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PRIMARY CARE ENGLISH

 Springer

Primary Care English

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Library of Congress Control Number: 2007933313

ISBN 978-3-540-49617-5 Springer Berlin Heidelberg New York

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Editor: Dr. Ute Heilmann, Springer-Verlag
Desk Editor: Wilma McHugh, Springer-Verlag
Production: LE-T_EX Jelonek, Schmidt & Vöckler GbR, Leipzig
Typesetting: K+V Fotosatz GmbH, Beerfelden
Cover design: Estudio Calamar, F. Steinen-Broo, Pau/Girona, Spain

SPIN 11939108

24/3180/YL - 5 4 3 2 1 0 - Printed on acid-free paper

*To my youngest brother,
Manuel Ribes Bautista,
for his always sensible advice.*

R. Ribes

*To my father, my first English teacher;
to Carmen, my best pupil;
and to all the brave doctors in the world
who dare to cross the language frontier.*

I. García-Gimeno

*I dedicate this book
to my children, Daniel and Rosie.*

R. Jones

Preface

After the successful publication of *Medical English* and *Radiological English* by Springer I considered a top priority to keep on writing medical English books by specialties that could become useful tools for health care professionals and medical students all over the world.

Like its predecessors, *Primary Care English* is not written by English teachers and aimed at English students, but it is written by doctors and aimed at doctors.

In this book, some of the chapters, and their methodological approaches to the learning of medical English of both Medical and Radiological English, have been adapted to Primary Care. Being a radiologist myself, I would not have dared co-write a book on Primary Care English without the valuable partnership of Dr. García Gimeno and Prof. Jones and their contributors.

Dr. García Gimeno has done an excellent work, on the one hand, adapting to Primary Care some of the chapters of its predecessors, *Medical English* and *Radiological English*, and on the other hand, designing and writing new chapters, some of them based on *The Oxford Textbook of Primary Medical Care*, edited by Roger Jones. Dr. García Gimeno's commitment to the project since its inception has been the driving force behind the book.

The next book of the series, *Cardiovascular English*, will be published in the first trimester of 2008. We are currently working on two fascinating book projects, *English for Biomedical Scientists* and *Surgical English*, and hopefully will write more books aimed at health care professionals in the future.

Ramón Ribes, MD, PhD
October 2007

Preface

As a non-native English speaker, I have been learning English for as long as I can remember. However, when I came to England eight years ago to work as a general practitioner, believing that language would not be a problem, I was hit by reality. Communicating in English was not that easy! My 'advanced' level in *general* English was not enough. I required an advanced level in *medical* English to survive. Not only that, but as a family doctor I needed to understand the patients' *colloquial* English to be able to treat them without the risk of misunderstanding.

There were no books on medical English available to me at the time, and even the few that appeared later were largely 'general' and therefore insufficient in content. The book that I would have really liked to have at that time was the one you now hold in your hands: a book on *Primary Care English*.

Family medicine is highly demanding in terms of language skills. You are required not only to have knowledge of the language of all medical specialities, but also to talk to patients extensively, touching all aspects of life, in a way that makes communication skills a major component of a family doctor's competence. This combination of *breadth* and *depth* makes learning English in the primary care setting much more challenging than in other medical specialities. *Primary Care English* is the first book to address this challenge.

I would think of this book as a tree, where the trunk is *Medical English*, the branches are *The Oxford Textbook of Primary Medical Care* and the leaves and fruits are our clinical, learning and teaching *experience*.

Medical English has already offered the fundamentals of the English language required by all doctors. Grammar, Scientific Literature, Courses and Talks, Latin and Greek, Abbreviations and Conversational Survival Guide are common chapters, adapted to the primary care setting. But then, *Primary Care English* expands *Medical English* to reach the vast geography of primary care. Of course, full coverage is not possible, but we have selected the most interesting avenues to help you progress and explore most of the landscape – then, you will be able to enjoy discovering the rest by yourself.

The guiding rail for this expansion has been *The Oxford Textbook of Primary Medical Care*, edited by Roger Jones, which ensures that all main issues are included and the most academically relevant terminology is covered. It should be stressed that Family Medicine is much more than just

seeing patients – it hosts an entire body of knowledge about human nature and healthcare. This knowledge is integral to any family physician's education and language; hence the organisation of *The Oxford Textbook* in two large volumes called “Principles and Concepts” and “Clinical Management”, which is reflected in *Primary Care English*.

Finally, another major source of this book is *experience*. As a mentor of the London Deanery's International Induction Programme, I have supported and supervised foreign doctors during their adaptation to both work and life in Britain. I have had the chance to detect the commonest needs and mistakes of newly arrived family doctors, which has given me an invaluable insight to orient the book in the most useful way. Like myself, all the contributors to the clinical-language chapters are experienced non-native English-speaking doctors working in the UK. We have gathered all of our (painful!) learning experiences in this book to try and make easy for you what was so difficult for us.

For this purpose, my task has been to develop and apply a structure and methodology suitable to teach the specific kind of medical English required by practising clinicians (Units I & VII–IX). I found the answer to this challenge in a ‘hands-on’ approach, using texts and clinical practice ‘stories’ to put the learner in the context where learning is most enjoyable and efficient: *real life*. Nothing better, I thought, than reading a ‘proper’ textbook to master your specialty's academic language, and nothing better than sharing ‘a day in the life’ of a clinician to get familiar with the language of clinical practice. Also, I thought it useful to provide further help through the addition of a unit on the language of job applications (X) and three appendices with practical tools.

Learning medical English will not only open a new and fascinating world for you but it will also increase your chances of professional success. However, do not expect this to happen overnight: as with any form of exercise, you will need to persevere and practise to see progress. I hope you find in this book an ideal coach to develop that muscle which will make you professionally stronger: your *primary care English* muscle.

This book is not only addressed to family physicians who want to improve their individual learning and practice, but also to those who have (or plan to have) a role in the wider management of health services. I believe that the greatest influence in health services is, or should be, exerted by family physicians worldwide, both in their clinical and management roles. We hope this book will be an aid to eliminate the language obstacle in the sharing of learning for the pursuit of better health for all.

Isabel García-Gimeno, LMS, MSc
July 2007

Preface

It is a real pleasure to write this preface to *Primary Care English*. I know that this book is the product of an enormous amount of hard work, much of which has been driven by the passion of Dr. Isabel García-Gimeno and Dr. Ramón Ribes, who invited me to comment on the idea for the book some time ago. I am delighted that all this work has come to fruition and has resulted in the production of a very useful book which should have global appeal.

English, for a range of historical and cultural reasons, remains the major language of medical discourse. Most of the major textbooks originate in English-language-speaking countries, including the United States of America, and the majority of peer-reviewed clinical and biomedical journals are also published primarily in English. English is more often than not the *lingua franca* of medical conferences, so that conference abstracts, posters and oral presentations all need to be prepared in English. Wherever research is undertaken, publication in the highest-quality peer-reviewed journals also requires a manuscript to be prepared in English, and the quality of writing is often an important factor in editorial decisions about acceptance or rejection. Finally, applications for positions in medicine in English-speaking countries require the preparation of a Curriculum Vitae in English where, once again, presentation, fluency and accuracy in writing all count towards the assessment of quality and influence the likely success of an application for employment.

Primary Care English takes a fresh and appealing approach to developing familiarity with medical English, and accompanies the reader on a journey, visiting such important destinations as scientific literature in primary care, writing for journals, attending international conferences and courses, giving talks and chairing sessions, and some of the origins, in Latin and Greek, of medical terminology. Frequently used acronyms and abbreviations are discussed, and then the text explores the language used in describing the principles and concepts of primary care and the language of clinical practice, using examples drawn from the recently published *Oxford Textbook of Primary Medical Care*, of which I had the privilege of being editor in chief. *Primary Care English* covers the clinical ground thoroughly, and concludes with a discussion on applying for jobs in general practice, conversation in English and a series of appendices which provide practical tools for later use.

Curiously, working as a general practitioner in a multi-cultural part of London, the dominance of English as the language of primary care discourse seems to have been somewhat eroded. Between 15 and 20% of all the consultations that we undertake in my practice in Lambeth are now with patients for whom English is not the first, and may not even be the second, language, so that linguistic skills in non-English languages are often prized by both general practitioners and their patients. We have undertaken several research studies on the possible misunderstandings that can develop when patient and doctor do not share a common language. *Primary Care English* will ensure that primary care physicians are well equipped for their role in these potentially confusing encounters.

Primary Care English deserves the widest possible readership. We look forward to your response to the book and to receiving comments on how we can make it even better.

Professor Roger Jones
Head of General Practice and Primary Care
King's College London

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Unit I Introduction to Primary Care English

Why Do You Need This Book?

Not being able to read, write or speak in English is a serious obstacle in your career. You may be thinking of improving your English for any or all of the following reasons:

- to understand scientific literature and be up to date in your clinical practice;
- to write research articles and contribute to the general body of knowledge and advancement of family medicine;
- to attend international courses or conferences;
- to give talks or presentations in international settings;
- to train abroad in a specialty or subspecialty;
- to spend a sabbatical abroad;
- to work as a family doctor in an English-speaking country;
- to receive international visitors in your country;
- to discuss clinical, academic or managerial issues in primary care with international colleagues;
- to read primary care books and textbooks avoiding delayed and poor translations.

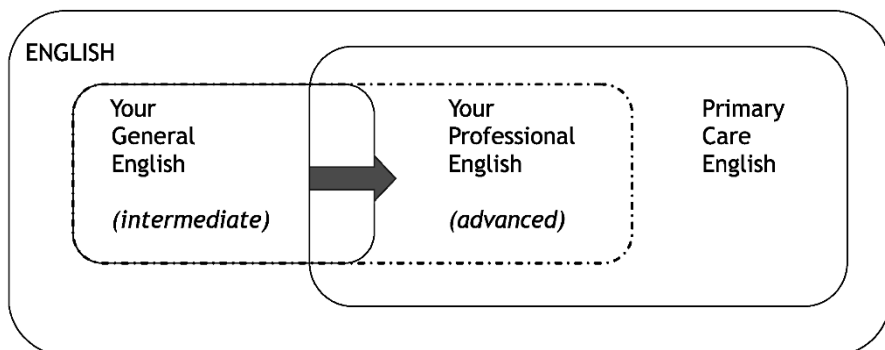
English is your key to international medicine. Only with good understanding and articulation of the English language can you be part of the international medical community and access the international body of medical knowledge – not only an exciting opportunity to develop personally and professionally, but almost a duty.

What Will It Do for You?

The starting point is your current level of *general* English, which we assume is *intermediate* or *advanced*. The end point after studying this book will be an *advanced level of primary care English*.

It is often said that doctors already need to have an advanced level of English to embark on medical English learning. Although this is the ideal

situation and it is highly recommended, unfortunately this is not always the case. It does not happen in the majority of cases. The reality is that most doctors have an intermediate level, and because their main motivation for learning English is Medicine, they are not likely to persevere towards an advanced level without incorporating Medicine into their English learning. This is why this book is addressed to both advanced and *intermediate* English speakers.



what this book expands in your English

What Kind of Book Is It?

This is not a conventional language book. It is written by doctors for doctors, not by English teachers for English students. It is a conversation between peers, from experienced professional learners to less experienced ones. We are trying to teach you what we have learned, including the ‘tricks’ and the ‘traps’ that have confused us and (hopefully) shall not confuse you.

The first six units form the general foundation, from which you will build specific primary care language using the other units.

In Units VII and IX, we have selected text and case examples that include a variety of expressions for which we give explanations and comments on the opposite page. Therefore, you won’t need to constantly consult a dictionary or your English teacher – the teacher is inside the book. This will help you learn much quicker and with less effort than you had imagined!

This book is a friendly, often informal, companion. We aspire to make your learning enjoyable. We aim to help you learn “*English without tears*” ... hopefully with a smile!

This is not an exercise book. Life is full of practice opportunities and you will probably prefer them.

Is it a reference book or a learning book? We were presented with this dilemma and have chosen a balance between the two – a balance between

easy-reading prose and easy-finding lists, between readable and useful, and between enjoyable and comprehensive.

How Should You Use It?

Choose the order

The English level required for the initial more ‘academic’ units (II–VI) is higher than the rest, as it is presumed that the interested readers would have attained this level. For learners with a lower level, we recommend reading the ‘explained’ units first (VII–IX) as an appetiser, and then going back to read the whole book from Unit II.

Read slowly

Reading is a great way to learn – probably the most realistic one for you, as it is relatively easy and most flexible. There is a lot of subliminal learning in reading, but you can enhance it by doing it *slowly* and paying careful attention to detail. This book is a concentrate, so drink it in small sips. Try to discover why each sentence is there for you. Do not rush: relax ... and read slowly, *very slowly*. Taste each word and phrase, repeat them in your mind, repeat them aloud; imagine the scene and yourself in it, be active and take part. Passive learning is good, but active learning is better!

Use dictionaries

Ideally, you would use several dictionaries for reference, including:

1. An English dictionary
2. A bilingual dictionary
3. An English medical dictionary
4. A bilingual medical dictionary

Some of the dictionaries we have used and recommend are:

- Oxford Concise English Dictionary
- Microsoft Encarta World English Dictionary
(available in Word with a right click of your mouse)
- Apple Dashboard Dictionary (available on Apple Macintosh computers)
- Stedman’s Concise Medical Dictionary for the Health Professions

The first dictionary is British and the other three are American. Oxford’s Dictionary has a useful footnote on all pages as a reminder of how the phonetic symbols sound, so you can learn to pronounce any word you look

up. Computer-based dictionaries are ideal to use while you are writing or reading documents in an electronic format. Stedman's Dictionary contains an audio CD-ROM with all the medical words pronounced for you. It also contains valuable anatomy plates to learn specific anatomical terms.

Take notes

Take a pencil and mark in the book anything that calls your attention.

Create your own personal bilingual dictionary as suggested in Appendix 1. Write down anything that you would like to have to hand, either taken from *Primary Care English* or elsewhere. Use it to practise and reinforce your learning, and for future reference.

Pronounce

As you know, of course, English pronunciation has been intentionally designed to embarrass you! There are not enough rules that you can study, so you will not know how words are pronounced correctly until you hear them first hand. You will use trial and error – and often discover that you have chosen the wrong option! Well, do not worry; it is not your fault! However, do not miss the opportunity to learn the right choice by noting it and repeating it. Repeat, repeat, repeat!

Use Stedman's dictionary, the symbols included in this book (PCE), or your English teacher.

Do not forget the abbreviations. A star (★) follows abbreviations that are very commonly used in spoken form and that we recommend practising.

Express yourself

This book should help you to express yourself, not just understand. While you read it, take note of the expressions that you would like to use at the next available opportunity. Do not assume that if you understood it easily, you already 'know' that piece of language. Read each line, each sentence and each word, carefully. Even if you do understand it easily, stop and think: 'Would I have been able to write or say this myself?' 'Is anything said in a different way to how I would say it in my own language?' Include the order of words, verb tenses and use of prepositions. Sharpen your observation and learn from your discoveries. This will help you to not only understand but also be able to express yourself much better in English.

This is important because, although you would be content with 'surviving' at first, quite soon you will want to say something interesting. You will want to be able to discuss practice management or medical ethics with an

international colleague, for instance. If you live or stay in an English-speaking country, you will also want to learn how to express yourself in areas that cross the borders of medicine; otherwise, your self-esteem may suffer. So, take note of anything you find in this book that could help you to express yourself.

Practise

- Read medical books
- Phone and write to international colleagues regularly
- Watch films/TV in English
- Join medical English courses

Feedback

Books like this require a collective effort. Your feedback could help us prepare an even better second edition of PCE. If you have any ideas or comments, would like to contribute to further editions or titles of the series, or would like to be informed of PCE courses, just write to us at primarycareenglish@yahoo.co.uk.



CAN I borrow your stethoscope?



LALANDA

MAY I borrow your stethoscope?



COULD I borrow your stethoscope?



MIGHT I borrow your stethoscope?

Unit II Grammar in Use

The first chapters are probably the least read by most readers, and in our opinion it is precisely in the first chapters that the most important information of a book is given. It is in its first chapters that the foundations of a book are laid, and many readers do not get the most out of reading a manual because they skip its fundamentals.

This is a vital chapter because unless you have a good knowledge of English grammar you will be absolutely unable to speak the English that is expected from a well-trained family physician. At your expected English level it is definitely not enough just to be understood; you must speak fluently and your command of the English language must allow you to communicate with your colleagues regardless of their nationality.

As you will soon see, this grammar section is made up of sentences used in primary care; thus, at the same time that you revise, for instance, the passive voice, you will be reviewing how to say usual sentences in day-to-day primary care English such as, “The first patient had already been seen by the locum when Dr. Late arrived at the surgery”.

We will review the following topics of interest:

- Verb tenses
- Modal verbs
- Conditionals
- Passive voice
- Reported speech
- Questions
- Infinitive/-ing
- Countable and uncountable nouns
- Articles: a/an and the
- Word order
- Relative clauses
- Adjectives
- Prepositions

Tenses

Talking About the Present

Present continuous

The present continuous tense shows an action that is happening in the present time at, or around, the moment of speaking.

Present simple of the verb *to be* + gerund of the verb: *am/are/is ...-ing*.

Study this example:

It is 6:15 in the evening and Dr. Smith is on his bicycle on his way to visit a patient at home.

So: He *is cycling* to a patient's home. He is cycling to the patient's home means that he is cycling now, at the time of speaking.

USES	To talk about: • Something that is happening at the time of speaking (i.e. now): – Dr. Hudson <i>is going</i> to the treatment room. – The practice nurse <i>is performing</i> an electrocardiogram. • Something that is happening around or close to the time of speaking, but not necessarily exactly at the time of speaking: – Jim and John are registrars of general practice and they are having a sandwich in the staff room. John says: “I <i>am writing</i> an interesting article on patient concordance and medication. I’ll lend it to you when I’ve finished it”. As you can see John is not writing the article at the time of speaking. He means that he has begun to write the article but has not finished it yet. He is in the middle of writing it. • Something that is happening for a limited period of time around the present (e.g. today, this week, this season, this year): – Our practice nurses <i>are working</i> hard this week. • Changing situations: – From a physical point of view, the patient’s condition <i>is getting</i> better. • Temporary situations: – I <i>am living</i> with some friends until I can buy my own apartment. – I <i>am doing</i> a rotation in general practice until the end of May. <i>Special use:</i> Present continuous with a future meaning.

USES	In the following examples doing these things has already been arranged. • To talk about what you have arranged to do in the near future (personal arrangements). – We are having a meeting to discuss the appointment system on Monday. – I <i>am having</i> dinner with a nurse practitioner from the United States tomorrow. We can also use the form <i>going to</i> in these sentences, but it is less natural when you talk about arrangements. We do not use the simple present or <i>will</i> for personal arrangements.

Simple present

The simple present tense shows an action that happens again and again (repeated action) in the present time, but not necessarily at the time of speaking.

FORM	The simple present has the following forms: • Affirmative: as in the infinitive (remember to add -s or -es to the third person singular) • Negative – I/we/you/they don't ... – He/she/it doesn't ... • Interrogative – Do I/we/you/they ... ? – Does he/she/it ... ? Study this example: • Dr. Allan is the chairman of the Primary Care Trust. He is at an international course in Greece at this moment. So: He <i>is not running</i> the Primary Care Trust now (because he is in Greece), but <i>he runs</i> the Primary Care Trust.

USES

- To talk about something that happens all the time or repeatedly, or something that is true in general. Here, it is not important whether the action is happening at the time of speaking:
 - I *do* minor surgery.
 - Counsellors *take care* of patient's psychological needs.
 - For ear syringing, the application of oil to the affected ear canal *serves* to loosen the cerumen.
- To say how often we do things:
 - I *begin* to see patients at 8.30 every morning.
 - The practice manager *does* the accounts.
 - When *do you go* on sabbatical? In 1 month.
- For a permanent situation (a situation that stays the same for a long time):
 - I *work* as a nurse practitioner in this health centre. I have been working here for 10 years.
- Some verbs are used only in simple tenses. These verbs are verbs of thinking or mental activity, feeling, possession and perception, and reporting verbs. We often use *can* instead of the present tense with verbs of perception:
 - Now I *can understand* why the appointment system needs to be changed.
 - I *can see* how inadequate the telephone system is.
- The simple present is often used with adverbs of frequency such as *always*, *often*, *sometimes*, *rarely*, *never*, *every week*, and *twice a year*:
 - The deputising service *always* works at/on weekends.
 - We *have* working lunches *every week*.
- Simple present with a future meaning. We use it to talk about timetables or schedules:
 - What time *does* the evening surgery *start*? It *starts* at 4.30 p.m.

Talking About the Future

Going To

USES	• To say what we have already decided to do or what we intend to do in the future: – I <i>am going to</i> complete all my paperwork next week. – I am going to speak to the patient now. <i>Are you going to</i> come with me? • To say what someone has arranged to do (personal arrangements), but remember that we prefer to use the present continuous because it sounds more natural: – What time <i>are you going to meet</i> the nurses? – What time <i>are you going to</i> begin the weekly staff meeting? • To say what we think will happen (making predictions): – The patient is angry. I think we <i>are not going to</i> get a reliable account of the problem. – Oh, the patient's chest X-ray looks terrible. "I think he is going to die soon", the specialist said. • If we want to say what someone intended to do in the past but did not do, we use <i>was/were going to</i>: – He <i>was going to</i> write to the patient and ask him to come to the surgery, but he changed his mind at the last minute. • To talk about past predictions we use <i>was/were going to</i>: – Dr. Kovac had decided what to say about the mistake but feared the patient <i>was going to</i> make a complaint.

Simple Future (Will)

FORM	I/we <i>will</i> or <i>shall</i> (<i>will</i> is more common than <i>shall</i>. <i>Shall</i> is often used in questions to make offers and suggestions): • <i>Shall</i> we go to the patient participation group meeting next week? Oh, great idea! <i>You/he/she/it/they will.</i> Negative: <i>shan't, won't.</i>

USES

- We use *will* when we decide to do something at the time of speaking (remember that in this situation, you cannot use the simple present):
 - Have you finished the protocol?
 - No, I haven't had time to do it.
 - OK, don't worry, I *will* do it.
- When offering, agreeing, refusing and promising to do something, or when asking someone to do something:
 - Are you running late in surgery this morning? Don't worry, I *will* help you out.
 - Can I have the book back about respiratory medicine that I lent you? Of course, I *will* give it back to you tomorrow.
 - I cannot go on the home visit now; I *won't* be back in time to start my afternoon surgery.
 - Once I have finished my paperwork I *will* join you in the meeting.
 - *Will* you ask the next patient to come in, please?
- To predict a future happening or a future situation:
 - The face of general practice *will* be very different in a hundred years' time.
 - The methods we use to refer patients to hospital *won't* be the same in the next two decades.

Remember that if there is something in the present situation that shows us what will happen in the future (near future), we use *going to* instead of *will*.

- With expressions such as: *probably, I am sure, I bet, I think, I suppose, I guess*:
 - I *will probably* attend the next annual conference.
 - You should go to Dr. Helms's conference. I *am sure* you *will* love it.
 - I *bet* the patient *will* recover satisfactorily after the reaction following the administration of pneumococcal vaccine.
 - I *guess* I *will* see you at the next meeting.

Future Continuous

FORM	<i>Will be</i> + gerund of the verb.
USES	- To say that we will be in the middle of something at a certain time in the future: - This time tomorrow morning I <i>will be doing</i> my first unsupervised surgery. - To talk about things that are already planned or decided (similar to the present continuous with a future meaning): - We can't meet this lunchtime. I <i>will be meeting</i> the family of the patient we talked about. - To ask about people's plans, especially when we want something or want someone to do something (interrogative form): <i>Will</i> you be available to help me with this medical report this evening?

Future Perfect

FORM	<i>Will have</i> + past participle of the verb.
	- To say that something will already have happened before a certain time in the future: - I think the baby <i>will already have been born</i> by the time she gets the appointment for the scan. - Next spring I <i>will have been working</i> in the NHS for 25 years.

Talking About the Past

Simple Past

FORM	The simple past has the following forms: - Affirmative: - The past of the regular verbs is formed by adding <i>-ed</i> to the infinitive. - The past of the irregular verbs has its own form. - Negative: <i>Did/didn't</i> + the base form of the verb. - Questions: <i>Did I/you/ ...</i> + the base form of the verb.

USES	• To talk about actions or situations in the past (they have already finished): – I really <i>enjoyed</i> the practice Christmas party. – When I <i>worked</i> as a visiting practitioner in Madrid, I <i>performed</i> 100 minor surgery operations in general practice. • To say that one thing happened after another: – Yesterday we <i>had</i> a terrible day. We <i>did two</i> full surgeries and then we <i>attended</i> an evening meeting on the current staff crisis at our local hospital. • To ask or say <i>when</i> or <i>what time</i> something happened: – When <i>were</i> you last on call? • To tell a story and to talk about happenings and actions that are not connected with the present (historical events): – Pasteur <i>discovered</i> penicillin.

Past Continuous

FORM	<i>Was/were</i> + gerund of the verb.
USES	• To say that someone was in the middle of doing something at a certain time. The action or situation had already started before this time but hadn't finished: • This time last year I <i>was writing</i> the article on the use of antibiotics in sinusitis that has been recently published. Notice that the past continuous does not tell us whether an action was finished or not. Perhaps it was, perhaps it was not. • To describe a scene: – A lot of patients <i>were waiting</i> in the corridor to have their flu jab done.

Present Perfect

FORM	<i>Have/has</i> + past participle of the verb.

USES

- To talk about the present result of a past action.
- To talk about a recent happening.

In the latter situation you can use the present perfect with the following particles:

- *Just* (i.e. a short time ago): to say something has happened a short time ago:
 - Dr. Spanswick *has just arrived* at the practice. He is our new GP Registrar.
- *Already*: to say something has happened sooner than expected:
 - The practice *has already run out of* flu vaccine.

Remember that to talk about a recent happening we can also use the simple past:

- To talk about a period of time that continues up to the present (an unfinished period of time):
 - We use the expressions *today, this morning, this evening, this week ...*
 - We often use *ever* and *never*.
- To talk about something that we are expecting. In this situation we use *yet* to show that the speaker is expecting something to happen, but only in questions and negative sentences:
 - Dr. Helms *has not arrived yet*.
- To talk about something you have never done or something you have not done during a period of time that continues up to the present:
 - I *have not injected a joint* since I was a resident.
- To talk about how much we have done, how many things we have done or how many times we have done something:
 - I *have submitted* that critical incident form twice because the first one was lost.
 - Dr. Timothy *has carried out* 20 home visits this week.
- To talk about situations that have existed for a long time, especially if we say *always*. In this case the situation still exists now:
 - Lidocaine *has always been* the preferred local anaesthetic agent used in minor surgical procedures.
 - Dr. Bartholomew *has always been* a reliable locum.

We also use the present perfect with these expressions:

- Superlative: *It is the most ...*:
 - This is *the most* tedious lecture I *have ever attended*.
- The *first (second, third ...)* time ...:
 - This is the *first time* that I *have seen* a home birth.

Present Perfect Continuous

Shows an action that began in the past and has continued to the present time.

FORM	Have/has been + gerund.
USES	• To talk about an action that began in the past and has recently stopped or just stopped: – You look tired. <i>Have you been studying</i> all night? – Yes, <i>I have been writing</i> an article on the incidence of chlamydia trachomatis infection in the under 25 s. • To ask or say how long something has been happening. In this case the action or situation began in the past and is still happening or has just stopped. – Dr. Sancho and Dr. Martos <i>have been working</i> together on the project <i>from</i> the beginning. We use the following particles: • <i>How long ...?</i> (to ask how long): – <i>How long</i> have you been working as a practice nurse? • <i>For, since</i> (to say how long): – I have been working as a practice nurse <i>for</i> ten years. – I have been working very hard <i>since</i> I got this grant. • <i>For</i> (to say how long as a period of time): – I have been doing practice nursing <i>for</i> three years. Do not use <i>for</i> in expressions with <i>all</i>: “I have been working as a health care assistant <i>all</i> my life” (not “<i>for all</i> my life”). • <i>Since</i> (to say the beginning of a period): – I have been teaching undergraduate medical students <i>since</i> 1991. In the present perfect continuous the important thing is the action itself and it does not matter whether the action is finished or not. The action can be finished (just finished) or not (still happening). In the present perfect the important thing is the result of the action and not the action itself. The action is completely finished.

Past Perfect

Shows an action that happened in the past before another past action. It is the past of the present perfect.

FORM	<i>Had</i> + past participle of the verb.
USES	- To say that something had already happened before something else happened: - When I arrived at the practice, the receptionist <i>had</i> already <i>be-gun</i> booking patients into the morning surgeries.

Past Perfect Continuous

Shows an action that began in the past and went on up to a time in the past. It is the past of the present perfect continuous.

FORM	<i>Had been</i> + gerund of the verb.
USES	- To say how long something had been happening before something else happened: - She <i>had been working</i> as a data input clerk for 10 years before she applied for the position of practice secretary.

Subjunctive

Imagine this situation:

- The GP says to the practice nurse, “Why don’t you do a blood pressure check on the patient with a headache?”
- The GP proposes (that) the nurse do a blood pressure check on the patient with headache.

The subjunctive is always formed with the base form of the verb (the infinitive without to):

- I suggest (that) you *work* harder.
- She recommended (that) he *give up* smoking.
- He insisted (that) she *contact* the patient as soon as possible.
- He demanded (that) the nurse *treat him* with more respect.

Note that the subjunctive of the verb *to be* is usually passive:

- He insisted (that) the blood pressure *be measured* immediately.

You can use the subjunctive after:

- Propose
- Suggest
- Recommend
- Insist
- Demand

You can use the subjunctive for the past, present or future:

- He *suggested* (that) the data input clerk correct the results on the report.
- He *recommends* (that) his patients *give up* smoking.

Should is sometimes used instead of the subjunctive:

- The doctor recommended that *I should give up smoking*; he suspects that I have COPD.

Wish, If Only, Would

Wish

- *Wish* + simple past. To say that we regret something (i.e. that something is not as we would like it to be) in the present:
 - *I wish I were* not working tomorrow (but I am duty doctor tomorrow).
- *Wish* + past perfect. To say that we regret something that happened or didn't happen in the past:
 - *I wish he hadn't treated* the patient's family so badly (but he treated the patient's family badly).
- *Wish* + *would* + infinitive without *to* when we want something to happen or change or somebody to do something:
 - *I wish you wouldn't start your surgery so late* (note that the speaker is complaining about the present situation or the way other people do things).

If Only

If only can be used in exactly the same way as *wish*. It has the same meaning as *wish* but is more dramatic:

- *If only* + past simple (expresses regret in the present):
 - *If only I were* not on call tomorrow.
- *If only* + past perfect (expresses regret in the past):
 - *If only he hadn't treated* the patient's family so badly.

After *wish* and *if only* we use *were* (with *I, he, she, it*) instead of *was*, and we do not normally use *would*, although sometimes it is possible, or *would have*.

When referring to the present or future, *wish* and *if only* are followed by a past tense, and when referring to the past by a past perfect tense.

Would

Would is used:

- As a modal verb in offers, invitations and requests (i.e. to ask someone to do something):
 - *Would* you help me to do a Doppler ankle brachial pressure measurement? (request).
 - *Would* you like to come to the practice party tonight? (offer and invitation).
- After *wish* (see *Wish*).
- In *if* sentences (see *Conditionals*).
- Sometimes as the past of *will* (in reported speech):
 - Dr. Smith: I will aspirate the cyst on your back next week.
 - Patient: The doctor said that he *would* do my cyst next week.
- When you remember things that often happened (similar to *used to*):
 - When we were at the old surgery we shared a consulting room.
 - When we were at the old surgery, we *would* share a consulting room.

Modal Verbs

FORM

- A modal verb always has the same form.
- There is no *-s* ending in the third person singular, no *-ing* form and no *-ed* form.
- After a modal verb we use the infinitive without *to* (i.e. the base form of the verb).

These are the English modal verbs:

- *Can* (past form is *could*)
- *Could* (also a modal with its own meaning)
- *May* (past form is *might*)
- *Might* (also a modal with its own meaning)
- *Will*
- *Would*
- *Shall*
- *Should*
- *Ought to*
- *Must*
- *Need*
- *Dare*

FORM

We use modal verbs to talk about:

- Ability
- Necessity
- Possibility
- Certainty
- Permission
- Obligation

Expressing Ability

To express ability we can use:

- *Can* (only in the present tense)
- *Could* (only in the past tense)
- *Be able to* (in all tenses)

Ability in the Present

Can (more usual) or *am/is/are able to* (less usual):

- Dr. Williams *can* do really delicate facial sutures.
- Dr. Mohammed *is able to* perform endometrial biopsies in his minor surgery clinics.
- *Can* you speak medical English? Yes, I *can*.
- *Are you able to* speak medical English? Yes, I am.

