Introduction: Through the Lens of Linguistic Theory

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We are delighted to introduce this symposium of the *Cambridge Quarterly of Healthcare Ethics* addressing communication, one of the most challenging issues in healthcare. The difficulty of discussing treatment options with seriously ill patients is not "new." What is new here is the application of linguistic theory to empirical research findings in the area of physician-patient communication in serious illness. The insights afforded by linguistic theory unveil how challenging it can be for physicians and patients to communicate effectively when stakes are high. While this line of thought has the potential to improve communication between physicians and patients, it also has the potential to challenge our foundational understandings of informed consent and shared decision making, leading us to question what is possible. Thus, we believe it is important for everyone who participates in discussions with the seriously ill—patients, family members, physicians, and clinical ethicists—to consider the communication challenges explored in the articles that follow.

The immediate locus of discussion revolves around what physicians intend, and what patients hear, when physicians tell them that their condition is "treatable." Physicians use a variety of words and phrases roughly synonymously (e.g., "This is a treatable condition…," "There are things we can do…," "We have treatments for this…"), which we call treatability statements. Our paper uses a branch of linguistic theory designated 'pragmatics' as the best way to explain and understand the wide range of meanings ascribed by patients and physicians to treatability statements. While this branch of linguistic theory has been extensively explored in the worlds of philosophy of language, linguistics, and linguistic anthropology, this work had not been broadly applied to physician-patient communication. We believe that bioethics has much to gain from applying pragmatics to the challenges of clinical communication.[1]

Sharon Kaufman brings her experience as a social scientist who focuses on the structural forces that shape physician-patient interactions at the end of life. She highlights the historical expansion of what is considered "treatable," and reveals the social factors driving this expansion. Critically, she shows how the emergence of new medical technologies ("treatments") reorganizes the obligations physicians have to offer these technologies. This in turn makes it increasingly difficult for both physicians and patients to avoid discussing these "treatments," regardless of whether further interventions lead to desirable outcomes.

In a similar vein, Joann Lynn examines how the contemporary fragmentation of care drives clinical focus away from the patient as a whole. This contributes to variations in the use and interpretation of treatability statements. Lynn builds upon previous work in which she and David DeGrazia distinguish between "fix-it" and "outcomes" models of medical decision making. For patients who do not have an affliction that can be successfully "treated," i.e., restored to health, the "fix-it" model does not fit very well. She describes how treatability statements

contribute to this problem, thus preventing physicians and patients from focusing on the outcomes that truly matter to patients.

Kevin Weinfurt uses another branch of pragmatics theory, J. L. Austin's theory of speech acts, to further explore and explain challenges in communication. Austin's theory shows us that speakers "do things with words" besides convey meaning—they promise, they warn, they make requests, etc. There can however be differences in understanding of what speakers are doing in their communicative interactions. While a physician may intend "treatable" to convey information as part of the informed consent process, a patient may interpret it as a very different activity (e.g., prognostication, emotional signaling). This provides a complementary lens for understanding how treatability statements can lead to severe miscommunication.

Similarly, Peter Brindley uses other complementary theoretical tools to explore these issues, particularly from rhetoric. A rhetorical model of communication has many virtues, and allows exploration of a wide range of aspects of communication (tone, body language, what is not stated). He also notes the relevant contextual features of communication exchanges to account for what works in communication and importantly, what can go awry. In doing so, he explores the importance of a shared understanding of the structure and purpose of a communicative act.

Vicki Xafis and Dominic Wilkinson utilize another aspect of pragmatic theory, H. P. Grice's Cooperative Principle, to introduce a normative element to evaluating communication. On their account, treatability statements can be used by physicians in an intentionally vague manner to avoid discussing grim prognoses or engaging with difficult family dynamics. They argue that this behavior violates one or more of Grice's maxims of communication as a cooperative activity.

In our response to this excellent set of commentaries, we explore the major theme that binds all of the articles together: miscommunication. In the case of treatability statements, this miscommunication is challenging to address because treatability statements are not clearly technical jargon that can be avoided. But how is it that such everyday language can cause such severe miscommunication? We explore several suggested mechanisms underlying this miscommunication, and we evaluate potential strategies for combating it.

Together, these articles are among the first attempts to use new theoretical tools from linguistics to explore communication challenges in serious illness. They also represent the first attempt to empirically and theoretically explore a key word or concept that is commonly used in clinical communication.

Note

1. Batten JN, Wong BO, Hanks WF, Magnus D. We convey more than we (literally) say. *American Journal of Bioethics* 2018;18(9):1–3.