NAVIGATING MEDICAL LANGUAGE: CHALLENGES AND IMPORTANCE OF CLEAR COMMUNICATION BETWEEN PHYSICIANS AND PATIENTS WITHIN THE CROATIAN HEALTHCARE SYSTEM

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Medical language is a specialised form of communication used by healthcare professionals in their daily practice and medical research. It is strongly influenced by globalisation and advancements in technology and science, leading to the continuous evolution of medical vocabulary and the development of new terms and meanings. Communication in healthcare depends on mutual understanding between physicians and their patients. However, this understanding is often hindered by the gap between the everyday language used by patients and the medical language used by physicians, which can create a communication barrier. A lack of comprehension and clear communication between patients and physicians may results in disagreements, conflicts, and even medical errors. This study examines how the use of medical language and terminology can impede communication with patients and explores the strategies that both patients and physicians use to achieve mutual understanding. The data analysed in this study were collected during fieldwork conducted in Zagreb between 2017 and 2020 using semi-structured interviews. This paper draws on the data from eleven semi-structured interviews in which medical language was identified as significant. Five interviews were conducted with healthcare users who had various health conditions and treatments, and six with physicians from different medical specialties. The study's limited number of interlocutors is

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not intended to offer a general account of communication issues in Croatia's public healthcare system. Instead, the research focuses on how wider systemic processes are reflected in the distinct experiences and perspectives of individual participants. These lived experiences highlight the continual importance of personal interaction and communication in patient–physician relationships and the effect it has on healthcare outcomes. However, despite advances in digital technologies and communication that can serve as a helpful tool in bridging communication gaps, improving communication is challenging within a strained healthcare system marked by staff shortages, long waiting times, regional disparities, and low wages.

1. Introduction

Communication within a healthcare system is similar to communication in any other setting. For effective understanding and interaction, it is essential to have a shared knowledge of the language, as well as a common understanding of the world and similar life experiences (Schramm 1954). What sets communication in a medical context apart from other settings is that, even though physicians and patients may share the same cultural and social background, physicians do not always use a language that patients can easily understand.

Medical language (ML) is a language for special purposes (LSP) used to facilitate communication within healthcare, both among healthcare workers and with patients (Gjuran-Coha and Bosnar-Valković 2017). Medical language serves various purposes, such as describing studies in journal articles, textbooks, popular science, or communicating with patients and professionals (Gjuran-Coha and Bosnar-Valković 2017). It is characterised by extensive use of specialised vocabulary, ranging from scientific medical terms to more common healthcare-related expressions used among healthcare workers and patients without medical training (Džuganová 2019). When discussing medical language, medical terminology is an unavoidable component, as it constitutes a structured set of terms that express the core concepts used in the field of medicine (Džuganová 2019). As such, medical terminology provides the initial access point to medical language and enables efficient and precise communication within healthcare contexts (Gjuran-Coha and Bosnar-Valković 2017). Croatian medical terminology is mostly based on Latin, with some influence from Greek, but there has also been a noticeable increase in English terms due to globalisation (Gjuran-Coha and Bosnar-Valković 2013). The shift towards English influence is also attributed to the fact that modern medicine has outgrown traditional Greco-Latin terminology, leading to the creation of new terms that are often borrowed from English (Džuganová 2019).

Given that language is key to successful communication, the use of medical language may present a significant barrier to effective communication within healthcare (Beauchamp and Baran 2017: 322). If physicians use medical terminology too frequently when communicating with patients, patients may not fully comprehend what is being conveyed. This may increase the likelihood that patients fail to follow instructions, miss necessary medical procedures and examinations, and take prescribed medications incorrectly (Beauchamp and Baran 2017). Patients' ability to understand basic health information is essential for making informed decisions about their health (Beauchamp and Baran 2017: 313). The challenges of medical language arise not only

in verbal communication but also in written form. Due to the use of Latin, Greek, and Anglicisms, as well as the frequent use of synonyms, various abbreviations, and the inconsistencies in medical terminology, there is often a lack of understanding and misinterpretation of spoken and written forms of medical language (Gjuran-Coha and Bosnar-Valković 2013).

