Indonesian Journal of Medical Linguistics
Vol. 1, No. 3, September 2026, pp. 230~241
ISSN: 3163-3676, DOI: https://doi.org/10.67490/ijml.v1i3.949

When patients do not ask: silence, deference, and the unequal distribution of voice in Indonesian medical consultations

Helen Qurrotu Aini
Universitas Pembangunan Nasional "Veteran" Jawa Timur, Indonesia

Article Info

Article history:

Received Aug 20, 2026
Revised Sep 23, 2026
Accepted Sep 30, 2026

Keywords:

deference;
Indonesia;
medical consultations;
patient silence;
voice distribution.

ABSTRACT

Background: Patient silence in Indonesian medical consultations remains insufficiently examined, although formal patient rights, medical hierarchy, linguistic difficulty, family involvement, and digital consultation formats increasingly shape how voice is distributed in clinical encounters. **Objective:** This study examines how silence, deference, and unequal access to question-asking are institutionally framed and pragmatically mediated in Indonesian medical communication. **Method:** This study applies a qualitative corpus-based discourse-pragmatic design to 26 public document–excerpt units, classified as primary, secondary, and contextual data, using institutional voice allocation analysis, pragmatic silence coding, and interactional mediation mapping. **Results:** Formal rights discourse strongly recognises patients as entitled to information, explanation, complaint, consent/refusal, and second opinion, yet these rights are more often stated as institutional entitlements than translated into concrete interactional procedures. Silence and deference appear as communicative risks linked to power asymmetry, embarrassment, jargon, language barriers, and compliance-oriented positioning. Patient voice is frequently mediated through family members, legal complaint channels, telemedicine, documentation systems, and comprehension supports rather than expressed as direct individual questioning. **Implication:** This study suggests that non-questioning should not be interpreted as understanding, consent, or satisfaction without examining the interactional conditions that make speaking possible. **Novelty:** This study contributes a three-part analytical model that reframes patient silence as an institutionally distributed, pragmatically constrained, and relationally mediated form of unequal voice.

This is an open access article under the CC BY-SA license.

Corresponding Author:

Helen Qurrotu Aini
Universitas Pembangunan Nasional "Veteran" Jawa Timur, Indonesia
Jl. Raya Rungkut Madya, Gunung Anyar, Surabaya, Jawa Timur 60294, Indonesia
Email: helenaini9@gmail.com

1. INTRODUCTION

Indonesia's health system now operates at a scale that makes clinical communication a matter of public significance rather than merely interpersonal style. BPJS Kesehatan reported 284,337,094 JKN participants as of 30 April 2026, alongside 23,623 first-level health facilities and 3,206 referral facilities, while World Bank data place Indonesia's physician density at only 0.5 physicians per 1,000 people in 2023. These figures indicate a health-care environment where large patient volumes, limited consultation time, and uneven professional availability may intensify asymmetry in everyday medical encounters. Within such conditions, patients' failure to ask questions cannot be treated as simple satisfaction, obedience, or comprehension. Silence may instead mark restricted access to voice, especially when medical authority,

social deference, jargon, embarrassment, and institutional routines converge. This issue is crucial because contemporary Indonesian health governance increasingly recognises patient rights, yet rights become clinically meaningful only when patients can actually speak, ask, clarify, and disagree.

Existing scholarship has established that patient–physician communication shapes explanation, medication management, risk discussion, participation, and trust, but it has less often examined silence as a distributed interactional achievement. Conversation-analytic work shows that clinical consultations are structured through turn allocation, question design, repair, and topic closure [1], [2]. Studies on medication talk and outpatient communication demonstrate that patients' opportunities to participate are shaped by physician framing, consultation duration, and institutional routine [3], [4]. Research on power asymmetry, embarrassment, and communication disparities further shows that patients do not always feel equally entitled to speak [5], [6]. Indonesian scholarship has examined telemedicine outcomes, medical jargon, directive speech acts, and multilingual barriers [7], [8], [9], [10]. Yet insufficient attention has been given to how not asking becomes socially, linguistically, and institutionally organised within Indonesian consultations.

This study examines how silence, deference, and unequal voice are produced in Indonesian medical consultations. Rather than asking whether patients participate in a general sense, this study asks how opportunities for question-asking are opened, narrowed, postponed, or closed within interaction. Three questions guide the analysis. First, how do institutional documents, clinical communication norms, and public health materials define patients as rights-bearing speakers? Second, how do pragmatic forms of deference, minimal uptake, agreement, hesitation, and non-questioning index unequal access to epistemic authority? Third, how do family mediation, language difference, and digital consultation formats redistribute patient voice across face-to-face and mediated medical settings? These questions allow this study to connect discourse-pragmatic analysis with medical communication research without assuming that silence has one fixed meaning. Silence may express trust, fear, respect, confusion, fatigue, or strategic compliance; analytically, its significance depends on interactional position, institutional context, and available routes for repair.

This study advances an argument that patient silence in Indonesian consultations should be read as an index of unequal communicative conditions, not merely as an individual reluctance to speak. When physicians control diagnosis, explanation, time, and topic progression, patients may appear cooperative while remaining unable to formulate uncertainty as a legitimate question. This provisional argument is consistent with research showing that silence and voice in health-care settings are shaped by hierarchy, professional authority, perceived futility, and safety concerns [11], [12], [13]. It also resonates with Indonesian studies on advance care planning, gendered credibility, and virtual consultation asymmetry, where patient voice is mediated by family roles, cultural expectations, diagnostic vulnerability, and platform constraints [14], [15], [16]. The implication is methodological as well as clinical: analysing who speaks, who asks, and who remains unheard can clarify how formally recognised patient rights become unevenly enacted in practice.

2. LITERATURE REVIEW

2.1. Patient silence

Patient silence in medical consultation should not be reduced to muteness, ignorance, or passive compliance. Recent scholarship increasingly treats silence as a communicative phenomenon whose meaning depends on interactional position, institutional pressure, and available opportunities for repair. Brown and Collini [11] argue that silence requires explicit acknowledgment in medical education because it may carry uncertainty, vulnerability, discomfort, or reflection. Rietze et al. [17] similarly problematize voicelessness as a condition produced within nursing practice rather than merely located in individual reluctance. Conversation-analytic research adds that silence becomes interpretable through sequence, turn design, and next action [1], [2]. Thus, silence is best understood as socially organised communicative absence.

