OFFERING HEALTHCARE THROUGH RADIO: AN ANALYSIS OF RADIO HEALTH TALK BY MEDICAL DOCTORS

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Abstract

With the advent of increasing diseases and inadequate access to healthcare by the general public, coupled with increasing focus on preventive healthcare, the radio has become a useful means of healthcare delivery in Ghana. This paper attempts to find out whether, as a situated linguistic behaviour in a professional setting, health talk given by medical doctors has a cohesive generic structure that allows for the fulfilment of a communicative purpose. Thus, using the genre-based approach (Swales, 1990; Bhatia, 1993), the paper explores the organisational pattern of medical doctors' health talk given on a local radio station in the University of Cape Coast, Cape Coast, Ghana. It is found that the presentation given by the medical doctors involves three moves, namely: (1) Introduction, which has two steps – Definition and Thesis/Previewing; (2) Problem, with four steps - Definition, Epidemiology, Causes/Risk Factors, and Signs and Symptoms; (3) Solution, with two steps - Prevention, Treatment. The paper has implications for healthcare delivery and genre studies.

Keywords:

genre, organisational structure, move, step, health talk

1. Introduction

According to Piotrow, Kincad, Rimon & Rinehart (1997), there is substantial evidence to show that in the field of public health people want to know about their health; they want to talk more about it to friends and family; they want to hear about it through the mass media, and discuss it with competent, caring service providers; people are willing to change their health behaviour; and public health communication programmes are helping people make these changes. Knowing that "the health challenges of the next century are formidable" (Piotrow et al, 1997:xvii), health professionals are finding new ways of offering health care to the general public. One of such ways is radio talk-shows.

With the increasing number of radio stations in Ghana in the last decade or so, health talk-shows on radio (and other media channels) are becoming more and more popular (e.g., *Nestlé Nutrition Line*, Joy FM; *Dwaso Nsem Health Titbits,* Adom FM; *You and Your Health*, Metro TV, *Complete Woman*, Ghana Television; *Health,* The Mirror newspaper, a. s. o.). This surfaced on the media landscape because, as part of their social services programmes, most radio stations (have) designed health programmes to reach out to and educate the public on health issues. And to make such programmes more successful, they normally engage the services of medical and other health professionals.

In these health talk-shows, because the natural face-to-face doctor-patient interaction is unavailable, how the medical professionals do the presentation is crucial for the understanding of the audience. Since the talk show normally has a specific purpose of informing and educating audience, it can be considered a genre – a class of communicative events, members of which share some communicative purposes (Swales, 1990) as well as it being identified and understood by the members of the discourse community in which it regularly occurs (Bhatia, 1993).

Thus, the purpose of this study is to explore the rhetorical-move/generic structure of the health talk-shows presented by medical doctors of the University of Cape Coast hospital, Cape Coast, on a radio station in the University.

The study is significant in two ways. First, it adds to the existing literature on medical discourse and genre studies by providing data and information from a different environment, culture and context. This is significant because "Different societies, periods and cultures assign different values to different priorities; in the

past 30 years, for example, medical care in the Western world has increasingly emphasised patient autonomy in decision-making" (Gotti & Salayer-Meyer, 2006:11). Second, it will inform healthcare delivery and access in Ghana and elsewhere in the world.

2. Some Studies on Medical Discourse

The importance of medical discourse dates back to antiquity even though its systematic study and recognition is quite recent (Roter & Hall, 1989). According to Roter & Hall,

> it is only since the mid-1960s that the actual dynamics of the therapeutic dialogue have been observed in any systematic manner and that an attempt to recast this aspect of medicine as science has been made. The evolution of methodological and technological sophistication has made observation and analysis of medical visit easier over the years, and, indeed, the number of empirical studies of doctor-patient communication doubled between 1982 and 1987 to over 60 (163)

