

Treatability Statements in Serious Illness: The Gap Between What is Said and What is Heard

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Abstract: Empirical work has shown that patients and physicians have markedly divergent understandings of treatability statements (e.g., “This is a treatable condition,” “We have treatments for your loved one”) in the context of serious illness. Patients often understand treatability statements as conveying good news for prognosis and quality of life. In contrast, physicians often do not intend treatability statements to convey improvement in prognosis or quality of life, but merely that a treatment is available. Similarly, patients often understand treatability statements as conveying encouragement to hope and pursue further treatment, though this may not be intended by physicians. This radical divergence in understandings may lead to severe miscommunication. This paper seeks to better understand this divergence through linguistic theory—in particular, H.P. Grice’s notion of conversational implicature. This theoretical approach reveals three levels of meaning of treatability statements: (1) the *literal meaning*, (2) the *physician’s intended meaning*, and (3) the *patient’s received meaning*. The divergence between the *physician’s intended meaning* and the *patient’s received meaning* can be understood to arise from the lack of shared experience between physicians and patients, and the differing assumptions that each party makes about conversations. This divergence in meaning raises new and largely unidentified challenges to informed consent and shared decision making in the context of serious illness, which indicates a need for further empirical research in this area.

Keywords: treatability statements; miscommunication; linguistic theory; H.P.Grice; literal meaning; intended meaning; received meaning

Introduction

During discussions with patients who are seriously ill and their families, physicians must communicate whether the patient or medical condition is ‘treatable.’ That is, they must explain whether or not there are available therapeutic interventions for the clinical issue at hand. Physicians use a variety of particular words and phrases to communicate that something (a “treatment”) can be done; in this paper, we call this family of statements “treatability statements.” Examples of treatability statements include, but are not limited to:

- 1) “This is a treatable condition.”
- 2) “We have treatments for your loved one.”
- 3) “We have interventions we can offer for this condition.”
- 4) “We can do something about this.”

In prior qualitative work exploring these statements,¹ we demonstrate substantial differences between physicians and patients, and amongst physicians, in how

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treatability statements are used and interpreted. For simplicity, we use 'patients' to refer to any nonphysician involved in a discussion or decision about a patient who is seriously ill, including the patient him- or herself, family members, other surrogate decision makers, etc.

Patients typically understand treatability statements as communicating good news for the patient's life and future (e.g., "Your condition can be treated" might mean "Your condition is not terminal," "You will survive," or "You will not be limited by this disease").

Physicians typically understand treatability statements through an entirely different lens: as communicating that treatment is available, without necessarily communicating improvement in prognosis or quality of life. Some physicians use treatability statements to communicate that disease-directed treatments are still available for an incurable disease (e.g., "Your cancer is treatable" might mean "Although your cancer is incurable, we can still treat you with palliative chemotherapy"). Other physicians use treatability statements to communicate that treatments may potentially cure or reverse a pathophysiological process (e.g., "We can treat the sepsis" might mean "We can potentially reverse the sepsis and return you to baseline"). To bluntly highlight the discordance, treatability statements can have opposite meanings to different physicians: some physicians use treatability statements to contrast treatability with curability, implying that the disease is certainly *incurable*; others use treatability statements to imply that a disease is potentially *curable*.

Explaining and understanding the source of these profound differences in meaning raises significant and largely unidentified challenges to informed consent and shared decision making. This paper is a first step in providing such a theoretical account. Specifically, we are interested in exploring several interrelated questions: How do treatability statements come to have such divergent meanings? How does this contribute (or not) to clinical miscommunication? How should this impact our understanding of informed consent and shared decision-making in the context of serious illness?

Thus far, literature about clinical miscommunication tends to assume that meaning is conveyed and derived from: (1) the literal meaning of words (semantics), and (2) features of communication such as posture, intonation, gaze, facial expression, or gesture. In addition to these two meaning-conveying aspects of communication, in this paper we point to a third, ubiquitous aspect of communication: the ability of ordinary speakers and listeners to convey and derive meaning beyond what is literally said. For example, when a father asks, "Has the paper come yet?" his daughter may reply, "It's on the table." She did not answer the literal question (e.g., by replying "Yes, the paper has come"), but rather correctly infers her father's intent and provides him with the information he is after: the location of the paper. We engage in such inferences using a wide array of contextual sources, including relevant background knowledge, the time and place of the conversation, the assumed purpose of the conversation, the assumed intent of the speaker, or implicit social conventions. Changes in these contextual factors would change what intent is inferred and, therefore, what meaning is derived by the listener.²

In linguistics and philosophy of language, this way of conveying and deriving meaning is designated "pragmatics."^{3,4} Pragmatics, which focuses on the use of speech and language in particular contexts, is understood in contrast to semantics,

which focuses on the literal meaning of linguistic forms. This paper aims to mobilize theoretical work in pragmatics to account for the divergent meanings that treatability statements come to have, and to consider the ramifications for miscommunication, informed consent, and shared decision making in serious illness.

