CHAPTER ONE

INTRODUCTION

1.1 General Background

Language is the verbal means of human communication. Although human beings and animals can exchange their ideas, emotions, and thoughts among the members of the same species through other means like olfactory, gustatory and tactile systems of communication; these means of communication are less discussed in comparison with the means of oral-aural communication. Language is defined variously by different linguists and scholars.

A language is a particular kind of system for encoding and decoding information. It is a systematic means of communication by the use of sounds or conventional symbols as in (en Wikipedia.org/wiki/language).

Language is the expression of human communication through which knowledge, belief and behavior can be experienced, explained and shared. This sharing is based on systematic, conventionally used signs, sounds, gestures, or marks that convey understood meanings within a group or community (www.nidcid.nih.gov 2010).

Language is used to communicate and convey meaning from one person to another. It is used to talk each other, write and e-mail and text. Language has rules which involve word structure (morphology), grammar and sentence structure (syntax), word meaning (semantics) and social appropriateness (pragmatics) as in (what_is_language.pdf).

According to Sapir (1921, p.8) as cited in Lyons (2002): "Language is a purely human and non-instinctive method of communicating ideas, emotions and desires by means of voluntarily produced symbols". Nowadays, language, the oral-aural means of communication, becomes a widely- discussed area of study.

Language has been studied from time immemorial. It had been a subject of study to Plato and Aristotle. But it has been studied unscientifically for centuries. Saussure (1857-1913), the father of modern linguistics, set up a foundation to study language scientifically after his posthumous publication of Course de Linguistique Generale (1916). The whole of the recent history of linguistics can be described in terms of successive discoveries or new approaches to view language. For a long period in the scientific study of language, there had been a very strong interest in the analysis of formal properties of language. Regarding the development of modern linguistics, Leech (1983, p.1) writes:

> To the generation which followed Bloomfield, linguistics meant phonetics, phonemics, and if one was daring –morphophonemic; but syntax was considered so abstract as to be virtually beyond the horizon of discovery. All this changed after Chomsky, in the later 1950s, discovered the centrality of syntax; but like structuralists, he still regarded meaning as altogether too messy for serious contemplation.

For a long period in the study of language, there had been a very strong interest in the analysis of formal properties of language. In the 1950s and 1960s, the structural linguists like Hockett, Sapir, and transformation linguists made their studies emphasizing on discovering some of the abstract principles that lie at the very core of language. Their studies were limited to find out "relationship between linguistic forms, how they are arranged in sequence and which sequences are well-formed" (Yule 2000, p.4). They discarded to study of the meaning of linguistic forms. However, "in the early 1960s, generative semanticists like Katz and his collaborates began to find out how to incorporate meaning into a formal linguistic theory" (Leech 1983, p.1-2). But their study was still limited to the study of meaning in isolation. They could not consider the fact that the linguistic forms convey the meaning when they are uttered by the speakers in real social situations. In a nutshell, language is an 'organized noise' used in actual social situations. That is why it has also been defined as

'contextualized systematic sounds'. In the Encyclopedia Britannica, vol.13, language is defined as "a system of conventional, spoken or written symbols by means of which human beings, as members of a social group and participants in its culture, communicate". The overlapping interest of linguistics and other disciplines has led to the setting up of new branches of the subject in both pure and applied contexts such as bio-linguistics, clinical linguistics, institutional linguistics,educational linguistics, sociolinguistics.

In the 1960s, sociolinguists like Halliday, Gumperz, Hymes and others considered language as a social phenomenon. "Language is a socially maintained and socially functioning institution" (Lyons 1992, p.266). They studied language regarding it as a dynamic phenomenon; not as a static phenomenon. They believed that the study of language must go beyond the sentences that are the principal focus of descriptive and theoretical linguistics. They attempted to study any communicative use of language in contexts. But sociolinguists' main attempt was to describe the linguistic properties in relation to social factors like social class, educational level, age, sex and geographical situation of language users. We can say that it is the study of language in relation to society. A very few sociolinguists went beyond it. Hymes and a few others would include the detailed study of interpersonal communication. In this way, sociolinguistics studies about changes and varieties in language use and seeks socially relevant explanations for regular patterns of variations in language use.

A native-speaker does not speak homogeneously in all psycho-social setting but uses several different styles of speech according to the needs of different situations. The variety of language that is distinguished by reference to the purpose and subject matter of communication or the fields of discourse e.g. sports, science, law, commerce, medicine. Some communications are oral medium and some are written. Lectures, conversations, announcement, debates are the example of oral communication whereas personal letters, poems, essays, newspaper, articles are the examples of written communication.

Communication depends on the relationship between participants. It may be formal, informal, slang/taboo, archaic/dated, modern. For example,

A: Have a cigarette!

B: Thanks (informal)

I. A: Would you like a cigarette?

B: That's very kind of you very much (formal)

II. 'Grass' (meaning informal) (criminal slang)

III. He doesn't give a fuck about anyone else (he doesn't care at all about any one else) (taboo)

IV. 'Though art' is an archaic form of 'you are'

1.1.1 The Medical Field

The language of medical sector is highly technical and it is difficult to grasp the medical concepts used in it. It is a register which is different from other fields. The students of medicine have to use language skills in their field. So they are required to develop specific language skills in their study. Students studying English at the institute of medicine have special need that is because they are required to know specific technical terms.

Medicine is the medical branch of medical science that deals with non-surgical techniques. There are different kinds of linguistics which are mentioned above. Among them clinical linguistics is the linguistics of pharmacology, patho-physiology and infections. This is medical terminology which is basically the language of medical professionals' use. Actually it is a basic requirement for most professionals who work in the field from clerks to doctor. There are different fields in medicine. The field of medical anthropology examines the ways in which culture and society are organized around or impacted by issues of health, health care and… (Medicine-Wikipedia, the free encyclopedia 2010)

The medical language provides the examples of different concepts and the texts of medical language which are not in fact as easy as they appear on the surface. The medical language requires practical language skills and the intention behind the choice of text for the medical language is to provide texts that present familiar information in a new way. Generally the specific terminologies, illustrations and unique way of presents make the medical language different from the language used in other fields.

1.1.2 Pragmatics

In the 1970s, a new approach appeared to study the meaning of linguistic forms. The pragmatic approach to study language accounts for all the social factors that are involved along with the actual utterances.

> This type of study necessarily involves the interpretation of what people mean in a particular contexts and how the context influences what is said. It requires a consideration of speakers organize what they want to say in accordance with who they are talking to, where, when and under what circumstance (Yule 2000, p.1).

