Pragmatics and power:  
Doctor-patient interactions at Nakhonphanom Hospital

Krittima Janyaphet  
Ph.D candidate in Linguistics, Faculty of Humanities, Mahachulalongkornrajavidyalaya University  
Tel: 09-2259-3145 e-mail: rosee5@gmail.com

Abstract  
The doctor-patient relationship is important of high-quality health care in treatment of disease. The relationship is built in terms of mutual respect and trust according to perspective about disease. The strong relationship bases on quality information about patient’s disease. For the study the doctor-patient interactions, Critical Discourse Analysis (CDA) is a field that mentioned. Language as discourse always involves power and ideologies. Power involves control by members of one group over other group. Action and cognition may be controlled. Power may limit the freedom of action of others, but influence their minds. Patients may show be truthful in informing their health to doctor before giving treatment. Many cultures view that “doctor always knows best” that is the idea that patients must give the right to provide informed consent to doctor. This paper is to examine pragmatics and power in relationship between doctor-patient at Nakhonpanom hospital, Nakhonpanom Province. The population of this study consisted of 100 patients at Nakhonpanom hospital. The instrument used the questionnaire. The results show that the social variable such as educational background, socio-economic class influenced the use of big words or powerful words on others. 90% of patients said that they don’t understand what they said. Some examples that they gave are doctors used some technical term like Hematocrit, Hernia. Patients suggested about language use of doctors that they should use Thai words for treatment more than use technical terms because they don’t understand and have to ask again and again for answer. Sometimes, doctors use big words in communication.

Keywords: Pragmatics, power, interaction, doctor, patient

Introduction

Pragmatics and power  
Nakhonphanom hospital is nearby Laos so, there are many Laos people come to this hospital to treat themselves. Moreover, Vietnamese people who are workers in Nakhonphanom are treated in this hospital as well. For English language as a language used in hospital. Many patients cannot understand some words that nurses or doctors said with them. English language influences in using in hospital and it is as a power language used in hospital as well.
For the study the doctor-patient interactions, Critical Discourse Analysis (CDA) is a field that mentioned. CDA is concerned with studying and analyzing both spoken and written texts about power and inequality. Fairclough (1995) defines CDA as

Discourse analysis which aims to systematically explore often opaque relationships of causality and determination between (a) discursive practices, events and texts, and (b) wider social and cultural structures, relations and processes; to investigate how such practices, events and texts arise out of and are ideologically shaped by relations of power and struggles over power; and to explore how the capacity of these relationships between discourse and society is itself a factor securing power and hegemony. (p.135)

Wodak and Ludwig (1999) told language as discourse always involves power and ideologies. Power involves control by members of one group over other group. Action and cognition may be controlled. Power may limit the freedom of action of others, but influence their minds.

A framework for critical discourse analysis of a communicative event

This critical approach shares an important ideology aim and to show connections between language and power.

Power is hegemony. Hegemony is term used to describe the leadership or dominance, especially by one social group over other.


1. ‘reward power’, which involves A controlling (B’s) positive outcomes by providing things that B desires and/or removing or decreasing things that B dislikes,
2. ‘referent power’, where B identifies with and desires to become more like A,
3. ‘expert power’, which involves A having specialist knowledge or expertise that B wants or needs and,
4. ‘legitimate power’, which involves A having the legitimate right to prescribe or request certain things of B.
All of four powers can happen in an institutional context. For doctor-patient interactions use the expert power that a doctor has influence specialist knowledge on a patient.

Text and interactions are important within pragmatics. Powerless are lacking a voice and/or being unfairly disadvantaged. (Archer, Aijmer and Wichmann, 2012:133)


Patients may show be truthful in informing their health to doctor before giving treatment. Many cultures view that “doctor always knows best” that is the idea that patients must give the right to provide informed consent to doctor.

Shared decision making

Shared decision making is the idea that a patient gives informed consent to treatment. A doctor can control over the patient’s treatment and pushes the patient to accept the treatment plan which they are presented.

Physician superiority

The doctor may be viewed as superior to the patient because doctors use big words and concept above patient. This concept is like power.

The doctor-patient relationship is hegemonic relations. Fairclough said that people do not have equal control in interactions, because there are inequalities of power (Cutting, 2008: 151).

