CONTEXT TYPES IN NIGERIAN PAEDIATRIC CONSULTATIONS: AN INTERACTIONAL SOCIOLINGUISTIC PERSPECTIVE

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Abstract

Communication in medical encounters is shaped by the contexts in which interactions occur. This study examines the contextual configurations that structure paediatric consultations in Nigerian clinical settings. Drawing on data from 20 recorded consultations across selected hospitals in Ondo and Lagos States, the study adopts Interactional Sociolinguistics as the theoretical framework. The analysis identifies institutional and social contexts as dominant organising frameworks, realised through features such as agency and hierarchy, communality, politics and governance, and religion, which shape participant roles, interactional behaviour, and meaning-making processes. The findings reveal that paediatric consultations are deeply embedded in institutional structures that regulate participation and interaction, while still allowing for dynamic negotiation among participants. The study contributes to research on medical discourse by foregrounding context as a primary determinant of interaction in paediatric healthcare settings.

Keywords: Context types; Paediatric consultations; Institutional discourse; Agency; Hierarchy; Nigeria

Introduction

Medical consultation is fundamentally an interactional process in which participants exchange information to achieve diagnostic and therapeutic goals (Cordella, 2004). Patients seek explanations and solutions to health problems

(Robinson, 2003), while doctors rely on patients' accounts to guide medical decision-making. This exchange is not merely informational but is shaped by the context within which it occurs.

Over the years, doctor–patient interaction has evolved from a strictly asymmetrical model to a more patient-centred approach that encourages participation and shared understanding (Tates & Meeuwesen, 2000; Butalid, 2014). Despite this shift, medical encounters remain institutionally grounded, and interaction is still influenced by structured roles, expectations, and norms. Thus, understanding medical discourse requires attention not only to what participants say but also to the contextual frameworks that shape how they say it.

Context plays a crucial role in determining interactional behaviour in institutional encounters. Participants draw on shared knowledge, cultural norms, and situational cues to interpret meaning and organise discourse (Heritage, 1997). In medical settings, these contextual factors include institutional structures, participant roles, epistemic rights, and socio-cultural influences. Botelho's (1992) distinction between the doctor as an "expert on disease" and the patient as an "expert on illness" highlights the coexistence of multiple knowledge systems within the consultation.

While previous studies have examined doctor–patient interaction broadly, relatively little attention has been paid to context types in paediatric consultations in Nigerian settings, where interaction is often triadic, involving the doctor, the child, and a caregiver. These encounters introduce additional layers of contextual complexity, including mediated communication, variable participation, and culturally grounded interactional norms.

This study, therefore, focuses specifically on context types in Nigerian paediatric consultations, to identify the contextual configurations that structure interaction and examine how these contexts shape participant roles and communicative behaviour. To achieve this, the study adopts Interactional Sociolinguistics for analysing how meaning is constructed within specific contexts.

Scholars have studied paediatric consultations from the perspective of parents' preference for a treatment option; pressure for antibiotics (Stivers 2002, 2005, 2007; Wang 2017), and communicative practices (Street 1992; Mangione et al. 2015). Other scholars have examined the characteristics of the triadic encounters (Tates, Meeuwesen, Bensing and Elbers 2002; Lorin 2015) and also the gender influence on the encounter (Bernzweig et al. 1997). These studies have found that participants employ discourse resources to negotiate both personal and institutional goals. Also, doctors and parents, to a large extent, dominate the discourse in paediatric consultations, and child participation is often restricted, which affects the communicative process. The closest to the present study is Street (1992). In the study, Street examines the communicative styles and variations in physician-parent consultations and how personal and interactive factors account for such variations.

One pragmatic theory appropriate for unpacking the contextual features of paediatric consultations is Interactional Sociolinguistics, to analyze how meaning is constructed within specific contexts. Interactional Sociolinguistics (IS), developed from the foundational work of John J. Gumperz and Erving Goffman, provides a framework for understanding how meaning is constructed in interaction rather than residing solely in linguistic forms. It views discourse as a social practice, where meaning emerges dynamically through the interaction of participants and is shaped by shared knowledge, cultural norms, and situational context (Tannen, 2005; Verschueren, 2010).

