



The Role of Medical Discourse in Patient-Doctor Communication: A Linguistic Analysis of Health Literacy and Comprehension in Pakistan

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Abstract

This research examines doctor-patient language and its influence on patient understanding and determines medical discourse limitations regarding language use. 15 doctors were selected from 5 cities to collect data by using purposive sampling methods. A qualitative method was employed to collect data from doctor-patient interview sessions in a clinical setting. The data was then analyzed by using SFL and 3D model of CDA. The analysis focused on language use, medical jargon, and conversation structures and their influence on patient understanding. The researchers found that complicated medical terms, minimal patient involvement, and hierarchical language use prevent effective doctor-patient conversations. Patients feel difficulty in understanding medical words and explanations with complicated vocabulary by doctors. Cultural and psychological elements also create hurdles in language understanding. It was concluded that effective doctor-patient conversation and language use strategies, including simplifying medical terms, using aids, and cultivating patient-focused conversation, are essential for adequate care provision. Communication training in medical schools and hospitals is recommended by this research study. This study also suggests recommendations for doctor-patient conversation and language use improvement in medical practice.

Keywords: Communication, Medical Discourse, Patient Engagement, Active Listening, Language Barriers, Healthcare Improvement, Linguistic Analysis

Introduction

Effective communication between medical professionals and patients is essential for high-quality care, with implications for diagnoses, compliance with care, and patient satisfaction (Religioni et al., 2025). Medical discourse, such as language and communicative strategies in medical settings, play a significant role in ensuring patients understand their disease and care regimens. Nevertheless, medical terminology and sociolinguistic factors impair effective communication (Paul, 2025). In Pakistan, with its language diversity and disparate levels of health literacy level, doctor-patient communications must be particularly transparent. This article examines medical discourse and its role in patient comprehension to identify critical communication barriers and offer recommendations for improving health literacy (Nazeer et al., 2023). Medical discourse is a technical language, and most terminologies in medical

discourse cannot be understood by laypeople (Wang et al., 2025). Medical terminologies have been proven, according to studies, to cause difficulty in understanding for most patients, and such difficulty can lead to poor medical care through misdiagnosis and improper compliance with medical orders (Hull, 2016). In Pakistan, Urdu and English serve as first-language instruction in medical schools and in providing medical care, and language gaps between medical professionals and patients can become even more significant in such a scenario. Regional languages make medical communications even more complex; sometimes, most patients cannot understand medical professionals' language. All these factors direct a deep analysis of medical discourse to make medical care and its understanding easier for patients (Martínez et al., 2021).

One of the primary concerns in doctor-patient communication is medical jargon, which can hinder patient understanding and contribute to low health literacy (Sim et al., 2016). Health literacy, or the ability of an individual to obtain, process, and understand basic health information, is a key determinant of patient engagement and adherence to medical advice (Nam & Yoon, 2025). Low health literacy is associated with worse health outcomes, increased hospitalization rates, and decreased adherence to prescribed treatments (Gözüm et al., 2025). In Pakistan, where health literacy is generally low, especially in rural areas, the need for patient-centered and simplified communication becomes increasingly critical. Physicians do not typically understand a patient's health literacy level, assuming verbal communication is sufficient without ensuring understanding through interactive communication techniques (Nouri, 2025).

Another critical medical conversation issue is cultural and contextual barriers that impact doctor-patient communications. In most instances, most, particularly marginalized, patients do not request clarifications for fear of exercising excessive power and undermining social orders in a hierarchical medical establishment (Travaglione & Avellino, 2025). In Pakistan, with a strong doctor-patient model, most patients do not voice out and request clarifications for fear of undermining the strong doctor-patient model (Shibli et al., 2025). There is an additional challenge for female patients when visiting male doctors, with gender relations contributing to an additional communication barrier (Nazeer et al., 2024; Shibli et al., 2025). All these necessitate a patient-centered medical conversation, emphasizing clarity, sympathy, and awareness of cultures.

This study investigates language structures in doctor-patient conversation and their contribution to patient comprehension. It also establishes key communication barriers in medical language use. By illuminating such barriers, the study contributes to developing interventions that can enhance health literacy and patient care in Pakistan. Examining language, comprehension, and medical communication makes medical encounters efficient and make medical care a patient-centered and accessible system.