The main indicators of patient silence include minimal response, delayed uptake, absence of follow-up questions, topic abandonment, and acceptance without clarification. These indicators become analytically meaningful when examined alongside physician prompts, explanation formats, and closure practices. Adelsjö et al. [3] show that medication management talk depends on how physicians create or limit openings for patient contribution, while Lee et al. [4] link communication patterns to consultation time and outpatient routines. Ozavci et al. [18] further demonstrate that participation often depends on formal and informal communicative opportunities. In Indonesian contexts, Laila [8], Nazulpa [9], and Nurtyas [10] show that jargon, directives, and multilingual barriers may restrict patients' question-asking capacity.

2.2. Deference

Deference refers to communicative orientation toward authority, expertise, status, or institutional role. In clinical settings, it may appear as respect, trust, politeness, embarrassment, fear of seeming difficult, or reluctance to challenge diagnosis. However, literature differs in whether deference is treated as cultural virtue, relational trust, or a symptom of unequal power. Scherer et al. [6] connect power asymmetry and embarrassment to participation preference and decisional conflict, while Keshavarzi et al. [19] identify

professionalism barriers within physician–patient relationships. Merchant et al. [5] show disparities in communication and counseling from multiple perspectives. Indonesian studies on directive speech acts and compassionate communication likewise suggest that authority and empathy are pragmatically negotiated [9], [20].

Indicators of deference include unchallenged agreement, honorific alignment, indirect uncertainty, mitigated disagreement, acceptance of unexplained advice, and reliance on companions to ask sensitive questions. Studies of hierarchy in healthcare organisations show that silence is not limited to patients; nurses and hospital staff may also withhold voice when hierarchy, futility, or disrespect is perceived (Essex et al., 2023; Lee & Lee [12]; Mawuena & Wilkinson, 2024; Van Dongen et al. [13]; Wen et al., 2025). This broader literature is relevant because it shows how speaking up depends on perceived legitimacy. In consultation settings, deference therefore becomes a pragmatic signal of constrained entitlement rather than merely politeness.

2.3. Unequal voice

Unequal voice concerns the uneven distribution of speaking rights, epistemic authority, and decision-making influence across participants. Patient-centred communication often assumes that patients can speak when invited, but recent work questions this assumption. Forsey et al. [2] frame communication as basic science because clinical understanding is produced through interaction, not simply transferred from physician to patient. Studies on risk, stigma, telehealth, and online consultation show that participation is shaped by medium, explanation design, and perceived credibility (Bavngaard et al. [21]; Cao et al., 2021; Chia et al., 2025; Guo & Chen, 2025; White et al. [22]). In Indonesia, Effendi et al. [7] and Shaban [16] indicate that mediated consultations may reproduce asymmetry rather than automatically democratise access.

The indicators of unequal voice include who initiates topics, who defines symptoms, who requests clarification, who authorises decisions, and whose account becomes medically actionable. Triadic and accompanied consultations complicate this distribution because family members may protect, replace, amplify, or constrain patient voice [23], [24], [25]. Research on advance care planning in Indonesia also shows how family, culture, and serious illness shape the articulation of preference and consent [15]. This study therefore positions silence, deference, and voice as interdependent analytical categories. Its theoretical contribution lies in examining non-questioning as an interactional and institutional pattern through which formally recognised patient participation becomes unevenly enacted.

3. METHOD

This study uses public-document items and selected textual excerpts as its unit of analysis. The material object is not individual patient behaviour observed in live consultation, but verifiable public discourse through which patient voice, silence, deference, rights, and participation are institutionally framed in Indonesian medical settings. Each document-excerpt pair is coded as one analytical unit because public health regulations, hospital patient-rights pages, service guides, and scholarly texts articulate different conditions under which patients may ask, comply, clarify, complain, or remain silent. The corpus contains 26 unique items: six primary patient-facing materials, twelve secondary scholarly or legal-health materials, and eight contextual governance documents.

Table 1. Dataset composition

Code	Data Type	Source	Location	Period	Number	Characteristics	Status
WPV-ID-001	Context data	BPK RI / Republic of Indonesia	Indonesia	2023	1	Law No. 17 of 2023 on Health	Included
WPV-ID-002	Context data	JDIH Kementerian Kesehatan	Indonesia	2026	1	Ministerial regulation on hospitals	Included
WPV-ID-003	Context data	JDIH Kementerian Kesehatan	Indonesia	2018	1	Previous hospital obligation regulation	Included with revoked-status note
WPV-ID-004	Context data	BPK RI / Kemenkes	Indonesia	2024	1	Puskesmas governance regulation	Included
WPV-ID-005	Context data	BPJS Kesehatan	Indonesia	2022	1	JKN-KIS participant rights and obligations	Included
WPV-ID-006	Context data	Kementerian Kesehatan RI	Indonesia	2023	1	Patient and health-worker rights article	Included
WPV-ID-007	Secondary data	Ditjen Kesehatan Lanjutan / Kemenkes	Indonesia	2024	1	Professional communication guidance	Included
WPV-ID-008	Context data	Ditjen Kesehatan Lanjutan / Kemenkes	Indonesia	2023	1	Medical-record information context	Included
WPV-ID-009	Secondary data	Kementerian Kesehatan RI	Indonesia	2024	1	Digital health and patient safety article	Included
WPV-ID-010	Primary data	RS Panti Rapih	Yogyakarta	2026	1	Hospital patient rights and obligations	Included
WPV-ID-011	Primary data	RSK Ngesti Waluyo Parakan	Central Java	2026	1	Hospital patient rights and obligations	Included
WPV-ID-012	Primary data	RS Bhayangkara Manado	North Sulawesi	Undated	1	Hospital patient rights and obligations	Included
WPV-ID-013	Primary data	RSUD Mijen Semarang	Semarang	Undated	1	Hospital patient rights and obligations	Included
WPV-ID-014	Primary data	RSUD Banyumas	Central Java	2022	1	Patient and family rights material	Included

