A MITIGATED AUTHORITARIAN MODEL: AGE HIERARCHY AND MAYBORODA'S DISCOURSE TYPES IN UZBEK CONSULTATIONS WITH OLDER PATIENTS

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Abstract. This article asks whether S. V. Mayboroda's distinction between authoritarian and collegial medical discourse applies in a speech community where age seniority is strongly marked. In Andijan, Uzbekistan, 21 consultations (9 with patients aged 60–65) were observed without audio recording; a survey of 99 doctors and telephone conversations supplied further material. Each consultation was assigned a dominant model from three closed items: recommendation form, recipient of the news and decision-maker. The authoritarian model dominated 13 consultations, 10 of them in a mitigated form in which the doctor decides while the directive is framed by respectful address, obligation modality and reassurance. This form dominated 7 of 9 consultations with older patients. No discrediting moves were recorded, and difficult moments never led to a harsher tone. Patient age was related to the doctor's speech, supporting the first hypothesis; the hypothesis that younger doctors mitigate more was not confirmed.

Keywords: authoritarian discourse, collegial discourse, medical discourse, older patients, age hierarchy, overaccommodation, Uzbek

1. Introduction

Mayboroda (2021) describes two types of medical discourse built on the cognitive strategies of subordination and agreed decision (p. 34). Authoritarian discourse is interaction between communicants of unequal status "in which the participant vested with power uses speech as a means of influencing the opponent's

cognitive sphere in order to control his behaviour" (p. 59). In collegial discourse the participants exchange information openly to solve a problem jointly, and between participants of unequal status "their difference in status is not manifested in speech" (p. 137).

The two types rarely occur "in a 'pure' form" (p. 246); a dialogue moves between them through bifurcation points, at which the speaker chooses between types of speech behaviour (p. 42). The patient's age "does not correlate with an orientation towards the collegial or authoritarian type of communication" (p. 246), although it is listed among the factors the doctor must take into account (p. 10). In her data social status takes priority over age status: a young female doctor can admonish an older patient "without the risk of retaliatory communicative sanctions" (p. 81; see also p. 115).

In Uzbek, age seniority is marked in grammar and address; addressing an older person with the familiar *sen* is not accepted (Muminova, 2015, p. 98). A doctor who is younger than the patient therefore stands above the patient institutionally and below the patient by age. Speech adjusted to stereotypes of old age can limit older people's communicative opportunities (Ryan et al., 1986), and in dependency-related overaccommodation talk becomes controlling because the older person depends on the speaker (Coupland et al., 1988). Such talk may overlap with authoritarian discourse.

The article asks how consultations with older Uzbek patients are distributed across Mayboroda's types and how the patient's and the doctor's age relate to them. Two hypotheses were formulated before data collection: that, unlike in the Russian material, patient age affects the communication model, with open authoritarian forms less frequent with older patients (H1), and that younger doctors address directives to older patients in a more mitigated form than older doctors (H2).

2. Data and methods

The data were gathered in Andijan in October 2026. With the doctor's consent, an observer attended 21 routine consultations (hospital 8, polyclinic 7, private clinic 6), took no part in the talk and noted key utterances verbatim on paper (98 quotations); without audio recordings there are no full transcripts. Nine consultations involved patients aged 60–65 and twelve patients aged 21–45. A 27-item form recorded the doctor's age group (under 35, 35–55, over 55), the main form of recommendation, the recipient of important news, the decision-maker and any difficult moment with the doctor's subsequent tone. A survey of 99 doctors (89 under 35) and unrecorded telephone conversations (S- doctors, K- older patients) supply further material. The dominant model of each consultation was assigned by applying the criteria in Table 1 in sequence: family-oriented features first, then collegial ones, with the remaining consultations divided by recommendation form. The classification is preliminary, and inter-annotator agreement was not calculated. Fisher's exact test was used for group differences ($p < 0.05$).

3. Results

3.1. Criteria and distribution of models

Table 1. Criteria for the dominant model and distribution of consultations

Model	Criterion	Patients 60+ (n = 9)	Patients under 60 (n = 12)	Total
Family-oriented	News given first or only to a relative, or decision made by a relative	0	4	4
Collegial	Recommendation in interrogative or inclusive "we" form, or decision made jointly	1	3	4
Mitigated authoritarian	Recommendation in obligation form or through a relative; decision made by the patient	7	3	10

Model	Criterion	Patients 60+ (n = 9)	Patients under 60 (n = 12)	Total
Direct authoritarian	Recommendation in the imperative; decision made by the patient	1	2	3

The authoritarian model was dominant in 13 of the 21 consultations, 10 in the mitigated and 3 in the direct form. With older patients the mitigated authoritarian model dominated 7 of 9 consultations, whereas with younger patients all four models occurred. The family-oriented pattern appeared only with younger patients who came with a parent or spouse and is not analysed here.

