Chapter 8
Healing, Wounding, and the Language of Medicine

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> *Every patient needs mouth-to-mouth resuscitation, for talk is the kiss of life.*
>
> Anatole Broyard [1].

Keywords Words • Language • Healing • Narrative • Doctor–patient relationship • Listen • Talk • Placebo • Sociolinguistics • Silence • Dementia • Military • Metaphor

If clinical medicine is, at least in part, the art of human interactions, then words are its stock in trade. The words we use form the mental models of our lived worlds and shape our perceptions, understandings, and meanings. Given the power of language to bend our thoughts and minds, it is hardly a surprise to discover the influence of verbal interactions on our affect, mindset, and physical and mental well being. Mother's words shape the development of her infant's brain, and lack of verbal stimulation leaves traces visible to the neuropathologist. A comforting word can light up a face, and a voodoo curse can cause cramps in the guts of a believer. The language of the clinical setting can lead to effects and outcomes as potent as those following the administration of pharmacologic agents, yet the powerful agency of words in healing or wounding receives scant attention in contemporary medicine – there is no linguistic *materia medica* in the library.

This is all the more surprising given the recurrent finding that "being listened to" is at the top of the lists of needs articulated by patients, and "the capacity to listen" is in their descriptions of the ideal physician, landing well above technical competence [2]. Perhaps correctly, patients presume their physicians have the competence to practice yet perceive that appropriate clinical communication skills are less common. This chapter explores the use of words in the clinical encounter with an emphasis on their meanings and impact. One might well describe this as "medical linguistics," a subset of sociolinguistics and a new field of study!

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Whose Words?

The first question we need to address is "whose words do we have in mind?" We naturally think of the words spoken by the caregivers, while forgetting that patients ask to be *listened* to, not *spoken* to – a reminder that attending physicians can be understood to mean, those who listen to their patients (from the Latin, *attendere*, "give heed to"). The opportunity for a patient to share his/her fears, anxieties, and uncertainties in facing the threatening, as yet unclear, implications of an illness is the first step in the construction of the relationship that will entwine the patient and physician and that can become the arena for trust and healing. Indeed, the various forms of psychotherapy in both traditional and contemporary psychiatry revolve around the story told by the patient, sometimes developed over many years of treatment. Equally familiar is the refrain, "all we did was talk, and I feel better already" cited by countless patients after a single clinical encounter. Though it is not clear how such a "talking cure" provides its benefits, it seems recurrently demonstrated that the attitude, mindset, and behavior of the listener are significant in this regard. It is likely that the patient finds solace in sharing the facts of the illness as he/she understands them and, through talk, extends a feeler into the darkness to decipher the import of his/her symptoms. Through talk, the patient constructs a plausible story of his/her illness and looks to the physician to help "name" the illness through diagnosis. The physician's role in this arena is multifold. He must first learn to listen attentively, without interruption, and thereby signal to the patient a readiness to enter into the partnership that constitutes the clinical dyad. To quote John Scott, who identified a series of attributes of physician-healers, "It [healing] resides neither in the doctor nor the patient, but in the space created by the network of relationships that enfold both doctor and patient" [3]. Second, the physician must learn to listen to silence and determine whether that signals anger, grief, or dementia. Drawing out an uncommunicative patient is a skill that requires a great deal of experience for mastery. Finally, the initial words of the patient provide strong clues to the role that the patient needs the physician to play in the particular clinical event. A skilled clinician expressed this idea as follows:

> Is this a story of shame and they need you to listen? Is this a story of fear and they need you to be there with them? Is this a story of blame…or self-blame and they need to hear that it wasn't their fault? I mean, what is the story? So what role do they need you to be in? [4]

Playing an interlocutor's role that the patient requires presumes a level of attunement based on a practiced combination of active listening and emotional mindfulness – a capacity to "hear" the ideas behind the words, to decode the semiotics of the body, and to interpret the hermeneutics of silences.

