

Speech Acts in Doctor-Patient Linguistic Communication

أفعال الكلام في الاتصال اللغوي بين الطبيب والمريض

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Authorization

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Dedication

This thesis is dedicated to my father and mother for their infinite love and support. For my dear father, who taught me to aim for the stars and always believed in me and my potentials. For my lovely mother, who taught me to work hard, and to stand up whenever life knocks me down. They have always been here for me and support me through thick and thin.....

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Speech Acts in Doctor-Patient Linguistic Communication

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Abstract

This study investigates doctor – patient interviews in terms of speech acts theory advocated by Austin (1962). The study, though, depends on D' Andrade's classification of speech acts in the analysis of the interviews. Furthermore, it sheds the light on the relationship between the doctor and the patient, i.e. it provides some viewpoints relevant to the distinction in speech between the two interactants in medical setting.

Depending on Andrade's typology, the research investigates seven medical interviews recorded at two internal medicine departments in Baqubah Teaching Hospital and Al-Batool Teaching Hospital/ Iraq.

Frequencies of speech acts categories are examined and the data found are explained via tables and histograms. The study finds that the most recurrent of speech acts categories are statements and questions, which is attributed to the nature of the discourse where in the doctor, asks to elicit information to diagnose, while the patient answers. Besides, there was expressive increase in the patient's speech, which is attributed to the fact that the patient is in need for care and cure. Reactives are also more frequent in the patient's speech particularly replies, since the patient answer the question raised by the doctor. This indicates that the patient is in a passive state. Nevertheless, directives are only found in the doctor's speech which indicates the control of the doctor over this speech event, the doctor speech is also distinguished by the more use of guarantees and promises, i.e. the doctor promises the patient.

The study ends with a discussion of the results, a conclusion stating the significance of more investigation in this field and recommendations.

Keywords: linguistic communication, doctor, patient, speech acts theory, discourse analysis.

أفعال الكلام في الاتصال اللغوي بين الطبيب والمريض

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الملخص

تتناول هذه الدراسة المقابلات التي أجريت بين الأطباء والمرضى بالبحث والتحليل حيث تم اعتماد نظرية افعال الكلام speech act theory وخصوصا تصنيف D'Andrade لأفعال الكلام في تحليل كلام كل من الطبيب والمريض في هذه المقابلات. حيث تم تحليل سبعة محادثات بين الأطباء والمرضى سُجلت باستخدام أداة تسجيل صوتي في مستشفى بعقوبة التعليمي ومستشفى البتول التعليمي/ العراق حيث تمت دراسة ومتابعة تكرار أنواع أفعال الكلام في هذه المقابلات وقد تم تمثيل هذه المعلومات بجداول ورسوم بيانية.

توصلت الدراسة بأن أكثر أنواع أفعال الكلام تكرر هي الأسئلة والجمل الخبرية questions and statements ويعزى ذلك الى نوعية الخطاب بين الطبيب والمريض حيث يقوم الطبيب بتوجيه الأسئلة الى المريض والحصول على بيانات تساعد في التشخيص والمريض بدوره يوفر هذه البيانات من خلال الردود statements.

الى جانب ذلك تبين ان المعبرات expressives تزداد في كلام المريض عنها في كلام الطبيب وذلك لان المريض يكون في حاجة لجذب انتباه الطبيب، اما بالنسبة الاستجابات اللفظية reactives فإنها تزداد بوضوح في كلام المريض خصوصاً الردود replies رداً على أسئلة ومطالب الطبيب. اما الموجهات directives فهي تزداد في كلام الطبيب وهذا يدل على سيطرة الطبيب على الحوار. كذلك يتميز كلام الطبيب باستخدام الملزمات commissives خصوصاً الضمانات

guarantees والوعود promises حيث يحتوي كلام الطبيب على الضمانات التي تساعد على طمأنة المريض. هذا فضلاً عن نتائج أخرى التي تشير الى دور أفعال الكلام في توضيح دور كل من الطبيب والمريض في هذا النوع من الحوارات. هذا وتنتهي الدراسة بمناقشة النتائج والاستنتاج الذي يشير الى أهمية تواصل البحث في هذا النوع من الحوارات وأخيراً تدرج بعض التوصيات التي توصي بها الدراسة.

الكلمات المفتاحية: الاتصال اللغوي، الطبيب، المريض، نظرية أفعال الكلام وتحليل الخطاب.

Chapter one

1.0. Introduction

This chapter starts with the background of the study, followed by the statement of the problem, objectives and questions of the study. It also sheds light upon the significance of the study and its limitations and limits. Finally, it ends with definitions of terms.

1.1. Background of the Study

Communication is the way of expressing concepts, thoughts, terms, words, and emotional states. It seems to be as the prime among the many functions of language. Every human being uses language to communicate his/her affairs. The current study is an attempt to deal analytically with spontaneous dyadic interviews, i.e. doctor-patient interviews, in terms of a theory which has been exercising a wide-spread influence in the linguistic tradition, i.e. speech acts theory. This theory has philosophical inquiries; it deals with what we do when we speak in a certain context and the functions of what we utter.

To speak a language, it is not a matter to occur in vacuum or in isolation of non-linguistic conditions. The speech acts theory allows the speaker to account for such conditions in a systematic and explicit way. Speakers, hearers, and utterances are accounted for and thus the theory claims to study language in use. Moreover, the theory deals with language as communication where the act is the minimal unit.

The current use of the term 'speech acts theory' goes back to J.L. Austin's principle of locutionary, illocutionary, and perlocutionary acts. It is developed by the great philosopher J.L Austin in the 1930s and set forth in a series of lectures, which he gave at Harvard in 1955. These were consequently developed in 1962 as *How to Do Things with Words*. He founded the modern study of speech acts.

The current study, anyway, is created from Haberland and Mey's (1981: 110) observation that "If a linguistic theory wants to be considered as a serious attempt at explaining human communication... (and) since so much of human language use happens inside institution, it makes good sense to study the use of language precisely within the frame of a particular institution".

According to Searle (1969: 51-52) institutions are " systems of constitutive rules" that govern language use. Therefore, he calls Austin's direction and his own as being "institutional theory of communication".

The present study assumes that the description of language is really an application of linguistic theory. According to Corder (1973: 137) description is " the 'primary' application of linguistic theory". Besides, the very act of describing is part of the process of developing the linguistic theory itself, i.e. a process of feedback to the theory.

Turned to the doctor-patient linguistic communication, everybody is expected to fall ill some time in his life because no one is immune from all diseases, disabilities, and disorders. Illness conditions are everyday facts of life which we all live with or consult about, or take precautions against.

The relationship between the doctor and the patient is not "pre-ordained but subject, more or less, to "negotiation, reinterpretation, misinterpretation, and disagreement" (Robinson, 1973: 62-63). Besides, in the medical setting, where the doctor meets the patients, the relationship is a professional one. The doctor is constrained by his profession to behave in a certain way towards his patient regardless of anything else, but in fact, he has his own feelings that drive him. Moreover, there could be a degree of motivational conflict in the determination of the speech style. (Giles and Powesland, 1975).

It is no surprise that doctors and patients hold different conceptions of illness. The professional's views moulded by clinical experience and training, may differ in emphasis

from the patient's views, which are influenced by the need to cope with a certain problem. The patient's views are also influenced by the cultural and social understanding of the nature of the problem.

(Robinson, 1973) argues that the patient is in a position of a layman in front of the expert, who is the doctor. Thus, it is a case where the patient will be, to a certain extent, passive in the interaction. Robinson presents a typology, constructed by Szasz and Hollander of doctor-patient relationships. These relationships are:

- A- Activity-passivity relation where the patient is passive to the doctor and submissive as in surgery.
- B- Guidance-cooperation relation where the doctor initiates more of the interaction than the patient. The patient seems less passive because he seeks help and is willing to cooperate.
- C- Mutual-participation relation where the two interactants mutually participate in the interaction. Patients, here, are required to take care of themselves.

Hadži-Jovačić (1976) assumes that the doctor's interaction with the patient places him in a position of advisor, where the patients are concerned with their troubles, uncertain, and worried. Besides, doctor, according to Haberland and Mey (1981), always complain that patients do not carry out the orders; patients, on the other hand, accuse doctors of not listening.

It seems obvious that there is a conflict relationship between the doctor and the patient. This conflict operates on all levels of interaction between the two parties.

1.2. Statement of the Problem

The study unveils that some verbal communications, such as doctor-patient one, is full of employing speech acts categories. These speech acts categories reflect what is going on

in such kind of communication. When examined carefully, speech acts categories provide a sound linguistic description of the doctor-patient communication.

1.3. Objectives of the Study

The study aims at:

- 1- Describing the speech acts categories introduced by doctors and patients in their linguistic communication.
- 2- Showing the linguistic values that show the extent to which these categories are divergent.

1.4. Questions of the Study

This study aims to answer the following questions:

1. What are the speech acts categories introduced by doctors and patients in their linguistic communication?
2. What are the linguistic values that show the extent to which these categories are divergent?

1.5. The significance of the Study

Many previous studies endeavor to shade some lights upon communication between doctors and patients. The current study is an attempt to assess the conversation between doctors and patients in the light of speech acts theory.

1.6. Limits of the Study

This research is conducted in Middle East University during the first semester of the academic year 2018/2019.

1.7. Limitations of the Study

This study is limited to the communication of doctors and patients. It focuses on seven internal medicine interviews at two major hospitals in Baqubah Teaching Hospital and Al-Batool Teaching Hospital. The investigation is restricted to the linguistic

communication of the doctor and the patient, in these interviews categories of speech acts are the elements to be studied.

1.8. Definitions of the Terms

Linguistic communication: Theoretically, communication can be defined as the act of transferring common understanding and information from one entity or group to another (Keyton, 2011).

Operationally, it represents the method by which one can convey ideas, expressions, thoughts, feelings and emotions to another one or group.

Speech acts theory: Theoretically, it refers to a theory which analyses the role of utterances in relation to the behavior of speaker and hearer in interpersonal communication (Aitchison, 1999).

Operationally, it is a term in linguistics that considers language as a kind of action and analyses the role of this action in relation to the manner of speaker and hearer in communication.

Discourse analysis: Theoretically, it is the study of language, and is a sub-field of linguistics. It studies the methods that sentences and utterances go together to make texts and interactions and also how those texts and interactions fit into a common world (Jones, 2012).

Operationally, it is the branch of linguistic that studies how sentences and utterances fit together to make an understandable text and interactions.

Chapter Two

Review of Literature

2.0. Introduction

This chapter reports what has been written on speech acts theory and its role played in assessing doctor-patient communication. The speech acts theory and its historical development are discussed in the theoretical literature. The empirical side of this chapter covers some studies that adopt speech acts theory in doctor-patient communication.

2.1. Theoretical Literature

Many speech acts theories' problems have already been formulated or a little bit is glanced at other opportunities through the western philosophy and linguistics' history. Many philosophers were interested in finding the relationship between what words mean and the act related to these words that are uttered, i.e. act of assertion. In early history, Aristotle made a distinction between what words mean and the assertiveness of declarative sentences. During the 20th century, the interest in the functions of languages has been developed into a wide variety of semiotic, linguistic and sociolinguistic writings (Verschuere & Östman, 2009).

Before the Second World War, most theories consider the goal of language as being actually to communicate factual information, and what can be true or false. Thus, elements of language are dealt with as "things" regardless of any consideration to the action and intentions of the speaker and the hearer. Stating facts as such is solely a single function of what humans do with language and what meaning lies in the use of the elements of language and not in the elements themselves (Searle, 1971).

Austin (1962:106) described the concept 'act' as "fixed physical action that we do". However, speech acts theory is one of the tactics of reference suggested studying language use. The theory considers the utterance as a performance of an act in a speech

situation. It is concerned with the functions and uses of language. The theory depends on the hypothesis that when we speak, we perform acts such as giving reports, promising, warning, asking questions and so on.

Furthermore, Austin discusses two different concepts: the 'performatives' where the speaker does something, and the 'constatives' that are used to communicate information. Performatives are the acts that cannot be true or false whereas constatives can be either true or false such as statements. Austin, in his lectures, contravenes the division that essentially leans on the difference among doings and sayings.

Consequently, Austin (1971) announces new terminology that are illocutionary acts and perlocutionary acts. Subsequently, Austin recognizes the unhappinesses, which related with the performatives, nullity, abuse, and breach of commitment. Performatives are useless when the speaker is unable to do acts of this kind. The acts are abused if the speaker is dishonest and thus the formula is abused. Moreover, Austin finds that constatives are accountable to these unhappinesses much like the performatives.

Felicity conditions or infelicity conditions state a serious problem that faces speech acts theory and pragmatics generally. They are concerned with the relationship between context and utterances. Nevertheless, because context is an entity without boundaries, one has to decide what aspects of context are relevant to the formulation of conditions on illocutionary act types. This problem of relevance is addressed by Holdcroft (1979) and Davidson (1979).

However, whereas Austin (1962) states infelicities in illocutionary acts, Searle (1969: 54-71) proposes four kinds of conditions for an illocutionary act. These are:

- a- Propositional content conditions,
- b- Preparatory conditions,
- c- Sincerity conditions,

d- Essential conditions.

Austin assumes that most utterances (constatives and performatives) contain a performative aspect which is called the illocutionary force and a constative aspect which is the propositional content. So, it can be said that the propositional content can be true or false.

Austin claims that there are three types of acts: locutionary, illocutionary, and perlocutionary acts. Locutionary acts are those acts of saying that something is the case. Searle confirms that these acts are species of illocutionary acts. Illocutionary acts are those, which are performed in saying something with an intention to do so, such as congratulations, promising, and challenging. These acts are identified by a class of verbs whose function is to make explicit what the speaker intends to be performing in uttering these phrases. The presence of the verb is not a decisive criterion because there are many utterances that convey an illocutionary act with no performative verb. These two kinds of acts are distinguished after the distinction is made between explicit and implicit performatives. The last does not contain an expression naming the act, a performative verb; for example, 'I shall go' is an implicit performative in a certain context which contains no performative verb. Perlocutionary acts are performed by saying something and can't be brought off merely by saying something, but require for their achievement, a production of a certain effect on the hearers. For example, persuading someone to believe in what we say is not accomplished unless the hearer is really persuaded.

There are two main distinctions and a peripheral one between illocutionary acts and perlocutionary acts. First, a perlocutionary act involves the production of some effect; second, illocutionary acts can be a means to perlocutionary acts but not vice versa; third, illocutionary acts require locutionary acts as bases (Alston, 1964: 36).

Searle (1969:24-25), on the other hand, gives other names to the speech acts, which are:

- a- utterance acts: they are the utterings of the words, morphemes, and/ or sentences;
- b- Propositional acts: the acts done in the course of performing illocutionary acts. They are not done unless illocutionary acts are performed, referring and predicating are these acts;
- c- Illocutionary acts: they are the same as those of Austin i.e., promising, stating, and questions are examples of this type.

Furthermore, a concept of significance in the theory of speech acts is the 'force'. Austin differentiates between force and meaning. The first one is the sort of function of language while the latter is corresponding to sense and reference. Meaning is nothing but the descriptive meaning of the expression. The illocutionary force depends upon the meaning of the expression uttered. The meaning of the sentence restricts the set of illocutionary roles in which it can come into play. Austin's concept of illocutionary force corresponds to the performative mode of an utterance and not the semantic aspect which is the whole meaning of the speech act.

Sadock (1974: 19) quotes Cohen defining illocutionary force as "that aspect of (utterance's) meaning which is either conveyed by its explicitly performative formula, if it has one, or might have been so conveyed by the use of such an expression". Sadock gives the following understanding of the notion of illocutionary force as "that part of the meaning of a sentence which corresponds to the highest clause in its semantic representation". As stated by Searle (1971: 46) meaning "is more than a matter of intention, it is also a matter of convention". Here, he finds that Grice's (1975) view doesn't pay attention to meaning as a matter of rules for "it does not show the connection between one's meaning something by what one says, and what that which one says actually means

in the language", what is more, this view confuses illocutionary acts with perlocutionary acts.

Force of an utterance is revealed by many factors. Illocutionary force representing device is the property that tells us that the utterance has such a force. For example, in English as stated by Searle word order, stress, intonation, punctuation, the mood, and the performative verb are the devices that point to the force of an utterance in a certain situation. Nevertheless, context plays the essential role in defining the illocutionary force of an utterance. Austin points out that a sentence like 'It is beautiful' can have different functions in different contexts; it can be a report, warning, or a recommendation. These are forces that this particular utterance may have. However, these are not read off from the sentence itself, context indicates the role of the sentence in communication.

Convention and intention are two key terms in the theory of speech acts. Some acts are controlled by the conventions and rituals such as the act of christening, other acts are being so due to the intention of the speaker. Searle (1971:16) believes that language is an intentional behavior. Considering the production of certain noise or mark as a linguistic communication depends upon the fact that it was produced by a being with intention. Austin (1962:105) emphasizes that illocutionary acts are being so since they conform to a convention. Thus, they are conventional. This assertion is taken by Strawson (1971) who argues illocutionary acts as conventional. He claims that any speech act involves a use of some linguistic conventions and extra-linguistic conventions to be performed. According to Strawson non-conventional acts are achieved when the intention of the speaker is fully grasped by the hearer. Searle (1971) affirms that Strawson falls short to understand the distinction made by Austin between illocutionary uptake and the perlocutionary effect.

Searle (1975) explains the concept of indirect speech acts. They are those acts performed indirectly when performing another. Then, the meaning consists in the intention of the speaker to produce certain understanding. However, speakers and hearers employ other than linguistic markers such as social conventions in performing and interpreting indirect speech acts. This is attributed to the fact that both are expected to share certain social conventions about these acts.

As soon as addressing the problem of performativity, Grewendorf (1979) follows Austin's sense. The question he raises is whether explicit performatives such as 'I guarantee that I shall success', as opposed to primary performatives such as the promise 'I shall success', belong to the performatives class of utterances only or also to the class of constatives about which truth judgments can be made. The possibility of making truth judgments about explicit performatives, and hence their status as statements is denied. This issue is relevant to the discussion of indirect speech acts. Grewendorf argues the claim that explicit performatives are indirect speech acts. The intuitive relevance of the notion of an indirect speech acts is the following: sometimes people mean more than what they actually say; if the implied meaning is an illocutionary force different from the literally conveyed one, then the force can be communicated indirectly. In the case of explicit performatives, though, the speaker says explicitly and literally what force he intends his utterance to achieve. The claim about the indirectness of explicit performatives is, therefore, intuitively vacuous. This does not mean at all that the sentence 'I order you to come' can never be a statement. Under certain circumstances, it is; for example, when it serves as a reply to 'what do you do if I come the room'. Nevertheless, there is a very simple semantic difference between its use as an order and its use as a statement; in the first case, the simple present tense refers to the moment of speaking;

whereas in the second it describes, as it usually does, a more general state of affairs. Therefore, the sentence has an ambiguous propositional content.

The notion of indirectness in speech acts directs immediately towards a discussion of literal meaning: in order to decide what the indirect force is, one has to be clear about the direct or literal one. Therefore, Raskin's work (1979) on literal meaning in speech acts contributes to the theory in general. His assumption is that no explanation of literal meaning has been given in speech acts theory. However, this assumption is no longer valid after the publication of Searle (1978).

Drew and Heritage (1992) suggest that the most vivid point of convergence between language and social organization arises at the level of speech acts; because activities or speech events are built out of particular component actions, speech acts are arguably central to the analysis of all forms of interaction.

2.2. Classification of Speech Acts:

When the speech acts theory appeared in the field of linguistics, theorists have attempted to provide specific classifications of speech acts. Each attempt is surely justified by one or more reasons, illocutionary force, illocutionary point, the speaker's intention, etc. Nevertheless, many classifications of speech acts, particularly in English, have been attempted.

2.2.1. Austin's Classification:

Austin (1962: 147-161) differentiates five common classes of speech acts. He treats the illocutionary force as the prime for his classification. Henceforth, he relates speech acts with illocutionary acts. They are as follows: verdictives, exercitives, commissives, behabitatives, and expositives.

Verdicatives: are those acts in which a verdict is given sometimes by someone who has a power to make that verdict. Assessing, ranking, diagnosing, analyzing, grading, etc. are samples of this kind of speech act.

Exercitives: are those acts that involve "giving a decision". There is an assertion of influence or exercising of power. Unlike verdicts, these acts are sentences. The result is that others are obliged to do specific acts. Appointing, resigning, dismissing, warning, etc. are examples of this kind.

Commissives: are those acts that commit the speaker to a certain course of action as soon as he utters the words. There is an obligation or declaring of intention. Undertaking, promising, contracting, vowing, adopting and consenting are examples of this kind of speech acts.

Behabitives: are the acts of adopting certain attitudes reactions to other's behaviours and attitudes. Sincerity has got a scope in this class of speech acts. Deploring, apologizing, welcoming, applauding, protesting, etc. are examples of this class of speech acts.

Expositives: are the acts where speakers clarify reasons, arguments, and communication. Acts of this sort are expositions that involve expounding of views and the conducting of arguments. Accepting, testifying, arguing, affirming, affirming, etc. are only few examples of the expositives.

2.2.2. Searle's Classification

According to Searle (1973, 1976) every speech act falls into one of only five categories. These categories depend on the intention of the speaker and the illocutionary point or the purpose of the act.

Representatives: are the acts where we tell others how things are. The purpose of the acts of this category is to commit the speaker to the truth of a certain proposition.

These acts are tested whether they are true or false. Claiming, asserting, reporting, saying, and the like are examples of this sort of speech acts.

Directives: are the acts where the speaker tries to influence the hearer to do something. Commands, suggestions, requests, begging, etc. are examples of directives. Wh-questions and yes/no questions are directives because the speaker attempts to get the hearer to provide information.

Commissives: are the acts whose purpose is to commit the speaker to a certain course of action. Promises and threats fall within this category of speech acts. Nevertheless, this category also subsumes vows, guarantees, contracts, and many other types of commitments.

Expressives: are uttered when the speaker wishes to express his psychological state about a certain state of affairs. Apologizing, deploring, regretting, thanking, welcoming, and others are examples of expressives. When uttering these, the speaker expresses how good or bad he feels about a certain event.

Declarations: are specific for use in certain cultural system such as law, government, church, and/or business. In declarations, the very words bring something new. Resigning, dismissing, christening, and the like are sorts of declaration.

2.2.3. D'Andrade's Classification:

This classification is the more recent typology of speech acts. It is followed by Cicourel (1980) as a model for discourse analysis of natural conversations. It is also manipulated by Conte (1981) in the analysis of medical interaction. The classification depends on the function of the utterance and the effect it exercises on the hearer. However, this classification doesn't claim to be exhaustive, i.e. it doesn't preclude new categories.

Statements are the utterances in which the speaker's intention is to make the hearer assume one of the former's assumptions. They may be reports, quotes, claims, stipulations, inferences, assertions, etc.

Directives are the utterances wherein the speaker's intention is to make the hearer do some action, the words convey a request for action. Examples of directives are suggestings, requests, orders, etc.

Questions are the acts performed when the speaker's intention is to make the hearer deliver information. So, he produces questions. The subcategories of questions are: wh-forms, yes/no forms, tag-forms, and intonation forms.

Reactives do not give anything about illocutionary value of the acts. Conte considers this category as 'residual'. The acts which are hardly included in any of the other categories are defined as reactives, any other category may be reduced to be a reactive. Among the examples of reactives are giving attention, answer to yes/no questions, agreeings, disagreeings, etc.

Expressives are the acts where the speaker intends to make the hearer assume an emotional state as his own. Examples of this category is giving approval, disapproval, sympathy, regret, accusation, etc.

Commissives are those acts where the speaker intends to be committed to accomplish a request, an expectation, or a desire of the hearer. Among the examples are promises, vows, offers, guarantees, etc.

2.3. Empirical Studies

Cerny (2007) suggested that speech acts can be understood as acts of communication "performed by the use of language, either in speech or writing, involving reference, force, and effect" (Widdowson 1996:131). These acts are generally categorized into five categories: namely declarations, representatives, expressives, directives and

commissives (Searle 1976). A distinction is also made between direct speech acts and indirect speech acts. " Asking questions is a very important part of your visit to the doctor. By asking questions your doctor can help clear up doubts, concerns, or worries. It is an important way in which you can get things straight." (Roter and Hall 1992:104). Therefore, it is clear that questions are the central point of any medical encounter. Their centrality is ingrained in the fact that they constitute key mechanisms " by which power can be exercised and resisted" (Humphreys 2002:2). Statistics which Černý gets in his study shows that as many as 649 turns (90%) out of 725 are formed solely by questions or answers. Out of 374 questions, 354 (95%) are initiated by doctors, 188 (53%) can be categorized as Yes/No questions, 52 (15%) as E/O questions, and 114 (32%) as open questions. 38 (11%) questions take place during the history-taking phase, 315 (89%) during the examination phase, and only 1 (0%) during the treatment phase. Only 20 (5%) are initiated by patients. 199 (53%) belong to Y/N questions, 52 (14%) to E/O questions, and 123 (33%) to open questions. 38 questions (10%) appear during the history-taking phase, 327 (87%) during the examination phase, and 9 (3%) during the treatment phase. The division of patient-initiated questions in his corpus is as the following: 11 of them (55%) belong to Y/ N questions, no question (0%) could be classified as E/O question, and 9 (45%) belong to open questions. There are no patient-initiated questions (0%) taking place during the history-taking phase, 12 questions (60%) take place during the phase of examination, and 8 questions (40%) take place during the phase of treatment.

