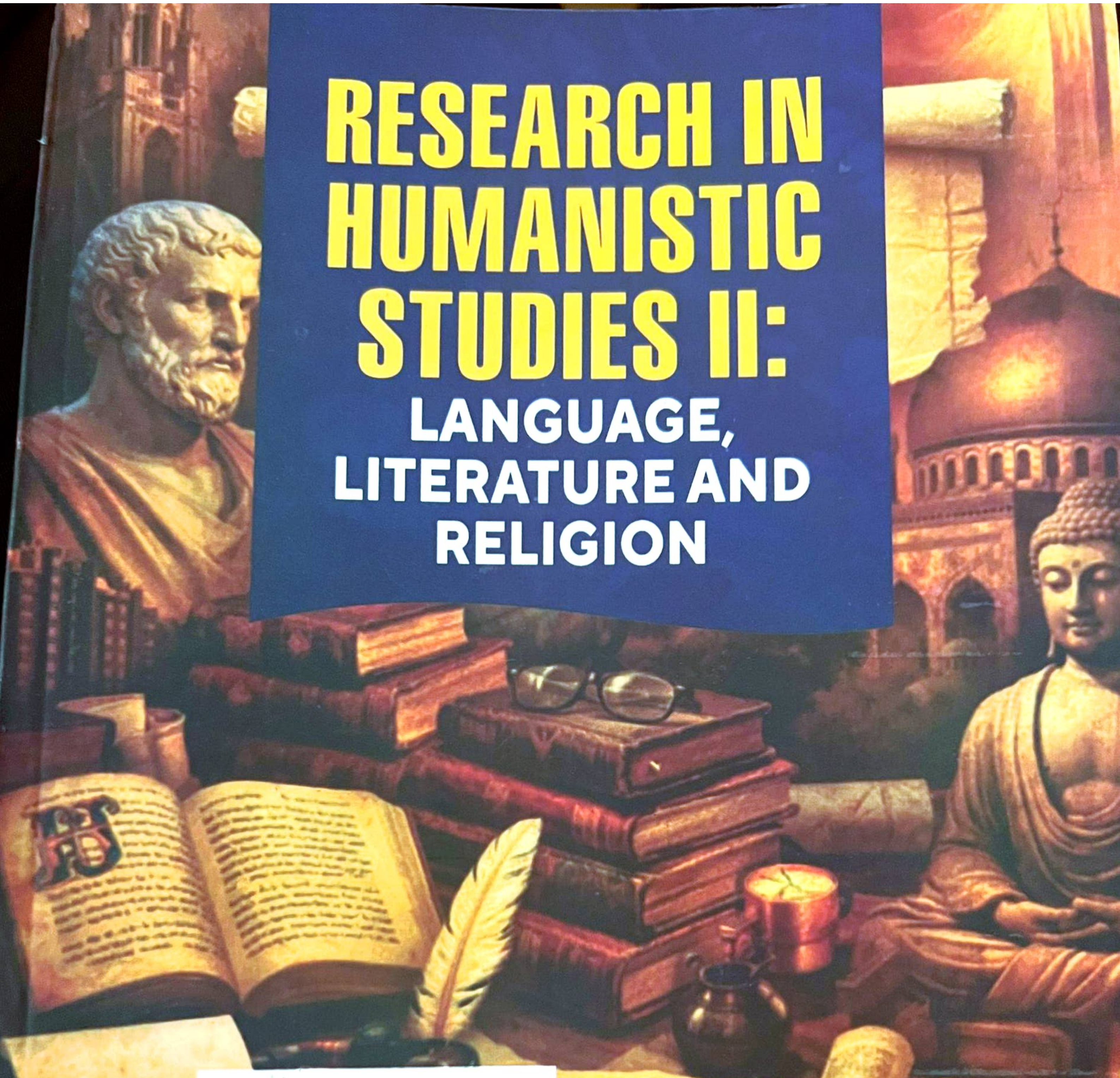

RESEARCH IN HUMANISTIC STUDIES II:

LANGUAGE, LITERATURE AND RELIGION

EDITED BY:

- Oluwole Oyetade
- Akin Odebunmi
- Ademola Ajayi
- Rasheed Olaniyi
- Ayo Osisanwo

ACKNOWLEDGEMENTS

Following the successful conclusion of the well-attended 5th Biennial International Conference of the Faculty of Arts, University of Ibadan, held in July 2025 with a focus on new research perspectives in the humanities and on humanistic development in Africa, Professor Oluwole Oyetade, the conference convener, proposed the idea of publishing selected papers. However, as the intention was not to produce conventional conference proceedings, a view shared by the participants too, given a book's professional advantage over a conference proceedings publication, paper presenters were informed in advance and prepared for a rigorous selection process. They were requested to revise their papers in line with the critical feedback received during their presentations. Subsequently, one hundred and fifty-two revised papers were submitted for peer review. These submissions underwent a thorough and demanding review process, with several papers requiring two or three rounds of revision to meet the expected scholarly standards. Ultimately, one hundred papers were accepted for publication, while the remaining submissions were either rejected or excluded because their revised versions were not submitted. The accepted papers constitute the chapters of these three book volumes: *Research in Humanistic Studies I: Humanities, Social Media and Artificial Intelligence; Research in Humanistic Studies II: Language, Literature and Religion; and Research in Humanistic Studies III: Discourse, Culture and Society.*

We, the editors, congratulate the scholars whose contributions appear in the three book volumes. We are grateful to the reviewers for the expertise that ensured the quality of the volumes through careful assessment and constructive feedback. We are equally grateful to the Faculty of Arts for offering us the role that enabled us to provide the huge editorial service.

