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Perspective

“Once you label me, you negate me”-Using words that heal, not words that hurt!



I am often reminded of Søren Kierkegaard's above mentioned quote when my residents and junior colleagues show me a patient saying, “he was admitted with heart failure”. I take them aside and tell them, “for heaven's sake please don't use the word FAILURE in front of the patient. Instead, please use innocuous alternatives such as CCF, LVF or HF!”

Sometimes I am told, “Sir, the heart is enlarged!” or that “he has a first degree av block”.

Added to this are our blunt (and sometimes wrong) prophecies of doom, like what was told to Vineet!

Vineet is a 38-year-old gentleman who visits me regularly for dilated cardiomyopathy. Vineet's ejection fraction (EF) was only 15% when he first came to me a year ago.

Since then, he and his wife regularly came for consultations. With medications and encouragement to gradually increase physical activity over the year, he became better and can now walk up one flight of stairs and walk a mile at moderate speed without difficulty.

But now, after about a year of treatment, at one such consultation, his wife wanted to ask two questions which had been bothering her since she had been first seeing me:

1. Will his ejection fraction have remained 15% or would it have improved now?
2. And more importantly, Can the family take him on a holiday, say, a hill station?

I said, of course, the EF must have improved by now, and yes, he can definitely go on a holiday with care about exerting himself, etc.

When I asked her why she was asking these questions now, she shocked me with her reply.

She said, “A year ago, our first consultant had said, ‘Your heart condition will not improve, there is no medicine to cure this and that he would always be confined to the house.’”

His repeat echo did show improvement in EF to 35%, and he did make the holiday trip.

There are two ways our words work like ‘swords’ on our patients' hearts and minds.

One is by scary words spoken within the hearing distance of our patients, mostly by our junior colleagues as mentioned previously. The second is the way we convey our diagnosis and prognosis to the patients as exemplified by Vineet's case.

But, both need not be or should not be, even if truthful, is my humble submission here.

Dr Normal Cousins says in ‘The Healing Heart’¹, “When a patient enters a hospital or a doctor's office, he suffers from two illnesses. The disease itself and the fear about it”. While we treat the first with our modern medical armamentarium, we may tend to aggravate the second with our words.

‘Failure’, ‘enlarged heart’, and ‘block’ are very scary and depressing labels for a patient to hear. Coming from a doctor, they are like gospel truths. Besides giving sleepless nights, they trigger his or her belief system, and what one intensely believes in manifests in reality because body's chemistry is known to work toward its manifestation. In other words, words have the power of being self-fulfilling prophecies. Belief becomes biology.

Fortunately, just as fear and depression impact the psycho–neuro–immunology axis adversely, hope, faith, and a sense of optimism impact it positively, and as Dr Bernie Siegel² says, “When a doctor can instill some measure of hope, the healing process sometimes starts even before the treatment begins!”

In a study, published in *Circulation: Cardiovascular Quality and Outcomes*,³ Huffman et al show that after acute coronary syndrome (ACS), a sense of optimism was prospectively and independently associated with superior physical activity and fewer cardiac readmissions. The study found that optimism, measured 2 weeks after ACS, was associated with greater number of mean steps per day at 6 months, after controlling for pre-ACS physical activity and numerous baseline demographic and medical factors, and independent of depression and anxiety, suggesting a unique effect of positive psychological well-being on post-ACS physical activity. To have such an independent effect in the days of optimal medical treatment is surprising and important. Thus, a sense of optimism may serve as a novel predictor of subsequent physical activity and fewer readmissions when measured shortly after an ACS.

Optimism is a general expectation that the future will be favorable. Believing that one's future (and future health) is likely to improve may play a substantial role in motivation and confidence to promote beneficial changes in health behavior and in improving health itself by independent pathways.

So, it would be important to note whether our own demeanor and communication as care givers increase or decrease this sense

Table 1

Table of suggested alternate vocabulary to be used in front of patients.

Words to avoid	Words to use
Heart is enlarged	There is cardiomegaly
Heart failure	HF, CCF, or LVF
Left or right bundle branch block	LBBB or RBBB
Complete heart block	CHB
First degree av block	Prolonged PR
Fall in BP	Hypotension
Falling urine output	Oliguria
Shock	Hypoperfusion
Coronary blocks or tight stenosis, t	Lesions
Low oxygen saturation	Hypoxia
Low/reduced LV function/low cardiac output/low EF	Hypokinesia or hypocontractility
Left main block	LMCA disease

of our patient's sense of optimism. Hence, the request is that we advise our residents and technical staff to avoid using such words with negative connotation in front of patients. If at all we have to use them, we can do it beyond the patient's hearing distance or else choose harmless alternatives in front of patients as mentioned in the alternative "vocabulary" Table.

With regard to conveying the diagnosis and prognosis to the patient himself or herself, neither the word "failure" need be used nor do we need to kill all glimmer of hope. Already HF patients are depressed a lot. Indeed, as many as 43% of patients with New York Heart Association functional class II or III symptoms are known to score high on the Beck Depression Inventory (BDI).⁴ (How much of that depression is due to the label 'failure' would be intriguing to know!). Anyway, as is well known, patients with heart failure who have moderate-to-severe depression are at a higher risk of mortality and rehospitalization.

On the brighter side, in a recent editorial⁵ titled "Time to Take the Failure Out of Heart Failure-The Importance of Optimism", John G.F. Cleland et al give a 3-year forecast of the clinical progress of heart failure patients based on available evidence with present line of treatment including sacubitril–valsartan, besides other technological advances such as cardiac resynchronization therapy (CRT)—clinical stability in about 55%, EF improvement in about 15% and death or deterioration in about 30%.

So, now when "hard evidence" goads us to be more optimistic, why keep it from our patients?

As physicians, we have to walk the tight rope between the patient's right to know on the one hand and possible psychological

harm created by full information; that is, between brutal honesty and benign deception.

But, even if we have to give a 'clear picture' to the patient and his/her relatives (for example, to 'prepare' them, to prevent future blame, or to ensure compliance with treatment), it can (now justifiably) be delivered with kinder words (such as 'reduced function' instead of 'failure') and a measure of hope, as the future is open and there is always something more that can be done (even if it is only to help ensure a peaceful passage!)

So, besides advising our juniors to use alternate 'vocabulary' in front of patients, maybe it is time we too change our terminologies, such as banishing 'failure' from 'heart failure'.

Maybe we should use the term 'Heart Dysfunction' instead of 'Heart Failure' and 'Heart Function Improvement Clinics' instead of 'Heart Failure Clinics'.

Let us give optimism a chance, because as Karl Menninger says,

"It is our duty as physicians to estimate probabilities and discipline expectations; but leading away from probabilities there are paths of possibility, towards which it is also our duty to hold aloft the light, and the name of that light is hope"

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