IRJE |Indonesian Research Journal in Education|Vol. 10| No. 1|March|Year 2026|

Utterances in pharmacist-patient communication: A critical discourse analysis

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Abstract

Effective communication between pharmacists and patients is essential for ensuring medication adherence, health literacy, and patient satisfaction. As pharmacists increasingly assume educational and counseling roles, the quality of their interaction with patients becomes a crucial determinant of healthcare outcomes. This study employs Critical Discourse Analysis (CDA) to examine utterance patterns and power relations in pharmacist–patient consultations within a community pharmacy setting. Using Fairclough's three-dimensional framework, the study analyzes three recorded consultations, focusing on terminology, questioning strategies, and expressions of authority. The findings reveal that pharmacists frequently use medical terminology and directive language, which may unintentionally reinforce hierarchical power structures and limit patient participation. Closed-ended questioning patterns further limit patient engagement, while patients often show linguistic deference toward to pharmacists' authority. The findings provide empirical evidence for integrating discourse awareness and patient-centered communication strategies into pharmacy education curricula. Strengthening pharmacists' communicative competence may foster collaborative relationships and improve health outcomes.

Keywords

Critical discourse analysis, pharmacist–patient communication, power relations, discourse, pharmacy education

Article History

Received 10 December 2025
Accepted 23 March 2026

How to Cite

Dewi, K. M. C. (2026). Utterances in pharmacist-patient communication: A critical discourse analysis. *Indonesian Research Journal in Education |IRJE|*, *10*(1), 519-535.https://doi.org/10.22437/irje.v10i1.51125

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Introduction

Effective communication is widely recognized as a cornerstone of quality healthcare delivery. In contemporary health systems, pharmacists are no longer limited to dispensing medications; they are increasingly expected to function as patient educators, medication counselors, and healthcare advisors. This expanded role requires not only technical knowledge but also advanced communicative competence. The interaction between pharmacists and patients plays a crucial role in shaping medication adherence, patient satisfaction, and health literacy. When communication is clear, empathetic, and participatory, patients are more likely to understand therapeutic instructions and actively engage in their treatment decisions. Conversely, ineffective communication may lead to misunderstanding, reduced adherence, and suboptimal health outcomes.

In community pharmacy settings, interactions are often brief and task oriented. Time constraints, workload pressures, and institutional routines may limit opportunities for extended dialogue. However, even within short consultations, linguistic choices significantly influence the quality of interaction. The vocabulary used, the types of questions posed, and the degree of directive language employed can either encourage patient participation or reinforce hierarchical structures. Recent research emphasizes that patient-centered communication improves therapeutic outcomes and collaborative decision-making (Sharkiya, 2023). Such findings suggest that communication should not be treated as a peripheral skill but as an integral component of professional healthcare practice.

Despite the growing emphasis on patient-centered care, communication in healthcare remains embedded within institutional power relations. Pharmacists possess specialized knowledge and professional authority, while patients often occupy a comparatively less powerful position. This asymmetry is not inherently problematic; expertise is necessary for safe and effective treatment. However, when authority is expressed through rigid or overly directive language, it may unintentionally silence patient concerns or discourage questions. Aremu et al. (2022) highlight that unresolved medication-related concerns frequently contribute to non-adherence, indicating that communication barriers can have tangible clinical consequences. Understanding how power operates through language is therefore essential for improving pharmacist–patient interaction.

One key challenge in pharmacist–patient communication is the use of specialized medical terminology. Technical vocabulary serves important professional purposes, ensuring precision and clarity within clinical contexts. Nevertheless, patients may lack the background knowledge required to interpret such terminology accurately. When pharmacists rely heavily on technical expressions without adequate explanation, communicative distance may increase. This distance can hinder comprehension and reduce patient confidence in asking for clarification. Pandey et al. (2021) demonstrate that linguistic barriers significantly affect healthcare access and understanding, particularly among populations with limited health literacy. These findings underscore the need to examine not only what is communicated, but how it is communicated.

Beyond vocabulary choice, questioning strategies also shape interactional dynamics. Closed-ended questions, which typically elicit brief "yes" or "no" responses, may promote efficiency but restrict elaboration. In contrast, open-ended questions invite patients to describe

symptoms, concerns, or experiences in greater detail. The type of questioning employed by pharmacists can thus determine the degree of patient participation in the consultation process. If discourse patterns systematically prioritize efficiency over dialogue, patients may remain passive recipients of information rather than active contributors to decision-making. Such patterns raise important questions regarding the educational preparation of pharmacists and the communicative models emphasized in professional training.