Roter and Hall, thus, explore some frameworks for coding medical interaction to aid research in the area. Some of these frameworks explored include: Bale's (1950) Interaction Process Analysis Approach, for assessing patterns of interaction, communication, and decision-making processes in small groups; Roter's (1977) Interaction Analysis System, a modification of Bale's, to study interaction dynamics in routine medical encounters; Stiles, Putnam, James & Wolf's (1979a, 1979b) the Verbal Response Approach, an alternative approach that made use of linguistic theories; Inui, Carter, Kukull & Haigh (1982), who compared the above-mentioned frameworks to see the effectiveness of each of them, among others. Roter & Hall mention that, in the application of the above-mentioned theories, it was found out that patients usually were unable to recollect about 50% of the information communicated to them by their physicians. If this is true, then it is important that how information is communicated to patients is studied to find out its effectiveness.

Waitzkin (1989) similarly examines some theories of medical discourse and concludes that personal troubles of patients often have their roots in social issues beyond medicine; and that while medical encounters involve 'micro-level'

interactions between individuals, these interpersonal processes occur in social contexts that are shaped by 'macro-level' structures in society. He further states that "The technical structure of medical encounter, as traditionally seen by health professionals, masks a deeper structure that may have little to do with the conscious thoughts of professionals about what they are saying and doing" (220). Waitzkin's observation implies that there is the need to study the structure of medical discourses in order to suggest other ways of improving medical interactions.

According to Gotti & Saleyer-Meyer (2006), in contemporary times, medicine has become so important and absorbing that there has been an increasing number of annual publications of medical journals and non-medical journals devoted to linguistic, sociolinguistic and socio-historical study of medical discourse. Thus, more theories have currently been applied to the study of medical discourses, as exemplified below.

Conversation Analysis (CA), Bowles (2006) suggests, has contributed to medical discourse studies by means of applied and interdisciplinary studies. He thinks that if medical discourse is considered as a social act then CA may concentrate on the phases, moves and the social action that is generated through the discourse. Candlin (2006) also uses CA to analyse audio-taped nurse-patient interactions, considering how social variables (age, gender, culture, etc.) affect such interactions. She postulates that patients' points of view and cultural background in medical interaction are as important as the doctors' and therefore attention should be given to both, so as to reduce power threat and ensure patients' cooperation in the interactions.

Also, Leon & Divasson (2006) examine the influence of the communicative and rhetorical features (e.g. introduction, discussion and conclusion sections) of biomedical research papers on the syntactic features of the noun phrase (NP) and vice versa. They conclude that there is some connection between the NP features (e.g. post-modification) and the rhetorical features of the said articles. Similarly, Mungra (2006) studies the macrostructure and rhetorical moves/steps in medical research articles and finds that the rhetorical moves of Introduction-Method-Results-Discussion (IMRD) or Create-a-Research-Space (CARS) proposed by Swales (1990) apply to these articles. Fløttum (2006) compares discipline and language features in medical research articles and concludes that disciplinary factors outweigh language factors and features in the articles.

Corriveau (2007), on the other hand, traces the history of penal law on 'homoerotic mores' in Quebec and opines that medical and religious discourses helped modify the meaning of homosexual crime in the legal repression of homoerotic behaviours in Quebec in the first three quarters of the 20th century. He believes that the pathologizing discourse ensured that homosexuality was no longer condemned as behaviour that was against nature. Thus, the penal law granted pre-eminence to medical discourses and their expertise in order to assist in the control of deviant homosexual behaviour. This means that medical discourses in our communities can inform law-making processes because medical and religious as well as legal discourses reinforce each other.

Adegbite & Odebunmi (2006), in a study of 'discourse tact' in doctor-patient interactions in South-Western Nigeria, find that the doctor-patient interaction during diagnosis is dominated by the doctor eliciting information from the patient while the patient also tries to respond appropriately. They also indicate that in such interaction, politeness principles are usually exploited to enhance successful diagnosis, even though conversation maxims (quantity, relation and manner) are sometimes flouted. They again indicate that doctor-patient interaction generally has problem-solution structure. Adegbite & Odebunmi recommend that medical communication requires the attention of language scholars "in order to gain insight into language as an act of social behaviour and action, especially with respect to the institution of medicine" (499).