Finally, we acknowledge with gratitude the benefaction of several personalities in Nigeria and the diaspora, which significantly facilitated the production of this publication. Above all, we give thanks to God Almighty for supporting the publication process.

Oluwole Oyetade
Akin Odebunmi
Ademola Ajayi
Rasheed Olaniyi
Ayo Osisanwo

37

POWER, PERCEPTION, AND PRACTICE: THE DYNAMICS OF MEDICAL ENCOUNTERS BETWEEN PATIENTS AND MEDICAL PERSONNEL

Nifemi ORIMABUYAKU

Abstract

Medical encounters extend beyond clinical procedures and are embedded in cultural meanings, power dynamics, and lived experiences. However, limited attention has been given to how these power asymmetries shape patient–provider interactions across different healthcare contexts. This study investigates how interpersonal, institutional, and sociocultural forces influence diagnosis, treatment, and the overall experience of care. Using qualitative textual analysis grounded in Linda and Ezekiel Emmanuel's doctor–patient interaction models and Kekeghe's pathotextualism, the article examines Rowing Without Oars by Ulla-Carin Lindquist and Burning Bright by Maryam Awaisu. Findings show that medical practice is sustained not only by clinical expertise but also by relational sensitivity, narrative awareness, and contextual understanding. The study concludes that integrating empathy, cultural literacy, and narrative competence into medical training is vital for reshaping power relations and fostering more humane, patient-centred care.

Keywords: medical encounters, power, narrative medicine, pathotextualism, patient-centred care.

1. Introduction

Medical encounters are formal interactions between medical personnel and patients to give medical advice or follow up on previous care. Filc (2006) describes the medical encounter as a place where doctors and patients collaborate in a way that is functional to the social order. On the other hand, he also asserts that the medical encounter is a place where patients are subordinated to physicians' domination. Schattner (2014) argues that several factors contribute to the suboptimal performance of the healthcare system, and the patient-physician encounter is the pivotal starting point for all subsequent events. Ong et al. (1995) argue that among different interpersonal relationships, the doctor-patient relationship is one of the most complex. He explains that the interactions between individuals in a medical encounter or patient-physician relationship involve binary oppositions, such as non-equal positions, which are often non-voluntary. Also, they concern issues of utmost importance, which are emotionally laden and require close cooperation. Although in the business parlance, service receivers have more rights than service providers, the same cannot be said of the healthcare sector. McLellan (1996) asserts that patients and physicians often disagree on treatments and interventions, even when they share the same goal in mind; they may differ on the best routes to achieve the best outcome. Interventions and treatments that seem routine to a surgeon might be unacceptable risks to a patient for various reasons, such as occupation, religious, and cultural beliefs. For instance, an artist might not agree to certain interventions or treatments based on their profession and might seek an alternative in this regard. This suggests a lack of interpersonal communication in the dyadic relationship between the physician and the patient. The World Health Organisation (WHO) in 2013 recognised that to ensure patient satisfaction, doctors need to have and spend enough time with their patients, as this is an essential tool for the success of any healthcare delivery.

Berger et al. (2020) assert that many patient complaints are not rooted in the medical expertise of healthcare providers but rather in poor communication. Frequently, patients express dissatisfaction with physicians who appear inattentive to their concerns. They seek clearer explanations about their conditions and treatment options, desire more information on potential side effects, and want guidance on self-care. Above all, patients increasingly wish to be active participants in their healing process. Medical encounters are now viewed as clinical transactions where profit is the sole gain, alongside a commensurate decline in patient satisfaction; however, in the Hippocratic Oath, which is a foundation for several other oath that binds the ethical considerations of the profession and spells out the practice of the medical profession, the patient is presented as the most important element in medical practise (Omobowale, 2003). While the patients have autonomy rights, which is the primacy of individual choice, the ethics of the medical profession bestows the doctor with beneficence, which is to act in the patient's best interest when it comes to the patient's physical, emotional, and spiritual well-being, whilst seeking adequate advice from his colleagues and other professionals when lacking sufficient knowledge (Omobowale, 2003).

The interaction in the clinical setting is significant because it sets the tone for other processes, and it's the ubiquitous starting point for every other process; however, it is largely susceptible to many process breakdowns (Schattner, 2014). Piemonte opines that a physician cannot come to know the patient's specific ailment as it is, but only as it appears through the interpretation of both the patient and physician. However, there are exceptions on some occasions, for example, in the case of an emergency. Svenaus also helps us to see that a clinical encounter is not simply an opportunity to come together and exchange information; rather, it is the coming together of two separate interpretative horizons of scientific medical knowledge and the lived experience of illness to create a mutual understanding that contributes to the health of the patients. This is because the narrative interpretation (hermeneutics) of a patient's experiences, in all shades, is integral to ensuring favourable health outcomes.

