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From diagnosis to doubt: epistemic authority, patient questions, and the pragmatics of medical explanation in Indonesia

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ABSTRACT

Background: Diagnostic explanation in Indonesian healthcare discourse is shaped by asymmetrical expertise, patient uncertainty, institutional authority, and increasing reliance on public digital health information. **Objective:** This study examines how epistemic authority is constructed, questioned, and recalibrated through patient questions and medical explanations in Indonesian diagnostic discourse. **Method:** Using a qualitative corpus-assisted pragmatic design, this study analyzed 35 public Indonesian explanation sequences drawn from patient Q&A texts, verified health education materials, and contextual documents on patient rights, second opinion, medical records, and diagnostic accountability. **Results:** Diagnostic authority was most visibly organized through expert interpretation, procedural validation, institutional diagnostic pathways, test-mediated evidence, professional redirection, and rights-based accountability. Patient questions functioned not merely as requests for information but as pragmatic acts of clarification, confirmation, risk inquiry, procedural checking, second-opinion comparison, and reassurance seeking. Medical explanations managed uncertainty through terminological simplification, evidential grounding, referral, risk calibration, uncertainty acknowledgement, and legally or institutionally framed accountability. **Implication:** This study shows that diagnostic trust depends on whether clinical authority remains intelligible, answerable, and reviewable when patients voice doubt. **Novelty:** This study contributes a pragmatic model for analyzing diagnostic doubt as a structured form of epistemic participation rather than a failure of patient compliance.

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1. INTRODUCTION

In Indonesia, diagnostic explanation occurs within a health system where professional authority, limited consultation time, uneven health literacy, and digital health information increasingly meet in the same interactional space. A crucial social fact is that patients often approach diagnosis not only as a biomedical conclusion but also as a decision that must be interpreted, trusted, questioned, and sometimes compared with other sources. Indonesia recorded only 0.5 physicians per 1,000 people in 2023, indicating a clinical environment in which communicative efficiency and institutional hierarchy may strongly shape explanation practices. At the same time, online health information seeking has become a major part of patient knowledge formation; a review found that 83% of online health information consumers used general search engines to

find health information. These conditions make diagnostic doubt socially consequential: patient questions are not marginal interruptions, but pragmatic sites where medical authority, uncertainty, and participation are negotiated.

Recent scholarship has examined several adjacent dimensions of medical communication, yet it has not fully addressed how diagnostic authority becomes interactionally unsettled through patient questioning. Indonesian medical linguistics has analyzed informed consent and medical jargon [1], directive speech acts in rural consultations [2], multilingual barriers in urban clinics [3], bad-news delivery [4], empathy in mental health communication [5], diagnostic inequality in gendered pain expression [6], and telemedicine asymmetry [7]. Internationally, work on epistemic injustice has shown that patients may be excluded as credible knowers despite possessing experiential knowledge of illness [8], [9], [10], [11]. However, existing research tends to examine either institutional authority or patient voice separately. What remains insufficiently theorized is how explanation, question, doubt, and authority are pragmatically organized within Indonesian diagnostic discourse.

This study addresses that gap by asking how epistemic authority is linguistically constructed, questioned, and recalibrated in Indonesian medical explanation. More specifically, this study examines three connected problems: first, how clinicians present diagnosis through certainty, technical vocabulary, institutional reference, risk framing, or deferred judgment; second, how patients formulate questions that seek clarification, confirmation, reassurance, alternative interpretation, or challenge; and third, how medical responses either validate, redirect, soften, close down, or redistribute epistemic agency. This focus allows diagnostic communication to be studied not as a simple movement from expert knowledge to lay understanding, but as an interactional sequence in which knowledge rights are continually managed. Drawing on pragmatics, epistemic injustice, and medical discourse analysis, this study treats patient questions as analytically central rather than supplementary. Such questions reveal how doubt becomes speakable, acceptable, risky, or institutionally constrained within clinical and public health communication.

This study advances the argument that diagnostic authority in Indonesian medical discourse is neither automatically stable nor simply undermined by patient doubt. Instead, it is pragmatically produced through explanation practices that determine whether uncertainty is shared, domesticated, deferred, or closed. This argument aligns with recent work on epistemic authority in medical AI and clinical judgment, which shows that authority depends not only on technical accuracy but also on explainability, responsibility, and trust [12], [13], [14]. It also extends interactional studies of medical turn-taking and patient agency, where questions, epistemic markers, and response designs shape participation in care [15], [16], [17]. The implication is methodological as well as theoretical: diagnostic doubt should be analyzed as a structured communicative phenomenon through which patients negotiate their status as knowers inside asymmetrical healthcare encounters.

2. LITERATURE REVIEW

2.1. Epistemic authority in medical communication

Epistemic authority in medical communication refers to socially recognized entitlement to define, explain, and validate health knowledge. In clinical settings, this authority is conventionally associated with physicians because diagnosis relies on professional training, institutional legitimacy, and technical interpretation. Yet recent scholarship complicates this view by showing that medical authority is not only possessed but interactionally performed and ethically accountable. Kerasidou and Kerasidou [12] and Akgün and Akgün [13] distinguish clinical expertise from broader architectures of trust and responsibility, while Wolkenstein [14], Funer [18], and Durán and Jongsma [19] question whether algorithmic or black-box systems can legitimately inherit medical epistemic authority. Authority, therefore, is relational rather than absolute.

