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*Corresponding author: Susan Olajoke Akinkulore, Department of Arts and Languages, Kampala International University, Kampala, Uganda
E-mail: akinkulore.suzan@kiu.ac.ug

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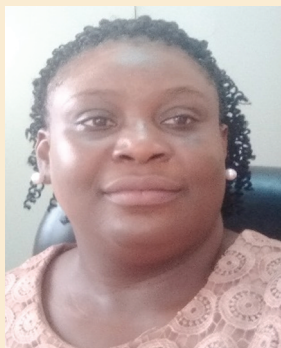
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Towards patient-centred style of communication: A cultural-pragmatic study of doctor-patient consultative encounters at general hospital, Ile-Oluji, Ondo State, Nigeria

Susan Olajoke Akinkulore^{1*}

Abstract: Medical humanities, as a sub-field in humanities, provide a ground for an in-depth study of medical practices' narratives or discourses through linguistic and non-linguistic approaches. No doubt, most doctors, in Nigeria or other developing countries, were trained in the context of a doctor-centred style of communication. In recent times, the call for patient-centred discourse engagement in the hospitals has prompted attention, among scholars, to consider the best skills that could enhance and sustain such. It was, therefore, imperative to investigate the influence of socio-cultural contexts on doctor-patient consultative encounters in hospitals. Eight doctor-patient consultative encounters at General Hospital, Ile-Oluji, Ondo State, Nigeria, were purposively selected. The data were analysed through the linguistic approach of cultural pragmatics. The study employed both qualitative and quantitative methods in the analysis. As such, a questionnaire was designed to elicit information on doctors' perceptions of a patient-centred style of communication. It was discovered socio-cultural context of both patients and doctors influence discourse engagement during consultation. Also, doctors are fast to adopt a doctor-centred style based on the belief that patients may not provide sufficient details needed for an appropriate diagnosis. This study, therefore, concludes that a patient-centred style of communication is appropriate and helpful in the hospital if the doctors have detailed knowledge and comprehension of the patient's socio-cultural context.

ABOUT THE AUTHORS



Susan Olajoke Akinkulore

Dr. Susan Akinkulore is an ardent researcher and academic, who currently works in the Arts and Languages at Kampala International University (KIU). Susan does research in Discourse Analysis, Multimodal Discourses, Stylistics and Pragmatics. She has approached hospital interaction from the cultural-pragmatics approach in this paper. She is projecting some research on the deployment of semiotic resources toward non-interacting intervention in the hospitals and a cultural-pragmatic approach to LGBTQ discourse.

Susan holds Bachelor of Arts in English, Master of Arts and Doctor of Philosophy in English Language, and Postgraduate Diploma in Education (English and Literature in English). She has a deep passion for research, having served as the Associate Dean of Research at the same university. She has also served in various academic and administrative positions in Nigeria and Uganda. She is currently the Ag. Principal, College of Education, Open and Distance Learning, Kampala International University, Uganda. Dr Susan Olajoke Akinkulore, in her office, as the Ag. Principal, College of Education, Open and Distance Learning, Kampala International University, Uganda.

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1. Introduction

Nigeria, as a country, has peculiar cultural experiences considering the heterogeneous linguistic and socio-cultural context. Culture has been defined as the ideas, customs, behaviours and attitudes of a particular people or society. Notwithstanding what people think, how they think, and what they say or do constitute the culture. In Nigeria, there are customs, laws, pieces of knowledge, morals, art and belief systems that constitute the socio-cultural system (Ademola-Olateju, 2019). With over 400 languages and three major ethnic groups in Nigeria (Ayeomoni & Akinkulore, 2012); Yoruba, Igbo and Hausa are the major ethnic groups with distinctive socio-cultural features. This cultural diversity reflects all spheres of human endeavours in the country including medical practice. Doctors practising in a particular region may belong to a different ethnic group while patients seeing the same doctor may be from different ethnic groups. This is a common experience in medical practice.

In the past, criticism of social context was not given attention in medical studies but with the development of medical humanities, socio-context, through the conscious awareness or unawareness of the participants, becomes apparent and relevant in medical discourse. The importance of discourse in medicine can never be over-emphasised as consultation, therapy; and healing processes require a great deal of discourse, which has to be managed. Managing doctor-patient discourse is imperative due to factors or features that interfere with it. No wonder, “language use” is perceived as a process of generating meaning as a set of production and interpretation choices from a variable and varying range of options, made in a negotiable manner, inter-adapting with communicative needs, and making full use of the reflexivity of the human mind (Verschuere, 2008).

Klugman (2017), cited in Wald et al. (2019), defines “medical humanities as an interdisciplinary field concerned with understanding the human condition of health and illness in order to create knowledgeable and sensitive health care providers, patients, and family caregivers”(3). Interpreting human experiences of illness is within the ambit of medical humanities but it is also apt to note that the integration of humanities/arts into medical education, as suggested by scholars, can support learners in developing essential qualities such as professionalism, self-awareness, communication skills, and reflective practice (Wald et al., 2019).

Culture is the human aspect of the environment. It is also the social system encompassing the values, norms and behaviours of a human in the society (Issa et al., 2016). From the different definitions of culture already stated, culture is perceived as crucial as people’s language. Indeed, speech, gesture, posture, and other acts jointly produce meaning in medical interaction (Wilce, 2009). Interaction or communicative encounter in a hospital context has received much scholarly attention from different linguistic approaches. Interaction, which begins in the minds of discourse participants, goes through continual modification.