Thus, pragmatics is the study of actual use of language to express the meaning. In other words, it is the study of speaker meaning as distinct from word or sentence meaning. Pragmatics is the study of utterances with an emphasis on the meaning created by speakers and listeners in interpersonal contexts.

Pragmatics is a newly-emerged branch of linguistics. The origin of 'pragmatics' can be traced back not to linguistics but to philosophical writings.

> Morris (1938), a great philosopher, first used the term 'pragmatics' when he was outlining the general shape of a science of signs (i.e. semiotics or semiotic as Morris preferred). He distinguished 'pragmatics' as a distinct branch of inquiry of semiotics – others being syntactic (syntax) and semantics (as cited in Levinson 1994, p. 1-2).

Similarly, Crystal (1996, p.301) states that:

In modern linguistics, it has come to be applied to the study of language from the point of view of the users, especially of the choices they make, the constrains they encounter in using language in social interaction, and the effects of their use of language has on the other participants in an act of communication.

Chomsky's distinction between competence and performance, pragmatics is concerned solely with performance of language use.

Since pragmatics studies the actual language use, it analyses how the contextual features are grammaticalized or encoded in the structures of language. Under the domain of this discipline comes the study of deixis, implicature, presupposition, speech act, discourse analysis, conversational analysis and so on. The actual use of language can be seen when two or more people are interacting with each other. The language they use conveys the situation where they are talking in, by the interpersonal factors and gestures they show. The research will, therefore, try to account some of the important factors associated with conversation.

1.1.3 Introduction to Conversation Analysis

Conversation Analysis (CA) is the study of talk in interaction (both verbal and non-verbal in situations of everyday life). CA generally attempts to describe the orderliness, structure and sequential patterns of interaction, whether institutional (in school, a doctor's surgery, court or elsewhere) or in casual conversation. It is particularly influential in interactional sociolinguistics, discourse analysis and discourse psychology, as well as being a coherent discipline in its own right (Conversational analysis− Wikipedia, the free encyclopedia).

People sometimes use the term 'conversation' to mean any spoken encounter or interaction. In conversation everyone can have something to say and anyone can speak at any time. The purposes of conversation include the exchange of

information; the creation and maintenance of social relationships such as friendship; the negotiation of status and social roles, as well as deciding on and carrying out joint actions. Conversation therefore has many functions, although its primary purpose in our own language is probably social. Conversation is such a natural part of our lives that many people are not conscious of what happens within it. However, conversation follows certain rules. According to Nolasco and Arthur, the rules of conversation are as follows:

- usually only one person speaks at a time;
- the speakers change;
- the length of any contribution varies;
- there are techniques for allowing the other party or parties to speak;
- neither the content nor the amount of what we say is specified in advance.

The basic unit of conversation is an exchange. An exchange consists of two moves (an initiating move and a response). Each move can also be called a turn, e.g.

A: Sister.

B: Yes?

A: Could I borrow your catheter, please?

B: Sure, it's in the OT.

A: Thanks very much.

Conversation analysis seeks to explain how this occurs, and the aim of the sections which follow is to make the readers sensitive to the main issues from a teaching point of view.

Conversational analysis was developed by Harvey Sacks (1972), which studies 'talk' during social interactions. Conversational analysis represents an attempt to characterize the patterns and structure of interactions. We can say that

discourse analysis is the study of language use with reference to the social and psychological factors that influence communication. One sub-area of discourse analysis has come to be known as conversational analysis (conversation analysis-psychopedia-pych.it.com.au 2008).

To conduct a conversational analysis, researchers scrutinize a short recording of a discussion in depth-perhaps in a therapeutic, legal, business, health, family, or social context. They might, for example, time the pauses between sentences, record rises in pitch and volume, examine interruptions, and consider the precise words and phrases closely (conversation analysis-psychopedia-pych.it.com.au 2008).

Speech is the primary manifestation of language whereas the written form of language is just the representation of it. Both the forms of language – spoken and written can be used for conveying a message, but the former is commonly used in communication. A person - to - person interaction is a conversation. It is a primary medium of interaction in the social world, and the medium through which children are socialized into the linguistic and social convention of a society. Interaction should occupy a central position in any holistic view of social life. CA transcends the traditional disciplinary boundaries of social anthropology by providing a perspective within which language, culture, and social organization can be analyzed not as separate subfields but as integrated elements of coherent courses of action. Conversation is not a structural product in the same way that a sentence is – it is rather the outcome of the interaction of two or more independent, goal-directed individuals, with often divergent interests.

The linguistic forms or expressions used in interaction between or among people are the actual use of language. While we are interacting with each other, we are exchanging our ideas, emotions, thoughts, etc mainly through the verbal form of language. The participants are using appropriate linguistic form in the situation where they are talking in. The gestures used by the participants and some contextual factors can play important role to make the meaning of

linguistic form more explicit. Therefore, the language in conversation is a real use of language. To quote Levinson (1994, p.284), "conversation is really the prototypical kind of language use".

The form and way of uttering linguistic utterances are determined by the situation we are talking in, the social status of person we are talking with, and sometimes by the topic we are talking about. The choice of linguistic form is primarily determined by the formal-informal condition of the discourse. The first pair of the following expressions, for example, is to be uttered in informal situation whereas the second pair in formal situation although both of them express the same message and are used for performing the same action.

I. A: Have a cigarette.

   B: Thanks.

II. A: Would you like a cigarette?

   B: That's very kind of you. Thank you very much.

On the other hand, the same linguistic form may have one meaning (i.e., function) in one situation and another meaning in another situation. Suppose, on a winter morning, a man reaches for a cup of tea. Believing that it has been freshly made, he takes a sip, and produces the following utterance. It is likely to be interpreted as a complaint.

I. It is really cold!

If the circumstance is changed, the meaning of the same linguistic utterance gets changed. The situation is changed to a really hot summer's day, for example, if the same person is served with a glass of cold juice, the same utterance is likely to be interpreted as praise if he produces after taking a sip.

The sequence of utterances, which are produced by two or more persons when they talk, makes a conversation. The participants in conversation are using the language orally. Ochs (1979) identified two types of oral use of language (i.e., speech): planned and unplanned speech (as quoted in Wardhaugh 1986, p.287).

- Planned speech is carefully planned even rehearsed. The welcoming speech by the king to the joint assembly of both the House – Upper and Lower House of Parliament – is an example of planned speech. Similarly, the conversation between the two actors in a drama performance is also a planned speech since the conversation is already rehearsed.
- Unplanned speech is a talk or interaction, which is not thought out prior to its expression. It proceeds without any conscious plan. It does not mean that it has no organization. Every naturally occurring conversation is organized systematically. Regarding the complex organization of conversation, Wardhaugh asserts: "unplanned speech is...not unorganized speech" (1986, p.287).