To approach this task, we will first clarify treatability statements as a phenomenon for study by situating them in a clinical case and defining the multiple levels of meaning they may convey. Second, we will mobilize theoretical work in pragmatics to explain how treatability statements come to have such divergent meanings in this context, relying in particular on H. Paul Grice's concept of conversational implicature. Because we believe this body of literature is generally unfamiliar to the healthcare ethics audience, we will explicate some of its foundational concepts as we go. Lastly, we will clarify how the divergent meanings of treatability statements may threaten disclosure and shared decision making, thus clarifying the challenges physicians face when discussing prognosis and treatment options with the seriously ill.

Case

Consider the treatability statements in the following hypothetical case, based on an actual clinical case, and mirroring many cases reported during interviews with physician participants in our empirical work. In this case, we highlight two treatability statements (sentence 1 and sentence 2) that we will refer back to throughout our analysis.

Ms. P, an elderly woman with a history of recently diagnosed metastatic breast cancer, was found unresponsive and sedated in her apartment by her only daughter. After being brought to the hospital by emergency medical services, treated for possible opioid overdose, and evaluated by the intensive care unit (ICU) team, she is admitted to the ICU with severe sepsis of multiple possible sources. Standard aggressive treatment with IV fluids, vasoactive medications, and broad-spectrum antibiotics is initiated.

Due to lack of insurance and fear of cancer, Ms. P had waited an entire year before presenting to clinic three months ago with a breast lump and chest pain. After work-up, she was diagnosed with metastatic breast cancer and started on appropriate treatment, including cancer-directed hormonal therapy, pain treatment, and treatment to manage the metabolic derangements from her multiple lytic metastases.

Ms. P is currently disoriented and cannot communicate meaningfully with the clinical team about treatment decisions or prognosis. There is no indication in her medical chart that a broader goals of care discussion has taken place; she has just begun cancer-directed treatment. Ms. P's daughter, her surrogate decision maker, knows that her mother has breast cancer, but has not yet spoken with anyone about prognosis or her mother's treatment preferences.

Given Ms. P's age and medical comorbidities, the ICU team wonders if she will survive this acute episode of sepsis. And even if she does survive, they predict she will return to the hospital with another decompensation. According to the oncologist, multiple forms of treatment for her breast cancer may be available if Ms. P stabilizes and survives to discharge, including further hormonal therapy, chemotherapy, or palliative radiation for symptomatic masses. However, her oncologist wonders if her poor functional status might mean that these treatments will have a poor benefit-burden ratio.

Treatability Statements in Serious Illness

To discuss these matters, the ICU team and the consulting oncologist hold a conference with the patient's daughter. The intensivist provides a summary of Ms. P's ICU course, being careful to explain that Ms. P is elderly, critically ill, and may not survive to discharge. As part of explaining what the ICU team is currently providing, the intensivist says that, in addition to providing supportive care:

Sentence 1: "We're continuing to treat her infection."

The conversation then turns to a discussion of the patient's underlying cancer. The oncologist carefully explains that, if Ms. P survives this hospital stay, "she will still ultimately die from her cancer." In order to reassure Ms. P's daughter, the oncologist adds:

Sentence 2: "The cancer is still treatable."

He clarifies that any treatment options "will need to be discussed" with Ms. P's outpatient oncologist at a later time.

At the conclusion of the meeting, the daughter feels generally overwhelmed and understands that her mother is critically ill and may die during the hospital stay. She thanks the physicians for everything they are doing and asks that they continue to "do everything." The physicians worry that Ms. P's daughter does not understand her mother's prognosis. Even though they feel they have communicated clearly, they worry about difficult goals of care conversations in the future, and how to help Ms. P's daughter better understand her mother's clinical situation.

