

THE BALANCE BETWEEN TERMINOLOGICAL ACCURACY AND COMMUNICATIVE CLARITY IN EXPLAINING MEDICAL RECOMMENDATIONS

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Abstract. The article analyzes the issue of preserving standard terminology while explaining its meaning in plain language when communicating medical recommendations to patients. Based on sources of medical discourse, model micro-dialogues, and official health literacy guidelines, the study identifies criteria such as accuracy, explanatory paraphrase, action guidelines, risk level, and comprehension checks. As a result, a five-step model for formulating medical recommendations is proposed.

Keywords: *medical recommendation, terminological accuracy, communicative clarity, doctor-patient communication, health literacy, explanatory paraphrase, teach-back.*

Introduction

A medical recommendation is not merely a simple verbal or written instruction provided by a physician. It determines the course of action following a diagnosis, guiding the patient in taking medication, adhering to dietary regimens, preparing for examinations, recognizing warning signs, and understanding when to seek follow-up care. Therefore, the linguistic quality of a recommendation directly influences clinical adherence. Highly complex terminology alienates the patient from the intended meaning, whereas oversimplification may distort the medical essence. In this article, terminological accuracy and communicative clarity are interpreted not as mutually exclusive concepts, but rather as two requirements that must be gradually and harmoniously integrated.

The World Health Organization (WHO) defines health literacy as an individual's ability to access, understand, appraise, and apply health information. The organization emphasizes that medical information must not only be reliable but also presented in a clear and actionable format [1]. Studies on Uzbek medical discourse have also demonstrated that the success of communication depends on the physician's ability to

adapt their professional knowledge to the patient's communicative capacity [2; 3]. Consequently, during the process of explaining a recommendation, the physician performs two simultaneous tasks: preserving the clinical content and converting it into a linguistic form accessible to the addressee.

Material and methods

The research material comprises instances of explaining pathological and diagnostic terms found in medical recommendations, published dialogues reflecting doctor-patient communication, and formulated model examples. The analysis utilized descriptive, structural-semantic, and pragmatic methods. Pragmatic analysis allows for the evaluation of a speech unit in relation to the context, the addressee, and the communicative goal [6]. Each linguistic unit was evaluated based on three criteria: whether the clinical meaning of the term was preserved; whether the unfamiliar part was explained to the patient; and whether the recommendation was transformed into a clear, actionable guideline. The model examples were formulated not as authentic clinical documents, but specifically to demonstrate the structural composition of medical recommendations.

RESULTS AND DISCUSSION

The first condition of terminological accuracy is to avoid losing the primary medical designation. For instance, replacing "arterial hypertension" simply with "you have pressure" obscures the medical boundaries of the condition. A more acceptable formulation would be: "You have been diagnosed with arterial hypertension, a condition where your blood pressure remains consistently higher than normal." In this construction, the core term is preserved and immediately followed by a brief explanation. Such a two-tiered structure ensures both inter-professional accuracy and patient comprehension.

The second condition is that the explanation must not alter the referent of the term. A source on medical discourse cites a dialogue where "chronic pancreatitis" is explained to a patient as "chronic inflammation in the gallbladder" [3]. This example clearly illustrates that professional terms require supplementary explanation; however, pragmatic convenience must not come at the expense of medical accuracy. Pancreatitis specifically relates to the pancreas, while the gallbladder is an entirely different organ. Therefore, an acceptable explanation for the patient should be formulated as "a long-lasting inflammation of the pancreas." This case highlights the critical boundary between simplification and distortion of meaning.

The third condition is the explicit articulation of the required action following the term's explanation. The conclusion "hepatomegaly detected" is an insufficient

recommendation for a patient. Its communicatively complete form is structured as follows: "The examination showed that your liver is enlarged. This is not the name of a separate disease; a blood test and a doctor's consultation are needed to determine the cause." Here, the conceptual content of the pathological term, its diagnostic status, and the subsequent required action are linked into a single logical chain. As a result, the patient receives an answer not only to the question "what was found?" but also to "what should be done next?"