Wardhaugh (1986, p.287) mentioned the following characteristics of unplanned speech of conversation.

- Repetition,
- Simple active sentences,
- Speaker and listener combining to construct proposition,
- String of clauses together with and or but or the juxtaposition of clauses with no overt links at all,
- Deletion of subject and referents, e.g. words such as this, that, here, there,
- Loose syntax, i.e. not as considered as in written form of language,
- Fragmented and overlapping utterances.

The term “unplanned” is used to refer to spontaneous conversational speech, the contrast being to the various forms of discourse that are thought through before transmission and realized in grammatically formal sentence (and sentence-sequence) structures. In any case, it might be argued that the critical issue is scripting, not planning.

The unplanned conversation takes place in a real social setting without any prior or rehearsal between the participants. Thus, the conversation can be characterized as a locally managed phenomenon. It is a cooperative activity in the sense that it involves two or more participants, each of whom must be allowed to be participated in conversation.

The conversation analysis is limited to the analysis of unplanned conversation. It does not study the planned speech. CA is, therefore, the systematic analysis of conversation. To quote Crystal (1996, p.92), CA refers to "a method of studying the sequential structure and coherence of conversation". He further mentions that its aim is "to establish what properties are used in a systematic way when people linguistically interact". Since CA analyses the recordings of naturally occurring conversations in order to discover how utterances are interrelated, it is basically an empirical and inductive study.

According to Richards et al. 1985, p.64, cited in Goffman, 1981, CA includes the study of:

a) How speakers decide when to speak during a conversation (i.e., rules of turn taking).

b) How the sentences of two or more speakers are related (i.e., adjacency pair).

c) The different functions that conversation is used for (for example, to establish roles and to communicate politeness or inquiry).

In short, CA is a descriptive study of actual language use. Research in CA requires recordings of naturally occurring conversations in order to discover how sequences of activities (both verbal and non-verbal) are generated spontaneously in verbal interaction. The most immediate origin of CA is the period during 1963-64 which Harvey Sacks (1935-75) spent at the Centre for the Scientific Study of Suicide in Los Angeles. During the short period, both, he analyzed telephone calls made to the Suicide Prevention Centre in order to

find out how suicide committers account for their trouble to others (Asher 1994. Vol: 2, p.749).

Roberts and Sarangi (1999) worked collaborately with the Royal College of General Practitioners to improve forms of Doctor-Doctor communication. Such collaboration can benefit patients and doctors, immigrants and nonimmigrant. U.K. doctors whose linguistic experience is with fluent English speakers might expect patients to maintain a factual orientation. Immigrant patients, however, sometimes bring to clinical encounters a troubles-telling orientation. Thus, in multicultural societies, doctors' "training for uncertainty" must now include training for managing "interactional uncertainty" as in (medical discourse-annual review of anthropology 2010).

1.2 Review of Related Literature

Much of the literature on medical discourse confines itself to practioner-patient interaction in biomedical setting and tailors proposals for improving communication to biomedical models of the doctor-patient, such as a "patient-centred" or "biopsychosocial" approach. For Maynard and Heritage (2005), introducing CA in medical education "facilitates the biopsychosocial approach to the interview, as well as a more recent emphasis on relationship-centred care" (p.434). Similarly, talk of "patient empowerment" can be "used...to constrain doctors" responsibility for patients" suffering" (Salmon and Hall 2003, p.1969). These ideologies representations of discourse (as empowering or culturally competent, for example) - or language ideologies-are as important to analyze as clinical interactions cited in (medical discourse-annual review of anthropology 2010).

Sinclair and Coulthard (1978) did a study on Classroom Discourse. They had propounded the theoretical model of ‘Classroom Discourse’ in terms of five discourse units: lesson, transaction, exchange, move and act.

Edmondson (1981) did a dissertation on Spoken Discourse. His Dissertation is concentrated on the use of language in classroom. He has also investigated the conversational behavior in relation to its uses effect in terms of linguistic orientation. He concluded that the teacher very often asked question to students and turn-taking was controlled by the teacher in the classroom interaction

The pragmatic study of language is the study of actual use of language. In Department of English Education of T.U., there are a few studies conducted regarding the actual use of language.

Sah (2003) has carried out a research entitled "An Analytical Study of Classroom Discourse". The researcher has taken Sinclair and Coulthard (1978) model as a reference for analyzing the classroom discourse. The study is highly valuable but it is limited to the analysis of only three units: act, move, and exchange (transaction). This study attempted to classify the different types of acts, moves, and exchanges found in the English classes. He found twenty six acts, three moves, three exchanges. His study also revealed that in most of the situations, the teacher initiated and dominated in the classroom interaction.

Adhikari (2006) conducted a research on "Analysis of Nepali Conversation: A practical study". He concluded that the language in conversation is different from that in written form. Language in conversation is prototypical use of language.

Marasini (2007) carried out a research entitled "Discourse Structure in Nepali T.V. Commercials". He found that the language and sentence structures have their own unique features which break the norms of the common language structure.

Tiwari (2008) studied on "An analysis of Classroom Discourse". He summarized that omission of subject and overt linkers, repetition of words or phrases, simple deviation in structures, etc. are proved to be common properties of Nepali Conversations.

Mazur (2009) found in the study "Conversational Analysis for Educational Technologists: Theoretical and Methodological Issues for Researching the Structures, Process, and Meaning of on-line talk" that within the applied CA framework, CA is a systematic method of understanding in the turns of talk between human speakers.

Strong study by Fam Pract (2009) on "Discourse analysis: what is it and why is it relevant to family practice" concluded that awareness of the dimension of the interaction (i.e. patients' 'hidden agendas' about legitimacy) could help doctors and patients to avoid unintended loss of face and/or conflict.

This is the only research which has never been carried out in conversational analysis, an area of pragmatics. No text study has been conducted in the actual use of language in the medical context. This study will, therefore, be different from the researches reviewed above.

1.3 Objectives of the Study

The objectives of the study were as follows:

i. To make an analysis of the following parts/components/forms of conversation,
    - Opening
    - Overlapping
    - Pause
    - Closing

ii. To find out the frequency of these components with examples.

iii. To suggest some pedagogical implications.

1.4 Significance of the Study

Medical language is highly technical and it is difficult to grasp the medical concepts. This study will be useful to the prospective researchers who want to undertake researches on any domain of pragmatics. It will primarily be significant to all who study 'Discourse Analysis'. It will also be significant to all linguists, syllabus designers, textbook writers, material producers, medical students, health workers and others who are directly or indirectly related to the language teaching.

