

There Is No Denying It, Our Medical Language Needs an Update

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There is no more difficult art to acquire than the art of observation, and for some men it is quite as difficult to record an observation in brief and plain language.

—Sir William Osler

Tell me about your patient.” Seated in a conference room with 11 medical students, I am facilitating a seminar on the finer points of “The Oral Presentation.” Having just started their first inpatient rotation, their excitement is palpable. Each student has clearly memorized the formulaic structure that primes the listener with the patient’s chief complaint and ends with, hopefully, a concise assessment and plan.

“Ms Smith is a 74-year-old hypertensive diabetic complaining of chest pain. She denies shortness of breath. She has a history significant for metastatic colon cancer, and recently failed chemotherapy.” As the group assembles to meet Ms Smith, we are introduced to a lady who is appropriately concerned about her sore chest, who feels that she is breathing normally, and for whom chemotherapy had been unfortunately ineffective. I find myself cringing as the student’s presentation unfolds and wondering how such harsh words as *complaining*, *denies*, and *failed* have found their way into the history of Ms Smith’s illness.

Medical language is deeply rooted in tradition, and sharing the patient’s history with colleagues is as old as the profession. The use of the words *complain*, *deny*, and *fail* in the context of a medical case (their medical etymology) dates back more than 300 years. The phrase *patient complaint* appears in the inaugural issues of major medical journals,^{1–4} although the phrase can be found as much as 200 years earlier.⁵ Early uses of the term *deny* almost uniformly refer to cases in which the patient did not admit to alcoholism or venereal disease.^{6–10} In addition, a case report that is more than 100 years old inadvertently and

somewhat humorously supports our notion that we should not attribute a poor outcome to the failure of the patient. Published in 1900, Dr Carroll¹¹ reports: “In spite of the above, together with bandaging all the limbs, and giving hypodermics of ether, whisky, nitroglycerin, strychnine, etc, my patient failed to react, and died at 4 PM, just in time to escape the transfusion which I was preparing to give.” Escape, indeed! Where Dr Carroll seems surprised at his patient’s demise, I remain rather astounded at the profound resilience of his patient in the face of those hypodermics.

Listening to the presentation of Ms Smith’s case, and sensing an opportunity, I ask the students, “What are the most important elements of medical language?” One student jokes, “Combining as many abbreviations as possible,” and we all laugh, each one of us guilty of progress notes filled with more abbreviations than words. The group readily agrees on the terms *accurate*, *concise*, and *efficient*, but also proposes *patient-centered* and *nonjudgmental* as other markers of competent communication. Aligned with the students, I gently voice my medical language pet peeves.

Chief Complaint

A patient worries about gnawing abdominal pain or might be concerned over the swelling in his left calf. These are the *chief concerns* that are brought to the physician with the hope of resolution or reassurance. These are not complaints, like those I reserve for the quality of the cafeteria’s coffee. Whether a breast lump is a simple cyst or a malignant tumor, it is this *concern* that has kept my patient up at night. My casual question to a family—“Has he been complaining about his pain for a long time?”—suggests subtle disapproval as though a more reasonable person would bear pain with less fuss. Qualifying a patient’s *concerns* as *complaints*, especially at the bedside, damages rapport and may even be perceived as offensive.

Deny

As physicians, we have adopted the word *deny* to summarize pertinent negatives in the review of systems or to highlight a symptom that the patient might have had if her diagnosis were different. “Although we first suspected a pulmonary embolism, the patient denied pleuritic chest pain, pushing this further down our list of differential diagnoses.” If we consider the psychiatric definition of

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denial, the term accurately implies a delusional refusal to accept an unpleasant or threatening truth. However, when my patient presents for evaluation of her chest pain, I do not doubt her when she says she does not have a malar rash, weight loss, or difficulty urinating. These are not *denials*, as though she would admit to these symptoms under a more careful cross-examination. The term *deny* reveals a thinly gilded disbelief and distrust, eroding our physician-patient relationship.

Fail

A patient with cellulitis cannot fail a course of dicloxacillin, although his cellulitis could worsen in the setting of a drug-resistant organism. In similar fashion, my patient does not fail his chemotherapy for prostate cancer; it is the ineffective chemotherapy that fails to eradicate the tumor. The phrase *the patient failed* seems to have snuck into our medical dictionary in place of more accurate and less emotionally charged alternatives. Why would any of us insist on a term that gives the appearance of assigning blame to an already suffering patient? In a concerned letter to the editor in *The Oncologist*, a colleague wrote “There are numerous ways to express the failure of cancer treatment without failing the patient, too.”¹²

After sharing these thoughts, I pause to allow the students to respond. *Silence...*

I fear that they see me less as a visionary and more as a medical language iconoclast. Trying to avoid losing the group completely, I ask, “Might medical language evolve like any other treatment?” Just as we champion best practices in patient care, shouldn’t we strive to update our medical lexicon? Would eliminating the anachronisms *complain*, *deny*, and *fail*, as well as their implied judgment, be a step toward clearer communication that strengthens the physician-patient relationship?

My junior colleagues remain unconvinced. On one hand, they are savvy at engaging patients in new ways. From shared decision making to texting patients, they quickly adopt new ideas and technology and are similarly quick to decry how paternalistic medicine used to be. On the other hand, however, the same students unquestion-

ingly emulate the language of their attending physicians who seem stuck using antiquated expressions without realizing their unintended consequences. Even the ubiquitous SOAP (subjective, objective, assessment, and plan) note suffers from the pejorative distrust of the patient’s subjective story, while overvaluing the clinician’s objective observations.

I look around the room and note a few blank faces and far-off gazes. Do they imagine that the ideal oral presentation is something to memorize rather than an undervalued skill that takes years to perfect? The oral presentation must seamlessly adapt to different patients and to different audiences. The best presentations may seem simple and effortless but are actually the most coherent and informative. As we share our patients’ stories, this is a virtuosity that I want my students to develop, and I hope that our vernacular may evolve along with the rest of our profession. No longer do we say, as Dr Carroll once did, that our patients *escape* therapy in their passing. Likewise, I no longer accuse my patients of failing a therapy, of denying, or of complaining. *Primum non nocere* [first, do no harm], like in diagnosis and therapy, applies to our language, too.

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