# Taboos, Hopis, and the power of words:
## Forbidden words in medical writing

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*Vogue words are to speakers and writers what the herd instinct is to lemmings.*[1]

Although eye-catching for the simile, the above statement should present no surprise to anyone familiar with the literature of a specialized field such as medicine. The vogue words, trite though they become, are as prevalent in medical writing as they are in everyday language, and probably the best way to let them lapse into merciful disuse is to avoid the herd instinct and accord them as little attention as possible.

What are more intriguing, at least in this specialty, are the vogue taboos, since it is frequently more challenging for anyone communicating about medicine to figure out which words are to be avoided than to decide which ones to use. Taboos, one soon discovers, are as rampant as the vogue words, owing somewhat to the fact that, like standard English, medical language is quite different in its written and its spoken forms. Therefore, what is accepted quite readily in ordinary conversation becomes forbidden as soon as it is put down on paper (as most authors who have had their work reviewed by a medical editor know), and to make matters even more difficult, terms that were acceptable in the recent past may be frowned upon today.

Patients, in writing at least, may not "suffer" from a disease, "complain" of symptoms, "develop" a disease, or be "diagnosed." They may not be called "cases" and certainly should never be referred to as "gallbladders" or "hips." Lately, they cannot be called "hemophiliacs" or "diabetics," and sometimes not even "males" or "females."

The proliferation of writing about AIDS has spawned a whole new list of taboo words, most reflecting the life-styles of those who are most susceptible to the disease. "Promiscuous," for example, is to be avoided[2] as are drug "abuser" and, according to some, "prostitute." (Rumor has it that someone from a major health organization was heard trying to avoid "prostitute" by referring to "someone in the sex industry," but no one will own up to the statement.)

The trend now seems to be toward depicting AIDS less and less as an illness, to the point that a reader might wonder if some of the current proposed terminology really emphasizes the person as opposed to the disease, or if it reflects a fear of acknowledging the seriousness of the disease itself. "Victims" of disease have been taboo for some time, but lately, at least with AIDS, "patients" are becoming suspect. "Persons with AIDS" are now acceptable, but it is questionable how long even this term will prevail; already "persons living with AIDS" has been proposed as the latest designation.[3]

Regardless of the disease, patients are frequently classified for study purposes according to race, and there opens another area ripe for the development of taboos. Of course, controversy over racial designations is not unique to medical terminology, but despite progress in other areas of civil rights, the trends in medical literature are so ambiguous that it is difficult to determine the overall direction or purpose of many of the recommendations or taboos. Many authors, despite editors' changes to the contrary, insist that white persons be called "Caucasians" (which the overwhelming majority, technically, are not) or that blacks be designated in every instance as "American blacks," when it is obvious from the text that all the study subjects are Americans. The vogue words, at least those used by these authors, do not even seem to mirror society's vogue words, much less those being touted in the medical editing establishment.

Even more curious is the apparent fear of some medical editors to mention race at all. Perhaps race need not be cited unnecessarily, but certainly epidemiologic considerations should override affectations of delicacy and ungrounded fears of causing offense. It may well be that a racial pattern of a disease will not be apparent until a large body of literature is reviewed, and it will never be apparent if race was not mentioned in a report.

Human beings, of course, are the subject of most taboos, but even animals or drugs can generate controversy, animals by being "sacrificed" rather than "killed," and drugs just by being "drugs." The more straightforward "killing," however, is recommended by editors, and, despite fears of their being associated with illegal drugs, the "drugs" used in medicine remain perfectly acceptable, a tribute to the fact that most readers of medical journals would be expected to know the difference.


In any case, a search of the vocabulary of most medical specialties will probably reveal much of the same, but it is sufficient to point out that medical language, as exacting and technical as it appears, is nevertheless subject to periodic fashion changes, and that these changes result not only in a gravitation toward the "in" or vogue words but also in the rendering of others as unacceptable; hence the taboos. A more thoughtful approach, however, shows that these taboos of medical communication can be regarded in more than one way. They can either be followed slavishly or they can be questioned and explored. The latter option, particularly if one examines the possible reasons behind the imposition of linguistic restrictions, may well lead into a pathway of thinking that leaves many questions still unanswered. It also gives rise, however, to some general observations about medical writing that can serve as

more solid guidelines for communicators than the lemming custom of latching on to the vogue word (or, in this case, the vogue taboo).

