Covenant Journal of Language Studies (CJLS) Vol. 9 No. 1, June, 2021
ISSN: p. 2354-3582 e. 2354-3523

An Open Access Journal Available Online

Argumentation in Doctor-Patient Interactions in Nigeria

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Received November 16, 2020; Accepted May 26, 2021
Date of Publication: June, 2021

Abstract

This paper examines argumentation in doctor-patient interactions, with a special focus on antenatal consultations between doctors and pregnant women, using the extended pragma-dialectical theory of argumentation. The data comprise two case studies, extracted from forty doctor-pregnant women interactions which were purposively selected from a private hospital in Ibadan, Nigeria. The findings show that depending on the stage of the interaction, the doctor and the pregnant women have interchangeable roles as protagonists and antagonists. The interactants tend to use causal argumentation scheme while employing subordinative and complementary coordinative argumentation structures. The interactants also employ different strategic manoeuvres at different argumentative stages of the critical discussion. Thus, the study shows the influence of the medical communicative activity type on the argumentative activities that can occur in a critical discussion. The study also recommends that argumentation should be included in the medical training of health personnel in order to enhance patient-centred communication.
Key Words: argumentation, antenatal discourse, medical consultation, pragma-dialectics, strategic manoeuvring.

Introduction

Doctor-patient interaction generally occurs during consultation periods; doctors' ward rounds, medical check-ups and any other formal interaction between the doctor and the patient (Author, 2007). It involves communication which is aimed at creating a good interpersonal relationship, exchanging information and making treatment-related decisions (Ong et al., 1995:903). Odebunmi (2006: 29) opines that doctor-patient interaction is engineered towards 'the transactional and interactional functions of language as well as the speech acts that accompany these functions.' The

transactional function 'captures the actual business of talk in the hospital' such as diagnosis, prescription and treatment while the interactional function deals with interpersonal features such as establishing and cementing relationships, which may be casual, cordial or professional. He points out that 'the transactional or interactional role played by language in the hospital environment depends on the nature of the interaction,' which depends on the kind of ailment being treated, the personalities of the interactants and the kind of information being sought in the encounter. He opines that the interactional mode can be used to achieve a transactional end. Interactions between doctors and patients have been found to be either doctor-centred or patient-centred. Bientzle et al. (2017) observes that doctor-centred communication focuses on the disease without taking the patient's individual feelings or concerns into consideration. This also includes interrupting patient, asking closed-class questions, using excessive medical jargon, excluding the patient from participating in decision making, and so on. On the other hand, patient-centred communication is open non-directive conversation in which the patient takes an active role in decisions about his or her health treatment. In patient-communication, doctors minimise the use of jargon, avoid interrupting patients and pay close attention to the concerns of the patient (Bientzle et al. 2017).

Several scholars have carried out studies on general doctor-patient interactions (e.g. (Odebunmi, 2008, 2011, 2016; Cusen, 2017; Fu, 2018). Some of these studies have focused on specific categories of patients such as geriatric (e.g., Coupland et al., 1994), cancer (e.g., Cordella, 2012), diabetic (e.g., Martin, 2015), paediatric (e.g., Rindstedt, 2016), and HIV patients (e.g., Boluwaduro, 2017, 2020, 2021). Moreover, some of these studies have examined different discourse-pragmatic aspects of medical consultation, such as framing (Coupland et al., 1994), diagnostic news delivery (Odebunmi, 2008), concealment (Odebunmi, 2011), accountability (Odebunmi, 2016), interruptions (Cusen, 2017), medical advice (Boluwaduro, 2020), and medical authority (Boluwaduro, 2021). This study focuses on a different class of patients - pregnant women.

