

PRAGMATIC FEATURES OF SPEECH ACTS IN DOCTOR-PATIENT COMMUNICATION

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Abstract. The article examines the pragmatic nature of doctor-patient communication as a central form of medical discourse. It discusses speech act theory, locutionary, illocutionary and perlocutionary levels, direct and indirect speech acts, and the role of context and deixis in clinical interaction. The study argues that a physician's communicative strategy should be adapted to the patient's age, social background, level of medical knowledge, psychological state and type of illness. Pragmatic goals such as persuasion, reassurance, explanation and guidance are analysed in relation to the formation of patient trust. The findings indicate that meaning in medical communication is produced not only by lexical semantics but also by the speech situation, communicative intention and the expected effect on the addressee.

Keywords: medical discourse, pragmatics, speech act, locution, illocution, perlocution, deixis, context, doctor-patient communication.

SHIFOKOR VA BEMOR MULOQOTIDA NUTQIY AKTLARNING PRAGMATIK XUSUSIYATLARI

Annotatsiya. Maqolada shifokor-bemor muloqotining tibbiy diskursdagi pragmatik xususiyatlari nutq aktlari nazariyasi asosida tahlil qilinadi. Lokutiv, illokutiv va perlokutiv bosqichlarning klinik suhbatdagi o'zaro aloqasi, bevosita hamda bilvosita nutq aktlarining kommunikativ vazifalari, kontekst va deysisning ma'no shakllantirishdagi roli yoritiladi. Shifokorning kommunikativ strategiyasi bemorning yoshi, ijtimoiy tajribasi, tibbiy bilim darajasi, psixologik holati va kasallik xususiyatiga moslashishi zarurligi asoslanadi. Ishontirish, tushuntirish, tavsiya berish, ruhiy qo'llab-quvvatlash va hamkorlikni shakllantirish kabi pragmatik maqsadlar bemor ishonchi bilan bog'liq holda ko'rib chiqiladi. Natijalar tibbiy muloqot samaradorligi faqat axborot mazmuniga emas, balki nutqiy niyat, vaziyat va adresatga ko'rsatiladigan ta'sirga ham bog'liqligini ko'rsatadi.

Kalit so'zlar: tibbiy diskurs, pragmatika, nutq akti, lokutsiya, illokutsiya, perlokutsiya, deysis, kontekst, shifokor-bemor muloqoti.

ПРАГМАТИЧЕСКИЕ ОСОБЕННОСТИ РЕЧЕВЫХ АКТОВ В КОММУНИКАЦИИ ВРАЧА И ПАЦИЕНТА

Аннотация. В статье анализируются прагматические особенности общения врача и пациента как одной из центральных форм медицинского дискурса. Рассматриваются теория речевых актов, локутивный, иллокутивный и перлокутивный уровни высказывания, прямые и косвенные речевые акты, а также роль контекста и дейксиса в клиническом взаимодействии. Обосновывается необходимость адаптации коммуникативной стратегии врача к возрасту пациента, его социальному опыту, уровню медицинской осведомлённости, психологическому состоянию и характеру заболевания. Такие прагматические цели, как убеждение, объяснение, рекомендация, поддержка и формирование сотрудничества, рассматриваются во взаимосвязи с доверием пациента. Результаты показывают, что эффективность медицинской коммуникации определяется не только содержанием информации, но и коммуникативным намерением, ситуацией общения и предполагаемым воздействием на адресата.

Ключевые слова: медицинский дискурс, прагматика, речевой акт, локуция, иллокуция, перлокуция, дейксис, контекст, коммуникация врача и пациента.

Introduction. Doctor-patient communication is a complex discursive process that integrates the clinical, ethical, and communicative dimensions of medical practice. In the traditions of Eastern medicine, alongside a physician's professional knowledge, special emphasis is also placed on gentleness, courtesy, and the ability to inspire trust in the patient. Abu Ali Ibn Sina notes that a physician's appearance, conduct, and sincere communication should evoke respect and trust in both the patient and the patient's relatives.

