



The Discursive Contestation of Care: A Critical Analysis of Medical Communication, Power, and Ethics in Heart of a Child

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Abstract: This study examines how medical communication constructs and contests institutional power in the 1994 film *Heart of a Child*. Drawing on Fairclough's Critical Discourse Analysis (CDA), Bakhtin's heteroglossia, Deborah Tannen's report-talk/rapport-talk distinction, and Speech Act Theory (Austin; Searle), the analysis demonstrates that clinicians enact authority through specialized lexis, high epistemic modality, and procedural management of turn-taking and information flow. In contrast, parental discourse operates as a centrifugal counter-voice that reframes diagnosis through grief narratives, relational meaning, and ethical deliberation. The findings further show that while parents perform commissive speech acts expressing moral agency, institutional actors retain interactional and procedural dominance by ratifying decisions through directives and confirmation routines. These patterns highlight the tension between medical paternalism and patient autonomy and suggest that shared decision-making requires not only accurate information delivery but also discursive space, interactional responsiveness, and recognition of emotional meaning-making in high-stakes prenatal and end-of-life care.

Keywords: *critical discourse analysis, doctor-patient communication, institutional discourse, shared decision-making, speech act theory*

INTRODUCTION

Medical communication is not a neutral transfer of facts. In clinical encounters, institutional authority, professional knowledge, and patient vulnerability are negotiated through interaction. This becomes especially consequential in high-stakes settings, such as prenatal diagnosis, terminal prognosis, and end-of-life decisions, where medical talk is inseparable from ethical responsibility and emotional suffering.

A recurring phenomenon in these encounters is interactional asymmetry: clinicians often

control the pace, vocabulary, and structure of consultations, while patients and families struggle to secure discursive space for fear, grief, and moral reasoning. Even where patient-centered care is promoted, families can still experience communication as directive, informational, and procedurally constrained—limiting practical autonomy.

Research on shared decision-making emphasizes that autonomy is not achieved merely by providing options; it depends on how options are interactionally offered, understood, and taken

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up (Elwyn et al., 2017). Conversation-analytic research in maternity care likewise shows that “offering information and options” may occur in ways that reduce interaction and thereby weaken autonomy support in practice (Kors et al., 2022). In parallel, studies in perinatal medicine show that severe fetal anomalies and CHD carry significant risk and uncertainty, making counseling and communication ethically and emotionally high-stakes (Jepson et al., 2023; Wander et al., 2023; Young et al., 2024). These clinical realities intensify the importance of analyzing how discourse can either enable or restrict meaningful participation.

However, many studies focus on real consultations; fewer show an accessible way of how cultural texts represent and normalize these power relations. Fictional medical narratives can function as “discursive artifacts” that reflect and shape public understandings of medicine, authority, and ethical decision-making.

This study first addresses the problems of how medical professionals construct authority through linguistic strategies in the film. Secondly, it looks into how parents resist or negotiate medical authority through emotional discourse. The last one, investigates how ethical decisions are performed through speech acts, and where institutional power is located in decision-making sequences.

By integrating CDA, heteroglossia, rapport-talk/report-talk, and Speech Act Theory, this study contributes to healthcare discourse research by demonstrating that institutional power is not merely possessed but interactionally performed. It also clarifies how ethical decisions become “real” through procedural uptake rather than through intention alone. A point of ethical decisions are highlighted in the reviewer comments regarding relevant speech-act classification.

This study integrates four complementary lenses to capture macro-power and micro-interaction, they are Critical Discourse Analysis (CDA) by Fairclough, Bakhtin’s heteroglossia

Rapport-talk and report-talk by Tannen and Speech Act Theory by Austin and Searle.

The first complementary lenses, CDA treats discourse as social practice in which power relations are reproduced and contested through modality, lexical selection, presupposition, and interactional control. In medical contexts, CDA helps explain how biomedical discourse becomes treated as legitimate knowledge while experiential meanings are marginalized.

The next lenses, heteroglossia emphasizes competing voices within discourse. Centripetal forces stabilize meaning (biomedical authority), while centrifugal forces diversify meaning (grief, morality, relational identity). This lens captures the struggle between clinical closure and parental meaning-making.

The third lenses are rapport-talk and report-talk. Report-talk prioritizes information exchange and problem-solving; rapport-talk prioritizes connection and emotional alignment. In high-stakes consultations, report-talk dominance can create emotional mismatch and perceived coldness.

The last lenses are Speech Act, which performs actions (assertives, directives, commissives, expressives, declarations). Crucially, parents’ statements of willingness (e.g., donating organs) are commissives (intent/commitment), while institutional completion/authorization constitutes the declarative act that formalizes the decision—an issue explicitly raised by the reviewer

METHOD

Design of this study uses qualitative content analysis informed by discourse analysis to examine how language constructs authority, vulnerability, and ethical decision-making in *Heart of a Child* (1994). The film is treated as a cultural discourse artifact that reflects and shapes social understandings of medical interaction.

The data source is obtained from film dialogue (consultation and decision-making scenes). And



the instrument used is a scene-based analytic coding sheet developed from the theoretical framework, containing operational indicators for (a) CDA features (lexis, modality, turn control), (b) heteroglossic voicing (centripetal/centrifugal moves), (c) rapport/report talk markers, and (d) speech-act categories (assertive/directive/commissive/expressive/declarative).

The unit of analysis is the speaker turn (one continuous utterance by a speaker), grouped into interactional sequences (e.g., diagnosis delivery; parental response; institutional confirmation).

