



Communicative competence in healthcare and linguistic theories: Insights and applications

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Abstract

Introduction: Physician–patient relationship has evolved from paternalistic model to cooperative one, known as patient-centered, where patients are experts on themselves in the socio-psychological, cultural, and material contexts. This transformed role has led physicians to adapt their highly specialized knowledge to effective communication pattern which is now a focal point in achieving therapeutic relationships in clinical context. Communicative competencies are of particular importance in medical practice and teaching medicine. Educational background derives from theories and foundations of linguistics and psycholinguistics.

Aim: The article presents main linguistic communicative theories that highly influence communicative competencies in medicine. It provides pragmatic guide to what is achieved from the principles of linguistic communicative competence in the current patient-centered model of communication in healthcare.

Material and methods: Most important linguistic theories that have their applicative use in teaching medical communication are presented. It is a part of a larger project aimed at bridging the gap between linguistic principles and clinical practice.

Results and discussion: In medical discourse, several types of message content functions are distinguished: informative, emotive, directive, motivational, and therapeutic to influence patients' emotional state. These discourse skills and associated motivational, volitional, and social abilities to use problem-solving successfully and responsibly, impact compliance, adherence, and concordance process.

Conclusions: Efficient communication in medicine consists of several important competencies, but in order to be properly developed, mastering linguistic communicative competence is necessary. Mastering them jointly with medical expertise is essential for healthcare professionals.

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1. INTRODUCTION

The physician–patient relationship has evolved from a paternalistic model to a cooperative one, known as the patient-centered model, where a patient is perceived as an expert on himself in the socio-psychological, cultural, and material contexts. This transformed role of a patient has led physicians to adapt their highly specialized knowledge to the effective communication pattern which is now a focal point in achieving therapeutic relationships in a clinical context. Communicative competencies are therefore of particular importance in medical practice and teaching medicine. Educational background in this field can be found in the theories and foundations of linguistics and psycholinguistics.

2. AIM

The article presents the main linguistic communicative theories that highly influence communicative competencies in medicine. It provides teachers and individuals interested in medical education with a pragmatic guide to what is learned and achieved from the principles and theory of linguistic communicative competence in the current patient-centered model of communication in healthcare. It also guides on how communicative competence principles make a prerequisite for a successful everyday medical practice.

3. MATERIAL AND METHODS

The article presents the most important linguistic theories that have their applicative use in the teaching of medical communication, according to the internationally accepted didactic methodology at the university level. This is a partial presentatin of a project proposed in the doctoral thesis, which was awarded the Rector's prize, aimed at bridging the gap between linguistic principles and clinical practice.

3.1. LINGUISTIC COMMUNICATIVE COMPETENCE

The most significant linguistic theories that influenced the understanding of linguistic competence and communicative competence in the second half of the 20th century were Noam Chomsky's generative theory and Dell Hymes' theory of linguistic behavior. Chomsky did not consider language from the point of view of the communication system and advocated relating it to the determinants of mental phenomenon, which was a reaction to the behavioral approach to language presented by Leonard Bloomfield. Chomsky believed that language is a peculiar biological capacity of humans,

which he referred to as 'language organ.'¹⁻³ He also stressed that since language realistically exists, since it is a materialized organ with physical characteristics, it can be studied in terms of four aspects, i.e. ontogenetic, phylogenetic, physiological and psychological mechanisms, as well as with regard to its functionality. Accordingly, he distinguished between an internal, individual, internalized language subject to study (I-language), and an external language, i.e. a language used by a specific community (E-language). The difference between I-language and E-language Chomsky referred to a real existence – internal language is concrete and individualized properties of the user's brain, external language (i.e. individual ethnic languages), on the other hand, has an indeterminate character, which is the result of the lack of an ontological aspect. Chomsky's theory of generative-transformational grammar is based on this assumption, in which the researcher directs attention to the sentence and the rules of its formation. He assumes that humans have innate and unconscious abilities to create an infinite number of sentences from a finite set of linguistic elements and that these abilities also allow them to simultaneously evaluate their correctness. The ability to do so has been defined by Chomsky as linguistic competence, which additionally equips the user with the ability to respond linguistically correctly in an unfamiliar situation, making it possible to follow the principle of appropriateness.⁴⁻⁶ Linguistic competence thus understood in the theory of generative grammar is distinguished by four features:

- (1) creativity – explained above,
- (2) grammaticality, which should be considered from the point of view of formal correctness, achieved on the basis of knowledge of the syntactic rules of the language, and semantic correctness, referring to the individual units of lexis and the rules of their combination,
- (3) acceptability, i.e. the evaluation of the correctness of statements,
- (4) internalization, consisting in the unconscious mastery of the native language.^{7,8}

