Negotiating patients' therapy proposals in paternalistic and humanistic clinics

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The negotiation of patients' therapy proposals often makes a strong statement about doctors' consultative styles in Nigerian clinical encounters. This invites a search into the relationship between patients' preferred treatment options and doctors' and patients' approaches to negotiating them. Analysis reveals the sequential and face orientation mechanisms deployed in negotiating patients' proposals in predominantly doctor-centred clinics, the interactional moves made by them in negotiating the proposals in predominantly patient-centred clinics, and the pragmatic implications of the proposals negotiated in both clinics. The negotiations in the clinics are anchored to strategic rapport building, the colonisation of patients' lifeworld and constrained joint decisions. Rapport is poorly built in the doctor-centred clinic with power-imbued strategies which stifle patients' voice and lead to completely-constrained joint decisions on therapy proposals by patients. Participatory consultation enhances negotiation in the patient-centred clinic, but the physician's misleading strategic sequences and exaggerated emotions somewhat weaken the ultimate consultative outcome.

Keywords: therapy proposals, paternalistic and humanistic doctoring styles, Kecskes'socio-cognitive approach, interactional moves, Yoruba culture, Nigerian clinical meetings

1. Introduction

Trends in modern medicine increasingly encourage more patients' participation in clinical encounters than traditional approaches to medicine had allowed. This means more patient talk at consultative meetings which is expected to lead up to shared decision making on both diagnoses and therapies. However, realities in Nigerian clinics show that many doctors still use the traditional approach which permits little involvement of patients in decisions on their treatment. The literature documenting academic interventions in clinics where patients are given

https://doi.org/10.1075/prag.18054.ode | Published online: 8 March 2021
Pragmatics 31:3 (2021), pp. 430–454. issn 1018-2101 | e-issn 2406-4238

high participation rights and those where they are not has labelled the styles used in the encounters "person-focused" or "patient-centred" (henceforth PCA) and "disease-focused" or "doctor-centred" (henceforth DCA) approaches (Mezzich et al. 2009), which respectively give priority to the sickness and the person who is sick.

A number of researches in medical pragmatics have dealt with the negotiation of therapeutic proposals by patients in Western clinics (see Stivers 2001; Costello and Roberts 2001; Ainsworth-Vaughn, 1995) and some have situated the negotiation in the humanistic clinic (de Kok et al. 2018). In Africa, some studies have been conducted on doctor-centred and patient-centred approaches from the clinical angle (Ajayi 2003; Lawal et al. 2018; Cubaka, Schriver, Cotton, Nyirazinyoye and Kallestrup 2018), but hardly any of these has investigated how patients' therapy proposals are negotiated in the two clinics, particularly from a pragmatic perspective. Odebunmi (2016), the only available relevant study in Nigeria, only sandwiches a tiny portion of the negotiation in a broader study on accountability in post-recommendation consultations. Other scholars in medical discourse have established a link between doctors' humanistic style and positive (but on rare occasions, negative) consultative outcomes (see Ainsworth 1995; de Kok et al. 2018).

Most current studies on clinical consultations (see Odebunmi 2017; de Kok et al. 2018; Cubaka, Schriver, Nyirazinyoye and Kallestrup 2018) have submitted that one of the best ways modern medicine could provide care that is satisfactory to patients is to allow greater participation of patients in clinical decisions. This brings with it the need to find out how doctors and patients fare in clinical encounters on therapy, particularly in Nigeria where little is heard in the scholarship about the way consultative parties negotiate patients' proposals. Determining this will not only reveal the nature of the relationship between the parties, but will also show the pragmatic mechanisms they deploy in negotiating the proposals, itself a useful clue for the understanding of the nature of the interactions in the clinics. It is, therefore, the concern of this research to examine the interactional moves activated by doctors and patients, explore the pragmatic mechanisms they deploy in the negotiation of therapy proposals of patients in the clinics and evaluate the level at which the resources and mechanisms fit with the principles of DCA and PCA in Nigeria. By "interactional moves" in this research is meant the discursive acts in doctor-patient exchanges that indicate the parties' goals in hospital encounters. These are singly or jointly expressed and negotiated by the parties in the interactions.

One pragmatic theory considered appropriate to unpack the negotiation of patients' proposals in the clinics is Istvan Kecskes' (2010, 2014) socio-cognitive approach (SCA), which deals with interactants' mutual access to conversational meaning. SCA treats discursive features such as intention, common ground and

salience as at once a priori (declarative) and emergent (procedural)[1] (Kecskes 2014). It recognises three types of knowledge in the construction and comprehension of meaning, namely, "collective prior knowledge, individual prior knowledge and actual situationally, socially created knowledge" (p. 23). These are utilised as analytical tools in this study alongside SCA's concepts of shared sense, culture sense and attention, which respectively refer to what is known to a group or all interactants, common knowledge about cultural norms and societal circumstances, and the "cognitive resources available to interlocutors that make communication a conscious action" (Kecskes 2014, 52). These resources are combined with aspects of Arundale's (2010) Face Constituting Theory (FCT) and Conversation analysis (turn design and distribution (including sequencing and repair), understanding checks and increments). The paper uses FCT's face connection (support) and face separation (threat) which, barring FCT's discursive dimensions, are somewhat respectively coterminous with Brown and Levinson's (1987) positive/negative politeness and bald on record act. Face connection or support conceptualises a boost (cf Ruhi 2006) to the face of co-interactants while face separation theorises a disconnect with or a harm to co-interactants' face orientation. Terms such as producings (productions -utterances and other attendant speech production cues) and interpretings (interpretations -inferences and understanding demonstration cues) are distinctive to FCT. The choice of SCA is informed by the theory's ability to account for doctors' and patients' knowledge and experiences before and during consultations. This choice is complemented by CA and FCT which, respectively, are able to provide effective explanations for the parties' emergent experiences and illustrate the pre-encounter and in-encounter clinical interactions of the parties as they reveal their face orientations. Consequently, they strengthen the analysis of the interactive moves (co-)constructed by the participants.

In Section 2 below, I present the methodology of the research, in Section 3, the analysis and findings, and in Section 4, the conclusion.