A doctor-pregnant woman (DPW) interaction is an institutionalised communicative practice between a doctor and a pregnant woman (see Pilgram, 2017). Pregnant women see their doctors for normal check-ups and complications that may arise during the pregnancy period (Blakey, 2003). DPW interactions focus on the health of the female guardian and the foetus on issues relating to physical exercise, diet, use of drugs, rest, avoidance of alcohol, and personal hygiene (Viccars, 2003). During the consultation between doctors and pregnant women, doctors may involve themselves in some level of argumentation in order to support the medical advice they offer by providing reasons for its truth, likelihood and trustworthiness (see Goodnight & Pilgram, 2011). Argumentation may also be used by patients (i.e., for non-use of some drugs or refusal of some kind of treatment). Thus, argumentation plays significant roles in ensuring that doctors convince their clients on the need to adhere to medical advice; while the pregnant women argue to ensure that their positions are taken into consideration when doctors give them medical advice. Argumentation itself is "a verbal, social, and rational activity aimed at convincing a reasonable critic of the acceptability of a standpoint by putting forward a constellation of propositions justifying or refuting the proposition

expressed in the standpoint" (van Eemeren and Grootendorst, 2004, p. 1). As Rubinelli (2013) posits, argumentation is important in legitimising the points of view of the doctor and the patient, adding or modifying a patient's set of beliefs; and enhancing how a patient processes the information received in order to make informed health decisions.

As important as argumentation is in the medical context, there is limited studies on its interactional value in antenatal consultations. On the one hand, scholars working on antenatal discourse have investigated interactional patterns in antenatal booking visits (McCourt, 2006); discourse acts in antenatal health talks (Author et al., 2007); ethnography of communication in antenatal consultations (Author, 2008); illocutionary acts in antenatal consultations (Author, 2010); contextual beliefs in antenatal consultations (Author, 2011); conversational analysis of antenatal screening (Pilnick, 2004; Pilnick and Zayts 2014); and speech acts in antenatal health talks (Author et al., 2015; Lamidi in press). On the other hand, scholars working on medical interactions have investigated strategic manoeuvring in doctor-patient interactions (Schultz and Rubinelli, 2008; Goodnight and Pilgram, 2011); argumentation in advertised medicines (van Poppel and Rubinelli, 2011); argumentation in breast cancer screening (Schultz and Meuffels, 2011; Akkermans et al., 2019); and argumentation in doctor-patient interactions (Rubinelli, 2013; Pilgram, 2017). For example, Goodnight and Pilgram (2011) examine how ethos enhances doctors' strategic manoeuvres in Dutch medical consultations, in order to build trust and foreground medical expertise. Also, Pilgram (2017) discusses the preconditions for strategic manoeuvring in medical consultation and shows how the characteristics of medical consultations influence the kind of strategic manoeuvring used by the doctor and patient, using a Dutch paediatric consultation as a case study. Thus, these studies do not address argumentation or the kinds of strategic manoeuvres used in an African hospital setting, which may differ in some respects from strategic manoeuvres used in western hospitals (for example, see the roles of openings in Boluwaduro & Groß, 2019), due to differences in sociocultural beliefs. More importantly, the studies on antenatal discourse do not address argumentation in antenatal consultations while research on argumentation in medical interactions does not focus on antenatal discourse. Therefore, there is limited understanding and knowledge of antenatal consultations since these may differ from other types of medical consultations. As scholars have posited, antenatal consultations are less clouded by the anxiety which often attends illnesses (Myerscough, 1992) and this may have implications for the type of argumentation used. Thus, this paper investigates argumentation in antenatal consultations between doctors and pregnant women, with a view to examining the critical discussion stages in the antenatal consultation and the speech acts used in the different stages; exploring the argumentative schemes and structures used in the consultations; and investigating the strategic manoeuvres in the argumentations. In order to achieve its aim, this paper employs the extended pragma-dialectical theory of argumentation, as it is expected that it would offer a better understanding of how argumentation is produced and evaluated in a medical context where the major goal is to assist pregnant women gain good health during the course of their pregnancy.

(Extended) Pragma-dialectical Approach to Argumentation

The (extended) pragma-dialectical theory of argumentation (van Eemeren, 2010) focuses on the dimensions of dialectical reasonableness and rhetorical effectiveness in exploring the production, description and evaluation of arguments in support of a standpoint (van Eemeren, 2017). It considers an argument as a communicative and interactional activity, and takes explicit account of all relevant contextual and pragmatic factors in the production and evaluation of arguments (van Eemeren and Grootendorst, 2004). Thus, the (extended) pragma-dialectical study combines both dialectical and rhetorical goals. While the dialectical goal is the resolution of the difference of opinion in a reasonable way, the rhetorical goal is to make the strongest possible choice from any set of dialectically relevant moves that may convince the prospective audience best (van Eemeren, 2010; van Eemeren and Houtlosser, 2007).

