A Symmetrical Power Relations and Language Use in Doctor–Patient Interaction

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Abstract

Language is the most fundamental medium of communication that builds social constructions and promotes group relationships in the society. It is the instrument of power and dominance by the people in civil, military, political authority or health system to fulfil and enforce their needs. Language is tied to the structures of power. The institutions of medicine, physicians and health care exert power through language. However, research in this area is just beginning to gain ground. The data for the study was sourced from a recorded interaction between a doctor and a patient in a private hospital in Ijebu-Ode, Ogun State, Nigeria. Triangulation method was adopted for the study. The data for the study was subjected to a symmetrical analysis using Systemic Functional Linguistics (SFL) and Critical Discourse Analysis (CDA) as theoretical tools. The study shows that Halliday's interpersonal function of SFT and power relations of CDA are found suitable for the analysis of doctor-patient interaction. The study concludes that for doctor-patient interaction to achieve the desired result, a good role relationship must exist between them in which the individual is identified and reinforced.

Keywords: language, power, family planning, doctor, patient

Introduction

Language is the most fundamental medium of communication whether spoken, written, demonstrated or indicated in any other form, for the purpose of expression and bonding. It builds social constructions and promotes group relationships in the society. Language can also be viewed as an instrument of power and dominance by the people in civil, military, political authority or health system to fulfil and enforce their governance objectives and perhaps other personal interests. The way we make use of language speaks volumes of a person's choice of discourse style towards any important issue whether political, social, local, national and international. The power of language and words is tied to the legitimacy of the words and of the legitimacy of the person who utters them, a belief which words themselves cannot produce but is determined in relationship (Laura and Terese, 2016). The field of medicine is imbued with symbolic power and one of the key areas of this field imbued with such

power is family planning or birth control. The WHO report of 2022 stated that the number of women adopting family planning has increased tremendously over the past two decades. From 900 million in 2000, it hits nearly 1.1 billion in 2020. The number of women who are using a modern contraceptive method has also increased from 663 million to 851 million while the contraceptive prevalence rate increased from 47.7 to 49.0 per cent. Undoubtedly, the number will keep on increasing geometrically.

Family planning involves an interaction between the doctor and the patient (the woman), and sometimes, the man (husband). They both participate in communicative act and set up a relationship that will bring about the desired result. Ideally, health management decisions involve a collaborative decision making process in which the doctor provides information on the patient's' clinical situation and helps elucidate the values embodied in available options (Emanuel & Emanuel, 1992).

The social institutions of medicine, physicians and health care exert power which is expressed through language. Power is present in all interpersonal relationship and there is no interaction in any social institution that does not involve power. Two major concepts are very important here: Interpersonal relationship and power. In doctor-patient interpersonal relationship, Halliday's interpersonal function of language is a very relevant tool for consideration. The interpersonal function is that function of the language that enables us to participate in communicative acts with other people, to take on roles and to express and understand feelings, attitudes and judgments. Here, according to Halliday (1996), the speaker is using language as the means of his own intrusion into the speech event: the expression of his comments, his attitude and evaluation and also of the relationship that he sets up between himself and the listener in particular, the communication role that he adopts of informing, questioning, greeting, persuading and the like. The set of communication role is unique among social relations in that it is brought into being and maintained solely through language. Halliday explains further that the interpersonal element in language extends beyond what we might think of as its rhetorical functions. In the wider context, language is required to serve in the establishment and maintenance of all human relationships, it is the means where social groups are integrated and the individual is identified and reinforced. In Halliday's opinion, since personality is dependent on interaction which is in turn mediated through language, the interpersonal function in language is both interactional and personal.