The concept of power in healthcare communication extends beyond overt authority. It is embedded in subtle linguistic features such as modality, pronoun use, and directive structures. For example, expressions containing deontic modality—such as "you must" or "you need to"—convey obligation and reinforce professional dominance. While these expressions may reflect legitimate medical advice, they also position the pharmacist as the primary decision-maker. Patients, in turn, may respond with deferential language that signals acceptance of hierarchical roles. From a discourse perspective, these recurring linguistic patterns contribute to the reproduction of institutional authority within everyday clinical encounters.

Critical Discourse Analysis (CDA) offers a useful framework for examining how language constructs and reflects such power relations. CDA views discourse not merely as a neutral vehicle for communication but as a social practice that both shapes and is shaped by institutional structures. By analyzing linguistic features at the textual level and connecting them to broader social practices, CDA enables researchers to uncover the implicit ideologies embedded within routine interactions. In healthcare settings, CDA can illuminate how professional authority is maintained, negotiated, or challenged through everyday speech.

Although numerous studies have investigated communication effectiveness in pharmacy practice, relatively few have applied a discourse-analytic perspective to examine the micro-linguistic mechanisms through which power is enacted. Much of the existing literature focuses on patient satisfaction surveys, adherence rates, or communication training interventions. While these approaches provide valuable quantitative insights, they may overlook the subtle linguistic strategies that structure interaction. A discourse-oriented approach complements existing research by exploring how institutional authority is reproduced through specific utterances, lexical choices, and conversational patterns.

In addition, there is limited research focusing on pharmacist–patient discourse within the Indonesian context. Cultural norms surrounding respect for professional authority may further shape interaction patterns. In societies where hierarchical relationships are culturally reinforced, patients may hesitate to question or challenge healthcare providers. This cultural dimension makes it particularly important to investigate how discourse practices operate within specific local contexts. Understanding these dynamics can inform educational reforms tailored to regional healthcare systems.

From an educational perspective, the communicative practices observed in pharmacy settings have significant implications. If professional training emphasizes biomedical knowledge without equally prioritizing discourse competence, graduates may lack the skills necessary to foster collaborative dialogue. Integrating communication awareness into pharmacy curricula is therefore essential. Educational programs should encourage students to reflect critically on their linguistic choices, recognize power asymmetries, and adopt patient-

centered strategies. Such reforms align with broader educational goals of developing reflective practitioners capable of adapting to diverse communicative situations.

This study seeks to address the identified gaps by applying critical discourse analysis to pharmacist–patient consultations in a community pharmacy setting. Specifically, it investigates how utterance patterns construct power relations and influence patient participation. By focusing on vocabulary use, questioning strategies, and directive expressions, the research provides insight into the interactional mechanisms that shape healthcare communication. The findings are expected to contribute to both discourse studies and pharmacy education by highlighting the importance of linguistic awareness in professional practice.

In summary, pharmacist–patient communication represents a complex intersection of professional expertise, institutional authority, and interpersonal interaction. Despite widespread recognition of effective communication as crucial to enhancing health outcomes, our understanding of the discursive mechanisms that enact authority remains limited. Recent scholarship underscores the importance of patient-centered dialogue (Sharkiya, 2023), the impact of communication barriers on adherence (Aremu et al., 2022), and the influence of linguistic proficiency on healthcare access (Pandey et al., 2021). Building on these insights, the present study examines how language functions as a site of power negotiation within community pharmacy consultations. By situating discourse analysis within the broader context of healthcare education, this research aims to promote more equitable, participatory, and effective communication practices.

Literature Review

Pharmacist–patient communication and patient-centered care

Pharmacist–patient communication has evolved significantly over the past decade, reflecting a shift in pharmacists' roles from dispensers of medication to healthcare educators and patient advocates. In contemporary practice, pharmacists are expected to provide counseling, clarify therapeutic regimens, identify potential drug interactions, and support patient adherence. This expanded role situates communication at the center of pharmacy practice. Effective interaction not only ensures accurate medication use but also enhances patient satisfaction and trust.