Two main observations can be made from the above-reviewed literature. First, the literature can be grouped into three. There are those that deal with general (or theoretical) issues in medical discourse (e.g. Bale, 1950; Howard, 1989; Kukull & Haigh, 1982; Roter & Hall, 1989; Roter's 1977; Stiles et al, 1979a, 1979b). These studies propose ways in which medical interactions may be analysed and discussed. The other group is those based on written discourse, ranging from research articles, newspaper articles and magazines addressing medical discourse (e.g. Flottum, 2006; Leon & Divasson, 2006; Mungra, 2006). The last group deals with spoken discourse, the majority of which are on interactions between doctors/healthcare providers and patients (e.g. Adegbite & Odebunmi, 2006; Bowles, 2006; Candlin, 2006).

The second observation is that, as suggested by Adegbite & Odebunma (2006), while a lot more studies of medical discourse have come from Western contexts and elsewhere, the same cannot be said of Nigeria, Ghana and elsewhere in Africa. This

makes the present study significant since all the studies have a central goal of informing healthcare delivery and access in specific contexts and situations. What makes it even more important is that none of the studies reviewed so far deals with spoken data on radio, a void that the current study seeks to fill.

3. The Current Study

3.1 Theoretical Approach

According to Gotti & Salager-Meyer (2006), doctor-patient interaction can be analysed using different approaches and different perspectives, ranging from ethical, how it "serves the goals of non-maleficence, beneficence, autonomy and justice", cross-cultural and -linguistic, gender to interdisciplinary perspectives.

Considering health talk as a genre, this study employs the genre-based approach of analysis (Swales, 1990; Bhatia, 1993), which has been applied variously to both written and spoken discourse in different contexts and settings by different scholars. Examples include: Bhatia (1993) professional settings, (1994) written discourse; Swales (1990, 1996, 2004), academic settings; Swales & Feak (2005) academic writing; Afful & Tekpetey (2011) oral testimonies in religious circles; Medway & Freedman (1994), Devitt (2004) rhetoric; Johns (2002) classroom discourse; Wang (2007) business letters; Frow (2006) linguistics.

In all these studies, the purpose has usually been clear: To examine how discourses in professional settings are broached, structured and developed. Thus, while discourse analysis attempts to examine why members of a speech community use language the way they do (Bhatia, 1993), genre analysis answers the question how a communicative purpose is achieved. According to Aitchison (1992:97), "when we use language, we do not necessarily do so in a random and unconstructed way. Both conversation and written texts have various ways for welding together miscellaneous utterances into a cohesive whole". It is against this background that the present study attempts to do a genre-based exploration of a health talk by medical doctors to observe how the talk is usually structured.

3.2 Methodology

3.2.1 Research Design

The study employs qualitative research design, which allows an in-depth description, analysis and interpretation of verbal behaviour in a localised setting (Afful & Tekpetey, 2011).

The data for the study were collected from Atlantic (ATL) FM, a campus-based radio station in the University of Cape Coast, Ghana. Initiated by a student in 1989 to entertain students in the Atlantic Hall of the University of Cape Coast, the Station, which transmits on a frequency modulation of 100.5 on a Harris 1000k transmitter, was officially recognised as a campus-based non-commercial radio station by the National Communications Authority in 1997 (personal communication with the Station Manager, 19th June, 2011). However, around 2006, it was recognised and categorised as a Community Radio station.

As a campus-based community radio, ATL FM provides education, entertainment and information to members of the University of Cape Coast community and its environs. However, "Programmes are skewed toward teaching, learning, research and outreach activities to enhance University of Cape Coast statutory mandate" (The Station Manager, 19th June, 2011). The authority of the Station is vested in the University of Cape Coast, and it is managed by a eleven-member Management Board to ensure that the Station's programmes conform with the rules and regulations governing the media industry in Ghana.

