FROM THE EDITORS' DESK

Medicine, Politics, and the English Language

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In his 1946 essay, “Politics and the English Language,” George Orwell famously wrote that “...if thought corrupts language, language can also corrupt thought.” His argument for freeing speech of unnecessary jargon and abstraction was simple: “when you make a stupid remark, its stupidity will be obvious, even to yourself.” Orwell’s indictment of vague or inchoate speech—and its effects on public policy—remains a classic of political criticism. Yet obfuscation often seems irresistible.

Two days before this column was complete, the House of Representatives passed its version of the American Health Care Act by a vote of 217–213. The facts seem clear enough. The bill cuts taxes by \$600 billion, with benefits accruing almost exclusively to wealthy individuals, corporations, and insurance companies. It slashes Medicaid, reduces health insurance subsidies for people with modest incomes, weakens protections for individuals with pre-existing conditions, and leaves lifetime out-of-pocket expense limits to the discretion of the states. Yet President Trump claimed that “this plan will be every bit as good for pre-existing conditions as Obamacare” (Bloomberg.com, May 1, 2017), Paul Ryan deftly replaced the ideal of “universal coverage” with the far more modest goal of “universal access” (NY Times, December 15, 2016), and presidential advisor Kelly Anne Conway insisted that “no one will lose coverage” under the Republican plan (CNBC, January 3, 2017). Meanwhile, a week before the House vote, the AARP projected that “if states return to pre-ACA high-risk pools in 2019, as proposed, high-risk pool premiums for people with preexisting conditions could be as high as \$25,700 annually” (<http://blog.aarp.org/2017/04/27/state-high-risk-pools-failed-consumers-in-the-past-and-theyd-fail-them-again/>).

Unfortunately, health professionals are just as vulnerable to distortions in thought and expression as are politicians and pundits.

In this issue of JGIM, two articles highlight areas of genuine confusion. In the first, Lee et al. describe a

clever demonstration in which patients with limited English proficiency (LEP) were informed about an upcoming invasive procedure using dual-handset telephone-delivered interpreter services.¹ The demonstration was successful, boosting the odds that LEP patients would achieve “adequately informed consent” by a factor of 2.56. However, the underlying premise—that so-called “informed consent” is either informed or involves true consent—is deeply flawed. Substantial empirical data suggest that patients’ recall of key facts on consent forms is poor² and that the reading difficulty levels of consent forms frequently exceed the capacity of patients to understand them.³ In some situations, patients signing consent forms do not even know that refusal of treatment is an option.⁴ In addition, being informed means imagining possible outcomes of alternative decisions. However, humans are reliably terrible at projecting how they will feel in the future. Therefore, informed consent may simply be beyond the capacity of real people facing real-life decisions.^{5,6} In this sense “informed consent” satisfies legal requirements and assuages moral anxiety at the cost of blurring what is actually happening.

Also in this issue, Alexandraki et al. survey internal medicine clerkship directors about their views of and experience with “interprofessional education.”⁷ Interprofessional education is now a mandated part of the medical school curriculum. The motivation is admirable. Modern healthcare is complex. In the midst of complexity, collaboration among and between disciplines is essential for high-fidelity care. In theory, such collaborations might proceed more seamlessly were individuals educated about the capabilities of other disciplines and trained to interact effectively in time-sensitive situations. In practice, we know very little about the knowledge, skills, and attitudes needed to create high-performing healthcare teams, let alone how to structure curricula that prepare students and trainees as effective team members. Given that we cannot even define what we are talking about, the chorus of support for interprofessional education may reflect sensibilities around interprofessional power dynamics and identity politics more than any solid evidence for the benefits of this approach.

Orwell’s 1946 essay is a clarion call not only for directness of expression but also for full and open admission of ignorance. Medicine is not politics, but we still need to pay attention to the English language.

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