

# Beyond Language Barriers: An Integrative Review of the Cognitive and Cultural Determinants of Doctor-Patient Communication in Malaysia

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## ABSTRACT

**Background:** Communication difficulties in multicultural healthcare settings such as Malaysia are frequently attributed to language barriers; however, misunderstanding often persists even when doctors and patients share a common language. This suggests that clinical dissonance is not merely linguistic but conceptual. **Aim:** This integrative review examines theoretical scholarship to explore the deeper cognitive and cultural mechanisms that shape doctor-patient interaction, with particular attention to how patients may become effectively 'voiceless' during clinical encounters due to misalignment in Explanatory Models (EMs). **Methods:** Adopting the methodology of Whittlemore and Knafl (2005), this review synthesises diverse literature from Social Constructionism, medical anthropology and cognitive linguistics. The analysis integrates work on EMs and Conceptual Metaphor Theory (CMT) to identify points of convergence relevant to hierarchical and medically pluralistic contexts. **Results:** The analysis reveals a critical theoretical gap: while EMs describe *what* patients believe about illness (content), CMT explains *how* such beliefs are cognitively structured (mechanism) yet these perspectives are rarely examined together. In the Malaysian context, communication breakdowns frequently arise when patients' culturally grounded metaphors, specifically those related to *angin* (wind) and *panas* (heat), are literalised or overridden by biomedical frameworks. **Conclusion:** On this basis, the paper proposes the Conceptual-Anthropological Framework (CAF) as an integrative model. By foregrounding metaphorical reasoning as a central dimension of meaning-making, CAF offers a lens to better understand and address the 'silent' non-adherence often observed in medically pluralistic societies.

**Keywords:** integrative review, doctor-patient communication, Malaysia, explanatory models, conceptual metaphor theory, medical pluralism

## INTRODUCTION

The clinical consultation is frequently idealised as a neutral exchange of objective information. However, sociologists and anthropologists have long argued that it is in fact a socially situated interaction in which meanings about illness, responsibility and authority are actively negotiated (Mishler, 1984; Pilnick & Dingwall, 2011). In multicultural societies, these negotiations are particularly complex because participants draw on different cultural, experiential and cognitive resources when making sense of illness and treatment.

In the context of Malaysia, communication challenges in healthcare are commonly attributed to linguistic diversity or limited health literacy (Hassali et al., 2012). With a population comprising Malay, Chinese, Indian and diverse Indigenous ethnic groups, the language barrier is often cited as the primary obstacle to effective care. While relevant, this focus does not account for persistent misunderstandings in consultations where doctors and patients share a common language, for example, the national language Malay and lingua franca English. Research suggests that misalignment often occurs at a deeper level within the conceptual frameworks through which illness is understood (Claramita et al., 2013; Kleinman, 1980).

Malaysia provides a compelling context for examining these dynamics due to its deep-seated medical pluralism. It accommodates biomedical practice alongside Malay, Chinese, Indian, and Indigenous healing systems (Chen, 1981). Contemporary evidence confirms that patients frequently move between these systems, integrating biomedical explanations with culturally embedded understandings of balance, spirituality, and thermodynamics (Siti et al., 2009; Wong et al., 2013). Yet, within formal consultations, such understandings are often marginalised. The hierarchical nature of Malaysian society often leads patients to appear compliant while remaining conceptually disengaged (Bagheri et al., 2012).

This paper presents an integrative literature review that synthesises theoretical perspectives typically examined in isolation. By bringing together Social Constructionism, Explanatory Models (EMs), and Conceptual Metaphor Theory (CMT), the review argues that to understand the ‘voicelessness’ of the patient, we must look beyond vocabulary and examine the metaphorical architecture of their thought.

### **Positioning The Review: Beyond Deficit Models**

Much research on communication in multicultural healthcare has focused on three dominant explanatory paradigms: language barriers, cultural competence and health literacy. While valuable, this review argues that each leaves important dimensions under-theorised.

#### **The limits of the language barrier models**

Language barrier research conceptualises misunderstandings primarily as a lexical problem. However, this ignores ‘false friends’ in conceptual understanding. Patients and clinicians may share vocabulary while operating within entirely different conceptual systems (Charteris-Black, 2002). For instance, the word ‘wind’ (*angin*) may mean ‘trapped gas’ to a biomedical doctor but a ‘pathogenic flow’ to a Malay patient (Lendik et al., 2017). Words may be mutually intelligible yet the meanings attached to them diverge.