Epistemic authority can be examined through several indicators: certainty claims, institutional referencing, technical terminology, evidential justification, and control over what counts as relevant knowledge. In medical education and practice, authority is also shaped by assessment regimes, hierarchy, and professional voice [20], [21], [22]. Indonesian medical linguistics shows similar dynamics in directive speech acts, jargon, and clinical explanation, where doctors often organize consultation through asymmetrical speech roles [1], [2]. However, authority may become unstable when patients ask for reasons, request clarification, or introduce experiential evidence. These indicators allow this study to analyze authority as discourse practice.

2.2. Patient questioning is commonly understood

Patient questioning is commonly understood as information seeking, but pragmatic research suggests that questions also perform epistemic, relational, and moral work. A patient question may ask for clarification, but it may also display doubt, request reassurance, negotiate responsibility, or contest closure. Shirokov [17] demonstrates that epistemic markers enable patients to enact agency without directly challenging clinical hierarchy, while Ramona et al. [16] show that patient–doctor Q&A patterns organize

expertise, uncertainty, and advice in online medical interaction. In Indonesian contexts, Shaban [7] and Nurtyas [3] show that communicative asymmetry intensifies when consultations are mediated, multilingual, or symptomatically ambiguous. Patient questions therefore cannot be reduced to comprehension problems.

Different types of patient questions indicate different forms of epistemic participation. Clarification questions seek intelligibility; confirmation questions test whether patients have understood; risk questions ask about probability and consequence; alternative-source questions compare medical advice with digital, familial, or experiential knowledge; and challenge questions query diagnostic adequacy. These categories connect pragmatic form with social positioning. Andayani [6] shows that credibility may vary across gendered expressions of pain, while Syaifuddin [23] foregrounds illness narratives as sites of medical identity formation. Nugroho [4] and Rusita [5] further demonstrate that bad news and empathy depend on response design. Patient questions thus reveal whether clinical discourse permits shared knowledge-making.

2.3. Medical explanation

Medical explanation is often treated as simplification of expert knowledge for lay understanding, yet contemporary scholarship frames explanation as a normative practice that distributes agency and responsibility. Rosen [9], Pot [11], Blease et al. [8], and Goldstein [10] argue that patients may experience epistemic injustice when their testimony is ignored, trivialized, or subordinated to institutional record systems. Explanation can therefore repair or reproduce injustice. Chapman and Carel [24] similarly emphasize that illness knowledge must include lived experience rather than only biomedical classification. Within Indonesian medical communication, informed consent, empathy, and telemedicine studies indicate that explanation is shaped by language accessibility, interactional timing, and institutional constraint.

Indicators of medical explanation include technical elaboration, analogy, reassurance, risk framing, uncertainty marking, referral to tests, and closure. These indicators matter because explanation may acknowledge doubt or pre-empt it. Salman and Baart [25] describe epistemic negotiation in psychiatric care as a situated struggle over whose knowledge matters, while Okoroji et al. [26] connect lived experience expertise with pragmatic collaboration in mental health research. Work on digital health platforms also warns that explanation may reproduce epistemic colonialism or platform authority rather than patient agency [27]. This study therefore positions diagnostic communication as a pragmatic field where authority, questions, and explanation jointly determine whether patients become passive recipients or legitimate knowers.

3. METHOD

This study uses explanation sequences as its unit of analysis, defined as public textual segments in which diagnosis, examination results, medical doubt, patient questioning, or explanatory response becomes visible. The corpus consists of 35 Indonesian public documents: 15 patient Q&A items, 12 official or verified health education texts, and 8 contextual documents on patient rights, second opinion, medical records, telemedicine, and diagnostic terminology. This unit is appropriate because the research does not examine individual patients or clinicians, but how diagnostic authority and doubt are linguistically organized across publicly accessible health communication.

Table 1. Dataset composition

Code Range	Data Type	Source	Location	Period	Number	Characteristics	Status
ID-MED-PR-001–015	Primary	Alodokter Tanya Dokter	Indonesia	2020–2024	15	Public patient questions on diagnosis, examination results, uncertainty, and clarification	Included
ID-MED-SE-001–012	Secondary	Ayo Sehat Kementerian Kesehatan and verified health platforms	Indonesia	2024–2026; n.d. where undated	12	Institutional explanations of diagnosis, symptoms, tests, risks, and treatment orientation	Included
ID-MED-CT-001–008	Context	Kemenkes service portals, JDIH legal sources, SATUSEHAT documentation, Halodoc	Indonesia	2004–2026; n.d. where undated	8	Legal, institutional, and technical context for patient rights, second opinion, medical records, and diagnostic data	Included
Total	Mixed corpus	Public and verifiable sources	Indonesia	2004–2026	35	Deduplicated Indonesian health communication corpus	Retained

This study adopts a qualitative corpus-assisted pragmatic design. The design is suitable because epistemic authority, patient doubt, and medical explanation cannot be adequately captured through frequency counts alone; they require close attention to turn design, pragmatic force, evidential stance, and institutional positioning. Rather than making claims about clinical outcomes, this study examines how public medical discourse structures the conditions under which patients may ask, doubt, confirm, or accept diagnostic explanations. The design draws on patient-oriented pragmatism and medical discourse studies, where knowledge production is treated as situated, interactional, and ethically consequential.

Information sources were selected to represent three complementary layers of Indonesian medical communication. Primary data consist of public patient Q&A texts because they show how lay users formulate diagnostic uncertainty in accessible digital settings. Secondary data consist of health education texts because they display institutional strategies for explaining diagnosis, symptoms, tests, and risk. Contextual data include legal, technical, and policy sources because they clarify the normative background of second opinion, informed explanation, medical documentation, and digital health systems. Combining these layers enables this study to connect patient questions with broader institutional conditions of medical explanation.