Socio-cultural factors emanate from different people, or a group of people, in relation to their habits, traditions, beliefs, ethnicity, race, attitudes, religion, language, sex and value systems. The diverse socio-cultural issues that relate to behaviour, thoughts, feelings and health outcomes are determinants of health and diseases (Gonzalez & Birnbaum-Weitzman, 2013). This has led to the observation that physicians are poised at the interface between the scientific and lay socio-cultures (Kleinman, 1988; Wald et al., 2019). As such, it has been proved beyond reasonable doubt that socio-cultural factors are significant factors of health which are associated with some health issues and health behaviours. Therefore, patients and doctors are regarded as social actors

engaged in a social performance-encounter, as determined by the established culture that influences such encounters.

Scholars have continually shown interest in medical discourse. Such include the study conducted by Aranguri et al. (2006) on the translation of patients-physicians discourse in a multicultural encounter. They discovered that the presence of an interpreter increased the difficulty of achieving good physician-patient communication. Hence, they recommended special training for interpreters and physicians in order to reduce conversational loss and maximize the information and relational exchange with interpreted patients.

Also, Hamilton (2004) examines the importance of considering the shaping influences of differences across medical concerns, both for discourse analysts in their quest to account for particularities within the physician-patient discourse and the realisation of attunement to each other's perspectives. While Paananen and Majlesi (2018) analyse the interactional work of interpreters from the viewpoint of patient-centred care. In the study, it was posited that interpreters can support patient-centred care by both translated and non-translated actions through a multi-modal analysis of interaction. Also, practices that enhance patient-centredness were presented.

Patient-centred care is manifested and realised through patient-centred discourse (De Silva Joyce et al., 2015). Patient-centred discourse involves communication that lays emphasis on the role of the patient as a participant in medical consultations especially, the extent to which patients' experiences, knowledge, and culture are acknowledged. Traditional consultative communication takes place in hospital consultation rooms where the doctors interact and provide medical services to both out-patients and patients but with the advent of technology, e-consultation and other digital health services are becoming relevant and acceptable. Any communication encounter that does not acknowledge the patients' socio-cultural factors is not patient-centred whether it takes place physically or digitally.

Siouta and Olsson (2020) argue that patient-centredness may not be totally clear as scholars study it differently but Pluut (2016) and Hughes et al. (2008) acknowledge that patient-centredness has a value in healthcare delivery which involve cultural, social, psychological and ethical sensitivities. Furthermore, three different discourses on patient-centredness have been identified by Puttin (2016). These are caring for patients' discourse, empowering patients' discourse and being responsive discourse. Any of these discourses could be analysed to examine the extent of the patient's centredness in it.

A previous research was on patients-centred care (Rosengren et al., 2021) and the authors argue "The traditional model of healthcare is focused on diseases (medicine and natural science) and does not acknowledge patients' resources and abilities to be an expert in their own life based on their lived experiences (226)". Hence, the traditional consultative principles adhere strictly to interactions basically on the illness. It is appropriate to emphasise patient-centred discourse as an integral component of patient-centred care. The traditional consultative practices are changing in recent times to accommodate patient centre care due to research, awareness and improvement in healthcare delivery.

Odebunmi et al. (2006) examines the pragmatic roles that illocutionary acts play in understanding the communication between doctors and patients in Southwestern Nigeria through John Austin's illocutionary acts. The data were collected through tape recordings of doctor-patient conversations and interviews of both doctors and patients (and/or their relations). It was discovered that locutions in Southwestern Nigeria bring standard lexical choices and local linguistic initiatives of medical practitioners into a pragmatic union while recommending that medical practitioners should master appropriate locutions for effective management of patients. Also, Alasiri (2013) identifies the speech act features of interactions between lecturers and student-nurses in selected schools in Southwest Nigeria. The identified speech act features of the

interactions were related to the contexts with a view to describing the pragmatics of the classroom tutorials in the schools of nursing.

Furthermore, Meyer and Bührig (2014) study how doctors and ad hoc-interpreters communicate information that is risky to patients. This was conducted in both monolingual and multilingual briefings for informed consent, and, they also examined how the seriousness and frequency of risks are constructed. From the findings, medical doctors are often not concerned with the stochastic and legal aspects of risk information. Rather, doctors perceive risk information as a form of obligation with less importance for the decision-making of the patient. Whereas ad hoc-interpreters face the challenge of struggling with modal expressions as well as with the embedding of risk information into the briefing.

On a cultural pragmatic approach, an investigation was conducted by Akinkulere and Masereka (2019) on users and viewers of tattoos to bring to fore meanings that justify or invalidate the trend in Uganda. The study employed both qualitative and quantitative methods in the analysis. The study revealed that tattooing was on the increase despite the strong resistance as a result of meanings influenced by culture in Uganda.

