PERSPECTIVE

The New Language of Medicine
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D uring our first year of medical school, we spent countless hours learning new words, memorizing vocabulary as if we were studying a foreign language. We discovered that some words that sounded foreign actually represented the familiar: rubeola was measles, pruritus meant itching.

Now, we find ourselves learning a new language of medicine filled with words that seem familiar yet feel foreign. Patients are no longer patients, but rather “customers” or “consumers.” Doctors and nurses have been transmuted into “providers.” Each medical professional — doctor, nurse, and patient must therefore be replaced with terminology that fits this new order.

The words we use to explain our roles are powerful. They set expectations and shape behavior. This change in the language of medicine has important and deleterious consequences. The relationships between doctors, nurses, or any other medical professionals and the patients they care for are now cast primarily in terms of a commercial transaction. The consumer or customer is the buyer, and the provider is the vendor or seller. To be sure, there is a financial aspect to clinical care. But that is only a small part of a much larger whole, and to people who are sick, it’s the least important part. The words “consumer” and “provider” are reductionist; they ignore the essential psychological, spiritual, and humanistic dimensions of the relationship — the aspects that traditionally made medicine a “calling,” in which altruism overshadowed personal gain. Furthermore, the term “provider” is deliberately and strikingly generic, designating no specific role or type or level of expertise.

What precipitated the increasing usage of this new vocabulary in medicine? We are in the midst of an economic crisis, and efforts to reform the health care system have centered on controlling spiraling costs. To that end, many economists and policy planners have proposed that patient care should be industrialized and standardized. Hospitals and clinics should run like modern factories, and archaic terms such as doctor, nurse, and patient must therefore be replaced with terminology that fits this new order.


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er, the generic term “provider” suggests that doctors and nurses and all other medical professionals are interchangeable. “Provider” also signals that care is fundamentally a prepackaged commodity on a shelf that is “provided” to the “consumer,” rather than something personalized and dynamic, crafted by skilled professionals and tailored to the individual patient.

Business is geared toward the bottom line: making money. A customer or consumer is guided by “caveat emptor” — “let the buyer beware” — an adversarial injunction and hardly a sentiment that fosters the atmosphere of trust so central to the relationship between doctor or nurse and patient. Reducing medicine to economics makes a mockery of the bond between the healer and the sick. For centuries, doctors who were mercenary were publicly and appropriately castigated, the subjects of caustic characterization in plays by Moliere and stories by Turgenev. Such doctors betrayed their calling. Should we now be celebrating the doctor whose practice, like a successful business, maximizes profits from “customers”?

Beyond introducing new words, the movement toward industrializing and standardizing all of medicine (rather than just safety and emergency protocols) has caused certain terms that were critical to our medical education to all but disappear. “Clinical judgment,” for instance, is a phrase that has fallen into disuse, replaced by “evidence-based practice,” the practice of medicine based on scientific data. But evidence is not new; throughout our medical education beginning more than three decades ago, we regularly examined the scientific evidence for our clinical practices. On rounds or in clinical conferences, doctors debated the design and results of numerous research studies. But the exercise of clinical judgment, which permitted assessment of those data and the application of study results to an individual patient, was seen as the acme of professional practice. Now some prominent health policy planners and even physicians contend that clinical care should essentially be a matter of following operating manuals containing preset guidelines, like factory blueprints, written by experts. These guidelines for care are touted as strictly scientific and objective. In contrast, clinical judgment is cast as subjective, unreliable, and unscientific. But there is a fundamental fallacy in this conception. Whereas data per se may be objective, their application to clinical care by the experts who formulate guidelines is not. This truth, that evidence-based practice codified in clinical guidelines has an inescapable subjective core, is highlighted by the fact that working with the same scientific data, different groups of experts write different guidelines for conditions as common as hypertension and elevated cholesterol levels or for the use of screening tests for prostate and breast cancers. The specified cutoffs for treatment or no treatment, testing or no testing, the weighing of risk versus benefit — all necessarily reflect the values and preferences of the experts who write the recommendations. And these values and preferences are subjective, not scientific.

What impact will this new vocabulary have on the next generation of doctors and nurses? Recasting their roles as those of providers who merely implement prefabricated practices diminishes their professionalism. Reconfiguring medicine in economic and industrial terms is unlikely to attract creative and independent thinkers with not only expertise in science and biology but also an authentic focus on humanism and caring.

When we ourselves are ill, we want someone to care about us as people, not as paying customers, and to individualize our treatment according to our values. Despite the lip service paid to “patient-centered care” by the forces promulgating the new language of medicine, their discourse shifts the focus from the good of the individual to the exigencies of the system and its costs. Marketplace and industrial terms may be useful to economists, but this vocabulary should not redefine our profession. “Customer,” “consumer,” and “provider” are words that do not belong in teaching rounds and the clinic. We believe doctors, nurses, and others engaged in care should eschew the use of such terms that demean patient and professional alike and dangerously neglect the essence of medicine.

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