

Language as a Tool in Medicine: Methodology and Theoretical Framework

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Abstract—Since language is the predominant instrument by which information is transmitted between doctor and patient, an understanding of the uses and functions of language in medicine is crucial to effective medical care. This paper describes a framework for the study of language as a tool in medicine. The work is based on a large volume of doctor-patient conversations tape-recorded in natural settings. A method of cataloging recorded material has been developed which allows rapid access to segments of interest on the tape itself. The writers' framework of analysis suggests that, in addition to the knowledge of social speech conventions, seven levels of linguistic information are necessary for successful communication. Based on this research, a curriculum is being designed to teach medical students the use of language as a tool in medicine in order to refine their skills as effective listeners and speakers.

Physicians and social scientists have devoted numerous publications to the reasons underlying communication problems between doctors and their patients. Indeed, the most common complaint patients have about their doctors is that they do not listen. Clearly, anything that would increase the doctor's ability to listen and to communicate would increase his effectiveness as a physician. But much more is involved. The spoken language is the most important tool in medicine. Speech is the medium by which patients inform doctors of their symptoms and concerns and by which doctors elicit and respond to the patients' needs. At least in our sophisticated society, no operation, treatment, medication, or even diagnos-

tic test is carried out without pertinent speech. Language is the predominant device by which information is transmitted. Successful patient compliance, initial interviewing, preoperative and postoperative explanations, doctor-family meetings, and doctor-to-doctor discussions, to say nothing of effective reassurance and comforting, are indicative of successful verbal interaction. Therefore, physicians should have an understanding of language as a tool of the trade—knowing how it functions, how it is used, and how it can be used.

Current Approaches

Most articles which focus on the reasons underlying communication problems between patients and doctors come from the social disciplines. Zborowski (1), Zola (2), Mechanic (3), and Waitzkin and Stoeckle (4), among others, discuss aspects of linguistic and cultural differ-

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ences which need to be considered to improve communication in the medical interview.* Korsch and her associates (5-7) have used audiotaped and videotaped interviews to study factors which influence patient compliance in a pediatric clinic. Only recently have linguists interested in the use of language in social settings begun to investigate empirically the verbal interaction between patients and doctors to discover their conversational patterns. Shuy (8) has emphasized the need for empirical data to analyze cross-cultural medical interviews. Coulthard and Ashby (9) have described specific patterns of language use between doctors and patients based on 24 tape-recorded interviews, and Skopek (10) has studied various aspects of patient-doctor verbal interaction by tape-recording 99 medical interviews in an urban clinic setting.

Although these attempts represent a positive step toward a better understanding of the content and form of patient-doctor verbal behavior, the sample populations are small and restricted to clinic outpatients, and the investigators have usually focused on interviews between patients and doctors from different social and cultural backgrounds. Furthermore, most studies are descriptive and offer no theoretical framework.

The present authors believe that limiting research to cross-cultural communication between patients and doctors narrows the scope of the problem, since cross-cultural misunderstandings merely represent one aspect of the wider and more pervasive problems which may arise when patient and doctor of any background interact.

In most medical schools instruction in language use is geared to teaching interviewing or skills in patient interaction

(11-13). Some of these courses are extremely sophisticated. In the first year of medical school they may stress interpersonal dynamics, the interpretation of unconscious motivation and behavior, and a wider understanding of the patient as person. However, as interesting and sophisticated as such teachings may be, they stand a good chance of failing in their objectives for two basic reasons. The first relates to the assumption that because students can speak a language, they understand how language functions in the special setting of medicine. The second reason, similar to the first, is that most teaching efforts perpetuate a confusion of the observation—hearing what someone says—with the interpretation—knowing what someone means (on whatever level).

The first assumption—knowing a language is equivalent to understanding how it works—is based on the common argument that people already “know” language since they have been using it since childhood. By adulthood, the argument goes, the effective use of language is an intuitive part of a person’s equipment that can be sharpened by demonstrations of its use (as in teaching interviewing) or by experience. Most people, however, have acquired language predominantly through use alone and do not have an understanding of its properties and functions. This is the difference between the use of a tool by instinct and its use by training. The trained person is in control of the phenomenon. Things do not just happen; they are caused to occur in the service of the conscious intellect. This is the case for things as diverse as cooking, running, and singing. But patient interaction and interviewing skills are overwhelmingly verbal, and native talent in their use is insufficient. Nowhere else in medicine do physicians, even the most experienced, depend on or wish to depend on intuition alone.

* There is a large body of literature on doctor-patient communication in the psychiatric setting which is not discussed here.