Broadcasting about 70% of its programmes in English, the Station operates 24 hours a day with programmes such as Talk (35%), Music (40%) and News (25%). The Talk programmes usually focus on providing education and information on issues such as health, tourism, governance, economy and education. It is interesting to note that ATL FM has international partnership with the Voice of America (VOA) and the British Broadcasting Corporation (BBC) to provide global news for the Station's audience.

'Health Talk' is one of the educative programmes of the Station. The programme was designed by the Station in collaboration with the University Health Directorate to disseminate information on health issues (especially diseases) to the listening public. The programme is aired between 8:30 and 9:30 a.m. on Mondays during

which medical doctors from the University of Cape Coast hospital educate listeners on various kinds of diseases, their causes, effects, treatment and prevention.

3.2.2 Data Collection and Treatment

Since 'Health Talk' was a weekly programme, there could be an average of 40 recorded segments per year and because the programme had been airing for over a period of two (2) years**,** there was so much to sample from. I therefore applied the theory of saturation in data collection, which states that "The size of the sample is determined by the optimum number necessary to enable valid inferences to be made about the population" (Marshall, 1996:522; Thomson, 2011). Thus, after analysing five randomly selected segments (each of which was about 40 minutes on the average), I observed a clear pattern. The data were then transcribed from audio to text files, with a word size of about 22, 676**,** and coded for easy referencing.

4. Analysis and Discussion

I employed the qualitative approach of analysis, using Swale's (1990) move analysis to analyse the data. For easy referencing, the orthographically-transcribed data were coded and represented as Cancer, Cataract, Diarrhoea, Stress and Pneumonia, representing the various diseases and/or health conditions discussed. To ensure anonymity, I represented the various speakers on the programme with letters or titles. In the analysis, I use the presentations on Cancer and Cataract for illustrations, but all the five are represented on Table 1.

4.1 The Organisational Pattern

The talk-show has three moves, namely: (1) Introduction, which has two steps – Definition and Thesis/Previewing; (2) Problem, with four steps - Definition, Epidemiology, Causes/Risk Factors, and Signs and Symptoms; (3) Solution, with two steps - Prevention, Treatment. The structure is similar to Adegbite & Odebunmi (2006:506) observation that the "overall content structure of the doctor-patient interaction can be summarised into two parts thus: (i) identifying the problem, its symptoms and sources ... and (ii) attempting to recommend solution(s) to the problem..." A close reading of Adegbite & Odebunmi's paper reveals an

introduction, which they call as "initial prefatory exchanges which contain initiations and replies of greetings and summons" (506). Even though they acknowledge the presence of the introduction ("prefatory exchanges"), they do not consider it as an integral part of the interaction. Thus, there is no major difference between Adegbite & Odebunmi's identified structure and what has been identified in this paper.

Move 1: Introduction

This move has two steps, namely, Opening and Thesis/Previewing

Step 1: Opening

Normally, the programme is introduced by the Host by announcing the presence of the resource person(s) as, for example: "... I am talking about Dr..., Dr... and Dr...." This is then followed by the mentioning of the disease (or medical condition/topic of the day), which is usually followed by a message from the University Health Directorate by one of the doctors:

Example 1 (on Cancer):

Host: As usual, Dr ... would want us to know what we should hear from the University Health Directorate.

Dr: Thank you listeners. We are so grateful for the opportunity ... As a directorate we are highly privileged to have this opportunity ... to liaise with our clientele. Today we plan talking about the cancer of the breast because this month is actually WHO cancer awareness, breast cancer awareness month and we think that we should not be left out of the global effort to perhaps reach out to the larger audience...