Ability in the Past

Could (past form of *can*) or *was/were able to*.

We use *could* to say that someone had the *general* ability to do something:

- When I was a registrar I *could* speak German.

We use *was/were able to* when we want to say that someone managed to do something in one particular situation (*specific* ability to do something):

- When I first started in general practice I *was able to* see 50 patients per day.

Managed to can replace *was able to*:

- When I first started in general practice I *managed to* see 50 patients per day.

We use *could have* to say that we had the ability to do something but we did not do it:

- He *could have* been a surgeon but he became a neurologist instead.

Sometimes we use *could* to talk about ability in a situation which we are imagining (here *could* = *would be able to*):

- I couldn't do your job. I'm not clever enough.

We use *will be able to* when we want to talk about ability with a future meaning:

- If you keep on studying Primary Care English you *will be able to* write articles for journals very soon.

Expressing Necessity

Necessity means that you cannot avoid doing something.

To say that it is necessary to do something we can use *must* or *have to*.

- Necessity in the present: *must*, *have/has to*.
- Necessity in the past: *had to*.
- Necessity in the future: *must* or *will have to*.

Notice that to express necessity in the past we do not use *must*.

There are some differences between *must* and *have to*:

- We use *must* when the speaker is expressing personal feelings or authority, saying what he or she thinks is necessary:
 - Your chest X-ray film shows severe emphysema. You *must* give up smoking.
- We use *have to* when the speaker is not expressing personal feelings or authority. The speaker is just giving facts or expressing the authority of another person (external authority), often a law or a rule:
 - All practice nurses *have to* learn how to perform cervical smears before they can carry them out independently.

If we want to express that there is a necessity to avoid doing something, we use *mustn't* (i.e. *not allowed to*):

- You *mustn't* eat anything before the intravenous administration of contrast agent.

Expressing No Necessity

To express that there is no necessity we can use the negative forms of *need* or *have to*:

- No necessity in the present: *needn't* or *don't/doesn't have to*.
- No necessity in the past: *didn't need*, *didn't have to*.
- No necessity in the future: *won't have to*.

Notice that “there is no necessity to do something” is completely different from “there is a necessity not to do something”.

In conclusion, we use *mustn't* when we are not allowed to do something or when there is a necessity not to do it, and we use the negative form of *have to* or *needn't* when there is no necessity to do something but we can do it if we want to:

- The doctor says *I mustn't* get overtired before the procedure but *I needn't* stay in bed.
- The doctor says *I mustn't* get overtired before the procedure but *I don't have to* stay in bed.

Expressing Possibility

To express possibility we can use *can*, *could*, *may* or *might* (from more to less certainty: *can* → *may* → *might* → *could*).

But also note that “can” is used to describe ability (or capacity) to do something; “may” of permission or sanction to do it.

Possibility in the Present

To say that something is possible we use *can*, *may*, *might*, *could*:

- Heavy smoking *can* cause you to get cancer (high level of certainty).
- Smoking *may* actually cause you to get cancer (moderate to high level of certainty).
- Smoking *might* cause you to get lung cancer (moderate to low level of certainty).
- Smoking *could* cause you to develop breast cancer (low level of certainty).

Possibility in the Past

To say that something was possible in the past we use *may have*, *might have*, *could have*:

- The lesion *might have* been detected on mammography if further views had been taken.

Could have is also used to say that something was a possibility or opportunity but it didn't happen:

- You were lucky to be treated with chemotherapy, otherwise you *could have* died.

I *couldn't have* done something (i.e. I wouldn't have been able to do it even if I had wanted to or tried to do it):

- She *couldn't have* felt that abdominal mass on palpation anyway, because it was extremely small on the ultrasound.

Possibility in the Future

To talk about possible future actions or happenings we use *may*, *might*, *could* (especially in suggestions):

- I'm not sure where to spend my sabbatical. I *may/might* go to the States.
- We *could* meet later at the practice to read through the partnership deed, couldn't we?

When we are talking about possible future plans we can also use the continuous form *may/might/could be + -ing* form:

- I *could be going* to the next child protection meeting.

Expressing Certainty

To say we are sure that something is true we use *must*:

- You have been staying at work till very late these last few days. You *must* be very tired (i.e. I am sure that you are tired).

To say that we think something is impossible we use *can't*:

- According to his clinical findings and test results, that diagnosis *can't* be true (i.e. It is impossible that that diagnosis be true *or* I am sure that that diagnosis is not true).

For past situations we use *must have* and *can't have*. We can also use *couldn't have* instead of *can't have*:

- Taking into consideration the situation, the family of the patient *couldn't have* asked for more.

Remember that to express certainty we can also use *will*:

- The patient has been told his biopsy results *will* be available at his next consultation.

Expressing Permission

To talk about permission we can use *can*, *may* (more formal than *can*) or *be allowed to*.

Permission in the Present

Can, may or am/is/are allowed to:

- You *can* smoke if you like.
- You *are allowed to* smoke.
- You *may* attend the Congress.

Permission in the Past

Was/were allowed to:

- *Were you allowed to* treat the patient in his home?

Permission in the Future

Will be allowed to:

- I *will be allowed to* sign my own prescriptions when my registration number comes through.

To ask for permission we use *can, may, could* or *might* (from less to more formal) but not *be allowed to*:

- Hi, Hannah, *can* I borrow your digital camera? (if you are asking for a friend's digital camera).
- Dr. Kildare, *may* I borrow your digital camera? (if you are talking to an acquaintance).
- *Could* I use your digital camera, Dr. Coltrane? (if you are talking to a colleague you do not know very well).
- *Might* I use your digital camera, Dr. De Roos? (if you are asking for the chairman's digital camera).

Expressing Obligation or Giving Advice

Obligation means that something is the right thing to do.

When we want to say what we think is a good thing to do or the right thing to do we use *should* or *ought to* (a little stronger than *should*).

Should and *ought to* can be used for giving advice:

- You *ought to* sleep.
- You *should* work out.
- You *ought to* give up smoking.
- *Ought he to* see a doctor?/Do you think he *ought to* see a doctor?
Yes, I think he *ought to*.
- *Should* he see a doctor? Yes, I think he *should*.

Conditionals

Conditional sentences have two parts:

1. “If”-clause
2. Main clause

In the sentence “If I were you I would go to the annual GP conference”, “If I were you” is the if-clause, and “I would go to the annual GP conference” is the main clause.

The if-clause can come before or after the main clause. We often put a comma when the if-clause comes first.

Main Types of Conditional Sentences

Type 0

To talk about things that are always true (general truths).

If + simple present + simple present:

- *If* you get the parent to hold the child’s head firmly, you can safely examine the external auditory canal.
- *If* you palpate a mass in the abdomen, refer the patient.
- *If* you drink too much alcohol, you get a headache.
- *If* you take drugs habitually, you become addicted.

Note that the examples above refer to things that are normally true. They make no reference to the future; they represent a present simple concept. This is the basic (or classic) form of the conditional type 0.

There are possible variations of this form. In the if-clause and in the main clause we can use the present continuous, present perfect simple or present perfect continuous instead of the present simple. In the main clause we can also use the imperative instead of the present simple:

- Delegates only get a certificate *if* they *have attended* the whole conference.

So the type 0 form can be reduced to:

- *If* + present form + present form or imperative.

Present forms include the present simple, present continuous, present perfect simple and present perfect continuous.

Type 1

To talk about future situations that the speaker thinks are likely to happen (the speaker is thinking about a real possibility in the future).

If + simple present + future simple (*will*):

- *If I find something new about the treatment of malignant obstructive jaundice, I will tell you.*
- *If we analyse contrast agents, we will be able to infer laws and principles about their effect over renal function.*

These examples refer to future things that are possible and it is quite probable that they will happen. This is the basic (or classic) form of the conditional type 1.

There are possible variations of the basic form. In the *if*-clause we can use the present continuous, the present perfect or the present perfect continuous instead of the present simple. In the main clause we can use the future continuous, future perfect simple or future perfect continuous instead of the future simple. Modals, such as *can*, *may* or *might*, are also possible.

So the form of type 1 can be reduced to:

- *If* + present form + future form

Future forms include the future simple, future continuous, future perfect simple, and future perfect continuous.

Type 2

To talk about future situations that the speaker thinks are possible but not probable (the speaker is imagining a possible future situation) or to talk about unreal situations in the present.

If + simple past + conditional (*would*):

- Peter, *if you studied* harder, you *would* be better prepared for doing your final exams in the summer.

The above sentence tells us that it is supposed that Peter is not studying hard enough.

- *If I were* you, I *would* go to the Annual Primary Care Nurse Meeting (but I am not you).
- *If I were* a medical student again I *would* choose a different subject to explore for my Special Study Module (but I am not a medical student any more).

There are possible variations of the basic form. In the *if*-clause we can use the past continuous instead of the past simple. In the main clause we can use *could* or *might* instead of *would*.

So the form of type 2 can be reduced to:

- *If* + past simple or continuous + *would*, *could* or *might*.

Type 3

To talk about past situations that did not happen (impossible actions in the past).

If + past perfect + perfect conditional (*would have*):

- *If I had known* the patient's ECG result, *I would* probably *have* not missed the myocardial infarction.

As you can see, we are talking about the past. The real situation is that I did not see the patient's ECG result so I did not know he already had heart disease.

This is the basic (or classic) form of the third type of conditional; however, there are possible variations. In the *if*-clause we can use the past perfect continuous instead of the past perfect simple. In the main clause we can use the continuous form of the perfect conditional instead of the perfect conditional simple. *Would probably*, *could* or *might* instead of *would* are also possible (when we are not sure about something).

In Case

"The surgeon wears two pairs of latex gloves during an operation *in case* one of them tears." *In case one of them tears* because it is possible that one of them might tear during the operation (in the future).

Note that we do not use *will* after *in case*. We use a present tense after *in case* when we are talking about the future.

In case is not the same as *if*. Compare these sentences:

- We'll buy some more food and drink *if* the new doctors come to the practice party. (Perhaps the new doctors will come to our party. If they come, we will buy some more food and drink; if they don't come, we won't.)
- We will buy some more food and drink *in case* the new doctors come to our practice party. (Perhaps the new doctors will come to our party. We will buy some more food and drink whether they come or not.)

We can also use *in case* to say why someone did something in the past:

- He rang the bell again *in case* the patient hadn't heard it the first time (because it was possible that the patient hadn't heard it the first time).

In case of (= if there is):

- *In case of* pregnancy, don't have an X-ray examination.

Unless

"Don't take these pills *unless* you are extremely anxious." (Don't take these pills except if you are extremely anxious.) This sentence means that you can take the pills only if you are extremely anxious.

We use *unless* to make an exception to something we say. In the example above the exception is *you are extremely anxious*.

We often use *unless* in warnings:

- *Unless* you send the application form today, you won't be accepted on the next Telephone Consultation Course.

It is also possible to use *if* in a negative sentence instead of *unless*:

- Don't take those pills *if you aren't* extremely anxious.
- *If you don't send* the application form today, you won't be accepted onto the next Telephone Consultation Course.

As Long As, Provided (That), Providing (That)

These expressions mean *but only if*:

- You can use my new pen to sign your report *as long as* you write carefully (i.e. *but only if* you write carefully).
- Going by car to the hospital is convenient *provided (that)* you have somewhere to park (i.e. *but only if* you have somewhere to park).
- *Providing (that)* she studies the clinical cases, she will deliver a bright presentation.

Passive Voice

Study these examples:

- The first ultrasound examination was performed at our local hospital in 1980 (passive sentence).
- Someone performed the first ultrasound examination at our local hospital in 1980 (active sentence).

Both sentences are correct and have the same meaning. They are two different ways of saying the same thing, but in the passive sentence we try to

make the object of the active sentence (“the first ultrasound examination”) more important by putting it at the beginning. So, we prefer to use the passive when it is not that important who or what did the action. In the example above, it is not so important (or not known) who performed the first ultrasound examination.

Active sentence:

- Fleming (subject) discovered (active verb) penicillin (object) in 1950.

Passive sentence:

- Penicillin (subject) was discovered (passive verb) by Fleming (agent) in 1950.

The passive verb is formed by putting the verb *to be* into the same tense as the active verb and adding the past participle of the active verb:

- Discovered (active verb) – was discovered (*be* + past participle of the active verb).

The object of an active verb becomes the subject of the passive verb (“penicillin”). The subject of an active verb becomes the agent of the passive verb (“Fleming”). We can leave out the agent if it is not important to mention it or we do not know it. If we want to mention it, we will put it at the end of the sentence preceded by the particle *by* (“... by Fleming”).

Some sentences have two objects, indirect and direct. In these sentences the passive subject can be either the direct object or the indirect object of the active sentence:

- The doctor gave the patient a new treatment.

There are two possibilities:

- A new treatment was given to the patient.
- The patient was given a new treatment.

Passive Forms of Present and Past Tenses

Simple Present

Active:

- The Primary Health Care Team reviews the most interesting cases in the clinical meeting every week.

Passive:

- The most interesting cases are reviewed in the clinical session every week.

Simple Past

Active:

- The nurse checked the brachial blood pressure of the patient before the Doppler foot pulse examination.

Passive:

- The brachial blood pressure of the patient was checked before the Doppler foot pulse examination.

Present Continuous

Active:

- Dr. Golightly is writing a report right now.

Passive:

- A report is being written right now.

Past Continuous

Active:

- They were carrying the injured person to the Treatment room.

Passive:

- The injured person was being carried to the Treatment room.

Present Perfect

Active:

- The practice nurse has performed ten ear syringing procedures this morning.

Passive:

- Ten ear syringing procedures have been performed this morning.

Past Perfect

Active:

- They had sent the medical records before the patient was seen.

Passive:

- The medical records had been sent before the patient was seen.

In sentences of the type “people say/consider/know/think/believe/expect/understand ... that ...”, such as “Doctors consider that AIDS is a fatal disease”, we have two possible passive forms:

- AIDS is considered to be a fatal disease.
- It is considered that AIDS is a fatal disease.

Have/Get Something Done

FORM

Have/get + object + past participle.

Get is a little more informal than *have*, and it is often used in informal spoken English:

- You should *get* your spirometer tested.
- You should *have* your spirometer tested.

When we want to say that we do not want to do something ourselves and we arrange for someone to do it for us, we use the expression *have something done*:

- The doctor had his car repaired in order to do home visits.

Sometimes the expression *have something done* has a different meaning:

- John had his knee broken playing a football match. The MRI showed a meniscal tear.

It is obvious that this does not mean that he arranged for somebody to break his knee. With this meaning, we use *have something done* to say that something (often something not nice and often out of their control) happened to someone.

Supposed To

Supposed to can be used in the following ways:

Can be used like *said to*:

- The practice manager is supposed to be the one who runs the reception.

To say what is planned or arranged (and this is often different from what really happens):

- The foundation year doctor is supposed to read this report.

To say what is not allowed or not advisable:

- She was not supposed to be at the practice yesterday.

Reported Speech

Imagine that you want to tell someone else what the patient said. You can either repeat the patient's words or use reported speech.

The reporting verb (*said*, in the examples below) can come before or after the reported clause (*there was a conference about cardiac failure that evening*), but it usually comes before the reported clause. When the reporting verb comes before, we can use *that* to introduce the reported clause or we can leave it out (leaving it out is more informal). When the reporting verb comes after, we cannot use *that* to introduce the reported clause.

The reporting verb can report statements and thoughts, questions, orders and requests.

Reporting in the Present

When the reporting verb is in the present tense, it is not necessary to change the tense of the verb:

- “I’ll help you guys with this presentation”, he says.
- He says (that) he will help us deliver this presentation.
- “The minor surgery will take place this morning”, he says.
- He says (that) the minor surgery will take place this morning.

Reporting in the Past

When the reporting verb is in the past tense, the verb in direct speech usually changes in the following ways:

- Simple present changes to simple past.
- Present continuous changes to past continuous.
- Simple past changes to past perfect.
- Past continuous changes to past perfect continuous.
- Present perfect changes to past perfect.
- Present perfect continuous changes to past perfect continuous.
- Past perfect stays the same.
- Future changes to conditional.
- Future continuous changes to conditional continuous.
- Future perfect changes to conditional perfect.
- Conditional stays the same.
- Present forms of modal verbs stay the same.
- Past forms of modal verbs stay the same.

Pronouns, adjectives and adverbs also change. Here are some examples:

- First person singular changes to third person singular.
- Second person singular changes to first person singular.
- First person plural changes to third person plural.
- Second person plural changes to first person plural.
- Third person singular changes to third person plural.
- Now changes to then.
- Today changes to that day.
- Tomorrow changes to the day after.
- Yesterday changes to the day before.
- This changes to that.
- Here changes to there.
- Ago changes to before.

It is not always necessary to change the verb when you use reported speech. If you are reporting something and you feel that it is still true, you do not need to change the tense of the verb, but you can if you want:

- The treatment of choice for severe urticaria after vaccination is epinephrine.
- He said (that) the treatment of choice for severe urticaria after immunisation is epinephrine.

or

- He said (that) the treatment of choice for severe urticaria after immunisation was epinephrine.

Reporting Questions

Yes and No Questions

We use *whether* or *if*:

- Do you smoke or drink any alcohol?
- The doctor asked if I smoked or drank any alcohol.
- Have you had any urticaria after immunisation injections?
- The doctor asked me whether I had had any urticaria after immunisation injections or not.
- Are you taking any pills or medicines at the moment?
- The doctor asked me if I was taking any pills or medicines at that moment.

Wh ... Questions

We use the same question word as in the *wh* ... question:

- What do you mean by saying you are feeling under the weather?
- The doctor asked me what I meant by saying I was feeling under the weather.
- Why do you think you feel under the weather?
- The doctor asked me why I thought I felt under the weather.
- When do you feel under the weather?
- The doctor asked me when I felt under the weather.
- How often do you have headaches?
- The doctor asked how often I had headaches.

Reported Questions

Study the following examples:

- How old are you?
- The doctor asked me how old I was.
- Do you smoke?
- The doctor asked me if I smoked.

Reported questions have the following characteristics:

- The word order is different from that of the original question. The verb follows the subject as in an ordinary statement.
- The auxiliary verb *do* is not used.
- There is no question mark.
- The verb changes in the same way as in direct speech.

Reporting Orders and Requests

FORM

Tell (pronoun) + object (indirect) + infinitive.

- Take the pills before meals.
- The doctor told me to take the pills before meals.
- You mustn't smoke.
- The doctor told me not to smoke.

Reporting Suggestions and Advice

Suggestions and advice are reported in the following forms:

- Suggestions
 - Why don't we discuss that patient this evening?
 - The GP suggested discussing that patient that evening.
- Advice
 - You had better stay in bed.
 - The doctor advised me to stay in bed.

Questions

In sentences with *to be*, *to have* (in its auxiliary form) and modal verbs, we usually form questions by changing the word order:

- Affirmative
 - You are a GP.
 - Interrogative: Are you a GP?
- Negative
 - You are not a GP.
 - Interrogative: Aren't you a GP?

In simple present questions we use *do/does*:

- His arm hurts after having a tetanus immunisation.
- Does his arm hurt after having a tetanus immunisation?

In simple past questions we use *did*:

- The nurse arrived on time.
- Did the nurse arrive on time?

If *who/what/which* is the subject of the sentence we do not use *do*:

- Someone paged Dr. W.
- Who paged Dr. W.?

If *who/what/which* is the object of the sentence we use *did*:

- Dr. W. paged someone.
- Who did Dr. W. page?

When we ask somebody and begin the question with “*Do you know ...*” or “*Could you tell me ...*”, the rest of the question maintains the affirmative sentence’s word order:

- Where is the seminar room?
- but
- Do you know where the seminar room is?
 - Where is the library?
- but
- Could you tell me where the library is?

Reported questions also maintain the affirmative sentence’s word order:

- Dr. Wilson asked: How are you?
- but
- Dr. Wilson asked me how I was.

Short answers are possible in questions where *be*, *do*, *can*, *have* and *might* are auxiliary verbs:

- Do you smoke? Yes, I do.
- Did you smoke? No, I didn’t.
- Can you walk? Yes, I can.

We also use auxiliary verbs with *so* (affirmative) and *neither* or *nor* (negative) changing the word order:

- I am feeling tired. So am I.
- I can’t remember the name of the disease. Neither can I.
- Is he going to pass the exams? I think so.
- Will you be doing a surgery tomorrow? I guess not.
- Will you be off duty the day after tomorrow? I hope so.
- Has the health visitor been invited to the party? I’m afraid so.

Tag questions

We use a positive tag question with a negative sentence, and vice versa:

- The GP registrar isn’t feeling very well today, is she?
- You are working late at the surgery, aren’t you?

After *let’s* the tag question is *shall we*?

- Let’s read a couple of articles, shall we?

After the imperative, the tag question is *will you*?

- Turn off the viewer, will you?

Infinitive/-ing

Verb + -ing

There are certain verbs that are usually used in the structure verb + *-ing* when followed by another verb:

- *Stop*: Please *stop talking*.
- *Finish*: I've *finished translating* the article into English.
- *Enjoy*: I *enjoy talking* to patients while I'm examining them.
- *Mind*: I *don't mind being* told what to do.
- *Suggest*: Dr. Knight *suggested requesting* rheumatic tests for the patient with multiple joint pains.
- *Dislike*: She *dislikes going* out late after a night on-call.
- *Imagine*: I *can't imagine you operating*. You told me you hate blood.
- *Regret*: He *regrets having left* 2 minutes before his patient had a seizure.
- *Admit*: The GP registrar *admitted forgetting* to reply to Mrs. Smith's prescription query.
- *Consider*: Have you *considered finishing* your residence in the USA?

Other verbs that follow this structure are: *avoid, deny, involve, practice, miss, postpone* and *risk*.

The following expressions also take *-ing*:

- *Give up*: Are you going to *give up smoking*?
- *Keep on*: She *kept on interrupting* me while I was speaking.
- *Go on*: *Go on studying*, the exam will be next month.

When we are talking about finished actions, we can also use the verb *to have*:

- The GP registrar *admitted forgetting* to reply to Mrs. Smith's prescription query

or

- The GP registrar *admitted having forgotten* to reply to Mrs. Smith's prescription query.

With some of these verbs (*admit, deny, regret* and *suggest*), you can also use a "that ..." structure:

- The GP registrar *admitted forgetting* to reply to Mrs. Smith's prescription query

or

- The GP registrar *admitted that he had forgotten* to reply to Mrs. Smith's prescription query.

Verb + Infinitive

When followed by another verb, these verbs are used with verb + infinitive structure:

- *Agree*: The patient *agreed to give up* smoking.
- *Refuse*: The patient *refused to give up* smoking.
- *Promise*: I *promised to give up* smoking.
- *Threaten*: The psychotic patient *threatened to kill* the doctor.
- *Offer*: The Medical Protection Society *offered to negotiate*.
- *Decide*: Dr. Knight's patients *decided to leave* the waiting room.

Other verbs that follow this structure are: *attempt, manage, fail, plan, arrange, afford, forget, learn, dare, tend, appear, seem, pretend, need* and *intend*.

There are two possible structures after these verbs: *want, ask, expect, help, would like*, and *would prefer*:

- Verb + infinitive: I *asked to speak to* Dr. Knight, the surgeon who operated on my patient.
- Verb + object + infinitive: I *asked Dr. Knight to inform* me about my patient.

There is only one possible structure after the following verbs: *tell, order, remind, warn, force, invite, enable, teach, persuade*, and *get*:

- Verb + object + infinitive: *Remind me to check* those blood test results tomorrow before 10 a.m.

There are two possible structures after the following verbs:

- *Advise*:
 - I *wouldn't advise learning* at that practice.
 - I *wouldn't advise you to learn* at that practice.
- *Allow*:
 - They *don't allow smoking* in the waiting room.
 - They *don't allow you to smoke* in the waiting room.
- *Permit*:
 - They *don't permit eating* in the clinical rooms.
 - They *don't permit you to eat* in the clinical rooms.

When you use *make* and *let*, you should use the structure: verb + base form (instead of verb + infinitive):

- The sight of blood *makes me feel* dizzy (you can't say: blood *makes me to feel* ...).
- Dr. Knight *wouldn't let me practise on* his patient.

After the following expressions and verbs you can use either *-ing* or the infinitive: *like, hate, love, can't stand, and can't bear*:

- She *can't stand being* alone while she is doing late-evening surgeries.
- She *can't stand to be* alone while she is doing late-evening surgeries.

After the following verbs you can use *-ing* but not the infinitive: *dislike, enjoy, and mind*:

- I *enjoy being* alone (not: I *enjoy to be* alone).

Would like, a polite way of saying *I want*, is followed by the infinitive:

- *Would you like to be* the chairman of the primary healthcare forum?

Begin, start and continue can be followed by either *-ing* or the infinitive:

- The patient *began to improve* after the foreign body had been removed.
- The patient *began improving* after the foreign body had been removed.

With some verbs, such as *remember* and *try*, the use of *-ing* and infinitive after them have different meanings:

- *Remember*:
 - I *did not remember to expel* the air fully before giving the injection. (I forgot to expel the air properly.)
 - I *could remember (myself) expelling* the air from the injection that day. (I can recall expelling the air.)
- *Try*:
 - The patient *tried to keep* her eyes open while the examination was going on.
 - If your headache persists, *try asking* for a visual acuity test.

Verb + Preposition + *-ing*

If a verb comes after a preposition, that verb ends in *-ing*:

- Are you *interested in working* for our practice?
- *What are the advantages of developing* new diagnostic techniques?
- *She's not very good at learning* languages.

You can use *-ing* with *before* and *after*:

- Check with the patient first *before changing* the patients' records.
- What did you do *after finishing* your training?

You can use *by + -ing* to explain how something happened:

- You can improve your medical English *by reading* scientific articles.
You can use *-ing* after *without*:
- Jim got to the practice *without realising* he had left his door key at home.

Be careful with *to* because it can either be a part of the infinitive or a preposition:

- I'm looking forward to see you again (this is NOT correct).
- I'm looking forward to seeing you again.
- I'm looking forward to the next General Practice conference.

Review the following verb + preposition expressions:

- *succeed in* finding a job
- *feel like* going out tonight
- *think about* the best treatment for that patient
- *dream of* being an academic GP
- *disapprove of* smoking
- *look forward to* hearing from you
- *insist on* inviting me to chair the meeting
- *apologise for* keeping Dr. Ho waiting
- *accuse* (someone) *of* telling lies
- *suspected of* having AIDS
- *stop from* leaving the premises
- *thank* (someone) *for* being helpful
- *forgive* (someone) *for* not writing to me
- *warn* (someone) *against* carrying on smoking

The following are some examples of expressions + *-ing*:

- *I don't feel like* going out tonight.
- *It's no use* trying to persuade her.
- *There's no point in* waiting for him.
- *It's not worth* taking a taxi. The hospital is only a short walk from here.
- *It's worth* looking at those blood test results again.
- *I am having difficulty* interpreting this electrocardiogram. *I am having trouble* interpreting this electrocardiogram.

Countable and Uncountable Nouns

Countable Nouns

Countable nouns are things we can count. We can make them plural.

Before singular countable nouns you may use *a/an*:

- You will be attended to by *a practice nurse*.
- Dr. Vida is looking for *an apron*.

Remember to use *a/an* for jobs:

- I'm *a* general practitioner.

Before plural countable nouns you use *some* as a general rule:

- I've read *some* good articles on topical steroid application techniques lately.

Do not use *some* when you are talking about general things:

- Generally speaking, I like medical textbooks.

You have to use *some* when you mean some, but not all:

- *Some* doctors carry a stethoscope but radiologists don't.

Uncountable Nouns

Uncountable nouns are things we cannot count. They have no plural.

You cannot use *a/an* before an uncountable noun; in this case you have to use *the, some, any, much, this, his*, etc. ... or leave the uncountable noun alone, without the article:

- The GP trainer gave me an advice (NOT correct).
- The GP trainer gave me *some* advice.

Many nouns can be used as countable or uncountable nouns. Usually there is a difference in their meaning:

- I had *many experiences* on my rotation at the Children's Hospital (countable).
- I need *experience* to become a good general practitioner (uncountable).

Some nouns are uncountable in English but often countable in other languages: *advice, baggage, behaviour, bread, chaos, furniture, information, luggage, news, permission, progress, scenery, traffic, travel, trouble, and weather*.

Articles: A/An and The

The speaker says *a/an* when it is the first time he talks about something, but once the listener knows what the speaker is talking about, he says *the*:

- This morning I did *an* extra session and *a* home visit. *The* home visit was not very complicated.

We use *the* when it is clear which thing or person we mean:

- Can you turn off the light?
- Where is *the* light switch, please?

As a general rule, we say:

- The police
- The bank
- The post office
- The fire department
- The doctor
- The hospital
- The dentist

We say: *the* sea, *the* sky, *the* ground, *the* city, and *the* country.

We do not use *the* with the names of meals:

- What did you have for lunch/breakfast/dinner?

But we use *a* when there is an adjective before a noun:

- Thank you. It was *a* delicious dinner.

We use *the* for musical instruments:

- Can you play *the* piano?

We use *the* with absolute adjectives (adjectives used as nouns). The meaning is always plural. For example:

- The rich
- The old
- The blind
- The sick
- The disabled
- The injured
- The poor
- The young
- The deaf
- The dead
- The unemployed
- The homeless

We use *the* with nationality words (note that nationality words always begin with a capital letter):

- *The* British, *the* Dutch, *the* Spanish.

We do not use *the* before a noun when we mean something in general:

- I love doctors (not the doctors).

With the words *school*, *college*, *prison*, *jail* and *church* we use *the* when we mean the buildings and leave the substantives alone otherwise. We say: *go to bed*, *go to work* and *go home*. We do not use *the* in these cases.

We use *the* with geographical names according to the following rules:

- Continents do not use *the*:
 - Our new foundation year-2 doctor comes from Asia.
- Countries/states do not use *the*:
 - The patient that underwent a bone marrow transplant came from Sweden.

(except for country names that include words such as Republic, Kingdom, States ...; e.g. the United States of America, the United Kingdom and The Netherlands).

As a general rule, cities do not use *the*:

- The next Women's Health Forum will be held in Zaragoza.

Islands do not use *the* with individual islands but do use it with groups:

- Dr. Holmes comes from Sicily and her husband from the Canary Islands.

Lakes do not use *the*; oceans, seas, rivers and canals do use it.

- Lake Windermere is beautiful.
- *The* Panama Canal links *the* Atlantic Ocean to *the* Pacific Ocean.

We use *the* with streets, buildings, airports, universities, etc., according to the following rules:

- Streets, roads, avenues, boulevards and squares do not use *the*:
 - The hospital is sited at Lewisham Avenue.
- Airports don't use *the*:
 - The plane arrived at JFK airport.
- We use *the* before publicly recognised buildings: *the* Houses of Parliament, *the* Empire State Building, *the* Louvre, *the* Prado Museum.
- We use *the* before names with of: *the* Tower of London, *the* Great Wall of China.
- Universities do not use *the*: I studied at Harvard.

Word Order

The order of adjectives is discussed in the section Adjectives under the heading Adjective Order.

The *verb* and the *object* of the verb normally go together:

- I studied medicine because I like *working with people* very much (*not* I like very much working with people).

We usually say the place before the time:

- She has been practising medicine in London since April.

We put some adverbs in the middle of the sentence:

If the verb is one word we put the adverb before the verb:

- I performed his urinary catheterisation and *also spoke* to his family.

We put the adverb after *to be*:

- You are *always* on time.

We put the adverb after the first part of a compound verb:

- Are you *definitely* attending the musculoskeletal update course?

In negative sentences we put *probably* before the negative:

- I *probably* won't see you at the conference.

We also use *all* and *both* in these positions:

- Jane and Ann are *both* able to carry out insertion of sub-cutaneous implants.
- We *all* felt sick after the meal.

Relative Clauses

A clause is a part of a sentence. A relative clause tells us which person or thing (or what kind of person or thing) the speaker means.

A relative clause (e.g. *who is on call?*) begins with a relative pronoun (e.g. *who, that, which, whose*).

A relative clause comes after a noun phrase (e.g. the doctor, the nurse).

Most relative clauses are defining clauses and some of them are non-defining clauses.

Defining Clauses

- *The book on paediatrics in general practice (that) you lent me is very interesting.*

The relative clause is essential to the meaning of the sentence.

