International Journal of Linguistics and Communication
June 2018, Vol. 6, No. 1, pp. 15-22
ISSN: 2372-479X (Print) 2372-4803 (Online)

Published by American Research Institute for Policy Development
DOI: 10.15640/ijlc.v6n1a2
URL: https://doi.org/10.15640/ijlc.v6n1a2

Meaning in Doctor-Patient Communication

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Abstract

For anybody to work and develop her/his environment, s/he must be well i.e. healthy. Unfortunately, the human body can fall sick and die. To avoid sufferance and sometimes death, people go to hospital to seek for recovery. This recovery depends on good medical treatment. A good health care is mostly based on a good communication between doctor and patient. This type of communication is called *Doctor-Patient Communication.* A good communication is the one in which both doctor and patient understand each other. Understanding requires a clear transfer of meaning. This article investigates into meaning in doctor-patient communication. It attempts to point out how much meaningful the interaction between doctor and patient is. How much do doctors and patients understand each other? How is meaning grasped? How is meaning processed? Are there any meaning barriers? If "yes" what are the suggestions? These are questions which this paper tries to answer.

Keywords: meaning, doctor-patient communication, communication process, meaning processing

Introduction

A good quality of health care relies on meaningful communication between doctor and patient. When meaning is obscured in doctor-patient communication, there is less hope for recovery. Therefore, doctors and patients should communicate meaningfully to reach the objective which is patient's recovery. If patients are not satisfied, they complain. Patients in Bonzola Hospital complain over time that they do not understand their Doctor's instructions. Furthermore, they do not communicate easily with their doctors. On the other hand, doctors complain that patients do not follow instructions.

Therefore, one may ask a question to know why both patients and doctors are complaining. It has been revealed that there is misunderstanding between Doctors and their patients. The aim of this article is to analyse meaning in Doctor-Patient Communication in Bonzola Hospital so as to point out the causes of misunderstanding and suggest better ways for making meaningful communication between Doctors and Patients.

The misunderstanding between doctors and patients has led to the choice of this topic. As a researcher in the field of semantics and pragmatics, I felt called to investigate meaning in doctor-patient communication. The research has been conducted in Bonzola Hospital through observation, interviews and library research. The observation helped listen to conversation between doctors and their patients. As far as the interview is concerned, I asked questions to both Doctors and Patients. My interview with doctors intervened after doctors have finished talking to patients. Patients have been interviewed outside of doctors' offices. The library research allowed me to collect some information from books, articles and web.

This paper is based on qualitative research, and it is elaborated on the basis of conversation analysis. As far as theories are concerned, I use semantic theories.

This paper has four sections. The first section supplies a survey on meaning. The second part deals with Doctor-Patient communication. The third section presents meaning barriers in doctor-patient communication. The last section suggests some ways to improve meaning transfer between doctors and patients.

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Meaning

Meaning is not easy to define by the simple fact that it is meaning. It is the source of any understanding. Linguists, psychologists and Philosophers have tried to define « meaning » but their definitions could not satisfy. As Miller (1973: 36-37) states that:

We find, historically, a variety of direct answers, including Plato's answer that meanings are eternal archetypes, John Locke's answer that meanings are the mental ideas for which words stand as external signs, the answer that meanings are the things in the world to which words refer, Wittgenstein's answer that meaning is use, the behaviorist's answer that meanings are stimuli that elicit verbal responses, the introspectionist's answer that meanings are mental images associated with verbal behavior, and so on. But every attempt to give a direct answer has failed.

On the other hand, Osgood at al. (1957 : 2) say that « *there are at least as many 'meanings' as there are disciplines which deal with language, and of course, many more than this because exponents within disciplines do not always agree with one another* ».

For Berlo (1960: 173) « *meaning* is related to the codes we choose in communicating ».

I can attempt to define *meaning* as a whole set of intention, idea and concept that a speaker or writer conveys in a specific context through utterances, words/sentences, symbols, body movement, eye contact, facial expressions or any other means. I think, it is for this reason that meaning is discussed through many aspects that lead to different types of meaning. Leech (1981:9) enumerates seven types of meaning: *conceptual meaning, connotative meaning, Social meaning, affective meaning, reflected meaning and collocative meaning, thematic meaning.*

Conceptual meaning

Leech (1981:10) states that "*the conceptual meaning of a language can be studied in terms of contrastive features*".