#### **The stagnation of cultural competence**

Cultural competence models attempt to address this gap but have been critiqued for treating culture as a static checklist of beliefs (Kleinman & Benson, 2006). This risks reifying culture and overlooking the interactional nature of meaning-making. As Wong et al., (2013) demonstrate, patients do not simply hold static beliefs; they dynamically negotiate their survival, often combining Western treatments with traditional practices like *Qigong* or herbal medicine to manage side effects. A static model fails to capture this fluidity.

#### **The deficit of health literacy**

Health literacy frameworks tend to frame patients as information-deficient (Nutbeam, 2008). This deficit model obscures the fact that patients are often experts in their own ‘lifeworlds’, possessing sophisticated logics for managing health based on hot/cold balance or spiritual causality (Wong et al., 2013). Misunderstandings are often not a failure of comprehension but a clash of logics.

## **METHODOLOGY: AN INTEGRATIVE REVIEW**

To ensure methodological rigour, this review follows the structured five-staged approach outlined by Whitemore and Knafl (2005): problem identification, literature search, data evaluation, data analysis and presentation. This method was selected for its capacity to synthesise diverse theoretical perspectives across disciplines such as anthropology and cognitive linguistics to generate new conceptual insights into complex, cross-disciplinary phenomena like clinical meaning-making. As the authors note, unlike systematic reviews, which prioritise exhaustive retrieval and methodological comparison, integrative reviews focus on conceptual relevance and theoretical integration.

Literature was identified through iterative, theory-driven searching consistent with established integrative review practices. The literature search was conducted between January 2023 and March 2025, covering

publications from 1980 to 2025 across three primary databases: Scopus, PubMed and Google Scholar. This timeframe was chosen to capture foundation works in Explanatory Models (Kleinman, 1980), Conceptual Metaphor Theory (Lakoff & Johnson, 1980), alongside contemporary developments in communication and healthcare (2024-2025). The inclusion of Google Scholar was deemed critical for this review for three reasons: (1) its ability to index interdisciplinary research at the intersection of linguistics and medical anthropology which traditional biomedical databases often overlook; (2) its coverage of non-indexed 'grey literature' and regional Malaysian journals essential for contextualizing local explanatory models and (3) its retrieval of recent publications not fully indexed in standard repositories.

The search strategy utilised a combination of Boolean operators tailored to each database. The primary search strings included ("doctor-patient communication" OR "clinical consultation") AND ("explanatory models" OR "conceptual metaphor theory" OR "medical anthropology" OR "culture" OR "metaphor" OR "communication barriers") AND ("Malaysia" OR "Southeast Asia"). Additional sources were identified through backward and forward citation tracking from foundational texts. To systematically document the selection process, strict inclusion and exclusion criteria were applied. Literature was included if (1) comprised of peer-reviewed articles, foundational academic books or established grey literature (e.g. national health reports), (2) was published in either English or Malay language and (3) focused conceptually on the cognitive, cultural or interactional dimensions of healthcare communication particularly in medically pluralistic or high powered-distance settings. Studies were excluded if they focused exclusively on clinical outcomes without exploring communication mechanics or if they examined health literacy strictly from a quantitative psychometric perspective without addressing cultural or linguistic meaning-making.

The screening workflow followed a three-stage process: title/abstract screening, full-text review for conceptual relevance and final synthesis. Initially, the database searches yielded a preliminary pool of articles from which duplicates were removed. Due to the high volume of returns in Google Scholar, results were screened by relevance, with the first 300 entries for each search string reviewed for suitability. In the second phase, titles and abstracts were screened against the inclusion criteria. Finally, full-text reviews were conducted on the remaining articles to assess their theoretical contribution to understanding how meaning is constructed, negotiated or suppressed in clinical encounters especially in multicultural or hierarchical contexts. Priority was given to texts that facilitated theoretical integration across the three target domains: Social Constructionism, Explanatory Models, And Conceptual Metaphor Theory (Whittemore & Knafl, 2005).