A Half-Word to the Wise

A wonderful example of the effect of altering a single, apparently innocent, qualifier is available in the work by Heritage et al. carried out in offices of community-based physicians. The physicians were randomized to ask one of the two following questions once the initial history had been discussed with the patient: “Is there anything else you want to address in the visit today?” or “Is there something else you want to address in the visit today?” The readout was a measure of the extent to which patients shared concerns noted in previsit questionnaires but not yet expressed during the visit (unmet concerns). The “something” question elicited positive responses in 90% of instances and revealed 78% of unmet concerns, whereas the “anything” question elicited positive responses in 53% of instances and revealed no additional concerns beyond those presented by patients in a control group who had no research-driven question posed to them [5]. Thus, the use of the qualifier *some* (but not *any*) was a useful trigger in inducing patients to bring forward issues that were troubling them prior to the visit. Of note, the “something” question did not lead to longer visits yet arguably led to improved communication and perhaps greater patient satisfaction, though this was not measured. What is of interest to us is the reason for the differences in responses. The authors note that the word *any* has negative polarity and tends to be used in interrogatory forms for which a “no” response is expected. Whatever the sociolinguistic mechanism, this work certainly makes the point that a single word (or part of a word) can have an enormous clinical impact, and physicians must be aware of the importance of seemingly innocent choices.

(Almost) An Hour of Healing

The impact of talking with a patient and the power of words as a vehicle for recognition, attention, and clinical improvement are evident from a series of experiments conducted by Kaptchuk et al. [6] to decipher the components of the placebo effect. A group of patients with irritable bowel syndrome were randomized to one of three interventions: a waiting list group (also served as control group), sham acupuncture (six sessions over a 3 week period), or sham acupuncture (as above) with the addition of a 45-min structured interaction between the patient and the acupuncturist practitioner. This included a discussion of the patient’s symptoms, his understanding of his illness as well as stipulated behavioral requirements for the practitioner of active listening, an articulation of empathy, and the transmission of a sense of confidence in the efficacy of acupuncture therapy. Improvements in symptom scores and quality-of-life indices were noted in all three groups after 3 and 6 weeks (compared to baseline measures). However, the degree of improvement showed an increasing trend line from the waiting list through the sham acupuncture group to the acupuncture plus interaction group. The latter group showed the greatest degree of improvement of the illness, and indeed, the trend followed the nature and the degree and intensity of interactions with the study team, that is, mere registration to a waiting list with its anticipation of future benefits is itself helpful. The actual interaction with practitioners who simply apply a sham therapy brings added benefits, and the provision of a positive discussion and words of empathy and encouragement provide the greatest benefits. The trend lines suggested to the authors that the practitioner interaction is the most potent of the amalgam of effects and that the percentage of patients in the third arm (ca. 60%) who demonstrated a beneficial clinical response is on the same order of magnitude seen in clinical trials of therapies for IBS. The suggestion from this interesting trial is that the benefits of a so-called *placebo* may reside in large part not in the pill and the ritual that attends its administration, but stems rather from the practitioner whose attention and words of support and confidence evince the requisite trust and belief by the patient whose own neurophysiologic mechanisms complete the cycle of improvement.

A Walking Placebo

These data open the door to the idea that all therapies, whether *verum* or *placebo*, are enabled or, at least, enhanced by the words of the practitioner who is the agent of caring and care. In fact, Benedetti et al. [7] have demonstrated the former, namely, the added benefit of open compared with the hidden administration of morphine for postoperative care. One group received the drug by machine administered infusion with no special announcement to the patient; the second group received the morphine by bedside infusion by a physician who informed the patient that a potent painkiller was being given. The pain suffered at 30 and 60 min after drug administration was significantly lower in the open administration group compared to the hidden administration group. The effect was extended in an interesting direction in another experimental group in which the interruption of morphine administration was announced or not. Again, knowledge by the patient of the cessation of the medication resulted in a more rapid recurrence of pain than in the second group in which the hidden interruption of medication permitted an extended therapeutic effect. There is no placebo in these trial designs, unless of course, we consider the physician a walking placebo (or nocebo) [8].

A highly cited paper that adds an interesting twist to the impact of the caregiver was carried out by Gracely et al. in a study of patients having dental extractions who were informed that they would be randomly assigned to receive placebo (saline), naloxone (an antagonist to narcotic agents), or fentanyl, a potent narcotic analgesic and that the pain levels, measured by questionnaire might increase, decrease, or not change. One subgroup of these individuals received their treatment and questionnaire administration from clinicians who were informed that their subjects would receive placebo or naloxone (PN group), and a second group received the same treatment and questionnaires from clinicians who were told they their patients would receive placebo or naloxone or fentanyl (PNF group). All drugs were administered double blind. At the end of 1 h, the members of the PN group who received placebo only reported an *increase* in pain while the members of the PNF group who received placebo only reported a *decrease* in pain – the two groups differed significantly in pain reports at 1 h. Please note that the only empirical difference between these two groups is the knowledge of the clinician of the range of possible treatments his subjects might receive. The clinicians did not know what treatments were actually given, and in these instances, it was placebo only in all subjects. And yet, the expectation of benefit (PNF group) or not (PN group) was somehow transmitted to the subjects despite the double blind nature of the design. This is a wonderful demonstration that the clinician's anticipation of benefit can induce a similar expectation in the patient through some subtle verbal or behavioral cues [9]. Thus, the power of words and language can be exceptionally cryptic and hidden yet transmissible all the same to the patient who can either be healed or harmed by verbal or body language, depending on the intent, mindset, and behavior of the clinician.

