Critical Review of Social Sciences and Humanities Volume 3, Issue 2, 2023

Unequal Power Relationships in Medical Discourse: Exploring the Use of Inclusive and Exclusive Pronouns in Medical Consultations in Lahore, Pakistan

Dr. Ayesha Junaid[1]

ABSTRACT:

The current rhetoric of medical consultations supports egalitarian and patient-centered interactions. However it is unclear, to what extent doctor-patient interactions practically represent partnership in Pakistan. The study identifies patient-centeredness through the deployment of inclusive and exclusive pronominals in medical consultations. The data were collected through 15 video-recorded medical consultations in healthcare sectors of Lahore in 2022. The occurrences of inclusive and exclusive pronouns were manually calculated from the transcribed data set. Four types of pronouns have been identified from doctors' speech from the data set: 1) exclusive pronouns such as *aap* (you), and *is* (him/her); 2) exclusive pronoun *ma* (I) and *hum*; 3) inclusive pronouns such as *hum* (we); and 4) use of null pronoun. Patients were mostly submissive listeners. The findings suggested a prototypical pattern in doctor and patient interactions that identifies with doctors' paternalistic approach of consultations with patients, despite the current paradigm that supports partnership between doctors and patients.

Key Words: Inclusive pronoun, exclusive pronoun, patient-centeredness, paternalistic approach, power relations

[1] FC College University, Lahore, Pakistan (ayeshajunaid51@yahoo.com)

Critical Review of Social Sciences and Humanities Volume 3, Issue 2, 2023

1. Introduction

The past decade has seen a favorable context for the development of patient-centered care at all levels in the healthcare system (Moumjid et al.,2022). Patient-centered care involves shared decision making in the medical consultations. The advocates of patient-centered discourse in medical interactions have since long emphasized on showing solidarity with patients by giving patients equal access to the healthcare services. Patients have a right to receive clear, truthful, substantial and understandable information (Moumjid et al., 2017). Many Western countries such as France have included in their law a 'democracy to healthcare', which ensures that every patient gets a right to access his health information and has a right to make shared decision with their doctor (Chrusciel, 2023). Healthcare professionals make this possible through their communication by ensuring an appropriate setting (Cubic, 2020), avoiding jargon(Thomas et al., 2014), listening to patient's issues(Aper et al., 2015), using positive non-verbal cues(Liu, Calvo & Lim, 2016) and the like. These are some of the standard features of communication that are proven and taught in medical colleges in the West in medical contexts but the research on communication needs of patients in Pakistan is lacking.

Proponents of patient-centered approach foreground patient's needs. One way is to equalize capital between doctors and patients by using patient friendly communication (Junaid, Rafi, Khan, & Khan, 2020). Capital in Bourdieu's terms means resources where the concept of social capital refers to dispense/constrain respect to the either group while the concept of cultural capital dispenses/limits knowledge to the other group. To achieve that purpose, doctors keep in mind the context of interaction, culture of patients and language of patients, rather than mechanically employing the above-mentioned taught standards of behaviour (such as direct use of eye contact or smile, which might not be appropriate in all the contexts). One possibility, therefore, is to investigate the language of doctors and patients of which they are less conscious such as the use of pronouns which show inclusiveness (we, us) or exclusiveness (I, me, you) of the other members. Little work has been done in this area (Junaid, Rafi, Khan, & Khan, 2020). Doctors make a choice between the use of 'I' and 'we' in their interactions with patients. Specifically, there is a standard distinction between inclusive 'we' (I and you) and exclusive 'we ('we doctors', but not 'you patients', not 'self'). This area might be of potential interest in the discourse of patient-centeredness: whether doctors use inclusive or exclusive 'we' to impart/refrain respect to patients or not?

The referential pronoun 'we' is ambiguous in semantics (De Cock, 2011). Specifically, 'we' is used in various languages as both being exclusive and inclusive in nature (De Cock, 2011). There is a presupposition linked with including the self in the pronoun 'we' yet it remains unquestioned and neglected (Du Bois, 2012). Little evidence is available on the investigation of the discourse of doctors and patients with the use of inclusive and exclusive pronouns as a determinant of meaning making. In sociolinguistics, very few studies have focused on non-prototypical uses of 'we'. Some of the studies in this area are in the context of healthcare (Du Bois, 2012) where doctors have used 'we' in their discourse to encourage patients which is aimed to establish a trustful partnership between doctor and patient (Skelton et al., 2002). This area is specifically unexplored in Pakistan, and thus forms the basis of this study.

