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What Does the Word “Treatable” Mean? Implications for Communication and Decision-Making in Critical Illness

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Abstract

Objectives: To explore how nonphysicians and physicians interpret the word “treatable” in the context of critical illness.

Design: Qualitative study using in-depth interviews.

Setting: One academic medical center.

Subjects: Twenty-four nonphysicians (patients and community members) purposively sampled for variation in demographic characteristics and 24 physicians (attending physicians and trainees) purposively sampled from four specialties (critical care, palliative care, oncology, and surgery).

Interventions: None.

Measurements and Main Results: We identified two distinct concepts that participants used to interpret the word “treatable”: 1) a “good news” concept, in which the word “treatable” conveys a positive message about a patient’s future, thereby inspiring hope and encouraging further treatment and 2) an “action-oriented” concept, in which the word “treatable” conveys that physicians have an action or intervention available, but does not necessarily imply an improved prognosis or quality of life. The overwhelming majority of nonphysicians adopted the “good news” concept, whereas physicians almost exclusively adopted the “action-oriented” concept. For some nonphysicians, the word “treatable” conveyed a positive message about prognosis and/or further treatment, even when this contradicted previously stated negative information.

Conclusions: Physician use of the word “treatable” may lead patients or surrogates to derive unwarranted good news and false encouragement to pursue treatment, even when physicians have explicitly stated information to the contrary. Further work is needed to determine the extent to which the word “treatable” and its cognates contribute to widespread decision-making and communication challenges in critical care, including discordance about prognosis, misconceptions that palliative treatments are curative, and disputes about potentially inappropriate or futile treatment.

Keywords

critical care; end-of-life care; health communication; medical futility; palliative treatment; shared decision-making

A recent research agenda for communication with seriously ill patients calls for further research on “the impact of specific clinician words and expressions” (1). A small amount of nonempirical literature identifies problematic words and phrases used in critical care (e.g., “no escalation of treatment,” “there is nothing more we can do,” “do everything”) (2–8). These are described as “confusing” or conveying “unintended negative messages” (2). However, there is still a dearth of empirical literature examining the impact of specific clinician words and expressions.

One example of potentially problematic language is the word “treatable.” Over 12,000 articles on PubMed contain the word “treatable” in their title or abstract (9), illustrating the wide professional use of this word. In our combined clinical experience caring for and providing ethics consultations to critically ill patients and their family members at several institutions, physicians use the word “treatable” in key discussions with patients and their surrogates.

Based on this experience, we hypothesize that physicians understand the word “treatable” differently than patients/surrogates do. These differences in understanding may contribute to miscommunication about prognosis, quality of life, and treatment options. Additionally, disputes about potentially inappropriate or futile treatments, which are common in critical illness, hinge on whether a patient or condition is “treatable” or not. Therefore, a deeper understanding of the word “treatable” may improve communication among physicians, patients, and surrogates, thereby improving the quality of decision-making and reducing conflict in critical care.

METHODS

We designed a qualitative study to explore how nonphysicians and physicians interpret the word “treatable.” In accordance with a symbolic interactionist model for qualitative communication research (10–12), we began with the assumption that individuals interpret words based on social context. We focused on the context of physician conversations with critically ill patients and their surrogates. We formed a research team to allow for triangulation in data collection and interpretation (13, 14) and took a flexible approach to analysis (see below description) in which multiple methods are used to characterize results

as they emerge (14, 15). Our study was approved by the Stanford University Institutional Review Board.

Sampling, Recruitment, and Demographics

We used stratified purposive sampling (16) to ensure that participants were diverse in ways that might impact their interpretation of the word “treatable.”

Nonphysicians.—We recruited 24 individuals from a research registry, excluding anyone who had earned an MD degree or practiced as a physician. The registry, located in an academic medical center’s department of medicine, recruits patients and community members from outpatient clinics and research studies from across the department of medicine. Because it includes individuals with varying degrees of health and experience with critical illness, we used the registry to explore the perspective of individuals who have been or may become critically ill patients/surrogates. We purposively sampled to achieve variation in age, sex, race, ethnicity, income level, and educational attainment.

