

Not Just Words

Caring for the Patient by Caring About Language

The problem with communication is the illusion that it has occurred.

—George Bernard Shaw

I DIDN'T FLINCH WHEN A clinic assistant recently brought me intake forms on a patient I was about to see, matter-of-factly noting, "FYI, she refused vitals."

"Okay, thanks," I replied. Years of hearing and participating in conversations we have about patients, I later realized, had dulled my reaction. These conversations have become part of the fabric of our everyday work routines, whether on the wards, in team rooms, clinics, offices, and even outside hospital walls. To the layperson, a word like "refuse" might conjure up the notion of a cross-armed, defiant, and emphatic stance against something "reasonable" and "right." In medicine, while patients rarely ever fit such a bill, the loaded label "refuser"—as

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well as other pejoratives—has entered our conversational medical lexicon. Even though this discourse (usually) takes place behind closed doors, it affects, in subtle but important ways, the manner in which we perceive and interact with patients and families. The subconscious neural circuitry might go something like this: If this patient is refusing to accept my recommendations, he must not only be wrong, but be pitted against me, and therefore I will similarly take a stance against him.

The automaticity of our language acquisition and daily practice perhaps accounts for this subtlety. After all, this assistant was known for being prompt, professional, dutiful, and most important, polite with patients. I had no doubt that he was consciously try-

ing to do no more than inform me as to why there were no vital signs recorded—indeed, he had likely picked up such verbiage along the way, but nonetheless was unknowingly coloring my approach to the patient I was about to meet. "Ugh—another defiant patient in my already long list of people to see and things to accomplish today," I might have thought.

The encounter brought to mind key examples of word choice commonly used in medical practice, their potential for harm, and proposed alternatives (**Table**). Because there are certainly many roads to better communication, clinicians should view this table as a guide and always personalize their language in a fashion with which they are most comfortable.

Indeed, the way we speak about patients is arguably as important as the way we perceive and label them,⁴ the fashion in which we communicate clinical options and possible outcomes,⁵ and of course, the way we speak *to* patients.² The rise of word usage like "consumers" and "customers" instead of "patients" and, likewise, "provider" instead of "doctor" or "nurse," represents a deleterious businesslike industrialization and standardization of medicine.⁴ Moreover, we must remain committed to such physician or nursing roles in sensitively but honestly availing patients and families of medical situations and options, advocating and remaining available to deliver upon recommendations that are consistent with patient goals and values. Terms such as "Would you like us to do everything possible?"²; "There is nothing more to do"²; and "We are going to withdraw care" demonstrate the difficult and delicate nature of communicating with patients and families all the while highlighting the need to think carefully about (and practice as much as possible) lan-

guage that ensures we uphold the responsibilities of these sacred roles. The importance of medical language also applies to my specialty: In medical oncology, vague terminology about chemotherapy, such as "manageable toxicity," inappropriately glosses over the potential for real treatment harm to patients, and generalizes an assumption to all, instead of finding out what "manageable" or "tolerable" would entail for each unique individual.⁵

When I cautiously entered the room of the patient who had "refused vitals," I was met by an equally hesitant middle-aged woman with newly diagnosed rectal cancer. After introductions, I outlined my goals for the visit, including discussing her history, and examining her. Trying her best to muster politeness through an apparent storm of worry, shame, and anger, she asked "Okay, but do you have to do a rectal ultrasound?—I've already had 2 of them this week, the second more painful and humiliating than the first because it was done without any anesthesia, and the doctor had a whole team in the room observing, without even asking me." The patient had understandably grown defensive of the medical system during her struggles navigating a newly diagnosed cancer. I do not know what she verbalized to the person requesting a measurement of her vital signs, but as I learned about this lovely and dignified patient and her plight, it was clear that she didn't "refuse" anything, but rather did what many people in her situation would do: "decline" something. We need to give patients like her the benefit of the doubt, and find out *why*.

