GENDER IDENTITIES IN DOCTOR-PATIENT INTERACTIONS IN SELECTED HOSPITALS IN LAGOS

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Abstract
The author analyses the discourse of twenty sessions of doctor-patient interactions that are recorded during consultation in selected hospitals in Lagos. He attempts to confirm the assumption that gender, as a dynamic and fluid category, influences doctor-patient interactions. Although the findings confirm the conventional doctor-patient interactional structural patterns, they also indicate, among others, that context and topic of interactions rather than gender are dominant factors. In fact, differences in the interactional styles of both sexes are wanting as sex differences give way to power asymmetries in doctor-patient interactions. These thus suggest the weaknesses of the binary approach that polarizes men and women interactional styles using either the biological sex or socialized gender while ignoring the roles of agency, diversity, culture, context and subject matter. Thus, discourse as a new and alternative approach to gender and language study might be more promising for insightful investigation.

Key words: gender, identity, discourse, doctor, patient, interactions, Lagos

1. Introduction
This paper examines doctor-patient interactions from a gender and language study approach which departs from the traditional gender difference orientation that occupied many scholars’ attention in the 1970s and 1980s. This undertaking is motivated by the need to bring to the fore a new understanding of how language is used to construct gender identity/ies using a discourse approach of analysing language use. This perspective is informed by the view that language could be used to enact ‘genders’ in the face of other sociocultural agencies. Therefore, it is not only the case that gender affects language use; rather, language is used to construct ‘gender’ depending on the context, topic of interactions and other factors that come to play in the process. For example, collective, social and individual agencies, the gender of interactional partners might be at work in a speech event. This new perspective of viewing the dynamics of gender and how gender is enacted in texts suggests that traditional binary opposition orientation might be ill-equipped to unveil how gender enactment and other factors manifest in varying unpredictable ways in text, whereas discourse approach might be well-equipped to handle same.

2. Literature Review
Before the advent of discourse approach to gender and language studies, deficit, dominance and difference approaches which traded in gender differences based on oppositional approach occupied the stage with the following concerns: to expose male
dominance in all its linguistic forms and to re-evaluate any gender differences as cultural differences. These traditional concerns were motivated by a tendency to represent masculinity and femininity as a gender binary (Litosseliti and Sunderland 2002). Although the approach has not fallen into entire abysmal depths in gender and language studies, certain shortcomings in the approach have necessitated the birth of new approaches such as discourse and indexicality that address some of the shortcomings. For example, earlier traditions did not account for context in language use, neither did their practitioners consider the agencies of individuality and society; thus gender was seen as a fixed category and humans, as automata. Some of the shortcomings of binary approach are discussed in Litosseliti and Sunderland (2002:04) thus:

The idea of gender differences in language use was criticized for several reasons. It underplayed the importance of context, variation and what Eckert and McConnell-Ginet 1999:193) term ‘intragroup differences and intergroup overlap’ (the groups here being women and men). Ironically, the idea of gender differences was conservative in that in rooting out differences rather than (in addition) investigating and acknowledging similarities, it inherently represented gender (masculinity and femininity) in binary opposition (which as Cameron (1992) points out, is something that vive la difference proponents also love to do).

Thus the departure from oppositional differences (an orientation that is often motivated by the need to perpetuate certain stereotypes or to challenge existing structures that favour androcentrism, patriarchy and erect new order that will ensure desirable change and equality which has been challenged by those concerned with political correctness) to discourse methodology. It became apparent to many scholars in the field that polarizing men and women using either the biological sex or socialized gender was inadequate if cognizance must be given to agency and diversity.

Discourse as a new approach to gender and language study appears promising. As a method, Jaworski and Coupland (1999:36, 38) define discourse analysis as a committedly qualitative orientation to linguistic and social understanding. This they claim, requires the ability to reflect critically on and analyse discourse which will increasingly become a basic skill for negotiating social life and for imposing a form of interpretative, critical order on the new discursive universe. Litosseliti and Sunderland (2002:06) capture the new approach thus: “A discourse approach to gender and language aims to accommodate ideas of individual agency, and of gender (identity) as multiple, fluctuating and shaped in part by language. This (in some ways post-structuralist) understanding crucially represents gender as variable, but, equally crucially, as both social and individual”.