This paper examines the experiences of using and understanding medical language from both patient and physician perspectives within the Croatian public healthcare system. The focus is on consequent communication challenges and the strategies employed to overcome them. First, we provide a brief overview of the development of health communication research and its implications for our study. Then, we analyse the strategies utilised by patients and physicians to address the communication barriers arising from the use of medical language. We also examine some structural challenges within the Croatian public healthcare system that hinder clear communication between patients and physicians. In conclusion, we consider the adjustments needed to enhance communication within the healthcare system based on the issues analysed in the previous parts of the text.

2. The Development of Health Communication Research

Much has been written about physician-patient interactions and their asymmetrical nature, with power imbalances often amplified by differences in medical knowledge and the use of medical language unfamiliar to patients (Waitzkin 1989; Beisecker 1990; Ainsworth-Vaughn 1994; Coulter 1999; Beauchamp and Baran 2017). However, the study of health communication is a relatively recent phenomenon. It grew in popularity in the 1980s and it developed from various academic disciplines, particularly behavioural and social sciences (Zoller and Kline 2008). Initially rooted in interpersonal and mass communication studies, the field has since evolved, with researchers creating research that is theory-driven and rooted in more advanced understandings of healthcare communication and health issues (Zoller and Kline 2008). In its early stages, health communication research was often quantitative, focusing on cognitive and behavioural factors–such as how people interpret and use information–while treating broader social, cultural, and environmental influences as secondary (Zoller and Kline 2008; Burke and Barker 2014). However, since the late 1990s there has been a notable shift towards more interpretive and critical approaches to studying health communication that takes into consideration the overall subjectivity of meaning, as well as the role that the broader social context and power structures have in communication

(Zoller and Kline 2008). Subsequently, various comprehensive volumes have been published adopting these contemporary perspectives and raising new questions about communication in healthcare (e.g., Obregon and Waisbord 2012; Hamilton and Chou 2014; Thompson and Schulz 2021).

A similar disregard for broader contextual influences, as seen in the early stages of health communication research, is evident in the biomedical approach to physician-patient communication and the subsequent diagnosis and treatment. Traditionally, physicians saw a disease as a dysfunction in the body and are concentrated on treating symptoms and finding a cure, often giving little consideration to social contexts that surround the patient and the illness (Good and DelVecchio Good 2000). This approach to communication in a hospital setting arose from physicians being trained to see medicine purely as a science, emphasising objectivity and efficiency when collecting information and testing diagnoses (Watson 2007).

During their training, physicians are taught various speaking practices, including presenting cases to colleagues, interviewing patients, discussing illnesses and outcomes with patients and families, and obtaining consent for treatments, while also developing clinical reasoning skills and proficiency in various medical procedures (Good and DelVecchio Good 2000). They are trained to extract the "essential" information during conversations with patients and to identify and understand which details in patients' narratives are necessary for making a diagnosis (Good and DelVecchio Good 2000). In contrast, patients experience sickness as part of their life's stories, situated in and shaped by their social contexts, but biomedicine has often overlooked these broader dimensions (Good and DelVecchio Good 2000). This practice, however, seems to be gradually shifting, accompanied by an increasing recognition of the importance for healthcare professionals to develop a deeper understanding of patients' suffering, social contexts, and personal narratives (Doobay-Persaud et al. 2019; Czerska 2021; Paik and Sung 2025).

In general, interest in health communication has been growing significantly due to healthcare users' increasing expectations, but also dissatisfaction and pressure that they have been putting on healthcare systems and practitioners globally (Coulter and Magee 2003; Wallington 2014; Schuh et al. 2025). Access to new communication technologies, availability of health information on the internet, digitalisation of healthcare, and a consumerist approach to healthcare all contributed to the growth of studies aimed at the challenges that healthcare users and practitioners are experiencing in today's changing healthcare landscapes (Coulter and Magee 2003; Wallington 2014). This growing interest in health communication underscores the critical need to address the challenges faced by both patients and healthcare profes-

sionals in an increasingly complex and consumer-driven healthcare landscape. By examining these dynamics, one of the purposes of this study is to contribute to the broader goal of fostering more effective, equitable, and patient-centred communication strategies.