In clinical reality, we often see the paternalistic approach, where the physician asserts power over the patients, which hinders the effective interpretation of the ailment or disease. Clark et al argue that the common theoretical models of preferred decision-making relationships do not correspond well with clinical experience. He analysed how physicians treat patients outside their family's context, and usually, patients do not want to make decisions alone. This submission aligns with Farhat Moazam's article titled "Families, Patients and Physicians in Medical Decision-making: A Pakistani Perspective" (2000), Omobowale's The Therapeutic Relationship: A Critical Appraisal (2003) and that culture is intrinsic to the personality of a person and taking care of patients from cultures other than one's own can be challenging and time consuming.

however the time spent in developing a trusting relationship that fosters clear communication and understanding may be more than recouped by the avoidance of conflicts or easier resolution of treatment dilemmas.

2. Theoretical Framework

This study is grounded in the established doctor-patient interaction models as propounded by Ezekiel and Linda Emanuel, as well as Kekeghe's Pathotextualism. The doctor-patient interaction is fundamental to understanding ethical principles in medical practice. We trace the evolution of the doctor-patient interaction model to illuminate the shifting emphasis from physician authority to shared decision-making. In 1972, Robert Veatch's seminal work introduced four foundational models of the doctor-patient relationship: the priestly, engineering, collegial, and contractual models. Veatch advocated for a shift away from the paternalistic (priestly) approach, where the physician unilaterally dictates treatment, towards a more contractual relationship. This contractual model emphasises a patient-centred approach that seeks to balance patient autonomy with the physician's medical expertise.

Building upon Veatch's contributions, Ezekiel Emanuel and Linda Emanuel (1992) later proposed an alternative, more refined typology of doctor-patient relationships, which will be adopted as the primary framework for this study. Their models include the paternalistic, informative, interpretive, and deliberative models. The paternalistic model, also known as the parental or priestly model, characterises a relationship where the physician exerts authority based on their medical expertise and knowledge of the patient's condition. In this model, the physician solely determines what is in the patient's best interest, with the patient having limited participation in decision-making. Th underlying assumption is that the patient will ultimately be grateful for the physician' choices, even if they would not have initially agreed (Emanuel and Emanuel, 1992). I contrast, the informative model (also referred to as the scientific, engineering, o consumer model) posits a system where the physician's primary role is to relay a necessary and relevant medical information to the patient. The patient the independently selects the most suitable medical intervention based on this information The interpretive model moves beyond mere information transfer, aiming to elucida the patient's values and preferences. The physician assists the patient in understandi these values and then helps them select medical interventions that align with and real these personal values. Finally, the deliberative model represents the most advan form of shared decision-making within this framework. The deliberative mode essentially rooted in the Hippocratic Oath, and the model's objective is to assist patient in discerning and articulating the best health-related values that are achieva within their specific clinical situation. Crucially, this model stresses the importanc persuading the patient to accept the physician's recommended treatment, diffe significantly from the paternalistic model, where the physician imposes their ch This persuasion, however, is rooted in a collaborative exploration of values and opt fostering a more engaged and autonomous patient. In Lindquist's Rowing Without and Awaisu's Burning Bright, there are myriad patient-doctor interactions highlight a poor therapeutic relationship between the patient and the caregiver, from the diagnostic encounters to the stage of treatment. This aligns with Michel Foucault's concept of medical gaze, which was primarily developed in his 1973 book, "The Birth of the Clinic", where he described how doctors fit and modify a patient's story into a biomedical paradigm, filtering out non-biomedical material (Misselbrook 2013). Foucault describes how doctors are trained to be doctor-oriented, not patient-oriented, given that medicine inadvertently creates an abusive power structure (Misselbrook, 2013). He opines that medical education has prioritised biomedicine at the expense of a comprehensive understanding of the patient as an individual. He challenged the medical tribe mentality, where healthcare professionals tend to dominate interactions rather than engage in collaboration. He went further to assert, "We control, stick people into appointment slots, strand them in waiting rooms, and talk above their heads.". All these are features of unprofessionalism which contradict the Hippocratic oath and inadvertently affect the success of medical encounters.

Kekeghe's Pathotextualism is a critical and evolving approach that employs the interplay of literature and analysis of disease documented in literary texts in understanding patients' narratives of illness. It is an evolving approach that emphasises the intersection between literature and medicine (2020:54). Schioldann (2003) asserts that the term pathography was first used by the German psychiatrist, Paul Julius Mobius, in 1899, and it was associated with insanity and mental health narratives. He also affirmed that,

> Pathography is also indispensable in assisting historians, political scientists and other groups in their quest for a better understanding of events where leaders or other "very important persons" have played a significant role, and where personality or illness, physical or mental, has been decisive, at times with far-reaching consequences for nations. (Schioldann, 2003).

