FROM THE EDITOR

To Understand and Be Understood: The Ethics of Language, Literacy, and Hierarchy in Medicine

Clear communication and understanding between patients and physicians is essential to the practice of medicine. And yet approximately 80 million Americans have limited health literacy—the ability to process and understand medical information in order to make decisions about health care [1]. Low health literacy can be the byproduct of differences in spoken language, underlying knowledge about medical conditions, and cultural beliefs about health and sickness. Demographically, low health literacy is associated with educational level, ethnicity, socioeconomic status, and age [2]. The tragedy of linguistic failures with respect to health outcomes is well known: low health literacy among patients is consistently associated with more hospitalizations, greater use of emergency care, lower receipt of critical preventative interventions such as mammography screening and influenza vaccination, poorer ability to take medications properly, and, among seniors, poorer overall health status and higher mortality rates [1]. In fact, poor health literacy partially explains the existence of racial disparities in some health outcomes [1]. The prevalence of low health literacy and its association with poor health outcomes create ethical challenges for medical practitioners.

Caring for patients with low health literacy is further complicated by existing social and administrative hierarchies that structure relations between patients and health care practitioners and among practitioners themselves. Rank within medical hierarchies is based on level of authority and experience, creating constraints concerning who speaks up, when to speak up, and how to speak in order to be heard [3].

Mindful of the fact that communication across barriers of health literacy and hierarchical status is a central challenge in the practice of medicine [4], this month's issue of the *AMA Journal of Ethics*® considers the theme of language and hierarchy in medicine. It seeks to characterize potential sources of miscommunication in medical settings, draws attention to the social disparities that complicate existing differences in spoken language and level of health literacy, and explores the conventions of language use within medicine.

Our foray into the topic begins with the most obvious question: Who must bear the burden to facilitate communication within the medical encounter? Alexander R. Green and Chijioke Nze note that while the law is very clear in placing responsibility for interpreter services on health care providers, there should be institutional programs to support them, which would require culture change in hospital medicine on the order of

what occurred with the introduction of hand hygiene. Gaurab Basu, Vonessa Phillips Costa, and Priyank Jain discuss patients' right to language services, noting that whoever serves as a translator must be both a competent and an impartial individual within the medical hierarchy. Similarly, in the podcast, Donald A. Barr emphasizes clinicians' legal and ethical obligation to rely on professional translators rather than family members in clinical settings and discusses how lack of health literacy and language barriers can negatively affect health care outcomes.

Medical education has a role to play as well in ensuring that adequate numbers of future physicians are able to meet the linguistic needs of this country's diverse population. Green and Nze show how residents' underutilization of interpreter services—even when available—is due to lack of incentive, time pressures, and indifferent attitudes towards limited English proficiency (LEP) patients. Barret Michalec, Maria Athina (Tina) Martimianakis, Jon C. Tilburt, and Frederic W. Hafferty argue that the responsibility for working in underserved areas with large numbers of patients with LEP falls on all future medical professionals and not just students belonging to underrepresented minority groups.

In addition to macro-level interventions, we must also consider implementing small-scale changes that can help surmount language barriers within a given clinical encounter. As Lara Killian and Margo Coletti note, even when a patient and clinician are speaking the same mother tongue, the use of medical jargon can be a formidable barrier. The authors advocate the use of Health Literacy Universal Precautions, a set of tools that enhance shared decision making by facilitating clear communication and ensuring that patients understand the health information they are given [5]. Overcoming linguistic and cultural barriers also has a great deal to do with reconstructing patients' stories in a way that is authentic and respectful. Annie Le, Kara Miller, and Juliet McMullin note that illness narratives, once promising in their ability to shed light on diverse cultural beliefs, can lead to stereotyping about patients of different backgrounds if, in reading them, certain particularities are focused on. Rather than falling into that pit, they argue that medical practitioners should guard against reductionist thinking by asking follow-up questions of patients that clarify the contexts of illness.

In seeking to implement these communication practices, we confront the issue of transparency. Noting that the mental health record is becoming increasingly available to patients, Robyn P. Thom and Helen M. Farrell argue that hesitancy to embrace transparency out of a desire to spare patients having to face labels and judgments contained in their medical record goes against the ethical principles of justice, autonomy, and beneficence. Focusing on the opportunities for communication and transparency that the electronic health record (EHR) provides, Angus Roberts explains that while there have been several efforts to uniformly structure medical information, the EHR is still dominated by unstructured natural language that traffics in nuances,

negations, temporal expressions, and hedging phrases. He argues that the tension in the EHR between easily coded "hard" data, which aims to narrowly characterize the population, and free text, which aims to comprehensively describe the individual, might be resolved—if incompletely—through linguistic analysis (i.e., natural language processing).

So what is the way forward? MaryKatherine Brueck and Angelique M. Salib discuss the legal implications of physicians' poor verbal and nonverbal communication, arguing that, in cases of physician error, the possibility of adverse legal action can be reduced through "apology statutes" that protect physicians from penalties for disclosing medical errors. Unsurprisingly, emphasis has been placed on training medical students to practice effective communication and cultivate empathy and reflectiveness. One method for doing this is through narrative training. Marcia Day Childress examines the relevance of Kathryn Montgomery's *Doctors' Stories* [6], which excavates medicine's narrative foundations. Childress believes that having medical students write stories can school them in the reflection, ethical awareness, and resilience needed to practice medicine.

To understand the importance of language to the practice of medicine, we must first appreciate the narrative aspect of medicine. As Ross Kessel writes in a review of Kathryn Montgomery's *How Doctors Think* [7], "using doctors' aphorisms, maxims and rules of thumb, as well as patients' often inchoate 'histories,' she shows us how physicians arrive at a clinical judgement about the person in front of them" [8]. This narrative encounter between patient and physician, which is at the heart of the practice of medicine, cannot serve the needs of patients if they are unable to communicate their symptoms, unable to understand how to take their medications, or are too intimidated by the medical hierarchy and medical jargon to speak up. The goal of this issue is to learn from this state of affairs and offer insights to medical professionals both for restructuring the way they record and disseminate information and for ensuring the success of each medical encounter.

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