First of all, medical language does tend to be extremely dehumanizing, and it is incumbent on writers to preserve by their mode of expression a sense of the human aspect of the discipline and of the patient as a person and not as a disease. Second, in spite of the first observation, the linguistic premise on which the notion of vocabulary proscriptions is based may be a generally accepted and even universal idea, but as a linguistic theory it is at best unproved and is most likely misapplied. (This is where the Hopis come in.) Third, like many other jokes, facetious remarks about taboos in medical language just may have some truth in them. Many of these sanctions have been carried beyond common sense and have resulted in laughable circumlocutions that do nothing to enhance the clarity of the language. The apparent contradictions notwithstanding, these and similar observations at least underscore the need for closer examination of the word choices made in writing about medicine.

The first observation, that medical language is dehumanizing, provides the basis for most of the popular taboos. This fact has, of course, been noted by several authors as well as being mentioned in most reputable style guides. A few examples can serve to show the variety of ways that the point has been made. John H. Dirckx, for instance, observed, "The technical language of medicine is long on names for diseases and short on terms for persons afflicted with those diseases."[4, p. 127] William J. Donnelly cited numerous examples not only of how the disease takes precedence over the patient in medical writing, reducing him to a "case," but also of how the patient's behavior is similarly pathologized (He was "noncompliant," or he "failed" chemotherapy). The author concluded, quite pointedly, that "almost everything said about the patient in a typical clinicopathologic exercise in the *New England Journal of Medicine* could be said as well for a lesser primate with remarkably good health insurance. The message is clear: disease counts; the human experience of illness does not."[5]

victim person

Other authors have noted the custom of deliberately depersonalizing medical terminology in order to remove its emotional overtones. While purportedly inducing more objectivity and less fear, especially in doctor-patient communication, this type of depersonalization has also been carried to extremes in such practices as calling a fetus a "growth" or "tumor."[6, 7] Along the same line, Emily Martin, on examining medical textbooks, concluded that women fare much worse than men when physiological processes are described, and that normal functions such as menstruation and menopause are described entirely in negative metaphors like "breakdown" or "failure."[8] Finally, Anthony S. Dixon, in an article on family medicine, faulted not only medical vocabulary but the underlying grammatical construction of English sentences, which make disease an "it" or an actor in a sentence, thereby giving it a reality of its own and removing it from the patient's control.[9]

All of which is to say that there is definite justification in advising those who write about medicine to remember that their subject is people with diseases, not the other way around. Medical jargon, at least in its spoken form, seems to militate strongly against that perception, and writers must be vigilantly on guard to preserve it. Therefore, many of the taboos on this subject are perfectly reasonable and warranted.

But is this true without qualification? Must writers and speakers heed every sanction against a particular word, or has the imposition of taboos become a form of self-righteous one-upmanship characterized by the flaunting of a vogue lexicon? Obviously, each situation needs to be judged individually. It seems apparent, however, that obsession with the "correct" word (closely akin to "the myth . . . of the real name," described by Dirckx [4, p. 150]) originates from a premise that could justifiably be questioned and need not be accepted at face value. The premise is an assumption, not so much that the word is "right" or "wrong" in itself, but that the word will somehow affect the feelings and intellect of those who hear it. In other words, the real question might be, Does using one word in preference to another cause the user or hearer to think any differently about the reality conveyed by that word?

This question has no ready answer, a fact that is extremely important and one that, unfortunately, is frequently ignored. The idea of "linguistic relativity," however, as this type of language study is termed, has been examined intensely, and its implications can be recognized almost as far back as the beginning of language itself. Perhaps it is these intuitive implications rather than the formal linguistic studies that have inspired those who insist on imposing a preferred vocabulary.

