

The Bilingual Physician: Seamless Switching From Medicaese to Plain Language

Kristie Hadden, PhD
Clifford Coleman, MD, MPH
Angela Scott, MD, PhD

Although approximately one-third of patients in the United States have low health literacy,¹ physicians continue to use jargon that is difficult for patients to understand.²⁻⁴ Little is known about why physicians use complex medical terms when talking with their patients, in spite of patient-centered recommendations to use plain language.^{5,6} In this perspective, we consider the roles of medical professional identity development and specialized language development—a language known as medicaese—in approaches for teaching residents to “code-switch” between medicaese and plain language in clinical encounters. We suggest that concepts from sociolinguistics may offer novel strategies to increase patient-centered communication. Focusing on “code-switching,” the seamless alternating between 2 or more languages observed in bilingual conversation,^{7,8} we consider reframing the professional identity of physicians as not solely experts fluent in the specialized language of medicine but also as bilingual speakers—skilled translators of medicaese into plain language.

Jargon and Medicaese

It is well known that physicians use medical jargon—words, phrases, or concepts that may be unfamiliar, misunderstood, or misinterpreted by others—when speaking with patients.²⁻⁴ Jargon is a component of the specialized professional language of medicine,⁹ often referred to as medicaese. Some evidence exists that physicians underestimate their use of jargon or overestimate patients’ comprehension of it, suggesting that they are so enculturated into the use of medicaese that they fail to recognize it.¹⁰⁻¹² Other studies indicate that medical professionals are well aware that their patients often fail to understand them and that the medical professionals become more pessimistic over the course of their training regarding patient comprehension of medical issues.¹³ This may imply that physicians’ failure to consistently use plain language in clinical encounters reflects the difficulty

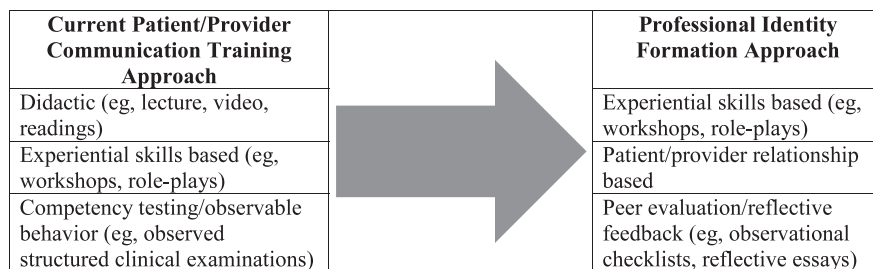
of the task or, perhaps, that inadequate attention is given to communication skills because of multiple competing priorities.

Code-Switching

When a speaker alternates between 2 or more languages, it is known as “code-switching” (or by the newer, related concept of “translanguaging”).^{7,8} Sociolinguists have studied code-switching for decades, but it is rarely mentioned as a factor in physician-patient communication. When a person code-switches between dialects (or styles), he or she may use different words, pronunciations, inflections, accents, idioms, and sentence structures. Most people naturally speak differently with different audiences and select which words to say to whom and how to say them. The speaker may not be aware of the change in his or her speech, because code-switching often occurs automatically. It is not known why some physicians fail to effectively code-switch from medicaese to lay language when speaking with patients and caregivers.

Early sociolinguists posited and tested paradigms that place the audience as a driver of code-switching, suggesting that physicians adjust the amount of jargon they use based on how they perceive a patient’s ability to understand. For example, patients who are perceived to have high health literacy may be subjected to greater amounts of jargon. However, this audience design theory has more recently been challenged by a speaker design theory, which proposes that speakers change the way they speak because of how they want to be perceived by their audience—the identity they wish to project.^{14,15} Therefore, residents’ use of jargon and medicaese may actually be driven, at least in part, by their desire to project a specific professional identity. Sociolinguistic scholarship highlights the extent to which language is tied to identity, suggesting that physicians’ continued use of undefined jargon may relate in interesting and modifiable ways to their perceived professional role within the encounter.¹⁶

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FIGURE

Description of Different Approaches to Training in Accreditation Council for Graduate Medical Education Competencies

Professional Identity Formation

Professional identity formation is the process by which residents transform from lay individuals into physicians.¹⁷ Before medical training, individuals use the language of the dominant culture(s) in which they live. Medical professional identity formation involves acculturation into the culture of western biomedicine, including learning the language of medicine.⁹ Residents' professional identities pass through a series of stages, characterized by differing developmental issues, including concerns about how they are perceived by others and the development of their competence.⁹ The use of medicalese may be 1 way in which residents and experienced physicians project a persona of competence, and this may evolve through the stages of professional development while competing with patient-centered communication competence.

