With doctor Ogutu
Information check	7 8 9 10	Seek information Provide information Seek information Provide information	R P R P	(1)When were you born? Ok . (er) .five two eighty one (2) and you are? I'm er . Atieno

Resolution 2	11
	12
		Instruct
		accept
			R
			P
				(4) very fine (.) sign here . you will see the nurse over there before you see the doctor
				//thank you
				// yes

In this example, service orientation is accomplished through one two part exchange, each conversation of which consists of only one speech act, that is, a greeting first and then a

question (1 and 2). It is followed by a resolution stage (3), in which the receptionist confirms whether the doctor is available which she finally affirms in stage (4). The informing move is achieved through one speech act, 'the doctor will be available at three o'clock=' but is preceded by two meta discursive utterances, the discourse marker 'oh', which affirms the availability of the doctor, and the fixed expression 'just a moment', a mitigated form of the imperative 'wait a moment', which holds up the discourse and closes down the preceding topic (see Heritage 1984). The patient's acceptance (5) also consists of two separate acts, the affirmation 'ok' and the assertion 'I'll be there', and is followed by an informing move (6), in which the receptionist completes the offer.

The information check follows which includes two questions, one a conventionally direct question (7) and the other in the form of an incomplete statement (9), and two answers, the first including two parts, the affirmation 'ok' and the numerical statement of the date (8), and the second a single statement (10). After a four minute delay, during which the receptionist is entering the bio data in the computer, the closing resolution stage (11 and 12) is introduced by the discourse marker 'very fine', which marks the end of one discourse stage and the beginning of another. The resolution stage and the encounter are completed by an instruction from the receptionist which is accepted by the patient.

These encounters between a receptionist and a patient as illustrated above in health facility B, is in line with roles and identities proposed by Goffman (2002) where participants enact their different roles and identities based on participant behaviour and activity type. Both the receptionist and the patient have assumed different footings based on the alignments taken in the different stages of conversational sequences.

In addition, although all transactional talk between receptionists and patients is accounted for by the stages described above in health facility B, the researcher observed that the ordering and length of the exchange and sequences, through which the four stages are in turn constructed, is influenced both by participant behaviour and activity type (c.f Goffman , 2002). A detailed examination of all transactional patterns are surveyed in the next section which includes moves, exchanges and acts.

The four stages to be examined in this section are service orientation, information check, confirmation and resolution. In the service orientation stage the first move is enacted by the receptionist in various ways. In the information check stage new information is introduced, while the confirmation and resolution stages both complete previous actions by marking transitions and contributing to discourse management. In confirmation stage this is achieved by ensuring that information is accurate and in resolution through proposals for completion of transactional stages.

2.3.1 Service orientation

The researcher found that in both government health facility A and private health facility B, the opening sequence of any interaction between the receptionists and the patients in both facilities defines the nature of social encounter which is taking place at the reception and indicates the proposed direction of the communication that follows (c.f Goffman,2002). In the frontline encounters the first stage is always a service orientation sequence, that begins when patients and receptionists engage in focused interaction (Goffman, 2002). Apart from a few unusual encounters, the receptionist's first move is always interpreted as a signal that service is available. Ventola (1987) describes this as the attendance allocation which is followed by a

statement from the patient of the reason for attendance at the health facility, a move which Ventola terms the service bid. It was noted by the investigation that the first move in the service orientation sequence is done by receptionists in one of the five ways noted below:

1.eye contact

2. greeting e.g. good morning

3.offer.e.g can I assist you?

4. elicitor e.g. have you been assisted?

5. combination e.g. good afternoon? . can I assist you? (greeting and offer)

Variations in the two health facilities under study are set out in Table 9. The opening exchange for some patients was inaudible on some recordings while some patients dealt with more than one matter at the receptions which have been excluded.

Table 9: Receptionists' first turns

Action	Facility A	Facility B	All facilities
	Number	**Number**	**Number**
Offer	2	35	**37**
Elicitor	5	20	**25**
Offer + elicitor	**-**	10	**10**
Greeting + offer	1	11	**12**
Greeting + elicitor	1	5	**6**
Greeting	30	39	**69**
Eye contact	10	30	**40**
Research related	35	15	**50**
TOTAL	**84**	**165**	**249**

The most commonly used opening at both health facilities A and B is the greeting (30 and 39 respectively). Far more direct offers of service are made at health facility B (35) than at health facility A (2). Openings resulting from eye contact (30) and elicitors are slightly more frequent at health facility B than at health facility A, where the figures are 10 and 5 respectively. Overall the most common choice is greetings at both health facilities (69), which is combined with other forms of opening like offer in the two health facilities to give a total of 12. Next come research related issue based openings at 50, a high number which could be as a result of the distorting effect of the research process and enquiries by the patients about the research. Eye contact openings at 40 are closely tied to research related issues when receptionists are clarifying the research process to the patients, then offers, which are used at 37 of openings overall.

The patient's response to the receptionist's opening move takes one of the forms described below:

1. eye contact (EC)
2. greeting
3. service bid
4. combination e.g. greeting and bid
5. research related (RR)

In Table 10, these five types of move from both facility A and B have been collated with the first moves of receptionists. The first moves by receptionists are listed vertically and the second moves by patients are listed horizontally.

Table 10: Moves by receptionists and patients

R	P	A	T	I	E	N	T	S
E	Move	Bid	Greet+ Bid	Greet+ R-R	Greet	R-R	EC	Total
C	Offer	25	3	-	1	6	2	**37**
E	Elicit	13	9	1	1	1	-	**25**
P	Elicit/offer	10	-	-	-	-	-	**10**
T	Greet/offer	6	2	-	1	2	1	**12**
I	Greet/elicit	3	-	-	-	3	-	**6**
O	Greet	25	24	1	14	4	1	**69**
N	R-R	20	5	10	-	15	-	**50**
I	EC	10	5	5	5	15	-	**40**
ST	TOTAL	**112**	**48**	**17**	**22**	**46**	**4**	**249**

As Table 10 indicates, patients make service bids after all types of opening move by receptionist, which also include non verbal ones and those that involve research matters. There is also a fairly high level of greeting use by patients which include 87 out of 249 of encounters between receptionists and patients at the two health facilities. The table also reveals the extent to which the research process disrupted normal procedures, since patients mention research related matters on 63 out of 249 occasions. The overview of patients first turns in Table 11 gives a summary of these patterns.

Table 11: Moves by patients

Verbal action	N	%
Service bid +/- greeting	160	64%
Research related +/-greeting	63	25%
Greeting only	22	8%
Other	4	1.6%
TOTAL	249	

The patients make more than 60% of service bid most of the time in the two health facilities. The researcher observed that this figure would have been higher had the research not been taking place in government facility A and private facility B. It was noted that any choice made by receptionists can lead to a service bid from the patients. In addition a number of receptionists at health facility B reported that in order to avoid interruption when working at the reception on other administrative duties, they had to avoid all eye contact with the patients.

The study corroborated this with what Schegloff (1986) observed that the opening of a receptionist-patient encounter works in the same way as that of telephone call. He adds that by virtue of being in position at the reception, the receptionist is perceived to be ready to provide service. The patient's arrival, which in this interpretation can be regarded as the first move, acts as a summon, in the same way as the ringing tone at the beginning of a telephone call. The receptionist's first utterance is a response to that summon. Like in telephone openings, the summonsing party, the patient, makes the reason for the summons or visit to the health facility the primary topic, because in roles and identities terms, it is an accountable action (Goffman,

2002). This demonstrates that both receptionists and patients have different linguistic roles and identities to accomplish at the frontline interface in the two health facilities under study.

2.3.2 Information check

The researcher found that this stage is an essential interactional tool for the accomplishment of service arrangements at the two health facilities under study. Different forms of information checking are required by both receptionists and patients in different encounter types at the reception. In the requesting and reviewing encounter types which involve appointment making, ordering prescription and problem solving by both the receptionists and the patients, checking is used by receptionists at both health facility A and B to establish patient eligibility or service needs and equally by patients for information about services sought. During the claiming encounter type which involves checking in at the health facility, it was noted that the receptionist checking of patient eligibility is salient, although there are also service related checks by patients ,for instance if they have forgotten the appointment time or the name of the prescription given by the doctor. The types of information that are checked are listed under three headings in Table 12 used at health facility B.

Table 12: Example of information check

Information checked	Receptionists	Patients
	Patient information	
Name		
Date of birth		
Postal address		
Health status		
	Service need	
Name of doctor		
Time of appointment		
Reason for appointment		
Reminder card		
Patient requirement		
Details of solution		
	Service availability	
Availability of patient		
Justification of appointment		
Date of prescription request		
Date of prescription availability		

The researcher observed that there was variability in the amount of checking which was done and in the length of the information check sequence, with more checking in the requesting and reviewing encounter types and less in the claiming ones. This was noted in both health facility

A and B. During checking in, the number of moves in the information check depends on the amount of information provided in the patient's service bid. As already mentioned, this stage is omitted when the patient volunteers the necessary information, that is, name, appointment time and name of doctor. This is shown in Extract 2.6, which is presented in tabular form for convenience.

Extract 2.6

(Facility B, Tape 2, episode 2, F/26-40/lm/o)

Service orientation	1	RB2: can I assist you? Can-AUX I-1PS you-1PS-OBJ
	2	PB2: yes . I have got an appointment with eh (.) with the gynecologist {RB2: yah} Dr Ogutu . at 10am Yes-DET I-1PS have-PRF an-ART
Resolution	3	RB2: (3) that's okay and have a sit That-DEM is-COP okay-SUBJ-COMP have-PRF a-ART sit-OBJ

There are encounters where patients who when checking in provide very little information, omitting their own name, that of the person to be seen and the time of the appointment (see Extract 2.7, row 2). The researcher noted that the receptionists normally supplement this by asking questions (rows 3 and 6).

Extract 2.7

(Facility B, Tape 2, episode 1, M/16-25/em/esm)

Service orientation	1 2	RB1: hello . may I help you Hello-DET may-AUX I-1PS you-2PS PB1: ya . I have an appointment Ya-DET I-1PS have-PRF an-ART
Information check	3 4	RB1: and who do you want to see if I may ask? Who-REL do-AUX you-2PS may-AUX PB1: eh . Dr Otieno Dr Otieno-OBJ
Confirmation	5	RB1: Dr Otieno
Information check	6 7	RB1: (20) and you <u>are</u>? You-2PS are-INTV PB1: George Omondi
Resolution	8	RB1: that's very good . kindly have a sit That-DEM is-COP very-ADV good-ADJ

Most of the patients who collected prescription at facility B gave their names at the information check. There was no prescription collection at facility A and therefore the researcher did not come across this stage. In addition the researcher noticed that most patients who collected their prescription from facility B did so after seeing other doctors outside facility B and only went their to collect prescription because they have medical covers. Their is an example of prescription collection in Extract 2.8, in which the checks are in the form of question and

answers (rows 2-3 and 6-7), in the first case followed by a confirmation stage involving the receptionist (RB1).

Extract 2.8

(Facility B, Tape 2, episode 20, F/26-40/lm/om)

Service orientation	1	PB20: good afternoon? do you have this (.) prescription? good afternoon-SUBJ do-AUX you-2PS have-PRF
Information check	2 3	RB1: and what is your name madam? what-REL is-COP your-2PS name-OBJ PB20: Diana Adhiambo Diana Adhiambo-OBJ
Confirmation	4 5	RB1: Diana Adhiambo RB20: (fills in the insuarance form) form-INS
Information check 2	6 7	RB1: (7) and what is your postal address? what-REL is-COP your-2PS post-OBJ PB20: 9460 Kisumu
Resolution	8	RB1: okay . you can proceed to the pharmacy can-AUX to the pharmacy-ADVL

Similarly, in Extract 2.9, because the receptionist's question is not responded to immediately, the receptionist at facility B prompts the patient by stating his address with question intonation (row 6), thus eliciting a response (row 7).

Extract 2.9

(Facility B, Tape 2, episode 15, M/41-60/ly/ey)

Service orientation	1 2	RB2: kindly have this (research forms are dealt with) have-PRF-PRS this-DEM PB15: okay . (2) came for prescription
Information check	3 4	RB2: (.) your name sir? your-2PS name-SUBJ PB15:John Were
Confirmation	5	RB2: Mr Were
Information check	6 7	RB2: (.) your address Mr Were? (.) RB2: // 1570 Kisumu? PB15: // oh yes . yes . 1570 Kisumu
Resolution	8	RB2:very well very-ADV

The researcher noticed that if the right procedure had been followed following Goffman's (2002) roles and identities theory, the receptionist RB2 in this health facility B would not have supplied the address herself but waited for the patient to produce it. This therefore is a case of the receptionist assuming the role of the patient. The researcher also noted that there are occasions when the requirement for check is overlooked when prescription is issued, either because the patient is well known or again because the correct procedure is not being followed. The researcher noticed this in health facility A, Extract 2.10, where a patient from Migori County in Nyanza region has come for repeat prescription at the facility. In this case therefore

the latter seems to be true because there are no signs of recognition in the discourse and questionnaire information shows that the patient rarely attends the health facility.

Extract 2.10

(Health facility A, Tape 1, episode 11, F/26-40/ly/ey)

Service orientation	1	RA1:habari yako sister? habari-DET yako-2PS sister-SUBJ (*how are you my sister?)*
	2	PA11: huwa nachukua madawa yangu ya support services huko Migori . na sasa nilikuwa na uliza . social support services ya hapa iko wapi?(research forms dealt with) Huwa-ADV yangu-1PS huko Migori-ADVL nilikuwa-1PS ya hapa-REL *(I usually collect my drugs from the social support services at Migori . so I wanted to know . where the support services are located here)*
Resolution	3	RA1: social support services yetu iko karibu na gate .. halafu utaona nyumba kubwa iko na roof ya blue . hapo ndio social support services. Yetu-1PL iko-COP karibu na gate-SUBJ-COMP halafu-DET utaona-2PS-AUX nyumba kubwa-OBJ iko-REL roof ya blue-OBJ-COMP (*our social support services is located near the gate .*

		then you will see a big house with a blue roof . there is the social services)

The researcher also noticed that information check stages in most checking in and prescription collection encounters are usually short because a limited amount of information is required. However, appointment making and problem solving encounters are characterized by longer, repeated, information checks. It was also observed that checks in appointment making encounters are also less formal than those in check in and prescription collection ones. In addition they are predictable in that they always relate to the availability and suitability of appointments. The question and answer sequences in problem solving information check encounters are non routine because each problem which is dealt with is slightly different. There is an example of a problem solving encounter in Extract 2.11, at the health facility A.

Extract 2.11

(Facility A, Tape 1, episode 3, F/41-60/lm/om)

Information check1	1	PA3:nimeleta mtoto hospitalini Nimeleta-A mtoto-OBJ (*I have brought a child to the hospital*)

Information check 2	2
	
	3
		RA1: (.) // nisaidie kitabu . jina la mtoto?
		Nisaidie-A kitabu-INS mtoto-OBJ
		((.) // *help me with the book . name of the child*?)
		PA3: //Ben Ondieki
		Ondieki-OBJ
		(// *Ben Ondieki*)

Information check 1	4 5	RA1:ako na miaka ngapi? {PA3:mnee}(.) na unaishi wapi? Ako-3PS na-COP miaka ngapi-SUBJ-COMP (*the child is how old*? {PA3:*three*} (.) *and where do you live*?) PA3:naishi . manyatta Naishi-1PS-VERB-PP manyatta-ADVL

		(I live in . manyatta)
Information check 3	6	PA3:madam . nilikua nikiuliza watoto wanatibiwa wapi? Nilikuwa-1PS-PST wapi-REL (*madam . I was asking where children get treated*)
Resolution 1	7	RA1:sasa . utaenda uko mbele penye watu wakubwa wamekaa karibu na gate halafu utaangalia juu . utaona wamama wamebeba watoto. utaenda-2PS-AUX penye-REL karibu-DET na gate-OBJ utaangalia-2PS-AUX utaona-2PS-AUX (*now . you will go infront there where there are grown ups near the gate then you will look up . you will see women carrying children*)
Confirmation1	8 9 10	PA3:sawa (.) halafu nitapanga laini Sawa-DET nitapanga-1PS-AUX (*ok* (.) *then I will queue*) RA1:ndio(*yes*) PA3: mtoto amechoka Mtoto-SUBJ amechoka-COP-SUBJ-COMP (*the child is tired*)
Resolution 2	11 12	RA1:sawa hutapanga laini Hutapanga-2PS-AUX (*ok you won't queue*) PA3:asante sana sister (*thanks a lot sister*)

In this illustration above, Extract 2.11, there are three checks, one of which the patient asks an indirect question by announcing the arrival of a sick child (row 1) and two in which the receptionists puts questions which clarify details of the sick child (rows 2 and 4). There is a step by step movement through these checks until a resolution which is acceptable for both receptionist and patient is reached and agreed (11-12).

As earlier noted Zimmerman (1990) considers that information checks, which he terms communicative frames, are central for task completion in calls to emergency services, finding that callers only receive answers to their first, service-seeking, adjacency pair parts after lengthy insertion of sequences, in which information checking is carried out. The researcher noted this

pattern in Extract 2.11, in that the resolution is only reached after a sequence of information seeking and provision moves. It was also observed that something similar also occurs when appointment times are negotiated. This is shown in Extract 2.12, which exemplifies the negotiation phase of appointment making at health facility B.

Extract 2.12

(Facility B, Tape 2, episode 6, M/41-60/ly/ey)

Stage		Action	Speaker	Text
Service orientation	1	Signal availability	RB1:	Good afternoon sir? SUB-COMP
	2	Bid for service	PB1:	(.) ya . please (.) I want to see an eye specialist ya-DET I-1PS eye specialist-OBJ
Confirmation 1	3	Request confirmation	RB1:	(.) do you want to make an appointment? Do-AUX you-2PS appointment-OBJ
	4	confirm	PB1:	I will really appreciate I-1PS will-AUX appreciate-SUB-COMP
Resolution 1	5	Inform about service	RB1:	The doctor will be available on . Tuesday or Friday . The doctor-DET-SUBJ will-AUX
	6	Acknowledge	PB1:	// okay (1) Tuesday is good
	7	Inform (contd)	RB1:	// good SUBJ-COMP
Information check 1	8	Elicit information	PB1:	Okay . actually I am not sick but wanted to bring my son who has an eye problem Okay-DET I-1PS am-BE Who-REL an-ART
	9	Acknowledge	RB1:	Mhm
	10	Elicit	PB1:	So that I get doctor's opinion That-DEM I-1PS
	11	Acknowledge	RB1:	Mhm

	12	elicit	PB1:	That's what I wanted That-DEM is-COP what-REL I-1PS wanted-SUB-COMP
Information check 2	13 14	Request information confirm	RB1: PB1:	Do you have a medical cover? Do-AUX you-2PS have-PFV a-ART medical cover-OBJ (.) yeah
Resolution 2	15	Inform about service	RB1:	Yeah . mhm . so (.) well if its very severe we will recommend you bring the child on Tuesday morning between nine and ten We-1PL will-AUX you-2PS The child-OBJ
Information check 3	16 17 18 19 20 21	Request information Provide Acknowledge Provide (contd) Request information provide	PB1: RB1: PB1: RB1: PB1: RB1:	//so . when you say severe is it possible I bring him right away? When-REL you-2PS I-1PS Mhm . that's not really possible coz you know . you'd need to make an appointment That-DEM is-COP you-2PS Yes You know You-2PS know-ADVL Can it be . er . earlier appointment= Can-AUX =earliest one is on Saturdays but subject to doctor's confirmation Is-COP but-CONJ
Information check 4	22 23	Request information provide	PB1: RB1:	On Saturdays? On-PP Saturdays-SUBJ-COMP mhm

Resolution 3	24	inform		(.)leave me your contacts . I'll just tell you when Your-2PS I-1PS will-AUX When-REL
Information check 5	25	Request information		(.) morning or afternoon? SUBJ-COMP
Information check 6	26 27	Request information acknowledge	PB1: RB1:	What time in the morning? What-REL the morning-SUB-COMP I'll just check and let you know I-1PS will-AUX
Information check 7	28 29	Request information confirm	 PB1:	(4) before Saturday SUB-COMP mhm
Resolution 4	30 31	Inform (contd) accept	RB1: PB1:	And I can even give you the doctor's number I-1PS can-AUX you-2PS That will be good That-DEM will-AUX

In this encounter, the parent of the patient has an urgent appointment need which because the doctor is not available and the patient not present cannot be treated as an emergency. The receptionist, in her role as gate keeper, makes two appointment proposals which are conditional upon the patient meeting the necessary requirements (rows 5-7 and 15). These are followed by information checks from the guardian of the patient (rows 8-12 and 16-23) which pave the way for a temporary resolution (rows 24-25),followed by further information checking on both sides, until a satisfactory resolution is reached and the guardian accepts the appointment which has been proposed (rows 30-31).

In summary, all these examples of information checks between receptionists and patients in health facility A and B, demonstrate their importance at the reception. Through them receptionists ensure that patients are correctly linked to services, while patients use them to

establish the precise nature of the services which they are organising and claiming. It has also been demonstrated that the number of questions in an information check depends on factors such as the activity type, the prior knowledge of the patient, the attention levels of interactants and whether or not any problems arise. The researcher has also observed that when receptionists are checking the personal details of patients at both facilities, the wording of the information check is formulaic and predictable. When information checking is done in the service of appointment negotiation or problem solving there are frequent insertion sequences and questioning and answering continues until mutual agreement or understanding is achieved.

2.3.3 Confirmation

It was noted that confirmation sequences complement information checks because the same types of information are covered but are different from them in that they are used to ascertain the correctness of items which have already been mentioned rather than obtain information. Therefore, during checking in, the information confirmed is the name, address or date of birth of patient or the details of appointment. During prescription collection it is the name and address of the patient and sometimes whether the patient is paying cash or has a medical cover. This was noted at the private facility B. During appointment making, it is likely to be the details of the patient's requirements or the date and time of the appointment while during problem solving it is both patient information and the acceptability of any arrangements which have been reached at.

As noted in the preceding illustrations, confirmation stages complete earlier actions, marking the transition from one stage to another. It was also observed that they are short and often take the form of repetition of all or part of the information component of the preceding utterance,

which may or may not have rising intonation. The researcher noted the latter in the confirmation stage of Extract 2.9, which is repeated here as Extract 2.13.

Extract 2.13

Information check	1 2	RB2 :(.) Your name sir? Your-2PS name-SUBJ PB15:John were SUBJ-COMP
Confirmation	3	RB2:Mr Were SUB-COMP

The confirmation in row 3 could be seen as the third part of the exchange initiated in row 1 but the researcher chose to analyse it as a separate stage because when receptionists repeat items of information provided by the patients they provide an opportunity for the patient to make a correction if they have misheard or misunderstood the receptionist. The example in Extract 2.12 also illustrates the reformulation of the preceding utterance which often occurs when confirmation is sought in this way. The change by the receptionist of 'John Were' to 'Mr. Were' suggests that alternative stances are adopted to the information, which reflects the personal and institutional identities of the two speakers. This study adopted Goffman's (2002) roles and identities as one of the theories used.

It was further noted that confirmation may also have a discourse management function. In Extract 2.12, the receptionist's reformulation, after a short pause, of the patient's '(.) ya . please (.) I want to see an eye specialist' to '(.) do you want to make an appointment?' (rows 2

and 3) was, on the surface, a clarification, which is designed to assist a hesitant parent to a sick child at the private health facility B. However as Heritage (1985) has observed that formulation is also a subtle form of discourse control which can move an encounter along to the next stage.

This was the case in the receptionist's reformulation in Extract 2.12, which incidentally confirms the use of formulation by doctors in consultations (Heritage and Watson, 1979). Therefore, the confirmation stage has several functions at the reception which include, first, allowing participants to establish that the information they exchanged is accurate, second, it facilitates transition from one stage of an encounter to another and finally provides an occasion for the display of contrasting identities.

2.3.4 Resolution

The researcher found that there are two types of resolution stage, that is, interim and final. It was observed that both are constructed through moves in which the receptionists inform or instruct patients. In addition, the initiating move of the receptionist is likely to be either the statement of an available appointment time or a solution to the patient's problem. The interim resolution of an appointment need has been illustrated in Extract 2.14.

Extract 2.14

(Facility B, Tape 2, episode 7, F/16-25/lm/om)

Service orientation	1	PB7: any chance for an appointment with a general physician this afternoon? With-REL a-ART physician-SUB-COMP
Resolution 1	2 3	RB2: I don't think . I-1PS don't-NEG-AUX Mhm (.) just a moment please (.) there is a . cancellation

	  4 5	at three o'clock= a-ART there-DEM is-COP a-ART PB7: =ok . I think I will take that one Ok-DET I-1PS will-AUX that-DEM RB2: with Dr Otedo With-REL Dr Otedo-SUB-COMP

The interim resolution stage may consist of only one brief exchange for example the receptionist's 'ok you wont queue' followed by the patient's 'thanks a lot sister' in Extract 2.11 (rows 11-12) but when it is staged as part of an appointment negotiation, it can also be lengthy. The researcher observed this in Extract 2.12, in which the receptionist includes detailed information with the proposed resolution (rows 5 and 15).