Following the data analysis stage outlined by Whittemore and Knafl (2005), we employed the constant comparison method. Extracted data were iteratively coded into thematic categories (e.g. structural asymmetry, metaphorical mismatch) to identify patterns across diverse methodologies. This process moved beyond a mere summary of existing literature to identify a persistent theoretical gap: while EMs identify what patients believe, they rarely address the cognitive mechanism in this case, the metaphors used that structure these beliefs during clinical talk. The aim was not to provide an exhaustive inventory of studies but to construct a coherent synthesis capable of explaining recurring patterns of communicative breakdown.

### **The negotiation of clinical reality**

To synthesise these diverse findings, this review interprets the literature through the lens of Social Constructionism. This theoretical perspective was selected because it provides the necessary explanatory power to understand how clinical reality is negotiated (Berger & Luckmann, 1966; Burr & Dick, 2017). Within this perspective, language is not merely a vehicle for transmitting information but a central mechanism through which social roles, power relations and forms of knowledge are enacted.

In medical consultation, this construction of reality is often asymmetrical. Mishler (1984) describes a structural tension between the 'voice of medicine', which is technical, disease-focused and abstract, while patients tend to carry the 'voice of the lifeworld' to reflect their lived experiences, social contexts and personal meaning. Clinical interaction typically privileges the medical voice, rendering patients' narratives of suffering into biomedical objects.

In Malaysia, this asymmetry is intensified by cultural norms that emphasise respect for authority and social hierarchy. The clinical encounter is a formal interaction between a layperson and a scholar-official, i.e. the doctor or healthcare providers. Central to this interaction is the concept of face preservation (*jaga air muka*) and courtesy (*budi bahasa*) (Hassali et al., 2012). Studies have shown that patients often adopt deferential interactional styles, avoiding direct disagreements or questioning (Mohajer & Endut, 2020). What appears as agreement through nonverbal cues like nodding or silence may function as a phatic politeness strategy rather than genuine conceptual alignment (Bagheri et al., 2012). Another common phenomenon is the patients' "dual citizenship" in the medical world. This refers to their acceptance of western medical treatments like chemotherapy to kill cancer tumour but simultaneously engage in traditional Chinese medicine (TCM) to 'cool' the body and restore balance to the body known as *Qi* (Wong et al., 2013). When doctors fail to acknowledge this pluralism, patients do not argue; they simply disengage. From a constructionist perspective, such interactions do not indicate shared understanding but rather the successful maintenance of social order (Auer, 1998).

This disparity in communication styles contributes to patient alienation. As one respondent in Syed Jamaludin et al.'s (2024) study articulated that traditional practitioners are often perceived to "hear me patiently", whereas conventional doctors "don't have time for me" and focus strictly on compliance metrics like glucose levels. This reinforces Mishler's (1984) contention that the biomedical voice frequently suppresses the patient's narrative.

### Cultural meaning and explanatory models

While Social Constructionism explains how clinical realities are negotiated, explanatory models (EMs) illuminate the cultural content of those negotiations. Introduced by Kleinman (1980), EMs refer to the beliefs that individuals hold about illness, including its causes, consequences and appropriate treatments. Research consistently demonstrates that patients and clinicians often operate from divergent explanatory models even when they appear to be discussing the same condition (Bhui & Bhugra, 2004).

Biomedical explanatory models tend to conceptualise disease as a malfunction within the body, prioritising diagnosis, intervention and cure. In contrast, patient explanatory models frequently frame illness as a disruption of balance, morality or social harmony (Young, 1982). In the Malay context, health is often associated with *Sejahtera*, a holistic state encompassing physical, emotional and spiritual well-being (Hassan, 2021).

These divergent models often lead to specific conflicts in treatment adherence. For instance, the concept of 'heat' (*panas*) remains a central organising principle for health behaviours in Malaysia. Syed Jamaludin et al. (2024) found that postpartum mothers often avoid Malay herbal preparation (*jamu*) during the early confinement period, fearing that the inherent 'heat' of the herbs could cause neonatal jaundice. Similarly, the use of black cumin is frequently cited not just for its physical properties but for its spiritual significance as a prophetic food (*makanan sunnah*), illustrating a holistic model where physical health is inseparable from spiritual observance (Syed Jamaludin et al., 2024).

