STRATEGIC INTERCHANGES IN NIGERIAN ONLINE MEDICAL CONSULTATIONS

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Abstract

Extant scholarship has revealed more attention devoted to the pragmatics of in-person clinical consultations than that of online medical consultations, leaving undescribed such consultative features as strategic voicing and shared consultative salience that are considered distinctive to online consultative interactions. This study addresses the lacuna by examining the strategic interchanges between doctors and patients in Nigerian online medical consultations with a particular focus on the contexts which define consultations and the pragmatic strategies employed by online doctors in the consultations. Prior's Polyphony theory and Clark's Common Ground theory were adopted as the study's theoretical framework. Fifty (50) interchanges between doctors and patients on Nairaland were purposively sampled for analysis. The sampled interactions centred on malaria, typhoid, menstrual pain, allergic reactions and growth. Only portions relating to patients' complaints and doctors' diagnoses and recommendations were analysed. Regarding common ground, the data revealed a strategic, contextual observance of community co-membership and linguistic co- presence by means of the invocation of real and assumed doctor-patient shared knowledge of Western medical jargons and alternative practice. Concerning Polyphony, the typified social voice indicates doctors' low and high levels of commitment to professional authority, a reenvoicing of patients' therapeutic biography is predominant and personalisation is achieved more as internalisation than externalisation. The study concluded that the analysis demonstrated online consultations' affordances for exchanges of medical information, which is pragmatically assessed to match with participants' interactive designs while doctors' and patients' strategic orientations to technicality and confidentiality sometimes weaken the epistemic base of the practice and reduce its reliability in Nigeria.

Keywords: Strategic communication; Nigerian online medical consultations; Common ground; Doctors' professional authority; Therapeutic biography.

Introduction

The 21st century is characterised by an increasing growth of Information and Communication Technology in connecting the world and, in the process, breaking spatial as well as temporal barriers. This has permeated medical practice and has resulted in the birth and growth of online medical consultations. Online medical consultations are Internet-based interactions between doctors and patients over the health conditions and complaints of the latter. The doctor and the patients, who are usually located at different spatial and temporal spaces but whose presences are only mediated virtually, defy these inhibitions to exchange health-related information. Online medical consultations, which may be synchronous or asynchronous, are strictly dialogic and are done via texting, messaging or voice calls. The dialogues take the forms of complaints, interrogation, diagnosis and recommendation. The consultative dialogues are executed in several digital telecommunication systems which include video calls, mobile apps, text-messaging and remote monitoring devices. Of interest to this study is the text messaging medium.

Online medical consultations between doctors and patients are selective, goal-driven exchanges of information which demonstrate specific strategic features:

a. restraint in the exchange of information among parties;
b. restrained declaration of identity;
c. largely indirect locutions of medical conditions and advice;
d. low professional commitment;
e. information flooding, barring medium-sensitivity (because of identity security).

When compared to physical clinical encounters, online consultations are proving increasingly effective in alleviating medical burdens and providing more benefits such as the ease and convenience of 24-hour consultation, zero consultation fees in several cases, prompt access to quality health care, easy information exchange between patients and doctors and availability of alternative treatments.

However, significant as these interactive features are, the response of the scholarship of medicine and medical linguistics to online medical consultations has oriented only to practice assessments (Carlisle George & Penny Duquenoy, 2008) and few pragmatic features (Zufferey Maria Caiata-, Abraham Andrea Sommerhalder Kathrin, and Schulz, 2010) with an infinitesimal emphasis on context and how it shapes online consultative encounters. This lacuna limits the extent to which the pragmatic practices of online medical exchanges are activated. This is what the present study fixes by combining theories of Polyphony (Prior, 2001) and Common Ground (Clark, 1996; Clark & Brennan, 1991) to examine the strategic interchanges between doctors and patients in Nigerian online medical consultations. Specifically, it explores the contexts which define consultations and the pragmatic strategies employed by online doctors in online medical practice.

Theoretical Background

The research relies on two theoretical models: polyphony and common ground. Each is reviewed briefly below.

a.Polyphony

In the 1990's , the notion of "polyphony" (or "heteroglossia") was identified by the Russian linguist Mikhail Bakhtin as a form of "multi-voicedness" in dialogism, the multiplicity of perspectives and voices in discourse. In his dialogic perspective of how discourse is enacted, Bakhtin posits that knowledge is produced within and against a polyphony of others' voices and the forms of knowledge (i.e. epistemes) and that these voices create dialogical tensions and contradictions between the epistemes (Renedo, 2010; Renedo, Komporozos-Athanasiou & Marston, 2018). Originally conceptualised for interpreting characterisation in literary discourse (specifically, the novel), polyphony has since been found applicable to social theory, especially informing social theory, sense-making and analysis of the intersubjective nature of society (Aveling et al., 2015; Hermans, 2001).

