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A Hippocratic oath for medical communicators

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How do you solve a problem as entrenched as racism in health research? Two tools you need are clear language to describe different population groups and good data. Both are lacking, argue Richard Powell and colleagues (doi:10.1136/bmj-2021-065574).¹ They identify racism in research commissioning, in recruitment of participants, and in the assessment and dissemination of research outcomes. Carefully using the term “racialised minorities,” they recognise that disadvantage is not uniform among the “ethno-racial groups” defined by phenotype, ancestry, and self-identification. More than 20 years after the Stephen Lawrence inquiry led to calls for better health related data, they say, the UK still relies on inadequate proxy measures of ethno-racial affiliation, as is evident in delays in understanding the effects of covid-19 on different groups.

If there were a Hippocratic oath for those aiming to communicate about science and medicine, might we pledge to choose words carefully and back them up with good data? Both are in short supply when it comes to understanding and treating “long covid.” Poor definition of the condition may have contributed to the delay in effective clinical response (doi:10.1136/bmj.o138).² Carl Jreidini tells us that open-mindedness and good communication can allow clinicians to help patients with long covid, even when data are in short supply (doi:10.1136/bmj.n3102).³ Peter Piot, an expert on transmissible diseases ranging from HIV to Ebola, experienced at first hand the exhaustion and other symptoms of long covid. He hopes that research on the condition might help explain other postviral syndromes (doi:10.1136/bmj.o138).²

Matt Morgan points out the peril for a doctor in speaking out at the wrong place and time about a controversial topic such as vaccine effectiveness (doi:10.1136/bmj.o172).⁴ And David Nutt asks just how much evidence, and of what type, is needed before doctors prescribe medicinal cannabis when real world evidence indicates that it is justified (doi:10.1136/bmj.n3114).⁵ Might the words used to describe this class of drugs contribute to hesitation about prescribing, whatever the data say?

This month a health technology entrepreneur was sentenced for fraudulently claiming broad efficacy for her company’s finger prick blood tests. The claims did not reflect the underlying data, causing harm to patients (doi:10.1136/bmj.o178).⁶ And the UK has been gripped by discussions of whether potentially work related gatherings at the heart of government constituted prohibited social activity when they were accompanied by cake, alcohol, or music (doi:10.1136/bmj.n3056),⁷ reminding us all of the serious implications of our choices of words.

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2 Looi M-K. The BMJ interview: Peter Piot. *BMJ* 2022;376:o138.

3 Jreidini C. How can you help me integrate my long covid care? *BMJ* 2022;376:n3102.

4 Morgan M. Matt Morgan: The trouble with “just asking questions.”. *BMJ* 2022;376:o172doi: 10.1136/bmj.o172.

5 Nutt D. Why doctors have a moral imperative to prescribe and support medical cannabis—an essay by David Nutt. *BMJ* 2022;376:n3114.

6 Richards T. False dawns: implications for patients of the Theranos debacle. *BMJ* 2022;376:o178doi: 10.1136/bmj.o178.

7 Cowper A. When is a Christmas party not a Christmas party? When it’s in Downing Street. *BMJ* 2021;375:n3056. doi: 10.1136/bmj.n3056 pmid: 34887254