Additionally, with regard to the development of health communication research within the Croatian academic and scientific community, most studies focus on general recommendations for improving communication in healthcare settings and on practices that should be avoided (e.g., Kabalin et al. 2002; Staničić 2002; Ljubešić 2013; Sorta-Bilajac and Sorta 2013; Štifanić 2013; Rakošec et al. 2014; Stilinović et al. 2014; Tomaš 2025). Considerable attention has also been paid to information sharing and informed consent (e.g., Marasović Šušnjara 2012; Brkljačić 2013; Pavličević and Simi 2014; Carti and Balaž Gilja 2022; Koščević and Režić 2023), as well as to paternalism, which is often perceived as inherent in the physician–patient relationship (e.g., Talanga 2006; Braš et al. 2011; Štifanić 2013). In 2011, Zagreb's School of Medicine also implemented a course *Temelji liječničkog umijeća1* that provides continuous, structured training in medical communication throughout medical education, which covers similar topics as the majority of available research.

However, little research has examined how medical communication practices contribute to patient comprehension difficulties within the Croatian healthcare system. This study therefore aims to contribute to existing research by further examining healthcare communication within its broader social and systemic context.

3. Research Methodology

The data analysed in this study were collected during fieldwork conducted in Zagreb between 2017 and 2020. This fieldwork was part of a study that focused on the patients' and physicians' narratives about their experiences in the public healthcare system and how their interactions within that system are shaped by various social and power dynamics that extend beyond the biomedical framework (Vukšić 2024). During the fieldwork, 33 interlocutors were interviewed (14 physicians, 16 patients, and 3 members of patient associations). The interviews with the patients were semi-structured and approximately between 40 and 90 minutes long, while the interviews with the physicians were in general shorter, up to 30 minutes due to their time constraints. Semi-structured interviews are useful because of their openness since there are a se-

[1] https://mef.unizg.hr/o-nama/ustroj/vijeca-predmeta/temelji-lijecnickog-umijeca/

ries of questions that are neither strictly predetermined nor necessarily tightly focused on a single topic, which allows the interlocutors the freedom to shift from one topic to another and to feel that they are participating in an interactive and informal dialogue (Mason 2002). Following Black and Riner's (2022) concept of *care* as a context-sensitive, reflexive approach to research ethics, the semi-structured interviews evolved organically, as new themes emerged over time and the participants interpreted and responded to questions in diverse and unique ways. Therefore, data related to medical language that the authors considered significant, but which were not examined in depth in the previous study, appeared in 11 of the 33 interviews. These interviews were thus selected for analysis in the present study.

Five interviews were conducted with healthcare users who had various health conditions and treatments, and six with physicians from different medical specialties. To maintain confidentiality, the participants' real names, age, specific health issues, medical procedures, and associated hospitals are not disclosed. All participants signed informed consent forms before the interviews, with the option to withdraw their responses or request more information at any time.

The study's limited number of interlocutors was not intended to provide a general overview or to generalise communication issues in Croatia's public healthcare system. Generalising from specific individuals' experiences risks flattening their differences and presenting them as a homogenous group, obscuring internal diversity (Abu-Lughod 2014). Instead, this research emphasises the embodiment of broader systemic processes in the unique actions and thoughts of individuals (Abu-Lughod 2014) represented in the study.

The interviews were recorded using a voice recorder and subsequently transcribed and coded. Since the research was based on the principles of grounded theory that prioritises data collection over testing theories and hypotheses in order to generate new insights (Škrbić Alempijević et al. 2016), the coding process was inductive as well. The interviews were conducted over a three-year period. The transcription and coding were carried out after each interview, resulting in an ongoing process of analysis that extended across the entire study. After each transcription, portions of the text that the authors deemed relevant to the goals of the research were identified and assigned labels or "codes" to succinctly capture and summarise their essence (Saldaña 2009). This process also involved repeatedly returning to earlier interviews to identify new codes and refine existing ones. Through repeated reading and reanalysis, patterns and codes gradually emerged, enabling a continuously evolving analytical framework that generated new insights and perspectives throughout the research process.