Power can be defined as the ability to influence or control what people do or think. According to Pappas (1990) power is a neutral concept. It neither inherently good nor evil, but it can be used or misused. The implication is that power not only constraints and prevents but is also productive. The doctor-patient re-

lationship should be based on voluntary 'adult-adult' relationships that respect and enable autonomy, accountability, fidelity and humanity (Siegler, 1981). The relationship between the doctor and patient promotes healing, as evidenced by the so-called placebo effect of the "*doctor as a drug*" (Brody, 1980; McWhinney, 1981). While doctors need specialized knowledge and the power to fulfil their obligations to their patients, the patients also need power to formulate their values, articulate and achieve their health needs. How power is used and exchanged is influenced by the personal qualities of the doctor and patient. This includes aspects such as trust, ethics, communication skills, assertiveness, and the sense of confidence within the interaction. Power has become important area of inquiry as the role it plays in medical interactions is becoming increasingly recognized. However, research in this area is just beginning to gain ground as scholars are now paying attention to this area of study. However, except for a few that are available such as Qasim's (2014) 'A Study of Power Relations in Doctor-Patient Interaction in Selected Hospitals in Lagos State, Nigeria' where he adopted the 'Transitivity' component of the Systemic Functional Linguistic and Goodyear-Smith and Beutow (2001) 'Power Issues in the Doctor-Patient Relationship in which the authors dwelled only on 'Power and Ideology'; none, from available literature, has adequately addressed a linguistic exploration of SFL interpersonal function of language and power relations in doctor- patient interaction. This study therefore arose from the need to address this gap.

Literature Review Conceptual Review: Family Planning

Family planning involves planning the number, frequency and timing of pregnancy. In order word, it is a program to regulate the number and spacing of children in a family through the practice of contraception or other methods of birth control. Family planning is about deciding how many children you choose to have and when you want to have them. There are two methods of family planning: natural methods and artificial methods.

Natural methods are strictly based on observations and recording of certain physiological events, which takes place in a woman's body during a menstrual cycle, and which demarcate the fertile and infertile phases. In this method, pregnancy is avoided by practicing strict sexual abstinence during the fertile period. Artificial method (contraception) is any method, medicine, or device used to prevent pregnancy. This method is based on application of physical instruments, chemicals or drugs. The type of family planning a woman uses depends on her health, her desire to have children now or in the future, and her need to prevent sexually transmitted infections. A woman's doctor can help her decide which type is best for her. This is why doctor/patient interaction becomes imperative. A woman can choose from many different types of family

planning methods to prevent pregnancy. These include: Female and male sterilization: This is female tubal ligation or occlusion, male vasectomy family planning that prevents pregnancy for the rest of one's life through surgery or a medical procedure. There is also Long-acting reversible contraceptives or «LARC» methods: These are intrauterine devices; hormonal implants that the doctor inserts one time and you do not have to remember to use birth control every day or month. LARCs last for 3 to 10 years, depending on the method. Another one is Short-acting hormonal methods: They are pill, mini pills, patch, and shot, vaginal ring that a doctor prescribes that you remember to take every day or month. The shot requires you to get a shot from your doctor every 3 months. There are others like **Barrier methods;** use of condoms, diaphragms, sponge, cervical cap you use each time you have sex (Nigerian Health Handbook, 1986).

Theoretical Background

In this study, two theories were employed: systemic functional linguistics (SFL) and critical discourse analysis (CDA). Systemic functional linguistic is considered as a suitable theory for this study as it contains a grammatical model that relates language to its social function. Cristal Discourse concerns itself with the consideration of language use as part of a critical analysis of social context.