2. Methodology

Twenty conversations which centred on therapy preference negotiations, recorded in 2014 and 2015 in private and government-owned hospitals in Oyo and Ondo States, Nigeria, constitute the data for this study. While all were examined for the interactive features of the negotiation of patients' proposals and considered

1. Apriori/declarative and emergent/procedural: respectively, the knowledge interactants brought into the interaction and the one that they have while the interaction is in progress.

for analytical categorisations, only two of them which exhibit almost a sharp contrast in the orientation to DCA and PCA are used in the analysis. A mix of Standard English, Nigerian English, Nigerian Pidgin and Yoruba is used by the doctor and the patient (both of whom are Yoruba by ethnic affiliation) in Conversation 1 which centres on ulcer and fatigue. Conversation 2, executed in a disproportionate combination of Yoruba (which is dominant) and Standard English (which is used sparingly), is on hypertension. In the two transcripts, Standard English is rendered in plain typeface, Nigerian English is underlined, Pidgin English is italicised and Yoruba insertions are rendered in the bold font.

The two visits lasted approximately 8 min and 3 min, featuring two main participants in each case. In-depth interviews were conducted with sections of doctors, patients and general public members on interactions in doctor-centred and patient-centred clinics. In addition, data interpretation sessions were held with two doctors to determine the accuracy or otherwise of the interpretations of the interactions. The purposively sampled setting for the two conversations is a university clinic in one of the Nigerian South-west states. The transcription model used is the one developed by Gail Jefferson (2004).

3. Analysis and findings

There are three parts to the analysis. The first (3.1) and the second (3.2) develop the interactional moves and face orientation mechanisms deployed to negotiate therapy proposals in predominantly DCA and PCA consultative meetings. The third (3.3) casts a critical look at the clinical implications of the interactional moves. I give attention to these sections below.

3.1 Negotiation of Patient's proposals in a predominantly doctor-centred clinic

In this section, analysis bifurcates into sequential negotiations (3.1.1) and face orientations (3.1.2) of participants. First, I summarise the conversation. This is followed by the presentation of relevant aspects of the conversation, and finally an analysis of sequences and facework. The conversation is an encounter between a patient[2] (henceforth Patient) and a doctor (henceforth Doctor). It is a follow up to the patient's earlier visit the previous evening during which the doctor ordered a laboratory test on her. Between Lines 1–72, the parties first review the event at the

2. The patient is a final year undergraduate student whose (critical) university-level education equips with the intellectual ability to engage the doctor.

previous meeting and the available laboratory results. This is followed by clerking in which Patient and Doctor exchange medical information on Patient's insomnia, headache and fatigue. Between Lines 73 (where the excerpt begins) and 137, Doctor seeks to know the treatment regimens Patient was placed on by earlier doctors. This is followed by Patient's preference of an injection to Doctor's offer of a drug, Patient's preference of faith healing to which Doctor openly disagrees and the duo's eventual compromise on a treatment course consisting of both injections and drugs.

Conversation 1

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73. Dr: So it's not as if you're on any drug that you're using everyday=
74. Pat: No=
75. Dr: Okay (0.14). Okay. I'm going to give you these drugs (.) Then (.) try to use them (0.1)
76. Pat: Sir, can't I take injection↓
77. Dr: You prefer injection↓ (.) WHY↑=
78. Pat: °Yes°
79. Pat: I don't --I DON'T LIKE USING DRUGS *sef* ( ). And I used to have ulcer too
80. ( )=
I actually don't like taking drugs
81. Dr: Okay↑
82. Pat: And I react to it=
83. Dr: You used to have ulcer=
84. Pat: Yes sir
85. Dr: ° Okay°. When was the last time you had the [symptom]?
86. Pat: [symptom] ( ) (0.2) ( )
87. Pat: It has, it used to disturb me before but this time it can just occur any time may
88. be what I am going through is stressful ( )
89. Dr: Okay. [They told you to avoid] some things **abi**?
They told you to avoid some things; didn't they?
90. Pat: [( )] . Yes sir
91. Dr: What are the things they asked you to avoid? =
92. Pat: Like peppery food, fried food (.)
93. Dr: [But not so peppery], but as in something that is too pepperish. Food that
94. not as if you won't eat pepper at all and something that is very
95. hot; food that=
96. Pat: [Food] Yes
97. Dr: And have you been obeying that↑ No=
98. Pat: No, initially, but=
99. Dr: Initially but later you decided to do your wish. So why did you stop
100. using your (0.1), why did you stop doing what they asked you to do? You
101. don't like yourself (0.2)
102. Pat: °No°
103. Dr: You always enjoy that pain ( ) and all of it.
104. Pat: °Faith°=
105. Dr: Uhn? =
106. Pat: FAITH=
107. Dr: You're using faith. Faith doesn't mean you should be stubborn (.) Is it
108. even good to eat hot food↑ Is it even good to eat pepperish food↑ even if
109. you don't have ulcer↓ Ok and another thing, what about drugs. There're
110. some drugs that they asked you not to take (.) like all these pain relievers.
111. Pat: No ( ), but [the doctor I saw then]
112. Dr: [They did not tell you to stop] things like Aspirin, Ibuprofen
113. Pat: They just told me that >ANY TIME I WANT TO GET A DRUG I
114. SHOULD LET THEM KNOW<that I want it so that
115. Dr: And you have [been doing] that **abi**? =
And you have been doing that, haven't you?
116. Pat: [Yes] Yes (0.3)
117. Dr: It's okay. So in a nut shell. You have been, you are one of those people

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118.     that refuse to follow the instructions doctors give you=
119.Pat: No: Not at all=
120.Dr:  You said you are using faith
121.Pat: No. it's like DURING THE INITIAL STAGE I WAS ACTUALLY
122.     ADHERING TO IT IT'S JUST NOW THAT I feel better and ( )
123.Dr:  Ok. I a::m so:: sorry to inform you that we cannot give you=
124.Pat: Injection
125.Dr:  No. we can give you. We're going to give you now but all your drugs
126.     cannot be injection. Yes. Because there is no way we'll be able to give you
127.     everything as injection. One, we won't be able to afford it; two, it will be
128.     too cumbersome. If you're going to be on some drugs for three days,
129.     four days, one week (.) I don't think we can afford giving you
130.     injection. Injection is like times five of normal drugs. It's too expensive
131.     and besides it's not even going to be easy for us. It's too cumbersome and it
132.     doesn't even make sense, even ethically speaking it doesn't make sense in
133.     terms of everything. (0.2). So, we give you two injections now right away
134.     then the rest you will go and use it at as drugs at home (0.06) ((clears his
135.     throat)). Alaba Grace, abi?
                   Alaba Grace, isn't it
136.Pat: Yes sir=
137.Dr:  Ok (0.20)
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.
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3.1.1 *Sequential negotiations in a doctor-centred clinic*

Four interactive moves made by Doctor and Patient in the conversation with their attendant discursive negotiation strategies are presented in a largely bottom-up fashion in this section. I handle these moves in turns.