"Following Emerson's interpretation of Bakhtin, voice may be understood as the expression of consciousness in dialogue, where meaning emerges through interaction among autonomous consciousnesses rather than from an isolated self (Emerson, 1997).". According to Renedo, Komporozos-Athanasiou and

Marston (2018), Bakhtin's dialogism helps to conceptualise the relational and contextually-situated nature of professional knowledge in two major ways. First, this is done through dialogical 'appropriation' (Bakhtin, 1981), which helps to reveal how (hybrid forms of) knowledge may be actively re-negotiated and reworked by investing one's perspective with others'. Second, it helps one to understand and examine how knowledge is unfinalisable or fluid, and so available for re-articulation by means of dialogue.

Any form of doctor-patient interaction basically instantiates human dialogue. Hence, in this form of medical discourse, attention to multivoicedness offers a way to see and reflect on the heterogeneity of the discourse and the multiple identities that clinicians and patients display in clinical dialogues. The dialogue is essentially 'saturated with voices of all who are related to a particular episode of illness. These voices may become audible as opinions, convictions, beliefs, fears or any other human methods of deciphering … reality' (Puustinen, 1999).

Prior (2001) identified three key dimensions of dialogic voicing: typified social, re-envoicing others' words and acts, and personalised voice.

(1) *Typified Social Voice*: It establishes a link between a social identity and particular contents; addresses forms of discourse, tone of interactions expressed through selected words in oral, written and gestural communication.

(2) *Re-envoicing*: This is related to the integration (weaving) of the lexical items used by particular language users into the discourse of others (Voloshinov 1973). It consists of two factors: the discourse being reported (the other person's discourse) and the discourse doing the reporting (the author's discourse). Re-envoicing is done through repetition and presupposition, reflections of utterances made earlier in particular places or times in connection with certain activities (cf Goffman 1974)

(3) *Personalisation:* This is realised both as internalisation and externalisation processes: elements of a person's biography. As internalisation, it is the shift between authority/power-imbued discourse and asymmetrical/power-neutral, persuasive one. As externalisation, it involves the ways particular addressees

contribute to the formation of authority/power-imbued authoritative discourses.

b.Clark's Common Ground theory

The term "common ground" (sometimes called, "grounding in communication") captures the knowledge individuals deployed in conversations, and the need to share them so as to understand each other and to have meaningful interaction. It thrives on the notion that communication is a collaborative process of knowledge, beliefs, assumptions and expectations that are mutually presupposed and emergent in the communicative process (c.f. Lewis, 1979; Prince, 1981; Clark, 1985, 1996; Clark & Brennan, 1991; Stalnaker, 2002; Odebunmi, 2006; Allan, 2013). According to Clark (1996), common ground in human communication emerges from two different sources: (i) beliefs, knowledge, assumptions and presuppositions believed to be commonly shared by all participants in the interaction; and (ii) information and knowledge emergent during the interaction.

While being engaged in grounding, parties co-construct concepts and meanings at two levels: Presenting utterance and Accepting utterance. In Presenting utterance, the speaker presents utterance to the hearer while in Accepting utterance, the hearer accepts utterance by providing evidence of understanding.

Across these phases, three types of positive evidence are recognised: Acknowledgements, Relevant Next Turn and Continued Attention. Acknowledgements refer to back-channel responses that affirm and validate the messages being communicated. Generally produced without the speaker taking a turn at talk, acknowledgements include continuers (e. g. "uh", "thanks"," "yeah," "really,"), assessments (e.g. "gosh, "really") and gestures (e.g. "head nods") (Clark & Brennan, 1991: 130). They are used to signal that a phrase has been understood and that the conversation can move on. Relevant next turn refers to the initiation of response or invitation to respond between speakers for turn-taking in conversation. This includes verbal and nonverbal prompts. For example, in adjacency pairs—question-answer, request-response, invitation-acceptance— the first pair-part of the conversation has to be relevant to the

second-pair part. For example, a relevant answer has to be given to a question for it to be accepted and considered an adjacency pair.