**Gender Identity and Its Construction**

Identity has been defined in different ways because of its complex nature. In fact, someone said that the notion of identity is a slippery one. However, for the purpose of this paper, we shall attempt a review of some of the claims in the literature. Gee (1999:39) notes that some people ... tend to reserve the term identity for a sense of self that is relatively continuous and fixed over time while Ivanic (1998) observes that though identity is a useful term, since it is the everyday word for people’s sense of who they are, it is “misleadingly singular”. However, the scholar opines that:
The plural word ‘identities’ is sometimes better, because it captures the idea of people identifying simultaneously with a variety of social groups. One or more of these identities may be foregrounded at different times; they are sometimes contradictory, sometimes interrelated: people’s diverse identities constitute the richness and dilemmas of their sense of self (Ivanic 1998:11)

Jaworski and Coupland (1999) also conceptualize identity as a series of choices one continually makes about oneself and one’s lifestyle, thus as a process, rather than a state or set of personal attributes. Ivanic (1998) adds that from a social constructionist point of view, identity emerges as a result of affiliation to particular beliefs and possibilities which are available to them in their social context but that this is not a question of determinism.

The above claims about identity suggest that individual identity is multi-facetted and has to do with affiliation, choice making and beliefs, but it is at the same time fluid rather than fixed. Litosseliti and Sunderland (2002) argue that identities also come from the attributions or ascriptions of others – though ascription may contribute to a resulting identity very different in nature to that intended by the ascribed. They opine that identity can be seen as emerging from an individual’s different sorts of relationships with others (perhaps within a community of practice) and as (at least potentially) changing as their relationships change ... gender identity can be seen as multiple and fluid, and never complete: “the emergence and re-emergence of the self” (2002:07).

From the foregoing, it appears that the way (our) identity is constructed in discourse is rather very complex although some scholars have tried to make it simpler in their exposition. For example, Cameron (2001) says that whatever else we do with words, when we speak we are always telling our listeners something about ourselves. In other words, our use of language whether spoken or written speaks much about us. But we do not very often use language in isolation of other people, which suggests that relationships come to play in the process of identity construction. Thus Jaworski and Coupland (1999) write that the way we speak, and the way we speak to and about others, turns individuals into subjective selves. However, identity construction stretches further just as Chouliaraki and Fairclough (1999:41) rightly observe that identity is however, a two-way process: the result of joint production. Litosseliti and Sunderland (2002: 23) capture this process thus: “the way we speak both to and about others, can be seen as affiliation, and this is important both for ourselves and for our contribution to existing discourses; but the way we are spoken about, attribution, can be important too”.

These views about gender identities and how they are enacted and/or performed through discourse is somehow connected to the idea of gender performance (“deriving from speech act theory”). This is akin to Butler’s (1990) view about performing, displaying or enacting one’s gender. Gender identities (masculinities and femininities) and how they are realised in discourse form the theoretical framework for our analysis of doctor-patient interactions in this study. The literature on orthodox medical discourse is recent in Nigeria, with existing studies by Adegbite and Odegun (2006, 2010), Faleke and Alo (2010) and a few others.
3. Data and Method of Analysis
Some doctor-patient interactions were collected during consultation in some general hospitals in Lagos between March, 2009 and January, 2010. The interactions were audio-tape recorded and later transcribed verbatim for analysis. Twenty sessions involving male and female doctors and their patients who were also of mixed sex were recorded. Transcript 1 is an example of our simple transcription of the recorded interactions.

In the next section, we attempt a discourse analysis (using interactional sociolinguistic tools) of the interactions between doctors and their patients. We identify the features of the genre, the various discourses, and their representational and constitutive characteristics. In other words, we look for the differences in doctors’ ways of seeing the world as males and females, how they perform or enact gender identities in their discourse. The same approach is applied to patients’ interactional styles. One of the main goals of this analysis is to test out the usefulness of discourse approach to gender studies in “an open and crucially non-deterministic ways”. According to Sunderland and Litosseliti (2002), discourses should uphold, reconstitute or produce social practices. The other objectives of our analysis are to unveil how interactional styles are shaped by speakers’ gender identity and to determine to what extent context, as a form of agency shapes interactions - how much of gendered styled and context-based interactions are at work in the text and to determine the significance of the interplay between gender and discourse in texts.