(Todd 1983) commented speech act theory states a device to breakdown the flow of talk into separated parts. In relation to this comment Černý found that 622 following speech acts (beside questions) have been extracted: 216 (35%) statements, 323 (52%) answers, 20 (3%) reactives, and 63 (10%) directives. 282 (45%) of these speech acts are initiated by doctors, 340 (55%) are initiated by patients. 65 (10%) are used during the

history-taking phase, 390 (63%) during the phase of examination, and 167 (27%) during the treatment section. Doctors produces 283 speech acts, besides questions, in the sample of the study. 183 (64%) of them refer to statements, 19 (7%) to answers, 19 (7%) to reactives, and 62 (22%) to directives. 27 (10%) of the speech acts occur during the history taking phase, 97 (34%) speech acts during the phase of examination, and 159 (56%) speech acts during the treatment section. As the statistics analysis shows, out of 339 patient-initiated speech acts (besides questions). 33 (10%) refer to statements, 304 (90%) to answers, 1 (0%) to reactives, and 1(0%) to directives. 38 (11%) appear during the history-taking, 293 (87%) during the examination, and only 8 (2%) during the treatment. In study referring to Ainsworth-Vaughn (1998), West (1983), suggests that only 9% of all questions in her sample are patient-initiated, while the relative frequency of patient-initiated questions in the corpus studied by Ainsworth-Vaughn is much higher (40%). Thus, the very first problem which needs to be solved is to find an explanation for this divergence.

(Cerny, 2017) argues it is clear that certain utterance types are far more frequent either on the part of the doctor or on the part of the patient. Also he found that the most numerous group of speech acts is the category of statements (782; 66%), while the least numerous category are commissives (17; 1%), commissives occur only during the treatment section, no matter whether they are doctor- or patient- initiated.

(Ohtaki, Ohtaki, and Fetters, 2003) make a study in which they compare doctor-patient communication in the USA and Japan. The study finds that the average length of doctor-patient encounters was 668.7s in the USA and 505s in Japan. US physicians spent relatively more time on treatment and follow-up talk (31%) and social talk (12%), whereas the Japanese had longer physical examinations (28%) and diagnosis or consideration talk (15%). Japanese doctor-patient dialogs contain extra silence (30%)

than those in the USA (8.2%). The doctor-patient proportions of entire speech acts were similar (USA 55% versus 45%; Japan 59% versus 41%). Doctors in both countries controlled communication throughout encounters via asking more questions than the patients (75% in the USA; 78% in Japan). The Japanese doctors and patients used back-channel answers and interruptions more often than those in the USA. However, doctor-patient communication differed between the USA and Japan for time spent in each. Stage of the encounter, length of pauses and the use of back-channel responses and interruptions, doctors versus patient proportions of questions and other speech acts were the same. The differences may reflect cultural differences, whereas the similarities may reflect professional specificity stemming from the shared needs to fill the information gap between doctors and patients. Adequate awareness of these differences and similarities could be used to educate clinicians about the best approaches to patients from particular cultural backgrounds.

Chapter Three

Methodology and Procedures

3.0. Introduction

This chapter describes the study design, the sample, the instruments, analysis of the data and the procedures that are adopted in the study.

3.1. Research Design

This study adopts descriptive-analytic approach in which the frequencies and percentages are used in the analysis of the interviews between the doctor and the patient and estimate the degree of availability of speech acts categories and their subcategories in these interviews.

3.2. Sample of the Study

The sample of the present study are the doctors and the patients. Doctors are the seniors in the two internal medicine departments of the two hospitals. They are Baqubah Teaching Hospital and Al-Batool Teaching Hospital, Diyala/ Iraq. The patients are the new-comers who have not already been admitted to the wards. This permits doctors to conduct a real case-history taking. It is significant to select the informants who are mature and who show no abnormal psychological disturbance.

It goes without saying that selection of informants is not easy because it is difficult to choose new-comer patients who can fit into the conditions of clarity of speech and not being acutely ill.

3.3. Instrument of the Study

Some of the research tools are employed to collect data, among which are direct interviews, conversations, and tape-recording. Audio tape-recording is used in the present study, because the study is after the verbal production of the speakers, and also tape-

recording reduces the influence of the presence of the researcher and the impact of the atmosphere of interviewing.

It is difficult for a fieldworker, trying to obtain data from private conversations such as the medical interviews, to be present during the interview. Otherwise, participants are precautious and on their guard when speaking. Thus, a recorder-Remax is used. The recorder is placed among other things on the table that placed between the doctor and the patient. The time devoted to do the recordings is one month, many trial recordings have been conducted, and some recordings have been neglected because they were not clear. Doctors were fully aware that they have been audio-taped while the patients were blind to this fact. Each couple of informants receive a couple of short personal information sheets (Appendices D&E): one is directed to the doctor, the other to the patient. Both are filled by the doctor. The main purpose is to provide some background information concerning the two informants.

The recorder is played for recording before the patient enters the side-room. The duration of the interviews recorded is from 3 to 6 minutes. The total time of recording is about 50 minutes. The data corpus, after finishing the collection of data, consists of seven medical case-history taking interviews.

3.4. Analysis of the Data

In attempt to analyze the collected data out of the conversations and interviews, the researcher follows D'Andrade's typology that manipulated by Cicourel (1980) and Conte (1981) in classifying speech acts categories which are investigated in the interviews. The major speech acts categories are six: statements, directives, questions, reactives, expressives, and commisives. In addition, Conte adds one more category, which is creators of expectations. This category is also manipulated in the present research. The subcategories that appear in the analysis are not all the categories, but only those that are found in the data. Some modifications, however, have been administered. Questions-

requests for information-are subcategorized into wh-forms, yes/no- forms, tag-forms, and intonation forms (Conte:138). Nevertheless, it is believed, in the present work, that such a subcategorization relies on structural criteria, i.e. grammatical form, which, according to speech acts theory, does not provide any clue to the function associated with the utterance. Thus, this study assumes that the adequate sub-categorization is that questions are: yes/no-questions the function of which is to elicit a short and decisive response from the hearer, information questions where the speaker attempts to elicit information that is more than a mere hasty response; and make sure questions where the speaker tries to draw information that enables him to make sure of something. Actually, this subcategorization relies on the purpose of raising the question (Coulthard and Ashby, 1975).

3.5. Research Procedures

The procedures used to conduct the study will be as follows:

1. Reviewing the theoretical literature and empirical studies related to the speech acts theory and its categories and their role in the analysis of the interviews between doctor and patient.
2. Developing the instrument of the study: the interviews.
3. Identifying the population and sample of the study.
4. Collecting the data and correcting it.
5. Analyzing the data of the conversations and interviews by using certain procedures in terms of the frequencies and percentages.
6. Presenting the results.
7. Results are charts, discussed with references to some studies mentioned in chapter two.
8. Drawing conclusion and providing recommendations.
9. All the references are listed according to APA style.
10. Useful appendices are added at the end of the study.

Chapter Four

Results and Analysis of Data

4.0. Introduction

This chapter provides answers to the questions of the study which aimed at highlighting the speech acts categories and subcategories in the communication between doctors and patients. The questions already raised, are the following:

- 1- What are the speech acts categories introduced by the doctors and the patients in their linguistic communication?
- 2- What are the linguistic values that show the extent to which these categories are divergent?

4.1. The Analysis of the Interviews

Interviews are taken one by one in investigation. All the interviews begin with the same personal information. That is, the doctor asks about the name, date of birth, place of residence, and similar personal information. A narrative of the general outline of the outsets of the interviews provides the reader with knowledge of what is going on before the case-history taking begins. Patients enter the sideroom in the ward and greet the doctor in the usual way; then, the doctor greets and asks the patient to have a seat; some speech exchanges start as an introduction to the coming interaction process. The doctor, then, starts asking the patient about certain personal matters such as the name, place of birth, date of birth, and place of residence. Meanwhile the patient answers all these questions. Finishing this, the two interactants start the real medical issues and right here begins the analysis of the data.

4.1.1. Interview I

- Participants: male senior doctor, age 56; male patient, age 36, literate, teacher.

- Duration: 6 minutes
- Number of dyadic interaction: 44
- Setting: internal medicine department, Baqubah Teaching Hospital

In this interview, the two interactants perform twenty-eight statements. The doctor performs ten statements; eight are assertions (I.4, I.5, I.9, I.11, I.12, I.13, I.42, I.44), and the other two are inferences (I.34, I.36). The patient performs the other eighteen statements; twelve are stipulations (I.1, I.2, I.7, I.8, I.11, I.14, I.16, I.20, I.24, I.26, I.33, I.43), three are assertions (I.3, I.18, I.34), two are explanations (I.10, I.42), and one is illustration (I.27). The following figure illustrates these remarks:

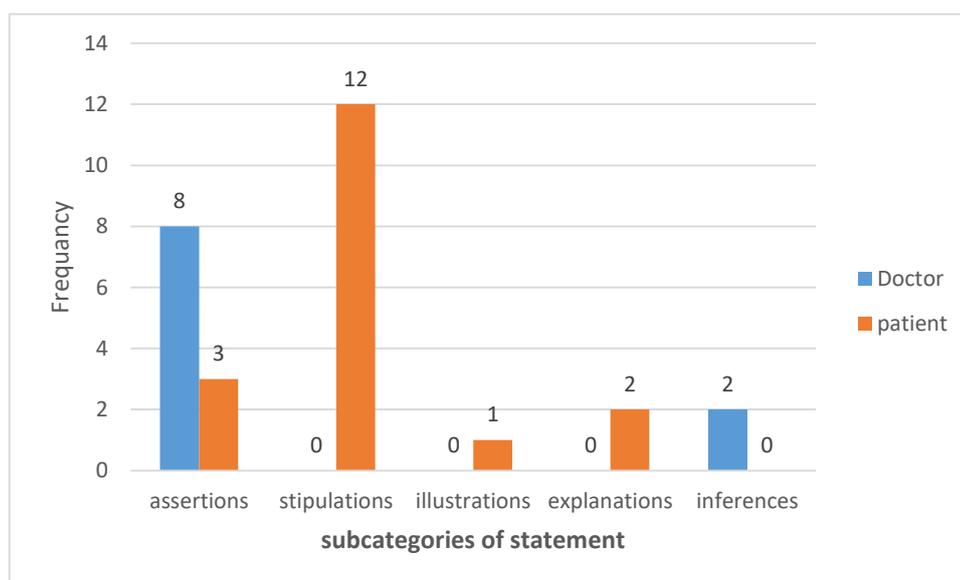


Figure (1): subcategories of statement.

As far as directives are concerned, the doctor gives all the four directives, which are requests, in the present interview (I.29, I.37, I.41, and I.44). Figure (2) shows these details:

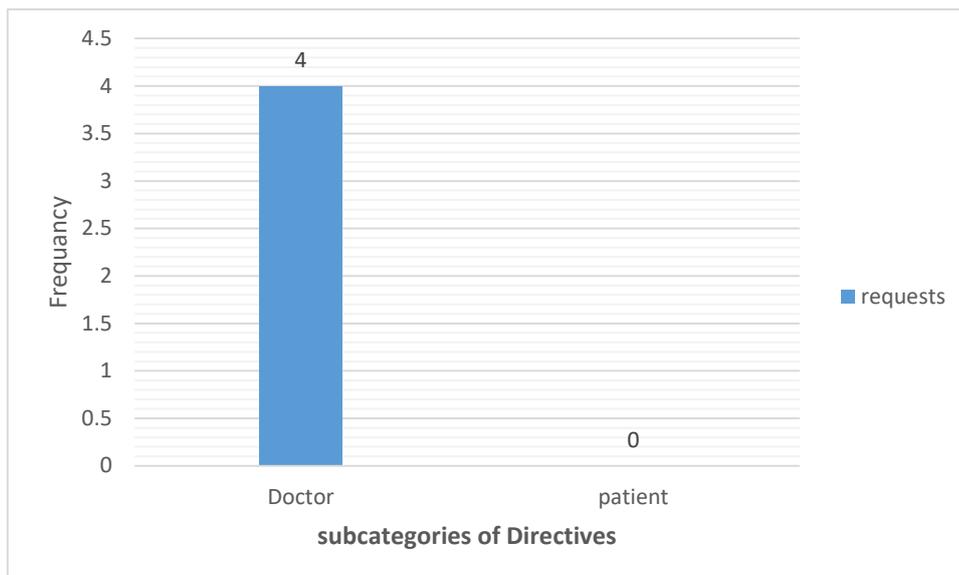


Figure (2): subcategories of Directives.

There are thirty-three questions in this interview. The doctor gives twenty nine questions; eleven of them are yes/no questions (I.6, I.16, I.17, I.18, I.20, I.21, I.29, I.30, I.31, I.32, and I.35); another ten information questions are raised by the doctor (I.1, I.2, I.7, I.8, I.14, I.24, I.26, I.27, I.33, I.34); and he raises eight make-sure questions (I.3, I.4, I.15, I.19, I.22, I.23, I.25, I.28). The patient, however, raises four questions, two of them are yes/no questions (I.37, I.39), and the other two are information questions (I.41, I.39). Figure (3) illustrates the above statistics.

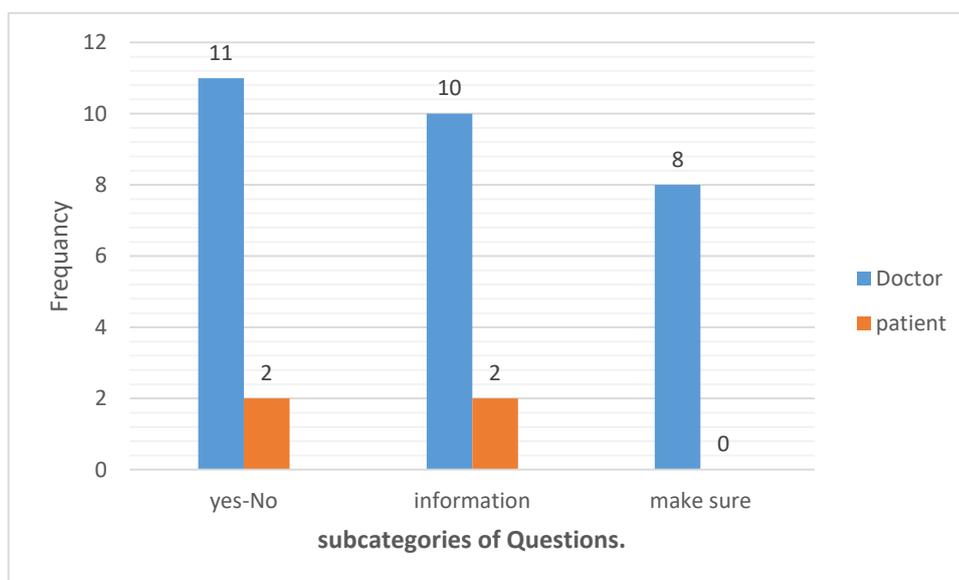


Figure (3): subcategories of Questions.

The two participants produce nineteen reactives. Three of them are replies and produced by the doctor (I.38, I.39, and I.40). While, the patient produces sixteen reactives, two of them are agreeings (I.5, I.44); four are disagreeings (I.9, I.11, I.12, and I.13); and ten are replies (I.3, I.4, I.6, I.16, I.17, I.21, I.29, I.31, I.32, and I.35). See figure (4) below:

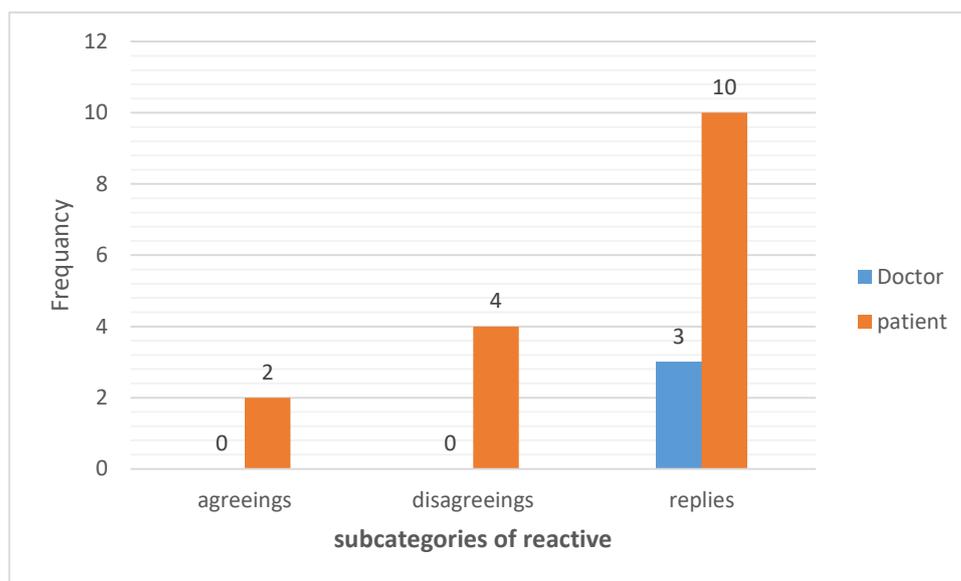


Figure (4): subcategories of reactive.

The interview, besides, contains two expressives. As indicated in figure (5), one expressive is produced by the doctor and it is an attention (I.43). The other one is produced by the patient and it is an approval (I.36).

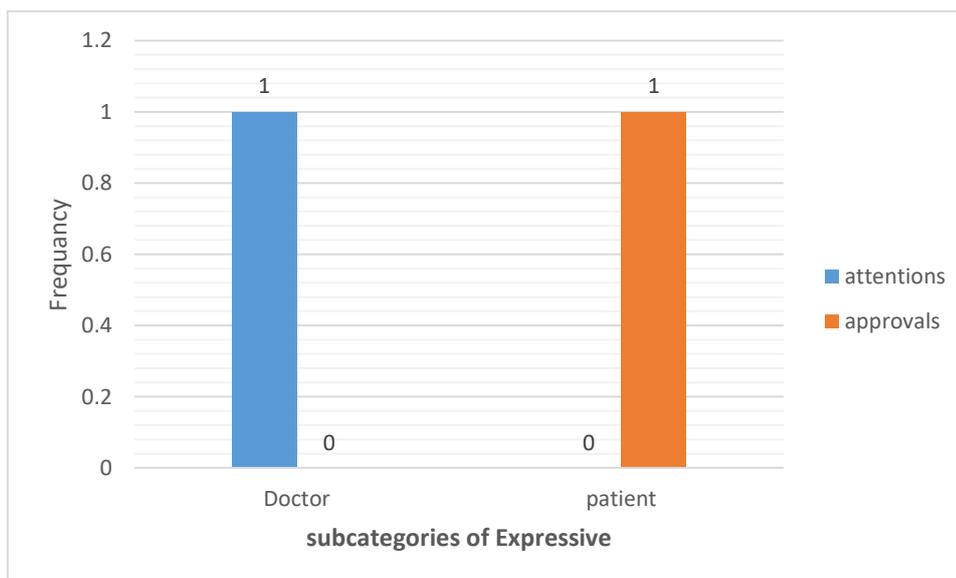


Figure (5): subcategories of Expressive.

There are six commissives produced by the patient in this interview. These acts are assurance (I.15, I.19, I.22, I.23, I.25, and I.28). Figure (6) shows them.

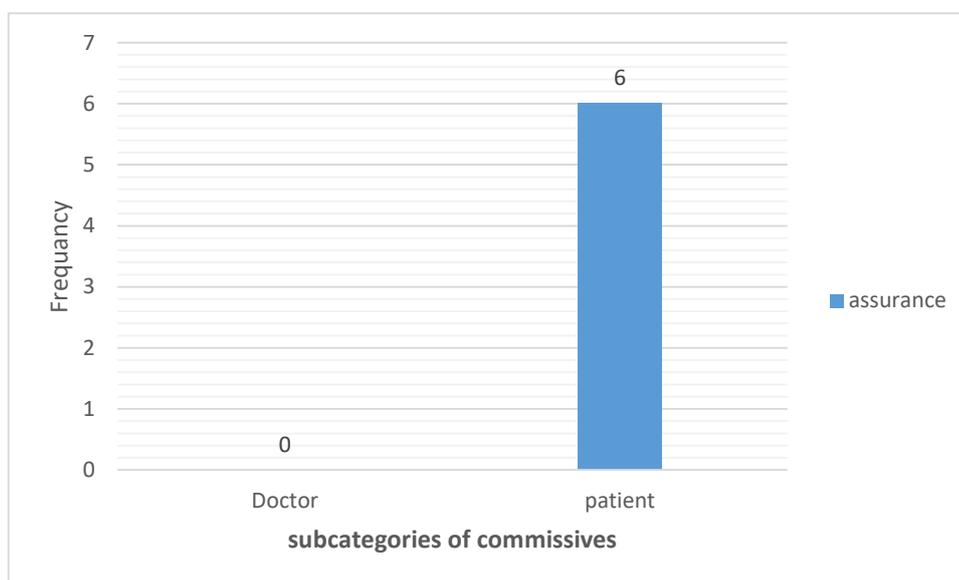


Figure (6): subcategories of commissives.

Figure (7) elucidates that the two participants produce twelve creators of expectation. Eight of them are produced by the doctor; one is a turn-taking (I.40) and seven are fillers (I.1, I.12, I.14, I.16, I.21, I.22, and I.26). The patient produces four creators, one of these creators is a turn-taking (I.10), another one is an introductory (I.31), and the other two are fillers (I.10, I.30).

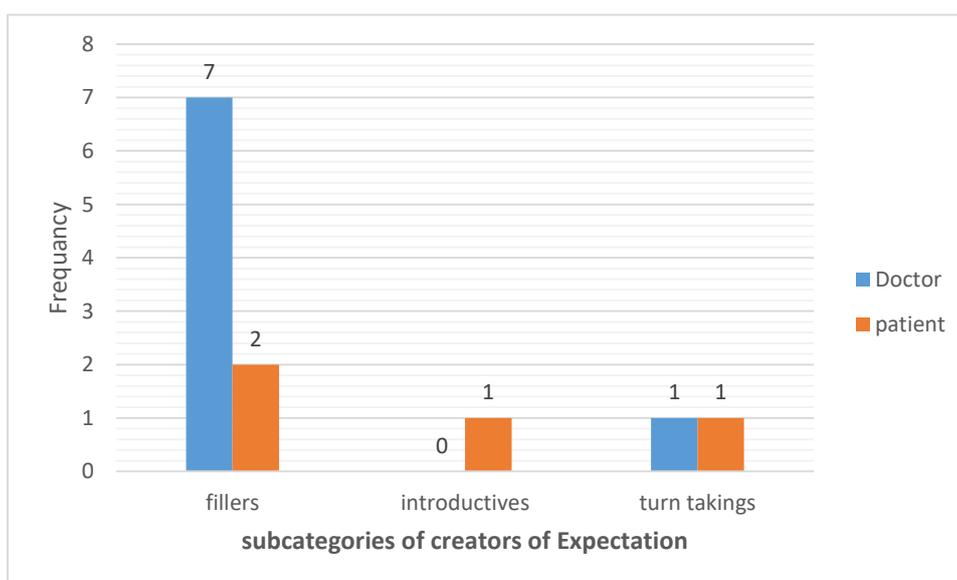


Figure (7): subcategories of creators of Expectation.

In short, the following are both a table and figure which illustrate the frequency distribution of speech acts categories and subcategories in the first interview.