Treatability Statements: Levels of Meaning

We have extricated sentence 1 and sentence 2 from their larger conversational context for two reasons. First, in our empirical research,⁵ we found that treatability statements are pivotal: patients tend to focus on them and derive a great deal of implicit meaning from them, often to the point of overwhelming other explicit information. Our physician participants also observed that patients often "cling onto" treatability statements in the context of serious illness, and derive unwarranted hope from them. Second, focusing on the treatability statements while still acknowledging their general conversational context allows us to analyze how a key conversational fragment may convey meaning pragmatically. Our aim is to illustrate that even a single sentence that conveys unintended pragmatic meaning may result in clinical miscommunication that impacts treatment decisions.

To unpack sentence 1 and sentence 2, we will define three levels of meaning for treatability statements. By *literal sentence meaning*, we refer to the conventional semantic meaning of spoken words. On this level, treatability statements simply mean that physicians have therapeutic interventions (treatments) they can use. Treatability statements communicate an essential aspect of a patient's clinical situation: can physicians do something, or not? For example:

Sentence: "This is a treatable condition."

Literal Sentence Meaning: A physician can use a treatment for this condition.

Note how lean the *literal sentence meaning* is. It does not convey whether the physician plans to use the treatment, whether the physician thinks the treatment is a good idea, or what the goal of the treatment is. It simply states that a treatment exists, and that physicians can use it.

However, our empirical work demonstrates that treatability statements convey meaning far beyond the *literal sentence meaning*.⁶ These additional meanings are informed by contextual factors—the identity of the speaker, assumptions about the speaker’s intent, knowledge of the clinical situation, etc. Accordingly, we define the remaining two levels of meaning with these elements in mind: by *physician’s intended meaning* and *patient’s received meaning*, we refer to the meaning a physician intends to convey, or that a patient receives, respectively, from a treatability statement in a particular conversational context.

In the case above, we can unpack these levels of meaning for the different participants as follows:

Intensivist (speaker), Levels of Meaning

Sentence 1: “We’re continuing to treat her infection.”

Literal Sentence Meaning: We are using a treatment for the infection.

Intensivist’s Intended Meaning: We are using a treatment (antibiotics) that may reverse the infection and return your mother to her baseline prior to ICU admission.

Oncologist (speaker), Levels of Meaning

Sentence 2: “The cancer is still treatable.”

Literal Sentence Meaning: Physicians can use treatments for the cancer.

Oncologist’s Intended Meaning: Physicians have cancer-directed treatment options for the incurable cancer.

Daughter (listener), Levels of Meaning

Daughter’s Received Meaning (from Sentence 1 and Sentence 2): There is some good news for my mother: physicians will treat the infection and the cancer. There is hope that my mother will have a meaningful life after treatment and I should pursue further treatment.

The marked difference between the *physician’s intended meaning* and the *patient’s received meaning* illustrates that patients do not “successfully” arrive at what the physicians intend to convey. There are several key differences between the intended and received meaning. First, physicians are primarily concerned with clarifying the goals of treatment (e.g., reversal of an infection, modifying the cancer), while the daughter is primarily concerned with prognosis (e.g., is there good news for my mother?). Second, the *physician’s intended meaning* is framed in technical terms relevant for the physician’s work (specific clinical problems and interventions), while the *patient’s received meaning* is framed in everyday terms relevant for the patient’s life and experience (surviving, hoping, getting better). Lastly, the *physician’s intended meaning* is neutral with regard to treatment efficacy and impact, while the *patient’s received meaning* assumes that treatment is effective and will help the patient. These two levels of meaning are rarely if ever identical, and our empirical research demonstrates how far apart they often are.

We chose these particular intended and received meanings to illustrate that treatability statements come to have divergent meanings. These meanings are

representative of some of our participants' actual responses. Of course, an individual physician or patient might disagree with a meaning above or view these uses of treatability statements as unwise; however, from our empirical data, at least some physicians and patients report using or interpreting treatability statements in these ways.⁷ The rest of this paper will explore how treatability statements come to have divergent meanings and the ramifications of these divergences for informed consent and shared decision making.