To achieve these goals, we adopt Litosseliti (2002:134) discourse analytic approach which revolves “around a wider cultural and ideological reading of the context in which the text occurs and aims to examine and problematize both the text organization (the linguistic practices or conversational and rhetorical strategies) and the text content, i.e. the culturally charged repertoires and emerging or salient themes. The first looks at how the interlocutors use linguistic resources to achieve different aims and effects, the second entails identifying and exploring the attitudes and beliefs involved in discourse and understanding the consequences (Litosseliti 2002).

Transcript 1

Background: A female doctor and a female patient in a clinic

  i. Dr: Yes, what is the problem?
  ii. Pt: I get rashes. They gave me one medicine to use for it and rashes never go since then.
  iii. Dr: Any problem? Have you checked your BP?
  iv. Pt: Yes.
  v. Dr: What’s your BP? Make sure you buy all these drugs I’m prescribing for you.
  vi. Pt: OK
  vii. Dr: Are you pregnant?
  viii. Pt: Not at all.
Dr: Did you do your weight?
Pt: No.

Transcript 2

Background: A male doctor and a female patient

i. Pt: Good morning, Sir.
ii. Dr: Yes, how are you?
iii. Pt: I want to take my BP.
iv. Dr: Why do you want to take your BP?
v. Pt: I’ve been hearing a kind of sound from my heartbeat.
vi. Dr: Something like palpitation? How often?
vii. Pt: At times 3-4 times in a day. At times it makes heavy sound.
viii. Dr: What is your occupation?
ix. Pt: I am a banker.
x. Dr: Do you stress yourself so much at work?
xii. Pt: Yes.
xiii. Dr. How come? Bankers supposed to sit down.
xiv. Pt: Mine is a special case. We deal with illiterates. To satisfy them, you have to go up and down from shop to shop.
xv. Dr: How old are you?
xvi. Pt: (Tells her age)
xvii. Dr: Are you married?
xviii. Pt: No.
ix. Dr: Why are you not married? Are you sure you are not bothered? I mean, are you not thinking about it?
xix. Pt: Not at all.
xx. Dr: I’ll do that for you. It is on the high side. However, I’ll give you medicine to monitor you for two weeks. If it does not go down, come back, I’ll place you on permanent medicine.
xxi. Pt: OK. For how long will I use it?
xxii. Dr: For life.
xxiii. Pt: No O! I don’t want.
xxiv. Dr: If that is the case make sure you rest very well and take this medicine I’m going to give you.
xxv. Pt: When should I come back?
xxvi. Dr: Two weeks’ time because the medicine would last for two weeks.
4. Analysis

Text organization
The organization of all the transcripts follows a pattern that is typical of traditional doctor-patient interactions; that is, greetings-enquiries-answers-prescription-leave-taking. For example, Transcript 4 starts with exchange of greetings (lines i and ii) (generally, patients greet first, as a strategy to connect with doctors). In this text, the doctor responds and then embarks on questioning (enquiries-answers section) (line 3-8). In line 9, the doctor hands in the prescription slip to the patient who takes his leave after expressing appreciation. In Transcript 2, the enquiries-answers section purposefully leads to casual private conversation, where the doctor probes into the lifestyle of the female patient in an attempt to diagnose or identify the cause of the patient’s problem.

Dr: What is your occupation?
Pt: I am a banker.
Dr: Do you stress yourself so much at work?
Pt: Yes.
Dr: How come? Bankers supposed to sit down.
Pt: Mine is a special case. We deal with illiterates. To satisfy them, you have to go up and down from shop to shop.
Dr: How old are you?
Pt: (Tells her age)
Dr: Are you married?
Pt: No.
Dr: Why are you not married? Are you sure you are not bothered? I mean, are you not thinking about it?
Pt: Not at all.

