

## Word-perfect

By Athos Rassias, M.D.

My colleagues sometimes wonder why I am so caught up in the meaning and proper usage of our language. I tend to focus on the use of a particular word or phrase, perseverate on it for a while, and then, after a year or so, move on to another linguistic topic.

My current issue (or stumbling block, some might say) is that I go around pointing out to people that antibiotic is, in fact, singular. DHMC, like many medical centers, has instituted a checklist for use before operations to improve communication among the members of the surgical team. When the checklist gets to the administration of antibiotics, the typical question is, “Are the antibiotics in?” We almost always use the drug cefazolin as the preoperative prophylaxis, so the correct response is “The antibiotic is in,” not “The antibiotics are in.”

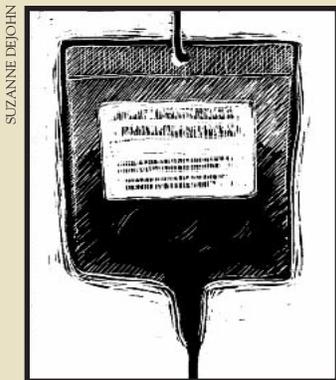
**Principle:** I have the same problem with steroid medications. When you prescribe prednisone, you are using a steroid, not “steroids.” Admittedly, things do get a bit complicated, as prednisone is converted by the liver into prednisolone, which is the active drug and is also a steroid. Regardless, the general principle is valid.

It is probably true that these are useless, obsessive thoughts, but it is also true that there are meaningful reasons to pay attention to the words we in medicine use. Our work is dependent upon clear, effective communication. As clinicians, we face constant demands. We are often doing more than one task at once, and our interactions with each other and with patients are often filled with interruptions; both multitasking and interruptions can contribute to medical errors. Researchers have found that about 80% of the time that clinicians are working, they are involved in some sort of communication, and 30% of all these communications involve interruptions.

This problem is very evident in the intensive care unit, where I spend about half of my time. This multidisciplinary work area might have different specialists, nurses, residents, respiratory therapists, pharmacists, dieticians, social workers, physical therapists, consultants, and others all working together at some point. It’s simply not possible to get through the ICU without talking to other physicians and staff members, and this diversity and abundance of people from different disciplines can make communication difficult.

**Complex:** It is wonderful to see effective communication, whether in the ICU or elsewhere. Unfortunately, medical errors do occur, of course, and a failure to communicate clearly is a common cause of

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medical errors. Hospitals are complex places, with many interconnected parts and interactions that are difficult to anticipate. Complexity is fertile territory for error, so health care has looked to other complex fields for ways to reduce error.

The aviation industry is a frequently cited example. The use of checklists and of language that is specific to a particular task are two means of reducing error, and both have a successful history in aviation. The use of checklists promotes collaboration and reduces the possibility of a communication failure. And using language specific to a given task

keeps communications regimented. For example, the interactions between a pilot and the control tower are tightly controlled, with a confirmatory response following every statement.

In medicine, as in aviation, precise thought and communication can foster a culture of safety, but the language we use must also be flexible enough to adapt to rapidly changing situations. Checklists might help in some of the situations we face, but they are not fluid or flexible, so we must use different types of language in different situations. And the problem with a purely prescriptive approach to language is that language changes. I was in a bookstore in Harvard Square many years ago and looked up to see a placard quoting my father, a language scholar at Dartmouth College: “Language is a living, kicking, fleeting, evolving reality.” Strict regimentation of the language we use in medicine will likely decrease our ability to respond to the types of emergencies common in medicine, possibly making medical errors more rather than less likely.

**Word:** The words we choose also matter to patients, particularly, I have found, in end-of-life care. Some time ago, a woman about my age was dying. She had a supportive family, and a child about the same age as my children. I was helping the family work through the process of allowing the woman to pass on. The ethical principle in this situation is that all individuals have the right to accept or refuse therapeutic interventions. In this particular situation, the decision-maker was the woman’s husband, as she was so ill that she was unable to participate. He was resistant to the idea of what we frequently call the “withdrawal of aggressive care.” But when we used the word “wean” to describe this process, he felt at peace. Conceptually, for him to have his wife weaned from, as opposed to abruptly stopping, the vasopressors, pulmonary vasodilators, renal dialysis, antibiotics, and other life-supporting treatments was what made all the difference. It was a simple distinction, but to him this one word changed everything.

Communication through language is a complex and multifaceted process; to treat it otherwise would be a mistake, potentially risking medical errors and affecting patient well-being. ■