Dell Hymes contrasted these views with his description of linguistic behavior, which he referred to as 'ethnography of speaking,' since he referred to both anthropology and sociology in his research. According to him, analyzing linguistic phenomena is interdependent on the accompanying socio-cultural conditions, so he proposed a broader approach than Chomsky and focused not only on linguistic competence, but considered it in the context of communicative competence.⁹⁻¹¹ This means that he viewed communicative compe-

tence from both a broader perspective, relating it to all modes of communication, and a narrower perspective, limited to linguistic phenomena. Hymes also identified four levels of competence that determine the formal and meaningful shape of an utterance:

- (1) systemic potential, indicating the extent to which an utterance is formally possible;
- (2) feasibility, i.e., the possibility of execution in relation to the mental and social situation of the utterer;
- (3) occurrence, determining the realization of the content of the utterance and its consequences;
- (4) appropriateness, i.e. the effectiveness of the utterance in relation to the social context.

Significant contributions to the development of the discussion of the concept of communicative competence training on the basis of Hymes' theoretical assumptions were also made by Merrill Swain and Michael Canal, Christina Bratt Paulston, and Lyle Bachman. Canale and Swain, proposed to distinguish the following components of communicative competence:

- (1) linguistic competence, i.e. knowledge of the sub-systems of the target language;
- (2) discursive competence understood as the learner's ability to produce grammatically and logically correct statements;
- (3) sociolinguistic, which is the creation of utterances adapted to the situation and socio-cultural norms;
- (4) strategic competence, allowing the user of the target language to continue communicating uninterrupted through the appropriate use of verbal and non-verbal interventions.^{13–15}

Paulston, on the other hand, understands communicative competence as knowing how to create and understand speech. She treats it as one of the components of the model she proposed, in which she distinguishes: linguistic competence, linguistic performance, communicative competence, and communicative performance.^{11,14,16} These components have a direct bearing on the teaching process, in which the learner must acquire:

- (1) knowledge of linguistic rules as the basis for the realization of grammatically correct sentences and their interpretation,
- (2) the ability to construct utterances as a manifestation of acquired linguistic rules,
- (3) proficiency in recognizing the social rules of language use,
- (4) participation in an impromptu communicative situation that is not socially characterized.

The author suggests that the most appropriate teaching model is the following order of the above components of the didactic process: linguistic performance – communicative performance – linguistic competence

– communicative competence. In this way, opportunities are created to learn how to respond appropriately to different situations, styles and non-verbal messages, and this in turn leads to strengthening learners' cultural awareness and sensitivity, as well as equipping them with the tools to correctly interpret intercultural communication. From a different premise came Lyle Bachman, who created the theory of communicative linguistic ability. He distinguished two types of competence that a learner should acquire:

- (1) organizational competence, which consists of grammatical competence and textual competence;
- (2) pragmatic competence, in which illoquial competence and sociolinguistic competence are distinguished.

This concept is based on the combination of knowledge with the skillful application of knowledge in a given situation and context.^{17,18}

A common feature of the presented concepts is the role of broad pragmatics in the use of language as a medium of communication. It involves developing learners' ability to make appropriate choices from their current linguistic stock to adapt utterances to the situational context of communication and in relation to communicative intent.

3.2. COMMUNICATIVE COMPETENCE IN MEDICINE

Communicative competence in medicine is a comprehensive concept of communication skills^{19–22} and can be defined as an organized, coordinated, goal-oriented activity that involves a sequence of sensory, cognitive, and motor mechanisms.^{23,24} Communication in health-care has two basic goals: the exchange of information and the creation of a relationship of friendliness and trust, as well as participation in the mental care of the patient.^{25,22} Communication between doctor and patient is therefore about 'understanding' and this term can be used synonymously in the context of patient care. This peculiar understanding enables the subjects of this communication process to achieve their own goals – for the first participant in the process (the doctor) it enables him/her to learn about the somatic and psychological state of the latter (the patient) and provides a basis for therapeutic planning, while the second participant (the patient) is equipped with knowledge regarding diagnosis and plans for further treatment. Moreover, this peculiar communication aims at mutual understanding and a positive psychic bond between the subjects of this process.^{26–31} In linguistics, language has a representational and a communicative function. The former is linked to Chomsky's theory of linguistic competence, which describes the knowledge

of an ideal user of any natural language. Communicative function, on the other hand, is the pragmatics of language use. Here, communicative competence (cf. Hymes' theory) is the ability (skill) to use language appropriately to the situation and the listener. Thus, analyzing medical communication, it can be assumed that to fulfill its purpose, participants should demonstrate communicative competence (especially the doctor – usually the sender of the message), thanks to which the expression of intentions will be effective and understandable (to the recipient – the patient). From the linguistic point of view, for the effectiveness of this interaction it is necessary to follow the principles of reality and cooperation, the first of which enables the recipient, to interpret the content of the message appropriately, while the second equips the participants of communication with conversational rules indicating in which direction the discourse should go.