Cultural distance has been identified as a major socio-cultural factor which could affect all kinds of human actions including communication. Others are temporal, geographical distances, and cultural dimensions such as power distance, uncertainty avoidance, individualism vs. collectivism, masculinity vs. femininity, long-term vs. short-term orientation, and indulgence vs. restraint (Vornanen, 2017). Cultural distance could also lead to misunderstanding especially when two languages come into contact (House, 2011). Hence, this paper deals with culture as a crucial context in medical discourse and its display in patient-doctor interaction. Analysing patient-doctor interaction is along the reasoning of Wald et al. (2019), who posits that medical humanities is “an integrated, interdisciplinary, philosophical approach to recording and interpreting human experiences of illness, disability, and medical intervention. More importantly, context plays an important role in determining meaning in communication since separate words and sentences alone are not sufficient for communication without interpretation within the context of its use and users (Nouraldeen, 2015). Therefore, recording and interpreting patient-doctor encounters at General Hospital, IleOlujii, is appropriate for cultural-pragmatic analysis of patient-centred communication.

2. Objectives

The study investigated patients’ cultural contexts in doctor-patient consultative encounters in the hospitals through the following specific objectives:

- i) To identify cultural influences in selected doctors’ and patients’ encounters.
- ii) To relate the cultural influences to meaning-making in consultative encounters.
- iii) To investigate doctors’ awareness of patients-centred consultative encounters in the hospitals towards better management of patients.
- iv) To assess patients’ awareness of patients-centred consultative encounters in the hospitals towards better treatment.

3. Methodology

It is the cultural-pragmatic perspective that has informed this work which was carried out in a Yoruba town-Ile-Oluji, Ondo State. It is premised on social performance model that social activities, such as discourse-making, are cultural performances. This theory is similar to cultural discourse theory which is designed to give special and detailed attention to two very general discursive matters, the exact terms people use when interacting with each other and the interactional forms in which these uses occur (Carbaugh & van Over, 2013). The adoption of Alexander’s

model is premised on the fact that the focus of this study is on meaning-making in the cultural context of patients.

Eight consultative encounters between doctors and patients were audio-recorded, transcribed and analysed for cultural features which are pragmatically significant. This served as the primary source of data while the secondary source of data included books, journal articles and the internet. The recorded interactions were carefully transcribed and analysed for socio-cultural features. In this methodology, physicians were the research subjects similar to patients, and all parties consented.

Some questionnaires were administered to doctors and patients which focused on cultural issues in their encounters with the patients. The questionnaire for doctors was administered at different periods from the questionnaire for patients at General Hospital, Ile-Oluji, Nigeria, through a research assistant. The patients that served as research subjects for qualitative data were different from the patients that were involved in the quantitative data. This allowed more patients to participate in the research. The questionnaire was administered to doctors in August 2020 and they were the same doctors that were involved in the qualitative data while the questionnaire for the patients was administered in July 2022. The patients that filled-out the questionnaire were the first ten literate patients that came to the hospital as outpatients after the public holidays in the month (10–12, July 2022).

To conduct this analysis, the doctors and patients were coded. For the recorded consultative encounters, the doctors were coded as Doctor A- Doctor J, and patients as Patient A- Patient J. Hence, there were consultative encounters A- J. The analysis involved two procedures. The recorded consultative encounters were descriptively analysed for socio-cultural features while the questionnaire administered to the doctors and patients was analysed through a quantitative approach using the software package of SPSS.

3.1. Analysis and discussion

The first stage of analysis involved the identification of cultural features which are presented in the table below:

In the recorded consultative encounters, there are some pieces of evidence of patients' cultural influence on meaning-making. Greetings, initiated mostly by the patients, were attempts to establish a relationship with the doctors and in some instances, doctors initiated such greetings which were in consonance with the cultural practices of people in Ile-Oluji, and Yoruba people in general. It was only Consultative Encounter B that did not involve greetings but it was apparent from the name of the patient that it was due to cultural distance as a non-Yoruba patient.

In Consultative Encounter (CE) A, there was a reference to the patient's reading culture when she complained about her eye problem. The doctor must have identified the patient as a Christian, either from her name or bio-data in her file because people in Ile-Oluji and its surrounding towns are Christians, Muslims, and traditional worshipers. The question raised by the doctor was answered in the affirmative. Also, the repetitive use of the lexical item "Madam" was a politeness strategy employed by the doctor to reduce face-threatening acts in the encounter. It is also observed that in a quite short Consultative Encounter (CE) B, the patient was quite polite through the use of the word "sir" three times despite the fact that no greeting was initiated by both the doctor and the patient. This implies that the patient ended each response with the lexical item "yes".

Consultative Encounters C and D, also comprised greetings and repetition of the lexical item "sir" five times by the patient in each consultative encounter. Also, in consultative encounter E, the doctor was polite by referring to the patient as "Mama" as Ile-Oluji people usually refer to elderly

Consultative Encounters	Cultural Features	
	Doctors' Discourse	Patients' Discourse
A	<ul style="list-style-type: none"> Greetings Do you read <i>Bible</i> or <i>books</i>? Repetition of "Madam"(3) 	<ul style="list-style-type: none"> Greetings
B	<i>No greetings</i>	<ul style="list-style-type: none"> Repetition of "sir" (3)
C	<ul style="list-style-type: none"> How are you? 	<ul style="list-style-type: none"> Greetings
D	<ul style="list-style-type: none"> Response to greetings through a salutation 	<ul style="list-style-type: none"> Greetings Repetition of "sir"(5)
E	<ul style="list-style-type: none"> Politeness through the use of "Mama" instead of patient's name. 	<ul style="list-style-type: none"> Repetition of "sir"(4) Repetition of "Thank you"(3)
F	<ul style="list-style-type: none"> Greetings How many <i>children</i> do you have? Do you have the history of hypertension in your <i>family</i>? 	<ul style="list-style-type: none"> Greetings I do sleep well but whenever the <i>worm</i> walks in my chest ... Repetition of lexical item "sir" (8)
G	<ul style="list-style-type: none"> Greetings ... some people will even tell you that there are <i>herbs</i> that cure it ... Does anyone have diabetes in your <i>family</i>? 	<ul style="list-style-type: none"> Greetings The only thing is daddy, my <i>husband</i>, has it and I am afraid maybe I contacted it from him.
H	<ul style="list-style-type: none"> Greetings Does any of your <i>relatives</i> have it 	<ul style="list-style-type: none"> No, I have not heard it any history of diabetes mellitus (DM) in my generation. Because my <i>husband</i> has this diabetes last time he was admitted.