This conceptual divergence is similarly pronounced among indigenous communities. Ting et al. (2025) observe that while suburban indigenous groups increasingly adopt lifestyle-based explanations for illness, rural communities frequently attribute sickness to spiritual disturbances of 'unknown' causes. This spiritual etiology often necessitates specific traditional healing rituals that may be viewed as incompatible with biomedical protocols (Ting et al., 2025).

Crucially, when these diverse models are not openly engaged, the result is often concealment rather than confrontation. Lee et al. (2025) report that despite the widespread use of traditional and complementary medicine (TCM) across Malaysia, patients frequently practice non-disclosure, withholding their health beliefs and practices from clinicians to avoid negative judgment. Wong et al. (2013) observe that Malaysian Chinese patients may conceal their diagnosis even from family to avoid 'bad luck' or shame. This silence effectively neutralises the consultation, preventing any meaningful negotiation of care.

Traditional approaches to cultural competence have often treated such models as static cultural traits. However, scholars argue that EMs are dynamic and interactional, shaped and reshaped during clinical encounters (Kirmayer, 2012; Kleinman & Benson, 2006). When patients perceive that their explanatory models are dismissed or misunderstood, they may withdraw from active participation, contributing to the phenomenon of ‘voicelessness’ in the consultation process.

### **Metaphor as cognitive mechanism**

A key question remains on how do divergent explanatory models surface in everyday clinical talk? This review argues that the primary mechanism is metaphor. According to Conceptual Metaphor Theory (CMT), metaphors are not merely linguistic devices but fundamental cognitive tools through which abstract experiences are understood (Gibbs, 1994; Lakoff & Johnson, 1980).

In healthcare, metaphors function as cognitive scaffolds. Landau et al. (2018) demonstrate that these scaffolds are not merely descriptive; they actively frame how health information is processed, influencing which treatment options appear viable and which are ignored. Clinicians often rely on dominant biomedical metaphors such as *The Body is a Machine* or *Medicine is War* which emphasise control and intervention (Bleakley, 2017). Patients, on the other hand, frequently employ metaphors of *Balance*, *Journey*, *Burden* or *Intrusion* to make sense of illness (Demmen et al., 2015; Liu et al., 2024).

When these metaphorical frameworks are misaligned, communication difficulties arise. As Charteris-Black (2002) demonstrates that metaphor use is deeply culture-bound, and navigating metaphor in a second language places additional cognitive demands on patients. In Malaysian contexts, metaphors such as ‘bad wind’ or ‘inner heat’ reflect culturally embedded understandings of circulation and balance (Lendik et al., 2017). When such metaphors are overridden by mechanical biomedical explanations, patients may appear compliant while remaining unconvinced.

### **Synthesis: An integrated approach**

Taken together, the reviewed literature suggests that no single theoretical perspective adequately explains communication breakdowns in multicultural medical settings. Social Constructionism highlights power asymmetries, Explanatory Models reveal divergent cultural meanings, and Conceptual Metaphor Theory explains how these meanings are cognitively structured. This review, therefore, proposes the Conceptual-Anthropological Framework (CAF) as an integrative model.

The CAF conceptualises the medical consultation as an interaction between competing metaphorical systems. Communication success is not defined by information transfer or compliance but by conceptual alignment, where clinicians recognise and bridge patients’ metaphorical reasoning rather than replacing it with a biomedical stance. In Malaysia, this addresses the ‘voiceless’ of the patient. Patients often carry the voice of the lifeworld which reflects lived experience, while the ‘voice of medicine’ remains technical and disease-focused.

When these models diverge, the result is often concealment rather than confrontation. For instance, the concept of ‘heat’ (*panas*) remains a central organising principle for health behaviours. Patients may avoid certain treatments because they perceive them as ‘hot’. But due to cultural norms of face preservation (*jaga air muka*), they may nod in agreement while remaining conceptually unpersuaded.