Table (1): General frequency distribution of speech acts categories in Interview (I)

Categories	Doctor	Patient	Total	%D	%P	%T
Statement	3	14	17	17.65%	82.35%	34.00%
Assertions	2	0	2	100.00%	0.00%	4.00%
Stipulations	0	9	9	0.00%	100.00%	18.00%
Reports	0	1	1	0.00%	100.00%	2.00%
explanations	0	4	4	0.00%	100.00%	8.00%
Inferences	1	0	1	100.00%	0.00%	2.00%
Directives	1	0	1	100.00%	0.00%	2.00%
Requests	1	0	1	100.00%	0.00%	2.00%
Questions	15	0	15	100.00%	0.00%	30.00%
information	12	0	12	100.00%	0.00%	24.00%
make sure	3	0	3	100.00%	0.00%	6.00%
reactives	0	4	4	0.00%	100.00%	8.00%
agreeings	0	3	3	0.00%	100.00%	6.00%
disagreeings	0	1	1	0.00%	100.00%	2.00%
Expressives	0	2	2	0.00%	100.00%	4.00%
thankings	0	1	1	0.00%	100.00%	2.00%
approvals	0	1	1	0.00%	100.00%	2.00%
commissives	0	3	3	0.00%	100.00%	6.00%
assurance	0	3	3	0.00%	100.00%	6.00%
creators of Expectation	7	1	8	87.50%	12.50%	16.00%
Fillers	6	0	6	100.00%	0.00%	12.00%
introductives	0	1	1	0.00%	100.00%	2.00%
turn takings	1	0	1	100.00%	0.00%	2.00%

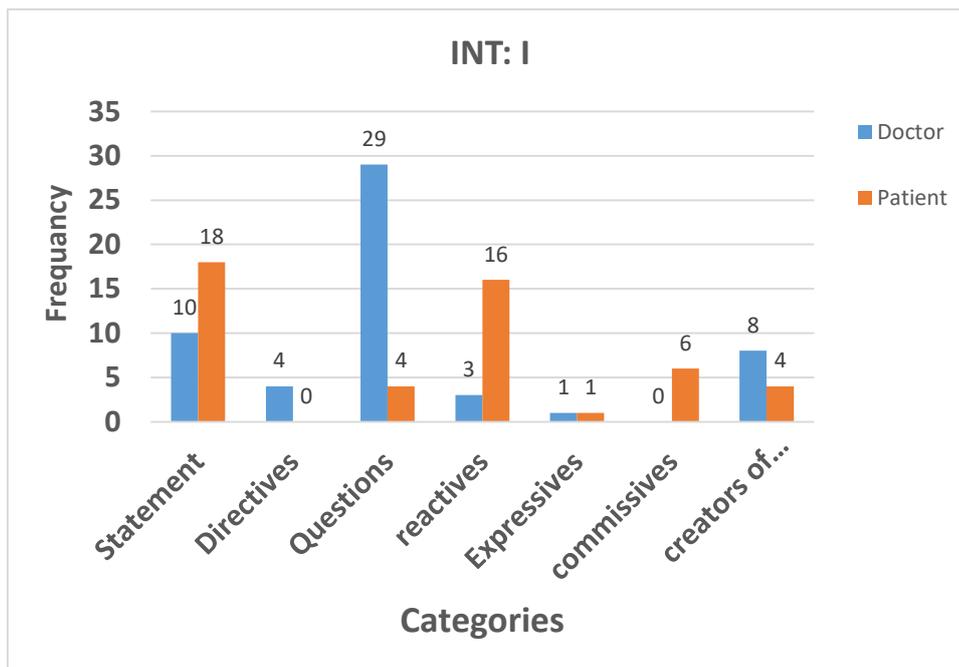


Figure (8): Frequency Distribution of Speech acts categories in Interview (I)

4.1.2. Interview II

- Participants: male senior doctor, age 46; female patient, age 52, illiterate, retired.
- Duration: 4 minutes.
- Number of dyadic interaction: 24
- Setting: Internal medicine department, Baqubah Teaching Hospital.

The present interview includes seventeen statements. Three of these statements are produced by the doctor; two are assertions (II.5, I.12), and the other one is an inference (II.8). The patient produces the other fourteen statements. One of these is a report (II.23), four are explanations (II.2, II.15, II.18, and II.22), and the remaining nine statements are stipulations (II.1, II.3, II.5, II.7, II.10, II.11, II.13, II.19, and II.20). The following figure illustrates the frequency distribution of the subcategories of statements:

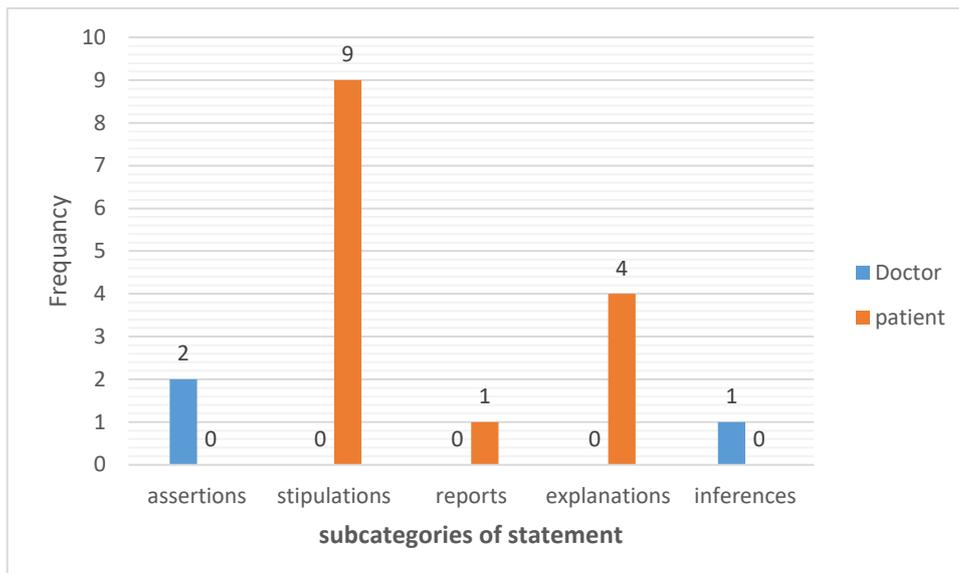


Figure (9): subcategories of statement.

As far as directives are concerned, this interview contains only one directive which is a request and produced by the doctor (II.24). This is clearly shown in figure (10).

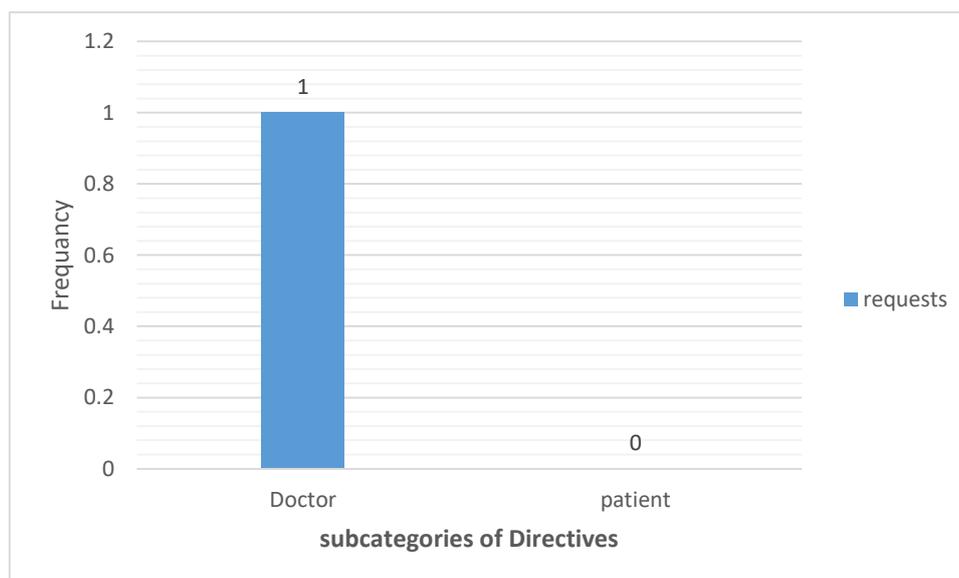


Figure (10): subcategories of Directives.

There are fifteen questions in this interview (see figure (11)), and all of them are produced by the doctor, twelve of which are information questions (II.1, II.2, II.3, II.5, II.7, II.11, II.13, II.15, II.19, II.20, II.21, and II.23), and three are make sure questions (II.4, II.9, and II.16).

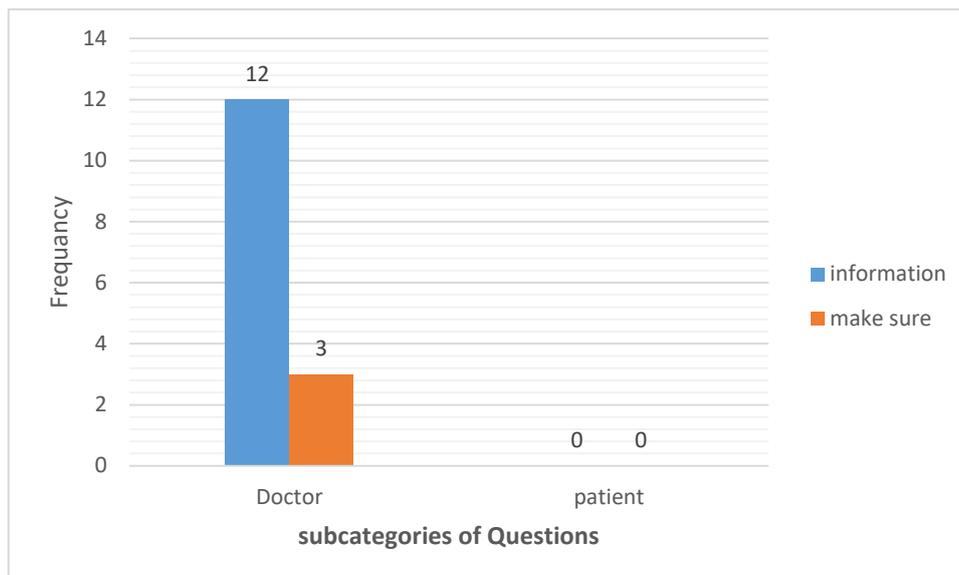


Figure (11): subcategories of Questions.

All the reactives in this interview are produced by the patient and none by the doctor. The patient reacts four times: three are agreeings (II.6, II.12, II.21), and one is disagreeing (II.9). Below is the figure, which demonstrates these details.

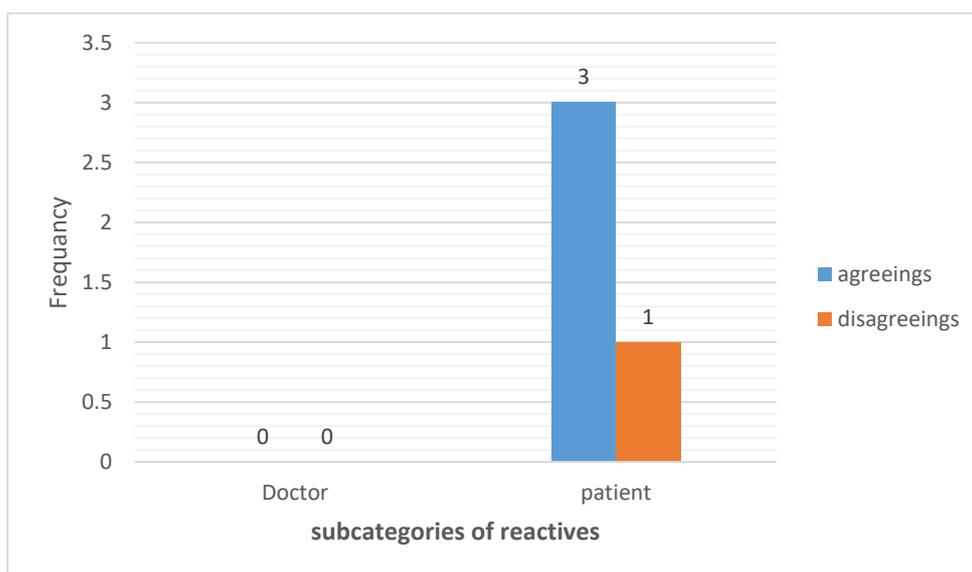


Figure (12): subcategories of reactives.

The interview, besides, includes only two expressives; both are produced by the patient. One is a thanking (II.24), and the other is an approval (II.28). Figure (13) shows these details:

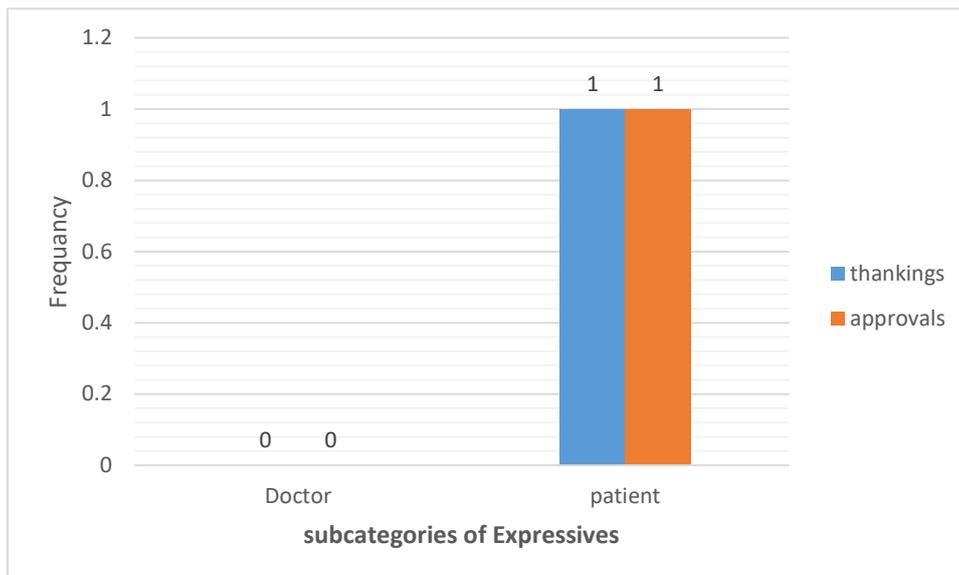


Figure (13): subcategories of Expressives.

There are, further, three commissives performed by the patient; they are assurance (II.4, II.14, II.16). (See Figure (14) below).

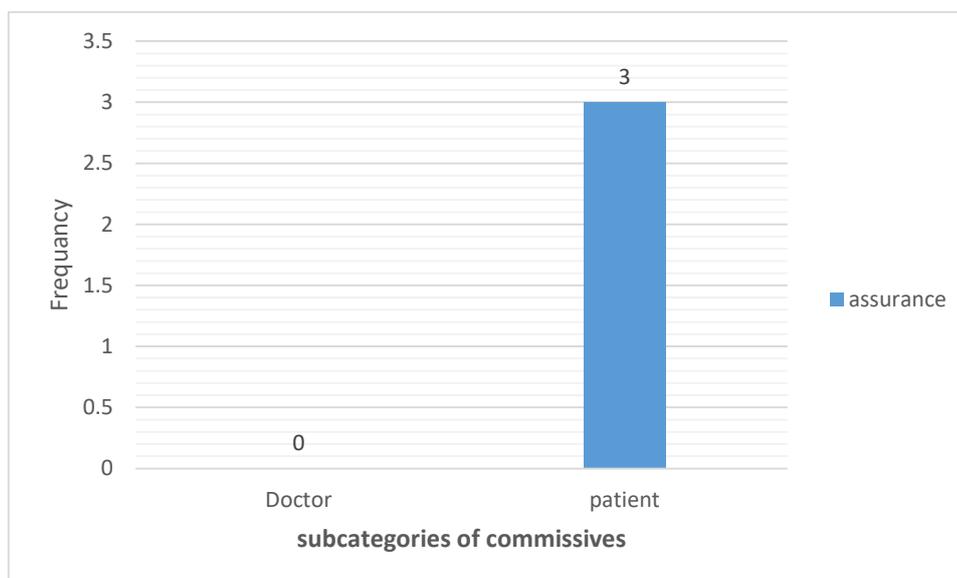


Figure (14): subcategories of commissives.

The two participants produce eight creators of expectation. Seven of them are produced by the doctor; one is a turn-taking (II.18), and six are fillers (II.1, II.6, II.10, II.14, II.17, and II.22). The patient, on the other hand, produces only one creator which is an introductory (II.17). Figure (15) shows them:

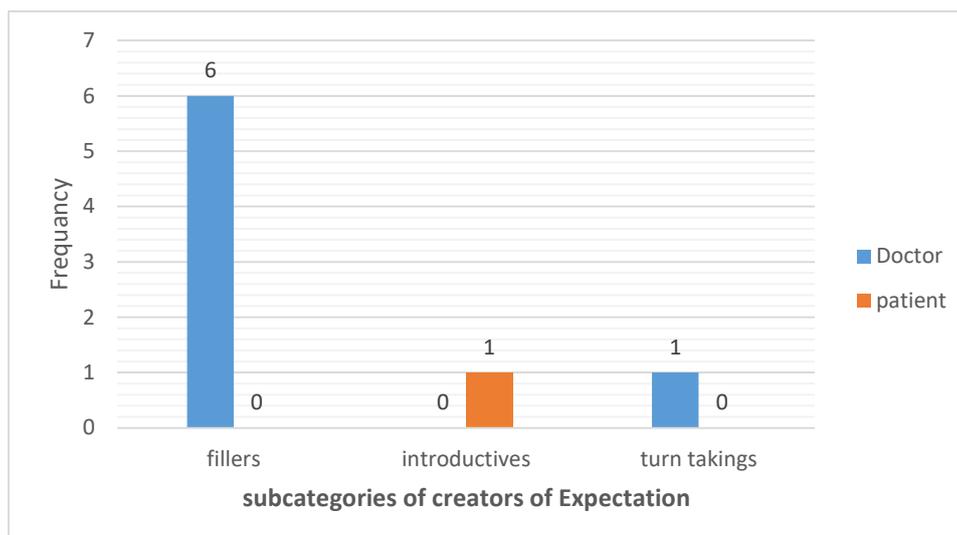


Figure (15): subcategories of creators of Expectation.

In brief, the following are both a table and figure which illustrate the frequency distribution of speech acts categories and subcategories in the second interview.

Table (2): General frequency distribution of speech acts categories in Interview II

categories	Doctor	Patient	Total	%D	%P	%T
Statement	3	14	17	17.65%	82.35%	34.00%
assertions	2	0	2	100.00%	0.00%	4.00%
stipulations	0	9	9	0.00%	100.00%	18.00%
Reports	0	1	1	0.00%	100.00%	2.00%
explanations	0	4	4	0.00%	100.00%	8.00%
Inferences	1	0	1	100.00%	0.00%	2.00%
Directives	1	0	1	100.00%	0.00%	2.00%
Requests	1	0	1	100.00%	0.00%	2.00%
Questions	15	0	15	100.00%	0.00%	30.00%
information	12	0	12	100.00%	0.00%	24.00%
make sure	3	0	3	100.00%	0.00%	6.00%
reactives	0	4	4	0.00%	100.00%	8.00%
agreeings	0	3	3	0.00%	100.00%	6.00%
disagreeings	0	1	1	0.00%	100.00%	2.00%
Expressives	0	2	2	0.00%	100.00%	4.00%
thankings	0	1	1	0.00%	100.00%	2.00%
approvals	0	1	1	0.00%	100.00%	2.00%
commissives	0	3	3	0.00%	100.00%	6.00%
assurance	0	3	3	0.00%	100.00%	6.00%
creators of Expectation	7	1	8	87.50%	12.50%	16.00%
Fillers	6	0	6	100.00%	0.00%	12.00%
introductives	0	1	1	0.00%	100.00%	2.00%
turn takings	1	0	1	100.00%	0.00%	2.00%

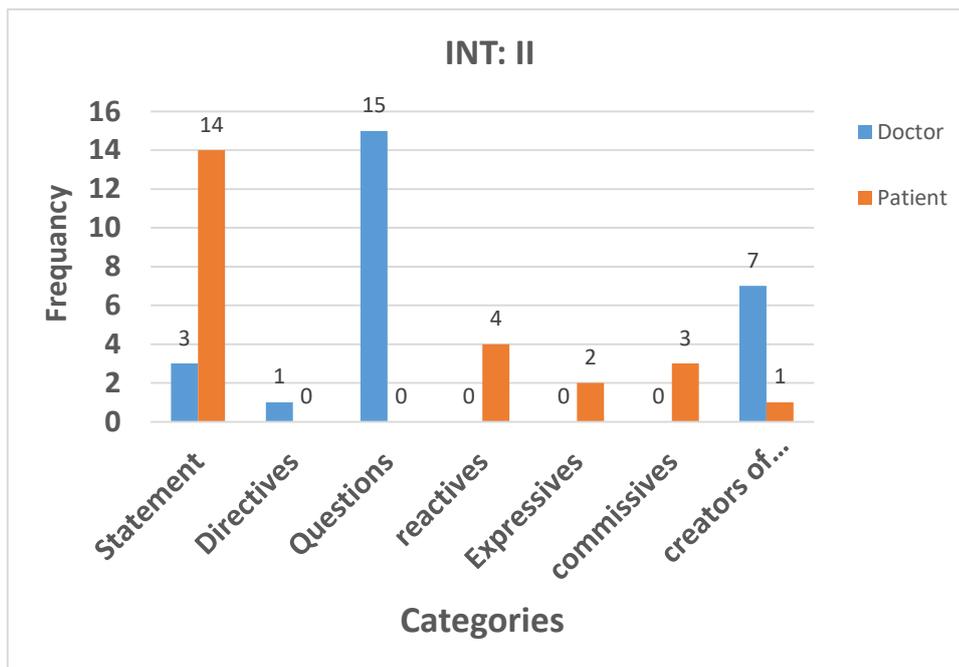


Figure (16): Frequency Distribution of Speech acts categories in Interview II

4.1.3. Interview III

- Participants: Male senior doctor, age 46, female patient, age 50, illiterate, retired.
- Duration: 4 minutes
- Number of dyadic interactions: 50
- Setting: Internal medicine department, Baqubah Teaching Hospital.

In this interview, there are thirty three statements made by the two participants. The doctor makes eight statements while the patient makes twenty five statements. The doctor produces one assertion (III.9), four stipulations (III.18, III.19, III.30, and III.47), two explanations (III.44, III.48), and one inference (III.7). The patient produces fifteen stipulations (III.1, III.2, III.4, III.6, III.8, III.9, III.13, III.16, III.24, III.31, III.33, III.35, III.36, III.38, and III.43), one report (III.30), and nine explanations (III.3, III.7, III.17, III.20, III.22, III.25, III.29, III.32, and III.42). The following figure illustrates these remarks:

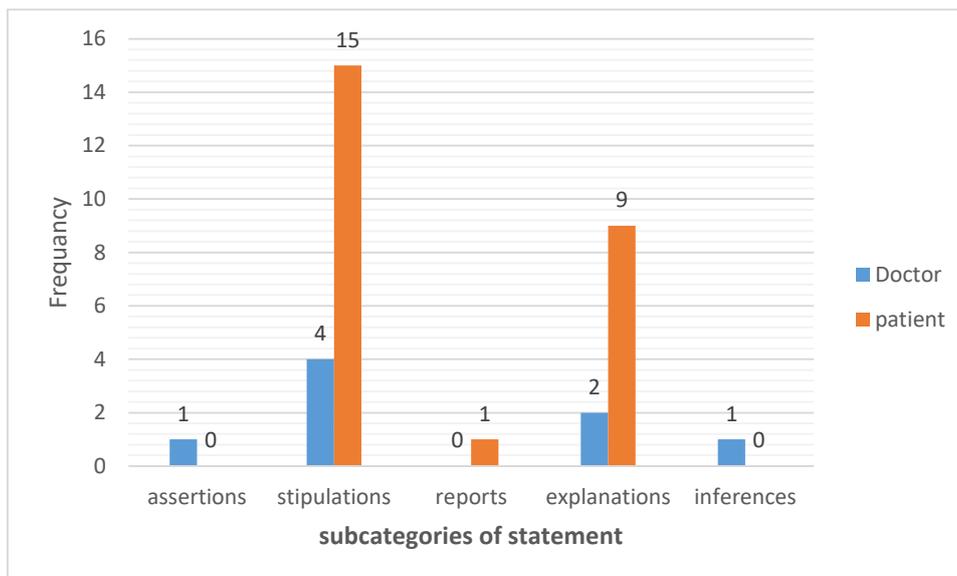


Figure (17): subcategories of statement.

Directives are produced five times in this interview. All of them are produced by the doctor. Three of which are requests (III.40, III.41, and III.45), and the other two are persuades (III.46, III.49). Figure (18) illustrates the above statistics:

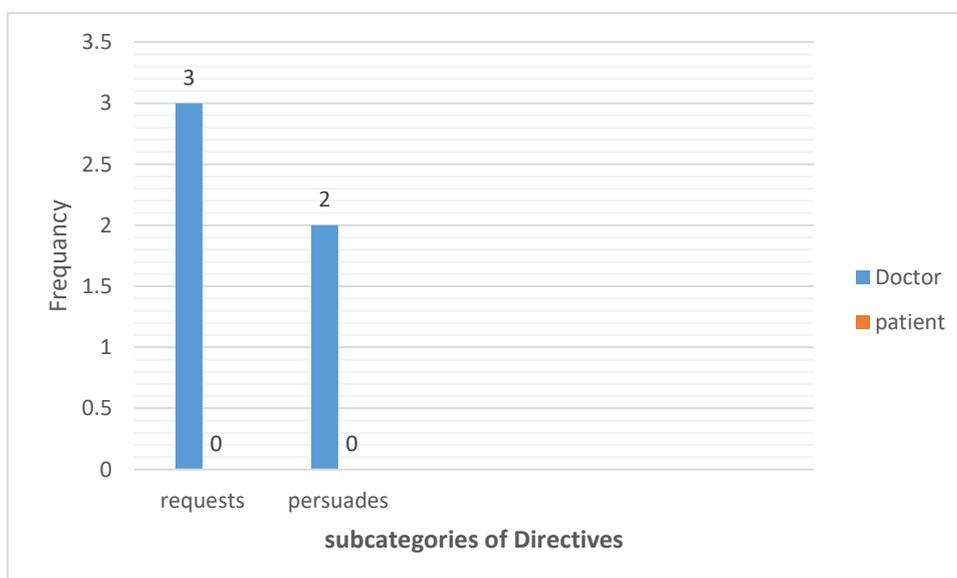


Figure (18): subcategories of Directives.

