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Doctors use of euphemisms and their impact on patient's beliefs about health: an experimental study of heart failure.

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Abstract

Doctors often use a range of euphemisms as a means to facilitate communication in the consultations. The present experimental study aimed to assess whether GPs use or avoid the term 'heart failure' and to evaluate the relative impact of the term 'heart failure' versus their preferred euphemism on patients' beliefs about the illness. This two part study involved a cross sectional survey of GPs and an experimental study of patients' beliefs and was based in one General Practice in a semi rural area of the UK. For the first part, 42 GPs completed a questionnaire about their preferred terms to describe symptoms of heart failure. For the second part, 447 patients completed ratings of their beliefs about a condition which was described as either 'heart failure' or the GPs' preferred euphemism. The results showed that GPs rated the majority of euphemisms as preferable to the term 'heart failure'. Their preferred euphemism was 'fluid on your lungs as your heart is not pumping hard enough'. Patients who received the condition described as 'heart failure' believed that the illness would have more serious consequences for their life, that the problem would be more variable over time and that it would last for longer and reported feeling more anxious and depressed than those who received the condition described using the euphemism. GPs are encouraged to be open with their patients and to respect their experience. The choice of language therefore presents a dilemma for doctors. The term 'heart failure' may be in line with the current climate of openness but may evoke a more negative response from the patient. In contrast, a euphemism may be less open but more protective of the patient's experience. This study suggests that the area of heart failure may be one where GPs may chose to compromise openness for the sake of the patient's experience and that this fear of upsetting the patient is well founded.

Key words: heart failure, language, consultations, euphemisms

1.0 Introduction

The current emphasis in primary care highlights the importance of patient autonomy and a respect of the patient experience (1, 6). In addition, shared decision making and openness are in vogue (1-8). The choice of language used within the consultation sometimes, therefore, presents a dilemma for doctors as the same term may have a contradictory impact on these aspects of the consultation. For example whilst using a medical term may facilitate shared decision-making it may in contrast result in negative emotions. Experience suggests that doctors often manage this dilemma by using euphemisms, which may seem more neutral and less emotive. In doing so they may be protecting the patient's feelings but it could be argued they are being less open. Recent research explored this dilemma and examined the ways in which the choice of a specific term can have an impact upon how patients perceive their problem. In particular, Ogden et al (9) carried out an experimental study of the impact of presenting patients with either a lay diagnosis (ie. Sore throat) or a medical diagnosis (ie. Tonsillitis). They reported that whereas the medical diagnosis made the patients feel that their symptoms were being taken seriously and reported greater confidence in the doctor, the lay diagnosis made the patient feel more ownership of the problem which could be associated with unwanted responsibility and blame.

The present study focused on the use of the term "heart failure" in GP consultations. 'Heart Failure' was deemed to be an emotive term, which may be avoided in preference to a euphemism (10-11). In addition, researchers have argued that 'heart failure' has no universally accepted definition (12) and that GPs may avoid its use or use it inappropriately in the absence of objective criteria (13). Furthermore, in line with Mazur's concept of the "medical conversation" (14) and recent discussions of risk communication (15-16), the term 'heart failure' may reflect a higher degree of risk than desired by the doctor. In particular the

present study aimed to firstly examine how doctors use or avoid the term ‘heart failure’ and secondly to examine the relative impact of the term ‘heart failure’ versus the doctors’ preferred euphemism on patients’ beliefs about the problem. The research consisted of two parts. The first cross sectional study examined whether doctors used ‘heart failure’ and described their choice of alternative euphemisms. The second experimental study assessed the relative impact of the term ‘heart failure’ versus the doctors’ preferred euphemism on patients’ beliefs about the problem. This experimental component drew upon the self regulatory model (SRM) developed by Leventhal and colleagues (eg. 17). This describes how patients develop illness representations about their illness and argues that these representations are consistent in terms of their core domains and suggests that these representations are central to the patient’s subsequent coping and adjustment. Ethics approval was obtained for both studies from the Local Research Ethics Committee.

2.0 Part 1: Doctors’ use of euphemisms.

A cross sectional survey was used to assess the likelihood of GPs using the actual term ‘heart failure’ or a range of possible euphemisms. Doctors completed a series of ratings following a vignette describing a patient with the symptoms of heart failure.

The final questionnaire was based upon two pilot studies and involved doctors from a General Practice Masters course and others who were colleagues of the researcher. They were from a different Primary Care Trust to those doctors who took part in the main study. For pilot study 1, 13 doctors were presented with the following patient vignette: “Imagine that you have a 75 year old female patient who has been unwell for three months. She feels tired, short of breath and off her food. After an ECG, chest x-ray and echo you make the diagnosis of heart failure”. They were then asked to rate how likely they would be to explain the problem to the patient using a four euphemisms derived from clinical experience and

discussion with colleagues in addition to the actual term heart failure. The doctors were also asked to add any additional terms that they were likely to use. This pilot study indicated that several terms were more commonly used than heart failure and the doctors suggested new ways of explaining the problem to the patient. On the basis of these results pilot study 2 presented the same vignette to 23 new doctors with 10 euphemisms. The eight most used euphemisms were used for the final questionnaire.