The person most noted for his studies of the relationship of language and perception is Benjamin Lee Whorf, who lived from 1897 to 1941. Drawing on the work of his teacher Edward Sapir, Whorf examined the languages of American Indian tribes in the southwest United States. He concluded that the structure of these languages actually imposed a different view of the universe on those who spoke them, and that the Indians he studied perceived some basic realities such as time and space differently from English-speaking persons. He developed what today is known as the Sapir/Whorf hypothesis, which essentially states that the language we use informs our perceptions of the reality we experience. That is, language not only expresses ideas, it also shapes them.[10, 11]

One of the languages studied by Whorf was that of the Hopi tribe in Arizona. One of the features of this language is that it contains little or no reference to time. There is no ready-made distinction as to when one "event" ends and "another" begins, since subjects are often implicit in verbs, and tenses like those in English do not exist. According to Whorf, the experience of time as it is organized by the Hopi language (for it is language that organizes our experience) is different from the experience organized by the very chronologically oriented English language. The Hopis, then, would perceive time in a different manner than we do. Interestingly, Whorf also observed that the Hopi perception of physical properties like time and space may not be any less scientifically accurate than the English speaker's perception.

Whorf did most of his investigation and writing in the 1920s and 1930s; obviously, there has been considerable progression in linguistic thought

a male man

since then. Most linguists today place less value than previously on his theory about the direct relationship of language and perception and, moreover, have found it nearly impossible to prove. Newer linguistic theories now place Whorf in a different perspective, although certainly not out of the picture altogether.

Nevertheless, he is still frequently cited by those desiring to change the vocabulary of others, and nowadays a citation of Whorf's work is often found in the debate about the use of "he" as a generic term, or about other "sexist" language. Those who advocate many of the taboos in medical communication are also subscribing, albeit unwittingly, to Whorf's idea that a change in language will effect a change in one's perception of the subject. What is often forgotten, however, is that even though both Sapir and Whorf recognized the importance of vocabulary as an indicator of culture, most of their hypotheses on linguistic relativity are based on the underlying structure of language. It is the grammatical and linguistic structure that influences perception and cultural thought rather than single words. Invoking Whorf in order to advocate for small vocabulary changes probably reflects an incomplete understanding of his major hypothesis.

So, are those who discourage the use of "hemophiliac" and "diabetic" misguided, misinformed, or both? On the surface, perhaps, but there is another consideration that confounds the situation even more. Linguists, for all their study, could hardly be credited for being the first to recognize the truly mind-shaking power of the word. Humans have long been instinctively aware of the "command of language" (a phrase meaningful in every sense), and literary history contains a multitude of evidence that words have been endowed with the physical power actually to bring about the reality they convey.

Runes and incantations brought favorable reactions from capricious gods; curses did the opposite. In the Bible, the world was created at the command of God, and Jesus was referred to as the "Word made flesh." Fairy tale and folk heroes evoked wondrous events by magic words and phrases (one of the more intriguing ones being Rumpelstiltskin, whose name held such power that even having it known was enough to cause his downfall). Lady Macbeth sought removal of her guilt by a verbal command, and many of Shakespeare's other characters used language to control the circumstances of nature and humanity. Countless other examples, right down to today's manipulative gimmickry of advertising, give evidence that human beings retain some belief, or at least *want* to believe, that language can create reality as well as convey it.

Therefore, despite the lack of empiric evidence to prove Whorf's theory that language informs our perception, most of us seem to have an intuitive conviction, bolstered by what we have read and heard, that words do have power over things. Which is probably why (to return to the prosaic world of medical communication) we receive so much advice on using the "right" word and avoiding the current taboo. But whether the advice, whatever its subconscious or literary underpinnings, is universally applicable is certainly debatable, at least when it gets down to specifics. Much of it seems to be the result of noble intentions that have become a bit curdled by being mixed with ignorance of the linguistic basis behind them, and the consequences have become prime examples of self-conscious pedanticism. Fortunately, for example, the author who referred to "a woman embarking on her obstetrical career" was corrected by an editor when it was discovered that all that was meant was that the woman was beginning to have children.

Obviously, the question of the exact effect of a word on the intellect or perception may yet remain unresolved. Even so, an awareness of linguistic ideas such as Whorf's or literary examples of the power of words can provide some insight into the nature of the advice that is constantly being foisted upon medical communicators. Perhaps it can also be of value in providing some measure of assistance in how to deal with it.