4. Analysis

In the selected interviews, it was observed that the patients highlighted their lack of understanding of certain medical terminology in verbal communication during the treatment process and consultations with physicians, as well as in written form when reading their diagnoses or discharge letters. They approached the problem of not understanding the terminology in several different ways: they would look up the terms which they did not understand on the internet; they would ask family members, acquaintances, or healthcare professionals who they personally knew for help with the interpretation; or they would directly ask their physicians to explain the terms which they did not understand.

The physicians who participated in the study also expressed an awareness of the communication and comprehension issues that can arise from the use of medical terminology. They approached the issue by attempting to adapt their register and avoiding strictly medical terminology when possible. In one case, patients were given brochures specifically designed to help them understand their treatment and condition following initial consultations.

In the analysis, we examine the issue from two perspectives: those of the patients and the physicians. We explore how both groups attempt to overcome communication barriers arising from the use of medical terminology and language, and how physicians make decisions about communication with different patients. Additionally, we consider the broader social, organisational, and cultural contexts that influence the use and potential misunderstandings caused by the medical language.

4.1. Medical Language and Its Impact on Patient Experience

The patients in the study frequently reported difficulties understanding certain medical terminology used in verbal or written medical communication throughout their treatment. This often led to feelings of uncertainty and disconnection from the healthcare process, thus highlighting once again that health and disease are not only determined by our physiology, but are also significantly influenced by language. Naming and understanding a health condition or a disease is sometimes as important to patients as the treatment itself (Rubin 2014). To address this challenge, the patients adopted various strategies. For example: searching online resources for quick and accessible explanations; seeking clarification from family, friends, or trusted healthcare professionals in their social networks; and directly asking their physicians for more detailed explanations.

Asking their physician for clarification is certainly one of the most straightforward ways for patients to resolve uncertainties about their treatment or disease. Engaging in direct questioning and follow-up inquiries can empower patients, giving them a greater sense of control in their interactions with physicians (Anisworth-Vaughn 1998).

However, many patients hesitate to voice their questions, even when they feel the need for clarification (Boreham and Gibson 1978; Beisecker 1990). For some, this reluctance stems from feelings of insecurity driven by the perceived disparity between their own medical knowledge and that of the physician, while others may be deterred by the authoritative status physicians hold in their eyes (Waitzkin 1985; Proso 2006). Additionally, some physicians may not respond favourably to patient inquiries, viewing them as disruptive or as challenges to their authority and expressions of doubt in their competence (Ainsworth-Vaughn 1998). One of our interlocutors, Ivana, recalled a similar issue she experienced with her physician when she asked for a clarification of the Latin terms her physician used in their conversation:

> He [the physician] started explaining in Latin, and I said, 'Excuse me, but I don't understand any of that. Could you please explain it in your own words? I don't know those terms.' But he didn't seem too happy when I said that. As far as I could tell, he thought I should have already known what it meant, but it didn't mean anything to me because I didn't understand it. He even said I was stupid for not knowing. I told him, 'I'm smart enough, but I don't know foreign words, whether you like it or not, I don't understand what you're saying to me.' He became a bit harsher, but later calmed down when I insisted that I wanted to understand and that I didn't know those terms. He's the physician–he should be able to explain it to me using the words I can understand. (Ivana)

What Ivana's physician failed to recognise is that when one physician speaks to another, it is reasonable to assume their communicative competence in medical language is at the same level, but this assumption should not extend to interactions with patients who lack medical expertise (Gjuran-Coha and Bosnar-Valković 2013). When choosing which words and expressions to use, speakers assume the listener's level of communicative competence. However, healthcare professionals frequently overestimate patients' familiarity with medical language (Bass et al. 2002; Koch-Weser et al. 2009). By asking questions directly and demanding an answer, Ivana was eventually able to obtain the explanation she required to understand the treatment.