Problem Statement

Effective doctor-patient communications are important for high-quality care. However, language complications in medical language tend to hinder patient comprehension, with an impact of misdiagnosis, misuse of medication, and poor compliance with care protocols (Jalil et al., 2017). In Pakistan, with various languages, including English, Urdu, and vernaculars, being used in medical practice, language mismatches between clinicians and patients

exacerbate communication barriers (Ahmad et al., 2015). Most patients, specifically rural and low-literacy ones, have difficulty with medical terminology and instructions, impacting poor medical outcomes (Mubushar et al., 2024).

Moreover, hierarchical communication during medical consultation discourages patients from requesting clarificatory information and, in turn, constrains their comprehension (Matusitz & Spear, 2015). Communication and gender differences in cultures impact doctor-patient communication, with female patients having more difficulty communicating concerns (Afzal et al., 2024). Despite these concerns, medical discourse and its linguistic nature have been the subject of very few studies in Pakistan. The present study aims to explore doctor-patient communication and its linguistic characteristics, identify primary challenges impacting patient comprehension, and propose recommendations for health literacy enhancement. These challenges can be surmounted to pave the way for improved healthcare interactions, patient empowerment, and Pakistan's health outcomes.

Research Objectives

This research was designed to achieve the following purposes:

- To find out the use of language in doctor-patient interactions and role of this language in patient comprehension.
- To find out the problems in medical communication and suggestions of improvements.

Significance of Study

This study has significance as it helps researchers to find out the use of medical language and its role for the betterment of patient comprehension. It helps to understand and improve health literacy. The research in hand finds out the problems in medical communications as it analyzes the language of doctor-patient conversations. With the help of this research study, we come to know the problems in medical communications. It provides the solution/suggestions as well. The setting of this study is clinical so it better helps the patients to understand the language of doctor and also help a doctor to understand the language / concerns of patients. Here in Pakistan, health literacy is very low and medical terms are unknown for a country man. This study helps by clarifying the linguistic and psychological issues that complicate physician-patient communication. The findings of this study helps to enhance better understanding between doctor and patient communication. This study should add in medical programs as a mandate to enhance patient-centered communications.

Literature Review

Medical jargons are difficult elements of medical language. Patients, specifically common people are not aware of these jargons and unable to understand medical terms properly. This may lead to misunderstanding and non-adherence. Most of the doctors play authoritative role while patients as recipients so it is the power structure of medical communication that is assumed and it increase the communication gap (Mustafa et al., 2023). Psychological and sociocultural obstacles are also the variable that help this communication breakdown and create adverse health outcomes and in this way the patient dissatisfies form the doctor (Rehman & Diah, 2020). Health literacy should be increased and public awareness programs should be held in this regard especially in the low literacy countries including Pakistan.

Linguistic Features in Doctor-Patient Communication

Medical language is used by the doctors while checking their patients. The non-understanding of the medical language make doctor-patient relationships compels and that leads to the dissatisfaction of the patient (Hamza et al., 2020). Most of the researchers concluded that medical jargons are not understand by the common man and it leads to the problems for the patients. Patients don't understand what is the problem behind their sickness (Lodhi et al., 2019). In this regard, direct speech of doctor should be replaced with the indirect speech and the doctor should use local language to make understand the patient. It is compulsory for the doctor and the patient should re-ask the doctor if he/ she is not satisfied (Yang, 2021).

Language mismatches can also occur in communication in multilingual contexts like Pakistan, where English, Urdu, and local languages are used. Patients may be unable to comprehend medical instructions when doctors use English medical terminology amidst Urdu communication (Nazeer et al., 2024; Fatima et al., 2022). Code-switching, frequent in such communication, does not always ensure clarity because patients may not have the requisite health literacy to comprehend even the simplified descriptions (Dahal & Aoun, 2023). Therefore, the linguistic complexity of medical communication directly affects patient comprehension and treatment adherence.

Communication Barriers to Medical Communication

Several studies have identified communication barriers that impair patient understanding. One such barrier is poor health literacy, in that most patients lack skill in reading medical terminology and directions (McGrath et al., 2013). Studies conducted in Pakistan have discovered that rural and urban patients encounter numerous obstacles in reading and understanding prescriptions, dosages, and laboratory reports simply because medical terminology is poorly understood (Rehman, 2023).