Soft Talk and Big Sticks

Caregivers often use innocent phrases to support patients and provide soothing words of concern. How often do we say, "This won't hurt a bit" or "It will feel like a bee sting," when about to administer an injection. The effect of such words was assessed by Lang et al. [10] in a study of interactions between patients and caregivers prior to and during interventional radiological procedures. Warning the patient with respect to pain or other undesirable experiences resulted in greater pain and greater anxiety than simply stating that the procedure was about to start. Furthermore, sympathizing with the patient using language that refers to negative experiences did not affect pain measures but did increase levels of anxiety. This effect is described by the authors as the nocebo effect and may stem from a phenomenon called negative affective priming, in which suggestions can produce the affect to which they refer, with even minimal input [11]. In fact, even the phrases, "you will feel no pain," "here is a prescription for your pain medicine," may evince paradoxical effects. This may be rather more common than suspected in medicine, where physicians may discuss side effects of medications, for example, even if to indicate how rare they are. Thus, words such as hurt, complication, pain, bleeding can be heard by the patient as expectations rather than rare occurrences.

An intriguing example of the import of a single word in healthcare education comes from a thesis project examining by interview the experiences of medical students in their third year of study and presented by Anna Romer for her doctoral work at Harvard University [12]. Romer noticed the recurrent use by the medical students of the word, "just," as in "I just sat there" or "I just talked to her" as deprecating their own activity by contrast with the active interventions of the residents who might, after all, do things such as lumbar punctures, bone marrow aspirations, and prescribe chemotherapy. Thus, the students reflected their learned presumptions that talk is, especially if they listen, particularly passive, nonmedical, and devalued by their mentors. Some students noted that their golden opportunity to talk with patients would evaporate when they entered the "real world" of medicine as they had observed from role models that talking with patients varies inversely with ability to provide care, place in the hierarchy and importance of rank and status. What was most interesting was the students' clear-eyed realization that what they are taught in classes on doctoring skills is often not supported, if not actively discouraged, when they reached the hospital wards. They learn quickly that the ability to reel off a differential diagnosis with arcane diseases receives more recognition and higher grades than their burgeoning "relational knowledge."

As Romer notes in her discussion, "relational concerns are simultaneously idealized and devalued (just talk)." Despite these pressures, the students understood that these interludes of talking with patients were moments of healing. A major admonition to teachers of medicine is to remember the paraphrase of the old saw, "students learn what we practice, not what we preach."

Silence is Golden

Hippocrates taught us to listen to the silences as well as the words. By that, he meant many things. Pauses, changes in breathing patterns, body shifts, paralanguage, facial expressions all communicate content and affect, and the skilled listener uses the silences to pay particular attention to these [13]. Silence can also mean that the patient is having difficulty in articulating a concern that may be laden with emotion and, indeed, may be particularly important. Hence, such silences must not be interrupted as they can be preludes to the most significant concern the patient is bringing to the particular encounter. Of course, silent pauses are spaces for reflection and can provide time for moments of mindfulness for the clinician.

Respect for silence is also a reminder that words must be measured and not abused, neither in number nor in kind. Is it possible to be too talkative? Is there such a thing as too much communication? The answer to this pair of questions stems from understanding that talk is not necessarily communicative. Some talk is mindless, at best. A study by McDaniel et al. [14] examined the frequency of physician self-disclosure in just over a hundred unannounced visits by standardized patients to primary care physicians; that is, how often did doctors talk about themselves? The researchers were "shocked" to find physicians talking about their own concerns, illnesses, and families in a third of patient visits [15]. In fact, the conversation returned to a patient-centered concern only 21% of the time, and the evaluators estimated that 85% of such self-disclosures were not useful to the patient and the purpose of the visit. There was no apparent benefit to the patients from such revelations by physicians of their own personal experiences.