A central assumption of IS is that talk is inherently incomplete; speakers do not encode all intended meaning explicitly. Instead, participants rely on inferencing, drawing on background knowledge and contextual expectations to interpret utterances (Gumperz, 2001; Rampton, 2017). Meaning, therefore, is not fixed but emergent, negotiated, and context-dependent, arising through interaction rather than individual linguistic production.

Closely related to inferencing is the concept of contextualization, which refers to how speakers signal and listeners interpret the context in which talk is embedded. This process is achieved through contextualization cues, linguistic

and paralinguistic features such as intonation, stress, code-switching, lexical choices, gestures, and postures that guide interpretation and frame interaction (Gumperz, 1982; Auer, 1992). These cues function as interpretive signals, helping participants determine how utterances should be understood within a given interactional frame.

Importantly, IS challenges the view of context as a static backdrop. Instead, context is seen as dynamic and reflexively constructed in interaction, with language both shaped by and actively shaping the context in which it occurs. Participants collaboratively produce context through their communicative choices, drawing on shared cognitive schemata and social knowledge (Auer, 1992; Jaspers, 2012).

Goffman's contribution further strengthens this perspective by emphasising participation frameworks and footing, highlighting how speakers shift alignment, roles, and stances during interaction. These shifts reflect participants' orientation to social roles and identities, which are continuously negotiated in discourse. Thus, interaction is not simply about exchanging information but about constructing social relationships and identities in context.

Overall, Interactional Sociolinguistics provides a robust framework for analysing how meaning, context, and social relations are co-constructed in interaction. It foregrounds the role of contextual cues, inferencing, and participant alignment in shaping communication, making it particularly relevant for examining institutional encounters such as paediatric consultations, where meaning is negotiated within complex social and professional frameworks.

Methodology

The data for this study were collected from paediatric clinics in Ondo and Lagos States, Nigeria. Ethical clearance and informed consent were obtained before data collection. A total of 20 consultation sessions were recorded across private and state-owned hospitals using a combination of convenience, stratified, purposive, and random sampling techniques. This approach ensured both representativeness and relevance. The relative uniformity of paediatric cases across clinical settings supports the broader applicability of the findings.

Analysis and Findings

The analysis reveals that paediatric consultations in the selected Nigerian clinics are structured by two broad context types: institutional and social. These contexts function as interpretive frameworks through which participants organise interaction and make sense of communicative actions. Within the present data, institutional context emerges as a force, shaping participation, role orientation, and meaning-making processes.

Institutional Context: Agency and Hierarchy

Institutional context refers to the norms, values, and regulatory frameworks that define participants' roles within professional settings (Perräkylä, 1995; Drew & Heritage, 1992). In medical consultations, this context governs how interlocutors orient to their identities as doctors, patients, and caregivers. From an Interactional Sociolinguistic perspective, participants signal their orientation to this context through contextualization cues such as directives, interrogatives, lexical choices, and turn-taking patterns (Gumperz, 1982).

Within the institutional context, two interrelated dimensions, agency and hierarchy structure interaction. Agency refers to participants' capacity to influence the trajectory of interaction, while hierarchy reflects the unequal distribution of epistemic and interactional rights. Unlike everyday conversation, participation in medical consultations is asymmetrical, with doctors occupying a position of authority grounded in institutional expertise.

Doctor–Doctor Agency

Doctor–doctor interaction demonstrates how institutional hierarchy is enacted and negotiated. It refers to the “dynamics of power, control and decision-making between healthcare providers during patient care" (Lingard et al. 2012:12). As observed by Odebunmi (2022), asymmetry is grounded in the relationship between doctors and also other members who are all agents in the hospital setting: the nurses, lab attendants, anaesthesiologists, pharmacists, receptionists, and others. Hierarchical agency is also identified by Hall et al. as a dynamic where one physician assumes a leading role while another remains subordinate. Hence, in consultations involving more than one doctor, the more senior doctor typically assumes control of the interaction, directing the diagnostic process and managing the flow of discourse.

This is evident in the following: During the consultation, two doctors, a resident and an intern named Doc 1 and Doc 2, are present. "Doc 1" holds a more senior position and plays a dominant role, while "Doc 2" takes on a slightly submissive function.