Data collection followed a transparent search-and-screening procedure. Sources were identified through Indonesian keywords such as diagnosis, hasil pemeriksaan, salah diagnosis, second opinion, penjelasan dokter, tanya dokter, gejala, pemeriksaan penunjang, rekam medis, and hak pasien. Items were included when they contained diagnosis-related explanation, examination-result interpretation, patient questioning, doubt, uncertainty, second opinion, or normative rights to medical information. Items were excluded when they were duplicates, inaccessible, non-Indonesian without relevance to Indonesia, promotional without diagnostic content, or private/non-public materials. Metadata, URLs, dates, source type, context, snippets, and analytical notes were stored in structured Excel sheets.

Data analysis proceeded through three linked stages. First, epistemic authority was mapped through certainty claims, technical vocabulary, institutional reference, evidential justification, and diagnostic closure. Second, patient questions were coded according to pragmatic function, including clarification, confirmation, risk inquiry, alternative-source comparison, challenge, and reassurance seeking. Third, explanatory responses were analyzed through simplification, analogy, risk framing, uncertainty marking, referral to tests, validation, redirection, or closure. Cross-reading then examined whether doubt was legitimized, deferred, constrained, or closed. This procedure preserves the distinction between data description, pragmatic interpretation, and theoretical discussion.

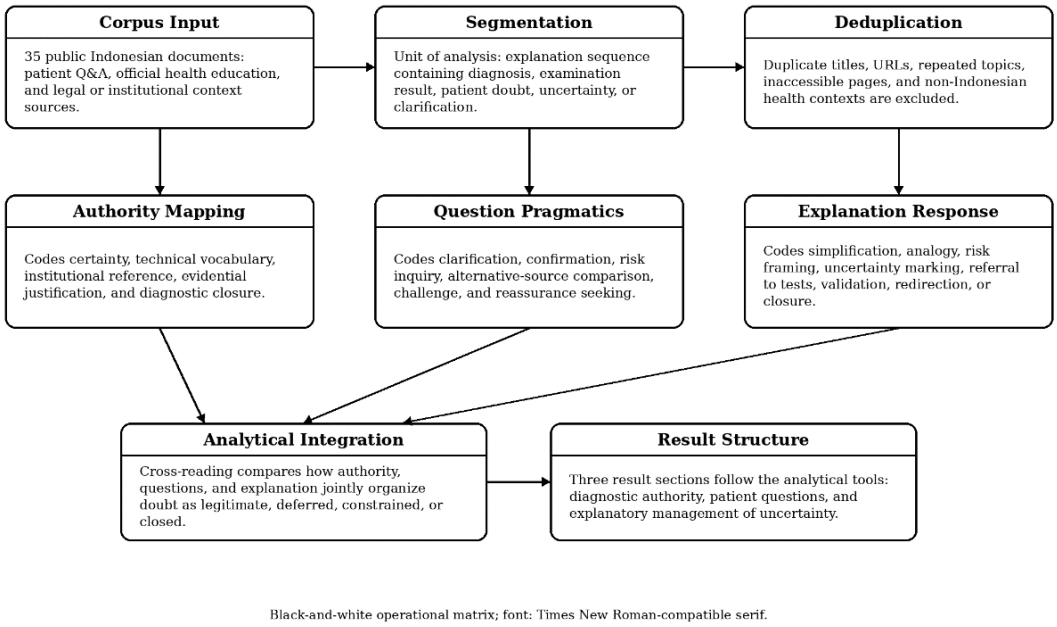


Figure 1. Operational analysis matrix

4. RESULTS

4.1. Epistemic authority formation in Indonesian diagnostic explanation

Diagnostic authority in this corpus is organized through a layered movement from patient-initiated uncertainty to institutionalized explanation. The largest category, expert interpretation requested, accounts for 10 of 35 documents, showing that patients most frequently approach medical discourse by asking experts to convert test results, diagnostic terms, or bodily signs into usable meaning. This is followed by institutional diagnostic pathways, where verified health texts present diagnosis as a staged procedure involving examination, testing, and confirmation. The distribution supports the methodological decision to treat explanation sequences, rather than individual speakers, as the central unit of analysis. Authority appears not as a single professional possession, but as a pragmatic arrangement linking patient questions, evidential procedures, institutional language, and rights-based accountability.