In medical communication, the physician is not merely a subject who conveys information about diagnosis and treatment. At the same time, the physician acts as a communicator who understands the patient's psychological state, identifies implicit

meanings in the patient's questions, provides reassurance when necessary, and explains medical decisions in an accessible manner. Therefore, the physician's pragmatic and professional competence is inseparably linked to their command of medical discourse and their ability to realize this communicative potential in a particular interactional context.

Pragmatics examines not only the form and lexical meaning of linguistic units, but also who uses them, to whom, in what situation, with what intention, and with what intended effect. This issue is particularly relevant in medical discourse: a message with the same propositional content may elicit completely different psychological and behavioral responses from a patient depending on intonation, context, or form of address.

The aim of this article is to characterize speech acts in doctor-patient communication from a pragmatic perspective, identify direct and indirect communicative strategies, and demonstrate the role of context and deictic devices in the construction of meaning.

Materials and methods.

The research material comprised theoretical observations on doctor-patient conversations, dialogic examples from clinical situations, scholarly sources on physicians' professional communication, and theoretical approaches to the pragmatic features of medical discourse. Descriptive, contextual-pragmatic, discourse, and component analysis methods were combined in the analysis.

Speech acts were analyzed in terms of locutionary, illocutionary, and perlocutionary levels. In distinguishing direct and indirect speech acts, attention was paid to the relationship between the grammatical form of an utterance and its communicative purpose. The contextual analysis took into account person, temporal, and spatial deixis, as well as the patient's psychological state, type of illness, age, and social factors.

As an additional analytical criterion, the triad "communicative intention — linguistic form — effect on the patient" was applied. This triad makes it possible to examine a speech act not merely as a grammatical unit, but as a communicative action capable of influencing a clinical outcome.

The analytical unit of the study was not an isolated sentence but a clinically meaningful communicative move: a question, explanation, recommendation, warning, reassurance, request for clarification, or response to a patient's concern. Such a unit was interpreted in relation to its immediate verbal environment and to the broader clinical purpose of the interaction. This approach makes it possible to distinguish between the literal form of an utterance and the pragmatic task it performs in a consultation.

The qualitative analysis proceeded in three stages. First, the propositional content and grammatical form of an utterance were identified. Second, the probable illocutionary intention was determined on the basis of the speech situation, role relations, and the topic under discussion. Third, the potential perlocutionary effect was evaluated in terms of understanding, anxiety reduction, willingness to cooperate, motivation for treatment, or the risk of communicative resistance. Particular attention was paid to situations in which the same linguistic form could perform different pragmatic functions depending on context.

A functional-pragmatic perspective was also used to examine communicative asymmetry. The physician usually possesses greater professional knowledge and institutional authority, whereas the patient possesses first-person knowledge of symptoms, fears, expectations, and previous experience. Effective medical discourse therefore depends on the physician's ability to translate professional information into a form that is understandable without oversimplifying clinically important content. In this sense, successful communication is treated as a process of coordinating different types of knowledge rather than merely transmitting information in one direction.

Results.

In speech act theory, every utterance performs a certain action. In the approach developed by J. L. Austin, locution refers to the production of the utterance and its literal content, illocution to the speaker's communicative intention, and perlocution to the effect produced on the listener as a result of the utterance. In medical communication, these three levels are especially closely interconnected.

For example, the locutionary content of the question "Do you want to recover?" is to ask about the patient's desire. In a particular clinical situation, however, its illocutionary force may consist in actively engaging the patient in the conversation, restoring hope and trust, and preparing the patient for subsequent medical instructions. If the patient's trust in the physician and motivation for treatment increase, this constitutes a perlocutionary outcome. In the clinical example cited in the source, the physician's timely adjustment of their behavior and patient-oriented speech act likewise leads to the restoration of trust.