Commas are not used to separate the relative clause from the rest of the sentence.

That is often used instead of *who* or *which*, especially in speech.

If the relative pronoun is the object (direct object) of the clause, it can be omitted.

If the relative pronoun is the subject of the clause, it cannot be omitted.

Non-Defining Clauses

- *The first patient to be referred to our in-house sports physiotherapist was very satisfied with the service.*

The relative clause is not essential to the meaning of the sentence; it gives us additional information.

Commas are usually used to separate the relative clause from the rest of the sentence.

That cannot be used instead of *who* or *which*.

The relative pronoun cannot be omitted.

Relative Pronouns

Relative pronouns are used for people and for things.

- For people:
 - Subject: *who, that*
 - Object: *who, that, whom*
 - Possessive: *whose*
- For things:
 - Subject: *which, that*
 - Object: *which, that*
 - Possessive: *whose*

Who is used only for people. It can be the subject or the object of a relative clause:

- The patient *who* verbally abused our receptionist has not returned for 2 weeks. Shall we remove him from our list now?

Which is used only for things. Like *who*, it can be the subject or object of a relative clause:

- The drugs, *which* are used for skin camouflage, are very expensive.

That is often used instead of *who* or *which*, especially in speech.

Whom is only used for people. It is grammatically correct as the object of a relative clause, but it is very formal and is not often used in spoken English. We can use *whom* instead of *who* when *who* is the object of the relative clause or when there is a preposition after the verb of the relative clause:

- The colleague *who* I am going to the conference with is very nice.
- The colleague with *whom* I am going to the conference is a very nice and intelligent person.
- The patient *who* I saw in the waiting room today has been diagnosed with incurable cancer.
- The patient *whom* I saw in the waiting room today has been diagnosed with incurable cancer.

Whose is the possessive relative pronoun. It can be used for people and things. We cannot omit *whose*:

- Nurses *whose* wages are low should be paid more.

We can leave out *who*, *which* or *that*:

- When it is the object of a relative clause.
 - The article on primary immunisation *that* you wrote is great.
 - The article on hepatitis B immunisation you wrote is great.
- When there is a preposition. Remember that, in a relative clause, we usually put a preposition in the same place as in the main clause (after the verb):
 - The conference *that* we are going to next week is very expensive.
 - The conference we are going to next week is very expensive.

Prepositions in Relative Clauses

We can use a preposition in a relative clause with *who*, *which*, or *that*, or without a pronoun.

In relative clauses we put a preposition in the same place as in a main clause (after the verb). We do not usually put it before the relative pronoun. This is the normal order in informal spoken English:

- This is a problem *which* we can do very little about.
- The nurse (*who*) I spoke to earlier isn't here now.

In more formal or written English we can put a preposition at the beginning of a relative clause. But if we put a preposition at the beginning, we can only use *which* or *whom*. We cannot use the pronouns *that* or *who* after a preposition:

- This is a problem *about which* we can do very little.
- The nurse *to whom* I spoke earlier isn't here now.

Relative Clauses Without a Pronoun (Special Cases)

Infinitive Introducing a Clause

We can use the infinitive instead of a relative pronoun and a verb after:

- The first, the second ... and the next
- The only
- Superlatives

For example:

- Roentgen was the first man *to use* X-rays.
- Joe was the only one *to discover* the diagnosis.

-ing and -ed Forms Introducing a Clause

We can use an *-ing* form instead of a relative pronoun and an active verb:

- Doctors *wanting* to train abroad should have a good level of English.

We can use an *-ed* form instead of a relative pronoun and a passive verb:

- The man *injured* in the accident was taken to the casualty department.

The *-ing* form or the *-ed* form can replace a verb in a present or past tense.

Why, When and Where

We can use *why*, *when* and *where* in a defining relative clause.

We can leave out *why* or *when*. We can also leave out *where*, but then we must use a preposition.

We can form non-defining relative clauses with *when* and *where*:

- The clinical notes, *where* everything about a patient is written, is a very important document.

We cannot leave out *when* and *where* from a non-defining clause.

Adjectives

An adjective describes (tells us something about) a noun.

In English, adjectives come before nouns (old hospital) and have the same form in both the singular and the plural (new hospital, new hospitals) as well as in the masculine and feminine.

An adjective can be used with certain verbs such as *be*, *get*, *seem*, *appear*, *look* (meaning *seem*), *feel*, *sound*, *taste* ...:

- He has been *ill* since Friday, so he couldn't complete the patient's report.
- The patient was getting *worse*.
- The minor surgery procedure seemed *easy*, but it wasn't.
- The pH test paper for bacterial vaginosis appears *green* when it is normal.
- You look rather *tired*. Have you tested your RBC?
- She felt *sick*, so she stopped the ear syringing procedure.
- Food in hospitals tastes *horrible*.

As you can see, in these examples there is no noun after the adjective.

Adjective Order

We have *fact adjectives* and *opinion adjectives*. Fact adjectives (*large*, *new*, *white*, ...) give us objective information about something (size, age, colour, ...). Opinion adjectives (*nice*, *beautiful*, *intelligent*, ...) tell us what someone thinks of something.

In a sentence, opinion adjectives usually go before fact adjectives:

- An *intelligent* (opinion) *young* (fact) nurse visited me this morning.
- Dr. Spencer has a *nice* (opinion) *red* (fact) Porsche.

Sometimes there are two or more fact adjectives describing a noun, and generally we put them in the following order:

1. Size/length
2. Shape/width
3. Age
4. Colour
5. Nationality
6. Material

For example:

- A tall young nurse
- A small round lesion
- A black latex leaded pair of gloves
- A large new white latex leaded pair of gloves
- An old American patient
- A tall young Italian doctor
- A small square old white computer monitor

Regular Comparison of Adjectives

The form used for a comparison depends upon the number of syllables in the adjective.

Adjectives of One Syllable

One-syllable adjectives (for example *fat*, *thin*, *tall*) are used with expressions of the form:

- *less ... than* (inferiority)
- *as ... as* (equality)
- *-er ... than* (superiority)

For example:

- On-calls are *less hard than* a few years ago.
- Eating in the hospital is *as cheap as* eating at the Medical School.
- Ultrasound examinations are difficult nowadays because people tend to be *fatter than* in the past.

Adjectives of Two Syllables

Two-syllable adjectives (for example *easy*, *dirty*, *clever*) are used with expressions of the form:

- *less ... than* (inferiority)
- *as ... as* (equality)
- *-er/more ... than* (superiority)

We prefer *-er* for adjectives ending in *y* (*easy*, *funny*, *pretty* ...) and other adjectives (such as *quiet*, *simple*, *narrow*, *clever* ...). For other two-syllable adjectives we use *more*.

For example:

- The presenting problem is *less simple than* you think.
- My arm is *as painful as* it was yesterday.
- The board exam was *easier than* we expected.
- His illness was *more serious than* we first suspected, as demonstrated on the blood test results.

Adjectives of Three or More Syllables

Adjectives of three or more syllables (for example *difficult*, *expensive*, *comfortable*) are used with expressions of the form:

- *less ... than* (inferiority)
- *as ... as* (equality)
- *more ... than* (superiority)

For example:

- Studying medicine in Spain is *less expensive than* in the States.
- The small hospital was *as comfortable as* a hotel.
- Studying the case was *more interesting than* I had thought.

Before the comparative of adjectives you can use:

- *a (little) bit*
- *a little*
- *much*
- *a lot*
- *far*

For example:

- I am going to try something *much simpler* to solve the problem.
- The patient is *a little better* today.
- The little boy is *a bit worse* today.

Sometimes it is possible to use two comparatives together (when we want to say that something is changing continuously):

- It is becoming *more and more* difficult to find a job in an academic practice.

We also say *twice as ... as*, *three times as ... as*:

- Going to the European Conference of General Practice is *twice as expensive as* going to the British one.

The Superlative

The form used for a superlative depends upon the number of syllables in the adjective:

Adjectives of One Syllable

One-syllable adjectives are used with expressions of the form:

- *the ...-est*
- *the least*

For example:

- The number of nurse practitioners in your country is the *highest* in the world.

Adjectives of Two Syllables

Two-syllable adjectives are used with expressions of the form:

- *the ...-est*
- *the least*

For example:

- Barium enema is one of the *commonest* tests in clinical practice.
- Barium enema is one of the *most common* tests in clinical practice.

Adjectives of Three or More Syllables

Adjectives of three or more syllables are used with:

- *the most*
- *the least*

For example:

- Common sense and patience are *the most important* qualities for a paediatric nurse to possess.
- This is the *least difficult* week in general practice I have had in ages.

Irregular Forms of Adjectives

- good better the best
- bad worse the worst
- far farther/further the farthest/furthest

For example:

- My telephone consulting skills are *worse* now than during my first year of training in spite of having attended several refresher courses.

Comparatives with The

We use *the* + comparative to talk about a change in one thing which causes a change in something else:

- The more you learn about the patient the easier it is to help them.
- The more you practise the technique of spirometry the easier it gets.
- The higher the dose the greater the risk of side effects.

As

Two things happening at the same time or over the same period of time:

- The GP registrar listened carefully *as* Dr. Fraser explained to the patient the different diagnostic possibilities.
- I began to enjoy the job more *as* I got used to being on call.

One thing happening during another:

- The patient died *as* the operation was being performed.
- I had to leave just *as* the differential diagnosis discussion was getting interesting.

Note that we only use *as* if two actions happen together. If one action follows another we do not use *as*, we use the particle *when*:

- *When* the injured person came to the treatment room, I decided to call the doctor on call.

Meaning *because*:

- As I was feeling sick, I decided to go to home.

Like and As

Like

Like is a preposition, so it can be followed by a noun, pronoun or *-ing* form.

It means *similar to* or *the same as*. We use it when we compare things:

- This round building with a garden inside is like a doughnut.
- What does he do? He is a GP, *like* me.

As

As + subject + verb:

- Don't change the dose of local anaesthetic. Leave everything *as* it is.
- He should have been treated *as* I showed you.

Meaning *what*:

- The practice nurse did *as* she was told.
- He made the diagnosis just with the electrocardiogram, *as* I expected.
- As you know, we are sending an article to the British Journal of General Practice next week.
- As I thought, the patient was under the influence of alcohol.

As can also be a preposition, so it can be used with a noun, but it has a different meaning from *like*.

As + noun is used to say what something really is or was (especially when we talk about someone's job or how we use something):

- Before becoming a GP I worked *as* a nurse in a small village.

As if/as though are used to say how someone or something looks, sounds, feels, ..., or to say how someone does something:

- The doctor treated me *as if* I were his son.
- John sounds *as though* he has got a cold.

Expressions with *as*:

- *Such as*
- *As usual* (Dr. Mast was late *as usual*.)

So and Such

So and *such* make the meaning of the adjective stronger.

We use *so* with an adjective without a noun or with an adverb:

- That first-year medical student is *so clever*.
- The practice nurse injected lidocaine *so carefully* that the patient did not notice it.

We use *such* with an adjective with a noun:

- She is *such a clever child*.

Prepositions

At/On/In Time

We use *at* with the time:

- *At* 7 o'clock
- *At* midnight
- *At* breakfast time

We usually leave out *at* when we ask (*at*) *what time*:

- *What time* are you starting your surgery this evening?

We also use *at* in these expressions:

- *At* night
- *At* the moment
- *At* the same time
- *At* the beginning of
- *At* the end of

For example:

- I don't like to be on call *at night*.
- Dr. Knight is reading some results *at the moment*.

We use *in* for longer periods of time:

- *In* June
- *In* summer
- *In* 1977

We also say *in the morning*, *in the afternoon*, *in the evening*:

- I'll check all the results *in the morning*.

We use *on* with days and dates:

- *On* October 9th
- *On* Monday
- *On* Saturday mornings
- *On* the weekend (*At* the weekend in British English)

We do not use *at/in/on* before *last* and *next*:

- I'll be on call *next* Saturday.
- They bought a new fax machine *last* year.

We use *in* before a period of time (i.e. a time in the future):

- Our trainee went to Glasgow to do a rotation on paediatric ENT. He'll be back *in* a year.

For, During and While

We use *for* to say to how long something takes:

- I've worked as a practice nurse at this practice *for* 10 years.

You cannot use *during* in this way:

- It rained *for* 5 days (not *during* 5 days).

We use *during* + noun to say when something happens (not how long):

- The manager fell asleep *during* the primary care conference.

We use *while* + subject + verb:

- The manager fell asleep *while* he was attending the primary care conference.

By and Until

By + a time (i.e. not later than; you cannot use *until* with this meaning):

- I sent the article on hepatitis B today, so they should receive it *by* Tuesday.

Until can be used to say how long a situation continues:

- Let's wait *until* the patient gets better.

When you are talking about the past, you can use *by the time*:

- *By the time* they got to the hotel the congress had already started.

In/At/On

We use *in* as in the following examples:

- *In* a room
- *In* a building
- *In* a town/*in* a country (Dr. Vida works *in* Cordoba.)
- *In* the water/ocean/river
- *In* a row
- *In* the hospital

We use *at* as in the following examples:

- *At* the bus stop
- *At* the door/window
- *At* the top/bottom
- *At* the airport
- *At* work
- *At* sea
- *At* an event (I saw Dr. Jules *at* the practice party.)

We use *on* as in the following examples:

- *On* the ceiling
- *On* the floor
- *On* the wall
- *On* a page
- *On* your nose
- *On* a farm

In or At?

We say *in the corner of a room*, but *at the corner of a street*.

We say *in* or *at* college/school. Use *at* when you are thinking of the college/school as a place or when you give the name of the college/school:

Thomas will be *in* college for three more years.

He studied medicine *at* Harvard Medical School.

With buildings, you can use *in* or *at*.

Arrive. We say:

Arrive in a country or town (Dr. Vida *arrived in* London yesterday.)

Arrive at other places (Dr. Vida *arrived at* the airport a few minutes ago.)

But: *arrive home* (Dr. Vida *arrived home* late after sending the article to the BMJ.)

Other Linguistic Notes

British and American English

This book is British-based in content and is written in British English. Some expressions will differ in other English-speaking countries. American and British spellings have some systematic differences, such as:

- British 's'/American 'z': organise/organize; analyse/analyze; etc.
- British 'ae'/American 'e': haemorrhage/hemorrhage, paediatrics/pediatrics, anaemia/anemia; etc.
- British 'oe'/American 'e': oedema/edema; oesophagus/esophagus/dyspnoea/dyspnea; diarrhoea/diarrhea; etc.
- British 're'/American 'er': centre/center; centimetres/centimeters; etc.
- British 'ou'/American 'o': colour/color; favour/favor, etc.

Gender

When we refer to people without specifying the gender (male or female) we may use the slash (/) as in 'he/she' and 'his/her', or use 'them' and 'their' despite the singular, e.g. "*a doctor* may be in trouble if the patient does not understand *them*".

The possessive 's'

Standard Abbreviations

i.e. = 'that is'

e.g. = 'for example'

Adding 's to a singular noun indicates possession.

The disease of this patient is called gastritis.

This patient's disease is called gastritis.

For the plural, only the apostrophe (') after the plural *s* is added, without adding another *s*.

The problems of the patients are varied.

The patients' problems are varied.

If the singular of the noun ends in *s*, then an apostrophe and another *s* is added.

The illness of the patient was non-specific.

The patient's illness was non-specific.

There is a hospital in London named after St. Thomas, where Dr. Jones works.

Dr. Jones works at St. Thomas's Hospital.

His job there is to treat cancer patients.

Dr. Jones's job is to treat cancer patients.

For objects (rather than persons) the possessive is *its* (NOT *it's*).

The old man was sick. *His* pulse was fast.

The heart was failing. *Its* ejection fraction was 20%.

HOW TO SUBMIT AN ARTICLE IN ENGLISH



這交是容易, 首先遞交你的介紹, 然後
內容遞交紙是容易, 首先遞交你的介。

LALANDA

Unit III Scientific Literature

Writing an Article

This chapter is not intended to be a “Guide for Authors” such as those that you can find in any journal. The primary message of this chapter is: Instead of writing in your own language and translating what you have written into English, write in English directly.

Preliminary Work

Once you have found a subject on which you would like to report, first of all you need to research your references. For example, the *Index Medicus* (<http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?db=PubMed>) is useful when searching for articles. Once you have found them, read them thoroughly and underline those sentences or paragraphs that you think you might quote or refer to in your own article.

In order to write the article directly in English, pick up, either out of these references, or out of the journal in which you want your work to be published, the article that you find closest to the type of study that you want to report. Then you can use this article as a model for your own by learning from how it is presented and written.

Although you must follow the instructions of the journal to which you want to send the paper, here we use a standard format that may be adequate for most of them. In each section, we give you a few examples just to show how you can get them from other articles.

Article Header

Title

The title of the article should be concise but informative. Put a lot of thought into the title of your article.

Abstract

An abstract of 150–250 words (it depends on the journal) must be submitted with each manuscript. Remember that an abstract is a synopsis, *not* an introduction to the article.

The abstract should answer the question: “What should readers know after reading this article”?

Most journals require the abstract to be divided into four paragraphs each with the following headings:

Aim of the Study

To state the purpose(s) of the study or investigation; the hypothesis being tested or the procedure being evaluated.

Note: Your sentence may often begin with an infinitive tense:

- *To evaluate* the impact of false-positive cervical smears in primary care.
- *To present* our experience of the transition to non-mercury-based blood pressure reading.
- *To study* the diagnostic value of endo-cervical swabs for chlamydia testing.
- *To assess* the uptake of the National Bowel Cancer Screening Programme.
- *To compare* the accuracy of mid-stream urine results according to methods of collection in children.
- *To determine* the prevalence of type-2 diabetes in our practice population.
- *To develop* a robust system for triggering a Significant Event Analysis.
- *To investigate* the prognostic value of *H. pylori* eradication.
- *To ascertain* recent trends in workload among the various types of primary care practices.
- *To describe* the varied clinical presentation of ectopic pregnancy in primary care.
- *To assess* the usefulness of cryotherapy in the removal of viral warts.
- *To establish ... , To perform ... , To study ... , To design ... , To analyse ... , To test ... , To define ... , To illustrate ...*

You can also begin with: “The aim/purpose/objective/goal of this study was to ...”:

- *The aim of this study was to* determine the prognostic importance of gamma GT in chronic ethanol abusers.
- *The purpose of this study was to* compare cognitive behavioural therapy (CBT) with exposure response prevention in obsessive-compulsive disorder (OCD).

- *The goal of this study was to assess primary care adherence to recent National Institute of Clinical Excellence (NICE) guidance on atrial fibrillation (AF).*
- *The objective of this study was to determine whether diabetes mellitus can be diagnosed by urine dipstick alone.*

You may offer context by providing background information and then stating what you have done.

- *Abnormal liver function tests (LFTs) are a common finding in primary care. The purpose of this study was to describe findings that are pathognomonic of disease.*
- *Coronary artery aneurysms are known to occur in some patients following Kawasaki's disease. This study was designed to assess the prevalence of this complication.*
- *... . We hypothesised that ...*
- *... . We compared ...*
- *... . We investigated ...*

Materials and Methods

Briefly state what was done and what materials were used, including the number of subjects. Also include the methods used to assess the data and to control bias.

- *N patients with ... were included.*
- *N patients with ... were excluded.*
- *N patients known to have/suspected of having ...*
- *... was performed on N patients with ...*
- *N patients underwent ...*
- *Quantitative/Qualitative analyses were performed by ...*
- *Patients were followed clinically for ... months/years.*
- *We examined the effects of treatment with lithium on thyroid function tests (TFTs), blood glucose and renal function in 14 healthy young volunteers.*

Results

Provide and clearly explain or display the findings of the study, including indicators of statistical significance. Include actual numbers, as well as percentages.

- After 1 year there was no difference between the proportions of participants with well-controlled BP in the intervention and control arms (36.6% versus 34.3%; $P=0.27$). (from Br J Gen Pract 2007 Feb; 57(535):136–143).

Conclusion

Summarise (in one or two sentences) the conclusion(s) made on the basis of the findings. It should emphasise new and important aspects of the study or observations.

The study data demonstrate ..., Preliminary findings indicate ..., Results suggest ...

- Despite increased monitoring and possibly higher doses of medication there was no improvement in blood pressure control. Improvements achieved by specialist nurse-led clinics in secondary care may not translate to people with type-2 diabetes in primary care settings (from Br J Gen Pract 2007 Feb, 57(535):136–143).

Keywords

Below the abstract you should provide, and identify as such, three to ten keywords or short phrases that will assist indexers in cross-indexing the article and may be published with the abstract. The terms used should be from the Medical Subject Headings list of the Index Medicus (<http://www.nlm.nih.gov/mesh/meshhome.html>).

Main Text

The text of observational and experimental articles is usually (but not necessarily) divided into sections with the headings *Introduction*, *Methods*, *Results*, and *Discussion*. Long articles may require subheadings (especially the Results and Discussion sections) to clarify content. Other types of articles, such as Case Reports, Reviews, and Editorials, are likely to need other formats. You should consult individual journals for further guidance.

Avoid using abbreviations. When used, abbreviations should be spelled out in brackets the first time a term is given in the text. For example, *peak expiratory flow rate (PEFR)*, thereafter it may be referred to as *PEFR*.

Introduction

This is the most important part of the article as it draws the reader into the subject. The text should begin with an introduction that conveys the

nature and purpose of the work, and quotes the relevant literature. Give only strictly pertinent background information necessary for understanding why the topic is important and references that inform the reader as to why you undertook your study. Do not review the literature extensively. The final paragraph should clearly state the hypothesis or purpose of your study. Brevity and focus are important.

Materials and Methods

Details of clinical and technical procedures should follow the Introduction. Describe your selection of the observational or experimental subjects (patients or laboratory animals, including controls) clearly. Identify the age, sex and other important characteristics of the subjects (if any). Because the relevance of such variables as age, sex and ethnicity to the object of research is not always clear, authors should explicitly justify them when they are included in a study report. The guiding principle should be clarity about how and why a study was done in a particular way. For example, authors should explain why only subjects of certain ages were included or why women were excluded. You should avoid terms such as “race”, which lack precise biological meaning, and use alternative concepts such as “ethnicity” or “ethnic group” instead. You should also specify carefully what the descriptors mean, and say exactly how the data were collected (for example, what terms were used in survey forms, whether the data were self-reported or assigned by others, etc.).

- *Our study population was selected from ...*
- *N patients underwent ...*
- *N consecutive patients ...*
- *N patients with proven ...*
- *Patients were followed clinically ...*
- *N patients with ... were examined before and during ...*
- *N patients with known or suspected ... were prospectively enrolled in this study.*
- *More than N patients presenting with ... were examined with ... over a period of N months.*
- *N patients were prospectively enrolled between ... (date) and ... (date).*
- *N patients (N men, N women; age range N–N years; mean N.N years).*
- *In total, 140 patients, aged 30–50 years (mean 40 years), all with severe acute pancreatitis fulfilling Ramson criteria, were included in the study.*
- *Patients undergoing elective coronary arteriography for evaluation of chest pain were considered eligible if angiography documented ...*

Identify the methods, instrumentation and procedures in sufficient detail to allow other workers to reproduce your study. It is essential that you state the manner by which studies were evaluated: independent readings; consensus readings; blinded or unblinded to other information; time sequencing between readings of several studies of the same patient or animal to eliminate recall bias; and random ordering of studies. It should be clear as to the retrospective or prospective nature of your study.

- *Entry/inclusion criteria included ...*
- *These criteria had to be met: ...*
- *Patients with ... were not included.*
- *The following patient inclusion criteria were used: ...*
- *The following exclusion criteria were used: ...*
- *Further investigations, including ... and ..., were also performed.*
- *We prospectively studied N patients with ...*
- *The reviewers were not blinded to the presence of ...*
- *A total of 33,357 participants aged 55 years or older with hypertension and at least one other CHD risk factor from 623 North American centres (from ALLHAT, JAMA 2002 Dec 18, 288(23):2981–2997)*
- *Two clinical psychologists (N.F., E.A.) in consensus studied the following parameters on successive patients ...*
- *Both the referring general practitioner and counsellors who performed the study and evaluated the results were blinded to drug administration.*
- *Blood test results were evaluated in a blinded manner by one of the authors and an outside general practitioner.*

Give references to established methods, including statistical methods that have been published but are not well known; describe new or substantially modified methods, give reasons for using these techniques and evaluate their limitations. Identify precisely all drugs and chemicals used, including generic name(s), dose(s) and route(s) of administration. Do not use a drug's trade name unless it is directly relevant.

- *The asthma protocol included ...*
- *To objectively assess the severity of chronic obstructive pulmonary disease (COPD), all patients were scored using the Medical Research Council's dyspnoea scale (10).*
- *The intra-uterine device used for contraception has been described elsewhere (12); it consists of a ...*
- *Severity of irritable bowel syndrome (IBS) was measured using the Manning criteria as described previously (2).*

Statistics

Describe statistical methods with enough detail to enable a knowledgeable reader with access to the original data to verify the reported results. Offer a general description of methods in the Methods section. When data are summarised in the Results section, specify the statistical methods used to analyse them:

- *The statistical significance of these differences was calculated with Fisher's exact test.*
- *The probability of ... was calculated using the Kaplan-Meier method.*
- *To test for statistical significance, ...*
- *Statistical analyses were performed with ... and ... tests.*
- *The levels of significance are indicated by p values.*
- *Interobserver agreement was quantified by using kappa statistics.*
- *All p values of less than 0.05 were considered to indicate statistical significance.*
- *Univariate and multivariate Cox proportional hazards regression models were used.*
- *The χ^2 -test was used for group comparison. Descriptive values of variables are expressed as means and percentages.*
- *We adjusted RRs for age (5-year categories) and used the Mantel extension test to test for linear trends. To adjust for other risk factors, we used multiple logistic regression.*

Give details about randomisation:

- *They were selected consecutively by one physician between February 1999 and June 2000.*
- *This study was conducted prospectively during a period of 30 months from March 1998 to August 2000. We enrolled 29 consecutive patients who had ...*

Specify any general-use computer programs used:

- *All statistical analyses were performed with SAS software (SAS Institute, Cary, N.C.).*
- *The statistical analyses were performed using a software package (SPSS for Windows, release 8.0; SPSS, Chicago, Ill.).*

Results

Present your results in logical sequence in the text, along with tables and illustrations. Do not repeat in the text all the data in the tables or illustrations; emphasise or summarise important observations only. Avoid non-technical uses of technical terms in statistics, such as “random” (which implies a randomising device), “normal”, “significant”, “correlations” and “sample”. Define statistical terms, abbreviations and most symbols:

- *Statistically significant differences were shown for both X and X.*
- *A significant correlation was found between X and X.*
- *Results are expressed as means $\pm$ SD.*
- *All the abnormalities in our patient population were identified on the prospective clinical interpretation.*
- *The abnormalities were correctly characterised in 14 patients and incorrectly in ...*
- *The characteristics of these patients are listed in Table 1.*
- *The spirometry results are shown in Table 1.*
- *The clinical findings are summarised in Table 1.*

Report any complications:

- *Two minor complications were encountered. After the procedure, one patient had minor bleeding from the excision site that did not require treatment, and one patient had localised pain for about 1 hour, and required cryotherapy.*

Give numbers of observations. Report losses to observation (such as drop-outs from a clinical trial):

- *The final study cohort consisted of ...*
- *Of the 961 patients included in this study, 69 were reported to have died (including 3 deaths identified through the NDI), and 789 patients were interviewed (Figure 1). For 81 surviving patients, information was obtained from another source. Twenty-two patients (2.3%) could not be contacted and were not included in the analyses because information on non-fatal events was not available.*

Discussion

This section requires ample use of subheadings. Emphasise the new and important aspects of the study and the conclusions that follow from them. Do not repeat (in detail) data or other material given in the Introduction or the Results sections. Include the implications of the findings and their

limitations, including implications for future research. Relate the observations to other relevant studies.

Link the conclusions with the goals of the study, but avoid unqualified statements and conclusions which are not completely supported by the data. In particular, avoid making statements on economic benefits and costs unless the report includes economic data and analyses. Avoid claiming priority and alluding to work that has not been completed. State new hypotheses when warranted, but clearly label them as such. Recommendations, when appropriate, may be included.

- *In conclusion, ...*
- *In summary, ...*
- *This study demonstrates that ...*
- *This study found that ...*
- *This study highlights ...*
- *Another finding of our study is ...*
- *One limitation of our study was ...*
- *Other methodological limitations of this study ...*
- *Our results support ...*
- *Further research is needed to elucidate ...*
- *However, the limited case number warrants a more comprehensive study to confirm these findings and to assess the use of inhaled steroids in COPD.*
- *Further research is needed once community services have been made available.*

Acknowledgements

List all contributors who do not meet the criteria for authorship, such as a person who provided purely technical help, writing assistance, or a department chair who provided only general support. Financial and material support should also be acknowledged.

People who have contributed materially to the paper but whose contributions do not justify authorship may be listed under a heading such as “clinical investigators” or “participating investigators”, and their function or contribution should be described: for example, “served as scientific advisors”, “critically reviewed the study proposal”, “collected data”, or “provided and cared for study patients”.

Because readers may infer their endorsement of the data and conclusions, everybody must have given written permission to be acknowledged.

- *The authors express their gratitude to ... for their excellent technical support.*
- *The authors thank Wei J. Chen, MD, ScD, Institute of Epidemiology, College of Public Health, National Taiwan University, Taipei, for the analysis of the statistics and his help in the evaluation of the data. The authors also thank Pan C. Yang, MD, PhD, Department of Internal Medicine, and Keh S. Tsai, MD, PhD, Department of Laboratory Medicine, National Taiwan University, Medical College and Hospital, Taipei, for the inspiration and discussion of the research idea of this study. We also thank Ling C. Shen for her assistance in preparing the manuscript.*

References

References should be numbered consecutively in the order in which they are first mentioned in the text. Identify references in text, tables, and legends by Arabic numerals in parentheses (some journals require superscript Arabic numbers). References cited only in tables or figure legends should be numbered in accordance with the sequence established by the first citation in the text of the particular table or figure.

- For example, “Stroke patients may experience a whole range of barriers to recovery of normal activities and participation; these can take the form of impairments directly caused by the stroke or other complications of the stroke (*see Box 1*) [44, 45] (from SIGN, Management of Patients with Stroke, Nov 2002)”.

Use the style of the examples below, which are based on the formats used by the NLM in *Index Medicus*. The titles of journals should be abbreviated according to the style used in *Index Medicus*. Consult the *List of Journals Indexed in Index Medicus*, published annually as a separate publication by the library and as a list in the January issue of *Index Medicus*. The list can also be obtained through the library’s website (<http://www.nlm.nih.gov>).

Avoid using abstracts as references. References to papers accepted but not yet published should be designated as “in press” or “forthcoming”; authors should obtain written permission to cite such papers as well as verification that they have been accepted for publication. Information from articles submitted but not accepted should be cited in the text as “unpublished observations” with written permission from the source. The references must be verified by the author(s) against the original documents.

Avoid citing a “personal communication” unless it provides essential information not available from a public source, in which case the name of

the person and date of communication should be cited in parentheses in the text. For scientific articles, authors should obtain written permission and confirmation of accuracy from the source of a personal communication.

The Uniform Requirements style (the Vancouver style) is based largely on an ANSI standard style adapted by the NLM for its databases. Notes have been added where the Vancouver style differs from the style now used by NLM.

Articles in Journals

Standard Journal Article

List the first six authors followed by et al. (*Note:* NLM now lists up to 25 authors; if there are more than 25 authors, NLM lists the first 24, then the last author, then et al.)

Cook NR, Cutler JA, Obarzanek E, Buring JE, Rexrode KM, Kumanyika SK et al.

Long term effects of dietary sodium reduction on cardiovascular disease outcomes: observational follow-up of the trials of hypertension prevention (TOHP). *BMJ*. 2007 Apr 28, 334(7599):885

If a journal carries continuous pagination throughout a volume (as many medical journals do), the month and issue number may be omitted. (*Note:* for consistency, the option is used throughout the examples in Uniform Requirements. NLM does not use the option.)

Poole KES, Compston JE. Osteoporosis and its management. *BMJ* 2006, 333:1251–1256

Organisation as Author

British Hypertension Society guidelines for hypertension management 2004 (BHS-IV): summary. *BMJ* 2004, 328:634–640

No Author Given

Cancer in South Africa [editorial]. *S Afr Med J* 1994, 84:15

Article Not In English

(Note: NLM translates the title to English, encloses the translation in square brackets, and adds an abbreviated language designator.)

Novikova IA, Sidorov PI, Solov'ev AG. [Main risk factors of psychosomatic diseases]. Ter Arkh 2007, 79(1):61–64. Russian.