Physicians.—We recruited 24 physicians, purposively sampling from four services (critical care, oncology, palliative care, and surgery) and a range of training levels and years of experience at a single academic medical center. These services were selected because each frequently functions as the primary team or a consulting team on challenging ICU cases. Further, they included physicians with both medical and surgical training.

Interviews

We conducted in-depth interviews to elicit participants’ interpretation(s) of the word “treatable.” We drafted a semi-structured interview guide that used two approaches to elicit interpretations of the word “treatable”: 1) a general question in which a physician tells a seriously ill patient that their condition is “treatable” and 2) a scenario-based question in which a physician describes incurable, metastatic cholangiocarcinoma as “treatable” with reference to palliative radiation (Table 1). We chose this grim scenario because it challenged the positive implications we hypothesized some participants would associate with the word “treatable.” The scenario was based on an observed case but simplified to facilitate better understanding. We refined the interview guide through pilot interviews with three community members and three physicians.

Three investigators conducted interviews by phone or in person depending on participant availability. All participants provided verbal informed consent prior to audio-recorded interviews, which lasted from 30 to 100 minutes. Interviews were transcribed verbatim, then deidentified before analysis.

Analysis

Since the word “treatable” had not previously been empirically studied, we used conventional content analysis, an inductive process in which results are derived directly from transcripts (17–19). First, we inductively identified and described two concepts of “treatable.” Through multiple rounds of analysis (rereading of transcripts and group discussion), we iteratively refined the description of the concepts until they accounted for all

participant responses. This analysis indicated that thematic saturation had been achieved (20, 21).

Second, to assess how often nonphysicians and physicians used each concept, we coded each participant's transcript based on which concept they used. In order to do this, we extracted two excerpts from each transcript: 1) response to the general question and 2) response to the scenario-based question (Table 1). Two investigators independently coded all excerpts in a randomized order, blinded from participant demographic data. Coders achieved excellent initial inter-rater reliability ($\kappa = 0.89$) (22). All disagreements were coded to consensus through discussion for a final inter-rater agreement of 100%.

RESULTS

Recruitment and Participant Characteristics

We interviewed 24 nonphysicians and 24 physicians, whose characteristics are shown in Table 2.

Two Concepts of “Treatable”

We inductively derived and described two distinct concepts of “treatable”: a “good news” concept and an “action-oriented” concept (Table 3). The overwhelming majority of nonphysicians adopted the “good news” concept, whereas physicians almost exclusively adopted the “action-oriented” concept (Fig. 1). Below, we describe each concept and its salient elements (representative quotes are shown in Table 4).

Concept 1: “Good News” Concept.—The “good news” concept assumes that physicians say the word “treatable” to convey a positive message about a patient's future, thereby inspiring hope and encouraging further treatment. It views treatment as a catalyst for substantial improvement in a patient's life and experience.

1a. Good news for prognosis.: Nonphysicians often perceived the word “treatable” as conveying good news about prognosis, including cure, survival, and increased length of life. They framed the good news in everyday language: the patient will “be okay,” the situation is “going to get better,” or the physician can “fix it.”

1b. Good news for quality of life.: Many thought the word “treatable” conveys good news for quality of life, expressing sentiments like: “My life will be good,” or “I’ll be able to do all the things I did before.” They described freedom from the effects of disease, explaining that patients with “treatable” diseases are “not going to have to deal with it.”

1c. Hope.: Many felt that the word “treatable” means “there’s hope,” with several going as far as to say ‘treatable’ equals hope.” Although some mentioned hope for the outcomes above, others discussed hope in a nonspecific manner.

1d. Encouragement to pursue treatment.: Some nonphysicians thought that physicians use the word “treatable” to encourage them to pursue treatment: ‘Treatable’ [is] a very positive suggestion: ‘Let’s do something and let’s see if it helps.’” Some thought that it

conveyed the physician's intention to "help me" and "do whatever is possible in the realm of their knowledge and facilities."