Table 2. Epistemic authority formation in Indonesian diagnostic explanation

Category	Subcategory	Pragmatic Indicator	Primary	Secondary	Context	Frequency	Percentage	Data Variation	Corpus Excerpt	Data Codes
Expert interpretation requested	Meaning, prognosis, terminology, and diagnostic implication	Patient asks expert to translate medical result into understandable meaning	10	0	0	10	28.6%	Laboratory results, blood pressure, EEG, URTI, testpack, ultrasound, prognosis	"Hasil pemeriksaan darah trombosit tinggi, apa artinya?"; "Apa yang dimaksud dengan URTI tersebut ya dok?"	ID-MED-PR-001, 003, 004, 005, 007, 008, 009, 011, 013, 014
Procedural or clinical validity queried	Test condition, recheck, treatment necessity, diagnostic error	Patient questions whether medical conclusion is valid, sufficient, or actionable	5	0	0	5	14.3%	Fasting requirement, cross-specialist checking, surgery urgency, clinical correlation, diagnostic error	"Apakah harus puasa dahulu?"; "perlu cek ulang ke Sp.KK"; "Kesalahan diagnosis…"	ID-MED-PR-002, 006, 010, 012, 015
Institutional diagnostic pathway	Diagnosis as staged clinical procedure	Official or verified source frames diagnosis as anamnesis, examination, testing, and confirmation	0	6	0	6	17.1%	Cancer, heart disease, screening, scabies, clinical examination, swab/blood testing	"Diagnosis … perlu dikonfirmasi melalui sejumlah pemeriksaan penunjang."	ID-MED-SE-001, 002, 005, 007, 008, 009
Test-mediated evidential authority	Biopsy, biomarkers, child blood test, ICD coding, medical records	Authority is stabilized through test evidence, coding systems, or documented history	0	5	0	5	14.3%	Biopsy, biomarker panel, blood sample, ICD-10, consultation records	"Biopsi adalah pemeriksaan utama untuk memastikan diagnosis."	ID-MED-SE-003, 004, 006; ID-MED-CT-005, 006
Professional redirection of doubt	Self-diagnosis warning and expert referral	Lay uncertainty is acknowledged but redirected to doctors, psychiatrists, or diagnostic testing	0	4	0	4	11.4%	Self-diagnosis, suspicious symptoms, child explanation, diagnosis–prognosis distinction	"Hindari mendiagnosis diri sendiri"; "mintalah dokter untuk melakukan pemeriksaan lanjutan."	ID-MED-SE-010, 011, 012; ID-MED-CT-008
Rights-based epistemic accountability	Second opinion, complete explanation, legal right, patient comprehension	Authority becomes reviewable through legal, institutional, and patient-rights frameworks	0	0	5	5	14.3%	Second opinion, informed explanation, legal obligation, understandable language	"Pasien … dapat mencari second opinion"; "berhak mendapat penjelasan lengkap dan mudah dipahami."	ID-MED-CT-001, 002, 003, 004, 007

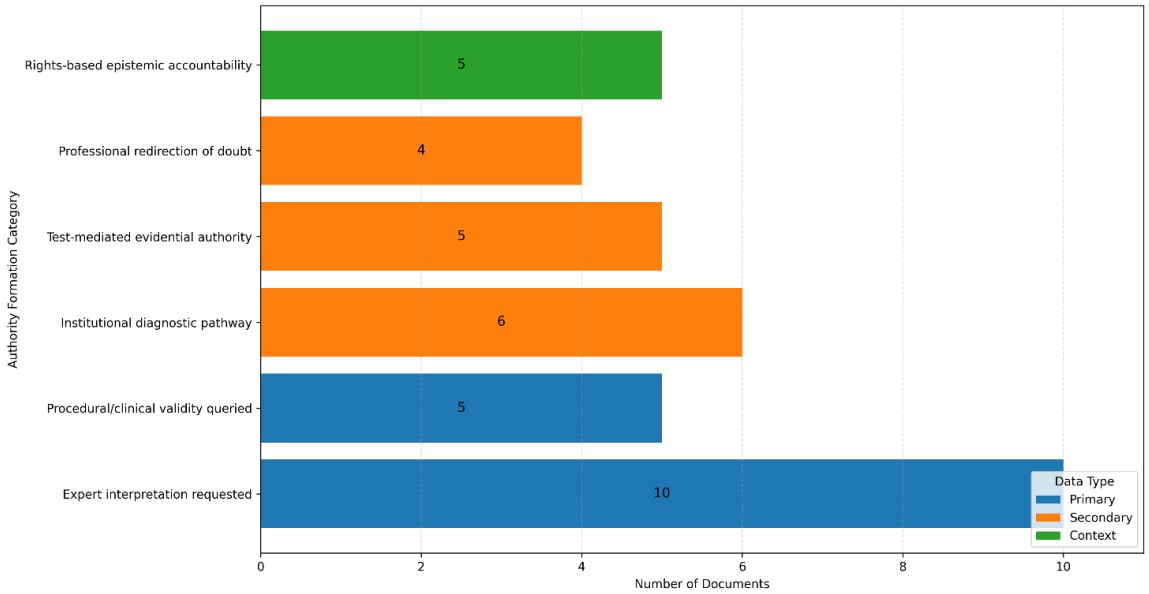


Figure 2. Epistemic authority formation across corpus types

The dominant pattern is the transformation of diagnostic information into epistemic uncertainty. Patient questions such as "Hasil pemeriksaan darah trombosit tinggi, apa artinya?" and "Apa yang dimaksud dengan URTI tersebut ya dok?" show that medical data become meaningful only after expert interpretation. Other excerpts intensify this uncertainty by questioning validity or sufficiency: "apakah harus puasa dahulu," "perlu cek ulang ke Sp.KK," and "Kesalahan diagnosis…" These formulations do not reject medical authority outright; they ask whether its evidential basis is adequate. Secondary sources stabilize this doubt by emphasizing diagnostic procedure, as in "perlu dikonfirmasi melalui sejumlah pemeriksaan penunjang." Contextual documents extend this pattern by framing second opinion and complete explanation as patient rights.

These patterns position diagnostic authority as negotiated rather than merely transmitted. Patients do not simply lack knowledge; they identify gaps between numbers, symptoms, medical terms, procedures, and future consequences. This supports Shirokov's [17] argument that epistemic markers can enact patient agency without direct confrontation, and it aligns with Ramona et al. [16], who show that Q&A formats structure medical expertise and uncertainty. Indonesian studies on jargon, directive acts, telemedicine asymmetry, and diagnostic credibility further clarify why explanation must be analyzed as a pragmatic event rather than a neutral information transfer [1], [2], [7], [6]. In this corpus, authority becomes strongest when it remains explainable, reviewable, and responsive to doubt.