1. *Patient makes a procedural appeal to deontic rights and institutional flexibility as a cue for a therapy proposal*

After Doctor at line 75 proposes a therapy plan designed from Patient's narrative account, Patient makes an emergent appeal to institutional flexibility. In other words, Patient's request for an injection at Line 76 which is opposed to Doctor's proposal of drugs, given her level of literacy, is a deliberate act, which is consistent with a patient's right to explore possible options, typically affordable for medical practice, and which Patient seems to be aware of.

The sequence, "Can't I take injection?" (Line 76) tacitly rejects Doctor's proposal and seeks his view on her preference, implicating Patient's desire for a personally convenient recommendation. Doctor's next interrogative turn at line 77, "You prefer injection (.) why?", a demonstration of emergent shared sense (Kecskes 2014), gives the impression of a democratic rather than a prescriptive and pontificating style which seems to accommodate Patient's request and, as a consequence, draw out Patient on her choice of therapy. At Line 79, Patient's "I don't – I DON'T LIKE USING DRUGS[3] *sef* " makes her point directly and emphatically. However, she immediately inserts the contribution, "And I used to

3. *Sef*: A polysemous, context-influenced Pidgin English word literally means "even".

have ulcer too" (Line 79), which shifts the footing of the conversation to ulcer talk, perhaps as an emergent ploy to appeal to Doctor's approval of her proposal.

2. *Doctor interprets the utterances of patient as indexes of personal goals*[4]
Between Lines 76 and 79, Doctor interprets Patient's utterances as indexes of personal goals. The first utterance by Patient: "Can't I take injection↓", which presupposes an alternative treatment proposal, is interpreted by Doctor as a venture in deontic disaffiliation: "You prefer injection↓(.) WHY↑" (Line 77). The falling pitch, indicating new information, voices Patient's strategic request. The rising one with the attendant loudness signifies given information and seeks a justification for Patient's expression of deontic right. It consequently expresses indirect disaffiliation with Patient's proposal

Doctor's response with "Okay↑" (Line 81) to Patient's second utterance, "I don't – I DON'T LIKE USING DRUGS *sef*" (Line 79) (which openly disaffiliates with Doctor's therapy proposal), followed by his preference for contiguity (see Landmark et al. 2015), i.e. responding only to the ulcer issue, trivialises Patient's deontic stance as inconsequential and implicates his preference for the somatic element rather than the patient. The third utterance, "And I used to have ulcer too" (Line 79), is an increment, which makes it an afterthought or an appendage and thus an emergent attention seeker. Doctor's "Okay↑" (Line 81) interprets the utterance as a doubtful account with Doctor's strategic repetition at Line 83: "You used to have ulcer". The response is complemented by Doctor's sequence "° Okay°. When was the last time you had the [symptom]?" at Line 85 which presents Patient's utterance as an emergent effort for Doctor to find the true reason for Patient's dispreference of his recommendation, Patient's sudden deflection to ulcer talk being suspicious.

3. *Both parties co-jointly construct patient's dispreference of Doctor's therapy proposal as an index of irresponsibility*
Between Lines 89–97, Doctor asks questions which check-list earlier therapy plans with Patient: things such as peppery and hot foods which previous doctors told her to avoid. At Line 98, by Patient's disaffiliative response, she confirms her non-compliance with the recommendations

Doctor's sequence terminating "No" at Line 97 is a power-imbued, preemptive insertion which seems to sequentially inform Patient's disaffiliation, but her disagreement-indicative insertion : "… initially but", in which she seeks to interactively enrich her position, is interrupted by Doctor at Line 99. Although the disaffiliative turn confirms non-compliance and consequently works to co-construct her action as an index of irresponsibility, Doctor's power-laden, inter-

4. Personal goals are agendas not declared to other participants (see Clark 1996)

ruptive and subsequent face separation (see Arundale 2010; Don and Izadi 2011) sequences suppress her intended lifeworld interventions as shown in 3.3 below. The irresponsibility thesis is sustained in Doctor's negative and positive face separationist perspectives between Lines 99–101. His sequences at Lines 99–100, which respectively imply that Patient is stubborn and that she flouts medical instructions at will, threaten her negative face. Her positive face is affected by Doctor's turn at Lines 100 b-101 which implies being disobedient and a hater of self-wellness.

4. *Patient sequentially appeals to spiritual healing as a preferred alternative to medical plan*

The barrage of threats directed at Patient's face up to Line 101 causes her to identify religion as the actual motivation for her non-compliance, a point which is not in the parties' a priori common ground. At Line 105, in a discourse coherent relationship with Doctor's turn at Line 104, Patient utters 'faith', which constitutes a difficult attention processing sequence to Doctor, who, as a consequence, has to initiate an understanding check at Line 105. At Line 106, Patient's repair with a louder mention of 'FAITH' gives clearer force to her expression of religious convenience as a preferred alternative to the therapy plans she had received at previous consultative meetings. This preference is fairly consistent with the practice among some Christian sect members in Nigeria who rely on spiritual healing, also known as 'faith healing', as an alternative to biomedical therapies.

3.1.2 *Face orientations and negotiations*

Face orientations in the interaction take two dimensions: cultural and institutional. They reflect the parties' differential or joint understanding of diagnostic and treatment options which call for productions and interpretations situated in the Yoruba culture and Western medical practice, and which, given the parties' disagreements in the clinical encounter, motivate dominant face separation and strategic face connection cues. These face orientation issues take two forms: face separation in the clash of cultural and institutional interpretations and strategic face connection as an institutional pressure.

1. *Face separation in the clash of cultural and institutional interpretations*

Between Lines 99 and 123, both Doctor and Patient get engaged in facework which reveals a clash between their cultural and institutional interpretations. Essentially, Doctor steps out of his institutional boundary and takes up a cultural role as a reaction to Patient's religious production of spiritually-tied healing preference (as shown in Sub-Section 4 above). Doctor's cultural interpretations manifest as threats which separate from Patient's face. In reacting to this situation, Patient abandons her earlier cultural (religious) production and opts for institu-

tional interpretations as a way of claiming her discursive rights and recontextualising the clinical encounter to both recover her positive face and achieve her original goal of expressing a preference for an injection.