[…]

3. DOC 1: [ogun wo le ti lo fun]
4. [what medications have you given him]
5. MOM: oun naa ni mo fe mu jade
6. that is what I am about to bring out
7. DOC 1: ehn () rash abi ?
8. Yea ( ) right?
9. DOC 2: ehn skin rash and itching
10. MOM: yes

Here, Doc 1 initiates and controls the diagnostic sequence through a series of interrogatives, which function as contextualization cues indexing institutional authority. Doc 2's contribution, although relevant, is positioned as supportive rather than directive.

However, the interaction also reveals moments of collaborative agency. For instance:

[…]

33. Doc 1: I guess that should be piritin or loratadine
34. Doc 2: I guess so (moves towards the patient to check the drug)

[…]

Although framed as a self-directed statement, Doc 1's utterance functions interactionally as an invitation for confirmation. Doc 2's uptake demonstrates alignment and participation, indicating that knowledge construction in the consultation is, at times, collaborative.

At other points, agency becomes negotiable for instance, at the treatment recommendation phase of the consultation doc 2 inquires about the condition of the patient

[…]

121. DOC 1: Ehn I will write calamine lotion
122. She should continue that antibiotics ()
123. It's now I'm thinking ( )

124. DOC 2: I would have preferred that benzyl bensuate
130. DOC 1: ( )

…

138. DOC 2: that benzyl, you will use it for 3 days,
139. you wait for another 3 days then you continue for 3 days

…

The use of the declarative construction *"I will write"* functions as a contextualization cue indexing epistemic authority and decision-making control, consistent with institutional expectations that position the senior doctor as the primary agent. In line 124, Doc 2 introduces an alternative treatment option, 'Benzyl benzoate.' The modal construction *"I would have preferred"* mitigates the force of the disagreement, signalling deference while simultaneously asserting professional agency. This reflects a strategic negotiation of participation within an asymmetrical institutional framework.

Although the response in line 130 is indistinct in the audio, the subsequent interaction suggests that Doc 1 aligns with the proposed alternative. This is evidenced by Doc 2's later elaboration for therapy explanation. The provision of detailed usage instructions indicates that the treatment recommendation has been interactionally ratified. This ratification can be inferred from the progression of the discourse, where the absence of overt resistance and the continuation of the proposed line of action signal alignment. This supports the view that institutional hierarchy, while present, is not rigid but interactionally achieved, with participants using linguistic and sequential resources to negotiate control and alignment.

Doctor–Patient Agency

Doctor–patient agency in paediatric consultations is shaped by the communicative competence of the child. Unlike adult patients, children often have limited ability to participate fully, resulting in redistribution of agency.

This is illustrated in the extract below:

[…]

7. Doc: (to the child)What happened?
8. Child: (inaudible response)

9. Aunt: when she was playing…
[…]
The doctor initially directs the question to the child, thereby recognising the child's potential agency. However, the child's minimal response creates an interactional gap, which the caregiver immediately fills. This shift reflects a reconfiguration of the participation framework, where the caregiver assumes communicative responsibility.
Notably, in line 11, the doctor re-engages the child:
[…]
11. Doc: You've not told me what happened
[…]

This move functions as a contextualization cue signalling inclusion and encouragement, aligning with patient-centred communicative practice. The doctor's repeated engagement reflects sensitivity to participation roles and an attempt to redistribute agency. Thus, the child's agency is not absent but emerges in graded form, shaped by age, confidence, and interactional support.

Doctor–Client Agency
The client (parent or guardian) occupies a central communicative role in paediatric consultations, often acting as the primary narrator of the child's condition. The client's agency is grounded in experiential knowledge and is frequently realised through extended narrative turns.
For example:

1. DOC 1: is this Tofunmi?
2. MOM: yes
3. last week Thursday, a lo fun immunization, it was when( )
4. That they were giving her injection, she was crying
5. The person that gave her said she has tongue tie. That's what we came for