1.5 Definition of the Terms

Opening : Opening in conversation refers to the way of initiation or beginning of conversation. Many conversations start with adjacency pairs. It generally involves an exchange of greeting, e.g. an exchange of 'Hello' or 'Hi' in an informal conversation and 'Good morning/evening' in formal one.

Closing : As opening, closing refers to the termination, or ending of a conversation. An exchange of 'Good bye' indicates the closing of English conversation.

Turn-Taking : The change of speaker's turn during the conversation. In other words, it is the exchange of role of participants, i.e. speaker and listener. In short, we can say there it refers to the change of speaker during a conversation.

Overlapping : It refers to interruption to current speaker by next speaker. If the hearer starts speaking before the current speaker ends his/her turn, it is known as overlapping. In other words, when more than one speaker talking at the same time in conversation, that is overlap. The initiation of next speaker's utterance slightly before the current speaker comes to the ending he/she was coming to, it is called overlap.

Adjacency pairs: The two moves in an exchange are related to each other through the use of adjacency pairs. Adjacency pairs are deeply inter-related units of conversation like question-answer, greeting-greeting, offer-acceptance or refusal, etc. They are also called exchanges. In another way, it is a sequence of two utterances by different speakers in conversation. The second is a response to the first.

Insertion sequence: A two part sequence that comes between the first and second parts of another sequence in conversation, it is called insertion sequence.

It is an adjacency pair which is embedded within another, e.g.

A: May I have a bottle of Mich? Q1

B: Are you twenty-one? Q2

A: No. A2

B: No. A1

(Levinson 1994:304)

The Q2-A1 pair is called an insertion sequence, which is embedded within another pair Q1-A1.

Phatic Communion: A language function which is not for seeking or conveying information but for establishing social relationship, e.g. nice day, isn't it?

Pause : It refers to the absence of vocalization. When silence occurs, it is considered as a pause.

Repair : Correction of misunderstanding, mishearing, or indeed non-hearing, e.g.

A: hh…..... well. I'm working through the Salt Corporation……..

B: The who?

A: Salt Corporation. It is a holding company.

(Levinson 1994, p.341)

Here the utterance 'It is a holding company' is the repair of A's first utterance.

So, “repair” as a covering term for all corrective action.

CHAPTER TWO

METHODOLOGY

The researcher adopted the following methodology during the study.

2.1 Sources of Data

Both primary and secondary sources of data were used to meet the objectives of this work.

2.1.1 Primary Sources of Data

The primary sources of data of this work were recording and translation of naturally occurring conversations into English between the people who were involved in the periphery of Kirtipur Hospital like doctor-doctor, doctor-patient, doctor-visitor, nurse-nurse, nurse-patient were recorded and translated then interpreted the conversations by scrutinizing the translation as well as replaying the recording. The researcher collected the conversations from the social setting, in the Hospital. The Hospital was the Kirtipur Hospital, Kirtipur and sectors were In-patient Door (IPD) and Out Patient Door (OPD). She collected 15 formal conversations.

2.1.2 Secondary Sources of Data

Various books, especially Levinson (1983), Wardhaugh (1986), Nolasco and Arthur (1987), Lyons (1992), Yule (2000), Varshney (2002-2003), Rai (2003), Kumar (2006), Mishra (2007), articles, research studies, reports, internet related articles were used as a secondary sources of data.

2.2 Sampling Procedure

The researcher applied quota sampling method, which is one of the useful non-probability designs. For this, she recorded 15 formal conversations in the setting, medical field. The conversations between the people having various sectors of health and illness as mentioned above were collected.

2.3 Tools of Data Collection

For this work, a tape recorder cum player was the tool for data collection. The researcher recorded conversations with letting (i.e. participatory) the interlocutors.

She listened conversations many times and translated the Nepali words and sentences into English. She listened and re-listened the conversations to get required information.

2.4 Process of Data Collection

The researcher adopted the following procedure to collect the data:

- The researcher met the Director of the Model Hospital to get permission to entry in the Hospital.
- She asked to the Incharge of Kirtipur Hospital how to entry in the different sectors of Hospital.
- The researcher visited the different sectors of hospital and recorded the conversations between the people.
- She frequently listened to the instances of conversations and translated them.
- The researcher listened to conversations many times and studied the translated conversations.
- She noted down of required information.

- The researcher analyzed and interpreted the information and presented the findings.

2.5 Limitations of the Study

This work had the following limitations:

1. The study area was Kirtipur Hospital, Kirtipur.
2. The research was limited to the conversations between only two people at a time.
3. The study was carried out on the basis of analysis of only 15 conversations.
4. Typically, the physical movements, mannerisms, and gestures of individuals, such as holds, gaze while scratching cheek, were not included. Such physical movements could not describe and interpret as unambiguously as vocal and para-vocal features.
5. The suprasegmental features like tone, intonation, which are entirely important in conversation, were not studied.

CHAPTER THREE

ANALYSIS AND INTERPRETATION

In this section, the components of conversations identified in the analysis of 15 recorded conversations are described and presented in the tables with examples from the data. The exponents of conversations are translated into their equivalent written form. The live record is available only in Compact Disk (CD) and translated form is presented in written form with examples. The translated form is included in Appendix-I also. This study had been analyzed according to Fairclough (1995). Similarly, it provides a comprehensive description of the different parts of conversation, firstly each part is described and analyzed, and then various expressions for each part are minutely described and exemplified with the help of the recorded data.

3.1 Parts of Conversations in the Medical Context

The common parts mentioned in the objectives of the study are analyzed and described here. Each part is described with how they are expressed in medical conversation.

3.1.1 Opening

The opening of total fifteen conversations were listened to and analyzed. On the basis of analysis, openings are categorized into three in this research. They are:

- **Greeting:** The established terms or expressions of greeting like ‘hello’, ‘good morning’ in English are found in the opening parts of conversations.
- **Phatic Communion:** A linguistic expression like ‘how are you’ which is used not for seeking or conveying information but for establishing social relationship is taken as phatic communion here.

- **Others (non-greeting/situational):** The expression like ‘do you have the problem of ‘white discharge’ which is used for the condition of current situation.

The study shows that most of the conversations start with non-greeting or situational expressions. Other usual ways to start conversations are by greeting and phatic communion.

3.1.1.1 Opening Using Greeting

It is observed that greeting is a way of opening in conversations. Some expressions of greeting for opening conversations are given in table no.1 below:

Table No.1: Expressions of Greeting

Conversations	**Expressions**
Con-1 (App. I)	N_1: guḍ morniṅg didī (Good morning sister) N_2: Good morning
Con-2 (App. I)	N_1: helo bahinī ke cha (Hello sister how are you) N_2: aṅ thikai cha (Hello I am fine)

English terms of greeting like ‘good morning’ and ‘hello’ are rarely found in opening part of medical conversations. Among 15 conversations, terms of greeting were used only in a couple of conversation.