Blueprint for 'Conceptual-Anthropological Framework (CAF): Integrating EMs and CMT in Clinical Discourse'

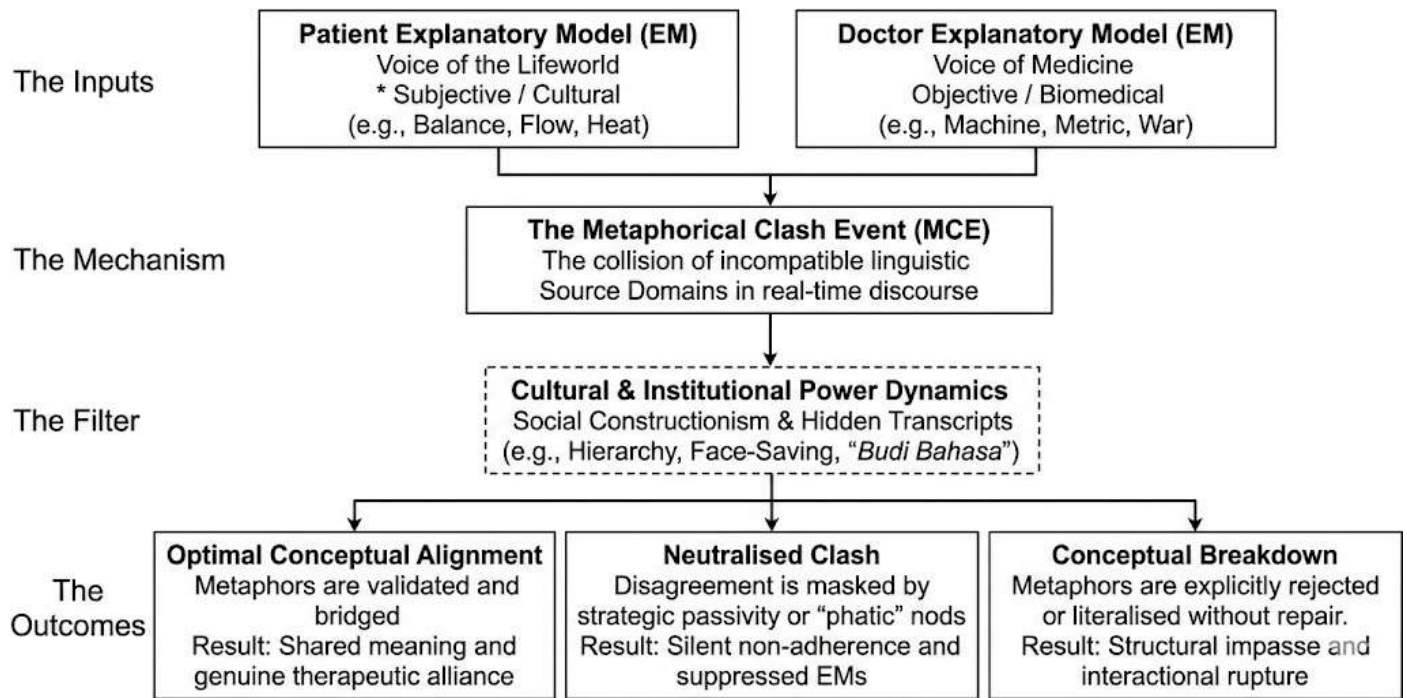


Figure 1: The Conceptual-Anthropological Framework (CAF) illustrating the intersection of Explanatory Models, Metaphorical Clash and interactional outcomes in multicultural consultations.

To operationalise the Conceptual-Anthropological Framework (CAF) for empirical application, it is necessary to establish a precise definition of communicative success. Within this framework, success is not measured by the patient’s ability to recall biomedical facts or comply with medical directives. Instead, the goal is conceptual alignment. Conceptual alignment is operationally defined as the interactional state wherein both the clinician and the patient successfully negotiate and share a metaphorical source domain to make sense of the illness experience, moving beyond mere surface-level semantic agreement to achieve cognitive congruence (Macagno & Rossi, 2019). When conceptual alignment is achieved, the patient’s culturally embedded explanatory model is neither literalised nor dismissed but dynamically integrated into the therapeutic dialogue.

It is crucial to distinguish the CAF from existing, prominent healthcare communication paradigms, specifically Patient-Centered Communication (PCC) and Shared Decision-Making (SDM). While the CAF shares the emancipatory goals of these models, it operates at a fundamentally different interactional level.