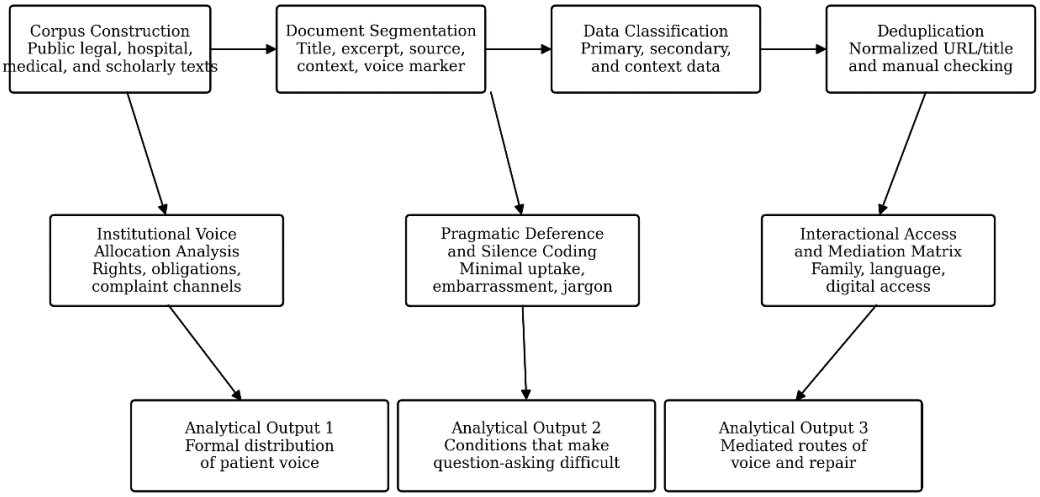
WPV-ID-015	Primary data	RS William Booth Surabaya	Surabaya	Undated	1	Hospital rights and obligations page	Included
WPV-ID-016	Secondary data	Alodokter	Indonesia	2024	1	Patient protection as health consumer protection	Included
WPV-ID-017	Secondary data	SIP Law Firm	Indonesia	2024	1	Legal protection of patient privacy	Included
WPV-ID-018	Secondary data	PubMed / PMC	International	2024	1	Primary-healthcare conversation-analysis review	Included
WPV-ID-019	Secondary data	PubMed / Wiley	International	2023	1	Silence in medical education	Included
WPV-ID-020	Secondary data	BMC Medical Informatics and Decision Making	International	2025	1	Power asymmetry and embarrassment	Included
WPV-ID-021	Secondary data	BMC Health Services Research	International	2024	1	Speaking-up behaviour in hospitals	Included
WPV-ID-022	Secondary data	BMC Palliative Care	Indonesia	2022	1	Advance care planning and family caregivers	Included
WPV-ID-023	Secondary data	IJMEAL	Banyuwangi	2025	1	Language barriers in pain-clinic communication	Included
WPV-ID-024	Secondary data	KNOWLEDGE / GARUDA	Indonesia	2025	1	Telephone consultation symptom reporting	Included
WPV-ID-025	Secondary data	Health Communication	Indonesia	2023	1	Telemedicine and physician–patient communication	Included
WPV-ID-026	Context data	arXiv	Indonesia	2024	1	AI transcription and clinical documentation context	Included as contextual preprint

This study adopts a qualitative corpus-based discourse-pragmatic design. This design is appropriate because the research question concerns how voice is institutionally authorised, pragmatically constrained, and mediated across Indonesian medical communication materials. Rather than measuring patient satisfaction or clinical outcomes, this study examines how public documents construct speaking rights, obligations, comprehension demands, complaint pathways, family mediation, and digital access. The design is informed by conversation-analytic sensitivity to turn-taking and silence, but it does not claim to reconstruct actual consultation sequences. This distinction keeps this study interpretive, document-based, and non-causal while remaining aligned with contemporary medical communication scholarship.

Information sources were selected to represent three levels of communicative infrastructure. Primary data comprise hospital-facing patient rights, obligations, and health-promotion materials because these texts address patients and families most directly. Secondary data include scholarly articles, legal-health commentary, and professional communication discussions that conceptualise silence, hierarchy, language barriers, telemedicine, and patient safety. Context data include national regulations, ministerial rules, insurance service guidance, and digital documentation materials that frame institutional conditions for patient participation. This layered source structure allows this study to compare formal rights discourse with more situated accounts of deference, comprehension difficulty, and mediated consultation without merging unlike evidence types.

Data were collected through targeted searches using Indonesian and English keywords, including patient rights, patient obligations, informed consent, medical explanation, doctor–patient communication, patient silence, deference, power asymmetry, speaking up, telemedicine consultation Indonesia, language barriers, and family caregiver communication. The main period was 2021 to 9 July 2026, with one 2018 regulation retained only as a documented regulatory comparator because of its relevance to later hospital-governance changes. For each item, metadata were recorded: code, title, date, source, region, source category, URL, excerpt, context, voice marker, silence/deference proxy, consultation mode, and verification status. Duplicate checking used normalised URL and title comparison.

Data analysis proceeded through three linked tools. First, institutional voice allocation analysis identified whether documents authorised patients to request information, refuse treatment, complain, seek second opinions, or merely comply with procedures. Second, pragmatic deference and silence coding marked textual indicators of embarrassment, hierarchy, jargon, comprehension difficulty, minimal uptake, and compliance-oriented positioning. Third, interactional access and mediation mapping examined whether patient voice was routed through family members, language support, institutional complaint channels, telemedicine, or clinical documentation systems. Coding was conducted at document-excerpt level and remains open to manual validation. Figure 2 presents the operational sequence from corpus construction to analytical outputs.



Note. All coding begins from the same public-document corpus and remains limited to document-level interpretation.

Figure 1. Operational analysis matrix

4. RESULTS

4.1. Formal rights and the institutional distribution of patient voice

Public medical communication in this corpus constructs patient voice unevenly: it is formally recognised, institutionally conditioned, and only marginally displaced into obligation-centred language. Table 2 shows that most documents authorise patients as rights-bearing subjects, particularly through information, explanation, complaint, consent/refusal, and second-opinion markers. However, a substantial portion of the corpus does not directly allocate speaking rights; instead, it defines the broader organisational, technological, or communicative environment in which voice may or may not become available. This distribution matters because patient participation is not only produced inside consultation rooms but also prefigured by public documents, service rules, hospital pages, and professional communication norms. This pattern resonates with Forsey et al. [2] and Barnes and Woods [1], who argue that medical communication is structured through institutional arrangements rather than individual expression alone.

Table 2. Institutional voice allocation across public medical communication corpus

Main Category	Subcategory	Analytical Indicator	Frequency	Percentage	Data Variation	Example / Textual Excerpt	Data Codes
Voice-authorising rights	Information, explanation, complaint, consent/refusal, second opinion	Patient is positioned as a rights-bearing speaker who may request information, receive explanation, refuse, consent, complain, or seek another opinion	16	61.5%	6 primary data; 4 secondary data; 6 context data	"patients have rights to health information and adequate explanation"; "patient right to information, complaint, consent/refusal, or second opinion"	WPV-ID-001, WPV-ID-002, WPV-ID-004, WPV-ID-005, WPV-ID-006, WPV-ID-007, WPV-ID-008, WPV-ID-010, WPV-ID-011, WPV-ID-012, WPV-ID-013, WPV-ID-014, WPV-ID-015, WPV-ID-016, WPV-ID-017, WPV-ID-022
Contextual governance	Regulation, service system, telemedicine, clinical communication, digital documentation, language access	Document frames the institutional, technological, or communicative setting that shapes consultation without directly giving patients a speaking turn	9	34.6%	0 primary data; 8 secondary data; 1 context data	"institutional or technical setting affecting consultation"; "frames organisational context rather than direct speech opportunity"	WPV-ID-009, WPV-ID-018, WPV-ID-019, WPV-ID-020, WPV-ID-021, WPV-ID-023, WPV-ID-024, WPV-ID-025, WPV-ID-026
Obligation-centred positioning	Compliance, information provision, procedural obedience	Patient is positioned primarily as someone expected to provide	1	3.8%	0 primary data; 0 secondary data; 1 context data	"patient positioned mainly as information provider or rule follower";	WPV-ID-003

		information, follow rules, or comply with procedures				"compliance and obligations more than question-asking"	
Total	—	—	26	100%	6 primary data; 12 secondary data; 8 context data	—	WPV-ID-001–WPV-ID-026