4.2. Pragmatic functions of diagnostic questions

Patient questioning in the corpus shows that doubt is not a single communicative act but a set of pragmatic operations through which patients make diagnostic knowledge usable. Clarification of meaning is

the largest function, appearing in 9 of 35 documents, followed by test/procedure inquiry in 7 documents and confirmation of adequacy in 6 documents. These categories remain consistent with the previous unit of analysis because each item is treated as an explanation sequence, not as a demographic respondent or clinical case. The pattern indicates that diagnostic doubt begins where medical information becomes available but remains insufficiently interpretable. Questions therefore function as bridges between expert evidence, patient understanding, institutional procedure, and the right to seek accountable explanation.

Table 3. Patient question pragmatics in diagnostic explanation sequences

Main Category	Subcategory	Pragmatic Indicator	Primary	Secondary	Context	Frequency	Percentage	Data Variation	Corpus Excerpt	Data Codes
Clarification of meaning	Translating diagnostic terms and test results	Patient seeks intelligible meaning of medical data, diagnosis, or terminology	8	1	0	9	25.7%	Blood test, EEG, URTI, testpack, ultrasound, diagnostic label	"Apa yang dimaksud dengan URTI tersebut ya dok?"; "hasil pemeriksaan darah … apa artinya?"	ID-MED-PR-001, 003, 004, 007, 008, 011, 013, 014; ID-MED-SE-012
Confirmation of adequacy	Checking whether diagnosis or action is sufficient	Patient asks whether existing conclusion, referral, or treatment plan is enough	5	0	1	6	17.1%	Recheck, cross-specialist consultation, diagnosis validity, second opinion	"perlu cek ulang ke Sp.KK?"; "apakah dokter salah diagnosa?"	ID-MED-PR-002, 006, 010, 012, 015; ID-MED-CT-001
Risk/prognosis inquiry	Asking about seriousness and future consequence	Question links diagnosis with danger, prognosis, severity, or possible deterioration	2	3	0	5	14.3%	Cancer, heart disease, abnormal results, child symptoms, prognosis	"apakah berbahaya?"; "prognosis … membantu memahami kemungkinan perjalanan penyakit"	ID-MED-PR-005, 009; ID-MED-SE-001, 002, 011
Test/procedure inquiry	Asking about examination condition or evidential process	Question concerns fasting, blood test, biopsy, biomarker, screening, or confirmatory procedure	3	3	1	7	20.0%	Laboratory procedure, biopsy, blood testing, screening, medical record	"apakah harus puasa dahulu?"; "pemeriksaan penunjang diperlukan untuk memastikan diagnosis"	ID-MED-PR-002, 006, 010; ID-MED-SE-003, 004, 006; ID-MED-CT-005
Second-opinion comparison	Comparing expert judgment with alternative authority	Question opens diagnostic authority to review by another doctor, institution, or legal right	1	0	3	4	11.4%	Second opinion, patient right, reviewability, diagnostic disagreement	"dapat mencari second opinion"; "berhak mendapatkan penjelasan lengkap"	ID-MED-PR-015; ID-MED-CT-001, 002, 003
Reassurance seeking	Reducing anxiety through expert response	Patient seeks emotional stabilization, certainty, or practical next step	3	1	0	4	11.4%	Pregnancy uncertainty, abnormal finding, symptom anxiety, self-diagnosis	"saya khawatir"; "hindari mendiagnosis diri sendiri"	ID-MED-PR-004, 008, 009; ID-MED-SE-010