The fourth condition involves not transforming risks and probabilities into categorical judgments. The statements "you have a tumor" and "a tumor-like structure was seen on the scan; a biopsy is recommended for clarification" do not carry the same pragmatic impact. The latter option does not conceal diagnostic uncertainty, yet it avoids inducing unjustified panic in the patient. Lexical units in the physician's speech such as "probably," "suspected," "requires clarification," and "cannot be ruled out" are not means of evading responsibility, but rather linguistic tools for accurately indicating the level of evidence. If left unexplained, patients may perceive a probable condition as a definitive diagnosis.

The fifth condition is verifying comprehension not by asking "Did you understand?", but through reformulation. The teach-back method, recommended by AHRQ, requires asking patients to state the recommendation in their own words; this method aims not to test the patient, but to evaluate how clearly the physician explained the information [4]. For example: "Can you tell me in your own words how you will take this medication once you get home?" If the patient responds incorrectly, the information is re-explained using a different formulation. This method directly links the linguistic form of the recommendation with practical clinical control.

Based on the analysis, a five-step model for explaining medical recommendations is proposed: 1) stating or writing the standard term; 2) explaining it with a simple but accurate sentence; 3) indicating the actionable step to be taken; 4) clarifying risks, probabilities, and timelines; 5) asking the patient to repeat the core message in their own words. Within this model, de-terminologization serves not to eliminate the term, but to unpack its conceptual meaning for the addressee.

In Uzbek medical recommendations, colloquial expressions offer significant communicative advantages; however, broad umbrella terms like "shamollash" (catching a cold/inflammation), "asab" (nerves/neurological issues), "qon suyulishi" (blood thinning), and "tuz yig'ilishi" (salt accumulation/osteocondrosis) can conflate entirely distinct pathological conditions under a single label. Therefore, it is advisable to provide colloquial alternatives alongside the standard medical terminology.

Qosimov emphasizes that a physician should build the conversation taking into account the patient's intellectual level and psychological state [5]. This principle also applies to the text of the recommendation: the length of the explanation, word choice, and tone must be adapted to the patient's age, health literacy level, and the severity of the diagnosis.

The distinction between oral and written forms of recommendations also dictates this balance. In a verbal consultation, a doctor can immediately modify their explanation based on the patient's facial expressions, questions, and hesitations. A written recommendation lacks such immediate feedback; consequently, the medication name, dosage, time of intake, duration, contraindications, and indicators for a follow-up visit must be explicitly specified. The phrase "take the drug twice a day" fails to clarify whether it should be taken before or after meals, the required interval between doses, or the total duration of the treatment. A more precise variant is: "Take one tablet in the morning and one in the evening, after meals, for seven days." Here, the terminology is not overly simplified, but rather the temporal and quantitative parameters of the instruction are thoroughly unpacked.

Measuring communicative clarity solely by the simplicity of vocabulary is insufficient. Grammatical structure, the sequencing of information, and the placement of key points also significantly impact the outcome. If the diagnosis is presented first, followed by its explanation, and finally the practical recommendation, the patient can trace the informational chain much more easily. Conversely, if multiple medical terms, laboratory values, and potential risks are crowded into a single sentence, even simple words will impede comprehension. Therefore, the "one message — one primary action" principle should be regarded as a crucial pragmatic criterion for recommendation texts.

When adapting medical recommendations, national speech etiquette must also be taken into consideration. While the imperative form "you must do" is necessary in certain situations, in a standard consultation, constructions like "I recommend," "the safer path for you," or "if you follow this regimen" foster a greater sense of cooperation. However, linguistic mitigation (softening) must not turn a mandatory instruction into an optional suggestion. For instance, if emergency signs are present, the phrasing should not be "seek help when you can," but rather "seek emergency medical attention immediately." Thus, conversational politeness should never obscure clinical urgency.

Conclusion

Effectively explaining a medical recommendation is achieved not by eliminating medical terminology, but by unpacking it both semantically and pragmatically. While

terminological accuracy preserves the core professional content, communicative clarity transforms this content into the patient's informed decisions and actionable steps. The five-step model proposed in this study integrates the standard medical designation, a clear explanation, practical guidelines, risk assessment, and comprehension verification into a single, cohesive linguistic structure. This approach can significantly serve to mitigate the risks of misinterpretation, undue anxiety, and non-adherence to recommendations in doctor-patient communication. Future research should focus on testing and validating this model using authentic consultation transcripts and empirical data on patient comprehension.

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