The Impact of Health Professionals’ Language on Patient Experience: A Case Study

Naomi T. Katz, MBBS, FRACP, FACHPM, GDipBioethics1,2,3,4,5, Jade Jones, MBBS1, Leanne Mansfield, BNurs (Hons)1, and Michelle Gold, MBBS, FRACP, FACHPM, GDipPallMed1,5

Abstract
When people become patients, they become vulnerable to their healthcare system and healthcare clinicians. In this case study, we describe an example of patient distress caused by language overheard in the perioperative environment. Clinicians need to be mindful that the language we use may have a significant impact on patient experience, be it during direct conversation or from conversations overheard. This is an important component of patient-centered care.

Keywords
clinician–patient relationship, communication, empathy, patient perspectives/narratives

Introduction
People typically become patients without choice, and often with little warning. Their independence and voice may be lost or dampened as they become dependent on the healthcare system and individual clinicians. There is literature that describes a concerning frequency of inappropriate and unprofessional comments by hospital employees in elevators (1), as well as privacy and confidentiality implications of shared spaces and environments where sensitive conversations can be overheard (2,3). In addition, there is literature that discusses the dehumanizing treatment of patients in the intensive care unit, for example, when clinicians assume patients are sedated or unaware and talk over, rather than to, them or when patients overhear distressing remarks made by clinicians (4). We were able to locate an article referencing a patient hearing how they were described or discussed by clinicians; in this case, a nurse became patient “overheard conversations that troubled and confused” her (5), but the specific language or words were not described. Furthermore, in general, health professionals may not be aware of the degree to which their patients are anxious or distressed, perhaps because patients do not talk about their worries with doctors or nurses (6).

The authors include specialist palliative care clinicians. We report our experience caring for a patient who was distressed by what she overheard spoken in the perioperative setting, and the implications for her and her management. We provide specific examples and commentary about language and words that were particularly distressing to our patients.

Description
Mrs AB (fictional initials) is a 60-year-old nurse who underwent major spinal stabilization in the setting of cancer with vertebral metastases and pathological fractures. She lives at home with her husband and has 3 supportive children. The decision to undergo surgery was not an easy one, and to add further challenge, took place during a time of visitor restrictions related to the COVID-19 pandemic. Mrs AB

1 Palliative Care Service, Alfred Health, Melbourne, VIC, Australia
2 Parkville Integrated Palliative Care Service, Peter MacCallum Cancer Centre, Melbourne, VIC, Australia
3 Victorian Paediatric Palliative Care Program, Royal Children’s Hospital, VIC, Australia
4 Department of Paediatrics, The University of Melbourne - Parkville Campus, Melbourne, VIC, Australia
5 Faculty of Medicine, Nursing and Health Sciences, Monash University, Clayton, VIC, Australia

Corresponding Author:
Naomi T. Katz, Palliative Care Service, Alfred Health, Melbourne, Victoria, Australia.
Email: n.katz@alfred.org.au

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understood that spinal surgery offered her a chance for physical rehabilitation and the chance for functional independence and cancer-directed therapy. Without surgery, she would require bed-based care and not be eligible for cancer-directed therapy. She understood that due to medical conditions, (including BMI > 35, obstructive sleep apnea, and a single kidney) there was a significant chance of complications, including death, related to having surgery. On balance, Mrs AB decided to proceed with surgery. She explained to the Palliative Care Team that she wished to focus on the chance for benefits or surgery, and although she understood the risks, she did not wish to “wait for death.”

Mrs AB underwent surgery, spent less than 24 h in the ICU for high-dependency monitoring, and was then discharged to a general ward. The pain was well-controlled by opioids and ketamine, and she appeared to be recovering well but then developed a persistent tachycardia without other localizing signs or symptoms. This was investigated with several tests that excluded diagnoses such as sepsis, pulmonary embolism, or a cardiac event. No medical cause was identified during the admission.

Results
During review with the palliative care team 5 days later, Mrs AB shared that she had been ruminating on what she had overheard in the ICU. In particular, she had heard her care team refer to her “morbid obesity,” as well as her diagnosis being that of “terminal cancer.” Mrs AB had been anxious that the status of her cancer had changed, that her prognosis was now significantly shorter than months to years, and in fact that the plan was to be sent home to die which no one was communicating with her. Mrs AB shared that she had not slept for 5 nights as she had been scared of the dark and scared to close her eyes due to worry that she may not wake up. She also shared the indignity of hearing the term “morbid obesity,” and her reflection that clinicians should always assume that patients can hear what they are saying. Due to visitor restrictions, she had not had her family present to talk about her worries in person and she had refrained from sharing these worries over the phone.

