Some Observations on the Use of Medical Terminology in Doctor-Patient Communication

Miroslav Černý

This paper concentrates on some aspects of the use of medical terminology in doctor-patient communication. Its main aim is to discuss the significance of medical terms for the distribution of asymmetry between doctors and their clients. In order to reveal a more comprehensive picture of the employment of medical terms, the article also attempts to provide a comparative analysis of doctor-patient interviews in different medical settings.

Keywords: doctor-patient communication, medical terminology, comparative analysis.

1. Introduction

According to various linguists (e.g. Müllerová & Hoffmannová 2000: 10), research in the field of doctor-patient interaction forms a very important part of many approaches interested in the interpretation of spoken discourse. In particular, conversation analysts (e.g. Heath 1992, ten Have 1991) have been attempting to reveal the functioning of medical encounters, and therefore they have challenged most levels of its analysis. Unfortunately, one aspect of the communication between doctors and patients, namely **the use of medical terminology**, has so far received little attention. The aim of this presentation is to stress the importance of medical terminology as part of medical interviewing, and discuss its significance for the distribution of asymmetry.

Before the present paper was worked out, some of the most recent collections of studies touching the topic of doctor-patient communication (Fisher & Todd 1983, Pendleton & Hasler 1983, Raffel-Engel 1989) had been consulted. Surprisingly, only one out of 47 contributions (Shuy 1983) deals with medical terminology, and there are just a few general findings scattered throughout a couple of monographs on medical encounters (Roter & Hall 1992, Gwyn 2002). Consequently, there are almost no sources with which my own findings could be compared; the only exception being *A Manual of English for the Overseas Doctor* (Parkinson 2004) and two Czech sources, *Jak vedeme dialog s institucemi* (Müllerová & Hoffmannová 2000) and *Ustálené modely komunikace ve zvoleném typu komunikační události/dialog lékař – pacient* (Petrovová 1997).[1]

2. Methods and material

The language material for the present inquiry is taken from the corpus of conversational texts recorded in consulting rooms throughout Great Britain and the United States during 1990s, available in the book *English for Doctors* edited by Mária Györffy in 2001 (see References). The corpus in its entirety represents **authentic face-to-face medical conversation.** It consists roughly of about one hundred transcripts of spontaneous doctor-patient interviews, which are further

divided into 13 units, each of them based on a different medical branch. For the purposes of the analysis five of them, namely **Internal Medicine, Obstetrics and Gynaecology, Paediatrics, Oto-rhino-laryngology,** and **Orthopaedics,** have been intentionally chosen. The total extent of the material under scrutiny is 725 turns, and the total word stock amounts to 12,000 items.

The reason for including the five medical disciplines is that they represent different types of the genre under consideration; in other words, different manifestations of social reality. Moreover, the corpus gives us an opportunity for the **"communicative comparison"**, i.e. a comparative analysis of doctor-patient interviews in different medical settings.[2] It is believed (cf. Müllerová, Hoffmannová, and Schneiderová 1992) that such an approach may reveal a more comprehensive picture of doctor-patient communication and the process of its change.

3. Analysis

The very first problem that needs to be solved before starting the actual analysis is to discuss criteria determining the definition of medical terminology. In other words, to answer the question: **"What is, in fact, a medical term?"** It is not as easy to discern such terms as one might think. It does not mean there are no definitions provided. However, all definitions I have been able to collect so far are too broad, and they do not define precisely which words can be regarded as medical terms and which cannot.

It could be stated that the best method to reach a satisfactory conclusion is to consult a medical dictionary, e.g. *Dictionary of Medicine* (Collin 1996), and all words included must obviously belong to the terminology of the medical field. Nevertheless, I would argue whether such dictionary entries as, for instance, **head** or **leg** can be given the status of a term:

> Termín je lexikální jednotka sloužící odbornému vyjadřování s přesným, zpravidla pojmovým významem, ve svém oboru jednoznačná, ustálená a normalizovaná, bez vedlejších příznaků citových. (Petrovová 1997: 61)

> [The term is a lexical unit serving the language of profession, with precise, usually notional content, in its scientific branch unambiguous, stabilised and standardised, without additional indications and emotional connotations; translated by M.Č.]