In addition, the interview contains twenty nine questions. Twenty five questions are raised by the doctor, while the patient produces four questions. The doctor produces sixteen yes/no questions (III.8, III.10, III.11, III.12, III.13, III.23, III.24, III.26, III.27, III.28, III.29, III.34, III.35, III.37, III.38, and III.39), six information questions (III.1,

III.2, III.5, III.6, III.16, and III.21), and three make-sure questions (III.14, III.20, and III.36). The patient produces one yes/no question (III.41), two information questions (III.18, III.47), and one make-sure question (III.19). See figure (19) below:

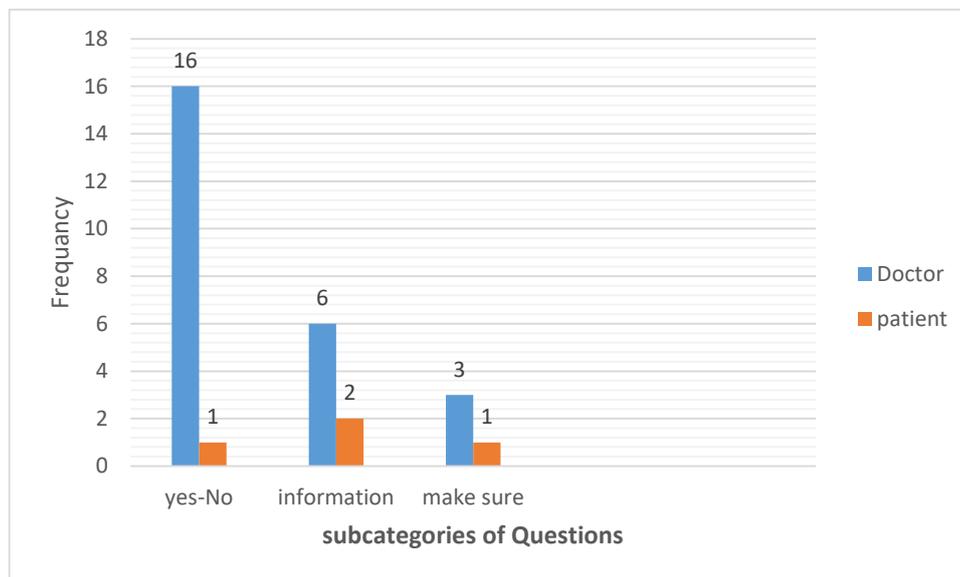


Figure (19): subcategories of Questions.

There are twenty-two reactives in this interview, four are produced by the doctor and eighteen are produced by the patient. The doctor raises two agreeings (III.45, III.42), and two replies (III.48, III.19). The patient raises four agreeings (III.20, III.30, III.45, and III.49), one disagreeing (III.7), and the other thirteen are replies (III.8, III.10, III.11, III.12, III.13, III.26, III.27, III.28, III.37, III.38, III.39, III.35, and III.24). This is clearly shown in figure (20).

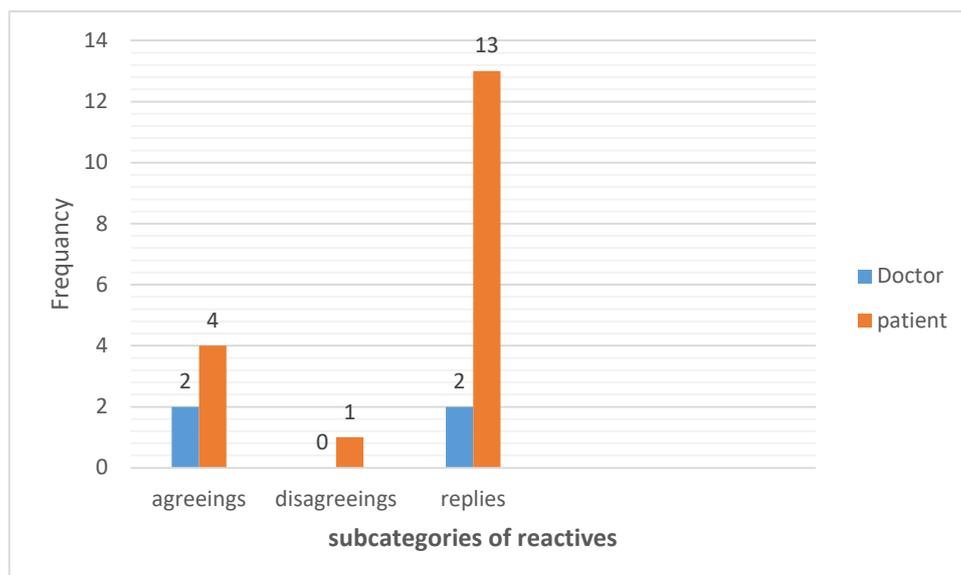


Figure (20): subcategories of reactives.

Expressives in this interview are six. The doctor produces three expressives: two are praises (III.4, III.26), and one is a greeting (III.50). The patient gives three expressives: one is a thanking (III.49), one is a praise (III.29), and one is an approval (III.46). Figure (21) elucidates that.

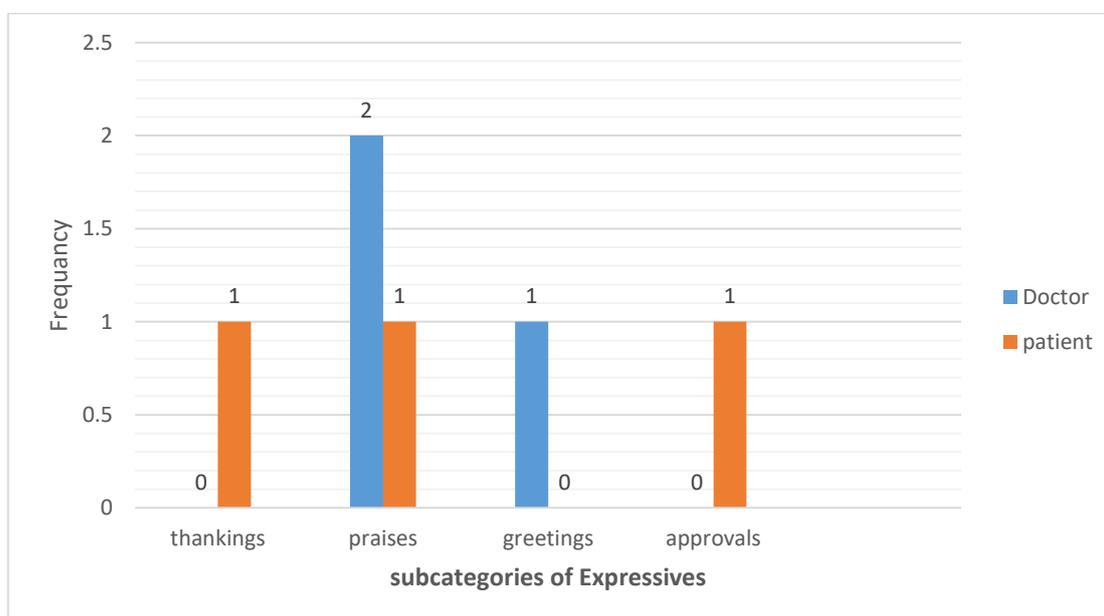


Figure (21): subcategories of Expressives.

All the commissives are produced by the patient. They are two assurances (III.11, III.14). Below is the figure that demonstrates these details.

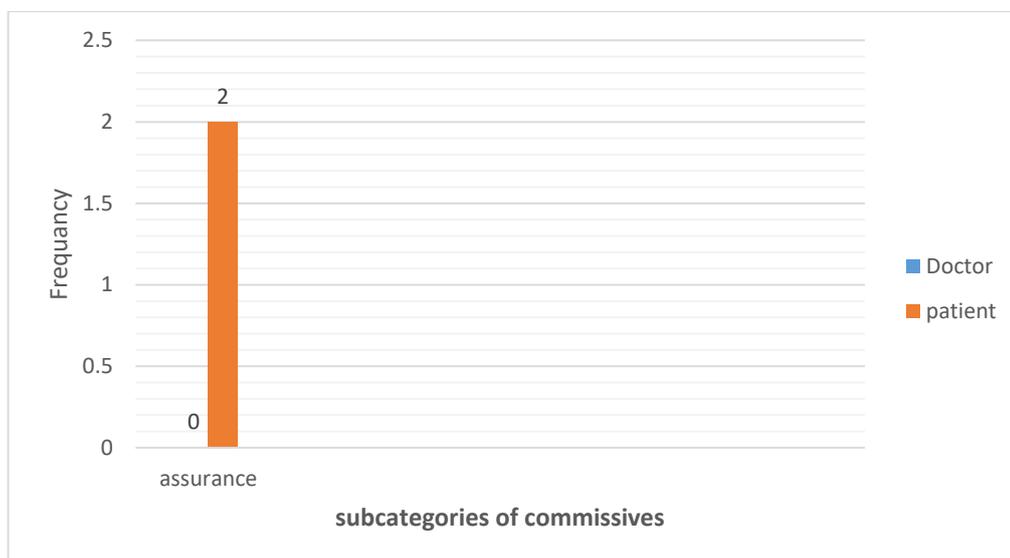


Figure (22): subcategories of commissives.

The two participants produce twenty-one creators of expectation. The doctor gives eleven creators, eight of them are fillers (III.5, III.15, III.25, III.31, III.32, III.33, III.43, III.17), and three are turn-takings (III.3, III.4, III.22). The patient gives ten creators; eight of them are fillers (III.5, III.17, III.21, III.23, III.34, III.40, III.45, and III.48), one is a conclusive (III.15), and one is a turn-taking (III.44). See figure (23).

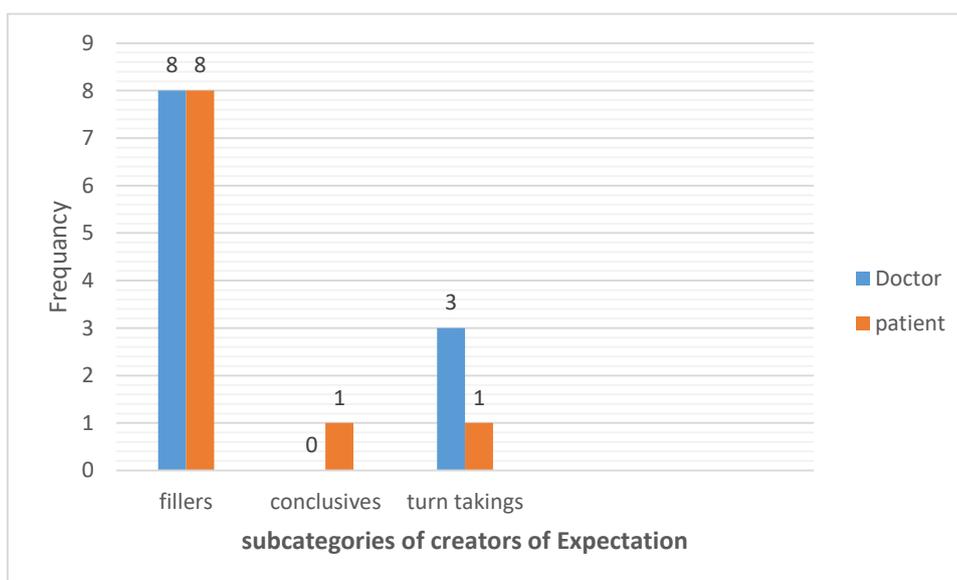


Figure (23): subcategories of creators of Expectation.

In short, the following are both a table and figure which illustrate the frequency distribution of speech acts categories and subcategories in the third interview.

Table (3): General frequency distribution of speech acts categories in Interview III

Categories	Doctor	Patient	Total	%D	%P	%T
Statement	8	25	33	24.24%	75.76%	27.97%
Assertions	1	0	1	100.00%	0.00%	0.85%
Stipulations	4	15	19	21.05%	78.95%	16.10%
Reports	0	1	1	0.00%	100.00%	0.85%
Explanations	2	9	11	18.18%	81.82%	9.32%
Inferences	1	0	1	100.00%	0.00%	0.85%
Directives	5	0	5	100.00%	0.00%	4.24%
Requests	3	0	3	100.00%	0.00%	2.54%
Persuades	2	0	2	100.00%	0.00%	1.69%
Questions	25	4	29	86.21%	13.79%	24.58%
yes-No	16	1	17	94.12%	5.88%	14.41%
Information	6	2	8	75.00%	25.00%	6.78%
make sure	3	1	4	75.00%	25.00%	3.39%
Reactives	4	18	22	18.18%	81.82%	18.64%
Agreeings	2	4	6	33.33%	66.67%	5.08%
Disagreeings	0	1	1	0.00%	100.00%	0.85%
Replies	2	13	15	13.33%	86.67%	12.71%
Expressives	3	3	6	50.00%	50.00%	5.08%
Thankings	0	1	1	0.00%	100.00%	0.85%
Praises	2	1	3	66.67%	33.33%	2.54%
Greetings	1	0	1	100.00%	0.00%	0.85%
Approvals	0	1	1	0.00%	100.00%	0.85%
Commissives	0	2	2	0.00%	100.00%	1.69%
Assurance	0	2	2	0.00%	100.00%	1.69%
creators of Expectation	11	10	21	52.38%	47.62%	17.80%
Fillers	8	8	16	50.00%	50.00%	13.56%
Conclusives	0	1	1	0.00%	100.00%	0.85%
turn takings	3	1	4	75.00%	25.00%	3.39%

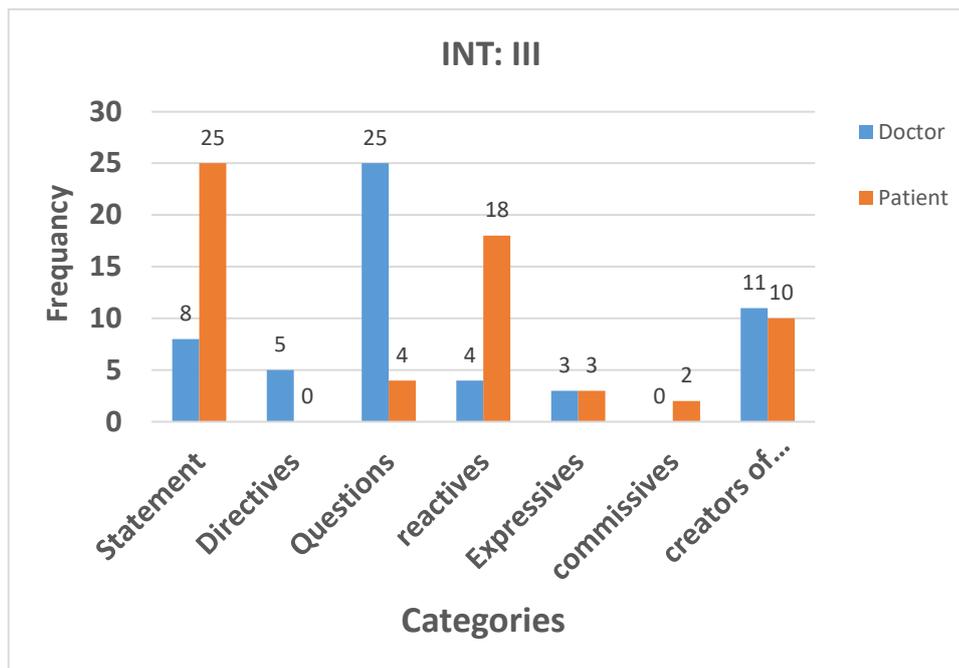


Figure (24): Frequency Distribution of Speech acts categories in Interview III

4.1.4. Interview IV

- Participants: Male senior doctor, age 56; male patient, age 61, literate, retired.
- Duration: 5 minutes
- Number of dyadic interactions: 40
- Setting: Internal medicine department, Baqubah Teaching Hospital.

In the present interview, the two interactants perform twenty seven statements. The doctor performs nine statements, two are assertions (IV.20, IV.24), three are stipulations (IV.12, IV.18, and IV.31), one is an evaluation (IV.34), two are explanations (IV.24, IV.27), and one is an inference (IV.19). The patient performs the other eighteen statements, three are assertions (IV.12, IV.18, and IV.31), and eight are stipulations (IV.3, IV.4, IV.6, IV.17, IV.24, IV.30, IV.32, and IV.38), one is an illustration (IV.15), one is a

report (IV.29), and five are explanations (IV.1, IV.2, IV.8, IV.23, and IV.34). The following figure illustrates these remarks:

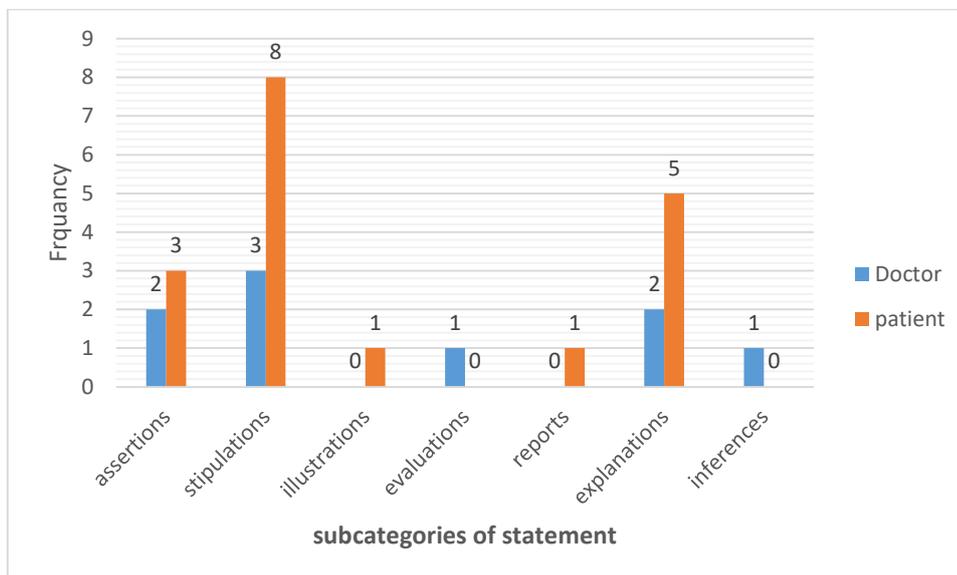


Figure (25): subcategories of statement.

There are fifteen directives and all of them are produced by the doctor, ten of which are requests (IV.12, IV.13, IV.14, IV.15, IV.16, IV.20, IV.29, IV.36, IV.37, IV.40), one is an offer (IV.35), and the other four are persuades (IV.26, IV.28, IV.33, IV.39). Figure (26) elucidates that:

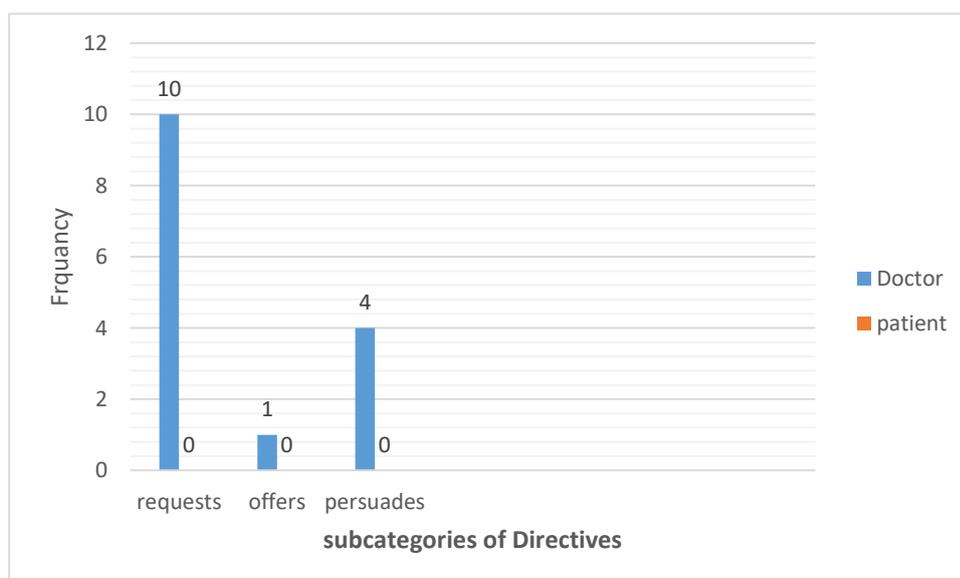


Figure (26): subcategories of Directives.

Questions, besides, are twenty-one in this interview. The doctor gives eighteen questions, eight are yes/no questions (IV.3, IV.5, IV.6, IV.7, IV.8, IV.9, IV.10, and IV.21), seven are information questions (IV.1, IV.2, IV.4, IV.17, IV.32, IV.23, and IV.31), and three are make-sure questions (IV.11, IV.25, and IV.30). The patient, on the other hand, raises only three questions, one is an information question (IV.21), and the other two are make-sure questions (IV.37, IV.22). This is clearly shown in figure (27).

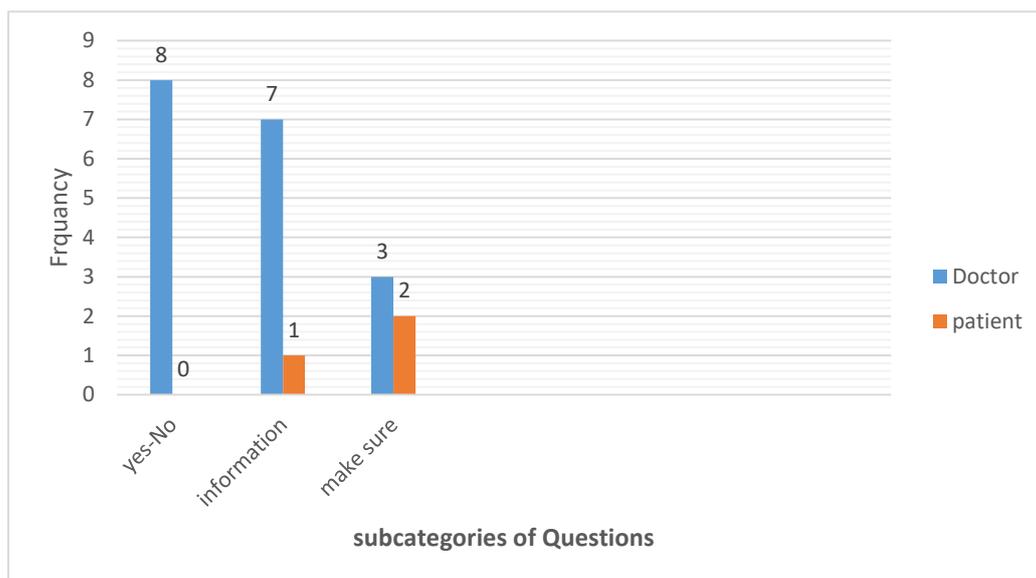


Figure (27): subcategories of Questions.

The patient produces the all ten reactives in the present interview, four are agreeings (IV.19, IV.27, IV.35, and IV.40), and the other six are replies (IV.3, IV.7, IV.5, IV.8, IV.9, and IV.10). See figure (28):

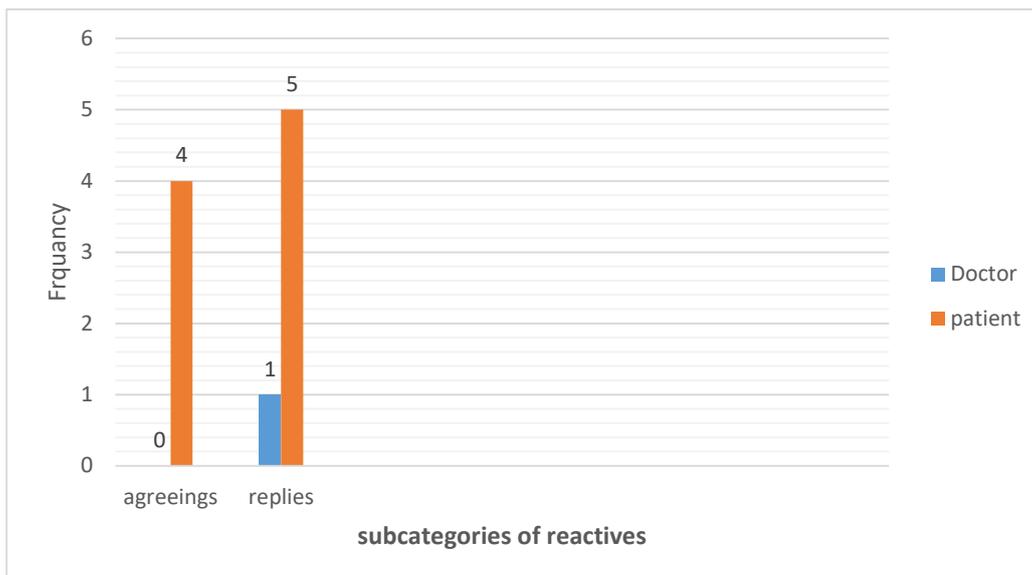


Figure (28): subcategories of reactives.

