Like Any Language, "Patient Talk" Is Best Learned at a Young Age

Having encountered countless instances in our practice of unsuitable language use among clinicians—in a memorable example, a patient confused a biopsy for an autopsy with a loud exclamation, "but I'm alive, doctor!"—we enjoyed reading the recent article that posed *medicalese* as a physician's second language. We welcome the framework set out by Hadden and colleagues[1] that likens the task of tailoring language to the audience with the sociolinguistic idea of code-switching that occurs in bilingual conversations. In addition to the potential causes identified in the article, we believe the issue is partly a failure of the undergraduate medical curriculum to emphasize the importance of plain speaking. We believe recent changes in our own medical school curriculum can point to potential solutions at all stages, and we would like to share our experience.

One technique that has been employed entails placing more emphasis on patient opinion in summative clinical examinations. Transitioning away from a checklist-style examination that rewards students for asking many specific questions to a more integrated or domain-based system that places greater emphasis on broad categories such as communication and diagnosis and management, affords the examiner greater freedom to make a holistic assessment of the student.

This has resulted in a shift in the perception of what qualities fellow medical students ascribe to an exemplary physician, encapsulating 1 of the most thought-provoking points Hadden et al[1] establish regarding identity. Previously, our idea of what makes a good physician was simply one who asks all the right questions. A system of examination that more directly, and significantly, rewards patient perceptions ensures that results-focused students emphasize communication topics like code-switching as a matter of course. Consequently, we have noticed that students' perceptions start to shift, with many actively seeking feedback on their relationship with the patient, which was not common in the previous system. We see this as an encouraging indicator that the identity they try to convey is not only that of a competent diagnostician but also that of a holistic and patient-centered physician.

Including these ideas early in the curriculum no doubt has played a part in their success, and we encourage the inclusion of code-switching (or any communication skills teaching) at as early a stage as possible. While acknowledging that such teaching falls in part under the hidden curriculum, we believe educators should recognize the need for structured teaching sessions around this topic to ensure that students are well versed in both medicalese and plain language. Thankfully, there are plenty of opportunities to incorporate comprehensible communication into everyday practice.

Mohamad Zeina, BSc (Hons)
Medical Student, GKT School of Medical Education, King's College London, United Kingdom

Mohammad Yusuf Abdoolraheem, BSc (Hons)
Medical Student, GKT School of Medical Education, King's College London, United Kingdom

Reference

1. Hadden K, Coleman C, Scott A. The bilingual physician: seamless switching from medicalese to plain language. *J Grad Med Educ*. 2018;10(2):130–133.

DOI: http://dx.doi.org/10.4300/JGME-D-18-00437.1