Getting to the heart of the patient's matter is not always as simple as it was with this forthright woman. It is much more difficult in many cases, but arguably all the more critical, to understand each person's in-

Table. Selected Deleterious Medical Phraseology and Proposed Alternatives

Word/Phrase	Potential Pitfall	Proposed Alternative(s)	Reason for Alternative
"Patient refused"	Establishes decision-making divide (subtle or overt) between patient and clinicians	"Patient declined," or "Patient preferred not to/would rather not"	Implies patient and clinician worked together in considering recommendation and alternatives
"Patient (or family) is difficult"	Creates antagonism (subtle or overt) between patient (or family) and clinicians	"They are struggling, and so am I," or "This is a difficult situation. The family is doing the best they can"	Gives patients/family benefit of the doubt, enabling consideration of reasons behind behaviors and emotions of all parties involved
"Patient/family want to be aggressive with treatment"	Implies plan of care is incommensurate with what clinicians believe is best for that patient; distances clinician from patient/family	"The patient/family are struggling with the illness, so I am going to discuss it and the options more with them," or "The patient/family believe we should do more, so we need to discuss the options further"	Clinician needs to (1) advocate for and with the patient and their best interests; (2) explore what "aggressive" means to that patient/family ^a
"Would you like us to do everything possible?" ^b [akin to "How aggressive do you want us to be?"]	Confusion regarding goals of care; colors care plan as unreasonable	"What is important to you?"	Realigns delivery of care with patient goals
"We can still aggressively treat your symptoms"	Colors symptom control as suboptimal to disease-modifying treatment; implies clinician absolution from untoward effects of symptom control in face of limitations in disease-modifying options	"We will work proactively in preventing and treating your symptoms," or "We will work hard to prevent and treat your symptoms"	Demonstrates intent to treat symptoms and belief that symptom-based care is worthy/appropriate
"There is nothing more to do" ^b [akin to "We are going to withdraw care"]	Patients and families will interpret such phrases literally and feel abandoned	"While there are unfortunately no disease-modifying options (or "no ways to slow your disease"), we can/will always be here to treat symptoms and assist with concerns"	Specifies the limitations in options and ensures ability and availability to continue the provision of patient care
"I'm just calling/here to check on you"	Devalues the importance of presence and checking-in	"I'm calling/here to check on you," or "How are you feeling/doing?"	Emphasizes the role of presence and continued follow-up as a valuable component of overall patient care
"He's palliative now"	Substantiates false dichotomy between curative and palliative treatment (the old and obsolete "cure vs care" model)	"The goals have now shifted (more) exclusively to comfort-directed care," or "Our main priority should be to make him and his family as comfortable as possible"	Specifies the transition in care goals and upholds palliative care's role early and concomitantly with disease-modifying therapy for serious illnesses, distinguishing it from solely comfort care or end-of-life care ^c

^aSee Quill et al.¹

^bSee Pantilat.²

^cSee Arends et al.³

dividual perspective and experience. Only in giving all people the chance to express themselves, especially when they have been labeled as "difficult," "refusers," or "unreasonable," can we avoid unintentionally pitting ourselves against the patients, and instead, align ourselves with them. For such patients, I try to ask myself, "What about this good human being is causing them to act in a way my colleagues label [or I am perceiving] as 'bad'?"

And the same question applies to why we, who care for the patients, are acting and speaking to each other in such ways. While the rigors of our work can understandably influence our practice norms, the dual promise of patient-physician bond

and pitfalls of antagonism behooves us to heed a subtle but crucial notion: Words are not just words—the language we use, both with and about patients, must be chosen carefully in order to care best for the patient.

Andrew S. Epstein, MD

Published Online: April 1, 2013. doi: 10.1001/jamainternmed.2013.365

Author Affiliation: Division of Gastrointestinal Medical Oncology, Memorial Sloan-Kettering Cancer Center, New York, New York.

Correspondence: Dr Epstein, Division of Gastrointestinal Medical Oncology, Memorial Sloan-Kettering Cancer Center, 300 E 66th St,

Room 1013, New York, NY 10065 (epsteina@mskcc.org).

Conflict of Interest Disclosures: None reported.

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