women. The patient repeatedly used the words "sir" and "thank you" to express appreciation. It is a common practice to show gratitude in Yoruba culture, even if it is only for attention.

Greetings and questions about children and family on the part of the doctor in consultative encounter F related to the socio-cultural life of the patient. Indeed, the patient's socio-cultural beliefs are reflected in her argument that worms walked in her chest, and repetitive use of "sir", and greetings. The doctor vehemently opposed her argument and emphasised the need for diagnosis.

In consultative encounter G, greetings, instruction regarding the use of herbs and questions about the patient's family were indications of the doctor's consciousness of the patient's socio-cultural background. The patient's opinion that she might likely have got the illness through her husband showed the import of her cultural belief. Indeed, IleOlujì town is popular as a land of great physicians and herbal healers.

Similar to CE G, communicative encounter H comprised greetings, a question relating to the patient’s relative from the doctor, and the patient’s reference to her generation and husband demonstrated cultural features evolving in the course of the encounter. Apparently, the various socio-cultural issues in the encounters portrayed various ways in which doctors’ consciousness of patients’ socio-cultural background manifest in doctors’ discourse. More importantly, patients interpreted doctors’ utterances in the light of their socio-cultural background. It is, therefore, striking and interesting that both Patients G and H claimed they must have contacted diabetes from their husbands whereas, they were different individuals who just realised their medical condition. They were able to give similar reasons because they shared similar socio-cultural backgrounds. No wonder, the doctors made frantic efforts to disabuse their minds.

The second stage, the quantitative approach, involves a discussion of frequency, percentage and cross-tabulation tables, which were derived from the data through statistical analysis. Tables were drawn for the discussion. The questionnaire was administered to ten doctors.

3 of the doctors were females while the other 7 doctors were males. Also, 7 of the doctors were within the age range of 21–40. This indicates that most of the doctors were still in their youthful age. It is also observed that 80 of the doctors were Yorubas while 2 were Igbos.

From Table 1, it is apparent that the ethnicity of the doctors did not affect their adherence to traditional consultative principles. Only 1 doctor posited that he sometimes complied with such while 1 doctor never did. 6 doctors, which implies 60% always followed the traditional principles, and 2 doctors often did that. The doctors were sustaining professionalism in their practice without realising that interaction, as an essential tool, should be creative.

It is indeed appealing that 100% of the respondents (mainly doctors) as shown on Table 2 posited that they took note of patients’ socio-cultural beliefs during consultative encounters. It was possible that those beliefs naturally reflected and doctors immediately recognised such. In a situation where a woman suffering from diabetes ascribed it to the fact the husband was already diagnosed of such illness. This reason for this could not be better understood except in the context of her culture.

It is also obvious from Table 3 that patients’ socio-cultural beliefs affect consultative encounters, whether negatively or positively. 10% of the doctors, which is quite minimal, insisted there was no relationship between socio-cultural beliefs and consultative encounters. The respondents (20%), who were not sure, were doctors that strongly affirmed the principles of traditional style of communication during consultative encounters.

Table 1. Cross tabulation of ethnicity and adherence to traditional consultative principles

		Adherence to traditional consultative principles				Total
		Always	Often	Sometimes	Never	
Ethnic group	Yoruba	5	1	1	1	8
	Igbo	1	1	0	0	2
Total		6	2	1	1	10

Table 2. Doctor’s consciousness of patients’ socio-cultural beliefs

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	10	100.0	100.0	100.0

Table 3. Patients' socio-cultural beliefs affect consultative encounters

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	7	70.0	70.0	70.0
	No	1	10.0	10.0	80.0
	Not sure	2	20.0	20.0	100.0
	Total	10	100.0	100.0	

On Table 4, only 50% of the respondents were in support of patient-centred consultative encounters in hospitals. It is apparent that 40% of the respondents were against this position. This might be due to their personal feelings based on some perceived disadvantages of recommending such.

Despite the fact that 40% of the respondents felt a patient-centred style of communication should not be recommended in hospitals, it is quite interesting, according to Table 5, that 80% of the same respondents agreed that there are benefits that could be derived from the patient-centred consultative encounter. This further shows such a style of communication does not only deserve scholarly attention but a pragmatic application in hospitals. This style is not only beneficial to patients but also to doctors.

Table 6 shows 80 % of the respondents agreed that patient-centred discourse enhances patients' emotional and psychological relief. Most patients experience conflicting situations in relation to their health along socio-cultural interpretations. When doctors are able to unravel the complexities, patients will definitely experience emotional and psychological relief. Such relief will hinder undue complications surrounding health challenges.