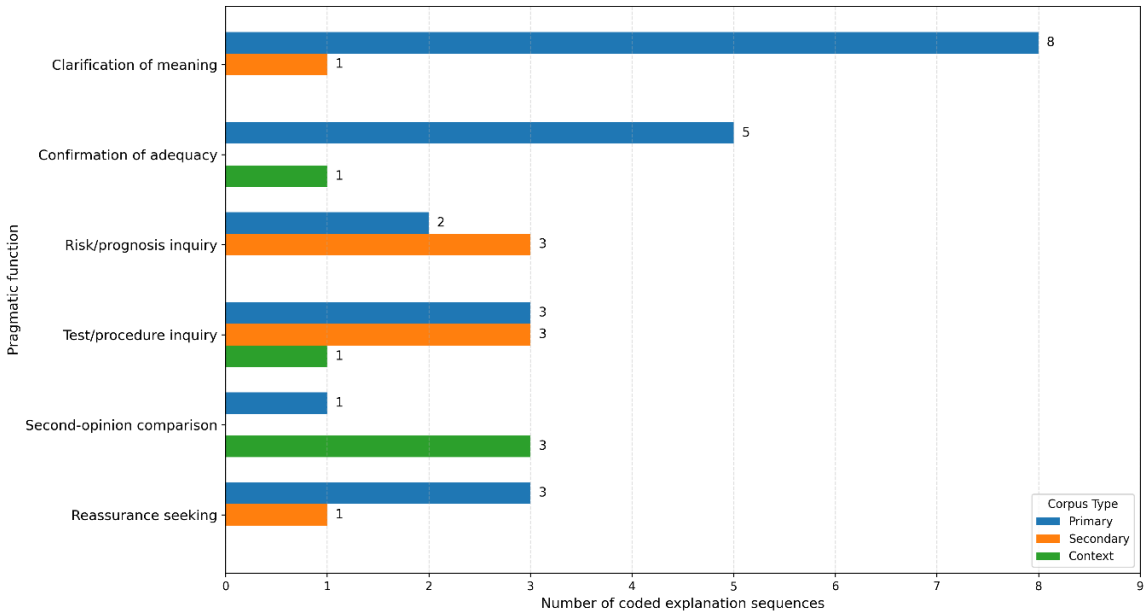


Figure 3. Pragmatic functions of diagnostic questions across corpus types

The dominant textual pattern is a movement from "what does this mean?" to "is this enough?" Excerpts such as "Apa yang dimaksud dengan URTI tersebut ya dok?" and "hasil pemeriksaan darah … apa artinya?" show clarification as the most direct form of epistemic participation. Procedural doubt appears when patients ask "apakah harus puasa dahulu?" or when institutional texts state that "pemeriksaan penunjang diperlukan untuk memastikan diagnosis." Confirmation questions, including "perlu cek ulang ke Sp.KK?" and "apakah dokter salah diagnosa?", are more demanding because they test the adequacy of expert judgment without necessarily rejecting it. Second-opinion references further show that doubt can become institutionally legitimate when framed as review, patient right, or accountable medical explanation.

Patient questions operate as disciplined forms of agency within asymmetrical medical discourse. They rarely overturn medical authority; instead, they request that authority become more intelligible, evidenced, and reviewable. This supports Shirokov's [17] claim that epistemic markers allow patients to enact agency without direct confrontation, while Ramona et al. [16] show that medical Q&A formats organize expertise

through patterned exchanges. Indonesian studies on medical jargon, multilingual barriers, telemedicine, and gendered diagnostic credibility further demonstrate why questions should not be reduced to ignorance or compliance problems [1], [3], [7], [6]. In this corpus, questioning is the pragmatic mechanism through which diagnostic authority becomes negotiated rather than merely received.

4.3. Medical explanation, uncertainty, and diagnostic closure

Medical explanation in this corpus works through a double movement: it translates diagnostic knowledge into patient-facing meaning while also protecting clinical authority through evidence, referral, and procedural closure. Terminological simplification and evidential grounding are the two most frequent response strategies, each appearing in 8 of 35 explanation sequences. This pattern is consistent with the earlier finding that patients most often ask for meaning and adequacy rather than openly rejecting professional authority. The corpus therefore shows explanation as a pragmatic mechanism that manages doubt by making diagnosis intelligible, actionable, and institutionally anchored. Explanation is not only informational; it determines whether uncertainty remains available for patient participation or is redirected toward professional procedure.

Table 4. Medical explanation responses across corpus types

Main Category	Subcategory	Pragmatic Indicator	Primary	Secondary	Context	Frequency	Percentage	Data Variation	Corpus Excerpt	Data Codes
Terminological simplification	Translating clinical terms into lay meaning	Explanation converts diagnostic terms, laboratory findings, or disease labels into accessible wording	6	2	0	8	22.9%	URTI, blood test, testpack, ultrasound, child diagnosis, symptom terminology	"Apa yang dimaksud dengan URTI"; "hasil pemeriksaan darah … apa artinya?"	ID-MED-PR-001, 003, 004, 007, 011, 014; ID-MED-SE-010, 012
Evidential grounding	Explaining diagnosis through tests and examination	Explanation stabilizes authority by referring to biopsy, blood test, screening, examination, or medical records	2	5	1	8	22.9%	Biopsy, biomarkers, laboratory checks, clinical confirmation, medical documentation	"pemeriksaan penunjang diperlukan untuk memastikan diagnosis"; "biopsi … memastikan diagnosis"	ID-MED-PR-002, 010; ID-MED-SE-003, 004, 006, 007, 009; ID-MED-CT-005
Directive follow-up/referral	Moving doubt toward professional action	Explanation directs patient to consult, recheck, repeat examination, avoid self-diagnosis, or see specialist	4	2	0	6	17.1%	Recheck, specialist referral, self-diagnosis warning, follow-up instruction	"perlu cek ulang ke Sp.KK?"; "hindari mendiagnosis diri sendiri"	ID-MED-PR-006, 008, 012, 015; ID-MED-SE-008, 010
Risk/prognosis calibration	Linking diagnosis to seriousness and future outcome	Explanation frames diagnosis through severity, prognosis, danger, or anticipated development	2	2	0	4	11.4%	Cancer, heart disease, abnormal result, prognosis explanation	"apakah berbahaya?"; "prognosis … perjalanan penyakit"	ID-MED-PR-005, 009; ID-MED-SE-001, 011
Uncertainty acknowledgement	Marking conditionality and diagnostic incompleteness	Explanation recognizes that diagnosis may require further evidence or cannot be concluded from one sign alone	1	1	1	3	8.6%	Ambiguous result, incomplete symptom basis, need for further confirmation	"perlu dikonfirmasi"; "tidak dapat dipastikan hanya dari satu keluhan"	ID-MED-PR-013; ID-MED-SE-005; ID-MED-CT-006
Rights-based accountability	Making explanation reviewable through patient rights	Explanation is framed as entitlement to information, second opinion, understandable explanation, or medical documentation	0	0	6	6	17.1%	Second opinion, informed explanation, legal right, medical records, patient access	"dapat mencari second opinion"; "berhak mendapat penjelasan lengkap dan mudah dipahami"	ID-MED-CT-001, 002, 003, 004, 007, 008