In more specific terms, the productions of both parties construct criticism, resistance, suppression and compromise which are co-jointly co-constructed as threats by them. Reacting to Patient's rationale for non-adherence to treatment regimens, (Line 107), Doctor drops his physician role and takes up the Yoruba paternalistic and disciplinarian role. First, he increments Patient's single-word sequence ("FAITH' Line 106)): "You 're using faith" (Line 107). This, by implication, denigrates Patient's preference of spiritual healing when considered alongside the subsequent co-text. His next sequence "Faith doesn't mean you should be stubborn" (same line) is an unmitigated threat which condemns Patient's preference as unreasonable and impractical. These are followed by a series of judgemental productions (up to Line 110), which criticise Patient's abandonment of prescribed therapy plans for the embrace of religious convenience as an unintelligent act.

Doctor's interpretations obviously miscontextualise the encounter as a sociocultural, rather than an institutional meeting, where insults can be freely hauled at a younger interactant with no consideration for their face orientation. Patient, however, defines the encounter strictly as an institutional one, co-constructing Doctor's productions as threats, and resists the patriarchal impositions placed by him. Her first attempt at Line 111 which is designed as a direct counter-argument against Doctor's self-generated, generalising information, " … the doctor I saw then" is suppressed by Doctor's interruption in a blatant expression of power, given its high face separation potential (see also de Belder 2012, 112). To further entrench physician power and keep up his paternalistic role, Doctor initiates another face separation sequence with cultural implications at Line 112: "They did not tell you to stop things like Aspirin, Ibuprofen". The negative statement structure is a reprimand format popular among the Yoruba to accuse a younger or junior co-interactant of a wrong done. While 'they' makes an exophoric reference to physicians who earlier prescribed Aspirin and Ibuprofen to Patient, the whole structure sustains the charge of disobedience which Doctor had earlier levelled against Patient. Disorienting to this accusation, Patient at Lines 113–114 negates Doctor's sequence as an emergent misrepresentation of her medical account. By this sequence, she separates from Doctor's face with her noisy contribution, which is a clear threat to Doctor's paternalistic face.

Doctor, having suffered face loss from Patient's resistance to his paternalistic style, evokes the Yoruba collectivist culture as a redressive action. At Line 115, he abandons his earlier premise and position on Patient's dispreference by inserting an intonation-based interrogative sequence "Abi" in "And you have been doing

that abi?" which is a pragmatic choice rooted in the Yoruba diplomatic culture. In its emergent use, *abi*, a Yoruba word often found inserted into Nigerian English discourses means: "Is that not so?" In its declarative sense, it is sometimes selected by the older/elder/superior co-interactant to express a personal, unilateral conclusion about an issue, usually following a positive, deceptively affiliative statement as in Line 115.

In the strict Yoruba cultural context, *abi* is selected pragmatically, as seen in this conversational context, on some occasions, as a power-imbued silencing strategy to save the face of older or superior co-interactants when they are sometimes already suffering guilt in an encounter with a younger folk. When that situation obtains, the younger addressee is expected to keep quiet in admittance of guilt for the moment, but this expectation fails in this interaction for three possible reasons. First, Patient herself has suffered heavy face loss and might not want to incur more as doing so may lead to taking unjustifiable responsibility for her health. Second, the interaction has developed into a sort of altercation, therefore, orienting to such cultural expectations as admittance of an uncommitted wrong, given the conflictual context in which the dyad relate, would not be the best pragmatic option. Third, both interactants seem not to be on the same cultural level. While Doctor orients to the Yoruba cultural concept, which he seems to intentionally mix up with the culture of the West he picked up while in training in the medical school, Patient seems to be largely influenced by the culture of her education, which to some extent, is Western, and, which therefore predisposes her to providing answers to all questions without collectivist cultural sensitivity. At Line 116, Patient's 'yes', which overlaps with Doctor's "been doing" at Line 115 provides a bold answer to what Doctor had designed as a rhetorical question to gain positive face. This spurs a complete footing change in Doctor's next turn. At Lines 117–118, Doctor, having failed to receive a face boost (Ruhi 2006) from Patient, abandons logic and accuses Patient of complete non-compliance with all therapy plans. This interactive action by Doctor fails again as he suffers further face loss with Patient's resistance framed disaffiliatively: "No: not at all" (Line 119).

Doctor, at Line 120, reverts to the earlier sequentially concluded religious proposal made by Patient (Lines 104/106) as an emergent mechanism to tackle his face loss. His action has a root in the Yoruba cultural ideological concept of wrong-free elderhood, expressed in the maxim, *àgbà kii jebi* (the elder is never wrong). His goal, considered from this cultural perspective, is to ensure Patient admits wrongness, at the least, to be able to reclaim his lost cultural face and assert his professional authority. After Patient has provided a response to his turn at Lines 117–118, which he has designed as a strategic overgeneralisation for the construction of Patient's religious proposal as a wrong alternative, Patient disaffiliates with his interpretation with the negative response at Line 119. Doctor's "You

said you are using faith" (Line 120), though connects with the concluded issue of faith raised between Lines 103–110, serves here both as a response to Patient's disaligning response and as a strategic choice to make Patient answerable to a charge for which she is apparently guilty for the restoration of Doctor's face to save "the elder" from "being wrong" before the younger folk. Doctor achieves his face redressive design by Patient's "No" at Line 121 which affiliates with Doctor's position, and which simply jointly co-constructs her preference for religious therapy as a wrong alternative. One of the doctors interviewed considered the cause of the interactive friction in the interaction as the consulting doctor's non-deployment of key principles of general medical and patient-centred communication which would have enabled Doctor to ask far reaching questions and offer several possible options to Patient, and consequently get most of the grey areas that constituted the friction clarified.

2. *Strategic face connection as an institutional pressure*

After Doctor has regained his face, he reverts to institutional power from Line 123. At this point, he stays within the scope of his institutional roles and affordances, and strategically connects with Patient's face apparently to avoid new interactive clashes.

After addressing the face orientation questions on the religious proposal, Doctor reverts to Patient's personal convenience proposal hitherto abandoned for the ulcer issue. He announces his disapproval of Patient's proposal of injection. "Ok" (Line 123) is a marker of footing change from negotiation to the full voice of medicine. "I a::m so:: sorry to inform you…" (Line 123) breaks the bad news (cf Maynard 1996) to Patient in an extremely formal manner, indicating Doctor's complete disapproval of Patient's preference for injection at line 76. The production, "…that we cannot give you" (Line 124), represents the voice of medicine, implying that prescribing an injection for the ailment is not affordable for medicine, which is not necessarily so, considering Patient's clinical antecedent. This notwithstanding, the mitigated manner in which the news has been announced demonstrates a strategic face support, informed by a suppressed ego resulting most probably from Patient's earlier resistance to Doctor's heavy face separation acts. However, Patient's pre-emptive completion of Doctor's turn with "injection" at Line 124, a context-shaped sequence, is a strategic insertion to subtly point Doctor's attention to her rights as a patient to suggest her preferred therapy type. Doctor's quick modification of his recommendation at Lines 125–134 seems a consequence of this strategic insertion, in spite of his paternalistic position earlier displayed in the encounter, and a strategic face connection to Patient's interactive preference.