Patient-Centered Communication focuses heavily on the affective and relational dimensions of the consultation, emphasizing empathy, active listening and the elicitation of patient values (Epstein & Street, 2011). However, PCC frameworks often lack the structural linguistic tools required to diagnose or resolve deep epistemic clashes. A clinician may demonstrate excellent affective empathy for example, validating a patient’s emotional distress while simultaneously committing an epistemic erasure by literalising the patient’s ‘wind’ (*angin*) metaphor into a biomedical symptom. The CAF addresses this by shifting the analytic focus from affective empathy to metaphorical competence, identifying the structural cognitive mechanics that block true patient-centeredness.

Similarly, Shared Decision-Making (SDM) focuses on the democratic negotiation of treatment options, aiming to balance evidence-based medicine with patient preferences (Land et al., 2017). The limitation of SDM in multicultural settings is its assumption of a shared ontological reality; it assumes both parties already agree on the fundamental nature of the problem being decided upon. In high-context, medically pluralistic environments like Malaysia, this assumption frequently collapses. Patients may engage in ‘phatic’ agreements during the SDM process to preserve harmony, while secretly operating from a thermodynamic (*panas/sejuk*) explanatory model that renders the biomedical decision illogical to them (Bagheri et al., 2012; Wong et al., 2013).

Therefore, the CAF posits that conceptual alignment operates upstream of shared decision-making. Before a clinician and patient can successfully share a medical decision, they must first share a metaphorical reality. By providing a diagnostic lens to detect the silent collision of source domains, the CAF equips researchers and clinicians to recognize when the foundational cognitive architecture necessary for SDM or PCC has fractured.

**Operationalising the framework: The metaphor menu**

To bridge this gap, clinicians must develop metaphorical competence. This involves listening for the source domain of patient language to align the clinical explanation with the patient’s logic.

Table 1: The Metaphor Menu for clinical practice

Patient Metaphor (Source Domain)	Cultural Logic (EM)	Biomedical "Voice" (Conflict)	CAF- Aligned Response (Metaphorical Competence)
<b>Wind (<i>Angin</i>)</b>	Illness as a pathogenic flow or blockage in circulation.	Interpreted as "trapped gas" or dismissed as non-clinical.	Use <b>Flow</b> metaphors: Explain hypertension as "turbulence" that needs "smoothing".
<b>Heat (<i>Panas</i>)</b>	Illness as a disruption of thermodynamic balance.	Interpreted strictly as "fever" or "inflammation".	Use <b>Balance</b> metaphors: Describe medication as a "cooling agent" to restore internal harmony.
<b>Harmony (<i>Sejahtera</i>)</b>	Health as a holistic state of physical and spiritual well-being.	Focused on "localised malfunction" or specific diagnostic metrics.	Use <b>Environmental</b> metaphors: Frame treatment as "nurturing the soil" (the whole body) rather than just "fixing the pump."
<b>Machine / War</b>	(Standard Biomedical) Health as control and intervention.	Can feel aggressive or alienating to patients focused on "Journey" or "Balance".	<b>Switch Domains:</b> If the "War" metaphor causes distress, pivot to "Journey" metaphors to emphasise the long-term management of chronic illness.

**Application of the framework: A clinical vignette**

To analytically demonstrate the integration of Social Constructionism, Explanatory Models (EMs) and Conceptual Metaphor Theory (CMT), we present a representative clinical vignette drawn from common interactions within the Malaysian multicultural healthcare context. This case illustrates how metaphorical misalignment occurs in real-time and how the CAF diagnoses the resulting communicative rupture.

**The context:**

Madam Lim, a 55-year-old Malaysian Chinese breast cancer patient, attends a follow-up consultation with her oncologist after her second cycle of chemotherapy.

**The interaction:**

Madam Lim: “Doctor, this medicine is very ‘heaty’ (*panas*). My body is burning up, my mouth is breaking. Can I reduce the dose? The heat is too strong.”

Doctor: (Checking the chart) “Your temperature is normal, madam. You don’t have a fever. The mouth ulcers are just a standard side effect of the chemotherapy attacking the fast-growing cells. We must maintain the dose to fight the cancer effectively.”

Madam Lim: (Looks down, nods slowly) “Ah...okay, doctor.”