Volume with Supplement

Shen HM, Zhang QF. Risk assessment of nickel carcinogenicity and occupational lung cancer. Environ Health Perspect 1994, 102(Suppl 1):275–282.

Issue with Supplement

Payne DK, Sullivan MD, Massie MJ. Women's psychological reactions to breast cancer. Semin Oncol 1996, 23(1 Suppl 2):89–97.

Volume with Part

Ozben T, Nacitarhan S, Tuncer N. Plasma and urine sialic acid in non-insulin dependent diabetes mellitus. Ann Clin Biochem 1995, 32(Pt 3):303–306.

Issue with Part

Poole GH, Mills SM. One hundred consecutive cases of flap lacerations of the leg in ageing patients. N Z Med J 1994, 107(986 Pt 1):377–378.

Issue with No Volume

Turan I, Wredmark T, Fellander-Tsai L. Arthroscopic ankle arthrodesis in rheumatoid arthritis. Clin Orthop 1995, (320):110–114.

No Issue or Volume

Browell DA, Lennard TW. Immunologic status of the cancer patient and the effects of blood transfusion on antitumor responses. Curr Opin Gen Surg 1993:325–333.

Pages in Roman Numerals

Fisher GA, Sikic BI. Drug resistance in clinical oncology and hematology. Introduction. *Hematol Oncol Clin North Am* 1995 Apr, 9(2):xi–xii.

Type of Article Indicated as Needed

Enzensberger W, Fischer PA. Metronome in Parkinson's disease [letter]. *Lancet* 1996, 347:1337.

Clement J, De Bock R. Hematological complications of hantavirus nephropathy (HVN) [abstract]. *Kidney Int* 1992, 42:1285.

Article Containing Retraction

Garey CE, Schwarzman AL, Rise ML, Seyfried TN. Ceruloplasmin gene defect associated with epilepsy in EL mice [retraction of Garey CE, Schwarzman AL, Rise ML, Seyfried TN. In: *Nat Genet* 1994, 6:426–431]. *Nat Genet* 1995, 11:104.

Article Retracted

Liou GI, Wang M, Matragoon S. Precocious IRBP gene expression during mouse development [retracted in *Invest Ophthalmol Vis Sci* 1994, 35:3127]. *Invest Ophthalmol Vis Sci* 1994, 35:1083–1088.

Article with Published Erratum

Hamlin JA, Kahn AM. Herniography in symptomatic patients following inguinal hernia repair [published erratum appears in *West J Med* 1995, 162:278]. *West J Med* 1995, 162:28–31.

Books and Other Monographs*Personal Author(s)*

Pendleton D, Schofield T, Tate P, Havelock P. The new consultation: developing doctor-patient communication, 3rd ed. Oxford: Oxford University Press, 2005.

(Note: Previous Vancouver style incorrectly placed a comma rather than a semicolon between the publisher and the date.)

Editor(s), Compiler(s) as Author

Rumack CM, Wilson SR, Charboneau JW, editors. Diagnostic ultrasound. St. Louis: Mosby Year-Book, 1998.

Organisation as Author and Publisher

Institute of Medicine (US). Looking at the future of the Medicaid program. Washington: The Institute, 1992.

Chapter in a Book

Levine MS. Benign tumors of the esophagus. In: Gore RM, Levine MS, editors. Textbook of gastrointestinal radiology, 2nd ed. Philadelphia, Pa: Saunders, 2000, pp. 387–402.

(Note: Previous Vancouver style placed a colon rather than a p before pagination.)

Conference Proceedings

Kimura J, Shibasaki H, editors. Recent advances in clinical neurophysiology. Proceedings of the 10th International Congress of EMG and Clinical Neurophysiology; 1995 Oct 15–19, Kyoto, Japan. Amsterdam: Elsevier, 1996.

Conference Paper

Bengtsson S, Solheim BG. Enforcement of data protection, privacy and security in medical informatics. In: Lun KC, Degoulet P, Piemme TE, Rienhoff O, editors. MEDINFO 92. Proceedings of the 7th World Congress on Medical Informatics, 1992 Sep 6–10, Geneva, Switzerland. Amsterdam: North-Holland, 1992, pp. 1561–1565.

Scientific or Technical Report

Issued by funding/sponsoring agency:

Smith P, Golladay K. Payment for durable medical equipment billed during skilled nursing facility stays. Final report. Dallas (TX): Dept. of Health and Human Services (US), Office of Evaluation and Inspections, 1994 Oct. Report No.: HHSIGOEI69200860.

Issued by performing agency:

Field MJ, Tranquada RE, Feasley JC, editors. Health services research: work force and educational issues. Washington: National Academy Press, 1995. Contract No.: AHCPR282942008. Sponsored by the Agency for Health Care Policy and Research.

Dissertation

Kaplan SJ. Post-hospital home health care: the elderly's access and utilization [dissertation]. St. Louis (MO): Washington Univ., 1995.

Patent

Larsen CE, Trip R, Johnson CR, inventors; Novoste Corporation, assignee. Methods for procedures related to the electrophysiology of the heart. US patent 5,529,067. 1995 Jun 25.

Other Published Material

Newspaper Article

Lee G. Hospitalizations tied to ozone pollution: study estimates 50,000 admissions annually. The Washington Post 1996 Jun 21, Sect. A:3 (col. 5).

Audiovisual Material

HIV+/AIDS: the facts and the future [videocassette]. St. Louis (MO): Mosby Year-Book, 1995.

Dictionary and Similar References

Stedman's medical dictionary, 26th ed. Baltimore: Williams & Wilkins, 1995. Apraxia, pp. 119–120.

Unpublished Material

In Press

(Note: NLM prefers “forthcoming” because not all items will be printed.)

Assessment of chest pain in the emergency room: What is the role of multidetector CT? *Eur J Radiol*, in press 2006.

Electronic Material

Journal Article in Electronic Format

Morse SS. Factors in the emergence of infectious diseases. *Emerg Infect Dis* [serial online] 1995 Jan–Mar [cited 1996 Jun 5], 1(1):[24 screens]. Available from: URL: <http://www.cdc.gov/ncidod/EID/eid.htm>.

Monograph in Electronic Format

CDI, clinical dermatology illustrated [monograph on CD-ROM]. Reeves JRT, Maibach H. CMEA Multimedia Group, producers, 2nd ed. Version 2.0. San Diego: CMEA, 1995.

Computer File

Hemodynamics III: the ups and downs of hemodynamics [computer program]. Version 2.2. Orlando (FL): Computerized Educational Systems, 1993.

Additional Material

Tables

All tabulated data, identified as tables, should be given a table number and a descriptive caption. Make sure that each table is cited in numerical sequence in the text.

The presentation of data and information given in the table headings should not duplicate information already given in the text. Explain, in footnotes, all non-standard abbreviations used in the table.

If you need to use any tables or figures from another journal, make sure you ask for permission and add a note:

Adapted, with permission, from reference 5.

Figures

Figures should be numbered consecutively in the order in which they are first cited in the text. Follow the “pattern” of similar illustrations of your references.

- *Figure 1. Photograph of a patient in the early stages of the syndrome shows ...*
- *Figure 2. X-rays of a patient with rheumatoid arthritis show ...*

Final Tips

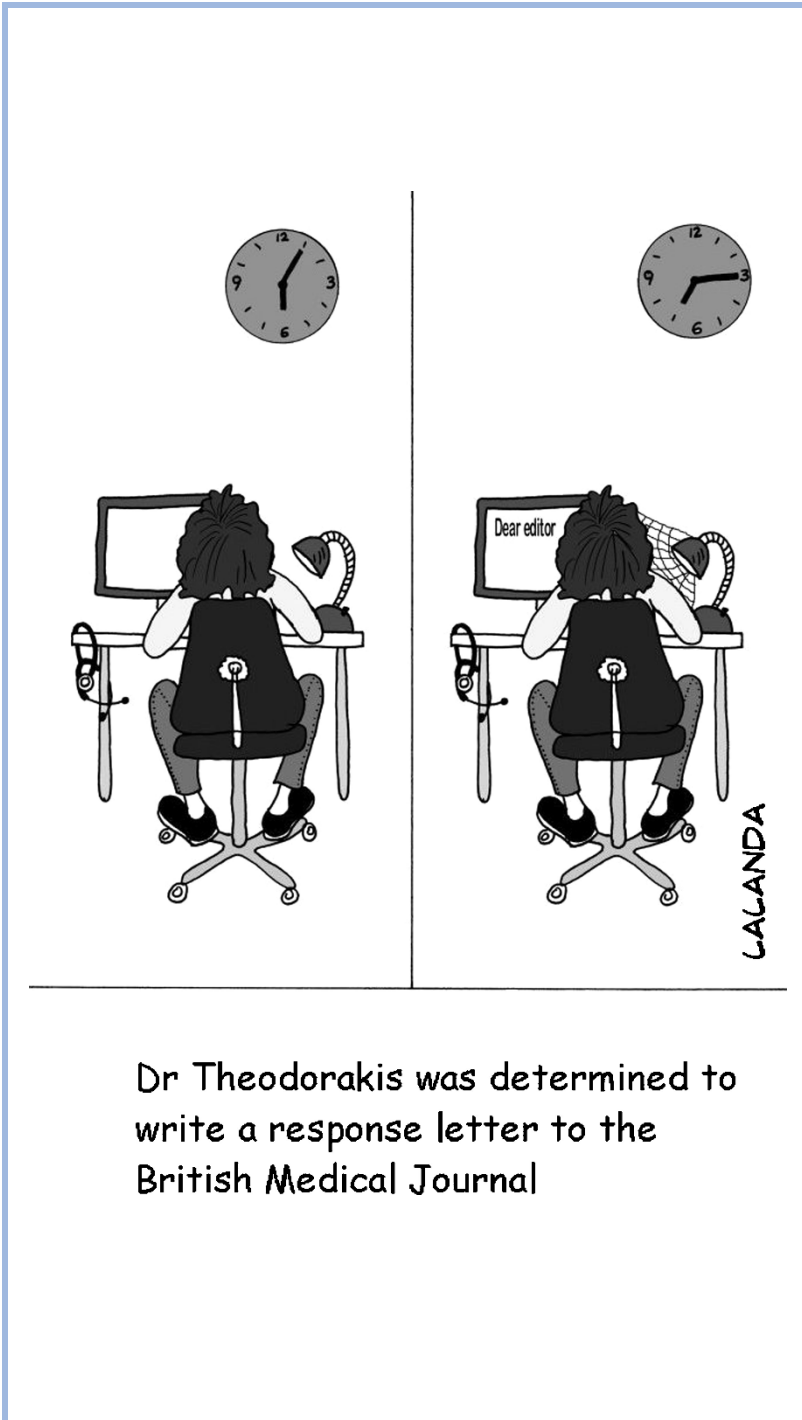
Before you submit your article for publication, check its spelling and go over your article for words you might have omitted or repeated by accident, as well as words you may have misused such as using “there” instead of “their”. Do not send an article with spelling or dosage errors or other medical inaccuracies and do not expect the spell-check function on your computer to catch all your spelling mistakes, or indeed to check your spellings reliably to the UK English standard.

Be accurate. Check and double-check your facts and reference citations. Even after you feel the article is finished, leave it for a day or two and then go back to it. The changes you make to your article after seeing it in a new light will often be the difference between a good article and a great article.

A useful tip is to print your article; you will often spot mistakes that sometimes go unnoticed on the computer screen.

Once you believe everything is correct, give the draft to your English teacher for a final informal editing. Do not send your first (or even second) draft to the publisher!

Do not forget to read and carefully follow the specific “Instructions for Authors” of the journal in which you want your work to be published.



Letters to Editors of Medical Journals

This chapter is made up of several examples of letters sent to editors. Our intention is to provide you with useful tools to communicate with journal editors and reviewers in a formal manner. It is our understanding that letters to editors have quite an important role in the fate of scientific manuscripts that is often overlooked.

Although we are not going to focus on letters from editors since they are, generally speaking, easy to understand, these letters can be divided into acceptance “under certain conditions” letters, acceptance letters and rejection letters.

- Acceptance “under certain conditions” letters. These letters are relatively common and usually mean a great deal of work since the paper (or parts of it) must be re-written.
- Acceptance letters. Congratulations! Your paper has finally been accepted and no corrections have to be made. These letters are, unfortunately, relatively rare, and quite easy to read. They do not require a reply.
- Rejection letters. There are many polite forms of letting you know that your paper is not going to be published in a particular journal. These letters are instantly understood, and since they do not need to be replied to, no time needs to be wasted on them from an idiomatic point of view.

We have divided up the “letters to editors” into:

- Submission letters
- Re-submission letters
- Re-configuration letters
- Letters of thanks for an invitation to publish an article in a journal
- Letters asking about the status of a paper
- Other letters

Submission Letters

Submission letters are quite easy to write since the only message to be conveyed is the type and title of the paper you are submitting and the name of the corresponding author. Many standard letters can be used for this purpose and we do not think you have to waste too much time on them since they are merely preliminary material that just needs to be sent along with the paper itself.

Your address

Date

Receiver's name and address

Dear Dr. Massa,

Please find enclosed (*N*) copies of our manuscript entitled "... (authors ..., ..., ...), which we hereby submit for publication in the ... Journal of Also enclosed is a diskette with a copy of the text file in Microsoft Word for Windows (version ...).

I look forward to hearing from you soon.

Yours sincerely,

A.J. Merckel, MD

Re-submission Letters

Re-submission letters must thoroughly address the comments and suggestions of acceptance letters. It is in these letters that the author must let the editor know that all, or at least most, of the suggested changes have been made and, in doing so, the paper could be ready for publication. These letters may play quite an important role in the acceptance or rejection of a paper.

Let's review the following example:

Dear Dr. Ho,

After a thorough revision in light of the reviewers' comments, we have decided to submit our paper "Type-2 diabetes mellitus; the use of nurse-led clinics in primary care", for re-evaluation.

First of all, we would like to thank you for this second chance to present our paper for publication in your journal.

The main changes in the paper are related to your major comments:

- to improve overall clarity in describing what was undertaken
- to indicate how the protocol for management was developed
- to present our findings in a manner that was more readily understandable, including visual aids

Following your advice, we have also included changes that are in accordance with the reviewers' comments.

We hope this new version will now be suitable for publication in your journal.

Yours sincerely,

Antonio Belafonte, MD, and co-authors

Re-configuration Letters

Sometimes the paper is accepted provided its configuration is changed, i.e. from a pictorial review to a pictorial essay. Re-configuration letters are re-submission letters as well and, therefore, tend to be quite lengthy.

Review this example from which we have extracted and underlined several sentences that can help you in your correspondence with journals.

“Proteinuria in primary care”

RE:01-1343

Dear Dr. Woods, (1)

We have re-configured the manuscript referenced above (2) following your suggestion (3) and we have made as many changes as possible with regard to the reviewers’ recommendations taking into account the space limitation imposed by the new format of the paper (4).

We have tried to cover all entities involving proteinuria, giving priority to the most prevalent conditions (5). The re-configuration of the manuscript has shortened it so drastically that we have had to rewrite it entirely and for this reason we do not attach an annotated copy (6). If you still consider this necessary, we will include it (7). We think that the inclusion of a single table on the classification of proteinuria would “allow the reader to more easily categorise the described imaging findings”(8) as stated by reviewer no. 2 (9) in his general remarks. The table has not been included due to the new format of the paper, but if you take our suggestion into consideration we will be pleased to add it (10).

The major changes in our manuscript are:

1. The title has been modified to “Managing proteinuria in a primary care setting” following your recommendation (11).
2. We have included the technical parameters of our protocol for investigation, although it has not been possible to expand the technical section as suggested by reviewer no. 1 (12) due to space limitation.
3. Similarly, the description of amyloidosis could not be expanded as suggested by reviewer no. 2 due to space limitation (13).
4. With regard to figures (14):
 - a. We have reduced them to three.
 - b. The image quality of Figure 2 has been improved.

5. We have assigned distinct figures to different entities in most cases, although the limited number of figures allowed (15) made it impossible to do it in all cases.
6. With regard to comments on figures by reviewer no. 1 (17):
 - Figure 4e is indeed our usual model of care, rather than adjusted for this paper (18).
7. Subset analysis section has been erased (20) due, again, to space limitation.

We look forward to hearing from you, (21)

Yours sincerely, (22)

John Best, MD, and co-authors (23)

1. *Dear Dr. Woods,*
This sentence ends with a comma rather than a semicolon.
2. *We have reconfigured the manuscript referenced above*
The content of the letter must be summarised in the first paragraph.
3. *... following your suggestion*
This is one of the commonest sentences in re-submission/re-configuration letters.
4. *... space limitation imposed by the new format of the paper*
Space limitation, if the new format limits it, must be taken into consideration by both the authors and the reviewers.
5. *... giving priority to the most prevalent conditions*
May be a criterion for the shortening of the manuscript.
6. *... for this reason we do not attach an annotated copy*
Whenever you don't follow a suggestion, you must give an explanation.
7. *... if you still consider it necessary we will include it*
Always leave open the possibility of adding more information in further correspondence.
8. *... "allow the reader to categorise the described imaging findings more easily"*
You can use as an argument what was literally suggested by the reviewer by writing it in inverted commas.
9. *... as stated by reviewer no. 2*
This is a common way of addressing a reviewer's comment.
10. *... if you take our suggestion into consideration we will be pleased to add it.*
This sentence can be used whenever you want to include something that has not been requested by the reviewers.
11. *The title has been modified to ... following your recommendation.*
This is a common way of addressing a reviewer's comment.
12. *We have included the technical parameters of our protocol for investigation as suggested by reviewer no. 1*
This is a common way of addressing a reviewer's comment.

13. *Similarly, ... could not be expanded as suggested by reviewer no. 2 due to space limitation*
Whenever you don't follow a suggestion, you must give an explanation.
14. *With regard to figures:*
Other options: *Regarding figures, as regards figures, as for figures ...*
15. *With regard to comments on figures by reviewer no. 1:*
This is a common way of addressing a reviewer's comment.
16. *Figure 4e is indeed our usual model of care, rather than adjusted for this paper*
This is a common way of addressing a reviewer's comment.
17. *Subset analysis section has been erased due, again, to space limitation*
This is a common way of addressing a reviewer's comment.
18. *We look forward to hearing from you,*
Remember that the verb following the verb "to look forward to" must be in its *-ing* form.
19. *Yours sincerely,*
Bear in mind that if you do not know the name of the editor, you should write "Yours faithfully" instead.
20. *John Best, MD, and co-authors*
Although the corresponding author is the only one who signs the letter, sometimes a reference is made to the co-authors.

Letters of Thanks for an Invitation to Publish an Article in a Journal

These are simple and usually short letters in which we let the editor of a journal know how pleased we are regarding his/her invitation and how much we appreciate his/her consideration.

Your address

Date

Receiver's name and address

Dear Dr. Massa,

Thank you for the invitation to submit a manuscript on insulin initiation in primary care to your journal.

Please find attached our paper, which details our protocol for such a process and makes a thorough revision of the literature on the subject.

I look forward to hearing from you.

Yours sincerely,

A.J. Cantona, MD

Asking About the Status of a Paper

In these letters we inquire about the situation of our article since we have not received any response from the journal. Regrettably, in the academic world, “no news” is not usually “good news”, and many of these inquiries end up with a polite rejection letter.

Dear Dr. Ross,

As I have not received any response regarding the manuscript “Patients’ perceptions of osteoporosis: a qualitative study”, I am interested in obtaining some information on the status of the paper.

Please, use the following E-mail address for further correspondence:
sanzzap@seram.es

I look forward to hearing from you at your earliest convenience,

J. Sanz, MD, PhD

Summary

To sum up, a few simple formal details must be reviewed:

- “Dear Dr. Smith,” is the usual way to begin an academic letter. Please note that after the name of the editor you must insert a comma instead of a semicolon, and continue the letter with a new paragraph.
- The usual formula “find enclosed ...” can nowadays be replaced by “find or see attached ...” taking into consideration that most papers are submitted via the Internet.
- “I look forward to hearing from you” is a standard sentence used to end a formal letter and you have to bear in mind, in order to avoid a usual mistake, that “to” is a preposition to be followed by a gerund rather than the infinitive particle of the verb that follows it. Do not make the usual mistake of writing “I look forward to hear from you”. Similar formulas are: “I look forward to receiving your comments on ...”
- “Your consideration is appreciated” or “Thank you for your and the reviewers’ consideration” are standard sentences to be written at the end of letters to editors.
- “I look forward to receiving your feedback on ...” is a slightly more casual formula commonly used in letters to editors.
- “Yours faithfully” is used when you do not know the name of the person you are writing to, whereas “Sincerely”, “Sincerely yours,” and “Yours sincerely” must be written when you address the letter to a person by name. Therefore, if the letter begins with “Dear Dr. Olsen,” it must end with “Yours sincerely,” and if it is addressed “Dear Editor” it must finish with “Yours faithfully”. Don’t forget that after the adverb or the pronoun

you must insert a comma, rather than a period, followed by your signature and printed name.

- Whenever you cannot address one of the editor's suggestions explain why it was not possible in the re-submission letter so the reviewers do not waste time looking for it in the manuscript. For example:

We have included the algorithm detailing our type-2 diabetes nurse-led clinic protocol, although, due to space limitations, it has not been possible to expand the information-gathering section that was necessary for its production, as suggested by reviewer no. 1.



- Dr Mmmrrcc..... Sorry, let me call you Anthony. I don't think I could pronounce your surname properly

Unit IV Courses and Talks

Attending a Course

Introduction

In the following pages we take a look inside international primary care meetings. We recommend upper-intermediate English speakers to quickly go over them and intermediate English speakers to review this section thoroughly in order to become familiar with the jargon of international congresses and that of the conversational scenarios such as the airport, plane, customs, taxi, hotel check-in, and finally the course itself that makes up the usual itinerary of a family doctor attending an international course.

Most beginners do not go alone to their first courses abroad. This fact, which in principle is a relief since they do not have to cope with the idiomatic difficulties on their own, has an important drawback: most non-native English-speaking general practitioners come back to their respective countries without having uttered a single word in English. Although it may be considered quite unnatural, speaking English with your colleagues is the only opportunity you will have to do so during course, since over 90% of your conversations are going to be those you have with your fellow countrymen. In parties of more than two people, it's virtually impossible to do this simple exercise.

Travelling alone is the only way of speaking English during an international primary care course and, for non-native English speaking-general practitioners, may be the only opportunity of keeping their English alive throughout the year. Do not waste this excellent opportunity to maintain your level of both colloquial English and primary care English.

Do not let your lack of fluency in day-to-day English undermine your ability to deliver a good, or even a great, presentation. Colloquial English and primary care English are two different worlds, and in order to be successful in the latter you must have a sound knowledge of the former.

This chapter provides you with tips and useful sentences in your itinerary to an international primary care course: airport; plane; customs; taxi; hotel check-in; and finally, the course itself. Unless you have overcome the conversational hurdles in the scenarios that come before the course, firstly, you are not going to get to the course venue and, secondly, if you do get to it, you will not feel like delivering your presentation.

Most non-native English-speaking lecturers resign themselves to just giving the lecture and ... “surviving”, forgetting that if they do not enjoy their lecture, the audience will not enjoy it either. They think that to enjoy giving a lecture, your native tongue must be English. We strongly disagree with this point since many speakers do not enjoy their talks in their own native tongues, and it is our understanding that having a good time delivering a presentation has much more to do with your personality than with your native tongue.

Travel and Hotel Arrangements

Airport

Getting to the Airport

- How do I get to the airport?
- How soon should we be at the airport before take-off?

Checking in

- May I have your passport and flight tickets, please? Of course, here you are.
- Are you Mr. Vida? I am. How do you spell it? V-I-D-A (rehearse the spelling of your last name since if it is not an English one, you are going to be asked about its spelling many times).
- Here is your boarding card. Your flight leaves from gate 43. Thank you.
- You are only allowed two carry-on items. You'll have to check in that larger bag.

Questions a Passenger Might Ask

- I want to book a flight to London leaving this afternoon. Is there a direct flight? Is it via Zurich?
- Is it direct? Yes, it is direct/No, it has one stop.
- Is there a stop-over? Yes, You have a stop-over in Berlin.
- How long is the stop-over? About 1 hour.
- Do I have to change planes? Yes, You have to change planes at ...
- How much carry-on luggage am I allowed?
- What weight am I allowed?
- My luggage is overweight. How much more do I need to pay?
- Is a meal served? Yes, lunch will be served during the flight.

- What time does the plane to Chicago leave?
- When does the next flight to Chicago leave?
- Can I get onto the next flight?
- Can I change my flight schedule?
- What's the departure time?
- Is the plane on time?
- What's the arrival time?
- Will I be able to make my connection?
- I have misplaced my hand luggage. Where is lost property?
- How much is it to upgrade this ticket to first class?
- I want to change the return flight date from Boston to Madrid to November 30th.
- Is it possible to purchase an open ticket?
- I have missed my flight to New York. When does the next flight leave, please?
- Can I use the ticket I have or do I need to pay for a new one?

Announcing Changes in an Airline Flight

- Our flight to Madrid has been cancelled because of snow.
- Our flight to Chicago has been delayed; however, all connecting flights can be made.
- Flight number 112 to Paris has been cancelled.
- Flight number 1145 has been moved to gate B12.
- Passengers for flight number 112 to London go to gate 7. Hurry up! Our flight has been called over the loudspeaker.

At the Boarding Gate

- We will begin boarding soon.
- We are now boarding passengers in rows 24 through 36.
- May I see your boarding card?

Arrival

- Pick up your luggage at the terminal.
- Where can I find a luggage cart?
- Where is the taxi rank?
- Where is the underground station?
- Where is the way out?

Complaining About Lost or Damaged Luggage

- My luggage is missing.
- One of my bags seems to be missing.
- My luggage is damaged.
- One of my suitcases has been lost.

Exchange Office

- Where is the exchange office?
- What is the current exchange rate for the pound sterling?
- Could you change 1000 Euros into pounds sterling?

Customs and Immigration Control

- May I see your passport, please?
- Do you have your visa?
- What is your nationality?
- What is the purpose of your journey? The purpose of my journey is a holiday, touring, family affairs, studying, business ...
- How long do you plan on staying?
- Empty your pockets and put your wallet, keys, mobile phone and coins in this tray.
- Remove any metallic objects you are carrying and put them in this tray.
- Open your laptop.
- Take off your shoes. Put them in this tray, too.
- Do you have anything to declare? No, I don't have anything to declare.
- Do you have anything to declare? No, I only have personal effects.
- Do you have anything to declare? Yes, I am a doctor and I'm carrying some surgical instruments.
- Do you have anything to declare? Yes, I have bought six bottles of whisky and four cartons of cigarettes in the duty-free shop.
- How much currency are you bringing into the country? I haven't got any foreign currency.
- Open your bag, please.
- I need to examine the contents of your bag.
- May I close my bag? Sure.
- Please place your suitcases on the table.
- What do you have in these parcels? Some presents for my wife and kids.
- How much duty do I have to pay?
- Where is the exchange office?

During the Flight

Very few exchanges are likely during a normal flight. If you are familiar with them you will realise how fluency influences your mood positively. Conversely, if you need a pillow and are not able to ask for it, your self-confidence will shrink, your neck will hurt, and you will not ask for anything else during the flight. On my first flight to the States I did not know how to ask for a pillow and tried to convince myself that I did not actually need one. When I looked it up in my guide, asked for it, and the flight attendant brought the pillow, I gladly and pleasantly fell asleep.

Do not let lack of fluency spoil an otherwise perfect flight.

- Is there an aisle/window seat free?
- Excuse me, you are in my seat. Oh! Sorry, I didn't notice.
- Fasten your seat belt, please.
- Your life jacket is under your seat.
- Smoking is not allowed during the flight.
- Please would you bring me a blanket/pillow?
- Is there a business class seat free?
- Can I upgrade to first class on board?
- Would you like a cup of coffee/tea/a glass of water? A glass of water, please.
- What would you prefer, chicken or beef/fish or meat? Beef/fish, please.
- Is there a vegetarian menu?
- Excuse me, I'm not feeling well. Do you have anything for flight sickness? Could you bring me another air-sickness bag, please.
- Excuse me, I have a headache. Do you have an aspirin?
- Excuse me, this gentleman is disturbing me.

In the Taxi (US Cab)

Think for a moment of taking a taxi in your city. How many sentences do you suppose would be exchanged in normal, and even extraordinary, situations? I assure you that with fewer than two dozen sentences you will solve more than 90% of possible situations.

Asking Where to Get a Taxi

- Where is the nearest taxi rank?
- Where can I get a taxi?

Basic Instructions

- Hi, take me to the Sheraton Hotel, please.
- Would you take me to the airport, please?
- Sorry, I am not on duty.
- It will cost you double fare to leave the city.
- I need to go to the Convention Centre.
- Which way do you want me to take you, via Oxford Street or Marylebone Road? Either one would be OK.
- Is there any surcharge to the airport?

Concerning Speed in a Taxi

- To the city centre as quick as you can.
- Are you in a hurry? Yes, I'm in a hurry.
- I'm late; please hurry.
- Slow down!
- Do you have to drive so fast? There is no need to hurry. I am not in a rush at all.

Concerning Smoking in a Taxi

- Would you mind putting your cigarette out?
- Would you mind not smoking, please?

Asking to Stop and Wait

- Stop at number 112, please.
- Which side of the street?
- Do you want me to drop you at the door?
- Pull over, I'll be back in a minute.
- Please, wait here a minute.
- Stop here.

Concerning the Temperature in a Taxi

- Would you please wind your window up? It's a bit cold.
- Could you turn the heat up/down/on/off?
- Could you turn the air conditioning on/off?
- Is the air conditioning/heating on?

Payment

- How much is it?
- How much do I owe you?
- Is the tip included?
- Do you have change for a twenty/fifty-pound note? Sorry, I don't (have any change).
- Keep the change.
- Would you give me a receipt?
- I need a receipt, please.
- I think that is too expensive.
- They have never charged me this before. Give me a receipt, please. I think I'll file a complaint.
- Can I pay by credit card? Sure, swipe your card here.

At the Hotel

Checking In

- May I help you?
- Hello, I have reserved a room under the name of Dr. Viamonte.
- For how many people? Two, my wife and me.
- Do you need my ID?
- Do you need my credit card?
- How long will you be staying? We are staying for a week.
- You will have to wait until your room is ready.
- Here is your key.
- Enjoy your stay. Thank you.
- Is there anybody who can help me with my bags?
- Do you need a bellboy? Yes, please.
- I'll have someone bring your luggage up.

Preferences

- Can you double-check that we have a double room with a view of the beach/city...?
- I would like a room at the front/at the rear.
- I would like the quietest room you have.
- I would like a non-smoking room.
- I would like a suite.
- How many beds? I want a double bed/a single bed.
- I asked for two single beds.
- I'd like a king-sized bed.

- I'd like a queen-sized bed.
- We will need a crib for the baby.
- Are all of your rooms en suite? Yes, all of our rooms have a bath or shower.
- Is breakfast included?
- Does the hotel have a car park?
- Do you have a car park nearby?

The Stay

- Can you give me a wake-up call at seven each morning?
- There is no hot water. Would you please send someone to fix it?
- The TV is not working properly. Would you please send someone to fix it?
- The bathtub has no plug. Would you please send someone up with one.
- The people in the room next to mine are making a racket. Would you please tell them to keep it down?
- I want to change my room. It's too noisy.
- What time does breakfast start?
- How can I get to the city centre?
- Can we change Euros into Pounds?
- Could you recommend a good restaurant near to the hotel?
- Could you recommend a good restaurant?
- Would you give me the number for room service?
- I will have a cheese omelette, a ham sandwich and an orange juice.
- Are there vending machines available?
- Do you have a fax machine available?
- Do you serve meals?
- Is there a pool/restaurant?
- How do I get room service?
- Is there wireless/Internet connection?
- The sink is clogged.
- The toilet is running.
- The toilet is leaking.
- My toilet overflowed!
- The toilet doesn't flush.
- The bath is leaking.
- My bathroom is flooded.
- The bath taps drip day and night.
- The water is rust-coloured.
- The pipes are always banging.
- The water is too hot.
- The water is never hot enough.
- I don't have any hot water.

Checking Out

- How much is it?
- Do you accept credit cards?
- Can I pay in Dollars/Euros?
- I'd like a receipt, please.
- What time is checkout? Checkout is at 11 a.m.
- I would like to check out.
- Is there a penalty for late checkout?
- Please would you have my luggage brought down.
- Would you please call me a taxi?
- How far is the nearest bus stop/subway station?