As far as doctor-patient communication is concerned, this type of meaning occurs when either the doctor or the patient tries to get meaning of an utterance by referring to the characteristics of the concept for which a word is used. This kind of getting meaning is not always assuring. For instance, the interaction below between doctor and patient shows that the features of the concept for which a word is used do not convey any precised meaning.

Doctor: What is the matter?
Patient: My belly hurts.

What does it mean to have pain in the belly? At this level of interaction, the doctor actually does not understand anything. In other words, s/he does not get any meaning of what the *belly* is. S/he starts to speculate around the features of *belly* to get meaning. What the matter can be? Perhaps the problem is about intestines, stomach, kidneys, etc. In brief, features are not enough to let meaning known.

Connotative meaning

Leech (1981:12) writes that "*connotative meaning is the communicative value an experience has by virtue of what it refers to, over above its purely conceptual content*".

Connotative meaning leads also to speculation. Both doctor and patient should interact in an explicit way to avoid misunderstanding. The word "*belly*" in the above interaction can have different connotations such as *stomach, uterus, etc.*

Social meaning

Leech (1981:14) says that "*social meaning is that which a piece of language conveys about the social circumstances of its use*".

The social meaning can be useful if both doctor and patient share the same knowledge of social realities. If they do not share the same knowledge, the communication between them can suffer of misunderstanding.

Affective meaning

Leech (1981:15) explains that "*affective meaning is largely a parasitic category in the sense that to express our emotions we rely upon the mediation of other categories of meaning-conceptual, connotative or stylistic*".

Some patients express their emotion by using lexical or conceptual meaning. For example, a patient who has swallowed a nail asks the doctor if the case requires an operation.

Patient: I have swallowed a nail. Am I going to undergo an operation?

Doctor: probably.
Patient: Is it possible to treat the case without an operation?
Doctor: It depends on …

It is clear that the patient does not want to undergo an operation by the fact he asks if another way of treating the case is possible. This can be understood as an affective meaning.

Reflected meaning

Leech (1981:16) considers the reflected meaning as "*the meaning which arises in cases of multiple conceptual meaning when one sense of a word forms part of our response to another sense*".

Doctors are more likely to have such type of meaning since they have to understand patients' desire from their utterances.

Collocative meaning

Leech (1981:17) assumes that "*collocative meaning consists of the associations a word acquires on account of the meaning of words which tend to occur in its environment*".

Doctors often have this type of meaning when they try to understand what is wrong with patients' bodies. They associate words uttered by a patient with other words to get the meaning.

Thematic meaning

Leech (1981:19) states that "*thematic meaning, or what is communicated by the way in which a speaker or writer organizes the message, in terms of ordering, focus, and emphasis*".

Some patients prefer to tell what happened to them before they fell sick so as to allow their doctors understand their problems. This is good but it requires much time. Most of time, doctors have a schedule of their activities, and because of time pressure, they would like to rush up with the consultations. So, doctors sometimes interrupt patients and ask them to say what the matter is. As Cerny (2010:16) argues that "*doctors, moreover, use these interruptions with the intention to change the phase of the consultation*".

Meaning processing

Meaning is conveyed through communication process, and it is grasped through brain processing.

"The human brain is ultimately responsible for all thought and movement that the body produces. This allows humans to successfully interact with their environment, by communicating with others and interacting with inanimate objects near position". (http:..www.md-health.com/Parts-Of-The-Brain-And-Function.html.)

The brain is the core of Doctor-Patient communication. What is uttered, performed or listened is processed by the brain. As it is written in *https://serendip.brynmawr.edu/bb/kinser/structure1.html* that "*sensory nerves gather information from the environment, send that info to the spinal cord, which then speed the message to the brain. The brain then makes sense of that message and fires off a response".*

Utterances, gestures, actions, words and symbols are changed into signals by the sensory nerves, and these signals are sent into the spinal cord. The spinal also sends the same signals to the brain to be processed. As the link *http://www.teach-nology.com/teachers/methods/info_processing/* reveals that *"information processing starts with input from the sensory organs, which transform physical stimuli such as touch, heat, sound waves, or photons of light into electrochemical signals".*

Meaning is not in the brain, but it is produced by the brain. As Putnam argued in his paper *Meaning and reference"* that "*meanings aren't in the head*". The brain processing takes into account lots of elements in order to provide utterances, gestures, actions, words, and symbols with meaning.