Similar approach to Ivana's was used by another of our interlocutors, Marta:

> They start off with technical terms, in 99% of the cases with every physician I've talked to, they begin with that kind of language, and then I say, 'I'm a layperson, please explain it to me in simple terms so I can understand.' I've done a lot of research online, so now I understand some terms, including the Latin ones, but when they say, 'You'll start radioactive iodine treatment'. What is radioactive iodine? And I think that if we don't ask, unfortunately, we won't get much information. (Marta)

Therefore, even though patients have traditionally been portrayed as powerless and passive participants in medical communication, this is an oversimplification of a more complex reality (Street 1991). As can be seen from Marta's and Ivana's examples, patients can actively shape conversations through their communicative styles, for example by asking direct questions, expressing opinions, or seeking clarification (Street 1991). Other communicative practices, such as topic control, ignoring questions, and the use of rhetorical questions can further alter the interaction by shifting empowerment from one speaker to another (Ainsworth-Vaughn 1994, 1998). Consequently, when discussing patient empowerment and communication within healthcare, we must recognise that some communicative strategies transcend the issue of medical language. Those strategies are part of a much broader set of social and communicative practices that shape physician-patient interactions within healthcare systems.

Besides asking direct questions, Marta also mentions relying on the internet as a source of information and explanation. The internet was also the most frequently cited source of information among the patients. They searched the internet to read about other people's experiences with similar illnesses and treatments, about their interactions with healthcare professionals in specific hospitals, and to better understand their own condition and the terms associated with it. For example, Tomislav, one of the patients we spoke with, searched the internet for the meaning of the word "ablation", which was the name of the procedure he was about to undergo. By learning more about the meaning of the word, he also learnt more about the procedure itself.

In 1999, Hardey predicted that the internet would become a new source of medical knowledge for laypeople, changing the relationship between healthcare professionals and patients by reducing patients' dependence on physicians for information, thereby diminishing their control over medical knowledge (Hardey 1999). Patients who use the internet for health-related information tend to be more informed and feel more confident, which can lead to more meaningful and productive discussions with

their physicians (Tan and Goonawardene 2017). However, in practice, the prevailing healthcare model that is based on the rapid processing of as many patients as possible does not support this type of consultations (Savage et al. 2014). Furthermore, physicians may not respond positively to patients who inform themselves via the internet (Savage et al. 2014). This was also the case with Mauricio, one of the physicians in the study. He expressed his frustration about the patients who arrived "prepared by doctor Google" with "ideas about what should be done" and the potential side effects. His response also aligns with the argument discussed earlier that some physicians may perceive patient involvement as disruptive and a challenge to their authority (Ainsworth-Vaughn 1998).

Another potential problem with using the internet is the fact that medical information is increasingly present online, and because of this, the accuracy of such information is difficult to control (Coulter and Magee 2003). In practice, reliable information can mostly be obtained only in collaboration with physicians (Klinar et al. 2010). This is not only because it is difficult to confirm the quality of information due to the sheer volume, but also because of the interpretative role that physicians have (Lupton 2003). Physicians possess knowledge that they have acquired through years of practice and personal experience which they use when interpreting the collected medical information about a patient, knowledge that the patient does not possess to the same extent (Lupton 2003).

Lastly, some of the patients relied on their social contacts to help them understand the terms they were unfamiliar with. For instance, when Stjepan could not understand his physician's discharge letter, he sought assistance from his neighbour, who was a surgeon:

> Well, I didn't really understand it. My neighbour across the street is a young surgeon, so I took the letter to him. He told me, 'It's all fine, everything's OK.' I read the letter. But the parts written in Latin… I didn't understand them. So, I didn't really put much effort into it. Why bother reading something I don't understand? (Stjepan)

The positive effect that social connections have on the quality of health and healthcare has been well documented (Carpiano 2007; Stephens 2008; Song 2013; Pinxten and Lievens 2014). These benefits are numerous and diverse. They can include greater access to healthcare institutions, professionals, and services, reduced psychological stress, the adoption of healthier behaviours, and higher overall health satisfaction (Song 2013). In Stjepan's case, his social connection with a surgeon neighbour helped

alleviate some of his post-treatment concerns.

It can be concluded that due to the use of Latin, Greek, and English terms, as well as the frequent use of synonyms, various abbreviations, and the general lack of consistency in medical terminology, misunderstandings and misinterpretations of both spoken and written communication often occur (Gjuran-Coha and Bosnar-Valković 2013).This linguistic disparity presents a unique challenge in medical communication, as it can seriously hinder patients' ability to understand medical information pertaining to their welfare and consequently engage with their healthcare providers effectively. In response, patients may try to bridge this gap by relying on their social connections, being more direct in communication with their physicians and turning to the internet for information. However, this only highlights the absence of a systemic effort to address the issue comprehensively.

