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You didn't give me to go and buy': Negotiating accountability for poor health in post-recommendation medical consultations☆

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Abstract

This research explores how doctors and patients discursively track responsibility for patients' poor health after treatment recommendations have been delivered in South-western Nigerian hospitals. Purposively sampling 10 audio-taped and five video-taped doctor–patient interactions in selected Nigerian hospitals, it takes a mid-course between aspects of the conversation analytic, exclusively bottom-up, and the discourse analytic, mostly top-down, approaches to clinical conversations. It argues that the discursive treatment of postrecommendation poor health, situated in common ground and sequentiality, is construed by participants as either patient- or doctor-induced. When construed as patient-induced, poor health is anchored to a patient-designed therapy plan and is co-constructed as a clear patient responsibility, necessitating a re-negotiation of an existing recommendation by doctors and patients. When construed as doctor-induced, poor health is co-constructed as a physician error, but responsibility for it is sequentially refused by the doctor, who negotiates a fresh therapy plan to neutralise physician blame. While the analysis shows that doctors' simplified language which facilitates consultative exchanges proves useful in negotiating responsibility in poor health discourses and, consequently, instituting a more effective medical procedure on patients, it reveals doctors' occasional communication of inadequate and misleading information, use of suppressive interactive power and or nonacceptance of clinical errors.
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1. Introduction

Hospital meetings are sites for medical, cognitive and social presentations intricately coordinated by discursive actions. In other words, the doctor and the patient, who are key participants in the meeting, mutually exchange information centring on medical facts and personal experiences, which ultimately lead to diagnoses and treatments.

Treatment or therapy, which is the focus of the current article, is often indicated by doctors' recommendations to patients. In a number of countries, particularly in the US and several European countries, patients are carried along in the treatment decisions taken on their ailments (Stivers, 2002b) as advised by medical associations. While the same practice

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is in existence, to some extent, in Nigeria, and by some fair extension, several African countries, what is more prominent in a number of Nigerian hospitals is the negotiation of responsibility after the recommendations administered by the patient have apparently failed.

At the hospital meetings where issues relating to patients' post-recommendation poor health are raised, especially when they are associated with non-compliance with therapy plans or wrong medical procedure, both doctors and patients sometimes deny responsibility for the condition. Poor health, in this paper, refers to the non-improving state of a patient's health condition. Post-recommendation poor health relates to this bad or worse condition occurring after therapy has been recommended and administered.

When doctors and patients deny responsibility, the parties are plunged into claims and counter claims of rightness which are often discursively negotiated in the asymmetrical power context of the hospital. The charges of responsibility for poor health sometimes attract vague or slippery responses from either party, or power-imbued dismissing position only from the doctor.

However, significant as these interactive features are, research on clinical encounters in Nigerian hospitals has focused more on the pragmatic properties, including context-driven language interactivity, power relations and stylistic choices, of the encounters in general (Odebunmi, 2003, 2005a,b, 2006, 2008, 2011, 2012a,b, 2013a,b; Adam, 2015; Salami, 2007; Salami and Taiwo, 2007, etc.) than on the discursive negotiations of accountability in post recommendation poor health situations. At the international level, particularly in the West, studies have been devoted to the construction and negotiation of accountability in the oncology clinic (e.g. Bishop and Yardley, 2004; Sinding et al., 2010), but the studies do not consider doctor-patient negotiations focused on poor health following earlier recommendations. Also, many studies have been committed to the negotiation of recommendations during consultative meetings, but most of them have been limited to clinical disagreement, often sandwiched within a larger therapy negotiation agenda (see Costello and Roberts, 2001; Stivers, 2002b, 2005), and not extended to post-recommendation contexts. In addition, with the exception of a few, these studies have utilised the instrument of conversation analysis (CA), which automatically discounts larger contextual properties of the interactions and participants' shared grounds which are of key importance in understanding the discourse of post-recommendation poor health. The knowledge shared between doctors and patients, the realities at their meetings (which are the only items considered by medical CA), the goal of the interactive space and the private goal of the participants, as a whole, would offer clearer insights into the discourse. This state of affairs means, as already noted by Ainsworth-Vaugh (1995), Sarangi and Roberts (1999), and Maynard (2003), that we need broader accounts of therapeutic negotiations to complement the CA resources available in interpreting discursive negotiations in the hospitals.

The CA bottom up approach (see, for example, Costello and Roberts, 2001) which differs essentially from a top down approach to therapeutic discourse as attempted, for example, by Kessler et al. (1995) highlights the commitment to strict sequential analysis as against ''an approach that views diagnosis and treatment decisions as influenced primarily by participants' cultural assumptions, perceived characteristics, and the aspects of the larger social setting'' (Costello and Roberts, 2001: 243). While the bottom up approach is result-oriented with respect to several domains of interaction, it is not sufficient for analysing medical interactions, especially acceptance or rejection of responsibility in poor health, which are essentially goal-driven activities. The decisions that lead to poor health on the part of the patient are hardly detachable from the social, cultural and cognitive contexts that inform their actions. Those that eventuate in doctors' actions could be emotional, social or professional. Consequently, the present study combines the top down (using common ground theory) and bottom up approaches in accounting for doctor-patient orientation to accountability in poor health interactive situations in South-western Nigerian clinics. It explores the contexts, the discursive evocations in poor health situations, and the formats and strategies deployed in negotiating accountability in the clinical encounters.

2. The context of clinical accountability in Nigeria

Nigeria does not have a national health system in the Western sense in which medical services are paid for through medical insurance schemes. But at the federal/national level, there is the National Health Insurance Scheme (NHIS) which heavily subsidises medical bills of federal workers in all accredited private or public health facilities.

With the exception of teaching hospitals which are visited or referred in critical conditions, many Nigerians prefer to patronise private hospitals when they have commensurate economic muscle to pay the bills, often considered to be high when compared to government hospitals with generally subsidised rates. In addition, private hospital doctors are believed to be less heavily visited than government ones. Hence, patients expect more prompt, dedicated and efficient services than in government hospitals where staff attitude, inclusive commitment to duty, is a serious problem (*Premium Times* 2013; Igbekoyi, 2013). The heavy patronage of government hospitals, with generally insufficient practitioners, often takes a huge toll on doctors who complain of overwork, and who, consequently, sometimes act wrongfully in terms of diagnosis or treatment.

The consultative procedure in public and government hospitals is standard, and high physician power is manifest in both, although suppressed to a large extent in teaching hospitals which are not covered at all in this research. In some degree, the power assumption could be blamed on patients' large uncritical acceptance of doctors' acts which has

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