Recent research emphasizes the importance of patient-centered communication in pharmacy settings. Patient-centered care prioritizes empathy, shared decision-making, and responsiveness to patients' concerns. Liu et al. (2024) argue that quality communication significantly improves patient-centered health outcomes, particularly among vulnerable populations. The study highlights that clear explanations, active listening, and opportunities for patient questioning are key predictors of treatment compliance and satisfaction. This perspective reinforces the idea that communication is not merely informational but relational and participatory.

Penn et al. (2011) similarly show a close link between medication adherence and communication quality. Their findings suggest that patients who feel heard and respected are more likely to follow therapeutic recommendations. When pharmacists provide opportunities for clarification and encourage dialogue, patients report greater confidence in managing their

treatment. Conversely, ineffective communication contributes to misunderstandings and non-adherence. This underscores the need to examine how discourse practices either facilitate or hinder collaborative engagement.

However, despite these advances, pharmacist–patient communication remains influenced by institutional constraints such as time pressure, workload, and standardized procedures. These contextual factors may limit the depth of interaction, resulting in transactional exchanges rather than meaningful dialogue. Pandey et al. (2021) emphasize that linguistic barriers and inadequate explanations can intensify disparities in healthcare access. Patients with limited health literacy may struggle to comprehend medical instructions, especially when professional terminology is used without simplification.

Within educational contexts, these findings have implications for pharmacy curricula. Communication training should extend beyond technical accuracy to include awareness of discourse, empathy development, and cultural sensitivity. Integrating patient-centered communication modules into pharmacy education can prepare students to navigate diverse patient interactions effectively. Therefore, examining the linguistic structures underlying pharmacist–patient interactions is essential for strengthening professional training and promoting equitable healthcare delivery.

Language, power, and authority in healthcare discourse

Institutional power relations inherently shape healthcare communication. Pharmacists, as licensed professionals, possess specialized knowledge that grants them authority in clinical interactions. While this authority is necessary for safe medication management, it can also create asymmetrical communication patterns. Power in healthcare is not always overt; it is often embedded in subtle linguistic choices such as modality, directive expressions, and question formats.

Critical scholarship has increasingly explored how power operates through discourse. Anisa et al. (2024) argue that institutional authority is frequently reproduced through language that emphasizes expertise and control. Although their research focuses on corporate communication, the findings are transferable to healthcare contexts where professional status shapes interactional dynamics. The use of declarative statements, obligation markers, and technical terminology may reinforce hierarchical relationships.

In pharmacy settings, directive expressions such as "you must take this medication" or "you need to follow this instruction" convey deontic modality, signaling obligation. While medically justified, such expressions position the pharmacist as the decision-maker and the patient as a recipient of instructions. According to Aremu et al. (2022), patients may outwardly comply while harboring unvoiced internal doubts or concerns. This phenomenon illustrates how authority, when expressed unilaterally, may limit genuine engagement.

Furthermore, questioning strategies also reflect power distribution. Closed-ended questions constrain patient responses, reinforcing professional control over conversational flow. Open-ended questions, in contrast, invite elaboration and signal willingness to share decision-making. Sharkiya (2023) emphasizes that collaborative dialogue strengthens trust and enhances treatment outcomes. Therefore, analyzing how pharmacists structure questions provides insight into the dynamics of authority and participation.

Cultural context further complicates power relations. In societies where hierarchical respect for professionals is strongly embedded, patients may be reluctant to challenge medical advice. This cultural deference may intensify communication asymmetry. Understanding these dynamics is essential for designing educational interventions that promote reflective practice. By recognizing how language constructs authority, pharmacists can adopt more inclusive discourse strategies that support shared decision-making rather than unilateral instruction.

Critical discourse analysis in health communication research

Critical Discourse Analysis (CDA) provides a theoretical and methodological framework for examining how language constructs social realities and power structures. Unlike traditional communication studies, which focus on effectiveness or satisfaction, CDA interrogates the ideological assumptions embedded in discourse. It views language as a social practice shaped by institutional norms and broader societal structures.

Recent scholarships have applied discourse-oriented approaches to healthcare communication, though relatively few studies focus specifically on pharmacy settings. Khan (2023) emphasizes that discourse reflects cultural and institutional power dynamics, suggesting that language both represents and reproduces social hierarchies. This perspective aligns with CDA's emphasis on uncovering implicit power relations within everyday interactions.

