Evaluation of the Use of Appropriate Medical Language in Surgical Consult Dictations

By: Adrianna Olszewski, CCPA, Irene Chhay, CCPA, Dr. Erin Kennedy, MD, Dr. Alexandra Easson, MD

Surgery
UNIVERSITY OF TORONTO

Introduction

- Accurate and descriptive medical documentation is essential to effective written communication between health care practitioners and with patients.
- With the increase in access to medical records by both patients and other practitioners in a circle of care, it has become exceedingly important to ensure the language used is respectful, objective, and detailed.
- Many common phrases taught in medical education programs are not objectively accurate or representative of patients' experiences.[2]
- Patients may feel that their symptoms, experiences, and values are misrepresented in medical documentation
- History taking, exploring a patient's background, and understanding their goals of care are vital in providing effective medical care.[1]

Objective

- To evaluate how often poor descriptive language as well as superior alternatives are used in documentation of new surgical patient encounters.
- This information will assist in determining how prevalent these terms are and allow for discussion around the best practice for medical documentation.

Methods

- One hundred patients who underwent elective general surgery between January and April of 2021 were randomly selected for review of their initial consult note.
- Eight terms listed below were identified as poor documentation terminology. The number of poor terms used were quantified in the clinical documentation.
- The author of the note was recorded as either a staff surgeon, fellow, resident, or medical student. Superior terms that were noted during the data collection process were recorded.

Concept	Example
Complaint	"Chief complaint"
Uncontrolled	"Uncontrolled diabetes"
Noncompliant	"Patient is noncompliant"
Label as illness	"Diabetic patient"
Denies	"Denies alcohol use"
Refuses	"Refuses surgical intervention"
Failed	"Failed medical management"
Body Habitus	"Large body habitus"

Table 1: Terms analyzed in clinical documentation.

Results

- There were a total of one hundred notes analyzed. Each patient was being seen by one of eleven staff surgeons. There were twenty six total authors of the clinical notes. The learners included 7 medical students, 8 residents, and 12 fellows. Two terms ("Complaint" and denies") were used in more than one notes.

Term	Total Uses	Used by __ Authors	Used in __ Notes
Complaint	11	7	10
Denies	24	10	12

Table 2: Analysis of the terms used in multiple notes.

Discussion

- The results demonstrate that documentation by surgeons and learners includes the terms "complain" and "deny" when describing patient experiences and symptoms. It was expected that the results would show increased use of these terms by learners earlier in their career, however, this was not the case.
- Superior terms were used in many notes as well.

Term	Alternative
Complains	"Reports", "describes", "has experienced", "endorses".
Denies	"Does not report", "has not had", "does not endorse".

Table 3: Alternative terms used in the documentation.

- These terms are taught in medical education programs as best practice, however, can be misinterpreted and influence the perception of a medical interaction.
- While patients report symptoms and experiences with their illness, labeling a concern as a complaint can be interpreted as negative judgement or disapproval of communicating the issue.
- Documenting that a patient denies alcohol use, or denies shortness of breath can be interpreted as defensive or potentially dishonest, while the patient simply does not consume alcohol and feels her breathing is normal.
- Another consideration discovered in the medical documentation were the terms "smoker" and "non-smoker". Labeling a patient as a smoker (instead of "a patient who smokes") bears a negative connotation as the term is associated with a specific stereotype.
- The goal of medical documentation is to provide an objective record of an interaction. These notes are referenced by the main physician as well as others in the circle of care.
- Therefore, the information must be presented succinctly, objectively, and accurately, which can be challenging. Inappropriate language can affect the perception of patients by health care practitioners which can perpetuate implicit bias.
- Patients are now able to access their medical information more easily, and some terminology that is commonplace among health care practitioners can be offensive or off-putting for patients to read. This can lead diminished trust in health care providers.

Conclusions

- The use of language that can be misinterpreted can have adverse effects on patient practitioner relationships, can inaccurately describe patient encounters, and can ultimately be detrimental to patient centred care.
- Discussion around appropriate terminology used to describe patient experiences should be facilitated by medical education programs throughout didactic and clinical training. It should also be discussed with staff physicians in an attempt to improve patient care overall.

Next Steps

- Moving forward it will be interesting to analyze medical education programs and the approach to teaching medical written communication.
- A focus group discussing patients' views of clinical notes written about them would be illuminating to assess patients' opinions of the accuracy and objectivity of the documentation. Discussion around how accurately their symptoms, concerns, and question are described, how they are perceived by their physician, and how the process of joint decision making is interpreted would be interesting.

References

1. *Foxman, S.* The ethics of communication. e*Dialogue by CPSO.* 2016; 12(3):33-34.
2. Sykes, D, Nichols, D. There is no denying it, our medical language needs an update. *Journal of Graduate Medical Education.* 2015; 7(1):137-138.