Although English medical terminology is partly of Anglo-Saxon origin (e.g. heartburn), it should be noted that the majority of genuine terms are based in Greek or Latin (Examples 1 and 2).[3]

(1)   D: … We're going to perform a test puncture of the **antrum** using a Tilley-Lichtwitz **Trocar** and **cannula** …

(2)   D: … We have to suck out your **tracheostomy** before we take the old tube out in case you have a lot of **mucus** …

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. According to Müllerová (2000: 77), the number of the most frequent groups of expressions appearing in medical encounters is not large. She distinguishes **diseases** and **their symptoms, methods of examination, surgical interventions, medical specialities** 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" (see MedicineNet.com), which is in sharp contrast with the definition of terms as presented above.

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 work with the following group of medical terms: (1) **Diseases & Illnesses** (Example 3), (2) **Medications** (Example 4), (3) **Medical tools** (Example 5), and (4) **Procedures & Methods** (Example 6).

(3)   D: … You've got **laryngitis** …

(4)   D: … **Aspirin** sometimes affects the stomach. I think you should take **Paracetamol** instead. It doesn't cause stomach problems.

(5)   D: … 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.

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

As most of these terms are Graeco-Latin expressions, I believe that such word stock reduction helps to diminish the flow of non-medical terminology into my samples. In this way I have excerpted 88 medical terms (see the Appendix), some of which are employed repeatedly. As a result, the total number of terms examined amounts to 116 items. Details about their further classification and results of the F-test are presented below. A more subtle typology of terms has not been adopted, as it would be quite difficult to organise its quantification.

Abs.	**Particip**		**Phase**			**Category**				**Total**
	D	*P*	*Hist*	*Exam*	*Treat*	*I&D*	*Med*	*Tools*	*Meth*	
Internal	11	7	12	6	0	12	5	0	1	**18**
Gynaec.	32	6	0	27	11	15	10	5	8	**38**
Paed.	9	9	2	15	1	5	3	2	8	**18**
ORL	25	1	1	11	14	7	1	9	9	**26**
Orthop.	11	5	2	7	7	5	2	2	7	**16**
Total	**88**	**28**	**17**	**66**	**33**	**44**	**21**	**18**	**33**	**116**

Table 1: *Absolute Frequency of Terms in D-P Interviews*

%	Particip		Phase			Category				Total
	D	P	Hist	Exam	Treat	I&D	Med	Tools	Meth	
Internal	61	39	67	33	0	67	28	0	5	**16**
Gynaec.	84	16	0	71	29	40	26	13	21	**33**
Paed.	50	50	11	83	6	28	17	11	44	**16**
ORL	96	4	4	42	54	27	3	35	35	**22**
Orthop.	69	31	12	44	44	31	13	13	43	**13**
Total	**76**	**24**	**15**	**57**	**28**	**38**	**18**	**16**	**28**	**100**

Table 2: *Relative Frequency of Terms in D-P Interviews*

F	Participant			
	Gynaec.	*Paed.*	*ORL*	*Orthop.*
Internal	0.12	0.92	3.15E-05*	0.86
Gynaec.		0.09	1.40E-03*	0.20
Paed.			1.99E-05*	0.79
ORL				9.78E-05*

F	Phase			
	Gynaec.	*Paed.*	*ORL*	*Orthop.*
Internal	0.76	0.53	0.44	0.14
Gynaec.		0.68	0.18	0.04*
Paed.			0.15	0.04*
ORL				0.39

F	Category			
	Gynaec.	*Paed.*	*ORL*	*Orthop.*
Internal	0.08*	0.04*	0.07*	0.03*
Gynaec.		0.54	0.85	0.47
Paed.			0.68	0.92
ORL				0.60

Tables 3, 4, 5: *Results of the F-test*

4. Findings

According to Shuy: "From a linguist's perspective, vocabulary is the most trivial aspect of language studies! In physician-patient communication, it is the most obviously repairable problem, provided it is noticed and understood" (1983: 190). However, in some cases, especially when the medical terminology is concerned, it could be very difficult for patients to understand what their doctors mean by using certain words (Example 7). Moreover, even doctors themselves frequently face the same problems as "the patient may also have a medical, social, or regional vocabulary that is at odds with that of physician" (Shuy 1983: 190), as you may see in Example 8.

