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Dennis J. Baumgardner

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## The Weight of a Word

Dennis J. Baumgardner, MD | Editor-in-Chief

Department of Family Medicine, Aurora UW Medical Group, Advocate Aurora Health, Milwaukee, WI

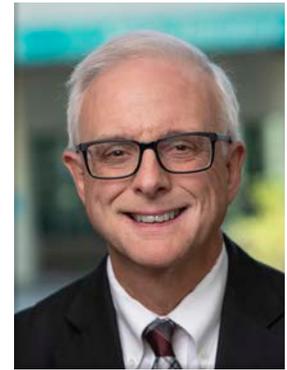
If, as Shakespeare wrote, “that which we call a rose; by any other name would smell as sweet,” then how much weight can we place on a single word? In asking the question “What’s in a word?” author Jennifer Henderson posited that words are labels yet are also “microcosms of language [with] their own histories, characteristics, and associations.”<sup>1</sup> When I read new manuscript submissions to the *Journal of Patient-Centered Research and Reviews (JPCRR)*, oftentimes one particular word will emerge as fundamental to the work’s potential impact.

For instance, on p. 248, Pham and colleagues explore the extensive use of non-patient-centered language in the medical literature involving patients with heart failure.<sup>2</sup> Reading their article, the word “stigma” jumped out at me. In brief, the authors contend that the stigma of heart failure and its frequent precursors can negatively impact quality of care for these patients. Moreover, they are concerned that this stigma leads to labeling patients by their diagnosis.<sup>2</sup> In all honesty, how often have we physicians depersonalized our patients by referring to them as “the CHF in 408,” or worse, suggesting that the new liver failure admission must have drank too much? Stigma has no place in patient-centered health care, nor does its perpetuation when reporting study results, and these findings certainly should give prospective authors pause.

So in this spirit of acknowledging the power of parlance, let’s examine which singular words stand out in the other 9 articles published within Volume 8, Issue 3 of *JPCRR*.

Starting with an easy one, “loneliness” is the one word that best represents the research by Oser et al.<sup>3</sup> In a cross-sectional study of adult outpatients at a Pennsylvania-based family medicine clinic, the investigators failed to find an association between loneliness and body mass index or health care utilization overall, but did show that women with greater body mass index exhibited

higher loneliness scores.<sup>3</sup> Based on the definition of loneliness posited by Heinrich and Gullone<sup>4</sup> — distressing emotion resulting from the (real or perceived) absence of expected meaningful interpersonal relationships — loneliness was measured using a 3-item scale that included lack of companionship, feeling left out, and feeling isolation from others. A previous report published in *JPCRR* on homebound older adults suggested that loneliness is more than, or at least different from, social isolation.<sup>5</sup> Precise definitions affect not only one’s perception of a word but the work itself. How do *you* define loneliness?



“Off” appears in all caps in the title of the article analyzing survey results from a cohort of persons with self-reported Parkinson’s disease (PD) ... and for good reason.<sup>6</sup> These researchers studied the OFF periods during which PD medications wear off in unpredictable, sometimes abrupt fashion, leading to the return of disabling PD symptoms. These periods were common, involved both motor and nonmotor symptoms, and were most frequently triggered by stress or anxiety/depression.<sup>6</sup> As the global population has gotten older, PD has gone from uncommon to endemic<sup>7</sup> and places substantial strain on family caregivers.<sup>8</sup> Having witnessed firsthand the fluctuations of PD in a dear family member, I am internally prompted to think twice before saying I “feel off” today because of some minor discomfort.

One’s eyes can’t help but be drawn to the word “burning” in the review article in which Giacomazzi et al describe the etiology, pathophysiology, and clinical features of burning eye syndrome, likely a discrete combination of dry eye syndrome and chronic neuropathic pain.<sup>9</sup> Similarly, there is burning mouth syndrome, a neuropathic pain entity that is similarly difficult to diagnose and treat.<sup>10</sup> The clinical challenge is identifying the patients who have these entities among the many who present with eye or mouth pain syndromes. Clues may be seemingly disproportional

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Corresponding author: Dennis J. Baumgardner, MD, Aurora Sinai Medical Center, 1020 N. 12th St., #4180, Milwaukee, WI 53233 (dennis.baumgardner@aah.org)

symptoms, a neuropathic-like burning quality, chronicity, and recalcitrance to traditional therapy.<sup>9,10</sup> I have heard from more than a few clinicians who felt “burned” by missing certain diagnoses.

“Predictor” is a standout word from the medical education offering in which Kenaga et al explored whether resident physician performance on the Objective Structured Clinical Examination predicted year-end scores for “Systems Based Practice,” an Accreditation Council for Graduate Medical Education (ACGME) Core Competency.<sup>11</sup> While there may be growing comfort with the utility of ACGME Milestones, questions have been raised regarding their use as predictors of physician competence and the use of other test measures as predictors of performance.<sup>12</sup> As an oft-quoted proverb so eloquently put it, “It’s difficult to make predictions, especially about the future.”

Continuing in the medical education realm, Atzenhoefer and colleagues investigated whether or not distribution of business cards of medical trainees improved feedback on standardized hospital patient surveys.<sup>13</sup> “Feedback,” the operative word here, is something we all profess to want to get, but not really. Such ambivalence is found in medical residents as well,<sup>14</sup> and multiple personal and interpersonal cultural issues contribute to it.<sup>15</sup>

Feeling “uncomfortable” was a key finding from the survey on primary care providers’ willingness to prescribe advanced diabetic technologies, presented by O’Donovan et al.<sup>16</sup> I would submit that getting comfortable with the uncomfortable is a nonnegotiable skill for any clinician claiming to practice contemporary, evidence-based medicine. Overcoming discomfort requires willingness to unlearn old practices and embrace new ones (along with a willingness to struggle to do so),<sup>17</sup> a delicate blend of humility and self-confidence. While there is some literature regarding clinician perception of comfort with their own medical care,<sup>18</sup> personal examination of our comfort with provision of medical advancements may be inadequately studied.

Though easy to look past, it would be a mistake to gloss over the first word in the title of the topic synopsis by Dutta and Zuiderveld — “incidental.”<sup>19</sup> Uncertainty often surrounds the management of an incidental finding during diagnostic workup of another concern.<sup>20</sup> Fortunately, *JPCRR*’s brief review and illustrative case of anomalous pulmonary venous return provides specific management information.<sup>19</sup>

Lust and colleagues ask whether exercise can “prevent” gestational diabetes.<sup>21</sup> Prevention is certainly a concept

that has crept to the front of everyone’s mind during the COVID-19 pandemic, yet preventive medicine is hardly limited to handwashing and social distancing. Reducing any patient’s risk of diabetes mellitus is critical, but particularly so in pregnancy. The authors concluded that regular exercise can reduce this risk, especially when the activity is something the patient enjoys, and should be a consistent educational topic in prenatal care.<sup>21</sup>

Finally, this issue features a brief report containing evidence on the quality of noninfection-related health care administered during the pandemic, specifically maternal and neonatal outcomes.<sup>22</sup> By now, one thing we can all agree on is that “COVID” needs no introduction.

I hope you enjoyed reading this brief tour of issue contents and took note of a few enlightening words in the process. Incidentally, I predict the stigma of loneliness can be prevented if you refrain from submitting uncomfortable feedback and instead quietly go off and burn this commentary. Oh, and of course, try to avoid COVID.

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