[…]
Here, the client expands a minimal response into a detailed narrative, effectively structuring the consultation. She demonstrates a form of initiatory agency that foregrounds her as an active participant in the consultation process. From line 3, she expands her minimal confirmation response into a self-initiated narrative of

the child's medical experience, thereby appropriating the conversational floor. Her extended turn, "Last week Thursday, we went for immunisation…" introduces not only the presenting complaint but also the origin of the medical concern, effectively constructing the child's experience as a narrative sequence. This aligns with Heritage and Maynard (2006), who note that clients' storytelling in medical consultations constitutes a form of agency through which they define the relevance of topics and reorient the interactional agenda. By doing this, the client transforms what could have been a simple response into an informational frame that guides the doctor's subsequent line of inquiry.
[…]
41. DOC 2: Doesn't she lift her tongue up? She doesn't lift up her tongue
42. MOM: You know it's not what I know, I don't know anything
[…]

Doc 2's utterance combines interrogative and declarative forms, functioning as a contextualization cue that simultaneously elicits confirmation, placing a somewhat epistemic power on the patient for the moment, which the caregiver explicitly relinquishes immediately. This utterance indexes epistemic downgrading, where the client distances herself from knowledge claims and aligns with the doctor's authority. From an Interactional Sociolinguistic perspective, this functions as a cue of deference, reinforcing the asymmetrical participation framework typical of institutional encounters.

Hierarchy as an Interactional Accomplishment
Hierarchy functions as a central organising principle within an institutional context, shaping participation, turn-taking, and decision-making. It operates at both official and epistemic levels and is enacted through interaction.
A clear example of official hierarchy is seen when a more senior doctor is introduced into the consultation:
[…]
229. Doc 1: Chief, we need your attention sir.
…
245. DOC 1: (to the chief) anytime she has that headache it comes with ( )
246. bleeding both from the nose and the mouth and
247. she said at some episodes, the blood is quite much. and some, little

blood
248. DOC 3: ok
249. DOC 2: so no issue of trauma to the head
250. DOC 3: ok

The address term *"Chief"* combined with the honorific *"sir"* functions as a contextualization cue indexing institutional rank and respect. This utterance signals a shift in the participation framework, marking the entry of a more senior authority (Doc 3) into the interaction. Here, Doc 1 adopts a reporting role, summarising the patient's condition for Doc 3. This shift from directive authority to informational relay reinforces the hierarchical structure of the medical institution, as Doc 1 relinquishes control of the consultation to the senior doctor.

From line 248, Doc 3's minimal responses function as acknowledgement tokens, yet within this context, they carry significant interactional weight. Despite their brevity, they index ratification and oversight, signalling that Doc 3 now occupies the position of evaluative authority. Both junior doctors align their contributions with the senior doctor's presence, demonstrating upward orientation to authority. Subsequently, the senior doctor assumes control of the consultation to the treatment recommendation.

While official hierarchy is based on formal roles, epistemic hierarchy is grounded in claims to knowledge and can be dynamically reshaped during interaction. Thus, meaning-making in medical encounters involves the continuous negotiation of who knows what, who has the right to speak, and whose knowledge is treated as valid or authoritative.

Example

14. Actually o ye ko en o si ye ko di ending ko to lo

15. I was supposed to give him at month end
16. Doc: why
17. Mom: I usually write the time every three three months
18. that I give him antimalarial medication
19. Doc: Why
20. Mom: Once he's running temperature

21. Doc: Are you a doctor or nurse
22. Mom: I'm not a doctor oo or nurse
23. I just think thatat least every three months
24. Doc: [that's rubbish]
25. Mom: ok
26. Doc: it's RUBBISH

[…]

Here, the caregiver positions herself as a knowledgeable agent within the domain of caregiving, drawing on routine practice and personal judgement. This reflects what Interactional Sociolinguistics recognises as the use of background knowledge and experience to construct meaning in interaction. However, the doctor immediately challenges this epistemic claim. The repeated "Why" in lines 16 and 19 functions as a contextualization cue that problematises the caregiver's reasoning and signals a shift toward institutional evaluation. It places the burden of justification on the caregiver, thereby destabilising her epistemic position. In line 21, the doctor's utterance, " Are you a doctor or nurse, explicitly invokes institutional identity as a basis for epistemic authority, drawing a boundary between professional (biomedical) knowledge and lay (experiential) knowledge. It repositions the caregiver from a tentative position to a non-expert status.