The six expressives produced in this interview are given by the patient. The patient gives two excuses (IV.32, IV.39), and four approvals (IV.24, IV.28, IV.33, and IV.36).

Below is the figure that demonstrates these details:

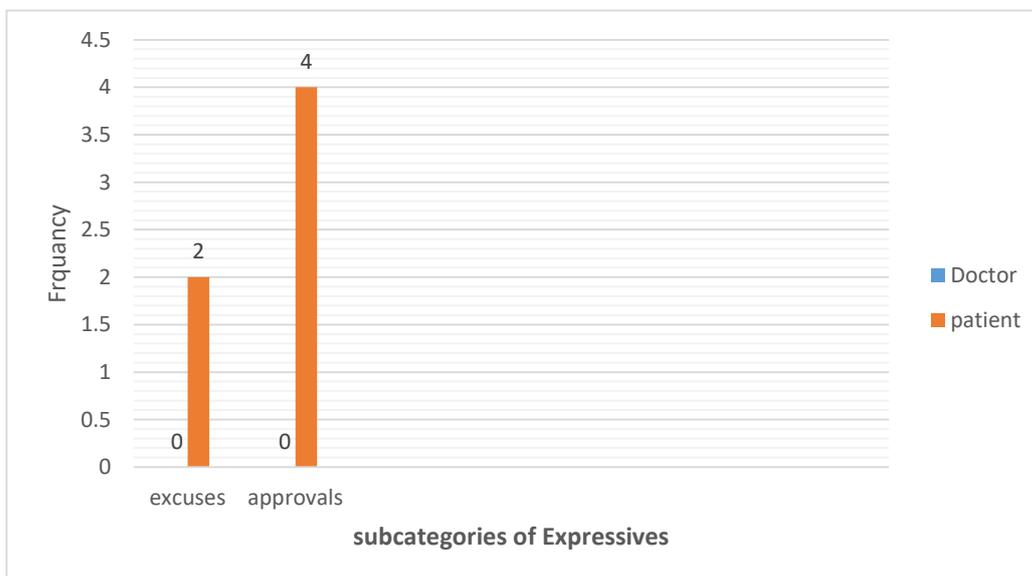


Figure (29): subcategories of Expressives.

There are four commissives performed in this interview; two of them are performed by the doctor and they are assurances (IV.38, IV.40); the other two assurances are performed by the patient (IV.11, IV.25). The below figure illustrates these remarks:



Figure (30): subcategories of commissives.

This interview, furthermore, contains eleven creators of expectation. The doctor produces six creators of expectation, four are fillers (IV.3, IV.4, IV.5, and IV.9), one is a conclusive (IV.36), and one is a turn-taking (IV.18). The other five creators are produced by the patient, four are introductives (IV.16, IV.19, IV.26, and IV.29), and one is a turn-taking (IV.20). Figure (31) shows these details:

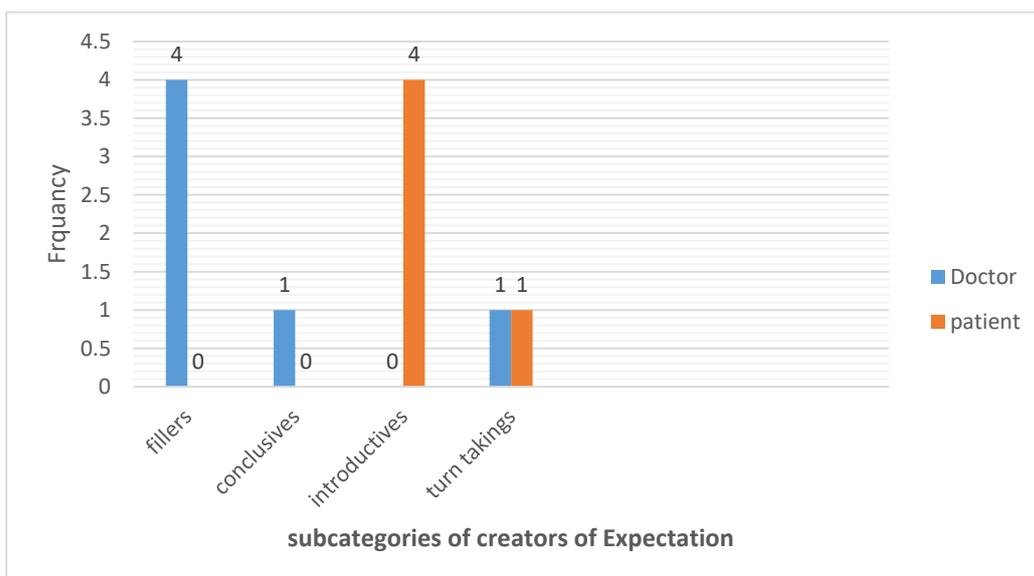


Figure (31): subcategories of creators of Expectation.

Briefly, the following are both a table and figure which illustrate the frequency distribution of speech acts categories and subcategories in the first interview.

Table (4): General frequency distribution of speech acts categories in Interview IV

categories	Doctor	Patient	Total	%D	%P	%T
Statement	9	18	27	33.33%	66.67%	28.72%
assertions	2	3	5	40.00%	60.00%	5.32%
stipulations	3	8	11	27.27%	72.73%	11.70%
illustrations	0	1	1	0.00%	100.00%	1.06%
evaluations	1	0	1	100.00%	0.00%	1.06%
reports	0	1	1	0.00%	100.00%	1.06%
explanations	2	5	7	28.57%	71.43%	7.45%
inferences	1	0	1	100.00%	0.00%	1.06%
Directives	15	0	15	100.00%	0.00%	15.96%
requests	10	0	10	100.00%	0.00%	10.64%
offers	1	0	1	100.00%	0.00%	1.06%
persuades	4	0	4	100.00%	0.00%	4.26%
Questions	18	3	21	85.71%	14.29%	22.34%
yes-No	8	0	8	100.00%	0.00%	8.51%
information	7	1	8	87.50%	12.50%	8.51%
make sure	3	2	5	60.00%	40.00%	5.32%
reactives	1	9	10	10.00%	90.00%	10.64%
Agreeings	0	4	4	0.00%	100.00%	4.26%
Replies	1	5	6	16.67%	83.33%	6.38%
Expressives	0	6	6	0.00%	100.00%	6.38%
Excuses	0	2	2	0.00%	100.00%	2.13%
Approvals	0	4	4	0.00%	100.00%	4.26%
commissives	2	2	4	50.00%	50.00%	4.26%
Assurance	2	2	4	50.00%	50.00%	4.26%
creators of Expectation	6	5	11	54.55%	45.45%	11.70%
Fillers	4	0	4	100.00%	0.00%	4.26%
Conclusives	1	0	1	100.00%	0.00%	1.06%
introductives	0	4	4	0.00%	100.00%	4.26%
turn takings	1	1	2	50.00%	50.00%	2.13%

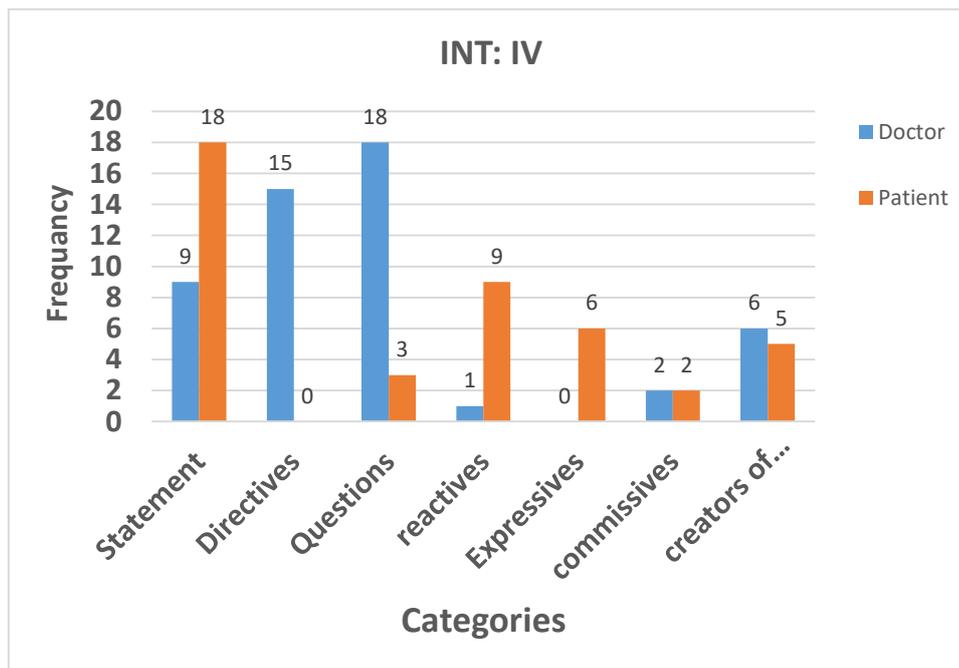


Figure (32): Frequency Distribution of Speech acts categories in Interview IV

4.1.5. Interview V

- Participants: Male senior doctor, age 56; female patient, age 8, literate, student.
- Duration: 3 minutes
- Number of dyadic interactions: 23
- Setting: internal medicine department, Baqubah Teaching Hospital.

The present interview includes ten statements. One of these statements is made by the doctor, i.e. an illustration (V.21).the other nine statements are made by the patient. The patient makes four assertions (V.7, V.12, V.14, and V.15), two stipulations (V.6, V.10), one report (V.9), and two explanations (V.8, V.11). Figure (33) clarifies this statistics:

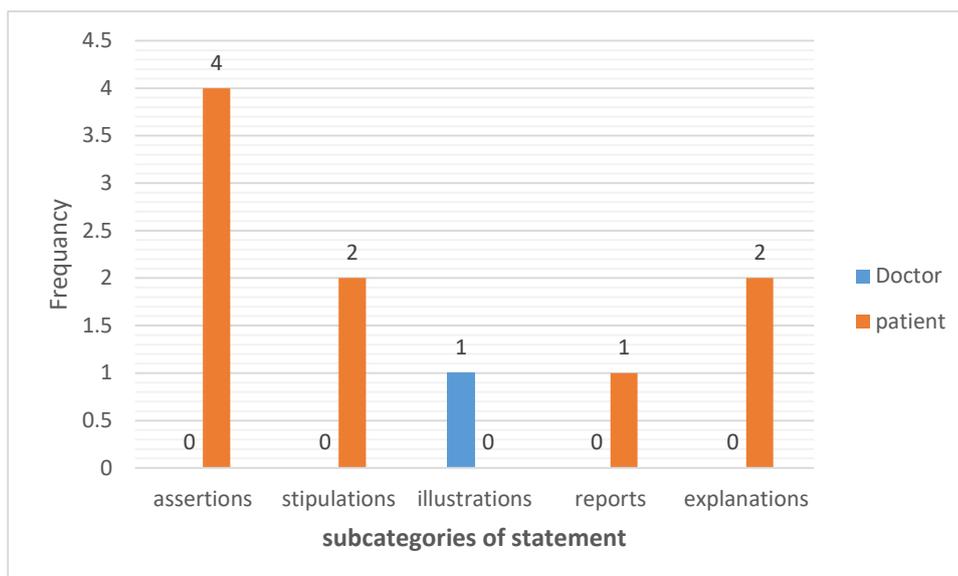


Figure (33): subcategories of statement.

There are four directives in this interview. All of them are requests and made by the doctor (V.18, V.19, V.20, and V.23). This statistics shown in figure (34):

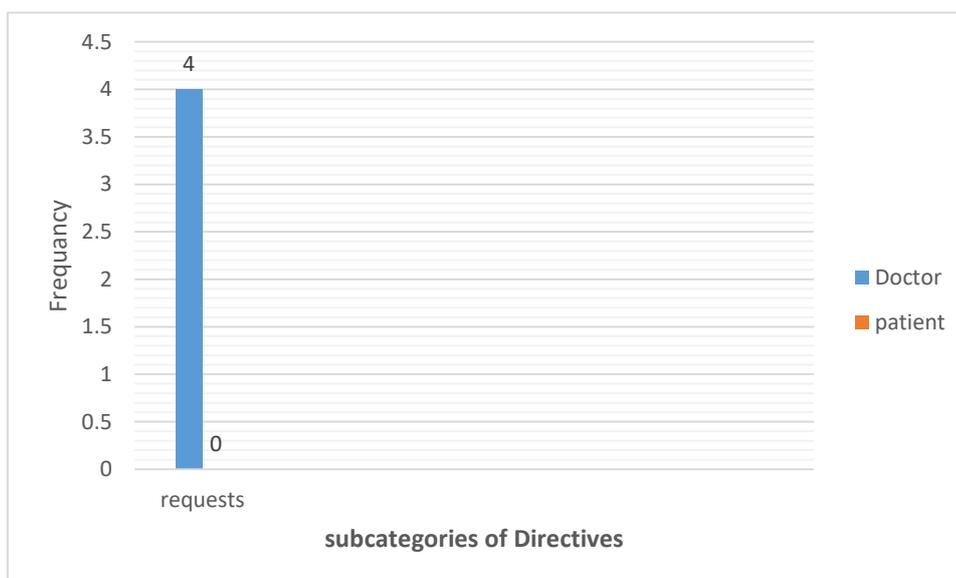


Figure (34): subcategories of Directives.

There are, in addition, fifteen questions raised by the two participants. The doctor, on one hand, raises fourteen question. Seven of these are information questions (V.1, V.3, V.5, V.6, V.7, V.10, and V.22), three are yes/no questions (V.4, V.16, and V.17), and four are make sure-questions (V.2, V.8, V.9, and V.13). The patient, on the other hand, raises only one information question (V.20). See the following figure:

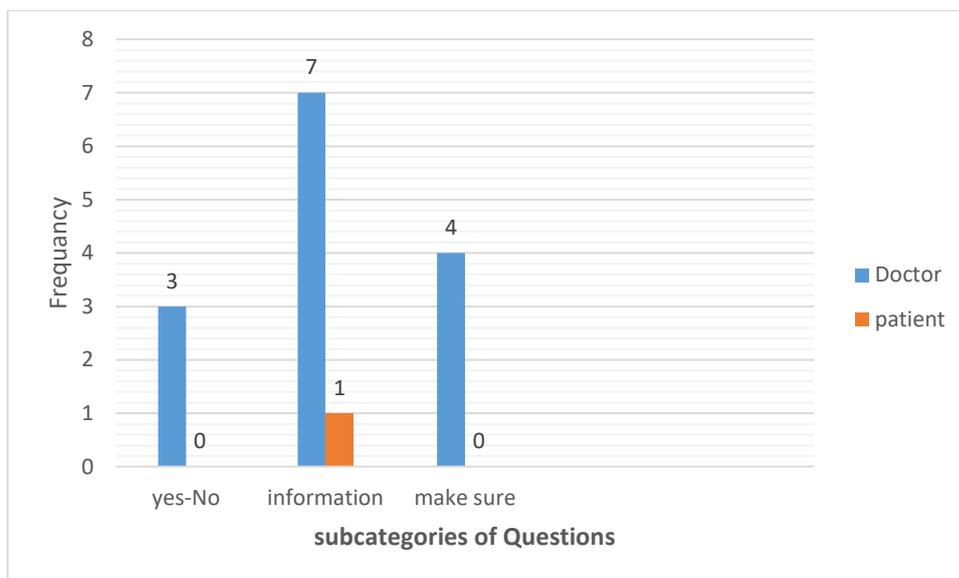


Figure (35): subcategories of Questions.

As far as the reactives are concerned, the patient produces eight reactives. One of these is an agreeing (V.21), the other seven are replies (V.1, V.3, V.4, V.5, V.16, V.17, and V.22). This is quite clear in figure (36):

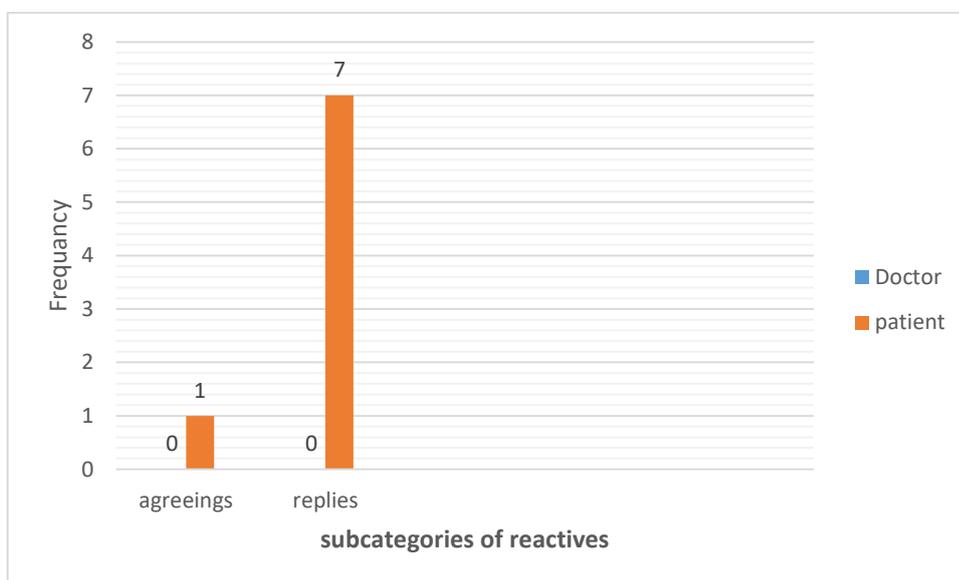


Figure (36): subcategories of reactives.

There are two expressive produced by the two participants as illustrated in figure (37). One is a praise and raised by the doctor (V.6); the other one is an excuse and given by the patient (V.8).

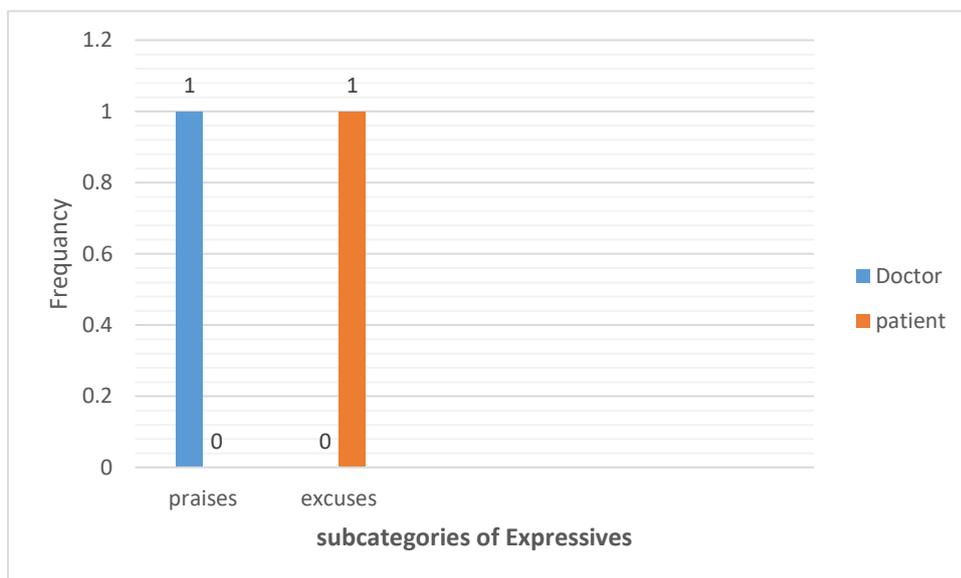


Figure (37): subcategories of Expressive.

The patient in this interview gives two commissives and both of them are assurances (V.2, V.13).

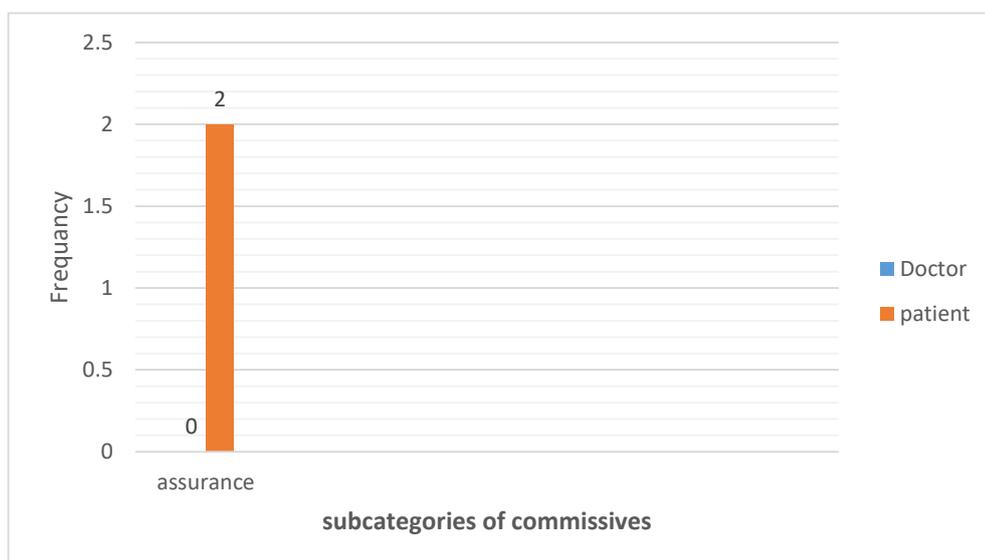


Figure (38): subcategories of Commissives

The doctor in this interview produces five creators of expectation; four are fillers (V.12, V.14, V.15, and V.16), and one is a turn-taking (V.11). See figure (39).

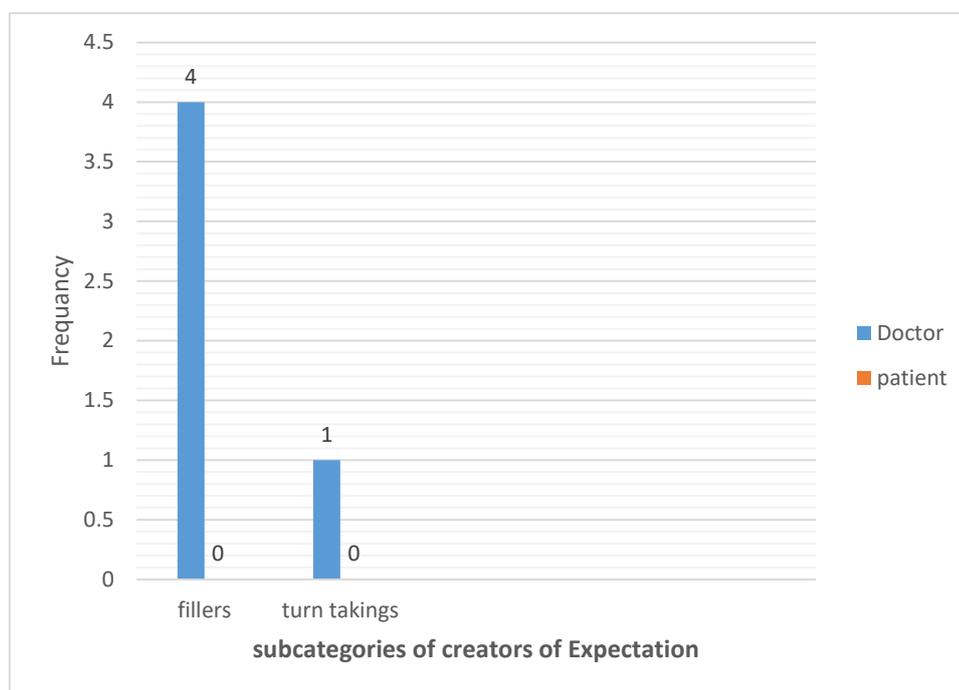


Figure (39): subcategories of creators of Expectation.

In short, the following are both a table and figure which illustrate the frequency distribution of speech acts categories and subcategories in the fifth interview.