Treatability Statements as Conversational Implicature

One way to understand how treatability statements convey meaning beyond the *literal sentence meaning* is to view them as instances of conversational implicature. An implicature is an "act of meaning or implying one thing by saying something else."⁸ A *conversational implicature* occurs when that meaning is conveyed not by the literal meanings of the spoken words, but rather by the relationship between the words and their conversational context. For example:

Alan: "Are you going to Paul's party?"
Barb: "I have to work."⁹

Barb intends to convey, "No I cannot go to Paul's party." She does so by saying something entirely different: "I have to work." Stripped from context, Barb's intended meaning cannot be derived from the literal (semantic) meaning of her words; there is no way to recombine the dictionary definitions of Barb's words ("I have to work") to make them mean "I cannot go to Paul's party." In fact, Barb's response could have conveyed the opposite meaning with the addition of a simple phrase: "I have to work...but I think I can still make the party." Barb's intended meaning is conveyed through the relationship between her spoken words and their conversational context.

H. Paul Grice (1989) proposed the concept of conversational implicature in his work exploring how speakers convey meaning in particular conversational contexts.¹⁰ Grice's work assumes that listeners are able to correctly calculate the intended meaning of the speaker, as in the example above. One of Grice's key contributions is to highlight that we are only able to determine a speaker's intended meaning by assuming that he or she participates in the conversation in a cooperative manner—that is, that the speaker intends to convey meaning that is *relevant*. In the example above, we assume Barb is communicating something relevant by: (1) not explicitly answering "yes", and (2) saying, "I have to work." In the conversational context, we conclude that she is answering the question, saying she cannot attend the party by providing the reason she cannot attend. We are able to reconstruct Barb's intended meaning by combining an assumption of cooperativity and relevance with a wide array of contextual knowledge and the semantic meaning of the spoken words.

Extending Grice's framework to treatability statements: a physician utters a treatability statement expecting to convey the *physician's intended meaning*, even though it is never explicitly said. The role that contextual knowledge and assumptions play in deriving this meaning remains largely implicit and may not even be recognized. The issue of interest for this paper is our empirical observation that the *physician's intended meaning* may diverge from the *patient's received meaning*.

Therefore, we now turn our attention to more deeply understand this divergence and its ramifications for informed consent and shared decision making.

The Importance of Shared Experience

William F. Hanks (2002) notes that successful conversational implicatures, in which the intended meaning and the received meaning align, depend on a “shared horizon of familiar experience.”¹¹ Listeners use this shared body of experience to derive the intended meaning of the speaker. Our empirical work illustrates that the unstated assumptions required for a shared understanding of treatability statements may not be shared even amongst physicians. For example, in the case above, the oncologist and the intensivist might disagree as to whether the patient’s incurable, metastatic cancer is ‘treatable’ or not. In our empirical work, many nononcologists claimed that incurable metastatic cancer is ‘not treatable’ by definition, and were surprised to learn that oncologists often reserved ‘treatable’ to describe such cancers.

This difference in perspective illustrates that the conceptual architecture employed in interpreting ‘treatable’ is historically and culturally specific; each physician sees ‘treatable’ as pointing to a distinction relevant from his or her vantage point in the healthcare system. These distinctions matter for conceptualizing the treatment decisions that each physician deals with on a day-to-day basis.

For the intensivist, the relevant distinction is between treating and supporting, because this makes a difference in determining the focus of ICU-level care: are we actually treating the patient’s core issue, or are we merely supporting them through the natural history of the disease? Since all ICU patients receive supportive care (physiologic support such as mechanical ventilation, vasoactive medications, fluids), treatment often refers to treatment beyond supportive care, which is disease-directed and intended to reverse a pathophysiologic process, returning the patient to their pre-ICU baseline.

For the oncologist, the relevant distinction is between treating and curing: do treatments aim to cure, or do they merely delay the patient’s inevitable decline and death? Therefore, by not explicitly stating that the cancer is potentially curable, the oncologist signals that treatment has some other goal. Since it is the cancer (and not the symptoms) that is “still treatable,” the treatment must still be cancer-directed. By saying that “the cancer is still treatable,” the oncologist conveys that this is an incurable cancer for which cancer-directed treatments are still available.

For both the intensivist and the oncologist, the intended meaning of the treatability statement only makes sense within a large body of clinical knowledge and experience, such as: (a) features of the disease at hand, (b) general categories of therapeutic interventions (e.g., disease-directed vs symptom-directed), (c) differences in scope and site of practice among physician specialties, and (d) general clinical concepts such as treatment, cure, or support.

