

Seven Dirty Words: Hot-Button Language That Undermines Interprofessional Education and Practice

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Abstract

An increasingly common goal of health professions education is preparing learners to collaborate with the full range of members on a health care team. While curriculum developers have identified many logistical and conceptual barriers to interprofessional education, one overlooked factor threatens to undermine interprofessional education and practice: language. Language reveals the mental metaphors governing thoughts and actions. The words that faculty members and health care providers use send messages that can—

consciously or not—undermine explicit lessons about valuing each member of the care team. Too often, word choices make visible hierarchies in health care that may contradict overt messages about collaboration.

In this Perspective, the author draws on his experience as an outsider coming to academic medicine, noticing that certain words triggered negative responses in colleagues from different professions. He reflects on some of the most charged (or hot-button) words commonly heard

in health care and educational settings and suggests possible alternatives that have similar denotations but that also have more collaborative connotations. By exploring seven of these dirty words, the author intends to raise awareness about the unintended effects of word choices. Changing exclusionary language may help promote the adoption of new metaphors for professional relationships that will more easily facilitate interprofessional collaboration and reinforce the formal messages about collaborative practice aimed at learners.

Researchers in health psychology have long recognized the power of language to shape how illness is perceived and treated. Advocacy groups, for example, recommend avoiding disease-based labels like “asthmatic” in favor of the more empowering “person with asthma.”¹ Such careful choice of words may not only minimize stigma but also have concrete effects on health. In a study of adults who had been treated for cancer, those who identified as a “survivor” displayed greater signs of well-being than those who identified as “victims.”² Language also provides a lens through which clinicians understand their roles. For instance, the nursing profession has become sensitized to the way in which language derived from military metaphors (such as “frontline” or “in the trenches”) can color the way nurses provide care.³

If the choice of words can affect both self-care and the delivery of care, how

might it influence the way students learn to collaborate? An increasingly common goal of health professions education is preparing learners to collaborate with the full range of members on a health care team. While curriculum developers have identified many logistical and conceptual barriers to interprofessional education, educators have long acknowledged that learners fashion their professional identities from much more than what is formally taught.⁴ Among other things, the language that faculty members and health care providers use sends messages that can—consciously or not—undermine their explicit lessons. As Lakoff and Johnson⁵ emphasize, referring to language as a metaphor does not diminish its concrete power. Language makes visible the conceptual system that governs our thoughts and actions. Talking about life as a journey does not reflect an objective reality; rather, it is a mental model for understanding that structures our perceptions, which, in turn, creates reality.

In health care, members of each profession carry a mental model of their role on the care team. At times, those models may come into conflict. An analysis of one academic health center showed that members of different professions held clear self-perceptions of their place in the team hierarchy

relative to other professions.⁶ The authors found that the power imbalance created by the differing opinions hindered interprofessional participation and impeded shared decision making. The same role divisions that participants spoke of in the interview transcripts of that study are encoded in everyday language that learners absorb from their professional role models. Too often, these word choices make visible hierarchies in health care that may contradict overt messages about collaboration. Which words reveal the potentially counterproductive metaphors health professionals live by? In this Perspective, I reflect on some of the most charged words commonly heard in health care settings and suggest possible alternatives that have similar denotations but that also have more collaborative connotations.

Outside Perspective

Since moving from an arts and sciences campus to work in health professions education seven years ago, I have had to learn a new set of professional metaphors. Outsiders are particularly well positioned to notice unspoken assumptions because they bring a different set of perceptions against which to contrast the prevailing model. People steeped in the predominant metaphors can rarely

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articulate the underlying conceptual system because it has become naturalized to them. Certain words that seemed innocuous to me would spark a strong reaction in my new colleagues, signaling the boundary of an unseen metaphor. For example, when I referred to an academic program as a student’s “training,” a faculty member quickly corrected me: “This is *education*, not training.” I was reminded of comedian George Carlin’s famous diatribe about the “seven dirty words” not allowed on the public airwaves. In one context words may have little punch, but in others they can be inflammatory.⁷