3.1.1.2 Opening Using Phatic Communion

In medical conversations, some expressions seem to be used for seeking or conveying information. In fact, they are not used for seeking or conveying

information but for establishing relationship. Such expressions are treated here as expressions of phatic communion, which are found in the opening part of medical conversations. Some examples of phatic communion are:

Table No. 2: Expressions of Phatic Communion

Participants	**Expressions**
Nurse Patient	ke cha (How are you) thikai cha (I am fine) (Con- 2, App. I)
Doctor Patient	Sanco bhaena ho (How are you feeling) sitāmolharu khāiraheko chu (I am taking Paracetamol) (Con- 14, App. I)

3.1.1.3 Opening Using Non-greeting or Situational Expressions

It is analyzed that non-greeting or situational expressions are often used term of opening in medical conversations. Some expressions of non-greeting or situational for opening medical conversations are presented in table no.3.

Table No.3: Non-greeting or Situational Expressions

Expressions	Doctor: tharmomitar rākhera hernu bhā cha (Do you use thermometer) Patient: hereko (Yes) (Con. 10, App. I)
	Doctor: seto pānī jane ta bhako chaina hai (Do you have the problem of White discharge) Patient: tyasto ta mins bhaisake pachi mātra huncha (It is seen only after menstruation) (Con.4, App. I)
	Doctor: tapāiṅle ek coti indoskopi garyo bhane rāmro huncha (You have better to do endoscopy) Patient: hajur (Ok) (Con.3, App. I)

3.1.2 Pause in Medical Conversation

In this section, the pauses found in medical conversations are taken for analysis. To describe and analyze pauses here, the absence of vocalization (or silence) found in the speech in the same person is termed as pause which do not refer to the same time duration. In terms of its duration, pauses are found into two types: short pause and long pause, which are marked, dots for 'short' pause and a dash for a 'long' pause. The distribution of these two types of pause is presented in table no.4.

Table No.4: Distribution of Pause

Types of Pause	**Frequency**	**Percentage (%)**
Short Pause	23	17.16
Long Pause	8	5.97
No Pause	103	76.86
Total	134	100

The table shows that 17 percent of the total 134 exchanges have short pauses, only 6 percent exchanges have long pauses and 77 percent of the total expressions do not have pauses in the medical conversations. It is also notified that the pause is found one or more times in the same expression.

3.1.2.1 Pause

By analyzing the pauses in the medical conversations, it is found that pause is of two types. They are habitual pause and pause for correction. It is found that some pauses are idiosyncratic in nature. Such types of pauses are termed here as habitual pause. Some examples of habitual pause are:

Doctor: uh**.**maile 2/3 tyahi penkilarharu aru kehi pani (uh**.**I had taken pain killer for 2/3 days and not others)

(Con.8, App. I)

Nurse: daktar um**.**le cār nambarko birāmilāi ali gāro cha (Doctor um. Said that patient in the four number bed is serious)

(Con.1, App. I)

Patient: um**.**thikai cha **(**Um. I am ok)

(Con.2, App. I)

Likewise, it is also found that the main purpose of pause is to correct. Some examples of pause for correction are:

Nurse: tyasaile bholi samma herne ki bhanne bhairācha tyaslāi alik keyar garnu holā aru**.**narmal nai cha (So observe and care up to tomorrow others. Are normal)

(Con.1, App. I)

Doctor: haina chaina**.**garākо chaina **(**No no. you did not)

(Con.4, App. I)

Doctor: ek haptā haina**.**haptā haptāmā āunu (No.visit once a week)

(Con.5, App. I)

(Conversation marker is based on Fairclough 1995, p.133)

In the examples, the nurse pauses after producing 'others' for a short time to correct it and makes the correction by producing 'normal'. In the second example, the doctor corrects her expression by pausing for short time after producing 'no/no'. In the last example, the doctor corrects her expression by stopping for short time after producing 'no'. These examples are all about short pauses.

According to data, some examples of long pause are as follows:

Patient: bihān−renj tyahi 101^0F (In the morning−101^0F is the range)

(Con.10, App. I)

Doctor: arko indaksan garnu thāleko−tara intarapt bhaidiyo (I start another induction−but it is interrupt)

(Con.12, App. I)

Doctor: pen kilarharu−khāirahanu bhako cha (Pain killers−you are taking)

(Con.8, App. I)

(Conversation marker is based on Fairclough 1995, p.133)

These are some examples of long pauses in the exchanges of medical conversations.

3.1.3 Overlapping in Medical Conversation

In this section, verbal overlapping is analyzed and described. The overlapped exchanges are marked with square bracket ([ ). Table no.5 shows the distribution of overlapped exchanges in medical conversations.

Table No.5: Distribution of Overlapped Exchange

	Frequency	**Percentage (%)**
Non-overlapping	106	79.10
Overlapping	28	20.89
Total	134	100

The above table shows that 21 percent of total 134 exchanges are found overlapped and 79 percent are non-overlapped. From the data, it was found that overlapping is a common property of conversation. It was found that the frequency of overlapped exchanges is less than paused exchanges. Some examples of overlapped exchanges are as follows:

Patient: alik [blidiṅg (I have slightly [bleeding)
Nurse: [blidiṅg [(bleeding)

(Con.2, App. I)

Doctor: ahile [tyasto cha (Now [it is)
Patient: [chaina [(not so)

(Con.4, App. I)

Visitor: [narmal nai cha (Is it [normal)

Doctor: pardaina narmal cha (Yes no need to worry)

(Con.7, App. I)

Doctor$_1$: nāinti anli (Ninety only)

Doctor$_2$: yeah (yeah)

(Con.12, App. I)

(Conversation marker is based on Fairclough 1995, p. 133)

3.1.4 Closing in Medical Conversation

In the study of the closing part of 15 recorded conversations, the researcher found that no medical conversations close with:

Terms of relation/addressing

Phatic communication but close with:

Terms of greeting (rarely)

Situational expressions (more often)

The following expressions are some of the many closing expressions found in the closing section of recorded medical conversations.