Here are the main elements on which the brain processing is based to produce meaning: *word, symbol or sound recognition in relationship with concepts and environment perception.*

Word, symbol or sound recognition in relationship with concept

Through senses (sight, hearing, taste, touch and smelling) the brain stores information in the form of "**mnesic traces**" which can be considered as knowledge. Words, symbols and sound that entered the human brain are stored in form of mnesic traces, and they relate specific concepts.

Whenever these words, symbols and sounds are used, the brain recognizes them and associates them with their concepts so as to provide them with meaning. That is to say, if these words, symbols and sounds do not meet any recognition by the brain, the brain will not produce meaning by respecting the truth condition.

Therefore, if the doctor's utterances are not recognized by the patient's brain, the patient will not get the true meaning of those utterances, as consequence the doctor-patient communication is impaired.

Environment perception

Another element that enters the brain processing mechanism is the environment perception. It is the ability of sensory nerves to film the environment or the scenario in which the communication takes place and send that into the spinal cord which also sends that signal to the brain so that the brain associates that signal with other signals to produce meaning. The environment perception includes gestures, actions, speaker's intention and whatever surrounds the communication act.

Meaning transfer/reception

Utterances, gestures, facial expressions and actions

Meaning in doctor-patient communication is conveyed through utterances, gestures and actions. As far as utterances are concerned, both doctor and patient use voices which are grammatically or ungrammatically structured. Apart from utterances, gestures are also used to convey meaning in doctor-patient communication. The gestures are often performed by using hands and arms.

Facial expressions and action are performed to convey meaning. Head movement is mostly used to accept or confirm and deny or refuse a saying. Actions are used to explain a given instruction.

Listening, watching and thinking

Listening

To catch meaning of an utterance requires a good listening. Self and Carlson-Liu (1988:20) define *good listening* as « *the active process of carefully receiving and responding to meaning in communication encounters which include an aural component* ». Tara Dixon, T. And M. O'Hara (-- :14) state that « *Effective communication is heavily dependent on effective listening* ».

Watching

Watching is derived from the verb '*watch'*. Flexner and Hauck (1987: 2146) explain the verb '*watch*' in this way: « *to be alertly on the lookout, look attentively, or observe, as to see what comes, is done, or happens ».*

Thinking

Flexner and Hauck (1987: 1971) « *to employ one's mind rationally and objectively in evaluating or dealing with a given situation* »

Doctor-Patient Communication Process

a) Situation

Any communication starts within a situation. For example, someone feels bad, and s/he would like to meet a doctor in order to know what is her/his sickness. This fact creates a situation which is going to generate into an interaction between the patient and the doctor.

Self and Carlson-Liu (1988:1) define the term *Communication* as « *a process of exchanging meaning, and that only takes place within the contexts and constraints of cultures* ».

b) Emitting

The patient emits her/his anxiety by producing utterances, gestures, head movement which are supposed to convey her/his desire to the doctor.

Utterances

Flexner and Hauck (1987: 2099) define the term *utterance* as « *any speech sequence consisting of one or more words and preceded and followed by silence: it may be coextensive with a sentence* ». Doctor and Patient produce utterances in order to communicate.

The Doctor would like to understand the patient's anxiety, and the Patient would like to be well understood by the doctor. As *Ha, Ant and Longnecker (2010) state that "Patient surveys have consistently shown that they want better communication with their doctors".*

The utterances produced by both doctor and patient can succeed or fail in conveying meaning. Therefore both doctor and patient should develop the communication skills in order to produce utterances which can be able to convey the exact meaning. Here are some communication skills.

1) Word selection
2) Clear voice
3) Right pronunciation

Word selection

Words do not have any meaning but they can convey the right meaning when they are well selected and adapted to the situation in which the communication takes place.