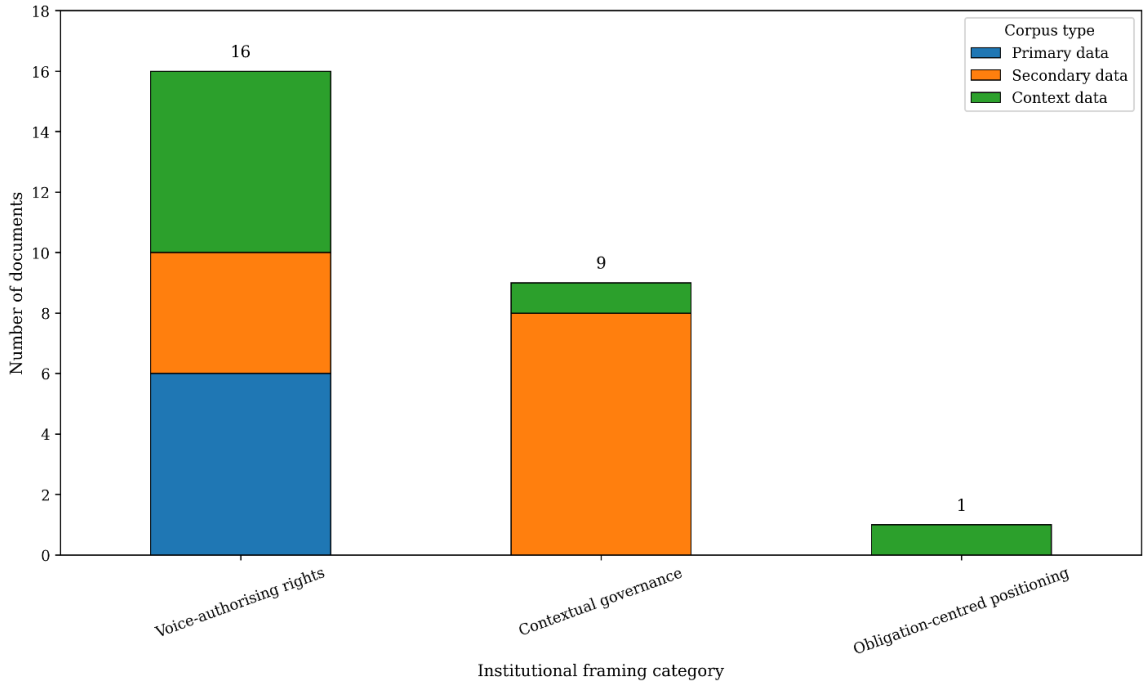


Figure 2. Institutional distribution of patient voice across corpus types

The dominant pattern is the prevalence of voice-authorising rights, which appears in 16 of 26 documents, or 61.5% of the corpus. These documents include national regulations, BPJS guidance, hospital patient-rights pages, and legal-health materials. Their recurrent language positions patients as entitled to "health information and adequate explanation," as well as to complaint, consent/refusal, and second opinion. Contextual governance appears in 9 documents, or 34.6%, mainly across secondary sources on communication, telemedicine, language barriers, silence, power asymmetry, and documentation systems. Obligation-centred positioning appears only once, but its presence is analytically important because it makes visible how patient voice can coexist with compliance expectations. The corpus therefore does not show the absence of formal voice; it shows a layered distribution in which rights, systems, and obligations coexist within the same communicative field.

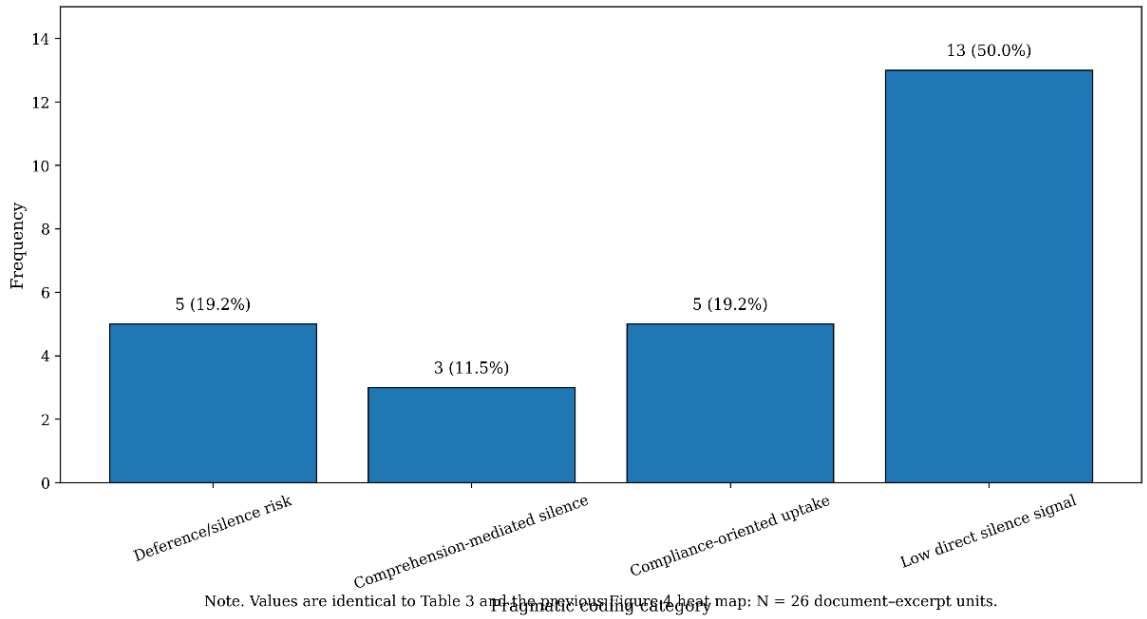
Patient silence becomes more intelligible when these formal patterns are read through institutional voice allocation rather than through assumptions about personal reluctance. If patients are granted rights to explanation, refusal, complaint, or second opinion, non-questioning cannot automatically be interpreted as understanding or consent. It may instead indicate a gap between formal entitlement and interactional usability. Brown and Collini [11] caution that silence in medical contexts may carry meanings that institutions fail to recognise, while Scherer et al. [6] connect participation difficulty to power asymmetry and embarrassment. Van Dongen et al. [13] further show that speaking up depends on enabling conditions, not merely individual willingness. This corpus supports that theoretical position: patient voice is institutionally named, but its practical distribution remains dependent on whether documents and consultation routines transform formal rights into usable speaking opportunities.