In an attempt to identify the cause of the high BP, the doctor asks about the private life of the patient. Aside from this example, the interactional styles of dyads follow the pattern typical of doctor-patient interactions - greetings, diagnosis, and inquiry complaint. This finding suggests a strict adherence to the demand of the context. In other words, context controls the interactions with little or no interplay of speaker identity among other factors.

Rhetorical strategies
Tavris (1992:299) argues that the traits that constitute masculinity and femininity are largely if not entirely, cultural constructs, effected by the omnipresent patriarchal biases of our civilization. Thus masculinity has culturally come to be identified as active, dominating, rational and creative while femininity tends to be identified as passive, acquiescent, timid, emotional and conventional. Thus, while men monitor their speech styles for aspects of power, women monitor theirs for signals of solidarity or intimacy – women are socialised to emphasise solidarity; men are socialised to emphasise power.
We found in our analysis that patients use greetings with vocative or the deference Sir or Madam to address their doctors as connectivity/deference device or solidarity or intimacy signals. This strategy, we found among male and female patients (the use of Good morning Sir/Ma/doctor) except in one or two transcripts where the doctors address the patients first but not with the formal mode of greetings e.g., Yes, what’s the problem/Yes, Mr/Mrs X what’s the problem/Yes, any problem? How may I help you)? It is very interesting to find that neither male nor female doctors took time to respond to patients’ greetings rather they respond with official/professional strategy of Yes, what’s the problem. For example, in Transcript 6, the female doctor’s response to the patient’s Good morning, Ma is: What is your problem?

A female doctor with a female patient

Pt: Good morning, Ma.
Dr: What is your problem?

However, on one occasion, we did find one female doctor reciprocating the proffered pleasantries with Oh, Madam, you’re welcome as in Transcript 15 where the elderly female patient greets the doctor – Good morning, doctor. The doctor’s response might have been warranted by the fact that the patient is older than the doctor. On another occasion, a male patient greets the doctor – Dr. Good morning, Ma and the female doctor goes – Good morning, what’s the problem without reciprocating with the use of vocative. Interestingly, some female doctors reciprocate patients’ greetings although most times without any linguistic form of deference aside from one female doctor’s response to a male patient – Good morning Doctor that received Good morning, Sir. The most preferred response of male doctors to patients’ greetings is Yes followed by the professional enquiry – What’s the problem?

Although it might be noted that few female doctors’ responses to patients’ greetings indicate connectivity tendency among females, it must be added that most of the female doctors do not respond to their patients’ greetings. This suggests that the doctors do not consider such pleasantries as important during consultation. In other words, there is an overarching culture of professionalism, an attitude that consequently indicates asymmetries between doctors and their patients. In fact, the overriding question What’s the problem/How can I help you? indexes a scenario where a needy person has come to meet a helper, an observation that is further heightened by the doctors’ seconder – What is your problem?

It appears that contextual factor prominently influences the linguistic strategies as female doctors are (arguably) often influenced to enact masculine identity because of their role as “helpers” or care providers to the needy (the patients). Thus the need to engender connectivity or reciprocate solidarity in this context is downplayed thereby suggesting that gender may not always be manifest in discourse. In sum, our analysis suggests that female doctors often enact both masculine and feminine discourse tendencies.
Other rhetoric strategies that we found in our subjects’ interactions are the use of direct question by the doctors and the use of statements in addressing the patients. Both male and female doctors’ use of questions is characteristically ‘bald’ or impolite. For example in the Transcript below, a female doctor uses baldness in couching her enquiries –

i. What is your problem?... How?...
ii. You don’t see it every month?...
iii. When was your last period?...
iv. For how many days did you see it?
v. Is it black in colour?
vi. Does thick, thick blood come out?...

vii. If you urinate, do you feel any pain when the urine is coming out?
viii. Do you have pains during menstruation?
ix. For how many days do you have the pains?
x. Any other complaints?

This directness or face threatening way of making enquiries characterize all the female and male doctors’ mode of asking questions. For example, the same rhetorical strategy characterizes a male doctor’s enquiries in Transcript 2...

How may I help you? Why do you want to take your BP? What is your occupation? Do you stress yourself so much at work? Are you married? Why are you not married? Are you sure you are not bothered? I mean, are you not thinking about it?