This highlights that the term pathography encompasses both physical and mental health conditions. Moreso, over the years, it has been referred to as the narrative of a patient's health condition from the auto/biographical perspectives (Kekeghe, 2021). In Kekeghe's development of this framework, he first applied it to the analysis of medical episodes in selected folktales of the Urhobo people of Western Delta in Nigeria. He illustrates:

> The term 'patho' is an offshoot of a Greek word, 'pathos', which denotes suffering or disease. In other words, 'patho 'or' pathy 'simply indicates illness or disease, while pathology is the scientific study of the nature, causes and manifestations of diseases. 'Text', on the other hand, indicates creative or literary works. 'Pathotext', therefore, suggests literary texts that explore Illnesses and diseases (Kekeghe, 2020:436).

3. A Synopsis of Rowing Without Oars and Burning Bright

Rowing Without Oars is a memoir written by Ulla-Carin Lindquist, a Swedish journalist, after being diagnosed with Amyotrophic Lateral Sclerosis (ALS). Knowing her illness is terminal, she documents her physical decline, emotional journey, and reflections on life, death, and dignity. The memoir offers a raw and intimate look into the experience of dying, capturing the tension between medical routines and the human need for connection and meaning. Lindquist critiques the often impersonal nature of clinical care while affirming the value of empathy, family support, and narrative voice. It is both a personal farewell and a call for more compassionate end-of-life care.

Burning Bright by Maryam Awaisu is a novel that delves into the challenging realities of living with sickle cell anaemia, particularly within the Nigerian context. The story centres on Nadia, a young woman navigating the physical pain, social stigma, and emotional toll associated with the genetic blood disorder. The narrative vividly portrays Nadia's struggles with recurrent pain crises, hospitalisations, and the constant threat of complications. Beyond the medical aspects, the novel explores the broader societal impact of sickle cell, including the misconceptions and discrimination faced by individuals with the condition. Nadia's journey is marked by her determination to live a full life despite her illness, pursuing education, friendships, and even romance, often against the backdrop of well-meaning but sometimes stifling family concern and societal prejudice.

4. When Words Heal or Harm: Communication as a Site of Power in Healthcare

Significant developments have been recorded in the historical evolution of medical encounters, regionally and globally, most especially since World War II. There has been increased information access, patient-centred care has emerged, coupled with the awareness of shared decision-making between both the physician and the doctor, emphasis on professional intercollaboration, advancement of patients' rights and the use of demographics in medical examination, diagnostic and analysis (Alea, 2021). Alea asserts that, among other things, the advent of the internet and the digital age, the media, high-profile scandals, the rise of cosmetic surgery, litigation, and, very recently, COVID-19 have contributed to the patient-doctor relationship. However, with some of the positive advancements come challenges, such as the media and the growing mistrust of doctors, which have somewhat contributed to the adverse impact on the patient-doctor relationship. In addition, media-led health scares eliciting contradictory medical advice have raised further concerns amongst patients about whether they can trust thei doctors. In all of these, Alea (2021) highlighted that

> Empathic, clear communication is seen by patients as an indicator of competence and skill. Poor communication is often the differentiating factor between those doctors who are sued and those who are not. Telemedicine relies heavily on communication, which is impaired by loss of verbal cues, non-verbal cues and impatience.

Alea's position above emphasises the significance of communication, both physically and even in telemedicine. One of Hippocrates' popular quotes is "wherever the art of medicine is loved, there is also a love of humanity." This quote brings to the fore not just the importance of the technical expertise of the physician but also empathy and compassion, which are necessary requisites in caregiving. Lindquist, on her fiftieth birthday, went to see the neurophysiologist and was curious to know what her result was, to which the physician replied

> 'It's not my business to give you an answer, replies the neurophysiologist, hesitantly. 'Your neurologist should tell you .'But I know it is ALS.' Do you really want to know?' Perhaps not, I say doubtfully, it's my fiftieth birthday and I'm having a party. Oh. What a bloody fiftieth birthday present. You mean it is ALS. Yes, or a strange kind of Parkinson's (27)

This conversation between Lindquist and the physician adversely defeats the humanist model of the Hippocratic Oath. It rather affirms the paternalistic or informative model of the patient-doctor relationship where the doctor stands as a father or a priest to the patient and uses his/her skill to inform patients about their medical state and necessary interventions without any form of empathy in the communication process. This also highlights a deficiency in the training of the medical doctor, which rids him of the necessary empathy needed to engage with the patient and educate her through the course of the illness. It corroborates Michel Foucault's medical gaze because the physician was just seeing the disease, not the person in question. It objectifies the patient's condition and makes her feel unsafe for further deliberations, conversation or communication, thereby harming her self-esteem and further stigmatising the patient. The unprofessional communication also underscores a breach of the ethics of medicine. In a diagnostic process, emotions are usually heightened, particularly on the part of the patient who awaits a result based on their health, and the result has the tendency to affect several other things in their lives. The doctor may also experience strain, who most likely has been working long shifts or extended calls for most of the day; this makes the diagnostic process essentially complex. However, these challenges do not undermine the imperative for a patient-centred approach. This is because the essence of medical practice lies in the treatment of the patient, and without the sick, the medical profession holds no relevance. Kekeghe (2021) asserts that the patient is the basis of medical practice; therefore, the activities of physicians and healthcare providers should lean towards providing care that is instrumental to the wholeness of the patients and humanity generally.

