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 simple, 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 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.²

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
The Pharo Summer 1990
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 over-mechanization, 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 deceptively 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.

References

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