The theory proposes that there is an ideal model of a critical discussion which is aimed at resolving a difference of opinion. This critical discussion has four stages: the confrontational, which indicates that a standpoint is not accepted because it encounters doubts or objections; the opening stage which addresses the starting points in the form of shared knowledge and rules necessary for a critical discussion; the argumentative stage which covers the arguments raised by the protagonists and antagonists of the standpoint; and the concluding stage where the critical discussion comes to an end (van Eemeren, Houtlosser and Snoeck Henkemans, 2007 p. 11-12). These stages are characterised by different speech acts such as assertives, directives, commissives and usage declaratives (van Eemeren, Houtlosser and Snoeck Henkemans, 2007; van Eemeren, 2017). For example, in the confrontational stage, a speaker may express a standpoint, s/he may accept the challenge to defend the standpoint in the opening stage, s/he may request argumentation in the argumentative stage, and request a usage declarative by demanding a definition or amplification. Within these different argumentative moves, interactants can employ different strategic manoeuvres with different aspects including topic potential, which refers to the range of topics or options available to an arguer for making an argumentative move; audience demand, which deals with the adaptation of argumentative moves to the needs of the audience; and presentational demand, which points to the communicative means used in presenting argumentative moves (see van Eemeren, 2010, p. 93-94). The theory considers different types of argumentative schemes such as analogy, which signals that there is some kind of similarity between what is stated in the argument and what is stated in the standpoint; causal argumentation, which indicates that the argument is the cause of the standpoint or the standpoint is the cause of the argument; and symptomatic argumentation, which suggests that the traits or signs of a person, thing or idea in an argument is applicable to a person, idea or thing in a standpoint (see van Eemeren, Houtlosser and Snoeck Henkemans, 2007, p. 137). Other aspects include argumentative structures which comprises multiple argumentation (which is a combination of different moves that acknowledge and contest criticism), subordinative argumentation (an additional argument that supports the acceptability of a previous argument), cumulatively coordinative argumentation (an additional argument which serves as a supplement to the first in the face of an insufficient argument), and complementary coordinative argumentation (an additional argument that

is used to refute an objection raised by an antagonist) (see van Eemeren et al., 2007, p. 193-194). The argumentative moves consist of different explicit and implicit argumentative indicators such as propositional attitude indicators (e.g., *I believe* and *I think*) and force modifying indicators (e.g., *in my view* and *of course*) (van Eemeren et al., 2007, p. 29). Thus, this theory is suitable in analysing, describing and evaluating arguments which may exist in doctor-patient interactions where doctors may be required to defend their prescriptions or expectations from patients while patients may also need to defend some of their actions in relation to their well-being or doctors' prescriptions and expectations.

Data and Method

The data comprise two case studies which were extracted from forty doctor-pregnant women interactions that were purposively selected from a private hospital in Ibadan, Nigeria. Only two case studies were used for the analysis because they were the only ones that contained critical discussions among the larger dataset. As noted later in this paper, it appears that that due to the medical context, there are limited cases where critical discussions occur between doctors and pregnant women, unlike what obtains in political debates and interviews. Ethical approval was received in order to collect the data, which were tape recorded and transcribed. The consultations lasted between ten and fifteen minutes and the exchanges were in English, Pidgin, Yoruba or a mix of these depending on the ethnic group or code preferred by the pregnant women. The data were then subjected to qualitative analysis, using the (extended) pragmatic dialectical theory of argumentation.