Clear voice

The speaker's voice should be as clear as possible so as to avoid confusion in communication. Unclear voice disturbs the hearing.

Right pronunciation

A right pronunciation allows the listener discriminate sounds and grasp meaning of an utterance.

Gestures

Flexner and Hauck (1987: 802) define *gesture* as « *a movement or position of the hand, arm, body, head, or face that is expressive of an idea, opinion, emotion, etc.* » Sometimes both doctor and patient combine utterances with gestures to convey meaning. Gestures can favour or impair the conveyance of meaning.

Gestures are bound to culture. To interpret a speaker or a listener's gesture, one has to know the culture of that speaker or listener.

Head movement

Head movement is one of nonverbal communication ways that both doctors and patients use in their communication. Nonverbal communication can favour or impair meaning. As Self and Carlson-Liu (1988: 61) argue that « *To a certain extent, nonverbal communication is universal. All human beings use it, and it adds to or contradicts our verbal language to generate new meaning* ».

Head movement is the fact of moving the head up and down or from right to left/left to right in order to accept or refuse what is said by an interlocutor.

Meaning is also conveyed by head movement i.e. moving the head up and down to mean « yes » or moving the head from right to left or vice versa to mean « no » in luba culture.

c) Signal or message

The Patient's desire is the signal that is sent to the doctor. This desire is encoded, and it must be well decoded by the doctor. Desire is the need that anyone can have. In this context, desire is the patient's need of recovery or healing.

d) Medium/space

The space between the patient and the doctor must be taken into account as to allow the sound wave to be well perceived. Sometimes, a patient can communicate with a doctor in a long distance by using a telephone any other communication means. But here the concern is the face to face communication. The volume of voice must be reasonable so as to enable both doctor and patient's ear to hear sound utterances.

e) Interference

Any noise or interruption should be avoided because they can interfere and disturb the sound wave. During consultation, both doctor and patient do not need any noise neither from a radio, television, telephone, cassettes or any other instrument or people. When noise or interruption interferes, the meaning of an utterance can be obscured.

f) Receiving

The doctor receives the signal from the patient, and he tries to decode it so as to get its meaning in order to reach the patient's desire. One can ask an important question: *How does a doctor grasp meaning from the patient's utterances?* Most of the time doctors grasp meaning of patient's utterances by referring to her/his background knowledge, experience and symptoms.

1) *Background knowledge*

Doctors refer to their background knowledge to understand what can be the trouble in patients' bodies. This reference can be useful if the patients' utterances were expressed through right words. Otherwise the reference can mislead the doctor.

2) *Experience*

Sometimes, doctors act by analogy i.e. s/he refers to the previous cases which are similar to the case under examination.

3) *Symptoms*

When a doctor associates the patient's utterance to the symptoms on the patient's body, the doctor can come to understand what the matter is.

4) *Medical tests*

Medical tests, when based on right diagnostic and well done in the laboratory, help doctors know what is wrong with the patient. From the laboratory results, the doctor prescribes a prescription. Flexner and Hauck (1987: 1529) define *prescription* as « *a direction, usually written, by the physician to the pharmacist for the preparation and use of a medicine or remedy* ».

g) Feedback

The doctor reacts to the signal by sending back a new signal to the patient. In this way, the communication process restarts in a reverse way.

Meaning Barriers in Doctor-Patient Communication

1. Lack of education

Longman Dictionary (1992: 407) defines education as « *the process by which a person's mind and character are developed through teaching, or through formal instruction at a school or college* ».

Lack of education is a serious meaning barrier in a way that some doctor's instructions require patient's background knowledge. If the background is poor, the patient does not grasp any meaning from what the doctor recommends.

2. Mentality

Longman Dictionary (1992: 833) « a *person's habitual way of thinking* ». Some patients have habit to cure themselves with some plant or leaves of plants. When doctors make diagnosis of the disease and suggest a kind of treatment, such patients use their traditional medicine without any permission of doctors.