3.2 Negotiation of patient's proposal in a predominantly patient-centred clinic

This section presents an analysis of four interactional moves deployed in the encounter between a woman in her early 60's and a doctor in a clinic where PCA has been used. The meeting starts with Doctor checking Patient's blood pressure (BP) following an affirmative response to Doctor's question about her health. Subsequent turns reveal Doctor's request for her compliance with his recommendations, her declared greater faithfulness to religious fasting than medication adherence, Doctor's adjustment of the regimen and his implicit warning over self-review of treatment plans.

Conversation 2:

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1.  Dr:  °Kini initials yin yen°; B.O. ABI? =
          What initials your you; B.O. Is not?)
          What are those initials of yours; B.O. Aren't they?
2.  Pat: >Yes, sir<
3.  Doc: Okay (0.13) °E [me le yi wa°]        ((asks to have one of Patient's hands))
                      You can bring this come
                      Give me this
4.  Pat:               [°Okay °     ] (0.18)
5.  Dr:  °Je ki n koko check BP won° (0.07). °But báwo lara yin°?=
          Let me first check BP them.          But how body you?
          Let me check her BP first.           But how is your body/health
6.  Pat: °Well-- mo dupe lowo Olorun°=
          Well, I thank hand God
          Well, I thank God
7.  Dr:  Se e e ni complaint kankan? =
          Is it you have no complaint any?
          Do you have any complaint?
8.  Pat: °Mi o ni complaint°=
          I not have complaint
          I don't have any complaint
9.  Dr:  °Okay° ((measures her BP)) (0.36). Igbawo le ti lo oogun yen last Ma? (0.03)
                                             When you use drug that last Ma
                                             When was the last time you used the drug, Madam
10. Dr:  O [ti se die]
            It has done little
            It's been a while
11. Pat:   [Ee ri naa pe] (.)
           You will see actually that
           You would actually realise that
12. Dr:     °Kilo sele?°=
             What happens
             What's the matter
13. Pat: A WA NI FASTING AND PRAYER NI CHURCH=
         We are in fasting and prayer in church
         We are observing a period of fasting and prayer in our church
14. Dr:  Oka:::y↑=
15. Pat: Uhn?=
16. Dr:  Okay::↑ Enh, @ E MA LO LAALE E, ABI SE MARATHON NI FASTING YEN
                 Yes,   you will use in night night, or is it Marathon is fasting that
                 Yes,   use it every night, or is the fasting absolute?
17.         NI↑=   ((enthusiastically))
            It
18. Pat: No, MO MA NLO LALE=
            I am using it in night
            I use it in the night
19. Dr:  Enh::,EN BOYA FOR THIS PERIOD KE SI GET ONI 30 MILLIGRAM YEN=
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Yes, yes maybe for this period you can get the one 30 milligram that
Yes, maybe for this period, you should get the 30 milligram one
20. Pat: OKA::Y↓
21. Dr: Uhm: °so, **e maa loo leekan l'oj[umo°**]
you using it once in every day
use it once a day
22. Pat: [°**Lojumo°**] =
every day
23. Dr: Uhm:: for the period of the fasting=
24. Pat: ***Igba ti AA BA TI** break fast **yen**=*
When that we have broken fasting that
When we have broken the fast
25. Dr: ***T'e ba ti** break, **e maa wa pada si ori oni** twenty=*
If you have broken, you will come back to the head that of twenty
When you have broken the fast, you will revert to the 20 milligram dosage
26. Pat: °Okay°↓=
27. Dr: ***MEJI NI** NIFEDIPINE **YEN**. >**IKAN WA TO JE** THIRTY MILIGRAM, **IKAN***
Two is nifedipine that. One is that is thirty milligram, one
There are two brands of Nifedipine. One is thirty milligram, the other
28. ***WA TO JE::** TWENTY<=*
is that is twenty
is twenty miligram
29. Pat: Okay↓
30. Dr: So for now=
31. Pat: ***Ola gan lo maa pari**↑=*
Tomorrow even will it end
It will even end tomorrow
32. Dr: ***Ola lo n pari abi**?=*
Tomorrow is it ending, it not it?
It is ending tomorrow, isn't?
33. Pat: ***Enh**=*
Yes
34. Dr: It's okay↓ So, ***E SI LE MAA LO ONI** TWENTY **YEN EYO KOOKAN LALALE**=*
You still can using that one twenty that one one one in night night
You can still be using the twenty milligram one, one every night
35. Pat: >**Mo N LOO**<↑=
I using it
I am using it
36. DR: ***Enh enh**, so, **to baa ti e bati wa pari** [fasting e maa pada]*
Yes, yes; so, if it once you now have ended fasting you will return
Yes, so once you finish the fasting, you will revert
37. Pat: > Hmm, ***maa pada** [**si** morning and night yen<=]*
Yes, I will return to morning and night that
Yes, I will revert to the morning and night plan)
38. Dr: ***E maa loo bee, tori o n** reflect **lara** BP **yin bayi tori**=*
You using it like that, because it reflecting on body BP you now because
Be using it that way because it is already affecting your BP because
39. Pat: ***O n** reflect, **emi gan n ri igba ti mo nbo**=*
It reflecting, I myself seeing it when I coming
It is affecting it, I too noticed it when I was coming
40. Dr: ***Tori** 156/94 **ni mo** get **bayi, abi** 154/94, **so o n** reflect=*
Because 154/94 is I get now, or 154/94, so it reflecting
Because 154/94 is my reading, or rather 154/94, so it is affecting it
41. ***O n** reflect **lara e**. Uhn (0.01). So, **se bee ni** complaint **kankan**?*
It reflecting on body it. So, is it no complaint at any?
It is affecting it. So, do you have any complaint?
42. Pat: ***Rara** sir=*
No sir
43. Dr: ***E le maa lo**=*
You can be going go
You can now leave
44. Pat: Okay sir=
45. Dr: ***E pele o**.*
You sorry please
Take care please

3.2.1 *Interactional moves in a PCA encounter*

The four moves characterising Interaction 2 are interspersed to reflect the sequential occurrences of the events.