Habermas said that “language not only as the primary means of understanding and consensus, but also as the potential instrument of power and inequality (Archer,2012: 245).

Disease—the doctor’s perspective (Cecil,2001:79)

Some of the basic premises of a medical perspective are:

1. Scientific rationality
2. The emphasis on objective, numerical measurement
3. The emphasis on physicochemical data
4. Mind-body dualism
5. The view of diseases as entities
6. Reductionism
7. The emphasis on the individual patient, rather than on the family or community.

‘Illness’—the patient’s perspective (Cecil,2001:84)

A number of subjective experiences including:

1. Perceived changes in bodily appearance, such as loss of weight, changes in skin color, or hair falling out
2. Changes in regular bodily functions, such as urinary frequency, heavy menstrual periods, irregular heart beats
3. Unusual bodily emissions, such as blood in the urine, sputum or stools
4. Changes in the functions of limbs, such as paralysis, clumsiness or tremor
5. Changes in the five major sense, such as deafness, blindness, lack of smell, numbness or loss of taste sensation

6. Unpleasant physical symptoms, such as pain, headache, abdominal discomfort, fever or shivering

7. Excessive or unusual emotional states, such as anxiety, depression, nightmares or exaggerated fears

8. Behavioral changes in relation to others, such as marital or work disharmony.

The Explanatory Model (EM) (Cecil, 2001:85)

The Explanatory Model is the notion about episode of sickness and its treatment that engaged in clinical process. They provide explanations for five aspects of illness:

1. The aetiology or cause of the condition
2. The timing and mode of onset of symptoms
3. The pathophysiological processes involved
4. The natural history and severity of the illness
5. The appropriate treatments for the condition.

The power used in clinicians showed their background may allow them to make fit into the medical model of disease, rather than allowing the patient’s own perspective on illness to emerge. There are questions that people may ask themselves when they perceive themselves as being ill. (Cecil, 2001:86)

1. What has happened? This includes organizing the symptoms and signs into a recognizable pattern, and giving it a name or identity.
2. Why has it happened? This explains the aetiology or cause of the condition.
3. Why has it happened to me? This tries to relate the illness to aspects of the patient, such as behavior, diet, body build, personality or heredity.
4. Why now? This concerns the timing of the illness and its mode of onset.
5. What would happen to me if nothing were done about it? This considers its likely course, outcome, prognosis and dangers.
6. What are its likely effects on other people (family, friends, employers, workmates) if nothing is done about it? This includes loss of income or of employment, or a strain on family relationships.
7. What should I do about it—or to whom should I turn for further help? This includes strategies for treating the condition, including self-medication, consultation with friends or family, or going to see a doctor. Before these questions can be asked or answered, the patients must see their symptoms or signs—such as muscular aches or runny nose—as abnormal before grouping them into pattern of a cold.

The doctor-patient consultation (Cecil, 2001:100-106)

There are three aspects of the doctor-patient interaction can be viewed:
1. Why do people decide (or not decide) to consult a doctor when ill?
2. What happens during the consultation?
3. What happens after the consultation?

Reasons for consulting, or not consulting, a doctor

The reason why some ill people consult a doctor while others with the same complaint do not, this is because people cannot afford to pay for medical care, or because medical care is not available to them. There are a number of non-physiological factors that influence. Terms the pathways to the doctor include:

1. The availability of medical care
2. Whether the patient can afford it
3. The failure or success of treatments within the popular or folk sectors
4. How the patient perceives the problem
5. How others around him or her perceive the problem.

Problems of the doctor-patient consultation

Relationship between two parties separated by differences in power, both social and symbolic. This power may base on social class, ethnicity, age or gender, and is an influence on any consultation.

An important source of problems in doctor-patient consultation is context. There are two aspects to this context play a role in the doctor-patient relationship:

1. An internal context of the prior experience, expectations, cultural assumptions, explanatory models (based on social, gender, religious) that each party brings to the clinical encounter.
2. An external context which the encounter takes place such as a hospital, clinic, or doctor’s office. The dominant ideology, religion and economic system of the society as well as its class, gender or ethnic divisions help to define who has power in the consultation and who does not. The role of economic and social inequalities is the differences in power, particularly between doctor and patient. (Cecil, 2001:106)

Objective

To examine pragmatics and power in relationship between doctor- patient at Nakhonpanom hospital, Nakhonpanom Province

Method

1. Studying from the documents
2. Collecting data by random indept interviewing from outpatient department and observation
3. Analyzing and conclusion
Population
The population of this study consisted of 100 patients at Nakhonphanom hospital.