The final questionnaire used the same vignette as the pilot and asked the doctors to rate how likely they would be to use a series of terms to explain the problem to the patient using 5 point Likert scales ranging from 'not at all likely' (1) to 'very likely' (5). The final eight terms chosen were: Heart strain, Your heart is not pumping properly, Your heart is a bit weaker than it used to be, Your heart is not working efficiently, Your heart, which is a pump, is not working as well as it should, causing back pressure on the lungs, You have fluid on your lungs, as your heart is not pumping hard enough, Your heart is not strong enough, Your heart is not as strong as it used to be. The term 'heart failure' was also included.

At this point in the study, the draft of the new GP contract was published which made specific mention of the diagnosis and care of left ventricular dysfunction, but did not mention the term heart failure. To reflect this, the term left ventricular dysfunction was added to the list of terms. Doctors therefore rated a total of ten terms. An additional question was also asked about the likelihood of coding on the computer for heart failure. The doctors were also asked to give details of their age, gender and whether they were part or full-time.

All the GPs, (including principals, salaried doctors, assistants and registrars) in one Primary Care Trust (PCT) were sent questionnaires. The PCT is situated in north Essex, in the UK,

and comprises 11 practices serving largely rural, semi-rural, and market town populations (n=55). Completed questionnaires were received from 42 GPs (response rate=76%).

2.1 Results

The GPs' data were analysed in the following ways: to describe their profile characteristics, to describe their ratings of the different euphemisms compared to the term heart failure and to assess the difference between their use of the term 'heart failure' to the patient and the likelihood of them putting the term on the computer .

Profile characteristics of GPs

The profile characteristics of the GPs are shown in table 1. The majority of GPs were male, full time and aged between 40 and 60. This appears to be representative of GPs working in a rural and semi-rural area.

-insert table 1 about here -

GPs use of terms

The GPs ratings of the different terms are shown in table 2.

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The results showed that the most commonly used euphemism was "you have fluid on your lungs as your heart is not pumping hard enough", followed by "your heart is a bit weaker than it used to be" and "your heart is not pumping properly". The least popular term was "left ventricular dysfunction". Paired t-tests were used to assess whether the euphemisms were more or less likely to be used than the term heart failure. The GPs were significantly more likely to use the following euphemisms than the term heart failure ($p < 0.001$): You have fluid on your lungs as your heart is not pumping hard enough, Your heart is a bit weaker than it

used to be, Your heart is not pumping properly, Your heart is not working efficiently, Your heart, which is a pump, is not working as well as it should, causing back pressure on the lungs. The GPs were equally as likely to use the following euphemisms as the term heart failure ($p>0.05$): Your heart is not as strong as it used to be, Heart strain. Finally, the GPs were significantly more likely to tell the patient that she had heart failure than use the following euphemisms ($p<0.01$): Your heart is not strong enough, You have left ventricular dysfunction.

Telling the patient vs using the computer

The results showed that GPs are significantly more likely to use the term 'heart failure' for the computer than to the patient (CIs of the difference: -2.00/ -0.97, $p<0.001$).

3.0 Part 2: Impact of the the term 'heart failure' vs the favoured euphemism on the patients' beliefs about the illness

The second study aimed to explore the relative impact of the term 'heart failure' versus the doctors preferred euphemism identified in study 1 on patients' beliefs about the illness. An experimental design was used with two arms with patients rating their responses to a vignette containing either the term 'heart failure' or the GPs preferred euphemism 'fluid on your lungs as your heart is not pumping hard enough'. The ordering of the vignettes was randomised and the researchers distributed the questionnaires in strict randomised order with no prior knowledge of the patients.

Questionnaires were given to 550 consecutive patients aged over 16 visiting one practice in north Essex. The practice is situated in a small market town (population 2,200), with a total of 6,800 patients derived from the town and the surrounding rural area. Patients were

excluded if they suffered mental illness. A sample size calculation was made using data from a similar previously conducted experimental study based on responses to Likert scales (9) which indicated that 200 patients in each group would be sufficient to detect a significant shift in beliefs between the two conditions. Completed questionnaires were received from 447 patients (response rate=81.3%). The euphemism vignette was completed by 218 patients (48.8%) and the heart failure vignette was completed by 229 patients (51.2%).