4.2. Deference, minimal uptake, and the withholding of questions

Patient non-questioning becomes analytically visible when silence is coded through its pragmatic conditions rather than treated as an empty space in interaction. Table 3 shows four document-level patterns: explicit deference or silence risk, comprehension-mediated silence, compliance-oriented uptake, and low direct silence signal. The distribution is intentionally conservative. Only five items are coded as directly naming deference or silence risk, while thirteen are retained as contextual rather than direct evidence. This distinction is important because public documents do not provide live turn-by-turn consultation data. They show how silence is made likely, intelligible, or institutionally backgrounded. This approach follows Brown and Collini's [11] argument that silence requires acknowledgment, while avoiding unsupported claims about actual patient conduct.

Table 3. Pragmatic silence and deference coding across document–excerpt units

Main Pattern	Subcategory	Analytical Indicator	Frequency	Percentage	Distribution by Data Type	Textual Excerpt / Corpus Marker	Data Codes	Interpretive Boundary
Deference and silence risk	Power asymmetry, embarrassment, emotional inhibition, or silence explicitly named	Document directly marks silence, shame, embarrassment, hierarchy, inhibited speech, or reluctance to speak as relevant to medical communication	5	19.2%	0 context; 0 primary; 5 secondary	"power asymmetry and embarrassment impede patient participation"; "silence is part of all interactions"; "patients struggle to express discomfort because of health literacy and emotional inhibitions"	WPV-ID-017, WPV-ID-019, WPV-ID-020, WPV-ID-021, WPV-ID-023	Supports interpretation of silence as communicatively meaningful, but does not prove observed patient behaviour
Comprehension-mediated silence	Language barrier, health literacy problem, explanation difficulty, clarification issue	Document links patient voice to comprehension, linguistic accessibility, informed explanation, or difficulty recognising misunderstanding	3	11.5%	2 context; 1 primary; 0 secondary	"language barrier, health literacy problem, explanation or clarification issue"; "patient right to information and adequate explanation"	WPV-ID-001, WPV-ID-003, WPV-ID-012	Indicates conditions under which patients may not ask because questions are difficult to formulate
Compliance-oriented uptake	Advice-following, procedural obedience, information provision, rule compliance	Patient is positioned as expected to follow advice, provide information, or comply with procedures rather than negotiate meaning	5	19.2%	2 context; 2 primary; 1 secondary	"patient expected to comply with advice/procedures"; "question-asking may be pragmatically subordinated to compliance"	WPV-ID-002, WPV-ID-006, WPV-ID-010, WPV-ID-013, WPV-ID-016	Shows how institutional language may privilege cooperative uptake over explicit questioning
Low direct silence signal	Background communication context without explicit silence or deference marker	Document contributes contextual information but does not directly name silence, deference, embarrassment, or inhibited questioning	13	50.0%	4 context; 3 primary; 6 secondary	"document provides background but little direct silence/deference signal"; "use as context rather than primary evidence for silence"	WPV-ID-004, WPV-ID-005, WPV-ID-007, WPV-ID-008, WPV-ID-009, WPV-ID-011, WPV-ID-014, WPV-ID-015, WPV-ID-018, WPV-ID-022, WPV-ID-024, WPV-ID-025, WPV-ID-026	Prevents overreading; these items support institutional context but are not treated as direct evidence of patient silence



Note. Values are identical to Table 3 and the previous Figure 4 heat map: N = 26 document–excerpt units.

Figure 3. Pragmatic silence and deference coding across document-excerpt units

The dominant pattern is low direct silence signal, found in 13 of 26 document–excerpt units, or 50.0% of the corpus. These texts contribute contextual evidence on rights, service systems, telemedicine, family involvement, and documentation, but they do not directly name silence, embarrassment, or deferential non-questioning. Two more specific patterns each appear in five documents: deference/silence risk and compliance-oriented uptake, each representing 19.2% of the corpus. The first appears only in secondary sources, where terms such as "power asymmetry," "embarrassment," and "emotional inhibitions" explicitly frame inhibited patient participation. The second appears across context, primary, and secondary data, suggesting that compliance language circulates beyond academic discussion. Comprehension-mediated silence appears in three documents, mainly around health literacy, explanation, and language accessibility.

The pattern suggests that Indonesian medical communication is publicly organised around rights and service procedures more strongly than around the interactional difficulty of asking questions. This does not mean that silence is absent; rather, silence is rarely named directly in patient-facing and regulatory discourse. Scherer et al. [6] show that power asymmetry and embarrassment shape participation preference, while Van Dongen et al. [13] demonstrate that speaking up depends on enabling conditions. Indonesian studies on jargon, directive speech acts, and language barriers similarly indicate that question-asking may be constrained before a patient ever refuses to speak [8], [9], [10]. This corpus therefore positions silence as a

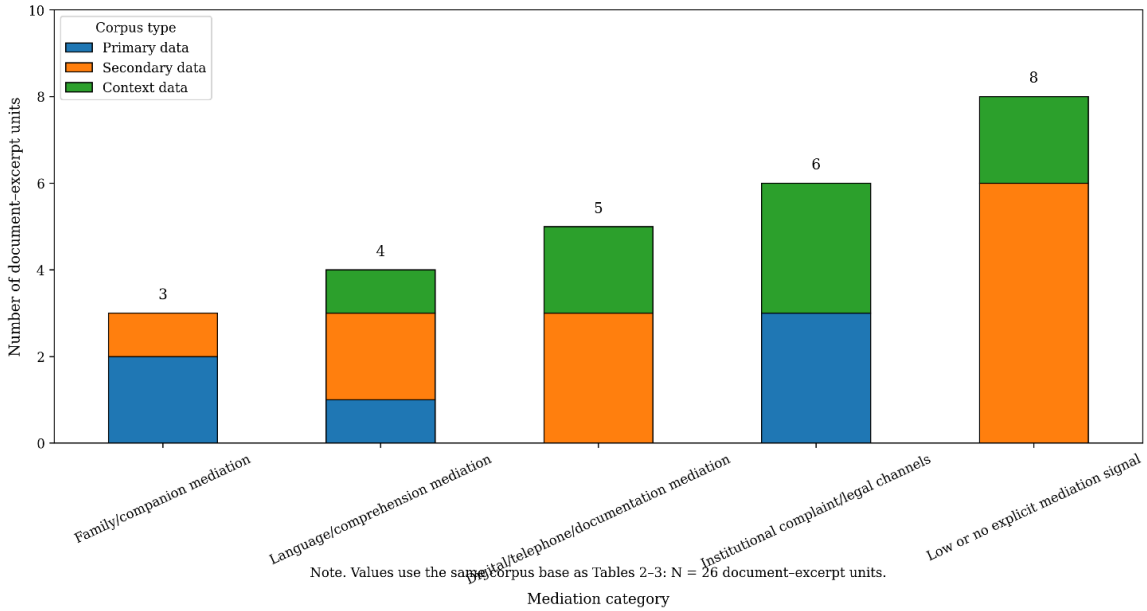
mediated pragmatic outcome: patients may be formally entitled to voice, yet the documents most visible to them often provide limited language for recognising silence as a clinical risk.