In *Burning Bright,* Nadia, the protagonist, regains consciousness to the sensation of someone tying something around her arm, and alas, it was the nurse. The nurse went on to poke Nadia with a thermometer, and when Nadia turned around, the nurse nodded to her that she should put the thermometer in her armpit. This interaction, devoid of explanation or empathy, reflects an inhumane and paternalistic approach to patient care. It underscores how power plays in medical encounters are communicated not only through words but also through nonverbal action. As Vogel 2018 opines, verbal as well as non-verbal communication and empathy play an important role in patient-physician encounters. Also, good communication in consultation is important to both patients and doctors and is seen as a marker of quality (Pawlikowska, 2012) Bensing et al. in their research study titled "Patient anxiety in the medical encounter: A study of verbal and nonverbal communication in general practice (2008)" found out that General Practitioners can facilitate patients to express their concerns more openly, not by direct questioning, but by showing verbal and nonverbal affect to the patient. This also agrees with a 2012 study by Pawlikowska et al. titled Verbal and non-verbal behaviour of doctors and patients in primary care consultations - How this relates to patient enablement, which concluded that consultations should be patient-centred, and doctors should facilitate socio-emotional interchange.

Another major aspect of power perception in medical practice is language barriers and medical jargon. The medical profession, just like many other fields of study, has terms that are peculiar to the field, and the adoption of these terms when communicating with an ill person or their family without an in-depth explanation always puts the patient or the caregiver in a state of confusion, while worsening their present condition instead of offering respite. According to Allen et al. (2023), in a study that worked on people's preferences on how clinicians communicate and why patients think they use jargon, findings showed that in a large sample of the general public, over 90% of respondents preferred the doctor who used jargon-free language. The respondents refer to them as a good communicator, caring, approachable, thorough and taking the problem seriously, and participants perceived the jargon-using doctor more negatively, describing them as cold, condescending, and difficult to understand.

Nadia just had a hip replacement surgery, and while going through the recovery phase in the hospital, a team of doctors came to her room to ask how she was faring. As a narrator, in her fragmented thoughts, she does not appreciate the rudeness and insensitivity of the doctors, and to further worsen the situation, they all talk over her head as if she weren't the one they were cross-examining. She narrates,

> Dr Samuel looked at the other doctors, "I think she is ready." They all nodded in agreement. Nadia just sat there, wondering what she was ready for… "Let's have him work with her today," Dr Samuel said to the team. They nodded and started filing out, to her bemusement. Eat well and rest", he added, addressing her this time… "Excuse me!" She shouted it before she could even help herself. They all paused, most of them already out of the door, "Who's working with me on what and why?" (14-15)

While the scene described above is not explicitly the outrageous display of medical terms and jargon to a patient who cares less, rather wants to, in plain terms, have an understanding of what is going on with his or her health, withholding salient information and talking over the heads of patients like they don't matter contribute significantly to barriers in the communication process. The doctors came to assess if Nadia was ready for her physiotherapy sessions. This kind of session requires mental preparedness; if a patient isn't prepared mentally for this, it could harm the process. What could be achieved in a short while might take a longer process and even limit the physiotherapist from delivering optimal results. Scholars and researchers alike have identified psychological factors such as anxiety, stress or lack of confidence as elements of language barriers. However, overconfidence on the part of the physician is also a significant psychological factor that disrupts communication processes in medical encounters, thereby enforcing the paternalistic model. The physician usually sees him or herself as a father figure who does not need to explicitly divulge all necessary information to the patient. Given the fact that the patient should automatically trust the doctor's decision, this often hampers the medical process and asserts power on the part of the physician. However, a part of the Geneva Declaration, a modern update to the Hippocratic Oath as amended last October 2017, states that "I WILL SHARE my medical knowledge for the benefit of the patient and the advancement of healthcare".

This shows that withholding information from patients, even when the physician knows better, is not in the best interest of what the medical profession stands for, nor the patient. This automatically leads to a breakdown in the communication process, and not every patient has the will like Nadia to request what is being discussed about, thereby preventing patients from actively participating in their healthcare decisions and further enforcing the paternalistic model in medical encounters. Meanwhile, after surviving the excruciating pain that comes with hip replacement surgery, Nadia was waiting to be discharged, but she found herself in another series of acute pain that led to her being unconscious and, finally, a coma that lasted for about four days. Nadia's coma was precipitated by septicemia arising from hospital-acquired pneumonia, a condition that she developed due to inadequate precautionary measures during her recovery. Notably, the attending physician failed to communicate this development to Nadia's parents until her father initiated the conversation. Lindquist, in her own experiences, concludes that

> This is exactly what I need: touch, comfort, and to feel trust. A maxim coined by Hippocrates, the father of medicine, instructs: 'seldom cure, often ease and always comforts.' The medical profession today often cures, often eases, but what about comfort?... I meet many comforters, among those whom doctors call 'auxiliaries. (95)

This creates a vacuum and reiterates a gap in the healing process of the patient. Sociologists argue that trust only exists when there is a deficit in knowledge by the person needing to trust, such as patients and clients (Ward, 2017). Trust is essential in situations like this because the patient has no detailed knowledge of the field being discussed, and it is an important part of the patient's journey to wellness. Trust also allows patients to feel comfortable discussing their health concerns openly and honestly, which can lead to better health outcomes (Souvatzi, 2024).