Systemic Functional Linguistics: The Interpersonal Function

SFT is a theory of meaning as choice by which a language, or any other semiotic system is interpreted as networks of interlocking options. The network of options proposed by Halliday (1994, 2004) corresponds to certain basic functions of language. Thus, he identifies three basic functions of language thus: (a) ideational function (b) interpersonal function and (c) textual function. These functions are referred to as metafunctions. The Interpersonal Function is the expression of Mood and Modality. The mood in SFL expresses the role relationship between the participants in the process of communication in speech event. The clause in the Mood system is divided into two parts: the Mood and the Residue. While the Subject and Finite constitute the Mood, the rest of the function in the clause constitutes the Residue (Predicator, Compliment, and Adjunct) (Bloor and Bloor, 1995). The mood function in any clause is realized by making choices from the mood system. It should be noted however that not all clauses have mood. Where clauses contain mood, an obligatory choice is made between indicative and imperative which are regarded as the two major moods. If however, indicative is chosen, an obligatory choice is made between declarative and interrogative. The interrogative mood is what is further categorized as

modality. Modality according to Halliday (2004) refers to the area of meaning that lies between yes and no – the intermediate between positive and negative polarity. The mood system is realized in the expression of attitudes, possibilities, familiarities, and proposition.

Critical Discourse Analysis

CDA is a broad and complex interdisciplinary theory or methodology for engaging different discourses and research issues. It is a relatively recent school of discourse that concerns itself with relations of power and inequality in language encounters. A language encounter may tend to have certain meanings which are not always transparent. CDA plays an important role in making those meanings known by revealing some of the ideas that are hidden in a spoken or written medium. CDA "is a way of viewing language use as part of a critical analysis of social context (Pennycook, 2001). CDA is a discipline that has a deconstructive agenda and is concerned with exposing language deployed in the service of power.

Critical discourse analysis is closely related to systemic functional linguistics (SFL), which provides theoretical basis and analytical methods for CDA. Critical discourse analysis, originates from critical linguistics and is an independent branch of discourse analysis. CDA reflects the linguistic turn in the study of social problems. It reveals the social significance expressed by language and how language establishes and maintains the power relations among social organizations by analyzing the language structure. In the past 30 years of its development, CDA has formed its own research perspective and method, which embodies the cultural turn of linguistic research and the linguistic turn of sociological research in recent years, and is one of the most active interdisciplinary research fields in linguistics (Shuqing and Huihui, 2020).

Critical discourse analysis was considered a suitable theory for this study as it brings about a sense of social responsibility in medical discourse. One very important concept in CDA is the understanding of discourse as a social practice in which language play a central role in the post-structuralist paradigm of discourse analysis.

Methodology

A symmetrical approach to a study of this nature requires the use of more than one method. It is from the foregoing that we adopted triangulation method for this study. Triangulation is the use of multiple methods to examine the same object. In the view of Wolfram-Cox and Hasard (2005), the implicit assumption in using triangulation is to develop a more effective method that will capture

and fix social phenomenon for the purpose of capturing accurate analysis and interpretation. Three types of triangulations were used in this study:

The first one is data triangulation: It involves the collection and use of data from a female patient in a private hospital in Ijebu-Ode. The research instrument used at the stage was oral interview and recording of the discussion of the interactants.

The second one is theory of triangulation: The adoption of SFL and CDA as theoretical tools. SFT and CDA were selected for the study because they are closely related. The adoption of CDA affords a critical perspective that ultimately seeks to combat inequity in doctor–patient interaction.

The third one is methodological triangulation: This is the adoption of both quantitative and qualitative methods in a study. In the application of qualitative analysis, the interview which served as data for the study was subjected to systematic descriptive analysis by the use of the interpersonal function of systemic functional linguistic and critical discourse analysis. At the level of quantitative method of analysis, we accounted for the frequency of occurrence of the mood system which we presented in tables.

