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Medical explanations and lay conceptions of disease and illness in doctor–patient interaction

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Abstract Hilary Putnam's influential analysis of the 'division of linguistic labour' has a striking application in the area of doctor–patient interaction: patients typically think of themselves as consumers of technical medical terms in the sense that they normally defer to health professionals' explanations of meaning. It is at the same time well documented that patients tend to think they are entitled to understand lay health terms like 'sickness' and 'illness' in ways that do not necessarily correspond to health professionals' understanding. Drawing on recent philosophical theories of concept possession, the article argues that this disparity between medical and lay vocabulary implies that it is, in an important range of cases, easier for doctors to create a communicative platform of shared concepts by using and explaining special medical expressions than by using common lay expressions. This conclusion is contrasted with the view that doctors and patients typically understand each other when they use lay vocabulary. Obviously, use of expressions like 'sickness' or 'illness' does not necessarily lead to poor communication, but it is important that doctors have an awareness of how patients interpret such terms.

Keywords Doctor–patient interaction · Communication · Medical language · Lay health beliefs

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Introduction

In order to secure successful patient communication, doctors should attempt to use and explain language related to health and medicine in ways that patients are capable of understanding [1–3]. This condition for successful doctor–patient communication can be met in two fundamental ways: Doctors can use language that patients already adequately understand, or they can explain the meaning of terminology patients are unfamiliar with. How different language expressions fall into the two categories will obviously depend on the context of the interaction. Some patients have a comprehensive medical history and a great deal of knowledge of their medical condition, while others have little or no medical knowledge and need, and therefore require more comprehensive explanations of relevant medical vocabulary.

At the start of clinical encounters, doctors will typically not know much about an individual patient's understanding of medical language. Consequently, some effort should be invested in trying to determine how well a patient is able to understand the language that is used. Even after the initial encounter, however, it is sometimes difficult to determine how well a patient understands a medical term. In such cases it is reasonable to suggest that doctors should practice a 'principle of charity' [4]: It is better to assume that patients know less than what they actually know, than to assume that they know more than what they actually know. In other words, unless there is evidence to the contrary, a patient should be regarded as someone who does not know much about the meaning of special medical terminology.

A possible strategy for avoiding poor communication in patient interaction is to minimize the use of special medical terms and instead use common, everyday health terms as much as possible. The motivation for doing this might seem straightforward: We are all familiar with lay terms like 'disease,' 'illness,' and 'sickness'; they have a comprehensive history of use outside the medical profession, and they do not have standard and theory-based definitions within the medical community [5–7]. One might therefore easily form the impression that doctors and patients typically understand each other when they use lay health terms.

This line of reasoning, however, involves a tremendous leap of faith. Successful doctor–patient communication requires more than simply the use of words of which both parties have an understanding [8, 9]. In general, when two persons learn the same expression, they do not necessarily learn it in the same way. A communicative platform of a shared language exists only if the expression is understood in a sufficiently similar manner [4, 10–12]. This point is of special importance in doctor–patient interactions, since it has been extensively documented that patients tend to understand many lay health terms strikingly different due to disparate social and cultural contexts [9, 13–15].

It is one thing to make this observation that the use of common lay health terms is no guarantee for successful doctor–patient communication. In this article, I present a more substantial argument. The aim is to use a theory of concept possession from recent philosophy of mind and language to raise a principled objection to the idea that doctors and patients normally understand each other when they use lay vocabulary. According to the theory I will focus on, communication of a health

concept presupposes that it is possible to define an understanding that the doctor and the patient have in common, or that the patient is willing to accept the doctor's explanation of what the concept means [11, 16]. The problem with most lay health concepts is that they do not have standard definitions, and that it is empirically well documented that patients think they are entitled to understand them in ways that do not necessarily correspond to a professional understanding [8, 9, 17, 18].

Interaction involving the use of a specialised medical language will typically involve the same problems of capturing the exact way patients understand the language. However, patients are normally what Putnam calls 'linguistic consumers' of medical expressions [10]; they are typically willing to defer to doctors' explanations of what they mean since they think that the medical profession know the correct meaning [10, 19]. I argue that this attitude of a deference–willingness to the meaning of medical language makes a crucial difference. In an important range of cases it is, contrary to what many discussions of health communication have presupposed, easier for doctors to communicate information related to disease and illness by introducing and explaining medical terminology than by using lay health terms.