Following reassurance about her clinical condition and validation about her experience during the palliative care review, Mrs AB shared that her anxiety had been relieved. She had felt unable to communicate her worries up until this point, but also had not been asked by others in her care team if she had worries on her mind. After this discussion, Mrs AB’s heart rate settled to normal, and she was again able to sleep at night. She has continued to have an excellent postoperative recovery and has been discharged to a subacute rehabilitation facility.

Practice Implications
Our case highlights the vulnerability of patients in the healthcare system, particularly vulnerability related to what they hear or overhear from health professionals. We should by now know the importance of treating a person, and not a disease (7), where not just the physiological but the psychosocial, emotional, and spiritual components of a person are considered. While “morbid obesity” may indeed be an ICD-10 diagnosis, overhearing health professionals use this language was damaging for Mrs AB. As health professionals, we have a responsibility to combat “tension between a reductionistic focus on disease and the consideration of the whole person” (8). We have a responsibility to consider the patient as a whole when communicating disease or person-specific information, whether this is directly in conversation with the patient or through handover to colleagues. A good rule is to “presume that all critically ill patients can hear, even if they are sedated” (5). It is also worth noting that dysphoria may affect thoughts and interpretations in the perioperative period, for example by medications such as ketamine (9).

In their article, “‘I just have admitted an interesting sepsis’. Do we dehumanise our patients?” Kompanje et al (10) suggest that a degree of “dehumanising” patients may be protective for health professionals who would be unable to continue practicing if they took on the pain and suffering of their patients. While there may be merit in this, our survival and protective mechanisms cannot be at the expense of our patients. Dehumanizing or devaluing patients risks patients and families feeling as though they are a burden to clinicians and losing trust in their medical teams, while clinician humanizing behaviors can decrease patient distress, improve patient–clinician relationships and increase clinician joy in work (4).

We should be sensitive in the language that we use and consider how we would feel if the tables were turned, and we were the patient. Furthermore, we should seek opportunities and be open to feedback from our patients to continually improve our care provision. When she felt safe, Mrs AB was able to provide a very articulate account of her experience and a desire to prevent difficult experiences for other patients.

Finally, our case highlights the impact of unspoken anxiety and distress for patients secondary to the language used by health professionals. It is possible that Mrs AB’s tachycardia was substantially related to the stress and anxiety of fearing that she would die if she fell asleep. Had further exploration of her worries been possible, perhaps fewer investigations would have been needed and she may have not suffered from worry as long as she did.

It is interesting to consider whether Mrs AB’s nursing background delayed her sharing her experience for fear of being labeled a “difficult patient!” and adding burden to a stretched healthcare system, or whether familiarity with the system allowed dialogue that disenfranchised patients may not experience. In their article, “Patient-centred care: the key to cultural competence,” Epner and Baile describe 4 patients with the same illness to highlight the importance of patient-centered care and they outline helpful models and suggestions for effective cross-cultural communication (11). A “cross-cultural” approach is one where communication skills
are utilized to sensitively and compassionately establish a patient’s goals, fears, priorities, and values to truly provide patient-centered care, a step beyond cultural competence where assumptions may be made based on the background, such as religion, race, sexuality or profession, of a patient (11).

Conclusions

Our case study highlights the importance of health professionals choosing their words carefully. The language we use has the potential to cause patients significant anxiety and distress, both during direct conversations and from conversations overheard. A patient-centered, cross-cultural approach to care can go a long way to helping clinicians carefully consider direct and indirect patient interactions. We should assume that all patients can hear, and consider whether we would find our language acceptable if we found ourselves in the position of “the patient.”

Acknowledgments

We wish to acknowledge and thank Mrs AB for trusting us, and consenting to us sharing her experience. We hope that this goes some way in prompting clinicians to think about the distress that their words may cause for patients.

Declaration of Conflicting Interests

The authors declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The authors received no financial support for the research, authorship, and/or publication of this article.

Informed Consent

Written informed consent was obtained from the patient(s) for their anonymized information to be published in this article. Available upon request (unable to be uploaded in PDF format).

ORCID iD

Naomi T. Katz (https://orcid.org/0000-0001-8326-1895)

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