I have compiled my own, less profane, list of seven dirty words in the context of interprofessional collaboration. By shining a light on language that I have come to see as illustrative of certain governing metaphors in health care, I do not mean to encourage self-censorship or superficial political correctness but, rather, to raise awareness about the unintended effects of word choices. Many of these words endure because their agreed-upon meanings help convey information quickly. Eliminating them entirely may sow confusion if their replacements do not provide the same familiar shorthand. Still, words may also exclude, and the dirty words on my list draw attention to the unquestioned assumptions that can threaten team-based care. For each of the seven words, I will explain how their connotations can be problematic and thus can potentially undermine interprofessional education and practice. I also recommend cleaner alternatives (Table 1) that might signal to both learners and other team members a more inclusive approach to advancing health.

Seven Dirty Words

Allied

Traditionally, allied health has referred to all licensed health professionals except for physicians and dentists. Some definitions also exclude nurses and pharmacists. It serves as a convenient umbrella term for the long list of therapists, technologists, and other providers who collaborate to deliver care. The organization that represents the institutions educating these health workers is called the Association of Schools of Allied Health Professions, and its primary publication is the *Journal of Allied Health*.⁸

Table 1

Seven Dirty Words That Undermine Interprofessional Collaboration and Team-Based Care and Possible Cleaner Alternatives

Dirty word	Cleaner alternative
Allied	Health professionals
Clinical	Experiential placement
Doctor	Physician ^a
Interdisciplinary	Interprofessional ^b
Medical	Health ^c
My	Our
Patient	Participant

^aWhen referring to a medical doctor as an abstract role. For other doctorally prepared members of the care team, use the name of their profession (e.g., nurse).
^bJust where “interdisciplinary” is serving as a synonym for “interprofessional.”
^cWhere it is appropriate to do so (i.e., where the medical model is not the only approach involved).

The problem with this shorthand is that “allied” implies a peripheral position with medicine at the center. In 1987, for example, the American Medical Association defined allied health practitioners as personnel responsible for “assisting, facilitating, or complementing the work of physicians.”⁹ Physicians may occupy the top rank of the prestige hierarchy, but, depending on the situation, different members of the care team may take the lead in directing treatment. Moreover, it is inconsistent with the notion of interprofessional practice to have anyone other than the person being treated at the center of care. A better alternative is to say “health professionals” when referring to team members in the aggregate. This phrase indicates that, in the context of collaboration, each member of the team may contribute care autonomously from the others.

Clinical

In health professions education, we tend to divide learners’ academic experiences into two portions: didactic and clinical. Curricula typically start with classroom-based activities (the didactic portion) and then move to supervised encounters where students can apply their newly acquired knowledge, skills, and attitudes (the “clinical” portion). For medical and dental students, the “clinical” portion may occur in hospitals or specialty practices, but not all health professions prepare learners to practice in clinical settings. More than half of all speech-

language pathologists, for instance, are employed in schools.¹⁰ Nurses and occupational therapists also provide services in schools, as well as homes and community centers. Moreover, simulation is gaining acceptance as a substitute setting for hands-on training.¹¹

Calling this phase of learning “clinical” needlessly narrows the scope of practice and overlooks the growing emphasis on population health management, which seeks to address the social determinants of health that affect well-being in the community. Depending on the program, the “clinical” portion of preclicensure education may be called a “clerkship,” “rotation,” or “fieldwork.” However, an overarching term that retains broad applicability while still including nonclinical settings is “experiential placement.” This term also conveys the practical nature of the learning and the deliberate selection of a site for supervision.

Doctor

In 2014, the American Occupational Therapy Association endorsed the doctorate as one of two entry-level degrees for the profession by 2025.¹² This move aligns with the American Physical Therapy Association, which has voiced support for making the doctorate the entry-level degree for physical therapists,¹³ and the American Association of Colleges of Nursing, which has recommended that the doctor of nursing practice degree become the entry-level degree for advanced practice nurses.¹⁴ Thus, it is conceivable that a care team in a hospital setting could include multiple members with doctoral degrees even though only those with a doctorate of medicine would typically be addressed by the title “doctor.”