1. *Patient strategically appeals to religious proposal as a cue of positive face orientation*

Prior to checking Patient's BP, Doctor has made a broad request (Odebunmi 2013) about Patient's condition at Lines 7/8. Her response aligns with the no-complaint format commonly adopted by patients in most South-western Nigerian clinics (Odebunmi 2016). At Line 9, Doctor makes a specific request (Odebunmi 2013) on therapy compliance to which he receives no response. This spurs Doctor's next generalising turn that charges Patient with possible non-adherence to therapy plans (Line 10). Caught in non-adherence, and knowing, as an elderly patient, the possibility of having to face criticism from the doctor, Patient appeals to religious common ground as a defence, the doctor being an adherent of a cognate Christian religious sect (as confirmed by one of the members of the university community interviewed – a registered patient in the same clinic). First, at Line 11, she opts for ideological inclusivity "*Ee ri naa pe*", which is designed to co-opt (Mey 2001) Doctor into her context to justify her non-compliance. This bid fails initially as Doctor partially disaffiliates with the inclusive agenda due to Patient's low voice which Doctor could not perceive. His requestive turn at Line 12: "*Ki lo sele*" which calls Patient's attention to her unheard utterance prompts her to deploy perceptual salience by which she is able to loudly and emphatically communicate her commitment to a fasting and prayer programme in her church. By this act, she is inviting Doctor's connection with her ideological evocation, with an expectation of his interactive cooperation, working on their shared culture sense (Kecskes 2014). In other words, she implies that Doctor is expected to understand the significance of fasting declared in a church and the compulsion for compliance against medical recommendations.

2. *Doctor constructs Patient's religious proposal as a positive act*

Patient's expectation of cooperation is met in Doctor's next turn in which he constructs Patient's religious proposal as a positive act through the expression of apriori knowledge. His use of a given token "Oka::ay↑=" at Line 14 approves of Patient's action as she has expected. The elongation of the sequence, completed with a fall-rise tune in the actual rendition, demonstrates Doctor's slow recognition of the religious event lexicalised in Patient's turn at Line 13. This is confirmed by Patient in her quick next turn "Uhn" (Line 15), establishing an ideological connection with Doctor. The scenario here is a complete contrast to the event in the DCA case discussed in 3.1 where the religious proposal is treated as an unreason-

able option. The acceptability or correctness of the attitudes to this proposal in the clinics is argued and determined in 3.3 below.

3. *Doctor and patient co-construct religion-informed non-compliance to doctor's therapy plan as an inconsequential action*

Following Doctor's inclusive acceptance of Patient's non-compliance, both parties jointly construct the non-compliance as an inconsequential action. This takes several sequential stages, reflecting different degrees of professional compromises on the part of Doctor. The first is Doctor's uncritical quick swing into redressive action:

```
13. Pat: A WA NI FASTING AND PRAYER NI CHURCH=
         We are in fasting and prayer in church
         We are observing a period of fasting and prayer in our church
14. Dr:  Ok:::ay↑=
15. Pat: Unh=
16. Dr:  Okay::↑ Enh, @ E MA LO LAALE E, ABI SE MARATHON IN FASTING YEN
         Yes, you will use in night night, or is it Marathon is fasting that
         Yes, use it every night, or is the fasting absolute?
17.      NI↑= ((enthusiastically)
         It
```

After Patient has provided a religious explanation for her non-compliance to therapy, Doctor quickly jumps to the next action without any moment of reflection over the implications of Patient's case as shown between Lines 14 and 16. With Oka::↑, at Line 16, he further confirms his ideological association with Patient and initiates a therapy process. These are followed immediately by the pre-decision sequence "Enh" (Line 16) and laughter on the same line. "Enh", as a pragmatic particle, works in conjunction with the preceding "okay" to provide the inference, "If that is the case" (i.e. if Patient is fasting). It suggests Doctor's privileging of religion over medicine, an act worsened by his laughter which trivialises the action.

Next is Doctor's spirited reconstitution of the therapy plan, carried out without relevant professional interrogations which should guide him on the actual therapeutic procedure Patient has currently designed for herself. This interpretation was confirmed by one of the doctors interviewed who believed that asking questions which query Patient's intent and modification of the dosage of the BP drugs is the expected standard practice. The re-constitution of the plan occurs first at Line 16 where Doctor hastily announces a new therapy plan of a nocte dosage of the prescribed medicine: "*E MA LO LAALE E*" . He re-modifies the earlier re-constituted therapy plan (Line 19: Enh::, *EN BOYA FOR THIS PERIOD KE SI GET ONI 30 MILLIGRAM YEN*=), by recommending a different dosage which is co-constructed as an acceptable act with Patient's salient turn at Line 20: OKA::Y↓. At Lines 34–35, he reverts, with Patient's affiliation, to his first reconstitution of the therapy (Line 16) at Patient's emergent intervention (the provision of

information about the duration of the fast – Line 31) expected to have been determined earlier by him.

Acting strictly in line with the principles of PCA, Doctor offers several options to Patient contrary to the style of the doctor in Conversation 1, including his readiness to further negotiate dosage and timing to permit more leverage for religious observance (Line 16). However, as pointed out in 3.3 below, while this is a democratic clinical action, its emergent unprofessionalism is salient. For example, when Doctor seeks to find out at lines 16–17 if the fasting is absolute: "*ABI SE MARATHON NI FASTING YEN NI*↑= . it is wondering if he would order the complete stoppage of the medication for the period if it is so. While the doctors interviewed agreed that the doctor acted properly by modifying the dosage of the drugs (particularly his offer of 30 milligrams of Nifedipine labelled "retard") to ensure compliance and respect Patient's religious beliefs, they contended that doing this in absolute lack of engagement of Patient on her self-decided treatment modifications and actions was an unprofessional act.

Doctor allows quite a number of turns for Patient, but he is insensitive to her contradictory sequences, which constitute further trivialisations of her actions. For example, when Doctor first asked if she has complaints (Line 7), her pat response is none, but at Line 39, she owns up to seeing symptoms of BP while she was on her way to the clinic. Also, Patient's refusal to provide an answer to Doctor's question regarding compliance with regimens (Line 9) informs Doctor's conclusion that she is not adhering to therapy plans. However, at Line 18, she contradicts herself by claiming that she is taking her drugs every night. It is curious that Doctor neither reacts to nor suspects Patient's seemingly fraudulent action in these contributions.