Concept 2: "Action-Oriented" Concept.—The "action-oriented" concept assumes a physician says the word "treatable" to convey that physicians have an action or intervention available, but does not necessarily imply an improved prognosis or quality of life. It views treatment as a physician's tool for addressing discrete clinical problems.

2a. Available intervention.: Physicians generally felt that the word "treatable" conveys that an intervention exists or can be offered. They did not feel that the word "treatable" consistently implies a clear net benefit for the patient; in some cases, physicians discussed interventions that provide little, if any, benefit for the patient, or even pose significant risks to the patient.

2b. No fixed implications for prognosis and quality of life.: Physicians articulated two reasons why the word "treatable" does not convey any consistent information about prognosis or quality of life. First, the word "treatable" is used with reference to a wide range of clinical goals; in one instance, the word "treatable" may imply curative intent, whereas in another, the word "treatable" may refer to an intervention that aims to palliate symptoms. Second, the word "treatable" does not convey that the intervention will successfully achieve its goal: "It's 'treatable,' but only 10% of patients respond to [the treatment]." Thus, the implications of the word "treatable" vary substantially based on the clinical context and the intention of the speaking physician.

2c. Limitations of intervention.: Some physicians explained that the word "treatable" is used primarily when interventions face significant limitations. For example, some contrasted treatability with curability, explaining that the word "treatable" implies that the intervention cannot cure a disease (i.e., the disease is "treatable," but not "curable"): "When I imagine a physician using the term 'treatable,' it means he's trying not to use the term 'incurable.'" Other physicians explained that the word "treatable" is used when an intervention can address a discrete clinical problem (e.g., an abnormal laboratory value), but cannot change the patient's overall clinical picture.

"Good News" in a Grim Scenario

Our interview guide asked participants to interpret the word "treatable" when applied to palliative radiation for an incurable, metastatic cholangiocarcinoma (Table 1). This scenario-based question challenged the positive implications that nonphysicians derived from the word "treatable." Many non-physicians struggled to make sense of the word in this setting: "Treatable ... honestly the first thing that came to my mind is that they could do something to cure it, but then I'm reminded that ... they said earlier [the radiation] was just something to control or shrink the tumor but not cure it, so I'm guessing that treatable might mean something else than what I originally thought." Nonphysicians used three distinct strategies to resolve their cognitive dissonance.

First, some nonphysicians constrained the good news within the negative information in the scenario: “There’s hope not necessarily for longevity of life, but hope for comfort during the rest of the life, whatever the life extension will be, that the person will not suffer.”

Second, some nonphysicians inferred a positive message about prognosis or treatment options that directly contradicted the negative information in the scenario. For example, even though the scenario repeated twice that the cancer cannot be cured, several nonphysicians interpreted from the word treatable that the cancer may be “obliterated,” “put into remission,” or may “just go away.” Several participants “envision[ed] treatable as not as serious,” with one explaining, “the quality of life is going to get a million times better” and “the outcome’s going to get a lot, lot better.” Several participants imagined new treatment options not described in the scenario, including “a very big surgery” or an experimental therapy from a “research doctor” who has “tried something that has worked with their patients.”

Third, some nonphysicians could not reconcile the word “treatable” with the negative information in the scenario. For these individuals, the disconnect was so profound that it generated mistrust of the clinical team: “I’d be leery ... they’re just trying to make us feel better versus reality.”

DISCUSSION

We report two concepts of “treatable” empirically derived from interviews with physicians and nonphysicians: a “good news” concept and an “action-oriented” concept. The overwhelming majority of nonphysicians adopted the “good news” concept, whereas physicians almost exclusively adopted the “action-oriented” concept.