The literature traditionally distinguishes three speech functions: informative oriented to the transmission of content, expressive oriented to the sender of the message and appellative oriented to the receiver of the message. In addition to these basic ones, a phatic function-oriented towards contact between interlocutors and a performative or causal function, whose purpose is to cause a new state in reality, are also recognized.^{32–35} When analyzing communication that occurs between a doctor and a patient, special attention should be paid to the so-called therapeutic function of speech, which aims to motivate the patient to action through dialogue. This form of interaction is now widely discussed both in the context of communication itself in medical practice and to search on the analysis of specialized discourse. Nowadays, the issue of communicating, talking, and dialoguing with the patient has been relegated to the background with the emergence of new diagnostic possibilities. Since the nineteenth century, as a result of the use of increasingly improved devices for observing the inside of the human body, the patient has ceased to be seen as an important, and often the only, source of information. According to Wade and Halligan, this gave rise to the so-called biomedical model, in which physiological aspects took over the key role in diagnosis – the patient was given the role of the recipient in the treatment process, and the associated psychological or social dimension was eliminated.³⁶ This perception of patient's role began to change in the 1950s,^{37–39} when cognition and analysis of both the social and psychological planes of an individual's life were included in making a diagnosis, and dialogue with patient began to be seen as a valuable source of information in the process of

diagnosis and treatment. In medical dialogue, we can speak of three principles that should guide physicians, clarity of speech, simplicity of language, and art of active listening. In all, the essential rule is adapting the manner of speech to the perceptive and cognitive capabilities of the recipient and making the medium, the language, generally accessible.

In a broad perspective, medical communication has a direct or indirect character and a cognitive or pragmatic purpose. Participants involved in this process use both linguistic (verbal) and extra-linguistic (non-verbal) signs consciously and intentionally, and it can take place through various channels of communication and it differs in terms of its duration (from short, outpatient visits to long ones in chronic diseases). Medical interpersonal communication can be, thus, referred to as deliberate, conscious and intentional, direct or indirect, transmission of information in a specific context, in a symmetrical or asymmetrical relationship.

4. RESULTS AND DISCUSSION

Communicative competence is the ability to achieve communicative goals which significantly contribute to adherence and compliance in the treatment process. Competence itself can be defined as the cognitive abilities and skills available to individuals or learnable by them to solve certain problems, as well as the associated motivational, volitional, and social readiness and ability to use problem-solving in variable situations successfully and responsibly. Efficient communication in medicine consists of several important competencies, but in order to be properly developed it is necessary to master linguistic communicative competence. After all, without acquiring an adequate linguistic resource (including specialized lexis) and various rules of its use (including sociocultural ones), it is impossible to establish proper contact either with patients and/or their relatives/proxies or with other healthcare professionals, with whom physicians encounter both in official and unofficial communication situations. It may, therefore, be referred to as a well organized and goal-oriented ability to achieve communicative goals in a socially appropriate manner.⁴⁰ In medical discourse, three types of message content are distinguished: informative, emotive, and directive in nature. The informational nature of communication here means obtaining the information necessary to take decisions (e.g., medical history, nursing history to plan the treatment process) and at the same time to achieve the set goal (i.e., cure, stop, stabilize, or slow down the development of the disease process, ensure an adequate quality of life in the case of palliative con-

ditions). It is also the transmission of information about patient's condition, about therapeutic plans, and about intended further therapeutic procedures. The emotive function is used to express the emotions and feelings of the interaction partners. The directive function in doctor-patient communication is connected with motivation to act, to make efforts leading to adherence to recommendations related to drug dosage, dietary adherence, peri- and postoperative management, etc. Of particular importance here is motivating the treatment process in the face of a poorly promising disease. In clinical communication, it is also possible to realize the therapeutic function of the message, that is, to influence the patient's emotional and belief state. Additionally, the increased attention is turned toward the impact of the message on mental and emotional state of the patient participating in medical discourse. Based on the above presented communication, several types of message content functions are distinguished: informative, emotive, directive, motivational, and therapeutic to influence patients' emotional and mental state. These discourse skills and associated motivational, volitional, and social abilities to use problem-solving successfully and responsibly, impact compliance, adherence, and concordance processes.

5. CONCLUSIONS

Mastering linguistic communicative competence is very important for native speakers of a specialized medical language, but it is even more important for non-natives when used in various professional realities and cultural environments. The above presented skills and techniques are therefore the basic elements that, in addition to highly specialized medical expertise, constitute professional preparation for successful compliance, adherence, and concordance processes in everyday medical encounters.

CONFLICT OF INTEREST

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