Complaints

- Excuse me, there is a mistake on the receipt:
- I have had only one breakfast.
- I thought breakfast was included.
- I have been in a single room.
- Have you got a complaints book?
- Please would you give me my car keys?
- Is there anybody here who can help me with my luggage?

Course Example***General Information***

By way of example let's review some general information concerning a course program, focusing on those terms that may not be known by beginners.

Language

The official language of the course will be English.

Dress Code

Formal dress is required for the Opening Ceremony and for the Social Dinner. Casual wear is acceptable for all other events and occasions (although formal dress is customary for lecturers).

Commercial Exhibition

Participants will have the opportunity to visit representatives from pharmaceutical, diagnostic and equipment companies, and publishers at their stands to discuss new developments and receive up-to-date product information.

Although most beginners do not talk to salespeople due to their lack of fluency in English, talking to salespeople in commercial stands is a good way to practise primary care English and, by the same token, receive up-to-date information on equipment and devices you currently use, or will use in the future, in your practice.

Disclosure Statements

To avoid commercial bias, speakers have to report whether they have significant relationships with industry or not.

As far as commercial relationships with industry are concerned there are three types of speakers:

1. Speakers (spouses/partners, and planners) who have no reported significant relationships with industry.
2. Speakers who have reported receiving something of “value” from a company whose product is related to the content of their presentations.
3. Speakers who have not provided information about their relationship with industry.

Faculty

Name and current posts of the speakers:

Professor Parle, Professor of Primary Care, University of Birmingham, UK

Guest Faculty

Name and current posts of speakers coming from institutions other than those organising the course:

Isabel Garcia, General Practice Principal, Rushey Green Group Practice, London, UK

How to Reach ...

Arrival by Plane

The international airport is situated about 25 km outside the city. To reach the city centre you can use the:

City airport train. Every half-hour. Non-stop; 18 minutes from the airport direct to downtown, and from downtown direct to the airport. Fare: single EUR 10; return EUR 18.
Regional railway, line 6. Travel time: 36 minutes. Frequency: every 30 minutes. Fare: single, EUR 12; return, EUR 20. Get off at “Charles Square”. From there use the underground line “U7” to “Park Street”.

Bus. International Airport to ... Charles Square. Travel time: 25 minutes. Fare: EUR 8.

Taxi. There is a taxi rank to the south of the arrival hall. A taxi to the city centre costs around EUR 45 (depending on traffic).

Arrival by Train

- For detailed information about the timetable you can call ...
- At the railway station you can take the underground to reach the city.

Congress Venue

(where the course is going to be held, e.g. hotel, university, convention centre ...)

Continental Hotel

32 Park Street, 23089 ...

Phone: ... Fax ...

E-mail: continentalhotel@hhs.com

To reach the venue from the city centre (Charles Square) take the U1 underground line (green). Leave the train at Park Street and take the exit marked Continental Hotel. Travelling time: approximately 10 minutes.

Financial Matters

The common European currency is the Euro.

Weather

The weather in ... in December is usually cold with occasional snow. The daytime temperatures normally range from -5° to $+5^{\circ}\text{C}$.

Registration

Generally you will have been registered beforehand and you will not have to register at the course's registration counter. If you do have to register at the congress venue, the following are some of the most usual exchanges that may take place during registration:

General practitioner: May I have a registration form, please?

Course attendant: Do you want me to fill it out (UK fill it in) for you?
Are you a general practitioner/GP?
Are you a WONCA member?
Are you attending the full course?

GP registrar: No. I'm a GP registrar (trainee GP)

Course attendant: Can I see your chairman's confirmation letter?

GP registrar: I was told it was faxed last week. Would you check that, please?

General practitioner: I'll pay with cash/by credit card.

Charge it to my credit card.

Would you make out an invoice?

Course attendant: Do you need an invoice?

Do you want me to draw up an invoice?

General practitioner: Where should I get my badge?

Course attendant: Join that line.

Registration fees and deadlines

	Until 1 September 2005	Until 13 November 2006	After 13 November 2006
Full fee member	230.- €	330.- €	450.- €
Full fee non-member	420.- €	540.- €	650.- €
GP member*	150.- €	190.- €	260.- €
GP non-member*	250.- €	310.- €	440.- €
GP registrar*	100.- €	140.- €	180.- €
Hospital administrator*	100.- €	140.- €	180.- €
Single-day ticket	On-site only	On-site only	240.- €
Single half-day ticket (Tuesday only)	On-site only	On-site only	80.- €
Weekend ticket (Saturday 07:00 to Sunday 18:00)	On-site only	On-site only	360.- €
Industry day ticket	On-site only	On-site only	90.- €
Student**	On-site only	On-site only	Free of charge!
GP registrar		120.- €	
Full fee member		180.- €	
Full fee non-member		300.- €	

Course Planning

The basic idea whenever you attend an international primary care course is that you must rehearse beforehand those situations that are inevitably going to happen and, in so doing, you will keep embarrassing situations to a minimum. Just a few words, set phrases and buzz words must be known in a primary care course environment and we can assure you that knowing them will give you the confidence needed to make your participation in the course a personal success.

The first piece of advice is: read the program of the course thoroughly and look up in the dictionary or ask your more experienced colleagues about the words and concepts you do not know. Since the program is available before the course starts, go over it at home; you do not need to read the program at the course's venue.

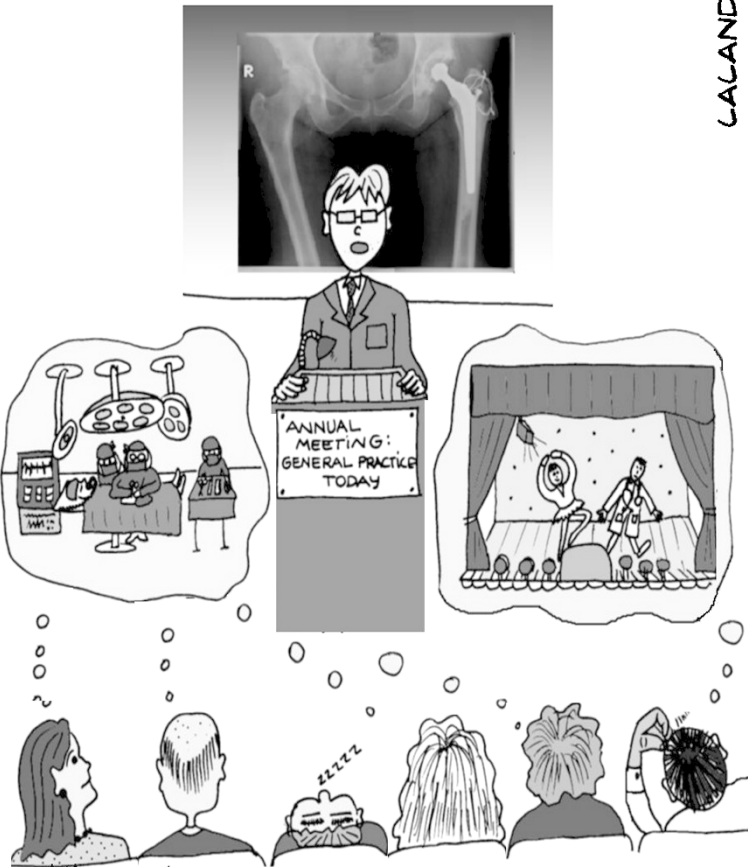
Table 1. Course plan

	8:30	10:30	12:15	14:00	16:00
Dec 4	Special focus session Categorical courses Refresher courses	State of the art Scientific sessions Workshops Satellite symposium	Opening ceremony Inauguration lecture	Scientific sessions Satellite symposium	Special focus session Categorical courses Refresher courses Adjourn
Dec 5	Special focus session Categorical courses Refresher courses	... meets Italy Workshops	Honorary lecture	Scientific sessions Workshops	Special focus sessions Categorical courses Refresher courses Adjourn
Dec 6	Special focus session Categorical courses Refresher courses	... meets Hungary Workshops Satellite symposium	Honorary lecture	Cases of the day	Special focus sessions Categorical courses Refresher courses Adjourn
Dec 7	Special focus session Categorical courses Refresher courses	State of the art Workshops Scientific sessions	Honorary lecture	... meets Japan Scientific sessions	Special focus sessions Categorical courses Refresher courses Adjourn
Dec 8	Special focus session Categorical courses Refresher courses	Workshops Scientific sessions	Closing ceremony		

“Adjourn” is one of those typical program terms with which one becomes familiar once the session is “adjourned”. Although many people may think that most terms are going to be integrated and understood by their context, our intention is to go over those “insignificant” terms that may prevent you from optimising your time at the course.

An example of a course plan is presented in Table 1. The course plan may contain the following elements:

- *Satellite symposia*: events sponsored by pharmaceutical firms where new drugs, techniques or devices are presented to the primary care community.
- *Plenary sessions*: These events usually take place at midday, gathering all participants around outstanding members of the primary care community.
- *Cases of the day*: A number of cases covering different sections of primary care. Participants can submit their diagnosis.
- *Categorical courses*: An important primary care subject is discussed focusing on the needs of general practitioners.
- *Refresher courses*: A concrete topic is reviewed in depth by experts in that particular field.
- "... meets" sessions: The purpose of these sessions is to forge closer ties between some invited countries and the congress. There are dedicated sessions for the primary care communities of these nations to demonstrate excellence in their countries and to meet other attendees.
- *Special focus session*: The aim of a special focus session is to deal with a relevant "hot topic", presented in such a way as to promote debate between the panellists and the audience.
- *Publication session*: The Publication Committee selects, from all the abstracts submitted, the most outstanding basic and clinical research work, and invites the authors to make a presentation of their methods and conclusions (usually not longer than 10–15 minutes). A round of questions and/or comments is usually permitted.
- *Adjourn*: Close (break or recess) at the end of a session.



...and the patient was taken to theatre for definitive treatment.

Giving a Talk

International primary care conferences are in a universe all their own. In this universe, attendees and speakers come from many different countries with their own cultures and consequently their own habits in terms of behaviour and public speaking; however, most speakers set aside, at least partially, their cultural identity to embrace the international medical conference style. This standardisation is part of the globalisation that we are all witnessing.

The most widely spoken language is not Chinese, English or Spanish anymore, but the new phenomenon of broken English. This language is the result of simplifying English to make it as neutral and understandable as possible, removing colloquial idioms, regional expressions or any other source of linguistic confusion.

In this new universe, healthcare professionals find themselves having to make a conscious effort to adapt to these explicit and implicit rules, some of which are discussed in the following sections.

Having read this chapter you will not only be able to improve your presentations or feel at ease giving them, but you might also actually end up being able to convey your message and, who knows ... you might even enjoy it – even if you have to deliver your presentation in the graveyard slot. (The graveyard slot is the first presentation after lunch, when most of the audience will be suffering from postprandial somnolence and it is very likely you will not hear a sound except for snores!)

Dos and Don'ts

Time is also a very cultural thing. This peculiarity should be taken into account. Eight o'clock in the morning might seem an early start in some countries but a perfectly normal starting time in others. Furthermore, the day is divided differently in various parts of the world, and in our primary care universe; thus, at an international conference, the day is divided into:

- The morning: from the start time to noon
- The afternoon: from 12:01 to 17:00 or 18:00
- The evening: from 17:00 or 18:00 to midnight
- *Do* remember to follow these tips:
 - *Good morning*: from the start time to 12:00.
 - *Good afternoon*: from 12:01 onwards, even though your metabolism is far from feeling afternoon-ish until your usual lunch time has gone by and is begging you to say “good morning”.
 - *Good evening*: from 18:00 onwards. Note that if we have to give a presentation, make a speech or offer a toast at 22:00, we should never begin with “good night”; that should be preferably reserved for when we

are going to bed. It can, however, be used for ending a speech after which everyone will depart, “Thank you, and goodnight”.

When giving a presentation, there is always a time limit. I understand, and have actually experienced myself, how difficult it is to cram all we have to say about the topic which we have been researching over the past few years into a mere 20 minutes. In view of this time constraint, there are various alternatives ranging from speaking as fast as the tongue can rattle, to cutting it down to 5 minutes and spending the other 15 minutes vacantly gazing at the audience. American, British and Australian physicians are often extremely fluent speakers (we know, we know ... they are using their mother tongue); however, remember that showing and commenting on five slides a minute and speaking faster than can be registered on a digital recorder might not be the best way of conveying a message.

- *Don't* speak too fast or too slowly.
- *Don't* ever say sorry for this slide. Since you are the one who chooses the slides to be presented, get rid of those for which you would have to apologise.
- *Do* summarise your presentation and rehearse to see how long you need for a clear delivery.

Sometimes lecturers tend to give too much data and minor details in their presentations. Their introduction is often full of information that is of little relevance to the international audience (for example, the name, date and code of local, provincial, regional and national laws regulating primary care standards in his/her institution; or even the background information on the main researchers of a trial including their graduation year and shoe size ... or a full history of the 16th Century building where the primary care centre stands today and subsequent restorations it has undergone; etc.). In these cases, by the time all these details have been given and the presentation has passed the introduction stage, time is up and the chairperson starts making desperate signs to the speaker.

- *Do* grab the pointer with both hands.

The best way of avoiding a trembling pointer is to grab it with both hands and place them over the lectern. If this does not work, we recommend using the mouse since, at least, your trembling will be confined to one plane instead of the three-dimensional shaking of a laser pointer!

- *Do* use either a pointer or the computer's mouse.

Although it may seem unbelievable, I attended a lecture at which the presenter, instead of using a laser pointer, directed the audience's attention to the images using a folded newspaper. The only person who could see the details the speaker was pointing out was the speaker himself.

- *Do* structure your presentation so that you convey a few clear messages instead of a huge amount of not-so-relevant information which nobody has a chance to absorb.
- *Don't* read slides, but instead try to explain a few basic ideas as clearly as possible.

Many intermediate English-speaking doctors may not agree with this point because they can only feel some confidence if they read the presentation. Reading is the least natural means of communicating experiences; we encourage you to present your paper without reading it. Although it will need much more intensive preparation, the delivery will be more fluid and – why not? – even brilliant. Many foreign doctors resign themselves to delivering just acceptable talks and explicitly reject the possibility of making a presentation at the same level as they would in their own language. Do not reject the possibility of being as brilliant as you would be in your own language; the only difference is in the amount of rehearsal. Thorough rehearsal can provide you with amazing results; do not give up beforehand.

- *Don't* read your presentation from a script.

Even worse than reading slides is to read from a script. I have witnessed complete messes happening to lecturers who tried, without any success at all, to coordinate scribbled pages on the lectern and slides. The noise of the passing pages was unbearable and the face of a speaker on the verge of a mental breakdown kept the audience from listening to the presentation itself.

- *Do* enjoy yourself.

When giving the presentation, relax; nobody knows more than you do about the specific subject that you are presenting. The only way to make people enjoy your presentation is by enjoying it yourself. You only have to communicate, not to perform; being a good researcher or a competent clinician is not the same thing as being a stand-up comedian or a model. This does not mean that we can afford to overlook our presentation skills, especially if you want most of your colleagues to still be awake at the end of your presentation!

- *Do* try to overcome stage fright and focus on communicating.

There must be somebody out there interested in what you have to say ... either to praise it or to tear it to pieces, but that doesn't matter!

- *Do* avoid anything that would make you nervous when giving your presentation.

One piece of advice is to remove all keys, coins or other metal objects from your pockets so that you are not tempted to rattle them around – a truly irritating noise that we have all learned to hate.

- Do put your mobile telephone and bleep on silent mode.

The only thing more embarrassing than an attendee's mobile telephone interrupting your lecture is your own phone ringing in the middle of your talk!

- Do make sure that your jokes can be understood internationally.

Creativity and humour are always appreciated in a lecture hall ... providing they are both appropriate and understood! We all know that humour is a very cultural thing, like time keeping, ties, food preferences, etc. Almost all American speakers will start their presentation with a joke that most Europeans will not understand, not even the Irish or British. A British speaker will probably throw in the most sarcastic comment when you are least expecting it and in the same tone as if he or she were telling you about the mortality rate in his or her unit. A foreign (neither American nor British) doctor might just try to tell a long joke in English based on a play on words in his or her mother tongue which obviously does not work in English, and possibly involves religion, sport and/or sex (as a general rule avoid religious, political and sex jokes in public/academic presentations).

Useful Sentences for Primary Care Talks

Introducing the Presentation

- Good afternoon. It is an honour to have the opportunity to speak to you about ...
- Good afternoon. Thank you for your kind introduction. It is my pleasure to speak to you about an area of great interest to me.
- In the next few minutes I'll talk about ...
- The topic I'll cover this afternoon is ...
- In the next 20 minutes I'll show you ...
- In my talk on urinary incontinence, I want to share with you all our experience on ...
- Thank you for sticking around (informal way of addressing the last talk attendees).
- I'd like to thank Dr. Ho for his kind invitation.
- Thank you Dr. Wilson for inviting me to attend this course.
- Thank you Dr. Olsen. It is a great honour to be here talking about ...
- On behalf of my colleagues and assistants, I want to thank Dr. Smith for his kind invitation.
- I'd like to welcome you to this course on ... (to be said in the first talk of the course if you are a member of the organizing committee)
- Today, I want to talk to you about ...
- Now, allow me to introduce ...

- What I want to talk about this morning is ...
- During the next few minutes, I'd like to draw your attention to ...
- First of all, let me summarise the contents of my lecture on ...
- Let's begin by looking at these models of primary care provision ...

Commenting on Images, Graphs, Tables, Schematic Representations ...

- As you can see in the image on your right ...
- As you will see in the next table ...
- As we saw in the previous slide ...
- The next image shows ...
- The next image allows us to ...
- In the bottom left table we can see ...
- What do we have to look at here?
- What do we have to bear in mind with regard to this graph?
- Notice how ...
- Bear in mind that this data comes from our pilot study ...
- Let's look at this schematic representation of the flow of patients between primary and secondary care ...
- As you can see in this table ...
- Looking at this table, you can see ...
- Having a look at this bar chart, we could conclude that ...
- To sum up, let's look at this diagram ...
- The image on your right ...
- The image at the top of the screen shows ...
- Figure 7 brings out the importance of ...
- As can be observed in this algorithm ...
- I apologise that the photograph *does not project well*. (When something is difficult to see on a projected image, it is said that *it does not project well*.)

Summing Up

- To sum up we can say that ...
- In summary, we have discussed ...
- To conclude ...
- Summing up, I would say that ...
- The take-home lesson of the talk is ...
- To put it in a nutshell ...
- To cut a long story short ...
- In short, ...
- To put it briefly ...
- Be that as it may, we have to bear in mind that ...

- If there is one point I hope you will take away from this presentation, it is that ...
- Hb_{A1C} has proven to be very useful in the assessment of glycaemic control by providing information about long-term glucose levels.
- Echocardiography is a powerful technique that yields valuable diagnostic information.
- The rate of growth and distribution of nurse led chronic disease management clinics will depend on investing in training and collaboration.
- Surgery may be helpful in the management of ... if medical management has failed.
- Oral glucose tolerance test is the most accurate investigation for the diagnosis of ...

Concluding

- Thank you for your kind attention.
- Thank you all for sticking around until the very last talk of the session.
- Thank you all.
- Thank you very much for your time. You have been a most gracious audience.
- Thank you for your attention. I would be happy to take any questions you may have.
- Thank you for your time. I would be happy to address any questions.
- This is all we have time for, so thank you and have a good time in London.
- Let me finish my presentation by saying that ...
- We can say to conclude that ...
- Let me end by wishing you a pleasant stay in our city.
- I'd be happy to answer any questions you might have.
- I'd be happy to address your comments and questions.

The “Dreadful” Questions and Comments Section

Many beginners would not hesitate to deliver a presentation at an international congress if there were not a short section of questions after them.

The following anecdote lived by Ramon Ribes may illustrate the feelings of many non-native English-speaking doctors in their first presentations in English.

After a short free communication on the MR follow-up of Ross operation (the surgical replacement of a patient's aortic valve by the pulmonary valve and the replacement of the latter by a homograft) which had so far gone reasonably well for a beginner, I was waiting, like a rabbit staring at a snake, for the round of questions that would inevitably follow my presentation.

On the very verge of a mental breakdown I listened to an English family doctor asking me a question I could barely understand. I asked him: "Could you please repeat your question?" and he, obediently, repeated the question with exactly the same words and the same pace with which he had formulated it before. As I could not understand the question the second time, the chairman roughly translated it into a more international and easily understandable English and I answered it as best I could. This was the only question I was asked since the time was over and there was no room for any other comment.

Let us think about this anecdote in a positive way by dissecting it into the following points that will lead us to some recommendations.

1. Do not be discouraged. Nobody said beginnings were easy.
2. Questions and comments by native English speakers tend to be more difficult to understand.
3. There are several types of questioners of whom you must be aware.
4. Do not complain if the questioner does exactly that for which you asked him/her.
5. Chairmen can always help you.
6. Time is limited and you can take advantage of this fact.

These points lead to some recommendations:

1. Dr. Ribes did not know by then that the worst was still to come. He wasted the whole morning recreating the scene over and over. "How could I not have understood such an easy question? How could I have spoiled so many hours of research and study? I even thought that people recognised me as "the one who didn't understand a simple query ...". Let us think for a moment how you performed the first time you did anything in your life, i.e., the first time you grabbed a tennis racquet or a golf club. In comparison to that, it was not that bad.
2. When the doctor who asks for the microphone is a non-native English speaker, you can begin to feel better since you are going to talk to an equal with regard to language, to one who has spent a great number of hours fighting to learn a language other than his own. On the other hand, when you have to deal with a native English speaker there are two main types of questioners:
Type A is a colleague who does not take advantage of being a native English speaker and reduces his normal rhythm of speech so you can

understand the question and, therefore, convey to the audience whatever you have to say.

Type B is a colleague who does not make any allowance for the difference between native and non-native English lecturers. Needless to say, I faced a type-B questioner in my first international presentation.

3. Types of questioners:

- *Type 1*: The questioner who wants to know a particular detail of your presentation; these are easy to handle by just answering his questions.

How did you obtain funding for this project?

Through local primary care commissioning agencies and the European Commission Social Fund.

- *Type 2*: The questioner who wants the audience to notice his sound knowledge of the subject that is being discussed; these are quite easy to handle as well since they do not formulate questions as such but make a point of their own. The replies tend to be shorter than the questions/comments and time goes by, leaving no room for another dreadful question.

I do agree with your comments

We are planning to include this point in our next paper on ...

- *Type 3*: This is a questioner who strongly disagrees with your points. This is obviously the most difficult to handle for a beginner due to the scarcity of his idiomatic resources. The only piece of advice is none other than that you must defend your points from a humble position and do not ever challenge your questioner.

I will consider your suggestions on ...

This is a work in progress and we will consider including your suggestions ...

4. If I had requested my questioner to ask his question again more slowly and in a different way so I could understand it, he would have been morally obliged to do so. But beginners lack this kind of modesty and pretend to be better and know more than they actually do, which is, by definition, a mistake.

I don't understand your question. Would you please reformulate your question in a different way, please?

5. When you feel you need some help, ask the chairman to help you.

Dr. Ho (chairman) I'm not sure I've understood the question. Would you please formulate it in a different way?

6. It is, at worst, 1 minute of stress. Do not let such a short period of time prevent you from a potentially successful career in international primary care!

Sentences That May Help

Go over these sentences that may help you escape from a difficult situation and minimise your fear of the questions and comments section:

Making Your Point

- Let me point out that variations in consultation length exist between doctors and practices ...
- You must bear in mind that not all consultations can be categorised ...
- If you look closely at the table, you will realise that ...
- I want to draw your attention to the fact that ...
- Don't forget the importance of spirometry in ...
- Before I move on to my next slide ...
- In view of the upcoming publication of ...
- From a primary care point of view ...
- As far as accountability is concerned ...
- The bottom line is ...

Giving Explanations

- To put it another way, changes in the way general practice is funded were responsible for ...
- Taking into consideration that the study was done under pragmatic rather than blinded conditions ...
- In a bit more detail, you can notice that ...
- This fact can be explained taking into account that ...
- Although study participation was agreed by most patients ...
- In short, you may need longer consultations using interpreters.
- What I'm saying is that endometriosis is related to ectopic growth of endometrial tissue ...
- We did not include the image in the study because the patient refused it.

Answering Multiple Questions

- There are two different questions here.
- It seems there are three questions here.
- It is my understanding that there are two questions to be addressed here.
- With regard to your first question ...
- Regarding your second question ...
- As far as your first question is concerned ...
- Answering your first question, I should say that ...
- I'll begin with your second question.
- Let me address your last question first.
- I'll address your last question first and then the rest of them.
- Would you please repeat your second question?
- I didn't understand your first question. Would you repeat it?

Disagreeing

- With all due respect, I believe that there is no evidence of ...
- To the best of our knowledge, no article has been published on this topic.
- With all respect, I think that your point overlooks the main aspect of ...
- Yours is an interesting point of view, but I'm not sure of its ...
- I see it from a different point of view.
- With all respect, I don't go along with you on ...
- I think that the importance of ... cannot be denied.
- I strongly disagree with your comment on ...
- I disagree with your point.
- I don't see a valid argument for supporting such a comment.

Emphasising a Point

- I do believe that ...
- I strongly agree with Dr. Ho's comments on ...
- It is of paramount importance ...
- It is a crucial fact that ...
- And this fact cannot be overlooked.
- I'd like to stress the importance of ...
- Don't underestimate the role of ...
- The use of bisphosphonates in these cases is of the utmost importance.
- With regard to ..., you must always bear in mind that ...
- It is well known that ...

Incomprehension

- I'm not sure I understood your question ...
- Sorry; I don't quite follow you.
- Would you repeat the question, please?
- Would you repeat the second part of your question, please?
- I'm afraid I still don't understand.
- Could you be a bit more specific with regard to ...?
- What do you mean by ...?
- Could you repeat your question? I couldn't hear you.
- Could you formulate your question in a different way?
- I'm not sure I understand your final question.

Playing for Time

- I am not sure I understood your question. Would you repeat it?
- I don't understand your question. Would you formulate it in a different way?
- That's a very interesting question ...
- I wonder if you could be a bit more specific about ...
- I'm glad you asked that question.
- Your question is of the utmost importance, but I'm afraid it is beyond the scope of our paper ...
- What aspect of the problem are you referring to by saying ...

Evading an Issue

- I'm afraid I'm not really in a position to be able to address your question yet.
- We'll come back to that in a minute, if you don't mind.
- I don't think we have enough time to discuss your comments in depth.
- It would take extremely long time to answer that.
- I will address your question in my second talk, if you don't mind.
- In my practice, we do not have experience on ...
- In our practice, we do not perform ...
- Perhaps we could return to that at the end of the session.
- We'll probably address your question in further papers on the subject.
- I have no experience of ...

Technical Problems

- May I have another laser pointer?
- Does anyone in the audience have a pointer?
- Video images are not running properly. In the meantime I'd like to comment on ...
- My microphone is not working properly. May I have it fixed?
- My microphone is not working properly. May I use yours?
- Can you hear me?
- Can the rows in the back hear me?
- Can you guys in the back see the screen?
- Can we turn the lights off please?

-We are having some problems with the lights. We'll make a short break but please don't go too far. We'll resume as soon as possible.



....and six hours later

-All of you who are holding candles should be aware of the risk of fire. Could everybody please make a mental note of the location of your nearest fire exit. Let's continue...

Chairing a Session

Chairing sessions at international meetings usually comes up when you have reached a certain level in your academic career. To reach this point many papers will have been submitted and many presentations will have been given, so the chances are your level of medical English will be above that of the target audience of this manual.

Why, then, do we include a section on chairing a session?

We include it because contrary to what many of those who have never chaired a session in an international meeting may think, even an experienced chairperson may face difficult, even embarrassing situations.

For those who have never chaired a session, to be a chairman means, firstly, not having to prepare a presentation, and, secondly, the use of simple sentences such as “Thank you, Dr. Vida, for your interesting presentation” or “The next speaker will be Dr. Jones who comes from ...”.

In our opinion, being a chairperson means much more than one who has never chaired a session might think. To begin with, a chairperson must go over not one presentation but thoroughly study all the recently published material on the subject under discussion. On top of that, a chairperson must review all the abstracts and must have prepared questions just in case the audience has no questions or comments.

We have divided this section into four subsections:

1. Usual chairperson's comments.
2. Should chairpersons ask questions?
3. What the chairperson should say when something is going wrong.
4. Specific primary care chairperson's comments.

Usual Chairperson's Comments

Everybody who has attended an international meeting is aware of the usual sentences the chairperson uses to introduce the session. Certain key expressions will provide you with a sense of fluency without which chairing a session would be troublesome. The good news is that if you know the key sentences and use them appropriately, chairing a session is easy. The bad news is that if, on the contrary, you do not know these expressions, a theoretically simple task will become an embarrassing situation. There is always a first time for everything, and if it is the first time you have been invited to chair a session, rehearse some of these sentences and you will feel quite comfortable. Accept this piece of advice: only “rehearsed spontaneity” looks spontaneous if you are a beginner.

Introducing the Session

We suggest the following useful comments for introducing the session:

- Good morning ladies and gentlemen. My name is Dr. Vida and I want to welcome you all to this workshop on chronic disease management in primary care. My co-chair is Dr. Vick who comes from King's College.
- Good afternoon. The session on depression in primary care is about to start. Please take a seat and disconnect your mobile phones and any other electronic devices which could interfere with the presentations. We will listen to ten 6-minute lectures with a 2-minute period for questions and comments after each, and afterwards, provided we are still on time, we will have a last round of questions and comments from the audience, speakers and panellists.
- Good morning. We will proceed with the session on falls prevention. As many papers have to be delivered, I encourage the speakers to keep an eye on the time.

Introducing Speakers

We suggest the following useful comments for introducing speakers:

- Our first speaker is Dr. Rodriguez from Guzman Health Centre in Madrid, Spain, who will present the paper: "Telephone triage in primary care".

The following speakers are introduced almost the same way with sentences such as:

- Our next lecturer is Dr. Adams. Dr. Adams comes from Makerere University, Kampala, Uganda, and his presentation is entitled "Gastroenteritis in resource-restricted settings".
- Next is Dr. Shaw from Beth Israel Deaconess Hospital, presenting "The role and availability of brain natriuretic peptide in the diagnosis of heart failure in primary care".
- Dr. Olsen from University College London is the next and last speaker. His presentation is: "Community palliative care provision in North London, UK".

Once the speakers finish their presentation, the chairperson is supposed to say something like:

- Thank you, Dr. Rodriguez, for your excellent presentation. Any questions or comments?

The chairperson usually comments on presentations, although sometimes they do not:

- Thank you, Dr. Adams, for your presentation. Are there any questions or comments from the audience?

There are some common adjectives (*nice, elegant, outstanding, excellent, interesting, clear, accurate ...*) and formulas that are usually used to describe presentations; these are illustrated in the following comments:

- Thanks, Dr. Shaw, for your accurate presentation. Does the audience have any comments?
- Thank you very much for your clear presentation on this always-controversial topic. I would like to ask a question. May I? (Although being the chairperson you are the one who gives permission, to ask the speaker is a usual formality.)
- I'd like to thank you for this excellent talk, Dr. Olsen. Any questions?
- Thanks a lot for your talk, Dr. Ho. I wonder if the audience has got any questions?

Adjourning

We suggest the following useful comments for adjourning the session:

- I think we all are a bit tired so we'll have a short break.
- The session is adjourned until 4 p.m.
- We'll take a short break.
- We'll take a 30-minute break. Please fill out the evaluation forms.
- The session is adjourned until tomorrow morning. Enjoy your stay in Vienna.

Finishing the Session

We suggest the following useful comments for finishing the session:

- I'd like to thank all the speakers and the audience for your interesting presentations and comments. (I'll) see you all at the congress dinner and awards ceremony.
- The session is over. I want to thank all the participants for their contribution. (I'll) see you tomorrow morning. Remember to take your attendance certificates if you have not taken them already.
- We should finish up over here. We'll resume at 10:50.

Should Chairpersons Ask Questions?

In our opinion, chairpersons are supposed to ask questions especially at the beginning of the session when the audience does not usually make any comments at all. Warming-up the session is one of the chairperson's duties, and if nobody in the audience is in the mood to ask questions, the chairperson must invite the audience to participate:

- Are there any questions?

Nobody raises their hand:

- Well, I have got two questions for Dr. Adams. Do you think the role on non-medical personnel in managing gastroenteritis is under used? and second: if so, how can these parties best be engaged?

Once the session has been warmed-up, the chairperson should only ask questions or add comments as a tool to manage the timing of the session, so that, if as usual, the session is behind schedule, the chairperson is not required to participate unless strictly necessary.