4.2. Physicians' Strategies for Managing Medical Language Barriers

The physicians participating in the study expressed awareness of the communication and comprehension issues that can arise from the use of medical language and terminology. To address this, they actively shifted or adapted their register and tailored the terminology they used based on what they believed each patient could understand.

Register shifting, understood as the adjustment of speaking style to suit different social contexts and conversation partners, is acquired through socialisation, with the range of registers an individual can use shaped by their experiences (Agha 2006). Register is also often used to facilitate comprehension or establish rapport between speakers (Ferguson 1994; Goulart et al. 2020), which was also the case with the physicians in the study. This process was closely tied to the physicians' assessments of their patients, which were formed during initial consultations through observations of socioeconomic status and personal characteristics. For example, in a group interview, three physicians shared that they considered the patient's occupation, clothing, speech style, age, place of residence, and ethnicity when making assumptions about the patient's familiarity with medical terminology and adjusting their register.

> Iva: Often, when we're in doubt, we look at the person's occupation in their records. I mean, we don't know what we're dealing with, so sometimes we take a quick look at their occupation. But, usually, just in the way in which they say 'Hello' or 'Nice to meet you', we already know what we're dealing with.
> Eva: Also, based on their habitus… I mean, as my colleague said, clothes don't make the person, but essentially, you can tell right away. The second thing is

when they talk, how they talk. You can quickly assess their level of eloquence within a few sentences.
Dora: When an old man from Lika addresses the physician informally with 'you'
Iva: Or, for example, if the patient is Roma.
Dora: Or if they call you 'dear'.
Eva: The ones who call the physician 'My dear'. Well, these are older people, we don't hold it against them, but then you realise how you should talk to them.

In another interview, the physician also pointed out the patient's age, general appearance, and speech style as most relevant for assessment:

> When a patient arrives, I don't know what they're like, so I assess them based on their age, appearance, and then I start talking. I ask them what happened, and then I can tell by the way they speak how much they understand and how much they know, how much I should say. [...] You can tell a lot from the way they speak and their vocabulary. I try not to use medical terminology, but sometimes people who work in medicine come and they use medical terms themselves, so I use them too. But yes, I adjust. Some may be younger than eighteen, and I speak to them more casually, like I would with someone over coffee. While with older people, I tend to be more serious, but I don't know how to explain it. You just adapt. (Katarina)

Factors such as the patient's education level, age, profession, demeanour, register, and communication style, as well as the place of residence (whether they lived in a rural or urban area) were mentioned by all the other physicians participating in the study as potentially relevant as indicators of the patient's familiarity with medical terminology.

In any given community or society, even among individuals who share the same culture, there is often a tendency to distinguish between different social groups. These distinctions help people categorise others based on specific traits or characteristics, which are perceived as common within each group (McGarty et al. 2002). These traits are then organised into mental frameworks called schemas–categories that we use to interpret new information or make sense of unfamiliar situations (Baran and Beauchamp 2017). Schemas are powerful tools that help individuals navigate the world, but they often lead to generalisations or stereotypes about others (Baran and Beauchamp 2017). These mental shortcuts enable people to make sense of others, re-

spond appropriately to various situations, and make communication easier and faster (McGarty et al. 2002; Baran and Beauchamp 2017). However, while these processes can help individuals navigate the complexities of social life, they also risk oversimplifying and reducing individuals to broad categories. Similarly, in fields like healthcare, where communication can mean the difference between effective treatment and misdiagnosis, the reliance on schemas risks oversimplifying complex interpersonal interactions, leading to potentially wrong assumptions about patients' understanding of medical language.