The doctor needs information as much as possible during consultative encounters. Information about a patient can never be overemphasised in diagnosis, treatment and recovery procedures. No wonder, Table 7 shows that 90 % of the respondents agreed that patient-centred consultative

Table 4. Consultative encounters should be patient-centered

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly agree	3	30.0	30.0	30.0
	Agree	2	20.0	20.0	50.0
	Disagree	3	30.0	30.0	80.0
	Strongly disagree	1	10.0	10.0	90.0
	Not decided	1	10.0	10.0	100.0
	Total	10	100.0	100.0	

Table 5. Doctors' awareness of benefits of patients-centred consultative encounters

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	8	80.0	80.0	80.0
	No	1	10.0	10.0	90.0
	Not sure	1	10.0	10.0	100.0
	Total	10	100.0	100.0	

Table 6. Patient-centred discourse enhances patients' emotional and psychological relief

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	8	80.0	80.0	80.0
	No	2	20.0	20.0	100.0
	Total	10	100.0	100.0	

Table 7. Patient-centred discourse reveals adequate and more information on patient's health condition

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No	1	10.0	10.0	10.0
	Yes	9	90.0	90.0	100.0
	Total	10	100.0	100.0	

encounters reveal adequate and more information on a patient's health condition, which helps in the process of caring for patients.

It is also imperative to state that patient-centred consultative encounters help doctors diagnose illnesses better. All information from the patients, even when flawed by socio-cultural beliefs, distance and sentiments provides the doctor with an insight into the nature of the illness. Therefore, Table 8 shows that 80% of the respondents agreed with this position while 20% disagreed.

Table 9, which borders on the negative implication of the patient-centred style of communication during consultative encounters, indicates that 50% of the respondents agreed that patient-centred discourse wastes time while 50 % disagreed. No doubt, doctors do not have any business in the hospitals if not because there are patients. Any effort that could help facilitate diagnosis, treatment and healing is not synonymous with a waste of time or efforts. It is therefore obvious that patient-centred discourse should be promoted among doctors in hospitals.

Table 8. Patient-centred discourse allows better diagnosis of illness

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No	8	80.0	80.0	80.0
	Yes	2	20.0	20.0	100.0
	Total	10	100.0	100.0	

Table 9. Patient-centred discourse leads to waste of time

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No	5	50.0	50.0	50.0
	Yes	5	50.0	50.0	100.0
	Total	10	100.0	100.0	

Table 10. Cross tabulation of age of patients and ethnic group of patients

		Ethnic Group of Patients		Total
		Yoruba	Igbo	
Age of Patients	31-40	4	0	4
	41-50	2	0	2
51>		3	1	4
Total		9	1	10

Questionnaire B was administered to ten patients who had cases of hypertension and diabetes. The data was also subjected to SPSS analysis and Tables 10–16 were generated for the discussions of patients’ opinions. For the purpose of eliciting quantitative data from patients, Table 10, below, shows that the patients’ age groups were in three categories: 31–40; 41 – 50 and 51 and above. Four patients were between the age range of 31–40, two patients were within the age group of 41–50 and three patients were above 50 years. Also, 9 patients are Yorubas and only 1 patient is an Igbo. This is premised on the fact that the research community is a Yoruba community. No Hausa patient was involved in the research.

Table 11 is a cross-tabulation of patients’ support for patient-centred consultative encounters vis-à-vis their ethnic groups. 4 Yoruba patients strongly agreed and 5 Yoruba patients agreed that the consultative encounter. Also, the only Igbo patient agreed that consultative encounters should be patient-centred. By implication, all patients agreed that consultative encounters should be patient-centred. Moreover, in Table 12, 90% of the patients acknowledged that they were aware of patient-centred consultative encounters in the hospitals. This shows that the patients knew that it is an approach of consultative encounter.

During patients’ consultative encounters, patients relate their illnesses to socio-cultural practices.

From Table 13, 70% of the patients affirmed they relate the socio-cultural practices to their health issues, and 20% of the patients indicated that they did not relate such practices to their health issues. However, 10% of the patients were not sure whether they had ever related socio-cultural practices to their health status during consultative encounters. On frequency of relating socio-cultural practices to health status, 10% of the patients always relate discuss the socio-

Table 11. Cross tabulation of ethnic group of patients and their support of consultative encounter to be patient-centred

		Support of consultative encounter to be patient-centred		Total
		Strongly Agree	Agree	
Ethnic group	Yoruba	4	5	9
	Igbo	0	1	1
Total		4	6	10

Table 12. Awareness of patient-centred consultative encounter

Valid		Frequency	Percent	Valid Percent	Cumulative Percent
	Yes		9	90.0	90.0
Not sure		1	10.0	10.0	100.0
Total		9	10	100.0	

Table 13. Whether patients relate socio-cultural practices to health status

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	7	70.0	70.0	70.0
	No	2	20.0	20.0	90.0
	Not sure	1	10.0	10.0	100.0
	Total	10	100.0	100.0	

Table 14. Frequency of relating socio-cultural practices to health status

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Always	1	10.0	10.0	10.0
	Often	4	40.0	40.0	50.0
	Sometimes	4	40.0	40.0	90.0
	Seldom	1	10.0	10.0	100.0
	Total	10	100.0	100.0	

cultural factors to their illnesses, 40% often do the same while another 40% sometimes relate the socio-cultural factors to their health situations. Only 10% seldom relate the socio-cultural practices to the health status.