4.3. Mediated routes of patient voice across family, language, digital, and institutional channels

Patient voice in this corpus is not only allocated formally or inhibited pragmatically; it is also routed through mediating structures that determine whether speaking becomes practically available. Table 4 identifies five pathways: family or companion mediation, language and comprehension mediation, digital or documentation mediation, institutional complaint/legal channels, and low explicit mediation signal. The largest category is not a direct route but a contextual one, which indicates that several documents discuss communication, hierarchy, or governance without specifying how patients may actually activate voice. This matters because access to voice is rarely a single event. It is distributed across family relations, linguistic accessibility, remote consultation formats, documentation systems, and complaint procedures. This pattern aligns with studies of accompanied consultations, telehealth, and communication hierarchy [21], [23], [24].

Table 4. Interactional access and mediation across document–excerpt units

Main Mediation Pattern	Subcategory	Analytical Indicator	Frequency	Percentage	Distribution by Data Type	Textual Excerpt / Corpus Marker	Data Codes	Interpretive Boundary
Family/companion mediation	Family as representative, caregiver, co-decision participant, or substitute speaker	Patient voice is routed through family members or caregivers, especially in serious illness, consent, care planning, or patient-family rights material	3	11.5%	2 primary; 1 secondary; 0 context	"patient and family rights"; "patients with cancer and family caregivers"; "family participation in preference and care planning"	WPV-ID-011, WPV-ID-014, WPV-ID-022	Shows mediated participation, not direct evidence that family always limits patient voice
Language/comprehension mediation	Explanation, health literacy, language accessibility, patient understanding	Patient voice depends on whether medical information is understandable enough to support clarification or question-asking	4	15.4%	1 primary; 2 secondary; 1 context	"patient right to information and adequate explanation"; "language barrier and health literacy problem"; "explanation or clarification issue"	WPV-ID-001, WPV-ID-012, WPV-ID-016, WPV-ID-023	Supports analysis of comprehension as a condition of voice, not as measured patient understanding
Digital/telephone/documentation mediation	Telemedicine, telephone consultation, digital safety, AI documentation, medical records	Patient voice is mediated by technological platforms, remote symptom narration, documentation systems, or digital health infrastructure	5	19.2%	0 primary; 3 secondary; 2 context	"telemedicine and physician–patient communication"; "telephone consultation symptom reporting"; "digital health and patient safety"; "clinical documentation context"	WPV-ID-008, WPV-ID-009, WPV-ID-024, WPV-ID-025, WPV-ID-026	Indicates mediated consultation conditions; does not claim platform effects are causal
Institutional complaint/legal channels	Complaint, refusal, consent, second opinion, service entitlement	Patient voice is recognised through formal mechanisms for complaint, consent, refusal, information request, or institutional accountability	6	23.1%	3 primary; 0 secondary; 3 context	"right to complain"; "right to consent or refuse"; "right to obtain information"; "service rights and obligations"	WPV-ID-002, WPV-ID-005, WPV-ID-006, WPV-ID-010, WPV-ID-013, WPV-ID-015	Shows formal routes for voice, but not whether patients feel safe using them
Low or no explicit mediation signal	Background governance, communication research, hierarchy, silence, speaking-up context	Document contributes to institutional or theoretical context but does not specify a concrete route through which patient voice is mediated	8	30.8%	0 primary; 6 secondary; 2 context	"background communication context"; "hierarchy and speaking-up"; "silence and medical education"; "primary-care communication review"	WPV-ID-003, WPV-ID-004, WPV-ID-007, WPV-ID-017, WPV-ID-018, WPV-ID-019, WPV-ID-020, WPV-ID-021	Retained as contextual support to prevent overclassification



Note. Values use the same corpus base as Tables 2–3: N = 26 document–excerpt units.

Figure 4. Mediated routes of patient voice across document-excerpt units

The most frequent explicit mediation route is institutional complaint/legal channels, appearing in 6 of 26 units, or 23.1% of the corpus. These documents use markers such as "right to complain," "right to consent or refuse," and "right to obtain information," showing that patient voice is often formalised through institutional accountability. Digital, telephone, and documentation mediation appears in 5 units, or 19.2%,

through references to telemedicine communication, telephone symptom reporting, digital health safety, medical records, and AI-related documentation contexts. Language and comprehension mediation appears in 4 units, while family or companion mediation appears in 3. Textual markers such as "patient and family rights," "patients with cancer and family caregivers," and "language barrier and health literacy problem" show that patient voice is frequently indirect, relational, or technically mediated rather than simply individual.

These findings sharpen the argument that patient silence must be interpreted through access conditions, not only through observable speech absence. A patient who does not ask may be positioned within a family-mediated encounter, a jargon-heavy explanation, a remote platform, or a rights framework that recognises complaint after care but gives limited support for immediate clarification during care. Zhang et al. [25] and Yang et al. [24] show that companions can contribute to information gathering, yet such contribution may also redistribute the patient's own speaking position. Effendi et al. [7] and Shaban [16] similarly suggest that digital consultation can extend access while preserving interactional asymmetry. This corpus therefore indicates that unequal voice is not produced by silence alone. It emerges when institutional rights, comprehension demands, family mediation, and technological formats unevenly determine who can speak, when, and through which channel.