(7)   P: 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?
D: Well, Mr Foster, **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.

(8)   D: What seems to be the problem at the moment?
P: Well, I've been feeling **so poorly recently**.
D: I see. Feeling **poorly**. **What do you mean by that?**
P: I've been getting very short of breath.

Based on these assumptions, it can be stated that the relationship between the doctor and the patient is strictly asymmetrical. However, a more careful investigation of different elements of the medical encounter seems to provide little support for such a definite conclusion. The situation in the field of medicine is, in my opinion, much more complicated. Henceforth, through a comparative analysis of D-P dialogues in different medical branches, I shall demonstrate the constant shifts in "hierarchies" on the example of medical terminology, and offer a more lucid account of its usage. As mentioned earlier, similar insights into the use of medical terms are still missing.

Robert W. Shuy (1983: 190) points out that both patients and doctors believe that using inappropriate vocabulary, i.e. medical terminology, has a negative effect, and they tend to avoid it. In Joy Parkinson's view, "no medical terms should be used that the patient cannot understand" (2004: 96). Nevertheless, the statistics I have attempted to elaborate show that the reality is different. In general, both doctors and patients use medical terminology quite frequently, in all the medical branches under discussion (Examples 9, 10, and 11), throughout all the parts of the medical encounter, and from all the word categories selected (see Examples 3, 4, 5, and 6). Furthermore, patients usually understand the medical terms initiated by doctors and, in most cases, are even able to use them correctly.

(9)   D: When you had your first child, do you remember what kind of **anaesthetics** you had for delivery?
P: I managed at first for a little while using gas and air but after that it really became too painful and I had to have an **epidural**.
D: Did you start labour by yourself or did they have to give you some help?
P: No, it began by itself, although I remember some of the other women in the ward having to get started off.
D: Do you remember how long the labour went on for?
P: It was quite long. It was at least 24 hours.
D: And the delivery itself; was it **Caesarean**, a **forceps** or was it normal?
P: Well, in the end they had to use **forceps** to help get the baby out because he was beginning to get a bit tired as well.
(Obstetrics and Gynaecology)

(10) D: What I'd like to do now, Mrs Smith, is just have a look at James and check things out, like his heart and his chest. What I'm doing now is I'm having a look at his reflexes to make sure that they are in places I would expect them to be. Now I'm going to have a gentle look in his mouth with this wooden **spatula**. Now looking in his mouth I can see that he has a little bit thrush so I'll give you something called **Nystatin** for that, to help it go away. Can you tell me, Mrs Smith, whether you have any concerns about James?
M: Well, yes Doctor, I'm a little bit concerned about his cord because I would have expected it to have come off by now.
(Paediatrics)

(11) D: What tablets are you taking at present?
P: I'm taking **ibuprofen**.
D: Have you had any problems with them?
P: I sometimes get **indigestion** and heartburn.
D: Have you had any treatments in the past?
P: I tried **Gold injection** before but it was stopped after I developed itching and a rash.
D: How does your **arthritis** affect your life?
(Orthopaedics)

Out of 116 medical terms, there are 88 (76%) doctor-initiated and 28 (24%) patient-initiated in my sample (see Tables 1, 2). 44 (38%) terms belong to the category of illnesses and diseases, 21 (18%) to the category of medication, 18 (16%) to the category of medical tools, and 33 (28%) to the category of medical procedures (see Tables 1, 2). 17 (15%) terms appear during the history-taking phase, 66 (57%) during the examination phase, and 33 (28%) during the treatment phase (see Tables 1, 2).

Importantly, the number of terms excerpted would be much higher if it has been decided to investigate more categories of medical terminology, not just the category of illnesses, medications, instruments and procedures. However, as has been stressed, the reason for selecting only four types of terms is (1) the attempt to secure the terminological status of the words under scrutiny (mostly of Graeco-Latin origin) and, moreover, (2) to meet the requirements of quantitative analysis, which is meant to explore the frequency distribution between particular variables.