Background

A central distinction in modern philosophy of language has been the distinction between 'linguistic experts' and 'linguistic consumers' [16, 20]. The general idea is that for many expressions within a natural language, it is possible to make a distinction between persons who have a complete understanding and persons who merely have a partial understanding but nevertheless qualify as speakers of the language. A person with a partial, incomplete understanding is defined to be a speaker of the language if he is willing to defer to a competent speaker's explanation of the correct understanding—if he sees himself as a consumer of the correct meaning [16, 19].

Probably the most influential analysis of the linguistic expert-consumer distinction has been Hilary Putnam's discussion of the 'division of linguistic labour.' Putnam's original focus was restricted to natural kind terms; his intention was to show that speakers of such terms normally think of themselves as members of the same linguistic community as those with a complete understanding [10, 21]. This led him to suggest that every linguistic community

> possesses at least some terms whose associate "criteria" are known only to a subset of the speakers who acquire the terms, and whose use by the other speakers depends upon a structured cooperation between them and the speakers in the relevant subsets [10].

This means, for instance, that detailed chemical knowledge of "water may become part of the social meaning of the word while being unknown to almost all speakers who acquire the word" [10]. In recent discussions, it has been recognised that Putnam's observations apply not only in communication involving the use of natural kind terms. There is widespread agreement that the distinction between

linguistic experts and consumers applies in all discourse involving use of expressions that have a standard meaning within the language that is used [16]. The idea has been that as long as a term has a correct meaning, then persons who have a complete understanding can be distinguished from persons who merely have an incomplete understanding [12, 19].

However, it has also been recognised that Putnam's linguistic expert-consumer distinction cannot be used to analyse use of expressions that do not have a standard, general meaning. Many terms are understood in strikingly different ways in what Wittgenstein (1953) calls different 'language-games'—different linguistic sub-groups where specific social or cultural contexts shape the way the term is understood [22]. When confronted with alternative ways of understanding a term that does not have a standard meaning, speakers in different 'language-games' will often disagree about the term's correct definition [22, 23].

This way of understanding the linguistic expert-consumer distinction has a striking implication in doctor–patient interaction. Common terms like 'pain,' 'ailment,' 'illness,' 'sick,' 'dizziness,' 'nausea,' and 'headache' are typical examples of lay health terms. Lay health terms, as I consider them here, share three characteristics: First, they have a comprehensive history of use outside the medical profession and more generally, in the health system. Lay health terms belong within a common, public language, and members of the linguistic community normally learn to use and understand them [13, 15, 18].

Second, lay terms do not have straightforward, general definitions that all or very many members of a linguistic community are willing to accept. How different persons understand lay terms depends to a large extent on their theoretical and practical background and their social and cultural contexts [9, 14, 17].

Third, it has been extensively documented empirically that patients tend to think they are entitled to understand lay health terms in ways that do not necessarily correspond to the meanings they encounter in the health services [6, 8, 13]. This point has received particular attention in analyses of the basic concepts *disease* and *illness*. Within medicine it has been common to make a sharp distinction between *disease* and *illness*: Illness has been thought of as a patient's experience of being ill, while disease has been thought of as the underlying physiological states of ill-health that cause illness [5]. However, it has been well documented that some patients associate the term 'disease' with subjective negative experience [5, 24]. These patients will not accept that the lack of a proven underlying physical cause means that disease has not been documented (consider cases of whip-lash, fibromyalgia, and chronic back pain).

This characterization of lay health terms can obviously be elucidated further, but the discussion above should be sufficient here. The point is that it is possible to make a reasonably clear distinction between lay health terms and medical vocabulary with a standard, normative meaning. Patients normally conceive of themselves as consumers of Latin vocabulary they are unfamiliar with, and they also typically accept explanations of more common medical expressions like 'spinal cord,' 'cardiac infarction,' 'diabetes,' 'arthritis,' 'cancer,' 'AIDS,' etc. What is special about these and other medical expressions is that patients normally assume that health professionals know their correct meaning. In keeping with Putnam's

linguistic expert-consumer distinction, even if patients merely have a vague or partially incorrect understanding, they will typically accept contrasting explanations provided by doctors and other members of the health services [25].