In the same way, Hussain and Panggabean (2024) show how word choices and semiotic elements create authority and persuasion in professional settings. Although their research centers on advertising discourse, the analytical principles are relevant to healthcare communication. In pharmacist–patient interactions, lexical choice, modality, and syntactic structure may indicate expertise and authority. CDA enables researchers to systematically analyze these features at the textual level and connect them to institutional practices.

In healthcare, CDA enables a multi-layered analysis that encompasses textual, discursive, and social dimensions. At the textual level, researchers examine vocabulary, grammar, and interactional patterns. At the discursive level, they analyze how conversations are produced and interpreted. At the social level, they situate discourse within broader institutional and cultural frameworks. This three-dimensional approach is particularly suitable for exploring pharmacist–patient communication, where professional authority intersects with patient autonomy.

Moreover, applying CDA to pharmacy discourse has educational implications. By identifying linguistic patterns that reinforce hierarchy, educators can design training modules that encourage more equitable communication strategies. Reflective discourse analysis can serve as a pedagogical tool, helping future pharmacists recognize how their language choices shape patients' experiences. As healthcare increasingly emphasizes patient empowerment, CDA offers valuable insights into transforming communicative practices.

In summary, recent studies highlight the relevance of examining communication quality (Sharkiya, 2023), adherence and trust (Aremu et al., 2022), and institutional power in discourse (Anisa et al., 2024; Khan, 2023). However, there remains a need for focused discourse-analytic research within pharmacist–patient interactions. Integrating CDA into pharmacy communication studies bridges this gap and contributes to both theoretical understanding and educational development.

Methodology

Research design

This study employed a qualitative research design using Critical Discourse Analysis (CDA) as its primary analytical framework. A qualitative approach was selected because the research aimed to explore how language constructs meaning, power relations, and professional authority within naturally occurring pharmacist–patient interactions. Rather than measuring communication effectiveness quantitatively, the study seeks to interpret linguistic patterns and uncover the social and institutional dimensions embedded in discourse.

Critical Discourse Analysis was chosen because it provides a systematic framework for examining the relationship between language and social power. CDA views discourse not merely as verbal communication but as a social practice shaped by institutional structures and ideological assumptions. In the context of pharmacist–patient consultations, CDA enables the researcher to analyze how utterances reflect professional authority, patient positioning, and hierarchical interactional patterns. This approach is particularly appropriate for investigating healthcare communication, where institutional expertise intersects with patient autonomy. The study adopts Fairclough's three-dimensional model of CDA, which examines discourse at three interconnected levels: (1) textual analysis, (2) discursive practice, and (3) social practice. This model allows for a multi-layered understanding of how specific linguistic features relate to broader institutional contexts.

Research setting and participants

The study was conducted in a community pharmacy setting in Bali, Indonesia. Community pharmacies represent a primary point of healthcare access for many individuals, making them an important site for examining everyday professional–patient interactions. Unlike hospital settings, community pharmacies often involve brief consultations focused on medication dispensing and counseling, which makes the linguistic structure of these short exchanges particularly significant.

Three pharmacist–patient consultations were purposively selected for analysis. Purposive sampling was employed to ensure that the interactions represented typical prescription counseling sessions rather than exceptional or highly specialized cases. The consultations involved licensed pharmacists and adult patients receiving prescribed medication for common health conditions. The pharmacists had formal professional training and were actively practicing at the time of data collection. Patients varied in age and gender, though all were adults capable of providing informed consent. The study did not focus on specific medical conditions but rather on communication patterns across routine consultations.

Data collection procedures

Data were collected through audio recording of naturally occurring consultations. Before recording, informed consent was obtained from both pharmacists and patients.

Participants were informed of the study's purpose, the voluntary nature of their participation, and their right to withdraw at any time. Confidentiality and anonymity were guaranteed, and identifying information was removed during transcription.

Each consultation lasted between five and ten minutes. The audio recordings captured verbal interaction, while supplementary field notes documented contextual factors such as environmental noise, interruptions, workload conditions, and observable non-verbal cues. These contextual observations were important for interpreting discourse within its situational setting. All recorded consultations were transcribed verbatim. Transcription included pauses, repetitions, and significant emphases where relevant to discourse interpretation. The transcription process ensured that the analysis was grounded in accurate linguistic representation rather than reconstructed summaries.