Continued attention, the most basic form of positive evidence, refers to the shared belief that the speaker and the hearer (addressees) have understood a message or have correctly identified a referent, as intended. To achieve common ground, conversational partners are interested in and do monitor what each party is attending to. In face-to-face interaction, this is achieved through eye gaze such that if one of the partners looks confused or turns away, there is no longer continued attention. In mediated communication, this can be done through starting, restarting or repeating an utterance. Positive evidence of understanding is attained through undisturbed and undiluted attention.

Further on in the conversation, the knowledge which a conversational partner has can be anticipated through three main ways: community co-membership, linguistic co-presence and physical co-presence

- Community co-membership: It indicates shared cultural beliefs, including shared knowledge of expertise among a set of people. Members of a group with knowledge in a particular field could use technical jargon when communicating with the group but would opt for layman terms when communicating outside the group.
- Linguistic co-presence: This indicates shared knowledge of linguistic resources possibly imported from previous conversations. For example, a party in a conversation can use a pronoun to refer to someone mentioned in a previous conversation; s/he can make reference to a topic discussed earlier either through direct or indirect reference.

- Physical co-presence: This refers to shared knowledge of a referent object or shared visual information. When speaker and hearer are physically co-present, any of them could point to an object within their physical environment and they will both be able to perceive the same objects and experience the same things (joint attention).

Methodology

Fifty interchanges between doctors and patients on Nairaland were purposively sampled. While the sampled interactions centered on malaria, typhoid,

menstrual pain, allergic reactions, and growth, only portions relating to patients' complaints and doctors' diagnoses and recommendations were analysed.

Data analysis followed the top-down approach, using the selected, relevant discourse and pragmatic theories of polyphony and common ground. Categorisations were done considering the medical activities found in the data and the voices characterising the activities. These were further situated in the online medical genre through the common ground theory of Clark, particularly the application of co-presences and features of online consultative communication. Also, aspects of polyphony were combined with common ground to account for the strategies and pragmatic actions revealed by the data.

Analysis and Findings

Each part of the analysis demonstrates the pragmatic design of the interchanges, as conditioned by their context types and the pragmatic strategies deployed and the voices evoked in the encounters. Online medical consultation instantiates four contexts: virtual, institutional, biographical and folk.

The virtual context captures the worldwide medium of the Internet, which indicates mass communication of contents and, hence, the source of much of the caution observed by participants. The institutional context relates to the factor of the profession of medicine, as well as the actions and professional power associated with the practitioners. Biographical context evokes the factor of patients' experience of sickness, often accounted for in their narratives (of current or past complaints, of history of ailments). Folk context captures the social and cultural realities sometimes found in the medical locutions of any of the parties (doctor or patient).

The deployment of six strategies—jargonisation of epistemic and deontic stances, orientation to professional commitment, evocation of authority, evocation of agency, association with patients' lifeworld, veiling privacy—was revealed in the data. These, together with their characterizing contexts, polyphonic resources and common ground features, are developed in the analysis that follows.

a. Jargonisation of Epistemic and Deontic Stances

This is a doctor-based act that presents medical knowledge and treatment in technical language. It occurs in institutional context and is characterised by linguistic co-presence, typified social voices and reenvoicing patient's words, as indicated in Example 1.

Example 1:

> Doctor: The antimalarial medications you took/take only eradicate the erythrocytic of the parasite known as the trophozoite. But the hypnozoite incubating in the liver later on (likely after 2wks or 3wks or more) hatch into the merozoite which is released into the bloodstream, and begins another malarial cycle.

Doctor's epistemic knowledge here is indexed by the choice of medical jargon, which includes "antimalarial medication, erythrocytic, trophozoite, hypnozoite, incubating, merozoite, and bloodstream". The adjective, "antimalarial", is derived from the disease, malaria, and serves as the qualifier to the headword, "medication". Also, the choice of the jargon: "hypnozoite, incubating, merozoite and bloodstream" reveals doctors' knowledge of the human anatomy, which represents strategic resources because of the doctor's observance of linguistic co-presence, demonstrating the patient's assumed mutual knowledge and thus somewhat restricting communication somehow to the duo.

Example 2:

> "u r very correct. I tend to have malarial/typhoid every 2 weeks. The thing has turned me into a drug addict. Which drugs do u recommend because I take artemether and lumefantrine anti-malarial each time I have malarial symptoms. Sometimes I go for mp and widal test".