Patients were asked to read the following vignette: ‘Imagine that you are 75 year old female patient who has been unwell for three months, who visits a doctor with symptoms of tiredness, weakness, shortage of breath and off her food’. The patients were then asked to rate a series of statements to describe how they would feel about being told that they had either ‘heart failure’ or “fluid on your lungs as your heart is not pumping hard enough”.

Patients’ responses to either the term ‘heart failure’ or the GPs’ preferred euphemism were assessed using questions derived from the Revised Illness Perception Questionnaire (IPQ-R, 18) on a 5 point likert scale ranging from ‘strongly disagree’ (1) to ‘strongly agree’ (5). This is a valid quantitative measure which describes how people make sense of an illness and is based on the components of illness representation described by the Self- Regulation Model (17). For this study 8 subscales were chosen reflecting patient beliefs about the illness in terms of the following core domains: patient understanding, timeline, consequences, personal control, treatment control, timeline cyclical and emotional representations. To simplify the questionnaire the number of items in each subscale were reduced to three based on published reliability data (18). In addition, the patients were asked to rate items reflecting trust in the doctor as this has been shown to be influenced by choice of term in previous research (9).

The data were analysed by summing the items into the eight subscales. The reliability of the subscales was assessed using Cronbach's alpha.

The subscales were as follows:

- i) Patients understanding: eg, "your illness is a mystery to you". (alpha = 0.58)
- ii) Consequences of the illness: eg. 'This illness would have major consequences on your life' (alpha= 0.57)
- iii) Cyclical time-line: eg. "Your symptoms will come and go in cycles' (alpha = 0.39).
- iv) Ability to personally control the illness: eg. 'Nothing you do will affect your illness' (alpha = 0.38).
- v) Treatment control: eg. "Your treatment can control your illness' (alpha = 0.78).
- vi) Timeline: eg. "Your illness is likely to be permanent rather than temporary' (alpha = 0.65).
- vii) The emotional impact of the illness: eg. "When you think about your illness, you will get upset", (alpha = 0.83).
- viii) Trust in the doctor: eg. "This diagnosis reassures you that the doctor is telling the truth", alpha = 0.80).

All but two of these subscales have acceptable reliability scores. The two subscales with the lowest scores were cyclical timeline and personal control which have only recently been added to the IPQ and it is possible that their low reliability reflects the needs for further psychometric work on this aspect of the scale.

Patients were also asked to describe their sex, age and how frequently they had visited their doctor in the past year.

3.1 Results

The patient data was analysed to describe their profile characteristics and to assess the relative impact of the term heart failure versus the GPs' preferred euphemism on patients' beliefs about the illness using independent t-tests. P values and confidence intervals are reported.

Patients' profile characteristics

Patients' profile characteristics are shown in table 3.

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The majority of patients were women, aged over 30 and had visited their doctor up to three times in the past year.

The impact of the term 'heart failure' versus the GPs' preferred euphemism on patients' beliefs about the illness.

Patient's beliefs about the illness are shown in table 4.

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The results showed that being told that the problem was "heart failure" resulted in the patient believing that the condition had significantly more serious consequences for their life, made them feel more anxious and depressed, that the problem would be more variable over time and that it would last for longer. However using the different terms had no significantly different effects on the patients' trust in the doctor, the likelihood that treatment could control the condition, their personal ability to affect the condition and their understanding of the condition.

4.0 Discussion and conclusion

4.1 Discussion

The present study aimed to explore whether how GPs use or avoid the term ‘heart failure’ in primary care consultations and if they avoid it, which are their preferred euphemisms. The results showed that GPs rate many euphemisms as more preferable than the term ‘heart failure’ and in particular, the majority preferred the phrase ‘you have fluid on your lungs as your heart is not pumping hard enough’. Previous research has suggested that GPs may avoid using the term ‘heart failure’ as they may consider it too emotive or may feel that it is ill defined (9,10,11). The present study provides empirical support for this suggestion. However, although the GPs were reluctant to use the term heart failure to the patient, they were likely to use it for coding the computer.

The present study also aimed to assess the relative impact of the term ‘heart failure’ versus the GPs preferred euphemism on patients’ beliefs about the illness. The results showed that the term heart failure made patients believe that the illness had more serious consequences, would be more variable over time and would last for longer than when the same symptoms were labelled using the euphemism. In addition, ‘heart failure’ made them more anxious and depressed. Previous research indicates that the choice of language to diagnose a problem may influence patients’ beliefs (9). The present study supports this and suggests that this is not only the case for lay and medical diagnoses but also for a commonly used euphemism. Furthermore, researchers have suggested that GPs may avoid using the term ‘heart failure’ for fear of upsetting the patient (10,11). The results from this study provide some evidence that this fear is well founded and that a euphemism may evoke a less emotive response.