It appears that this mode of couching enquiries does not in any way indicate empathy or any sense of sympathy. Rather it paints the picture of a singular you (the patient) at the centre of the problem (What is your problem?).

Similarly doctors’ directives (for treatment or follow-up treatment) are characterised by unmitigated commands. This calculated rhetoric strategy is widely in use among male and female doctors. A female doctor tells her patient...you’ll go to the laboratory for test... then you will come back on Friday. These unmitigated directive and disclosure of diagnosis are evident in Transcript 11.

Transcript 11 – A female doctor and a male patient

Dr: Yes, any problem?
Pt: Yes, this is my test.
Dr: Who came with you? Did you come alone?
Pt: Yes, there is nobody with me.

Dr: You have to call your people on phone immediately. The result of your test shows that your blood level is very low. It is too low. So you need to call your people to bring money for you, you are going on admission so that you can be given blood. Go back to the lab, to do these tests. Don’t go home and don’t take
any drug yet so that you’ll not say it’s your doctor that asked you to take medicine. You have to be very careful. Anything can happen now.

Pt: What is wrong with me? Does it mean I am dying?
Dr: No, but you have to go on admission quick. What of your wife?
Pt: She didn’t come.
Dr: You can’t go alone, so just sit down in the hall here until somebody comes for you.
Pt: Doctor, please, se [pragmatic particle] I will survive?
Dr: By the grace of God, you will.

The only soothing expression that indicates empathy in this exchange from the female doctor is By the grace of God you will (survive). This came after her unmitigated disclosure and directives (in italics) that might have alarmed the patient. In Transcript 12, we found that the male doctor’s interactional styles appear rather inconsistent with his conventional masculine identities.

Transcript 12

A woman in her 50s with a male doctor

Pt. Good morning, doctor.
Dr: Oh, Madam, you’re welcome. Have you finished the drugs?
Pt: Some left, but ... (was interrupted by the doctor)
Dr: I will add a few ones; then see on the 20th. Is that OK?
Pt: OK, but doctor, the sleep problem, I mean in the night, each night...my sleep is bad. And this condition, I mean ... (interrupted again)
Dr: How bad is it? Does it mean you don’t sleep at all?
Pt: At all.
Dr. For how many days now?
Pt: Three weeks, doctor. Please what’s wrong with me? Wouldn’t I die? This trouble...

(about to break down in tears)

Dr. Madam, cool down. You have acute hypertension. It cannot be cured, but we can control. I will place you on medication permanently and you will need to be using it for life.
Pt: Doctor, does it mean it can lead to stroke?
Doctor: Yes, if not controlled...so start with this and come back on the 20th.

Interestingly, the male doctor’s interactional style in this encounter is rather feminine as he empathises with the woman ... using we in (...we can control it). This signals cooperativeness or collaboration in the effort to control the acute hypertension. Seeking professional information, assurance and consolation, the patient asks pertinent questions (What’s wrong with me?/...does it mean it can lead to stroke?) which receive frank
professional informative answers (You have acute hypertension/ It cannot be cured/Yes, if not controlled) and at the same time firm assurance and empathy (...but we can control it).

In this exchange, the male doctor’s interactional style enacts feminine identity that is inconsistent with the conventional masculine tendencies although at other times he is consistent with interactional styles that index masculine tendencies such as power and professionalism.

A comparison of the interactions in Transcript 12 and Transcript 14 indicates how interlocutors do enact gender identity that is inconsistent with their gender. This observation confirms the claims that persons are not automata and that gender identity is fluid and dynamic.

Transcript 14

Pt: Good morning, Ma
Dr: Good morning, what happened?
Pt: (explains)
Dr: You should have come to the hospital since. Why are you just coming today since last week? Pt: I was thinking it would subside.

Dr. That time you gave birth, did you give the baby any cough syrup?
Pt: Yes.
Dr: When is your next appointment?
Pt: The doctor said three months after delivery.
Dr: Who is the doctor that said that? I’m sure you forgot. You’re expected back in the clinic one month after delivery.
Pt: One month? Na November I born[Nigerian Pidgin]
Dr: You should have checked your small card. Always make sure you come for your appointments, so that doctor can monitor your baby’s health very well. That’s why they always announce in the clinic your date, so that you will know when to come.
Pt: Honestly, I forgot.
Dr: You forgot. How did you know that it is today you should come?
Pt: I just brought my baby to the hospital because of his cough.
Dr. Are you supposed to come here? Come back tomorrow. Tomorrow is clinic for babies.
Pt: OK, Ma. Thank you, Ma. But for this one, which day should I come back?
Dr: When you come tomorrow.