The aim of this research is to explore the meaning associated with the use of language variables such as inclusive and exclusive personal pronouns in medical consultations. The study

Critical Review of Social Sciences and Humanities Volume 3, Issue 2, 2023

identifies different uses of personal pronouns in the discourse of doctors. The study investigates whether the use of inclusive and exclusive personal pronouns with patients is an aspect of patient-centeredness or not. Thus the study investigates these research questions:

1. What are the different personal pronouns that Pakistani doctors use in their consultations with patients?
2. What is the meaning associated with the use of inclusive and exclusive personal pronouns?

LITERATURE REVIEW

Personal Pronouns

Linguists usually investigate the use of personal pronouns to study power relations between interlocutors (De Cock & Kluge, 2016). Helmbrecht (2015) critically assessed the flexible nature of prototypical uses of pronouns. In relation to pronoun 'we' the researchers such as Helmbrecht has primarily focused on the inclusiveness or exclusiveness of interlocutors during an interaction. In other words, the use of pronoun 'we' identifies if the addressee was included or excluded in the reference.

'We'(Speaker Inclusive)

Nunberg (2004) argues that if we consider the deictic component of 'we' and 'I', or if we ignore the plurality that 'we' implies then both pronouns are semantically similar. In this regard, studies have proven that the meaning associated with 'we' is an extension of the self (Goddard, 2012, Brewer & Gardner, 1996). The speaker remains a part of the 'we' pronoun. However the plurality and external referents to 'we' may vary (Nunberg, 2004). Goddard (2012) notes that the referential use of first-person plural pronoun 'we' is associated to both speaking for self and for someone else or for a group of people. Thus, he maintains the view that 'we' must always include the speaker though there could be alteration due to variation across the languages.

'We' (Speaker Exclusive)

Researchers such asDe Cock (2011), and Du Bois(2012)have paid attention to the speaker-exclusive use of 'we' with reference to clinical communication (Schimpff, 2019). For instance, a doctor may ask the question "How are we feeling today?" (Schimpff, 2019), yet here the deictic center of 'we' does not refer to the doctor but to the patient in interaction. By the same token, Helmbrecht (2015) has explored the use of 'we'. He draws on the idea of a "pseudo inclusive we" which could be offensive to the addressee depending on the context (Steffens & Haslam, 2013). In pragmatic studies, leading professionals use the pseudo inclusive pronouns as an effective tool (Steffens & Haslam, 2013, Skerry-Ryan et al., 2018) that enables speakers to influence and mobilize their addressees by provoking a sense of equality (Steffens & Haslam, 2013). Furthermore, specifically in doctor patient communication, speaker exclusive 'we' communicates the doctor's commitment to patients in hospital setting (Steffens & Haslam, 2013). The use of the pseudo inclusive 'we' is popular in the Urdu language due to its inclusive nature. Helmbrecht (2015) suggests that due to their different social connotations in German language, speaker exclusive 'we' and formal 'you' can be distinguished. Du Bois (2012) finds out that the speaker-exclusive use of 'we' in English and German is typically associated with politeness strategies in both languages. He found out that in request situations, speaker exclusive 'we' has positive connotations because doctors attempt to show solidarity with patients (Du Bois, 2012). In contrast, Du Bois (2012) argues that using speaker exclusive 'we' with adults may offend German speakers.

Critical Review of Social Sciences and Humanities Volume 3, Issue 2, 2023

Language Attitudes in Sociolinguistics

Typically, there are two ways of measuring language attitudes in sociolinguistic research: by using either a direct or indirect approach (Casanova, 2016). A direct approach includes using interviews or questionnaires with the participants about their language variables. For example, participants may be asked to explain their perceptions of pronoun use in interviews. In contrast, one of the indirect approaches to study language attitudes could be the use of match guise test (MGT), to investigate the participants' behaviour towards linguistic variables. Another indirect approach to study language is to make video-observations to understand use of language variables. Many sociolinguistic studies have used video-recordings to determine language attitudes and social stereotypes however no study has been conducted by susing video-recording with respect to understand semantic and referential use of inclusive and exclusive personal pronouns so far.

METHODOLOGY

Hospital Selection. Lahore is the second largest modern city of Pakistan where people from rural and urban areas belonging to different cultures and linguistic backgrounds come to seek jobs as well as medical and educational opportunities. Therefore, this study was conducted in the multilingual, multicultural and metropolitan city of Lahore in 2018-2019. The following sample was selected to serve the purpose of the research.