Table (5): General frequency distribution of speech acts categories in Interview V

Categories	Doctor	Patient	Total	%D	%P	%T
Statement	1	9	10	10.00%	90.00%	21.74%
Assertions	0	4	4	0.00%	100.00%	8.70%
Stipulations	0	2	2	0.00%	100.00%	4.35%
Illustrations	1	0	1	100.00%	0.00%	2.17%
Reports	0	1	1	0.00%	100.00%	2.17%
explanations	0	2	2	0.00%	100.00%	4.35%
Directives	4	0	4	100.00%	0.00%	8.70%
requests	4	0	4	100.00%	0.00%	8.70%
Questions	14	1	15	93.33%	6.67%	32.61%
yes-No	3	0	3	100.00%	0.00%	6.52%
information	7	1	8	87.50%	12.50%	17.39%
make sure	4	0	4	100.00%	0.00%	8.70%
reactives	0	8	8	0.00%	100.00%	17.39%
agreeings	0	1	1	0.00%	100.00%	2.17%
replies	0	7	7	0.00%	100.00%	15.22%
Expressives	1	1	2	50.00%	50.00%	4.35%
praises	1	0	1	100.00%	0.00%	2.17%
excuses	0	1	1	0.00%	100.00%	2.17%
commissives	0	2	2	0.00%	100.00%	4.35%
assurance	0	2	2	0.00%	100.00%	4.35%
creators of Expectation	5	0	5	100.00%	0.00%	10.87%
Fillers	4	0	4	100.00%	0.00%	8.70%
turn takings	1	0	1	100.00%	0.00%	2.17%

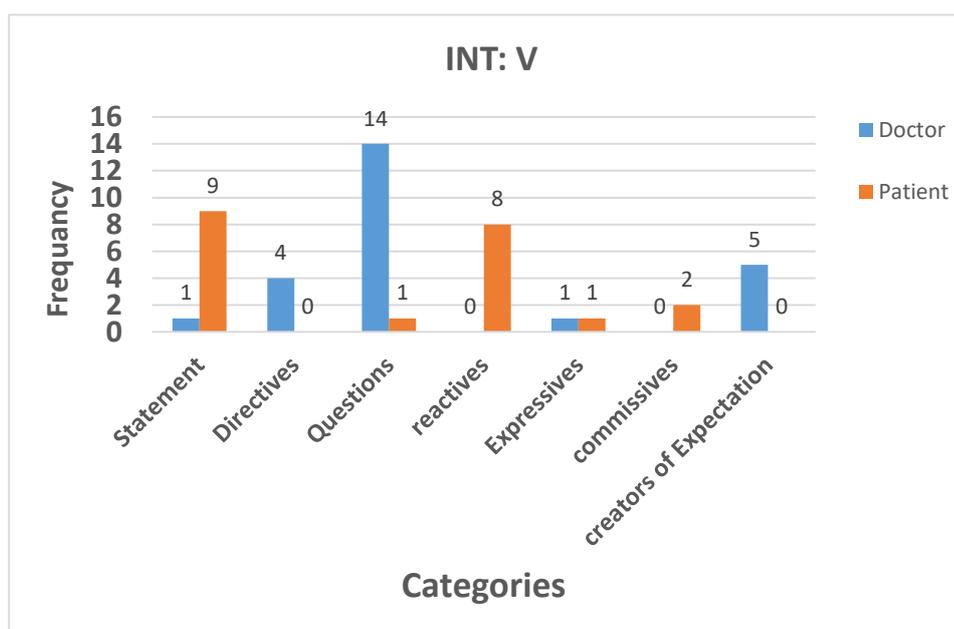


Figure (40): Frequency Distribution of Speech acts categories in Interview V

4.1.6. Interview VI

- Participants: Female senior doctor, age 53; female patient, age 39, literate, retired.
- Duration: 4 minutes
- Number of dyadic interactions: 29
- Setting: internal medicine department, Baqubah Teaching Hospital

The two participants in this interview make twenty-one statements. The doctor makes ten of these statements; four are assertions (VI.13, VI.20, VI.25, and VI.27), three are stipulations (VI.17, VI.18, and VI.26), and another three are inferences (VI.8, VI.12, and VI.13). The patient, however, makes the other eleven statements. She makes two assertions (VI.6, VI.22), and nine stipulations (VI.1, VI.2, VI.4, VI.9, VI.10, VI.11, VI.15, VI.19, and VI.20). Figure (41) elucidates that:

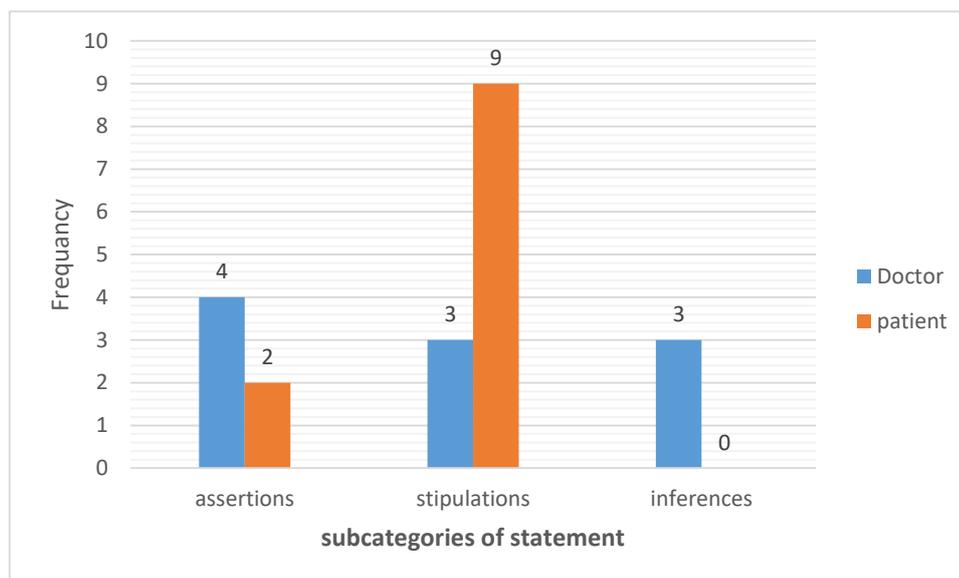


Figure (41): subcategories of statement.

All the directives in the present interview are produced by the doctor. They are two requests (VI.17, VI.23), and one offer (VI.17). This quite clear in figure (42).

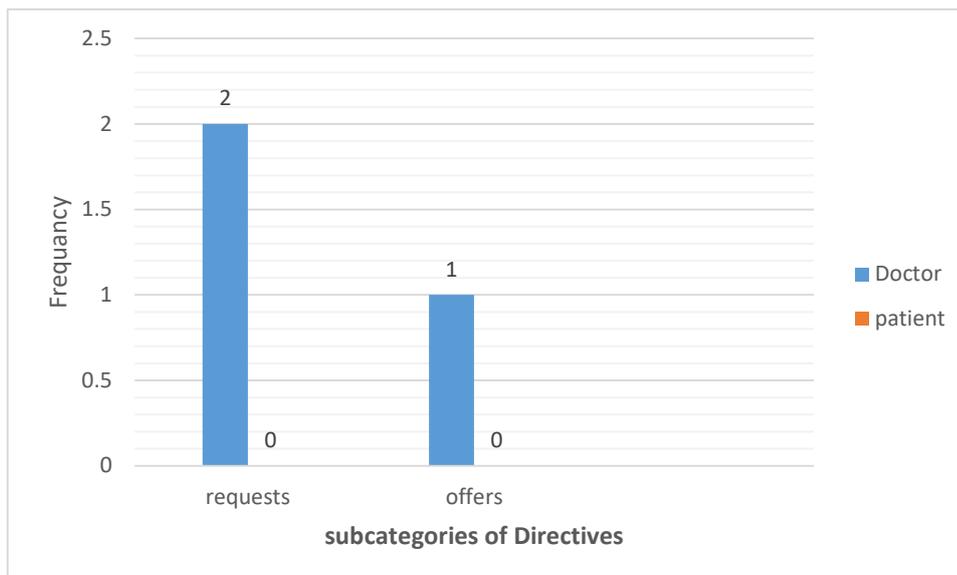


Figure (42): subcategories of Directives.

As far as questions are concerned, the interview comprises twenty-one questions. Fifteen of them are produced by the doctor; two are yes/no questions (VI.21, VI.22), ten are information questions (VI.1, VI.2, VI.3, VI.4, VI.6, VI.9, VI.10, VI.11, VI.15, and VI.19), and three are make-sure questions (VI.5, VI.7, and VI.24). On the other hand, the patient raises six questions; two are yes/no questions (VI.8, VI.13), three are information questions (VI.15, VI.16, and VI.17), and one is a make-sure question (VI.27). See the figure (43):

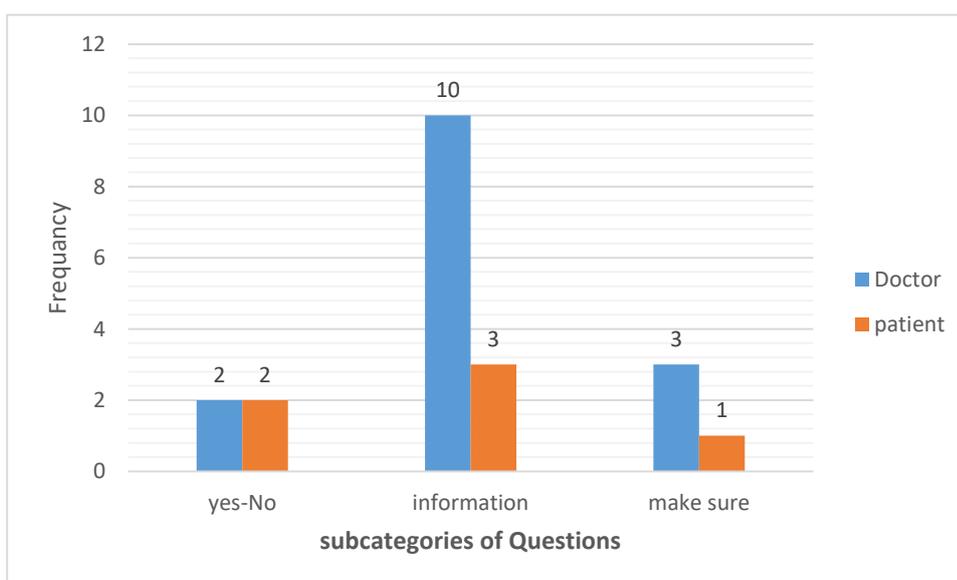


Figure (43): subcategories of Questions.

There are thirteen reactives in this interview as pointed out in figure (44). Four of them are replies and produced by the doctor (VI.9, VI.14, VI.17, and VI.18). The patient, besides, makes nine reactives; four are agreeings (VI.12, VI.18, VI.23, VI.28), two are disagreeing (VI.14, VI.24), and three are replies (VI.1, VI.3, VI.21).

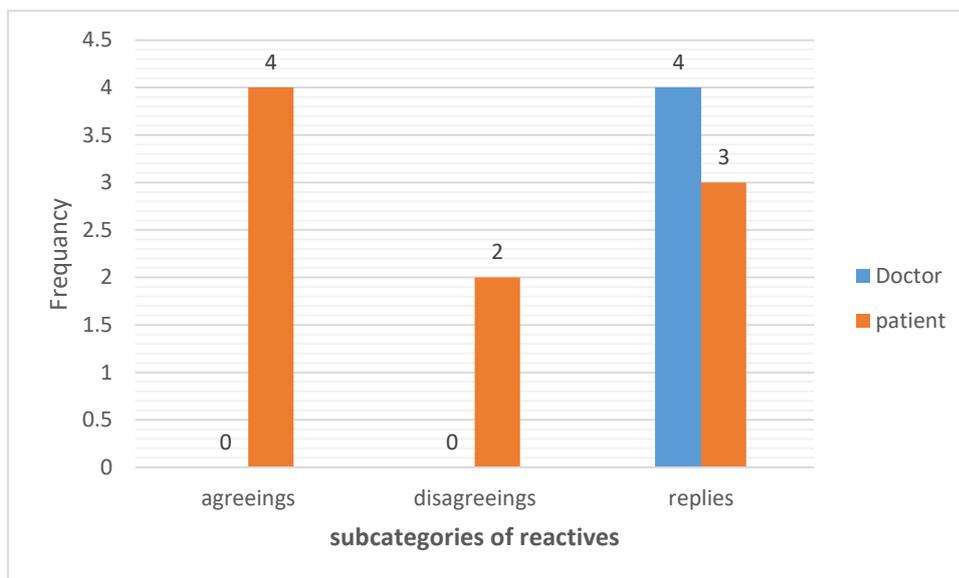


Figure (44): subcategories of reactives.

Figure (45) clarifies that expressives in this interview are three and all of them are raised by the patient; one is a thanking (VI.28), and two are pleads (VI.15, VI.25).

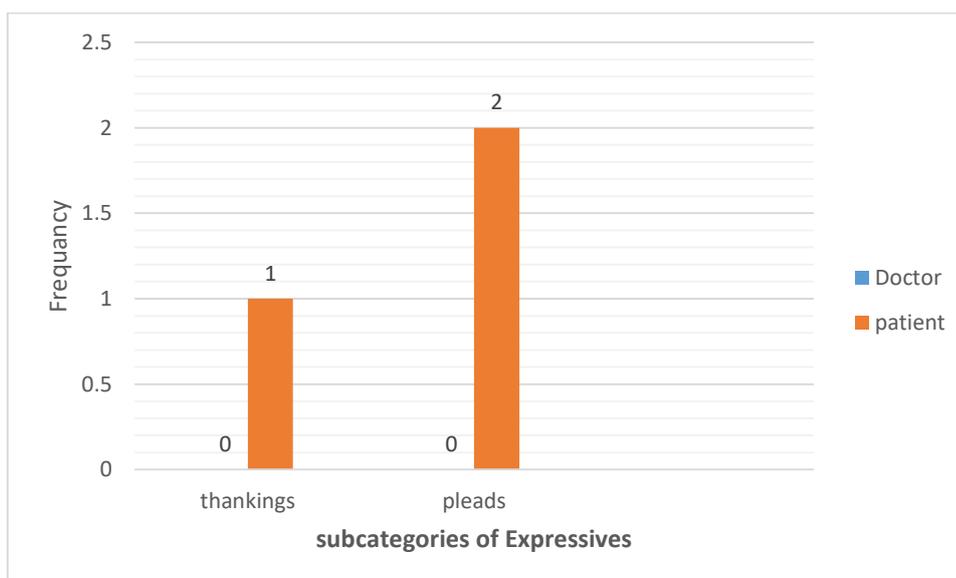


Figure (45): subcategories of Expressives.

There are four commissives in the present interview. The doctor raises two of them; one is an assurance (VI.28), and the other one is a guarantee (VI.16). The patient raises the other two commissives and they are assurances (VI.5, VI.7). figure (46) illustrates this:

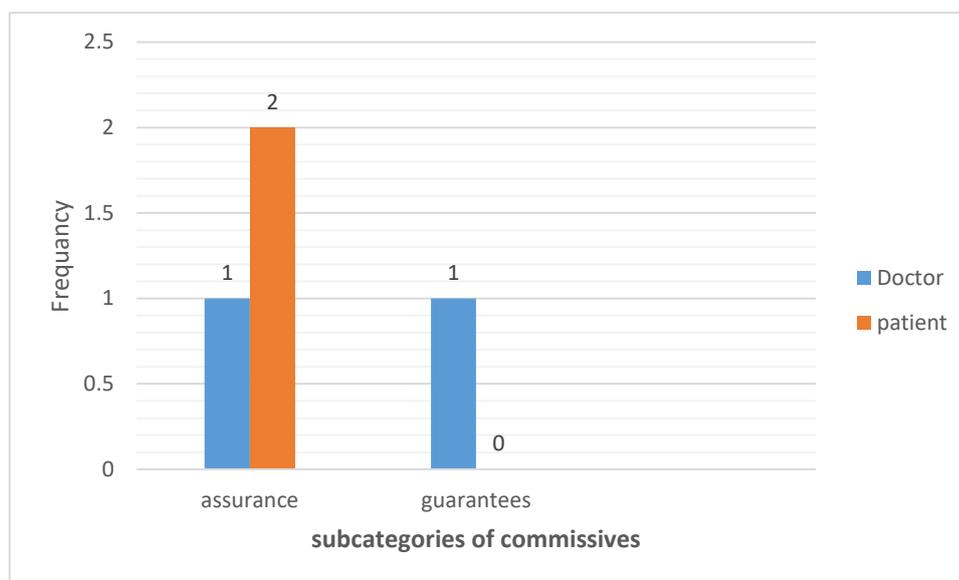


Figure (46): subcategories of commissives.

This interview, moreover, contains five creators of expectation. The doctor, on one hand, produces three fillers (VI.2, VI.15, and VI.20). The patient, on the other hand, produces two creators; one filler (VI.8), and one introductory (VI.26). See the following figure:

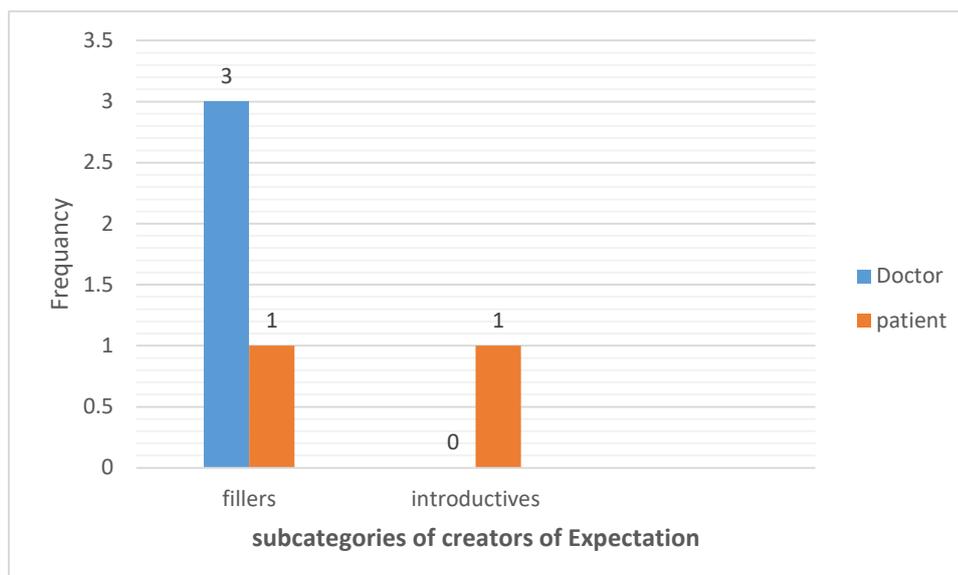


Figure (47): subcategories of creators of Expectation.

In brief, the following are both a table and figure which illustrate the frequency distribution of speech acts categories and subcategories in the sixth interview.

Table (6): General frequency distribution of speech acts categories in Interview VI

Categories	Doctor	Patient	Total	%D	%P	%T
Statement	10	11	21	47.62%	52.38%	30.00%
assertions	4	2	6	66.67%	33.33%	8.57%
stipulations	3	9	12	25.00%	75.00%	17.14%
inferences	3	0	3	100.00%	0.00%	4.29%
Directives	3	0	3	100.00%	0.00%	4.29%
requests	2	0	2	100.00%	0.00%	2.86%
offers	1	0	1	100.00%	0.00%	1.43%
Questions	15	6	21	71.43%	28.57%	30.00%
yes-No	2	2	4	50.00%	50.00%	5.71%
information	10	3	13	76.92%	23.08%	18.57%
make sure	3	1	4	75.00%	25.00%	5.71%
reactives	4	9	13	30.77%	69.23%	18.57%
agreeings	0	4	4	0.00%	100.00%	5.71%
disagreeings	0	2	2	0.00%	100.00%	2.86%
replies	4	3	7	57.14%	42.86%	10.00%
Expressives	0	3	3	0.00%	100.00%	4.29%
thankings	0	1	1	0.00%	100.00%	1.43%
pleads	0	2	2	0.00%	100.00%	2.86%
commissives	2	2	4	50.00%	50.00%	5.71%
assurance	1	2	3	33.33%	66.67%	4.29%
guarantees	1	0	1	100.00%	0.00%	1.43%
creators of Expectation	3	2	5	60.00%	40.00%	7.14%
fillers	3	1	4	75.00%	25.00%	5.71%
introductives	0	1	1	0.00%	100.00%	1.43%

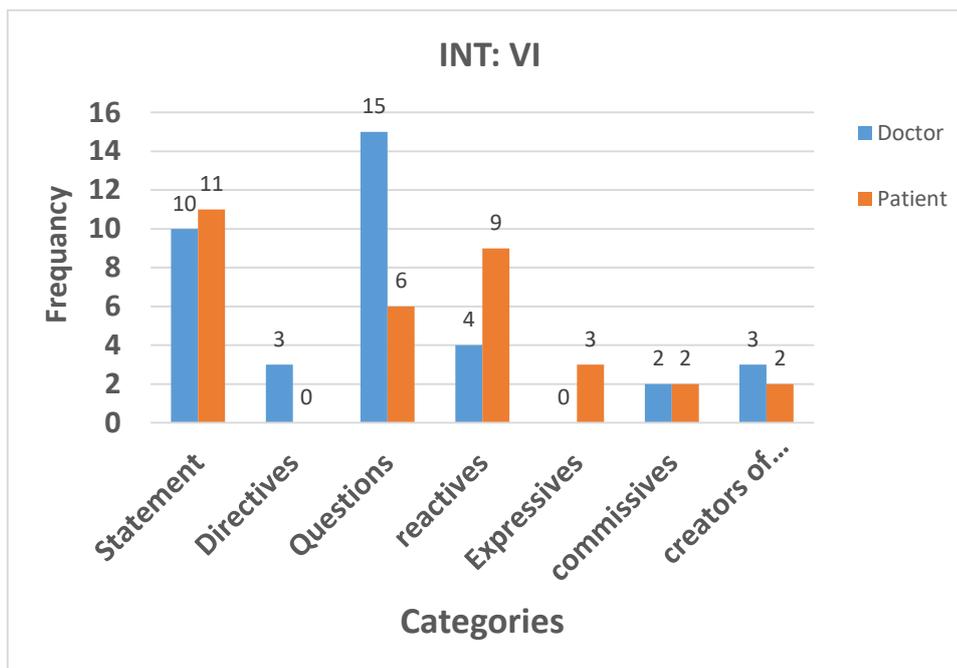


Figure (48): Frequency Distribution of Speech acts categories in Interview VI

4.1.7. Interview VII

- Participants: Male senior doctor, age 56; male patient, age 16, literate, student.
- Duration: 5 minutes
- Number of dyadic interactions: 19
- Setting: internal medicine department, Baqubah Teaching Hospital.

The statements in the present interview are ten. Four of them are made by the doctor; one is an assertion (VII.5), one is a stipulation (VII.17), and two are explanations (VII.15, VII.13). The patient, besides, makes the other six statements; two assertions (VII.1, VII.9), three stipulations (VII.2, VII.4, and VII.15), and one illustration (VII.11). Figure (49) explains this statistics.

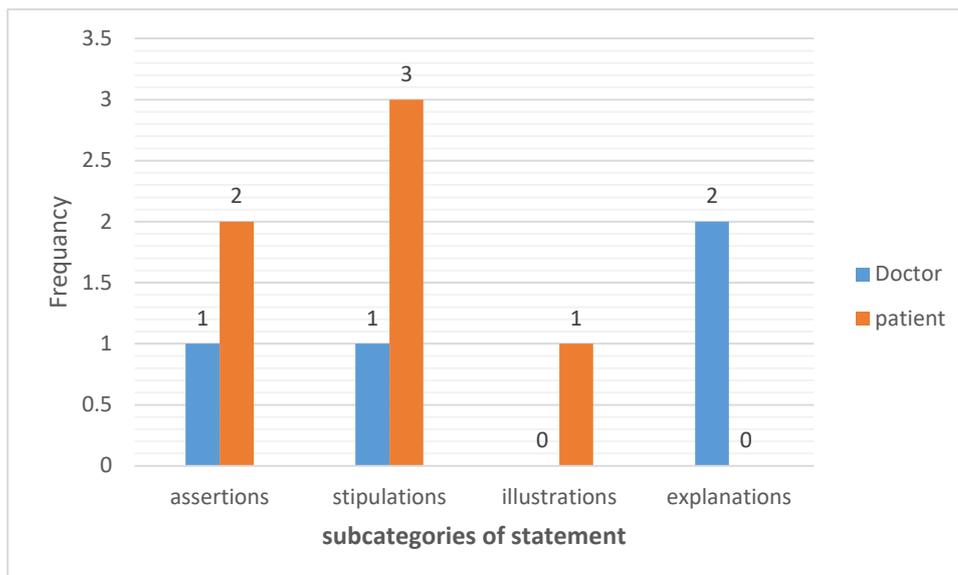


Figure (49): subcategories of statement.