Example 2 is the patient's follow up response to the doctor's jargon-based intervention in Example 1. Linguistic co-presence is indicated by the patient's response, 'U r very correct', which demonstrates client's clear uptake of the technical locutions of the doctor. Social voice is indicated by the professional identity shown in the doctor's use of jargon, which serves to establish his medical authority and which the patient connects with quite easily. Reenvoicing is marked off in the common ground of the patient's therapeutic biography

acknowledged by the doctor's utterance in Example 1: 'The antimalarial medication that you took…'

b.Medium-constraining Orientation to Professional Commitment

This is a doctor-based act that signals a level of commitment to medical authority as a result of the medium of consultation. It occurs in virtual contexts and is characterised by community co-membership and reenvoicing. It is illustrated in Example 3.

Example 3:

> I sincerely can't recommend or Rx some kinds of drugs on this platform, because the moderator keeps infringing on my right by banning me from replying on health topics. So I'll have to ask you to PM me or add me on BBM

Doctor's orientation to the medium of consultation here indicates a low level of commitment to medical authority. This is indexed by the phrase, 'I sincerely can't recommend or Rx [recommend/make a recommendation of] some kinds of drugs on this platform'. To evoke community co-membership and linguistic co-presence, the doctor assumes the patient's access to the expressions, 'PM' and 'BBM', which indicates shared social and cyber experiences, and shared knowledge of codes marking off the experiences. Reenvoicing is indexed by the doctor's refocusing an earlier experience considered relevant to current decision, i.e. the decision to ask for a PM or BBM.

c. Evocation of Authority

This refers to a doctor-based act that includes using the voice of medicine as an authority-vesting device. It occurs in institutional contexts and is characterised by typified social voices, reenvoicing and linguistic co-presence as illustrated below.

Example 4:

> Your menstrual pain (dysmenorrhea) is the action of prostaglandin on the smooth muscles of your uterus (womb). The hormone causes the muscles to contract so the endometrium can shed. In your case, the hormone secretion is quite much, and that's why you're having unbearable menstrual cramp.

The dominant voice here is the voice of medicine, with the use of the jargon, 'dysmenorrhea', 'prostglandin', 'uterus' and 'endometrium', designed to flaunt skills as well as downplay patient's knowledge. This is sometimes mitigated in medical practice to avoid miscommunication and patient dissatisfaction. Linguistic co-presence is signaled by the doctor's assumption of the patient's knowledge of medical jargon. Social voice is invoked as the doctor orients to the use of the voice of medicine. Reenvoicing here is indicated by the doctor's reference to the preceding discourse.

d.Evocation of Agency

This is a doctor-patient act that relates the discourse to evidential factors that contribute to or are connected to the discourse. It includes citing medically-related evidence and people related evidence. It occurs in biographical contexts and is characterised by reenvoicing and linguistic co presence

Example 5:

> Maximum Respect to all the Health Professionals in the House
> . . .
> (1)I had a sex (first) with a lady on August 8 ,2014..
> (2) She called me 9days later (17/8/2014) that she is having stomach disorder and malaria.
> (3) I advise her to carry out pregnancy test which she did and told me the result is positive .. that is exactly two weeks after the sex. (22/08/2014).
> (4) Got an info that she went to an hospital last week Thursday (30-10-2014) with another guy (she claimed the guy his her brother) to carry out abortion on the pregnancy.
> (5)The doctor told them that the pregnancy is already more than three months but he did not tell them the no. of weeks above three months . (So, the abortion will take place in two days and above their budget).
> (6) I Took her to one of the best Specialist Hospital in town for a scan yesterday (7-11-2014).. Which the result shows that the pregnancy is in good state and 15 WEEKS .
> NOTE .
> SEX= 7-8-2014 ,. (12 weeks today)
> FIRST SCAN= 30-10-2014 (11weeks after sex.) result shows

over three months pregnancy ....*** I was not there with them and I don't see the result. SECOND SCAN = 7-11-2014.(12 weeks after sex) The baby in good position, head and leg so visible but the sex was unable to be determined and result shows 15weeks pregnancy .

In Example 5, linguistic co-presence is marked off by the shared knowledge of gestation indexes: the doctor's profession takes the knowlegde for granted; the consultee's experiential orientation accounts also for a level of access. Mutual knowledge of and joint experiential access to technical, lexical, number, code and disjointed syntactic choices (first scan, second scan, head and leg so visible, etc) smoothen communication. Reenvoicing involves echoing a third party's (the girlfriend's) discourse and past events with reference to place and time. The girlfriend's and the consultee's social (sexual relationship) and medical biographies in concrete temporal and spatial locations, connected to specific biological, social and medical actions, are contextually demonstrated.

e.Veiling

This concerns doctor/patient-based act of partially or completely concealing disease-related information in the context of the online communicative medium. As exemplified in Examples 6 and 7 below, the biographical context, linguistic co presence, reenvoicing and personalization are prominent in the interchanges.