The data (see above) suggests that Shuy's and Parkinson's standpoint about "the simple language used by doctors and the avoidance of medical terminology" (2004: 110) cannot be taken for granted. In the following I shall consider why such a disparity in our findings exists.

In my view, the most likely explanation for the distinction in our opinions rests with the approaches we have adopted when considering the phenomenon of **social revolution**[4] and its impact on the language of medicine. According to Shuy's and Parkinson's understanding, what has changed are the **attitudes of doctors towards their patients**. They believe that society has experienced a certain balancing in the asymmetry between doctors and patients, especially as regards the vocabulary used. They maintain that doctors prefer simple language, tend to avoid medical terminology, and behave as partners.

Personally, I would also stress the changes in the **attitudes of patients towards their doctors**. In my view, patients, thanks to media and other forms of modern technology, have greater access to the field of medicine than ever before, and are generally better educated than previous generations. As a result, they are more likely to understand particular terms and their doctors may feel freer to use them.

5. Doctor-Initiated Medical Terms

Petrovová (1997: 72) maintains that "it is quite typical to use medical terminology in doctor-patient interviews". As has been mentioned above, medical terms used by doctors are more numerous than those used by patients. Out of 88 medical terms, 35 (40%) terms can be classified as illnesses and diseases, 13 (14%) as medications, 15 (17%) as medical tools, and 25 (29%) terms as medical procedures (see Tables 6, 7). 12 (13%) take place during the history-taking phase, 44 (50%) during the phase of examination, and 32 (37%) during the treatment phase (see Tables 6, 7).

Abs.	**Phase**			**Category**				**Total**
	Hist	*Exam*	*Treat*	*I&D*	*Med*	*Tools*	*Meth*	
Internal	9	2	0	8	2	0	1	**11**
Gynaec.	0	21	11	15	8	3	6	**32**
Paed.	1	7	1	3	1	1	4	**9**
ORL	1	10	14	6	1	9	9	**25**
Orthop.	1	4	6	3	1	2	5	**11**
Total	**12**	**44**	**32**	**35**	**13**	**15**	**25**	**88**

Table 6: *Absolute Frequency of Doctor-Initiated Terms*

%	**Phase**			**Category**				**Total**
	Hist	*Exam*	*Treat*	*I&D*	*Med*	*Tools*	*Meth*	
Internal	10	2	0	9	2	0	1	**12**
Gynaec.	0	24	13	17	9	4	7	**37**
Paed.	1	8	1	3	1	1	5	**10**
ORL	1	11	16	7	1	10	10	**28**
Orthop.	1	5	7	4	1	2	6	**13**
Total	**13**	**50**	**37**	**40**	**14**	**17**	**29**	**100**

Table 7: *Relative Frequency of Doctor-Initiated Terms*

These figures indicate that there are at least two important points which should be discussed. Their significance is stressed by some results of the F-test and correlation between particular variables.

Firstly, it needs to be stressed that most medical terms in my sample are implemented by doctors specialised in Obstetrics and Gynaecology. In this case, it

is not too difficult to find an explanation. Women visit these specialists quite regularly, and pregnancy for them is one of the most important events in their lives. They spend a lot of time talking about their "problems" and "joys" with partners and parents. They exchange information with other women. Media offer a notable amount of information, as well. Simply said, ladies understand a significant amount of information from this medical branch, and gynaecologists are aware of this fact, too (Example 12). That is why they use medical terms quite frequently without the need for an associated explanation.

(12)   D: Now, have had a **smear** done within the last 3 years?
          P: I had one done about 5 years ago, Doctor.
          D: Do you remember the results of it?
          P: Yes, they said it was clear.
          D: Do you know how often you ought to be coming for **a smear test?**
          P: I think it's every 2 or 3 years.

Of greater interest are the figures obtained from the branch of Oto-rhino-laryngology. Medical terms used within this medical speciality are also very numerous (Example 13). This time, however, we cannot explain the situation by the frequency of visits and its importance for patients. The explanation is to be sought somewhere else. The correlation between the category of terms and medical branches is 0.33, i.e. there is quite a significant correspondence between these two attributes of the consultation. Moreover, the result of the F-test for the comparison of ORL and Internal Medicine with regard to the category of medical terms is 0.03, which also means it is worth investigating the significance of the category of terms for their distribution.