At the public health facility A, the researcher found that when resolution is final, it comes at the end of an encounter and formulaic expressions are used to indicate that tasks have been successfully completed. These expressions include, from the receptionist, instructions, positive assessments, which are recognised as end markers or pre closing bids (c.f Linde, 1997), and basic information provision and from the patient, acknowledgements and thanks. These forms are illustrated in Extract 2.15 (row 4) and Extract 2.16 (row 4).

Extract 2.15

(Facility A, Tape 1, episode 8, M/16-25/ly/ey)

Service orientation	1 2	RA2: Nango brother? Nango-BE you-2PS my-DET brother-SUB (*how are you my brother*?) PA8: Ber ahinya . awinjo ka atuo to akia achak gi kanye Ber ahinya-ADV awinjo-1PS ka-BE atuo-SUB-COMP akia-1PS-NEG-AUX achaki-REL (*I am very fine . I feel like am sick but I don't know where to start from*)
Information check	3	RA2: (4) in wendo kae? In-BE-2PS ART

		(*are you a visitor*?)
Resolution	4	RA2:Ibonyiewo book kacha {PA8: kama ji ngeny?}as tikelo to andiko ni kae Ibonyiewo-2PS-AUX- there-DEM kama-REL (*you will buy a book there* {PA8: *where people are many*? }*then you bring it I register you*)

Extract 2.16

(Facility A, Tape 1, episode 15, F/16-25/lm/om)

Information check	1	RA1: Jina <u>yako</u>? Your-2PS name-SUB (*your name*?)
	2	PA15: Rashidi Ramadhan SUB (*Rashid Ramadhan*)
Confirmation	3	RA1: (2) Rashid Ramadhan SUB ((2) *Rashid Ramadhan*)
Resolution	4	RA1: Sawa . utaenda ward three (*ok . go to ward three*)

In Extract 2.16, as well as indicating successful completion with the positive evaluation, 'sawa (ok)', a sign of attention to relational matters (c.f Goffman,2002), the receptionist gives the patient explicit information about the doctor's whereabouts, 'utaenda ward three (go to ward three)', in a display of institutional competence. Moreover the researcher observed that the provision of information of this type can be superfluous and a form of face protection. However it was equally noted that new patients do need instruction as shown in Extract 2.17 at facility B, which is a longer resolution stages in the data. The patient has already been registered at the customer care desk but prefers to see the doctor at a later date.

Extract 2.17

(Facility B, Tape 2, episode 8, M/61-75/lm/om)

Confirmation	1	R confirm	RB1:	Okay . u could wait for your turn Okay-DET u-2PS could-AUX
Resolution	2	R instruct 1		If unaweza fanya kabla uzidiwe things will be okay Will-AUX
	3	P accept 1	PB8:	Sawa hh hh . najua Najua-1PS
	4	R instruct 2	RB1:	Okay . if you could just make the appointment You-2PS could-AUX
	5	P accept 2	PB8:	// I will make the appointment I-1PS-A will-AUX appointment-OBJ
	6	R instruct 3	RB1:	//When you have made the arrangement . it doesn't take long . its only 30 minutes When-REL you-2PS have-PFV
	7	P accept 3	PB8:	Sawa sawa . good . thank you DET ADJ you-2PS
	8	R acknowledge	RB1:	Thanks
	9	P informs	PB8:	Good afternoon Good afternoon-SUB-COMP
	10	R accept	RB1:	You too You-2PS too-OBJ

In this Extract the receptionist makes three instructing moves (rows 2, 4 and 6), each of which is accepted by the patient. It was observed that like the informing and instructing moves of receptionists in the examples in Extracts 2.15 and 2.16, the responses of patients also manifest relational features. In Extract 2.17 this is observed in both the positive evaluation and polite thanking formula (row 7) and in the use of a good afternoon in row 9.Therefore both patients and receptionists exhibit their respective roles and identities which this thesis uses as one of its conceptual framework (see Goffman, 2002). In addition this is a transactional move, which also has a discourse management function, since it indirectly informs the hearer that the speaker is

about to leave and so end the encounter. This is also noted by Laver (1974) who observes that thank you and good afternoon/morning are a form of phatic discourse and tend to be used at boundary points to mark the ritual of transition.

However the researcher also observed deviant cases where resolution stage in an encounter is followed by confirmation stage. As mentioned earlier, almost all encounters end with resolution, making it the most consistently present stage after service orientation. This non-normative case was noted in health facility A, which has been captured in Extract 2.18.

Extract 2.18

(Facility A, Tape 1, episode 2, F/26-40/lm/om)

Resolution	1	RA2: Sasa . Dr Otedo hayuko na utaona Dr Omondi Dr Otedo-SUB hayuko-COP-NEG utaona-2PS Dr Omondi-OBJ (*now dr Otedo is not available but you will be seen by dr Omondi)*
Confirmation	2	Hiyo ni sawa? Dr Otedo ameenda emergency Is-COP that-REL you-2PS emergency-OBJ-SUB-COMP (*is that okay with you?dr Otendo is attending to an emergency)*
	3	PA2: Hh // niko sawa Am-SUB sawa-OBJ (*hh//am ok)*
	4	RA2: // kulikuwa na mgonjwa amezidiwa PGH Kulikuwa-SUB-BE na-ART mgojwa-OBJ amezidiwa-ADVL (*there was a very sick patient at PGH)*
	5	PA2: // Nilikuja ani angalilie result zangu za lab Nilikuja-1PS-V aniangalilie-DET-DET-SUB-AUX result-OBJ zangu za lab-ADVL (// *I came so that he could interpret my results from the*

		lab)
	6	RA2: Hope sija ku mess? Hope-PRE MOD sija ku-1PS-AUX-NEG mess-OBJ (*hope I have not messed you up)*

The non-normative ending of this encounter at the public health facility A seems to be the result of exceptional circumstances. The patient has arrived to find that her results cannot be interpreted by the doctor who sent her to the laboratory and therefore cannot see the doctor of her choice. The receptionist must confirm that the patient will accept the new arrangements. The receptionist does so with two checking moves, 'is that ok with you' and 'hope I have not messed you up', accompanied by two remedial accounts, 'Dr Otedo is attending to an emergency', 'there was a very sick patient at the PGH' in mitigation for the changed arrangements.

Therefore in conclusion, resolution stages at the two health facilities have four functions. First, they are a response, either conclusive or inconclusive, to service bids, second, they confirm that the transaction is progressing smoothly, indicating that procedurally all is well, third, they work as a form of conversational management, as boundary markers which signal that the discourse stage, or the whole encounter is nearing completion and fourth they have an interpersonal content and contribute to the maintenance of positive relationships through their various roles and identities (see Goffman,2002).

In the following section the researcher has given a detailed description of opening verbal moves that both receptionists and patients used at the two health facilities in Kisumu County. These moves have been summarised under service signals in 4.1.5.

2.4 Service signals used at the health facilities

In this section the study has given a description of opening verbal moves which are heard as signals that patients make when seeking service bids, and then the researcher gives a short summary of their transactional functions.

2.4.1 Greetings

Greetings were noted by the researcher as the most frequent choice at the reception of the two health facilities. Although as Searle (1969) noted, they are expressive speech acts or acts of phatic communication, which in the first instance, simply mark recognition of the other party (c.f Schiffrin, 1977). According to Duranti (1997), greetings also serve as attention getting devices which indicate that focused interaction may begin. The researcher has demonstrated this in Extract 2.19 which takes place at the public health facility A. The patient responds to the receptionist's greeting with a service bid, allowing no pause before speaking.

Extract 2.19

(Facility A, Tape 1, episode 1, F/26-40/lw/ow)

RA1: Habari yako =
How-PRE MOD are-V you-2PS
(*How are you =)*
PA1: = Nimeleta mtoto hosipitalini . anakohoa sana
Nimeleta-1PS-AUX-V mtoto-OBJ hosipitalini-ADVL
(*I have brought my child to the hospital because he has a cough)*

The researcher also observed that because the receptionist's presence behind the reception works as an indicator of availability for service, there is sometimes simultaneous claiming of the floor as illustrated in Extract 2.20, in which receptionist and patient attempt to open the verbal action at the same time.

Extract 2.20

(Facility B, Tape 2, episode 9, M/41-60/ly/ey)

RB2: // Good afternoon sir
Good afternoon-PRE MOD sir-SUB
PB8: // Afternoon . any chance of an appointment with a dentist this afternoon?

PRE MOD ART OBJ REL ART OBJ

Therefore, at the two health facilities it was noted that receptionists use greetings to explicitly signal their readiness to enter into a state of talk which leaves no doubt that the encounter between them and the patients can begin. However, simple eye contact can lead to confusion, as Extract 2.21 demonstrates,

Extract 2.21

(Facility B, Tape 2, episode 30, F/41-60/ly/ey)

1 PB30: Eh . Mary Atieno . I've come to collect prescription
I-A have-AUX prescription-OBJ

2 RB1: I'm just handing over:::
I-1PS just-ADV handing over-OBJ

3 PB30: Ok . right
Ok-DET right-SUB

4 RB1: to the next shift (4) ya . and you want to collect prescription?

OBJ DET 2PS ADVL

In this Extract the patient assumes that a non verbal opening has been offered and makes the service bid (line 1), obliging the receptionist at this facility to provide an account of why service is not immediately available (line 2). The patient's recognition of her mistake is marked by the

change of state marker ‘ok’ (Heritage, 1984) combined with the acknowledgement token ‘right’ (line 3). It is only after a four second pause (line 4),during which the receptionist completes another task, that she provides an elicitor, hence moving to a situation where it is legitimate for the patient to make the service bid. The researcher therefore postulated that it is the receptionist who determines when the patient can take a turn, an illustration of the asymmetry in speaking rights between the receptionists and the patients at the two health facilities in Nyanza, Kenya. This was captured under the theoretical framework of power where receptionists act as gate keepers of institutional discourse by regulating access to roles, statutes and authority structures.

2.4.2 Offers

The researcher noted that offers were the most common act to occur between the receptionists and the patients at the two health facilities. It was observed that most service offers are made using the standard polite question format that include first person modal verb + first person pronoun + help/assist verb + second person pronoun, generating ‘can I help/assist you? and ‘may I help you?’. This style of opening that was observed in both facilities, remove any imposition on the patient because both the modality and the use of first person limit the level of assumption about the patient’s needs. As Schegloff (1973) noted, a question forms the first part of an adjacency pair and therefore anticipates a responsive second pair part.

Therefore this makes it an efficient discourse strategy for use in service offers, since it prepares the ground for the service bid even more explicitly than a greeting, directly encoding the receptionist’s readiness to help the patient. This is illustrated by Extract 2.22, in which the patient at health facility A, makes a detailed service bid in immediate response to the offer.

Extract 2.22

(Facility A, Tape 1, episode 5, M/16-25/lm/esm)

RA1: Anyalo konyi?
Can-AUX I-1PS help you-V-2PS
(*can I help you*?)
PA5: Sister: eh . nineteen eighty nine . Tom Onyango

PRE MOD SUB

The researcher equally noted that alternative versions of offer formula are also used, for instance at the health facility B, the receptionists modified once to 'can I help anyone?' to meet the situational need which arises when a receptionist has been away from the reception and returns to find a group of patients waiting. Because she doesn't know who is at the front of the queue, she makes her service offer more general by using the indefinite pronoun 'anyone'

2.4.3 Elicitors

It was noted that when elicitation is used, then there is an implicit assumption that the listener already requires something, in this case the service at the health facilities, of the speaker. Elicitors take two forms in these data gathered at the two health facilities. Either they are generalised covert invitations to speak, for example 'yes?', 'who is next?', 'who is first?', 'have you been served?', 'are you okay madam/sir?', and 'okay?', or they are overt polar questions such as 'do you have an appointment with the doctor?', 'have you got an appointment?', 'have you come for prescription?'.Both elicitations are framed as questions which like direct service offers, await responsive second pair parts.

According to Goffman (2002) on roles and identities which this study is based upon, generalized elicitors have the same openness like direct service offers. Goffman describes 'yes?' the form which occurs most frequently as the functional equivalent of 'hello'. An illustration is shown in Extract 2.23.

Extract 2.23

(Facility B, Tape 2, episode 37, F/26-40/lm/ey)

RB2: Yes::?
DET
PB37: Could I see a physician please?

Could-AUX I-1PS a physician-OBJ

The researcher also observed that 'who is next?' and 'who is first?' are more specialized and as 'can I help anyone?', are used when a receptionist arrives at the reception to find a number of people waiting and hence obliged to make the offer to all patients rather than to one patient. In addition, each is used only once, despite the frequency with which patients are obliged to wait at the reception for the services. Contrary, 'are you okay?', is used when a receptionist arrives at the reception to find one patient waiting and must clarify whether service has been offered. It therefore doubles up as a clarification request. In closed question elicitors it was noted that the question is restricted to the mentioned topic and that they are present when there is a need to limit the service offer as shown in Extract 2.24.

Extract 2.24

(Facility B, Tape 2, episode 38, F/26-40/lm/om)

RB1: Is there anybody waiting to see the duty nurse?
Is-COP there-DET anybody-SUB to see the duty nurse-OBJ
PB38: No . but have you got a piece of paper? . if you don't mind
Have-AUX you-2PS paper-OBJ
RB1: (3) is there anybody waiting to see the duty nurse?
Is-COP there-DET anybody-SUB the duty nurse-A-DET-OBJ
PB40: Me . I'm waiting to see the nurse as well

Me-DET I-1PS am-BE the nurse-A-DET-OBJ

Because the receptionist is not a trained receptionist and her duties entail only to deal with patients waiting to see the duty nurse at the health facility, the receptionist is obliged to define her role for patients by using the closed question. Note that the same closed question is repeated by the receptionist when the patient does not take the service which is offered but instead asks for a pen.

2.4.4 Combinations

The researcher observed several combinations of moves in receptionist openings. These included greetings with offers (Extract 2.25), elicitors with greetings (Extract 2.26) and elicitors with offers (Extract 2.27).

Extract 2.25

(Facility A, Tape 1, episode 10, F/16-25/lm/esm)

RA1: Habari dada . naweza kuku saidia?
habari-DET-BE-2PS naweza-AUX-1PS kuku-V-2PS
(*how are you sister . can I help you*?)
PA10: Daktari ya watoto yuko oleo?
Yuko-COP daktari-SUB
(*is the pediatrician around today*?)

Extract 2.26

(Facility A, Tape 1, episode 20, F/41-60/ly/ey)

RA2: Ye:s . mama . amosi:
Yes-DET mama-SUB amosi-SUB-COMP
(*ye:s . mama . hello:)*
PA20: Omiya karatas mar yath . koro atere kanye?
Omiya-1PS-AUX-BE-V karatas-OBJ koro-REL atere-1PS-DO
(*I have been give a prescription form . where do I take it*?)

Extract 2.27

(Facility B, Tape 2, episode 11, F/16-25/lm/ey)

RB1: Hello . can I assist you?
Hello-DET can-AUX I-1PS you-2PS
PB11: (4) Er . I have a doctor's appointment now at two

Er-DET I-1PS have-AUX a-ART doctor's appointment-OBJ now at two-ADVL

It was noted that in the examples above all of them are double offers in which different opening styles are combined. This is in contrast with the combined sequences such like the one in Extract 2.28 in which patients have the opportunity to respond to offers but do not take them up.

Extract 2.28

(Facility B, Tape 2, episode 13, F/26-40/lw/om)

RB1: Hello (.) may I help you? (.) do you want to see a doctor?
Hello-DET may-AUX I-1PS you-2PS do-DO you-2PS a doctor-ART-OBJ
PB13: I want to see a doctor

I-1PS to see a doctor-SUB-COMP

In this illustration both the greeting (hello) and the offer (may I help you), remain unanswered, despite the noticeable pause after each. Sacks et al (1974) have found that such a pause in the flow of speech, together with the completion of syntactic and intonation units, signals a transition relevance place (henceforth TRP), a point at which the conversational floor becomes open to new speakers. Goffman (2002) also recognises the importance of TRP in roles and identities taken up by different interlocutors during speech. This study is based on these roles and identities that receptionists and patients take in their enactment of TRP. In the example the TRPs which become available are not taken up by the patient, which causes the receptionist to resume the floor herself, repeating the service offer by using the more overt question. The receptionist uses restricted move and closed question elicitor 'do you want to see a doctor?' which acts as a prompt after an initial offer has been ignored.

2.5 Service bids used at the health facilities

The researcher reported service bids used by the patients ate the two health facilities. Service bid is the patient's response to the receptionist's service signal. It was found that a wider variety of forms are used in patient bids than in receptionist signals because patients have a wider range of discourse goals. The researcher further noticed that the style of service bid depends on the service which is required and that most patients use routine language of some kind. This range

from elliptical forms used by patients checking in for their appointments (Extract 2.29) to the polite forms used when appointments are being made (Extract 2.30).

Extract 2.29

(Facility B, Tape 2, episode 12, M/41-60/ly/o)

RB1: // How are you today?
How are-PRE MOD you-2PS-SUB today-SUB-MOD
PB12: //Otieno Atieno . Dr Odhiambo . ten o'clock

Otieno-OBJ Dr Odhiambo-SUB ten o'clock-ADVL

Extract 2.30

(Facility B, Tape 2, episode 16, M/61-75/lm/o)

RB2: Good morning sir=
PRE-MOD-SUB
PB16: = Can I make an appointment with a throat specialist please . this week on Friday

Can-AUX I-1PS an appointment-OBJ with REL this week-ADVL

2.6 Conclusions

A number of observations can be drawn about the discourse patterns described by the researcher in this chapter. It has been noted that the transactional structures at the reception desk of the two health facilities are similar to Mitchell's (1957) predictable stages, Ventola's (1987) recursion and Hewitt's (2006) transactional structures between bus drivers and passengers. In addition frontline encounters at the reception include the frequent checking of personal information which is characteristic of receptionists and clients in other institutional settings. The language of individual moves is frequently patterned, reflecting the routine nature of the tasks which are being carried out. This is similar to Goffman's (2002) roles and identity theory which this study

is based upon with regard to the different roles and identities constructed by receptionists and patients in their endeavor to achieve their goals.

The way in which the patients make their service bids can also be seen as evidence of high level of knowledge of the situational requirements and the strong orientation to service goals. The researcher has illustrated this very clearly by the analysis of the service orientation stage of the encounters. The frequent use of covert service offers by receptionists, the extremely high incidence of service bids in response to all types of opening, and elliptical formulation by patients in both health facilities, suggest that both the receptionists and patients are familiar with the social practices of the frontline and are keen to maintain their roles and identities during the encounters.

The researcher has also illustrated that although there are varying levels of efficiency among the receptionists and patients at the two health facilities when accomplishing verbal encounters at the reception, there is complementarity and reciprocity in their joint completion of administrative encounters. Apart from when there are problems, tasks are completed rapidly through a small amount of discourse stages. These involve, first, information checks, which can include extended sequences of orderly, co-ordinated talk, second, confirmation sequences which as well as performing the important task of ensuring that information is accurate, also facilitate transition to the next discourse stage, and lastly, resolution sequences, which have several functions that include first, responding to service bids, second, marking the completion of tasks, third, indicating the ending of encounters and lastly, providing the interpersonal forms which mark the ritual of passage from a state of talk to the lack of it.

Therefore as Duranti (1997) has observed that all language use is situated on formulaic creative patterns which are indexed for socio cultural roles, this study has demonstrated the different roles and identities enacted by receptionists and patients at the two health facilities (Goffman, 2002). In addition the researcher has also stated that despite the tight structure of the discourse and the high incidence of formulaic language, both the receptionists and patients have ample room for subtle variation in the enactment of individual moves in frontline discourse at the receptions of both facilities.

CHAPTER THREE

DISCOURSE ROLES AND IDENTITIES OF RECEPTIONISTS AND PATIENTS

3.0 Introduction

In this study receptionists and patients at the two health facilities were seen to be enacting their receptive roles and identities, respectively as service seekers who wish to have health problems resolved, and purveyors of services, who are able to provide access to solutions. As outlined earlier receptionists and patients categorise and position themselves and others, changing frames and footings and displaying the roles and identities which are salient for them at the time of speaking.

Roles and identities are exemplified by discourse decisions at different linguistic levels, from phonological choices to lexico grammar and discourse organisation. The study concentrated on two areas which revealed the positioning of receptionists and patients at the two health facilities. First, the researcher considered how receptionists and patients situate themselves and others through person reference, and lastly, demonstrated how receptionists and patients add to the performance of roles or the representation of self through changes of topic. Throughout this section the researcher kept in mind the second research question: How do receptionists and patients enactment their discourse roles and identities?

3.1 Person reference

According to Duszaki (2002) the 'us-them' relationship is an aspect of social deixis which has a central role in identity construction. This relationship is conventionally marked by indexicals such as forms of address and pronouns, which reveal the production pattern which is adopted by

the speakers (Goffman, 2002). Speakers include first persons (I/we) and addressees second persons (you). Therefore, the researcher analysed forms of address as indicators of how speakers position themselves in relation to their addressees and then pronominal reference as a way of understanding how speakers represent themselves.

3.1.1 Forms of address

Biber (1999) as cited in Hewitt (2006) provides three main styles of address which include, first, zero address in which no vocative form is used, second, respectful forms such as title and surname or deference marker, and lastly forms such as first names, diminutive, endearments and solidarity markers, which suggest either familiarity or intimacy.

In addition the omission of a form of address is rationally the most neutral approach, because it avoids any expression of relationship or status difference. Titles and deference markers are conventionally used by those in subordinate positions to address those with greater power or higher status but may also be deployed in remedy for face threats (Brown and Levinson, 2001). First names according to McConnell-Ginet (2003) are used reciprocally between people who are close to one another or non-reciprocally down a hierarchy. This study therefore, adopted these forms of address with the aim of finding out whether they are present in these facilities or not.

Hence, the main forms of address which occurred at the two health facilities A and B are, among receptionists, titles (Mr. or Mrs. and surname), deference markers (Sir), first names and terms of endearment (sister, dear). Among the patients there is one solidarity marker (sister wangu-*my sister*) and several different terms of endearment (sister, dear,). Patterns of use at the two health facilities were considered in turns, first receptionists and then for the patients. The

researcher noted that the first choice for receptionists at health facility A was zero address form. First names and titles together with the patients' names are used in about equal measure of the use of address forms. Terms of endearment and deference markers account for minimal use of the address forms. These patterns are presented out in Table 13.

Table 13: Address forms by receptionists at facility A

Receptionists	Zero		First name		Endearment		Title + surname		Deference marker	
	F	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**
RA1	15	10	10	4	5	2	5	8		2
RA2	9	6	7	3	3	1	4	6		1
M/F TOTAL	24	16	17	7	8	3	9	14		3
TOTAL	40		24		11		23		6	

The table shows how the two receptionists favour different styles. However, in the encounters both receptionists use direct address forms because as reported by the receptionists, it is the most practical approach since it ensures that mistakes with names are avoided. RA1 frequently uses first names especially with female patients, even when she does not know them, and also occasionally title plus surname, five times with males and eight times with female patients. RA2 also uses titles, four times to address male patients and six times to address female patients. Deference markers are also used by the two receptionists but to a lower degree, that is, RA1 two times and RA2 one time, to address patients. Table 14 shows that the address patterns of receptionists at health facility B are in some ways similar to those at health facility A, because the most frequent choice by receptionists is the omission of a direct address and use of first

names. However, endearments, titles and deference markers are rarely used in the encounters between the receptionists and the patients.

Table 14: Forms of address by receptionists at facility B

Receptionists	Zero		First name		Endearment		Title + surname		Deference marker	
	F	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**
RB1	12	13	10	5			1	3		
RB2	11	6	7	4				2		
M/F TOTAL	23	19	17	9			1	5		
TOTAL	42		26				6			

The study found that there are fairly similar levels of use of zero forms and first names at both health facilities, less use of titles at facility B than at facility A, and more use of terms of endearment at health facility A as opposed to B. The level of deference markers is higher in health facility A than B. The study did not find any use of deference markers by receptionists at private health facility B, although it was noted that there is a strong tendency for deference markers and titles to be used more to address males in both facilities.

The study found that the high levels of use of endearment at facility A is entirely due to the interactional style of RA1, who uses endearments 7 times to address patients at the government health facility. The receptionist use ‘sister’ sometimes more than once in the same episode to address female patients and ‘dear’ to address male patients. In addition, RA1, uses a first name 14 times, a title plus surname 13 times, and deference 2 times in her encounters with patients.

