

# Learning to Talk

*The bricks and mortar of medicine . . . were words. You needed only words strung together to describe a structure, explain how it worked and to explain what went wrong. . . . How extraordinary that a word could serve as a shorthand for an elaborate tale of disease.*

Abraham Verghese, *Cutting for Stone*

*The doctor's answer to his patient . . . will come naturally—or at first unnaturally—from the intersecting of the patient's needs with the physician's as yet untried imagination. The doctor must usher the patient out of the ordinary world into whatever place awaits him. The physician is the patient's only familiar in a foreign country. . . . In learning to talk to his patients, the doctor may talk himself back into loving his work.*

Anatole Broyard, "Doctor Talk to Me"

LIKE VERGHESE'S MAIN CHARACTER IN *CUTTING FOR STONE*, whose initial encounters with medical words are described above, as a beginning first-year medical student I was fascinated by the utility and beauty of the language of medicine. We started out learning the musculoskeletal system, and I quickly realized that this really was an entirely new language, and not an easy one. I briefly regretted not having studied Latin in high school, yet there were still so many connections to be made to words in English and the romance languages I had studied that it was likely almost as fun. The other women in my study group and I did pirouettes to remember piriformis and gave ourselves headaches demonstrating the two heads of the sternocleidomastoid muscle and the platysmus, which called to mind a platypus tail. The Lachrymose section of Mozart's *Requiem* sounded in my head as I located the lachrymal duct on our cadaver. I marveled that I would have spent my life not knowing the names of these parts of the body had I not gone into medicine. I felt privileged to be taught such an intimate road map to the bodies all of us are born and die with.

The medical naming of our insides in the musculoskeletal block was my initiation into a magical, nerdy cult of words and phrases describing the human body, from micro to macro, normal to pathological. There was a level of precision to this new language of the body that made very good sense to me. *Superior/inferior, medial/lateral, and distal/proximal* were terms that I found to be highly applicable to locations in space beyond the human body. I especially enjoyed the phrase "deep to," as in "the milk is deep to the orange juice in the fridge." As I progressed, the words became more sophisticated, telling "an elaborate tale of disease"; *cirrhosis* conveyed a complex and dangerous landscape of interconnected pathophysiologic changes. In my clinical years, I worked on perfecting my presentation and documentation skills through efficient and accurate word-

ing, using not only correct medical terms but also standard acronyms and formatting. I felt proud to earn the respect of my colleagues through the crispness of my words.

Having long since emerged victorious from the uphill yet thrilling battle of learning medicalese, my use of this language, while still a source of delight in residency, has now become routine. So routine that I have almost forgotten how it felt not to know these words, phrases, and acronyms. I am reminded of this prelingual state when I encounter bewildered patients who have not comprehended a word of what has been "explained" to them about their illness. The patient who is nodding her head through our monologues and who has no questions at the end is often one we have to watch out for, because it usually means we are doing something wrong. Words that recently rolled off my tongue at bedside rounds in the ICU come to mind: "The rise in Ms M's cardiac index on the noninvasive cardiac monitor with the straight leg raise indicates that she is still hypovolemic." In the moment, I was pleased with the high level at which our team was communicating, but this sentence later came back to give me pause. What a lot of fancy talk for "The patient is dehydrated." Ms M happened to be sedated and unconscious at the time, but frequently patients are listening and wanting to know what the heck we're talking about, which is part of the point of bedside rounds.

The more doctor-speak becomes second nature to us, the more it can distance us from our patients. It is easy to lose sight of the possibility that even the most basic medical words may be jibberish to our patients. Our best efforts to translate our understanding of disease processes into lay language too often fall short. In the era of patient-centered medicine with bedside rounds, transparent medical records, and shared decision-making, the patient has great potential to take ownership of his health and be a collaborative agent in medical decisions. However, for our patients to fully engage at this level, we must open the door for them and invite them in. Making the language we worked so hard to learn accessible to patients is key to this process. Conducting truly two-sided conversations with patients necessitates our being bilingual in the language of the medical profession and the language of the layperson, acting as our own interpreters. As Anatole Broyard says, "The physician is the patient's only familiar in a foreign country." This role contains enormous power and privilege with significant potential to marginalize patients. The role of the physician as the patient's guide to their illness must be recognized as such,

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valued, embraced as well as emphasized in medical education. How we convey information to our patients and how we involve them is critical to their becoming comfortable in the foreign country of disease that has become theirs to navigate.

It took me four years of medical school to learn to talk in doctor-speak, but the hard part is just beginning. Honing my skills in interpreting the ever more complex medical world into language my patients can grasp may take my whole career. Despite my own high literacy level, I have found myself stumbling, awkwardly trying to explain an infiltrative cardiomyopathy or the nuances of harms and benefits of cancer screening to patients. Through my mistakes, I have learned to pause frequently, assess more thoroughly for understanding with open-ended questions and teach-back, screen for educational level, and reframe my language continually to align more closely with the patient's perspective and knowledge base. Drawing a picture and breaking down complex words can also be helpful.

I recently caught myself launching into a monologue from the door in the emergency department about precautions

to take and what to expect after a concussion to a 22-year-old patient. I paused, examined his frightened face, and then asked if he knew what a concussion was—he hesitated, then shyly shook his head no. I sat down by his bed, started over, and walked him through it. I felt like I had made a connection. This is a feeling I want to have more as I continue in my development as a budding primary care physician. It feels just as good as how I feel when I rattle off complex medical terms to colleagues—and often a little better. As I start out as a new primary care attending in August, I hope to keep Broyard's words in mind as I struggle through long days of 20-minute appointments. I hope I can translate the joy I found in learning medical language into a lifelong joy of talking to my patients, which is really why I did this whole thing in the first place. In learning to talk to my patients, I hope to keep what I love about this work.

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Uncommon things must be said in common words,  
if you would have them to be received in less than a  
century.

—Coventry Patmore (1823-1896)