(13)   D: Have you taken any medicine?
          P: Yes, I've had some **Vibramycin**, and some nose drops.
          D: Any benefit?
          P: I'm not really sure.
          D: Sit up in this chair. I'll turn on the light to look up your nose. I'm holding your nostril open with this **speculum**.

Internal Medicine has been mentioned for there is no term initiated in the category of tools. On the contrary, ten words for tools and instruments are utilised by specialists in Ear-Nose-Throat, more than in any other discipline. Those who have visited an oto-rhino-laryngologist know that the medical professionals in this branch use different kinds of tools and instruments quite often. Because some of their interventions are complicated, Oto-rhino-laryngology practitioners tend to explain the process of examination or treatment and, at the same time, the use of instruments (Example 14).

(14)   D: You've got some weak blood vessels here. They are very prominent in what we call "Little's area". I think that's where you're bleeding from. I'd like to **cauterise** those. … Now I'm going to spray this area with some **anaesthetic**. Open your mouth and breathe through your mouth while I do it.

It doesn't taste very good. Now wait a couple of moments. Has the taste gone? Good. Let me see your nose again. I'm putting this **speculum** in. I'm going to touch this area with this stick. We can **cauterise** it…

If there is a need to explain the meaning of a medical instrument, the ORL specialist either shows the particular tool to the patient (Example 15) or s/he is inclined to describe its medical function. Nevertheless, in my opinion, this type of explanation is not fruitful as it frequently produces other medical terms that require further clarification (Example 16). From the point of view of communicative effectiveness, such interaction can be characterised as inefficient and counter-productive.

(15)   D: Let me put **this** tongue depressor on your tongue… I'm shining **this** light… I'd like to test your hearing with **this** tuning fork.

(16)   Now we're going to irrigate the antrum using the **Higginson's syringe**. We put some warm water in a basin. The **Higginson's syringe** is a rubber syringe with a central bladder, and piping at both ends which we'll attach through an **Iver-lock connector** to the **cannula**, and we'll place the other end in the water. Then pumping the bladder, the sinus is irrigated.

To conclude the section on doctor-initiated terminology, it can be stated that all the above features of doctor-patient interaction do contribute to the frequency of medical terms, in particular within the branch of oto-rhino-laryngology. Moreover, some doctors' strategies (e.g. doctors explaining the process of the examination and treatment, and the use of medical instruments) may also be viewed as important methods for balancing the asymmetry between the doctor and the patient, as their employment expresses that doctors are willing to respect patients' fears and worries of the unknown (cf. Humphreys 2002: 34).

For further research it may be interesting to consider the use of medical terms depending on social, gender and age differences of both the doctor and the patient. The research may also be extended to other subgenres of the discourse of medicine, for instance, to doctor-nurse and/or doctor-doctor communication, in which the mutual verbal contact on the level of medical terminology could reveal a more comprehensive picture of its usage.

6. Patient-Initiated Medical Terms

The distribution of medical terms used by patients in my sample is as follows: there are 9 (32%) medical terms belonging to the category of illnesses and diseases, 8 (29%) of them belong to the category of medication, 3 (11%) to the category of medical tools, and 8 (28%) to the category of medical procedures (see Tables 8, 9). 5 (18%) of them appear during the history-taking phase, 22 (78%) take place during the phase of examination, and only 1 (4%) medical term appears during the phase of treatment (see Tables 8, 9).

Abs.	Phase			Category				Total
	Hist	Exam	Treat	I&D	Med	Tools	Meth	
Internal	3	4	0	4	3	0	0	7
Gynaec.	0	6	0	0	2	2	2	6
Paed.	1	8	0	2	2	1	4	9
ORL	0	1	0	1	0	0	0	1
Orthop.	1	3	1	2	1	0	2	5
Total	5	22	1	9	8	3	8	28

Table 8: *Absolute Frequency of Patient-Initiated Terms*

%	Phase			Category				Total
	Hist	Exam	Treat	I&D	Med	Tools	Meth	
Internal	10	14	0	14	10	0	0	24
Gynaec.	0	21	0	0	7	7	7	21
Paed.	4	29	0	7	8	4	14	33
ORL	0	4	0	4	0	0	0	4
Orthop.	4	10	4	7	4	0	7	18
Total	18	78	4	32	29	11	28	100