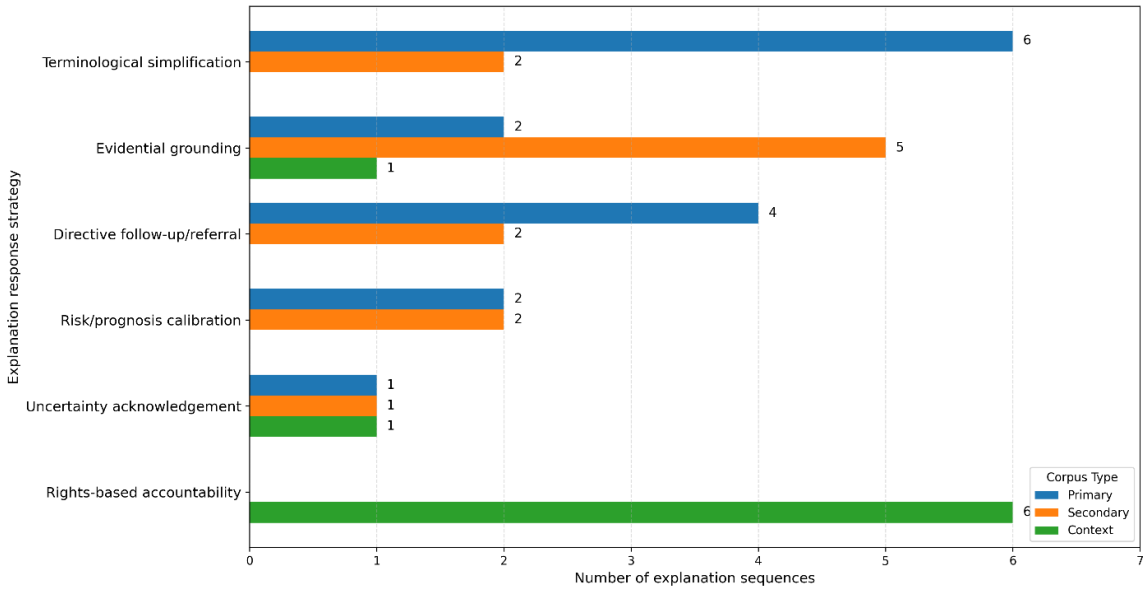


Figure 4. Medical explanation responses across corpus types

The dominant pattern is visible in paired excerpts that move from patient uncertainty to institutional confirmation. Patient-facing questions such as "Apa yang dimaksud dengan URTI" and "hasil pemeriksaan darah … apa artinya?" invite terminological simplification, whereas institutional explanations such as

"pemeriksaan penunjang diperlukan untuk memastikan diagnosis" and "biopsi … memastikan diagnosis" shift authority toward evidential procedure. Directive responses also appear through formulations such as "perlu cek ulang ke Sp.KK?" and "hindari mendiagnosis diri sendiri," where doubt is neither ignored nor fully opened for negotiation but redirected toward authorized clinical action. Contextual documents add a different layer by defining explanation as a right, especially through second opinion, medical records, and understandable information.

These findings position medical explanation as a site where epistemic authority is maintained through responsiveness rather than silence. Explanation becomes authoritative when it can translate terminology, justify evidential grounds, acknowledge diagnostic incompleteness, and allow review through patient rights. This supports Rosen's [9] view that patients must be affirmed as knowers and Pot's [11] argument that epistemic solidarity requires attention to how knowledge is shared in care. It also extends Blease et al. [8] and Goldstein [10] by showing that epistemic injustice may occur not only when patients are denied information, but also when explanation closes doubt without making its evidential basis understandable. In this corpus, diagnostic closure is legitimate only when it remains explainable.

5. DISCUSSION

The first empirical pattern shows that diagnostic authority in Indonesian public medical discourse is organized through interpretation, procedural validation, institutional pathways, evidential tests, professional redirection, and rights-based accountability. Its implication is that authority functions less as a fixed professional possession than as a communicative achievement that must be made legible to patients. When patients ask what a result means or whether a diagnosis is adequate, they do not necessarily weaken medical authority; they expose its dependence on explanation. This extends Kerasidou and Kerasidou's [12] distinction between technical expertise and practical authority, because clinical authority becomes trustworthy only when patients can follow its evidential and interpretive grounds. It also qualifies stronger accounts of professional dominance by showing that authority can remain intact while becoming reviewable. In this sense, diagnostic doubt is not merely a dysfunction of compliance but a condition through which legitimate authority is tested, clarified, and socially sustained.

The structure underlying this pattern lies in the gap between biomedical evidence and patient-facing meaning. Laboratory values, diagnostic abbreviations, examination pathways, and specialist judgments do not speak for themselves; they require institutional translation before patients can treat them as actionable knowledge. This explains why expert interpretation and test-mediated authority appear as complementary rather than opposing categories. The finding supports Laila's [1] work on medical jargon and comprehension, where technical language risks excluding patients unless it is pragmatically adapted. It also resonates with Blease et al. [8], who argue that restricted access to medical information can become epistemic injustice. Yet this corpus complicates a simple access-based model: information alone is insufficient when patients cannot interpret its relevance. Authority is therefore structured by an asymmetry between possession of evidence and capacity to explain evidence, making diagnostic explanation a central site of epistemic responsibility.