5. DISCUSSION

The prominence of formal rights language in the corpus has an important functional implication: Indonesian medical communication already possesses a normative vocabulary for patient voice, but this vocabulary does not automatically secure interactional participation. Documents that recognise rights to information, explanation, complaint, refusal, consent, and second opinion construct patients as legitimate speakers before the institution. This is significant because silence cannot be read as simple approval when institutional texts themselves acknowledge that patients are entitled to ask, clarify, and contest. Yet the same pattern also reveals a dysfunction: patient voice is often articulated as a formal entitlement rather than as a practical communicative procedure embedded in consultation talk. This finding extends Forsey et al.'s [2] argument that patient–physician communication is not a soft skill but a constitutive part of clinical practice. It also aligns with Barnes and Woods [1], who show that participation depends on interactional organisation. Rights discourse therefore functions as a necessary but insufficient condition for voice.

The underlying structure behind this gap lies in the difference between institutional recognition and interactional usability. Public documents can name patient rights without specifying how those rights are activated during a rushed explanation, a hierarchical encounter, or a moment of diagnostic uncertainty. This study does not claim that formal rights fail in practice, because consultation transcripts are not used as direct evidence. Rather, the corpus suggests a structural tension: voice is legally and administratively authorised, while the interactional conditions required to make voice usable remain less explicit. This helps explain why patient participation may remain uneven even when rights are publicly available. Adelsjö et al. [3] show that medication-management communication depends on openings created within consultation sequences, not merely on the existence of information. Similarly, Lee et al. [4] demonstrate that outpatient communication patterns are shaped by consultation time. Formal voice becomes meaningful only when institutional recognition is translated into turn-taking opportunities, repair practices, and comprehension checks.

The second finding, centred on silence, deference, and compliance-oriented uptake, shifts attention from whether patients have rights to whether they can occupy a questioning position without social or emotional cost. Its implication is clinically consequential: non-questioning may function as cooperation, but it may also mask uncertainty, embarrassment, fear of appearing disrespectful, or inability to formulate a question. This matters because a consultation can appear smooth precisely when voice is constrained. Brown and Collini [11] argue that silence in medical education and practice should be acknowledged rather than treated as absence. Scherer et al. [6] similarly show that power asymmetry and embarrassment shape participation preferences and decisional conflict. The corpus supports this line of scholarship by showing that explicit silence and deference markers are concentrated in secondary literature, while patient-facing documents more often foreground rights or obligations. Silence therefore operates as a hidden communicative risk: recognisable to scholars, but less visible in everyday institutional language.

The pattern can be explained by a structural asymmetry between expertise and entitlement. Physicians are institutionally licensed to diagnose, explain, recommend, and close topics, while patients must transform bodily experience into medically acceptable speech. In such a structure, deference is not merely a cultural trait; it is a pragmatic adaptation to unequal epistemic authority. Nazulpa [9] shows that directive speech acts in Indonesian rural consultations shape patient response positions, while Laila [8] demonstrates that medical jargon can limit comprehension in informed consent practices. Nurtyas [10] further indicates that multilingual barriers may intensify communicative dependence. These studies help explain why compliance-oriented uptake appears alongside formal rights in this corpus. When patients are addressed as recipients of explanation or followers of procedure, the cost of interrupting, asking again, or challenging advice may

increase. This study therefore interprets silence as structurally patterned, though not causally determined, by professional authority, linguistic difficulty, and routinised clinical expectations.

The third finding, concerning mediated routes of voice, shows that patient participation is frequently indirect. Voice may pass through family members, complaint channels, digital platforms, telephone consultation, documentation systems, or language and comprehension supports. The implication is that "patient voice" should not be conceptualised as a single autonomous act performed by an isolated individual. In Indonesian medical settings, voice may be relational, delegated, delayed, translated, documented, or procedurally rerouted. This has both functional and dysfunctional consequences. Family or companion mediation can help patients gather information, remember instructions, and articulate concerns, as shown in studies of accompanied consultations by Zhang et al. [25], Yang et al. [24], and Van Woerden et al. [23]. Yet mediation may also obscure whose preference is being voiced. Martina et al. [15] similarly show that advance care planning in Indonesia is shaped by family-caregiver involvement. Participation is therefore expanded and complicated at once.

The structure behind mediated voice lies in the interaction between relational care, institutional accountability, and technological mediation. Indonesian consultations are not always dyadic encounters between one physician and one patient; they may include families, insurance systems, hospital procedures, remote platforms, and documentation technologies. Effendi et al. [7] suggest that telemedicine communication in Indonesia is associated with health outcomes, while Shaban [16] argues that virtual consultations may preserve symptom-narration asymmetry and diagnostic uncertainty. Bavngaard et al. [21] and White et al. [22] likewise show that video and telehealth consultations require tailored communicative practices rather than simple transfer of face-to-face norms. This study's corpus indicates that mediated voice is not peripheral but central to how participation is organised. The theoretical contribution is therefore to reframe patient silence as distributed across institutional, relational, linguistic, and technological arrangements. Patients may not ask not because they lack concern, but because voice is unevenly channelled before consultation begins.

6. CONCLUSION

This study demonstrates that patient silence in Indonesian medical consultations should be understood not as communicative emptiness, but as a patterned outcome of formal rights, pragmatic deference, and mediated access to voice. Its central lesson is that patients may be legally recognised as speakers while remaining interactionally constrained in asking, clarifying, or disagreeing. By combining institutional voice allocation analysis, pragmatic silence coding, and mediation mapping, this study renews medical communication scholarship by shifting attention from whether patients speak to how conditions for speaking are distributed. This contribution refines inquiry into patient participation by linking silence, hierarchy, comprehension, and mediation within one coherent analytical framework.

This study is limited by its reliance on public documents and document–excerpt coding rather than direct recordings of clinical consultations, patient interviews, or longitudinal observation of communicative outcomes. Consequently, this study cannot claim how often patients remain silent in actual encounters, nor whether silence produces specific clinical consequences. Future research should therefore incorporate naturally occurring consultation transcripts, multilingual interaction data, patient and clinician interviews, and comparative sites across urban, rural, public, private, and telemedicine settings. Further studies should also examine how family members, nurses, translators, and digital platforms reshape question-asking in real time, enabling a fuller account of unequal voice in Indonesian healthcare.

ACKNOWLEDGMENTS

The author thanks the reviewers and editorial team for their constructive feedback on this manuscript.

FUNDING INFORMATION

Author states no funding involved.

AUTHOR CONTRIBUTIONS STATEMENT

Helen Qurrotu Aini: conceptualization, methodology, formal analysis, writing – original draft, writing – review and editing.

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-rights documents, verified public-health and scholarly materials, and contextual regulatory sources on patient voice, silence, deference, and mediated medical communication.

ETHICAL APPROVAL

This research did not involve human or animal subjects; it analyzed publicly accessible patient-rights documents and verified public-health and scholarly materials, 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-rights documents and verified public-health and scholarly materials on patient voice, silence, deference, and mediated medical communication analyzed in this study are available from the corresponding author upon reasonable request.

