

## Words That Harm, Words That Heal

**A** PHYSICIAN ENTERS A patient's hospital room and says: "Good morning. Well, tell me, how is your chest pain? I just reviewed the pictures from your catheterization. You have a severe blockage, and you may be living with a time bomb in your chest." The patient sits motionless, waiting for her physician's recommendation.

Conversations akin to this one between physician and patient may seem contrived but are not uncommon. Being ill inherently humbles and corrodes the sense of self, making patients vulnerable to the words of their physicians.<sup>1,3</sup> Language reinforces the tendency of the patient to yield to the authority of the physician, and it is one way that physicians inadvertently distance themselves from patients.<sup>4</sup> Rather than describe the complexity of a situation, physicians may use words that generate fear, anxiety, despair, or hopelessness, thus silencing all further discussions. As a result, patients have more difficulty making intelligent decisions and becoming active participants in their care.<sup>5</sup> Such intense emotions also dissipate hope and aggravate symptoms, and may adversely affect healing.

Indeed, the goal of language is to be understood; physicians can use language to evaluate, inform, educate, and reassure their patients, thus building a foundation for a trusting physician-patient relationship.<sup>6,7</sup> Much has been written about how the right words can be powerful medicine; they convey vital messages and infuse optimism.<sup>1,3,7-10</sup> They are a means to help patients direct the

course of their own health care and mobilize the inner resources that are required for healing.

Language is not neutral, however.<sup>8</sup> As Spender<sup>11</sup> said in *Man-Made Language*, language is "not merely a vehicle which carries ideas. It is itself, a shaper of ideas," influencing the nature and quality of interpersonal experiences. Yet language is often misused. Medicine, like other professions, remains bogged down by technical jargon and metaphors that create fear and become what de Saint-Exupery<sup>12</sup> calls "the source of misunderstandings." These are words that harm. In response, some professions, such as the law, have introduced a quiet linguistic revolution that is focused on plain language.<sup>13</sup> It is time to revitalize the language of medicine and to replace its pseudo "medicoargot" with clear and simple dictation in which ambiguity, frightening words, and incomprehensible language have no place. These words exist in all specialties, but we use examples from cardiology because they are related to our experience in a cardiology center and because of the powerful imagery that the heart may connote.

### FRIGHTENING METAPHORS

How ubiquitous is language that harms? Over several years of observations at teaching conferences and daily rounds, we encountered harmful words with regularity. We recorded words used in cardiologists' everyday communication with patients and identified language that is often ambiguous, confusing, or evocative of fearful images. For example, consider a patient who has

just had a heart attack: the first few hours of uncertainty in the coronary care unit are also an introduction to mortality, eliciting worry that every beep on the heart monitor might be the last. Then, at the height of the patient's anxiety, the physician might come in and gravely announce, "You have the type of lesion we call a widow maker." Other patients may be told that "the next heartbeat may be your last" or that "you are living on borrowed time." Subsequently, these patients are informed that they must proceed with cardiac surgery to see if the "dangerous anatomy" can be corrected.

When physicians reach for metaphorical expressions to explain their diagnoses, these metaphors frequently strike the patient in unintended, sometimes needlessly frightening, ways. For instance, the phrase "a time bomb in your chest" conjures alarming associations, urging instant action before it goes off. Other efforts to explain or name the seriousness of a cardiovascular disease, including *widow maker* or *ugly anatomy*, fare no better, each raising a patient's anxiety level.

Furthermore, the metaphors that are used may reflect a particular therapeutic approach, thereby implicitly shaping the patient's decision making. Discussions about the "blockage of heart vessels" or how one's "life is hanging by a thread," for example, suggest an altogether domesticated problem that awaits a plumber's visit—or a surgeon's attention. An often-used phrase, "flunking an exercise tolerance test," raises specters of failing middle school examinations and leaves the patient desperate about the prognosis. Does this

mean that the patient has life-threatening heart problems and should no longer continue to enjoy pleasurable pastimes? Does such a “failing” result require decisive or immediate intervention? Using these metaphors, however earnest the wish to communicate clearly with patients, introduces therapeutic bias into the patients’ “perception of illness.”<sup>14</sup>

#### MISUNDERSTOOD JARGON AND TECHNICAL LANGUAGE

Medical language also contains idioms that physicians use reflexively without considering their precise meaning or possible impact on the patient. Examples such as “abnormal electrocardiogram,” “silent changes on the electrocardiogram,” or “sick sinus syndrome” are jarring when heard by a patient. Furthermore, such phrases mask the spectrum of possible meanings contained within them. A so-called abnormal electrocardiogram in one person may be “normal” in someone else. Similarly, a patient with sick sinus syndrome may have a long-standing history of asymptomatic pauses. Perhaps it would be more helpful to avoid determination of normalcy and simply describe the findings in a way that educates the patient about his or her problem. Instead of referring to sick sinus syndrome, the physician might simply say, “Occasionally your heart slows down, and I believe that this explains your symptoms.”