Another significant barrier is the hierarchical structure of medical consultation. Doctors dominate the conversation, using dominant speech forms that discourage patient contribution (Peimani et al., 2020). There is a one-way information flow, and patients do not desire to query clarifying information and voice concerns about care (Chi et al., 2012). Medical settings have time restrictions, and doctors value efficiency over checking patient comprehension (Saeed et al., 2018).

Cultural aspects also influence medical discourse, especially in traditional cultures like Pakistan. Gender-based differences in communication between male doctors and female patients can sometimes prevent information from being communicated completely (Hashmi et al., 2023). Traditional beliefs and misconceptions about the disease can lead to mistrust between doctors and patients and complicate communications further (Malik et al., 2017).

Strategies to improve patient understanding

Given these barriers, numerous strategies have been proposed for improving doctor-patient discussion and patient comprehension. Medical language simplification is universally recommended using lay language instead of technical terms (Kamal et al., 2016). Empirical studies have proven that pictorial representations and diagrams can significantly improve comprehension, most notably in low-literacy patients (Faisal et al., 2024).

Doctor-patient communication that is patient-centered, with an actively engaged patient through questioning and checking for comprehension, has been proven to promote compliance and health literacy (Saleem et al., 2015). Doctor training programs in communications that convey empathy, active listening, and appropriately sensitive language can also bridge social and language gaps in the clinic (Zakar et al., 2021).

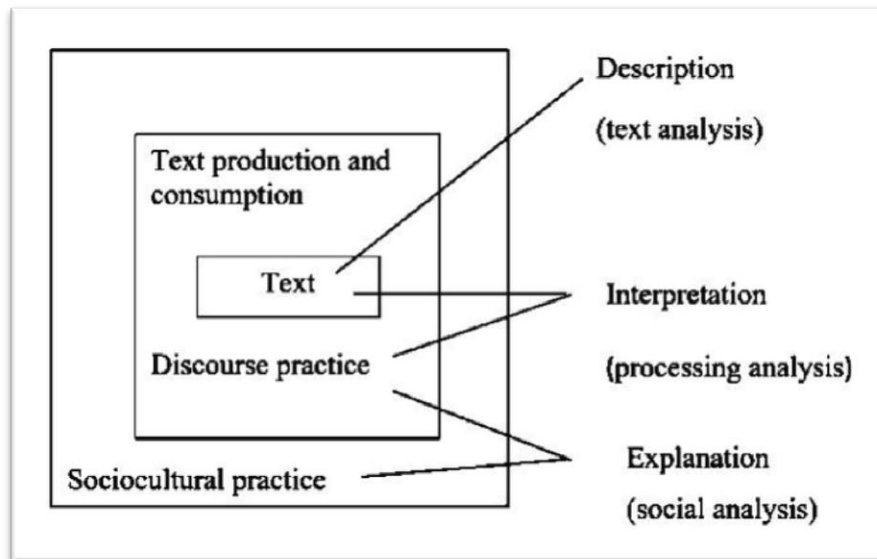
In Pakistan, integrating multilingualism in communications, such as providing medical information in both languages and utilizing trained medical interpreters, has been considered a mechanism for overcoming language barriers (Saleem et al., 2021). Health literacy interventions through mHealth programs with audio feedback in the native language have also improved patient education (Hussain et al., 2023; Bibi, 2017).

Analysis of medical discourse and its implications for patient comprehension is vital in optimizing medical communication, particularly in linguistically diverse contexts like Pakistan. Research has identified complex medical terminology, authoritarian doctor-patient hierarchies, and culture as the causes of problematic medical communication. However, healthcare providers can optimize patient comprehension and engagement through simple terminology, patient-centered talk, and multilingual practices. Future research is needed to explore how technology can help break barriers in medical communication and health literacy in diverse groups of patients.

Methodology

This is a qualitative study. In this study, doctor-patient conversation and its role in patient comprehension have been examined by studying linguistic features in doctor-patient conversation. For this research study, information (doctor-patient conversation) from 15 doctors from 5 different cities has been collected. Doctors and cities have been purposefully considered because most doctors cannot record their conversations. However, information has been collected with the collaboration of some colleagues and their respective doctors and with permission in the case of some of them. 5 Punjab cities, including Gujranwala, Sialkot, Gujrat, Hafizabad, and Lahore, have been taken for selection purposes. Purposeful selection of three doctors from each city and the patient's consent at the time of record have been taken. Fifteen patients have participated in this study as well.