However, there are some problems with the present study which need to be considered. First the experimental study was based upon a hypothetical vignette rather than a real consultation interaction. Although the case vignette is a frequently used tool in primary care research it is

possible that such vignettes elicit a different set of responses than a face to face interaction. In addition, the study aimed to isolate the impact of the use of one word versus one explanation from the interpersonal context of the consultation itself. The strengths of such an experimental approach are that all other components of the consultation can be kept constant so that the unique impact of the different form of language being used can be examined. However, this methodology also has its weaknesses in that language is a central part of these other components of the consultation and it could be argued that the isolation process in itself misses the complexity of the interaction between patient and doctor. Such a design does, however, enable an area of research which is sometimes seen as only open to observation and description to be explored both quantitatively and experimentally.

4.2 Conclusion

The present study illustrates that GPs avoid the term 'heart failure', perhaps for fear of upsetting the patient and prefer a euphemism. This fear may be justified as being told that the problem was 'heart failure' resulted in the patients believing that the illness was more serious and made them feel more upset than when a euphemism was used.

4.3 Practice implications

The current emphasis in primary care is one of shared decision making and openness (5-7). In addition, GPs are encouraged to consider the patient's experience (1,6). The results from this study suggest that these two goals may sometimes be contradictory. By using the term 'heart failure' the GP may be sharing their knowledge and expertise with the patient but at the same time creating anxiety and worry. In contrast, using a euphemism may be less open but more protective of the patient's experience. These results suggest a dilemma for doctors. If doctors wish to protect the patient's experience then the area of heart failure may be one

where openness is compromised for the sake of the patient and euphemisms should be used. If however, doctors prioritise openness than a more blunt approach using the harsh language of medicine may be necessary at the cost of the patient's experience. This latter approach may be particularly preferred, if patients' negative emotional response is deemed to be more realistic and predictive of compliance in the longer term. Some doctors may be consistent in the way in which they resolve this dilemma showing a preference for either openness or protecting the patient. The majority, however, may make the decision of openness over patient experience on the basis of each patient and each consultation. Factors which determine such choices are open to future similarly experimental research.

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Contributors: MT and JO designed the study, MT collected the data, JO and MT analysed the data and wrote the paper. MT will act as guarantor for the study.

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Table 1: GPs' profile characteristics

	N	%
Male	25	60%
Female	17	41%
Full-time	23	55%
Part-time	18	43%
<u>Age:</u>		
20-30	4	10%
31-40	10	25%
41-50	14	35%
51-60	12	30%
61+	0	
No age given	2	

Table 2 Rank and mean rating of each term when explaining problem to patient

<u>Rank</u>	<u>Condition described to patient as:</u>	N	Mean	Std.Deviation
1	You have fluid on your lungs as your heart is not pumping hard enough	42	3.71	0.92
2	Your heart is a bit weaker than it used to be	42	3.67	0.98
3	Your heart is not pumping properly	42	3.67	1.19
4	Your heart is not working efficiently	41	3.34	1.24
5	Your heart, which is a pump, is not working as well as it should, causing back pressure on the lungs	41	3.31	1.35
6	Your heart is not as strong as it used to be	42	2.27	1.2
7	Heart failure	41	2.56	1.42
8	Heart strain	41	2.15	1.24
9	Your heart is not strong enough	42	1.67	0.79
10	You have left ventricular dysfunction	42	1.17	0.37

Table 3: Patient profile characteristics

	Frequency	Percent.
Men	152	34.5
Women	285	63.8
<u>Age:</u>		
16-30 years	71	16
31-45 years	120	27.1
46-60 years	115	26
61-75 years	101	22.8
76-90 years	36	8.1
Not recorded	4	
<u>Annual visits to doctor:</u>		
0-3	218	50.1
4-7	132	30.3
8-10	30	6.9
More than 10	55	12.6
Not recorded	12	

Table 4: Patients' beliefs about illness

<u>VARIABLE</u>	<u>Told Euphemism</u>		<u>Told Heart failure</u>		t	p	<u>CI</u>	
	Mean	SD	Mean	SD			upper	lower
Patient's understanding	2.96	0.97	3.01	0.92	-4.76	0.63	-231	-0.37
Consequences of the illness *	3.07	0.78	3.44	0.89	-4.6	0.001	-0.53	-0.21
Emotional impact of the illness*	3.47	1.11	3.71	1.02	-2.33	0.02	-0.44	-0.03
Trust in the doctor	3.89	1.02	3.93	0.89	-0.51	0.6	-2.33	0.136
Ability to personally control the illness	2.99	0.8	3.06	0.83	-0.8	0.42	-0.22	0.09
Treatment control	3.17	1.02	3.26	0.8	-0.99	0.32	-0.27	0.09
Cyclical timeline*	2.79	0.91	3.04	0.82	-2.91	0.04	-0.42	-0.08
Timeline*	3.89	0.68	4.34	0.63	-6.9	0.001	-0.58	-0.32

(* significant difference between terms)