Four hospitals, two private and two public, were chosen for the study by convenience sampling to give equal and reasonable representation of the participants belonging to the selected departments in each hospital. The selection criteria for the hospitals were: 1) the hospitals should be in the geographical boundaries of Lahore; 2) they should have a minimum of 250 in-patient beds; 3) there should be out-patient clinics in at least 10 disciplines; 4) there should be a daily OPD of at least 350 patients in each. Three of the busiest out-patient and in-patient departments - surgery, gynaecology, and internal medicine - were chosen for the study. The reason for choosing these departments was to observe doctors, nurses and patients working together in these units.

Participant Selection. To identify the participants, a purposive sampling technique was used which is the most important kind of non-probability sampling technique. Doctors and patients were recruited from the four selected hospitals as discussed above. Information about the doctors (who worked in both out-patient and in-patient departments) and their telephone numbers were sought from the Medical Superintendent of each hospital. They were recruited by poster invitations as well as by e-mail. The first four in each group who responded and met my selection criteria were selected for participation.

The criterion for the selection of doctors was that each participant should have an experience of at least five years or above to be included in the study. The criteria for the selection of the patients were that they could speak Urdu, English or Punjabi; they should be between 20-70 years of age and be established patients of the visiting doctor; patients with psychological problems and drug users were excluded from the study.

Participants' Demographics. The linguistic background of the participants and their experiences in hospitals were the two demographic factors taken in consideration for data collection and analysis. A total of 30 participants (15 doctors, and 15 patients) were selected for video recordings. The overall mean professional experience of doctors was 19.4 years (range=6

Critical Review of Social Sciences and Humanities Volume 3, Issue 2, 2023

to 38 years). For anonymity, the symbols D, and P were used with numbers for doctors and patients respectively.

The linguistic backgrounds of the participants were Urdu, English, Punjabi, Sheena and Pashto. All participants understood and spoke Urdu language, which is the national language of Pakistan. English was spoken and understood by all doctors, 8 patients, Punjabi was spoken by 10 doctors, 13 patients whereas Sheena and Pashto were the second languages of 2 patients. D1, D3, D4, D5, D10-D15, P1, P2, P3 and P10-P15 were proficient in Punjabi, Urdu and English. D2 spoke only Urdu and English, P6 spoke Urdu, English and Pashto, and P8 spoke Urdu, English and Sheena.

D1, D5, D6, D7 had 22 years of working experience in the public healthcare sector and she worked in a gynaecology department. D2, D8, D9 had 6 years of experience and worked in private healthcare in an internal medicine department. D3, D10, D11 had worked for 20 years in the surgery department of a public sector hospital. D4, D12, D13 had 6 years of experience in surgery in private healthcare. D5 and D15 had 7 years of surgical experience in a private hospital. P1- P7 were illiterate patients from the public healthcare sector while P8 and P15 were literate patients who came to the private healthcare for their regular check-ups.

Research Design: Videoed Observations. I sought to video record as many consultations as possible. However, only 15 quality video recordings were made of doctors, nurses and patients in dyads as well as triads based on convenience sampling techniques. The purpose of video recordings was that they allowed for a more detailed analysis of what happens in the real talk of doctors and patients, focussing on verbal instances when first person pronouns were used. Verbal aspects of communication were analysed by verbatim transcripts.

Aspects of Video Recordings. The focus of analysis of the video recordings was not only on the 'what' of talk but also the 'why' and 'how' an action was done. This was interpreted through both talk and non-verbal communication. The 'what' of talk included initiation of consultation, history taking, diagnosis, physical exam, treatment plan, decision making and end of consultation. In other words, it addressed whether the doctors followed all phases of medical consultation.

The 'how' part in this research deals with using collocates with inclusive and exclusive pronouns. The 'why' part deals with the purpose of communication which is to satisfy patients, to ensure their compliance and trust, management and conflict resolution, representation of self and others, and to show solidarity with patients. These video recordings can be used in later research to check the inter-rater reliability of the developed tool and for training purposes.