RA2 equally uses the same forms as receptionist RA1 which create a more clearly defined rapport with patients at the facility.

Overall the study has found that receptionists have routine personal styles of address use but occasionally make adjustments in response to individual patients at the facilities. In addition the researcher observed that a relationship is created between the receptionists and the patients through the level and style of forms of address used and their preferred styles of opening. Receptionists who open encounters in the rapport centered style, for example, by greeting 'hi', are more likely to use the first names of patients and receptionists who adopt a formal style when providing service signals are more likely to use deference markers and titles. The study has also noted that receptionists at health facility A and B react differently to male and female patients. They are inclined to show deference to male patients but with females use first names or terms of endearment, which is designed to build solidarity or communality but is also interpreted as being over familiar or patronising when there is no previous relationship between the receptionist and the patient.

Therefore in the majority of cases, the use of terms of endearment at health facility A seem to mark solidarity based interactional style. This is particularly true of male patients in the older age groups, as in the case of PA6,who makes more than one use of 'nyathina' (*my child*) (Extract 3.1, line 3 and 5).

Extract 3.1

(Facility A, Tape 1, episode 6, M/41-60/lm/em)

1 PA6: Abondikoni form kakiwacho

Abondikoni-1PS-AUX-V-PP form-INS kakiwacho-ADVL

(*I will fill in the questionnaire as requested*)

2 RA2: (*Hands questionnaire to patient*)

3.PA6: Ero kamano **nyathina**

Ero kamano-PRE-MOD you-2PS nyathina-DET-OBJ

(*thank you* ***my child***)

4 RA2: kate e box kisetieko

Kisetieko-REL-2PS-AUX-SUB COMP

(*put it in the box when you've completed*)

5 PA6: To atimo kare **nyathina**? . ero kamano (*passes over prescription request*)

To-COP-DEM nyathina-DET-N ero kamano-PRE MOD 2PS

(*is that right* ***my child****?* . *thank you*)

In this Extract, the term of endearment seems to be a habitual means of reinforcing face saving moves, boosting the thanking move (line 3) and mitigating the request to have the receptionist assist in the prescription given (line 5).

The researcher also observed one example where endearment is used as an attitude marker in which the patient signals his strong appreciation of the work of RA1 who has helped him to be discharged from the health facility. The patient refers to the receptionist as 'nyara'.

Extract 3.2

(Facility A, Tape 1, episode 9, M/41-60/lm/esm)

RA1: Donge isetieko?

Donge isetieko-2PS-AUX-BE-V

(*you've been sorted*?)

PA9: Ero kamano . **nyara**

Erokamo-PRE MOD-2PS nyara-DET-N

(*thank you* . ***my daughter***)

In Extract 3.2 the patient uses the endearment when he has already achieved his goal. In summary, patients have less choice than receptionists in the use of forms of address because they have no way of knowing receptionists names, whereas receptionists do know their names.

3.1.2 Pronouns

Coupland and Coupland (2000) as cited in Labov(1997) and Hewitt(2006) suggest that pronominal address and reference are the most obvious and powerful linguistic features used to mark relational frames. They also, as Goffman (2002) has shown, reveal the balance of power between speakers and through them. Goffman (2002) observes that 'I' may refer to more than one figure, or persona, and may be the principal, the author or the animator of what is said depending on the footing which is adopted while 'we' indexes discourse referents who are seemingly limitless. The study found that receptionists and patients use both first person singular (I, me, my) and first person plural (we, us) for self reference. In addition subject pronouns are sometimes deleted to give expressions such as 'help you?', 'just give you this', or

'got an appointment'. All these encounters were observed at health facility B. The self referential pattern of patients was noted to be straightforward, although many patients were found to make elliptical statements in which the subject pronoun is omitted. A small number of patients use the pronoun 'we' when representing other family members at the health facility, while a majority use first person singular pronouns and possessives. In contrast, it was noted that receptionists assume different footings for different actions, sometimes in the course of the same encounter, or the same turn (see Goffman, 2002). According to Goffman, on roles and identities, receptionists use first person pronouns for the referents listed below:

I1 – non institutional self

I2 – representative of institution

We1 - I and all other people

We2 – I and patient

We3 – I and receptionist colleagues

We4 – the health facility

Therefore, as Labov (1997) and Hewitt (2006) state that these choices indicate whether personal responsibility is assumed, responsibility shared, or health facility attributed elsewhere, the study also found the same interpersonal dynamics with regard to receptionists and patients. In addition when they are correlated with different actions, they provide insights into receptionists' interpretation and understanding of their different roles and identities (Goffman, 2002). An outline of receptionist pattern is provided in Table 15.

Table 15: Pronoun used by receptionists

Activity	1st person s.	1st person p.	3rd person s/p.
Reception tasks	I1 and I 2		
Apologies	I2		
Patient problems	I2	we2, we3, and we4	
Appointment allocation	I2	we3 and we4	various
Registration / procedures	I2	we4	various
Comments	I2 and I2	we1 and we2	various

The researcher noted that in both health facility A and B, reception tasks such as making service offers (e.g. can **I** help you?) and issuing instructions (e.g. kindly take a seat for **me**), or in routine apologies for locally generated errors (e.g. **I'm** sorry about that), a receptionist's 'I' should be interpreted as I2 (the representative of the institution).When carrying out these tasks, it was found that receptionists appear to draw on the authority they are granted in their special capacity as institutional representative to act as authors and animators of an institutional voice (Goffman, 2002).When patients bring problems to the reception and receptionists continue to use this voice, they also use 'we' which seems to stand for we3 (I and receptionist colleagues). When allocating appointments, receptionists again use 'I' and 'we' for I2 and we3 however, in some cases, appear to further reduce direct personal responsibility either by using 'we' in the we4 sense (health facility) or by attributing the health facility computer (health facility B). 'We' also seems to be used in the we4 sense during registration or when health facility rules and procedures are explained. There is also the use of the personal I1, we1 (I and all other people) or we2 (I and patient), in which the speaker is principal as well as animator and source.

Therefore how this variation works in the health facilities is demonstrated, first, in the analysis of pronoun use during appointment allocation at health facility B, and second, through a consideration of the institutional and interpersonal functions of the self referring comments of receptionists. In the first illustration of appointment allocation at facility B, in Extract 3.3, the receptionist seems to be speaking in the I2 voice, in her institutional role (line 1 and 4).

Extract 3.3

(Facility B, Tape 2, episode 17, M/41-60/ly/ey)

1 PB17: Good morning there (.) **I**'ve to make an appointment . for blood test at the lab

PRE MOD-DEM 1PS-AUX OBJ ADVL

2 RB2: Right . I can give you eleven o'clock . or two o'clock appointment

PRE MOD 1PS AUX 2PS OBJ

3 PB17: Nothing different?=

PRE MOD N

4 RB2: = the latest being . mmh . eight . or **I** can give you . eh (.) the evening at five

DET-PRE MOD-N 1PS AUX 2PS OBJ

In this Extract the receptionist RB2 takes personal responsibility for the appointment allocation and there is no separation of individual and role. Appointments are presented as gift from the receptionist ('I can give you eleven o'clock', line 2 and 4), which is an open acknowledgement of gate keeping power of receptionists. However in Extract 3.4, receptionist RB1 appears to make a distinction between the institutional position and her personal performance.

Extract 3.4

(Facility B, Tape 2, episode 14, F/lw/om)

1 RB1: <u>Hello!</u>

DET

2 PB14: Hello . can I see the (.) Dr Nyakinda on the (.) eleventh

DET AUX 1PS OBJ ADVL

(*receptionist confirm the diary)*

3 RB1: (.) Now **we will** see what **we** can do . **I** don't know whether **I** can help

DET 1PL AUX REL 1PL AUX DO 1PS DO-NEG REL

The receptionist RB1 begins by using the collective *we*, which can be interpreted as the voice either of the health facility or of the reception team, or even as a marker of solidarity with the patient. However when she turns to the physical task of finding an appointment for the patient in the diary, she switches to an in role first person singular. The study concludes that the alternation between 'we' and 'I' forms that RB1 uses indicates acceptance of shared involvement in the facility responsibility. This is made clear when one compares her approach to appointment making with the position she adopts when dealing with research forms. Extract 3.5 shows that she distances herself from the research process by using the adverb 'apparently'. This indicates that the responsibility for the action lies elsewhere.

Extract 3.5

(Facility B, Tape 2.episode 19, M/26-40/lm/om)

RB1: (*hands questionnaire to patient*) apparently I've to give you this

PRE MOD 1PS AUX 2PS OBJ-DEM

The study also found that there are encounters in which the receptionists distance themselves from appointment decision by passing responsibility for availability to other health workers. This is shown in Extract 3.6, in which receptionist RB2 uses the pronoun 'he' to refer to Dr Ogweno, who has already been mentioned by the patient earlier.

Extract 3.6

(Facility B, Tape 2, episode 40, F/41-60/ly/ey)

1 PB40: I would like to make an appointment with Dr Ogweno {RB2: yes} some time on

2 Friday . may be at nine morning . or whatever available

I-1PS would-AUX appointment-OBJ with-REL

3 RB2: (2) On Friday (3) he's got on Saturday at . eleven . next Monday afternoon or evening

On Friday-PRE MOD he-A

It was also noted in the study that receptionists sometimes go further to avoid the use of the role specific I2 and show a willingness to attribute the health facility to the computer, which becomes a participant alongside human agents.

Extract 3.7

(Facility B, Tape 2, episode 18, M/lm/ey)

1 RB2: Hi there

Hi-DET there-SUB

2 PB18: I want an appointment with an ENT doctor

I-1PS-A an-ART appointment-OBJ with-REL an-ART doctor-OBJ

(*receptionist checks the diary*)

3 RB2: (4) for any day Wasike? You need to register so that **the computer** generates your detail **We're** . looking (.) maybe the following week

For any-PRE MOD day-SUB wasike-A you-2PS that-DEM the-ART computer-INS

4 PB18: (.) I prefer it this week

I-1PS prefer-SUB COMP it-OBJ this week-ADVL

5 RB2: You want it this week?

You-2PS it-OBJ this week-ADVL

6 PB18: Ya

7 RB2: If you could call **us** (.) may be half past four today for tomorrow

If-COND you-2PS could-AUX us-1PL may-AUX

The receptionist starts by attributing responsibility for appointment availability to the computer (line 3) and telling the patient, who is marked by the use of familiarised first name what he is supposed to do ('you need to' line 3). As the short negotiation is carried out, the receptionist aligns herself with the patient ('we're looking'). By attributing responsibility to the computer, the receptionist disguises her power to allocate appointments, distances herself from the situation in which an appointment is not immediately available, and thereafter constructs herself, like the patient as being unable to do anything, when in reality she has a number of appointments.

Therefore, although there are no overall differences between the two health facilities with regard to patterns of pronoun use, individual receptionists approach their work in different ways. For example, receptionists at facility B use 'I' most of the time while receptionists at

facility A adopt 'we' or pass the health facility to a third person. The researcher observed that both styles of pronoun use were consistent with these receptionists' comments made during interviews. Receptionists at health facility B treated work as a profession and expressed a high degree of personal commitment to carrying out their work effectively, while receptionists at health facility A stated that they were in the job only because they were not qualified to do anything else and that they were not paid to take personal responsibility for the facility decisions. In these terms, the researcher concluded that it was entirely understandable that receptionists at facility B always use the first person singular whereas receptionists at facility A attribute the health facility to a third person or share it with others.

3.1.3 Person reference and discourse roles and identity

Holmes and Schnurr (2005) state that the use of forms of address by receptionists is an additional feature of their relational practice and the variations in individual choice like those observed in this study, contribute to the identity style which each receptionist projects for the role. The patterns of use observed for address forms indicate that some receptionists take an approach which leans towards social solidarity and rapport, while others routinely maintain social distance. A third group of receptionist move between these dominant styles and others maintain neutrality. It was also found that there are examples of stylistic changes which appear to mark responses to individual patients or groups of patients, for example with regard to age and gender groups. This further indicates the major social and institutional differences between health facility A and B.

Hanks (1990) states that all deixis is oriented to and constrained by the asymmetric distributions of cultural capital in the form of prestige, knowledge and sanctioned access to recognised modes of speaking, rights over space and objects. The use of a name or title is a form of cultural capital which is available to receptionists but not to patients. The asymmetry between the two groups is particularly salient when receptionists address patients by their first names. It is the more powerful member of a dyad who instigates asymmetric address. Therefore when receptionists use a first name in addressing a patient, it can be seen as a means by which they imply that patients are subordinate, not only to receptionists themselves but also to doctors, whose formal titles are always used during interaction between receptionists and patients. However when receptionists use deference markers or titles, they reduce the asymmetry by placing themselves in a position of subordination. Patients who make use of terms of endearment or solidarity markers redress the imbalance created by the unequal distribution of knowledge of names and at the same time indexing their transportable social roles and identities and finding additional support in the pursuit and attainment of transactional goals.

The researcher also found that receptionists and patients use different pronouns to mark changes of footing. Most receptionists especially at health facility B take personal responsibility for the performance of the reception work routine but others especially at facility A, are inclined to index shared institutional responsibility for gate keeping decisions by pointing a third person agent.

3.2 Topic

The study found that receptionists and patients in both facilities changed the discourse frame or brought other identities into play through changes of topic at the reception. The researcher came up with five forms of talk in both health facilities which included, first, task related topics which are related to everyday reception activity. These talks were also identified by Hewitt (2006). This includes supplementary observations by the receptionists and requests of additional information from the patients. Second, there are topics which are not directly related to the completion of the reception work. This includes additional task talk, small talk and research talk.

In the following section, the study considers the roles and identity implications first of task related topics and then of additional task talk. The researcher then analyses the contribution of small talk to the construction of speakers' roles and identities, and finally, make comments on the research related talk.

3.2.1 Task related topics

It was noted that in task related comments, the transactional focus is maintained but there is a topic shift towards actions supplementary to those completed in the four routine stages, that is, service orientation, information checking, confirmation and resolution. Comments can be either general observations or specific observation about actions by the receptionists or patients. Labov (1997) and Hewitt (2006) also make the same observation about the routine stages. In Extract 3.8, a patient makes an additional comment to the receptionist.

Extract 3.8

(Facility A, Tape 1, episode 7, M/16-25/lm/ly)

1 RA1: Wacha ni agalie kama atakuja Monday tarehe tisa

Ni-3PS kama-REL ata-AUX

(*let me check whether the doctor will come on Monday 9th*)

2 PA7: Sasa nikuje lini?

Sasa-DET nikuje-1PS-DO-V

(*so when do I come?*)

3 RA1: Kuja Friday

Kuja-V Friday-OBJ

(*come on Friday*)

4 PA7: Usiweke mtu mwigine mbele yangu

Usiweke-DO-NEG-V mtu-OBJ mbele yangu-ADVL

(*don't put anybody in front of me*)

In this Extract the patient who is unable to get the appointment he needs, give the receptionist what is on the surface a very direct instruction (line 4). However as Searle (1979) notes, the felicity conditions are not met for this imperative to work as an order, since appointment which are not yet available cannot be reserved. Therefore this has to be treated and interpreted as a joke and is an illustration of additional linguistic capital which indexes male dominance.

The researcher also noted a change of frame in receptionist RA1, who at all times shows that she is sensitive to the relational as well as the transactional needs of patients .This adds to the relational value of an encounter with one patient who wants to make an appointment with the

consultant physician, to have sugar levels checked and a heart condition monitored. The receptionist has to therefore give a careful outline of reasons for double appointment.

Extract 3.9

(Facility A, Tape1, episode 12, F/41-60/ly/ey)

1.RA1: Sasa hiyo huko na barua ni special clinic . wewe ni odhiambo . wanaangalia

2 vitu zingine

Sasa-DET hiyo-DEM huko-2PS

(now *one that you've got the letter about is a special clinic . you are Odhiambo*

They are monitoring certain things)

3 PA12: sasawa

Sasawa-1PS-V

(*I see)*

4 RA1: (4) Sawa . ni vile hizi zita chukua nusu saa kwa sababu (.) utakuwa tested

Sawa-DET hizi-DEM zita-DEM utakuwa-2PS-AUX

(*right . it's just that these are half an hour appointments because (.) you'll be tested*)

5 PA12: Sawa sawa

Sawa sawa-SUB-COMP

(*its okay*)

6 RA1: Na itachukuwa muda

Itachukuwa-SUB-V muda-SUB-COMP

(*and it takes a bit longer*)

In the above Extract, the comments seem to be designed to reassure the patient. This is suggested not only by the receptionist's explanation but also by the down toning of the content through hedging, 'it's **jus**t that', (line 4), use of vague language, 'special clinic', (line 1), 'certain things' (line 2), which also maintains patient confidentiality, and 'a bit longer' (line 6). There is also the sharing of the perspective of the patient, 'you are Odhiambo' (line 1) and 'you'll be tested' (line 4). Therefore by introducing a topic and presenting it, the receptionist uses additional style as a form of symbolic capital to add another dimension to the performance of her institutional role by bringing herself closer to the medical staff (doctor) whose work she helps to organise.

3.2.2 Additional requests and task talk

Labov (1997) and Hewitt (2006) observe that patients make requests for additional information which are related to the standard task content of the encounters. Most of the requests related to standard tasks concerning medical staff and therefore tell us something about the information which reception expertise does entail. This was also observed in the data collected from health facility A where a patient is not aware that she has to pay for the prescription given at the health facility.

Extract 3.10

(Facility A, Tape 1, episode 15, F/16-25/new patient)

1 PA15: Na penjo . itimango . napenjo ka yath ichulo

Na penjo-A-1PS-AUX-SUB-COMP itimango-REL-DO napenjo-1PS-BE-SUB-COMP ka-COND

(*I was wondering . what do they do . I was wondering if we pay for medicine*)

2 RA2: (2) Iwacho?

Iwacho-OBJ-COMP

(*sorry?*)

3 PA15: Be ichulo yath esiptande sirkal //

Be-DO-3PS esiptande sirkal-ADVL

(*do we pay medicine in government hospitals //*)

4 RA2: // Ibo chulo matin

Ibo-2PS-AUX

(*// you will pay very little*)

This young female patient is evidently not aware that prescription is paid for at government health facilities and asks if she is to pay a fee for the medicine. She does this vaguely with the word 'what do they do' (line 1) and then, when the receptionist does not understand and so initiates repair in line 3. This encounter reveals that the patient has an inadequate understanding of how to play her role and the receptionist has to come in and help through additional information.

3.2.3 Small talk

McCarthy (2003) points out that small talk is in some way an extra to the business at hand. She discusses a range of talk types from brief phatic exchanges to personal anecdotes to evaluative comments. This study considers a type of small talk referred to as overly talk by Kuiper and Flindall (2000). This type of talk takes place during the completion of transactions and is

relational in content and covers personal or situational topics which are not connected with business at hand.

The study observed that most of this talk is confined to single comments which are not developed by receptionists. The patient's request about a receptionist's personal well being 'are you well' is not taken up although this may be because the receptionist does not hear it. An example of a receptionist ignoring additional comments is shown in Extract 3.11.

Extract 3.11

(Facility B, Tape 2, episode 21, M/41-60/ly/ey)

1 RB2: And you're . what can I do for you?

2PS REL AUX DO 2PS

2 PB21: I'd like to make an appointment please . with Dr Obidi

1PS AUX ART OBJ ADVL

3 RB2: Aha

4 PB21: **I'd better write it in my diary {RB2: aha} and see how it works out (6)**

// **not sure what have written already**

1PS AUX DET N

5 RB2: //His first appointment wouldn't be till second of July

3PS POST.MOD AUX NEG

6 PB21:// **I . I thought it'd be something like that** (4) **thought I had my diary with me**

(3) oh ok . it should be okay with me . second July then.

1PS AUX BE DEM

7 PB21: So that's the second of july

DEM COP ART

8 RB2: (2) At two afternoon

MOD

9 PB21: At two thirty pm

10 RB2: (.) with Dr Obidi

REL-COMP

11 PB21: Okay (.) right . **he seems to be popular**

12 RB2: Yes he is . and he is very commited as well

In this Extract the receptionist treats the task related comments about the patient's dairy (line 4 and 6) as self directed, responding only as far as is necessary for an appointment to be made but she does react to his hedged assessment of doctor (line 11). She does this through two moves (line 12). First there is an agreement with the patient's assessment and then a remark in which she treats the comment about the doctor's popularity as a cause to the difficulty of getting an appointment with him. By orienting to the comment in this way rather than for example encouraging discussion of reason for the doctor's popularity, she ensures that the discourse perspective remains task related and thus holds to her institutional role.

3.3 Conclusion

In this study the analysis of person reference, speech styles and supplementary topics just as in Labov (1997) and Hewitt (2006), has revealed the presence of a variety of a speaker positions and attitudes. It has been observed that receptionists mark their occupancy of the reception role by increasing the formality of their speech styles or using less informal language. In addition,

while some patients occupy formal positions, remaining in their roles within their situated identities and limiting the range of their discourse, others draw on symbolic capital available to them from their wider identities and hence construct both themselves and their interlocutors as persons with identities beyond the current role (Zimmerman, 1998).

Participants in this study at the reception appear to follow existing norms more frequently than challenge them. This is also captured in Sarangi (1999,) Labov (1997) and Hewitt (2006). This is because there is little digression from the stages and moves which define frontline discourse activity types. Furthermore, patients are not given much opportunity, nor do receptionists often choose, to draw on full range of linguistic capital available to them.

According to Hanks (1990) as cited Hewitt (2006), shared knowledge is symmetric and separating knowledge asymmetric. Patients may share part of the receptionists' knowledge of the frontline but it was observed that receptionist access to privileged inside information for example, names of patients and number of appointments available, and their knowledge of the bureaucratic obligations associated with their roles, there is knowledge of symmetry in receptionists favour. Moreover, receptionists make a display of the authority which this asymmetry gives them, for instance when they make use of the power of naming, especially first names or terms of endearment, which imply a rank disparity in their favour. In addition, when receptionists use first person pronouns during decision making about appointment it shows asymmetry in their encounter with patients. When receptionists close down off task topics introduced by patients or when they reformulate patients' utterances using more formal or specialist terminology are all examples of asymmetrical interlocution.

Cameron (2000) as observed in Sarangi (1999), Labov (1997) and Hewitt (2006), states that receptionists are often under pressure and it would be inappropriate for them to spend too much time in off task or the expression of self, but immersion in the role and identity. However if carried to extremes, it can become the denial of selfhood of the receptionists (Cameron, 2000). Therefore, receptionists use popular idioms and share humour with patients in order to expand frontline discursive capital and construct a more multi facetted version of self while at the same time improving the service offered to patients.

CHAPTER FOUR

CONSTRUCTION OF POWER THROUGH ROLES AND IDENTITIES

4.0 Introduction

Goffman (2002) on roles and identities, states that social actors maintain relationships by collaborating to protect both their own face and that of others and ritual interchanges are used to maintain equilibrium, between participants. Goffman (2002) defines face as the positive social value a person effectively claims for herself by line others assume he has taken during a particular interaction. He identifies two types of ritual interchange, which include the supportive and the remedial. In supportive interaction, ritual equilibrium is maintained through the exchange of verbal offerings, hence the power is symmetrical, whereas in remedial ones interlocutors negotiate power to real or projected self.

Goffman further suggested that the choice of face protecting move is determined by factors such as the perceived level of imposition and the relative status and degree of familiarity of speakers, with higher levels of imposition and greater differences in status and familiarity requiring more attention than lower ones.

In this study, although the encounters in the data take place in the same institutional context and involve speakers with a limited set of roles, structures of face protection are nevertheless affected by a number of differences between sites, activities and participants. First, health facility A, is visited by socially deprived speech community who use local variety and lower variety of English, whereas health facility B is visited by a middle class speech community with its own social and verbal rules. Second each health facility has its own verbal norms, for

example, members of staff at health facility A, have informal and egalitarian working relationship whereas at health facility B, there is formal and hierarchical working structure for receptionists. Third, it was observed that there are variations between the dominant relational styles of individual receptionists and patients at both facilities. Fourth different activity types involve different levels of imposition which determine if the relationship is symmetrical or asymmetrical. Fifth, it was noticed that there are different forms of face threat inherent in the roles of receptionists, who provide services and are gatekeepers, and patients, who require them. Lastly, the researcher observed that there are different understanding of the rights and duties created by the institutional context.