The chairperson does not have to demonstrate to the audience his or her knowledge on the discussed topics by asking too many questions or making comments. The chairperson's knowledge of the subject is not in doubt since without it he or she would not have been selected to chair.

What the Chairperson Should Say When Something Is Going Wrong

Behind Schedule

Many lecturers, knowing beforehand that they have a certain amount of time to deliver their presentations, try to talk a little bit more, stealing time from the questions/comments time and from later speakers. Chairpersons should cut short this tendency at the very first chance:

- Dr. Berlusconi, your time is almost over. You have got 30 seconds to finish your presentation.
- Dr. Ho, you are running out of time.

If the speaker does not finish his presentation on time, the chairperson may say:

- Dr. Berlusconi, I'm sorry but your time is over. We must proceed to the next presentation. Any questions, comments?

After introducing the next speaker, sentences such as the following will help you handle the session:

- Dr. Goyen, please keep an eye on the time, we are behind schedule.
- We are far from being ahead of schedule, so I remind all speakers that you have 6 minutes to deliver your presentation.

Ahead of Schedule

Although unusual, sometimes there is some extra time and this is a good chance to ask the panellists a general question about their experience at their respective institutions:

- As we are a little bit ahead of schedule, I encourage the panellists and the audience to ask questions and offer comments.
- I have got a question for the panellists: What measures have been effective in tackling obesity in your practice?

Technical Problems

Computer Not Working

We suggest the following comments:

- I am afraid there is a technical problem with the computer. In the meantime I would like to make a comment about ...
- The computer is not working properly. While it is being fixed I encourage the panellists to offer their always interesting comments.

Lights Have Gone Out

We suggest the following comments:

- The lights have gone out. We'll take a hopefully short break until they are repaired.
- As you see, or indeed do not see at all, the lights have gone out. The hotel staff have told us it is going to be a matter of minutes so do not go too far; we'll resume as soon as possible.

Sound Has Stopped Functioning

We suggest the following comments:

- Dr. Hoffman, we cannot hear you. There must be a problem with your microphone.
- Perhaps you could try this microphone?
- Would you use the microphone, please? The rows in the back cannot hear you.

Lecturer Lacks Confidence

If the lecturer is speaking too quietly:

- Dr. Smith, would you please speak up? The audience cannot hear you.
- Dr. Alvarez, would you please speak up a bit? The people in the back cannot hear you.

If the lecturer is so nervous that he/she cannot go on delivering the presentation:

- Dr. Olsen, take your time. We can proceed to the next presentation, so whenever you feel OK and ready to deliver yours, it will be a pleasure to listen to it.

Specific Primary Care Chairperson's Comments

Since chairpersons are supposed to fill in the gaps in the session, if a technical problem occurs, the chairperson must say something to “entertain” the audience in the meantime. This fact would not create any problem to a native English speaker but may be troublesome for a non-native English-speaking chairperson. In these situations there is always a helpful topic to be addressed “in the meantime”, namely, the current situation in the panelists’ countries of what is under discussion.

- Regarding cervical screening, how are things going in Italy, Dr. Toldo?
- As for the use of human papilloma virus vaccination, what’s the story in Japan, Dr. Hashimoto?
- How is the current situation in Germany regarding repayment policies?
- May I ask how many children complete their vaccination schedules at your respective practices?
- What’s going on in the States, Dr. Olsen?

By opening a discussion on how things are going in different countries, the not-too-fluent chairperson shares the burden of filling in the gaps with the panellists. This trick rarely fails, and once the technical problem is fixed the session can go on normally with nobody in the audience noticing the lack of fluency of the chairperson.

Besides the usual expressions, there are some typical comments with which a chairperson should be familiar. These comments vary depending upon the experience and expertise of the chairperson and are, generally speaking, easy to deal with for even non-native English speakers. By way of example, let’s review the following:

- Dr. Petit, would you please use the pointer so that the audience can know about which table you are talking?
- Dr. Negroponte, did you arrange an abdominal ultrasound scan for this patient?
- Dr. Maier, do you use expectant management for asymptomatic prostate cancer?
- Have you had any adverse reactions to this recently licensed treatment for erectile dysfunction?
- Do you use non-absorbent dressings for this purpose?
- Dr. Pons, I’m afraid that the video is not running properly. Could you try to fix it so we can see your excellent consultation?
- Dr. Hashimoto, would you tell us a little more about why didn’t you use a beta blocker in these circumstances?
- Dr. Soares, are you currently using spironolactone in cases like this one?
- Dr. Mas, is contact tracing that important in these cases?
- Do you do checks in all postoperative patients, regardless of whether this is undertaken in secondary care?
- Do you perform digital rectal examination in all patients undergoing prostate-specific antigen testing?



OMNIA DICTA FORTIORA SI DICTA LATINA

(Everything sounds more impressive
if you say it in Latin)

Unit V Latin and Greek Terminology

Introduction

Latin and Greek terminology is another obstacle to overcome on our way to becoming fluent in medical English. Romance-language speakers (Spanish, French, Italian) are undoubtedly at an advantage, although this advantage can become a great disadvantage in terms of pronunciation and, particularly, in the use of the plural forms of Latin and Greek.

Since most Latin words used in medical English keep the Latin plural ending, e.g. metastasis, *pl.* metastases; viscus, *pl.* viscera, it is essential to understand the basis of plural rules in Latin.

All Latin nouns and adjectives have different endings for each gender (masculine, feminine, or neuter), number (singular or plural), and case – the case is a special ending that reveals the function of the word in a particular sentence. Latin adjectives must correlate with the nouns they modify in case, number and gender. Although we can barely remember it from our days in high school, there are five different patterns of endings; each one of them is called declension.

The nominative case indicates the subject of a sentence, whereas the genitive case denotes possession or attachment. Dropping the genitive singular ending gives the base to which the nominative plural ending is added to build the medical English plural form.

For example:

- *Corpus* (nominative singular), *corporis* (genitive singular), *corpora* (nominative plural). This is a third-declension neuter noun that means body. The corresponding forms for the accompanying adjective *callosus* are *callosum*, and *callosa*, respectively; thus, *corpus callosum* (nominative, singular, neuter), *corpora callosa* (nominative, plural, neuter).

Another example:

- *Coxa vara* (feminine singular), *coxae varae* (feminine plural), but *genu varum* (neuter, singular), *genua vara* (neuter, plural).

Table 1. The endings of Latin substantives listed by case and declension

Case	Declension							
	1st	2nd		3rd		4th		5th
	Fem.	Masc.	Neut.	Masc./ Fem.	Neut.	Masc.	Neut.	Fem.
Nominative sing.	-a	-us	-um	–	–	-us	-u	-es
Genitive sing.	-ae	-i	-i	-is	-is	-us	-us	-ei
Nominative pl.	-ae	-i	-a	-es	-a	-us	-ua	-es

This unit provides a selected glossary of the Latin terms which are most likely to be encountered by a family doctor in an English-speaking country. It includes the singular and plural nominative, and the genitive singular forms of each word as well as the declension and gender of each word. In some terms, additional items have been added, such as English plural endings when widely accepted (e.g., *fetus*, Latin plural *feti*, English plural *fetuses*), and Greek-origin endings kept in some Latin words (e.g., *thorax*, pl. *thoraces*, gen. *thoracos/thoracis*: chest; Table 1). The pronunciation in English of Latin words can be challenging: just try “nuclei” [nyōō’-klē-ī’] as an example.

Examples:

- 1st declension:
 - Feminine words: *patella* (nom. sing.), *patellae* (gen.), *patellae* (nom. pl). English *patella*.
- 2nd declension:
 - Masculine words: *humerus* (nom. sing.), *humeri* (gen.), *humeri* (nom. pl.). English *humerus*.
 - Neuter words: *interstitium* (nom. sing.), *interstitii* (gen.), *interstitia* (nom. pl.). English *interstice*.
- 3rd declension:
 - Masculine or feminine words: *Pars* (nom. sing.), *partis* (gen.), *partes* (nom. pl.). English *part*.
 - Neuter words: *os* (nom. sing.), *oris* (gen.), *ora* (nom. pl.). English *mouth*.
- 4th declension:
 - Masculine words: *processus* (nom. sing.), *processus* (gen.), *processus* (nom. pl). English *process*.
 - Neuter words: *cornu* (nom. sing.), *cornus* (gen.), *cornua* (nom. pl.). English *horn*.

- 5th declension:
 - Feminine words: *facies* (nom. sing.), *faciei* (gen.), *facies* (nom. pl.). English *face*.

The endings of the adjectives change according to one of these two patterns:

1. Singular: masc. *-us*, fem. *-a*, neut. *-um*. Plural: masc. *-i*, fem. *-ae*, neut. *-a*.
2. Singular: masc. *-is*, fem. *-is*, neut. *-e*. Plural: masc. *-es*, fem. *-es*, neut. *-a*.

Plural Rules

It is far from our intention to replace medical dictionaries and Latin or Greek textbooks. Conversely, this unit is aimed at giving some tips related to Latin and Greek terminology that can provide a consistent approach to this challenging topic.

Our first piece of advice on this subject is that whenever you write a Latin or Greek word, firstly, check its spelling and, secondly, if the word you want to write is a plural one, never make it up. Although guessing the plural form could be acceptable as an exercise in itself, double-check the word by looking it up in a medical dictionary.

The following plural rules are useful to at least give us self-confidence in the use of usual Latin or Greek terms such as *metastasis* – *metastases*, *pelvis* – *pelves*, *bronchus* – *bronchi*, etc. ...

Some overseas doctors do think that *metastasis* and *metastases* are equivalent terms, and they are absolutely wrong. The difference between a unique liver metastasis and multiple liver metastases is so obvious that no additional comment is needed.

There are many Latin and Greek words whose singular forms are almost never used as well as Latin and Greek terms whose plural forms are seldom said or written. Let us think, for example, about the singular form of *viscera* (*viscus*). Very few physicians are aware that the liver is a *viscus*, whereas the liver and spleen are *viscera*. From a colloquial standpoint this discussion might be considered futile, but those who write papers do know that Latin/Greek terminology is always a nightmare and needs thorough revision, and that terms seldom used on a day-to-day basis have to be properly written in a scientific article. Again, let us consider the plural form of *pelvis* (*pelves*). To talk about several *pelves* is so rare that many doctors have never wondered what the plural form of *pelvis* is.

Although there are some exceptions, the following general rules can be helpful with plural terms:

- Words ending in *-us* change to *-i* (2nd declension masculine words):
 - *bronchus* → *bronchi*

- Words ending in *-um* change to *-a* (2nd declension neuter words):
– *atrium* → *atria*
- Words ending in *-a* change to *-ae* (1st declension feminine words):
– *vena* → *venae*
- Words ending in *-ma* change to *-mata* or *-mas* (3rd declension neuter words of Greek origin):
– *sarcoma* → *sarcomata/sarcomas*
- Words ending in *-is* change to *-es* (3rd declension masculine or feminine words):
– *metastasis* → *metastases*
- Words ending in *-itis* change to *-itides* (3rd declension masculine or feminine words):
– *arthritis* → *arthritides*
- Words ending in *-x* change to *-ces* (3rd declension masculine or feminine words):
– *pneumothorax* → *pneumothoraces*
- Words ending in *-cyx* change to *-cyges* (3rd declension masculine or feminine words):
– *coccyx* → *coccyges*
- Words ending in *-ion* change to *-ia* (2nd declension neuter words, most of Greek origin):
– *criterion* → *criteria*

List of Latin and Greek Terms and Their Plurals

Abbreviations:

adj. adjective
Engl. English
fem. feminine
lit. literally
m. muscle
masc. masculine

gen. genitive
Gr. Greek
Lat. Latin
neut. neuter
pl. plural
sing. singular

A

- **Abdomen**, pl. **abdomina**, gen. **abdominis**. Abdomen. 3rd declension neut.
- **Abductor**, pl. **abductores**, gen. **abductoris** (from the verb *abduco*, to detach, to lead away). 3rd declension masc.
- **Acetabulum**, pl. **acetabula**, gen. **acetabuli**. Cotyle. 2nd declension neut.
- **Acinus**, pl. **acini**, gen. **acini**. Acinus. 2nd declension masc.
- **Adductor**, pl. **adductores**, gen. **adductoris**. Adductor. 3rd declension masc.
- **Alveolus**, pl. **alveoli**, gen. **alveoli**. Alveolus (lit. *basin*). 2nd declension masc.
- **Ampulla**, pl. **ampullae**, gen. **ampullae**. Ampoule, blister. 1st declension fem.
- **Anastomosis**, pl. **anastomoses**, gen. **anastomosis**. Anastomosis. 3rd declension.
- **Annulus**, pl. **annuli**, gen. **annuli**. Ring. 2nd declension masc.
- **Anterior**, pl. **anteriores**, gen. **anterioris**. Foremost, that is before, former. 3rd declension masc.
- **Antrum**, pl. **antra**, gen. **antri**. Antrum, hollow, cave. 2nd declension neut.
- **Anus**, pl. **ani**, gen. **ani**. Anus (lit. *ring*). 2nd declension masc.
- **Aorta**, pl. **Aortae**, gen. **aortae**. Aorta. 1st declension fem.
- **Apex**, pl. **apices**, gen. **apices**. Apex (top, summit, cap). 3rd declension masc.
- **Aphtha**, pl. **aphthae**, gen. **aphthae**. Aphtha (small ulcer). 1st declension fem.
- **Aponeurosis**, pl. **aponeuroses**, gen. **aponeurosis**. Aponeurosis. 3rd declension.
- **Apophysis**, pl. **apophyses**, gen. **apophysos/apophysis**. Apophysis. 3rd declension fem.
- **Apparatus**, pl. **apparatus**, gen. **apparatus**. Apparatus, system. 4th declension masc.
- **Appendix**, pl. **appendices**, gen. **appendicis**. Appendage. 3rd declension fem.
- **Area**, pl. **areae**, gen. **areae**. Area. 1st declension fem.
- **Areola**, pl. **areolae**, gen. **areolae**. Areola (lit. *little area*). 1st declension fem.
- **Arteria**, pl. **arteriae**, gen. **arteriae**. Artery. 1st declension fem.
- **Arteriola**, pl. **arteriolae**, gen. **arteriolae**. Arteriola (small artery). 1st declension fem.
- **Arthritis**, pl. **arthritides**, gen. **arthritidis**. Arthritis. 3rd declension fem.
- **Atlas**, pl. **atlantes**, gen. **atlantis**. First cervical vertebra. 3rd declension masc.
- **Atrium**, pl. **atria**, gen. **atrii**. Atrium. 2nd declension neut.

- **Auricula**, pl. **auriculae**, gen. **auriculae**. Auricula (ear flap). 1st declension fem.
- **Auricularis m.**, pl. **auriculares**, gen. **auricularis**. Pertaining to the ear. 3rd declension masc.
- **Axilla**, pl. **axillae**, gen. **axillae**. Armpit. 1st declension fem.
- **Axis**, pl. **axes**, gen. **axis**. Second cervical vertebra, axis. 3rd declension masc.

B

- **Bacillus**, pl. **bacilli**, gen. **bacilli**. Stick-shape bacterium (lit. *small stick*). 2nd declension masc.
- **Bacterium**, pl. **bacteria**, gen. **bacterii**. Bacterium. 2nd declension neut.
- **Basis**, pl. **bases**, gen. **basis**. Basis, base. 3rd declension fem.
- **Biceps m.**, pl. **bicipites**, gen. **bicipitis**. A muscle with two heads. 3rd declension masc.
– Biceps + genitive. Biceps *brachii* (*brachium*. Arm)
- **Borborygmus**, pl. **borborygmi**, gen. **borborygmi**. Borborygmus (gastro-intestinal sound). 2nd declension masc.
- **Brachium**, pl. **brachia**, gen. **brachii**. Arm. 2nd declension neut.
- **Bronchium**, pl. **bronchia**, gen. **bronchii**. Bronchus. 2nd declension neut.
- **Bulla**, pl. **bullae**, gen. **bullae**. Bulla. 1st declension fem.
- **Bursa**, pl. **bursae**, gen. **bursae**. Bursa (bag, pouch). 1st declension fem.

C

- **Caecum**, pl. **caeca**, gen. **caeci**. Blind. 2nd declension neut. (adj.: masc. *caecus*, fem. *caeca*, neut. *caecum*)
- **Calcaneus**, pl. **calcanei**, gen. **calcanei**. Calcaneus (from *calx*, heel). 2nd declension masc.
- **Calculus**, pl. **calculi**, gen. **calculi**. Stone (lit. pebble). 2nd declension masc.
- **Calix**, pl. **calices**, gen. **calicis**. Calix (lit. *cup*, *goblet*). 3rd declension masc.
- **Carcinoma**, pl. Lat. **carcinomata**, pl. Engl. **carcinomas**, gen. **carcinomat-
is**. Carcinoma (epithelial cancer). 3rd declension neut.
- **Carina**, pl. **carinae**, gen. **carinae**. Carina (lit. *keel*, *bottom of ship*). 1st declension fem.
- **Cauda**, pl. **caudae**, gen. **caudae**. Tail. 1st declension fem.
– *Cauda equina* (adj.: masc. *equinus*, fem. *equina*, neut. *equinum*. Concerning horses)
- **Cerebrum**, pl. **cerebra**, gen. **cerebri**. Brain. 2nd declension neut.
- **Cervix**, pl. **cervices**, gen. **cervicis**. Neck. 3rd declension fem., declension neut.
- **Coccus**, pl. **cocci**, gen. **cocci**. Coccus (rounded bacterium, lit. *a scarlet dye*). 2nd declension masc.

- **Coccyx**, pl. **coccyges**, gen. **coccygis**. Coccyx. 3rd declension masc.
- **Cochlea**, pl. **cochleae**, gen. **cochleae**. Cochlea (lit. *snail shell*). 1st declension fem.
- **Comedo**, pl. **comedones**, gen. **comedonis**. Comedo (a dilated hair follicle filled with keratin). 3rd declension masc.
- **Condyloma**, pl. **condylomata**, gen. **condylomatis**. Condyloma. 3rd declension neut.
– *Condyloma acuminatum*
- **Conjunctiva**, pl. **conjunctivae**, gen. **conjunctivae**. Conjunctiva. 1st declension fem.
- **Corpus**, pl. **corpora**, gen. **corporis**. Body. 3rd declension neut.
– *Corpus callosum*, *corpus cavernosum* (penis)
- **Corpusculum**, pl. **corpuscula**, gen. **corpusculi**. Corpuscle. 2nd declension neut.
- **Cortex**, pl. **cortices**, gen. **corticis**. Cortex, outer covering. 3rd declension masc.
- **Coxa**, pl. **coxae**, gen. **coxae**. Hip. 1st declension fem.
- **Cranium**, pl. **crania**, gen. **cranii**. Skull. 2nd declension neut.
- **Crisis**, pl. **crises**, gen. **crisos/crisis**. Crisis. 3rd declension fem.
- **Cubitus**, pl. **cubiti**, gen. **cubiti**. Ulna (lit. *forearm*). 2nd declension masc.
- **Cubitus**, pl. **cubitus**, gen. **cubitus**. State of lying down. 4th declension masc.
– *De cubito supino/prono*

D

- **Dermatitis**, pl. **dermatitides**, gen. **dermatitis**. Dermatitis. 3rd declension.
- **Dermatosis**, pl. **dermatoses**, gen. **dermatosis**. Dermatitis. 3rd declension.
- **Diverticulum**, pl. **diverticula**, gen. **diverticuli**. Diverticulum. 2nd declension neut.
- **Duodenum**, pl. **duodena**, gen. **duodeni**. Duodenum (lit. *twelve*. The duodenum measures 12 times a finger). 2nd declension neut.

E

- **Ecchymosis**, pl. **ecchymoses**, gen. **ecchymosis**. Ecchymosis. 3rd declension.
- **Effluvium**, pl. **effluvia**, gen. **effluvii**. Effluvium (fall). 2nd declension neut.
- **Endocardium**, pl. **endocardia**, gen. **endocardii**. Endocardium. 2nd declension neut.
- **Endometrium**, pl. **endometria**, gen. **endometrii**. Endometrium. 2nd declension neut.

- **Endothelium**, pl. **endothelia**, gen. **endothelii**. Endothelium. 2nd declension neut.
- **Epicondylus**, pl. **epicondyli**, gen. **epicondyli**. Epicondylus. 2nd declension masc.
- **Epidermis**, pl. **epidermides**, gen. **epidermidis**. Epidermis. 3rd declension.
- **Epididymis**, pl. **epididymes**, gen. **epididymis**. Epididymis. 3rd declension.
- **Epiphysis**, pl. **epiphyses**, gen. **epiphysis**. Epiphysis. 3rd declension.
- **Epithelium**, pl. **epithelia**, gen. **epithelii**. Epithelium. 2nd declension neut.
- **Esophagus**, pl. **esophagi**, gen. **esophagi**. Esophagus (British: oesophagus). 2nd declension masc.
 - Extensor carpi ulnaris m., *extensor digitorum communis m.*, *extensor hallucis longus/brevis m.*, etc.

F

- **Fascia**, pl. **fasciae**, gen. **fasciae**. Fascia. 1st declension fem.
- **Fasciculus**, pl. **fasciculi**, gen. **fasciculi**. Fasciculus. 2nd declension masc.
- **Fetus**, pl. **feti/fetus**, gen. **feti/fetus**. Fetus. 2nd declension masc./4th declension masc.
- **Fistula**, pl. **fistulae**, gen. **fistulae**. Fistula (lit. *pipe, tube*). 1st declension fem.
- **Folliculus**, pl. **folliculi**, gen. **folliculi**. Follicle. 2nd declension masc.
- **Foramen**, pl. **foramina**, gen. **foraminis**. Foramen, hole. 3rd declension neut.
 - *Foramen rotundum*, *foramen ovale*
 - *Foramina cribrosa*, pl. (multiple pores in lamina cribrosa)
- **Formula**, pl. **formulae**, gen. **formulae**. Formula. 1st declension fem.
- **Fossa**, pl. **fossae**, gen. **fossae**. Fossa, depression. 1st declension fem.
- **Fovea**, pl. **foveae**, gen. **foveae**. Fovea, depression, pit. 1st declension fem.
- **Fungus**, pl. **fungi**, gen. **fungi**. Fungus (lit. *mushroom*). 2nd declension masc.
- **Furunculus**, pl. **furunculi**, gen. **furunculi**. Furuncle. 2nd declension masc.

G

- **Gingiva**, pl. **gingivae**, gen. **gingivae**. Gum. 1st declension fem.
- **Glomerulus**, pl. **glomeruli**, gen. **glomeruli**. Glomerule. 2nd declension masc.
- **Gluteus m.**, pl. **glutei**, gen. **glutei**. Buttock. 2nd declension masc.

H

- **Hallux**, pl. **halluces**, gen. **hallucis**. First toe. 3rd declension masc.

- **Hiatus**, pl. **hiatus**, gen. **hiatus**. Gap, cleft. 4th declension masc.
- **Hilum**, pl. **hila**, gen. **hili**. Hilum (the part of an organ where the neurovascular bundle enters). 2nd declension neut.
- **Humerus**, pl. **humeri**, gen. **humeri**. Humerus. 2nd declension masc.
- **Hypophysis**, pl. **hypophyses**, gen. **hypophysis**. Pituitary gland (lit. *undergrowth*). 3rd declension.

I

- **Index**, pl. **indices**, gen. **indicis**. Index (second digit, forefinger), guide. 3rd declension masc.
- **Indusium**, pl. **indusia**, gen. **indusii**. Indusium (membrane, amnion). 2nd declension neut. (Lit. *intermedium*), 1st declension fem.
- **Interstitium**, pl. **interstitia**, gen. **interstitii**. Interstice. 2nd declension neut.
- **Iris**, pl. **irides**, gen. **iridis**. Iris. 3rd declension masc.
- **Ischium**, pl. **ischia**, gen. **ischii**. Ischium. 2nd declension neut.

J

- **Jejunum**, pl. **jejuna**, gen. **jejuni**. Jejunum (from Lat. adj. *jejunus*, fasting, empty). 2nd declension neut.
- **Jugular**, pl. **jugulares**, gen. **jugularis**. Jugular vein (lit. relating to the throat, from Lat. *jugulus*, throat). 3rd declension.

L

- **Labium**, pl. **labia**, gen. **labii**. Lip. 2nd declension neut.
- **Lacuna**, pl. **lacunae**, gen. **lacunae**. Pond, pit, hollow. 1st declension fem.
- **Larynx**, pl. Lat. **larynges**, pl. Engl. **larynxes**, gen. **laryngis**. Larynx. 3rd declension.
- **Locus**, pl. **loci**, gen. **loci**. Locus (place, position, point). 2nd declension masc.
- **Lumen**, pl. **lumina**, gen. **luminis**. Lumen. 3rd declension neut.

M

- **Macula**, pl. **maculae**, gen. **maculae**. Macula, spot. 1st declension fem.
- **Malleollus**, pl. **malleoli**, gen. **malleoli**. Malleollus (lit. *small hammer*). 2nd declension masc.
- **Maxilla**, pl. **maxillae**, gen. **maxillae**. Maxilla. 1st declension fem.
- **Meatus**, pl. **meatus**, gen. **meatus**. Meatus, canal. 4th declension masc.
- **Medulla**, pl. **medullae**, gen. **medullae**. Marrow. 1st declension fem.
– *Medulla oblongata* (caudal portion of the brainstem), *medulla spinalis*
- **Meningococcus**, pl. **meningococci**, gen. **meningococci**. Meningococcus. 2nd declension masc.
- **Meniscus**, pl. **menisci**, gen. **menisci**. Meniscus. 2nd declension masc.

- **Metacarpus**, pl. **metacarpi**, gen. **metacarpi**. Metacarpus. 2nd declension masc.
- **Metaphysis**, pl. **metaphyses**, gen. **metaphysis**. Metaphysis. 3rd declension.
- **Metastasis**, pl. **metastases**, gen. **metastasis**. Metastasis. 3rd declension
- **Metatarsus**, pl. **metatarsi**, gen. **metatarsi**. Metatarsus. 2nd declension masc.
- **Mitochondrion**, pl. **mitochondria**, gen. **mitochondrium**. Mitochondrion. 3rd declension neut.
- **Mitosis**, pl. **mitoses**, gen. **mitosis**. Mitosis. 3rd declension (from Gr. *mitos*, thread)
- **Myocardium**, pl. **myocardia**, gen. **myocardii**. Myocardium. 2nd declension neut.

N

- **Nephritis**, pl. **nephritides**, gen. **nephritidis**. Nephritis. 3rd declension.
- **Neurosis**, pl. **neuroses**, gen. **neurosis**. Neurosis. 3rd declension.
- **Nevus**, pl. **nevi**, gen. **nevi**. Nevus (lit. mole on the body, birthmark). 2nd declension masc.
- **Nodulus**, pl. **noduli**, gen. **noduli**. Nodule (small node, knot). 2nd declension masc.
- **Nucleolus**, pl. **nucleoli**, gen. **nucleoli**. Nucleolus (small nucleus). 2nd declension masc.
- **Nucleus**, pl. **nuclei**, gen. **nuclei**. Nucleus (central part, core, lit. *inside of a nut*). 2nd declension masc.

O

- **Os**, pl. **ora**, gen. **oris**. Mouth. 3rd declension neut.
– *Os* + genitive case: *os coccyges* (coccygeal bone), *os ischii* (ischium)
- **Os**, pl. **ossa**, gen. **ossis**. Bone. 3rd declension neut.
- **Ostium**, pl. **ostia**, gen. **ostii**. Opening into a tubular organ, entrance. 2nd declension neut.

P

- **Papilla**, pl. **papillae**, gen. **papillae**. Papilla (lit. *nipple*). 1st declension fem.
- **Paralysis**, pl. **paralyses**, gen. **paralysos/paralysis**. Palsy. 3rd declension fem.
- **Patella**, pl. **patellae**, gen. **patellae**. Patella. 1st declension fem.
- **Pelvis**, pl. **pelves**, gen. **pelvis**. Pelvis. 3rd declension fem.
- **Penis**, pl. **penes**, gen. **penis**. Penis. 3rd declension masc.
- **Pericardium**, pl. **pericardia**, gen. **pericardii**. Pericardium. 2nd declension neut.

- **Perineum**, pl. **perinea**, gen. **perinei**. Perineum. 2nd declension neut.
- **Peritoneum**, pl. **peritonea**, gen. **peritonei**. Peritoneum. 2nd declension neut.
- **Peroneus m.**, pl. **peronei**, gen. **peronei**. Peroneal bone. 2nd declension masc.
- **Petechia**, pl. **petechiae**, gen. **petechiae**. Petechiae (tiny hemorrhagic spots). 1st declension fem.
- **Phalanx**, pl. **phalanges**, gen. **phalangis**. Phalanx (long bones of the digits). 3rd declension fem.
– *Os phalangi*, pl. *ossa phalangium*
- **Pharynx**, pl. **pharynges**, gen. **pharyngis**. Pharynx. 3rd declension.
- **Phimosis**, pl. **phimoses**, gen. **phimosis**. Phimosis. 3rd declension masc.
- **Placenta**, pl. **placentae**, gen. **placentae**. Placenta (lit. *cake*). 1st declension fem.
- **Pleura**, pl. **pleurae**, gen. **pleurae**. Pleura. 1st declension fem., 2nd declension fem.
- **Prophylaxis**, pl. **prophylaxes**, gen. **prophylaxis**. Prophylaxis (from Gr. *prophylasso*, take precaution). 3rd declension.
- **Prosthesis**, pl. **protheses**, gen. **prosthesis**. Prosthesis. 3rd declension fem.
- **Psychosis**, pl. **psychoses**, gen. **psychosis**. Psychosis. 3rd declension fem.
- **Ptoxis**, pl. **ptoses**, gen. **ptosis**. Ptoxis. 3rd declension.
- **Puerperium**, pl. **puerperia**, gen. **puerperii**. Puerperium. 2nd declension neut.
- **Pylorus**, pl. **pylori**, gen. **pylori**. Pylorus. 2nd declension masc.

R

- **Radius**, pl. **radii**, gen. **radii**. Radius. 2nd declension masc.

S

- **Sacrum**, pl. **sacra**, gen. **sacri**. Sacral bone (lit. *sacred vessel*). 2nd declension neut.
- **Scapula**, pl. **scapulae**, gen. **scapulae**. Scapula, shoulder blade. 1st declension fem.
- **Sclerosis**, pl. **scleroses**, gen. **sclerosis**. Sclerosis. 3rd declension.
- **Scotoma**, pl. **scotomata**, gen. **scotomatis**. Scotoma. 3rd declension neut.
- **Scrotum**, pl. **scrota**, gen. **scroti**. Scrotum. 2nd declension neut.
- **Sepsis**, pl. **sepsis**, gen. **sepsis**. Sepsis. 3rd declension.
- **Septum**, pl. **septa**, gen. **septi**. Septum. 2nd declension neut.
- **Sequela**, pl. **sequelae**, gen. **sequelae**. Sequela. 1st declension fem.
- **Serum**, pl. **sera**, gen. **seri**. Serum (lit. *whey*). 2nd declension neut.
- **Sinus**, pl. **sinus**, gen. **sinus**. Sinus. 4th declension masc.
- **Sphincter**, pl. Lat. **sphincteres**, pl. Engl. **sphincters**, gen. **sphincteris**. Sphincter. 3rd declension masc.

- **Sputum**, pl. **sputa**, gen. **sputi**. Sputum. 2nd declension neut.
- **Staphylococcus**, pl. **staphylococci**, gen. **staphylococci**. Staphylococcus. 2nd declension masc.
- **Stasis**, pl. **stases**, gen. **stasis**. Stasis. 3rd declension masc.
- **Stenosis**, pl. **stenoses**, gen. **stenosis**. Stenosis. 3rd declension.
- **Sternocleidomastoideus m.**, pl. **sternocleidomastoidei**, gen. **sternocleidomastoidei**. 2nd declension masc.
- **Sternum**, pl. **sterna**, gen. **sterni**. Sternum. 2nd declension neut.
- **Stigma**, pl. **stigmata**, gen. **stigmatis**. Stigma (mark aiding in diagnosis). 3rd declension neut.
- **Stimulus**, pl. **stimuli**, gen. **stimuli**. Stimulus (lit. *spur*). 2nd declension masc.
- **Stoma**, pl. **stomata**, gen. **stomatis**. Stoma, opening, hole. 3rd declension neut.
- **Stratum**, pl. **strata**, gen. **strati**. Stratum. 2nd declension neut.
- **Stria**, pl. **striae**, gen. **striae**. Fluting, channel. 1st declension fem.
- **Sulcus**, pl. **sulci**, gen. **sulci**. Sulcus. 2nd declension masc.
- **Symphysis**, pl. **symphyses**, gen. **symphysis**. Symphysis. 3rd declension.