After transcribing the text, the collected information was transcribed and checked for meaning retention, grammar accuracy, cultural awareness, fluency, and readability. After that, Systemic Functional Linguistics (SFL), developed by Michael Alexander Kirkwood Halliday (1985, 2013), was used to assess medical language's meaning construction. The 3D Model of Critical Discourse Analysis (CDA) developed by Fairclough (1989, 1995) was used to assess medical communication regarding power relations. Text analysis, processing analysis, and social analysis were conducted to gain an in-depth understanding of the text.



To discover communication barriers in medical communication and suggest improvement strategies, the researchers interviewed the patients one by one right after recording patient-physician conversations for every patient. The researchers used open-ended questions to conduct the interviews, and the patients' suggestions were also elicited. The researchers wrote no questions for an interview, but the questions put forward by the patients were asked as needed on the site.

Data Analysis Outcomes

This research gathered doctor-patient conversation data from 15 doctors in five cities of Punjab, Pakistan: Gujranwala, Sialkot, Gujrat, Hafizabad, and Lahore. Three doctors were in each city and selected through purposive sampling, as many doctors did not agree to have their discussions recorded. There were 15 doctor-patient interactions recorded, one patient per doctor, and each discussion lasted 03 to 07 minutes, totaling approximately 17 minutes of recorded data.

The researchers manually transcribed the spoken conversation and reviewed it with an expert to ensure meaning maintenance accuracy, grammatical correctness, cultural sensitivity, fluency, and readability. SFL and Fairclough's 3D Model of CDA were used to analyze language forms and power relations in communication.

1. Linguistic Features in Doctor-Patient Communication

Lexical Choices and Medical Terminology

Medical consultations have lexical options with specific frames for doctor-patient conversation. Medical professionals have long used technical terms to report diagnoses, interventions, and therapies. Medical terminology, even when specific, can affect patient comprehension, most notably when a patient is not medically literate.

For example, in the dialogue corpus, physicians frequently use terms like "gastroesophageal reflux," "bronchitis," and "hypertension." Patients, however, use laypeople's terms or symptomatic descriptions instead of medical terms. For example, instead of uttering "hypertension," a patient says "high blood pressure."

Physicians sometimes apply simplification techniques to bridge medical terminology and patient understanding gaps.

1. **Paraphrasing:** Restating medical terms in simple language (e.g., “gastroesophageal reflux” in terms of “stomach acid moving up”).
2. **Analogies and metaphors:** Comparing medical ailments with ordinary experiences (e.g., “Your lungs resemble a balloon that cannot expand”).
3. **Repetition and Clarification:** Repetition of key information and assurance of patient understanding (e.g., “So, when I say hypertension, I mean your blood pressure is consistently high”).

However, in a few instances, little effort is made to simplify terms, which can lead to miscommunication and patient disengagement.

Grammatical Structures and Sentence Complexity

The structure and complexity of doctor-patient speech vary immensely in terms of speakers. Doctors speak in a more complex and organized manner, but patients speak in shorter, broken sentences in speech.

1. **Doctors’ Explanations:** Doctors use compound and complex sentences to convey in-depth medical information. For example, “Since your blood pressure readings have consistently been high, your medication dosage have to be changed in an attempt to prevent any future complications.” Such sentences, while informative, could overburden patients with information in one go.
2. **Patients’ Responses:** Short and direct, and make specific references to symptoms and concerns, for example, o\t “I have been dizzy, and I am feeling tired.” o\t “The medication is not working.”

These responses indicate that patients prefer to report in a simple form over generating complex explanations.

Sentence Types in Communication

Different sentence structures play a role in how information is exchanged:

1. **Imperatives:** Physicians give commands when giving instruction (e.g., “Avoid oily food” and “Take twice daily”). Imperatives create commands and instruct explicitly.
2. **Declaratives:** Used in conveying information (e.g., “Your test report shows a mild infection”). Declarative statements inform, not instruct.
3. **Interrogatives:** Questions are prevalent, particularly from physicians requesting information (e.g., “How long have you been having this pain?”). Patients also request information in an assurance or understanding “Is it a serious disease?”).

Use of Code-Switching and Multilingual Communication

In multilingual settings, doctor-patient communication plays a significant role in code-switching. Code-switching among Urdu, English, and region-specific languages occurs in speech, with language use varying by participant language proficiency and comfort level.