Tables 15–18 reflect the opinions of patients on patient-centred consultative encounters. In essence, 100% of the patients agreed that patient-centred consultative encounters could give patients some relief as reflected in Table 15. This is premised on the fact that information on socio-cultural factors received with empathy by the doctors could help patients experience some psychological relief. Also, in Table 16, the patients disagreed that patient-centred consultative encounters could be perceived as a waste of time. Any effort that is beneficial, even though, it requires some additional time is not a waste of effort.

From Table 17, 100% of the patients acknowledged that patient-centred consultative encounters provided the doctors with adequate information about the patients and their illnesses and 90% of the patients, according to Table 18, agreed that illnesses were better diagnosed through patient-centred consultative encounters.

Table 15. Patient-centred consultative encounter(PCCE) leads to patient's relief

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	10	100.0	100.0	100.0
	Total	10	100.0	100.0	

Table 16. PCCE leads to waste of time

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	10	100.0	100.0	100.0
	Total	10	100.0	100.0	

Table 17. PCCE leads to adequate information on patients

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	10	100.0	100.0	100.0
	Total	10	100.0	100.0	

Table 18. PCCE leads to better diagnosis of illness

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	9	90.0	90.0	90.0
	No	1	10.0	10.0	100.0
	Total	10	100.0	100.0	

The inclusion of patients, opinions in this paper has provided a further basis for the adoption and application of patient-centred discourse in consultative encounters in Nigerian hospitals. Even though the socio-cultural differences between both doctors and patients could be apparent, the importance and effectiveness of a patient-centred style of communication can never be over-emphasised.

4. Recommendations

No doubt, the traditional style of interaction between doctors and patients helps to elicit the information required but more could still be prompted by interpreting patients' responses through their socio-cultural background, which requires that doctors are flexible and creative during a consultative engagement. Indeed, patients' cultural differences could pose challenges to a productive realisation of patients-centred discourses in the hospitals. From the opinions of the patients, it was acknowledged that there are benefits of patient-centred consultative encounters. Hence, a patient-centred discourse is recommended which enhances care for patients with due attention and interpretation of discourse in the context of their culture.

Generally, human communication is often more innovative than structured. Therefore, patient-centred discourses help relieve patients' emotional and physical influence of background issues. Especially, the cultural context of patients. This indeed allows patients' compliance which enhances healing and recovery.

Patients-centred discourse requires that doctors are sensitive to patients' culture, and assumptions about race and culture, which doctors could use to enhance successful consultation in the hospital. Moreover, this style reveals the social context in which people manage their health and ill-health (Pulvirenti et al., 2014). Seen in this light, patient-centred discourses in the hospital become mini circumstances that help doctors unravel contextual sources of their patients' difficulties, which boost patients' conformity to the expected desirable behaviours once the doctors have won their understanding of troubling social conditions.

Finally, the study should be conducted in more hospitals in Ondo State. This will further provide empirical evidence on the patient-centred style of communication in hospitals. Indeed, a comparative study of consultative encounters in public and private hospitals is strongly recommended.

5. Conclusion

The paper has shown the need for doctors to be sensitive to patients' socio-cultural contexts and the fact that they should balance between direct interpretation and culturally-mediated interpretation of medical conditions of patients in order to produce a clear diagnosis of illness. It is important doctors appreciate the benefits of patient-centred discourse and demonstrate how to give patients interactional space so that they can express difficult situations arising from their socio-cultural background.

In fact, Issa et al. (2016) claim that all communication is cultural. This is premised on the fact that communication depends on factors like context, individual personality, and mood interacting with a variety of cultural influences and choices. Therefore, doctors should pay attention to the cultural background of patients in consultative encounters.

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Author details

Susan Olajoke Akinkulore¹
E-mail: akinkulore.suzan@kiu.ac.ug

¹ Department of Arts and Languages, Kampala International University, Kampala, Uganda.

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Appendices

Questionnaire A (Doctors)

Dear respondent,

I am conducting a study, titled “**Towards Patient-Centred Style of Communication: A Cultural-Pragmatic Study of Doctor-Patient Consultative Encounters at Ondo State General Hospital, Ile-Oluji**”. I kindly ask you to fill in this tool (questionnaire). The information shared in this tool will solely be used for academic purposes and will be kept with the highest level of confidentiality.

Thank you.

Susan Akinkulere (PhD)

For every question asked, please append a tick (T) in a single box, that expresses your opinion or answer.

1. What is your age?

(a) 20 or below

(b) 21-30

(c) 31- 40

(d) 41- 50

(e) 51 or above

2. What is your gender?

(a) Male

(b) Female

3. Which of the three major ethnic groups are you from?

(a) Yoruba

(b) Igbo

(c) Hausa

4. How many languages do you know?

b) Mention them

5. How often do you adhere to traditional consultative principles?

(a) Always

(b) Often

(c) Sometimes

(d) Seldom

(e) Never

6. Are you conscious of patients' about their socio-cultural beliefs during consultation?

(a) Yes

(b) No

(c) Not sure

7. Does the patients' socio-cultural beliefs affect consultative encounters?

(a) Yes

(b) No

(c) Not sure

8. Should consultative encounters be patient-centred?

(a) Strongly agree

(b) Agree

(c) Disagree

(d) Strongly disagree

(e) Not decided

9. Are you aware of the benefits of patients-centred consultative encounters?

a) Yes

b) No

c) Not sure

10. Could a patient-centred consultative encounter lead to the following?

a) Patient's Emotional and psychological relief No Yes

b) Adequate and more information on the patient's condition No Yes

c) Waste of time No Yes

d) Better diagnosis of illness No Yes

Questionnaire B (Patients)