Nurse$_1$: oke bāi Ok bye)

Nurse$_2$: bāi bāi (Bye bye)

(Con.1, App. I)

Doctor: ausadhi kantiniu garnu parcha (Take medicine continue)

(Con. 10, App. I)

Doctor: ausadhi bańki cha hai (Still do you have any medicine to take)

Patient: hm (Hm)

(Con.5, App. I)

Visitor: narmal nai cha (Is it normal)

Doctor: narmal cha ā̄ttinu pardaina (Yes no need to worry)

(Con.7, App. I)

In conclusion, it is found that the medical conversation generally ends with the situational expressions.

CHAPTER FOUR

FINDINGS AND RECOMMENDATIONS

4.1 Findings

On the basis of the analysis and interpretation of the data, the findings of the study can be summarized as follows:

1. Medical conversation maximally opens with non-greeting or situational expression (e.g. do you use thermometer), rarely with greeting (e.g. good morning) and sometimes with phatic communion (e.g. how are you).
2. Pause is very common in medical conversations. Although silence for a short time can be a habit of some speakers, pause in the expression of the same speaker is for correcting the previous piece of speech. There are two types of pause: short pause and long pause. This study shows that the frequency of short pause is more than the frequency of long pause in the conversations.
3. Overlapping is a common feature of conversation which occurred less frequently than pauses in medical conversations. The study shows that only 21 percent of the total exchanges are overlapped whereas 79 percent are non-overlapped.
4. Medical conversations generally ends with closing situational expressions like ‘take medicine continue’, ‘is it normal’, ok bye’, ‘bye bye’.
5. The following are the common features of medical conversations:
    a. Repeated items
    b. Conversational markers

a. The same item or word appears more than once in the same expression of the medical conversation. The word ‘plaster’, for example, is found repeated in the expression “no need to plaster for this” (Con.8, App. I)

b. Some conversational markers like uh, hm, e:, yeah are found in medical conversations. For example, “uh. Visit once on Thursday” (Con.7, App. I). These words are not common in the written form of the English language. Such special items are conversational markers in medical conversations.

In conclusion, the language in medical conversation is different from that of written form. Certain linguistic items are more characteristic of speech than of writing or occur only in speech.

4.2 Recommendations

This is a descriptive study. Although this study was not based on classroom discourse, there are some fields related to teachers of the of the English language education who are studying and teaching ‘Discourse Analysis’. A few recommendations are suggested as follows:

a) To practice the learners, use different expressions of opening and closing for the first time to make communicational interaction with others lively.

b) To make the speakers communicatively competent, correction of piece of speech, repetition of a word or phrase and pause should be accepted and entertained by language teachers in the speech of their learners during language teaching.

c) Simple deviation in structure should not be corrected in language teaching.

d) The researcher has found that language in conversation (oral discourse) is different from that of writing (written discourse). It is, therefore,

recommended for language teachers in general that they should make their students familiar with the language in conversation.

e) Special conversational features of the language should be taught.

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APPEDICES

APPENDIX-I

The conversation markers are based on: Fairclough 1995, p.133, which indicate in the following way:

Marker	Indicates
–	Long pause
.	Short pause
[	Overlap

Conversation-1

$Nurse_1$: Good morning sister

$Nurse_2$: Good morning how about Patients in the ward

$Nurse_1$: Round is finished Doctor um**.** Said that patient in the four number bed is serious So he told that do observe more She has over bleeding plus heart disease So she must be referred

$Nurse_2$: What did the doctor say

$Nurse_1$: She is from poor family and she will be in trouble when we refer immediately So let's observe up to tomorrow Others**.** are normal

$Nurse_2$: Ok

$Nurse_1$: You are here so**.** I am going ok bye

$Nurse_2$: Bye bye

Conversation-2

Nurse: Hello sister how are you

Patient: Hello I am fine

Nurse: Are you sleeping It's time for your medicine

Patient: No I am not sleeping

Nurse: How are you feeling now

Patient: Um**.** I am ok**.** But I have slightly [bleeding

Nurse: [bleeding

Patient: I have bleeding

Nurse: Take two tablet of medicine and tomorrow tell this problem to the doctor otherwise it will be difficult for you

Patient: Ok

Conversation-3

Doctor: You have better to do endoscopy

Patient: Ok

Doctor: Because if occult blood is positive it is better to do endoscopy

Patient: What about food [doctor

Doctor: [don't take oily and fried things

Patient: Um

Doctor: And take much soup

Patient: Can [I take curd milk

Doctor: [You can take

Patient: Can [I take fruit also

Doctor: [Yes you can Once you can do endoscopy

Patient: What is the cost for endoscopy um

Doctor: I do not know the price for endoscopy It is depend up on time and place

Conversation-4

Doctor: Do you have the problem of white discharge

Patient: It is seen after menstruation

Doctor: Now it is

Patient: not so

Doctor: not it is now Did you do urine culture You did not

Visitor: Yesterday I gave in lab

Doctor: No no. You did not Other investigation are normal There is infection in urine Though routine is normal sometime organism is found in urine

Patient: Yeah

Doctor: It's better to do culture

Visitor: Do you feel medicine is sufficient for infection or we will have to do other more

Doctor: You can consult after taking medicine

Visitor: Do you think infection is the cause of stomach pain

Doctor: I think so Did you take injection for gastritis what other medicine did he give

Visitor: One bottle of syrup and then

Doctor: green tablet

Visitor: Hm

Doctor: Take one tablet for three days this antibiotic after giving culture

Visitor: I can take antibiotic only**.** After giving culture

Conversation-5

Patient: It is going to be date off from Thursday

Doctor: One week no**.** visit once a week

Patient: I think so

Doctor: e:

$Doctor_2$: Are you [here only to show your report

Doctor: [hm there is not time limitation for report Cephalic

$Doctor_2$: Hm

Doctor: Do you feel the movement of child in your womb Do you feel any pain

Patient: Hm No

Doctor: Still do you have any medicine to take

Patient: Hm

Conversation-6

Patient: When I will come

Doctor: Come on Thursday after one month

Patient: Doctor told**.** It has become seven months but I don't [understand

Doctor: [In video x-ray there is difference**.** Of 2/3 weeks It shows 2/3 weeks plus minus It doesn't show exact**.** Take rest and come on Thursday

Conversation-7

Doctor: Uh**.** Visit once**.** On Thursday− Uh drink water about one and half litre

Patient: I have [severe headache

Doctor: [Some are chronic headache which have not exact cause

Visitor: No need [to worry like that

Doctor: [No need to worry

Visitor: Is it [normal

Doctor: Yes [no need to worry it's normal

Patient: [hm

Conversation-8

Patient: Or need to plaster

Doctor: No need to plaster no need to plaster for this it should be immobilized

Patient: Uh

Doctor: Immobilize it with tape Are you taking any medicine

Patient: Uh**.** I had taken pain killer for 2/3 days and not others

Doctor: Pain killers− you are taking uh**.** then exam. Remove during exam and then again tie up it