To most health care consumers, the title “doctor” with no additional clarifier refers to health professionals with MD or DO after their names. Although it may be more accurate and fair to acknowledge each person’s educational preparation, it might confuse patients to introduce multiple providers as “doctor.”¹⁵ The confusion could be compounded in English, where “Dr.” is a recognized title like “Mr.” or “Ms.” and is followed by a surname in a way that, say, “physical therapist” is not. In a further twist, male surgeons in the United Kingdom are addressed as “Mr.,” a legacy of a former distinction that marked them as

less qualified than university-educated physicians that has been repurposed as a marker of higher status.¹⁶

One solution is to follow the introduction of a doctor with an explanation of his/her role on the care team. A physical therapist, for example, could say: “Hello, I’m Dr. Jackson, your physical therapist. Dr. Gomez, your neurologist, asked me to see you.” When referring to an abstract role and not a specific person, it may be best to avoid “doctor” altogether because it no longer differentiates between colleagues. Instead, it is both clearer and more respectful to call team members by their specific profession. For medical doctors, “physician” distinguishes them from other doctorally prepared professionals. To refer to advanced practice nurses, say “nurse,” and so on.

Interdisciplinary

Despite the consistent use of “interprofessional” in journal titles and conference names, in conversation I still hear “interdisciplinary” used as a synonym. The terms are not interchangeable, and it is worth maintaining their separate meanings. For education to be “interprofessional,” more than one representative from different health professions must be learning “with, from and about each other to improve collaboration and quality of care.”¹⁷ “Interdisciplinary” activities may occur within a single profession. On an arts and sciences campus, for example, I participated in interdisciplinary groups with historians, philosophers, and sociologists. We approached a common question from different scholarly traditions, but we all came from the same profession of academic researchers.

The stakes are higher than the subtle distinction may suggest because “interdisciplinary” work may be used as a weaker substitute for “interprofessional” education.¹⁸ As long as scheduling and curricular alignment remain significant obstacles for interprofessional learning, it could be tempting to avoid substantive solutions by instead convening learners from different disciplines within the same profession (e.g., medical residents from a range of specialties or nursing students from more than one advanced practice track). “Interdisciplinary” does not need to be retired in all cases, just where it serves as a synonym for “interprofessional.”

Medical

Like “interdisciplinary,” “medical” is another word whose use has extended past its original meaning. Nursing faculty members first brought its misuse to my attention when we were discussing personal statements that applicants wrote for admission to a nursing program. Reviewers would cringe when reading about an applicant’s lifelong interest in pursuing a “medical” career because nursing follows its own holistic approach that separates it from medicine. The same imprecision characterizes the term “electronic medical record.” Not every professional who contributes to the record subscribes to the medical model.

At the same time that nurses defend their exclusion from the “medical” field, rehabilitation professionals have expressed to me little discomfort with their profession being referred to as “medical.” Indeed, the word “medical” has come to stand for the broader health care community, embracing even surgeons, who can also be said not to practice through strictly medicinal means. At least one journal—*Health Care Management Review*—defines “medical” care as diagnosis and treatment from licensed professionals, while “health” care connotes a broader goal.¹⁹ Where it is appropriate to do so, I believe “health” is worth using, as it is language that does not suggest the primacy of one approach (medical, holistic, etc.) over another.

My

When former Secretary of Labor Robert Reich visited companies, he would deploy the “pronoun test” to assess employees’ engagement.²⁰ If workers used first-person pronouns like “we” and “our” in talking about their organization, it indicated a sense of connection and mutual investment. By contrast, workers who spoke of “they” and “their” signaled distance from their employers. In health care settings, a similar test may reveal the level of commitment to interprofessionalism. When a provider refers to “my” patient, it conveys a personal investment, but it also potentially undermines the team’s collective responsibility to deliver person-centered care.

Although most health professionals would agree that health care is a team sport, I have heard some physicians assert

that because the patient’s bracelet in an acute setting carries their name, they bear ultimate responsibility. It would certainly be impractical to list every health professional involved in a patient’s treatment on a bracelet. However, using the first-person plural pronouns “we” and “our” conveys the message that while a single leader may coordinate care, the patient does not belong to any one provider. One study of physician–patient communication raises an important caveat: First-person plural statements with negative or ambiguous meaning (e.g., “Let’s see what we can do”) are not associated with higher satisfaction.²¹ The use of “we” and “our” must be accompanied with a sincere intent for shared responsibility.