1. What is your age?
 - a) 20 or below
 - b) 21-30
 - c) 31- 40
 - d) 41- 50
 - e) 51 or above
2. What is your gender?
 - a) Male
 - b) Female
3. Which of the three major ethnic groups are you from?
 - a) Yoruba
 - b) Igbo
 - c) Hausa
4. How many languages do you speak?
 - a) Mention them
5. Do you believe in socio-cultural practices?
 - a) Yes
 - b) No
 - c) Not sure
6. Have you ever related your socio-cultural beliefs to your health status during consultation in the hospital?
 - (a) Yes
 - (b) No
 - (c) Not sure
7. How often do you make reference to your socio-cultural beliefs during consultative encounters?
 - (a) Always
 - (b) Often

- (c) Sometimes
- (d) Seldom
- (e) Never

8. Should consultative encounters be patient-centred?

- (a) Strongly agree
- (b) Agree
- (c) Disagree
- (d) Strongly disagree
- (e) Not decided

9. Are you aware of the benefits of patients-centred consultative encounters?

- a) Yes
- b) No
- c) Not sure

10. Could a patient-centred consultative encounter lead to the following?

- a) Patient's Emotional and psychological relief No Yes
- b) Adequate and more information on the patient's condition No Yes
- c) Waste of time No Yes
- d) Better diagnosis of illness No Yes

Doctors' and Patients' Consultative Encounters

Patient A

Doctor: Come in and sit down, good morning madam

Patient: Good morning Doctor

Doctor: Have you done lab tests?

Patient: Yes

Doctor: So, what's your complaint?

Patient: It's about this my right eye, it always brings out water, it's not hurting me o

Doctor: Do you read Bible or books?

Patient: Yes, but before reading three lines, it will start bringing out water, it's the water that will not allow me to see with the eye again

Anytime wind blows into the eye, it also brings water

Doctor: Since when madam?

Patient: For about two weeks now

Doctor: Are you sure it does not hurt or itch you?

Patient: Not at all doctor

(The doctor starts writing something down)

Doctor: You are already on drugs before now

Patient: Yes doctor

Doctor: Bring out *your* drugs and let me see

(The patient brings her drug out)

Doctor: How did you use these drugs?

Patient: 2 tablets in the morning and 2 tablets at night.

Doctor: Okay, we will have to reduce the dose to 1 1/2 tabs in the morning and 1 1/2 tabs at night.

(1) Meanwhile you will have to go and see an optician, we don't have one here at General Hospital Ile-Oluji here. So, I will give you a referral letter to the State Specialist Hospital Ondo.

(Doctor starts writing the referral letter). A nurse came in to ask question and left, as the doctor writes he continue with interrogation again to be sure of what he is writing in a referral letter so that it will be clear to the next doctor.

Doctor: Madam, you said the right eye abi

Patient: (confirming by nodding)

Doctor: Talk now

Patient: Yes sir

Doctor: Okay, And it started about 2 weeks ago or when?

Patient: Yes sir, 2 weeks ago.

Doctor called out for a secretary to bring a staple machine in order to make the letter confidential. He told the patient to show the doctor that attends to her at Ondo and she will be directed to the eye clinic.

In the content of the letter is the age of the woman health history, drugs that were used before, probably drug reaction on the eyes that leads to the doctor reducing the drug dosage, the patient presented the complaints.

Patient B

Doctor: Next patient, (calls patient's name).

Patient: Yes sir.

Doctor: Have you eaten?

Patient: Yes sir.

Doctor: Please you will have to go and do the following test from the lab and please let me have the result of the test and tell me when you are around

(She came from the lab and told the doctor that the scientist says the time is over for the type of the test that she went for).

Doctor: Haa! this is a problem, you will have to come for the test tomorrow but continue with your former drugs and make sure you are around tomorrow

Patient: yes sir (she left)

Patient C

Doctor: Hello sir.

Patient: Hello Doctor, Good morning.

Doctor: How are you?

Patient: Fine o, I came to your house yesterday I didn't meet you in the house

Doctor: I am off here but I run another clinic in town

Patient: Okay, well-done sir. I want to tell you that the drugs you gave me to buy is very good and effective but since I've finished it I have not seen to buy since four days ago, so you can write it on the prescription form for me to go and buy at Ondo

Doctor: okay, no problem are you still feeling the symptoms

Patient: yes, also the chest pains are still coming little the cough is now only in the early morning.

(Back to the coughing patient, the doctor writes the prescription for him to go and buy at Ondo).

Patient D

Next Patient

Doctor: Calls Patient D

Patient: Good morning sir.

Doctor: You came for what ma?

Patient: I'm having a serious cough.

Doctor: When did that start?

Patient: It's up to 2 weeks now.

Doctor: Is there anyone that is coughing in your environment or house?

Patient: No.

Doctor: Is there any history of cough?

Patient: No sir.

Doctor: do you think you've lost weight since you started coughing

Patient: Noo.

Doctor: ... And do you think you breathe so high?

Patient: Yes sir.

Doctor: What drug have you bought for the cough?

Patient: None.