Pedagogical Strategies

Recognizing the complex relationship between language and identity, we propose that tying communication skills to a resident's professional identity might lead to novel strategies for cultivating patient-centered language. Rather than conceptualizing the use of plain language as a momentary pause in their professional role, we suggest that residents may demonstrate more effective code-switching between medicalese and patient-centered language if code-switching is emphasized as a part of their professional identity formation. Framing the identity of a physician as not only an expert fluent in a specialized language but also a skilled bilingual speaker, capable of seamlessly shifting between 2 lexica as needed, may represent a way to leverage the "hidden curriculum" to motivate behavior change. Presenting code-switching as a specialized skill may lead to the use of plain language as a sign of intellectual prestige normally reserved for medical jargon.

Although most people shift their speech patterns somewhat based on the context of a conversation,

code-switching between 2 languages has also been characterized as a specific neurolinguistic capability of bilingual speakers.^{18,19} Once considered to be a sign of language incompetence (lack of true fluency in a second language, requiring the continued intermittent use of the first), code-switching between languages is now well established in the psycholinguistic literature as neurocognitive flexibility, which allows for a seamless fusion of 2 languages that are constantly and simultaneously activated in the speaker's neural circuitry.^{18,20,21} Reframing clinical communication in these terms may allow medical educators and residents to understand their idealized role as fundamentally bilingual—experts not only in content but also in communication. From this perspective, residents are not asked to step out of the role of expert to ensure patient comprehension. They are reminded that skillful integration of medical terminology and plain language is, in and of itself, a high-level professional skill to be mastered. Approaches to achieving Accreditation Council for Graduate Medical Education competencies on inter-professional and communication skills are further detailed in the FIGURE. This conceptual shift may be incorporated at various points in medical education and clinical training. Several curricular strategies and specific examples are listed in the TABLE. These examples are intended to be suggestions to foster further discussion, not an exhaustive list.

Future Directions

In this article we have introduced the sociolinguistic concept of code-switching as a potentially useful way to understand the relationship between clinical communication skills and physicians' professional identity formation. Specific curricular strategies also need to be explored to further elucidate concrete ways in which this conceptual reframing may be operationalized at various stages of medical training, including explicit discussion of code-switching in didactic sessions on professionalism and communication

TABLE

Strategies for Interprofessional and Communication Skills Development

Educational Strategy	Specific Examples
Inclusion of code-switching in didactic sessions related to professionalism and communication	Discussion of code-switching as a specific neurolinguistics skill during a session on communication skills Discussion of the physician's role as "translator" of medical information in a session on professionalism Role-playing exercises centered on the idea of physician as translator during case-based learning sessions
Collaboration between teaching faculty in ethics and professionalism and communication skills	Joint didactic presentations given by faculty from these areas to emphasize the relationship among them Interdepartmental collaboration to incorporate code-switching content and activities during group sessions
Explicit coaching on code-switching during daily clinical activities	Pre-encounter and postencounter discussion of the patient's needs related to a clinician's communication skills on rounds Asking residents to present the plan to the team "as they would to the patient" and discuss differences Peer and mentor monitoring of code-switching during patient interactions
Faculty modeling of consistent, skilled code-switching as part of their role as physician mentors	Faculty development related to modeling and practicing code-switching Opportunities for faculty reflection on professional identity, daily clinical duties, and mentoring
Specific competencies related to the overlap of communication skills and professionalization	Inclusion of specific communication skills, as related to patient advocacy, in professionalism milestones

skills, inclusion of code-switching in the evaluation rubric for simulated patient encounters, and use of peer or mentor exemplars to model and evaluate residents as they strive to embody the professional identity of an expert communicator. Additional research exploring professional identity formation, linguistic behavior, and relationships from the perspectives of medical residents, educators, and patients is needed to empirically investigate our conceptual suggestions.

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Kristie Hadden, PhD, is Assistant Professor and Executive Director, Center for Health Literacy, University of Arkansas for Medical Sciences; **Clifford Coleman, MD, MPH**, is Associate Professor, Department of Family Medicine, Oregon Health & Science University; and **Angela Scott, MD, PhD**, is Assistant Professor, Department of Pediatrics, University of Arkansas for Medical Sciences.

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Corresponding author: Kristie Hadden, PhD, University of Arkansas for Medical Sciences, #599A, 4301 W Markham Street, Little Rock, AR 72205, 501.686.2594, fax 501.661.7967, khadden@uams.edu