Conversation-9

Doctor: You can repeat once The repeat [is if you have like lower abdomen pain and burning

Patient: [It is not like that

Doctor: If you feel improvement no need to do immediately**.** Or you can do urine culture to investigate bacteria How do you feel about improvement in ten portion of symptoms

Patient: It's improving Sometime it [comes nicely and sometime slowly

Doctor: [It comes slowly If there is not improvement after taking medicine repeat culture once more

Patient: [After taking medicine for 5 days

Doctor: [Ok [after taking only

Patient: [Syrup**.** Can't it be in tablet

Doctor: Yes I have prescribed in tablet

Conversation-10

Doctor: Do you use thermometer

Patient: Yes it [was 101^0F

Doctor: [Was it 101^0F How much in this morning

Patient: In the morning− 101^0F is the range [101^0F

Doctor: [It is 101^0F Totally take for ten days if the organism is seen in the blood take for 14 days This is typhoid fever It is not necessary to see in blood culture if it is seen take medicine continue**.** For 14 days

Conversation-11

$Nurse_1$: Separate only in fourth visit

$Nurse_2$: Hm

$Nurse_1$: It can be easy for reporting For reporting and to submit

$Nurse_2$: Hm

$Nurse_1$: [Clearly

$Nurse_2$: [We must be clear about report

$Nurse_1$: Hm

Conversation-12

$Doctor_1$: I have started another induction− but it is interrupt

$Doctor_2$: Yeah

$Doctor_1$: Ninety [only

$Doctor_2$: [Yeah

$Doctor_1$: Wait and watch till then tomorrow [if not clear

$Doctor_2$: [Yes it is

Conversation-13

Doctor: Is abdomen burning

Patient: Yes I have nausea also

Doctor: Do you have nausea Was not it improve You should take this antibiotic

Visitor: She likes too much− too much tea every time but she doesn't like to drink water

Doctor: It can be gastritis If you have abdomen burning nausea it can be gastritis Take medicine for ten days Once do video x-ray

Visitor: Do the kidney problem can be found out from stool

Doctor: From urine

$Doctor_2$: From urine

Doctor: Urea sodium potassium− count also

$Doctor_2$: Hm

Doctor: Is it 100% free for you or− free

Patient: 100% free

Visitor: Free Only it takes longer time

Conversation-14

Doctor: How are you feeling on these 3/4 days

Patient: Hm**.** Not fine I am taking cetamol

Doctor: Cetamol**.** How many tablets are you taking in one day

Patient: Three

Doctor: How many days did you take

Patient: I took total three I mean**.** One in a day

Doctor: Have you got high fever in the evening Have you feel high fever

Patient: Hm I have problem of anorexia

Doctor: You have problem of anorexia Is the examination running

Patient: Preparation class is running

Doctor: Preparation class

Conversation-15

Patient: My sister had operation First child was male It was operation Her operation had already been

Doctor: Is it

Patient: Do I have or not

Doctor: You should do if you will have you will do. In emergency and if not it will be done after planning Next week− we must do

Patient: I am feeling so afraid

APPENDIX-II

Roman Transliteration of live recorded conversations in the medical context based on Turner (1931):

Conversation-1

Nurse$_1$: guḍ morniṅg didi

Nurse$_2$: guḍ morniṅg ke cha wāḍko pyāsenṭko khabar

Nurse$_1$: ahile raunḍ bhai sakyo dactar um**.**le 4 nambarko birāmilai ali gāro cha tyaslāi absarb dherai garirākhnu bhannu bhā cha Ovar bliding plas hārṭ dijij pani bhandai cha ani rifar garne ki bhanne kurā bhairaheko cha

Nurse$_2$: ani dactarle chaṅhi ke bhannu bhā cha

Nurse$_1$: tyahi ta garib phyāmliko racha tyasle gardā tatkālai rifar gardā pani kān lāne kun thāunma lāne bhanne bhairācha tyasaile bholi samma herne ki bhanne bhairācha tyaslāi alik keyar garnu holā aru**.**narmal nai cha

Nurse$_2$: oke

Nurse$_1$: tyaso bhae aba**.**tapaiṅ āihālnu bhaecha ma chāṅhi gaeṅ la bāi

Nurse$_2$: bāi bāi

Conversation-2

Nurse: helo bahinī ke cha

Patient: aṅ thikai cha

Nurse: aba medisin khāne belā bhayo nidāunu bhayo ki kyā ho

Patient: haina nidāeko chaina

Nurse: tapāiṅlai kasto cha ahile

Patient: um**.**thikai cha**.**tara alik bliding

Nurse: bliding

Patient: bliding bhairācha

Nurse: yo medisin khānu yo dui tyablet chāṅhi hai ani bholi tyo samasyā chāṅhi bhannu gāro huncha tapāiṅlāi

Patient: huncha

Conversation-3

Doctor: tapāiṅle ek choti indoskopi garyo bhane rāmro huncha

Patient: hajur

Doctor: kinabhane akalṭ blaḍ posetib cha bhane ek coti indoskopi garnu rāmro huncha

Patient: khanālāi ke ke bārne daktar sāb

Doctor: dherai chillo bhuteko cij nakhāne

Patient: um

Doctor: jhol khānekurāharu khāne

Patient: dahiharu dudh khāṅda huncha

Doctor: dahiharu dudh khae huncha

Patient: falful khae pani huncha

Doctor: falful khae pani huncha ek coti tāpaiṅle indoskopi garnu bhae huncha

Patient: indoskopi gardā kati jati lāglā um

Doctor: thāuṅ anusar huncha tyo malāi prāis kati huncha thāhā hudaina

Conversation-4

Doctor: seto pāni jāne ta bhako chaina hai

Patient: tyasto ta mins bhaisake pachi huncha

Doctor: ahile tyasto chaina

Patient: chaina

Doctor: ahile tyasto chaina pisābko kalchar garāyo garāeko chaina hai

Visitor: khai hijo lyabma lagera dieko

Doctor: haina chaina**.**aru inbhestigesan ta narmal nai cha pisābmā ali infeksan cha rutinmā narmal āe pani kahilekāhi kirā dekhā parcha

Patient: hajur

Doctor: kalchar garāuṅdā rāmro huncha

Visitor: infeksanko lāgi ausadhi yuj gardā niko huncha ki aru kehi garnu parcha

Doctor: pahile ausadhi khāera hernus na

Visitor: pet infeksanko kāranle dukheko ho

Doctor: tyastai lagcha hai gyāstrikko ausadhi ke injeksanmā aru ke ke ausadhiharu diyo