Data Analysis and Discussion

- Mood analysis of doctor-patient interaction
- dominant mood uttered by doctor/patient in the interaction

Table 1: Use of Mood System by doctor and patient

	Doctor	%	Patient	%	Total
Subject	14	54	12	46	26
Predicator	26	81	6	19	32
Finite	30	81	7	19	37
Adjunct	12	86	2	14	14
Complement	4	57	3	43	7
Circumstance	4	67	2	33	6
Total	90	74	32	26	122

The dominant moods in the data are subject, predicator and finite. The doctor features 14 times (54%) in the discussion while the patient features 12 times (43%). Of the 32 predicators used by both doctor and patient in the entire data, the doctor used 26 (81%) while the patient used 6 (19%). For finite, of the 32 used across the data, the doctor used 30 representing 81% of the total while the patient used 6 representing 14%. This shows the doctor dominating the use

of the major mood system. The total number of the other mood elements (adjunct, complement and circumstance) amounts to 27 (22%). Of this number, the doctor used 20 (74%) while the patient used 5 (26%) which shows the doctor dominance over the patient. The breakdown of this shows that in the use of adjunct, the doctor used 12 representing 86% while the patient used 2 representing 14%. For complement, the doctor used 4 (57) and the patient 3 (43%). The number of circumstance indicates 4 (67%) for doctor and 2 (33%) for patient. The implications of this interaction in terms of power relations and network between the doctor and the patient is that the interaction enables the interlocutors to take on roles, to express and understand their feelings, attitudes and judgment. The mood in SFL as shown in this table indicates expression of role relationship between the two major participants in the interaction

Role projection, role allocation and exclusion which are major features of CDA also feature prominently in the interaction. Role projection is noticeable in the interaction as the doctor projects himself more than he projects the patient as he features 54% in the discussion while the patient participation amounts to 46%. Though, the interaction focuses on the patient, the doctor dominates the discussion because he is an expert on the medical field and more knowledgeable than the patient. However, the dominance is not too significant as the patient also participates actively in the discussion.

Role allocation also features prominently in the interaction. Difference in the role projection is not so pronounced in the discussion as both the doctor and patient adopt 'mutual role projection'. A good interaction entails fair distribution of the chain of communication which involves role sharing and turn taking. Though the doctor dominates the discussion but not at the detriment of the patient as he allows the patient to express her feelings. Activation and passivation are two major elements in role allocation. Activation is when a participant plays active role in a discussion while passivation is when a participant is relegated to the background. As indicated in the table, the two participants actively participated in the discussion, even though the doctor dominated the interaction as a result of his role as an expert whose duty is to assist the patient to solve her medical issue.

Exclusion according to Van Leeuwen (1996) is "an important aspect of Critical Discourse Analysis". He postulates two types of exclusion- suppression and backgrounding. Suppression and backgrounding occur when a powerful social actor attempts to exclude a less powerful social actor in a discourse or attempts to forcefully accept his view or decision. In this data however, suppression and backgrounding is not so evident; partly because the face to face dialogue nature of doctor- patient interaction. The only instance of suppression is when the

doctor repeatedly asked the patient if she actually got the approval of her husband to do the family planning as shown in the following example:

> Doctor: Madam, are you sure your husband approved this family planning because some women do family planning without the consent of their husband?
>
> Patient: Doctor, do you doubt me? Even if my husband refused, this has to do with my health. I'm the one that carries the burden not my husband. I have told you we both agreed.
>
> Doctor: Don't feel offended madam.

The issue of suppression was however quickly resolved when the doctor apologizes to the patient haven realized that she was upset by his comment. At times, in adult-adult relationships, conflicts and complexities arise. Such a conflict can however be resolved through negotiated care as exhibited by the doctor here. The patient also exhibits her power in terms of language -transitivity mechanism of the dialogue.

Indicative Mood in the Interaction

Table 2: Use of Indicative Mood by doctor and patient

	Doctor	%	Patient	%	Total
Declarative	8	50	8	50	16
Interrogative	10	77	3	23	13
Total	18	62	11	38	29

Declarative: The linguistic choice of the participants in this interaction shows that the declative is predominantly used in communication their messages. As indicated in the table, there is even distribution of the declarative statements uttered by both doctor and patient as each of them used this type of sentence eight (8) times representing (50%). The implication of this is that no barrier is created in the chain of communication in this interaction. As the patient freely expresses herself, the doctor also listened attentively to understand her feelings and attitudes and passed his value judgment accordingly. The major function of language as stated by Halliday is fully established in this discourse, that is, the

use of language for social interaction. The establishment and maintenance of human relations; the means where social groups are intergraded and individual is identified and reinforced are evident in this'. Since personality is dependent on interaction which in turn mediated through language, the interpersonal function in language is both interactional and personal.