This part of the programme tries to establish a rapport with the audience and to create the awareness that the programme had been officially instituted by an authority (in this case, the University Health Directorate) and that the doctors represent the Health Directorate. The main purpose is thus to raise the credibility of the programme, and also give a reason for choosing to talk about the particular disease/health situation, and thereby appealing to the audience to recognise that the disease/health situation under reference is a major problem. In other words, it gives a background to the programme, conceptualises the discussion, and serves as an attention-getter (Afful & Tekpetey, 2011).

The establishment of rapport is akin to Adegbite & Odebunmi's prefatory exchanges involving greetings and summons, which may also serve as an attention-getter.

Example 2 (on Cataract):

Host: So what about cataract?

Dr: Actually in our bid to perhaps reach out to a lot of people with respect to health conditions we thought that at least eye care and er cataract particularly is a major issue that we need to look at in our bid to reach out to as many people as possible.

Step 2: Thesis/Previewing

This part of the Introduction presents a guide to the listener as to what to expect from the discussion. It previews the structure of the presentation, and serves as a kind of summary of the content of the presentation.

Example 3 (on Cancer):

Dr: So as usual the discussion is going to go through we try to talk about the (i) definitions of the condition ... (ii) the epidemiology ... (iii) clinical features in terms of signs and symptoms ... (iv) some risk factors but our emphasis is usually on (v) trying to prevent if it is preventable . (vi) to be sure that people will not look at breast cancer as if it's a witch hunting somebody ... (vii) definitive treatment...

Example 4 (on Cataract):

Dr: We will about what cataract is. We want to talk about the epidemiology. What are the causes. We want to talk about the distribution. ... We want to look at how cataract manifests in terms of signs and symptoms. How you first could know and how you can make the diagnosis and what are the modalities of treatment. And the way to prevent cataract if there's any.

It also states the objectives/purpose of the presentation, as in:

Example 5 (on Cancer):

Dr: Today at the end of the presentation what we will want listeners to take home if nothing at all is that for both men and women they should learn how to do breast self-examination. And that we should also be aware of breast cancer and let's help in its early detection and treatment...

Example 6 (on Cataract):

Dr: at the end of the presentation we want listeners, including you, to understand what cataract is.

Previewing the presentation is important because it allows the audience an opportunity to follow the discussion in view of the absence of face-to-face interaction. It tells the audience what to expect as it provides a picture of the sequence of ideas to be presented.

The Introduction resembles the introduction of an essay (especially an expository essay), which normally contextualises the topic, engages it and previews the structure of the essay (Afful, 2010; 2006). However, definitions appear in Move 2 unlike Afful's finding that definitions appeared in the Move 1 of the introduction of students' essays. It is also related to Swale's (1990) Move-Step structure in research article introductions as there is usually an attempt at 'claiming centrality' with general health situations. There is normally an attempt to create a space for the discussion that is to follow. The doctors create the sense of a niche (in the form of lack of knowledge of the health condition on the part of the audience) that has to be filled. Thus, Swales' (1990) Create a Research Space model (CARS) applies here (Leon & Divasson, 2006; Mungra, 2006).

Move 2: The Problem

The second move of the presentation involves a discussion of the problem along the lines of issues stated in the Thesis/Preview as seen above. This Move can be considered as the point of elaboration (Mann & Thompson, 1987; 1988). Move 2 makes attempts at occupying the niche that was established in the introduction (Swale, 1990; Leon and Divasson, 2006; Mungra, 2006; Wang, 2007 Jian, 2010), that is, providing the audience with the knowledge that they seem to lack.

Step 1: Definition

This is the first step of Move 2. As indicated in Examples 7 and 8, the doctors usually try to define or explain the problem the disease or health condition, as in:

Example 7 (on Cancer):

Dr: Breast cancer is a cancer of the breast. To put it … it's an abnormal harmful growth in the breast and this harmful growth has the propensity or has the ability to move out of the breast to other sites. So this growth will occur in the breast and it's harmful ... It will harm the breast. It will harm other parts of the body also.