The second empirical pattern shows that patient questions operate as disciplined forms of epistemic participation. Their significance lies in how doubt is made socially acceptable through clarification, confirmation, risk inquiry, procedural questioning, second-opinion comparison, and reassurance seeking. These questions rarely appear as direct confrontations; instead, they allow patients to enter clinical knowledge without openly rejecting professional expertise. This supports Shirokov's [17] claim that epistemic markers help patients enact agency within unequal interactions. It also aligns with Ramona et al. [16], who show that medical Q&A formats organize authority through patterned exchanges of inquiry and response. However, this finding challenges interpretations that reduce patient questions to information deficits. Questions function as pragmatic tools for managing uncertainty, anxiety, and responsibility. Patient doubt therefore becomes productive when it is recognized as a request for accountable explanation, not dismissed as hesitation, ignorance, or resistance.

The distribution of question types reflects an underlying structure of asymmetrical but negotiable knowledge. Clarification questions emerge where terminology obstructs comprehension; confirmation questions appear where patients are unsure whether an explanation is sufficient; procedural questions arise where evidence requires technical conditions; and second-opinion questions become relevant when authority must be reviewable. This structure corresponds with Nazulpa's [2] analysis of directive speech acts in Indonesian consultations, where institutional roles shape what can be asked and how responses are organized. It also relates to Nurtyas [3] and Shaban [7], who show that multilingual and mediated consultations intensify communicative asymmetry. The corpus suggests that patient agency is not simply present or absent; it is formatted by the available pragmatic route. Patients can ask, but not all questions carry equal interactional force. Doubt becomes legitimate when framed as clarification or procedural need, while challenge remains more institutionally delicate.

The third empirical pattern shows that medical explanation responds to uncertainty through simplification, evidential grounding, referral, risk calibration, uncertainty acknowledgement, and rights-based

accountability. Its broader implication is that explanation functions as a gatekeeping mechanism: it can open diagnostic reasoning to patient participation, or it can close uncertainty by redirecting patients back to professional authority. This finding supports Rosen's [9] argument that patients should be affirmed as knowers, because explanation is one way of recognizing their interpretive role in care. It also extends Pot's [11] idea of epistemic solidarity by showing that solidarity is not abstract goodwill but a communicative practice: translating terminology, explaining evidence, acknowledging incompleteness, and allowing review. At the same time, explanation may become dysfunctional when it ends doubt without making evidence understandable. Diagnostic closure is therefore ethically fragile; it becomes legitimate only when patients can see why closure has been reached.

The structure behind explanatory response lies in the tension between clinical efficiency and epistemic accountability. Medical discourse must often reduce uncertainty quickly, yet patient-centered communication requires that uncertainty not be prematurely silenced. This tension helps explain why directive follow-up and evidential grounding appear alongside rights-based accountability. The pattern is consistent with Goldstein's [10] framing of medical epistemic injustice as a clinical problem, but it also adds a pragmatic dimension: injustice can occur not only through disbelief, but through explanation that is formally provided yet interactionally insufficient. Andayani's [6] work on diagnostic credibility and Rusita's [5] analysis of compassionate communication further suggest that explanation must be evaluated by how it positions patients as credible, anxious, confused, or entitled knowers. This study therefore argues that diagnostic doubt should be treated as a communicative threshold where trust depends on whether authority remains explainable, answerable, and ethically revisable.

6. CONCLUSION

This study demonstrates that diagnostic authority in Indonesian medical discourse is not a fixed institutional possession but an interactional accomplishment shaped by explanation, questioning, evidential grounding, and patient rights. Its central lesson is that doubt should not be treated as communicative failure; it is a pragmatic resource through which patients seek intelligibility, accountability, and participation. By combining corpus-assisted pragmatics, epistemic authority mapping, question-function analysis, and explanation-response coding, this study renews perspectives on doctor–patient communication beyond compliance models. Its scholarly contribution lies in repositioning patient questions as analytical evidence of how medical knowledge becomes trusted, contested, or made reviewable.

This study is limited by its reliance on public textual materials rather than recorded clinical encounters, meaning that interactional timing, prosody, non-verbal cues, institutional workload, and patient demographic variables could not be examined. Public Q&A and health education sources also represent mediated discourse, not private consultation practice. Future research should therefore integrate ethically approved consultation recordings, interviews with clinicians and patients, multilingual clinical settings, and longitudinal observation of diagnostic explanation across hospitals, primary care, and telemedicine platforms. Comparative work across regions, specialties, and patient groups would further clarify how epistemic authority changes when doubt is voiced under different clinical, cultural, and technological conditions.

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CONFLICT OF INTEREST STATEMENT

Author states no conflict of interest.

AI USE DECLARATION

The author used artificial intelligence tools to assist with the generation of illustrative figures and with the formatting and layout of this manuscript. AI was not used to generate the substantive content, conceptualization, data, analysis, or conclusions of the research, all of which remain the sole responsibility of the author.

INFORMED CONSENT

Not applicable – this study did not involve direct human participants. Data consisted solely of publicly accessible patient Q&A texts, verified health education materials, and contextual documents on patient rights, second opinion, medical records, and diagnostic accountability.

ETHICAL APPROVAL

This research did not involve human or animal subjects; it analyzed publicly accessible patient Q&A texts, verified health education materials, and contextual documents on patient rights, second opinion, medical records, and diagnostic accountability, and therefore no institutional review board approval was required. Where research does involve human subjects, the author affirms that such research would be conducted in full compliance with all relevant national regulations and institutional policies, in accordance with the tenets of the Declaration of Helsinki, and would be approved by the author's institutional review board or equivalent committee.

DATA AVAILABILITY

The corpus of publicly accessible patient Q&A texts, verified health education materials, and contextual documents on patient rights, second opinion, medical records, and diagnostic accountability analyzed in this study are available from the corresponding author upon reasonable request.

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