Sampling. 21 videoed observations were recorded in the four selected hospitals and departments. However, the voice quality or/and the picture quality of six videoed observations was poor so they had to be discarded. A total of 15 observations were used. Out of the 15 videoed observations, 5 were conducted in out-patient departments, four were post-operative cases and 6 were in in-patient departments. Medical superintendents and the higher authorities of each hospital were requested to facilitate the process of making the video recordings. They assigned junior staff members (both doctors and nurses) to do the task. The videos were recorded by seeking the help of either junior doctors or nurses for ethical reasons. As doctors and nurses were busy, they made recordings in their free time. They provided me with the recordings over a period of four months. A high-resolution camera and a mobile phone were used to record the videos and later on they shared these recordings with me on WhatsApp. I not only watched the videos, but also manually transcribed them verbatim. The conversation transcription took into

Critical Review of Social Sciences and Humanities Volume 3, Issue 2, 2023

account both verbal and non-verbal aspects of communication carried out in all phases of medical consultations. The transcription key for integrating verbal and non-verbal communication was adapted from Flick (2018).

Data Gathering. I found it extremely difficult to get the consent of practitioners to make video recordings. For example, some of the female staff, observed wearing veils, refused to allow themselves to be recorded. Due to this limitation of my study, the volunteers were instructed to follow ethical considerations regarding local cultural norms while they made the videos. They were particularly instructed to avoid making videos of any participant (doctor or patient) if they wore a veil. This exclusion decision was also based on the requirements of the research which was to study both verbal and non-verbal aspects of communication. The heads of the concerned departments were consulted. They assigned their junior nurses and doctors to record videos of the consultations in both out-patient and in-patient departments. The videos were recorded with the consent of the concerned doctors and patients. I kept in close touch with these volunteers. I specifically instructed them not to miss out any phase of consultation and requested them to keep an angle where both verbal and non-verbal features of all the interlocutors could be recorded. Due to the busy routine of the doctors, I was able to get 15 video recordings of good quality made over a four-month period.

Video analysis. Data were collected through video recordings of doctors and patients in medical consultations. 15 videos were recorded on participants belonging to 2 private and 2 public healthcare sectors of Lahore, Pakistan, over a period of 4 months in 2022. Video recordings were manually transcribed verbatim, and thematic analysis of the data was carried out under the theoretical lens of Bourdieu's Social Practice Theory. The instances of the use of exclusive and inclusive pronouns were identified manually from the data, keeping the context in consideration. All instances of words 'I', 'me', 'you', inclusive 'we' and exclusive 'we' and 'us' in the data set, have been considered along with their collocates. A collocate is a word that occurs in the immediate textual environment of another word e.g. 'kith' collocates with 'kin'. The data has been analysed for identification of personal pronouns that serve as patient-centered linguistic facilitators and condition-centered linguistic barriers in doctor-nurse and patient interactions.

MGT. Along with that, the culture of the participants *(capital)* was also kept in mind before making any inference. This is supported by Zand, Baradaran, Najafi, Maleki and Golbazi Mahdipour (2020). Gender and personality are some important aspects of determining non-verbal communication (Gabbott, & Hogg, 2001) but interpretation associated with these demographics was not in the scope of this study. I have therefore limited my interpretation to the dimensions of context and culture. This is one of the limitations of my study. In order to overcome this limitation and be sure of the meaning of inclusive and exclusive pronouns, the volunteer team (comprising of a doctor, a linguist and myself) watched the videos. They were asked to watch videos individually and comment on the meaning associated with the instances when pronouns were used by doctors and patients. They were requested to arrange a common time to meet for a focus group discussion. This facilitated a thorough discussion on the verbal communication of doctors and patients in each video. Any discrepancy in meaning was resolved through the discussion. Due to the varying routines of the observers, three meetings/focus group discussions of one hour each were scheduled within one month. In each meeting, five videos were discussed and notes were taken that were used in analysis later on. The criteria of consensus were that if two or more people agreed on the positive or negative use of a pronoun, it

Critical Review of Social Sciences and Humanities Volume 3, Issue 2, 2023

was noted as such. The instances of neutrality or/and disagreements were reported as such. Cohen Kappa was calculated to measure the inter-rater reliability of this screening process revealing a score of .802.

Ethical Considerations

The aims and objectives of the research were made clear to all potential participants. They could withdraw anytime from the research. The written consent was taken from all the participants before the conduct of this research. Also, the participants who wore veil were not video recorded. Ethical guidelines of anonymity and confidentiality were followed. Ethical permission was sought from all the hospitals, and the University of Management and Technology gave ethical approval through its committees to conduct this research.

RESULTS

The video data shows that the mean number of words per consultation was 1569 (total number of words= 11238). The mean number of words (percentages) spoken by each party per consultation was: doctors 1169 (75%), and patients 400 (25%). The frequency distribution indicates that in an average video of 4 minutes, doctors spoke more than patients.