Besides relying on schemas to assume the level of a patient's communicative competence and adjust their registers, physicians Mauricio and Vinko emphasised that they strived to avoid using medical terminology during patient interactions whenever possible, opting instead to communicate in what they described as "everyday language". They also expressed the belief that any medical documentation intended for patients should be written in standard Croatian with as little medical terminology as possible. Mauricio also mentioned brochures that he hands out to his patients as a useful tool for understanding their treatment and disease:

> Well, that's why we have written materials for patients. These materials contain everything about the treatment–what the side effects are, how to behave, what to eat. We hand them out during appointments so that patients can read them at home in peace. [...] These materials are based on sample brochures I brought back from Germany over twenty years ago. We translated and adapted them to suit our patients and our conditions. We update the materials every ten to fifteen years. (Mauricio)

However, Mauricio was also aware that using non-personal communication like brochures and similar informational materials may not always be the most effective way of conveying information:

> And then I ask the patient if he's read it, and he says, 'No, my wife read it; I wasn't interested.' So, I talk to his wife, and ask her if she has any questions, while he just signs the consent form. (Mauricio)

The use of brochures and other informational tools may help in some cases, but Mauricio's experience highlights that such methods may not always engage the patient directly. Patients may not always read or fully engage with the provided materials, as evidenced by Mauricio's example of a patient relying on his wife to read the infor-

mation. This suggests that while written resources can be useful, a more personalised, interactive approach to communication may be necessary to ensure that patients fully understand their diagnosis and treatment options. Especially since the exchange of information often depends on the physician's perception of the patient's interest in obtaining additional details about their illness and treatment process (Waitzkin 1985).

5. Beyond Medical Language: Structural Issues Within the Croatian Public Healthcare System

A lack of clear communication cannot be attributed solely to the use of medical language. Despite varying approaches to addressing the issue of medical language barriers in communication, all the physicians and the majority of patients participating in the study acknowledged that one of the greatest obstacles to effective communication was the physicians' lack of time to fully explain information and address the patients' questions.

> Your physician should explain your test results to you, and then you could understand what is written… but that doesn't happen, because they [the physicians] have hundreds of patients and no time. (Vinko)

For patient Gordana, the feeling that physicians do not have enough time led to her reluctance to ask additional questions because she felt that doing so might be a burden or disrupt the limited time available during her appointment. For Vera, the same issue turned into a source of frustration:

> They are elusive. They're not around. They're either in the operating room, at a meeting, on rounds, or simply nowhere to be found. They're not available to you; if you happen to catch one of them, they'll just rush by, tell you they don't have time, and hurry along. In our healthcare system, there's no opportunity to have a conversation with them. There just isn't. (Vera)

This time constraint is a symptom of broader, systemic issues within the Croatian healthcare system, such as the ageing population's increasing healthcare demands (Puntarić and Stašević 2017) and certain regions' insufficient healthcare capacities, which leads to patients being referred to other, already overwhelmed, hospitals (Ropac and Stašević 2015). Long waiting times, sometimes lasting several months, are fur-

ther aggravated by the uneven distribution of medical equipment, such as CT and MRI machines (Ropac and Stašević 2015). Financial limitations, including healthcare workers' relatively low wages and unpaid overtime, are also major contributors to dissatisfaction and the subsequent departure of healthcare workers from Croatia, which only adds on to the existing problem of too many patients per physician in certain regions (Bakar 2009; Varjačić et al. 2013; Babacanli et al. 2016; Jurić 2020).

Despite various efforts to deal with medical language barriers, both physicians and patients mentioned in this study recognised that the limited time available during consultations often prevents thorough explanations and the opportunity for patients to ask questions. This issue, as expressed by patients like Gordana and Vera, highlights the broader systemic problems within the Croatian healthcare system. These challenges, coupled with the strain on healthcare workers, contribute to a situation where effective communication between physicians and patients is compromised, ultimately affecting the quality of care and patient satisfaction

6. Conclusion

While physicians may simplify communication by avoiding medical terminology and utilising everyday language, as well as provide written materials for patients, the effectiveness of these strategies can be limited. The use of brochures and other informational tools may help in some cases, but such non-personal communication methods may not always properly engage the patient. Even though advancements in digital and non-personal communication have expanded access to medical and healthcare information, they cannot adequately replace the dynamic nature of personal communication in patient-physician interactions and the physicians' interpretative role.

