PERSPECTIVE

Watch Your Language!—Misusage and Neologisms in Clinical Communication

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Despite our best efforts to ensure appropriate care for patients, we often find ourselves distracted on rounds by the sometimes bewildering array of jargon during bedside presentations. Why does our team want to "sprinkle" or "hit" the patient with diuretics? Do our patients have the capacity to "fly" off the ventilator or "throw" PVCs (premature ventricular contractions)? Is there a reason we frequently refer to the culinary arts and acts of violence in our discussions of patient care?

Faculty in preclinical courses spend considerable time teaching not only principles of physiology and pathophysiology, but also the language students must master to communicate effectively in their clinical work. We serve in this role and are fairly certain that this instruction does not include the terms and phrases mentioned in the prior paragraph. Yet somehow when students transition to the clinical setting, use of such terms is common. Why does this occur?

If we are honest, we will admit to a simple fact: it comes from us. As with learning any new language, attaining fluency stems from cultural immersion and modeling the vernacular used by those who are well versed. As clinical preceptors, we are the role models. By listening to us and to more senior trainees, our students become immersed in the unofficial language of medicine.

Problems With Jargon

Like other professions, medicine has its own jargon. While it can be fun to needle trainees in a lighthearted way about some of these terms, many of them have little effect on patients. The **Table** provides examples of improper terminology and more appropriate language.

However, there are a host of commonly used terms that are problematic because of their potential to affect patient care. Practitioners commonly conflate terms such as *hypoxia* and *hypoxemia*, *acidosis* and *acidemia*, and *atrial fibrillation* and *atrial flutter*. This usage may inaccurately describe the patient's clinical issues and risk overlooking distinctions that impact disease management. For example, respiratory acidosis may not require intervention when the pH is normal but does warrant action in the setting of acidemia. Atrial fibrillation and atrial flutter often warrant different management strategies in the acute and chronic setting.

Another challenging set of terms are neologisms, newly coined words or old words used in a new way. Examples related to technology include terms such as *malware* and *webinar*. Medical neologisms, including *syncopize*, *satting*, and *surgerize*, can be confusing to those who have not heard them before and can lead to misinterpretation and error.

Other jargon is problematic because of its ability to shape the medical team's perspective in ways that ultimately affect care delivery. Referring to patients as *COPDers* or *CHFers*, or placing the term *end-stage* before the name of a disease, may result in anchoring bias or unintentionally conveying an unavoidable risk of clinical worsening, leading to less-aggressive treatment than warranted. For instance, patients with chronic obstructive pulmonary disease (COPD) develop respiratory failure for reasons other than COPD exacerbations, and those with heart failure may warrant aggressive fluid repletion when they present with sepsis. Patients with various types of so-called end-stage disease can live for many years with appropriate medical care.

Perhaps the biggest challenges arise when we consider how our words sound to patients and their families. Many of our word choices run the risk of confusing them rather than clarifying the patient's condition, diagnosis, or treatment. They may nod, but do they clearly understand what we have said? Even worse, are they offended by what they hear?

Patients and family members may be familiar with the terms we use in presentations but not with their use outside of the traditional context. They might wonder why we want to "blast" them with medications, "move them to the floor" when a bed suits them just fine, or refer to them as a "vasculopath" rather than a person with a particular disease. They likely do not want to hear about indwelling vascular catheters that are "dying," as this could easily be misconstrued that the patient is the one who is about to expire. Frequent puzzled looks from patients and their families are an important signal that our use of the unofficial language of medical communication—one which we inappropriately try to excuse by saying "we're going to talk shop and will fill you in when we're done"—needs our attention.

Achieving Better Communication

So how do we temper the endurance of common yet problematic phrases and build a culture of clear and accurate patient- and family-centered communication? The solution likely lies in a combination of modeling and feedback. Given that those seeking to join the medical community are likely to adopt the language they see and hear every day while in training, it falls on us to choose our words deliberately and with purpose. We need to recalibrate our language. Conscious efforts on our part can redefine the standard learners seek to achieve.

Feedback also has a role. Those who use inappropriate terms and phrases yet never receive feedback may not understand that their communication is problematic. Admittedly, it makes no sense to stop presentations every time neologisms such as *troponinemia* or *transaminitis* are uttered, for it would lead to overly long rounds and likely just engender frustration. However,

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Table. Examples of Improper Terminology and More Appropriate Language

Improper term or phrase	Why the term or phrase is problematic	More appropriate language
Misused terms and neologisms		
Chest x-ray	An x-ray is a beam of energy that we cannot see	Chest radiograph
Room air	The inspired oxygen fraction is the same inside or outside of a room	Air or ambient air
The patient denies drug use	Denying something connotes that it is there, but the patient refuses to admit it	The patient reports no use of illicit drugs
The patient endorses pain	To endorse is to declare public approval or support of something; patients are unlikely to be in favor of pain	The patient reports pain
Transaminitis	The liver enzymes are not inflamed; the liver or muscle cells are injured	Elevated liver enzymes
Troponinemia or troponemia	Neologisms	Elevated troponin
Problematic phrases from patient- and family-centered care standpoint		
Big-gun antibiotics	Terms related to guns or violence should not be used with patients or colleagues	Broad-spectrum antibiotics
Mr/Mrs [surname] is our CHFer	Patients are more than their medical problems; this usage runs the risk of altering team perspectives on the patient	Mr/Mrs [surname] is a person with heart failure
The patient is a poor historian	Historians gather and interpret information; the patient is the source of information but may not be able to provide data for many reasons	I had difficulty obtaining a full history because…
The patient is trying to die	Patients rarely come into the hospital with the intention of dying	The patient is very ill and at high risk of dying
Transfer to the floor	The floor is a surface on which we stand or put furniture; patients are transferred to a specific unit in the hospital	Transfer to the [name of unit]
We should circle the wagons and…	The phrase implies gathering in defense of a group and may have negative connotations for some patients	We should touch base with the [appropriate team] for help
We should pull the trigger and…	Terms related to guns or violence should not be used with patients or colleagues; resonates poorly with patients who have experienced gun violence	We should administer [insert medication]

feedback that is well timed, directed toward the most problematic language, and delivered in a safe space may chisel away at the problem. Incorporating feedback about communication in end-of-rotation evaluations would likely be welcomed by most learners. Furthermore, such feedback might carry more weight if learners saw it delivered among members of the community rather than only in a top-down manner toward those in training.

Conclusions

On the surface, it may seem daunting to try to reframe all of our communication, given the ubiquity of inaccurate and arguably inappropriate terminology. But if we reflect on what we do each day, it becomes obvious that we have abundant opportunities to model better communication skills and speak the official language that is a privilege to learn.

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