In addition to medical terminology that refers to states of disease, illness, and other bodily states of ill health, many medical terms have a more technical meaning. During interaction with patients, it is sometimes relevant to describe medical procedures or the functioning of advance medical equipment by using terms like 'electrocardiography,' 'intravenous,' 'endoscopy,' 'magnetic resonance imaging,' or 'computerized tomography.' Challenges related to communication of these concepts are in all essential respects similar to those surrounding the use of concepts that directly refer to biological states and events. For simplicity's sake, I will in the following mainly focus on medical names and descriptions of bodily states relating to disease and illness.

For doctors and other health staff, the choice between the use of lay terms and medical vocabulary will obviously depend on the context of interaction [3]. Patients' own preferences are also important [2]. Some patients may prefer to use everyday terms as much as possible, while others are more eager to learn and use theoretical and technical vocabulary. The rule and not the exception, however, is that health professionals to a large extent influence the style of language that is used in patient encounters, and that they should attempt to explain the meaning of words they believe may not be understood by their patients [1, 3].

It is important for doctors to bear in mind that words that they use on an everyday basis often seem entirely new to patients. Consider straightforward concepts like *systolic blood pressure* and *diastolic blood pressure*. A patient who merely goes to a routine check-up will often have nothing more than a vague understanding of these concepts. A doctor may nevertheless be disposed to make statements like "There is nothing wrong with your blood pressure," without explaining in more detail what the term 'blood pressure' means. The problem is that for a patient with a vague understanding, the meaning of the term 'blood pressure' is not very clear unless it is accompanied by more precise explanations of what it means. Furthermore, the patient may feel somewhat embarrassed about his lack of medical knowledge and therefore hesitate to ask what the expression means. Consequently, the patient may leave the doctor's office without a clear, informative understanding of his actual medical condition.

Asymmetrical theories of concept possession

Within a recent tradition in philosophy of mind that is based on the linguistic expert-consumer distinction, the diversity of understanding of terms related to health and illness is highly relevant for understanding successful doctor–patient communication. Theories within this tradition share two fundamental assumptions about concept possession and communication.

The first assumption is that successful communication of thoughts and beliefs can be analysed as an exchange of concepts [11, 12, 26]. The idea is as follows: A doctor has a belief or thought he wishes to communicate to a patient. The belief or thought is a propositional attitude, an attitude to a proposition made up of concepts

[20, 26, 27]. For instance, the belief that arthritis is inflammation of joints is a propositional attitude of the type belief, to the five concepts *arthritis, is inflammation, of* and *joints*.[1] In order for a doctor to successfully communicate these concepts to a patient, the doctor needs to use language that can be observed, and in face-to-face interaction the doctor will typically utter the sentence “Arthritis is inflammation of joints.” The patient hears the sentence, associates it with his own concepts, and communication of the doctor’s belief has succeeded if these concepts are identical to the concepts the doctor intends to communicate.

It is important to note that this assumption about communication of concepts is consistent with different theories about the more specific nature of concepts [20, 26, 27]. For the purpose of analyzing doctor–patient communication understood as exchange of beliefs, it is sufficient to assume that a patient possesses a concept if he has beliefs involving the concept. Thus, if it is correct to ascribe to a patient the belief that arthritis is a disease, then the patient has met a sufficient condition for possessing the concepts *arthritis*, *is, a* and *disease*. The idea about doctor–patient communication as exchange of beliefs follows from this: When a doctor uses a sentence to express a belief in dialogue with a patient, then his intention is to communicate this belief to the patient. If the patient associates the sentence with the same belief involving the same concepts as the doctor, then communication of the belief is successful.

It should also be emphasised that this assumption about exchange of concept-involving beliefs does not represent the only possible way of conceiving of a successful doctor–patient communication. Conditions for patient communication can be discussed from a number of perspectives that deserve theoretical attention [1–3]. For the present argumentative purposes, the important point is that the idea of communication of beliefs constitutes one fundamental aspect of interpersonal communication [20, 28, 29]. Having a shared language in the sense of having a shared platform of concepts is a basic pre-condition for successful interaction and understanding in clinical encounters.