Example 8 (on Cataract):

Dr: so the eye lens is shifting form er er transparent to opacity. And the opacity of the eye lens either partial or complete is what is called cataract in the medical terms ... So when we talk of cataract as my director said it's er the opacification in the lens or of the lens. That is the transparent nature of the lens in our eye is lost and the lens then becomes opaque.

This step is significant as it describes the disease or health situation that is under discussion. It helps the audience to know the specific kind of disease that is being discussed.

Step 2: Epidemiology

This step talks about Epidemiology (the distribution and determinants of a health condition). Thus, the doctors make attempts at creating a picture of the prevalence of the disease or health situation around the world or a locality.

Example 9 (on Cancer):

Breast cancer is the commonest female cancer in the world. It accounts for close to about 20% of all cancers of women ... In the US alone, about 46,000 people die annually from breast cancer and the figure for the United Kingdom is over 16,000. Ghana, we don't have very good data to show us how many deaths occur because most of those ones do not even come to hospital they end up dying in the community. But in Korle-Bu, every year not less than 200 cases of breast cancers are diagnosed ... Then you can go to Komfo Anokye and the rest. But I must say worldwide breast cancer is on the increase, it's on the rise.

Example 10 (on Cataract):

Dr: We want to classify its distribution. It affects all ages. It can be in a day old baby and in a ninety year old grandfather, so it cuts through all ages such that if you are born with it today then we can describe yours as congenital, that is, you were born with. If it's with somebody who is may be about erm three years old or something we can describe it as infantile. If it's in the juvenile somebody about fifteen years old then we describe it as juvenile. If it's in somebody who is before about seventy years old we can describe it as pre-senile and if it is in somebody who is about seventy years old and above then we can describe it as senile. So it cuts through all ages, but it is most seen in those who are aged.

As Example 10 indicates, the step also mentions the group of people who are likely to suffer from the problem under reference. It is part of the ways to draw listeners' attention to the need to listen to the programme; it creates a sense of

urgency for the listeners. However, There was no epidemiology of Stress (see Table 1).

Step 3: Causes/Risk Factors

This step states and discusses causes/risk factors of the health situation being discussed as exemplified in Examples 11 and 12.

Example 11 (on Cancer):

Dr: there is no known cause of breast cancer ... but they have factors ... Some of the risk factors or some of the major risk factors here are age, increasing age ... then family history. ... And then we have early age of menstruation. ... And then with the delayed age of first pregnancy ... Another big thing that accounts for the high rise globally is our diet as usual. ... Alcohol intake, smoking, they are all risk factors. When people also have developed other breast diseases in their past

Example 12 (on Cataract):

Dr: That's one of the causes is with age ... And another cause is er trauma to the eye. ... Diabetes predisposes [one] to cataract development. ... drugs that we we use sometimes also may result in us getting cataract. ... Cataract may also be a complication of another eye disease. ... Our pregnant women as we always say there are some infections that have been seen to cause cataract in new born babies that is rubella. When a pregnant mother has rubella infection 50% percent of these babies born will have cataract.

The major aim of the programme is to offer preventive health care. The doctors therefore try to get audience to be preventive instead of curative. It is thus important that the audience are educated on the causes/risk factors associated with diseases. The idea is that if people know what causes a particular kind of health situation, they will be in a better position to avoid catching the disease.

Step 4: Signs and Symptoms

This step talks about the clinical features that indicate the presence of the health condition in question. Examples are:

Example 13 (on Cancer):

Dr: a painless breast swelling. That's the cardinal presentation of breast cancer. ... other presentations include some eczema around the nipple area ... The nipple instead of showing outward

is kind of pulled inside the breast. ... You begin to start to have heavy chest ... you may also see that one of your breast is becoming bigger than the other. ... Another thing is nipple discharge... If it has some stains of blood in it when it's getting late the breast starts developing a sore around it.