Visitor: eutā botalmā ⎧ tyaspachi

Doctor: ⎩ hariyo tyābleṭmā

Visitor: hm

Doctor: dinko ek cakki tin din samma khānu yo entibitik kalchar diepachi mātra**.**khānu

Visitor: entibitik kalchar diepachi

Conversation-5

Patient: bihibār sammamā deṭ siddincha bhanera

Doctor: ek haptā haina**.**haptā haptāmā āunu

Patient: bāhira tyaso bhannu bhā thyo

Doctor: e:

$Doctor_2$: riport mātra dekhāunu āunu ⎧ bhā haina

Doctor: ⎩ hm riporṭ dekhāunulai pardaina Sefālik

$Doctor_2$: hm

Doctor: baccā rāmrari calirācha peṭ dukheko chaina

Patient: hm chaina

Doctor: ausadhi bāṅki cha hagi

Patient: hm

Conversation-6

Patient: kahile āunu kunni

Doctor: ek mahinā pachi bihibār pārera āunu

Patient: tyo daktarle**.**hai sāṭ mahinā bhayo bhannu huncha ki khai ma kehi bujhdina

Doctor: bhidio eksremā cāiṅ 2/3 haptā plas mainas dekhāuṅcha uniharule igjyakṭ hudaina**.**ārām garnu bihibār pārera āunu

Conversation-7

Doctor: uh**.**ek coti**.**bihibār liera āunu−uh pāni dedh litar jati khānu

Patient: kati dherai tāuko dukhcha

Doctor: kunai kronik hedek bhanne huncha igjyacṭ kaj jasto hudaina

Visitor: tyasto āttinu pardaina

Doctor: āttinu pardaina

Visitor: narmalai cha

Doctor: pardaina narmal cha

Patient: hm

Conversation-8

Patient: ki plāstar garnu

Doctor: plāstar garnu pardaina plāstar garnu pardaina yaslāi imobilāijesan garnu paryo

Patient: uh

Doctor: tep lāera imobilāij gardā huncha ausadhi kehi khāirahanu bhaeko cha

Patient: uh**.**maile 2/3 din tyahi pen kilar haru aru kehi pani

Doctor: pen kilarharu−uh**.**aba igjyām**.**igjyām tāimma mātrai nikālera feri kholera bāṅdhnuhos hai

Conversation-9

Doctor: ek coti ripit garera here pani huncha jasto ripit chāṅhi kasto bhane tapāiṅko tallo pet dukhne jasto cha bhane

Patient: tyasto ta bhā chaina

Doctor: āfulai imrubh bhae jasto fil bhā cha bhane turuntai garnu parcha bhanne chaina**.**athawā kitānu katiko dekhā pariracha bhanera yurin kalchar garnu bhae pani huncha simtams daś bhāgmā katiko imprubh bhā jasto lāgcha

Patient: kam bhaeko cha kunai belāmā khulera āuṅcha kunai belā bistārai āuṅcha

Doctor: bistārai āirahancha ausadhi khāera pani bhaena bhane kalchar ripit garera hernu parcha

Patient: yo 5 din ausadhi khāepachi

Doctor: khāepachi mātrai

Patient: jhol ausadhi**.**aru tyableṭmā pāuṅdaina

Doctor: tyahi tyābma lekhidieko chu

Conversation-10

Doctor: tharmomitar rākhera hernu bhā cha

Patient: hereko 101^0F thiyo

Doctor: 101^0F thiyo bihān nāpdā kati thiyo

Patient: bihān−renj tyahi [101^0F

Doctor: [101^0F hai totally ten dej puryānu parcha argyanisam bladmā orgyanisam dekhā parcha vanne chaina dekhā pare pachi 14 din samma**.**ausadhi kantiniu garnu parcha

Conversation-11

$Nurse_1$: forth bhijiṭmā mātra chuṭṭyaune

$Nurse_2$: hm

$Nurse_1$: riporṭ nikālnu pani sajilo huncha riporṭ nikālnu pani ani utā bujhāunu paryonita

$Nurse_2$: hm

$Nurse_1$: [kliyarly ta

$Nurse_2$: [kliyarly ta bhannu saknu paryo nita

$Nurse_1$: hm

Conversation-12

$Doctor_1$: arko indaksan garnu thāleko−tara intarapṭ bhaidiyo

$Doctor_2$: yeah

$Doctor_1$: nāinti [anli

$Doctor_2$: [yeah

$Doctor_1$: aba bholi samma herauṅ bholi samma kliyar bhaena [bhane

$Doctor_2$: [ho

Conversation-13

Doctor: peṭ polirācha

Patient: hajur wākwāk pani āiracha

Doctor: wākwāk pani āuncha kām bhako chaina yo entibāyotik khānu parcha tapāiṅle

Visitor: si lāiks tu mac−tu mac ti ebhri tāim baṭ si daj naṭ lāik tu drink wāter

Doctor: gyastrik pani huna sakcha peṭ polne wākwāk āune cha bhane gyastrik pani huna sakcha 10 din samma ausadhi khānu parcha ek choti bhidiyo eksre garnuhos

Visitor: istul bāta fāind huncha haina kidniko prablam

Doctor: yurin bāta

Doctor$_2$: yurin bāta

Doctor: yuriya potāsiyam−kāunṭ pani

Doctor$_2$: hm

Doctor: tyahaṅ 100% fri ki tapāiṅlai−fri

Patient: 100% fri

Visitor: fri tāim mātrai waist hune

Conversation-14

Doctor: 3/4 din bhayo haina sanco nabhaeko

Patient: hm.sitāmolharu khāiraheko chu

Doctor: sitāmol.dinmā katiwata khānu bhairācha

Patient: tin watā

Doctor: kati din khānu bhayo

Patient: tyahi total 3 watā khāeko bhannāle dinko.eutā

Doctor: belukā badhi fibar āune badhi jworo āe jasto fil huncha

Patient: hm khāna ruci chaina

Doctor: khāna ruci chaina ikjyam chalirācha

Patient: pripyaresan klās chalirācha

Doctor: pripyaresan klās

Conversation-15

Patient: didiko pani aparesan thiyo haina pahilāko ni chorā thiyo aparesan nai thiyo didiko ta bhai sakyo ni

Doctor: ho

Patient: mero chāṅhi garnu parcha ki pardaina

Doctor: garnu parcha bichmā charkyo tyasto bhayo bhane imarjensimā bhae pani gari dinchauṅ.haina imarjensi chaina bhane plān garera garne ho aba āune haptā cāṅhi–garnu parcha

Patient: kasto dar lāgiraheko cha