The female doctor’s interactional style in Transcript 14 appears to be void of empathy. It is rather hard to observe that the doctor fails to make any sympathetic comments about the ailing baby who needs attention after the woman (her patient) acknowledges her fault (forgetfulness) and asks for attention for her baby. Rather, the female doctor indict her
and reiterates the woman’s fault... which puts the woman down and helps to heighten the asymmetrical power talk between the doctor and the patient.

Asymmetrical power in talk is repeated in what we found among male and female doctors’ unmitigated commands/imperatives. This widens the power gap between them and their patients, who unquestionably say OK, Yes, Sir/Ma to the directives of their doctors. The doctors ask more questions than their patients. In fact their patients rarely ask questions and when they do, the doctors are not obliged to answer their patients. Thus, we see asymmetrical power at play in their interactions. This is further enhanced by the patients’ address forms for their doctors (Doctor, Sir/Ma) while they are rarely addressed by any form of address term, apart from one or two doctors that use Madam/Sir to address their patients.

5. Findings and Discussion

Our analysis revealed that contextual factor and topic of discussion influence the organization of doctor-patient interactions thus their discourse rigidly adheres to the conventional pattern of doctor-patient discourse that has been reported in the literature. In addition, we found that the interactional tendencies of male and female doctors are rather fluid and dynamic thus making it difficult to pin their style to fixed identity. For example, we found both masculine (power, status) and feminine (empathy and co-operativeness) interactional styles among male doctors. Similarly, female doctors’ interactional styles indicate professionalism, power and empathy at the same time.

We also found that both male and female patients’ interactional styles signal their conventional powerless status (ready to greet first, ready to apologise when they are and are not to blame, give thanks/offer appreciation when they are not expected to, ask few questions (that are rarely answered)).

Compared to what has been reported in the literature on doctor-patient interactions, our findings indicate no divergence. Doctor-patient interactions are largely controlled by doctors because they ask more questions than the patients. The discourse pattern/structure of greetings, diagnosis, inquiry complaints, clarification, follow-up and treatment and failure to meet the face needs of patients characterise their interactions (Adegbite and Odebunmi 2006). These features have been reported in many studies (see Davis 1966; West 1984; 1990. Coulhard and Ashby 1976; Ohtaki and Michael 2003; Lierbarman, 2010 and others).

However, our findings contrast with what binary opposition studies (gender difference) have reported. For example, West, (1984; 1990) support the evidence that female patients tend to ask more questions than male doctors. According to her study, female doctors also provide more verbalization of empathy, clearer explanations in response to patients’ concerns than male doctors do. Male doctors, on the other hand, tended to give aggravated directives that explicitly established status differences, whereas female doctors tended to mitigate their commands, using directive forms that minimize status
distinctions between themselves and their patients. West (1984) concludes that women constitute the role of doctors in a way that exercises less interactional power than male doctors typically exercise. Other studies report that while female doctors provide more preventive services and psychosocial counselling; male doctors spend more time on technical practice behaviours such as medical history taking and physical examination. In our study, we found that both male and female doctors’ interactional styles signal little or no difference. Thus, according to our findings both female and male doctors constitute the role of doctors as professionals that exercise interactional power over their patients.

There are other studies (within the binary tradition) that found that women downplayed status differences by using reciprocal topic shifts that share interactional power between doctors and patients, whereas men doctors tended to shift topics unilaterally without waiting for patient agreement. We found little or no evidence in our study that corroborates these polarized tendencies. Thus, studies on the influence of gender on doctor-patient interactions that indicate that there are significant differences in the practice style behaviours of female and male doctors might require further scrutiny.