Data analysis

The data analysis followed Fairclough's three-dimensional framework of Critical Discourse Analysis (CDA), which examines discourse at the levels of textual analysis, discursive practice, and social practice. This approach enabled a systematic exploration of how linguistic features in pharmacist–patient consultations reflect and reproduce institutional power relations. At the textual level, the study focused on identifying specific linguistic features within both pharmacist and patient utterances. The analysis examined lexical choices, particularly the use of medical terminology, as well as modality markers such as "must", "need to", and "should". In addition, attention was given to imperative and declarative sentence structures, question types (open-ended and closed-ended), and pronoun usage, including references to "you" and "we". Each transcript was read multiple times to become familiar with the data and to identify recurring linguistic patterns. Utterances were then coded into thematic categories, including directive expressions, reassurance strategies, clarification attempts, and deferential responses. This systematic coding process enabled comparison across consultations and revealed consistent discourse patterns.

Emphasis was placed on deontic modality, as modal verbs frequently signal obligation and authority in institutional discourse. For example, statements such as "You must take this medication daily" were analyzed to examine how they position the patient within a hierarchical relationship. Similarly, the use of technical medical terminology was examined to determine whether explanations were provided or whether knowledge asymmetry between pharmacist and patient was reinforced.

At the level of discursive practice, the analysis explored how consultations were organized and how interaction unfolded between participants. This included examining turn-taking patterns, initiation–response sequences, repair and clarification mechanisms, and topic control. The study investigated who initiated conversational topics, who directed the flow of discussion, and how patients responded to instructions or advice. For instance, frequent pharmacist-initiated exchanges accompanied by limited patient elaboration were interpreted as indicators of restricted participation. This stage of analysis also considered how institutional routines shape discourse production. The typically brief duration of consultations and their focus on medication instruction were understood as contextual factors influencing interactional structure.

At the social practice level, the findings were interpreted within the broader institutional and cultural context of healthcare communication. The analysis considered how discourse reflects professional authority, institutional norms, and sociocultural expectations surrounding respect for expertise. In the Indonesian context, hierarchical respect toward healthcare professionals may influence patient communication styles. Therefore, deferential language patterns were understood not merely as individual choices, but as socially embedded practices shaped by cultural values. By connecting micro-linguistic features to macro-level institutional structures, the study demonstrates how everyday utterances contribute to the reproduction of professional hierarchy within pharmacy practice.

Trustworthiness

To ensure analytical rigor, the study employed several strategies. First, repeated readings of the transcripts enhanced familiarity with the data and reduced interpretive bias. Second, coding categories were systematically applied across all consultations to ensure consistency. Third, contextual field notes were used to triangulate linguistic findings with situational factors.

Although the dataset comprises three consultations, the depth of the qualitative analysis enables detailed exploration of discourse features. The aim of the study is not generalization but analytical insight into interactional patterns.

Ethical considerations

Ethical principles were strictly observed throughout the research process. Participants provided informed consent, and confidentiality was maintained. Names and identifying details were anonymized in transcripts and reporting. The study adhered to general ethical guidelines for research involving human subjects, ensuring voluntary participation and protection of privacy.

Findings

The findings are presented according to Fairclough's three-dimensional Critical Discourse Analysis framework: textual analysis, discursive practice, and social practice. The data reveal systematic patterns in lexical choice, modality, questioning strategies, and interactional control that construct professional authority within pharmacist–patient consultations.

Textual level: Linguistic construction of authority

a. Medical terminology and knowledge asymmetry

One recurring feature in the consultations is the pharmacist's use of medical terminology without extended elaboration. For example:

Pharmacist: "Ini obat antihipertensi untuk menurunkan tekanan darah Bapak". (In Bahasa)

Pharmacist: "This is an antihypertensive medication to lower your blood pressure". (In English)

The term *antihipertensi* reflects professional precision and biomedical expertise. However, it assumes a level of medical literacy that patients may not possess. The pharmacist does not follow this statement with simplified clarification, such as "obat untuk darah tinggi" (medicine for high blood pressure). From a CDA perspective, lexical choice functions as a symbolic marker of institutional authority. Technical vocabulary reinforces knowledge asymmetry between pharmacist and patient. Although the utterance is medically accurate, it positions the pharmacist as the expert and the patient as dependent on specialized knowledge. The absence of explanatory reformulation suggests that communicative efficiency may be prioritized over shared understanding.

b. Deontic modality and directive language

Directive language appears consistently across consultations. Consider the following example:

Pharmacist: "Bapak harus minum obat ini setiap hari supaya kondisinya stabil". (In Bahasa)

Pharmacist: "You must take this medication every day so your condition remains stable". (In English)

The modal verb *harus* (must) expresses obligation and constructs a hierarchical relationship. In discourse analysis, deontic modality signals authority by defining required action. The utterance establishes the pharmacist as the agent of instruction and the patient as the subject of compliance. Another example illustrates a similar modality:

Pharmacist: "Jangan sampai terlewat, ya". (In Bahasa)

Pharmacist: "Make sure you don't miss it". (In English)

This imperative structure further reinforces the authority of the directive. While medically necessary, repeated use of obligation markers may limit opportunities for collaborative negotiation. The interaction remains instructional rather than dialogical.

c. Questioning patterns

Closed-ended questioning dominates pharmacist discourse. For example:

Pharmacist: "Ibu ada minum obat lain?" (In Bahasa)

Pharmacist: "Are you taking any other medication?" (In English)

This yes/no format restricts elaboration and maintains conversational control. The pharmacist determines the scope of acceptable response. In contrast, patients tend to use open-ended questions:

Patient: "Kalau saya lupa minum obatnya bagaimana, ya?" (In Bahasa)

Patient: "What should I do if I forget to take the medicine?" (In English)

Here, the patient seeks guidance and clarification. The question indicates a willingness to actively participate in treatment management. However, pharmacist responses often return to directive statements rather than exploratory discussion. The asymmetry in questioning styles reflects an unequal distribution of conversational power.

Discursive practice level: Interactional structure

a. Topic initiation and control

The analysis of turn-taking patterns reveals that pharmacists consistently initiate, organize, and conclude the consultations. The interaction typically follows a structured, predictable sequence: the pharmacist begins by explaining the prescribed medication, then provides dosage instructions, seeks brief confirmation from the patient, and finally closes the consultation. This structured progression reflects an institutionally shaped communicative routine in which the pharmacist assumes primary responsibility for directing the flow of conversation.

Patients rarely initiate new topics unless prompted or when expressing specific concerns. Even when concerns are raised, the interaction often returns quickly to instruction-focused discourse. The pharmacist's control over topic development and sequencing demonstrates how conversational authority is maintained throughout the consultation. Such organization reinforces the pharmacist's professional role as the primary knowledge-holder and decision-maker, while positioning the patient as a recipient of information rather than an equal conversational partner. This interactional structure illustrates how institutional norms shape discourse production and contributes to the reproduction of hierarchical relationships within healthcare communication. For instance:

Pharmacist: "Obat ini diminum dua kali sehari setelah makan". (In Bahasa)

Pharmacist: "This medicine is taken twice a day after meals". (In English)

Pharmacist: "Sudah jelas, ya?" (In Bahasa)

Pharmacist: "Is that clear?" (In English)

Patients rarely introduce new topics unless expressing concern. Even when concerns are raised, the discussion quickly returns to instructional discourse. This structured interaction reflects institutional routine. Pharmacists control thematic progression, reinforcing professional dominance in conversational organization.

b. Patient deference and mitigation

Patients frequently use deferential language when responding:

Patient: "Baik, saya ikut saran Ibu saja". (In Bahasa)

Patient: "Alright, I will just follow your advice". (In English)

This statement reflects acceptance of authority and minimal negotiation. The phrase *ikut saran* (follow your advice) signals compliance.

Even when expressing anxiety, patients mitigate their concern:

Patient: "Saya agak takut efek sampingnya, boleh saya tanya?" (In Bahasa)

Patient: "I'm a little worried about the side effects, may I ask?" (In English)

The phrase *agak takut* (a little worried) softens the concern. The use of permission-seeking language (*boleh saya tanya?*) demonstrates deference. These linguistic strategies indicate that patients position themselves within a hierarchical framework. Rather than directly challenging authority, they frame concerns cautiously.

Social practice level: Institutional and cultural context

At the social level, these discourse patterns reflect broader institutional norms within healthcare. Pharmacists are trained as experts responsible for patient safety. Directive language aligns with biomedical authority and professional accountability. However, the findings also reflect sociocultural expectations regarding respect for healthcare professionals. In Indonesian contexts, hierarchical respect toward authority figures is culturally embedded. Patients may avoid overt disagreement to maintain politeness and social harmony. Thus, discourse does not operate in isolation. The repeated use of technical terminology, deontic modality, and controlled questioning reproduces institutional authority. Patients' deferential responses reinforce this hierarchy.