T

- **Tarsus**, pl. **tarsi**, gen. **tarsi**. Tarsus. 2nd declension masc.
- **Telangiectasis**, pl. **telangiectases**, gen. **telangiectasis**. Telangiectasis. 3rd declension.
- **Testis**, pl. **testes**, gen. **testis**. Testicle. 3rd declension masc.
- **Thalamus**, pl. **thalami**, gen. **thalami**. Thalamus (lit. *marriage bed*). 2nd declension masc.
- **Thenar**, pl. **thenares**, gen. **thenaris**. Relative to the palm of the hand. 3rd declension neut.
- **Thesis**, pl. **theses**, gen. **thesis**. Thesis. 3rd declension fem.
- **Thorax**, pl. **thoraces**, gen. **thoracos/thoracis**. Chest. 3rd declension masc.
- **Thrombosis**, pl. **thromboses**, gen. **thrombosis**. Thrombosis. 3rd declension.
- **Thrombus**, pl. **thrombi**, gen. **thrombi**. Thrombus, clot (from Gr. *thrombos*). 2nd declension masc.
- **Thymus**, pl. **thymi**, gen. **thymi**. Thymus. 2nd declension masc.
- **Tibia**, pl. **tibiae**, gen. **tibiae**. Tibia. 1st declension fem.
- **Tophus**, pl. **tophi**, gen. **tophi**. Tophus. 2nd declension masc.
- **Trachea**, pl. **tracheae**, gen. **tracheae**. Trachea. 1st declension fem.
- **Tympanum**, pl. **tympaana**, gen. **tympani**. Tympanum, eardrum (lit. *small drum*). 2nd declension neut.

U

- **Ulcus**, pl. **ulcera**, gen. **ulceris**. Ulcer. 3rd declension neut.
- **Ulna**, pl. **ulnae**, gen. **ulnae**. Ulna (lit. *forearm*). 1st declension fem.

- **Umbilicus**, pl. **umbilici**, gen. **umbiculi**. Navel. 2nd declension masc.
- **Uterus**, pl. **uteri**, gen. **uteri**. Uterus, womb. 2nd declension masc.
- **Uveitis**, pl. **uveitides**, gen. **uveitidis**. Uveitis. 3rd declension fem.
- **Uvula**, pl. **uvulae**, gen. **uvulae**. Uvula (lit. *small grape*, from *uva*, pl. *uvae*, grape). 1st declension fem.

V

- **Vagina**, pl. **vaginae**, gen. **vaginae**. Vagina, sheath. 1st declension fem.
- **Vaginitis**, pl. **vaginitides**, gen. **vaginitidis**. Vaginitis. 3rd declension fem.
- **Vagus**, pl. **vagi**, gen. **vagi**. Vagus nerve. 2nd declension masc. (adj.: masc. *vagus*, fem. *vaga*, neut. *vagum*. Roving, wandering)
- **Varix**, pl. **varices**, gen. **varicis**. Varix, varicose vein. 3rd declension masc.
- **Ventriculus**, pl. **ventriculi**, gen. **ventriculi**. Ventricle (lit. *small belly*). 2nd declension masc.
- **Verruca**, pl. **verrucae**, gen. **verrucae**. Wart. 1st declension fem.
- **Vertebra**, pl. **vertebrae**, gen. **vertebrae**. Vertebra. 1st declension fem.
- **Vesica**, pl. **vesicae**, gen. **vesicae**. Bladder. 1st declension fem.
- **Vesicula**, pl. **vesiculae**, gen. **vesiculae**. Vesicle (lit. *lesser bladder*). 1st declension fem.
- **Virus**, pl. Lat. **virī**, pl. Engl. **viruses**, gen. **virī**. Virus. 2nd declension masc.
- **Viscus**, pl. **viscera**, gen. **visceris**. Viscus, internal organ. 3rd declension neut.
- **Vitiligo**, pl. **vitilignes**, gen. **vitiligis**. Vitiligo. 3rd declension masc.
- **Vulva**, pl. **vulvae**, gen. **vulvae**. Vulva. 1st declension fem.



- Let's have a look at your discharge letter...
 58 y old male, TCId to the MAU by the RMO,
 CO SOB and CP. PMH COPD and IHD. CXR
 and FBC NAD. Dx LRTI. TTOs Amoxyl 500mg
 TDS and PRN paracetamol. Please FU.

Unit VI Acronyms and Abbreviations

Introduction

“The patient had an MI diagnosed in A&E and is now in ICU.”

[MI: Myocardial infarct; A&E: Accident and Emergency (Department); ICU: Intensive Care Unit.]

Doctors’ speech is full of abbreviations. Including the writing, we use several abbreviations per minute. This high prevalence has led us to consider medical abbreviations as a challenging pandemic.

Not only are doctors aware of medical abbreviations, but patients are familiar with many of them as well. Not uncommonly a patient in the UK would tell you in consultation something like “I have this weakness in my leg, and I am worried about MS” (multiple sclerosis). In my early months in London, I learnt many medical abbreviations from the patients themselves!

There are several “types” of abbreviations, namely:

- Straightforward abbreviations
- Extra-nice abbreviations
- Expanded-term abbreviations
- Energy-saving abbreviations
- Double-meaning abbreviations
- Mind-blowing abbreviations

Let us begin with the nice ones; we call them the *straightforward* abbreviations because for each nice abbreviation in your own language there is a nice English equivalent. It is just a matter of changing letter order, identifying the abbreviations and learning them. For example:

HRT Hormone replacement therapy

There are other kinds of abbreviations: the *extra-nice* ones. They are mostly used for drugs or chemical substances whose names have three or four syllables too many. They are extra nice because they are usually the same in many languages. For example:

CPK Creatine phosphokinase

In the next group, we have put together some examples of abbreviations that are widely used in English but that are generally preferred in their expanded form in other languages. Since language is an ever-changing creature, we are sure that these terms will eventually be abbreviated in many languages, but so far you can hear them referred to mostly as expanded terms:

MI Myocardial infarct

There is another group, which we can call *energy-saving* abbreviations. These are abbreviations that many languages leave in the English original and, of course, when expanding them the first letter of each word does not match the abbreviation. We call them energy-saving abbreviations because it would not have been so difficult to come up with a real “national” abbreviation for that term. When looking for examples, we realised that most hormone names are energy-saving abbreviations:

FSH Follicle-stimulating hormone

There is yet another kind, which we call *double-meaning* abbreviations. This is when one abbreviation can refer to two different terms. The context helps, of course, to discern the real meaning; however, it is worth keeping an eye open for these because, if misinterpreted, these abbreviations might get you into an embarrassing situation:

PID

- Pelvic inflammatory disease
- Prolapsed intervertebral disc

CSF

- Colony-stimulating factor
- Cerebrospinal fluid

The funniest abbreviations are those that become acronyms in which the pronunciation resembles a word that has nothing to do with the abbreviation's meaning. We call this group *mind-blowing* abbreviations.

A *cabbage* in English is a vegetable known for its gas-producing properties; however, when an English-speaking surgeon says “This patient is a clear candidate for *cabbage*”, he/she is not talking about what the patient should have for lunch, but rather the type of surgery he/she is suggesting should be performed. Thus, *cabbage* is the colloquial way of referring to CABG (coronary artery bypass grafting).

If you hear an oncologist saying “I think your patient needs a *chop*”, you walk on down the corridor, wondering whether this new alternative therapy will consist of a pork or a lamb chop. But then you quickly realise that the specialist is actually referring to a **CHOP** (a regimen of cyclophosphamide, hydroxydaunomycin, oncovin and prednisone, used in cancer chemotherapy).

There are more abbreviations out there, and there are also more to come. The medical profession is sure to keep us busy catching up with its incursions into linguistic creation.

We offer a list of common abbreviations and will show you more in Unit IX by clinical areas. We advise you to practise reading them in a natural way. Bear in mind that to be able to identify written abbreviations may not be enough. From this standpoint, there are three types of abbreviations:

1. Read abbreviations (acronyms)
 2. Spelt abbreviations
 3. Half-spelt/half-read abbreviations
1. Nobody would understand a spelt abbreviation if you read it and nobody would understand a read abbreviation if you spelt it. For example, *AIDS* stands for acquired immune deficiency syndrome and must be read *aids* [ādz]. Nobody would understand you if instead of saying *aids* you spelt (saying each letter by its name) A-I-D-S; therefore, never spell a “read abbreviation” and never read a “spelt abbreviation”.
 2. Most abbreviations are spelt abbreviations and are usually those in which the letter order makes them almost impossible to read. Think, for example, of *COPD* (chronic obstructive pulmonary disease) and try to read the abbreviation instead of spelling it. Never use the “expanded form” (chronic obstructive pulmonary disease) of a classic abbreviation such as this one because it would sound extraordinarily unnatural.
 3. The third type is made up of abbreviations such as *CPAP* (continuous positive airway pressure) which is pronounced something like *C-pap*. If you spell out *CPAP* (C-P-A-P), nobody will understand you.

The most common abbreviations used by a family doctor are listed below; however, the use of abbreviations varies locally. You may need to add to this list some others that are used in your environment.

Besides more or less formal abbreviations, there are also “short forms” for some commonly used words in medical notes, such as *abd* for abdomen, *creps* for crepitations, *Paeds* for Paediatrics, *Gynae* for Gynaecology/ist, etc.

Note that sometimes abbreviations for units of measurement are also spelt, for example *kg* is pronounced *kā-jē* and *mg* is pronounced *ēm-jē*. Although you may prefer to pronounce the whole word (kilograms or milligrams), be aware that native English speakers may use the abbreviations in spoken language.

Plus, you must be aware of many other abbreviations, unrelated to medicine, that are used in “daily life”. Britons are particularly keen on spoken abbreviations, even if it would be just as easy to say the whole sentence. For example, is it easier to say A-S-A-P (spelt abbreviation) than “as soon as possible”? Probably not, but ASAP is quite common. Other interesting examples (all *spelt*) are BO (body odour), OTT (over the top, to indicate an exaggerated reaction), TLC (tender love and care), PA (personal assistant), etc.

Alphabet Pronunciation

It is worth writing down the alphabet and making sure you remember the names of all the letters in English; some that may need to refresh are the H, J, K, Q, R, X, W, Y or Z (see Appendix 3).

Abbreviations List

ACJ	Acromioclavicular joint
ACE	Angiotensin-converting enzyme
ACEI	Angiotensin-converting enzyme inhibitor
ACL	Anterior cruciate ligament
ADHD	Attention deficit hyperactivity disorder
ADL	Activities of daily living
ADR	Adverse drug reaction
AF	Atrial fibrillation
AFB	Acid-fast bacilli (tuberculosis bacilli)
AI	Aortic incompetence
AIDS	Acquired immunodeficiency syndrome
AJ	Ankle jerk (reflex)
ALP	Alkaline phosphatase
a.m.	In the morning
AN	Antenatal
ANA	Antinuclear antibodies
AP	Antero-posterior
ARDS	Acute respiratory distress syndrome
ARF	Acute renal failure
AS	Ankylosing spondylitis
AST	Aspartate aminotransferase
ATN	Acute tubular necrosis
AXR	Abdominal X-ray
BCC	Basal cell carcinoma
BCG	Bacillus Calmette-Guérin
BID, b.i.d.	Bis in die (twice a day)
BM	Bowel movement
BNF	British National Formulary
BO	Bowels opened
BP	Blood pressure
BS	Bowel sounds
BV	Bacterial vaginosis
CA	Cancer
CABG	Coronary artery bypass graft
CAD	Coronary artery disease
CAT	Computerised axial tomography

CBD	Common bile duct
CBT	Cognitive behavioural therapy
CCF	Congestive cardiac failure
CF	Cystic fibrosis
CHF	Congestive heart failure
CIN	Cervical intraepithelial neoplasia
CML	Chronic myeloid leukaemia
CMML	Chronic myelomonocytic leukaemia
CNS	Central nervous system
C/O	Complains of
COAD	Chronic obstructive airways disease
COPD	Chronic obstructive pulmonary disease
CPAP	Continuous positive airways pressure
CPN	Community psychiatric nurse
CPR	Cardio-pulmonary resuscitation
CrCl	Creatinine clearance
CRF	Chronic renal failure
CSF	Colony stimulating factor
CSU	Catheter specimen of urine
CT	Computerised tomography
CV	Cardiovascular
CVA	Cerebrovascular accident
CVS	Cardiovascular system
Cx	Cervix
CXR	Chest X-ray
D&C	Dilatation and curettage
D&V	Diarrhoea and vomiting
D/D, DDX	Differential diagnosis
DCIS	Ductal carcinoma in situ
DIB	Difficulty in breathing
DLE	Discoid lupus erythematosus
DN	District nurse
DNA	Did not attend
DNA	Deoxyribonucleic acid
DNR	Do not resuscitate
DOA	Dead on arrival
DOB	Date of birth
DPB	Diastolic blood pressure
DRE	Digital rectal examination
DU	Duodenal ulcer
DVT	Deep venous thrombosis
Dx	Diagnosis
EAU	Emergency admission unit
EBV	Epstein-Barr virus
ECG	Electrocardiogram
ECT	Electroconvulsive therapy

EDD	Expected date of delivery
EEG	Electroencephalogram
EMS	Emergency medical service
ENT	Ear, nose and throat
ER	Emergency room
ERCP	Endoscopic retrograde cholangiopancreatography
ESR	Erythrocyte sedimentation rate
ESRD	End-stage renal disease
ETT	Exercise tolerance test
FB	Foreign body
FEV ₁	Forced expiratory volume in 1 second
FH, FAHX	Family history
FH+/FH-	Family history positive/negative
FB	Foreign body
FBC	Full blood count
FOB	Faecal occult blood
FPC	Family Planning Clinic
FUO	Fever of unknown origin
G	Gravidity
GFR	Glomerular filtration rate
GGT	γ -Glutamyltranspeptidase, -glutamyltransferase
GH	Growth hormone
GI	Gastrointestinal
GIS	Gastrointestinal system
GORD	Gastro-oesophageal reflux disease
GOT	Glutamic oxaloacetic transaminase
GP	General practitioner
GPT	Glutamic pyruvic transaminase
GTN	Glyceryl trinitrate
GTT	Glucose tolerance test
GU	Gastric ulcer
GUM	Genitourinary Medicine
HBP	High blood pressure
HBV	Hepatitis B virus
hCG	Human chorionic gonadotropin
HCV	Hepatitis C virus
HIV	Human immunodeficiency virus
HO	house officer
HPV	Human papilloma virus
HR	Heart rate
HRT	Hormone replacement therapy
HS	Heart sounds
HVS	High vaginal swab
IBD	Inflammatory bowel disease
IBS	Irritable bowel syndrome
ICU	Intensive care unit

INR	International normalised ratio
IP	Interphalangeal
IP	In-patient
IQ	Intelligence quotient
ISQ	In statu quo (condition unchanged)
ITU	Intensive therapy unit
IU	International unit
IUD	Intra-uterine device
IUCD	Intra-uterine contraceptive device
IV, i.v.	Intravenous
IVF	In vitro fertilisation
IVP	Intravenous pyelogram
IVU	Intravenous urogram
Ix	Investigation
JVP	Jugular venous pressure
KUB	Kidney, ureter and bladder
L	Left
LA	Left atrium
LAD	Left anterior descending coronary artery
LAD	Left axis deviation
LBBB	Left bundle branch block
LBP	Low back pain
LCX	Left circumflex coronary artery
LE	Lupus erythematosus
LE	Left eye
LFT	Liver function test
LIF	Left iliac fossa
LLL	Left lower lobe (of lung)
LLQ	Left lower quadrant (of abdomen)
LMP	Last menstrual period
LP	Lumbar puncture
LRTI	Low respiratory tract infection
LSCS	Lower segment caesarean section
LUL	Left upper lobe (of lung)
LUQ	Left upper quadrant (of abdomen)
LUTS	Lower urinary tract symptoms
LV	Left ventricle
LVD	Left ventricular dysfunction
LFV	Left ventricular failure
LVH	Left ventricular hypertrophy
M	Male
M.B.	Bachelor of Medicine
MCHC	Mean corpuscular haemoglobin concentration
MCP	Metacarpophalangeal
MCTD	Mixed connective tissue disease
MCV	Mean corpuscular volume

M.D.	Medicinae doctor [American]
MI	Myocardial infarction
MI	Mitral insufficiency/incompetence
MMR	Measles, mumps, rubella (vaccine)
M/R	Modified release
MR	Magnetic resonance
MRCGP	Member of the Royal College of General Practitioners
MRI	Magnetic resonance imaging
MRSA	Meticillin resistant <i>Staphylococcus aureus</i>
MS	Multiple sclerosis
MS	Mitral stenosis
MSU	Mid-stream urine
MTP	Metatarsophalangeal
MVP	Mitral valve prolapse
N/A	Not applicable
NAD	No abnormality detected
NGU	Non-gonococcal urethritis
NHS	National Health Service
NI	National insurance
NK	Not known
NPO	Nil per os (nothing by mouth)
NSAIDs	Nonsteroidal anti-inflammatory drugs
NUD	Non-ulcer dyspepsia
N & V	Nausea and vomiting
OA	Osteoarthritis
OAP	Old age pensioner
Obs	Obstetrics
OCG	Oral cholecystography
OD	Overdose
OGD	Oesophagogastroduodenoscopy
O/E	On examination
OM	Otitis media
OOH	Out of hours
OP	Out-patient
OPA	Outpatients appointment
OPD	Outpatients department
OSA	Obstructive sleep apnoea
OT	Operating theatre
OT	Occupational therapist
OTC	Over the counter
P	Pulse
P	Parity
p.c.	Post cibum (after meals)
p.r.n.	Pro re nata (according to circumstances, may require)
p.v.	Per vaginam
PAN	Polyarteritis nodosa

PAT	Paroxysmal atrial tachycardia
PBC	Primary biliary cirrhosis
PC	Present complaint
PCL	Posterior cruciate ligament
PCP	<i>Pneumocystis carinii</i> pneumonia
PDA	Patent ductus arteriosus
PE	Pulmonary embolus
PERLA	Pupils equal and reactive to light and accommodation
PE	Pulmonary embolism
PH, PHx	Past history
PID	Pelvic inflammatory disease
PM	Post mortem
p.m.	In the afternoon or evening
PMB	Post-menopausal bleeding
PMH	Past medical history
PMS	Premenstrual symptoms
PN	Postnatal
PND	Postnatal depression
PND	Paroxysmal nocturnal dyspnoea
PO	Per os (by mouth, oral)
POMR	Problem-oriented medical record
POP	Progesterone only pill
PPH	Postpartum haemorrhage
PR	Per rectum
Pt	Patient
PUO	Pyrexia of unknown origin
PRL	Prolactin
PSA	Prostate-specific antigen
PTH	Parathyroid hormone
PV	Per vaginam
QALY	Quality adjusted life year
q.i.d.	Quater in die (four times daily)
q.v.	Quantum vis (as much as desired)
R	Right
RA	Rheumatoid arthritis
RA	Right atrium
RBBB	Right bundle branch block
RBC	Red blood cell or count
RDA	Recommended daily allowance
RE	Right eye
RF	Rheumatoid factor
RIF	Right iliac fossa
RLL	Right lower lobe (of lung)
RLQ	Right lower quadrant (of abdomen)
RML	Right middle lobe (of lung)
RMZ	Right middle zone

RPGN	Rapidly progressive glomerulonephritis
RTA	Road traffic accident
RTA	Renal tubular acidosis
RUL	Right upper lobe (of lung)
RUQ	Right upper quadrant (of abdomen)
RV	Right ventricle
Rx	Prescribe, prescription drug
S	Sugar
SAH	Subarachnoidal haemorrhage
SBC	Secondary biliary cirrhosis
SBP	Systolic blood pressure
SAD	Seasonal affective disorder
SC	Subcutaneous
SCC	Squamous cell carcinoma
SCLE	Subacute cutaneous lupus erythematosus
SCM	Sternocleidomastoid muscle
SHO	Senior house officer
SI	Sacro-iliac
SIADH	Syndrome of inappropriate secretion of antidiuretic hormone
SIDS	Sudden infant death syndrome
SLE	Systemic lupus erythematosus
SOAP	Subjective, objective, assessment, and plan (used in problem-oriented records)
SOB	Shortness of breath
SOBOE	Short of breath on exertion
SOL	Space-occupying lesion
SpR	Specialist registrar
SSc	Systemic sclerosis
STD	Sexually transmitted disease
STI	Sexually transmitted infection
SVCS	Superior vena cava syndrome
Sx	Symptoms/signs
T	Temperature
Tab	Tablets
TENS	Transcutaneous electrical nerve stimulation
t.i.d.	Ter in die (three times daily)
TB	Tuberculosis
TFTs	Thyroid function tests
TIA	Transient ischaemic attack
TM	Tympanic membrane
TMJ	Temporomandibular joint
TOP	Termination of pregnancy
TPN	Total parenteral nutrition
TSH	Thyroid-stimulating hormone
TTP	Thrombotic thrombocytopenic purpura
TURP	Transurethral resection of the prostate

TV	Trichomonas vaginalis
UC	Ulcerative colitis
U&E	Urea and electrolytes
URTI	Upper respiratory tract infection
USs	Ultrasound scan
UTI	Urinary tract infection
VC	Vital capacity
VE	Vaginal examination
VF	Ventricular fibrillation
VV	Varicose vein
WBC	White blood cell
WNL	Within normal limits
XR	X-ray
#	Fracture
^^	Increased

-So Dr Signore, how many surgeries per week do you do back home?

-Mamma mia!!! No, no! In my country we have surgeons to do surgeries. No wonder how you get so much MRSA....! Surgery at the GP office, bah!



LALANDA

Unit VII The Language of Principles and Concepts in Primary Care

Selected, adapted and commented texts from
The Oxford Textbook of Primary Medical Care
Vol. I (R. Jones et al., 2004)

In this unit the selected texts provide a guided tour through the expressions used in commonly discussed topics in primary medical care.

The texts are a “concentrate” of expressions you need to learn, so you are advised to read them slowly. It may be worthwhile reading sentences aloud to yourself and personalising your book where necessary by underlining some words. The meanings of the various expressions you will encounter on the following pages are either explained in the text or on the opposite (right) page to the text. Note that the definitions provided by this book are by no means exhaustive. Many words are only given their contextual meaning, so remember that some of the words have a number of meanings which may not be specified in the course of this book.

The punctuation codes used for the definitions are as follows:

A dot “.” following the expression means a formal or general definition.

A colon “:” means an informal or contextual definition.

A dash “–” is used when a phrase is replaced by another one with a similar meaning.

A dash and dot (–.) is used when an expression is not followed by a definition but by a comment.

Abbreviations commonly used in spoken language are marked ★. These are spelt type abbreviations (read letter by letter) unless specified differently.

Please note that the following texts have been selected on the basis of their suitability for teaching language – they are not intended to be a summary of the topic discussed. For an adequate discussion on these topics we refer you to the original source: *The Oxford Textbook of Primary Medical Care*.

In order to make the most of these texts and comments we suggest that you imagine yourself talking about each of these topics with an international colleague. What would you like to say? Would you know how to pronounce it? If you had to write about it, would you know how to spell it?

Here is how to start your way to becoming an international family doctor.

Primary Medical Care

Most people with a health problem who seek medical help would initially consult a family doctor. Primary medical care, therefore, plays a central role in health care systems.

Primary health care is the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients and practising in the context of family and community. The word “integrated” is used to encompass comprehensive, coordinated and continuous services in a seamless process, combining events and information from disparate settings and levels of care. “Accessible” refers to the ease with which an individual could initiate an interaction for any health problem with a clinician. Access involves financial, geographical, cultural, language and temporal considerations. “Health care services” refer to all settings of care from home to hospital. “Clinician” implies an expert using a recognised body of scientific knowledge and having the authority to direct the delivery of personal health care services. “Accountable” applies to both individual clinicians and the systems in which they work, and includes responsibility for the quality of care, patient satisfaction, efficient use of resources and ethical behaviour. “Majority of personal health care needs” clarifies an essential characteristic of primary care clinicians: they receive whatever patients bring to them unrestricted by problems or organ systems, including physical, emotional, mental and social concerns. “Sustained partnership” refers to the centrality of the relationship established between patients and their personal clinicians and the expectation that the relationship will continue over time, predicated on mutual trust, respect and responsibility.

“Context of family and community” refers to the need to understand the patient’s living conditions, family dynamics and cultural background. “Community” could be a geopolitical unit or refer to neighbours who share values, experiences, language, religion and/or culture. The focus on community also implies responsibility for the entire population, whether they are patients or not.

Primary health care is broad in scope and comprises treatment of common diseases and injuries, health promotion, immunisations, maternal and child care, family planning, etc.

Escalating health care costs are challenging all health care systems. Effective primary care physicians refer relatively infrequently and are often labelled as “gatekeepers” and valued for their contribution to containing costs.

Care is the provision of what is necessary to protect or restore the health or wellbeing of individuals. 'Care for' or 'look after' is to provide care. Whenever you see a patient in your consulting room or at home, or organise vaccinations or screening, you are providing care. It can be medical, nursing, etc.

Seek: look for, ask for. **Clinician:** professional who does clinical work.

Accountable for: responsible for.

To address (verb) a problem is to think about and try to solve it. To address something **to** someone is to direct a speech or a letter to that person, e.g. if a letter has your name on the envelope, it is addressed to you.

Partnership: a relationship or association between **partners**, based on mutual participation and common interests.

Encompass: include. **Involve.** Include as a necessary part or result. You may also be or get **involved in** a project, a fight, a relationship, etc.

Comprehensive: complete, thorough, including everything. Do not confuse with **comprehensible**, which means understandable.

Seamless: with no interruptions.

Setting: context, situation, environment – can be a hospital setting, a general practice setting, a home setting, etc. Also, gerund for set.

The **ease** with which – how easy it is. Also, to feel **at ease** with something or somebody is to feel comfortable in their presence.

Concern. Worry. Patients come to the doctor with a concern or many concerns.

Two people **trust** each other when they are sure the other one will not fail or disappoint them.

Your **cultural background** is the kind of culture from which you come.

Your **neighbours** are those who live very close to your home.

Share: have in common.

Broad in scope – The scope of a discipline means the extent of the area that it covers; obviously family medicine has a very broad (wide) scope because it covers many things (digestive problems, psychiatric problems, skin problems, social problems, etc.).

Injury. Physical damage to the body or part of the body.

Escalating: quickly increasing or going up.

Challenging: posing a challenge. **Challenge:** a task or situation that tests someone's abilities (because it is difficult).

To **refer** a patient is to ask another professional (e.g. medical specialist) to see them.

Gatekeepers – they control access to other services.

"To **practise**" (verb) but "the **practice**" (noun). Note the general rule applies also to advise/advice, devise/device, etc.; however, in American English, practice is used both for noun and verb.

Coordinate, as cooperate and similar words may be written with a dash or not: co-ordinate, co-operate, etc. **Injury** [ɪn'jə-rē]

Placing health care into context and setting priorities is the realm of primary care. Primary care is essential for effective, sustainable health care systems. Its importance and salutary effects are supported by evidence. As the information age emerges, primary care is a frontier full of challenges in the midst of further development and exploration. Its future is sure because primary care is necessary. Indeed, primary care is primary in the sense of being care that is first, foremost and fundamental.

The Health Care Team

A team can be defined as a group of people who make different contributions towards the achievement of a common goal.

The primary care team is an interdependent group of general medical practitioners, nurses, secretaries and/or receptionists, who share a common purpose and responsibility, each member clearly understanding his/her own function and those of the other members, so that they all pool skills and knowledge to provide an effective primary health care service.

The primary care team is the staff comprising an organisational unit with responsibility for primary care provision, usually in a practice or health centre. The specific structure of these teams varies from country to country.

Primary Health Care Team in the UK

In the UK, the basic practice team comprises:

- *general practitioners (family doctors)*
- *practice nurses*
- *receptionists*
- *practice secretary*
- *practice manager*

A primary care nurse practitioner may also be a part of the team.

Sometimes a counsellor is also included, who would usually work part-time for the practice.

The team works closely with other health care workers from separate organisations, such as other primary care nurses:

- *district nurses*
- *health visitors*
- *midwives*

Set priorities – establish or decide what the priorities are.

Realm. A field or domain of activity or interest. Similar to “scope”.

Sustainable. Able to be maintained.

Goal: aim, purpose. Of course, it is also what a footballer scores when he kicks the ball inside the football goal.

Practitioner. A person actively engaged in an art, discipline or profession, esp. medicine. Generically it is applied to doctors, nurses, physiotherapists, etc. In the UK **General Practitioner** is the specific name given to family doctors, and the term **Nurse Practitioner** is used to describe nurses with a high level of specialist training (either in primary care, or dermatology, diabetes, epilepsy, etc.) who work relatively independently. General practitioners are most often called “GPs” (gee-pees), but nurse practitioners are not normally called ‘NPs’.

Pool: accumulate, put together.

Staff. All the people employed by a particular organisation. The word staff can be treated as singular or plural: “the practice has a staff of 46”, or “the staff were happy with their salaries”.

Practice. Besides meaning ‘the act of practising’ it also means another two things in this context: (a) The organisation providing primary care (e.g. Rushey Green Group Practice). (b) The building where the care is provided. The building or premises are also called “the **surgery**”, however surprising this may be. To make it even more confusing, **surgeries** are also the times or sessions when doctors see patients. That is, you can say that your practice looks after 7,000 patients, that you cycle every day to your practice or surgery, and that you start your morning surgery at 9 a.m. and finish it at 11.30 a.m.

Practice manager: the person employed to manage the practice, i.e. to make sure everything works well for staff and patients. They deal with finances, administration, personnel, customer services, etc.

Counsellor. A person trained to give guidance on personal, social or psychological problems.

Practice nurse: the nurse who works closest to the GP at the practice. Employed by the GP partners.

District nurses: primary care nurses who look after the housebound patients (those who are unable to go to the surgery). Employed by the PCT.

Health visitors: nurses who provide preventive care for children under 5 years of age. They do regular “baby checks” and give advice and support to the parents. Employed by the PCT.

Midwives: plural of midwife. They look after pregnant women.

Realm [rɛlm]. Goal [gɔl]. Practitioner [prāk-tɪʃh'ə-nər]. Purpose [pʊr'pəs]. Nurse [nɜrs]. Counsellor [koun'sə-lər]. Surgery [sʊr'jə-rē].

*In the UK general practitioners employ their own staff, which includes practice nurses. Although GPs provide care both at the surgery and on home visits, their “practice nurses” **only** provide care at the surgery. When primary nursing care is required at patients’ homes, a GP needs to refer the patient to a “district” nurse, employed by a larger community organisation (Primary Care Trust or PCT). Similarly, although GPs provide routine and preventive care for children, the nursing aspect of preventive care of children under the age of 5 years is carried out by the “health visitors” who are nurses specifically trained in this area (also employed by the PCT). District nurses and health visitors sometimes work in the same building as the GPs and their core teams, but most often they do not.*

Primary care in the emergency department (ED). *Estimates of the proportion of attenders who are appropriate to emergency departments vary widely: in the UK, for instance, it ranges from 28 to 95%. There are numerous perspectives on what constitutes “appropriate” attendance. The term “inappropriate” is most often used to describe patients who present with injuries or ailments that on clinical assessment are judged not to require urgent hospital intervention. Why do patients attend emergency departments with non-urgent problems? Some reasons are high levels of distress, poor health education and inaccessibility of routine primary care services. The quality of care provided to patients who attend EDs with non-urgent needs has been questioned and criticised for being unduly interventionist. Patients are often over-investigated and over-treated suffering consequent harm. Emergency department medical staff often have difficulty eliciting and responding to the psycho-social concerns of patients and important clinical matters and significant psycho-social problems may be overlooked. Even when psycho-social problems are recognised, therapeutic options and follow-ups are seldom discussed with the patient. Some A & E (Accident and Emergency) departments have triage nurses who assess the patient first and will re-direct the patient back to their GP if their problem is judged to be non-urgent.*

Traditional healers. *There are many different traditional medical cultures around the world, which do not always have more in common with each other than with modern Western medicine. A doctor trained in Western biomedicine concerns himself in the first place with the natural causes and bodily manifestations of disease, without intervening or sharing in the patient’s social fabric. In contrast, traditional African healers interpret illness within the broader context of life forces at work. It is common to see an African healer talking to a tree so that he may control and use the life force within for the benefit of his patient. When African patients receive an herbal infusion, they expect to benefit from the life force of its ingredients and from the power of the ancestors or any other spirits invoked.*

Carry out: do, perform.