The key difference between the concepts is what each assumes about a physician’s intention in saying the word “treatable.” Our results suggest that nonphysicians hear the word “treatable” as conveying good news about the future, thereby inspiring hope and encouraging further treatment. In contrast, physicians use the word “treatable” in a technical sense, to convey that they have an action or intervention available, which does not necessarily imply an improved prognosis or quality of life. In short: nonphysicians are concerned with how they will do; physicians are concerned with what they can do.

The contrast between these two concepts is similar to a previously described contrast between two models of medical decision-making: the “outcomes” model and the “fix-it” model (23). The breakdown between these two models is hypothesized to contribute to clinical momentum and unwanted care in the ICU (24). Similarly, the differences between the two concepts of “treatable” may pose challenges for communication and decision-making in critical care (25). This is particularly likely when physicians use the word “treatable,” but treatment has a limited impact or low probability of success (e.g., when treatment cannot cure a disease, or when treatment cannot change a patient’s overall clinical trajectory). In these cases, the physician’s meaning is quite discordant with the good news and encouragement to pursue treatment that patients or surrogates may derive from the word “treatable.”

In our study, the word “treatable” led some nonphysicians to reinterpret or entirely negate previously stated information. Nonphysicians heard that an incurable disease was curable, imagined significant improvements in a grim clinical situation, or predicted new treatment options. This vividly illustrates a well-established fact about communication: a single word can dramatically shape how other clearly stated information is understood (26–28). The word “treatable” may function as a nidus for miscommunication in key conversations between physicians and patients and their surrogates.

Thus, we hypothesize that the contrasting concepts of “treatable” may contribute to several widespread communication and decision-making challenges in critical care. First, critically ill patients and their surrogates often estimate the patient’s prognosis more positively than physicians do, even when physicians clearly state prognostic information (29, 30). Existing literature attributes prognostic discordance to misunderstandings and optimistic biases (29, 31, 32). Our study suggests that physician word choice may further contribute to this problem: physicians who use the word “treatable” may unintentionally convey good news. Since physicians may not intend to provide prognostic information, this source of discordance may go unrecognized (33, 34).

Second, patients receiving palliative therapies often misconceive these interventions as curative (35, 36). This dynamic may be especially challenging in ICUs, as treatments can oscillate between curative and palliative (37). By using the word “treatable” with reference to palliative therapies, physicians may unintentionally convey good news that treatment will make a substantial difference for a patient’s future, potentially including cure.

Third, patients and surrogates request potentially inappropriate or futile treatment (38), leading to conflict about whether treatment may be withdrawn or withheld (39, 40). Our results suggest that the word “treatable” may contribute to this dynamic by engendering false encouragement to pursue continued treatment. In the setting of a truly poor prognosis, the word “treatable” may also cause cognitive dissonance and generate mistrust of the clinical team, a known driver of conflict in the ICU (41–44).

Our study has several limitations. First, given that it was not feasible to prospectively identify and record clinical interactions that included the word “treatable,” we did not directly examine how physicians, patients, and surrogates use the word “treatable” in actual clinical care. Future work in this area will require audio- or video-recorded clinical interactions in conjunction with methods of eliciting unstated interpretations of particular words and phrases.

Second, our study focused exclusively on the word “treatable.” However, language besides the word “treatable” may also contribute to communication challenges in critical care. Physicians use multiple words and phrases that refer to “treatable” as a concept, such as “We can treat ...,” “We have something to offer ...,” or “There are things we can do ...” Future work should explore the extent to which these cognates of the word “treatable,” and other language used in critical care (2–8), may also be understood differently by physicians and nonphysicians, thus contributing to miscommunication.

Third, we conducted our study in a single academic center, which limits generalizability; this is mitigated, however, by our use of purposive sampling, especially across physician specialties that are likely to have distinct cultures. Furthermore, our findings are concordant with existing literature on physician-patient communication challenges, as discussed above.