Examples of Code-switching

1. **Doctors changing to Urdu or native language:** In describing disease, a doctor can switch to Urdu for ease of expression. For example: "Your disease is bronchitis, jo aik lung infection hai." Changing helps in describing technical terms to the patient.
2. **Patients blending language:** Patients switch between medical language in English and speaking Urdu, for example: "Doctor sahab, I'm a diabetic and I'm taking insulin."

This indicates an attempt at using medical terminology understood but depend for fluency on the native language

Reasons for Code-Switching

1. **Simplification:** Doctors can use a language to simplify complex medical terms.
2. **Cultural Relevance:** Some words and phrases are more significant in the patient's own language, and communication becomes more personalized.
3. **Patient Comfort:** Switching to a patient's native language during a conversation instills trust and deepens engagement.

Effect on Patient Comprehension and Comfort Level

Effective code-switching promotes ease of comprehension and reduces anxiety. If a doctor speaks a language a patient is familiar with, consultation is no longer daunting, and patients will be more willing to ask questions. Excessive switching confuses patients when jargon turns into unintelligible language.

Doctor-patient communication is conditioned via lexical selection, sentence structure, and language switching. Medical terms are conveyed accurately but have to be translated for adequate understanding. Medical professionals' structured explanations contrast with patients' direct reporting of symptoms. Information is exchanged through imperative, declarative, and interrogative sentences; code-switching introduces additional ease and comfort. Analysis of these language factors brings out the imperative for personalized approaches to communication that prioritize patient comprehension and engagement.

2. Power Dynamics in Doctor-Patient Communication (CDA Analysis)

Text Analysis (Linguistic Level)

i. Conversational Dominance

In medical consultation, physicians dominate the conversation. Physicians direct dialogue through initiation, questioning, and explaining, with little opportunity for patients to direct conversation and respond in kind. According to the data, physicians produce a more significant proportion of turns and more significant turns than patients, supporting physician authority.

ii. Frequency of Interruptions

Interruptions serve as a conversation-controlling function. Interruptions occur most frequently when physicians interrupt, specifically when patients attempt to elaborate on symptoms or request information. Inevitable interruptions, including clarification and discussion redirects, have a cooperative function, but others can function as a hierarchical imbalance in that efficiency substitutes for patient independence. Patients, for their part, interrupt less and, sometimes, truncate in midsentence, a sign of an awareness of the physician's expert role.

iii. Formal and Informal Language

Physicians typically use formal speech, particularly in describing diagnoses or regimens for treatment. Medical jargon is prevalent, contributing to formality in speech. Nevertheless, certain physicians use less formality in communicating a response to patient queries, using lay language to make information accessible to them. Patients, in contrast, use informal, quotidian language and express uncertainty through such hedging statements as “I think” or “perhaps,” contributing to asymmetry in information and expertise.

Processing Analysis (Interactional Level)

i. Sustaining Authority through Dialogical Form

Doctors structure conversation in a form calculated to maintain control using imperative (“Take twice a day”) and declarative (“The best for your disease is this one”) speech acts. Questioning is a prevalent tactic, with doctors tending to use closed-ended questions to manage the conversation. Open-ended questions arise less often, perhaps at the expense of patient contribution.

ii. Patient Reactions: Passivity, Assertiveness, and Reluctance

Patients exhibit both passivity and assertiveness. Most become passive, providing little reaction and hardly ever challenging a doctor’s prescription. Some, however, manifest assertiveness by asking for clarifications and inquiring about therapy concerns. There is reluctance when patients resist reporting symptoms and concerns, sometimes out of perceived power inequality.

iii. Emotional Tone and Politeness Strategies

Physicians tend to use neutral, distance-maintaining, and sometimes authoritative. Politeness strategies such as indirect suggesting (“You could try that treatment”) and mitigated directives (“I’d prefer it if you took these precautions”) mitigate overtones of authority, however. Patients make use of deferential markers of politeness (“Sir,” “please,” “Doctor”) to mark deference to the doctor’s superior rank. Patients sometimes use humour and stories to build rapport and diffuse tension.