This study therefore begins the discussion of construction of institutional power through different roles and identities at the reception with a reanalysis of the service orientation procedures which were discussed earlier. The study will then examine the forms of remedy provided by receptionists as gatekeepers and patients as service seekers when infringements are committed. The analytical method used by researcher in this study to identify patterns of power structure consists of actions by receptionists and patients across different contexts. The study pay particular attention to fixed ritual forms such as greetings and conventional offers and request to demonstrate how receptionists use their institutional power over patients. This chapter therefore seeks to answer the third research question: How do linguistic patterns and practices implicate in the construction and orientation to institutional power?

4.1 Service signals

The study observed that receptionist's opening move functions as a signal that service is available but it also provides evidence of the type of participation frame that receptionists and patients wish to adopt for the interaction (Goffman, 2002). Therefore, as well as indicating that transactional work can be done, a receptionist's service signal projects a particular form of a server who has institutional power to provide service and a client who is powerless and dependent on the receptionist. Each of the service signals used (greetings, elicitors or a combination of the two) encodes a different approach to power structure. In addition it was noted that both greetings and offers have conventional power implications. Greetings are access rituals, supportive moves which neutralize the potential threat of patients not receiving the services at the health facilities by building rapport with the receptionists. Elicitors, in contrast, are task focused used by receptionists to keep their space and institutional power.

The researcher found that greetings are widely used in health facility B than at facility A. The high incidence of supportive signals, rapport building and greetings seem to reflect both the health facility policy of creating a friendly environment for its patients. This demonstrates symmetrical relationship between receptionists and patients at the health facility. It is also a possible consequence both of a stated aim of providing a friendly service and the professional approach shared by all members of staff. The relatively low number of greetings at health facility A is a result of lack of professional training and formality of asymmetrical relationship created by the receptionists.

It was observed that although there is evidence that each health facility has a dominant relational styles, the receptionists within each health facility do not behave in a uniform manner

in construction of institutional power. Each has a preferred routine speech act, or set of speech acts, with which she opens an encounter with a patient. The different styles of receptionists are presented in Table 16, which shows the code number of the receptionist, the preferred act type, and the preferred realisation of the act.

Table 16: Service signals by receptionists at the facilities

Code	Act	Preferred realisation
RA1	Offer, greeting, eye contact	can I help you? hello --
RA2	Elicitor, offer, eye contact, greeting	yes? may I help you? -- how are you?
RB1	Greeting, eye contact, offer	hi there -- can I help you?
RB2	Greeting, eye contact,	Morning/afternoon --

This table indicates that most receptionists use a mixture of act types but the preference for a particular format for power construction whether symmetrical or asymmetrical is more marked in some receptionists than others. The researcher observed that receptionists at health facility B use greetings more times than other acts at the reception to break power barrier between themselves and the patients. By doing this, they also over come a relationship of dominance and submission (Goffman, 2002).

Receptionists at health facility A prefer making offers with ‘may I help you’ and ‘can I help you’ which marks for asymmetrical relationship between them and the patients. They are seen as solving problems brought by the patients at the health facilities thereby showing a relational

facet of institutional power facet at the reception. For patients to have their problems solved they must pass through the receptionists who act as gate keeper at the health facilities.

4.1.1 Greetings

It was found that when receptionists issue the service signal with a greeting, they are using a pattern which is common in face to face interaction in creating egalitarian relationship between participants. According to Goffman (2002) a greeting is an everyday ritual, a small act of phatic communion, which protects both speaker and hearer by acknowledging that a rite of passage is taking place through symmetrical relationship. According to Dare (1999), greeting can be individualised to encode social meanings by eliminating dominance in a relationship. Table 17 shows different styles of greeting found in the study.

Table 17: Greetings used by receptionists at the health facilities

Greeting	Facility A	Facility B	Total
Hello	5	15	**20**
Hi	-	10	**10**
Morning/afternoon	2	8	**10**
Good morning/afternoon	3	7	**10**
Total	**10**	**40**	**50**

The table indicates that each form of greeting used by the receptionists reflect a particular underlying attitude to power construction. The most frequently used type, ‘hello’ (20 tokens), which is used far at facility B than A, connotes an approach designed to be rapport oriented but non personal. It belongs to a more standard language style, which explains why it is most used

at health facility B, which has a very formal and professional way of doing things. Correspondingly, as one would expect, the informal 'hi' (10 tokens) was only observed at facility B. This indicates a rapport oriented approach, but the remaining greeting types used, 'good morning/afternoon' in its full (10 tokens) and reduced form, 'morning/afternoon' (10 tokens), are more formal and associated with social distance, particularly when used in combination with a deference marker or formal title.

These greetings suggest that although receptionists use them as attention getters and signals of availability, their greetings do encode additional information, both about their identities as greeters and their perceived power dominance with the patients.

4.1.2 Offers

The researcher found that offers are made using variants of the conventional polite formula, 'can I assist you?', in which 'I' the receptionist, seeks permission to give help to 'you', the patient. By using this formula, a receptionist is presenting herself as subservient to the patient, putting her own face at risk while protecting that of patient, who is given the option of declining (c.f Hewitt 2006). It was also observed that the 'can I assist you?' offer is ritualised form which is institutionalised, predictable and so formulaic that is almost bleached of semantic content (Goffman, 2002).

The study noted that although offers are made using one or other form of 'can I assist you?', there are a few receptionists who use a different formulation in both health facility A and B. When receptionists RB1, who has a very formal routine style, makes an offer, she always uses the verb 'may', which, because it encodes the modality of permission rather than possibility

(‘can’), means there is greater distance and less imposition. On the other hand, RA1, who opens encounters more frequently with a greeting, routinely uses the longer phrase ‘naweza kuku saidia na jambo lolote?’(*can I help you with something*?) as a prompt after research forms have been exchanged. In this case the face threat to the patient is reduced through the addition of vague prepositional phrase ‘with something’, which increases the scope of the offer and at the same time provides implicit acknowledgement that, while research forms were being exchanged, a side play was in progress and the receptionist was not helping the patient attain a service goal (Goffman, 2002).

There are also occasions when receptionists make less routine choices. In one encounter, with a male patient aged 61+, RB2, for whom the routine choice is ‘can I help you?’ asks ‘may I help you?’ (Facility B, Tape 2, episode 25, M/61-75/ly/ey), perhaps switching to a more formal and respectful style because of age, or status, of the patient.RB1 also diverges once from her routine choice of ‘can I help you?’ producing the more distant, and thus more face protective, ‘could I help’ when making the service offer to a woman aged between 16-25 who attends the facility regularly (Facility B, Tape 2,episode 30,F/16-25/lm/om).

4.1.3 Elicitors

Goffman (2002) observes that elicitors are functionally similar to greetings but they index a different roles and identities which generates a different power approach. The researcher noted two forms of elicitor: non-explicit and explicit. Receptionists in the two facilities use four different non-explicit elicitors: ‘yes?’, ‘are you being served there?’, ‘who is next?’ and ‘who is first?’.The study found that the most common of these is the single word ‘yes?’ spoken with a rising intonation. This indexes the power wielded by the receptionists as gatekeepers of these

institutions. It is the preferred opening move at the public health facility A and it is also used once by RB2, who employs a wide range of openings. Therefore the researcher concluded that 'yes?' is the service signal which has the least relational content, unless it is combined with a rapport- building term of endearment.

The next most frequent choices of non - explicit elicitor are 'whom is next?' and the similar 'who is first?', both again very direct and devoid of overt face protecting content. In addition, both choices presuppose that there is more than one person waiting to be served, and therefore point to the absence of relational power move in the form of an apology for any delay. The study noted one instance of a direct question about service at health facility A, 'are you being served there?', which is again mitigated, this time by the direct adverb 'there', which increases the attention to face by situating the discourse perspective with the patient.

The second group of elicitors noted in the study, the explicit ones, are used as prompts when the service bid is delayed. These were noted in private health facility B. The two main forms used are 'have you got an appointment?' and 'do you have an appointment?'. There are also three explicit elicitors which refer to prescriptions: 'is there anybody waiting on a prescription?', are you waiting for prescription?' and 'have you come for prescription?'

Therefore, explicit elicitors are very direct and create the potential for relational discomfort in the patients. This is because they create pressure to provide a specific reply, which is interpreted as a dispreferred negative action, and they are potentially threatening to the face of the patients because of the gatekeeping role of the receptionists. This is shown in Extract 4.1 where the

declarative shape of the elicitor and the tag which is appended make the receptionist's question appear coercive. The patient counters this with a firm reply.

Extract 4.1

(Facility B, Tape 2, episode 22, M/26-40/ly/ey)

RB1: that is for <u>you</u> (gives patient questionnaire) . and do you have an appointment?

DEM COP 2PS DO 2PS PRF OBJ

PB22: no . I want to make one

NEG 1PS OBJ

Even when discomfort is shown by the patient, it is not very marked, as shown in Extract 4.2 (line 4).

Extract 4.2

(Facility B, Tape 2, episode 31, F/41-60/lw/om)

1 RB1: hello

2 PB31: hello (*consent form is handed*)

3 RB1: that is what you need (.) for that (questionnaire) . have you got an appointment?

DEM COP REL 2PS DEM PRF 2PS ART-OBJ

4 PB31: no . I . it is a pr- prescription I want to pick

NEG 1PS ART-OBJ ADVL

The patient giving a negative response in Extract 4.46 makes two false starts ('I' and 'pr-' in line 4) while explaining her reason for coming to the health facility while the patient in Extract

4.3, who responds positively to the receptionist's elicitation question, pauses twice as well as making a false start, suggesting that although her response is positive, she is experiencing slightly greater discomfort.

Extract 4.3

(Facility B, Tape 2, episode 23, F/41-60/ly/esm)

RB2: now I will just be with you in a minute . do you have an appointment?

1PS AUX BE REL 2PS DO 2PS PRF ART-OBJ

PB23: (.) yes . I do (.) I think it must . it is a vaccination

DET 1PS DO 1PS AUX

4.1.4 Combinations

The study observed that there are occasions on which receptionists use composite opening moves, whether combining a greeting with an offer, a greeting with an elicitor or an elicitor with an offer. Combination service signals show that, as well as developing routine approaches to face protection, receptionists construct their power positions online and in direct response to their perception of patients. When receptionist RB2 follows a greeting with an offer (' hello . can I help you?',) as well as defining the signal more clearly, she projects a combination of friendliness and deference, whereas when receptionist RB1 follows an elicitor with greeting ('yes . hi') one has the impression that an initially impersonal style has been remedied as the patient who attends the facility monthly is recognised. When receptionist RB2 follows an elicitor with an offer ('yes . may I assist you?'), it seems that she is correcting the direct approach ('yes') at first taken to a young patient by adding the polite offer. In all these cases the

power position of the receptionists is highlighted and their relational considerations with the patients appear to have stimulated the double signals.

4.2 Service bids

The study noted that patient's service bid is made in response to the receptionist's service signal. The majority of patients use the bid to make or check in for an appointment, or to order or collect a prescription. The four activities correspond to four stages in a cycle. When patients ask for appointments, they have symptoms of illnesses which they wish to have treated. They check in to see doctors, who attend to the symptoms and often provide them with prescriptions. These in turn entitles them to obtain medicines, which will remove their symptoms. Through the ordering and collection of prescriptions, patients achieve ongoing accomplishment of treatment by replenishment of drug supplies.

It was observed that of these four activities, making appointment presented receptionists with an opportunity to display their power and represent the greatest face threat for the patients, since in their bid to access the health facilities they have to go through the receptionists. In contrast, when checking in, patients are claiming appointments which have already been given, just as when collecting prescriptions they are claiming entitlements which have already been granted. The researcher observed that patients have four different approaches when making their service bids:

1.make the bid without using any face protecting moves

2. present the bid as an obligation or nedd (e.g. 'I've got to', 'I've to', 'I need to')

3. mitigate the bid (e.g. 'just', humour)

4. use formulaic politeness (e.g. ‘please’, ‘can I’, ‘I was wondering if’)

4.2.1 Checking in

The study noted that all patients in health facility B checked in for appointment either by making of presence or by prefacing a factual statement with a verb of possession. In the presence of style, appointment details are given either by alone or prefaced by ‘I am here’ or ‘it is + name’ and in the possession style appointment details are preceded by one of two verbs, ‘have’ and ‘have got’. The possession style is more common than the presence one. The researcher noted that the marked difference between public facility A and B was a reflection of availability of appointments, because the possession style was most used at health facility A, where appointments seemed to be few and the patients had to seek permission more from the gatekeepers. The patients had to work harder and wait longer for their appointments at the public health facility A. Almost half the patients who asked for appointments at the reception were told either the doctor is not there or busy with other engagements. However at the private health facility B, appointments were always given unless patients asked for dates and times well into the future. Because of these difficulties patients at public health facility A, were inclined to regard receptionists as gatekeepers who had the power to determine patients who get access to the institution.

The study noted that like receptionists, patients also tend to either to be positive, rapport oriented or negative, distance oriented in their personal styles. The patient in Extract 4.4 has a rapport oriented style because she uses the informal greeting ‘hi’, makes the bid more casual by omitting both the subject and the operator, omits the doctor’s title, uses the preposition ‘for’, rather than the more formal ‘to see’, and uses an affiliative high rising tone at the end.

Extract 4.4

(Facility B, Tape 2, episode 27,F/16-25/lm/esm)

PB27: hi . got an appointment for . Okinda at two o'clock

DET ART-OBJ ADVL

In contrast, the patient in Extract 4.5 has a socially distant style. He makes a formal statement, using the full verb form 'I have', rather than the reduced conversational 'I've', or the more informal 'I've got', accords the doctor his full title and also spells out the time.

Extract 4.5

(Facility B, Tape 2, episode 26, M/41-60/lw/om)

PB26: I have an appointment with Dr Omondi at three o'clock

1PS PRF ART-OBJ REL

The above examples are both from the private health facility however, both styles are represented at both health facilities.

4.2.2 Making an appointment

The study found that most appointments were made at the private health facility B and the approach adopted by the patients was the use of a stereotypical polite request to the gatekeepers with one of the interrogative forms 'can I' and 'could I', accompanied by the marker 'please'. Several other forms of roles and identities to indicate asymmetrical relationship between the receptionists and patients were also used, as shown in Table 18.

Table 18: Appointments bids used by patients

1	2	3	4	5	6	7
Can/could I	make get have	an appointment	to see with for	doctor/ nurse	today next week on the 10th	please
I was wondering if I can						
I'd like to						
It was just to						
I've to						
I want/am writing						
any chance of me seeing						

The researcher found that the forms in column 1 above 'can/could I' indicate the style of mitigation which was used by the patients in health facility B. Moreover it was observed that the choice with the highest level of unreality and distance, and consequently the highest level of protection for both speaker and hearer in terms of their roles and identities is 'I was wondering if I can', which is illustrated in Extract 4.6.

Extract 4.6

(Facility B, Tape 2, episode 24, M/41-60/ly/ey)

PB24: okay . ya . I was wondering . this is my first visit . and was wondering if I can have an appointment

1PS BE SUBJ.COMP DEM COP 1PS AUX PRF ART-OBJ

The above patient, as he indicates, has visited the facility for the first time and has to make an appointment through the receptionists. The increased imposition/threat to her own face which entails in making appointment, is the main reason why his conventional request is more indirect than normal, combining the unreality of the verb 'wonder' and the conditional 'if' clause, the distance of the past tense ('was wondering') and the possibility of 'can' with the hesitation markers ('ya') and a mitigated explanatory account ('I'm just visiting').

The researcher also noted that bids are also made using other modalised expressions. In one case at private health facility B, the modality of possibility is encoded in the noun 'chance', ('hello . is there a chance . of seeing Dr Akula this week?'). It was also noted that three patients make their bids using deontic rather than epistemic modality, which signal that they must perform the activity. One of the patient present the bid as a necessity('I need to make an appointment with the lab for some blood tests') and two more patients make obligation statements ('I've got to make an appointment with the doctor '). All the three patients have been asked to make appointments and protect their own face from the receptionists by attributing responsibility to the laboratory nurses or doctor.

The ideas of needing and wishing was also observed at the public health facility A, in which the verb 'want' is used, each time with a different effect because of contextual variation. It was noted that two of these bids are made by patients with little knowledge of English. The patient who uses the verb 'want' (Extract 4.7) makes her bid in dholuo (vernacular) using a present progressive verb form.

Extract 4.7

(Facility A, Tape 1, episode 12, F/16-25/ly/ey)

RA1: amosi kanyo

Amosi-DEM

(*hi there*)

PA12: neadwaro neon daktari

Neadwaro-1PS-V

(*I wanted to see the doctor*)

In this Extract, the bid is an unusually direct expression of the speaker's wants, which shows the patient's need to access the facility through the receptionist. However receptionists do have a gatekeeping role which is seen most clearly in the discretion which they exercise over the allocation of appointments. In other words, receptionists can decide which patients will be given priority. In Extract 4.7 RA1 does not respond to the appointment request by giving the patient PA12 the appointment which she subsequently asks for.

4.3 Infringements

The study noted that when social interaction take place, infringements of social expectations and norms are inevitable. These infringements include a greater than usual threat to the face both of those who commit them and those affected by them and, when they occur, higher levels of provision of verbal remedy are to be expected. As Goffman (2002) suggest on the role and identities, the simplest form of remedy for an infringement is an apology. Apologies are produced when offences are thought to have been committed and therefore as Goffman (2002) states, social claims to have offended someone and communicate awareness and acceptance of moral responsibility for the offensive behaviour.

An apology can be generated in a number of ways (Goffman, 2002). The only direct method is through the performative verb 'I apologise', which is also an illocutionary force indicating device but the most commonly used forms are ritual expressions of regret ('sorry', 'I'm sorry') and requests for pardon ('I beg your pardon', 'pardon me', 'pardon'). In conjunction with the apology, fault may be considered and apologies may also be replaced or supplemented by accounts, which Goffman (2002) divided into two categories: justifications, which involves the actor taking responsibility for the behaviour in question, and excuses, which entails the actor divorcing him or herself from responsibility. In addition the apologising actor may continue to generate accounts until relief or absolution is granted (Goffman, 2002).

The researcher noted four types of minor offences in the data which affect the relationship between the receptionists and patients with regard to power relations. These include, discourse problems, which can be attributed to receptionists or patients, procedural omissions, which are unique to patients at the two facilities, delays, for which both the health facilities and patients

can be responsible, and non provision of appointments which is the responsibility of the health facilities.

4.3.1 Discourse offences

The study noted that slip-ups such as mishearing, misstatements and false starts are common in the interaction between receptionists and patients. The detail of this type of offence in the present study is shown in Table 19, together with an indication of the forms of solutions which are applied.

Table 19: Solution for discourse mistakes

Offence	**R/P**	**Solution**		**Solution**	
		Facility A		**Facility B**	
mishearing	R			pardon	3
	P	sorry	5	sorry/pardon	7
misstatement	R	sorry	1	sorry	2
	P	I'm sorry/sorry	4	sorry	5
forgetting	R				
	P	I'm very sorry/I'm sorry	8	Sorry about that/sorry	2

The study found that discourse infringements are likely to occur among patients than receptionists. This is probably because the patients are the ones seeking solutions to their problems at the health facilities than receptionists. This therefore demonstrates the power of receptionists and their asymmetrical relationship with the patients. In seeking solutions, a majority of patients at both the facilities use some form of sorry based units of talk to aid their

admission into the health facilities when infringements happen, whether caused by themselves or the receptionists. As Goffman (2002) in his roles and identities observes that discourse solutions are not only appropriate for trivial offences, but also act as a disarmer or softener, attention getter and phatic expression establishing a harmonious relationship with the hearer.

The study established that the most common infringement is mishearing, for which the ritual solution also function as request for repetition. This is illustrated in Extracts 4.8 ('sorry') and 4.9 ('I beg your pardon').

Extract 4.8

(Facility B, Tape 2, episode 35, F/41-60/lm/ey)

1 RB1: mornig

2 PB35: morning nurse (3)

PRE-MOD

3 RB1: (2) how do I assist you this morning?

DO 1PS 2PS ADVL

4 PB35: sorry?

Extract 4.9

(Facility B, Tape 2, episode 29, M/75+/lm/esm)

1 RB2: hello

2 PB29: I wanted to collect my medicine . sent by Dr Nyakinda

1PS PRE.MOD-N

3 RB2: (4) give me the diagnosis sheet

3PS OBJ

4 PB29: I beg your pardon

1PS 2PS

4.3.2 Procedural omission

The study noted offences that are the result of non- performance, or gaps in the patient's knowledge of reception procedures. Non performance or omission of an expected discourse move, such as non provision of name, making the service bid without delay or providing necessary information, is treated by most patients in the same way as a slip up and repaired with a brief ritual of apology. The distribution of these offences by health facilities is shown in Table 20.

Table 20: Solution for procedural mistakes

	Facility A		**Facility B**	
omission of information	sorry + account	5	sorry	1
omission of procedure	account	7	I'm sorry	2
unaware of procedure	account	10	I'm very sorry	1
Total		22		4

A patient's reaction when he realises that he has not provided necessary information is illustrated in Extract 4.10, while Extract 4.11 is an example of a patient apologising for failing to bring the doctor's diagnosis sheet. In both cases the patients appear to interpret their omission as offences because they have failed to fulfill the obligation of patient's role which may impede them accessing the health facilities.

Extract 4.10

(Facility A, Tape 1, episode 14, M/41-60/lw/ow)

RA2: mae mar nga?

Mae-REL mar nga-COP

(*and who is it for?)*

PA14: mos . en mar chiega

Mar-PRE.MOD chiega-N

(*sorry . it is for my wife*)

Extract 4.11

(Facility B, Tape 2, episode 32, M/41-60/lm/om)

PB32: morning . I have come for my prescription

1PS PRF SUB-MOD

RB1: yes . get me the prescription sheet//

3PS OBJ-INS

PB32: //I forgot the sheet in the car . I am sorry

1PS OBJ ADVL

The apology in Extract 4.11 is a self initiated self repair, seen by Goffman (2002) as the preferred form of correction. It is followed by the apology token 'I'm sorry', whereas 'sorry', in Extract 4.10 is an apology which responds to an other initiated repair, threatening to the face of the addressee, the receptionist, who can refuse to solve his problem.

4.3.3. Delays

The study observed that both receptionists and patients are also involved in offences connected to timing. Receptionists can be slow to offer services based on their roles as gatekeepers, patients arrive late and consultations are not given at the appointed time. The pattern of solution for this type of offences is shown in Table 21.

Table 21: Solution for delays

	Facility A		**Facility B**	
patient waiting	sorry sorry + account	4 6	sorry pardon	1 1
patient late	sorry	5	I'm sorry	2
Total		15		4

In Extract 4.12, the receptionist apologises for the delay which has taken place because she has been speaking on the telephone for several minutes to her colleagues, and in Extract 4.13, the receptionist provides an account in the form of a justification for the unusual length of time it is taking to see a doctor.

Extract 4.12

(Facility A, Tape 1, episode 28, M/16-25/lm/esm)

RB1: ok . sorry about that

DET N DEM

Extract 4.13

(Facility B, Tape 2, episode 37, M/41-60/lm/esm)

RB1: // hello . can I assist

AUX 1PS

PB37: // hello . want to see Dr Odeny . it is a referral

A OBJ ADVL

RB1: right (30) trying my best

PTCP 3PS N

Both the apology in Extract 4.12 and the account in Extract 4.13 seem to be given because there is one patient who has been waiting for an exceptionally long time. The study noted that many patients were obliged to queue for several minutes before receptionists were able to serve them, especially at health facility A, where in most cases one receptionist had to attend to all the patients, yet for most of these delays, neither apologies nor accounts were provided. Whereas the receptionist in Extract 4.12 dissociates herself from the cause of the delay by using the distal demonstrative pronoun 'that', the one in Extract 4.13 personalises her account by using first person possessive 'my'.

4.3.4. Appointment problems

The final form of minor infringement considered in this study is failure on the part of the receptionists to meet an appointment need immediately. Table 22 shows that accounts are provided but no apologies given.

Table 22: Solutions for non availability of appointments

	Facility A		Facility B	
no appointment available	account zero	3 10	account	**7**

The researcher noted that the accounts given at public health facility A were mainly excuses which were different from health facility B, where the receptionists shared responsibility for the cancellation of appointments.

4.4 Conclusions

The researcher has shown that in the opening stages of encounters and in response to minor infringements, relational matters as a result of power are mainly attended to by receptionists and patients through the use of short, routinised remedial patterns (Goffman, 2002). The presence in the data of this study of relational formats supports Goffman's contention (2002) that linguistic roles and identities in healthcare contexts reflects power matrix of receptionists over patients. The data shows variations in usage which appear to reflect power variation between receptionists and patients, personal styles of both receptionists and patients, the differences between activity types, the respective roles and identities of receptionists and patients and interpretations of situational rights and duties.

