Becoming a doctor involves learning a new language of medical jargon, technical terms, and common phrases. In fact, it almost entails learning an entirely new syntax. Using succinct, clear communication is an important part of working in a healthcare team. Often, we use stereotypical phrases which allow our colleagues to rapidly understand what we are saying.

The language of ED

Succinct communication is exemplified by staff in the Emergency Department (ED), a fast-paced environment where there is no time to mince words. This blog and the podcast by Dr Edwards and Dr Chalkley give consideration to the particular language used in the ED. The aim of discussing this language is not to criticise individuals or teams for its use, but rather to encourage reflection on how we might all communicate with even greater clarity and respect to both our colleagues and patients, as well as illuminate how this terminology may be viewed by patients and families.

The ED is a stressful environment which inevitably takes a toll on staff. Unfortunately, this can be reflected in the language we use. At times, our language to describe patients may sound almost adversarial, as if we were trying to distance ourselves from our patients as a protective mechanism. The language we use can impact upon the way we feel about our patients. Improving our language is one way of improving the healing and respectful relationship we aspire to create with our patients.

Our documentation and verbal presentation sometimes takes a litigious tone. A commonly used term that demonstrates this is “denies”, for example, “the patient denied illicit substance use”. This can sound adversarial and accusatory, and if heard or read by a patient, can give the impression he or she was not believed or valued.

Similarly, the term “refuses” can distance us from our patients. This is often in the context of pain relief, for example, “the patient refused analgesia”. This could be more accurately phrased as “the patient declined analgesia”. There is usually a reason for the patient declining an investigation or intervention. Sometimes this is a communication issue, or due to preconceived ideas of the patient. For example, some patients are concerned about masking their symptoms by accepting pain relief ("what if I get worse and hide it?").

It is our role to enquire with patients about their reasoning, and to clearly communicate our own reasoning to inform their decisions. We tend to objectify pain in our patients, and there may be a perception by staff that if a patient “refuses pain relief”, his pain is not actually severe enough to come into ED. Pain is a subjective experience, and
different people have different thresholds of tolerance to pain. By objectifying this profoundly subjective experience, and allowing prejudices or stereotypes to affect the way we relate to the patient, we are not providing our best care.

“Alleges” is a term which commonly enters our verbal and written communication in the context of presentations where there will likely be resultant forensic or legal proceedings. There are clear medicolegal reasons for the use of this term (e.g. a patient who presents following an “alleged assault”). However, it is also important to consider that the history is what the patient tells you has happened. It is acceptable to document, for example, “the patient states that he was punched in the face”.

Our patients will often read the discharge summary, and if this contains repeated use of the term “allegedly”, it may once again give the patient the impression that we do not believe him or her. This may even lead to the belief that the appropriate care was not provided to the patient at that time. Consequently, this may seriously damage a core pillar of the patient-doctor relationship, in which each party should assume truth from the other.

Terminology around having patients admitted to hospital from ED can also create barriers between different hospital teams. An example is “the hard sell”, or “selling a patient” to an admitting team. The “sell” implies that the patient’s presentation was not really worthy of an admission, but we couldn’t think of anything better to do for them. This does not give the patient due respect for their illness, and it certainly doesn’t give the inpatient teams the respect they deserve for continuing their specialist care of the patient. The implication in saying we have “sold” a patient’s story to an inpatient team is that we have been misleading or dishonest.

For the vast majority of patients, the initial diagnosis made in the ED sticks for the remainder of their admission, and omitting important information can have a major effect on the care a patient receives. It is difficult to admit uncertainties of a diagnosis to a colleague; however, sometimes ED doctors think this is the only way to ensure the patient receives the best care. Inpatient teams would often like a patient to be “packaged” (another term which does not do justice to the complexity of medical care), with all investigations complete, and management underway.

Occasionally inpatient teams may complain of being “dumped” with a patient (“ED dumped a patient on me”). This term is disrespectful to the patient, and also implies underhanded deferment of responsibility. Furthermore, these terms simply do not do justice to the care provided by Emergency and inpatient staff, and are not how we would like to hear a family member’s admission being described.

Terminology surrounding a patient’s disposition can also be confronting. Unfortunately, sometimes staff will discuss how to “get rid of” a patient when they really mean “safely discharge him home.” The more we use phrases like this, the more we begin to subconsciously internalise the emotional connotations of these terms, and view our work as an annoyance. Junior doctors are most influenced by this language. No-one comes to Emergency because they have “nothing better to do”. People come to Emergency because they want our help. It is our job to provide whatever the appropriate help may be, and we should never make people feel unwelcome.
Sometimes, our documentation may contain controversial phrases such as the disparaging remark that a patient is a “poor historian”. Our teaching may tell us that there is no such thing as a poor historian, only poor history-taking, however many of us have experienced that this is not completely true! Nevertheless, we must remember that everything we do is guided by the history. Barriers to communication, such as language or cognition issues, absolutely must be navigated in order to obtain an adequate history. This is our responsibility as doctors. Root cause analyses for adverse outcomes commonly identify poor initial communication as a contributing factor.

Our negative attitudes which separate us from patients, and hamper our patient-doctor relationships, are encompassed by the phrase “I don’t know why he’s here”. To utter this phrase completely misunderstands our role in our community. We are a public service, whose purpose is to look after people who are sick, worried, and need our care.

This blog does not aim to stigmatise individuals or groups within our hospital team. Our aim is to encourage reflection on the language we use, so that our words and documentation mirror the outstanding work that is done in our Emergency Departments. It is easy to change the terminology we use. More difficult, however, is to change our culture by gently challenging these statements when we hear them. There is nothing more important than the health and safety of a patient’s physical and mental state. When we consider how we truly care for our patients and how we would like them to feel, it is abundantly clear that empathetic language is at the core of a respectful and healing patient-doctor relationship.

*This blog has been adapted from a podcast by Dr James Edwards and Dr Dane Chalkley (Emergency Department Staff Specialists at Royal Prince Alfred Hospital, Sydney), originally published on onthewards on 28 September 2015.*

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