Despite the fact that a simple medical term can evoke allusions to the Hopi tribes in Arizona, to fairy tales and folk heroes, and to our own subconscious mind, the implications for communicating about medicine are all too down-to-earth and practical. They are aptly summed up in the all-purpose quote, "When in doubt, use common sense." Subjective though the term *common sense* may be, it seems that what can be garnered from such a sojourn into speculation is a respect for words, a respect that ensures that their power is used in the best way possible to convey the knowledge and principles of medicine. It also seems inherent in this statement that one of the most important of these principles should be honesty in communication.

For, in all honesty, it must be ad-

mitted that "hemophiliac" and "diabetic" are perfectly reasonable as words go and probably never caused any offense until someone decided that they should. Here, as in many cases, linguistic considerations have taken a back seat to sociological opinions, often to the point where the offense is actually imposed on the listener; that is, the listener, being told to be offended, in fact is!

Of course, anyone trying to communicate medical knowledge is also aware that it is not the theory of linguistic relativity that will govern the use or avoidance of a particular word so much as the title of the person who has issued the latest recommendation. In some instances, at least in official communication, there is little choice about word usage. But when there is a choice, there is ample justification for applying the principles of clarity and directness in the same manner as they would be applied to any writing.

It is true, for instance, that handicapped persons are people and should not be characterized only by their disability. It is not true, however, that blind persons are "visually impaired." There is a rather large difference between the two terms. It is true that for health professionals, controlling the spread of AIDS takes priority over judging the life-styles of others. That, however, does not change the meaning of the words *promiscuous, prostitute,* or *drug abuser,* all of which have been discouraged as being deprecating of certain life-styles. It is doubtful if a "person living with AIDS" would be regarded or treated any differently than a "person with AIDS" or even a "patient." (And certainly the "sex industry" is an undeserved overmechanization, even if only because of the courtesy due such an ancient profession!)

It is also true that abortion is a controversial issue frequently debated with strong emotion. Nevertheless, a fetus is not "pregnancy tissue," a decidedly deceptive substitute. Finally, it is true that illness is an occasion of mental as well as physical distress for a patient. It should be quite possible, however, for medical professionals to remain sensitive to a patient's feelings and intelligence and at the same time communicate without undue condescension or obfuscating jargon.

Perhaps those linguists are right who believe it unlikely that a single word will alter our perception of reality. Assuming they are, the preoccupation with the "correct" word or the vogue taboo would then be rendered invalid, for using the preferred word would not really make any difference about how a patient or an illness is perceived. Not that any one word would be as good as another, but recommending words to represent a sociological agenda at the expense of linguistic clarity would be essentially pointless, to say nothing of inaccurate.

Assuming, however, that Whorf's ideas have some validity, or that words do have power over perception, would not some of the same conclusions be reached, even if by a different route? In this case, the principle of truth would be the guiding factor, for above all, medical communication must represent accuracy and truthfulness. But there is no call for a priggish adherence to an arbitrarily determined vocabulary or phraseology in every instance. It can certainly be admitted that a "person with hemophilia" is acceptable as a designation; the point is that the "myth of the 'true' meaning," or the idea that there is only one way to express a thought is a fictitious concept that Whorf would have undoubtedly disputed.


But if words do inform our perception, then it is incumbent upon medical communicators to create accurate and honest perceptions, not only of the knowledge they convey but also of the people and the diseases to whom that knowledge applies. Sometimes the vogue word is the best word, sometimes not. But the lemming instinct cannot be the guiding force in a field so important as medicine.

Medicine changes, and language changes, and surprisingly, given the extent of the lexicon, there are no words to express some important ideas in certain medical fields.[9] No doubt, words will arise or be coined to fill these needs, and fresh perceptions will be created from the use of these words. No doubt too, the vogue words will make their appearance at the same time. The challenge for the writer or communicator is exciting: to exert creativity, communicate honesty and accuracy, and through it all, instill a respect for the words that are their most essential tools.

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