Lindquist met Nurse Margaretha and asked her, "Who's your typical patient?" and she replied

> Well-educated, highly intelligent, with great integrity. Seldom overweight or careless with themselves. Often sporty. Eighty per cent of my patients are what one usually calls type-A individuals. They are high achievers with integrity who make huge demands on themselves. (48)

Lindquist wrote that this made her feel proud even though she is terminally ill. She says, "I, who am terminally ill, am vain enough to feel proud" (48). The response above deconstructs the paternalistic, informative and interpretive model of the doctor-patient relationship while showing that empathy is not impossible in the health sector. In one of Lindquist's sessions in the hospital, she met her physician, Anne Zachau, and asked if she had a friend for her, someone like her who is in the same situation? She replies, "Not just at the moment. I haven't any other patient as bright and gifted as you". Lindquist replies, "Vanity allows me to feel flattered" (36). This compliment, in a way, made her feel safe and comfortable with the nurse. It was not so much about the compliment that was given, but a lot about the empathy, trust and understanding that Lindquist felt at that moment.

In addition, what communicates empathy sometimes is not just in conversations but also in the physical outlook and appearance of the hospitals where the patients are being attended to. Empathy can also be reflected in the structures in which the patients live and have consultations. The hospital space communicates and goes a long way in shaping care in medical practice. A calming and well-designed space promotes feelings of comfort and safety psychologically, while a disordered and melancholic-looking space projects feelings of detachment and worsens the condition of the patients. Natural light and nature-inspired elements, soothing colour, acoustic considerations to ameliorate noise pollution, which makes the environment quieter and restful, and an intuitive wayfinding contribute to the well-being of the patients. Lindquist mentions that

> The reception area for neurology at the Karolinska Hospital is run-down and gloomy. It looks dreadful. The patients' lavatory is often dirty and stinks of urine. It's a pity. As a patient, it affects me: the environment depresses me, makes me feel less valuable (132).

These sights remind the patients that they are less valuable, and this is not good for their psychological well-being. Nadia was thankful to God that her father was able to afford putting her in a single room, one because she is antisocial, but most importantly because she does not want to see people sick and vomiting, as this would stress her mind and bring up more sickness for her. A critical examination of the protagonists, Lindquist and Nadia, reveals that their encounters with medical practitioners significantly erode thei trust in medical authority. This erosion of trust, shaped by prior experiences, ha profound psychological implications that, in turn, affect their overall health and wel being.

5. Permission and Power: Rethinking Informed Consent in Medical Encounters

Informed consent and shared decision-making are both important ethical decisions in medical practice. While informed consent provides sufficient information and details about medical intervention to both the patient and the family/caregiver, shared decision making is the collaborative process where the physician and the patient deliberate on the best possible intervention to adopt in the situation. Informed consent includes relaying to the patients and caregivers, potential risks, benefits and alternatives based on the peculiarities of the patient's ailment, disease or challenges as against the previous experiences of the doctor. This is not to rule out previous experiences in diagnosis; however, it is to place more emphasis on the peculiarities of the patient's challenge. Bernat and McQuillen (2021) describe it as the optimal blending of physician expertise and patient choice. McNutt (2004) describes it metaphorically as a moving vehicle in which the patient serves as pilot and the physician as navigator, or as the process of locating the optimum balance between physician power and patient choice.

As against the paternalistic, informative and interpretive model, informed consent emphasises that the physician must convey adequate information to the patient, the patient's consent must be obtained freely and without coercion by individuals or agencies, and the patient must have the capacity to consent or refuse. Informed consent does not assert clinical transaction, coercion, or gain motives; rather, it places a premium on communication and disseminating adequate information. Researchers have identified two major extremes in the patient-relationship, one is the educated and assertive patient who seeks to take control, directing which tests and treatments should be pursued. Having read widely, such patients often possess considerable knowledge and firmly held views. In this case, the physician's role is largely that of an advisor and facilitator, supporting the patient's chosen course of action. On the other hand, there is another patient who may be clueless, too sickly and depends entirely on the physician's decision (Bernat and McQuillen, 2021). This oftentimes puts the physician in a state of dilemma; however, this is where Zbigniew Bankowski moves further beyond the core principles of health care ethics, which include autonomy, beneficence, competency, and power to saddle the physician with levels of moral responsibilities that physicians should exercise in making decisions for patients and preferences essential even in policy formation and operation. They include the physician as the patient's advocate, the physician as a technical expert, the physician as a citizen, the physician as a moral agent and the physician implementing health policies, all of which inform the decisions of the physicians and culminate in shared and collaborative decision making.