3. The cultural taboo

Longman Dictionary (1992: 1346) « *strong social or religious custom forbidding a particular act or word* ». In luba culture, the term "sex" is almost a taboo. When a man is consulted by a she-doctor, he does not feel comfort to say something relating to sex. It is the same case when a woman or a young girl is consulted by a he-doctor. Such a taboo hinders the meaning transfer.

4. Time pressure

Doctors need to listen to patients carefully in a comfortable way in order to get a good diagnostic. But it is noticed that doctors are too busy to the extent that they have not much time to listen to their patients.

5. Doctor Inattention

Sometimes doctors respond to the phone callings while they are consulting patients. This fact leads doctors to forget what the patient has uttered. Another case is that doctors become inattentive when they think to preoccupations they have in the mind. Longman Dictionary (1992: 407)

6. The transmission error

When the language used by the patient is not known by the doctor or vice versa, they both look for an interpreter. The interpreter may fail to translate exactly what has been said and lead the doctor or patient to get a wrong statement.

7. Ignorance of Certain Important Terms

Each domain, society or social environment has its own terms which, to some extent, are not known by the people of another domain or social environment. Most of the time doctors use the terms which patients do not understand. In this context, meaning of utterances is impaired.

8. Assimilation

Assimilation is a two-way phenomenon. Patients can hide his sickness or can declare pseudo-disease. This is called *assimilation.*

Suggestions for effective conveyance of meaning in Doctor-Patient Communication

Continuing sanitary education of general public through mass media

The society is composed with educated people and uneducated people. As far as educated people are concerned, I distinguish three sorts of educated people: highly, middle and low educated people. *Highly educated people* are persons who completed their studies at University or College. *Middle educated people* are persons completed their studies at high school. *Low educated people* are persons who stopped their studies at the level of elementary school. On the other hand, *uneducated people* are persons who did not go to school or did not complete the elementary school.

It has been proved that even highly educated people have difficulties to understand some of doctor's instructions. So, a continuing sanitary education through mass media is very important in the sense that it helps the population to come to knowledge of how to communicate with doctors.

Sanitary education of patients in every hospital

Apart from continuing sanitary education through mass media, another way to facilitate a meaningful Doctor-Patient Communication is to inform patient how they can interact with doctors. People who are coming to hospitals should be trained each morning before any consultation.

Continuing doctor training, seminars and conference

Doctors should have an on-going training in order to share their experiences through seminars and conferences.

Reasonable number of doctor for each section

A doctor can work effectively when s/he is not tired. If a doctor has to consult more than fifty patients a day, s/he cannot produce a good work. It is reasonable to appoint a sufficient number of doctors referring to the number of patient. I suggest that a doctor consults more or less 20 patients a day.

Semantic verification

It is difficult to believe that a patient has understood exactly doctor's instructions. Even if the doctor has been giving instructions very clearly, s/he has to verify whether the patient has grasped the meaning. To ask the patient to resay what s/he has understood is the best way to verify her/his comprehension.

Conclusion

This article has been discussing meaning in doctor-patient communication. It mainly focused on *meaning, meaning processing, meaning transfer, doctor-patient communication process, meaning barriers in doctor-patient communication, and suggestions for effective conveyance of meaning in doctor-patient communication.*

As far as the definition of meaning is concerned, it has been shown that it is difficult to define meaning. But there is an attempt of definition that states that meaning is a whole set of intention, idea and concept that a speaker or writer conveys in a specific context through utterances, words/utterances, symbols, body movement, eye contact, facial expression or any other means.

The human brain processes signals from the spinal cord and produces meaning of a word, sentence, symbol, an utterance, etc. This is to say that meaning is not in the brain but it is produced by the human brain. In doctor-patient communication, meaning is conveyed and received through words, utterances, signs/symbols, facial expressions, body movement.

The doctor-patient communication process includes *situation, emitting, signal or message, medium/space, interference, receiving, and feedback.*

The following meaning barriers have been pointed out so that they can be avoided: *lack of education, mentality, the cultural taboo, time pressure, doctor inattention, transmission error, ignorance of certain important terms and assimilation.*

In order to get an effective doctor-patient communication, the following suggestions have been proposed: *continuing sanitary education of general public through mass media, sanitary education of patients in every hospital, continuing doctor training/seminars/conference, and semantic verification.*

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