Thus, the fact that this philosophical condition focuses on beliefs and concepts, means that it does not, in it self, capture all conditions for successful communication in doctor–patient interaction. It can nevertheless shed light on other conditions. Consider for instance the idea that successful communication is equivalent to patient satisfaction, and that patient satisfaction therefore can be used to evaluate the quality of a doctor’s communication.[2] The philosophical framework does not focus directly on the aim of patient satisfaction, but this does not mean that the framework is irrelevant in discussions of satisfaction. On the contrary, it is reasonable to assume that satisfaction will typically not be achieved if communication of concepts fails. If a patient thinks that a doctor expresses concepts he does not understand, or

[1] The *thought* that arthritis is inflammation of joints is thus understood as a different attitude (the attitude of thinking) to the same proposition. For a more detailed explanation of this assumption about concept involving propositional attitudes, see [11].

[2] It seems important to make the qualification ‘often.’ It seems reasonable to assume that satisfaction cannot always be used as a criterion for successful communication. Consider, for instance, a patient who thinks that a doctor gives a more positive prognosis than what the doctor intends to communicate. The patient may be satisfied, but communication has not been successful.

if the patient thinks that the doctor does not understand the language that is used in a way that the patient thinks he is entitled to understand it, then patient satisfaction and other conditions for successful doctor–patient communication are unlikely to be met. In short, although the condition of exchange of beliefs and shared concepts is not a sufficient condition for overall communication, it is a fundamental necessary condition. This is the crucial assumption that the further discussion will be based on.

The second assumption about concept possession I wish to focus on is less straightforward, but the general idea can be formulated as follows: a person's willingness to defer to what he thinks is the correct understanding of a term is part of his understanding of the term [11, 12, 20]. According to this assumption, it is not only a patient's actual understanding of a health term that determines which concept he associates with the term, but also how he responds when confronted with an alternative understanding. An example will serve to clarify this idea. A patient believes that the word 'arthritis' applies to an inflammation that can occur in joints, but he is uncertain about the more precise meaning of the term. In particular, he is not certain that arthritis can only occur in joints. In an encounter with a doctor, the patient reports fear that his inflammation in his knee has spread to his thigh. The doctor reassures him that arthritis can only occur in joints, and the patient changes his beliefs about 'arthritis' in accordance with the explanation provided by the doctor.

According to the assumption about deference-willingness, the fact that the patient defers to the doctor's explanation means that he possesses the same concept *arthritis* as the doctor. The patient's new belief that arthritis can only occur in joints involves the same concept—*arthritis*—as the doctor's belief that arthritis can only occur in joints, and they both believe that the patient's arthritis has not spread to his thigh.

On the other hand, if the patient had not deferred to the doctor's explanation, then he would correctly be described as a person who intends to understand the word 'arthritis' in his own idiosyncratic way—a way that does not correspond to the correct, medical understanding of the term. In such a case he would have associated the word 'arthritis' with his own, alternative concept, i.e., a concept that applies to what he incorrectly thinks arthritis applies to.

Peacocke sums up the idea of deference-willingness to standard meaning as a condition for concept possession as follows:

> Deference [to standard meaning] is essential. It is what distinguishes the case we are interested in, partial understanding (and partial misunderstanding) of a word in a communal language, from the quite different case of an individual's taking over a word from his community and using it in his own individual, different sense [12, p. 29].

The idea here is not that deference-willingness in itself is sufficient for concept possession. As Burge observes, "total misunderstanding often seems to block literalistic mental content attribution" [11, p. 91]. Cases involving persons with no command of a foreign language and a small child's imitation of words provide similar examples. Burge notes that in such cases sufficient "mastery of the language and responsibility to its precepts have not been developed; and mental content attribution based on the meaning of words uttered tends to be precluded" [11, p. 90].

Correspondingly, a patient who defers to an explanation of the meaning of a medical term will only possess the standard concept if he has a partial understanding. The fundamental philosophical assumption is that when a person

> has attained a certain competence in large relevant parts of his language and has (implicitly) assumed a certain general commitment or responsibility to the communal conventions governing the language's symbols, the expressions the subject uses take on a certain inertia in determining attributions of mental content to him. In particular, the expressions the subject uses sometimes provide the content of his mental states and events even though he only partially understands, or even partially misunderstands, some of them [11, p. 114].