Table 1: *Distribution of Pronouns*

Speaker	**Distribution of 'ma', 'hum', 'is', 'aap' by speaker**			
	Frequency of *ma* (I)	Frequency of *hum* (we)	Frequency of *is* (he/she)	Frequency of *aap*(you)
Doctor	244	285	348	374
Patient	85	0	78	103
TOTAL	329	285	426	487

Table 1 illustrates the frequency and distribution of pronouns *ma* (I), *hum* (w)', *is* (he/she) and *aap* (you) (and their possessives such as aapki, aapko, aapkay, aapnay, apni, aapab, aaplog, aapsay, aapka; iski, isko, iska, isay, osay, iskay, inki, inkay, inka and unhay; mainay, mera, meri, mujhay, meray, mujh; hamaray, hamari, and humai) by doctors and patients in the given video data. Three types of pronouns have been identified from the data set: 1) doctors have mostly used exclusive pronouns such as *aap* (you), and *is* (him/her). By using these pronouns, doctors have referred to patients only and they have excluded other healthcare professionals from discussion. 2) doctors have used exclusive pronoun *ma* (I) and *hum* (we) that seemed to include patients in discussions, as this pronoun has always been followed by either *aap* (you) or its possessive forms as collocates. 3) Similarly, when doctors have used inclusive pronouns such as *hum* (we doctors), it has always been accompanied with a pronoun that addressed the patient. The use of *hum* (we) is particularly interesting because it has been used both as an exclusive (self has been excluded: referring to patients) and an inclusive pronoun (we=doctors; doctors and patients; self and patient). These pronouns have been used with or without their possessive forms: aapki, aapko, aapkay, aapnay, apni, aapab, aaplog, aapsay, aapka; iski, isko, iska, isay, osay, iskay, inki, inkay, inka and unhay; mainay, mera, meri, mujhay, meray, mujh; hamaray, hamari, and humai. 9 possessive forms of *aap* (you); 10 possessive forms of *is* (him/her); 5 possessive forms of *ma* (I); and 3 possessive forms of *hum* (we, us) have been identified from the data. Apart from this,

Critical Review of Social Sciences and Humanities Volume 3, Issue 2, 2023

verbs of physical activity or mental activity have been used after these pronouns. 4) Data have also identified a majority of utterances of the doctors in which they used no pronoun or null pronoun.

Findings of the data reveal that doctors have used *aap* more than any other pronoun. This is followed by *is*, *hum* and *ma*. However, doctors have preferred to use *hum* in the data more than *ma*. While referring to *hum* in data, doctors have included healthcare professionals in discussions. This seems to shift the responsibility from self to the inclusive doctor group. On the other hand, doctors have used *is* and its possessive forms to either refer to patient or disease. While referring patient as *is*, apparently doctors seem to objectify patient and his disease.

There are 244 and 285 instances in the data where doctors have used inclusive *ma* and *hum* respectively. It appears that when doctors use these pronouns, they seem to take the responsibility of an action to themselves. This is paternalistic aspect of communication with patients where doctors take the role of care takers. *Ma* and *hum* could be called inclusive pronouns here because their immediate collocates are *aap* and its possessive forms (Transcript 1 [1] and [2] below). On the other hand, *aap* and *is* have been treated as exclusive pronouns, because they refer to patients and not to doctors in the data set (Transcript 3 [3]).

Transcript 1

1. D: hum aap ki Abhi thook nikaltay hain. [We will take out your sputum now.]

Transcript 2

2. D: mai nay aapko teeno dafa deikha hai. [I have seen you on all three occasions.]

Transcript 3

3. D: Or is say 10 din pehlay aap bilkul theek thi saray kaam kerti thi? [And before that, were you alright and had been doing all your routine tasks?]

The position of these pronouns in the beginning and end of a sentence reveals a certain pattern. In more than 78% data, doctors have either used *aap* and its possessive forms at the end of the sentence (Transcript 3 [4]) or missed it completely (Transcript 1 [5] and [6]). Out of an average of 45 lines per consultation, pronouns are missing in 32 lines per consultation. Moreover in such instances, mostly nouns such as the names of diseases or procedures are foregrounded while the patients are backgrounded (Transcript 11 [7], Transcript 3 [4]). Some such examples are:

Transcript 3

4. D: Ulti haray rang ki toh nai aai aapko? [Did you vomit something green?]

Transcript 1

5. D: lambay lambay saans lain. [Take deep breaths].
6. D: achi tarah nikalnihai balgham sari. [Spit out sputum well.]

Transcript 11

7. D: pain killer lag gia hai aapko? [Were painkillers given to you?]

Critical Review of Social Sciences and Humanities Volume 3, Issue 2, 2023

There were some collocates of *ma*, *aap*, and *hum* found in the data. In 59 instances, after *aap* both doctors and patients have used the verb of doing or/and knowing (Transcript 3 [8] and [9], Transcript 12 [10]). These are either requests to seek information, to seek consent or to seek medical advice. Pronouns used with such verbs appeared to sound more caring, polite and respectful. Pronouns used with verbs of knowing or doing seemed to mitigate questions. Only doctors are noted to use *hum* pronoun in the video data. There are 30 occurrences when somatic words such as 'cardiography' and 'dil k pathoon' (Transcript 12 [11] and [12]) and 43 instances when verbs of doing such as 'prevent ker sakain' (Transcript 12 [14]) are observed after *hum*. The immediate collocate of *hum* on its right is *aap* observed 63 times in the data (Transcript 12 [13]). One collocate of *hum* that occurs mostly in the data is *aapko*. This refers to future planning or action in the form 'we will'. The doctors have used this form 40 times in the given data.

Transcript 3

8. D: Jab yahan p aap aaye thay toh emergency mai aa paaye thay? [Did you first come to emergency here?]
9. D: Kuch cheezain mai nay aap say aur pochni hain [I have to ask you a few things.]

Transcript 12

10. P: Dr. sahib aap check kerlein na mujhay bhi [Dr. please check me too.]
11. D: Is ko hum cardiography kehtay hain… [We call it cardiography.]
12. D: Is mai hum dil k pathoon ko deikhtay hain [We see heart muscles in it.]
13. D: Sub say pehlay hum aap k dil ki takleef ko dur kernay ki koshish kerain gay [First we will try to eradicate your heart pain.]
14. D: Dil ki further condition ko hum prevent ker sakain. [We want to prevent further heart conditions.]

DISCUSSION

The average time of 4 minutes per consultation indicates rushed interactions between doctors, nurses and patients. The nature of medical interactions in Pakistan is such that patients are mostly at the receiving end. The high frequency of doctors' talk in the data reveal power differentials in doctor and patient interactions. To understand how doctors dispense/constrain their power in the form of giving respect to patients or/and to acknowledge patients about their illness, the investigation into doctor, nurse and patient's use of pronouns has been fruitful. The findings reveal several instances of use of *ma* (I), *aap* (you), and *hum* (we) in the video data. It is evident from the data that when doctors use pronouns to refer to the patients, they feel respected. Moreover, the position of pronoun at the beginning or at the end of a sentence also helps in meaning making. The consultations in which doctors have used *aap* at the beginning of their interactions, they have foregrounded their patients rather than their disease. This appears to be an aspect of patient-centric consultation. Although *aap* has been used by doctors in the data as an exclusive pronoun, it refers to patients in the data and seems to include patient's problems in discussion. Moreover, *aap* pronoun has its alternative form *tum* in Urdu where the former one is associated with respect and distancing while the later one is used in more informal and intimate contexts and is associated with deference (Kidwai, 2022). It is observed that doctors have only used *aap* in the data. There is no instance of use of its alternative form *tum*.

Critical Review of Social Sciences and Humanities Volume 3, Issue 2, 2023

Moreover, *ma* and *hum* are interpreted as inclusive pronouns because their collocates in data are mostly *aap* and its possessive forms. The pattern in which these pronouns appear in doctors' talk is *ma* or *hum* followed by *aap*. The deictic center of *aap,* in the given data, refers to patients. By using these structures in interactions, doctors seem to either extract information from patients or are observed requesting patients for compliance (Hassan, 2020) which can be interpreted in Bourdieu's sense to dispense cultural capital to patients (Junaid & Rafi, 2019).