We found similarities in the interactional styles of male and female doctors. For example, both male and doctors give aggravated directives that explicitly establish status difference, which is averse to exercising less interactional power that is said to characterise the role of female doctors. Both female and male doctors provide little or no verbalization of empathy; they give less clear explanations in response to patients’ concerns and utterly fail to use directive forms that minimize status distinctions between themselves and their patients. Similarly, both female and male patients ask less questions and use address forms that mark power difference – subordinate to the powerful (the doctors) in their interactional styles. In summary, we found that both male and female doctors are difficult to pin down to polarized interactional styles, rather the culture of using interactional power to establish their higher status over their patients is prevalent.

It is interesting to note that recent works have highlighted the shortcomings of traditional (binary) gender difference method of studying interactions/texts. These shortcomings have been highlighted in the literature (see Litosseliti and Sunderland (2002) for extensive discussion). For example, Litosseliti and Sunderland (2002:04) observe that:

The idea of gender differences in language use was criticized for several reasons. It underplayed the importance of context, variation and what Eckert and McConnell-Ginet (1999:193) term ‘intragroup differences and intergroup overlap’ (the groups here being women and men). Ironically, the idea of gender differences was conservative in that in rooting out differences rather than (in addition) investigating and acknowledging similarities, it inherently represented gender
(masculinity and femininity) in binary opposition (which as Cameron out, is something that vive la difference proponents also love to do)

6. Conclusion
This study strongly suggests that polarizing men and women using either the biological sex or socialized gender might be inadequate in analyzing interactions if due attention must be given to agency, diversity, culture, topic of discussion and context. Discourse as a new approach to gender and language study might be more promising for insightful investigation. Describing this new trends, Litosseliti and Sunderland (2002:06) opines that a discourse approach to gender and language aims to accommodate ideas of individual agency and of gender (identity) as multiple, fluctuating and shaped in part by language crucially represents gender as variable, but, equally crucially, as both social and individual.

In addition, this study suggests that dichotomy in gender identities that have been used to polarize male and female sexes into diverging placement and roles should be downplayed, especially as recent trend in gender studies shows that gender is not static but dynamic and that individuals enact gender identities for themselves in consonance within their environment or context. In other words, rigid gender dichotomy should give way to linguistic marketplace where individuals freely enact or negotiate their preferred gender identities in consonance with their prevailing circumstances and contexts. Thus Litosseliti and Sunderland (2002) argue that rather than remain glued to approaches that were motivated according to a tendency to represent masculinity and femininity as a gender binary, a discourse approach should pre-occupy scholars in order to evolve discriminate equality between men and women. Findings of similar studies might contribute towards creating an order that would be found favourable for complementary contributions for national development. As Litossetti and Sunderland’s submission lends support to our recommendation in this study it is noted that the place of binary tradition should not be overlooked as it has its place in gender studies.

References


APPENDIX

Transcript 3

Female doctor to male patient

Dr: Yes, any problem?
Pt: Na my test be this [This is my test]
Dr: Who came with you? Did you come alone?
Pt: Yes. There is nobody with me.
Dr: You have to call your people on phone immediately. The result of your test shows that your blood level is very low. It is too low. So you need to call your people to bring money for you, you are going on admission so that you can be given blood.
Go back to the lab, to do these tests. Don’t go home and don’t take any drug yet so that you will not say that it is your doctor that asked you to take medicine. You have to be very careful. Anything can happen now.
Pt: What is wrong with me? Does it mean I am dying?
Dr: No, but you have to go on admission quick. What of your wife?
Pt: She didn’t come.
Dr: You can’t go alone, so just sit down in the hall here until somebody comes for you.
Pt: Doctor, please (se=will) I survive?
Dr: By the grace of God, you will.