Often a doctor's explanation of a medical term will give a patient a partial understanding. In such cases, if the patient adopts the understanding provided by the explanation as his own, then the idea of 'responsibility to the communal conventions' implies that he has the doctor's concept. In other cases, patients may have a partial understanding independently of any encounters with doctors (they may have learned about the term in other ways), and in such cases it is sufficient that the patient would have deferred. The reason is that it is not actual deference that matters, but deference-willingness as an underlying attitude. In other words, a patient who has the *intention* of conforming to a term's standard understanding possesses the same concept as doctors who have a complete understanding.

Correspondingly, a patient with a minimal understanding who is not willing to defer to the correct explanation of a medical expression does not possess the standard medical concept. According to the idea of commitment to standard meaning, the patient should instead be viewed as someone who is, as Peacocke said above, " taking over a word from his community and using it in his own individual, different sense" [12, p. 29].

All theories that accept this assumption about deference to standard, communal meaning can be characterised as asymmetrical theories of concept possession. They are asymmetrical in the sense that they assume that even if a person P has an understanding of a term that is less competent than another person Q, P associates the term with the same concept as Q as long as he is willing to defer to Q's understanding. Asymmetrical theories hold that communicators do not have to understand language in the same way in order to be able to share and exchange concepts. If a layperson with a partial understanding is willing to conform to an expert's explanations of what a word means, then this attitude outweighs the individual differences of understanding [11, 16, 19].

It is important to note that this perspective on language and communication involves more than statements about observable facts about the use of language. As explained above, the linguistic producer–consumer distinction focused on the fact that some speakers have a complete understanding, and consumers were simply defined to be speakers whose use of the term "rely on the judgement of these 'expert' speakers" [10]. In the light of the assumption about communication of beliefs and shared concepts, the asymmetrical theories make a further crucial theoretical assumption about what it is to share a language. When a producer and

a consumer speak the same language, then that is because they associate the same concepts with the same expressions.

In recent years asymmetrical analyses of concept possession have gained in popularity [20, 27, 30]. Perhaps the most influential argument focuses on the idea of deference-willingness as a condition for possessing standard concepts [12, 27]. Proponents of asymmetrical analyses have often claimed that this idea matches fundamental intuitions we have about what it is to speak the same language and be members of the same linguistic community. Applied to the area of doctor–patient interaction, if a patient refuses to accept the meaning of a medical term, or if he is not willing to change his idiosyncratic understanding of a health term, then we will typically think of him as someone who associates the term with his own personal concept. The same point applies in analyses of an understanding that cultural groups of patients may share [15, 17]. If the way a group of patients understand a term is heavily shaped by a common cultural and social context, and if they are not willing to defer to alternative meanings, then it is reasonable to assume that they have a concept that matches their social and cultural framework of understanding.

Some may nevertheless object that the idea that doctors and patients often have the same concepts despite the diversity of understanding is counterintuitive. How can they share medical concepts when they do not understand the medical language they use to express their concepts in the same way? The problem with this objection is that it fails to make a distinction between two interpretations of what it is to "understand medical language." The asymmetrical perspective on concept possession is consistent with the fact that doctors and patients typically "understand medical language" differently in the sense that they have some different beliefs about what medical expressions mean.[3] But this does not necessarily mean that doctors and patients typically "understand medical language" differently in the sense that they express different concepts. The key idea in the asymmetrical perspective is precisely that this does not follow. According to asymmetrical theories, the idea that doctors and patients often manage to communicate and share medical concepts is problematic only if one collapses the distinction between these two interpretations of what it is to "understand medical language."

In addition to arguments in favour of the asymmetrical theories that have been framed within philosophy of mind and language, a third argument appeals more directly to common sense beliefs about the possibility of successful expert-layperson communication. These beliefs have a direct, immediate appeal in the area of health care and doctor–patient interaction. We have a fundamental idea that it should be possible for doctors to communicate medical concepts to patients even when patients do not have detailed and complete expert knowledge of the meaning of the concepts. It is natural to assume that doctors and patients are able to exchange thoughts and beliefs about disease and illness, even when they do not understand the concepts that are communicated in exactly the same way.

