Drawing on your experience of the language doctors use in their day-to-day practice and teaching, reflect on the ways it can promote or impede feelings of inclusivity and belonging in patients and students.

Riya Gosrani

Word Count: 997

My interest in the role of language in medical settings stemmed from a conversation that I had with a psychiatrist several years ago, after he described working with homeless-ed populations in London[1]. Notably, he engaged in a technique of converting the commonly used adjective *homeless* into the verb *homeless-ed*. He explained that this denominal method was purposefully employed to enable a consideration of the wider structural factors and social forces implicated in homeless-ed patients' lived experiences of suffering. This revelation into the power of language was striking because the addition of only two letters to a word was shown to profoundly affect modes of thinking. When a person is described as homeless, this appears as a static, indisputable fact, because the processes involved in constituting this identity are not mentioned. After proactively engaging in using the verb homeless-ed when conversing with other medical professionals, I noticed that new ways of discussing the patient arose. This fostered greater scope to consider broader factors needing to be addressed both within and beyond the clinic, which placed less blame on the individual. In fact, I identified a noticeable shift in ensuing conversations to that of a more compassionate nature when using the verb to discuss this patient cohort. In addition to diminishing harmful stereotypes, these dialogues positively impacted management plans and future interactions with homeless-ed individuals.

This experience laid the foundations from which I began to understand the significance of language used by doctors. I have resultantly adopted a reflexive impetus in clinical settings, in which I sometimes experimentally change nouns or adjectives to verbs. In doing so, I aim to not only envision but also foster more

[1] https://falling-walls.com/people/sushrut-jadhav/

equitable healthcare practices. Whilst this might sound like an arduous process, the vast potential of this approach lies in generating new ways of thinking that were previously unimaginable. Before providing a personal anecdote of how language can be reworked to promote feelings of inclusivity and belonging, I would like to discern what might impede these processes in current-day practice. I already suggested that adjectives or nouns are static in comparison to verbs because medical practitioners can use them without considering the actions involved in sustaining them. I would like to build upon this notion by directing attention to the following part of this essay's question prompt: *the language doctors use in their day-to-day practice and teaching*. I am suggesting that the repetitive, daily use of certain terms in medical spaces means that doctors are unaware of the harm caused. Akin to the static nature of certain words, I am not pointing this out to condone ignorance or passivity to the mechanisms through which language can impede patient care. Instead, this is to acknowledge that certain linguistic processes perpetuating harm might be hard to intuitively recognise and therefore dismantle.

This leads me onto the second reflective case, which occurred when I attended a ward round as a student on my psychiatry rotation in a London hospital. Notably, this interaction occurred several years after my first seminal experience regarding the importance of language use in the clinic discussed earlier. On this occasion, the consultant psychiatrist was introducing the patients on the ward round list to myself and a fellow medical student. He explained that we were about to meet a homeless black woman with schizophrenia, who had been recently admitted. I noticed that the psychiatrist was almost inevitably describing her tendencies towards drug abuse. It was through this seamless integration that he even went on to claim that the patient was equivalent to a textbook example. He then began to ask members of the multidisciplinary team questions about the condition, extending this to the risk factors for psychosis. After we ran out of ideas, he explained that race (specifically the black race) was a risk factor to be aware of. I precisely remember that it was at this moment when I started to question his assertion. Perhaps such a reflection arose because his previous comment meant that I was already wondering

whether the psychiatrist would have spoken in a more compassionate manner about the patient's substance misuse if dominant modes of conversing involved using the term homeless-ed, or the phrase 'being homeless' instead of homeless.

In fact, the psychiatrist's linguistic use of the term race engages in a practice which views race as a static risk factor for disease by way of genetic differences (Lewontin, 1972). This has increasingly been recognised as erroneous because it does not allow one to consider the processes involved in sustaining race. For example, the described patient was born to a black father and a white mother. The psychiatrist did not encompass this fact, because he instinctively placed the patient into the black category. This is significant when one considers his subsequent statement in which race itself was used to explain disease burdens in schizophrenia. The assertion that "racial differences exist because of race is a tautology" (Goodman, 2016: 75). The argument is invalid because the statement is constructed in such a way that the proposition is logically indisputable, so that the same idea is reinforced. In an attempt to overcome how practitioners might be blind-sided to these broader structures within the confines of the language being used, I initiated the denominal shift from *race* to the verb *racialis-ed* or the phrase 'doing race'. This increases awareness of the processes through which racial groups are formed and sustained. In doing so, this may shed light on the factors which are being overlooked when clinicians talk about race as a fixed variable. As such, one might consider how racism (rather than race) predisposes individuals to adverse environmental conditions. These circumstances might have increased the patient's likelihood of substance abuse and subsequent psychosis.

In conclusion, I am recommending that clinicians and medical students adopt a reflexive impetus in relation to the day-to-day language used in the medical arena. My reflections have elucidated that even seemingly small changes to language can hold vast potential for promoting inclusivity and belonging.

References

Goodman, A.H. (2016) Chapter 4 Disease and dying while black: how racism, not race, gets under the skin. In: Zuckerman, M.K. and Martin, D.L. New Directions in biocultural anthropology. Hoboken, NJ: John Wiley & Sons, pp. 69-87.

Lewontin, R.C. (1972) 'The apportionment of human diversity', *Evolutionary Biology*, 6, pp. 381–398. doi:10.1007/978-1-4684-9063-3_14.