THE COMMUNICATIVE LANGUAGE IN MEDICINE. *TO BE* AND *TO HAVE* IN MEDICAL EXPRESSIONS

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What's wrong (with you)?
What do you complain of?
What's the matter (with you)?
What's troubling/bothering you?
What disturbs/ails you?
Where does it hurt?
What kind of pain is it?

We live in a stressed and dramatic world where such questions are frequently heard and used either from specialists in medicine or from common people, good friends, ready to give a good advice of health. The most important and primordial field is and will remain health, the world of doctors and pharmacists being frequently the first request.

For quite some time health and social care has been the locus of interdisciplinary research in a number of disciplines in the human and social sciences: anthropology, education, law, philosophy, psychology, sociology, literature and linguistics. The different disciplines have engaged with core themes, *e.g.*, social psychological aspects of coping, narratives of illness, cultural models of health belief, sociological studies of medical ideology and power relations, media studies of health and disease representations, public understanding of science and medicine etc.

What's upsetting you?
How long does it last?
Does it irradiate? Where?
In what circumstances does it appear/disappear?

Simple questions asked by the doctor to the patient. Communication in medicine is committed to a broad notion of language and communication, as well as an integrated notion of medical and healthcare practices. A starting point is the role of language, taking into account its multiple layers of meaning and its linkages with coexisting contexts. Like in all fields, medicine has also a special language. There is an aspect of the communication between doctors and patients, namely the use of medical terminology has so far received little attention.

The clinical encounter between doctors and patients, and between healthcare professionals and clients more generally, has long been recognized as a communicative relationship. The notion of communicative relationship is better seen as a continuum, ranging from the pathological to the holistic.

Please lie down.
Please stay relaxed.
Hold your breath.
Does it hurt here?
Relax your belly.
Bend your knees.
Breathe deeply with your mouth open.

Language plays a prominent role in all stages of the medical process: from noting symptoms, questioning patients and describing physiological functions, to history taking and noting the progress of disease, to writing a prescription (and can be extended to medical). When we address to a doctor (GP), we don't forget he is a **doc**, if we do not find him, he could be in the **lab** and his patient has a **flu** and some problems with his **tummy**. The **surgeon** is a specialist who operates. In British English, in cases we address to the surgeon, we will not use the formula Doctor, but Mr., Mrs. or Ms.; but, "Mr. Kelly is a very experienced surgeon".

In the contemporary clinic, communication issues come to the fore, in light of medical uncertainties about new illnesses defying diagnosis or definitive prognosis. This leads to a shift in healthcare from diagnosis and cure towards prevention and care. Added to this is the coming of age of the literate patient who has unrestricted access to health information via websites and other support networks. In the area of telemedicine and e-health where face-to-face contact is absent, communicative resources are stretched to their maximum potential.

The same also holds for dealing with asymptomatic conditions, such as genetic disorders which are family illnesses and have consequences for significant others in terms of decisions about predictive or carrier testing, disclosure about health status etc.

Another way to approach the delimitation of medical terms could be the investigation of the most common categories of words used by doctors and nurses. The auxiliaries **To Be** and **To Have** are much used in such medical expressions.

To be fit, to be on a diet, to be run down, to be out of one's senses, to be seized by cramps, to be sensitive to, to be treated for, to be unwell, to be in want, to be liable to etc.

To have a bad sight, to have a fit of, to have a running nose, to have a sore throat, to have a fever, to have a buzzing in the ear, to have influenza etc.

The number of the most frequent groups of expressions appearing in medical encounters is not large. There are diseases and their symptoms, methods of examination, surgical interventions, medical specialties and hospital departments. However, even such delimitation is not without further complications. For example, a symptom is sometimes defined, at least on the part of the patient, as "any subjective evidence of disease".

Although my ability to present a new definition of a medical term is certainly limited, in the present paper I have attempted to exclude expressions which suffer from the above mentioned subjectivity, ambiguity, and other problematic features.

As a result, I have decided to present some medical terms:

You've got **laryngitis**…

Aspirin sometimes affects the **stomach**. I think you should take **Paracetamol** instead. It doesn't cause stomach problems.

Now I'm going to have a look with the magnifying **otoscope**, and if we need to later we can use the operating **microscope** to see your eardrum in more detail.

If you do have problems we can always help by giving you **HRT** (hormone replacement therapy)…

Doctor, you recommended that I saw a physiotherapist for my tennis elbow when I last visited you. She mentioned a treatment called **iontophoresis**.

What does it involve?

Well, this involves putting some cream on the skin over the elbow and then using a special electrical device to encourage it to penetrate the skin.

What seems to be the problem at the moment?

Well, I've been feeling so poorly recently.

I see. **Feeling poorly**. What do you mean by that?

I've been getting very short of breath.

Still, there are many examples of symmetrical features of doctor-patient communication, I understand especially the fact that: (1) Doctors tend to explain the process of examination; (2) Doctors are willing to explain the use medical terms; (3) Patients usually employ medical terminology correctly. On the contrary, as has been shown above, the findings below are believed to belong to the category of asymmetrical features: terms of doctor-initiated, patient-initiated; doctors initiate the use of medical terms; Patients only respond to doctor initiated questions; Doctors employ terms from all the categories; patients do not employ medical terms from the category of tools; doctors pose medical terms throughout the interview; only one patient-initiated term is posed during the treatment phase.

These findings are only preliminary, and can require subsequent analyses. However, both the quantitative and the qualitative findings suggest that medical terminology is deeply rooted in the medical encounter, and the tendency to use it is increasing.

Medical terms are scattered throughout our conversations, and a much wider knowledge of

terminology is discernible in everyday discourse than existed a generation ago. Thus, the avoidance of medical terminology in doctor-patient communication, is not the best way to bridge the gap between the doctor and his/her client. The patient should rather be understood as a responsible adult who is competent enough to find necessary information, especially about those medical branches he/she has not been in contact so far.

References

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