If we judge this on contemporary norms of what is appropriate medical consultation, the above scenario is encouraging on the surface. The doctor seeks information from patient, the doctor diagnoses his patient's problem, the doctor gives possible solution, and offers partnership to solve the problem. However, there is some fundamental ambiguity in deciding if doctors aim to be inclusive or exclusive, or if patients perceive doctors to be doing so. Power differentials are specifically evident when doctors use *hum*. *Hum* has been used only by doctors in the given data. Clearly, doctors have used *hum* to include doctor group in the discussions. The immediate collocate of *hum* is mostly *aap* or its variants which suggest that they have included patients in discussions. However, it is unclear if doctors have included nurses too when they have used *hum* in video data. The *aapko* and *aapki* collocates of *hum* (in the form: we will give you…) in data suggest that doctors control the right to nominate what topics are to be discussed, retained or dropped. Here, like in many other instances in the data, doctors seem to have excluded self. *Hum* pronoun here, is therefore used as speaker exclusive 'we'. De Cock and Barbara (2011) suggest that speaker exclusive 'we' is used to create closeness that does not really exist. Moreover, they stressed that this pronoun is strongly associated with authority. This fact is particularly noteworthy that patients have not used *hum* in data and it suggests strongly that patients do not consider doctors as participants in care but as powerful figures who are coordinators of care.

The findings from the data set where doctors have used null pronouns seem to constrain dispensing social capital to patients. This appears to be an aspect of condition-centered approach to treat patients. Calling patients by names or their referential equivalent dispense a lot of respect to them (Harris, 2016). Du Bois (2012) in his study found out that patients not only feel respected when they are called by their names or pronouns, they also feel confident that the doctor cares about them. Harris (2016) concluded that patients develop trust in doctors who use inclusive pronouns to address patients. Evidently, when doctors use inclusive pronouns, they are expressing solidarity, closeness, politeness, inclusiveness, commonality, compassion and equality with patients. In other words, doctors seem to mitigate power relations and directness when they employ inclusive pronouns in their communication with patients.

CONCLUSION

The research findings suggest that despite the rhetoric of patient-centeredness as a popular discourse and doctors' efforts to realize it in healthcare consultations in Pakistan; doctors find it challenging to engage in patient-centered communication. Four kinds of exclusive and inclusive pronouns were identified in the data. It is clearly evident that using inclusive and exclusive pronouns, their position in utterances, or avoiding these completely (null pronoun) can change the dimensions of clinical consultations from being patient-centered to condition-centered. When doctors use inclusive pronouns in consultations, it is considered evidence of partnership in consultations. This implies that doctors and patients work together to solve the problem, thereby lessening social distance, improving solidarity (Defibaugh, 2014) and equalizing any form of capital between them. On the other hand, when they use exclusive

Critical Review of Social Sciences and Humanities Volume 3, Issue 2, 2023

pronouns in their communication, it is indicative of power dynamics and a tendency to impart unequal amount of social and cultural capital to patients. The research has implications to train prospective and in-service doctors in actual medical consultations for improved patient-outcomes.

REFERENCES

Aper, L., Veldhuijzen, W., Dornan, T., van de Ridder, M., Koole, S., Derese, A., &Reniers, J. (2015). Should I prioritize medical problem solving or attentive listening?": The dilemmas and challenges that medical-students experience when learning to conduct consultations. *Patient education and counseling*, *98*(1), 77-84.

Azim, M. U., Hussain, Z., Bhatti, A. M., & Iqbal, M. (2020). 'Observable Signals' of Motivation in Teaching-Learning Process. *Journal of Communication and Cultural Trends*, *2*(1). https://doi.org/10.32350/jcct/2020/21/849

Brewer, M. B., & Gardner, W. (1996). Who is this" We"? Levels of collective identity and self-representations. *Journal of personality and social psychology*, *71*(1), 83.

Casanova, V. (2016). Peter Garrett 2010: Attitudes to Language (Key Topics in Sociolinguistics). Cambridge: Cambridge University Press. *Lingua Americana*, *20*(38), 134-141.

Chrusciel, J., Clément, M. C., Steunou, S., Prost, T., Duclos, A., & Sanchez, S. (2023). Effect of the Implementation of the French Hospital Regionalization Policy on Patient Mobility. *Health Systems & Reform*, *9*(1), 2267256.

Cubic, B. (2020). Consultation in medical settings.

Du Bois, Inke. (2012). Grammatical, pragmatic and sociolinguistic aspects of the first-person plural pronoun. In Subjectivity in Language and in Discourse, ed. N. Baumgarten, I. Du Bois,and J. House, 319–338.Bingley, UK: Emerald.

De Cock, Barbara. (2011). Why we can be you: The use of 1st person plural forms with hearer reference in English and Spanish. Journal of Pragmatics43(11): 2762–2775.https://doi.org/10.1016/j.pragma.2011.04.009

De Cock, B., & Kluge, B. (2016). On the referential ambiguity of personal pronouns and its pragmatic consequences. *Pragmatics. Quarterly Publication of the International Pragmatics Association (IPrA)*, *26*(3), 351-360.Defibaugh, S. (2014). Solidarity and alignment in nurse practitioner–patient interactions. *Discourse & Communication*, *8*(3), 260-277.