Analysis and Discussion

This section presents and explores the different discussion stages in the antennal consultation based on the model of a critical discussion. The findings show that the antenatal consultation, as a communicative activity type, belongs to the medical domain (see Pilgram, 2017), with the institutional goal of providing medical advice aimed at ensuring that the pregnant woman achieves good health during and after pregnancy. The two case studies represent two kinds of pregnant women who attend the antenatal clinic: those who are visiting the clinic for the first time and those who have previously visited the clinic during the course of the same pregnancy. The findings show that depending on the stage of the interaction, the doctor and the pregnant women have interchangeable roles as protagonists and antagonists. The interactants tend to use causal argumentation scheme while employing subordinative and complementary coordinative argumentation structures. The interactants also employ different strategic manoeuvres at different argumentative stages of the critical discussion such as raising a number of topics that focus on the peculiar nature of the patient. Table 1 shows the different discussion stages in the antenatal consultation based on the model of a critical discussion (see also, Pilgram 2017). These are fully discussed in 4.1 and 4.2.

Table 1. Discussion stages in the antenatal consultation based on the model of a critical discussion

Critical Discussion (Communicative activity type)	**Confrontational stage (Initial situation)**	**Opening Stage (Procedural and material starting**	**Argumentation Stage (Argumentative**	**Concluding Stage (Possible outcome)**

		point)	**means and criticism)**	
Antenatal consultation	(Assumed) mixed disagreement between the doctor and the pregnant woman	Implicit rules of investigation (the doctor controls the discourse) and implicit concessions (obtains patient agreement; Hippocratic Oath)	Argumentation for defending the standpoint in response to expressed or anticipated critical reactions from the doctor or pregnant woman	Acceptance of doctor's claims; no return to initial situation

(i) Family planning as a source of argumentation

The first case study focuses on a pregnant woman who is visiting the doctor for the first time during the course of the current pregnancy. Thus, Text A is a first consultation between the doctor and the pregnant woman, and in the course of diagnosis, there is a dispute over family planning. For spatial reasons, only the part that contains the argumentation is presented. As Eemeren et al. (2007) opine, it is only when there is a difference of opinion that an argumentation can take place.

Text A

DR: *Oyun elekelo le yi?*
'What round of pregnancy is this?'

PW: *Eyi je seven.*
'This is the seventh one.'

DR: *Oje seven*
'That is the seventh.'

PW: *Mo o fe bimo leyin eleyi. Oyi'wo ni.*
'I didn't want to have a child after this one. It backfired.'

DR: *E ni lati f'eto si. E lo f'eto si.*
'You have to go for family planning. Go for family planning.'

PW: *Mo ti se.*
'I have done it.'

DR: *Bawo le se wa ti se?*
'How did you do it? How then did you do it?'

PW: *Daddy wa … o ni ki n ma feto si.*
'My husband…he said I should not go for family planning'

DR: *Ehn, Daddy*
'Really, daddy'

PW: *But eleyi, Ha*
'But this one, Ha'

DR: *E lo f'eto si bo ba se*
'You go for family planning afterwards.'

PW: Ok

DR: *Oda. Kilo de ti o fe jeki e f'eto si?*
'Okay why does he not want you to plan it?'

PW: *E mo, t'elo mi ba se,*
You know, when someone else does it,
inu a ma run tabi ko ma wu.
'she starts having stomach pain or she starts swelling up.'

T' ori e ni mi o se fe se
'That is why I don't want to do it'

DR: *Ehn, t' o ba di oyun elekewa, e e se.*
'Well, when it gets to the tenth pregnancy, you will do it'

PW: *Eleyi ni opin e.*
'This one ends it'

The confrontation stage begins when PW expresses a standpoint that she did not want a child after the last one but did not succeed as she became pregnant. Here, PW acts as the **protagonist** while the doctor acts as the antagonist who expresses doubt about PW's claim and raises a counterclaim by requesting that she goes for family planning. This counterclaim is implicit as the doctor indicates that PW's desire of not wanting a child is not genuine if she did not go for family planning before the current interaction. PW counters this claim by claiming that she had done family planning. The presence of a counterclaim makes the dispute a mixed one. While PW uses assertives to make her claim and counterclaim, DR uses a directive because of the authority that DR possesses. In addition, DR's use of a request rather than an explicit counterclaim, which could have been in the form of an assertive, indicates politeness (see Odebunmi, 2005; Pilgram, 2017). DR's request represents polemic negation as he negates the proposition expressed by PW (see van Eemeren et al., 2007).