In a direct speech act, grammatical form and communicative purpose correspond to one another: the statement "I will come to your appointment tomorrow" openly expresses the speaker's intention. In an indirect speech act, one form is used to express another purpose: although the question "Will you be at the hospital tomorrow?" appears to request information, in context it may convey the implicit intention "I would like to come for an appointment tomorrow."

Indirectness in medical discourse is often associated with communicative tact. When a patient is not ready to speak directly about a serious diagnosis, fear, or personal matters, another need may lie behind their questions, ironic remarks, or vague expressions. If the physician fails to recognize this implicit meaning, they may provide a formally correct answer while pragmatically failing to address the patient's actual need.

The illocutionary purposes of a physician's speech can be divided into several groups: providing information and explanation; persuading and substantiating; giving recommendations and instructions; reassuring the patient; obtaining clinical information through questions; and managing the thematic and temporal boundaries of the conversation. Each of

these purposes is reinforced by linguistic choices, tone of voice, forms of address, and nonverbal behavior.

Table 1.

Pragmatic model of the main speech acts in medical discourse.

Speech act	Illocutionary purpose	Expected perlocutionary effect	Clinical function
Asking questions	Obtaining / clarifying information	Active response from the patient	Completing the medical history
Explanation	Reducing uncertainty	Reduced anxiety	Communicating the diagnosis and treatment
Recommendation	Prompting action	Adherence to treatment	Therapeutic cooperation
Reassurance	Establishing trust	Hope and calm	Supporting emotional stability

Context is a decisive factor in interpreting the meaning of medical discourse. As M. Hakimov notes, the objective content of certain utterances can be fully understood only within a specific speech situation and contextual environment; an utterance removed from its context may be misinterpreted. The same phenomenon is observed in doctor–patient communication: the same expression may carry one pragmatic force during diagnosis and another when discussing treatment outcomes.

Deictic devices—such as “I,” “you,” “this,” “here,” “now,” and “tomorrow”—identify the participants, time, and place of communication. A. Ko‘chiboyev explains person deixis in terms of the first person referring to the speaker, the second person to the addressee, and the third person marking a relation to someone who is not a direct participant in the interaction. In medical discourse, person deixis can also function as a means of signalling responsibility, collaboration, and interpersonal distance.

For example, the sentences “You need to take the medication” and “We will continue the treatment according to this plan” may convey similar recommendations; however, in the second form the deictic “we” brings the physician and patient together within a shared framework of therapeutic cooperation. In some situations, such a choice may help the patient avoid feeling alone in the decision-making process.

Functional-pragmatic classification of speech acts.

Within clinical interaction, speech acts can be grouped according to the practical task they perform. Assertive acts are used when the physician states, explains, or interprets information: for example, when describing examination findings or clarifying the probable cause of a symptom. Their pragmatic success depends on accuracy, comprehensibility, and the degree to which the patient can relate the explanation to their own experience. A technically correct statement may fail pragmatically if its terminology is inaccessible or if it does not answer the concern that motivated the patient’s question.

Directive acts are especially frequent in medical discourse because diagnosis and treatment require the patient to perform actions: take a medicine, return for follow-up, undergo an examination, change a routine, or seek urgent help if a warning sign appears. However, the pragmatic force of a directive can vary considerably. The forms “Take this medicine twice a day,” “I recommend that you take this medicine twice a day,” and “Could you take this medicine twice a day?” are close in propositional content but differ in directness, interpersonal distance, and the amount of choice linguistically presented to the patient. The physician’s task is to choose a form that preserves clarity while remaining appropriate to the situation.

Commissive acts express the physician’s commitment to a future professional action, as in “I will review the results when they arrive” or “We will reassess your condition next week.” Such utterances can reduce uncertainty because they provide the patient with a clear expectation of what will happen next. Their perlocutionary value is especially high when the patient is worried about continuity of care. At the same time, a commitment that is vague or not subsequently fulfilled can weaken trust more strongly than the absence of a promise.