CONCLUSIONS

When physicians use the word “treatable,” patients and surrogates may infer unwarranted good news and false encouragement to pursue treatment, even when physicians have explicitly stated information to the contrary. Further work is needed to determine the extent to which the word “treatable” and its cognates contribute to widespread decision-making and communication challenges in critical care, including discordance about prognosis, misconceptions that palliative treatments are curative, and disputes about potentially inappropriate or futile treatment.

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Figure 1.
Number of participants using the “good news” and “action-oriented” concept of “treatable” in response to general and scenario-based questions.

TABLE 1.

Interview Guide, Selected Questions

General question	
Physician and nonphysician version	
Imagine that a doctor is treating a seriously ill patient and during a discussion with that patient, the doctor tells the patient that their condition is “treatable.” Describe what you think “treatable” might mean about the patient or their condition.	
Scenario-based question	
Nonphysician version	Physician version
Think about someone that you love very much. Imagine that they are 70-yr-old. They were recently diagnosed with cancer of the bile duct. The cancer is stage IV, meaning that it has already spread to other parts of their body and cannot be cured. For every 100 people who receive this diagnosis, 98 will die in 5 yr, and two will survive, regardless of what medical therapies they receive.	Imagine that you are taking care of a 70-yr-old man who was recently diagnosed with stage IV cancer of the bile duct, which cannot be cured. For every 100 people who receive this diagnosis, 98 will die in 5 yr, and two will survive, regardless of what medical therapies they receive.
Your loved one is experiencing severe abdominal pain. As a result, the medical team is considering administering palliative radiation. The radiation will kill cancer cells and may cause the tumor to shrink. This cannot cure the cancer, but the medical team believes it may relieve your loved one’s pain. It may also prolong their life.	Your patient is experiencing severe abdominal pain. As a result, the medical team is considering administering palliative radiation. This cannot cure the cancer, but the medical team believes it may relieve the patient’s pain. It may also prolong the patient’s life.
Although you are in the hospital with your loved one, a group of doctors meets with you and your loved one to discuss palliative radiation, the proposed therapy. During this conversation, one of the doctors says that the cancer is “treatable.” Describe what you think “treatable” means as your doctor is using it in this situation.	You and several of your colleagues are having a discussion with the patient about the proposed therapy of palliative radiation. During this conversation, you hear one of your colleagues tell the patient that his cancer is “treatable.” Describe what you think “treatable” means as your colleague is using it in this situation.

TABLE 2.

Participant Demographic Characteristics (*n* = 48)

Physicians (<i>n</i> = 24)		Nonphysicians (<i>n</i> = 24)	
Age (yr)	Age (yr)	Age (yr)	
Range	32–67	Range	19–82
Median	40	Median	57
Sex (% male)	58% (<i>n</i> = 14)	Sex (% male)	50% (<i>n</i> = 12)
Ethnicity (% Hispanic/Latino)	0% (<i>n</i> = 0)	Ethnicity (% Hispanic/Latino)	21% (<i>n</i> = 5)
Race	Race	Race	
White	75% (<i>n</i> = 18)	White	38% (<i>n</i> = 9)
Black/African-American	0% (<i>n</i> = 0)	Black/African-American	17% (<i>n</i> = 4)
Asian	25% (<i>n</i> = 6)	Asian	25% (<i>n</i> = 6)
Other	0% (<i>n</i> = 0)	Other	21% (<i>n</i> = 5)
Specialty	Education	Education	
Critical care	25% (<i>n</i> = 6)	High school	8% (<i>n</i> = 2)
Palliative care	25% (<i>n</i> = 6)	Some college or associate's degree	25% (<i>n</i> = 6)
Oncology	25% (<i>n</i> = 6)	Bachelor's degree	38% (<i>n</i> = 9)
Surgery	25% (<i>n</i> = 6)	Master's degree	21% (<i>n</i> = 5)
		Professional or doctorate degree	8% (<i>n</i> = 2)
Experience (years post residency) ^a	Annual income (US\$)	Annual income (US\$)	
Range	1–39	< 10,000	13% (<i>n</i> = 3)
Median	9	10,000–49,999	17% (<i>n</i> = 4)
		50,000–99,999	21% (<i>n</i> = 5)
		100,000–149,999	17% (<i>n</i> = 4)
		150,000–249,999	21% (<i>n</i> = 5)
		250,000+	8% (<i>n</i> = 2)
		No reply	4% (<i>n</i> = 1)

^aTwo fellows were sampled from each specialty.