4. *Doctor and patient co-construct religious option as a serious health hazard*

The consultative event takes a different turn towards the end of the meeting. After jointly negotiating the religious option as an acceptable act, both parties, jointly re-construct it as a serious health hazard, which negates their collective decision on religious convenience.

In retrospect, Doctor re-constructs religious convenience as a negative alternative by foregrounding its effect on Patient's health. A telling interactive action taken by Doctor to construct religious convenience in this light is his cancellation of his earlier interactional move which licensed the religious option (Lines 36–39). At Line 36, Doctor's re-enactment of the dyad's joint decision on Patient's religious proposal implicates the compromising sacrifice of medical procedure for religious observance. At Line 37, his turn overlaps with Patient's, evoking the same object: reverting to the original therapy plan after the exhaustion of

the religious option i.e. when the fast ends. However, right from Line 38, Doctor shifts his frame from the democratic, humanistic voice to the voice of medicine. This is consistent with the medical framework in PCA as reported by de Belder (2012), although unexpected in this conversation which is somewhat tainted with religious emotion.

When at Line 38 Doctor says, "*E maa loo bee, tori o n reflect lara BP yin bayi tori*=", he evokes medical evidence and simultaneously implicitly drops his license for the religious option. "*Ee maa loo be*" implicates continuous compliance without disruption. The scope of the compliance by implication includes religious situations which form the risk factor in the current interactive circumstance. Doctor, therefore, by this reference, picks out the health hazard triggered by Patient's religious decision co-jointly approved by the consultative parties. In the clause, "...*tori o n reflect lara BP yin bayi tori*" , Doctor links Patient's religious position with her poor health (high BP) through the adverbial subordinator "*tori*" in the first use of the word. In this case, he practs (see Mey 2001) a warning, itself strengthened by his earlier reference to the risk factor and advice on uninterrupted compliance. "*Bayi*" selected, following the honorific pronoun "*yin*", is a temporality marker with a pragmatic implication. While it semantically points to the current consultative session, it strategically signifies the construction of Patient's self-approved dosage modification as a health-crisis index. This inference is rooted in the Yoruba socio-cultural orientations to "*bayi*" as a lexical constructor of complications. In this light, the second use of "*tori*" works alongside the implicatures of "*bayi*" to serve as a pragmatic disclaimer from Patient's self-constructed health issues. This turns the whole sequence to a discourse marker of responsibility exoneration in the possible negative prognosis of Patient's condition.

The shift in Doctor's role frame and his newly assumed institutional power stirs a change in Patient's interactive disposition. She takes up responsibility for her health by co-constructing her religious option as a health hazard with Doctor. Contrary to her typical complaint-free position, at line 39, she affiliates with Doctor's medical opinion on the negative implication of the religious option through the expression of apriori knowledge. "*O n reflect, emi gan n ri igba ti mo nbo*=" presents Patient's epistemic stance on her health which she has not expressed until this point in the interaction. In a way, the position implicates Patient's possible compliance with a stern and strict religious obligation-free therapy plan if Doctor perhaps had proposed it. This confirms that PCA calls for wider medical knowledge (Robert di Sarsina and Iseppato 2010), which Doctor does not sufficiently demonstrate in this interaction.

Sustaining the voice of medicine which eventually shrinks Patient's lifeworld voice as from Line 40, Doctor cites medical evidence to support his claim. He

announces the BP reading of Patient which he has withheld since the beginning of the consultation: "*Tori 156/94 ni mo get bayi…*=. The interviewed doctors saw the delay in the announcement of Patient's BP status as an unprofessional act. For them, that announcement should precede the interchanges on Patient's current health state and compliance with therapy plans. However, contrary to this standard practice, Doctor announces the BP reading at the tail end of the encounter seemingly as a strategic insertion to press home the effect of Patient's religion-motivated non-compliance. His deployment of repetition as a pragmatic act of emphasis and warning is equally strategic. "*Tori*" (Lines 38 and 40) and "*o n reflect*" (Lines 38, 40 and 41) are repeated in quick succession

3.3 Clinical/pragmatic implications of therapy proposal negotiations

In this section, three modified features of DCA and PCA, "strategic rapport building", "colonisation of patients' lifeworld" and "constrained joint decision making", are critically discussed with consideration for their clinical and pragmatic implications.

Strategic rapport building, which refers to the tactful creation and allowance of rapport in clinical meetings, occurs in the two conversations. This means that in spite of the seemingly person-centred nature of Conversation 2, it, like Conversation 1, when considered critically, does not demonstrate an agenda-free interaction. In point of fact, no institutional discourse, not least, medical interaction, is agenda-neutral. Doctor in Conversation 1 permits good rapport at the initial stage but stops it in the middle of the meeting after obtaining almost enough medical and social information from Patient. While he still allows patient participation after the major disagreement at Line 107, he dominates the encounter with paternalism. Although Doctor in Conversation 2 orients to the current guidelines for person-centred medicine that mutually recognise the epistemic and deontic rights of both consultative parties, rapport building in the interaction is rather subtly deliberate and strategic. He creates a more congenial and friendly environment than in Conversation 1 and allows rapport until the tail end of the meeting. He relates with Patient's attention disposition as ideologically-oriented perspectives, and permits so much Patient leverage that she seems to dominate the interaction, a seemingly weak professional attribute. However, his frame shift to a power-wielder from Line 40, signified by his strategic use of concealed key information about Patient's BP condition, reveals strategic rapport building which ultimately seems to diminish the relationship built. His offer of equipoise (Lines 16, 19–21 and 34), "situations where two or more treatment options have different but equally acceptable outcomes" (Landmark et al. 2015, 56), which is warmly negotiated by the parties, seems a ruse inspired more by religious affiliation with Patient

than with the actual medical standard eventually voiced by Doctor. Hence, his indirect disclaimer of his earlier deontic commitment associated with the religious option, as shown in 3.2 above, represents his true professional epistemic and deontic stances.

The colonisation of patients' lifeworld plays out more in Conversation 1 than in Conversation 2 as the high-handedness and extreme paternalism of Doctor in the former stifles Patient's lifeworld voice (Mishler 1984). With high institutional power, Doctor personifies a tension between Patient's biographic context and his own institutional orientation, a technical standpoint that believes only in the sanctity of the biomedical solution (Akper and Eggly 2004). He orients not only to the authority conferred to elderly males in the patriarchal Yoruba culture but also to the respect-imbued societal attitude typically accorded the physician even in its Western context (cf de Belder 2012).