3.2. The structure of mitigated authoritarian consultations

The mitigated consultations with older patients follow a recurrent sequence. They open with a respectful address (*otaxon*, *hoji ota*, *onaxon*); the recommendation is given with obligation modality (*ichishingiz kerak* 'you need to take [it]'); reassurance or normalisation follows, for example *Hech narsamas bu, sizdan battarlariyam tuzaldiku* 'This is nothing, people worse off than you have recovered' (KZ-07); and the consultation ends with a wish (*Otaxon, o'zingizni asrang* 'Otaxon, take care of yourself', KZ-17). Normalisation was the most frequent means of reassurance overall (10 of 21 consultations). One patient was described by the observer as *soddagina aytganni qiladigan inson* 'a simple person who does what he is told' (KZ-01); submission here appears to rest on respect and trust.

The direct authoritarian model dominated three consultations, two with women aged 35 (KZ-03) and 42 (KZ-11). About KZ-03 the observer wrote *Doktor dadil gapirdi, bemorni o'ziga qaratib, bo'ysundirdi* 'The doctor spoke confidently, drew the patient's attention and made the patient submit', the case closest to Mayboroda's classic type. With older patients the direct form was coded once (KZ-08) and the collegial model once (KZ-21, joint decision).

Of the auxiliary strategies of the authoritarian type, encouragement (*Avvalgidan ancha yaxshisiz* 'You are much better than before', KZ-05, KZ-15) and negative motivation (see 3.3) were present. Discreditation was not recorded in the 21 consultations or in the informant and telephone material. The sharpest utterance stays within irony: *Meni oldimga dam soldirgani kelmagandirsiz* 'I don't suppose you came to me to have a prayer breathed over you' (S-1).

3.3. Turning points and refusals

A difficult moment, treated as a bifurcation point, occurred in 7 of the 21 consultations, 6 with older patients. In four cases the patient did not hear or understand (three of them older patients), in two an older patient became agitated or anxious, and in one a relative intervened. The doctor's tone then softened (four cases) or stayed unchanged (three), never harsher. In KZ-19, after the patient's agitation, the doctor moved from the formal *otaxon* to *Otajon, yaqinlaringizni o'ylang* 'Otajon, think of your loved ones'.

In the survey, doctors' responses to an older patient's refusal were warning about the consequences (38%), offering another medicine or method (24%), explaining again (20%) and involving a relative (17%). One doctor framed avoiding harsh speech as a professional norm: *Qattiq gapira olmayman. Chunki bemor sizdan davo izlab keldi* 'I cannot speak harshly, because the patient came to you looking for a cure' (S-2).

3.4. Patient age, doctor age and the hypotheses

Patient age was associated with significant differences in three features. Kinship or religious-status address (*otaxon*, *hoji ota*) was used with 8 of 9 older patients and none of 12 younger ones ($p < 0.001$); obligation modality was the main recommendation form with 7 of 9 and 3 of 12 ($p = 0.03$); and the direction of information differed ($p = 0.045$). The authoritarian model, mostly mitigated, dominated

8 of 9 consultations with older patients and 5 of 12 with younger ones, a difference that approaches but does not reach significance ($p = 0.07$). H1 is therefore supported in this material.

All three consultations of doctors over 55 were mitigated authoritarian. The imperative as main form was recorded only with doctors under 35, in 7 of their 10 consultations against none of the 11 consultations of older doctors ($p = 0.001$). However, 8 of the young doctors' 10 consultations were with younger patients; with older patients, young doctors used the imperative once (KZ-08) and obligation modality once (KZ-19). H2 is not confirmed. In the survey, only doctors under 35 chose "I explain again" as their response to an older patient's refusal (20 of 89, 22%; 0 of 10 older doctors), while older doctors more often chose warning (5 of 10). With ten respondents over 35, this is descriptive.

4. Discussion

4.1. A subtype of authoritarian discourse

The mitigated consultations meet the core of Mayboroda's definition: the participant vested with power controls the other's behaviour, and the other shows readiness to submit (Mayboroda, 2021, p. 59). They differ from her description in that discreditation was absent and directives to older patients were framed by obligation modality and respectful address. Their verbal form approaches the collegial type, in which status differences are not manifested in speech (p. 137), while decision rights remain authoritarian. Since pure types are rare (p. 246), it seems useful to treat one recurrent mixture, authoritarian decision rights in a respectful verbal form, as a subtype. The dynamics point the same way: a bifurcation point can turn a collegial dialogue into an authoritarian one (p. 42), but here turning points were followed by a softer or unchanged tone.

