Commentary: Dangerous Disconnections

KEVIN P. WEINFURT

During their training, physicians are encouraged to avoid using medical jargon when communicating with their patients, and this can surely improve the quality of communication. However, as Jason Batten and colleagues[1] point out, there is another category of clinical discourse that poses a challenge—the use of everyday language in very different ways by clinicians and patients. Specifically, Batten et al. draw on their empirical work showing that statements made by physicians about what treatment(s) can be offered ("treatability statements") are often interpreted by patients in ways that are inconsistent with the physicians' intentions. The authors also show that the intended meaning of treatability statements can differ even between medical specialties (for example, between intensivists and oncologists).

Central to Batten et al.'s achievement is a focus on the pragmatic features of language used by physicians and patients. The authors enlisted Paul Grice's notion of *conversational implicature* to identify cases where the meaning of an utterance derives from the words within a particular context. This helps to explain how, for example, an apparent disagreement between an intensivist and an oncologist about a patient's prognosis could actually arise from the role of treatability statements in the different clinical contexts in which the physicians work. As Batten et al. observe, in the intensivist's clinical environment, the relevant distinction is between treating and supporting, whereas in the oncologist's clinical environment, the relevant distinction is between treating and curing.

Grice's account of communication is a valuable framework within which to analyze these exchanges between physicians and patients. A complementary account that I[2,3] have found useful is John Austin's notion of *speech acts*.[4] Austin observes that episodes of communication consist of utterances that are made by agents to achieve certain goals. Within an episode of speech, the *illocutionary act* is what the speaker intends to accomplish by the utterance and the *perlocutionary act* is the actual effect of the utterance on the hearer. Viewing episodes of speech in this way encourages a focus on what speakers are trying to do instead of what their utterances might mean. As Batten and colleagues point out, the impact of these treatability utterances on patients is conditioned by the patients' assumptions about what the physicians are trying to do with the utterance: "to communicate good or bad news about the patient (prognostication), to express whether or not they will 'help' the patient (intentionality), or to communicate hope (emotional signaling)."[5]

It would be interesting to expand the investigation of speech acts within these conversations to include the questions asked of the physicians by patients and their families: *What are her chances? How does it look, Doc?* For most seriously ill patients and their families, trying to resolve uncertainty about the future is paramount. They want to know the best course of action and what will happen if that action is taken. These imperatives color conversations with their health care providers in many ways. What are patients and their families trying to do with the questions they ask, and what effects do those questions have on the clinicians they

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ask? This could be a fruitful and impactful area of research from the Gricean/Austinian point of view.

I could continue this discussion of Batten et al.'s paper in the context of research on the challenges of communicating prognostication[6,7] (for example, Fried et al. 2003, White et al. 2009), studies of the ways in which patients understand language in research consent documents differently than was intended,[8] and other related issues. Indeed, this is an intellectually rich area. I however find myself returning to my initial reaction to this paper as a past, present, and future recipient of health care. I think that reaction might be more important than my intellectual musings. Specifically, I find Batten et al.'s findings very alarming. What they have observed is a disconnect between physicians and patients—and even between physicians—in the use of words that one would assume are interpreted uniformly. Worse, this disconnect occurs in the middle of critical life scenarios and can tip patients' and families' beliefs one way or another. Therefore, I hope their work will be disseminated widely and digested by all who provide care to patients. In that spirit, I will cut this commentary short and urge the reader to use the extra time to send Batten et al.'s paper to some friends.

Notes

1. Batten JN, Wong BO, Hanks WF, Magnus DC. Treatability statements in serious illness: The gap between what is said and what is heard. *Cambridge Quarterly of Healthcare Ethics* 2019;28(3):394–404.
2. Weinfurt KP, Sulmasy DP, Schulman KA, Meropol NJ. Patient expectations of benefit from phase I clinical trials: Linguistic considerations in diagnosing a therapeutic misconception. *Theoretical Medicine and Bioethics* 2003;24(4):329–44.
3. Weinfurt KP. Discursive versus information-processing perspectives on a bioethical problem. *Theory & Psychology* 2004;14(2):191.
4. Austin JL. *How to do Things with Words*, 2nd ed. Cambridge: Harvard University Press; 1962.
5. See note 1, Batten et al.
6. Fried TR, Bradley EH, O'Leary J. Prognosis communication in serious illness: Perceptions of older patients, caregivers, and clinicians. *Journal of the American Geriatric Society* 2003;51(10):1398–403.
7. White DB, Engelberg RA, Wenrich MD, Lo B, Curtis JR. The language of prognostication in intensive care units. *Medical Decision Making* 2009;30(1):76–83.
8. Kim SY, Wilson R, de Vries R, Kim HM, Holloway RG, Kieburtz K. "It is not guaranteed that you will benefit": True but misleading? *Clinical Trials* 2015;12(4):424–31.