Example 14 (on Cataract):

Dr: The main symptom of cataract is progressive loss of vision, progressive. It starts as something oh ok things are a bit blurred or something and then it goes and it progresses from one stage of er visual loss to the other form one stage of visual loss the person will try to adjust er to try and see very well ....

The issue of signs and symptoms is important in the presentation because it is these factors that will normally make one see whether they have a certain medical/health condition so that they may seek medical attention. Step 4 resembles Adegbite & Odebunmi's established "doctor's initiation move which elicits information about the nature and symptoms of a client's illness..." (506); however, theirs is elicitation while this is provision of information.

Move 3: Solution

Move 3 makes an attempt at offering possible preventive measures, if necessary, and then offers treatment procedures if the disease or health condition is contracted. It has two steps.

Step 1: Prevention

This step focuses on how not to acquire or contract a certain health condition; it tells about precautionary measures.

Example 15 (on Cancer):

Dr: So we have to take precautions ... And if you are between 20 from age 20 at least every 3 years once every 3 years you have to go to the hospital for breast screening. ... you'll be testing for breast swelling and any other which includes cancer itself. ... And they'll also teach you how to do it yourself ... so that you will be able to detect ... bring it to the hospital. That is between age 20 and to about 39. From age 40 there's something call mammogram that every woman has to do at least annually ... to check when any lumps are...

Example 16 (on Cataract):

Dr: err let's let's let's err go for screening. If you are told oh go and see the eye specialist here or there so that they check your eye let's do it especially those people who have diabetes ... We we

should endeavour as much as possible not to get eye drops from a chemical shop and just start putting it on our eye because may be our eyes are aching or something. For all you know these eye drops could contain steroids and we talked that steroids predispose to the development of cataract. ... If you have the means you can immunise yourself against rubella so that you are you are assured that the children that you bear will not have any.

The Doctors always emphasise that the main focus of the programme is to help listeners prevent diseases/health conditions, as the following quotation indicates "our emphasis is usually on trying to prevent if it is preventable and that is what our emphasis will be". This is important as preventive healthcare has become a major focus of healthcare providers. The main purpose of this part of the programme is to initiate behaviour "change, accelerate changes already under way, or reinforce change that has already occurred" (Piotrow et al, 1997:2).

Step 2: Treatment

Treatment talks about how to deal with the disease/health condition if diagnosis indicates the presence of it.

Example 17 (on Cancer):

Dr: There are various modes of treatment. One of them is surgery. ... They also give some what you call chemotherapy. Other times too ... they do what we call radiotherapy...

Example 18 (on Cataract):

Dr: the good news about cataract is that it is something that can be corrected; t can be surgically corrected. There are no known medicines that you take by mouth or you put on the eye that will completely take out the opaque lens or which try to make the opaque lens transparent again so eventually it has to be taken out the lens that lens has to be taken out by a short very short surgical procedure. They take out the lens and then either they leave it that way or they put in another lens. They put in an artificial lens into the eye to correct it or they will give a spectacle or spectacles to correct the defect that will be created

This step states what health professionals/providers do in order to cure a certain kind of disease/health condition. They usually discuss methods and procedures of treatment.

Table 1: The overall move/rhetorical structure of the presentations

No. Of Moves/Steps	Cancer	Cataract	Diarrhoea	Stress	Pneumonia
MOVE 1: INTRODUCTION	+ i	+ i	+ i	+ i	+ i
Step 1: Opening	+ 1	+ 1	+ 1	+ 1	+ 1
Step 2: Thesis/Previewing	+ 2	+ 2	+ 2	+ 2	+ 2
MOVE 2: THE PROBLEM	+ ii	+ ii	+ ii	+ ii	+ ii
Step 1: Definition	+ 3	+ 3	+ 3	+ 3	+ 3
Step 2: Epidemiology	+ 4	+ 4	+ 4	-	+ 4
Step3:Risk Factors/Causes	+ 5	+ 5	+ 5	+ 4	+ 5
Step 4:Signs & Symptoms	+ 6	+ 6	+ 6	+ 5	+ iii 6
MOVE 3: SOLUTION	+ iii	+ iii	+ iii	+ iii	+
Step 1: Prevention	+ 7	+ 8	+ 7	+ 7	+ 8
Step 2: Treatment	+ 8	+ 7	+ 8	+ 6	+ 7
Step $_{xxx}$: Demystification*/ Misconception	+ 5, 7	+ 8	-	-	+ 5

+ means present; - means absent; i, ii, iii represent Moves; 1, 2, 3 ... represent the order in which steps appear.