Social Analysis (Context Level)

i. Social Hierarchy and its Influence on Medical Discourse

Doctor-patient relationships are shaped by broader social hierarchies, with institutionally conferred doctor power. Communication is affected through such a hierarchy, with differences in doctor knowledge and acceptance of doctor advice at face value. Power is reinforced through language use like authoritative speech and medical jargon.

ii. Impact of Doctor-Centric Communication on Patient Empowerment

A doctor-centric model, in which a doctor controls conversation and decision-making, can hinder patient empowerment. Patients become less motivated to question and speak out, and less actively engaged in medical decision-making, therefore. However, a few physicians attempt to enable a balanced conversation through eliciting patient feedback and explaining medical terms in simple language.

iii. Gender-Based Communication Differences

Gender influences doctor-patient interactions in complex terms. Female and male clinicians utilize direct, commanding speech, and female clinicians utilize relational communicative

strategies, such as active listening and empathetic behavior, respectively. Female and male patients, respectively, utilize concerns and seek clarifications, and male patients utilize a guarded position. These follow general social conventions for gender and expertise in a workplace environment.

Power dynamics in doctor-patient dialogue manifest at language, interaction, and social levels. Doctors maintain conversation control through formal speech, organized conversation, and high interruption rates, with passive patient roles in most instances. Social structures and gender roles organize forms of conversation, bearing on patient empowerment. Identifying such dynamics can lead to more patient-oriented conversation, with positive implications for understanding and medical care.

3. Communication Challenges in Medical Communication

Effective communication between a doctor and a patient is crucial to effective care and correct diagnosis. However, many barriers exist, resulting in a lack of comprehension and impaired care delivery. This discussion discusses three significant barriers in medical communication: medical jargon and technical terminology, cultural and contextual barriers, and psychological and emotional barriers.

Medical Jargon and Technical Terms

In the context of this study, some of the technical terms and medical jargon that could be relevant to your research include:

- Technical terms or phrases used by medical professionals that might not be comprehensible to patients. Examples: hypertension, hyperglycemia, pulmonary embolism, antibiotics, immunization, and diagnostic criteria. The capacity to obtain, process, and understand key health information to make informed health choices.
- Verbal and nonverbal communication between a healthcare provider and patient includes explaining illnesses and treatments and offering emotional support. The extent to which a patient adheres to the recommended medical intervention or treatment regimen depends on variables such as understanding medical instructions and trust in the healthcare provider.
- The disparity in power distribution between healthcare providers and patients can affect communication dynamics and the quality of interaction. These encompass the patient's cultural background, values, and psychological state that can influence how they perceive and understand medical information, a process whereby patients are provided with proper information to make an informed choice about their treatment.

Cultural and Contextual Challenges

Socio-contextual and cultural factors contribute a significant role in doctor-patient communication. Patients present a range of linguistic and cultural backgrounds, a consideration that can affect behavior during medical consultation. Perhaps one of the greatest barriers is not wishing to challenge physicians. Physicians occupy a position of trust in most cultures, and patients will not challenge them regarding recommendations and seek information in a form that will make them uncomfortable. That can contribute to passive patient behavior and poor information transfer.

Additionally, gender relations in medical practice have an impact when it comes to open communications. Female patients in some cultures will not necessarily reveal information to male physicians about specific medical concerns, for example, reproductive concerns. They will not reveal information; therefore, diagnoses and care will not necessarily reflect reality. In a similar manner, male patients will not necessarily reveal symptoms. They will not seek medical care in a timely manner in an attempt not to reveal weakness and maintain a strong social position.

Physicians who understand such cultural and contextual factors can modify their communication style to promote openness. They can break such barriers by employing inclusive language, a nonjudgmental setting, and explicitly inviting questions.

Psychological and emotional obstacles

Patient's psychological and emotional states directly affect the processing of medical information. Fear, tension, and anxiety can impair comprehension and recall, and it can become increasingly difficult for patients to have effective dialogue regarding medical care.

For example, when a patient receives a serious diagnosis, their first reaction can be shocked or dismay. In those situations, they can devote less attention to details about the physician's report and its implications and more to their emotions. That can breed misconceptions and missed information and perhaps influence compliance with treatment. Anxious patients can even avoid asking for information and clarifications, thus participating in a communication breakdown.

Doctors' tone and level of empathy play a significant role in overcoming such psychological barriers. Patient-sensitive and empathetic behavior, including assuring language, maintaining constant eye contact, and acknowledging concerns, can maximize effective communication. Patients will become resistant and frustrated with follow-up communications when a doctor uses a cold and neutral tone feels heard and not taken care of and will not respond positively to follow-up communications.