Social Context

Beyond institutional structures, paediatric consultations are also shaped by social context, which encompasses the broader socio-cultural norms, values, and power relations that participants bring into the interaction. Social context operates as an interpretive layer through which participants construct meaning, negotiate roles, and orient to authority. In the Nigerian setting, this context is particularly salient, reflecting deeply embedded cultural orientations such as hierarchy, collectivism, and socio-economic realities. These social dimensions are not external to the interaction but are actively indexed through discourse, shaping how participants speak, respond, and align with one another.

Asymmetry as Socially Embedded Context

A central feature of social context in the data is asymmetry. While institutional asymmetry is rooted in professional authority, social asymmetry is reinforced by cultural expectations of deference to authority figures, which manifest in

knowledge and status. One way to conceptualise knowledge asymmetry is as a socially entrenched phenomenon that is influenced by participants' larger socio-cultural and cognitive aspects. According to this viewpoint, asymmetry results from disparities in social experience, communication skills, and knowledge availability in addition to professional duties.

This is evident in the following extract:

[…]

20. DOC 2: kini birth weight e?

21. What's her birth weight
22. MOM: shey this ( ) eh:::n
23. DOC 2: When you gave birth to her

24. Ki lo weigh
25. MOM: 3 3.2

[…]

The doctor's question presupposes that the caregiver possesses specific medical information—birth weight which is treated as relevant and retrievable within the consultation. However, the caregiver's hesitation ("eh:::n") functions as a contextualization cue signalling difficulty in recall or uncertainty. This hesitation reflects the cognitive and experiential dimensions of knowledge asymmetry, where access to information is shaped by memory, record-keeping practices, and familiarity with medical expectations. Such asymmetry is influenced by factors that include health literacy, educational background, and communicative norms. As Kaplan (2004) notes, medical information can be complex and difficult for patients to process, even when they are otherwise educated. In this interaction, the caregiver's hesitation is not simply a lack of knowledge but reflects the situational demands of recalling medically relevant information within an institutional setting. Status asymmetry, on the other hand, reflects broader cultural expectations about authority, responsibility, and moral conduct in caregiving.

Collectivism and Communal Framing of Illness

Another defining feature of social context is collectivism, which foregrounds the role of family and community in shaping health experiences and decision-making. Cultures such as Asian and African cultures uphold collectivism, which means they prioritise social harmony, social hierarchy, and interconnectedness. This is illustrated in the extract below:

[…]

134. Doc: how did you know you lost weight
135. Patient: people kept asking me what happened to me

[…]

The patient's response invokes *"people"* as a source of validation, indicating that health perception is socially constructed rather than purely individual. This reflects the communal orientation of Nigerian society, where others' observations contribute to self-awareness and decision-making. Similarly, caregiving is often distributed across extended family networks as evident in the following example:

[…]

49. DOC: are you her mother
50. MOM: I'm her grandmother
51. DOC: What of her mom
52. MOM: she's at home
53. DOC: who is the person you are all living together what of her daddy
54. MOM: we are not living together with her daddy
55. DOC: so who is the main person taking care of her
56. MOM: I'm the one who is taking care of her

[…]

Here, the grandmother assumes the role of primary caregiver, demonstrating that paediatric consultations are not strictly dyadic (doctor–parent) but embedded within extended familial structures. This reflects a collectivist framework in which responsibility for child care is shared. From an Interactional Sociolinguistic perspective, these interactions reveal how participants draw on shared cultural knowledge to frame illness, caregiving, and decision-making.

Socio-Economic Context and Infrastructure

Social context is also shaped by economic and infrastructural realities of the society, which directly influence both health outcomes and communicative practices. The economy of a society largely determines the essential conditions of the life of individuals. It is one way in which a society is constituted and maintained. It is an important aspect of human life and permeates every other aspect. It is an important determining factor in the quality of life of individuals. In many societies, the state of the economy is directly tied to the strength and effectiveness of the healthcare system. This is evident in the following extract, where the patient presents with skin rash:

[…]
41. Doc: what kind of water do you use
42. Mom: well water
43. Doc: do you treat it::: with dettol or purit
[…]

The doctor's line of questioning links the child's condition to environmental factors, specifically water quality. The caregiver's response indexes limited access to infrastructure, a common feature in many Nigerian communities. This exchange illustrates how contextual knowledge of the environment and living conditions becomes relevant in diagnostic reasoning. The consultation thus extends beyond the body to include socio-economic realities.