Table 1 indicates that all the texts considered had the three-move structure, with the various steps as shown. The steps appeared in almost the same order, except between prevention and treatment, where for Cancer and Diarrhoea prevention came before treatment while for Cataract and Pneumonia, treatment was before prevention. There was no epidemiology of Stress; but this is seen more as an exception rather than a norm.

Step*: Demystification/Misconception

Demystification as a step is not fixed. Where it occurs depends on the specific kind of misconception that the audience appear to have. It can appear immediately

after causes/risk factors, as for instance, in the discussion on Breast Cancer, it appeared twice: after the statement of risk factors and after the statement of treatment, but it appeared after treatment measures for Cataract.

Example 19 (on Cancer):

Dr: Among the risk factors that have been found to be associated with breast cancer, size of the breast has no relationship with whether one would develop breast cancer or not ... if that analogy continues then males shouldn't develop breast cancer

Example 20 (on Cancer):

Dr: for the concern about seeking medical care, it's not actually getting the diagnosis for most of the women we don't have a problem they are coming but then when they see small thing they come. But it's the modality of treatment that they don't they haven't come to terms with or they. So we are using this forum to actually let them know that there are people who are top level executives who are presidents who are big time who have one breast or no breast at all. ... and they are living more resourceful lives.

Example 21 (on Cataract):

Dr: Know that in the various communities, there are people who say they can push the eye ... They look at the eye and put some instrument to grab the dark the white lens out. At the end of it all you see the whole eye leaking liquid and then it collapses ... That they will operate and people could go with about ten years of impaired vision and that in 2 3 days they could see clearly and what a reincarnation you see.

These examples mean that the audience were thought to have some misconceptions relating to causes and treatment of Breast Cancer, while the misconception on Cataract was related to treatment measures. This is so because misconceptions are related to specific issues relating to specific diseases/health conditions.

5. Conclusion/Implications

This study sought to explore the organisational structure of radio health talk-shows held by medical doctors on a local radio station in the University of Cape Coast. Using Swales' (1990) and Bhatia's (1993) Move-Step structural analysis, the

study found three moves: Introduction, Problem and Solution. The Introduction, Move 1, had two steps, which were Opening and Thesis/Previewing. The Problem, Move 2, consisted of four steps, namely, Definition, Epidemiology, Causes/Risk Factors, and Signs/Symptoms. The Solution, Move 3, had two steps, which were Prevention and Treatment. There was Demystification step which was not fixed; its occurrence depended on the specific kind of misconception that the audience appeared to have.

This study has some implications for genre studies; it adds to the existing scholarship on genre studies. It has been observed that Swales move-step analytical tool is applicable to health talk-shows even though there appears to be some subtle differences in terms the specific move and step patterns. This is understood considering that Bhatia (2004) and Afful (2011) admit that, even within the same genre, definable forms will not always recur in the same way.

Given that radio health talk-shows have become part of the social responsibilities of radio stations in Ghana, and elsewhere, the findings have particular implications for presentation formats. In a more general sense, the paper has some implications for healthcare, especially preventive healthcare, delivery in Ghana and elsewhere.

I recommend further studies into health talk-shows in Ghana and other places to explore the extent to which the findings made here can be generalised. Such studies may also consider those presented on television stations. The focus of such studies may be on micro and macro features such as vocabulary and other linguistic choices as well as socio-economic features and implications of such talk shows.

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