Presentation Pet Peeves

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It is a common trope that medical trainees learn a new language. The quantity of vocabulary mastered during medical training is staggering. Trainees must master words that are unusual in common parlance (perineum, edema) and those never uttered outside the hospital (neurosarcoidosis, encephalomalacia). Just like any language, medical speech is more than just vocabulary. Students learn a new grammar and syntax as part of their acculturation. They learn new connotations, such that "crushing substernal chest pain," "rusty sputum," or "black tarry stools" refer to unique conditions. The language allows us to transmit information in a way that is concise and accurate. A picture may be worth a thousand words, but "He is a 45-year-old with alcohol-related cardiomyopathy presenting with paroxysmal nocturnal dyspnea," is certainly worth more than its 15.

Like any language, ours is alive. As physicians, we know more than anyone that with time living things acquire imperfections. Odd constructions, shortcuts, and linguistic maneuvers to conceal laziness or ignorance accumulate in our medical vernacular. While our language acquires imperfections, so do physicians. Most of us develop idiosyncratic, practice-related aggravations. On bad days these are an annoyance; on good days they are a source of amusement.

As an academic general internist I listen to hundreds of case presentations each year. Certain aspects of our language have become my pet peeves, and I would like to share them with you:

Please do not refer to patients as *males* and *females*. We are men and women.

I do not need to hear the patient's *race* in the chief complaint. It is almost never important and probably fits best in the social history. When a black patient with cystic fibrosis or a white patient with sickle cell disease is admitted, let me know the race—otherwise, leave it out.

"*The patient denied . . .*" You are taking a history. If the patient said she did not experience a symptom, she did not experience it. If you are saying this to impress me by letting me know that you asked the question, realize that I have more faith in your knowledge than you think. If you think the patient is concealing something, let me know that.

"*This is a 50-year-old man with . . .*" a list of 12 diagnoses, and *then* the chief concern. This is distracting. I assume it is done only to avoid committing to 1 or 2 important aspects of the medical history. The best way to learn is to commit and be corrected.

"*Deferred.*" If you did not do a rectal examination, you did not defer it. You did not do it. It was a choice you made, and you might or might not have made a good one. I will tell you.

"*Complaint.*" Some people are complainers, and some patients are complainers—most are not. Use this word only when you need to provide its negative connotations.

"*Compliant.*" I think every one of us would strive to be adherent to a physician's recommendations. I cannot imagine that any of us would like to be described as compliant.

"*The vital signs are stable.*" Over the years, my colleagues have reminded me that the condition associated with the most stable vital signs is death.

"*The patient endorses . . .*" Who talks like that?

"*The labs are normal.*" Tell me the labs; I'll tell you if they are normal.

"*Do you want to hear the meds?*" My specialty is internal *medicine*.

"*The patient is a poor historian.*" You are the historian; the patient is the informant. Besides, I do not really think there are poor informants, just poor history takers.

"*Provider/client.*" I went to medical school to become a physician who cares for patients, not a provider who serves clients.

I'm happy to report that I am not the only one who harbors these irritations. Most of my colleagues, including my surgically oriented friends, are happy to reel off lists of their own.

On the one hand, these objections may seem unreasonable or even bizarre—but is that not what pet peeves are supposed to be?

On the other hand, these points, and many others that my precepting colleagues might add, are important. We reason with language. Thus, how we express ourselves affects what we think. Using phrases like "poor historian" and "noncompliant" cannot benefit our relationship with those for whom we care.

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Allowing trainees to present "stable vital signs" and "normal labs," but to skip reporting the medication list teaches them laziness in a field where careful attention is critical.

Precision, another trait that should be a hallmark of our field, is lost when we say "denies" to mean "lacks" or "deferred" to mean "opted not to."

It's not just for the benefit of today's patients (and preceptors) that we need to teach these lessons. We need to teach them for the benefit of future patients. I hope to avoid the day that a young physician at my bedside begins his presentation, "This is an elderly, bald, noncompliant, white, male, retired physician who appears much older than his stated age. He denies chest pain but endorses dyspnea."

I can only hope that he will defer the rectal examination.

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