Communication barriers in medical language arise through medical terminology, contextual and cultural variation, and psychological and affective factors. Overcoming such barriers entails a conscious attempt to simplify language about cultural sensitivities and an empathetic orientation. Doctor-patient communications can yield increased health, patient satisfaction, and effective medical practice.

4. Patients' Perceptions and Suggestions for Improvement

Key Findings of Patient Interviews

i. Patients' experiences with medical discourse

Patients have mixed experiences with doctor-patient communication. Some have an informative and helpful consultation, but for others, it is challenging to understand medical information and navigate through the system of care. Most patients report being intimidated by a doctor's authoritative behavior, which sometimes leads them to not seek information by asking questions and requesting clarifications. Time constraints during consultation are a common cause of difficulty in processing information delivered by a doctor for many patients.

ii. Difficulties in Understanding Medical Directions

Another significant problem detected by patients is technical medical terminology. Patients have often complained about unfamiliar terms that make it challenging for them to comprehend their diagnoses, therapy, and drugs. Misunderstanding arises from such terminologies and improper disease management in a few cases. Some patients even say that doctors speak too rapidly or present too much information in a short period, and therefore, it is not easy for them to grasp important information. Language is a cause of miscommunication in the case of patients who do not speak Urdu and English and speak in a regional language.

iii. Their Suggestions for Doctor-Patient Communication

Patients suggest several ways to enhance communication with doctors. Among the principal recommendations is for doctors to explain medical conditions and interventions more straightforwardly. Most patients also wish to be provided with more visual aids, i.e., diagrams or leaflets, to help better understand their conditions. Patients also emphasize the need for doctors to be more patient and courteous so there is open communication in which they feel free to ask questions. They also suggest that follow-up visits or written summaries of medical advice reaffirm understanding.

Proposed Strategies for Improvement

i. Need for Simple Language and Everyday-Language Definitions

Medical professionals must speak in layperson to bridge doctor-patient communication gaps and not use medical jargon. Doctors must become patient-focused, assess patient comprehension, and adapt their explanations to correspond with that level. Instead of “hypertension,” one can say, “high blood pressure.” Providing analogies and examples taken from real life can simplify medical terms and make them easier to comprehend. Presenting printed or electronic sources in simple terms can make verbal communication even more effective.

ii. Importance of Active Listening and Patient Engagement

Communication is two-way; doctors must listen appropriately to patients’ concerns. Patients feel disrespected when doctors interrupt or fail to listen to their concerns. Doctors can create a more participative and empathetic consultation setting through eye contact, positive body language, and paraphrasing what the patient is communicating. Empowering patients to express concerns and reflect feelings can make them generally satisfied with medical consultation.

iii. Contribution of Doctoral Level Training towards the Development of Communication Skills

Communication skills must be a component of healthcare education in medical training programs. Physicians can learn to explain medical conditions simply through workshops and simulations, be more empathetic, and use non-verbal communication effectively. Continuing professional development must also emphasize culturally competent communication so physicians can understand patients’ multicultural backgrounds and language requirements. Training programs can also highlight the importance of time management skills that allow physicians to conduct quality patient interactions despite busy schedules.

Improving doctor-patient communications is important for medical outcomes and patient satisfaction. With simple language, active listening, and focused training programs, physicians can create a caring and friendly environment for care. Patients become more confident and active when they understand their medical conditions and alternatives; thus, they comply with medical guidance and positively maintain overall wellness.

Findings

The study revealed that doctor-patient conversation in Punjab, Pakistan, is characterized by specific linguistic markers, including the use of medical terms, complexity in sentences, and multilingualism in conversation. Doctors consistently used technical terms like "hypertension" and "bronchitis," and these terms consistently presented comprehension barriers for speakers of nonmedical language. Despite a few physicians' use of simplification strategies such as analogies, repetitions, and simplifications for easier comprehension, many only used expert terms, and, therefore, miscommunication could arise. Sentence structures also exhibited significant variation, with physicians using long, complex sentences and shorter, direct statements in response. Code-switching between Urdu, English, and native region language was common, and it operated as a device for increased intelligibility and comfort for the patient. Despite that, excessive and inconstant code-switching sometimes generated barriers in terms of comprehension and not ease in conversation.

