

Doctor-Speak™: Medical Habitus, Epistemic Injustice, and the **Ethical Imperative** to Reclaim Narrative Dignity in Clinical Language

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What is Doctor-Speak™?

Refers to the specialised medical jargon, terminology, and shorthand used by clinicians to communicate efficiently within healthcare settings.

Understanding Doctor-Speak

Positively Connoted Definitions

Functional Efficiency:

Doctor speak is the specialised clinical shorthand and terminology that allows healthcare professionals to communicate complex information quickly and accurately.

Standardisation:

Doctor speak refers to the shared medical vocabulary that standardised communication across teams, supporting clarity, consistency, and coordinated patient

Understanding Doctor-Speak

Negatively Connoted Definitions

Comprehension Barrier:

Doctor speak is the technical language used by clinicians that may be difficult for patients or non-clinical staff to understand, potentially hindering clear communication.

Depersonalisation:

Doctor speak involves shorthand that can reduce individuals to diagnoses or acronyms, which may unintentionally contribute to patient depersonalisation within clinical settings.

Definitions

Medical Habitus: *The ingrained **dispositions, norms, and interpretive habits** clinicians acquire through training that **shape how they perceive, speak, and act in clinical contexts***

Epistemic Injustice: *The **fair recognition** of individuals as **credible knowers**, ensuring **their experiences and knowledge** are **appropriately heard and understood***

Narrative Dignity: *The **preservation** of a patient's **ability to express and maintain their own coherent life story, affirming their personhood in clinical care***

The Question

What **ethical and epistemic consequences** arise from depersonalising language in healthcare, and how does such language **shape the moral dispositions** of clinicians and future clinicians?

Conceptual Framework Overview

- 1. Depersonalising Language and the Construction of Clinical Reality***
- 2. The Hidden Curriculum and the Normalisation of Moral Distancing***
- 3. Feminist Bioethics: Power, Relationality, and the Ethics of Recognition***
- 4. Epistemic Injustice and Diagnostic Overshadowing***
- 5. Moral Atmospheres and the Ethical Weight of Everyday Speech***

Lit Review: Depersonalising Language and the Construction of Clinical Reality

- *Language in healthcare constructs reality*
- *Shorthand as framing*
- *Diagnostic labels as “epistemic anchors”*
- *Depersonalising phrases reflect biomedical ontology*
- *Disproportionate use for “complex” patients*
- *Not value neutral: shapes moral perception*

Lit Review: The Hidden Curriculum and the Normalisation of Moral Distancing

- *Hidden curriculum shapes norms through observation*
- *Depersonalising language is transmitted informally*
- *Language signals professional identity*
- *Ethical consequence: socialisation into moral distancing*
- *Over time, language becomes embodied habitus*

Lit Review: Feminist Bioethics: Power, Relationality, and the Ethics of Recognition

- *Feminist bioethics foregrounds relationality and power*
- *Depersonalising language operates as a mechanism of power*
- *Disproportionate impact on structurally vulnerable patients*
- *Depersonalising labels often gendered and racialised*
- *Tangible clinical consequences*

Lit Review: Epistemic Injustice and Diagnostic Overshadowing

- *Testimonial injustice: depersonalising labels (e.g., “the borderline”) preemptively reduce patient credibility.*
- *Hermeneutical injustice: dominant biomedical frames make certain experiences unintelligible; diagnostic labels obscure alternative explanations.*
- *Diagnostic overshadowing: physical symptoms misattributed to psychiatric diagnoses → delayed or missed diagnoses.*
- *Empirical evidence (psychiatry & ED): patients with mental illness/intellectual disability face worse diagnostic accuracy and outcomes.*
- *Language reproduces, not just reflects, bias—shaping clinicians’ interpretive assumptions and decision-making.*
- *Epistemic injustice causes both epistemic harm (loss of credibility) and material harm (poorer health outcomes)*

Lit Review: Moral Atmospheres and the Ethical Weight of Everyday Speech

- *Moral atmosphere: ethics shaped by ambient norms, habits, and routine language—not just rules or intentions*
- *Depersonalising language frames patients as problems to manage, not persons to care for.*
- *Clinical encounters are inherently moral events; language shapes clinician–patient positioning.*
- *Small linguistic practices accumulate, contributing to:*
 - *Moral disengagement*
 - *Burnout*
 - *Erosion of empathy*
 - *Depersonalising language is both a symptom and mechanism of broader ethical erosion in strained health systems*

Sources

Observational notes were collected across multiple clinical environments:

- *Inpatient ward rounds*
- *ED handovers*
- *Multidisciplinary team meetings*
- *Bedside reviews*
- *Informal discussions among clinicians*
- *Documentation (progress notes, discharge summaries)*

Clinical Taxonomy of Depersonalising Clinical Language Observed in Clinical Settings Observed On Placement

Diagnostic Shorthand	Psychiatric and Behavioural Labelling
Moralising/Blame-Implicating Language	Social Reduction/Identity Erasure
Ambiguous/Euphemistic Clinical Tropes	Emotionally Distancing Terms

Findings

1. *Linguistic Reduction*
2. *Moral Distancing and Emotional Containment*
3. *Hierarchical Socialisation and the Hidden Curriculum*
4. *Epistemic Disqualification of Marginalised Patients*
5. *Moments of Resistance and Humanising Counter-Practices*

Re-humanising Clinical Discourse: A Moral Imperative

- *Language is a moral practice, not a technical one*
- *Small linguistic shifts have disproportionate ethical impact*
- *Humanising language counters structural inequities*
- *Resistance must be modelled, not just taught*
- *Re-humanising discourse enhances clinical reasoning*
- *Moral imperative: recognition as the core of ethical care*

Concluding Thoughts

- *Depersonalising language in healthcare is not a benign communicative shortcut, but a morally and epistemically consequential practice that shapes the fabric of clinical encounters*
- *Language operates as a subtle but powerful mechanism of moral orientation; it regulates what clinicians attend to, whose voices they trust, and how they understand the people in their care.*
- *Depersonalising language disproportionately harms those already marginalised by mental illness, race, gender, or disability, amplifying existing inequities and undermining the*