### CAF analysis:

The CAF deconstructs this brief exchange across its three theoretical dimensions to reveal the hidden dissonance:

#### 1. Explanatory Models (The cultural content):

The interactants are operating from divergent ontological frameworks. Madam Lim’s EM is grounded in traditional Chinese thermodynamics where health requires a balance of *yin* (cold) and *yang* (heat). She perceives the chemotherapy as a potent, excessively ‘hot’ (*yang*) agent disrupting her internal equilibrium. Conversely, the doctor operates from a biomedical EM, viewing the illness as a localized cellular malfunction requiring targeted eradication.

#### 2. Conceptual Metaphor Theory (The cognitive mechanism):

These EMs collide linguistically through mismatched metaphors. Madam Lim utilizes the conceptual metaphor of The Body as a Thermodynamic System, expressing her distress through the source domain of Heat (*panas*). Her doctor commits a ‘Metaphorical Clash Event’ (MCE) by literalising her metaphor. Instead of recognising ‘heat’ as a structural expression of systemic imbalance, the doctor reduces it to a measurable biomedical metric by referring to her body temperature or fever. Furthermore, the doctor imposes the dominant biomedical metaphor of Medicine is War with expressions like ‘attacking’ and ‘fight’. The doctor’s mechanical/war metaphors completely bypass Madam Lim’s thermodynamic reality.

#### 3. Social Constructionism (The interactional outcome):

In a Western paradigm, Madam Lim might explicitly argue that the medication feels toxic. However, within the high power-distance and high-context culture of Malaysia, she engages in face-saving (*jaga air muka*) and deference (*budi bahasa*). Faced with the dominant ‘voice of medicine’ that has invalidated her lifeworld narrative, she retreats. Her final utterance (“Ah...okay, doctor”) is not cognitive agreement, but a ‘phatic nod’ which represents a social performance of compliance.

#### The CAF conclusion (Neutralised Clash):

Through the CAF lens, this encounter is diagnosed as a Neutralised Clash. The metaphorical misalignment was structurally suppressed by institutional hierarchy. The clinical danger here is invisible non-adherence where Madam Lim leaves the clinic feeling her thermodynamic crisis was ignored. As supported by literature on medical pluralism, she is highly likely to secretly reduce her chemotherapy dose or ingest unverified ‘cooling’ traditional herbs to restore balance, engaging in non-disclosure to avoid further clinical judgment. By tracking the metaphor, the CAF successfully isolated the exact cognitive and interactional mechanics of this clinical failure.

## DISCUSSION

### Transferability and the limits of generalisation

While the Conceptual-Anthropological Framework (CAF) is operationalised within this review using the Malaysian healthcare context, care must be taken when generalising these findings to broader multicultural settings. The specific Explanatory Models (EMs) and metaphorical source domains highlighted in this paper such as ‘wind’ (*angin*) and thermodynamic ‘heat’ (*panas*) are deeply bound to the cultural and historical

specificities of the Malay archipelago and Chinese diasporic traditions. These specific content mappings cannot be universally applied to other minority populations.

However, while the content of the metaphors is locally bound, the mechanism of the Metaphorical Clash Event (MCE) wherein a dominant biomedical framework structurally invalidates a patient's culturally grounded source domain is theoretically transferable. The interactional dynamics of the 'Neutralised Clash' are particularly applicable to other high-context, high-power-distance medical environments across Asia and the Global South, where deference to authority frequently masks conceptual dissent. Future applications of the CAF in distinct cultural settings must first ethnographically identify the local metaphorical domains before applying the framework's interactional typologies.

### From conceptual heuristic to empirical validation

Furthermore, because this framework emerges from an integrative review of existing theoretical and qualitative literature, the CAF currently functions as a conceptual heuristic rather than an empirically validated diagnostic tool. As it stands, this limits its immediate practical applicability in clinical communication training or intervention design.

To transition the CAF from a theoretical model to an applied clinical instrument, future research must undertake rigorous empirical validation. This will require moving beyond secondary literature to apply the framework to primary data, specifically audio or video recordings of naturally occurring clinical consultations. By analysing real-time conversational transcripts, future researchers can empirically measure the frequency of Metaphorical Clash Events, track the exact linguistic markers that signify conceptual alignment and validate whether the proposed interactional trajectories accurately capture the reality of clinical discord on the ground.

### Implications For Clinical Practice

Based on the review, we propose three ways the CAF can contribute to the improvement of clinical practice.