[3] More generally, in this sense of 'understand language' two persons will very seldom have the same understanding of a language expression. This requires that they form exactly the same beliefs about the expression, but this is unlikely to happen as long as their beliefs are shaped by their individual histories and social and cultural background [26].

In sum, if doctors and patients needed an identical understanding in order to share beliefs involving the same medical concepts, we would have to accept the unreasonable conclusion that doctors and patients seldom are able to communicate and share health beliefs. The asymmetrical theories of concept communication can be used to explain why this conclusion is implausible: As long as a patient has a partial understanding, and as long as he is willing to defer to the doctor's understanding, then the patient possesses the doctor's concept.

The patient's perspective

Discussions of doctor–patient interaction have often focused on the assumption that doctors should use a language that patients are capable of understanding [1–3]. The theoretical perspective I have outlined is compatible with this assumption. The inconsistency arises only if one believes that the assumption implies that it is normally very difficult to secure communication by using a specialized, medical language. It follows from the asymmetrical perspective on concept possession that this inference is unjustified. The perspective implies that the easiest way of creating a communicative platform of shared concepts often is to introduce and explain medical terminology: Patients who regard themselves as linguistic consumers of medical language will defer to such explanations, and they will thereby possess similar concepts as those possessed by doctors.

Obviously, the requirement of explanation of meaning is here crucial. Uncritical use of medical terminology that is not explained in more everyday terms will often fail to give patients a sufficiently good understanding. However, the fact that explanation is needed and sometimes difficult to grasp for patients does not necessarily mean that it is easier to achieve the communicative aim of shared concepts by using lay terms. Doctors may easily assume that there exists a common understanding when patients take the initiative to use familiar lay terms like 'illness,' 'sick,' or 'pain.' But as emphasized above, when two persons have learned to use the same words, they have not necessarily learned to use them in the same way.

In ordinary clinical encounters, it does not help if a doctor tries to secure a comprehensive understanding of how a patient understands a lay health term; in such a case, the doctor will need to go far beyond the patient's use there and then. He will need to form an overall conception of how the patient's understanding is shaped by the patient's specific social and cultural context [15]. The problem for doctors is that it is overwhelmingly difficult to acquire detailed knowledge of patients' perspectives on disease and illness. Such knowledge can be the aim in a comprehensive hermeneutic process of understanding [20, 31], but this ideal of understanding does not correspond very well with the limits of real-life clinical encounters.

Obviously, this observation does not mean that doctors should use medical terms as much as possible. Often, a doctor and a patient understand a lay term in a quite similar way, and it is often natural and convenient to use many lay terms [32]. A conversation about a patient's symptoms will typically focus on the patient's

description of experiences and symptoms, and this description will ordinarily be formulated and discussed in lay language. Furthermore, it is often natural and necessary to use both medical terms and lay language in a clinical encounter, typically when symptoms are linked to underlying causes and possible diagnoses [2, 3, 33]. As Downie and Macnaughton note, a doctor's "explanations will vary in style according to variations in many factors, such as the knowledge, ability, and interest of the listener" [34].

It should be emphasised that the asymmetrical theories are consistent with these contextual aspects of clinical discourse. The perspective does not imply that lay terms should not be used, or that communication necessarily fails when lay terms are used.[4] The only substantial implication of the perspective is that it is often easier to secure a platform of shared concepts by using medical terms than by using lay terms since patients typically conceive of themselves as consumers of medical terms. This is a theoretical implication that should have an action-guiding role, but it should obviously be weighed against other factors that influence successful doctor–patient communication.

Another way of stating the same point is to say that the choice between medical language and a lay communicative strategy will depend on the nature of the clinical encounter. The asymmetrical analysis applies in situations where there are no other practical considerations that outweigh the key theoretical implications. Thus, if a doctor can choose between a lay and a medical communicative strategy, if there is uncertainty surrounding the meaning of relevant lay terms (as often is the case), and if the patient understands and defers to explanations of medical terms, then it is easier for the doctor to know that he has communicated concepts when he is using medical terms. There are undoubtedly many cases of this kind, and that is the main reason why the asymmetrical perspective has a striking application for doctors in this area.

