

LINGUACULTURAL FEATURES OF MEDICAL DISCOURSE IN DIFFERENT CULTURES

<https://doi.org/10.70728/phil.v05.i03.085>

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Abstract: Medical discourse reflects not only professional communication but also cultural values, beliefs, and social norms. This study examines the linguacultural characteristics of medical discourse across different cultural contexts, focusing on communication strategies, terminology usage and doctor patient interaction patterns. The study contributes to a better understanding of intercultural communication in healthcare settings.

Keywords: medical discourse, communicative behaviors, medical contexts, metaphorical expressions, pragmatic strategies, intercultural communication

Introduction. Medical discourse is a special type of language used in the communication between health care providers and their patients, and it is influenced by cultural norms and *linguae*. Medical discourse has gained popularity in recent years because of globalization and intercultural interactions in healthcare. Different cultures used different methods of communication in medical settings. For instance, Western culture uses directness, privacy, and autonomy for patients, while Eastern cultures use politeness, indirectness, and hierarchy [1, 34]. The primary goal of this study is to investigate the linguacultural nature of medical discourse in various cultures and how language reflects cultural attitudes towards health, illness, and authority in the medical community. According to the Shodiyeva's view, "In EFL, medical students need not only to understand general English but also to learn specific medical vocabulary to understand professional texts and communicate successfully in academic and clinical settings. Nonetheless, traditional vocabulary instruction approaches use fixed words and basic book material; such tools may not provide an accurate picture of the real medical conversation. Content-Based Instruction (CBI) stresses learning language through content and has been recognized as an effective pedagogical approach for English for Specific Purposes (ESP). The use of authentic materials is vital in this context as they offer exposure to language used for practical purposes." [7, 210]

Methods. This research employs a *qualitative comparative approach*.

The data consists of:

- Extracts from literary works depicting medical interactions
- Doctor-patient dialogues from English and Uzbek contexts
- Secondary linguistic and cultural studies

The analysis focuses on:

- *Lexical features* (terminology and metaphor)
- *Pragmatic strategies* (politeness, indirectness)
- *Discourse structure* (interaction patterns)

Comparative analysis is used to identify similarities and differences between cultures.

This qualitative comparative study examined the linguistic and cultural characteristics of medical discourse in different contexts. It focused on interpreting communication patterns rather than numbers. In order to do this, we used extracts from literary texts of medical encounters, doctor-patient dialogues in English and Uzbek, and language and cultural studies related to communication. The research is able to study both realistic and culturally influenced communication.

The analysis is based on aspects of lexicon and medical language use, as well as metaphors. Another aspect of communication, such as politeness and indirect, is looked at to understand differences in communication within cultures. Finally, the discourse structure is examined in terms of interactions between doctors and patients.

An important element of this study is a comparative study of similarities and differences in cultures and the role those cultural norms play in medical communication.

Results. As the results of the analysis indicate, there are several features of the medical conversation that are common to various cultures.

1. Lexical and terminological differences. Medical terminology varies not only linguistically but also culturally. In English discourse, technical terms are often simplified for patient understanding. In contrast, in some Eastern contexts, terminology may remain formal and less adapted to the patient [2, 57]. Additionally, metaphorical expressions differ. For example, illness in Western discourse is often conceptualized as a “*battle*,” while in Eastern discourse it may be viewed as a “*test*” or “*fate*” [3, 112].

2. Pragmatic features and politeness strategies. Western medical discourse tends to use direct communication: “You need surgery.” “This condition is serious.” In contrast, Eastern discourse often employs indirectness and mitigation: “*It might be better to consider treatment.*” “*We will try our best.*” These differences reflect cultural attitudes toward authority and face-saving strategies [4, 89].

3. Doctor-patient relationship. In Western cultures, the relationship is more egalitarian, emphasizing patient autonomy and informed consent. Patients are encouraged to ask questions and participate in decision-making. In East cultures, the

relationship is more hierarchical. Doctors are seen as authority figures, and patients trust them without question [5, 143].

4. Emotional and cultural interpretation of illness. Cultural background influences the way patients describe pain and illness. Western patients typically describe symptoms explicitly, while Eastern patients may describe symptoms indirectly, or in symbolic terms. E.g., in western cultures: *"I have sharp pain in my chest."* In eastern cultures: *"My heart feels heavy."* Such differences reflect the importance of a cultural conception of health discourse [6, 76].

Discussion. These results suggest that medical discourse is strongly influenced by cultural norms and socially accepted patterns of communication. The way language is used in medical settings including the level of directness, the choice of terminology, and the use of metaphorical expressions reflects deeper cultural expectations about how information should be delivered and understood. In some contexts, clarity and precision are prioritized, while in others, maintaining politeness and emotional sensitivity becomes more important. Such differences show that medical communication cannot be separated from its cultural background.

An important implication of these findings is the growing need for intercultural competence in healthcare practice. When healthcare professionals are not familiar with the cultural communication styles of their patients, misunderstandings may occur even if the medical information itself is accurate. For instance, a direct explanation of a diagnosis may be considered clear and professional in one culture, but it can be perceived as too harsh or insensitive in another. On the other hand, indirect or softened communication, which is intended to show respect, may lead to confusion or uncertainty for patients who expect straightforward information. For this reason, effective medical communication requires more than just professional knowledge; it also involves the ability to recognize and adjust to cultural differences. Healthcare providers should be flexible in their communicative approach, choosing language and strategies that match the expectations and needs of their patients. Developing such awareness can help build trust, improve understanding, and ultimately lead to better healthcare outcomes in culturally diverse settings.

Conclusion. This study demonstrates the importance of culture in forming medical discourse and communication in healthcare. Language is culturally influenced by choice and use of medical terms, but also by how health care professionals use language, and how they interact with patients. For example, some cultures use direct and explicit language, while others use indirect and polite language to convey the same medical information. The variations include the use of metaphors, expressions, and references that are culturally specific and can impact the understanding and emotions of patients. Recognizing and understanding the differences is crucial for improving intercultural communication and for providing

compassionate and individualized care to patients. Recognizing cultural norms allows healthcare providers to adapt their communication style, avoid potential misunderstandings, and foster trust and cooperation in the clinical context. Also, these findings highlight the need for training programs and educational programs that make cultural competence part of the training and education provided to healthcare professionals.

Future research in this area could expand on the current findings to include a wider and deeper range of cultures, and look at other aspects of medical communication such as writing, digital consultations, and patient education material. These studies could also examine how linguistic and cultural adaptations can impact patient outcomes, satisfaction, and follow-up to treatment. Such research would contribute to the ongoing effort to develop more inclusive, culturally sensitive, and effective healthcare communications strategies worldwide.

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