The examination of the present interview indicates that the doctor makes all the directives, and all of them are requests (VII.11, VII.13, and VII.16). See figure (50):

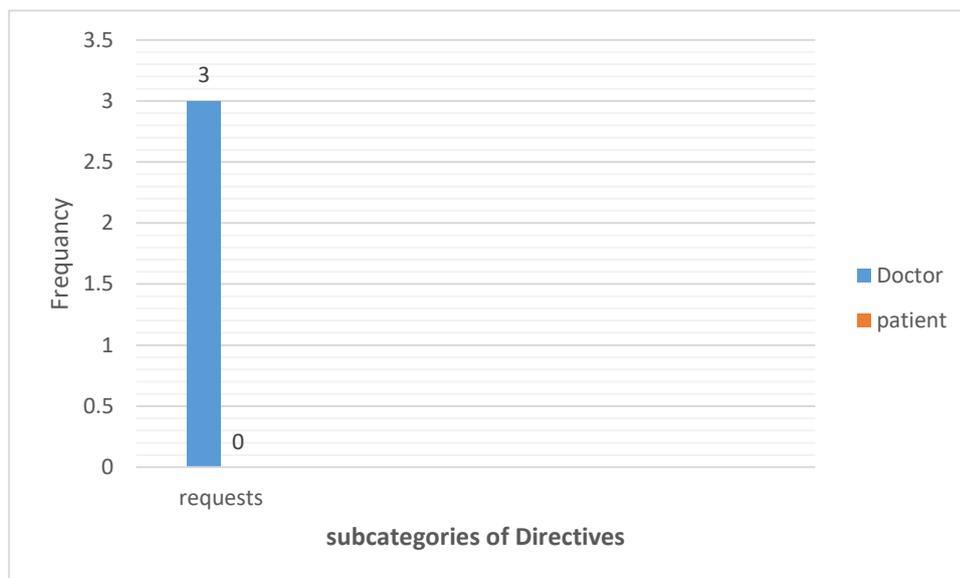


Figure (50): subcategories of Directives.

The two participants in this interview as indicated in figure (51) raise twelve questions. The doctor raises eleven questions, four of them are yes/no questions (VII.3, VII.4, VII.7, and VII.10), four are information questions (VII.1, VII.2, VII.9, and VII.11), and three are make sure question (VII.6, VII.8, and VII.12). Besides, the patient raises only one yes/no question (VII.13).

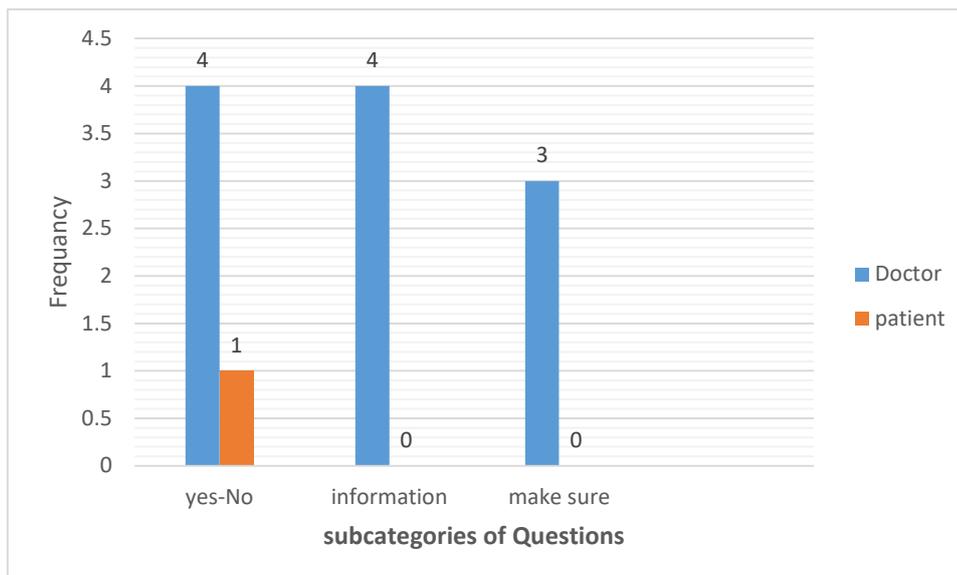


Figure (51): subcategories of Questions.

Reactives in this interview are seven. The doctor reacts once with a reply (VII.14). The patient, however, reacts six times. One is an agreeing (VII.19), one is a disagreeing (VII.5), and four are replies (VII.3, VII.4, VII.7, and VII.10). Figure (52) illustrates the above statistics:

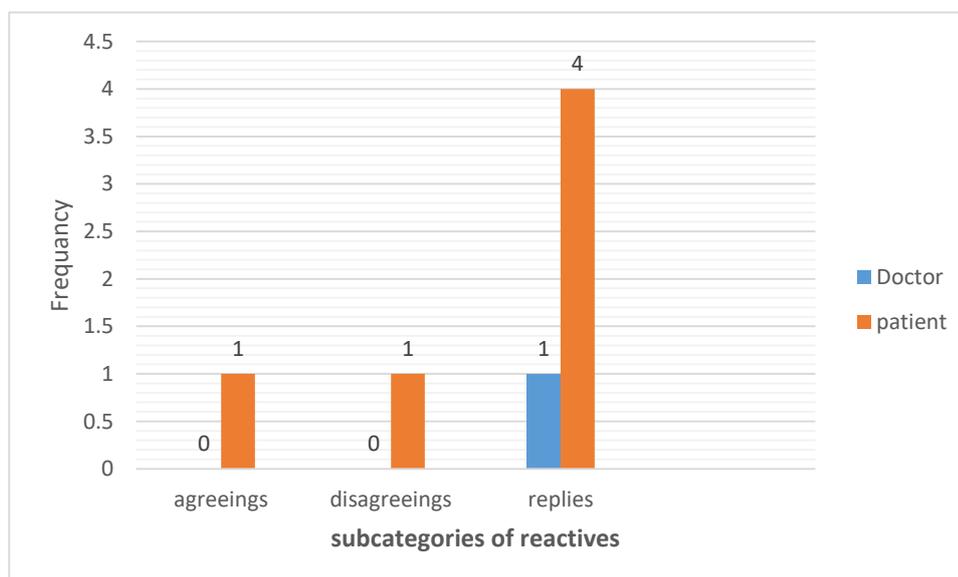


Figure (52): subcategories of reactives.

With respect to expressives, there are three of them in this interview that are produced by the patient; one is a thanking (VII.19), one is an attention (VII.16), and one is an approval (VII.17). Figure (53) shows these details:

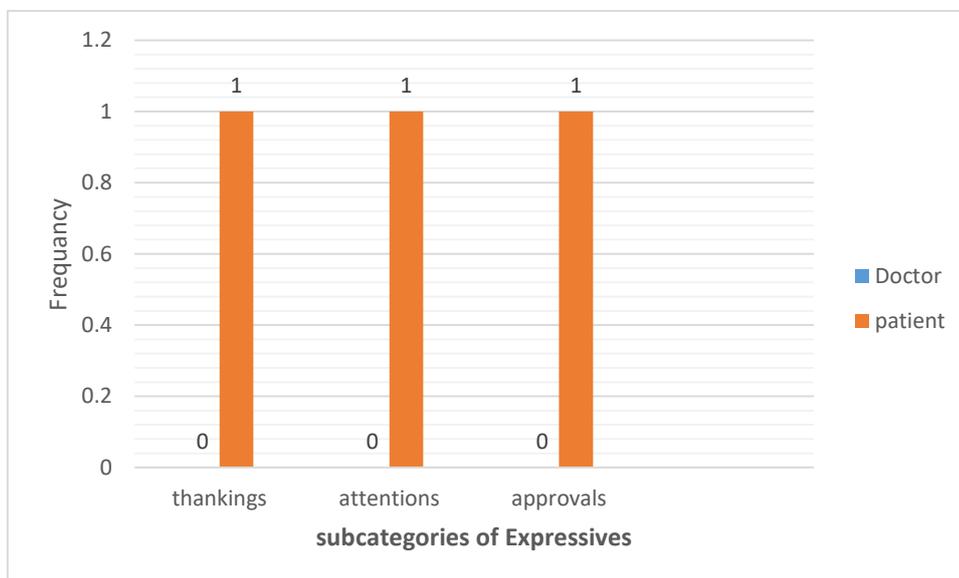


Figure (53): subcategories of Expressives.

As far as commissives are concerned, the doctor and the patient give five of them. The doctor gives three commissives; one is a promise (VII.19), and the other two are guarantees (VII.13, VII.16). The patient, besides, gives two assurances (VII.6, VII.8). See figure (54) below:

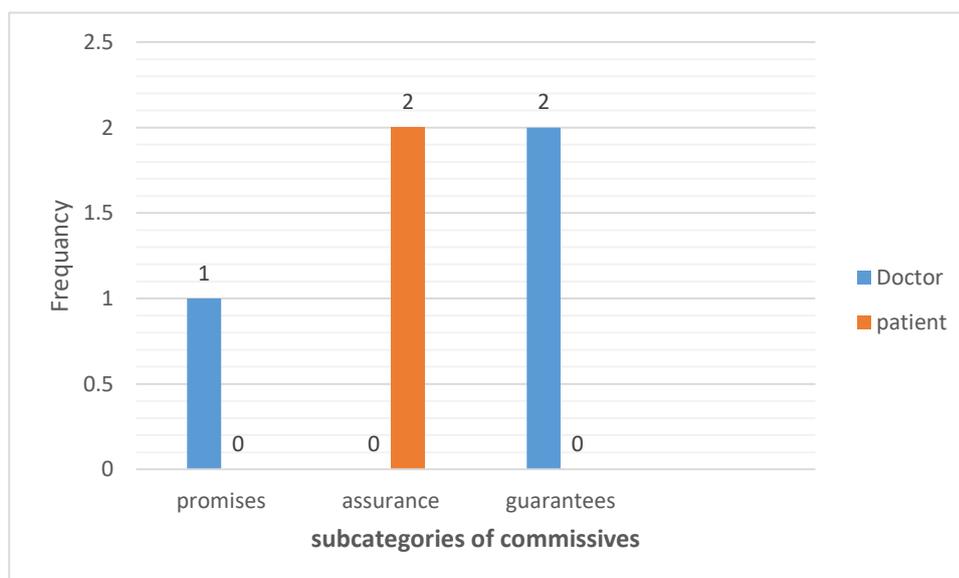


Figure (54): subcategories of commissives.

Five creators of expectations are given in this interview. As indicated in figure (55), the doctor gives three of them that are fillers (VII.2, VII.9, and VII.18). The patient gives the other two fillers (VII.14, VII.18).

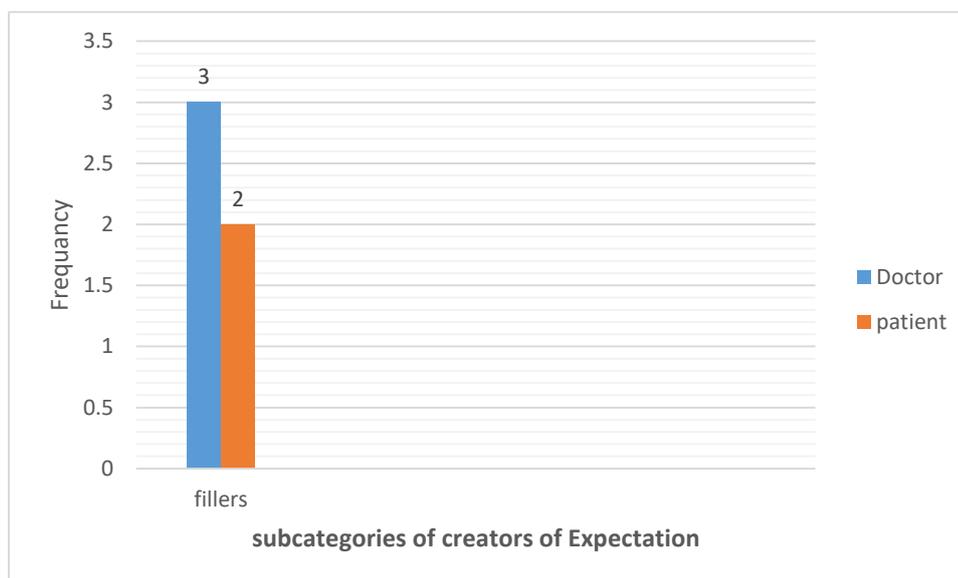


Figure (55): subcategories of creators of Expectation.

Finally, the following are both a table and figure which illustrates the frequency distribution of speech acts categories and subcategories in the seventh interview:

Table (7): General frequency distribution of speech acts categories in Interview VII

categories	Doctor	Patient	Total	%D	%P	%T
Statement	4	6	10	40.00%	60.00%	22.22%
assertions	1	2	3	33.33%	66.67%	6.67%
stipulations	1	3	4	25.00%	75.00%	8.89%
illustrations	0	1	1	0.00%	100.00%	2.22%
explanations	2	0	2	100.00%	0.00%	4.44%
Directives	3	0	3	100.00%	0.00%	6.67%
requests	3	0	3	100.00%	0.00%	6.67%
Questions	11	1	12	91.67%	8.33%	26.67%
yes-No	4	1	5	80.00%	20.00%	11.11%
information	4	0	4	100.00%	0.00%	8.89%
make sure	3	0	3	100.00%	0.00%	6.67%
reactives	1	6	7	14.29%	85.71%	15.56%
agreeings	0	1	1	0.00%	100.00%	2.22%
disagreeings	0	1	1	0.00%	100.00%	2.22%
replies	1	4	5	20.00%	80.00%	11.11%
Expressives	0	3	3	0.00%	100.00%	6.67%
thankings	0	1	1	0.00%	100.00%	2.22%
attentions	0	1	1	0.00%	100.00%	2.22%
approvals	0	1	1	0.00%	100.00%	2.22%
commissives	3	2	5	60.00%	40.00%	11.11%
promises	1	0	1	100.00%	0.00%	2.22%
assurance	0	2	2	0.00%	100.00%	4.44%
guarantees	2	0	2	100.00%	0.00%	4.44%
creators of Expectation	3	2	5	60.00%	40.00%	11.11%
fillers	3	2	5	60.00%	40.00%	11.11%

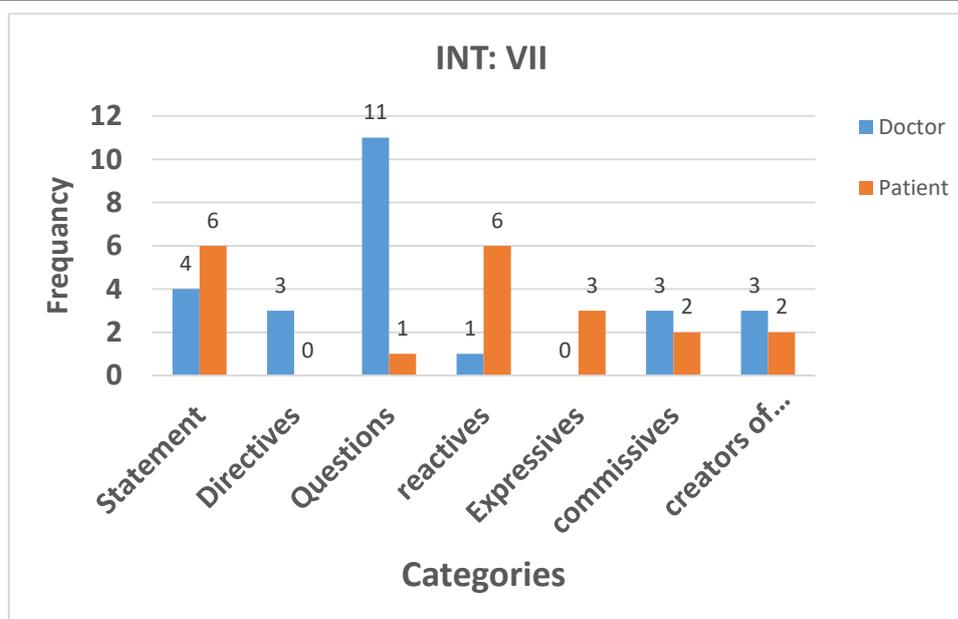


Figure (56): Frequency Distribution of Speech acts categories in Interview VII

Chapter Five

Discussion, Conclusion and Recommendations

5.0. Introduction

In the present chapter the researcher introduces a brief discussion of the study questions and attempts to explain the results in the light of what had been reported in Chapter Four and the reviewed literature. This chapter ends with conclusion and recommendations for future literature.

5.1. Discussion of the Study Results:

Due to the nature of the discourse, i.e. questions/ response, the most common of the speech acts categories are the questions and statements. The doctor, who is in charge of eliciting information from the patient, raises the questions, which are requests for information while the patient responds in many various ways. Nevertheless. The patient makes statements to cope with the linguistic behavior of the doctor. So, this leads to the fact that the quantity of the linguistic behavior is not the chief factor in deciding who controls over the interaction. The quality of the linguistic behavior decides who may control or guide the speech event, the medical interview.

In the medical interview patients perform the largest number of statements. This is because of their position as interviewees where they state their illness, and their need for medication. Stipulations and explanations are mainly performed by the patient, whereby they try to provide as much information as they can in relation to what the doctor wants. Moreover, doctors use statements but comparatively fewer in number. Assertions are the most of the subcategories of statements that are used by the doctors, this is because the doctors, sometimes, try to know what the patient may think indirectly, i.e. without using questions. Moreover, the doctor may sometimes encourage the patient to interact

effectively to the aim of diagnosing the illness. Reports are solely used by the patients to tell the doctor about previous medications and diagnosis, and assertions made by other doctors.

Doctors frequently use questions as devices to elicit information. Information questions are used when detailed and extensive information is required. This device gives the patient an opportunity to behave, linguistically, more than usual. Nevertheless, the use of information question would let the patient state matters more than performing other acts, and medically, it is referred to as open questions. Yes/no questions are used when the patient is weak, reluctant, or hesitant; and sometimes the lack of time is one of the reasons that necessitate the use of yes/no questions which is medically referred to as leading questions.

Directives appear to be mostly produced by the doctors. This speech acts category is a distinctive feature of the doctor's linguistic behavior in the case-history taking interview. The doctor gives requests for the patient to act according to his will, this enhances the assumption that the doctor really controls the medical interview. This is particularly obvious in the interviews where the doctor conducts a physical examination; he asks the patient to act in a certain way rather than another.

Reactives are largely realized in these interviews by replies. Patients perform the largest number of this speech acts category. They react to the linguistic behavior of the doctors, i.e. they reply to the questions raised by the doctors, especially the yes/no questions. Furthermore, agreeings, are more recurrent in the speech of patients, this shows that the patient react in accordance with the doctor's domination over the interview.

Expressives are realized in the interviews and are majorly performed by the patients. The use of this speech acts category is a sign of an attempt to build a mutual ground for understanding. Expressives help establish a sort of intimate relationship

between the two participants. The use of various types of expressives may be due to the need of patients for care and sympathy. The doctor, on the other hand, attempts to win the trust of his patient in order to obtain as reliable results as possible.

Commissives are produced in the interviews and realized by the frequent use of assurances. Assurances are mainly used by the patients to make the doctor be assured of the assertions and stipulations he himself makes. The other commissives manipulated are promises and guarantees. The doctor tends to give promises and guarantees trying to grease the relationship with his patient. So, it can be a device to draw the patient into an interaction in which he may talk and hence provide the required information for the doctor.

Doctors perform most of the creators of expectation. They make the larger number of fillers and turn-takings. This definitely shows that doctors try to let the patient feel relaxed and participate effectively in the interview. Creators of expectation help make the interview more coherent and fluent; henceforth, the doctor is provided with the adequate information to diagnose. This declares that the doctor's linguistic behavior monitors the patient's in this setting. Nonetheless, the patient also gives a large number of fillers.

This study goes side by side with Cerny's study (2007) which suggests that speech acts can be understood as acts of communication. These acts are usually classified into five categories: declarations, representatives, expressives, directives, and commissives. A distinction is also made between direct and indirect speech acts.

Another study is congruent with Cerny (2017) which claims that certain utterance types are far more frequent either on the part of the doctor or on the part of the patient and also he found that the most numerous group of speech acts is the category of statements, while the least numerous category are commissives.

This analysis indicates that there are doctor-raised acts and patient-raised ones. In the table (8) below it is clear that there is no great difference in number between the two raised acts. The difference does not make that gap except in interviews (**I, III, IV**). The doctor, in interview **I**, produces fifty-five speech acts while the patient forty-nine. In the interview **III**, the doctor makes fifty-six speech acts while the patient sixty-two. Moreover, the doctor, in interview **IV**, produces fifty-one speech acts while the patient forty-three.

Interview	Doctor	Patient	Total
I	55	49	104
II	26	24	50
III	56	62	118
IV	51	43	94
V	25	21	46
VI	37	33	70
VII	25	20	45

Table (8) Speech Acts Categories in the Seven Interviews

All of the above indicates that the two participants in this kind of interviews are committed to a certain course of action. Each participant realize that he is not free to behave linguistically; he is connected to the other participant's linguistic behavior. The doctor follows the procedures of eliciting information to the aim of diagnosing the real illness, while the patient is conscious of his situation as being unequal and hence verbally and medically supervised by the doctor.

5.2. Conclusion

Investigating the case-history taking interviews in terms of speech acts categories include revealing a certain pattern of linguistic behavior, i.e. doctors and patients have been conscious of the setting they are in. The doctor questions and the patient answers.

The intimate relationship between the two participants is revealed by the use of reactives and expressives, particularly on the part of the patient. This enhances the assumption that in the medical interview the relationship, though professional, is not mechanical. Furthermore, there appear to be general differences between the doctors and the patients, with regard to the use of questions and statements, the reason of which is the nature of the interview elicitation of information.

The present study indicates a presentation of relatively new modified procedures in the analysis of interviews. It assumes that these procedures are comparatively adequate to tackle this sort of speech event. These procedures claim to be flexible in dealing with spoken form of language.

Eventually, this research has concluded that the doctor controls over, and in a position of supervisor in, the medical interview, because he has the role of initiation; initiative operate as controllers over the speech event.

5.3. Recommendations

As far as the results of the study are concerned, the researcher suggests the following recommendations:

1. As the study concentrates on the functions and uses of language, other factors are not taken to be decisive. So, a further investigation of this field is required.
2. Considering speech acts in other fields or occasions such as social speeches.
3. Medical discourse is required to be analyzed in socio and psycholinguistic terms which would help reveal other mechanisms functioning in the linguistic behavior.

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Appendices

Appendix (A)

Interview I

- 1- ط : خير ,شئو تشتكي ؟
م : هنا ألم كلش قوي .
- 2 - ط : شكذ صارلة ؟
م : البارحة الظهر .
- 3 - ط : بس ؟
م : لا فلونزا و سخونة .
- 4- ط : لا اسمعني على الوجع البارحة الظهر بدء ؟
م : أي .
- 5- ط : يعني البارحة الصبح كلشي ما عندك ؟
م : كلشي ما عندي .
- 6- ط : و اتريكت ؟
م : أي , اكلت .
- 7- ط : و الظهر بييش الساعة بدء الوجع ؟
م : من رجعت من الدوام الساعة 10:30 .
- 8- ط : ليس بال 10:30 راجع من الدوام ؟
م : معلم , امتحانات عندي .
- 9- ط : ها يعني مو رجعت علمود الم او
م : لا لا .
- 10- ط : أي ؟
م : بس اني من صعدت السيارة حسيت بألم .
- 11- ط : يعني من الصبح حسيت بالالم !
م : لا يعني من صعدت و وصلوني حسيت بالالم .
- 12- ط : زين ... يعني بالليل من نمت ما عندك الم جان ؟
م : لا الليل كله يوجعني .
- 13- ط : على الليلة قبلها مو البارحة .

- م : لا لا ما عندي ما عندي .
- 14- ط : زين زواع يصير وياه ؟
- م : البارحة اكلت ركية و اليوم ذبيتها .
- 15- ط : يعني لعبان نفس لو زواع ؟
- م : لعبان نفس و شوية ذبيتها .
- 16- ط : زواع ... خروجك عادي ؟
- م : لا يعني يطلع و قبض .
- 17- ط : قبض عندك ؟
- م : أي .
- 18- ط : البارحة تعشيت ؟
- م : بس ركية .
- 19- ط : منشتهي لو شنو ؟
- م : أي ما اشتهي .
- 20- ط : و اليوم تريكت لو لا ؟
- م : شوية هيچ خاشوكتين روبة خليتها بحلكي .
- 21- ط : زين ... زواع ما صار عندك ؟
- م : بس شوية .
- 22- ط : بس ؟
- م : أي شوية .
- 23- ط : سخونة هم صخنت انت كلتي ؟
- م : أي أي سخونة .
- 24- ط : ورا هذا لو قبله جان عندك ؟
- م : لا وياها وياها .
- 25- ط : وياها بدت تصخن ؟
- م : أي وياها .
- 26- ط : أي ... قبل هم شاكي فد شي انت هالشكل ؟
- م : العام جان عندي هنا حصاوية .
- 27- ط : حصوة وين ؟
- م : هنا بالمثانة .

28 - ط : يعني سويت سونار و كالولك حصوة ؟

م : أي كلولي .

29- ط : اصعد افحصك ... ادراك يحركك ؟

م : أي .

30- ط : يقطع ؟

م : ها ؟

31- ط : يقطع ؟

م : أي دكتور عندي هواية سكر .

32- ط : تبول هواية ؟

م : أي .

33- ط : كم مرة تروح للتواليت ؟

م : بالليل 3 مرات هيچ .

34- ط : يعني انت عندك سكر من زمان ؟

م : أي من زمان .

35- ط : عمليات هم مسوي ؟

م : هيچ عمليات خارجية .

36- ط : و الله هو اكو احتمال زائدة دودية .