Lindquist was supposed to get a hole in her stomach in about a week, but it was moved forward to Tuesday because of the urgency of her health. This is a good decision made by the doctors; however, not informing the patient or involving her is not the best. This exacerbates the patient's psychological state. Lindquist says, “Why didn't they want to speak to me? Why didn't they tell me?, They thought I could…, her carer replied. “Bloody hell, no!, Lindquist added, “This was wrong of the doctors. I might be terminally ill and unable to express myself comprehensibly, but I have no problem in understanding. The doctor should have informed me, not my carer.” (138). Lindquist laments about the state of her health, she says,

> ALS has deprived me of the spoken word. My speech. The tool of my trade. Today, nobody has understood what I said. Fury. In my head, my thoughts are clearer than ever before. I hear my voice inside me. A melody and an intonation that were an important part of my job. But now my voice passes the larynx, the ALS filter, and only an inarticulate sound comes out. Like a braying donkey (73).

This highlights that while her physical body is not in the best shape to have the conversation with the medical doctors, her mind was, and the doctors who were taking care of her are aware. However, her speaking complexities could delay the deliberations; other structures could be put in place, but outrightly jumping the gun to communicate with her carer without a caveat of informing her to know if she agrees or not and then getting feedback was against the ethics of informed consent and the deliberative model of the doctor-patient physician even though the decision was important for the patient. Another similar case is that of Mrs Mattsson, Lindquist narrates that she is perhaps sixty, and she has severe diabetes. She says her toes have blackened and rotted because her blood circulation is poor. She emphasises that Mrs Mattson is blind, but her mind is completely clear, and one day, without Mrs Mattson's knowledge, her two legs were amputated. Linduist says, "She lies in bed and waves the stumps. She tries to reach her feet with her hands. Feet that are no longer there. And her blind eyes are crying". (108) Lindquist, in her experience, concludes that the intellect becomes keener at the same rate as the body declines, and this experience narrated by Lindquist highlights a profound breach of informed consent and shared decision-making. Mrs Mattson, though physically impaired and blind, retained full mental clarity, yet the decision to amputate her legs was made without her knowledge or participation. This exclusion underscores how medical authority can override patient autonomy, reducing the individual to a passive subject of intervention rather than an active participant in their care. The emotional aftermath of her futile attempts to reach absent feet and the grief expressed through her tears demonstrates the psychological harm that results when patients are denied agency in decisions that fundamentally alter their bodies and lives. Such an account illustrates the ethical imperative of ensuring that patients are not only informed but also actively engaged in the decision-making process regarding their treatment.

Lindquist requires personal home care, and she needs to write the reasons why she needs a carer and what she needs help with. A week later, a team of people who will decide her case if she will be getting a carer comes home to assess her, and they ask her, "How long does it take you to carry out different activities?" She replies, "How do you mean?" and they went on to question her, saying, "But I'm unable to get dressed." The assessor inquires further, "About how long?" "I really can't do it. Didn't you read the letter I wrote?" The alternating conversation went on between the assessors and Lindquist for a while, and Lindquist concluded that "It becomes clear that they want to make a show of their power". An individual grappling with illness should not be subjected to power struggles or the imposition of authority. Rather, such a person deserves to be met with care, empathy, and understanding.

Following Nadia's hip replacement surgery, a team of doctors led by Dr Samuel approached Nadia and determined that the physiotherapy session, which is usually done ten days post-surgery, could begin after only four days because of her quick recovery. However, although this decision was made in Nadia's presence, she was neither informed nor consulted. She remained unable to comprehend the discussion concerning her own health. While her clinical condition appeared adequate for an early start, the absence of direct communication or shared deliberation reflects a paternalistic approach. Engaging Nadia in conversation, preparing her for the process, and either involving her in the decision-making or awaiting her parents' participation would have constituted a more ethically sound strategy. Such an approach would not only align with the principles of the Hippocratic Oath but also resonate with the deliberative model of doctor–patient interaction, which emphasises dialogue, respect, and shared decision-making.

Other significant features that constitute power, perception and practice in medical encounters include patient compliance and resistance, navigating bad news and end-of-life conversations, influence of cultural beliefs on diagnosis, treatment, and healing, socioeconomic, racial, gender, and educational factors affecting power balance, amongst many others. Each of these features contributes to emotionally distant healthcare systems that foster clinical detachment and heighten the need for patients' agency

6. Conclusion

This study shows that medical encounters are shaped not only by clinical expertise but by power dynamics, cultural perceptions, and relational practice. While medical expertise, competence and technological advancement have contributed to medicine in no small measure, through the analysis of Burning Bright and Rowing Without Oars, it is evident that patients do not simply seek cures; rather, they seek to be seen, heard, and understood. Effective care, therefore, depends on more than diagnostics; it requires empathy, cultural competence, and communication skills that acknowledge the patient's humanity and lived experience. To improve the quality of patient-provider relationships, medical training must go beyond technical knowledge to include intentional development in empathy, cultural literacy, and narrative competence. A shift toward patient-centred care, improving the physical environment and physical space of a hospital, is integral in shaping medical reforms. Investing in narrative medicine and digital tools helps bridge communication gaps and restore patient agency in increasingly diverse and complex healthcare environments. Also, co-creating care with patients through shared decision making, acknowledging patients' lived experience. Mental stability and clarity should be recognised in cases where there are difficulties in speaking, and they should be directly involved in discussions about their health. Trauma-informed approaches could also be employed in critical contexts where stigma, inequality, or historical silences undermine trust in medical institutions. Ultimately, medicine can fulfil both its scientific promise and human obligations when these systemic investments and institutional reforms are put in place.