It was noted that when giving service signals most receptionists display asymmetrical styles but there are also facility by facility tendencies. At facility A, a preference for the use of rapport building supportive patterns with little conventional role and identity. The receptionists therefore reduce asymmetrical relationship with the patients. At facility B, a mixture of rapport

building and conventional role and identity also reduces the symmetrical relationship between receptionists and patients. Therefore, the performance of service signals suggest that the approaches taken at facility A and B fall somewhere between client centered and bureaucratic formats. The use by receptionists at both facilities of greetings and polite offers implies that, as envisaged in the hospital's charter of both facilities, the patient is being treated as a valued customer, whether through informal rapport, synthetic personalisation or the more traditional means of conventional roles and identities. However there are instances of high incidence of unmitigated, direct, forms, which suggest a bias towards an impersonal bureaucratic pattern that indexes power relation between the receptionists and the patients. The directness may be the result of the cognitive overload experienced by receptionists as they try to complete a range of different task types simultaneously but it nevertheless highlights the difference between the institutional approaches, in which scant attention is accorded to roles and identities.

It was also noted that the amount of face protective language produced by a majority of patients when making service bids, indicate respect for the authority of receptionists, an interpretation which is reinforced by the many signs of hesitation and tentativeness in the discourse of patients. The ritual observable in the provision of solution for minor infringements supply further insights into participants' interpretation of their situational rights and duties. Patients always atone for minor procedural errors with remedial relational talk, suggesting that they consider themselves under an obligation to perform in an institutionally competent manner.

CHAPTER FIVE

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

5.0 Introduction

In this chapter, the summary of findings emerging from the analysis and discussion are analysed. This is then followed by conclusion based on the research questions and objectives of the study. Afterwards, an evaluation of the extent to which the objectives of this study were arrived at is given. This is followed by a conclusion that addresses the concerns raised in the statement of the research problem. Recommendations that are both practical and policy driven are then proposed and the dissertation ends by making suggestions for further research.

5.1 Summary of Findings

The study found that the discourse patterns in the reception of the two health facilities were found to share features with those of other service encounters of short interface, and more so in their transactional structure than in their relational and interpersonal repertoire. In addition the staging and sequencing of the task content of the talk was very similar in encounters at the two health facilities, whereas relational styles varied by facility, by participants and by activity at hand. Whatever the dominant relational style, it was observed that these encounters were realised through formulaic routines.

Secondly, it was noted that both receptionists and patients appeared to orient strongly towards task completion, remaining within the complementary roles of service provider and service seeker and thereby treating relational matters as a secondary concern. In addition the absence of small talk may have reflected the pressure on receptionists to complete their work.

The power asymmetry between receptionists and patients was observed in the front desk activities of both health facilities. First, like doctors described by Hak (2004), receptionists are comfortable at work while patients are visitors. This therefore gives them greater competence in the completion of activities, which they perform more often than the patients, who attend the health facilities only rarely. Receptionists also have expert insider knowledge of both procedures and patient information. Second, because they work for an organisation, receptionists are obliged to make gatekeeping decisions which involve prioritisation. According to Luke (2005) people accept their roles in the existing order of things because they can see or imagine no alternative to it, or because they see it as natural and unchangeable. This was observed to be the case for receptionists in this study of health facilities in Kisumu County. Moreover, the researcher heard no comments which indicated that receptionists regard themselves as powerful in relation to patients. In fact, patients appeared to be aware of their lowly position in the two health facilities under study.

In addition, patients for their part collaborated in treating receptionists' decision making as a situational rule. The investigator observed patients at both health facilities who show signs in their self presentation as needy or having physical needs, emotional anxieties and situational dependency which parsons (1952) associates with the sick role. A discourse system therefore exists in which both groups of participants collaborate in dealing only with surface details. This is because receptionists on the whole do not contribute directly to the work of care, neither do patients expect them to do so. In addition receptionists do not seem to regard themselves as collectively accountable for health facilities decisions but attribute agency elsewhere. It is only the receptionists who have taken ownership of their profession and regard themselves as important members of a team which is dedicated to providing a high quality service, who

maintain the levels of responsibility and affective neutrality associated with the professional medical goal of similar treatment for all. Receptionists at private health facility B accepted the consequences of their decisions than those from public health facility A who were less motivated in their work. They also denied personal responsibility and appeared to differentiate between patients by protecting the face of some more than others hence favouring them when gatekeeping decisions are made.

Although the researcher observed that there are variations in the degree to which participants are subsumed by their roles and in the levels of formality and affective neutrality with which the front desk activities are accomplished, both receptionists and patients appear to be constrained by discourse rules which discourage them from drawing on all the symbolic linguistic capital available to them and confine them within narrower situational identities and roles. This therefore leads to a situation in which receptionists and patients are trapped by their own conversational routines, which as Coulmas (1981) suggests are agreements which the members of a community presume to be shared by every reasonable co-member. Therefore by modifying and developing these routines, receptionists and patients might also change and develop their health facilities. This is the role of recommendation for receptionist training.

5.2 Conclusion

In view of the foregoing findings, the conclusion on the research problem is that the receptionists' approach in their interactions with patients is characterised with asymmetrical strategies that go against the Vision, Mission and Charters of both health facilities, A and B. This in the long run impedes the access to health services by patients in both health facilities. It

also runs against the government policy on Vision 2030 which aims to improve the health of its citizens by the year 2030. Access to these services is a key pillar to the Vision 2030. In addition, by preferring asymmetrical relationship, receptionists are more inclined to reinforce the unequal relationship between them and the patients who visit the two health facilities. However, the receptionists at the private health facility B strove to maintain symmetrical relationship between them and the patients. Therefore, further conclusions based on the objectives of the study are as follows:

The first objective in this study was to analyse the linguistic patterns and practices of front desk services between receptionists and patients. A number of observations can be drawn about the discourse patterns described by the researcher in this chapter. It has been noted that the transactional structures at the reception desk of the two health facilities are similar to Mitchell's (1957) predictable stages, Ventola's (1987) recursion and Hewitt's (2006) transactional structures between bus drivers and passengers. In addition frontline encounters at the reception include the frequent checking of personal information which is characteristic of receptionists and clients in other institutional settings. The language of individual moves is frequently patterned, reflecting the routine nature of the tasks which are being carried out. This is similar to Goffman's (2002) roles and identity theory which this study is based upon with regard to the different roles and identities constructed by receptionists and patients in their endeavor to achieve their goals.

The way in which the patients make their service bids can also be seen as evidence of high level of knowledge of the situational requirements and the strong orientation to service goals. The researcher has illustrated this very clearly by the analysis of the service orientation stage of the

encounters. The frequent use of covert service offers by receptionists, the extremely high incidence of service bids in response to all types of opening, and elliptical formulation by patients in both health facilities, suggest that both the receptionists and patients are familiar with the social practices of the frontline and are keen to maintain their roles and identities during the encounters.

The investigation has also illustrated that although there are varying levels of efficiency among the receptionists and patients at the two health facilities when accomplishing verbal encounters at the reception, there is complementarity and reciprocity in their joint completion of administrative encounters. Apart from when there are problems, tasks are completed rapidly through a small amount of discourse stages. These involve, first, information checks, which can include extended sequences of orderly, co-ordinated talk, second, confirmation sequences which as well as performing the important task of ensuring that information is accurate, also facilitate transition to the next discourse stage, and lastly, resolution sequences, which have several functions that include first, responding to service bids, second, marking the completion of tasks, third, indicating the ending of encounters and lastly, providing the interpersonal forms which mark the ritual of passage from a state of talk to the lack of it.

Therefore as Duranti (1997) has observed that all language use is situated on formulaic creative patterns which are indexed for socio cultural roles, this study has demonstrated the different roles and identities enacted by receptionists and patients at the two health facilities (Goffman, 2002). In addition the researcher has also stated that despite the tight structure of the discourse and the high incidence of formulaic language, both the receptionists and patients have ample

room for subtle variation in the enactment of individual moves in frontline discourse at the receptions of both facilities.

The second objective was to examine how receptionists and patients enact their respective social roles and identities. The conclusion is that the analysis of person reference, speech styles and supplementary topics has revealed the presence of a variety of a speaker positions and attitudes. It has been observed that receptionists mark their occupancy of the reception role by increasing the formality of their speech styles or using less informal language. In addition, while some patients occupy formal positions, remaining in their roles within their situated identities and limiting the range of their discourse, others draw on symbolic capital available to them from their wider identities and hence construct both themselves and their interlocutors as persons with identities beyond the current role.

Participants in this study at the reception appear to follow existing norms more frequently than challenge them. This is because there is little digression from the stages and moves which define frontline discourse activity types. Furthermore, patients are not given much opportunity, nor do receptionists often choose, to draw on full range of linguistic capital available to them.

According to Hanks (1990) shared knowledge is symmetric and separating knowledge asymmetric. Patients may share part of the receptionists' knowledge of the frontline but it was observed that receptionist access to privileged inside information for example, names of patients and number of appointments available, and their knowledge of the bureaucratic obligations associated with their roles, there is knowledge of symmetry in receptionists favour. Moreover,

receptionists make a display of the authority which this asymmetry gives them, for instance when they make use of the power of naming, especially first names or terms of endearment, which imply a rank disparity in their favour. In addition, when receptionists use first person pronouns during decision making about appointment it shows asymmetry in their encounter with patients. When receptionists close down off task topics introduced by patients or when they reformulate patients' utterances using more formal or specialist terminology are all examples of asymmetrical interlocution.

It was also observed that receptionists are often under pressure and it would be inappropriate for them to spend too much time in off task or the expression of self, but immersion in the role and identity. Therefore, receptionists use popular idioms and share humour with patients in order to expand frontline discursive capital and construct a more multi facetted version of self while at the same time improving the service offered to patients.

The third objective was to investigate the extent to which these linguistic patterns and practices are implicated in the construction and orientation to institutional power. The study has shown that in the opening stages of encounters and in response to minor infringements, relational matters as a result of power are mainly attended to by receptionists and patients through the use of short, routinised remedial patterns. The presence in the data of this study of relational formats supports Goffman's contention (2002) that linguistic roles and identities in healthcare contexts reflects power matrix of receptionists over patients. The data shows variations in usage which appear to reflect power variation between receptionists and patients, personal styles of both receptionists and patients, the differences between activity types, the respective roles and identities of receptionists and patients and interpretations of situational rights and duties.

It was noted that when giving service signals most receptionists display asymmetrical styles but there are also facility by facility tendencies. At facility A, a preference for the use of rapport building supportive patterns with little conventional role and identity. The receptionists therefore reduce asymmetrical relationship with the patients. At facility B, a mixture of rapport building and conventional role and identity also reduces the symmetrical relationship between receptionists and patients. Therefore, the performance of service signals suggest that the approaches taken at facility A and B fall somewhere between client centered and bureaucratic formats. The use by receptionists at both facilities of greetings and polite offers implies that, as envisaged in the hospital's charter of both facilities, the patient is being treated as a valued customer, whether through informal rapport, synthetic personalisation or the more traditional means of conventional roles and identities. However there are instances of high incidence of unmitigated, direct, forms, which suggest a bias towards an impersonal bureaucratic pattern that indexes power relation between the receptionists and the patients. The directness may be the result of the cognitive overload experienced by receptionists as they try to complete a range of different task types simultaneously but it nevertheless highlights the difference between the institutional approaches, in which scant attention is accorded to roles and identities.

It was also noted that the amount of face protective language produced by a majority of patients when making service bids, indicate respect for the authority of receptionists, an interpretation which is reinforced by the many signs of hesitation and tentativeness in the discourse of patients. The ritual observable in the provision of solution for minor infringements supply further insights into participants' interpretation of their situational rights and duties. Patients always atone for minor procedural errors with remedial relational talk, suggesting that they consider themselves under an obligation to perform in an institutionally competent manner.

5.3 Recommendations

From the present study, some recommendations are put forward for consideration for researchers who would like to make their contribution to the field of study of institutional discourse specifically interaction between health care receptionists and patients who visit health facilities.

The study therefore recommends that receptionists should be made aware of the different linguistic stages identified in their communication in order to facilitate communication with patients. Second, very great care should be taken to avoid exposing individual receptionists to public analysis of their performance brought about by their different roles and identities. Third, receptionists should be made aware that in order to achieve the millennium development goals, they should use their roles and identities to facilitate access to health services to patients. The power structure brought about by different roles and identities should enhance symmetrical interpersonal dynamics between receptionists and patients. Therefore, receptionists should be made aware of power, brought about by their roles in the health facilities, which they hold and of polite ways of expressing this power.

5.4 Suggestions for Further Research

The line of research begun in this study can be continued in a number of different ways. Despite what is already known about institutional discourse, further studies are necessary to identify the various linguistic operations involved during the interaction between various interlocutors in an institutional context. Therefore in this study, broad coverage has been given to many features of reception discourse, which it would be desirable to investigate in greater detail.

1) Attention is given to syntactic variations in order to identify patterns of convergence and divergence, which would in turn shed further light on the positioning of participants and in order to foster greater understanding between receptionists and patients.
2) If data were to be collected in other locations and regions it might also be possible to determine whether the linguistic and communicative styles identified in this study are typical of the discourse of receptionists and patients in Kenya.
3) Although detailed profiles are provided of the different receptionist enactments of service bids, it would be useful to relate these to the performance in subsequent stages by the same individuals in order to observe whether relational styles are consistent as shown in this study or fluctuating.
4) Speech acts used to complete Information Check, Confirmation and Resolution stages and their relational implications could be analysed with the same attention given to those used for Service Orientation.

REFERENCES

Agar, M. (1980). *The professional stranger: An informal introduction to ethnography*. London: Academic press.

Adults with Incapacity Act (2000) http://www.enable.org.uk/ld/awi/ Accessed 9th February 2012.

Agar, M. (1980). *The professional stranger: An informal introduction to ethnography.* London: Academic Press.

Aijmer, K. (1996). *Conversational routines in english*. Harlow: Addison Wesley Longman.

Aijmer, K. (2002). *English discourse particles: Evidence from a corpus*. Amsterdam and Philadelphia: John Benjamin.

Ainsworth-Vaughn, N. (1998). *Claiming power in doctor-patient talk*. New York and oxford: Oxford University Press.

Al-Nasser, A. (1993). The social function of greetings in Arabic. *Journal of Arabic linguistics* 26:15-27.

Angelelli, C. (2004). *Medical interpreting and cross-cultural communication*. London: Cambridge University Press.

Antaki, C. (2002). “Lovely”: Turn-initial high grade assessment in telephone closings. *Discourse studies* 4.1:5-23.

Antaki, C. (2002). Discourse analysis means doing analysis: A critique of six analytical shortcomings. http://www.shu.ac.uk/daol/previous/vl/nl/index.htm. Accessed April, 20, 2012.

Arber, S and L .Sawyer. (1985). The role of receptionists in general practices. A dragon behind the Desk. *Social science and medicine*: 911-921.

Armstrong, D. (1997). The place of interrater reliability in qualitative research: An empirical study. *Sociology* 31: 597-606.

Arundale, R. (2005). Face *as relational and interactional: Communication approaches to examining face as culture-general and culture-specific*. Paper presented to the Linguistic Politeness Research Group Conference, Nottingham, 12th March 2005.

Aston, G. (1995). Say ‘Thank you’: Some pragmatic constraints in conversational closings. *Applied linguistics* 16:57-86.

Atkinson, P. and C.Heath (eds) (1981). *Medical work: Realities and routines*. Farnborough: Glowers.

Atkinson, P., Coffey, A. and S. Delamont (2003). *Key themes in qualitative research*. Walnut springs CA: Altamira.

Auer, P. and A. Di Luzio (eds) (1992). *The contextualisation of language*. Amsterdam and Philadelphia: John Benjamins.

Bailey, B. (1997). Communication of respect in interethnic service encounters. *Language in Society* 26: 327-356.

Bain, D. and D. Durno (1982). Assessment of receptionists by questions on patient management. *British Medical Journal* 284: 1165-1167.

Bakhtin, M. (1986). *Speech genres and other late essays*. Austin: University of Texas Press.

Balint, M. (1957). *The doctor, his patient and illness*. London: Pitman.

Bamberg, M. (ed.) (1997). Journal of Narrative and Life History. Special Issue. *Oral versions of personal experience: Three decades of narrative analysis*. London and Mahwah, NJ: Lawrence Erlbaum.

Bargiela, F. Boaz, C., Gokzasze, L., Hamza, A., Mills, S. and N. Rukhadze. (2002). *Ethnocentrism, politeness and naming strategies*. Sheffield Hallam working Papers on the Web. http://www.shu.ac.uk/wpw/politeness/bargiela.htm

Bargiela-Chiappini, F. (2003). Face and politeness: New (insights) for old (concepts). *Journal of Pragmatics 35: 1453-1469.*

Bastos, L. (1996). Power, solidarity and the construction of requests in service encounters. *The ESPecialist* 17:151-174.

Bell, A. (1984). Language styles as audience design. *Language in society* 13: 145-204.

Bhatia, V. (1993). *Analysing genre: Language use in professional settings*. Harlow: Longman.

Bhatia, V. (2004). *Worlds of written discourse: A genre- based view*. London: Continuum.

Biber, D. (1988). *Variations across speech and writing*. Cambridge: Cambridge University Press.

Biber, D., Johansson, S., Leech, G., Conrad, S. and E. Finegan. (1999). *Longman grammar of spoken and written english*. Harlow: Longman.

Biber, D., Johansson, S. and G. Leech. (2002). *Longman student grammar of written and spoken english*. Harlow: Longman.

Bloor, M. (1997). Techniques of validation in qualitative research: In Miller and Dingwall (eds):37-50. *A critical commentary* .Oxford: OUP.

Blum-kulka, S. (1987). Indirectness and politeness in requests: Same or different. *Journal of pragmatics* 11: 131- 146.

Blum-Kulka, S., House, J. and G. Kasper. (1989). *Investigating cross-cultural pragmatics: An introductory overview*. In Blum-Kulka, S., House, J. and G. Kasper (eds.). Cross-cultural pragmatics: Requests and apologies. Norwood, N.J.: Ablex.

BBC News Online.Sunday, 13th July 2003.htpp://www.bbc.com

Bolanakis, S. (2004). Training receptionists on repeat prescribing designed to improve safety. http://www.pjonline.com

Bourdieu, P. (1977). *Outline of a Theory of Practice*. Cambridge: Cambridge University Press.

Bourdieu, P. (1977). *The economics of linguistic exchanges*. Social Science Information 16.6: 645-668.

Bourdieu, P. (1984). *Distinction. A social critique of the judgment of taste*. London: Routledge.

Bourdieu, P. (1991). *Language and symbolic power*. Cambridge: Polity Press.

Boxer, D. (2002). *Applying sociolinguistics: Domains and face-to-face interaction*. Amsterdam: John Benjamins.

Boxer, D. and F. Cortes-Conde. (1997). From bonding to biting: Conversational joking and identity display. *Journal of Pragmatics* 27: 275-294.

Brazil, D. (1997). *The communicative value of intonation in english*. Cambridge: Cambridge University Press.

Brown, A. and R. Gilman. (1972). The pronouns of power and solidarity. In Laver, J and S. Hutcheson (eds.): 103-127.

Brown.G and G.Yule. (1983).*Discourse analysis*. Cambridge: Cambridge University Press.

Brown, P. and S. Levinson. (1978). Universals in language use: politeness phenomena. In Goody, E. (ed.) *Questions and Politeness: Strategies in Social Interaction.* Cambridge: Cambridge University Press. 56-289.

Brown, P. and S. Levinson. (1987). *Politeness: Some universals in language usage*. Cambridge: Cambridge University Press.

Bruner, J. (1990). *Acts of meaning*. Cambridge, MA: Harvard University Press.

Bury, M. (1997). *Health and illness in a changing society*. London: Routledge.

Buttny, R. and P. Williams. (2000). Demanding respect: The uses of reported speech in discursive constructions of interracial contact. *Discourse and Society* 11: 109-133.

Button, G. (1991). Conversation-in a-series. In Boden, D and D. Zimmerman (eds.): 251-277.

Button, G. and J. Lee (eds.) (1987). *Talk and social organisation*. Clevedon, Philadelphia: Multilingual Matters.

Cameron, D. (2000). *Good to talk? Living and working in a communication culture*. London: Sage.

Cameron, D., Frazer, E., Harvey, P., Rampton, M. and K. Richardson (eds.) (1992). *Introduction. Researching language: issues of power and method*. London: Routledge.1-28.

Cameron, R. and J. Williams. (1997). Sentence to ten cents: A case study of relevance and communicative success in non-native speaker interactions in a medical setting. *Applied Linguistics* 18.4: 415-455.

Candlin, C., Moore, A. and G. Plum. (1988). From compliance to concordance: shifting discourses in HIV medicine. Paper presented to the International Pragmatics Conference, Reims, 19-24 July

Candlin, C. and K. Hyland. (1999). *Writing: Texts, processes, and practices*. London: Longman.

Candlin, S. (2000).New dynamics in the nurse-patient relationship. In sarangi, S. and M.Coulthard (eds):230-245.

Candlin, S. (2000). New dynamics in the nurse-patient relationship. In Sarangi, S. and M.Coulthard (eds.): 230-245.

Candlin, C and S.Candlin. (2003).Health care communication: A problematic site for applied linguistic rsearch.*Annual review of applied linguistics*.23:134-154.

Candlin, C. and S. Candlin. (2003). Health care communication: A problematic site for applied linguistic research. *Annual Review of Applied Linguistics*. 23: 134- 154.

Candlin, S. (2003). Issues arising when the workplace is the site of applied linguistic research. *Applied Linguistics* 24.3: 386-394.

Candlin, C. (2004). Constructing concordance - discursive and ethical aspects of compliance in medical settings. Plenary talk presented to COMET 2, Linköping, Sweden, 4th June 2004.

Carter, R. and M.McCarthy. (1997). *Exploring spoken English*. Cambridge: Cambridge University Press.

Carter, R.and M.McCarthy. (2000).*Exploring grammar in context*.Cambridge: Cambridge University Press.

Cicourel, A. (1992). The interpenetration of communicative contexts: Examples from medical encounters. In Duranti, A. and C. Goodwin (eds.) Rethinking context: Language as an interactive phenomenon. Cambridge: Cambridge University Press. 291-310.

Cicourel, A. (1999). The interaction of cognitive and cultural models in health care delivery. In Sarangi, S. and C.Roberts (eds) 1999:183-224.

Cicourel, A. (2000). What counts as data for modeling medical diagnostic reasoning and information processing. *Intellectica* 30: 115-149.

Cicourel, A. (2001).*Genre and institutions*. London: Cassell.

Cicourel, A. (2003). On contextualizing applied linguistic research in the workplace. *Applied Linguistics* 24.3: 360-373.

Cicourel, A. (2004). Cognitive overload and communication in two healthcare settings. *Communication and Medicine* 1.1: 35-44.

Channell, J. (1994). *Vague language*. Oxford: Oxford University Press.

Channel, J. (2000).Working on the telephone-how telephone receptionists work with language. In Coulthard, M, Cotterill, C. and F. Rock (eds) 2000:221-230

Christie, F. and J. Martin (eds.) (1997). *Genre and institutions: Social processes in the workplace*. London and Washington: Cassell.

Christie, C. (2002). Politeness and the linguistic construction of gender in parliament: An analysis of transgression and apology behaviour. Sheffield Hallam Working Papers on the Web 3.
http://www.shu.ac.uk/wpw/politeness/christie.htm

Christie, F. (2005). *Classroom discourse: A functional perspective*. London and New York: Continuum.

Clark, H. and J. Wade French (1981). Telephone goodbyes. *Language in Society* 10: 1-19.

Clark, H. (1996). *Using language*. Cambridge: Cambridge University Press.

Clarke, A. (2003). On being an object of research: Reflections from a professional perspective. *Applied Linguistics* 24.3: 374-385.

Clift, R. (2001). Meaning in interaction: the case of 'actually'. *Language*, 77.2: 245- 291.

Coates, J. (1996). *Women talk: Conversation between women friends*. Oxford: Blackwell.

Coffin, C., Hewings, A. and K. O'Halloran (eds.) (2004). *Applying English Grammar: Functional and Corpus Approaches*. London: Open University; Arnold.

Cook-Gumperz, J. and J. Gumperz. (1997). Narrative explanations: Accounting for past experience in interviews. In Bamberg, M. (ed.): 291-298.

Cook-Gumperz, J.(2001). Cooperation, collaboration and pleasure in work: Issues for intercultural communication at work. In Di Luz, S., Günthner, S. and F.Orletti (eds.) Culture in Communication: Analyses of Intercultural Situations. Amsterdam: John Benjamins. 117-139.

Coperman, J.and T.Van Zwaneberg. (1988).Practice receptionists: Poorly paid and taken for granted? *Journal of the Royal College of General Practitioners* 38:14 - 16

Cordella, M. (2004). *The Dynamic consultation: A discourse analytical study of doctor-patient communication*. Amsterdam: John Benjamins.

