CRITICAL DISCOURSE ANALYSIS IN MEDICINE

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ABSTRACT
This article explores the anthropological significance of medical discourse-a high-stakes topic with clear applied relevance (Cooper et al. 2003, Maynard & Heritage 2005, Roberts et al. 2005) that is also rich ground for developing anthropological theory. Studying discourse (language in its fullness) and medicine together brings us to encounter culture as discursively constituted. As historically situated practices, forms of medical discourse play a role in cultural production and reproduction.
KEY WORDS: *discourse analysis, medical discourse, anthropological theory, cultural production and reproduction*

INTRODUCTION

Discourse analysis at this level involves not only the examination of text and the social uses of language but also the study of the ways in which the very existence of specific institutions and of roles for individuals to play are made possible by ways of thinking and speaking.

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.

MATERIALS AND METHODS

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 (Roseman 1991); disability discourse (Hadder 2007); "laughter as a patient's resource" (Haakana 2001); the iconicity between a sufferer's voice quality and denotative expressions of pain (Wilce 1998, p. 123); and the representation of talk itself as a symptom (of mental illness; Ribeiro 1994; Desjarlais 1997; Wilce 2004a,b). 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 (Nuckolls 1991). But lost cows are also diviner-eligible topics (Wilce 2001). 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 (Carr 2006, Desjarlais 1997). Note, however, that referring is social action, for example directing a doctor's attention toward, or mutually

constructing, the object of a clinical encounter (Engestrom 1995). ¨ Talking about sickness may point to apparently nonmedical topics such as speaker traits (other than illness), relationships, family resources, and the moral order.

For many close analyses of medical discourse (Mishler 1984). CA highlights emergent coconstruction of meaning, denying for instance that doctors unilaterally impose diagnoses or therapies (Engestrom 1999, Maynard & ¨ Frankel 2003). Like all interlocutors, doctors and patients are accountable to each other, i.e., they have an "obligation to index the grounds on which their conclusions are formed" (Heritage 2005, p. 92). News deliveries follow the same rules in the clinic as in conversation (Gillotti et al. 2002, Perakyl ¨ a 1998, ¨ Wittenberg-Lyles et al. 2008), particularly a preference for foreshadowing revelations. Bluntness, however, is another strategy medical personnel may follow in certain circumstances, not to assert power but for immediate interactional reasons, e.g., to break through resistance (Maynard 2003). A rare example of raw power may be the case of company doctors urging workers complaining of illness back to their jobs, downplaying the seriousness of complaints (Mishler 1984, Waitzkin 1991). More universal is the healer's power to "name the world" (Heritage 2005, p. 99). Yet clients also have some authority (regarding their own experience) and influence. Parents sometimes demand antibiotics for their children (Stivers 2002), leading doctors to push back or negotiate (Stivers 2005). Physicians in other circumstances may secure patient agreement by offerings grounds, early on, for diagnoses announced later.

RESULTS AND DISCUSSIONS

Studies of medical discourse have contributed to broader anthropological projects including the analysis of ideologies that empower some communicators and stigmatize others as pre-modern (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.

Finally, given that some studies consistently uncover patient-practitioner collaboration and a degree of agency on the part of patients, whereas others find in somewhat similar settings a straightforward reproduction of power relations, both empirical and theoretical work to illuminate this contradiction are needed. Such studies stand to contribute to critical medical anthropology and to help those seeking not only to describe but to change medical worlds.

Researchers in cultural studies, sociology, and philosophy use the term critical discourse analysis to encompass an even wider sphere that includes all of the social practices, individuals, and institutions that make it possible or legitimate to understand phenomena in a particular way, and to make certain statements about what is "true." Critical discourse analysis is particularly concerned with power and is rooted in "constructivism." Thus the discourse analyses of Michel Foucault, for example, illustrated how particular discourses "systematically construct versions of the social world." Foucault's study of madness, for example, uncovered three distinct discourses that have constructed what madness is in different historical periods and in different places: madness as spiritual possession, madness as social deviancy, and madness as mental illness. In a similarly oriented study, Speed showed how different discourses about mental health service in use today construct individuals' identities as "patients," "consumers," or "survivors" and are made possible by specific institutional practices and ways for individuals to "be." In a different context, Stone contrasted the specific discourses used in the education literature for diabetes patients ("patient self-care" and "autonomy") with the medical literature's use of doctor centred discourses ("compliance" and "adherence"). Stone related the resulting tension (and the important implications for patients' behaviours) to the ways in which the roles that physicians and patients play are historically determined by different and conflicting models of what disease and healing are.

Finally, Shaw and colleagues used a discourse analysis to illustrate the many ways in which research itself can be defined (for example, by a lay person, a medical editor, the World Medical Association, a hospital, the taxman) and how these various definitions are linked to the power and objectives of particular institutions. In these examples of critical discourse analysis, the language and practices of healthcare professionals and institutions are examined with the aim of understanding how these practices shape and limit the ways that individuals and institutions can think, speak, and conduct themselves.

The researchers conducted in-depth interviews with medical students and faculty members. Pairs of researchers also observed 16 oral case presentations as well as the teaching exchanges that surrounded them. All of these encounters were tape recorded and transcribed (for a total of 555 pages of text); the transcriptions were iteratively analyzed. The analysis was structured to allow themes to emerge from the data (that is, as indicated by multiple examples of such themes throughout the data). However, it particularly focused on themes that helped to illuminate the rules around certain modes of case presentation and on the role of these rules in teaching and learning. The study showed a pronounced tension between the educational ("schooling") uses and clinical ("workplace")

functions of case presentations. For example, students saw the case presentation as a school mode and emphasized that they wanted to get through their presentations without being asked any questions. Faculty, on the other hand, understood the case presentation as a way for professionals to jointly create shared knowledge. Their cross-purposes affected the effectiveness of faculty feedback to the students about their case presentations.

Given the wide variety of approaches to discourse analysis, the elements that constitute a high quality study vary. Rogers has argued that some discourse analysis research suffers from scanty explanation of the analytical method used. Thus one should expect clear documentation of the sources of information used and delimitation of data sources (including a description of decisions made with regard to selection of groups or individuals for interviews, focus groups, or observation) and, importantly, a description of the context of the study. The method of analysis should be clearly explained, including assumptions made and methods used to code and synthesize data. Finally, given that the goal of critical discourse analysis is to illuminate and critique structures of power, it is especially important that researchers describe the ways in which their own individual sociocultural roles may influence their perspectives.

CONCLUSION

Discourse analysis is an effective method to approach a wide range of research questions in health care and the health professions. What underpins all variants of discourse analysis is the idea of examining segments, or frames of communication, and using this to understand meaning at a "meta" level, rather than simply at the level of actual semantic meaning. In this way, all of the various methods of discourse analysis provide rigorous and powerful approaches to understanding complex phenomena, ranging from the nature of on-the-ground human communication to the inner workings of systems of power that construct what is "true" about health and health care. While these methods are gaining popularity, much remains to be done to develop a widespread appreciation for the use, funding, and publication of discourse analyses. As a start, we hope this article will help readers who encounter these approaches to understand the basic premises of discourse analysis.

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