An example of declarative:

ii. Doctor: I will give you injection/drugs that will prevent ovulation of egg...

Interrogative: Table 2 reveals uneven distribution of the interrogative in the interaction. As indicated in the table, 77% of the interrogative statement is allocated to the doctor while only 23% is allocated to the patient. This is so because the patient is the one that needs medical attention and the doctor must have adequate background information of the patient that will guide him to offer the proper medical advice and treatment to her. The implication of this in medical practice is that the patient is put at the core of the interaction. The patient too, requires knowing how safe the type of family planning the doctor wants to give her? The curiosity and anxiety develops by the patient prompts in her asking more questions. In health interaction of this nature, as the doctor needs power to fulfil his professional obligations to the patient, the patient too needs power to formulate her values, articulate and achieve her health needs:

iii. Doctor: What is your complaint madam?

Although, most of the interrogative utterances are allocated to the doctor, the communication role requires the patient to also ask questions from the doctor. For instance, the patient inquired from the doctor if the type of family planning he wants to give her has any side effect:

iv. Patient: Can't it result to stoppage of menstruation?

Imperative Mood in the Interaction

Table 3: Use of imperative mood by doctor and patient

	Doctor	%	Patient	%	Total
Imperative	5	83	1	17	6

Imperative: Table 3 indicates the difference in the way imperative roles are pro-

jected for doctor and patient in the interaction. Recall that imperative is a statement that gives command, directive or instruction. The doctor projected himself (83%) more than the patient (17%). This is because he has acquired more knowledge and professional skills than the patient and hence in a better position to handle her health issue. After the doctor had carried out the family planning, he gave the patient some instructions to follow in order to avoid complications that can affect her health:

v. Doctor: Please don't go to quack doctor or nurse...

vi. Doctor: Don't hesitate to come here for any complaint and regular check-up.

Table 4: Summary of use of mood by doctor and patient

	Doctor	%	Patient	%	Total
Dominant Mood	90	74	32	26	122
Indicative	18	62	11	38	29
Imperative	5	83	1	17	6
Total	113	72	44	28	157

Table 4 is the summary of the mood system in the patient-doctor analysed in this study. The table shows that the dominant mood is the predominantly used by both the doctor and the patient occurring 122 times (while the indicative mood features 29 times. The less used mood is the imperative which features in the interaction 6 times.

The above analysis has clearly shown the influence of CDA on the text interpretation. The fact that power is present in social interactions and that there is no interaction in any social institution that does not involve power has established the relevance of the interpersonal metafunction of language and CDA in medical discourse as exemplified in this study.

The establishment and maintenance of human relations; the means where social groups are intergraded and individual is identified and reinforced are clear linguistic features of this discourse. It should be noted that health management decisions involve a collaborative decision-making process by both the doctor and the patient as demonstrated in this study. The doctor-patient relationship therefore would be based on voluntary 'adult-adult' relationships that

respect and enable autonomy, accountability, fidelity and humanity (Siegler, 1981). Both doctors and patients have rights and responsibilities in a medical discourse. As shown in this study, the doctor is more knowledgeable than the patient and is therefore empowered to guide, advice and provide medical treatment to the patient. However, this should not be done at the detriment of the patient who should also be given increased control and autonomy. In doing this however, care must be taken not to disempower doctor in the process. Therefore, balancing of power between the doctor and the patient is a key factor in achieving positive health outcomes.

