SOUNDING BOARD

Two Easy, Essential Proscriptions in the COVID–19 Era: Locking Down Clarity and Respect

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(1) the term “elderly”
(2) the use of any form of “manage” applied to patients
(3) the empty crib in my home office

I can’t do anything (for who knows how long) about that third item; for most of this past year, I delightfully babysat my great-nephew up to 5 days/week—until mid-March, when the impact of the coronavirus disease 2019 (COVID–19) pandemic hit home here in Minnesota. With their workplaces upended, my niece and her husband began sheltering in place with their son, practicing physical distancing for the safety of all of us.

But I CAN try to do something about those first 2 items, which I touched on years ago in my dissertation-turned-book1 and in several previous AMWA Journal articles.2,3 Those 2 bugbears remain persistent and are particularly damaging in this daunting new world of isolation and unrest. So I renew my recommendation to all medical communicators to help further the use of precise and empathetic language by (1) banning the term “elderly” in our own work and by (2) never applying any form of “manage” to patients. Let’s lock down clarity and respect, rather than allow wording that enshrines looking down on certain groups.

This winter, when public-health and government officials started warning that the “elderly” constituted an especially at-risk subgroup for the direst effects of COVID–19, I had no idea what age range they were purportedly pinpointing—certainly not MINE. Nor did my fellow 60-something friends. We were astonished when someone clarified what was now usually meant: people 60 and older, with or without serious comorbidities. To us, “elderly” conjured our parents’ cohort of octogenarians, nonagenarians, and centenarians.

I always advised the surgeon-authors of manuscripts I edited during my long (and much-missed) career to simply and objectively specify the age range, rather than deploy the amorphous, too often pejorative term “elderly.” It takes just a few more characters—and a lot more character, in my view—to instead write “patients ≥65” or “people ≥80” or whatever the cutoff is within a given context. To illustrate with just 1 now-jarring example of the ever-shifting age range of this vague term, “elderly primigravida” was common as recently as a few decades ago for first-time mothers ≥35!

Tolerating labels like “elderly” sets the stage for mockery and devaluation of an entire set of diverse humans on the sole basis of a fuzzily defined age bracket. I was appalled to read in a recent New Yorker about a standup comic blithely mentioning, as reported by the author of that article, “a certain demographic whose members were struggling to navigate Zoom”4; the comic followed up her condescending, ageist stereotype about techie prowess with this superficially pitying, decidedly unfunny quip: “I was trying to say boomers, but I couldn’t bring myself to say it. … I feel bad making fun of them, given the coronavirus. They’re having a tough time.”4

(I would never contemptuously counter with “okAY, millennial,” knowing how multifarious every artificially demarcated age group is, knowing how cruel it is to taunt slow or late learners of any generation with regard to any subject.

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matter, knowing how little we as a society can afford any pretense for more divisiveness.)

In a field like medicine that’s supposed to be all about caring, I similarly find it imprecise and disrespectful to posit patients as inanimate things or unruly kids or hapless subordinates to be managed by the powers-that-be. Manage patients’ care, yes; their symptoms, of course; their treatment plan, by all means—but don’t manage patients themselves. I object to the objectification inherent in phrases like these: “the way we isolate, treat, and manage patients” and “the way we manage patients, hospitals, and populations.” Those phrases, in the same New Yorker issue cited above, were penned by a physician whose acclaimed books I deeply respect, Siddhartha Mukherjee, and who I know deeply respects patients. Then why not write instead “the way we isolate, treat, and care for patients” and “the way we care for patients, run hospitals, and advise populations”? Those rewrites not only are clearer but also make it clear that most caregivers in the health arena truly do live up to that title, skillfully giving top-drawer care and not superciliously imposing top-down management.

In conclusion, these 2 changes in diction (again, scrapping the term “elderly” and never slapping “manage” onto patients themselves) are simple to make—and profoundly important. When vulnerable populations don’t realize that “elderly” encompasses them, its use is downright dangerous; when coronavirus patients are subsumed under a corporate buzzword like “manage,” their already-eroding dignity becomes even more marginalized. Specific, compassionate public-health communication is crucial as we continue to grapple with the new threat of the pandemic and the old threat of ageism and other forms of inhumanity.

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Introduction to New Members Matters Section Editor: Govindi (Jaya) Samaranayake, PhD

I joined AMWA in 2018 and have not looked back since! As an officer for the AMWA Florida Chapter, I have always enjoyed interacting with the AMWA membership at both the local and national levels. I now look forward to serving as editor for the Members Matters section to give back to this wonderful community of medical communicators who have been so critical in shaping my medical writing career. My sincere thanks goes to my friend and colleague Melory Johnson, VN—the previous section editor and, more importantly, the founder of this section—for her fabulous work in getting this section up off the ground and running. If you have a topic being discussed at a local level within your chapter that you would like to share on a national platform in this section, please reach out to me at gjayanikasa@gmail.com.

A brief background on my professional journey: I completed my Master’s degree in cancer immunology in the United Kingdom and obtained my PhD in cancer biology at the University of Miami, Florida. I presently work as a regulatory medical writer at Trilogy Writing & Consulting in Durham, North Carolina. My therapeutic areas of expertise, garnered over my many years as a bench scientist, are in oncology, immunology, epigenetics, and ocular diseases.