Doctor: Okay, let me see your former drugs you've been using for hypertension

Patient: (bringing all the drugs out)

Doctor: let us reduce the dosage to one in the morning and one in the night

Patient: Okay sir.

Doctor: I will write a cough syrup for you in addition to the reduction of the drug dosage, let us watch the changes for three days.

Patient: Okay, Doctor.

Doctor: You can go.

Patient: Thanks sir.

Patient E:

Doctor: Mama please come here.

Patient: Thank you Doctor.

Doctor: Did you do the blood sugar test this morning?

Patient: Yes, Doctor.

Doctor: Let me have it.

Patient: Hands in the result to the Doctor

Doctor: The result is welcoming. Hope you still use your drugs.

Patient: Yes sir.

Doctor: And you don't have any reaction like dizziness.

Patient: Not at all sir, it is only that there was a time I complain of my eyes and they said it was catarrh

Doctor: (laughs) that is not a drug reaction.

Patient: Thank you sir

Doctor: You can go if there is no complaint. Just continue with the way you are using your drugs.

Patient: Thank you sir and good bye

Patient F:

Doctor: Hello

Patient: Hello sir

Doctor: What is the problem madam?

Patient: Chest worm.

Doctor: How did you know the problem?

Patient: I noticed that the thing is always moving in my chest.

Doctor: Do you sleep well?

Patient: Yes sir.

Doctor: Can you sleep without a pillow or how do you sleep?

Patient: I do sleep well but whenever the worm walks in my chest ...

Doctor: No, no, no, don't talk about worm here until we diagnose what is wrong with you.

Patient: Okay sir.

Doctor: Do you have the history of hypertension in your family?

Patient: Nooo!

Doctor: Do you have ulcer?

Patient: Nooo!

Doctor: How many children do you have?

Patient: five.

Doctor: From our investigation how your BP is high, and it is advisable we place you on drugs fast.

Patient: Okay sir.

Doctor: You will still need to do further test.

Patient: Okay sir.

Doctor: A bigger file will be needed so that we can keep recording your BP and you will have to go to the laboratory for the test (a nurse came in and greeted the patient familiarly asking if her drugs has finished).

Doctor: Haa! Is she aware of having BP?

Nurse: Yes sir.

Doctor: Facing the patient but you did not tell me this, you were talking of worm.

Nurse: She knows sir, don't mind her.

Doctor: This patient can be so difficult and I've documented wrong information now anyway, madam, please go and buy your drugs and start using it immediately.

Doctor: (facing the nurse) Thank you madam.

Patient: Thank you sir (she left).

Patient G

Patient: Good morning sir

Doctor: Good morning come and sit here I think I asked you to do blood test.

Patient: Yesterday (looking at the result from the patient)

Doctor: Have you eaten this morning before you did this test? (patient nodding to indicate no)

Doctor: Does anyone have diabetes in your family (sugar in the urine)?

Patient: I have not heard of it in my family.

Doctor: (looking surprised) have not heard of it?

Doctor: This test confirms that you have diabetes and henceforth you will be placed on drugs and you will continue to use it, and I will advise you check your blood sugar of your children so that they can avoid or manage it as soon as they know their status, because that is why I first ask you if any of your people has it, it is nothing to be afraid about, because it can be managed and if not managed well managed, it destroys the kidney and, even the heart and there is an advantage in it that you knew early now.

Patient: I have not even heard of it before.

Doctor: Do you experience seizures in your legs seriously before?

Patient: Yes, but recently it has not been affecting me again.

Doctor: Okay, it's one of the signs anyway, but if you are on drugs at early stage it cannot cause a severe harm. It can be seriously controlled at early stage.

Patient: The only thing is daddy, my husband, has it and I am afraid maybe I contacted it from him.

Doctor: So your husband had it where is he now?

Patient: He is at home?

Doctor: It is not communicable but it can only be inherited so don't think it is your husband that infected you, not at all, it's hereditary.

Doctor: (writing something down) then anything sugary should be avoided especially coke and some people will even tell you that there are herbs that cure it, it is all lies, so you will have to be coming to the clinic regularly now and whenever you come you will have to do some test. It is just like hypertension early detection and management saves a lot, don't take sugar again and use your drug regularly test is blood sugar test and if possible get a glucometer so that you do the test by yourself before coming to the clinic.

(Doctors still writing something on the sheets) so you can get a folder in your next visit for the records of the management, so your next visit for checking is in the next two weeks

Patient H

Doctor: Good morning I asked you to run an investigation

Patient: Yes

Doctor: You have not eaten this morning you are asked to conduct DM test

It has been confirmed that you are diabetic from your laboratory result.

You will start the management by taking your regular medication. When you start the medications you must not stop. Did any of your relative have it, it is inherited from single or both parents, your children should be carrying out laboratory investigation to confirm their own status. So, regular laboratory test should be carried out, the earlier the better.

Patient: No, I have not heard it any history of diabetes mellitus (DM) in my generation.

Doctor: There are different complications of DM like organ damage. That is, damage to the eyes, kidney, liver, heart etc. Are you not experiencing “seizure”?

Patient: Is this disease communicable? Can it be contacted from human?

Doctor: No it is an inherited disease

Patient: Because my husband has this diabetics last time he was admitted

Doctor: What was the last result of the fasting blood sugar (FBS)?

Patient: It was 4.8 mmol/L

Doctor: Henceforth, don’t consume anything sugary like coke and all the likes reduce your CHO foods, eat more of protein food and fibers.



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