REFERENCES

Alea. 2021, March 3. "The patient will see you now – The evolution of the doctor-patient relationship." News. Retrieved August 11, 2025, from https://www.alea.com/en/blog/the-patient-will-see-you-now.

Allen, K.A., et al. 2023. "Jargon be gone – patient preference in doctor communication." Journal of Patient Experience, 10: 23743735231158942. https://doi.org/10.1177/23743735231158942. Accessed August 13, 2025.

Awaisu, Maryam. 2014. Burning Bright: A Novel About Surviving Sickle Cell Anaemia. Bloomington, IN: iUniverse.

Bankowski, Z. 1989. "Ethics and health." World Health, 2-6.

Bensing, J.M., et.al. 2008. "Patient anxiety in the medical encounter: A study of verbal and nonverbal communication in general practice." Health Education 108.5: 373-383.

Berger, Z.D., et al. 2020. "Covid-19: control measures must be equitable and inclusive." Bmj 368: 1-2.

Bernat, J.L., & Peterson, L.M. 2006. "Patient-centred informed consent in surgical practice." Arch Surg, 141: 86–92.

Bernat, J.L., & McQuillen, M.P. 2021. "On Shared Decision-making and Informed Consent." Neurology: Clinical Practice, 11(2): 93. https://doi.org/10.1212/CPJ.0000000000000823. Accessed August 20, 2025.

Clark, T., et.al 2025. Making healthcare decisions on behalf of people in a disorder of consciousness. A "Risk-Making" Theory of Decisional Practices. AJOB neuroscience: 1-17.

Emmanuel, E. J. and Emanuel, L. L. 1992. "Four models of the Patient-physician Relationship." Journal of the American Medical Association, vol. 267, no. 16, pp. 2221-2226.

Filc, D. 2006. "Power in the primary care medical encounter: Domination, resistance and alliances." Social Theory & Health, vol. 4, no. 3, 2006, pp. 221-243.

Institute of Medicine (US) Division of Health Sciences Policy. 1983. Medical education and societal needs: A planning report for the health professions. Washington (DC): National Academies Press (US).

Kekeghe, S.E. 2020. Narrating the Pandemic: Ethical Issues of Medicine in Nigerian COVID-19 Patient-Pathography. Issues in Language and Literary Studies: Vol 6 (1), 56-63.

Lindquist, Ulla-Carin. 2006. Rowing Without Oars: A Memoir of Living and Dying. New York: Viking.

McLellan, M. Faith. 1996. "Images of physicians in literature: from quacks to heroes." The Lancet 348.9025: 458-460.

McNutt, R. A. 2004. "Shared medical decision making: problems, process, progress." JAMA, vol. 292, no. 20, pp. 2516-2518.

Misselbrook, D. 2013. "Foucault." The British Journal of General Practice, 63(611): 312. https://doi.org/10.3399/bjgp13X668249. Accessed July 16, 2025.

Moazam, F. 2000. "Families, Patients and Physicians in Medical Decision-Making: A Pakistani Perspective." Hastings Centre Report, vol. 30, no. 6, pp. 28-37.

Omobowale, E. B. 2003. "The therapeutic relationship: A critical appraisal." Bio Quarterly, vol. 14, no. 2, pp. 12-14.

Ong, L.M.L., de Haes, J.C.J.M., Hoos, A.M., & Lammes, F.B. 1995. "Doctor-patient communication: A review of the literature." Social Science & Medicine, 40(7): 903–918. doi:10.1016/0277-9536(94)00155-m.

Pawlikowska, T., et al. 2012. "Verbal and non-verbal behaviour of doctors and patients in primary care consultations–How this relates to patient enablement." Patient education and counselling 86.1: 70-76.

Piemonte, N. 2017. "More to the story: how the medical humanities can learn from and enrich health communication studies." Review of communication 17.3: 137-148.

Schattner, A. 2014. "The clinical encounter revisited." The American Journal of Medicine, 127(4): 268-274. https://doi.org/10.1016/j.amjmed.2013.11.015. Accessed June 5, 2025.

Schioldann, J. A. 2003. "What is pathography?" Medical Journal of Australia, 178(6): 298-303. https://doi.org/10.5694/j.1326-5377.2003.tb05209.x. Accessed August 11, 2025.

Souvatzi, E. et al. 2024. "Trust in healthcare, medical mistrust, and health outcomes in times of health crisis: A narrative review." Societies, vol. 14, no. 12, p. 269.

Vogel, D., Marco M., and Sigrid H. 2018. "Verbal and non-verbal communication skills, including empathy during history taking of undergraduate medical students." BMC Medical Education 18.157: 1-10.

Ward, P.R. 2017. "Improving access to, use of, and outcomes from public health programs: The importance of building and maintaining trust with patients/clients." Frontiers in Public Health, 5: 22. https://doi.org/10.3389/fpubh.2017.00022. Accessed August 14, 2025.

World Health Organisation. 2013. Health System Performance Assessment: Care for People Living with Chronic Conditions. European Observatory on Health Systems and Policies Technical Report. Copenhagen: WHO Regional Office for Europe.