The physicians participating in the study demonstrated efforts to tailor their communication to patients' assumed levels of understanding. These adjustments were influenced by their schemas based on the patients' observable traits such as age, education, speech style, and socioeconomic status. Although this can facilitate quicker assessments and adjustments in communication, it also risks oversimplifying individual patients and perpetuating stereotypes. In the context of healthcare, where clear communication is essential for effective treatment, such generalisations can lead to inaccurate assumptions about a patient's familiarity with medical language. To bridge this gap, physicians must strive for a more nuanced approach, balancing the use of schemas with individualised assessments to ensure that communication fosters understanding without relying solely on preconceived notions.

While asking questions and seeking clarification can empower patients and foster a sense of control over their healthcare experience, the effectiveness of this approach depends heavily on the physician's response. Physicians need to recognise that the communicative competence of their patients often differs significantly from their own, necessitating the willingness to provide explanations.

However, improving communication in healthcare requires an understanding of the broader systemic challenges that hinder the system. With an overburdened healthcare system facing growing demands from an ageing population, regional disparities in healthcare capacity, extended waiting times, unequal access to medical equipment, and issues such as low wages for healthcare workers, it may be challenging to prioritise resolving communication issues effectively until these systemic problems are addressed. Nevertheless, the findings of this research point to important practical implications that could be particularly useful in the education and training of future and current healthcare professionals. They would also be a valuable addition to the existing healthcare education curricula. Greater emphasis on communication skills, patient-centred language, and awareness of linguistic barriers could contribute to more effective and equitable healthcare interactions even within the existing structural constraints.

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Razumijevanje medicinskog jezika: izazovi i važnost jasne komunikacije liječnika i pacijenata u hrvatskome zdravstvenom sustavu

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Sažetak

Medicinski jezik specijalizirani je oblik komunikacije koji koriste zdravstveni djelatnici u svojoj svakodnevnoj praksi i medicinskim istraživanjima. Na njega snažno utječu globalizacija te napredak u tehnologiji i znanosti, što dovodi do stalne evolucije medicinskog rječnika i stvaranja novih pojmova i značenja. Učinkovita komunikacija u zdravstvenom okružju ovisi o međusobnom razumijevanju liječnika i pacijenata. Međutim, to je razumijevanje često otežano razlikama između svakodnevnog jezika kojim se koriste pacijenti i stručnoga medicinskog jezika kojim se koriste liječnici, što može predstavljati prepreku u komunikaciji. Nedostatak razumijevanja i jasne komunikacije može dovesti do nesporazuma, sukoba, pa čak i medicinskih pogrešaka. Ovo istraživanje analizira načine na koje uporaba medicinskog jezika i terminologije može predstavljati prepreku u komunikaciji s pacijentima te razmatra strategije kojima se pacijenti i liječnici služe za postizanje međusobnog razumijevanja. Podatci analizirani u ovom radu prikupljeni su tijekom terenskog istraživanja provedenog u Zagrebu od 2017. do 2020. godine putem polustrukturiranih intervjua. U radu su korišteni podatci iz jedanaest intervjua u kojima se medicinski jezik spominje kao značajan čimbenik – pet intervjua provedeno je s korisnicima zdravstvenih usluga koji su imali različite dijagnoze i oblike liječenja, a šest s liječnicima različitih medicinskih specijalnosti. Iako broj sudionika u istraživanju nije dovoljan kako bi se prikazalo opće stanje komunikacijskih izazova u hrvatskome javnom zdravstvu, istraživanje se usredotočuje na to kako se širi društveni i institucionalni procesi odražavaju u osobnim iskustvima i pogledima ispitanika. Iskustva sudionika potvrđuju da je neposredna i dvosmjerna komunikacija liječnika i pacijenata presudna za postizanje uspješnih ishoda liječenja. Iako suvremene digitalne tehnologije i komunikacijski alati mogu olakšati prevladavanje komunikacijskih prepreka, unapređenje komunikacije ostaje i dalje složen izazov u okviru preopterećenoga zdravstvenog sustava obilježenog nedostatkom kadra, dugotrajnim listama čekanja, regionalnim razlikama i niskim primanjima.

Ključne riječi:
hrvatski zdravstveni sustav, medicinski jezik, medicinska terminologija, komunikacija liječnik–pacijent, specijalizirani jezik