Example 6:

Hello Doctor,
Please I need your assistance, something whitish in colour coming out of my husband pe**s and he did urine culture test. The test revealed klebsiella sp infection. Please can this infection affect his fertility because we are on TTC and what is the way out?

Example 7:

Yes it can, and does affect fertility if left untreated. The form of Klebsiella infection your hubby has is UTI. It is responsible for the penile discharge he's having, and sadly, it can be transmitted

sexually. It is not actually safe for you to indulge in unprotected s*x with him. You may need to abstain from s*x with him or you insist he uses cond*m till he's completely free from the infection. Treatment would be in line with the outcome of his sensitivity test. So maybe you can send me an email with the result of his sensitivity test.

In Example 6, linguistic co presence is signalled by the shared knowledge of orthographic coding, 'pe**s'.The socio-culturally tabooed open reference to male sexual organ, "penis", is veiled as a joint orientation to publicly inoffensive language. This is in addition to protecting the husband's privacy with visually-restricted access to both his body part and any related information. This veiling is sustained by the doctor's use of 's *x' and 'condo*m' in his response in Example 7. Both "sex" and "condom", which indexicate extremely private contexts and presuppose obscenity and therefore absence of decency in public engagement, especially in an online medium, must have their uses veiled particularly by a Nigerian or African woman. It is the tabooed and sanctioned nature of the words that accounts for the replacement of "e" in "sex" with an asterisk and the insertion of the asterisk between "o" and "m" of "condom| as defamiliarisation strategies to veil the words. Reenviocing is signalled by a patient's complaint, which is based on past events and experiences of a third party (her husband). Personalisation is achieved as externalization, as the patient's input (about her husband's ailment) contributes to doctor's authority-imbued utterances via a strategic hybridisation of voice, a conceptualization connected to Mishler's (1984) the voices of medicine and the voice of lifeworld.

f.Indigenisation of Medical Procedure

This is a doctor-based act of utilising indigenous knowledge in conventional medical practice. It involves offering recommendations in folk medicine. It occurs in folk context and is characterised by typified social voices and community co-membership as shown below.

Example 8:

That's likely laryngopharyngitis. **Well, you can take honey mixed with lemon**. Or you can get strepsil tabs (OTC) and

> lick. It's a lozenges. If the dysphagia persists after 3days, then consult a physician in person for Rx!

Here, typified social voice is marked off by the dominant voice of medicine designed to flaunt skills and consequently block shared decision making. Also, in the process of evoking community co membership, the doctor assumes the patient's knowledge of alternative (folk) medicine, '...Well, you can take honey mixed with lemon...', without specific prescriptions on the quantity or method. The recommendation of honey and lemon apparently evokes joint lay and folk knowledge, and as a consequence indigenizes treatment. Sandwiching the recommendation between the speculative diagnosis, "That's likely laryngopharyngitis", the medical scientific alternative recommendation: "Or you can get strepsil tabs (OTC) and lick. It's a lozenges" and the typical medical warning follows: "If the dysphagia persists after 3days, then consult a physician in person for Rx!" Both integrate folk medicine into Western medicine and demonstrate all four voices identified by Odebunmi (2021:27): "the conjectural voice of the doctor, the medical institutional voice, the voice of medical science and the voice of culture".

Conclusion

This study has investigated the pragmatics of conversations in Nigerian online medical consultations, deploying the theories of common ground and polyphony. Regarding common ground, the data reveal contextually-strategic observances of community co-membership and linguistic co-presence by means of the evocation of real and assumed doctor-patient shared knowledge of Western medical jargon, some practices of Western medicine and alternative medical options. Concerning polyphony, the typified social voice indicates doctors' low and high levels of commitment to professional authority, a reenvoincing of patients' therapeutic biography is predominant, and personalisation is achieved more as internalisation than externalisation.

Overall, the analysis demonstrates online consultations' affordances for exchanges of medical information, which is pragmatically assessed to match participants' interactive designs. The interchanges' strategic orientations are consistent with the extremely public nature of the encounters, and thus the need for the parties to provide and share information cautiously. However, the same cautious tone weakens epsitemics and reliability of the consultations, and

implicates a strong in-person complementation of the virtual meetings. This suggests the need for caution to see online consultative meetings as merely preliminary and temporary steps in the process of wellness.

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