Flick, U. (2018). Doing qualitative data collection–charting the routes. *The SAGE handbook of qualitative data collection*, 1-16.

Gabbott, M., & Hogg, G. (2001). The role of non-verbal communication in service encounters: A conceptual framework. *Journal of Marketing Management*, *17*(1-2), 5-26.

Godard, D. (2012). Indicative and subjunctive mood in complement clauses: from formal semantics to grammar writing. *Empirical issues in syntax and semantics*, *9*, 129-148.

Critical Review of Social Sciences and Humanities Volume 3, Issue 2, 2023

Harris, M. (2016). Commentary Responses to "What Is Your Professional Name and Title?". *Home Healthcare Now*, *34*(10), 580-582.

Hassan, S. (2020). Populism and popularity in Imran Khan's 2018 election speeches. *Politics and Populism across Modes and Media. Edited by Ruth Breeze and Ana María Fernández Vallejo. Bern: Peter Lang AG, Available online: https://www. Research gate. net/publication/339336980 (accessed on 24 April 2021)*.

Helmbrecht, J. (2015). A typology of non-prototypical uses of personal pronouns: Synchrony and diachrony. *Journal of pragmatics*, *88*, 176-189.

Junaid, A., & Rafi, M. S. (2019). Communication barriers between doctors, nurses and patients in medical consultations at hospitals of Lahore Pakistan. *Pakistan Armed Forces Medical Journal*, *69*(3), 560-65.

Junaid, A., Rafi, M. S., Khan, N. U. S., & Khan, J. S. (2020). POWER SHARING IN MEDICAL CONSULTATIONS. *Pakistan Armed Forces Medical Journal*, *70*(6), 1756-64.

Kidwai, S. (2022). A Survey of Urdu Subjects and their Properties.

Liu, C., Calvo, R. A., & Lim, R. (2016). Improving medical students' awareness of their non-verbal communication through automated non-verbal behavior feedback. *Frontiers in ICT*, *3*, 11.

Moumjid, N., Carretier, J., Marsico, G., Blot, F., Durif-Bruckert, C., & Chauvin, F. (2017). Moving towards shared decision making in the physician-patient encounter in France: state of the art and future prospects. *ZeitschriftfürEvidenz, Fortbildung und QualitätimGesundheitswesen*, *123*, 41-45.

Moumjid, N., Durand, M. A., Carretier, J., Charuel, E., Daumer, J., Haesebaert, J., ... & Blot, F. (2022). Implementation of shared decision-making and patient-centered care in France: Towards a wider uptake in 2022. *ZeitschriftfürEvidenz, Fortbildung und QualitätimGesundheitswesen*, *171*, 42-48.

Nunberg, G. (2004). *Descriptive indexicals and indexical descriptions*. na.

Schimpff, A. (2019). 'We'but Not 'Me': A Sociolinguistic Study of the Speaker-exclusive First-Person Plural Pronoun 'We'". *Lifespans & Styles*, *5*(1), 1-15.

Steffens, N. K., & Haslam, S. A. (2013). Power through 'us': Leaders' use of we-referencing language predicts election victory. *PloS one*, *8*(10), e77952.

Skelton, John R., Andy M. Wearn, and F. D.Richard Hobbs. 2002. 'I'and 'we': A concordancing analysis of how doctors and patients use first person pronouns in primary care consultations. Family Practice19(5): 484–488.https://doi.org/10.1093/fampra/19.5.484

Skerry-Ryan, R. J., Battenberg, E., Xiao, Y., Wang, Y., Stanton, D., Shor, J., ... &Saurous, R. A. (2018, July). Towards end-to-end prosody transfer for expressive speech synthesis with tacotron. In *international conference on machine learning* (pp. 4693-4702). PMLR.

Critical Review of Social Sciences and Humanities Volume 3, Issue 2, 2023

Thomas, M., Hariharan, M., Rana, S., Swain, S., & Andrew, A. (2014). Medical jargons as hindrance in doctor–patient communication. *Psychological Studies*, *59*, 394-400.

Zand, S., Baradaran, M., Najafi, R., Maleki, A., & GolbaziMahdipour, A. (2020). Culture and Gender in nonverbal communication. *Rooyesh-e-Ravanshenasi Journal (RRJ)*, *8*(12), 123-130.