Table 9: *Relative Frequency of Patient-Initiated Medical Terms*

The most noticeable fact concerning these figures is the absence of medical terms used by patients during the treatment phase. We see there is only one term initiated during the phase of treatment (see Example 7) As the F-test proves ($F=2.00E-06$; $F=3.00E-08$), the distinction between the treatment section and the other parts of the medical encounter from the standpoint of participants is very significant, and thus worth studying. In my opinion, the distinction is closely connected with the function of the treatment phase. It is used by doctors to explain the process of treatment or therapy, and by patients to ask some additional questions about their diagnosis and the associated cure.

A closer examination of doctor-patient interviews reveals that it is the doctor who uses a particular term initially, usually when asking questions. Patients only use these terms in their responses (Example 17 and 18). Since there exist almost no questions asked by doctors during the treatment phase (see Černý 2007: 62), we can hardly expect any medical terms to be used on the part of patients.

(17)   D: And were there any problems afterwards? Did you need a **D&C** (dilatation and curettage) or anything?
P: Yes, I had a quick **D&C** afterwards but there weren't any further problems. (Obstetrics and Gynaecology)

(18)   D: As far that you know, are there any illnesses that run in your family?
P: None that I know of, Doctor.
D: Nothing like **diabetes**, high blood pressure, or heart disease, stroke, cancer, mental illness or anything like that?

P: Oh, I see! My father had a heart condition, and I have two aunts who have **diabetes**. (Internal medicine)

Moreover, the treatment section is the last phase of the medical interview and where everything, including options, risks, and benefits of the medical treatment, should be explained and clarified (Example 19). It is no surprise that patients, unlike doctors, prefer to avoid medical terms, in order to assure that there is no misunderstanding. This would support the idea that conventional, i.e. asymmetrical, roles of doctors and patients have been preserved so far.

(19)　D: Damien, I have put the plaster on to keep your bone in the right position. It's very important that you do not get the plaster wet, because then it will become soft and the bone may move. I would also like you to come back to hospital straight away of your fingertips feel tingly or numb or if your fingers go pale or blue. This would suggest that the plaster is too tight and we would need to split it to relieve the pressure. In order to avoid swelling within the plaster, I recommend that you keep your hand elevated so that the swelling can drain away. You'll need to be in the plaster for six weeks altogether, but we'll need some X-rays done before then, to make sure the bones haven't moved.

The figures obtained from each medical branch are interesting as well. Patients[5] use the most medical terms when visiting a paediatrician (Example 20). On the contrary, there was only one term initiated during a consultation with an oto-rhino-laryngologist (Example 21). The remaining three specialties (gynaecology, orthopaedics, and internal medicine) show similar numbers and range between these two poles.

(20)　P: Yes, he was taken to the special care unit because he was very small and he was getting cold and needed to be given **oxygen**.
　　　D: Was the baby premature – pre-term, appropriate for dates, or overdue?
　　　P: He was three weeks early.
　　　D: What did he weigh?
　　　P: Only 5 lb.
　　　D: Was he **jaundiced** – when he was born?
　　　P: Yes, he had **photo therapy** for **jaundice**.

(21)　D: Was it a normal birth?
　　　P: No, he was born ten weeks early and went to a special care baby unit. He had **meningitis** then. But looked as if he was normal.

In my view, these results are not surprising, since parents, who usually accompany their children to the doctor's, are well informed about the most common terms used throughout the visit; they either remember the times of their own childhood, or they (especially mothers) acquired the knowledge when talking to other parents. On the contrary, ORL practitioners are not visited so often, and therefore their patients are less familiar with this medical branch.

7. Concluding remarks

In place of a conclusion, let me summarise this article with a paragraph including the most significant findings in relation to symmetry and/or asymmetry of the medical interview. It should be stressed that the validity of all the suggested conclusions is largely limited by the extent of the corpus data. For anybody who is to continue with the research within doctor-patient interaction it will be, of course, inevitable to investigate much larger and more elaborate language material. Especially the sociological characteristics of both the doctor (e.g. gender and age) and the patient (e.g. gender, age, social status, education) should not be neglected next time, as they do relate to the way patients/clients employ and comprehend the medical terms posed throughout the medical encounter. Also a more subtle typology of terms into particular subfields may be useful.