Patient

In writing about the dirty words, I have had to strain in places to avoid using the hot-button words that I am aiming to defuse. The one provocative word that I have found inescapable, though, is “patient.” Interprofessional collaborative practice aims to put the patient at the center of care, yet “patient,” which derives from the root “to suffer,” implies passivity and forbearance. It also fails to encompass recipients of therapeutic services, who are often referred to as “clients,” or recipients of health care in residential shelters, who are known as “guests.” Some educators use the phrase “patients and clients,” which can be cumbersome to say multiple times.²²

The most straightforward replacement for “patient” is “person,” as in “person-centered care.” It places no judgment on the role of the person being treated and plainly conveys that anyone could be in that position. On the other hand, a focus on the individual excludes social networks like families and communities that support a person’s well-being. “Person” also lacks the specificity of “patient,” which could potentially lead to ambiguity. Some administrators favor terms from the hospitality industry like “customer” or “consumer,” though these introduce monetary associations that many providers find inappropriate in a caring relationship. After weighing different alternatives, health advocate Julia Neuberger²³ settled on “user” as the most apt description of someone actively seeking health care. Of course, “user” brings to mind unsavory connotations as well. One word that has few negative

overtone and conveys an active role in seeking health is “participant.” Its extra syllables make it unwieldy to pronounce, but it has the advantage of fitting the existing abbreviation for “patient.” Even so, the word “patient” is so ingrained in the health care vocabulary that gaining acceptance for “participant” is unlikely. A more effective course of action may be to shift the connotations of “patient” to promote the image of an engaged participant in health services.

A Vocabulary of Hierarchy

I did not set out to systematically collect sensitive language. As I became familiar with health professions education and practice, I learned which words of mine would trigger negative reactions or gentle corrections. These seven examples by no means exhaust the lexicon of hot-button words in health professions education and practice. Other terms that I have learned will rankle some health professionals include “orders,” “midlevel provider,” and “physician’s assistant” (as opposed to “physician assistant”). No doubt in this Perspective I have used other words that may have inadvertently pushed some readers’ buttons. Because we tend to naturalize the language and traditions that surround us, awareness of our mental models arises only when the self-conception is challenged. Therefore, even if I had attempted to conduct interviews with health professionals to elicit their dirty words, it might not have yielded a comprehensive list.

Many of the dirty words I identified emerge specifically from hospital-based care and reflect the hierarchies characteristic of the acute setting. With so many different professions in close proximity, language choices help separate both caregivers from care seekers and health professionals from one another.²⁴ This protective stance is not surprising when you consider how health professions emerged from 16th-century craft guilds, which worked to advance their members’ interests.²⁵ Of course, it is not just in health care that high-status workers deploy symbolic means such as language choice to shore up professional boundaries.²⁶ Still, the persistence of language derived from hospitals speaks to the paucity of metaphors from other health care settings that might suggest other ways of working together. Although changing a word does not by itself alter

interpersonal dynamics, by calling attention to unspoken assumptions and their underlying mental models, new words can create a space for explicit conversations about larger conflicts over values, power, and purpose.

For the informal curriculum to reinforce formal efforts in promoting interprofessional collaborative practice, we will need new metaphors. By looking to models from community-based care or other settings, we may be able to adopt different concepts about the relationships between health professionals and thereby generate new language for learners to hear and take in. By identifying some of the dirty words that undermine successful interprofessional education and practice, I do not anticipate an end to all hierarchies. Different health professions exercise different roles and responsibilities, and some are subordinate to others in certain contexts. Exclusionary language, however, impedes the smooth operation of health care teams, whose members all need to feel respected to perform their roles. As George Carlin (the man behind the original seven dirty words) acknowledged, choosing our words carefully has power: “[W]e do think in language. And so the quality of our thoughts and ideas can only be as good as the quality of our language.”²⁷ Replacing dirty words with cleaner ones may help promote the adoption of new metaphors for professional relationships that will more easily reinforce the formal messages about collaborative practice aimed at learners.

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