Now, it may be the case that a physician can express a sense of understanding by noting, for example, that he too is a diabetic and forming a bond with the patient. However, this study reminds us that if we find ourselves talking instead of listening, and especially talking about ourselves, to be mindful of that and remember that we are there for the patient, not the converse.

Elderspeak: Geriatric Baby Talk

An interesting phenomenon that seems to accompany the growing numbers of individuals in our society over the age of 70 is the advent of elderspeak. In a word, this is the use of what would otherwise pass for baby talk in communicating with the frail, and not so frail, elderly. This form of speech is especially common in settings where older individuals require care, such as hospitals, nursing homes, and institutions caring for those with dementia [16]. In some strange sense, once we provide care for those who are, like children, at least in part dependent, we use the same simplified word choice and syntax at both ends of the span of life. The examples are endless – dear, sweetie, young lady (for a woman of 68) – and the questions even more charming, e.g., the collective noun (How are we today?), check for comprehension (did you understand what I just told you?), directing the question to a son or daughter while ignoring the patient (please tell your father what I just told you), the breezy presumption of first name address (Hi, Mr. Bill!), and the quest for yesteryear (what did you used to be?). These forms of infantilizing discourse are very irritating and insulting to the elderly and undermine their sense of self-confidence and self-worth. Very few, if any, retirees find this language endearing or respectful. That alone would be a warning to change our mode of communication. However, the effects may be even more pernicious than at first thought.

A study of a patient with dementia in a nursing home demonstrated a correlation between the degree of elderspeak used in interacting with the patient and her "resistiveness to care," a measure of a series of behaviors that signal an aversive response to the interaction [17]. This initial finding was later replicated in a larger sample of 20 patients studied in 80 encounters [18]. Thus, even in an individual whose cognitive functions are diminished, the ability to distinguish between infantilizing and normal language appears to remain intact, and more significant, disrespectful language may lead the person to resist an intervention intended to be helpful.

A second perspective on the impact of language felt by the elderly recipient to be demeaning is afforded by an interesting longitudinal study of aging by Levy et al. [19] in a sample of 660 persons. They found "that older individuals with more positive self-perceptions of aging....lived 7.5 years longer than those with less positive self-perceptions of aging." This finding was a complement to a parallel longitudinal assessment that demonstrated that functional health among the elderly over a two decade span was influenced by their self-perceptions of aging at the outset of the period [20]. Together, those aging persons who have positive attitudes and views about growing old do so in better health and live longer than their peers who have a negative outlook. The tantalizing (and depressing) conclusion is that by undermining elderly persons' self-confidence and self-esteem by the use of elderspeak, we can transform them to patients who need more care because of poorer functional health status, resist the care when it is offered, and have a shorter life expectancy. Whoever said "it's only words" neglected the rich connections among social environment, mind, brain, and body!

The Gall Bladder in Room Six

Language can simultaneously shape our thoughts while revealing our mindsets and mental models. The words we choose to describe patients and diseases indicate a dramatic shift in the attention of the physician, that is, in what is important to him/her. A traditional focus on the patient with illness has been supplanted by a substitution of the patient by the disease. This has occurred in a stepwise fashion in which the first was the inordinate attention paid to diagnosis, in both the medical and popular imaginations. In medicine, the development of pathology and more precise imaging techniques permits physicians to use MRI machines to peer directly at disease processes so that patients have become transparent. An echocardiogram allows the cardiologist to examine the heart valves and diminishes the need for a stethoscope, which brought the doctor in direct physical contact with the patient. Now, a machine suffices, and the cardiologist examines computer screens and paper traces. This transition from person to disease was abetted by what Charles Rosenberg calls the "tyranny of diagnosis" [21], and indeed, the television heroes of the recent past are expert diagnosticians rather than inspired therapists. It is now presumed, and quite incorrectly, that once a diagnosis is established, treatment follows automatically and successfully. Just as the technically adept surgeon is the role model on a surgical service, the diagnostic "star" is emulated on internal medicine wards. With the advent of an increasingly technologized medicine over the past 25 years, more of the doctor's attention is channeled toward modalities that mediate between him/her and the patient, and less direct contact with the individual is evident in both inpatient and outpatient medicine. The effect of all these forces has been the reification of disease, that is, a thing that stands by itself, rather than a process of illness that happens to a patient. As Levenstein et al. [22] have aptly noted, "In the process of differential diagnosis there is a well-tried clinical method for understanding diseases, but no equivalent method for understanding patients." This, in turn, leads to a dissociation between the needs of physicians and those of patients, and these two partners in the clinical dyad now have different objectives, with the doctor developing a relationship to the disease which he intends to identify and eliminate, while the patient seeks attention, understanding, comfort, and a return to health. As expressed so aptly by Pauline Chen in her column in the New York Times, "…we see ourselves on opposite sides of a divide. There is this sense that we're facing off with each other and we're not working together. It's a tragedy" [23].