While such authority ensures clinical safety, it may limit patient empowerment and shared decision-making. From an educational standpoint, these findings highlight the importance of incorporating discourse awareness into pharmacy curricula. Teaching future pharmacists to balance professional authority with collaborative dialogue may promote more equitable healthcare interactions.

Integrated interpretation

Across the textual, discursive, and social dimensions of analysis, the consultations reveal consistent, interconnected patterns. At the textual level, the use of technical medical terminology reinforces knowledge asymmetry between pharmacists and patients. Lexical choices such as specialized clinical terms position the pharmacist as the primary knowledge-holder, while patients are implicitly framed as dependent on professional expertise. The frequent use of deontic modality, including expressions such as *harus* (must) and *jangan* (do not), further constructs obligations and strengthens the pharmacist's authoritative stance. These linguistic features signal institutional responsibility but also reinforce hierarchical positioning.

At the discursive level, closed-ended questioning patterns maintain conversational control and limit patient elaboration. The pharmacist predominantly directs the progression of the topic and determines the structure of the interaction, while patients respond briefly and often use deferential or mitigating expressions. This interactional structure reflects an institutionally organized format that prioritizes efficiency and procedural clarity.

Collectively, these patterns construct a hierarchical communicative model. Although this model is functionally effective in delivering medication instructions and ensuring compliance, it constrains opportunities for shared meaning-making and collaborative dialogue. By analyzing original utterances in Bahasa Indonesia, this study demonstrates how power relations are embedded in everyday linguistic choices. The findings highlight the importance of reflective communication training in pharmacy education to promote more patient-centered and dialogical discourse practices.

Discussion

Medical terminology and knowledge asymmetry

One of the central findings of this study concerns the frequent use of medical terminology in pharmacist–patient consultations. Pharmacists often employed technical expressions such as *antihipertensi* without further simplification. While biomedical accuracy is essential in clinical contexts, the consistent use of specialized vocabulary may reinforce knowledge asymmetry between pharmacist and patient.

Research suggests that effective healthcare communication requires adapting language to patients' health literacy levels (Street et al., 2020). When medical terminology is not accompanied by clarification, patients may have only a partial understanding while appearing compliant. From a Critical Discourse Analysis (CDA) perspective, lexical choices are not neutral; they function as markers of institutional expertise. By using technical vocabulary without negotiation of meaning, pharmacists position themselves as authoritative knowledge holders.

Although this authority is professionally legitimate, its linguistic expression may unintentionally create communicative distance. In patient-centered care models, understanding is co-constructed through dialogue rather than assumed through declarative

explanation (Epstein & Street, 2021). Therefore, balancing technical precision with accessible language is essential for equitable interaction.

Deontic modality and the construction of professional authority

The study also revealed the frequent use of deontic modality, particularly expressions such as *harus* ("must") and imperative constructions. These linguistic forms communicate obligation and reinforce professional authority. For example, directives such as "You must take this medication every day" construct a clear hierarchy between the advising professional and the instructed patient.

Directive language in healthcare is often justified by ethical responsibility and patient safety. However, repeated reliance on obligation markers may limit opportunities for shared decision-making. Heritage and Robinson (2021) argue that authoritative speech forms can secure compliance but may reduce patient participation if not balanced with collaborative strategies.

The issue is not the presence of authority itself, but how it is linguistically framed. Shared decision-making frameworks emphasize inclusive language that invites patient input while maintaining clinical responsibility (Thomas et al., 2020). The findings suggest that pharmacist discourse in this setting tends toward instruction-centered rather than dialogue-centered communication. This pattern reflects institutional expectations but may constrain relational engagement.

Questioning strategies and conversational control

Another significant finding relates to questioning patterns. Pharmacists predominantly used closed-ended questions, which limited patient responses to brief confirmations. While efficient, this approach restricts narrative elaboration and reduces opportunities for patients to express concerns in detail.

In contrast, patients' questions were typically open-ended and clarification oriented. This asymmetry indicates that conversational control remains largely with the pharmacist. According to Barnes (2019), question design plays a crucial role in shaping patient participation; open-ended questions foster elaboration, while closed-ended formats maintain professional dominance over interactional flow.