In the opening stage, DR challenges PW to defend her standpoint through the use of the interrogative clause, *Bawo lese wa ti se?* This indicates a request for justification as it relates to the validity of the information provided by PW. PW accepts the challenge to defend the standpoint by providing a response, *daddy wa*…, and this leads to the argumentative stage. Here PW, gives a reason for her standpoint, her husband does not want her to go for family planning, which represents a causal argumentation scheme as her argument is the cause of her standpoint. Thus, there is a two sided-burden of proof as both DR and PW have the burden of proof to convince the other about his or her claim. DR raises further doubt about this information but rather than explicitly negate this assertion, he repeats the order, *e lo feto si…*which PW accepts. This should then be the conclusion stage since PW appears to have accepted DR's counterclaim. However, DR does not believe that PW is truly convinced or accepts his claim and repeats the process through another interrogative.

DR uses another interrogative clause which is a request for clarification when he requests that PW gives him reasons why the husband does not want her to go for family planning. PW then provides an argument which indicates an analogy argumentation scheme as she argues that when other women go for family planning, they have stomach pains or gain a lot of weight. The analogy or comparison here is that people who go for family planning tend to endure different side effects, thus, if she goes for family planning, she may have stomach pains or gain some weight. This also represents a subordinative argumentation structure since DR finds the first argument unacceptable with regard to its propositional content. DR implicitly rejects this argumentation by making a sarcastic statement that when it gets to the tenth pregnancy, PW will be forced to go for family planning due to the attendant economic and health effects.

At the closing stage, PW accepts the DR's claim due to the technical knowledge that DR possesses (see Author, 2011). Thus, there is no return to the initial situation as PW will have to adhere to DR's advice for her own health.

(ii) Non-attendance at the antenatal clinic as a source of argumentation

The second case study focuses on a pregnant who is accompanied by her female guardian for a subsequent consultation. A difference of opinion occurs when the DR discovers that PW did not keep her previous appointments and he wants her to start doing so. As in the first case study, only the part that contains the argumentation is presented.

Text B

DR: Nje o ti gba abeere e akoko? On the 5?
Haven't you taken your first injection? On the 5th?

Ko wa?
She didn't come?

Woman: Beni
Yes
Yes

DR: Kilo de t'o wa? O ye ki o ti wa ni on 05/10 (.) T'eni.
Why didn't you come? You should have come on 05/10 (.) The one for today.

DR: E de wa ni eleven abi o o ri date ni? Owo tani card wa?
You came on the 11th or didn't you see the date? Who holds the card?

Woman: Owo e naa ni.
It was in her hands indeed.

DR: Ngbo o mo?
Is it true you don't know?

PW: Ehn, tori pe mummy wa osi ni ile.
Well, it is because our mummy was not at home.

DR: O ni lati wa, t'eba fe ko bimo ni bi.
She has to come if you want her to give birth here.

T'o o ba mu wa,
If she doesn't come with it,

a ni gba ko bimo ni bi tori alakobi ni o.
we will not allow her to give birth here because this is her first pregnancy o.

So, a ni la ti monitor e dada.
So, we have to monitor her well.

E mo pe ko bi ikan ri.
You know that she has not given birth before

Woman: Oun na laro tele
That's what we thought before.

DR: Omo kekere de ni. So o ni lati wa on the date t'aba fun.
'She is a small child also. So she has to come on the date we give her.'

so that taba ri anything ti o correct, a tete correct e,
'so that if we see anything that is not correct, we will quickly correct it,'

ko to di pe o ma bimo. (inaudible) from now till January,
'before she gives birth (inaudible) from now till January'

O ni lati wa ni date taba fun.
'She has to come on the date we give her.'

At the confrontational stage, there is disagreement between DR and PW over adherence to medical advice, based on the fact that PW did not keep her previous appointments in the clinic. Thus, DR believes that the patient hesitates to fully accept or follow medical advice. DR as the protagonist, uses an assertive to express his standpoint: *o ye ki o ti wa ni on 05/10.* PW is the antagonist who is reluctant to follow medical advice. PW's counterclaim is not verbalised and therefore, it is implicit. Thus, PW's female guardian responds on her behalf.