A second step in this evolution is the disappearance of the patient and the metonymic substitution by the disease or the afflicted organ. Hence, the phrases heard on wards, "the gall bladder in room six," or "the heart failure in the coronary care unit." These habits are of course disrespectful and inconsonant with any sense of civility or dignity – they are also clinically dangerous as all attention is focused with laser like intensity on a single locus that may have little to do with the source of suffering afflicting the individual patient. And woe betide the patient who has no diagnostic label – he becomes either "a poor historian," "idiopathic," "nonspecific," or one who simply disappears in a blind spot of clinicians who do not know what to call him/her and thus call him/her not at all.

Military Metaphors: Whose War Are We Fighting?

A clear indication of the reification of disease comes from the military metaphors that are so pervasive in the discourse of and about medicine [24]. We speak of the war on cancer, the battle against disease, the therapeutic armamentarium; we use silver bullets, magic bullets, and targeted therapies; we eradicate, eliminate, destroy, and issue doctor's orders. By turning disease into the enemy, we again emphasize its status as a "thing," independent of the patient, and establish a new, though adversarial, relationship between the protagonist physician and the disease. It is then a matter of an additional rhetorical and functional flourish to replace the patient with the disease. The doctor's interlocutor is now the disease, and while the battle rages, the patient has become the battlefield, not even an ally. This substitution may explain the limited communication with the preoperative patient who has become a vessel bearing the disease and the field of combat onto which the surgeon leads his troops. Not by accident does the old term for operating room, the operating theater, foreshadow the twentieth-century phrase, theater of war.

In this construct, the patient as a counterparty who is recognized and respected disappears, and the lessons of attentive listening become mooted victims of a new social order in which bodies are scanned or probed to find the disease lurking in little corners, much like the devil in Presbyterian churches. Illness, the patient's experience of being sick, is made irrelevant, and therapy is geared to extirpation. Diagnosis becomes agent-centered, not patient-centered, and public health is transformed into a barrier to the immigration of strange foreign agents, SARS, for example.

The metaphors we use not only reflect our beliefs and the meaning we attach to the objects of our worlds, but they also shape our thoughts and by placing emphasis on one feature of an object may obliterate another. Hence, the celebration of diagnosis as an end in itself and the reification of disease turn the patient into an increasingly passive object, one that is almost superfluous to the technologized physician. Indeed, the hierarchical structure of the medical team of a teaching hospital ward provides a perverse figure in which the "lower" on the team, the more likely you are to recognize the patient as an individual. Medical students report that they have much more contact with the patients they look after than the residents who in turn provide more hands on care than the attending staff. It seems that once you attain the status of a mature attending physician, you are able to provide care vicariously and perform the magic trick of patient-centered care while not ever seeing the actual person. Little wonder we speak of the hidden curriculum as a powerful teaching tool. Our students, thus, learn that the further a physician advances in training, the less he talks with patients [25]. Of course, this is in part the skewed perspective of inpatient medicine, but its influence is strong, as we have learnt in previous sections of this chapter.

Winners and Losers

The usual structure of the military metaphor is that physicians are engaged in fighting the enemy disease. However, the advocacy for patient involvement in care has placed an additional burden on the shoulders of some patients by insisting that they fight whatever illness afflicts them. Two unintended consequences have followed in the wake of such an expectation. Some patients have elaborated a different mental model of illness and healing that entails equilibrium and restoration of harmony and balance as the aims of medicine. Such individuals can become very upset by the aggressive language they hear from their caregivers and from friends and neighbors [26]. Even Lance Armstrong, a world-renowned athlete and cyclist who “fights his way” to the tops of French mountains and who might be expected to be quite comfortable with a military metaphor was in “shell shock” when confronted with the martial images and incendiary language of one oncologist to whom he was referred. He immediately left and sought care from a team with whom he could build a trusting relationship.[1] Another patient with cancer found the discourse of fighting and winning less than palatable. He had already experienced real war in Vietnam and “was not anxious to repeat anything closely resembling that.” Listen to this question from a patient living with a malignancy and receiving chemotherapy, “But can you fight your disease and not yourself?” [27]. This person understood keenly what too many physicians have forgotten – disease cannot be psychologically removed from a patient’s body and mind and placed somewhere “out there” where it can be ignored, let alone fought without collateral damage. For that matter, patients are all too aware that when physicians take up arms against disease, the collateral damage is painful and many know stories of the casualties of “friendly fire.”