Still, as 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 explained above, the findings below are believed to belong to the category of asymmetrical features: (1) 88 terms are doctor-initiated, 28 are patient-initiated; (2) Doctors initiate the use of medical terms; (3) Patients only respond to doctor-initiated questions; (4) Doctors employ terms from all the categories; (5) Patients do not employ medical terms from the category of tools; (6) Doctors pose medical terms throughout the interview; (7) Only one patient-initiated term is posed during the treatment phase.

These findings are only preliminary, and will 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.[6] As Gwyn (2002: 7) puts it: "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, as suggested by Shuy (1983) and Parkinson (2004), 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.[7]

Notes

[1] I do not attempt to compare Czech and English versions of doctor-patient interaction. However, such a comparison could be very interesting and needed. In my opinion, it should become the perspective of further research.

[2] The corpus under scrutiny suffers several disadvantages: e.g. the incompleteness of dialogues, lack of tagging, and poor sociolinguistic information provided (for details see Černý 2007). However, when preparing this analysis no better source of conversational texts was available.

[3] Cf. Gwyn (2002: 124) and his notes on medical metaphors: "…the more closely we examine the etymology of medical terms, the more likely we are to find a metaphor behind every dictionary definition. Thus, 'cancer' is itself a metaphor of the creeping motion of the crab. Malaria, from the Italian *mala aria* (bad air); measles, from the middle English *mesel* (a leper); mumps, from sixteenth century English *mump* (to grimace) are further examples."

[4] "In general, the newly emerging form of society is termed the *risk society*. The risk society can be defined as advanced liberalism in Western countries. The state withdraws from its responsibility for individuals, thus forcing risks upon individuals who develop a variety of strategies to avoid these risks or to deal with them" (Parusníková 1999: 149).

[5] In this case, patients=parents. As it has been shown elsewhere (Müllerová & Hoffmannová 2000, Tannen & Wallat 1983), the paediatrician uses different linguistic registers when talking to the parent, and when talking to the child. Considering medical terminology, we may expect that parents are the audience to be addressed.

[6] For details about other reasons some doctors tend to use medical terminology so often, see Roter & Hall (1992: 95).

[7] Cf. Parusníková (1999: 150): "In medicine, the risk society manifests itself above all in the ideology of *healthism*. Healthism involves a total medicalization of society, where health issues become part of people's everyday life. This corresponds to the general ethos of the risk society: since it is we, individuals, and not the state who are responsible for our health, we also must acquire some basic medical knowledge, we must lead healthy lives and avoid health hazards."

Appendix

anaesthetics	diphtheria	laparoscopy	pneumonia
appendicitis	eczema	laryngitis	poliomyelitis
arthritis	endometriosis	laxative	psittacosis
arthroscope	epidural	lock-connector	psoriaris
arthroscopy	episiotomy	malaria	scoliosis
aspirin	forceps	mammography	smear test
asthma	German measles	mastectomy	spatula
Caesarean section	gold injection	measles	syringe
cannula	gonorrhoea	meningitis	thrombosis
catheter	hepatitis	microscope	thyroidectomy
cauterise	HRT	mumps	tracheotomy
chemotherapy	hysterectomy	mycosis	trachoma
chickenpox	ibuprofen	Nystatin	transfusion
constipation	immunization	osteoarthritis	trocar
curettage	incubator	osteoporosis	tumour
curvature	indigestion	otitis	tuning fork
cytology	infection	otoscope	ulcer
depressor	inflammation	paracetamol	vaginitis
diabetes	inhaler	paronychia	varicose veins
dialysis	iontophoresis	penicillin	Vibramycin
diarrhoea	jaundice	photo therapy	wart
dilatation	laparoscope	physiotherapy	X-ray

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Miroslav Černý
Katedra anglistiky a amerikanistiky
Filozofická fakulta Ostravské univerzity
Reální 5
701 03 Ostrava
Czech Republic
miroslav.cerny@osu.cz