MEDICAL LANGUAGE: NECESSARY DOUBLESPEAK?

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DURING OUR MEDICAL SCHOOL years we roughly double our vocabulary and by graduation have learnt a new language. While we may try to revert to our mother tongue with patients, communication problems abound [1-3] often because patients do not understand the *technical* language of medicine. Australian writers have called attention to the serious misunderstandings produced by the use of medical lingo across the Tasman [4,5]. Such problems of comprehension are likely to be aggravated, for patients and doctors alike, by the current proliferation of medical acronyms [6] and euphemisms [7,8].

Another sort of medical language is the unofficial, sometimes subversive *slang* commonly learned on the wards by clinical students and junior house-staff. A recent review catalogues a vast array of North American medical slang, and suggests a number of functions it may serve [9]. Examples of antipodean medical slang (see Table) offer a sometimes alarming glimpse into housestaff attitudes and images.

Medical language has some obvious advantages. For example, that rounded dangly thing behind the palate is accurately and succinctly labelled the *uvula*. Technical terms help to keep collegial conversation brief and to the point. Our specialised vocabulary has additional more subtle properties, which don't always work to our advantage, or that of our patients.

INTENTIONAL OBFUSCATION

Medical language, both technical and slang, is sometimes deliberately obscure. One emergency room is said to have received a woman demanding admission for severe abdominal pain; after a brief assessment she was diagnosed as having Münchhausen Syndrome. Her medical bracelet confirmed the diagnosis. She had thus unwittingly spared herself unnecessary investigations and, quite possibly, surgery.

Arcane language also functions to simultaneously express and conceal hostile feelings toward patients [9] and administrators [7]. The striking calumny implicit in many slang references to patients here and overseas may reflect the resentment junior doctors feel about their workload and patients who take a lot of time but don't get better. Such slang is often used when house-staff discredit 'crock' patients thought to have psychological problems masquerading as physical ('real') ones [9]. Apart from the potential humiliation caused when such references are heard and understood by patients, it can also be embarrassing for a registrar to discover that puzzling symptoms labelled 'supratentorial' may turn out to be just that in missed cases of multiple sclerosis [10].

SOFTENING THE BLOW, GAINING COMPLIANCE

Breaking bad news to patients and their families is an important and stressful task for many doctors. Doing it well requires preparation, timing and tact. Awareness of patients' vocabulary, prior knowledge, and emotional readiness to hear the facts, all need taking into account. Use of euphemism at such times is risky, but may be helpful, for example in telling an anxious patient that his tumour 'might take a few years off his life' (his cancer will kill him). By reframing unpleasant facts, euphemisms minimise our contact with the distressing reality of a patient's illness. The question is: who benefits from such 'aseptic conversation'? Doctors need to be mindful of their own emotional reactions to patients and how these may distort clinical judgement.

The use of euphemism has variable consequences, depending on the situation. Over-protective parents may be usefully relieved to learn that their child's breathlessness, rather than asthma, is merely a *bronchitic wheeze*. On the other hand, some patients require anxiety (e.g. regarding precancerous cells rather than *cervical dysplasia*) to prompt compliance with medical advice. As with exam performance, an optimal level of anxiety or arousal leads to the best result – the so-called Yerkes–Dodson inverted 'u' shaped curve [11]. The trouble is, both the requisite anxiety, and the vocabulary to drive it, vary from patient to patient.

MEMBERS OF THE CLUB

Our impressive vocabulary adds to our profession's considerable kudos. We report erythrocytes as *microcytic* and *hypochromic*. Only after visiting the doctor can a patient discover that his red blood cells are excessively small and pale. No longer do we lock up mad people; however, labelling someone as actively psychotic might justify their committal. With our exclusive vocabulary we maintain not only prestige, but also control [12,13]. Group

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identification is typically reinforced by unique features of appearance or language [14]; medical students and junior doctors quickly learn to adopt both. This process is promoted by, and helps to cope with, the stress of huge responsibility, urgent decision-making and long working hours [15].

As with other specialised professions, some of us are prone to extend our vocabulary beyond our knowledge. As Molière noted so incisively in one of his plays, this hardly does our effectiveness or our public image any favour [16].

A NEED FOR INTERPRETERS?

A myriad of reasons leads us to use our own language in medicine. Unfortunately, it is easy to forget the consequences. Rather than appear ignorant, patients often will not question medical terms or advice [12]. One disgruntled young man was left with a bitter taste in his mouth after misunderstanding the meaning of *suppository*. A more serious consequence was narrowly avoided when a young woman was admitted for a 'his directory' It was only a short while before surgery when she discovered her womb (not just her 'you-truss') would be removed. Our use of what amounts to a foreign language with patients makes a mockery of informed consent; the ethical and medico-legal implications are extensive [17].

Nurses often act as 'communication brokers', translating the wisdom of the physician into everyday language [18]. Our confusing jargon may also be interpreted by 'complementary' practitioners outside the medical setting. Herbalists, naturopaths, chiropractors and magazine doctors may provide (over-)simplified advice, and for this reason are preferred by many patients. It would be unfortunate indeed if the demand for plain speaking were in the future to be met by health-care personnel generally, apart from medical staff and perhaps psychotherapists.

CONCLUSION

Courses in communication skills have been developed in most English-speaking medical schools, including those in the antipodes. Unfortunately, such learning is seldom effectively followed up through the clinical years and beyond. By the time they graduate, most doctors have been fully inculcated with the trappings of medical culture, including arcane language. Regrettably, many doctors are by that stage unable, or unwilling, to translate effectively for their patients. The consequences, from patient satisfaction through to cost-effectiveness, are uniformly negative [12].

Although it has not, to our knowledge, been systematically studied, local experience (see Table) suggests that NZ medical jargon is similar to that found overseas. Our medical language will inevitably evolve along with our art and science, and, as a topic, undoubtedly deserves more serious attention than it gets [4]. Little is known, for example, about how various factors – job characteristics, house-staff gender and personality – influence acquisition and use of medical slang. Patient variables are also likely to be important: to what extent does our use of slang or technical terms with patients depend on their diagnosis, age, sex, ethnic and educational background?

For good or ill, collegial conversation is likely to remain largely obscure to those outside the guild. Yet to do our job well, we need also to be understood by other health-care personnel, our patients and, increasingly, the community at large. As with our investigations and treatments, we must remember to choose our words carefully.

Table: Recent examples of medical slang in NZ and Australia

Slang	Meaning
crumble	deteriorate, die
carpopedal perambulator	low IQ patient
houseplant	house officer
TF Bundy	demanding, terminally ill patient (totally fucked but unfortunately not dead yet)
vitamin C	captopril
vitamin D	droperidol
vitamin F	frusemide (or fluoxetine)
Winner of: Rothman's Medal, Winfield Cup, Benson & Hedges Award	patient with lung cancer
WOFTAM	worthless procedure (waste of fucking time and money)
WOMBAT	frustrating clinical situation (waste of money, brains and time)

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