TABLE 3.

Summary of “Good News” and “Action-Oriented” Concepts of “Treatable”

Element of Concept	“Good News” Concept	“Action-Oriented” Concept
Speaker’s intent	Physician says “treatable” to convey a positive message.	Physician says “treatable” to convey that an intervention exists or can be offered.
Definition	There is good news for the patient’s future.	The physician has a clinical action (intervention) available.
General characteristics	Everyday language. Focused on patient’s future life and experience.	Technical language. Focused on physician action.
Details	Positive implications for prognosis and/or quality of life: Cure or potential cure. Survival. Increased length of life. Maintenance or improvement in quality of life. Carries implications for emotions and decision-making: There’s hope. Physician intends to help patient. Patient must follow physician’s plan.	No fixed implications for prognosis or quality of life: Intervention may not aim to improve prognosis. Intervention may not aim to improve quality of life. Intervention may have a low probability of success.
Impact of treatment	Treatment substantially improves a patient’s life or experience (“helps” the patient).	May convey a significant limitation of the intervention: Can treat, but not cure, a disease. Can treat a discrete problem but not alter the overall clinical picture. Treatment may not improve the patient’s overall trajectory (may not “help” the patient).

TABLE 4.
“Good News” and “Action-Oriented” Concepts of “Treatable,” Representative Quotes

Concept 1: good news concept (nonphysician quotes)	
1 a. Good news for prognosis	“Treatable.” I’m thinking number one, from the perspective of a patient, that it’s not lethal, that in other words the person is not necessarily going to die of it... And by ‘treatable’ I also hear... that it’s curable ... there’s a good possibility that a person will overcome whatever this condition might be and maybe even eradicate it completely.”
1 b. Good news for quality of life	“I would say if a condition is ‘treatable’ I would be able to maintain my quality of life ... Whatever the condition is, however limiting it is, I can be treated and it will no longer limit me. I will be able to thrive and go on with my life.”
1 c. Hope	“I think ‘treatable’ equals hope. H-O-P-E, and that’s good news ... to me the hopefulness that you’re ‘treatable’ would overcome any crap you’d have to put up with. Excuse my French.”
1 d. Encouragement to pursue treatment	“To me, if I were in that situation, [‘treatable’] means it’s not terminal, so I would completely adhere to what the doctor would say under those circumstances ... If it’s ‘treatable,’ go for it! Whatever the doctor would say, I would follow him completely.”
Concept 2: action-oriented concept (physician quotes)	
2a. Physician action	“When we as physicians talk about something being ‘treatable’ or not we tend to think of the term ‘treatable’ as meaning, do we have a therapy that we can offer.” “[‘Treatable’] can mean simply we have some kind of treatment that might have some kind of effect on you, but does not necessarily mean a cure. It does not necessarily mean the treatment will be effective.”
2b. No fixed implications prognosis and quality of life	“One may have a ‘treatable’ condition that may or may not affect prognosis ... people oftentimes misconstrue ... ‘treatable’ as being a good prognosis, but I would say they’re not necessarily related.” “I don’t know if I would connect the word ‘treatable’ with quality of life because there are a lot of things that we can treat that will still result in a horrible quality of life.”
2c. Limitations of treatment	“Most physicians who use the word ‘treatable’ are referring to a condition that is not curable ... but a condition that could potentially be well-managed with medications or other interventions.” “Sometimes I’ll hear colleagues say something’s ‘treatable’ and they’re referring to just like an electrolyte imbalance, that we can treat this electrolyte imbalance but big picture-wise we aren’t able to treat what really is happening.”