Governance and Institutional Limitations

Politics and governance shape the framework through which resources are allocated, infrastructure is developed, and social systems are maintained. They encompass power relations, policy-making processes, and the distribution of status and resources within society. Hence, they are not abstract forces but central determinants of infrastructure, development, and the quality of life and healthcare experienced by citizens. This is illustrated in the extract below:

[…]
72. DOC 1: ( )
73. MOM: you don't have it
74. DOC 1: er:::m
75. MOM: [>where can we find it<]

76. Where can we get it
77. DOC 1: owo ( ) we don't have ENT here […]

The doctor's acknowledgement of inadequate facilities indexes systemic limitations within the healthcare system. The recommendation to seek care elsewhere introduces geographical and economic constraints, which the caregiver must navigate. The interaction escalates to a socio-political commentary:

[…]
113. MOM: This is whole hospital state government, they do not have ehn
114. DOC: ( ) ( )
115. MOM: they don't have equipment
116. DOC 2: Are you not the one that votes for them, when they give N5, 000 and N7, 000
[…]

This utterance explicitly links healthcare inadequacies to governance and political practices, demonstrating how macro-social realities are interactionally invoked within the consultation. From an Interactional Sociolinguistic perspective, such moments reveal how participants move beyond immediate clinical concerns to situate the interaction within broader societal structures.

Religion

Religion also emerges as a salient contextual factor, shaping both language use and emotional framing. This is evident in the following exchange:

[…]

98. Doc: you should be thankful
99. Mom: "Alhamdulillah"

[…]

Although the doctor's statement is not explicitly religious, it is interpreted within a religious frame, as evidenced by the caregiver's response. The use of

"Alhamdulillah" indexes Islamic belief and functions as an expression of gratitude to God. This sequence illustrates how shared cultural-religious knowledge enables participants to co-construct meaning. Religion thus operates as both a coping mechanism and a communicative resource within the consultation.

Conclusion

This study has examined the context types that structure interaction in Nigerian paediatric consultations, with a particular focus on how institutional and social contexts shape communicative practices. The analysis demonstrates that medical encounters in paediatric settings are not merely sites of information exchange but are deeply embedded within layered contextual frameworks that regulate participation, meaning-making, and decision-making processes.

At the institutional level, context is realised through structured norms, roles, and expectations that organise interaction around professional authority. Features such as agency and hierarchy were shown to govern the distribution of participation rights, with doctors occupying epistemically privileged positions while other participants, particularly caregivers and children, negotiate varying degrees of involvement. However, this hierarchy is not rigid; rather, it is dynamically enacted and negotiated through interaction, revealing the fluidity of institutional authority in practice.

Beyond institutional structures, social context emerges as a critical layer shaping paediatric consultations. Cultural orientations such as asymmetry, collectivism, and respect for authority influence how participants position themselves and respond to interactional demands. The findings show that caregiving in Nigerian contexts is often communal, with extended family networks playing active roles in consultation processes. Similarly, socio-economic realities and infrastructural limitations are not external to the consultation but are interactionally invoked, influencing both diagnostic reasoning and treatment pathways. Religion also functions as a salient interpretive resource, shaping how illness is understood and how participants align with one another within the consultation.

These findings highlight that context is not a static backdrop but an interactional accomplishment, continuously indexed through linguistic choices, participation frameworks, and contextualization cues. Participants actively draw on shared cultural knowledge, institutional norms, and situational resources to construct meaning and negotiate roles within the consultation.

The study contributes to existing research on medical discourse by foregrounding context as a central analytic category in paediatric consultations, particularly within an African setting that remains underrepresented in the literature. It demonstrates that effective healthcare communication cannot be fully understood without accounting for the interplay between institutional structures and socio-cultural realities.

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