The second and more serious result of all the Web sites telling patients to fight and admonishing them to “think positively” is the entailed idea that winning the war (defeating the cancer) is only a matter of fighting hard enough. This in turn leads to the commonly expressed notion that so-and-so became “too tired to fight” and “gave up.” Obituaries are filled with descriptions of patients who were defeated “after a courageous battle.” Note the shift in agency: physicians are winners when things go well yet patients are losers when physicians cannot “win.” Sontag [28] describes aptly how the words of war can evolve into the language of guilt ascribed to patients.

When All Else Fails, Blame the Patient

The mindless statement too often heard in oncology settings is, “the patient failed chemotherapy.” What a peculiar syntax to express the fact that chemotherapy failed to help the patient! Why then do we use it? Why do we say, as Donnelly pointed out 25 years ago, that the patient “threw an embolus” or “dropped his blood pressure”? The language structure of the hospital and clinic assigns agency to the patient when things go awry. It creates a neat split that permits physicians to claim credit when treatment succeeds yet assign blame to patients when therapy fails or complications arise. This is of course not a self-conscious action or intent to disparage.

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[1] Despite this, the Web site of the Lance Armstrong Foundation tells us to “Find out how you can get involved in the fight against cancer.”

This interesting and widespread phenomenon is rooted in part in the military metaphors of medicine described above and the entailment of winners and losers. A second source is the advent of the modern pharmacopeia. When physicians select active therapeutic interventions, they thereby permit themselves to declare victory should the patient get better. However, to maintain the self-confidence needed to “fight another day” for the next patient, physicians have developed this linguistic mechanism of ascribing failure to patients. This takes many forms: poor historian, poor compliance, communication barrier, lack of will to live, lack of energy to fight, and as noted above, the patient gave up.[2]

These phrases demonstrate that we are far from a form of medical care in which patients are partners and respected as autonomous individuals. This evident lack of regard for our patients’ abilities to understand when we are clear in our explanations, and their desires to live longer and well when we listen carefully to their hopes and dreams serves to undermine the doctor–patient dyadic relationship without which medicine is bankrupt.

There are many studies of the barriers to clear communications between caregivers and patients that also document the deleterious consequences of such lapses. However, too many of them again conclude that patients are at fault in some fashion. One recent example comes from a careful study by Engel et al. [29] who studied the ability of English-speaking patients to understand the information and instructions they received in an emergency room. They noted that “Seventy-eight percent of patients demonstrated deficient comprehension” and furthermore found that “most patients appear to be unaware of their lack of understanding and report inappropriate confidence in their comprehension and recall.” In other words, most patients did not comprehend what they were told and indeed, were not aware of their gaps in understanding. What is of interest to our question of blame is the fact that while the authors consider various barriers to comprehension, they ascribe the failures solely to the patients. It is quite remarkable that the possibilities that the physicians or other caregivers were less than clear in their instructions or insensitive to the need for extreme clarity in such high-stakes settings for their interlocutors were virtually ignored in the publication. Once again, if we fail to communicate, the listeners, our patients, are at fault.

Words, Words, Words

> If words fall into disrepair, what will substitute? They are all we have.
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> Tony Judt [30].

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[2] The most egregious example that I have heard was related by a colleague in gynecology who heard the following statement at a conference: “the patient perforated her uterus during the procedure.”

Language in the clinical situation is a means to an end. It is the modality of attunement in the clinical dyad and forges a bond of trust. Words create the conduit between physician and patient that channels bilateral recognition of worth and respect that in turn make possible the intimacy necessary for truth. Narratives are needed to make sense of sickness, and their partnered coconstruction can repair the breach in a life story whose rending is the onset of illness and whose mending is the aim of therapy. Finally, the skein of recognition, commitment, and directedness toward the other that can relieve suffering and permit healing is spun by language and knotted by words [31].

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