Expressive acts communicate empathy, concern, acknowledgment, or support. Statements such as “I understand that this has been difficult” do not provide new diagnostic information, yet they perform an important pragmatic function by recognizing the patient’s emotional experience. In clinical discourse, emotional acknowledgment is most effective when it remains connected to the medical task: it can create the conditions in which the patient is more willing to disclose symptoms, ask questions, and participate in decisions. Reassurance, by contrast, should not become a substitute for explanation, because unsupported reassurance may be interpreted as dismissal of the patient’s concern.

Institutional or declarative acts occur when a physician’s utterance changes the practical status of the clinical situation within an established procedure, for example when a patient is formally admitted, discharged, referred, or declared ready for a particular stage of care according to applicable rules. The force of such statements arises not only from the words themselves but also from the professional role of the speaker and the institutional context. This demonstrates that the pragmatics of medical speech cannot be separated from role relations and the conventions of the healthcare setting.

Communicative tact, indirectness, and feedback.

Indirect speech is often useful when the topic is emotionally sensitive, but indirectness is not automatically more polite or more effective. In some situations, a carefully softened formulation can preserve the patient’s dignity and reduce defensiveness. In others, excessive hedging may obscure the seriousness of a recommendation. The pragmatic criterion is therefore functional adequacy: the linguistic form should be tactful enough to maintain cooperation but explicit enough to prevent misunderstanding about clinically important information.

Feedback is a central mechanism for testing whether the intended illocutionary force has produced the expected perlocutionary result. A patient's silence, brief agreement, or polite nod does not necessarily demonstrate understanding. The physician may need to invite reformulation, for example by asking the patient to explain in their own words how they will follow the treatment plan. Such a move transforms communication from one-way transmission into a cyclical process in which meaning is checked and, if necessary, repaired.

Communicative repair becomes especially important when the physician and patient attach different meanings to the same expression. Terms such as "normal," "serious," "positive," or "negative" may be interpreted differently in everyday and professional language. A clinician can reduce ambiguity by linking the term to a concrete explanation and by observing the patient's reaction. In pragmatic terms, repair restores alignment between intended meaning and interpreted meaning.

The interactional value of questions also depends on their sequence and formulation. Closed questions are efficient for confirming specific symptoms, while open questions allow patients to introduce concerns that may not have been anticipated by the physician. A strategically organized consultation can move from open exploration to focused clarification and then to explanation and planning. This sequence supports both information gathering and the patient's perception that their account has been heard before a decision is presented.

Discussion.

The pragmatic effectiveness of medical communication cannot be measured solely by a physician's vocabulary or grammatical accuracy. What matters is how the utterance is received by the patient and what emotional and behavioral response it evokes. Accordingly, professional communication skills have been reported to help patients better understand the causes of their illness, evaluate the treatment process more accurately, and participate more actively in their care.

In communicating with a patient, the physician should take into account factors such as the type of illness, age, gender, social circumstances, occupation, level of medical knowledge, and psychological state. In situations involving serious diagnoses, oncological conditions, or mental disorders in particular, the illocutionary force of an utterance may have powerful perlocutionary consequences for the patient. For this reason, not only "what" the physician says but also "how" it is said constitutes a pragmatic criterion.

In communication, "trust" may be regarded as a distinct pragmatic category. It is not the result of a single phrase; rather, it is formed through logically consistent explanation, attention to the patient's questions, appropriate intonation, attentive listening to the patient's response, and congruence between verbal and nonverbal behavior.

From a pragmatic perspective, effective physician speech should meet three conditions: the communicative intention must be clear, the linguistic form must be selected in accordance with the patient's capacities, and the expected perlocutionary outcome must not conflict with the clinical objective. These criteria can be used as practical analytical tools for evaluating medical communication.