Data collection
Questionnaire
Questionnaire for patients asked for occupation, income and educational background. Duration of collecting data is April 2017.

<table>
<thead>
<tr>
<th>Table 1 Education levels of patients</th>
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<tbody>
<tr>
<td>Frequency</td>
</tr>
<tr>
<td>Less than high school</td>
</tr>
<tr>
<td>High school</td>
</tr>
<tr>
<td>Bachelor’s degree</td>
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<tr>
<td>Total</td>
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<tr>
<th>Table 2 Income of patients</th>
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<tbody>
<tr>
<td>Frequency</td>
</tr>
<tr>
<td>Less than 10000</td>
</tr>
<tr>
<td>10001-20000</td>
</tr>
<tr>
<td>Total</td>
</tr>
</tbody>
</table>

<table>
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<tr>
<th>Table 3 Occupation of patients</th>
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<tbody>
<tr>
<td>Frequency</td>
</tr>
<tr>
<td>Government official</td>
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<tr>
<td>Merchant</td>
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<tr>
<td>Worker</td>
</tr>
<tr>
<td>unemployed</td>
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<tr>
<td>Total</td>
</tr>
</tbody>
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In addition, 100 questionnaires were handed out to patients in the Nakhonphanom hospital to elicit their background information. All questionnaires were returned 100%. Obviously, mostly patients are less income and studied less than high school. It effected on the relationship between doctor-patient.

Results
For the questions asked in questionnaire are as follows:
1. How often do the doctors whom you interact with use the big word or power words in your communication?
2. Did you understand what they said?
3. If you don’t understand please give me some examples.
4. Do you have any suggestion about language use of doctors?

For the first question, 100% of patients answered that doctors may use big words or powerful words in communication. Sometimes, they used English words that they don’t understand. Some doctors complained patients when they don’t understand what they said. The second question, 90% of patients said that they don’t understand what they said. Sometimes they asked them again and again for information. For the third question, some examples that they gave are doctors used some technical term like Hematocrit (ความเข้มข้นของเลือด), Hernia (อาการไส้เลื่อน). These words patients don’t understand if doctors don’t explain in Thai. For the last question, patients suggested about language use of doctors that they should use Thai words for treatment more than use technical terms because they don’t understand and have to ask again and again for answer. Moreover, sometimes, doctors use big words in communication. It effected on their feelings when listening like “because your low income, you must choose this hospital more than go to private hospital”. This patient was upset and don’t want to see like this doctor any more.

Table 4 Doctor-patient communication

<table>
<thead>
<tr>
<th>Categories</th>
<th>Doctor to patient</th>
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<tbody>
<tr>
<td>Friendliness</td>
<td>20%</td>
</tr>
<tr>
<td>Tension Release</td>
<td>60%</td>
</tr>
<tr>
<td>Strong agreement</td>
<td>40%</td>
</tr>
<tr>
<td>Simple attention</td>
<td>40%</td>
</tr>
<tr>
<td>Gives instructions</td>
<td>80%</td>
</tr>
<tr>
<td>Gives opinion</td>
<td>60%</td>
</tr>
<tr>
<td>Gives information</td>
<td>80%</td>
</tr>
<tr>
<td>Ask for information</td>
<td>100%</td>
</tr>
</tbody>
</table>

In table 4, friendliness that the doctor communicates with the patient is quite low. Tension release is quite high. But the doctor gives instructions and information to the patient the rate is quite high. Findings suggest that although friendliness of the doctor is quite low, he/she works on his/her duty responsibly.

The results show that the social variable such as educational background, socio-economic class influenced the use of big words or powerful words on others.

Recommendations for further studies
1. Further studies should compare pragmatics and power: doctor-patient between private hospital and public hospital to find out the different result between two types of hospital.
2. Further studies should study pragmatics and power between nurses and patients.
3. Doctors should use this study to improve medical discourse in communication with patients.

References

Electronic sources