The analysis of doctor-patient conversation revealed a strong hierarchical structure, with physicians controlling conversation through initiation, questioning, and commanding speech acts. Physicians initiated a more significant proportion of turns in conversation, interrupted at high rates, and adopted powerful language, confirming the dominant position. Patients, in contrast, exhibited passivity, hesitation, and deference and restricted active contribution to medical decision-making. Social and gendered conventions continued to organize conversation, with male physicians taking a direct stance and female physicians employing relational approaches such as active listening and empathizing. Observations underpin a call for a more excellent patient-centered approach to conversation, with physicians actively working to enable patient contribution through simplifying medical language, inviting open discussion, and balancing conversation power to promote medical outcomes.

Discussion

The findings of this investigation reveal significant insights into dominant language and power relations in doctor-patient dialogue. While necessary for accuracy, medical terminology and technical language are barriers to understanding patients, specifically for less illiterate patients. Physicians attempt to counteract this through simplification strategies such as simplification and analogies, but such actions occur in an unsystematic and unorganized manner, with a risk of miscommunication present. Besides, conversation grammar describes a contrast in speech, with complex and controlling speech generated by medical professionals and shorter, symptomatic statements generated in response by patients. Code-switching is an important tool in multilingualism, explaining and reassuring a patient when executed well.

Power asymmetries in medical dialogue can manifest in conversation dominance, over-interruption of the doctor, and dominant speech use. Communication structures intended for effective medical guidance can limit patient contribution, supported through a doctor-priority model. Patients inclined to defer, with little assertivity, with a few challenging propositions or requesting for clarification, social, gendered, and cultural forms drive such processes and affect the level of patient contribution in medical decision-making. Reorienting towards a patient-priority model, with a direction towards free conversation and shared decision-making, could maximize patient contribution and medical outcomes.

Communication barriers, including medical terminology difficulty and cultural constraints, have a strong bearing on doctor-patient effectiveness in communication. Polite language and colloquial use by a section of physicians make communication more straightforward, but doctor-patient communications generally follow a hierarchical model in form predominantly. In its unmediated form, such a model can result in the disengagement of patients and a lack of comprehension of medical instruction. By assuming a participatory form of communication, such as routine use of lay terms, providing an open platform for patient queries, and being sensitive to social and language factors, physicians can engender shared comprehension, culminating in improved experiences in healthcare.

Conclusion

The analysis of linguistic structures in doctor-patient communication is important in patient comprehension. Medical professionals use technical terms for accuracy, but technical terms are a barrier to patient comprehension, with fewer familiarities with technical terms. Sentence complexity and conversational structures, i.e., conversational turns, are elements of effective conversation, and simplification strategies, code-switching, and discourse markers are elements of breaking the barrier to comprehension. Therefore, a strong imperative for routine activities toward pragmatic expression and patient involvement in medical communication is defined.

Medical discourse barriers in patient identification silence them in the clinical environment. Hierarchy in linguistic structures, interruptions, and cultural expectation features make them distant and clash with patient decision-making. Certain doctors try to reverse such a trend with politeness strategies and informal language, but such asymmetries dominate. Breaking such barriers entails a move toward patient-centered care with an emphasis on clear explanations, listening, and shared decision-making. Such strategies can improve understanding, trust, and health outcomes.

Recommendations

To enhance doctor-patient communication, physicians must use patient-centered communication, for instance, explanations of medical jargon, visual aids, and interactive communication. There should be communication skills training in medical schools to equip physicians with language skills that promote patient comprehension. There should be hospital policies for promoting sensitive language, listening carefully, and shared decision-making to overcome communication barriers and enable patient activation.

Implications

This study is a contribution to medical linguistics, a relatively new discipline, in the way that it brings language's significant contribution to medical consultations into perspective. It emphasizes the imperative for interdisciplinary collaboration between medical professionals and linguists in developing frameworks for effective doctor-patient relations that enable positive patient outcomes. There are practice, policymaking, and service delivery implications in terms of medical training, and these include prioritizing language awareness in developing practical and empathetic doctor-patient relations.

Ethical Considerations

Ethical considerations have always been respected. Before taping, informed consent was obtained from both patients and medical professionals. Patients were informed regarding the study's intention, and confidentiality was maintained through individual information anonymization. Tapes have been kept secure and for use in research only. The study adhered to language and medical studies' ethical standards, always safeguarding participant anonymity and voluntariness during the inquiry.

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