Transcript 4

Male doctor to a male patient

Pt: Good morning, Sir.
Dr: Yes, good morning. How are you?
Dr: What's your name?
Pt: (tells his name)
Dr: What’s wrong with you?
Pt: I have an injury on my leg.
Dr: Was it on the field?
Pt: No, it was at home.
Dr: When?
Pt: Yesterday evening.
Dr: Go and collect these medicines at the pharmacy.
Pt: Thank you Sir.
Transcript 5

Female doctor to a female patient

Pt: Good morning, ma.
Dr: Good morning. What happened?
Pt: (Explains to the doctor)
Dr: You should have come to the hospital since. Why are you just coming today since last week?
Pt: I was thinking it would subside.
Dr: That time you gave birth, did you give the baby any cough syrup?
Pt: Yes.
Dr: When is your next appointment?
Pt: The doctor said three months after delivery.
Dr: Who is the doctor that said that? I’m sure you forgot. You are expected back in the clinic one month after delivery.
Pt: Three months? Na November I born.
Dr: You should have checked your small card. Always make sure you come for your appointments, so that doctor can monitor your baby’s health very well. That’s why they always announce in the clinic your date, so that you will know when to come.
Pt: Honestly, I forgot.
Dr: You forgot? How did you know that is today you should come?
Pt: I just brought my baby to the hospital because of his cough.
Dr: Are you supposed to come here? Come back tomorrow. Tomorrow is clinic for babies.
Pt: Okay, Ma. Thank you, Ma. But for this one, which day should I come back?
Dr: When you come tomorrow.

Transcript 6

A female doctor with a female patient

Pt: Good morning, Ma.
Dr: What is your problem?
Pt: My menses no dey regular.
Dr: How? You don’t see it every month?
Pt: No, not every month.
Dr: When was your last period?
Pt: December 2009.
Dr: For how many days did you see it?
Pt: Three days.
Dr: Is it black in colour?
Pt: Yes, very black. What is the reason for that, doctor?
Dr: Does thick, thick blood come out?
Pt: No.
Dr: If you urinate, do you feel any pain when the urine is coming out? Do you have pain during the menstruation? For how many days do you always have the pain?
Pt: Like the first two days?
Dr: Any other complaint?
Pt: No.
Dr: You will go to the laboratory for test. Then you will come back on Friday.
Pt: Thank you, Ma.

Transcript 7

Female doctor to female patient

Pt: Good morning Ma.
Dr: Yes, what is the problem? Hello baby girl, how are you?
Pt: She says fine.
Dr: What is wrong with the baby?
Pt: Na my baby. She just dey cry, cry cry for night and her stomach dey hot.
Dr: What did you give her at home?
Pt: Na breast, but she no take am.
Dr: Go and buy this medicine and give her today and tomorrow. Come back on Wednesday.
Pt: What is the matter with her doctor?
Dr: Your baby is okay. There is nothing wrong with her.
Pt: Na the lab test be this.
Dr: Where did you do the test? You will do the test again and come back on Monday.

Transcript 8

A male doctor to a male patient

Dr: Yes, Mr X, what is the problem?
Pt: I just discovered that for some time now, I’ve not been able to read things clearly.
Dr: Things like what?
Pt: Books, newspapers and Bible.
Dr: What’s your profession?
Pt: Computer programmer.
Dr: OK, let me examine the eye.
Pt: You’ll go for refraction and dilation. Then tomorrow morning, you’ll come back with the result of this test.
Pt: Okay, thank you.
Transcript 9

*Female doctor to female patient*

Pt: Good evening.
Dr: Good evening. Yes, how are you? What is happening to your eye?
Pt: I experience pain, itching. If I pass through a dusty area, I feel as if I have Apollo.
Dr: Which eye is affected?
Pt: Both.
Dr: Are they always read? Is there any discharge?
Pt: Yes, especially early in the morning.
Dr: OK. For now we are going to give you some eye drops. You’ll take them for two weeks, and then you will come back.

Transcript 10

*Female doctor to male patient*

Pt: Dr, Good morning, Ma.
Dr: Good morning. What is the problem?
Pt: I have rashes on my laps and hi dey scratch me well, well. I no sleep at all for night.
Dr: You no sleep?
Pt: For the past one month, I no dey sleep at all. I no sleep at all and I dey urinate too much.
Dr: Did you urinate in the night? How many times did you urinate before day break?
Pt: Like four times. I have pains here.
Dr: Let me see it. Have you treated it before?
Pt: These rashes no dey allow me to sleep in the night.
Dr: Which one?
Pt: The one I have on my lap. Is it the drug I’m using that is causing the rashes?
Dr: Let me see your medicines.
Pt: How many times am I supposed to use this one?
Dr: Three times daily.

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