Coulmas, F. (ed.) (1981). *Conversational routine: Explorations in standardized communication situations and prepatterned speech.* The Hague: Mouton.

Coulthard, M. (ed.) (1992). *Advances in spoken discourse analysis*. London: Routledge.

Couper-Kuhlen, E. (1986). *An introduction to english prosody*. London: Edward Arnold.

Coupland, N. (1984). Accommodation at work: Some phonological data and their implications. *International Journal of the Sociology of Language* 46: 49-70.

Coupland, J., Coupland N. and J.D. Robinson. (1992). '"How are you?": Negotiating phatic communion'. *Language in Society* 21: 207-230.

Coupland, J. Robinson J. and N. Coupland (1994). Frame negotiation in doctor-elderly patient consultations. *Discourse and Society* 5.1: 89-124.

Coupland, J. (ed.) (2000). *Small talk*. Harlow: Pearson Education.

Coupland, N. and J. Coupland.(2000). Relational frames and pronominal address/reference: The discourse of geriatric medical triads. In Sarangi, S.and M. Coulthard (eds.) : 207-229

Coward, B. (2003). *Appointment management control*. Oxford: OUP

Cruttenden, A. (1986). *Intonation*. Cambridge: Cambridge University Press.

Crystal, D. and D. Davy. (1969). *Investigating english style*. London: Longman.

Crystal, D. (1975). *The english tone of voice*. London: Edward Arnold.

Culpeper, J. (1996). Towards an anatomy of impoliteness. *Journal of Pragmatics* 25:349-367.

Culpeper, J., Bousfield, D. and A. Wichmann. (2003). Impoliteness revisited: with special reference to dynamic and prosodic aspects. *Journal of Pragmatics* 35.10/11: 1545-1579.

Culpeper, J. (2005). Impoliteness and entertainment in the television quiz show: The Weakest Link. *Journal of Politeness Research* 1.1: 35-72.

Daly, J, McDonald I and E. Willis (eds.) (1992). *Researching health care: Designs, dilemmas, disciplines*. London: Routledge.

Daly, J., McDonald I and E. Willis. (1992) Why don't you ask them? A qualitative research framework for investigating the diagnosis of cardiac normality. In Daly, J, MacDonald I and E. Willis (eds.): 189-206.

Daly, N., Holmes, J., Newton, J. and M. Stubbe.(2004). Expletives as solidarity signals in FTAs on the factory floor. *Journal of Pragmatics* 36.5: 945-964.

Dare, A. (1999). English and the culture of the Yoruba. *English Today* 15/1: 17- 22.

Davies, B. and R. Harré. (1990). Positioning: The social construction of selves. *Journal for the Theory of Social Behaviour* 20: 43-63.

Denzin, N. (1978). *The research act: A theoretical introduction to sociological methods*. New York: McGraw-Hill

Denzin, N. and Y. Lincoln (eds.) (1994). *Handbook of qualitative research*. Thousand Oaks, CA and London: Sage.

Diamond, J. (1996). *Status and power in verbal interaction : A study of discourse in a close-knit social network*. Amsterdam : John Benjamins.

Dingwall, R.(1992). Don't mind him - he's from Barcelona: Quantitative methods in health studies. In Daly, J, MacDonald I and E. Willis (eds.): 161-175.

Dingwall, R. (1997). Accounts, interviews and observations. In Miller, G and R. Dingwall (eds.): 51-65.

Dixon, C. et al. (2004).Abusive behavior experienced by primary care receptionists: Across-sectional survey. *Family practice* 2:137-139

Dörnyei, Z. (1997). Psychological processes in cooperative language learning: Group dynamics and motivation. *The Modern Language Journal* 81.4: 482-493.

Dornyei, Z. (2007).*Research methods in applied linguistics*. Oxford: Oxford University Press.

Drew, P. (1989). Recalling someone from the past. In Roger, D.and P. Bull (eds.). Conversation: An Interdisciplinary Perspective. Clevedon, Phil: Multilingual Matters. 96 -115.

Drew, P. (1991). Asymmetries of knowledge in conversational interactions. In Marková, I. and K. Foppa (eds.): 21-48.

Drew, P. and J. Heritage (eds.) (1992). *Talk at work: Interaction in institutional settings.* Cambridge: Cambridge University Press.

Drew, P. and J. Heritage. (ed.) (1992). 'Analysing talk at work: an introduction' in Talk at Work: Interaction in Institutional Settings. Cambridge: Cambridge University Press. 3-65.

Drew, P and M-L. Sorjonen. (1997). Institutional dialogue. In van Dijk, T.A. (ed.) Discourse as Social Interaction. London, Thousand Oaks and New Delhi: Sage. 92-118.

Du Bois, J. Achuetze-Coburn, S., Cumming, S. and D. Paolino. (1993). Outline of discourse transcription. In Edwards, J. and M. Lampert (eds.):45-87.

Duranti, A. and C. Goodwin (eds.) (1992). *Rethinking context: Language as an interactive phenomenon*. Cambridge: Cambridge University Press.

Duranti, A. (1997). *Linguistic anthropology*. Cambridge: Cambridge University Press.

Duranti, A. (1997). 'Universal and culture-specific properties of greetings'. *Journal of Linguistic Anthropology* 7: 63-97.

Duszak, A. (ed.) (2002). Us and others: An introduction. In Duszak, A. (ed.) Us and Others: Social Identites across Languages, Discourses and Cultures. Philadelphia: John Benjamins. 2002: 1-28.

Edmondson, W. (1981). On saying you're sorry. In Coulmas, F. (ed.): 273-288.

Edwards, D. and J. Potter. (1992). *Discursive psychology*. London: Sage.

Edwards, J. (1993). Principles and contrasting systems of discourse transcription. In Edwards, J. and M. Lampert (eds.): 3-31.

Edwards, J. and M. Lampert (eds.) (1993). *Talking data: Transcription and coding in discourse research*. London: Lawrence Erlbaum Associates:

Edwards, J. (2001). The transcription of discourse. In Tannen, D., Schiffrin, D. and H. Hamilton (eds.): 321-348.

Ehlich, K. (1993). A transcription system for discourse data. In Edwards, J. and M. Lampert (eds.): 123-148.

Eisner, M. and N.Britten. (1999).What do general practice receptionists think and feel about work? *British journal of general practice* 49:103-106

Erickson, F. (1975). Gatekeeping and the melting pot: Interaction in counseling encounters. *Harvard Educational Review* 45.1: 44-70.

Erickson, F. and J. Schultz. (1982). *The counselor as gatekeeper: Social interaction in interviews*. New York: Academic Press.

Erickson, F. (1992). They know all the lines: Rhythmic organization and contextualization in a conversational listing routine. In Auer, P. and A. Di Luzio (eds.): 265-397.

Ervin-Tripp, S. (1972). Sociolinguistic rules of address. In Pride, J. and J. Holmes (eds.) Sociolinguistics. Harmondsworth: Penguin.

Essex, B. and J. Bate. (1991). Audit in general practice by a receptionist: A feasibility study. *British Medical Journal* 302 (6776):573-576.

Fairclough, N. (1989). *Language and power*. London: Longman.

Fairclough, N. (1992). *Discourse and social change*. Cambridge: Cambridge University Press.

Fairclough, N. (1993). Critical discourse analysis and the marketisation of public discourse: The Universities. *Discourse and Society* 4.2: 133-168.

Fairclough, N. (1995). *Critical discourse analysis*. London: Longman.

Fairclough, N. (1995). *Media discourse*. London: Edward Arnold.

Fairclough, N. (2000). *New labour. New language*. London: Routledge.

Fairclough, N. (2003). *Analysing discourse: Textual analysis for social research*. London: Routledge.

Ferguson, C. (1976). The structure and use of politeness formulas. Language in Society 5: 137-151.

Fielding, N. and J. Fielding. (1986). *Linking data*. London: Sage.

Fillmore, Charles J. (1982). Frame semantics. In Linguistics in the Morning Calm. Seoul: Hanshin Publishing Co. 111-137.

Firth, A. (ed.) (1995). *The discourse of negotiation: Studies of language in the workplace*. Oxford: Pergamon.

Firth, R. (1972). Verbal and bodily rituals of greeting and parting. In La Fontaine, J. (ed.) Interpretation of Ritual: Essays in Honour of A. I. Richards. London: Tavistock. 1-38.

Fisher, S and A Todd (eds.) (1983). *The social organization of doctor-patient communication*. Washington: Center for Applied Linguistics Press.

Fisher, S. and S. Groce. (1990). Accounting practices in medical interviews. *Language in Society* 19: 225-250.

Fletcher, J. (1999). *Disappearing acts: Gender, power and relational practice at work*. Cambridge: MIT.

Flowerdew, J. (ed.) (2002). *Academic discourse*. Harlow: Longman.

Foucault, M. (1973). *The birth of the clinic: An archaeology of medical perception*. London: Tavistock.

Foucault, M. (1980). *Power/knowledge*. New York: Pantheon.

Francis, G and S. Hunston. (1992). Analysing everyday conversation. In Coulthard, M (ed.): 123-161.

Frank A. (1991). From sick role to health role: Deconstructing Parsons. In Robertson, R. and B. Turner (eds.) Talcott Parsons: Theorist of Modernity. London: Sage. 205: 216.

Frank, R. (2000). Medical communication: Non-native speaking patients and English speaking professionals. *English for Specific Purposes* 19: 31-62.

Frankel, R. (1990). Talking in interviews: A dispreference for patient-initiated questions in physician-patient encounters. In Psathas, G. (ed.) Interactional Competence. Washington: University Press of America. 231-262.

Fraser, B. and W. Nolen. (1981). The association of deference with linguistic form. *International Journal of the Sociology of Language* 27: 93-109.

Fraser, B. (1990). An approach to discourse markers. *Journal of Pragmatics* 14: 383-395.

Freidson, E. (1970). *Profession of medicine: A study of the sociology of applied knowledge*. New York: Dodd, Mead.

Gafaranga, J. (2001). Linguistic identities in talk-in-interaction: Order in bilingual conversation. *Journal of Pragmatics* 33: 1901-1925.

Gafaranga, J. and N. Britten. (2003). 'Fire away': The opening sequence in general practice consultations. *Family Practice* 20.3: 242-247.

Gafaranga, J. and N. Britten. (2004). Formulation in general practice consultations. Text: *An Interdisciplinary Journal for the Study of Discourse* 24: 147-170.

Gafaranga, J. and N. Britten. (2005). Talking an institution into being: The opening sequence in general practice consultaions. In Richards, K. and P. Seedhouse(eds.) Applying Conversation Analysis. Houndmills: Palgrave.

Gal, S. (1989). Language and political economy. *Annual Review of Anthropology* 18: 345-367.

Gallagher, M. et al. (2001).Managing patients' demand: A qualitative study of appointment-making in general practice. *British journal of general practice* 51:280-285

Gardner, R. (2001). *When listeners talk: Response tokens and listeners' talk*. Amsterdam: John Benjamins.

Garfinkel, H. (1967). *Studies in ethnomethodology*. Englewood Cliffs.: Prentice Hall.

Gavioli, L. (1995). Turn-initial versus turn-final laughter: two techniques for initiating remedy in English/kiswahili bookshop service encounters. *Discourse Processes* 19.3: 369-384.

Gavruseva, L. (1995). Positioning and framing: Constructing interactional asymmetry in employer-employee discourse. *Discourse Processes* 20: 325-345.

Gee, J. (2001). Identity as an analytic lens for research in education. *Review of Research in Education* 25: 99-125.

Geertz, C. (1973). *The interpretation of cultures: Selected essays*. New York: Basic Books.

Giles, H. Coupland, J. and N. Coupland (eds.) (1991). *Contexts of accommodation: developments in applied sociolinguistics*. Cambridge: Cambridge University Press.

Glaser, B. and A. Strauss. (1967). *The discovery of grounded theory*. Chicago: Aldine.

Goffman, E. (1955). On face-work: An analysis of ritual elements in social interaction. *Psychiatry* 18: 213-231.

Goffman, E. (1963). *Behavior in public places*. New York: The Free Press of Glencoe.

Goffman, E. (1963). *Stigma: Notes on the management of spoiled identity*. Eaglewood Cliffs: Prentice Hall.

Goffman, E. (1969). *The presentation of self in everyday life*. London: Allen Lane.

Goffman, E. (1971). *Relations in public: microstudies of the public order*. London: Allen Lane the Penguin Press.

Goffman, E. (1972). *Interaction ritual: Essays on face-to-face behaviour*. London: Penguin Press.

Goffman, E. (1976). The structure of remedial interchanges. In Harre, R. (ed.) 1976: 66-74.

Goffman, E. (1981). *Forms of talk*. Oxford: Blackwell.

Goffman, E. (1983). The interaction order. *American Sociological Review* 48: 1-17.

Goffman, E. (2002). *Frame analysis: An essay on the organization of experience*. Boston: Northeastern University Press

Gonzales, P. (2004). *The "gatekeeping" role of general practitioners: does patients' information matter?*.

www.bu.edu/econ/isp/6th_IOOHC/papers_6th/gonzalez.pdf. Accessed 27th July 2012

Goodwin, C. (1981). *Conversational interaction: Talk between speakers and hearers*. New York: Academic Press.

Goodwin, C. (1996). Transparent vision. In Ochs, E., Schegloff, E. and S. Thompson (eds.) Interaction and Grammar. Cambridge: Cambridge University Press. 370-404.

Goodwin, C. (1996). Communality as a dimension of service relationships. *Journal of Consumer Psychology* 5.4: 387-415.

Goodwin, M. (1997). Toward families of stories in context. In Bamberg, M. (ed.): 107- 112.

Goody, E. (1972). ‘Greeting, ‘begging’ and the presentation of respect. In La Fontaine, J.S. (ed.) 1972: 39-71.

Gosling, J. (2002). Practice management: Gender offenders. *Health Service Journal.* 26.112 (5824): 26-27.

Grice, H.P. (1975). ‘Logic and conversation’ in Cole P. and J.L. Morgan (eds) 1975. Syntax and Semantics 3: Speech Acts. New York: Academic Press.

Griffiths, L. (2001). Categorising to exclude: The discursive construction of cases in community mental health teams. *Sociology of Health and Illness* 23.5: 678-700.

Gudykunst, W. and Y. Kim. (1997). *Communicating with strangers: An approach to intercultural communication*. 3rd ed. New York: McGraw Hill.

Gumperz, J. (ed.) (1982). *Language and social identity*. Cambridge: Cambridge University Press.

Gumperz, J. (1982). *Discourse strategies*. Cambribdge: Cambridge University Press.

Gumperz, J. and N. Berenz. (1993). Transcribing conversational exchanges. In Edwards, J. and M. Lampert (eds.): 91-122.

Gumperz, J. (1996). The linguistic and cultural relativity of conversational inference. In Gumperz, J. and S. Levinson (eds.): 374-406.

Gumperz, J. (1997). A discussion with John Gumperz. In Eerdmans, S., Previgano, C. and P. Thibault (eds.) Discussing Communication Analysis 1: John Gumperz. Lausanne: Beta Press.

Gunnarson, B-L., Linell P. and B. Nordberg (eds.) (1997). *The construction of professional discourse*. London: Longman.

Gwyn, R. (2002). *Communicating health and illness*. London: Sage.

Habermas, J. (1984). *Theory of communicative action*. London: Heinemann.

Hak, T. (2004). The interactional form of professional dominance. In Annandale, E., Elston, M. and L. Prior (eds.): 351-369.

Hall, A. (1974). *The point of entry: A study of client reception in the social services*. London: George Allen and Unwin.

Hall, C., Sarangi, S. and S. Slembrouck. (1997). Moral construction in social work discourse. In Gunnarson, B-L., Linell P. and B. Nordberg (eds.): 265-291.

Hall, C., Sarangi, S and S. Slembrouck. (1999). The legitimation of the client and the profession: Identities and roles in social work. In Sarangi, S. and C. Roberts (eds.): 293-332.

Hallam, L. (1993).Access to general practice and general practitioners by telephone: The patient's view. *British journal of general practice* 43:331-335

Halliday, M. (1961). Categories of the theory of grammar. *Word* 17.3: 241-292.

Halliday, M. (1978). *Language as social semiotic: The social interpretation of language and meaning*. London: Edward Arnold.

Halliday, M. (1985). *An introduction to functional grammar*. London: Arnold.

Halliday, M. (1994). *An introduction to functional grammar*, 2nd ed. London: Arnold.

Hammersley, M and P. Atkinson. (1983). *Ethnography: Principles in practice*. London: Tavistock.

Hanks, W.F. (1990). *Referential space: Language and lived space among the Maya*. Chicago: University of Chicago Press

Hardey, M. (1999). Doctor in the house: The internet as a source of lay knowledge and the challenge to expertise. *Sociology of Health and Illness* 21.4: 820-835.

Harris, S. (2001). Being politically impolite: extending politeness theory to adversarial political discourse. *Discourse and Society* 12.4: 451-472.

Hasan, R. (1978). Text in the systemic functional model. In W. Dressler (ed.) Current trends in text linguistics . Berlin:Walter Gruyter. 228-246.

Hasan, R. (1985). The structure of a text. In Halliday, M. and R. Hasan. Language, Context and Text: Aspects of Language in a Social Semiotic Perspective. Deakin University: Deakin University Press. 52-69.

Heath, C. (1981). The opening sequence in doctor-patient interaction. In Atkinson, P and C. Heath (eds.): 71-90.

Heath, C. (1989). Pain talk: The expression of suffering in the medical consultation. *Social Psychology Quarterly* 52: 113-125.

Heath, C. and J. Hindmarsh. (2002). Analysing interaction: Video, ethnography and situated conduct. In May, T. (ed.) Qualitative Research in Action. London:OUP.

Heritage, J. and D. Watson. (1979). Formulations as conversational objects. In Psathas, G. (ed.): 123-162.

Heritage, J. (1984). *Garfinkel and ethnomethodology*. Cambridge: Polity Press.

Heritage, J. (1984). A change of state token and aspects of its sequential placement. In Maxwell Atkinson, J. and J. Heritage (eds.): 299-345.

Heritage, J. (1985). Analysing news interviews: Aspects of the production of talk for an overhearing audience. In van Dijk, T. Handbook of Discourse Analysis. Vol. 3. London: Academic Press.

Heritage, J. and D. Greatbatch. (1991). On the institutional character of institutional talk: the case of news interviews. In Boden, D. and D. Zimmerman: 93-137.

Heritage, J. and S. Sefi. (1992). Dilemmas of advice: Aspects of the delivery and reception of advice in interactions between health visitors and first-time mothers. In Drew, P. and J. Heritage (eds):331-358

Heritage, J. and D. Maynard (eds.) (2006). *Communication in Medical Care Interaction between Primary Care Physicians and Patients*. Cambridge: Cambridge University Press.

Hester, S. and P. Eglin. (eds.) (1997). *Culture in action: Studies in membership categorization analysis*. Washington: University Press of America

Heuston, J .et al. (2001).Receptionists and their dealings with substance misusing patients. *Journal of Substance use* 6:151-157

Hewitt, H. (2001). *Encounters between bus drivers and passengers*.Cambridge: Cambridge University Press.

Hewitt, H. (2003). Facing both ways: reception work in general practice. Paper given at the 1st Interdisciplinary Conference on Communication, Medicine an Ethics, University of Wales, Cardiff.

Hewitt, H. (2006). *Receptionists strategies. Cambridge*: Cambridge University Press.

Hewitt, H. (2006). *Front desk talk: A study of interaction between receptionists and patients in general practice surgeries.* Unpublished PhD thesis, University of Edinburgh.

Heydon, G. (2004). *The language of police interviewing: A critical analysis*. Basingstoke: Palgrave MacMillan.

Hickey, L. and M. Stewart.(2005.). *Politeness in europe.* Clevedon: Multilingual Matters.

Hodge, R. and G. Kress. (1988). *Social semiotics*. Cambridge: Polity.

Holmes, J. (1982). The function of tag questions. *English Language Research Journal* 3: 40-65.

Holmes, J. (1986). The functions of you know in women's and men's speech. *Language in Society* 15: 1-22.

Holmes, J. (1990). Apologies in new Zealand English. *Language in Society* 19: 155- 199.

Holmes, J. (1995). *Women, men and politeness*. London: Longman.

Holmes, J. (2001). *An introduction to sociolinguistics*. 2nd ed. Harlow: Longman.

Holmes, J. and M. Stubbe. (2003). *Power and politeness in the workplace*. Harlow: Longman.

Holmes, J. and M. Marra. (2004). Relational practice in the workplace: Women's talk or gendered discourse? *Language in Society* 33.3: 377-398.

Holmes, J. and S. Schnurr. (2005). Politeness, humor and gender in the workplace. *Journal of Politeness Research* 1.1: 121-149.

Holtgraves, T. (2005). Social psychology, cognitive psychology and linguistic politeness. *Journal of Politeness Research* 1.1: 73-93.

Hughes, C. and S. McCann. (2003). Perceived interprofessional barriers between community pharmacists and general practitioners: A qualitative assessment. *British Journal of General Practice* 53. 493: 600-606.

Hughes, D. (1989). Paper and people: the work of the casualty reception clerk. *Sociology of Health and Illness* Vol. 11. 4: 382-408.

Hunt, S. and R. Benford. (1997). Dramaturgy and methodology. In Miller, G. and R. Dingwall (eds.): 106-118.

Husain-Gambles, M, Neal R., Dempsey, O. Lawlor, D. and J. Hodgson. (2004). Missed appointments in primary care: Questionnaire and focus group study of health professionals. *British Journal of General Practice* 54.499: 108-113.

Hutchby, I. (1996). Power in discourse: The case of arguments on a British talk radio show. *Discourse and Society* 7.4: 481-497.

Hydén, L-C. (1997). Illness and narrative. *Sociology of Health and Illness*. 19.1: 48- 69.

Hyden, L-C and E.Mishler. (1999).Language and medicine. *Annual Review of Applied Linguistics* 19:174- 192

Iacobucci, C. (1990). Accounts, formulations and goal attainment strategies in service encounters. In Tracy, K. and N. Coupland (eds.) Multiple Goals in Discourse. Clevedon: Multilingual Matters.

Iacobucci, D. and A. Ostrom. (1993). Gender differences in the impact of core and relational aspects of services on the evaluation of service encounters. *Journal of Consumer Psychology* 2.3: 257-286.

Ide, R. (1998). 'Sorry for your kindness': Japanese interactional ritual in public discourse. *Journal of Pragmatics* 29: 509-529.

Iedema, R., Sorensen, R., Braithwaite, J. and E. Turnbull. (2004). Speaking about dying in the intensive care unit, and its implications for multidisciplinary end of- life care. *Communication and Medicine* 1.1: 85-96.

Illich, I. (1976). *Limits to medicine - medical nemesis: The expropriation of health*. Harmondsworth: Penguin.

Irvine, J. (1979). Formality and informality in communicative events. *American Anthropologist* 81.4: 773-790.

Irvine, J. (1996). Shadow conversations: the indeterminacy of participant roles. In Silverstein, M. and G. Urban (eds.) 1996. Natural Histories of Discourse. Chicago and London: University of Chicago Pres. 131-159.

Jacobs-Huey, L. (1996). Negotiating social identity in an African-American beauty salon. In Warner, N., Ahlers, J., Bilmes, L., Oliver, M. and S. Wertheim (eds.) Gender and Belief Systems. Proceedings of the 1996 Berkely Woman and language Group Conference. Berkely: University of California Press. 85-97.

Jaffe, A. (2000). Introduction: Non-standard orthography and non-standard speech. *Journal of Sociolinguistics* 4.4: 497-513.

Jaffe, A. and S. Walton. (2000). The voices people read: Orthography and the representation of non-standard speech. *Journal of Sociolinguistics* 4.4: 561- 587.

Jakobson, R. (1960). Closing statements: linguistics and poetics. In Sebeok, T. (ed.) Style in Language. Cambridge, Mass.: the MIT Press. 350-377.

Jean, Y. (2004). Inclusive intake screening. *Sociology of Health and Illness* 26:385-410

Jefferson, G. (1979). A technique for inviting laughter and its subsequent acceptance declination. In Psathas, G. (ed.): 79-96.

Jefferson, G. (1985). An exercise in the transcription and analysis of laughter. In van Dijk, T. A. (ed.) Handbook of Discourse Analysis. Orlando, FL: Academic. 25-34.

Jefferson, G. (1989). Preliminary notes on a possible metric which provides for a 'standard maximum' silence of approximately one second in conversation. In Roger, D and P. Bull (eds.): 166-196.

Jefferson, G. (1996). A case of transcriptional stereotyping. *Journal of Pragmatics* 26: 159-170.

