Editor's Briefing

LANGUAGE MATTERS

The English poet Elizabeth Jennings has captured, with lucid, lyrical precision, her experiences of illness, both as a surgical and a psychiatric patient.[1] In a series of eight poems called *Sequence in a Hospital* (1964), she evokes the isolation and terror that precedes surgery and, in *Night Sister*, describes the values of the healing art: *'You have a memory for everyone; None is anonymous and so you cure. What few with such compassion could endure.'* In the poem *A Mental Hospital Sitting Room* from the book *The Mind has Mountains* (1966), Jennings writes with aching honesty about depression and madness: *'It is as if a scream were opened wide, a mouth demanding everyone to listen.'*

Reading these poems can add immeasurably to an understanding of the experiences of adversity, fear, and loss, and of how they can be absorbed, accepted, and sometimes overcome. At the centre is the accurate and elegant use of language.

The accurate use of language is also at the very centre of the patient–clinician encounter, in which almost nothing can be taken for granted.[2] Medical 'talk' is often littered with jargon, strange military allusions, and pseudo-scientific archaisms. Safety netting to avoid missing unconsidered and unconfirmed diagnoses needs to be applied with equal energy to check for understanding and misunderstandings.

This in itself is quite a task: the chances of clarity of expression and comprehension leading to mutually satisfactory outcomes are greatly reduced when patient and doctor hold widely divergent ideas about the meanings of symptoms and the nature of illness, which more often than not is probably the case. These problems might look quite tractable when what is at issue is a prescription for an antibiotic or a new antihypertensive. The chances of a successful outcome are less good when, as you will see from some of the papers in this issue of the *BJGP*, the consultation includes topics such as common mental health disorders and the highly contested territories of persistent but 'medically' unexplained symptoms and maladaptive responses to commonplace adversities. Lacking a shared vocabulary and agreed meanings is a recipe for discord and often conflict. Patients can be left feeling short-changed and doctors puzzled and helpless. The doctor dutifully applies the biopsychosocial model and sees possible links to sadness, deprivation, and loss. The patient reports that the doctor said it was all in my mind. Neither is satisfied.

The very phrase 'medically unexplained symptoms' is now contested, the biopsychosocial model itself has had a mixed press in the last few years, and the traditional taxonomy of the common mental health disorders is being shaken up with new ideas about psychiatric comorbidity, susceptibility, and the 'p' factor.[3] Commenting on progress in dealing with unexplained physical symptoms a year ago, Malterud and Aamland asked:

'How can doctors respectfully show their patients that they understand their particular problems and offer specific advice? Moreover, how can such wisdom be elaborated, contested, and shared within scholarly standards for innovative research?.'[4]

Workload and bureaucratic pressures threaten the ability of the consultation to accommodate these essential, personal, considerations. RCGP Chair Professor Martin Marshall has described how, in today's workforce crisis, general practice consultations are in danger of moving from the personal to the merely transactional.[5] Depersonalising the clinical encounter, whether by the application of new technologies or by creating untested new roles in primary care, could turn out to be a false economy.

Roger Jones,
Editor

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