The structured format of consultations—explanation, instruction, confirmation, and closure—further reinforces this imbalance. While such a structure supports procedural clarity, it may reduce dialogical engagement. Patient-centered communication requires not only delivering information but also actively inviting patient perspectives (Sharkiya, 2023). The findings suggest that opportunities for expanded dialogue remain limited within routine pharmacy practice.

Patient deference and cultural context

At the social practice level, discourse patterns reflect broader cultural norms. Patients frequently used deferential expressions such as *ikut saran Ibu saja* ("I will just follow your

advice"), signaling respect for professional authority. In Indonesian sociocultural contexts, hierarchical respect toward healthcare providers is deeply embedded.

While deference may indicate trust, it does not necessarily guarantee comprehension. Patients may comply verbally while still experiencing uncertainty. Aremu et al. (2022) emphasize that medication adherence improves when patients feel comfortable expressing doubts and seeking clarification. Therefore, linguistic compliance should not be interpreted as communicative success without deeper examination.

CDA highlights how everyday language reproduces institutional power structures. In this study, the combination of directive modality, technical vocabulary, and deferential patient responses reflects a hierarchical communicative model shaped by both institutional and cultural forces.

The findings have important implications for pharmacy education. While biomedical knowledge remains central to professional training, communicative competence must be equally emphasized. Communication is not merely a soft skill but a professional competency that directly affects patient outcomes.

Educational programs should incorporate discourse awareness into curricula. Training that focuses on plain language use, open-ended questioning, and collaborative framing can help future pharmacists balance authority with patient participation. Street et al. (2020) demonstrate that communication skills training improves patient satisfaction and adherence outcomes. Moreover, reflective practice exercises—such as analyzing transcripts of consultations—can help students recognize how modality and lexical choices influence power dynamics. By developing awareness of how language constructs professional identity, pharmacy education can foster more patient-centered communicative practices.

Overall, the discussion indicates that, for pharmacists, several interconnected discourse patterns characterize patient interactions in this study. The frequent use of specialized medical terminology reinforces knowledge asymmetry, positioning the pharmacist as the primary holder of expertise while implicitly limiting patient comprehension. The consistent use of deontic modality constructs obligation, framing medication instructions as authoritative directives rather than negotiated decisions. In addition, the predominance of closed-ended questioning restricts patient elaboration and maintains conversational control within the pharmacist's domain. Interactional structures are further shaped by institutional routines that prioritize efficiency and procedural clarity, resulting in a predictable consultation format. Finally, cultural norms surrounding respect for healthcare professionals reinforce patient deference, as patients often respond with compliance-oriented and mitigating expressions. Together, these elements create a hierarchical communicative model that supports professional authority but may constrain opportunities for collaborative dialogue and shared meaning-making. While effective in ensuring procedural clarity and professional accountability, this model may limit collaborative engagement.

Future research could expand the dataset across multiple pharmacy settings or incorporate multimodal analysis to explore how tone, gesture, and spatial organization further influence communicative power. Strengthening discourse awareness in pharmacy education may contribute to more equitable and dialogical healthcare interactions.

Conclusion

This study applied Critical Discourse Analysis (CDA) to examine how utterances in pharmacist–patient consultations construct professional authority and influence patient participation. The findings reveal that linguistic features such as medical terminology, deontic modality, and closed-ended questioning contribute to hierarchical communication patterns in community pharmacy settings.

At the textual level, the use of technical terms without simplified explanation reinforces knowledge asymmetry between pharmacists and patients. Directive expressions, including modal verbs such as "must" and imperative constructions, position the pharmacist as the authoritative expert responsible for decision-making. At the discursive level, pharmacists largely control topic development and questioning formats, while patients frequently respond with brief confirmations or deferential language. These patterns reflect institutional norms and sociocultural expectations that emphasize respect for healthcare professionals.

While professional authority is essential for ensuring patient safety, its linguistic expression may limit opportunities for shared decision-making. Therefore, balancing clarity of instruction with dialogical engagement is crucial.

From an educational standpoint, the study highlights the importance of integrating discourse awareness and patient-centered communication strategies into pharmacy curricula. Strengthening communicative competence alongside biomedical expertise can promote more collaborative and equitable healthcare interactions. Future research involving larger datasets and diverse contexts is recommended to further explore discourse and power dynamics in pharmacy practice.

Disclosure Statement

No potential conflict of interest was reported by the authors.

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