م : أي دكتور

37- ط : راح نسويلة تحاليل كملياهن جيبهم دا اشوفهم و سويلة هم اشعة

م : التحاليل يطلعن اليوم ؟

38- ط : يطلعن أي

م : انت باقي دكتور ؟

39- ط : باقي أي هاي ال

م : مختبر

40- ط : لا هاي ودي مختبر ذيج الاستشارية .

م : أي ؟

41- ط : و هاي سويلة اشعة .

م : هنا هاي ؟

42- ط : أي .

م : عندي

43- ط : نعم ؟

م : عندي

44- ط : أي مخالف ... سويلياهن عيني نني و جيبلياهم

م : ماشي .

Interview (II)

- 1- ط : أي ... خيرج ؟
 م : صدري يوجعني يعني دائما جكات تصير عندي و يوجعني .
- 2 - ط : شكك صارلة الوجع عندج ؟
 م : و الله اني دا اخذ حبوب همينة .
- 3- ط : شعندج ضغط عندج سكر قبل ؟
 م : غدة عندي .
- 4 - ط : عندج غدة ؟
 م : أي .
- 5- ط : ضغط و سكر ما عندج .. و هذا الوجع مال صدرج منين يجي ... كل شكك ؟
 م : و الله من اتعب
- 6- ط : من اتعيبن
 م : أي ... و خاصة بالليل ميخليني انام
- 7- ط : من انتي كاعدة ماكو الم ؟
 م : دورات من اتعب
- 8 - ط : يعني بالجهد يزيد
 م : أي هسة من دا انزل فد مرة تعبت
- 9 - ط : ضغط و سكر نهانيا ما عندج
 م : لا ضغط عندي
- 10 - ط : ضغط عندج
 م : بس مو دائما
- 11 - ط : تاخذيلة علاج
 م : أي دا اخذ هاي حبة ام 40
- 12 - ط : أبو 40
 م : أي
- 13 - ط : مسوية فحوصات قبل انت يشي
 م : و الله من زمان ما جاية دكتور
- 14 - ط : من زمان ما جاية
 م : لا لا ما جاية

- 15 - ط : عدكم مشاكل بالقلب بالعائلة بعمر مبكر
 م : لا من صارت عندي مشاكل بالغدة ...
- 16 - ط : اهلع اهلع عدهم امراض مال بالقلب
 م : لا لا ما عدهم
- 17 - ط : ما عدهم
 م : دكتور اني صارتلي غدة من زمان
- 18 - ط : أي
 م : الغدة اثرت عليّة
- 19 - ط : الغدة شنو زيادة او قلة بالافراز
 م : و الله هو علاج مال غدة ...
- 20 - ط : شنو حباية لو عدة حبوب تاخذين
 م : حب صغير ابيض
- 21 - ط : وحدة باليوم لو شلون
 م : أي وحدة باليوم
- 22 - ط : وحدة باليوم
 م : أي د اذا سامع بي دكتور
- 23 - ط : يعني كلولج ما تفرز الغدة لو شنو
 م : و الله كال بالدم ما عرف تحاليل هم جان دائما كل شهرين اسوي تحليل تركتها بعدين ... كنت اسوي تخطيط
- 24 - ط : هاي اتفضلي
 م : شكرا دكتور

Interview (III)

- 1- ط : شنو مشكلتج
- م : مشكلتي عندي ضمور بالغدة الدرقية
- 2- ط : شنو الاعراض العندج يعني شتتشكين
- م : جسمي يعني كله تعبان
- 3- ط : أي !
- م : كام زيادة بالوزن عندي
- 4- ط : عفية أي بعد ؟
- م : و ... مفاصلي هسة بدت عندي مفاصل
- 5- ط : ام ... دورتج شلونها
- م : آآآ ... لا هسة مو اني
- 6- ط : شكذ عمرج انتي ؟
- م : مواليد 68 .. 50 سنة
- 7- ط : دوة ما عندج يعني
- م : لا عندي بس كل شهرين و الثالث هسة يعني تقريبا صارلها ...
- 8- ط : وزنج زاد عن قبل
- م : أي طبعا مع العلم داسوي دايت
- 9- ط : و كسلانة تحسين نفسج
- م : تعبانة و كلشي يوجعني
- 10- ط : شعج يوكع
- م : لا
- 11- ط : حواجبج راسج شي ؟
- م : لا لا ما عندي مشكلة بالشعر
- 12- ط : قبض بطنج لو اسهال ؟
- م : لا عادية
- 13- ط : تحسين نفسج بردانة مستحرة
- م : لا مستحرة احب البرودة
- 14- ط : تحبين البرودة اكثر شي
- م : أي أي

- 15- ط : نعم
 م : بس تعبانة كل جسمي تعبان
- 16- ط : تاخذين دوة مال غدة انتي
 م : آآآ ... تايروكسين أبو 100 حبايتين اخذ باليوم
- 17- ط : حبايتين باليوم
 م : أي ... هسة بالتحليل ماعرف جابة ابن اختي
- 18- ط : أي زين تحليلج
 م : يعني شكذ اخذ النسبة هسة تبقى حبايتين لو اقلل
- 19- ط : لا قليها ... اخذي حباية و نص
 م : حباية و نص
- 20- ط : تاخذين انتي 2 باليوم مو ؟
 م : أي ثنينهم سوية ... بس يعني الي امشيتها من هاي الفترات كلبي ليهسة ديرجف
- 21- ط : زين صوتج اختلف بالبداية جان خشن هسة صار انعم لو شنو
 م : صوتي ؟
- 22- ط : أي
 م : لا لا خشن و لا انعم بس احس مو ذيج اللباقة الي احجي بيها يعني احس اكو شي يعني
- 23- ط : هم كالولج شكلج منغير
 م : نعم ؟
- 24- ط : هم داير مدايرج كلولج شكلج اتغير ؟
 م : أي ... صاير شيم و طبيعي يعني
- 25- ط : أي
 م : أي ... عبالك شلون يعني كبرت اكثر
- 26- ط : مضبوط ... خشمج كبران شفایفج كبرانة
 م : كلشي
- 27- ط : شحوب ... شحوب بوجهج
 م : أي
- 28- ط : و سمنة ؟
 م : أي أي
- 29- ط : خشونة بالجلد

م : عفية دكتور يعني عبالك شلون يعني

30- ط : امشكة

م : أي ... بس اني تعرضت لصدمة يعني قبل 20 سنة صارت عندي حالة ... مو ضمور ... غدة سامة ...
صرت حامل ... الدكتور كال خلال طلاقات الولادة يا اما تروح يا اما نسوي لوج عملية

31- ط : أي

م : فمن جبت ابني راحت الغدة السامة

32 - ط : خوش

م : و هسة تعرضت لحالة نفسية قوية ... صدمة

33 - ط : أي

م : صار عندي ضمور

34 - ط : سكر هم عندج

م : ها ؟

35 - ط : سكر ؟

م : لا ضغط عندي صار

36 - ط : بس ضغط سكر ما عندج

م : لا ما عندي

37 - ط : بهاق بجسمج شي ؟

م : لا ما عندي لا لا

38 - ط : اسهال شيم اكو ؟

م : لا ما عندي ... معدتي زينة بالاكل

39 - ط : قبض ما عندج

م : لا ما عندي

40 - ط : هاي حباية و نص تاخذين

م : أي

41 - ط : ورا شهرين تعيدين التحليل

م : شهرين بس ؟

42 - ط : أي كل

م : اشو يا هو الاجي اريد اخذ كل شهرين يكولي لا كل 3 اشهر يلا ماكدر ...

43 - ط : شنو هاي

م : و الله العظيم ميقلبون هنانة

- 44 - ط : لا مو انتي مو كلنة دتاخذين حبوب فالحنة يعني
م : حتى اعرف النسبة
- 45 - ط : أي ...كل سنتين يوم تجيني تسوين تحليل
م : كل سنتين يوم ... زين
- 46 - ط : لان انتي اذا تبقين على الحبوب يصير زيادة عندج و كل 6 اشهر هواية
م : كلش هواية طبعاً
- 47 - ط : و ممكن تدخلين يعني بزيادة بالافراز
م : يعني زيادة تصير ؟
- 48 - ط : ممكن ... فليش احنة شهرين يجوز نقلل نسوي حباية مثلا او نسوي نص حباية
م : أي
- 49 - ط : هاي الفكرة مالتنة
م : زين شكراً
- 50 - ط : اهلاً

Interview (IV)

- 1 - ط : شنو الشكوة مالتك..... شتشيكي
 م : و الله هنا مثل الفتك و مرات يصير ... هيج مثل الدمار
- 2 - ط : يعني شدتس انت ورمة ؟
 م : مثل ورمة مو فترات ... يعني من اصعد بايسكل او بالمشي او بالتنقل تنفتح هنا دمارات ...
- 3- ط : أي ..ز يعني من تشتغل و تتعب تورم ؟
 م : أي ... تقريبا تصعد و بعدين تفش
- 4- ط : تصعد و بعدين تفش ..ز زين شكك صارلها ؟
 م : 6 شهور هيج هواية
- 5- ط : 6 شهور .. من تكح شي همين تكبر
 م : والله ما اعرف ... ما ...
- 6- ط : صخونة شي عندك
 م : مرات تصعد الصخونة عندي
- 7- ط : مرات ... حركة بالادرار ؟
 م : لا ما عندي
- 8- ط : بيها وجع من تنفخ بيها وجع
 م : أي .. تنفخ اكوم اضغط عليها تفش شلون كأنه بيها هوا **تخففه**
- 9- ط : تفش ... أي ... سكر ضغط شي عندك
 م : لا لا
- 10- ط : تشرب جكاير
 م : لا
- 11- ط : متشرب
 م : لا لا
- 12- ط : أي .. ديلا تعال هنا افحصك .. اشوفك ... و واكف احسن
 م : أي أي دكتور
- 13- ط : أي .. ارفع ملايسك .. دقيقة دقيقة ... او كف هالشكل ... كح
 م :
- 14- ط : حيل اقوى
 م :

- 15- ط : كحة قوية هاي متأثر
 م : دكتور اهنا هالمنطقة هايه توجع تنقلص
- 16- ط : كح ...
 م : دكتور اني كبل مسوي عملية هنائة
- 17- ط : مال شنو
 م : مال حصوة
- 18- ط : أي ؟
 م : أي دكتور هنائة
- 19- ط : أي هاي فتق عندك حجي
 م : أي دكتور يصير عندي مثل الحركة
- 20- ط : أي ... فتق عندك حجي هذا ... سوي تحاليل حضرة حتى نسويكياه عملية
 م : ها دكتور
- 21- ط : تريد نسويها عملية ؟
 م : هسة يعني هالساعة اسويها لو شنو
- 22 - ط : انت على راحتك هو فتق هذا يرادله عملية
 م : خو ما يخوف يعني مثلا ؟
- 23 - ط : يعني شلون يخوف !
 م : يعني يسد الشرايين مثل هيح شي
- 24- ط : لا هو مالة علاقة بالشرايين .. بس المضاعفات مالتة هذا الفتق ممكن انت ... انت موت كول يورم و يرجع يفش ...
 م : أي خاصة من اركب البايسكل هواية يورم اقرانة ويا هذا اشوفه جبير ..
- 25- ط : و تضغطة يفش
 م : أي شوية شوية هيح يفش
- 26- ط : أي ... هذا المشكلة مالتة انه مرات بيه امعاء يورم و ميرجع يفش يصير فتق مختنق ... هاي المضاعفات مالتة
 م : دكتور القبض عندي مرات يأدي
- 27- ط : هو هذا من الأسباب الي تزيده انه تصير قبض و يزيده عليك
 م : أي
- 28 - ط : فلذلك نسوي و هم ما طول بيك حيل
 م : أي أي هذا هو

- 29 - ط : لان هذا يبقى و يكبر ... فسوي تحاليل و حضرها من نسويكياه عملية
 م : هو اني دكتور مرات يصير عندي هنا نرف بالمعدة و خروجي يصير اسود فترة يعني أسبوع و يروح و
 كالوا ناظور مال معدة
- 30 - ط : يصير اسود
 م : فترة أسبوع و يروح
- 31 - ط : زين ... هاي جم مرة صاير عندك
 م : هواية يعني يتكرر
- 32 - ط : لعد ليش متسوي ناظور
 م : دا اسوي ناظور و كمت أخاف وما سويتها
- 33 - ط : غير تعالجها هاي قرحة نازفة بسموها ... هاي هم خطرة
 م : أي دكتور كالوا كلش خطرة
- 34 - ط : هاي اخطر من الفتق
 م : مرة صارت عندي و اذنتي فد نوب .. اصفرت و وكعت
- 35 - ط : لعد احنة مراح نسوي العملية اذا منحل مشكلة هاي الفحة
 م : أي
- 36 - ط : لان هاي اهم ... راح ادرك على ناظور سوي ناظور و بعدين نسويك عملية الفتق ... لان هاي يجوز
 بالعملية يصير عندك نريف تسوي عندك مشكلة
 م : أي و خاصة من اكل زيادة راسا يصير عندي هنا بالمعدة
- 37 - ط : تروح عالجهاز الهضمي
 م : الناظور خوفا يأذي
- 38 - ط : لا مياذي
 م : مرة كتبولي ناظور و مسويته
- 39 - ط : لا ميصير بابا لازم تسوي
 م : أخاف من الناظور كالولي يخنك
- 40 - ط : ميخنك ... تروح تسوي ناظور نحل مشكلة القرحة النازفة بعدين نسوي العملية ... اتفضل
 م : ماشي دكتور

Interview (V)

- 1 - ط : منو المريض
م : هاي البنية
- 2 - ط : شسمها..... شنو ؟
م :
- 3 - ط : شكذ عمرها
م : 8
- 4 - ط : مسجلة بالمدرسة
م : أي
- 5 - ط : يا صف
م : ثالث
- 6 - ط : شنو شبيها دعاء
م : و الله دكتو هنا هيجي ورمة
- 7 - ط : شكذ صارلها
م : صار 8 اشهر ... 7 اشهر ... تكول بطني توجعني صخنت
- 8 - ط : انتي ما منتبهة عليها كبل ؟
م : و الله وديناها .. اني .. عمته و جتي يمي بالعيد خطر البارحة صخنت و تكول عمه هاي توجعني
- 9 - ط : يعني كبل ما شايفيها هايية ؟
م : هي تكول كالي ها يشي بسيط
- 10 - ط : قبل شكذ شايفيها
م : جانت بالمدرسة صف ثاني موديهها
- 11 - ط : أي ؟
م : كالت هاي شغلة بسيطة عادية . شلون عادية .. اني كلتلها شنو عادية خابرت امها كالت شلون عادية هاي موت كول مورمة و توجعني
- 12 - ط : زين
م : **ف** اليوم جبتهها اشوف شبيها
- 13 - ط : صخونة عدها كلتي ؟
م : هي البارحة أي مصخنة و فلاونزا و صارت فدمرة
- 14 - ط : أي

م : بالليل كالت هاي توجعني

15 - ط : أي

م : أي هي هاي و الله دكتور ... و يصير عدها ففقدان شهية

16 - ط : زين ... كحة شي عدها ؟

م : لا لا كلشي ما عدها

17 - ط : وزنها تشوفي طبيعي او ديقل ؟

م : و الله لا زينة وزنها

18 - ط : كعديها خلي اشوفها

م : هنا كعدي عمه كعده كعدي

19 - ط : طلعي لسانج برا

م :

20 - ط : بلا سويلها سونا و جيبيلياه

م : وين

21 - ط : هناك بذيج الاستشاية سوي و جيبني

م : أي دكتور

22 - ط : شسمها

م : دعاء امين

23 - ط : يلاه اي سويلها السونا و جيبيلياه

Interview (VI)

- 1 - ط : اسمج ؟
 م :
- 2 - ط : عمرج 39 سنة ؟
 م : أي .. اني صار عندي اسقاط و جيت اراجع من ذاك الشهر
- 3 - ط : أي ... كم اسقاط عندج ؟
 م : هو واحد
- 4 - ط : و شكذ عندج اطفال ؟
 م : ما عندي
- 5 - ط : شكذ صارلج متزوجة ؟
 م : 9 اشهر
- 6 - ط : ها جديد متزوجة
 م : أي أي
- 7 - ط : اول زواج لو متزوجة قبل
 م : متزوجة قبل بس ما صار عندي
- 8 - ط : يعني هذا الزواج الثاني
 م : أي أي دكتورة
- 9 - ط : عندج تكيس و الله صاعد هورمون خربطة ... مخربط
 م : ها ... حليب ما عندي
- 10 - ط : بلي صاعد ... يعني اول زواج شكذ جان عمرج من تزوجتي بيا عمر ؟
 م : من تطلكت لما تزوجت تقريبا 10 سنوات 11 سنة
- 11 - ط : شكذ بقيتي يم ذاك
 م : اقل السنة
- 12 - ط : و هسة شكذ صارلج متزوجة
 م : 9 اشهر
- 13 - ط : يعني 11 - 12 سنة خلي نكول
 م : أي
- 14 - ط : بس انتي سنتين بس باقية وياهم ... نعتبرها سنتين

- م : ويا ذاك ؟
- 15 - ط : أي
- م : دكتورة ماكو سنة
- 16 - ط : أي ... شمخصة
- م : ملخصة سادس ابتدائي ... تتعالج ان شاء الله دكتورة ؟
- 17 - ط : ان شاء الله ان شاء الله الج علاج
- م : نسبة قليلة ؟
- 18 - ط : أي ... حتى الغدة هم شوية ننطيج هاي العلاجات تاخذيها و هاي المعلومات خليها يمج حتى لا انسى
- م : اخذ العلاج من برا ؟
- 19 - ط : لا هياته موجود ... الباقي الي ما موجود اكتبه الج من برا
- م : ان شاء الله
- 20 - ط : دورتج شلونها
- م : اجتي قبل الموعد بيومين
- 21 - ط : ها ... لا مو قصدي هسة
- م : منتظمة شهر بشهره
- 22 - ط : شعر خشن ميطلعج
- م : لا لا
- 23 - ط : متسمنين سريع
- م : ابد ما اسمن هذا جسمي
- 24 - ط : هذا حب منشط اكتبج تاخذيها و حب حليب
- م : ان شاء الله
- 25 - ط : اليوم ثالث يوم من الدورة مو ؟
- م : لا الرابع دكتورة بس ...
- 26 - ط : رابع يوم ... يعني تجين بعد 8 ايام
- م : الله كريم
- 27 - ط : نشوف البيوض مالتج ...
- م : يعني اليوم ...
- 28 - ط : يعني يصادف الثلاثاء اسبوع الالاخ
- م : ان شاء الله يعني اليوم اثنين
- 29 - ط : هو الثلاثاء الجاية
- م : ان شاء الله ... شكرا دكتورة

Interview (VII)

- 1 - ط : خير شيشكي
- م : و الله هاي صارلة 10 أيام هيجي حباية بئدية
- 2 - ط : حباية بئدية ... شكذ صارلها
م : فد 10 أيام
- 3 - ط : 10 أيام يعني ديزيد الحجم مالها لو نفسه صارله 10 أيام
م : لا ميزيد
- 4 - ط : وياها وجع ؟
م : لا بس يصير عليها ضغط يعني تأذيه
- 5 - ط : بس اذا تضغطها ترجع وجع .. زين سخونة شي اكو وياها
م : لا لا
- 6 - ط : ماكو سخونة
م : كلشي ما بيه الحمد لله النهار كله يلعب طوبة
- 7 - ط : ما بيه شي ... اكو ادوية معينة شي ياخذها
م : لا لا ماكو
- 8 - ط : ماكو ادوية قبل يأخذ
م : لا لا ماكو الحمد لله
- 9 - ط : زين ... غير شي ما عنده اسهال زواع .. خروجه طبيعي ادراره طبيعي ؟
م : كلشي ما عنده الحمد لله
- 10 - ط : كحة ما عنده
م : ابد
- 11 - ط : بلا اصعد اشوفك عمو ... انزع حدانك عمو واصعد ... وينها ؟
م : هنا
- 12 - ط : توجعك هيج
م :
- 13 - ط : انزل بلا ... نزل بابا منا ... ان شاء الله ماكو شي هذا طبيعي هيج عمر تبدي هورمونات تشتغل
عالجسم فيصير ورم بالانسجة
م : تحاليل ما تحاليل ما يحتاج ؟
- 14 - ط : و الله حجي حاليا ما يحتاج كلشي
م : ها

15 - ط : هذا يصير انت شايفه يعني بالرجل و المرة وقت البلوغ هورمونات تبدي تشتغل عليه يصير شوية ورم بالتدي يجوز انت بشبابك هم صاير هالشكل ... بس ما تتذكر

م : و الله ما اذكر اليوم البارحة

16 - ط : أي ... يصير طبيعي هذا ... ان شاء الله ماكو شي يخوف ... ننطي علاج و فد شهر اذا بقى نفس الوضعية هاي خلي ماكو شي بس اذا صارت اكبر رجعيه نشوفه ... زين

م : و الله دكتور كلش خايفه من عدها

17 - ط : هو هذا موضوع التدي شوية يصير بيه يعني قلق بس واحد يستشير الطبيب

م : هو كنت اتظمن عليه

18 - ط : ان شاء الله

م : و الله العظيم

19 - ط : لا ان شاء الله ماكو شي

م : ان شاء الله شكرا دكتور

Appendix (B)

Iraqi Ministry of Health Permission Letter

جمهورية العراق
وزارة الصحة

وزارة الصحة العراقية
Iraqi Ministry of Health
Public Health

وزارة الصحة
دائرة صحة ديالى
مكتب المدير العام
مركز التدريب والتنمية البشرية

العدد: ٣٥٤٦
التاريخ: ٢٠١٨/٩/١٩

الى / جامعة الشرق الاوسط
م / تسهيل مهمة

.....
نهديكم اخلص التحيات

استنادا الى كتابكم المرقم د / ح / ٣٢ / ٢٤٧٦ في ٢٠١٨/٨/١٣ واستناداً لموافقة اللجنة العلمية للبحوث في ٢٠١٨/٩/٤ بخصوص تسهيل مهمة طالبة الماجستير (فاطمة محمد ذياب المشهداني) ورقمها الجامعي (٤٠١٦٢٠٠٠٧) جامعة الشرق الاوسط والذي تروم فيه انجاز بحثها الموسوم (Speech acts of doctor – patient communication) في مستشفى بعقوبة التعليمي ومستشفى البتول التعليمي .
نود إعلامكم بان لا مانع لدينا من تسهيل مهمة الباحثه على ان لا تتحمل دائرتنا اي تبعات مادية .
علماً انه تم استيفاء الاجور .

للتفضل بالاطلاع مع الاحترام...

الدكتور
علي حسين حسن التميمي
المدير العام

١٨
مجهود عمدة الوحة الحوزي
18 SEP 2018

نسخة منه الى ///
- مكتب السيد المدير العام ... للعلم مع الاحترام .
- مستشفى بعقوبة التعليمي . مستشفى البتول التعليمي .
- مركز التدريب والتنمية البشرية مع الاوليات .

انتصار / ٢٠١٨

Appendix (C)

Middle East University Permission Letter

MEU جامعة الشرق الأوسط
MIDDLE EAST UNIVERSITY
Amman - Jordan

مكتب رئيس الجامعة
President's Office

الرقم، در/خ/32/2476

التاريخ، 13/8/2018

٩١٥
٩١٥

الأستاذ الدكتور المدير العام المحترم

مركز التدريب والتنمية البشرية/ دائرة الصحة

مكتب دائرة صحة دياالى

تحية طيبة وبعد،،،

أرجو التكرم بتسهيل مهمة الطالبة فاطمة محمد ذياب المشيداني/ ورقمها الجامعي (401620007) // ماجستير لغة إنجليزية وآدابها في جامعة الشرق الأوسط في مقابلة الأطباء والمرضى للبحث المعنون ب:

'Speech acts of doctor – patient communication'

وتفضلوا بقبول فائق الاحترام والتقدير

رئيس الجامعة

أ.د. محمد محمود الحيلة

١٥.٨.٢٠١٨

جامعة الشرق الأوسط
مكتب رئيس الجامعة
MEU
President's Office
MIDDLE EAST UNIVERSITY

نسخة، ق.أ. عميد الكلية.

أتم الحسابات
رئيس استناد الجور
تسهل حرمه البالغة
عشرة آلاف دينار
ذات

مواضع

٩١٥

QA

مكتب: (+9622) 4700222 الفاكس: (+9622) 4129913 ج.ب. 383 عمان 11831 الأردن بريد إلكتروني: enquiry@meu.edu.jo
www.meu.edu.jo

Appendix (D)
Information Sheet for the Patient

استمارة معلومات عن المريض

اسم المريض:

التولد:

مكان الولادة:

الجنس:

التحصيل الدراسي:

الوظيفة:

Appendix (E)
Information Sheet for the Doctor

استمارة معلومات عن الطبيب

الاسم:

التولد:

الجنس:

مكان الإقامة:

الشهادة والتحصيل: