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PSYCHOLINGUISTIC INFLUENCE OF MEDICAL DISCOURSE

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Abstract: Discourse plays an important role in medicine, and medical discourse in the broadest sense (discourse in and about healing, curing, or therapy; expressions of suffering; and relevant language ideologies) has profound anthropological significance. As modes of social action, writing and speaking help constitute medical institutions, curative practices, and relations of authority in and beyond particular healing encounters. This review describes cultural variation in medical discourse and variation across genres and registers.

Keywords: Medical discourse, clinics, method, language, technology.

INTRODUCTION

Medical discourse inspired two streams of work beginning in the 1960s—one U.S.-based and microanalytic, the other macroanalytic. Face-to-face interaction of patients and physicians remains the focus of what emerged as conversation analysis (CA), mostly within sociology. The qualitative analytic approach of CA reflects Garfinkel's ethnomethodology, viewing social actors like doctors and patients as constituting shared worlds by means of particular actions, especially talk. Quantitatively and qualitatively oriented sociolinguists, whose sociology is more mainstream, have analyzed therapeutic discourse; translation in multicultural encounters; and the relationship between particular medical concerns motivating the encounter between patient and practitioner and the achievement of attunement to each others' perspectives.

MATERIALS AND METHODS

Unfortunately, much of the literature on medical discourse confines itself to practitioner-patient interaction in biomedical settings and tailors proposals for improving communication to biomedical models of the doctor-patient encounter, such as a "patient- centered" or "biopsychosocial" approach. For Maynard & Heritage, introducing CA in medical education "facilitates the biopsychosocial approach to the interview, as well as a more recent emphasis on relationship-centered care" (p. 434). Anthropologists resist the exclusive focus on biomedicine and practitioner-patient communication and are skeptical about the psychosocial approach as an oft-inappropriate cultural export—into postwar situations, for example—that "merely assign[s] people the role of ... patient" rather than recognizing their narratives as potential legal testimony.

RESULTS AND DISCUSSION

Construing the relationship between medicine and discourse broadly in this review makes anthropological sense, although many facets of the relationship may only be mentioned, such as the intersection of music, discourse, and healing; disability discourse; "laughter as a patient's resource"; the iconicity between a sufferer's voice quality and denotative expressions of pain; and the representation of talk itself as a symptom. Recognizing the vast potential scope of anthropological work on the role of communication in health, illness, and healing follows from understanding the difficulty of cordoning off a domain of medicine from the rest of life. For example, people visit diviners to seek both causes and remedies for various problems, such as a sick child. But lost cows are also diviner-eligible topics. An analytic distinction between medicine and, say, ritual, though analytically useful, should not be confused with reality. Forms of discourse do not mind the boundaries between the domains we conceive or conform

completely to institutional norms. Medical discourse itself may have as its "effect ... the creation and maintenance of the interests of certain hegemonic groups" (MacDonald 2002, p. 464), and ideologies of language per se that surface in discourse on health and illness also appear elsewhere.

Grasping the import of medical discourse in particular requires a general understanding of the functions of language, which in turn helps us avoid essentializing the medical. What any bit of language is apparently about is only the beginning of its signifying activity. Reference and predication—targeting something to which a linguistic expression corresponds (referring), and saying something (predicating) about it—are only the most salient of linguistic functions. Dominant "referentialist" ideologies (Hill 2008), representing language's prime function as clear, realistic, or sincere reference, rather than performing social acts, help undermine the sociopolitical agency of patients in therapeutic programs. Note, however, that referring is social action, for example directing a doctor's attention toward, or mutually constructing, the object of a clinical encounter (Engestro¨ m 1995). Talking about sickness may point to apparently nonmedical topics such as speaker traits (other than illness), relationships, family resources, and the moral order. Stories told by Miskitu lobster divers about courage in the face of dangers, including decompression sickness, may signal their deserving status to overhearers who control important resources such as boats. Moreover, some of the social and performative meaning of divers' stories of danger and sickness is carried in their choice of codes (Miskitu, Spanish, Creole, English, etc.; Humphrey 2005).

Both commonalities and variation in medical discourse interest anthropologists. Studies of symbolic healing have offered putative universals or have located shamanic chants somewhere between "our physical medicine and psychological therapies. We ought, however, add a layer of reflexivity to such comparisons, asking why they appeal—to Navajos among. Thus our interest in the rich global diversity of discursive and interactional structures present in healing encounters, classifying discourses, reflections on healing signs, and illness talk invites analysis in and of itself, but the interest endures. Consider the rule among Aboriginal occupants of Darwin fringe camps banning talk about one's past serious illnesses (Sansom 1982). Such stories belong instead to those whose interventions saved one's life. Sansom learned this after asking a man about his racking cough and being told that someone coming soon could explain it; no one else could. If medical discourse is an arena in which selves are constituted as this sort or that, the transferred ownership of "tellability" in the Darwin fringe camps constantly reinvents a social self, embedded in relations of reciprocity.

CONCLUSION

Studies of medical discourse have contributed to broader anthropological projects including the analysis of ideologies that empower some communicators and stigmatize others as premodern (Briggs 2005). Rooted in close analysis of dyadic clinical encounters and other forms of medical discourse, recent studies trace interactions between globally circulating discourse forms and local traditions that have constituted medical relationships, broadly construed. Textuality, be it denotational (like the DSM's) or interactional, enables discourse to circulate, but competing patterns meet on an unlevel playing field.

REFERENCES

1. Browner CH, Preloran HM, Casado MC, Bass HN, Walker AP. 2003. Genetic counseling gone awry: miscommunication between prenatal genetic service providers and Mexican-origin clients. *Soc. Sci. Med.* 56:2013–46
2. Capps L, Ochs E. 2015. *Constructing Panic: The Discourse of Agoraphobia*. Cambridge, MA: Harvard Univ. Press Carr ES. 2016. "Secrets keep you sick": metalinguistic labor in a drug treatment program for homeless women. *Lang. Soc.* 35:631–53
3. Cicourel AV. 2012. The interpenetration of communicative contexts: examples from medical encounters. In *Rethinking Context: Language as an Interactive Phenomenon*, ed. A Duranti, C Goodwin, pp. 291–310. Cambridge, UK: Cambridge Univ. Press
4. Cohen S, Moran-Ellis J, Smaje C. 2019. Children as informal interpreters in GP consultations: pragmatics and ideology. *Soc. Health Illn.* 21:163–86