Another example of how deeply socialized and steeped physicians may be in the language of their profession is the seemingly innocent phrase *congestive heart failure*. This term, or its abbreviation *CHF*, is often used casually by physicians but may signal doom to the patient. One daughter recounts the following history about her father:

A physician, coming to visit his sick brother, took one glance at his brother’s swollen face and limbs and muttered “congestive heart failure.” I was present, and my immediate response was terror, conviction that my father had something irreversible and terminal. After all, *heart failure* sounds pretty final and irreparable. That impression hardly wavered in the ensuing trip to the ER [emer-

gency department] and the CICU [cardiac intensive care unit], as the acronym *CHF* became part of the conversation among physicians held above my father’s bed.

Heart failure is not a disease, only a description of clinical syndromes with causes so myriad as to make it an imprecise indicator of etiology, though with ominous implication for the patient. Prognosis is no longer what it used to be; much of the damage that occurs to the heart may be reversible and the symptoms controlled over decades. Perhaps a better term would be *stiff muscle syndrome* or *fluid retention*. The simple clarity of an explanation in a recent *JAMA* “Patient Page” on heart failure, describing it as a “common, chronic condition,”<sup>15</sup> would have gone a long way toward alleviating that daughter’s panic.

In contrast to frightening metaphors and idioms in which the words themselves are understood by the patient, technical language becomes another source of anxiety because it is not understood. Physicians who talk about disease of the right circumflex artery or an ejection fraction of 50% leave a patient confused and worried. A simple clarification of a 50% ejection fraction, such as “your heart is pumping well,” does much to relieve anxiety. The linguistic shortcut, which is sometimes misinterpreted by patients, represents another type of frightening technical language. A physician we know once told a patient that she had TS. The physician meant tricuspid stenosis, but the patient, according to a report she gave her son, interpreted TS as “terminal situation.” The patient was too afraid to ask the physician for confirmation, and she died later that day.<sup>1</sup>

#### REASONS WHY PHYSICIANS USE WORDS THAT MAY HARM

The origins of words, or terms, that harm are uncharted, and some, such as *congestive heart failure*, likely reflect physicians’ use of common clinical jargon without awareness of its impact on patients. Even intimidating phraseology such as “the time bomb in your chest” may have evolved as an innocuous use of metaphor to explain a technical concept. Trying to categorize the intent of phy-

sicians when they use words that harm is problematic, for intent surely varies from physician to physician and from one encounter to another. We propose 4 explanations for the use of words that harm.

Medicine’s inherent uncertainty may prompt the use of words that harm. When treating patients with coronary disease, physicians may be unsure of a patient’s outcome or response to medications. Both physicians and patients are disquieted by this uncertainty. It is natural for the patient to want to explore options when facing the possibility of a major intervention, but a patient’s searching questions may expose the thin veneer of medical knowledge. It is natural for a physician to want to avoid a discussion of uncertainty and to present a definitive solution to a problem. Ironically, the solution may be expressed through language that harms. Furthermore, when uncertainty exists, ambiguous language may offer the illusion of protection against the threat of malpractice in a litigious age.

Time pressure may also encourage physicians to curtail patients’ questions through use of words that harm. Physicians and patients alike value time, but “time is not highly valued by those who pay the bills.”<sup>16</sup> In a rushed clinical setting, it is all too easy to interject a glib, frightening phrase, rather than take the time for a more meaningful, detailed explanation. Just as a patient who is rushed may forget his or her questions, a pressured physician may not take the time to establish the open, inquiring, and self-reflective mindset that is required for empathic and educational discussion with the patient.<sup>17</sup>

Sometimes a caring physician may reach for alarmist language in order to convey a sense of urgency, thus hoping to ensure that his or her patient will comply with life-saving recommendations. In non-emergency situations, the physician may believe that these words are necessary to persuade the patient to accomplish what needs to be done to maintain health. For example, physicians may resort to fearful imagery in exhorting patients to stop smoking. In the case of a patient who might continue to smoke after a first

heart attack, the physician may tell the patient that this heart attack is “guaranteed” to be just one of many to come if the habit is not discontinued. Through such doomsday scenarios, physicians use anxiety as a means to enhance compliance or to alter patients’ behavior.