1. Clinicians should be trained not just in culture but also in **Metaphorical Competence** (Kirmayer, 2012). This involves listening for the source domain. When a patient says 'heat' or 'wind', the clinician should recognise these as structural metaphors for state and flow, rather than dismissing them as vague symptoms.
2. Following Semino et al. (2018), medical education could introduce a **Metaphor Menu**. If a 'machine' metaphor fails to resonate, the doctor should be skilled enough to switch to a 'balance' or 'flow' metaphor for example to explain hypertension not as mechanical pressure but as a turbulence in the flow that needs smoothing.
3. As healthcare moves toward digitisation, the implications of the findings from this study extend to **Artificial Intelligence**. Current Large Language Models (LLMs) used in medical chatbots are predominantly trained on Western or English-centric biomedical literature. There is a significant risk of 'algorithmic dead metaphors' that these tools will replicate the 'voice of medicine' at scale, prioritising semantic accuracy over cultural resonance. An AI trained on Western texts may interpret 'wind' as only a meteorological phenomenon or flatulence, completely missing the Southeast Asian pathogenic concept of *Angin*. Future research must investigate whether AI health assistants can be trained on the metaphorical menu of diverse cultures. Can an AI recognise a user's 'heat' metaphor and respond with a culturally congruent explanation of thermodynamics? If not, the digital divide may soon become a 'conceptual divide', further alienating patients who do not speak the metaphors of the algorithm.

### Limitation

Several limitations regarding the literature search and selection process of this integrative review should be acknowledged. First, because the review is theory-driven rather than systematic, it prioritises conceptual synthesis over exhaustive completeness (Whittemore & Knafl, 2005). Consequently, the reliance on major

indexing databases such as PubMed and Scopus introduces a potential disciplinary coverage gap. These repositories historically prioritise biomedical paradigms and quantitative methodologies, potentially underrepresenting critical qualitative work published in niche linguistic, sociological or regional anthropological journals.

Second, the search strategy remains susceptible to database limitations and algorithmic indexing biases, as well as potential publication bias. Studies demonstrating clear, observable communicative conflicts or successful cultural interventions are often more likely to be published than null findings or studies documenting passive, uneventful clinical encounters. This bias may inadvertently amplify the visibility of ‘clashes’ in the literature.

Furthermore, the search was restricted to English or Malay literature. This language parameter may have unconsciously excluded valuable insights documented in vernacular Chinese or Tamil scholarship concerning medical pluralism and traditional healing practices within the Malaysian context. Finally, the proposed Conceptual-Anthropological Framework (CAF) lacks empirical validation at this stage. It should currently be understood as a conceptual heuristic rather than a validated diagnostic tool. Future research must apply the CAF to naturally occurring, real-time consultation transcripts to test its operational utility and measure conceptual alignment empirically.

## CONCLUSION

This integrative review suggests that communication breakdowns in Malaysian healthcare cannot be fully explained by language barriers alone. Instead, they emerge from deeper cognitive and cultural misalignments that are enacted through metaphor. By integrating insights from medical anthropology, cognitive linguistics, and Social Constructionism, the Conceptual-Anthropological Framework exposes the hidden mechanics of the clinical encounter and offers a coherent lens for understanding why patients may become voiceless even in linguistically shared consultations. It suggests that the path to better communication lies not just in translating words but in bridging worlds. Attending to patients’ metaphorical reasoning may therefore represent an important step toward more meaningful and inclusive clinical communication.

## Declarations

### Author contributions

MEF conceptualised the study, developed the theoretical framework and drafted the original manuscript.

HAK and RKM provided supervision, critical review and validated the theoretical arguments. All authors reviewed and approved the final manuscript.

## Conflict of Interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper. This research was conducted as part of a doctoral study.

## Ethical approval

This article is an integrative literature review and does not contain any studies with human participants or animals performed by any of the authors. As no empirical data was collected, ethical approval was not applicable.

## Informed consent

This article does not contain any studies with human participants performed by any of the authors. Therefore, informed consent was not applicable.

## Data availability

Data sharing is not applicable to this article as no datasets were generated or analysed for the purpose of preparing this manuscript.

## Declaration on the use of AI in the writing process

During the preparation of this work, we used Google Gemini Pro solely to enhance readability and refine language. After using this tool/service, we reviewed and edited the content as needed and take(s) full responsibility for the content of the published article.

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