Granted, if it were possible to formulate definitions of lay health terms that captured a common understanding that doctors and patients tended to share, then this implication would not be very significant. In that case, doctors could ground dialogue with patients in such definitions, i.e., unless evidence to the contrary, they could assume that patients use and understand lay terms in accordance with these definitions. This explains why so many theorists have attempted to define common basic health concepts like *disease*, *illness*, and *sickness*. If it is possible to formulate common definitions, then they would have a straightforward role in ordinary doctor–patient interaction. As Nordenfelt observes, a definition that does not capture a common understanding "would not be used in ordinary discourse, and would therefore be of no interest for us" [35]. The problem is that as more and more definitions have been thought of as inadequate, there is now a widespread pessimism about the prospect of formulating common definitions [6, 24, 36].

The same problem of capturing definitions arises if one attempts to define a common meaning of medical language. Patients typically encounter the health

[4] This will also depend on what one means by 'communication.' As emphasised above, I do not presuppose that the idea of exchange of beliefs necessarily represents the only possible way of conceiving of successful doctor patient communication.

services with an idiosyncratic understanding of medical language shaped by their specific social and cultural context, but this understanding will seldom be identical to the comprehensive, theoretical understanding doctors have (and evidently not match when patients have an incorrect understanding or no understanding at all). And it would not help if doctors tried to meet this challenge by attempting to base their communication of medical terms on the definitions held by their patients, i.e. by adopting and conforming to the exact way patients understand medical terms for communicative purposes. As with lay terms, the problem is that it is impossible to achieve such comprehensive knowledge within the limits of ordinary doctor–patient interaction.

The unique feature of asymmetrical theories of concept possession is that they imply that doctors do not need this kind of comprehensive knowledge in order to secure communication of beliefs and thoughts involving medical concepts. According to the asymmetrical theories, the communicative aim of having shared concepts is achieved if there is a shared attitude of deference-willingness to correct meaning. For doctors, this is a much less demanding condition to meet, and it is in this light that the linguistic expert-consumer distinction becomes so striking: When medical terms are used, patients are typically willing to accept explanations of what they mean. And when they do, the asymmetrical theories of concept possession claim that the condition for shared concepts is met.

In this light, the way doctors explain meaning becomes crucial. It is not sufficient simply to formulate a meaningful explanation. It is necessary to establish with a reasonable degree of certainty that patients has not only heard but also understood and internalised the explanation. If it is impossible for a patient to understand an explanation, then it might be better to use lay terms and rely on some common understanding. A partial shared understanding of lay health concepts that are more or less similar is a better communicative basis than medical concepts that are understood in totally different ways.

Furthermore, explanations of what medical expressions mean should be presented in ways such that patients feel comfortable with accepting them. If patients feel alienated from the 'medical community,' if they think there is a great mental divide between themselves and the language of the medical profession, then this may in itself create a situation that constitutes the exception to the rule that patients are willing to defer to explanations of medical terminology. For a doctor, using fundamental communication skills and displaying friendliness, sympathy and empathy can be crucial for creating an atmosphere more conducive to encouraging a patient to defer to alternative definitions [15, 18]. Within the asymmetrical perspective, a shared platform of concepts will in this way often depend on a doctor's *precommunicative* attitudes: The doctor needs to present himself as a 'sympathetic linguistic expert' in the first place, so that the patient sees himself as a linguistic consumer and consequently acquires the doctor's medical concepts.

A further important consequence is that doctors should attempt to give explanations that are neither too detailed nor too difficult to grasp. Patients will normally find it difficult to internalize a great deal of new and detailed information in the context of a single encounter with a doctor [2, 3, 32]. But again, this fact fits well with the asymmetrical analysis of concept possession. The idea that patients

need comprehensive medical knowledge in order to possess medical concepts is incompatible with the asymmetrical perspective. According to asymmetrical theories, the aim of shared concepts can be achieved in another way, namely by offering explanations in such a way that patients achieve a partial understanding of the correct meaning.

At any rate, it is important to remember that if one thinks that there is no threshold condition that it is possible to meet in real life—if one thinks that patients more or less need a complete medical education in order to possess medical concepts—then one also has to accept the pessimistic conclusion that doctors and other health personnel very seldom are able to communicate beliefs involving medical concepts to patients. The implausibility of this conclusion constitutes in itself a strong argument in favour of the perspective on doctor–patient communication that this article has outlined.

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