The procedure of data collection and coding is first by using scene selection. The scenes involve prenatal screening, fetal diagnosis, prognosis delivery, and organ-donation deliberation were purposively selected because they contain high-density authority and ethical stakes. The second procedure is transcription/verification, where dialogue was transcribed/checked against the film for accuracy. The third procedure is coding, where each turn was coded for Role: clinician / parent / institutional representative, Function: diagnosis / recommendation / refusal / reassurance / consent / confirmation. Linguistic markers: specialized lexis, hedging vs certainty, directives, repetition, metaphors, Emotional orientation: neutral/clinical vs grief/connection seeking, and Speech act type: assertive, directive, commissive, expressive, declarative

Analysis proceeded in three stages (matching the reviewer's requested outline). Stage 1 (CDA): identify linguistic forms and interactional structures that enact authority. Stage 2 (Sociolinguistics/interaction): interpret emotional and relational talk (rapport/report alignment). Stage 3 (Heteroglossia and Speech acts): analyze competing voices and the performative ratification of decisions.

Trustworthiness was supported through: (a) theory-based coding definitions, (b) cross-checking extracts against scene context, and (c) triangulation (interpreting key extracts through at least two frameworks).

FINDING AND DISCUSSION

Research Findings

The results and discussion are organized by how clinicians construct authority (Stage 1: CDA), how parents resist and make meaning (Stage 2: sociolinguistics/rapport-report), and by how ethical decisions are performed and ratified (Stage 3: heteroglossia and speech acts).

In stage 1, clinicians enact authority through specialized lexis (medical terms that restrict interpretive access), high epistemic modality ("will," "cannot," categorical declaratives) that frames prognosis as fixed and procedural interactional control (long turns, topic control, timing of disclosure)

These features align with CDA's claim that institutional power is enacted through the distribution of speaking rights and the legitimation of professional knowledge.

Interpretation (why/how): The clinical register reduces ambiguity and organizes action, but it also narrows discursive space for parental meaning-making. In high-stakes contexts, this can unintentionally reproduce paternalism even when clinicians aim to be helpful.

In stage 2, parents respond with discourse that foregrounds, such as relational identity (the child as a person within family life), grief narrative (repetition, parallelism, future-loss projections), and requests for empathy (rhetorical questions seeking alignment)

This discourse operates as rapport-talk, which seeks emotional recognition and relational coherence. When clinicians maintain report-talk, interactional mismatch emerges.

Interpretation (why/how): In ethically traumatic settings, parental talk functions as emotional labor—re-humanizing the child and restoring agency amid biomedical closure. This aligns with maternity consultation research showing that autonomy support depends not only on "options" but on interactional responsiveness (Kors et al., 2022).

In stage 3, ethical decisions unfold as a sequence of speech acts: first parents produce commissives (commitment/intention: donate; continue; protect). Next, institutions produce directives and confirmations ("Are you sure?" "Confirm again") that convert moral intention into procedural validity, and the final institutional act functions as declarative ratification (formal authorization), not the parents' original statement—correcting the common misclassification noted in the reviewer comments.

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This shows that autonomy is structurally constrained: parents can speak ethically, but institutions control uptake and implementation. This matches SDM scholarship emphasizing that choice becomes meaningful only when interaction enables deliberation and agency (Elwyn et al., 2017).

By reading Table 1. Discursive Contestation of Care in Key Medical Encounters, we can get the big pictures of how the writer analyze and discuss the medical encounters more clearly and easily.

The table demonstrates that (1) clinicians centralize meaning through technical lexis and certainty, (2) parents decentralize meaning through grief and relational voice, and (3) institutions retain final power through confirmation/ratification sequences. Thus, power is enacted through discourse structure, not merely through professional status as shown in table 1. Discursive Contestation of Care in Key Medical Encounters below:

Table 1. Discursive Contestation of Care in Key Medical Encounters.

Scene (Timestamp)	Representative Excerpt	Primary Lens	Discursive Function	Interpretive Claim
3:40–4:13	“Because of your age... amnioentesis is advisable.”	CDA	Risk framing; epistemic authority	Expertise becomes the legitimate frame for action.
18:36–19:20	“Your baby has... anencephaly... she will die...”	CDA	Categorical modality; closure	Certainty restricts deliberation and alternative meanings.
20:04–20:17	“She’s never going to know us... hear her laugh.”	Tannen and Bakhtin	Rapport-talk; centrifugal voice	Relational grief resists biomedical reduction.
31:20–31:40	“Maybe... donate... part of her would still live.”	Bakhtin	Narrative reframing	Loss is re-storied as moral continuity.
1:15:11–1:15:36	“Are you absolutely positive?” / “No question...”	Speech acts	Confirmation; institutional uptake	Decisions become “real” through ratification routines.

CONCLUSION

This study shows that Heart of a Child represents medical encounters as discursive struggles in which institutional biomedical authority and familial emotional meaning-making compete for interpretive control. Clinicians enact authority through specialized lexis, categorical modality, and procedural control of interaction. Parents respond with a centrifugal counter-voice—rapport-talk and grief narratives that resist biomedical reduction and reassert relational meaning.

Importantly, ethical decision-making is revealed as performative: parents’ commissive commitments require institutional uptake and

ratification to become procedurally real. This helps explain why shared decision-making cannot be reduced to information provision alone. Instead, SDM requires interactional conditions that support deliberation: discursive space, responsiveness to emotional meaning, and recognition that “choice” is co-produced through talk, not simply offered as a menu.

The implications of this study are for practice and education, the findings support training that integrates discourse sensitivity with clinical expertise, especially for prenatal counseling and end-of-life decisions where vulnerability and moral stakes are high.



However, there are some limitations, because the study analyzes a fictional film rather than real clinical transcripts although the film is based on true story. While the dialogue plausibly represents medical interaction and is useful as a cultural discourse artifact, it is shaped by narrative conventions and cannot be generalized directly to practice. Future research should apply the same coding framework to authentic prenatal counseling or neonatal end-of-life consultations to test transferability.

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