REFERENCES

[1] R. K. Barnes and C. Woods, "Communication in primary healthcare: A state-of-the-art literature review of conversation-analytic research," Research on Language and Social Interaction, vol. 57, pp. 7-37, 2024.

[2] J. Forsey, S. L. Ng, P. Rowland, R. Freeman, C. Li, and N. N. Woods, "The basic science of patient–physician communication: A critical scoping review," Academic Medicine, vol. 96, pp. S109-S118, 2021.

[3] I. Adelsjö, L. Nilsson, A. Hellström, M. Ekstedt, and E. Lehnbom, "Communication about medication management during patient–physician consultations in primary care: A participant observation study," BMJ Open, vol. 12, 2022.

[4] M. Lee, B. Oh, and M. You, "Consultation time and communication patterns in outpatient care: An observational study in South Korea," BMC Health Services Research, vol. 25, 2025.

[5] A. A. Merchant, N. Q. Shaikh, N. Afzal, A. Noorali, K. A. Rahim, R. Ahmad, A. Ahmer, A. Khan, S. Bakhshi, S. B. Z. Mahmood, M. Lakhdir, M. R. Khan, M. Tariq, and A. Haider, "Disparities in patient-resident physician communication and counseling: A multi-perspective exploratory qualitative study," PLOS ONE, vol. 18, 2023.

[6] K. A. Scherer, B. Büdenbender, A. K. Blum, B. Grüne, M. C. Kriegmair, M. S. Michel, and G. Alpers, "Power asymmetry and embarrassment in shared decision-making: Predicting participation preference and decisional conflict," BMC Medical Informatics and Decision Making, vol. 25, 2025.

[7] D. Effendi, S. Handayani, A. Nugroho, I. Ardani, Y. Fitrianti, K. Karlina, and C. Latifah, "The significance of physician-patient communication on telemedicine patients' health outcomes: Evidence from Indonesia," Health Communication, vol. 39, pp. 1932-1941, 2023.

[8] N. Laila, "Medical jargon and patient comprehension: A linguistic analysis of informed consent practices in Indonesian hospitals," Indonesian Journal of Medical Linguistics, vol. 1, no. 1, pp. 13-25, 2026.

[9] I. L. Nazulpa, "Doctor–patient communication in rural Indonesia: A pragmatic study of directive speech acts in clinical consultations," Indonesian Journal of Medical Linguistics, vol. 1, no. 1, pp. 1-12, 2026.

[10] M. Nurtyas, "Language barriers in healthcare delivery: A sociolinguistic case study of multilingual patients in Indonesian urban clinics," Indonesian Journal of Medical Linguistics, vol. 1, no. 1, pp. 26-38, 2026.

[11] M. E. L. Brown and A. Collini, "On acknowledging silence within medical education," Medical Education, vol. 57, pp. 1191-1197, 2023.

[12] S. E. Lee and J. Lee, "Effects of hierarchical unit culture and power distance orientation on nurses' silence behavior: The roles of perceived futility and hospital management support for patient safety," Journal of Nursing Management, 2024.

[13] D. Van Dongen, F. Guldenmund, I. Grossmann, and J. Groeneweg, "Classification of influencing factors of speaking-up behaviour in hospitals: A systematic review," BMC Health Services Research, vol. 24, 2024.

[14] S. R. Andayani, "Whose pain is taken seriously? Linguistic credibility, gendered expression, and diagnostic inequality in Indonesian clinical encounters," Indonesian Journal of Medical Linguistics, vol. 1, no. 2, 2026.

[15] D. Martina, C. Y. Kustanti, R. Dewantari, N. Sutandyo, R. Putranto, H. Shatri, C. Effendy, A. Van Der Heide, C. V. D. Van Der Rijt, and J. Rietjens, "Advance care planning for patients with cancer and family caregivers in Indonesia: A qualitative study," BMC Palliative Care, vol. 21, 2022.

[16] M. Shaban, "Can telemedicine hear the patient? Interactional asymmetry, symptom narration, and diagnostic uncertainty in Indonesian virtual consultations," Indonesian Journal of Medical Linguistics, vol. 1, no. 2, 2026.

[17] L. Rietze, M. Purkis, K. Stajduhar, and D. S. Cloutier, "The sounds of silence: Problematizing voicelessness in nursing practice," Nursing Inquiry, vol. 33, 2025.

[18] G. Ozavci, T. Bucknall, R. Woodward-Kron, C. Hughes, C. Jorm, and E. Manias, "Creating opportunities for patient participation in managing medications across transitions of care through formal and informal modes of communication," Health Expectations, vol. 25, pp. 1807-1820, 2022.

[19] M. Keshavarzi, S. Safaie, S. A. Faghihi, and S. Zare, "Barriers of physician-patient relationships in professionalism: A qualitative study," Journal of Advances in Medical Education & Professionalism, vol. 10, pp. 199-206, 2022.

[20] Y. D. Rusita, "Constructing empathy through language: A linguistic perspective on compassionate communication in mental health services," Indonesian Journal of Medical Linguistics, vol. 1, no. 1, pp. 67-81, 2026.

[21] M. Bavngaard, E. Lüchau, E. A. Hvidt, and A. Grønning, "Exploring patient participation during video consultations: A qualitative study," Digital Health, vol. 9, 2023.

[22] S. J. White, A. D. Nguyen, P. Roger, T. Tse, J. Cartmill, S. Hatem, and S. M. Willcock, "Tailoring communication practices to support effective delivery of telehealth in general practice," BMC Primary Care, vol. 25, 2024.

[23] C. S. Van Woerden, H. Vroman, and P. L. P. Brand, "Child participation in triadic medical consultations: A scoping review and summary of promotive interventions," Patient Education and Counseling, vol. 113, 2023, Art. no. 107749.

[24] Z. Yang, W. Wu, and X. Wang, "Problem presentation in accompanied medical consultations: Patterns for multi-person participation," Health Communication, pp. 1-15, 2025.

[25] S. Zhang, M. Cheng, and W., "Companions' contributions to information gathering in Chinese outpatient clinical interaction," Sociology of Health & Illness, 2023.

BIOGRAPHY OF AUTHOR



Helen Qurrotu Aini Her primary research and professional expertise focus on marine pollution control: Studying the environmental impacts of contaminants from industrial, domestic, shipping, and radioactive sources on ocean ecosystems, along with evaluating international conventions (such as IMO regulations) designed to mitigate marine pollution, and also in relation with health care communication. She can be contacted at email: helenaini9@gmail.com.

InPress