Where Mayboroda's data show social status taking priority over age status (pp. 81, 115), in the Uzbek data age status appears to operate with a force close to that of institutional status.

4.2. Patient age and doctor age

Support for H1 contrasts with Mayboroda's finding that patient age does not correlate with an orientation towards either type (p. 246). The results are not directly comparable, since she measured the patient's orientation and this study the doctor's speech, and they fit with her proposition that the doctor must take the patient's age into account (p. 10). H2 is harder to interpret, as doctor age and patient age are confounded and the numbers are too small to separate them. Young doctors' softness may lie in their readiness to explain again, while the form of their directives follows the patient's age. The three consultations of doctors over 55 agree with Mayboroda's report that older doctors prefer the authoritarian model, though here it was realised without commands.

4.3. Relation to overaccommodation

Both authoritarian discourse and dependency-related overaccommodation (Coupland et al., 1988) involve controlling talk addressed to a dependent person. In the mitigated model the doctor keeps control over the decision while the verbal form remains respectful, combining control with deference to the elder. The inclusive "we", which the elderspeak literature lists among typical markers (Kemper, 1994; Shaw & Gordon, 2021), was a main recommendation form only with younger patients (2 of 12). Mayboroda (2021, p. 143) reads "we" constructions, used only by the doctor, as a sign of paternalistic status inequality; Barsukova and Rodionova (2021, p. 177) see the "we" form as supporting cooperation, and Markova and Barsukova (2022, pp. 139–140) evaluate "we" reassurance to a 76-year-old patient as successful. One older patient's

positive evaluation of *Birga davolanamiz* ‘We will be treated together’ (K-1) cannot settle how older patients hear it.

5. Conclusion

In the observed consultations the authoritarian model dominated 13 of 21 cases and, with patients aged 60 and over, mostly took a mitigated form (7 of 9): the doctor retains the decision, the directive is framed by respect and reassurance, discreditation was not recorded, and difficult moments led to a softer or unchanged tone. Patient age was related to the form of the doctor’s speech, supporting H1; H2 was not confirmed, since direct imperatives occurred only with young doctors and mainly with patients of their own age. Mayboroda’s typology thus seems applicable to Uzbek material if age hierarchy is added as a factor in how the authoritarian type is realised. With a small sample from one city and one observer, routine consultations with patients up to 65 and no full transcripts, this proposal needs testing on fuller recorded data.

References

1. Barsukova, M. I., & Rodionova, T. V. (2021). Kommunikativnye riski v diade “vrach – patsient” [Communicative risks in the doctor–patient dyad]. *Izvestiya Saratovskogo universiteta. Novaya seriya. Seriya: Filologiya. Zhurnalistika*, *21*(2), 176–179. https://doi.org/10.18500/1817-7115-2021-21-2-176-179

2. Coupland, N., Coupland, J., Giles, H., & Henwood, K. (1988). Accommodating the elderly: Invoking and extending a theory. *Language in Society*, *17*, 1–41.

3. Kemper, S. (1994). Elderspeak: Speech accommodations to older adults. *Aging, Neuropsychology, and Cognition*, *1*, 17–28.

4. Markova, A. A., & Barsukova, M. I. (2022). Taktika soobshcheniya plokhikh novostey v professional'nom obshchenii vracha i patsienta [The tactic of breaking bad news in professional doctor–patient communication]. *Arkhiv vnutrenney meditsiny*, *12*(2), 136–142. https://doi.org/10.20514/2226-6704-2021-12-2-136-142

5. Mayboroda, S. V. (2021). *Rechevye strategii vracha v usloviyakh kollegial'noy i avtoritarnoy modeli kommunikatsii doktora i patsienta: Skhozhdeniya i protivorechiya* [Doctor's speech strategies in the collegial and authoritarian models of doctor–patient communication: Convergences and contradictions] [Candidate of Sciences dissertation, Saratov State University].

6. Muminova, A. A. (2015). Uzbekskiy rechevoy etiket: sen (ty), siz (vy, Vy) [Uzbek speech etiquette: sen (ty), siz (vy, Vy)]. *Vestnik RUDN. Seriya: Teoriya yazyka. Semiotika. Semantika*, (3), 95–102.

7. Ryan, E. B., Giles, H., Bartolucci, G., & Henwood, K. (1986). Psycholinguistic and social psychological components of communication by and with the elderly. *Language & Communication*, *6*(1–2), 1–24.

8. Shaw, C. A., & Gordon, J. K. (2021). Understanding elderspeak: An evolutionary concept analysis. *Innovation in Aging*, *5*(3), Article igab023. https://doi.org/10.1093/geroni/igab023