Jefferson, G. and J. Lee. 1992 (1981). The rejection of advice: managing the problematic convergence of a "troubles-telling" and a "service encounter". *Journal of Pragmatics* 5: 399-422. Reprinted in Drew and Heritage (eds.): 521-548.

Jucker, A. and S. Smith. (1998). And people just you know like 'wow': Discourse markers as negotiating strategies. In Jucker, A. and Y. Ziv (eds.): Discourse Markers: Descriptions and Theory. Amsterdam and Philadelphia: John Benjamins.171-201.

Kaspar, G. (1990). Linguistic politeness. Current research issues. *Journal of pragmatics* 14:193-314.

Kaspar, G. (2000). Data collection in pragmatic research. In Spencer-Oatey H. (ed):316-341

Kothari, C.R. (2003). *Research methodology*. New Delhi: New Age International.

Labov, W. and J. Waletzky. (1967). Narrative analysis: Oral versions of personal experience. In Helm, J. (ed.) Essays on the Verbal and Visual Arts. Seattle: University of Washington Press.

Labov, W. (1972). *Language in the inner city*. Philadelphia: University of Pennsylvania Press.

Labov, W. (1972). *Sociolinguistic patterns*. Oxford: Blackwell.

Labov, W. (1972). Some principles of linguistic methodology. *Language in Society* 1: 97-120.

Labov, W. (1982). Objectivity and commitment in linguistic science: the case of the Black English trial in Ann Arbor. *Language in Society* 11: 165-201.

Labov, W. (1997). Some further steps in narrative analysis. *The Journal of Narrative and Life History* 7.1-4: 395-415.

Ladd, D.R. (1978). Stylized intonation. *Language* 54/3: 517-540.

Lakoff, R. (1989). The Limits of politeness: Therapeutic and courtroom discourse. *Multilingua* 8: 101-129.

Lamoureux, E. (1988). Rhetoric and conversation in service encounters. *Research on Language and Social Interaction* 22: 93-114.

Latour, B. (2005). *Reassembling the social: An introduction to actor-network theory*. Oxford: Oxford University Press.

Lave, J and E. Wenger. (1991). *Situated learning: Legitimate peripheral participation*. Cambridge: Cambridge University Press.

Laver, J. and S. Hutcheson (eds.) (1972). *Communication in face to face interaction*. Harmondsworth: Penguin.

Lawton, J. (2003).Lay experiences of health and illness. *Sociology of Health and Illness* 25:23-40

Leech, G. (1983). *The principles of pragmatics*. Harlow: Longman.

Lemke, J. (1998). Analysing verbal data: Principles, methods and problems. In Tobin, K. and B. Fraser (eds.) International Handbook of Science Education.

Lerner, G. (1996). Finding 'face' in the preference structures of talk-in-interaction. *Social Psychology Quarterly* 59.4: 302-321.

Lerner, G. (ed.) (2004). *Conversation analysis: Studies from the first generation*. Amsterdam : John Benjamins.

Levinson, S. (1988). Putting linguistics on a proper footing: Explorations in Goffman's concepts of participation. In Drew, P and A. Wootton (eds.) Erving Goffman. Oxford: Polity Press.

Levinson, S. (1983). *Pragmatics*. Cambridge: Cambridge University Press.

Levinson, S. (1992). Activity types and language. *Linguistics* 17: 356-399.

Linde, C. (1997). Evaluation as linguistic structure and social practice. In Gunnarson B-L., Linell, P. and B. Nordberg (eds.) The Construction of Professional Discourse. London: Longman. 151-172.

Linell, P. and T. Luckmann. (1991). Asymmetries in dialogue: Some conceptual preliminaries. In Marková, I. and K. Foppa (eds.): 1-20.

Linell, P. and E. Fredin. (1995). Negotiating terms in social welfare office talk. In Firth, A. (ed.): 299-318.

Linell, P. (1998). *Approaching dialogue: Talk, interaction and contexts in dialogical perspectives*. Amsterdam and Philadelphia: John Benjamins.

Lipsky, M. (1980). *Street level bureaucracy*. New York: Russell Sage.

Locher, M. (2004). *Power and politeness in action: Disagreements in oral communication*. Berlin: Mouton de Gruyter.

Locher, M. and R. Watts. (2005). Politeness theory and relational work. *Journal of Politeness Research* 1: 9-33.

Luchjenbroers, J. (1997). In your own words: Question and answers in a Supreme Court trial. *Journal of Pragmatics* 27: 477-503.

Lukes, S. (2005). *Power: A radical view*. 2nd ed. Basingstoke: Palgrave MacMillan.

Lyons, J. (1995). *Linguistic semantics: An introduction*. Cambridge: Cambridge University Press.

Mays, N and C. Pope. (2000). Quality in qualitative health research. In Pope C. and N. Mays (eds.): 89-101.

Ministry of Health, 1999.The first national health sector strategic plan of Kenya.Nairobi, Kenya: Government printer

Ministry of Health, 2005. The second national health sector strategic plan of Kenya. Nairobi, Kenya: Government printer

Ministry of Medical Services, 2008.The first national medical sector plan of Kenya. Nairobi, Kenya: Government printer.

Ministry of Medical Services and Ministry of Public Health and Sanitation, 2012. Kenya health policy. Nairobi, Kenya: Government printer.

Ministry of Medical Services and Ministry of Public Health and Sanitation, 2012. Kenya health sector strategic and investment plan. Nairobi, Kenya: Government printer.

McCarthy, M. (1998). *Spoken language and applied linguistics*. Cambridge: Cambridge University Press.

McCarthy, M. (2000). Mutually captive audiences: Small talk and the gener of close-contact service encounters. In Coupland, J. (ed):84-109)

McCarthy, M. (2003). Talking back: “Small” interactional response tokens in everyday conversation. *Research on Language and Social Interaction* 36.1: 33-63.

McCarthy M. and A. O'Keeffe. (2003). What's in a name?: Vocatives in casual conversation and radio phone-in calls. *Language and Computers* 46.1: 153- 185.

Merritt, C. (1976) .On questions following questions in service encounters. *Language in society* 5:315-357

Merritt, M. (1980). On the use of OK in service encounters. In Baugh, J. and J. Scherzer (eds.) Language in Use: Readings in Sociolinguistics. Englewood Cliffs, NJ: Prentice Hall.

Miller, G. and R. Dingwall (eds.) (1997). *Context and method in qualitative research*. London: Sage.

Miller, J. (1993). The grammar of Scottish English. In Milroy, J. and L. Milroy (eds.) The Grammar of English Dialects in the British Isles. London: Longman. 99-138.

Mills, S. (2002). Rethinking politeness, impoliteness and gender identity. In Litosseliti, L. and J. Sunderland (eds.) Gender Identity and Discourse Analysis. Amsterdam: John Benjamins. 69-89.

Mills, S. (2003). *Gender and politeness*. Cambridge: Cambridge University Press.

Milroy, L. (1980). *Language and social networks*. Oxford: Blackwell.

Milroy, J. and L. Milroy. (1991). *Authority in language*. 2nd ed. London: Routledge.

Milroy, L. (2002). *Observing and analyzing natural language*. London: Oxford University Press.

Muga, R.et al (2008). *Overview of the health system in Kenya*. MOH-GOK.

Mugenda, O. &A.Mugenda. (1999). *Quantitative and qualitative approaches*. Nairobi: Acts press.

Mumby, D. (1988). *Communication and power in organizations: Discourse, ideology and domination*. Norwood: Ablex.

Munro, J.et al. (2004). Why are patients removed from their doctors' lists? A comparison of patients' and doctors' accounts of removal. *Family practice* 21:515-518

Myers, G. (1995). Disciplines, departments and differences. In Gunnarson, B-L. and I Bäcklund (eds.) Writing in Academic Contexts. Uppsala, Sweden: Uppsala University: 3-11.

Myers Scotton, C. and J. Bernstein. (1988). Natural conversations as a model for textbook dialogue. *Applied Linguistics* 9.4: 372-384.

Naish, J. (2002).Brief encounters of aggression and violence in primary care. *Family practice*19:504-510

Ndavi, P.M. et al (2009). *Decentralizing Kenya's health management*. Nairobi: University of Nairobi Publishers.

Ochs, E. (1979). Transcription as theory. In Ochs, E. and F. Schieffelin (eds.) Developmenal Pragmatics. New York: Academic Press. 43-72.

Ochs, E. (1992). Indexing gender. In Duranti, A. and C. Goodwin (eds.): 335-357.

Offredy, M. (2002). Access to primary care: decision making by GP receptionists. *British Journal of Community Nursing* 7.9: 480-485.

Ogden, J., Branson, R., Bryett, A., Campbell, A., Febles, A., Ferguson, I., Lavender, H., Mizan, J., Simpson, R. and M. Tyler. (2003). What's in a name? An experimental study of patients' views of the impact and function of a diagnosis. *Family Practice* 20.3: 248-253.

Ojwang, B. (2010). A *pragmatic analysis of politeness strategies in nurse-client interactions in selected public health facilities in Nyanza Province, Kenya*. Unpublished PhD thesis, Maseno University.

Parsons, T. (1952). *The social system*. London: Routledge.

Pennycook, A. (1994). The politics of pronouns. *ELT Journal* 48.2: 173-178.

Petchey, R.et al. (2001).The maintenance of confidentiality in primary care: A survey of policies and procedures. *Aids care: Social and socio-medical aspects of AIDS/HIV* 13:251- 256

Pope C. and N. Mays, (eds.) (2000). *Qualitative research in health care*. (2nd edition) London: BMJ Books.

Pope, C. and N. Mays. (2000). Qualitative methods in health research. In Pope C. and N. Mays, (eds.): 1-10.

Potter, J. (1996). *Representing reality: Discourse, rhetoric and social construction*. London: Sage.

Quirk, R., Greenbaum, S., Leech, G. and J. Svartvik . (1985). *A comprehensive grammar of the english language*. London: Longman.

Roberts, C and S. Sarangi. (1999). Hybridity in gatekeeping discourse: Issues of practical relevance for the researcher. In Sarangi, S. and C. Roberts (eds.):

Roberts, C. (2000). Professional gatekeeping in intercultural encounters. In Sarangi, S. and M. Coulthard (eds.) : 102-120.

Roberts, C. and S. Sarangi. (2002). Mapping and assessing medical students' interactional involvement styles with patients. In Spellman-Miller, K. and P. Thompson (eds.) Unity and Diversity in Language Use. London: Continuum. 99-117.

Roberts, C.et al. (2003). A discourse analysis study of good and poor communication: A proposed new framework for teaching students. *Medical education*.37.3:192-201

Sacks, H., Schegloff, E. and G. Jefferson. (1974). A simplest systematics for the organisation of turn-taking for conversation. Language 50: 361-382.

Sacks, H. (1975). Everyone has to lie. In M. Sanches and B. Blount (eds.) Sociocultural Dimensions of Language Use. New York: Academic Press. 57-79.

Sacks, H. and E.Schegloff. (1979). Two preferences in the organisation of reference to persons in conversation. In Psathas, G. (ed.): 15-21.

Sacks, H. (1992). *Lectures on conversation*. Oxford: Basil Blackwell.

Sarangi, S. and C.Roberts. (1999). Introduction: Discursive hybridity in medical work. In Sarangi, S. and C.Roberts (eds) 1999:61-74

Sarangi, S. and S. Slembrouck. (1996). *Language, bureaucracy and social control*. London: Longman

Sarangi, S. and C.Candlin. (2003).Teaching between reflexivity and relevance: new challenges for applied linguistics. Introduction to special issue. *Applied linguistics.*24.3:271-285.

Schegloff, E. (1968). Sequencing in conversational openings. *American Anthropologist* 99: 190-94.

Schegloff, E., Jefferson, G. and H. Sacks. (1977). The preference for self-correction in the organization of repair in conversation. *Language* 53: 361-382.

Schegloff, E. (1981). Discourse as an interactional achievement: some uses of uh huh and other things that come between sentences. In Tannen, D. (ed.) 1981. Meaning, Form and Use in Context. Georgetown University Roundtable on Language and Literature. Washington DC: Georgetown University Press. 71-93.

Schegloff, E. (1986). 'The routine as achievement'. *Human Studies* 9: 111-152.

Schegloff, E. (1991). Reflections on talk and social structure. In Boden and Zimmerman (eds.): 44-70.

Schegloff, E. (1992). On talk and its institutional occasions. In Drew, P. and J. Heritage: 101-134.

Schegloff, E. (1997). "Narrative analysis" thirty years later. In Bamberg, M. (ed.): 97- 106.

Searle, J. (1979). *Expression and meaning: Studies in the theory of speech acts*. London: Cambridge University Press.

Selinger, W.H and E.Shohamy. (2011). *Second language research methods*. Oxford: Oxford University Press.

Shilling, C. (2002). Culture, the sick role and the consumption of health. *British Journal of Sociology* 53:621-638

Shuy, R. (1976). The medical interview: Problems in communication. *Primary Care* 3: 365-386.

Silverman, D. (1987). *Communication and medical practice*. London: Sage.

Silverman, D. (1992). Applying the qualitative method in clinical care. In Daly, J, MacDonald I and E. Willis (eds.):176-188.

Silverman, D. (1997). *Discourses of counselling: HIV counselling as social interaction*. London: Sage.

Silverman, D. (2000). *Doing qualitative research: A practical handbook*. London: Sage.

Silverman, D. (2001). *Interpretating qualitative data: Methods for analyzing talk text and interaction*.2nd Ed London: Sage.

Spencer-Oatey, H. (ed.) (2000). *Culturally speaking: Managing rapport through talk across cultures*. London: Continuum.

Spencer-Oatey, H. (2005). (Im)politeness, face and perceptions of rapport: Unpackaging their bases and interrelationships. *Journal of Politeness Research* 1: 95-119.

Strong, P. (1979). *The ceremonial order of clinic*. London: Routledge and Kegan Paul

Taylor, C. (1989). *Sources of the self: The making of modern identity*. Cambridge: Harvard

Togher, L.et al. (2004).Training communication partners of people with traumatic brain injury: A randomized controlled trial discourse. In Halliday, M.A.K., Gibbons, J. and H.Nicholas (eds):493-508

Trudgill, P. (1992*). Introducing language and society*. London: Penguin.

Ventola, E. (1987). *The structure of social interaction: A systematic approach to the semiotics of service encounters*. London: Francis Pinter.

Ventola, E.(1990). Linguistic difficulties in institutional discourse. In Halliday, M.A.K., Gibbons, J. and H. Nicholas (eds.): 493-508.

Watson, D. (1981).Conversational and organisational uses of proper names: An aspect of counsellor-client interaction. In Atkinson, P. and C. Heath (eds.): 91-106.

Wenger, E. (1998). *Community of practice: learning, meaning and identity*. Cambridge: Cambridge. University Press

Zimmerman, D. (1971). The practicalities of rule use. In Douglas, J. (ed.) Understanding Everyday Life. London: Routledge and Kegan Paul. 221-238.

Zimmerman, D. (1992). The interactional organisation of calls for emergency assistance. In Drew, P. and J. Heritage (eds.): 418-469.

Zimmerman, D. (1998). Identity, context and interaction. In Antaki, C. and S. Widdicombe (eds.) Identities in Talk. London: Sage. 87-106.

APPENDICES

Appendix 1

Transcription of audio recordings

Public health facility A

Extract 1

(Facility A, Tape 1, episode 22)

1,RA2: koro? anyalo konyi?

Koro-DET-BE-1PS can-AUX you-1PS

(*how are you? can I help you*?)

2. PA22: ber.atimo gima rach.Wiya-.Wiya owil gi (.) yath momiya gi daktar!

atimo-SBJ-1PS wiya-1SP gi-ART momiya-PTCP daktar-OBJ

(*fine.I have done something bad.I have-.have forgotten the medicine given by the doctor!*)

Extract 2

(Facility A, Tape 1, episode 4)

1.RA1: amosi?

amosi-DET-BE-1PS

(*how are you*?)

2. PA4: ber ahinya

Ber-1PS ahinya-ADV

(*i'm very fine*)

3. RA1: ithi nade?

Ithi-DET nade-COP-PTCP

(*how is everything?)*

4. PA4: *i'm going well*

I-1PS-SBJ going-PTCP well-ADV

(*i'm doing fine*)

Extract 3

(Health facility A, Tape 1, episode 11, F/26-40/ly/ey)

Service orientation	1 2	RA1:habari yako sister? habari-DET yako-2PS sister-SUBJ (*how are you my sister?)* PA11: huwa nachukua madawa yangu ya support services huko Migori . na sasa nilikuwa na uliza . social support services ya hapa iko wapi?(research forms dealt with) Huwa-ADV yangu-1PS huko Migori-ADVL nilikuwa-1PS ya hapa-REL *(I usually collect my drugs from the social support services at Migori . so I wanted to know . where the support services are located here)*
Resolution	3	RA1: social support services yetu iko karibu na gate .. halafu utaona nyumba kubwa iko na roof ya blue . hapo ndio social support services.

		Yetu-1PL iko-COP karibu na gate-SUBJ-COMP halafu-DET utaona-2PS-AUX nyumba kubwa-OBJ iko-REL roof ya blue-OBJ-COMP (*our social support services is located near the gate . then you will see a big house with a blue roof . there is the social services)*

Extract 4

(Facility A, Tape 1, episode 8, M/16-25/ly/ey)

Service orientation	1 2	RA2: Nango brother? Nango-BE you-2PS my-DET brother-SUB (*how are you my brother*?) PA8: Ber ahinya . awinjo ka atuo to akia achak gi kanye Ber ahinya-ADV awinjo-1PS ka-BE atuo-SUB-COMP akia-1PS-NEG-AUX achaki-REL (*I am very fine . I feel like am sick but I don't know where to start from*)
Information check	3	RA2: (4) in wendo kae? In-BE-2PS ART (*are you a visitor*?)
Resolution	4	RA2:Ibonyiewo book kacha {PA8: kama ji ngeny?}as tikelo to andiko ni kae Ibonyiewo-2PS-AUX- there-DEM kama-REL (*you will buy a book there* {PA8: *where people are many*? }*then you bring it I register you*)

Extract 5

(Facility A, Tape 1, episode 15, F/16-25/lm/om)

Information check	1	RA1: Jina <u>yako</u>? Your-2PS name-SUB (*your name*?)
	2	PA15: Rashidi Ramadhan SUB (*Rashid Ramadhan*)
Confirmation	3	RA1: (2) Rashid Ramadhan SUB ((2) *Rashid Ramadhan*)
Resolution	4	RA1: Sawa . utaenda ward three

		(*ok . go to ward three*)

Extract 6

(Facility A, Tape 1, episode 2, F/26-40/lm/om)

Resolution	1	RA2: Sasa . Dr Otedo hayuko na utaona Dr Omondi Dr Otedo-SUB hayuko-COP-NEG utaona-2PS Dr Omondi-OBJ (*now dr Otedo is not available but you will be seen by dr Omondi)*
Confirmation	2	Hiyo ni sawa? Dr Otedo ameenda emergency Is-COP that-REL you-2PS emergency-OBJ-SUB-COMP (*is that okay with you?dr Otendo is attending to an emergency)*
	3	PA2: Hh // niko sawa Am-SUB sawa-OBJ (*hh//am ok)*
	4	RA2: // kulikuwa na mgonjwa amezidiwa PGH Kulikuwa-SUB-BE na-ART mgojwa-OBJ amezidiwa-ADVL (*there was a very sick patient at PGH)*
	5	PA2: // Nilikuja ani angalilie result zangu za lab Nilikuja-1PS-V aniangalilie-DET-DET-SUB-AUX result-OBJ zangu za lab-ADVL (// *I came so that he could interpret my results from the lab)*
	6	RA2: Hope sija ku mess? Hope-PRE MOD sija ku-1PS-AUX-NEG mess-OBJ (*hope I have not messed you up)*

Extract 7

(Facility A, Tape 1, episode 1, F/26-40/lw/ow)

RA1: Habari yako =
How-PRE MOD are-V you-2PS
(*How are you =)*
PA1: = Nimeleta mtoto hosipitalini . anakohoa sana
Nimeleta-1PS-AUX-V mtoto-OBJ hosipitalini-ADVL
(*I have brought my child to the hospital because he has a cough)*

Extract 8

(Facility A, Tape 1, episode 5, M/16-25/lm/esm)

RA1: Anyalo konyi?
Can-AUX I-1PS help you-V-2PS
(*can I help you*?)
PA5: Sister: eh . nineteen eighty nine . Tom Onyango

PRE MOD SUB

Extract 9

(Facility A, Tape 1, episode 10, F/16-25/lm/esm)

RA1: Habari dada . naweza kuku saidia?
habari-DET-BE-2PS naweza-AUX-1PS kuku-V-2PS
(*how are you sister . can I help you*?)
PA10: Daktari ya watoto yuko oleo?
Yuko-COP daktari-SUB
(*is the pediatrician around today*?)

Extract 10

(Facility A, Tape 1, episode 20, F/41-60/ly/ey)

RA2: Ye:s . mama . amosi:
Yes-DET mama-SUB amosi-SUB-COMP
(*ye:s . mama . hello:)*
PA20: Omiya karatas mar yath . koro atere kanye?
Omiya-1PS-AUX-BE-V karatas-OBJ koro-REL atere-1PS-DO
(*I have been give a prescription form . where do I take it*?)

Extract 11

(Facility A, Tape 1, episode 6, M/41-60/lm/em)

1 PA6: Abondikoni form kakiwacho

Abondikoni-1PS-AUX-V-PP form-INS kakiwacho-ADVL

(*I will fill in the questionnaire as requested*)

2 RA2: (*Hands questionnaire to patient*)

3.PA6: Ero kamano **nyathina**

Ero kamano-PRE-MOD you-2PS nyathina-DET-OBJ

(*thank you* ***my child***)

4 RA2: kate e box kisetieko

Kisetieko-REL-2PS-AUX-SUB COMP

(*put it in the box when you've completed*)

5 PA6: To atimo kare **nyathina**? . ero kamano (*passes over prescription request*)

To-COP-DEM nyathina-DET-N ero kamano-PRE MOD 2PS

(*is that right* ***my child****? . thank you*)

Extract 12

(Facility A, Tape 1, episode 9, M/41-60/lm/esm)

RA1: Donge isetieko?

Donge isetieko-2PS-AUX-BE-V

(*you've been sorted*?)

PA9: Ero kamano . **nyara**

Erokamo-PRE MOD-2PS nyara-DET-N

(*thank you .* ***my daughter***)

Extract 13

(Facility A, Tape 1, episode 7, M/16-25/lm/ly)

1 RA1: Wacha ni agalie kama atakuja Monday tarehe <u>tisa</u>

Ni-3PS kama-REL ata-AUX

(*let me check whether the doctor will come on Monday 9th*)

2 PA7: Sasa nikuje lini?

Sasa-DET nikuje-1PS-DO-V

(*so when do I come?*)

3 RA1: Kuja Friday

Kuja-V Friday-OBJ

(*come on Friday*)

4 PA7: Usiweke mtu mwigine mbele yangu

Usiweke-DO-NEG-V mtu-OBJ mbele yangu-ADVL

(*don't put anybody in front of me*)

Extract 14

(Facility A, Tape1, episode 12, F/41-60/ly/ey)

1.RA1: Sasa hiyo huko na barua ni special clinic . wewe ni odhiambo . wanaangalia

2 vitu zingine

Sasa-DET hiyo-DEM huko-2PS

(now *one that you've got the letter about is a special clinic . you are Odhiambo*

They are monitoring certain things)

3 PA12: sasawa

Sasawa-1PS-V

(*I see)*

4 RA1: (4) Sawa . ni vile hizi zita chukua nusu saa kwa sababu (.) utakuwa tested

Sawa-DET hizi-DEM zita-DEM utakuwa-2PS-AUX

(*right . it's just that these are half an hour appointments because (.) you'll be tested*)

5 PA12: Sawa sawa

Sawa sawa-SUB-COMP

(*its okay*)

6 RA1: Na itachukuwa muda

Itachukuwa-SUB-V muda-SUB-COMP

(*and it takes a bit longer*)

Extract 15

(Facility A, Tape 1, episode 15, F/16-25/new patient)

1 PA15: Na penjo . itimango . napenjo ka yath ichulo

Na penjo-A-1PS-AUX-SUB-COMP itimango-REL-DO napenjo-1PS-BE-SUB-COMP ka-COND

(*I was wondering . what do they do . I was wondering if we pay for medicine*)

2 RA2: (2) Iwacho?

Iwacho-OBJ-COMP

(*sorry?*)

3 PA15: Be ichulo yath esiptande sirkal //

Be-DO-3PS esiptande sirkal-ADVL

(*do we pay medicine in government hospitals //*)

4 RA2: // Ibo chulo matin

Ibo-2PS-AUX

(*// you will pay very little*)

Extract 16

(Facility A, Tape 1, episode 14, F/41-60/lm/om)

1. PA14: Hi yote ni kwa sababu yako!

Hi-DEM-COP yako-2PS

(*this is all your fault*)

2 RA2:Yes// yes . nimekubali (.) ha ha

Nimekubali-1PS-PRF-V

(*I've accepted (.) ha ha*)

3 PA14: //Ha ha ha ha ha

Extract 17

(Facility A, Tape 1, episode 12, F/16-25/ly/ey)

RA1: amosi kanyo

Amosi-DEM

(*hi there*)

PA12: neadwaro neon daktari

Neadwaro-1PS-V

(*I want an appointment to see a doctor*)

Extract 18

(Facility A, Tape 1, episode 14, M/41-60/lw/ow)

RA2: mae mar nga?