Individuals may be completely unaware of the extent to which their communication depends on a large body of everyday knowledge and experience. In our empirical work, we observed that some intended meanings of treatability statements become so automatic that they are virtually idiomatic within a clinical specialty. For example, many of our oncology participants discussed that “treatable” *means* or *implies* “incurable” in an almost definitional sense. Similarly, many of our intensivist participants discussed that “treatable” *means* or *implies* “reversible”

or “curable.” The pragmatic logic underlying these intended meanings was largely implicit, and only elicited through extensive interviews. To some degree, these intended meanings appeared to be automatic among certain groups of physicians who shared a particular clinical context and culture as their everyday environment. This matters because the discordances between the intended and received meaning may go undetected: the average physician who utters a treatability statement is likely not cognizant of the extensive clinical knowledge and analysis required to arrive at the intended meaning.

In everyday conversation, the unconscious and automatic nature of conversational implicature is an advantage: it signals pragmatic fluency and allows for greater efficiency of communication. But in the clinical environment, when differing parties arrive to high-stakes conversations with vastly different experiences and knowledge, there may be unintentional or undetected misfires. The intended meaning, though it is automatic or even obvious for the cultural insider (a physician of a particular specialty), remains opaque for the cultural outsider (a physician of a different specialty, or a patient). Thus, one reason treatability statements come to have divergent meanings is because the different parties do not have access to the same knowledge and experience.

This is particularly relevant for communication between physicians and patients. Physicians couch complex technical distinctions in the ostensibly everyday language of ‘treatment.’ In our empirical data, some physicians discussed that ‘treat’ is useful language precisely because it appears to be nontechnical—a convenient “middle ground” for discussions between expert and lay individuals. But as we have shown, physicians’ understanding of ‘treat’ relies on a complex network of clinical experience and knowledge. Consider that a dictionary definition of ‘treat’ is simply “give medical care or attention to.”¹² This definition, which seems to approximate patient understanding, might include all of the interventions we have discussed (physiologic support, antibiotics, curative chemotherapy, and palliative chemotherapy). Thus, based solely on the treatability statements above, a patient would have no reason to suspect that the speaking physician is drawing technical distinctions between types of therapeutic interventions and whether or not they constitute treatment. In treatability statements, technical concepts masquerade in everyday language.

Our empirical data suggests that even the most sophisticated patients do not possess the relevant contextual and background knowledge to successfully arrive at the physician’s intended meaning. Patients who become more familiar with the clinical context over time (e.g., through chronic illness) may be more familiar with the technical jargon of the healthcare environment. Though helpful, this semantic fluency does not mean we can expect that pragmatically conveyed ideas will be understood.

Divergent Assumptions About Conversations

Thus far, we have claimed that the divergent meanings of treatability statements stem from differing ideas and asymmetry in clinical knowledge and experience. This dynamic is further complicated by differing assumptions about the conversation itself—that is, assumptions about what physicians who utter treatability statements intend to accomplish. By comparing the *physician’s intended meanings* with the *patient’s received meaning*, we can elucidate these important, unstated assumptions.

Physicians assume that treatability statements are made to communicate that something can be done, and to clarify what that is; treatment is conceived of as a tool to accomplish particular clinical goals, defined in specific, technical terms. Hence, physicians use treatability statements to convey that they can “do something.” In contrast, patients assume that treatability statements are made to provide news about a patient’s future; treatment is conceived of as inherently beneficial, making a substantial difference for a patient’s life or experience in terms that matter to the patient. Hence, patients hear “good news.” This difference explains why the physician interpretation is inherently technical, while the patient interpretation is inherently prognostic. For the physicians, treatability statements emphasize *what* the physician can do; for patients, they emphasize *how* the patient will do.

We hypothesize that these differences in reasoning, which are clearly apparent in our empirical data, are grounded in differing understandings of the conversational context. Physicians tend to approach conversations in serious illness with informed consent in mind. In the standard bioethical narrative of informed consent, treatment options are presented, the risks and benefits of each option is discussed, and the patient or surrogate is allowed to select a treatment option according to their own autonomous preferences.¹³ Therefore, it is somewhat common practice among physicians, especially trainees or junior attending physicians, to discuss and even offer treatments that they do not believe are beneficial, with the ultimate intent of persuading patients or surrogates against them.¹⁴

But patients are not privy to the shared implicit understanding of informed consent that physicians rely on. Patients generally do not exhibit awareness, in our data at least, that physicians might offer or even discuss treatment that they would not recommend or would consider to be inappropriate or nonbeneficial. In fact, some patients even expressed mistrust or suspicion when a physician described a terminal cancer as “treatable” when only palliative therapies were available.¹⁵ Instead, our data suggests that patients assume an entirely different set of conversational purposes when providing updates regarding serious illness: 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). Because patients and physicians do not possess the same understanding of the conversation itself, they make different assumptions about the speaker’s intent. This unavoidably affects the pragmatic inferences drawn by physicians and patients.