In the opening stage, DR requests for justification, *abi o ri date ni?* which interrogates PW's non-verbalised counterclaim. Because PW is silent, DR

requests for clarification, *owo tani card wa?* to which PW's female guardian responds. Because DRs needs PW's agreement, he asks another question, *ngbo o mo?,* through which he challenges PW to defend her non-verbalised counterclaim. PW accepts the challenge to defend her standpoint by providing a response: *Ehn tori pe mummy wa osi ni ile* which indicates a causal argumentation scheme since the argument is the cause of her standpoint or claim of not attending the clinic. DR, as the protagonist, has the burden of proof to convince PW to accept his claim. The doctor acts as discussion leader and is more influential in the manner in which the disagreement is resolved.

At the argumentative stage, DR raises a number of arguments in order to support his standpoint that PW should keep her appointments. Thus, DR, the protagonist, uses a cumulatively coordinative argumentation structure where the second and third arguments are supplements to the first argument since no objection was raised when PW's female guardian responds *oun na la ro tele.* These involve strategic manoeuvring based on topic potential where DR raises a number of topics that focus on the peculiar nature of PW (she is young, this is her first pregnancy too and the implications of PW's non-adherence to medical advice (She will not be allowed to attend the hospital without a card).

In the closing stage, there is agreement between the discussion parties about the patient following the doctor's medical advice. PW's female guardian accepts on behalf of PW when she says *beni*, which indicates a commissive speech act. Thus, there is no return to the initial situation of the critical discussion.

Conclusion

This paper examines argumentation in DPW consultations, with a view to examining the argumentative schemes and structures that exist in the interactions. The findings show that depending on the stage of the interaction, the doctor and the pregnant women have interchangeable roles as protagonists and antagonists. The interactants tend to use causal argumentation scheme while employing subordinative and complementary coordinative argumentation structures. The interactants also employ different strategic manoeuvres at different argumentative stages of the critical discussion. Thus, the study shows the influence of the medical communicative activity type on the argumentative activities that can occur in a critical discussion and proposes that argumentation should be explored in order to enhance negotiated communication in patient-centred consultations.

In addition, the study shows that family planning and non-adherence to medical advice are sources of argumentation in antenatal consultations. While the former is linked to the influence of cultural beliefs (see also Gueye et al. 2015), the latter has been identified as prevalent in Nigerian consultative encounters (see Boluwaduro & Groß, 2019). Since scholars have indicated that argumentation enhances how patient processes information received in order to make informed health decisions, it is imperative that argumentation techniques are taught in medical schools. As scholars have noted, argumentation and argumentation techniques are rarely addressed in medical trainings (see Rubinelli and Zanini, 2014). As Rubinelli and Zanini (2014: 76) note, doctors need these argumentations skills in order to know how to construct arguments, refute a point of

view, engage in critical discussion, and negotiate in case of shared decision-making. Thus, it is highly recommended in this paper that argumentation and argumentation techniques are introduced in the curriculum of medical students, especially in Nigeria, since argumentation aids patient-centred care. In this way, doctors can be trained to engage in critical discussion and encourage patients to be involved in critical discussion. As evident in the study, out of forty antenatal consultations, only two cases showed evidence of argumentation. It appears that that due to the medical context, there are limited cases where critical discussions occur between doctors and pregnant women. Within the medical context, the kind of medical authority wielded by doctors as a result of their medical expertise may limit the patients' desire to question the doctor or object to directives given by the doctors. (see Boluwaduro, 2020, 2021).

In all, this work has focused on argumentation in Nigerian antenatal consultations obtained from a hospital in south-western Nigeria, using two case studies. The study can be extended to a wider population in south-western Nigeria and to other parts of Nigeria. In doing this, one could examine the social and educational statuses of the patients, which might have some influence on the extent to which pregnant women would be involved in argumentation. Future work may further explore different argumentation styles (van Eemeren, 2019) in antenatal consultations in Nigerian hospitals, and these could be compared with hospitals in Africa and beyond.

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