Mae-REL mar nga-COP

(*and who is it for?)*

PA14: mos . en mar chiega

Mar-PRE.MOD chiega-N

(*sorry . it is for my wife*)

Extract 19

(Facility A, Tape 1, episode 28, M/16-25/lm/esm)

RB1: ok . sorry about that

DET N DEM

Private health facility B

Extract 1

(Facility B, Tape 2, episode 3)

1. PB5:hello.I've got an appointment at.eh.the <u>radiology</u> for (.) two o'clock

I-1PS have-PRF-PRS

2. RB1: (5) what is your name?

What-DET is-COP your-2PS

3. PB5: Mary Atieno

4. RB1: Mary Atieno?

5. PB5: right

6 RB1: ye:s they will do ECG {PB5: right} just go in the radiology and you will be given directions//

They-DET will-AUX the-ART you-2PS

7. PB5: it's room?

8. RB1: // just behind yo:u

You-2PS-OBJ

9. PB5: // behind me?. right.hh hh.right.thank you

Extract 2

(Facility B, Tape 2, episode 5)

1. RB1: hello

hello-DET

2. PB1 :(.) hi

hi-DET

3. RB1:*hi.kindly//fill for me this consent form and questionnaire*

hi-DET kindly-ADV this-DEM consent form-INS questionnaire-INS

4. PB1:// *that's okay with me and thanks. my name is Martine Otieno to see Dr Omondi*

that-DEM is-COP my-DET name-SUBJ Martine Otieno-SUBJ COMP

Extract 3

(Facility B, Tape 2, episode 4)

1. RB2://hello

hello-DET

2. PB2://Onyango.came for check-up

Onyango-SUBJ check-up-OBJ

3. RB2: *good (.) and do you have your (3) yes. Good.*

do-AUX have-PRF

4. PB2: *what do you want? do you want it to be filled?* (*Consent form*)

what-DET do-AUX

5. RB2:*yes.i want it filled {PB2:okay.okay} and you can take that* (*questionnaire*).*thank you very much.*

I-1PS-SUBJ filled-PTCP you-2PS can-AUX that-DEM

6. PB2: thank <u>you</u> too.

Extract 4

(Facility B, Tape 2, episode 2, F/26-40/lm/o)

Service orientation	1 2	RB2: can I assist you? Can-AUX I-1PS you-1PS-OBJ PB2: yes . I have got an appointment with eh (.) with the gynecologist {RB2: yah} Dr Ogutu . at 10am Yes-DET I-1PS have-PRF an-ART
Resolution	3	RB2: (3) that's okay and have a sit That-DEM is-COP okay-SUBJ-COMP have-PRF a-ART sit-OBJ

Extract 5

(Facility B, Tape 2, episode 1, M/16-25/em/esm)

Service orientation	1 2	RB1: hello . may I help you Hello-DET may-AUX I-1PS you-2PS PB1: ya . I have an appointment Ya-DET I-1PS have-PRF an-ART
Information check	3	RB1: and who do you want to see if I may ask? Who-REL do-AUX you-2PS may-AUX

	4	PB1: eh . Dr Otieno Dr Otieno-OBJ
Confirmation	5	RB1: Dr Otieno
Information check	6 7	RB1: (20) and you are? You-2PS are-INTV PB1: George Omondi
Resolution	8	RB1: that's very good . kindly have a sit That-DEM is-COP very-ADV good-ADJ

Extract 6

(Facility B, Tape 2, episode 20, F/26-40/lm/om)

Service orientation	1	PB20: good afternoon? do you have this (.) prescription? good afternoon-SUBJ do-AUX you-2PS have-PRF
Information check	2 3	RB1: and what is your name madam? what-REL is-COP your-2PS name-OBJ PB20: Diana Adhiambo Diana Adhiambo-OBJ
Confirmation	4 5	RB1: Diana Adhiambo RB20: (fills in the insuarance form) form-INS
Information check 2	6 7	RB1: (7) and what is your postal address? what-REL is-COP your-2PS post-OBJ PB20: 9460 Kisumu
Resolution	8	RB1: okay . you can proceed to the pharmacy can-AUX to the pharmacy-ADVL

Extract 7

(Facility B, Tape 2, episode 15, M/41-60/ly/ey)

Service orientation	1 2	RB2: kindly have this (research forms are dealt with) have-PRF-PRS this-DEM PB15: okay . (2) came for prescription
Information check	3 4	RB2: (.) your name sir? your-2PS name-SUBJ PB15:John Were
Confirmation	5	RB2: Mr Were
Information check	6 7	RB2: (.) your address Mr Were? (.) RB2: // 1570 Kisumu? PB15: // oh yes . yes . 1570 Kisumu
Resolution	8	RB2:very well very-ADV

Extract 8

(Facility B, Tape 2, episode 6, M/41-60/ly/ey)

Stage		Action	Speaker	Text
Service orientation	1 2	Signal availability Bid for service	RB1: PB1:	Good afternoon sir? SUB-COMP (.) ya . please (.) I want to see an eye specialist ya-DET I-1PS eye specialist-OBJ
Confirmation 1	3 4	Request confirmation confirm	RB1: PB1:	(.) do you want to make an appointment? Do-AUX you-2PS appointment-OBJ I will really appreciate I-1PS will-AUX appreciate-SUB-COMP

Resolution 1	5
	
	6
	7
		Inform about service
		
		Acknowledge
		Inform (contd)
			RB1:
			
			PB1:
			RB1:
				The doctor will be available on . Tuesday or Friday .
				The doctor-DET-SUBJ will-AUX
				// okay (1) Tuesday is good
				// good
				SUBJ-COMP

Information check 1	8 9 10 11 12	Elicit information Acknowledge Elicit Acknowledge elicit	PB1: RB1: PB1: RB1: PB1:	Okay . actually I am not sick but wanted to bring my son who has an eye problem Okay-DET I-1PS am-BE Who-REL an-ART Mhm So that I get doctor's opinion That-DEM I-1PS Mhm That's what I wanted That-DEM is-COP what-REL I-1PS wanted-SUB-COMP
Information check 2	13 14	Request information confirm	RB1: PB1:	Do you have a medical cover? Do-AUX you-2PS have-PFV a-ART medical cover-OBJ (.) yeah
Resolution 2	15	Inform about service	RB1:	Yeah . mhm . so (.) well if its very severe we will recommend you bring the child on Tuesday morning between nine and ten We-1PL will-AUX you-2PS The child-OBJ
Information check 3	16 17 18 19 20	Request information Provide Acknowledge Provide (contd) Request information	PB1: RB1: PB1: RB1: PB1:	//so . when you say severe is it possible I bring him right away? When-REL you-2PS I-1PS Mhm . that's not really possible coz you know . you'd need to make an appointment That-DEM is-COP you-2PS Yes You know You-2PS know-ADVL Can it be . er . earlier appointment= Can-AUX

	21	provide	RB1:	=earliest one is on Saturdays but subject to doctor's confirmation Is-COP but-CONJ
Information check 4	22 23	Request information provide	PB1: RB1:	On Saturdays? On-PP Saturdays-SUBJ-COMP mhm
Resolution 3	24	inform		(.)leave me your contacts . I'll just tell you when Your-2PS I-1PS will-AUX When-REL
Information check 5	25	Request information		(.) morning or afternoon? SUBJ-COMP
Information check 6	26 27	Request information acknowledge	PB1: RB1:	What time in the morning? What-REL the morning-SUB-COMP I'll just check and let you know I-1PS will-AUX
Information check 7	28 29	Request information confirm	 PB1:	(4) before Saturday SUB-COMP mhm
Resolution 4	30 31	Inform (contd) accept	RB1: PB1:	And I can even give you the doctor's number I-1PS can-AUX you-2PS That will be good That-DEM will-AUX

Extract 9

(Facility B, Tape 2, episode 7, F/16-25/lm/om)

Service orientation	1	PB7: any chance for an appointment with a general physician this afternoon? With-REL a-ART physician-SUB-COMP
Resolution 1	2 3 4 5	RB2: I don't think . I-1PS don't-NEG-AUX Mhm (.) just a moment please (.) there is a . cancellation at three o'clock= a-ART there-DEM is-COP a-ART PB7: =ok . I think I will take that one Ok-DET I-1PS will-AUX that-DEM RB2: with Dr Otedo With-REL Dr Otedo-SUB-COMP

Extract 10

(Facility B, Tape 2, episode 8, M/61-75/lm/om)

Confirmation	1	R confirm	RB1:	Okay . u could wait for your turn Okay-DET u-2PS could-AUX
Resolution	2	R instruct 1		If unaweza fanya kabla uzidiwe things will be okay Will-AUX
	3	P accept 1	PB8:	Sawa hh hh . najua Najua-1PS
	4	R instruct 2	RB1:	Okay . if you could just make the appointment You-2PS could-AUX
	5	P accept 2	PB8:	// I will make the appointment I-1PS-A will-AUX appointment-OBJ
	6	R instruct 3	RB1:	//When you have made the arrangement . it doesn't take <u>long</u> . its only 30 minutes When-REL you-2PS have-PFV
	7	P accept 3	PB8:	Sawa sawa . good . thank you DET ADJ you-2PS
	8	R acknowledge	RB1:	Thanks
	9	P informs	PB8:	Good afternoon Good afternoon-SUB-COMP
	10	R accept	RB1:	You too You-2PS too-OBJ

Extract 11

(Facility B, Tape 2, episode 9, M/41-60/ly/ey)

RB2: // Good afternoon sir
Good afternoon-PRE MOD sir-SUB
PB8: // Afternoon . any chance of an appointment with a dentist this afternoon?

PRE MOD ART OBJ REL ART OBJ

Extract 12

(Facility B, Tape 2, episode 30, F/41-60/ly/ey)

1 PB30: Eh . Mary Atieno . I've come to collect prescription
I-A have-AUX prescription-OBJ

2 RB1: I'm just handing over:::
I-1PS just-ADV handing over-OBJ

3 PB30: Ok . right
Ok-DET right-SUB

4 RB1: to the next shift (4) ya . and you want to collect prescription?

OBJ DET 2PS ADVL

Extract 13

(Facility B, Tape 2, episode 37, F/26-40/lm/ey)

RB2: Yes::?
DET
PB37: Could I see a physician please?

Could-AUX I-1PS a physician-OBJ

Extract 14

(Facility B, Tape 2, episode 38, F/26-40/lm/om)

RB1: Is there anybody waiting to see the duty nurse?
Is-COP there-DET anybody-SUB to see the duty nurse-OBJ
PB38: No . but have you got a piece of paper? . if you don't mind
Have-AUX you-2PS paper-OBJ
RB1: (3) is there anybody waiting to see the duty nurse?
Is-COP there-DET anybody-SUB the duty nurse-A-DET-OBJ
PB40: Me . I'm waiting to see the nurse as well

Me-DET I-1PS am-BE the nurse-A-DET-OBJ

Extract 15

(Facility B, Tape 2, episode 11, F/16-25/lm/ey)

RB1: Hello . can I assist you?
Hello-DET can-AUX I-1PS you-2PS
PB11: (4) Er . I have a doctor's appointment now at two

Er-DET I-1PS have-AUX a-ART doctor's appointment-OBJ now at two-ADVL

Extract 16

(Facility B, Tape 2, episode 13, F/26-40/lw/om)

RB1: Hello (.) may I help you? (.) do you want to see a doctor?
Hello-DET may-AUX I-1PS you-2PS do-DO you-2PS a doctor-ART-OBJ
PB13: I want to see a doctor

I-1PS to see a doctor-SUB-COMP

Extract 17

(Facility B, Tape 2, episode 12, M/41-60/ly/o)

RB1: // How are you today?
How are-PRE MOD you-2PS-SUB today-SUB-MOD
PB12: //Otieno Atieno . Dr Odhiambo . ten o'clock

Otieno-OBJ Dr Odhiambo-SUB ten o'clock-ADVL

Extract 18

(Facility B, Tape 2, episode 16, M/61-75/lm/o)

RB2: Good morning sir=
PRE-MOD-SUB
PB16: = Can I make an appointment with a throat specialist please . this week on Friday

Can-AUX I-1PS an appointment-OBJ with REL this week-ADVL

Extract 19

(Facility B, Tape 2, episode 17, M/41-60/ly/ey)

1 PB17: Good morning there (.) **I**'ve to make an appointment . for blood test at the lab

PRE MOD-DEM 1PS-AUX OBJ ADVL

2 RB2: Right . I can give you eleven o'clock . or two o'clock appointment

PRE MOD 1PS AUX 2PS OBJ

3 PB17: Nothing different?=

PRE MOD N

4 RB2: = the latest being . mmh . eight . or **I** can give you . eh (.) the evening at five

DET-PRE MOD-N 1PS AUX 2PS OBJ

Extract 20

(Facility B, Tape 2, episode 14, F/lw/om)

1 RB1: Hello!

DET

2 PB14: Hello . can I see the (.) Dr Nyakinda on the (.) eleventh

DET AUX 1PS OBJ ADVL

(*receptionist confirm the diary)*

3 RB1: (.) Now **we will** see what **we** can do . **I** don't know whether **I** can help

DET 1PL AUX REL 1PL AUX DO 1PS DO-NEG REL

Extract 21

(Facility B, Tape 2.episode 19, M/26-40/lm/om)

RB1: (*hands questionnaire to patient*) apparently I've to give you this

PRE MOD 1PS AUX 2PS OBJ-DEM

Extract 22

(Facility B, Tape 2, episode 40, F/41-60/ly/ey)

1 PB40: I would like to make an appointment with Dr Ogweno {RB2: yes} some time on

2 Friday . may be at nine morning . or whatever available

I-1PS would-AUX appointment-OBJ with-REL

3 RB2: (2) On Friday (3) he's got on Saturday at . eleven . next Monday afternoon or evening

On Friday-PRE MOD he-A

Extract 23

(Facility B, Tape 2, episode 18, M/lm/ey)

1 RB2: Hi there

Hi-DET there-SUB

2 PB18: I want an appointment with an ENT doctor

I-1PS-A an-ART appointment-OBJ with-REL an-ART doctor-OBJ

(*receptionist checks the diary*)

3 RB2: (4) for any day Wasike? You need to register so that **the computer** generates your detail

We're . looking (.) maybe the following week

For any-PRE MOD day-SUB wasike-A you-2PS that-DEM the-ART computer-INS

4 PB18: (.) I prefer it this week

I-1PS   prefer-SUB COMP   it-OBJ   this week-ADVL

5 RB2: You want it this week?

You-2PS   it-OBJ   this week-ADVL

6 PB18: Ya

7 RB2: If you could call **us** (.) may be half past four today for tomorrow

If-COND   you-2PS   could-AUX   us-1PL   may-AUX

Extract 24

(Facility B, Tape 2, episode 21, M/41-60/ly/ey)

1 RB2: And you're . what can I do for you?

2PS   REL   AUX   DO   2PS

2 PB21: I'd like to make an appointment please . with Dr Obidi

1PS   AUX   ART   OBJ   ADVL

3 RB2: Aha

4 PB21: **I'd better write it in my diary {RB2: aha} and see how it works out (6)**

// **not sure what have written already**

1PS   AUX   DET   N

5 RB2: //His first appointment wouldn't be till second of July

3PS   POST.MOD   AUX   NEG

6 PB21:// **I . I thought it'd be something like that** (4) **thought I had my diary with me**

(3) oh ok . it should be okay with me . second July then.

1PS   AUX   BE   DEM

7 PB21: So that's the second of july

DEM COP ART

8 RB2: (2) At two afternoon

MOD

9 PB21: At two thirty pm

10 RB2: (.) with Dr Obidi

REL-COMP

11 PB21: Okay (.) right . **he seems to be popular**

12 RB2: Yes he is . and he is very commited as well

Extract 25

(Facility B, Tape 1, episode 25, M/41-60/lm/om)

1 RB1: (.) Can I write it down for you?

AUX 1PS 2PS

2 PB25: Please . if you don't mind

DET COND 2PS

3 RB1: Ya

4 PB25: (4) Got a busy schedule you see and have to up date my diary

ART-DET-ADJ-N 2PS AUX

5 RB1: // Ha ha yes// you have a busy . busy life style

2PS AUX ART-DET-N-N POST.MOD

6 PB25: // Ha ha . what are you laughing at?

REL BE 2PS

7 RB1: Ha ha ha ha ha

Extract 26

(Facility B, Tape 2, episode 21, F & M/41-60/lm/em)

1.PB21: There is the reception

DEM COP OBJ

2 PB21W: Ya I can see it

DET 1PS AUX

3 RB1: Hi there!hello! how are <u>you</u>?

DET DEM BE 2PS

4 PB21: Si mbaya (.) I thought you didn't see us

Si mbaya-SUB-COM 1PS 2PS DO-NEG

(*not bad*)

5 RB1: No I didn't . I was chatting with a colleague

NEG 1PS DO-NEG 1PS BE REL ART-N

6 PB21: (Not clear)

7 RB1: Aha . ha ha ha ha

8 PB21: Hee hee hee

9 RB1: I can see you have a wonderful sense of humour // anyway

1PS AUX 2PS AUX ART-N

10 PB21: //a . hee hee hee

11 RB1: I can see you// ha ha ha

1PS AUX 2PS

12 PB21: // Hee hee hee

13 PB21W: (Not clear)

14 RB1: Are you <u>okay</u>

BE   2PS

15 PB21W: Ana penda . kuongea sana!

Anapenda-3PS-V   kuongea sana-OBJ-COMP

(*he likes . to talk too much*)

16 RB1: Ha ha ha

17 PB21: Heh heh heh heh heh heh

18 RB1: How is your knee?

DET   COP   2PS   OBJ

19 PB21: Och . very painful . wanted to see an orthopedic

INTER   ADV

20 RB1: I just thought I'd ask you because . you know . its long since tuonane

1PS   AUX   2PS   2PS   tuonane-1PL-V-DET-N

(*we saw each other*)

Extract 27

(Facility B, Tape 2, episode 22, M/26-40/ly/ey)

RB1: that is for you (gives patient questionnaire) . and do you have an appointment?

DEM   COP   2PS   DO   2PS   PRF   OBJ

PB22: no . I want to make one

NEG   1PS   OBJ

Extract 28

(Facility B, Tape 2, episode 31, F/41-60/lw/om)

1 RB1: hello

2 PB31: hello (*consent form is handed*)

3 RB1: that is what you need (.) for that (questionnaire) . have you got an appointment?

DEM COP REL 2PS DEM PRF 2PS ART-OBJ

4 PB31: no . I . it is a pr- prescription I want to pick

NEG 1PS ART-OBJ ADVL

Extract 29

(Facility B, Tape 2, episode 23, F/41-60/ly/esm)

RB2: now I will just be with you in a minute . do you have an appointment?

1PS AUX BE REL 2PS DO 2PS PRF ART-OBJ

PB23: (.) yes . I do (.) I think it must . it is a vaccination

DET 1PS DO 1PS AUX

Extract 30

(Facility B, Tape 2, episode 27,F/16-25/lm/esm)

PB27: hi . got an appointment for . Okinda at two o'clock

DET ART-OBJ ADVL

Extract 31

(Facility B, Tape 2, episode 26, M/41-60/lw/om)

PB26: I have an appointment with Dr Omondi at three o'clock

1PS PRF ART-OBJ REL

Extract 32

(Facility B, Tape 2, episode 24, M/41-60/ly/ey)

PB24: okay . ya . I was wondering . this is my first visit . and was wondering if I can have an appointment

1PS BE SUBJ.COMP DEM COP 1PS AUX

PRF ART-OBJ

Extract 33

(Facility B, Tape 2, episode 35, F/41-60/lm/ey)

1 RB1: mornig

2 PB35: morning nurse (3)

PRE-MOD

3 RB1: (2) how do I assist you this morning?

DO 1PS 2PS ADVL

4 PB35: sorry?

Extract 34

(Facility B, Tape 2, episode 29, M/75+/lm/esm)

1 RB2: hello

2 PB29: I wanted to collect my medicine . sent by Dr Nyakinda

1PS PRE.MOD-N

3 RB2: (4) give me the diagnosis sheet

3PS OBJ

4 PB29: I beg your pardon

1PS 2PS

Extract 35

(Facility B, Tape 2, episode 32, M/41-60/lm/om)

PB32: morning . I have come for my prescription

1PS PRF SUB-MOD

RB1: yes . get me the prescription sheet//

3PS OBJ-INS

PB32: //I forgot the sheet in the car . I am sorry

1PS OBJ ADVL

Extract 36

(Facility B, Tape 2, episode 37, M/41-60/lm/esm)

RB1: // hello . can I assist

AUX 1PS

PB37: // hello . want to see Dr Odeny . it is a referral

A OBJ ADVL

RB1: right (30) trying my best

PTCP 3PS N

Appendix 2

Interview Schedule

Information from interviews with receptionists.

The following interview guide was administered by the researcher to the receptionists at health facility A and B to determine their interpersonal dynamics.

1. What is your name?

2. What is your age?

3. How long have you worked at the facility?

4. Do you have any formal training on your job?

5. What is the most favourite aspect of your job?

6. What is the least favourite aspect of your job?

7. What motivates you at work?

8. Do people respect your job?

9. Do you have any gatekeeping role at the facility?

10. Are you at the receiving end from patients?

Appendix 3

Information sheet for patients

Receptionist research study

Over the next few days Mr. Robert Onyango, a linguist will be working at the hospital, studying conversations between receptionists and visitors to the public and private health facilities. It is hoped that the results of the study will be used to improve the services received both at the health facilities and elsewhere. They may also be published in medical or linguistic journals.

We would like to make the audio recording of your conversations with the patients who visit your hospital. If you are happy for us to do this, we would be grateful if you could sign the attached consent form. We can assure you that the study will be completely CONFIDENTIAL and ANONYMOUS i.e.

i. Your name will not be used

ii. The hospital will not be identified

iii. Only Mr. Robert Onyango will see the notes and hear the recordings which will be destroyed when the study is complete

Consent form

I have read and fully understood the information sheet and I am willing to take part in the Receptionist study.

Name: ____________________________________

Signature: ____________________________________

Date: ____________________________________

Appendix 4

Sample Questionnaire for patients

Receptionist Research Study Questionnaire

To assist with the study, it would be helpful if you could answer the following 4 questions. Please tick as appropriate.

1. Are you male or female?
   Male ___________________________
   Female _________________________

2. Which age group do you belong to?
   16 – 25 __________________________
   26 – 40 __________________________
   41 – 60 __________________________
   61 – 75 __________________________
   75+ __________________________

3. When did you last visit this hospital?
   Yesterday __________________________
   In the last week __________________________
   In the last month _________________________
   In the last year _________________________
   Other _________________________

4. How often, on average, do you visit the hospital?
   Once a week _________________________
   Once a month _________________________
   Every six months ________________________
   Every year ________________________
   Other ________________________

Appendix 5

Information for receptionists and hospital administrators

Communication between receptionists and members of the public in the hospitals:

Reasons for research

i) Receptionists do an important job yet health service researchers have taken little interest in their work

ii) Language is the main tool of the receptionist's trade. It would be both useful and interesting to know exactly how receptionists use the speech routines which allow them to carry out their work.

iii) Expert analysis of what receptionists actually say might make it possible to introduce new elements into training programmes, particularly in order to help them to deal with difficult situations.

Method

1. Ask the consent of receptionists
2. Spend a few days in the hospital observing and finding out how things work
3. Talk to each receptionists informally about her job (about 10 minutes)
4. Make recordings of all receptionists – patient interaction both face-to-face and by telephone. In the course of one session/one day. (this will depend on how many patients will consent to be recorded. I would like to get a total of about 30)
5. Transcribe and analyze conversations

Imposition on the hospitals

Apart from the fact that I will be on the hospital premises for a few days, this relates mainly to the provisions for getting the informed consent of subjects.

i) Notices about research will be put up at the reception area

ii) On the day of the recording, the receptionist will hand out information sheets and consent forms. Those willing to be recorded would be asked to hand in the signed consent form back to the receptionists. The researcher will activate the audio recorder only if a consent form is handed back.