Informed Consent and Shared Decision Making

Having unpacked the divergent meanings of treatability statements, we will now explore the stakes of this divergence. We will consider the ramifications of this divergence first for informed consent, then for shared decision making.

Disclosure, or physician communication of relevant clinical information, is an important element of informed consent.¹⁶ For treatability statements to function effectively in disclosure, the *physician’s intended meaning* must align with the *patient’s received meaning*. But these meanings, as we have shown, can diverge—sometimes radically so. This divergence in meaning poses two distinct threats to the process of disclosure: treatability statements become (a) underinformative, and (b) falsely informative.

As physicians intend them, treatability statements are underinformative, since they primarily clarify whether therapeutic interventions of a particular sort exist, and what these interventions aim to accomplish. In interviews, physicians typically stated that treatability statements have no fixed implications for prognosis, quality of life, or probability of treatment effectiveness—all of which are vital pieces of information to be disclosed, and all of which are often what the patient wishes to know when hearing a treatability statement. These pieces of information are especially vital for “preference-sensitive” decisions, as the patient’s final choice may hinge on what information is presented and how it is presented.¹⁷

Our case illustrates this well: while Ms. P’s infection is ‘treatable’ by antibiotics, the physician does not mention that the antibiotics may have a low probability of success. The patient may, in fact, have a higher chance of dying from her infection than clearing it, yet it is still ‘treatable.’ And while the antibiotics aim to return the patient to her pre-ICU baseline, that baseline is still dying of metastatic cancer. Similarly, while the cancer is ‘treatable,’ in that cancer-directed therapies can be given, the oncologist has neither said nor implied that he thinks this treatment is a good idea; further cancer treatment may have a horrible benefit-to-burden ratio or may result in an unacceptable quality of life.

It is these unsaid elements that may be particularly discordant with the good news and encouragement to pursue treatment that a patient may derive from the treatability statements. In other words, for the patient’s daughter, the treatability statements are *falsely* informative, conveying positive information about prognosis, quality of life, and physician intention to treat—none of which were intended by the physicians.

These dynamics challenge conventional understandings of shared decision making, which tend to assume that requisite information transfer is possible and can be accomplished by stating the relevant information.¹⁸ But as we have seen, lack of attention to the pragmatic features of communication can lead to loss of relevant information and the conveyance of unintended information. Whether or not these pragmatic misfires can be identified and/or overcome by physician communication strategies is a topic for further empirical research. Frankly acknowledging these communication challenges (and whether or not they may be ameliorated) may cause us to question the achievability of shared decision making as we currently conceive of it; at the very least, we need to consider how our current methods of operationalizing shared decision making—by attempting to convey information literally—may be ineffective.

Conclusion

It is of crucial importance to pay attention to the difference between what words literally mean (semantics), and what they convey in particular contexts (pragmatics). Existing literature on physician-patient communication, though it is important and helpful, has largely ignored the latter. This paper is one of the first attempts that we are aware of to draw upon well-established theoretical work in pragmatics from the disciplines of linguistics and philosophy of language and apply these works to physician-patient communication.¹⁹ Prior to our work, theoretical work in pragmatics has only been applied, in the biomedical context, to question empirical bioethics findings on the therapeutic misconception.^{20,21,22}

Paying attention to pragmatics sheds new light on the challenges physicians face in discussing treatment options with the seriously ill: physicians must discuss whether or not a condition is 'treatable' in order to achieve disclosure, informed consent, and shared decision making; yet, by invoking 'treatable,' physicians risk invisible miscommunications that threaten the very values they seek to uphold. While treatability is one important example of a concept that may result in pragmatic misfires, there are many other key concepts worthy of study, such as 'medically-indicated,' 'candidacy,' or 'comfort care.' Future studies of these and other concepts are needed to improve physician-patient communication in the high-stakes world of serious illness.

Notes

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