It is also likely that physicians are so close to the language of medicine, to the specific words of their subspecialty, that they may no longer really hear the words that they use.<sup>8</sup> The words we describe are learned on routine rounds or in grand lecture halls. What negative connotations are there to CHF for physicians who have used this acronym a thousand times. As one physician said, when referring to a patient as a *diagnosis* or a *really good case*, “These words were sliding past without me even noticing.”<sup>18</sup>

Whatever the explanation for the persistence of harmful metaphors, their use is not innocuous, and it undermines the trust between physician and patient. Ambiguous or fear-inducing language engenders a series of responses that neither physician nor patient really wants. Conversations about therapeutic directions become fraught, as anxiety displaces a patient’s ability to evaluate medical options calmly.

## LANGUAGE THAT HEALS

Therefore, what is needed is the courage to start from scratch, to search for words with clear, precise meaning and with connotations that do not evoke dread in the patient. Healing language avoids words that intensify these emotions or destroy hope and any prospect for rational self-determination. The best way to communicate is not through tenacious “medicobabble,” but through language that adapts and responds to a patient’s experience. Although metaphors are often useful in clarifying the nature of a diagnosis, they should not be used to intensify fear. Even when an innocent metaphor is used, the physician should elicit feedback from the patient to be sure that the patient has understood what the imagery was intended to convey.

Healing language provides the stage for collaborative decision making between the physician and the

patient, with each of them sharing his or her “own expertise to help the patient make the best possible decision.”<sup>19</sup> In this setting, the physician provides information about the therapeutic options and clarifies the patient’s priorities as they relate to these choices. Healing language is also silent; it includes a pause during which the patient can quietly consider the physician’s explanations or suggestions.

In its essence, language that heals simply explains what is happening rather than cloaking a diagnosis in a frightening term. Instead of talking about time bombs, the physician might progress from first defining the problem (“you have a narrowing in one of your arteries”) to elaborating on the specific interventions that will help the problem (“we can give you medications or surgery to correct this problem”). The physician may want to ask clarifying questions to be sure he or she has really understood what the patient is saying. Further reassurance that “there is every indication you will do well” will help an anxious patient. It may also be helpful to involve family members when making recommendations for patients, since the patient’s relatives can ask for further clarification or alert the physician when he or she uses words or terms that are frightening.

The essential feature of language that heals is empathic communication, eloquently described by Coulehan et al<sup>20</sup> as language that aides the process of healing by bolstering patient’s strengths, validating their perspective, and teaching them how to grow to be more self-reliant. In this context, physicians can also reaffirm their role as etymological teachers and so embrace a clinical language that is clear and coherent. Using everyday words can convey a physician’s compassion, earn the trust of patients, and sustain a bond between equals. Furthermore, verbal communication can and should be reinforced by the nonverbal, eg, a grasp of a hand or a touch on the shoulder, and by carefully worded written instructions summarizing the physician’s recommendations.<sup>3,7,18,20-23</sup>

Shouldn’t we ask more of language than that it do no harm? Physicians are privileged to share pa-

tients’ most intimate fears and hopes. Doesn’t this very intimacy imply that the physician is more than a technician and that the physician has a responsibility to use language in a way that will lift the human spirit? What if critical conversations elicited hope rather than fear?<sup>24</sup> No matter how difficult or complex the situation, the physician who brings to it optimism can make the work of problem solving worth pursuing. Spiro<sup>25</sup> describes “the reassurance of rhetoric” as powerful medicine; he and others recognize that the positive affirmation it can evoke will redefine the nature and the quality of our relationships with patients.<sup>1,3,8,20</sup> As Faulkner<sup>26</sup> said of writers when he accepted the Nobel Prize for Literature, “It is a privilege to help man endure by lifting his heart. The poet’s voice need not merely be the record of man, it can be one of the props, the pillars to help him endure and prevail.” So, too, can the cogent humanity of a physician’s voice offer hope for the patient to prevail in the face of disease.

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