Conclusion

This study has established the interpersonal function of language which is well entrenched in the doctor-patient interaction investigated. The study has shown, on one hand that Halliday's interpersonal function of the mood system is found suitable in the analysis of this interaction as it expresses role relationship between the two participants in the interaction. On the other hand, the study has revealed that critical discourse analysis is a suitable tool in the study of power relations in a medical discourse. In conclusion, for doctor-patient interaction to achieve the desired result, a good role relationship must exist between them in which the individual is identified and reinforced. Success in helping the patient achieve well-being is unlikely in an atmosphere of suspicion and mistrust. Both parties need to behave respectfully and not abuse their power.

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Appendix

Doctor: Good morning, madam. How are your husband and children?

Patient:	Thank you Dr.
Doctor:	What is your complaint madam?
Patient:	I here for family planning.
Doctor:	How many children do you have and the age range?
Patient:	Two children. One is two years old and the other, four years.
Doctor:	Two children! Ok, why do you want to do family planning?
Patient:	The main reason is that I don't want to have additional children now.
Doctor:	Is your husband aware of your intension to do family planning?

Patient: Yes doctor. We both agreed on the decision.

Doctor: Madam, are you sure your husband approved this family planning because some women do family planning without the consent of their husband?

Patient: Doctor, are you doubting me? Even if my husband refuses, this has to do with my health. I'm the one that carries the burden not my husband. I have told you we both agreed.

Doctor: Don't feel offended madam. I said that because there are some husbands who see this modern method of birth control as against the doctrine of their religion. We also have cases where the husband wants to have more children and the wife is not willing.

Doctor: Ok, let's move on with our discussion. When last did you menstruate?

Patient: Last month

Doctor: Ok! This family planning is good. Not that when you do it, you won't have children again. The main purpose is to give room for spacing. We have different types of family planning. We have the injection type and the drugs type. For the injection type, we have for two months, three months. There is another type you put on the arm and it ranges from three to four years. This type is removable, that is, you can easily remove it when you decide to be pregnant. I will first examine you to know the type of family planning that will be appropriate for you.

Patient: No problems.

Doctor: I will carry out a test on you to know if you are pregnant or not because some women will be pregnant already and come for family planning. This can lead to termination of pregnancy or abortion. I will do the test now to know if you are pregnant or know the type of family planning that will suit your body system. Are you ready for the test?

Patient: yes Doctor.

Doctor: Madam, I have carried out the test. With the result, you can take injection with three months duration or the one you put on the arm which can be removed when you are ready to be pregnant. You can repeat it when you are breast feeding your child to avoid pregnancy. Do you have any question?

Patient: I want you to shed more light on the effects of that of three years duration. If I take that, hope it can't have any side effect?

Doctor: Not at all madam. Like I said earlier, this type is removable and it is safer. So you don't need to entertain any fear. In fact, many women go for this type.

Patient: Can't it result to stoppage of menstruation?

Doctor: No! I will give you injection/drugs that will prevent ovulation of egg.

It is the eggs that will mix with a man's sperm and germinate into foetus. And if at all a woman produces eggs, they will not mature and once the eggs are not matured, they cannot germinate into foetus even when the eggs mix with man's sperm. It is the eggs that are not fertilized that eventually broken into menstruation and blood clothing cannot occur. It is only about 25% of women that can do menstruation after doing family planning. The other 75% will not menstruate. It depends on individual nature. Some women get pregnant easily while some take time. If, however you have any reaction or symptoms you should let me know. Please don't go to any quack doctor or nurse. Don't hesitate to come here for any complaint and regular check-up. Don't wait till three years before you come. You should come after six months for check-up but if you have complaint before then, please just come here and we will attend to you. At times, people attribute health challenges to family planning which is not true. Make sure you come for medical advice or treatment if you have any health issue. Do you have any other question?

Patient: No doctor. Thank you for your attention.

Doctor: Oh! It is my pleasure. We are here because of you people. Regards to the family.