Doctor in Conversation 1 suppresses Patient's effort at negotiating personal proposals through frustrating disaffiliations and outright disregard for Patient's humanity, negating the principles of PCA which prescribe full freedom of participation for patients. While it is true that sometimes patients' lifeworld accounts and dispositions are completely opposed to medical logic and might not be affordable for biomedicine, physicians are expected to provide options or, where only the offered solution is available, humanistically negotiate recommendations. Doctor in Conversation 1 displays no such etiquettes. Patient's proposal for an injection which is eminently affordable for biomedicine, at least by half, even by Doctor's own judgement, is grudgingly approved after much consultative time has been wasted. The improbable proposal for religious convenience is not only rejected; it also comes with a lot of face damage to Patient where empathy, an integral feature of PCA, considered the substructure of medical ethics (cf Emanuel and Dubler 1995), would be handy.

Although Doctor in Conversation 2 displays strategic rather than routine rapport building, his overall empathetic orientation to Patient's religious proposal affiliates much better with PCA. In addition to relinquishing power until the end of the interaction which enables Patient's full participation, he associates himself with Patient's socio-cultural and emotional concern, an interactive action that considerably reduces friction and resistance in the encounter, even in the last bit of the interaction where he contradicts his earlier advice by cancelling his interactional move. The absence of this empathetic quality accounts for the tension in the first clinic. Patient's resistance, connected to Doctor's use of face threats and evocation of some inaccurate medical evidence against Patient which led to Doctor's evocation of cultural power would have been unnecessary if the PCA option-listing method had been used.

Decisions in the two interactions are partially or completely constrained, thus flouting in different degrees the principles of PCA. Analysis of Conversation 1 has already indicated the dominance of physician power throughout the encounter, and a compromised decision instrumentalised by Patient's pressure and resistance. The decision in Conversation 2 presents pseudo-sharedness from the very beginning of the interaction till the close where Doctor shifts to the medical frame and reverses the whole process through indirect disclaimer interactional moves. While the first physician keeps the profile of a hard, almost unyielding medical agent unexpected to allow some consideration for a compromise, the second one is misleading and a little unprofessional for a stretch too long to disclose his final decision. Consequently, in a way, Patient in the second clinic might experience disappointment and dissatisfaction as against the one in the first clinic who does not expect a favourable decision. However, when strict PCA principles are considered, barring the error of Physician Two, Conversation 2 exemplifies a true PCA process which "offer[s] to the patient the option to partake in the decision making process" (Khawaja nd, 28). Thus, by Taylor and Kelner's (1987) classification, he is an experimenter whereas the first is a therapist[5].

4. Conclusions

I have argued in this paper that the negotiation of patients' therapy proposals, effected through interactional moves and face negotiation mechanisms, points to a level of clinical consultative success or failure anchored to strategic rapport building, colonisation of patients' lifeworld and constrained joint decision making. The socio-cognitive approach which centrally steers the analysis has been made to interact with the conversation analytic approach, face constituting theory and medical principles of DCA and PCA to show how the evocation or allowance of apriori and emergent knowledge has enhanced or marred consultative meetings in Nigerian hospitals.

I have shown that while the events in the two clinics differently contextualise DCA and/or PCA, the style of the second doctor that largely typifies the principles of PCA is a more effective approach in negotiating patients' proposals or suggested options, barring misleading consultative procedures. I have equally demonstrated that strategic rapport building is a weakness of the two doctors. In each case, it strips the consultation of its naturalness and creates a context for suspicion, fault-finding and distrust which subdue the concept of humanistic medicine.

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5. Therapists exclusively control decision making but experimenters give patients the opportunity to participate in the process (cf. Taylor and Kelner 1987).

The study connects with extant scholarship such as Lings et al. (2003), Taylor 2009, de Belder (2013) and Belanger et al. (2016) to establish the point that doctors' styles which may be paternalistic or humanistic significantly influence the outcome of consultative encounters. Its demonstration of the deployment of DCA and PCA in hospital clinics, while utilising Mishler's terms, meshes more with the middle-ground positions of Young (1997) and Hyden and Bulow (2006), which do not see the two as distinct, mutually exclusive approaches. It establishes a link between the US clinics studied by Lings et al. and, to a great extent, the Nigerian clinic in which Conversation 2 is held which confirms the observation that "patients expect technical competence.... availability and ease of access" (Lings et al. 2003: 1). While it establishes an instance of DCA in Nigerian clinics, confirming Ajayi's (2003) view that the dominant consultative style in Nigerian hospitals is the DCA, it is unable to validate Ajayi's position because of its limited data. However, beyond Ajayi (2003), it both locates an almost quintessential PCA clinic and establishes a somewhat dynamic blend of different styles in single clinics. It equally negates Ajayi's submission that the level of patients' education determines the selection of approach by doctors. While Ajayi's finding is possible with an ethnographic methodology, the interaction-based approach used in the current research would reveal more practical clinical realities. This is established in part with the results of the in-depth interviews conducted which show that the same set of doctors claims to handle patients' doubt of their recommendations by explaining issues to them and at the same time ignoring others as inconsequential.

Funding

Research funded by Alexander von Humboldt-Stiftung to Akinola S Odebunmi.

Acknowledgments

This research is a product of my three-month stay at Freiburg University, Germany (June – August, 2017). I am thankful to Prof. Dr Peter Auer, my host, for his excellent contributions, the editorial team of *Pragmatics* for their thoroughness, and two *Pragmatics*' anonymous referees for their comments and suggestions. I appreciate Dr Emmanuel Amao of Shalom Medical Centre, Ogbomoso and Dr Dele Afolabi of LAUTECH for participating in data interpretation sessions. Other doctors, patients and members of the public are also appreciated for their participation in the in-depth interviews.

I am grateful to the Alexander von Humboldt Foundation for sponsoring the visit to the University of Freiburg (1 June – 30 August, 2017) that produced the research.

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Appendix Transcription notations

[ ]	indicating overlap
(0.2)	indicating elapsed time in tenths of seconds
(.)	indicating a brief pause
( ),	indicating inaudibility
< >	talk said more slowly than surrounding talk
> <	talk said more quickly than surrounding talk
@	laughter
:::	prolongation
↑ ↓	high or low pitch
(( ))	transcriber's descriptions
WORD	(upper case) loud sound relative to the surrounding talk
°word°	word/utterance indicating that the sounds are softer than the surrounding talk
=	no break or gap
- -	indicating a short or untimed interval without talk

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Publication history

Date received: 1 November 2018
Date accepted: 6 October 2020
Published online: 8 March 2021