The analysis also suggests that the pragmatic quality of a consultation is closely connected with the management of asymmetry. Professional asymmetry is unavoidable: the physician has specialized knowledge, diagnostic authority, and responsibility for clinical decisions. Yet communicative asymmetry can be moderated by explaining reasoning, inviting questions, and making the patient's perspective relevant to the conversation. This does not eliminate role differences; rather, it makes those differences compatible with therapeutic cooperation.

A further distinction should be made between informational success and interactional success. Informational success occurs when accurate medical content is transmitted. Interactional success occurs when the patient understands why the information matters, knows what action is expected, and feels able to respond or seek clarification. Medical discourse is most effective when both forms of success coincide. A consultation may be factually accurate but pragmatically unsuccessful if the patient leaves uncertain about the next step.

Trust, therefore, can be viewed as a cumulative perlocutionary effect produced across a sequence of speech acts. It is reinforced when explanations are consistent, questions are taken seriously, commitments are fulfilled, and recommendations are framed in a way that connects professional reasoning with the patient's situation. Conversely, abrupt topic shifts, unexplained terminology, contradictory messages, or premature reassurance may weaken trust even when individual sentences are grammatically correct.

These observations support the use of pragmatic analysis in professional training. Teaching clinicians to identify the intention, form, and likely effect of an utterance can help them notice communicative problems that are not visible at the level of grammar alone. Short clinical scenarios, role-play, and reflective analysis of alternative formulations may be used to demonstrate how a small change in wording can alter perceived certainty, politeness, responsibility, or willingness to cooperate.

Practical implications for clinical communication.

For practical use, the physician can evaluate an important utterance through four questions: What is my communicative intention? Which linguistic form expresses it most clearly? How is the patient likely to interpret this form in the present context? How can I verify the effect? This brief sequence operationalizes the intention-form-effect model and can be applied to explanations of diagnosis, treatment recommendations, informed discussions, and emotionally difficult conversations.

When communicating complex information, it is useful to divide the message into manageable semantic units, signal transitions between them, and check understanding before moving to the next point. Deictic expressions such as "today," "after this examination," "at your next visit," and "we" should refer to clearly identifiable participants, times, and actions.

Precise deixis reduces uncertainty and helps the patient construct a coherent plan from the conversation.

In pediatric and family-centered communication, the pragmatic structure becomes more complex because more than two participants may be involved. The physician may address the child, a parent, or both, and the choice of addressee changes the interpersonal meaning of the utterance. Age-appropriate explanations directed to the child can support involvement, while clear guidance to the parent can preserve responsibility for care. The communicative strategy should therefore coordinate several addressees without excluding the patient whose condition is being discussed.

Finally, pragmatic competence should be understood as adaptable rather than formulaic. No single phrase is universally appropriate for all patients or all diagnoses. The same recommendation may need a more direct form in an urgent situation and a more exploratory form when several reasonable options are being discussed. The physician's competence lies in preserving clinical accuracy while adjusting directness, detail, tone, and feedback to the needs of the particular interaction.

Conclusion.

Doctor-patient communication is a multilayered pragmatic phenomenon in which the literal content of an utterance, the speaker's intention, and the effect produced on the patient must be analyzed together. The locutionary, illocutionary, and perlocutionary levels help reveal the nature of speech acts such as questioning, explaining, recommending, reassuring, and warning in medical discourse.

Correct interpretation of direct and indirect speech acts, the ability to infer implicit meaning from context, and the appropriate use of person, temporal, and spatial deixis are key components of a physician's pragmatic competence. In medical communication, a speech strategy adapted to the patient's age, psychological state, social experience, and the nature of the illness strengthens trust and supports therapeutic cooperation.

In practical terms, it is advisable to assess physician speech using the sequence "intention — form — effect," to identify the patient's readiness and needs before delivering any important clinical message, and then to verify how the message has been understood.

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