Attendees to the Emergency Department are those patients who go to the ED to get medical care.

Appropriate attendees to the ED are those who really needed to go there. Inappropriate attendees to the ED are those who should have gone somewhere else, e.g. to their family doctor.

Range. To vary between a particular upper and lower limit. You may also say “the range is 28–95%”.

Ailment. A mild (not serious) illness or injury, especially a persistent one.

Over – do too much of something, do in excess. A patient with a common cold is over-investigated if he has a chest X-ray done and is over-treated if he is given antibiotics.

Harm. Physical or mental damage or injury.

Elicit: to obtain certain information by questioning, or a certain response by applying a stimulus.

Overlooked: not noticed, not detected, not seen. It does not mean “look too much” but the opposite! Do not confuse with “**oversee**” which means “supervise”.

Follow-up. Further observation or treatment of a patient. After the initial visit, you offer the patient “follow-up visits” to monitor progress.

Seldom. Rarely, infrequently, almost never.

A & E = Accident and Emergency, also called “Casualty”.

Triage. The process of prioritising sick or injured people for treatment according to the seriousness of the condition or injury.

Assess. Examine in order to judge or evaluate.

Healer. Somebody who cures or treats illnesses or injuries, often using spiritual rather than scientific methods.

Western is much more used than Occidental.

Concerns himself with – is interested in.

Fabric is literally what clothes are made of, but in this case it means “network”.

Within: inside a context or a group.

At work – functioning, having influence.

(In)Appropriate [ɪn'ə-prō'prē-īt]. Therapeutic [thēr'ə-pyōō'tik]. Triage [trē'āzh].

A & E, A n' E [A and E].

Rural Primary Care

There is usually a shortage of GPs in rural areas, which means reduced patient access to care. Many countries are campaigning to increase the supply of doctors in these areas.

Rural primary care most often involves living and working in rural communities where, over a period of many years, the rural family physician gets to know patients very well. A rural doctor provides a very broad range of care from cradle to death, in the office, on house calls and in the hospital.

Developing Health Care Systems

The term “developing” is often used interchangeably with “third world”, or “south” or “non-Western”. It generally means “poor”: these countries carry an overwhelming share of the burden of disease and cannot join the “rising curve of health” that other, more fortunate countries are enjoying.

Management and Leadership

Family physicians are often called on to improve care for patients beyond those they see in day-to-day practice. Familiarity with multiple medical disciplines makes family physicians particularly well suited for leadership roles.

Leadership roles have two components. The management role oversees and solves day-to-day problems, such as assuring that a clinic is adequately staffed, assessing medical quality and dealing with personnel and finances. In contrast, the leadership role requires changing the structure and course of an organisation. In practice, the two roles overlap.

Some family physicians who assume a more formal leadership role are often called “medical directors”. For those who find providing care to individuals and families to be satisfying, being able to help health care systems and meeting the needs of entire communities can be equally rewarding, and makes the challenges of a leadership role worthwhile.

There is a **shortage** of something when there are not enough, when more are needed. Rural areas are “**short of**” doctors; the **supply** of doctors in rural areas is insufficient; more doctors need to be **supplied** to rural areas. To **campaign** for something is to organise a series of actions to achieve a goal.

Get to know the patient – obtain and increase knowledge of the patient.

From cradle to death: all life. “Cradle” is the little bed for babies.

Interchangeably – people use one word or the other to mean the same.

Overwhelming: extremely large or strong.

Burden. A difficult or worrying responsibility or duty.

Join – become a participant of something, together with others.

Rise – go up. The sun rises in the morning. Prices rise every year. To **raise** is to make something go up. ESR is **raised** in rheumatic conditions. To **raise funds** (e.g. for a project) is to collect money by asking others for donations.

Management. The process of, and responsibility for, the organisation of a company or similar institution. The type of management of most interest to us is “health care management”. When GPs are private or independent contractors, they are the **managers** of their practices or health centres.

Leader is the one who is in command or shows the way to others.

Improve – to get or make something better. **Worsen** – to get or make something worse. Superlatives: **best/worst**.

Beyond – outside, past something, not included in.

Day-to-day. Everyday, daily, routine, usual.

You are **familiar** with something when you have seen or used it before. It has nothing to do with the family. Your parents, brothers, sisters, cousins, uncles and aunts are not your “familiar” but your **relatives**.

Assure: guarantee.

Adequate: sufficient in quality or quantity to satisfy a need. Note “appropriate” has not been used here. **Appropriate** means “suitable, correct”. *Having 2 doctors for 10,000 patients is inadequate. Having a secretary to assess patients’ medical needs is inappropriate.*

Deal with. To take action with regard to something or somebody, for example, to solve a problem or to help somebody.

Personnel: staff. Do not confuse with **personal** (individual or private).

Overlap: have common characteristics, coincide.

Satisfying, rewarding: produces a feeling of satisfaction. **Satisfactory**, however, is not emotional and simply means “acceptable”.

Meet the need(s): satisfy the need(s), make the need disappear.

Worthwhile: rewarding or beneficial enough to justify the time taken or the effort made.

supply. [sə-plɪ] component [kəm-pō'nənt]. develop [dɪ-vəl'əp]
developing [dɪ-vəl'ə-pɪŋ] development [dɪ-vəl'əp-mənt].

Primary Care Around the World

Health Care Systems: Understanding the Stages of Development

A health care system is the organised response to the health problems of a society. In mature economies the health sector absorbs around 10% of their gross domestic product (GDP), whilst in developing economies this is around 5%.

Health care systems are characterised by defined operational goals, division of labour, coordination, planning and evaluation cycles, and relative autonomy from other systems. Coherence within the system is expected but also between primary, secondary and tertiary services, and between different types of services. Borders with sectors adjacent to health care, such as those with welfare, social security, and education, may not be well defined and differ from country to country.

There is a crucial relationship between “health” and “wealth”. Growing wealth results in more and more varied nutrition and a prolonged life expectancy, which leads to the epidemiological transition from mainly infectious diseases to an increasing prevalence of chronic diseases.

The extent to which resources can be generated for health care depends on the stage of development of the economy. Only advanced economies will be able to reserve sufficient proportions of their income for health care, although rising costs due to an ageing population is making this increasingly difficult. Low-income countries will struggle to provide a minimum of services.

Health care funding and provision varies from country to country. For instance, public funding and provision is predominant in Spain, public funding with private provision in the UK, and a mixture of private and insurance funding in the USA with added public services for the indigent and the elderly.

Services can be primary care led or hospital based. Some research studies show that primary care led systems are not only cheaper than systems with direct access to hospitals and medical specialists, but their outcomes are better, too.

Systems can be centralised (UK, Spain) or decentralised (Switzerland). A centralised system seems to offer good coordination, division of labour and shared goals, although in practice this can be spoiled by bureaucracy and too much regulation.

Merely by its design one system cannot be declared superior to the other.

Stage: a step, level or period in the development or progress of something. Diseases, e.g. tumours are often staged I, II, III, etc.

Whilst: while, at the same time. Here it is used to compare too different situations.

Evaluation – To evaluate is to examine and judge carefully, applied to processes (to know how good they are or not); **assessment** may be applied to processes or to patients (in order to know what illness they have and how severe).

Welfare. The physical, social and financial conditions under which somebody may live satisfactorily. Developed countries seek to live in a “state of welfare”.

Wealth: abundance or richness of material goods and money.

Lead to something – produce something as a consequence.

Growing, increasing: getting bigger or higher.

Mainly: chiefly, mostly or most importantly. The text explains that infectious diseases were the main diseases in the past, and nowadays chronic diseases are the main ones.

The extent to which – how much.

Income: money received over a period of time. Your income is usually your monthly salary which you receive from work. Governments’ is come mainly from taxes.

Ageing population – a population whose members are increasingly older.

Struggle. To try with great effort to deal with a challenge, problem or difficulty. For example, “I am struggling with my English”. It also means “prolonged fight or conflict”.

Funding. Financial support; money provided, especially by an organisation or government, for a particular purpose. Typically, you need to get funding for your research, service development or learning project.

(-) **led.** (-) **based.** We used these words after the “protagonists” or main setting of something. Led is the past participle of “lead”. “Primary care led” means that it is initiated and controlled by primary care organisations. Hospital based means that it happens in or is controlled by the hospital.

Practice-Based Commissioning (PBC) is a new form of contract developing in the UK whereby GPs will organise or arrange all the health care the patient requires, including their secondary care.

Spoil. To damage or ruin something in such a way that its value, beauty or usefulness is diminished. When something good is turned bad, we say it has been spoiled. A child is **spoiled** when their parents give them whatever they want.

society [sə-siī-tē]. mature [mə-tyoor']. characterised [kār'ək-tə-rīz'].

coherence [kō-hīr'əns]. tertiary [tūr'shē-ēr'ē]. varied [vār'ēd]. varies [vār'ēz].

provision [prə-vīzh'ən]. mixture [mīks'chər]. control [kən-trōl']. design [dī-zīn'].

Africa

In Africa, many people never have access to a medically trained health care worker, and the vast distances and relatively poor transport system make access to services more difficult.

Asia

In East and Southeast Asia, rural areas are likely to be underserved. Primary care is provided as part of public health, some of it by the state and the rest by communities themselves. Non-government organisations (NGOs) may be a welcome source of care but this is often transient. Urban areas have many competing providers, including the state and a number of private and charitable organisations. General practices, similar to those seen in Western countries, are found in the urban areas. Besides these providers, there are the so-called complementary and alternative medicine (CAM) providers with varied treatment techniques such as herbal medicine, massage and acupuncture.

Australasia

Funding arrangements have changed in the past 20 years.

- *Australia has a universal health insurance scheme called Medicare funded by contributions from taxes and a levy (1.5% of post-tax income) on individual taxpayers, providing access to free care as a public patient in a public hospital and free or subsidised treatment by GPs and medical consultants. Medical practitioners operate on a fee-for-service basis and charge fees that they consider suitable for the services they provide. Reimbursements are then paid based on a percentage of the Medicare Schedule fee (usually 85%) from the Treasury. A private sector exists through private health insurance, operating on a community-rating scheme where all premium holders pay the same premium, regardless of age or pre-existing conditions. Maldistribution of GPs remains a major problem. There is an oversupply in urban centres and a concomitant undersupply in rural and remote areas.*
- *In New Zealand, there is a higher ratio of practice nurses to population than in many other countries. There is a move towards nurses being trained in the prescribing of medications, in order to compensate for the shortage of GPs.*

Latin America

Family physicians employed by the public health care sector are typically paid on a salary basis, except in Uruguay where the ministry of health compensates them based on a capitation method.

Health care worker is the generic name for those (professionals or not) who provide health care: doctors, nurses, health care assistants, psychologists, etc. The term **worker** is used to define many new roles, such as “drug misuse worker” (person trained to help drug users), “mental health worker”, etc.

Underserved: not served enough, in this case, with not enough doctors.

Transient: temporary.

Competing – they compete with each other, they are in competition. Do not confuse “competitive” (who tries to do something better than others or win something) with “competent” (who does their job well), or “competition” with “competence”.

Charity or charitable organisation is an organisation that collects money and other voluntary contributions for groups of people in need, such as Cancer Research or Red Cross, etc. They are also called NGO’s (non-Governmental Organisations).

Besides: apart from, in addition to. **Beside:** in apposition, next to (e.g. the wife was sitting beside the patient), apart from, in addition to.

So-called: commonly known as, commonly called.

Arrangements: preparation, planning, organisation and procedure.

Insurance. An arrangement by which a company or government agency gives customers financial protection against loss, damage, illness or death, in return for the payment of a premium. The text refers to “health” insurance.

To **fund** is to pay for. This is different from **found** which is to start an institution or business. “Found” is also the past of “find”. *The British NHS is a publicly “funded” health care system which was “founded” in 1948, and which I “found” difficult to understand when I came to London.*

Scheme: design, system or plan with a very specific purpose.

Post-tax income what is left of your income after paying taxes. **Tax.** The money from your income that you have to give to the government (in the UK to the Inland Revenue office). If you pay this, you are a **taxpayer**. What the government spends is “taxpayer’s money”. **Levy.** A tax for a specific purpose.

Subsidise: pay part of the cost. **Suitable:** appropriate.

Fee-for-service – they are paid for each thing they do. **Fee** is the payment for a professional service. *Our fee for medical reports is £ 70.* To **charge** is to ask for a payment. *We charge £ 70 for a medical report.*

Reimbursement. Repay an amount of money that has been spent or lost. You get 100% reimbursement if you get all your money back.

Schedule: programme. **Regardless of:** independently from.

Capitation method – a payment method for GPs by which they receive a fixed amount of money per patient on their list.

access [āk’sēs]. technique [tēk-nēk’]. massage [mā-sāj’]. insurance [īn-shoor’əns]. percentage [pər-sēn’tij]. suitable [sōō’tə-bəl].

Europe

- *In the UK, general practitioners enjoy an “independent contractor” status – the general practitioner being self-employed but contracting with the NHS to provide services for a named population of patients. Doctors employ their own staff and organise their own work. Eighty-seven percent of GPs work full-time; the rest are part-time to variable degrees of their choice (half-time, three-quarters, etc). The average number of persons cared for by each GP is around 1700–1800. Vocational training (residency) in General Practice has been mandatory since 1981. Primary Care Trusts (PCTs) are responsible for assessing local health needs and (increasingly) for the commissioning of health services for their population of patients, served by a variable number of practices.*
In most medical schools in the UK, students have community-based clinical exposure and attachment from the earliest years of the medical curriculum. The 5 years spent in undergraduate medical education are followed by a year spent as a “house officer” before full registration with the General Medical Council, and pursuit of specialist or generalist training. Doctors entering general practice must undertake a further 3 years of vocational training. Successful completion of vocational training involves summative assessment of competencies.
- *In Germany, a rapid growth in health care expenditure ended in 1977, with the introduction of the Health Insurance Cost Containment Act. Family physicians have no gatekeeping role – patients can choose to see any doctor affiliated to an official sickness fund.*
- *In Spain, practices usually have between 5 and 15 family physicians; infrequently and only in rural areas they may work in solo practice. Doctors are paid a salary by the state as civil servants. Although the post-graduate structure of family medicine is now well established in Spain, undergraduates do not have much exposure to primary care.*
- *The Netherlands has a strong primary care orientation in its health care system and a high score on international health indicators.*
- *All the Scandinavian countries have a long tradition of a firmly established primary health care system and a strong GP sector. Their health care systems are publicly financed through state and county taxes, with a small patient co-payment when they consult.*
- *In Sweden, the duration of medical studies is 7 years and of vocational training is 5 years. Family doctors spend a minimum of 15 min per consultation and see around 15 patients per day.*
- *Finland has a formal specialist general practice examination and doctors without an examination get paid less.*

Self-employed – you are your own boss.

Named: specified by name, listed.

Full-time: more than 35 h per week. **Part-time:** less than 35 h per week.

Average: mean, calculated by adding the numbers together and dividing by the total amount of numbers.

Mandatory: obligatory, compulsory.

To commission is to order or authorise (a person or organisation) to do or produce something. In Practice-Based Commissioning (PBC) family doctors are asked to arrange secondary health services for their patients.

Exposure: the experience of coming into contact with something.

Attachment: in this case, learning period based at a clinical centre.

House officer. A resident physician and surgeon of a hospital (the “house”) who is receiving further training, usually in a medical or surgical specialty, while caring for patients under the direction of the attending staff.

Pursuit. The effort to achieve something over a period of time.

Vocational training: residency, training in a medical specialty.

Summative assessment: a formal way to assess students using scores.

Expenditure: amount of money spent, expenses, costs.

Containment: repression, control.

Solo practice: a practice with only one doctor; also called “single-handed”. This is opposed to “**group practice**” where two or more doctors work together.

Doctors in general comprise two groups: **physicians** and **surgeons**.

Civil servant. A member of the civil service. **Civil service:** the permanent professional branches of the government’s administration, excluding military and judicial branches and elected politicians.

Undergraduates: university students.

Its – Note the possessive article for non-human nouns.

Score. A rating or grade, such as a mark achieved in a test.

Publicly financed: paid for by the state.

average [āv'rīj]. pursue [pər-sōō']. pursuit [pər-sōōt']. physician [fī-zīsh'ən].

Asia

- *In India, when the term general practice is used it usually refers to private medical practice by qualified allopathic medical practitioners. Figures on the total number of private health practitioners in India are difficult to obtain, but there are possibly more than 400,000 qualified doctors registered with the medical councils of India.*
- *In Pakistan, primary care providers deliver cost-conscious, culturally sensitive care but work virtually without any regulation or continuing education. Health indicators show a positive trend but are still poor. This has been attributed to a low literacy rate, lack of clean water and sanitation, and neglect of the health care sector at the government level. A rapidly growing population further strains the health services. Urban population is increasing dramatically. Average household size is 6.8 persons. Government clinics and hospitals provide essential health care services for those who cannot afford private sector fees; however, patients still end up paying out-of-pocket for “covered” items such as medicines and surgical supplies. Rationing of services also occurs, with the exclusion of under-served groups to the benefit of “entitled” classes such as higher-rank government and military officials, and family contacts of health care providers.*
- *Although Israel has a well-developed primary care system, formal post-graduate training in general practice is not a prerequisite to become a primary care physician, and only around 15% of doctors delivering primary care services are board certified specialists in family medicine.*
- *In Jordan, the number of trained general practitioners has increased but still fails to meet the existing population needs in primary care.*
- *In Saudi Arabia there is a training programme in conjunction with the Royal College of General Practitioners in the UK in which candidates become eligible to sit for membership of the RCGP after 3 years of training.*

North America

- *In North America, a ‘general practitioner’ is now a physician who did not complete formal specialist training in any specialty and is ineligible for specialty certification in family practice or any other discipline. General practitioners not trained in family practice residencies become fewer each year. ‘Family doctors’ are required to sit recertification exams every 7 years in the U.S. and every 5 years in Canada to maintain their certification in family medicine.*

International Organisations

The World Organisation of Family Doctors (WONCA) has the mission to improve the quality of life of the peoples of the world by fostering high standards of care in general practice/family medicine. It pursues excellence as well as equity.

Qualified: having the appropriate qualifications for a position or task; holding an official degree or diploma after undertaking official studies.

Cost conscious, culturally sensitive – expressions used to describe that the providers are careful about the money they spend and the cultural background of the people they serve. **Trend:** tendency.

Poor: not good; not adequate in quality. To be financially poor means having little or no wealth and few or no possessions.

Literacy. The ability to read and write to a competent degree.

Neglect. Lack (absence of) of proper care and attention.

Further: even more. **Strain:** intense demand or pressure.

Dramatically: considerably, significantly, spectacularly. Here it refers to quantity – not necessarily associated with “drama” or passionate emotions.

Household: the people who live together in a home.

Clinic [noun] can have many meanings: (a) a medical centre for outpatients, which may be attached to a hospital or form part of it; (b) a medical centre that specialises in a particular condition or area of medicine; (c) a suite of offices or an office where a number of doctors practice general medicine as a partnership; (d) a teaching session during which student doctors are allowed to examine patients in hospital wards, or the teaching of medicine by this method; (e) a session in a hospital that patients attend for specialised treatment or advice.

Clinical. [adjective] Based on or involving medical treatment, practice, observation or diagnosis.

Afford: to be able to pay; to be able to meet the cost of something without difficulty. **End up** paying – in the end, they pay. **Out-of-pocket:** with their own money. **Covered:** included in the insured policy. **Rationing:** restriction of something that is in short supply.

Entitled: with rights or privileges. **Eligible:** entitled, qualified, permitted, accepted or acceptable, considered a good candidate for something. The opposite is **ineligible**.

Board certified – they hold a degree or diploma issued by an official board of the specialty, usually after training and/or examination. **Sit** an exam – attend and do an exam. **Membership:** the condition of being a member. **Training** can be intellectual (education) or physical (exercise). In this book we usually refer to the first option.

Standard: the level of quality or excellence attained by somebody or something, or that is accepted as the norm (often used in the plural).

Equity in a health care system means that all groups of people get the same standards of care irrespective of social class, financial state or ethnic background. No group or class (e.g. low income classes or an ethnic group) are discriminated against.

Foster: promote, cultivate.

literacy [lɪt'ər-ə-sē]. further [fʊr'thər]. rationing [rāsh'ən ing].

discipline [dɪs'ə-plɪn]. maintain [mān-tān'], maintenance [mān'tə-nəns].

Reasons for Consultation

By far the most important factor that influences whether formal health services are consulted is the severity of the illness experience. Cultural values, such as stoicism, self-reliance or being unwilling to acknowledge psychological distress, also influence service use. The presence of social support can increase or decrease the likelihood of consultation with primary care services. For example, talking to family and friends about worrying symptoms may either increase the likelihood of consultation (where friends feel it is “better to be safe than sorry”) or decrease the likelihood of consultation (where just talking is enough to reduce the burden of worry and “normalise” the experience).

The characteristics of the health system, especially how it is financed, has a great influence, too. In universal health systems that nevertheless demand some co-payment from patients, such as in New Zealand, lack of money can be suggested as a reason for not consulting a doctor when care was felt to have been needed. The New Zealand National Health Survey asked if respondents had not visited a GP when they felt they had needed to, as a measure of unmet need. Of those who felt they had unmet health needs, nearly half identified cost as their main reason for not consulting.

***Illness behaviour** is a term used to describe what people do when they are ill. Some will continue their daily routine, some will stay at home, some will consult a pharmacist or a doctor, etc. A more formal definition is: “the ways in which given symptoms may be differentially perceived, evaluated, and acted (or not acted) upon by different kinds of people”. Variables important to understanding behaviour include psychological phenomena such as cognition and emotions.*

The options sick people have are: self-care; consulting lay people; or seeking professional help. Self-care may include self-medication, either with prescribed or over-the-counter (OTC) medicines.

The appropriateness of illness behaviour in the choice of these options will vary: self-medication may be useful or harmful; professional advice may be necessary or a waste of resources (for non-serious problems or “trivia”).

*Psychological models focus on the extent to which health behaviours can be predicted by **health beliefs**; these include the patient’s perceptions and cues to actions. The “perceived susceptibility” of risk ranges from denial to*

By far: with a great difference from the others.

Whether is a conjunction expressing doubt or choice between alternatives. The text means “whether services are consulted **or not**”, although the “or not” may be omitted.

Unwilling – not wanting or refusing to do something.

Support: help, assistance, comfort.

Likelihood: probability. **Likely:** probable.

You say it is **better to be safe than sorry** when you do something that you probably do not need to do, but you do it “just in case”.

Burden. A load being carried. Something that is emotionally difficult to bear.

Felt. Past of **feel**. Note to use of “**felt to be**”. Patients felt the need for care – care was felt to be needed.

Unmet need. A need that has not been satisfied or fulfilled.

Daily: every day. Do not confuse with **dairy** – dairy products are milk, cheese and eggs; or **diary**, which is a written daily record, especially a personal record of events, experiences and observations; a journal. You would write in your diary your meetings, appointments, birthdays, etc.

To **act upon** a symptom is to do something about it, e.g. to go to the doctor.

Phenomena. Plural of **phenomenon**.

Lay: non-professional, in this case, with no training in health sciences. Usually friends or relatives. There is a whole world of “lay medicine”.

OTC ★: over-the-counter medicines are those that people can buy at the pharmacy or supermarket without the need for a medical prescription.

Harmful. Causing or capable of causing harm, injury or damage.

Advice. Opinion about what could or should be done about a situation or problem; counsel. The verb is **Advise:** recommend; suggest, or offer guidance.

To **waste** something is to use it carelessly, extravagantly or without effect. “*It is a waste to have doctors seeing patients with common colds*”.

Health beliefs are things that people believe about various aspects of health and health care. They may believe that insulin makes them fat, that smoking is not so bad, that the doctors are no good, etc.

Cue to action: signal for action; something that prompts or reminds us to do something. A patient may decide to consult because their friend died of a similar condition to the one they currently have.

Prompt: to incite, urge, motivate to do something.

Denial. A state of mind marked by a refusal or an inability to recognise and deal with a serious personal problem. Typically a smoker would be in a state of denial when they say that smoking would not harm them.

lay [ley] denial [dī-nīəl]

hypochondria, with a moderate level of belief in which the individual admits that there is a statistical possibility of contracting an illness. “Perceived severity” of the condition and “perceived benefits” from acting on it would also increase the likelihood of taking action. On the contrary, “perceived barriers”, such as inconvenience, expense, pain, upset and unpleasantness, would decrease the likelihood of taking action (e.g. consulting). “Cues to action” are the events that motivate or prompt a person to take action (a new symptom, advice from a friend, etc.).

*The **media** can inform or mislead the public. Health professionals are often wary of the media’s role in the coverage of health issues, as it is often a distorted one. “Mass media” includes newspapers and television and radio programmes and excludes books, specialist journals, educational leaflets or patient information booklets about specific diseases or treatments.*

“Health scares” provoked by the media range from the appearance or increase of “nasty bugs” (e.g. MRSA) to alleged side effects of treatments (the contraceptive pill, the MMR vaccine).

*Sick individuals who choose to “**self-care**” rather than professional care may seek “lay advice” (from friends or relatives) or resort to “home remedies” (OTC medication they store at home and use at their discretion).*

Self-medication with OTC medicines has benefits and drawbacks. On the positive side, they increase patient empowerment and limit demand for health services but on the negative side, misuse (or abuse or overuse) may pose a risk. Leaflets for patients can help to encourage appropriate usage.

Patients with chronic illness can be taught to manage their conditions for themselves.

Complementary and alternative medicine. *This comprises those health-related practices that are not taught in medical schools or generally available in mainstream medicine. The boundaries, though, are increasingly relaxing. Examples include acupuncture, homeopathy, osteopathy, massage, hypnotherapy, aromatherapy, etc. People often turn to these options due to dissatisfaction with orthodox care.*

Patients’ Expectations of Treatment

Diagnostic information is highly valued by many patients. Many patients seem to value medical information related to their body for its own sake, regardless of what treatment is provided (if any).

To **contract** an illness is to *catch* an illness. When an object contracts it becomes smaller, it shrinks. To contract a service **with** a company means to sign a contract with that company.

Whether has the same pronunciation as **weather** [wɛðə'ər] but a very different meaning. *The weather is unpredictable, I don't know whether it is going to rain today or not.*

Inconvenient. Causing discomfort, difficulty or annoyance. Late-evening appointments are **convenient** for patients, as they can see the doctors after work.

Upset: distress. A person can be upset because they are sad (e.g. after a relative's death) or because they are angry (e.g. an unhappy customer).

Pleasant: that produces pleasure; nice. **Unpleasant** is the opposite.

Media: the means of mass communication, regarded collectively. Mainly television, radio, newspapers, Internet.

Mislead. To cause somebody to make a mistake or form a false opinion or belief, for example, by supplying incorrect information.

Leaflet. A sheet of printed paper, usually folded, that is distributed free as part of an advertising or information campaign. **Booklet.** A small information book with very few pages.

To be **scared** is to be very frightened. A **scare** is a situation causing general fear or alarm. "Health scares" are relatively common in Anglo-Saxon countries.

Nasty: very bad, producing a lot of harm. There are nasty people, such as cruel criminals or unjust bosses. Diseases, or pathogens, may be "nasty".

Bug: colloquial name for micro-organisms (virus, bacteria) or insects.

MRSA ★. Meticillin-resistant *Staphylococcus aureus*.

MMR ★. Measles, Mumps, Rubella (triple viral) vaccine.

Benefits and drawbacks – advantages and disadvantages, pros and cons.

To **empower** somebody is to make them stronger, more confident and more able to control their life and look after themselves.

Complementary is something that complements another one. Do not confuse with **complimentary** which means either (a) free of charge, not to be paid, as a courtesy. For example: *The attendees of the Course in Primary Care English will receive a complimentary copy of this book;* or (b) flattering, as a compliment (a polite expression of praise or admiration). For example: *He was very complimentary about my new look, and said the dress was beautiful.*

For its own sake. Used to indicate something that is done as an end in itself, rather than to achieve some other purpose. **For the sake of something:** for the purpose of, in the interest of, in order to achieve or preserve. *"For the sake of completion, I will arrange some more rheumatic tests, although everything has been normal so far and they are likely to be normal as well".* **For God's sake!** or **For goodness sake!** Used to express impatience, annoyance, urgency or desperation.

barrier [bār'ē-ər]. pleasant [plēz'ənt] pleasure [plēzh'ər]. measles [mē'zəlz].

Descriptive Epidemiology

The metaphor of the “iceberg of illness” means that only a minority of health problems present to the GP – the submerged portion of the iceberg, the hidden morbidity below the water surface, comprises diseases not medically attended, medically attended but not accurately diagnosed and diagnoses not reported to GPs. The iceberg metaphor relates not only to objective morbidity (“disease”) but also to subjective experiences (“illness”). **Disease** is a physiological/psychological dysfunction and **illness** is a subjective state of the person who feels aware of not being well. So the words disease and illness are not synonymous.

For the patient, the decision to consult would depend, for example, on the extent to which symptoms are perceived as threatening, disruptive or embarrassing. When a patient presents his problem the doctor immediately starts formulating in his mind a number of hypotheses about the possible cause, considers the symptoms and signs and the a priori risk and ends with a “working diagnosis”. When making diagnoses in primary care there is often a degree of uncertainty. This is perfectly acceptable for self-limiting “common” conditions. Many patients present a health problem with the underlying worry of whether they have a serious disease and not with the question of which pathogen exactly causes the problem. Patients want to know their prognosis rather than their diagnosis.

Incidence usually reflects the number of newly diagnosed persons with a certain condition in a certain time period. The **prevalence** of a disease represents the number of persons with a certain disease at one moment in time (“point prevalence”). As it is not feasible to establish this measure in 1 day, the “period prevalence” (the number of persons with a certain disease in a period of time, usually 1 year) is used as a proxy measure.

Nowadays, coding is an important aspect of clinical record keeping. When we enter health problems or diagnoses onto a computer or database using ready-made terms, they can be easily retrieved and analysed. Widespread systems are the International Classification in Primary Care (ICPC) and the International Classification of Diseases (ICD) which are available in many languages (www.who.int/classifications). A caveat should be put in with regard to the potential utility of medical vocabularies used in ICD. Their content is “Anglo-Saxon” and their utility in countries other than the UK and the United States is, especially in family practice, not certain. If you plan to browse these classifications you may be helped by some definitions of terms:

Do not confuse “**disease**” with “**decease**” which means death or die. “The **deceased**” is a formal way to call a person who has recently died. You will find this term in death certificates.

Threatening: causing fear.

Disruption: interruption or unexpected disorder in normal activity.

Embarrassing. Causing painful self-consciousness, discomfort, shame or humiliation. **Embarrassed:** feeling embarrassment (produced by something embarrassing). “Some people find it *embarrassing* to talk about very private problems with a doctor”. “Some people are very *embarrassed* about talking about very private problems with a doctor”.

Degree: amount, proportion, level. Also, an academic achievement after formal studies (e.g. a degree in Medicine, or a medical degree). A **grade** is a level achieved in studies (e.g. “she got good grades at medical school”) or work (e.g. a nurse may be grade A, B, C, etc., according to their level of ability or responsibility). Degrees (but not grades) are used to measure temperature (e.g. fever is over 37.5°).

Uncertainty: doubt. **Uncertain:** unknown, unpredictable.

Underlying. Present and important but not immediately obvious.

Newly: recently; diagnosis not previously known.

Feasible: possible, practicable, realistic.

Proxy: substitute; a figure that can be used to represent another (truer) one.

Coding: use of codes.

Note that we **enter** information or codes into a record clinical system when we type them.

Ready-made: invented and prepared by someone else for you to use.

Retrieve: recover, get back.

Widespread. Existing or happening in many places, or affecting many people.

Available: accessible, existing.

Caveat. Something said as a warning, caution, or qualification. To **qualify** in this case is to modify or limit something in meaning, scope or strength.

With regard to: in respect of, relating to. A similar phrase is “**as regards**” (note there is a final “s” here), normally used at the beginning of a phrase. “As regards the potential utility of medical vocabularies used in ICD, a caveat should be made”.

Browse. To read through something quickly or superficially. You can browse the BMJ before you decide to read an article, or you can browse a patient’s record up and down in the computer screen looking for the last consultation about a particular problem.

disease [dī-zēz'] decease [dī-sēs'] hypothesis (singular) [hī-pōthĩ-sīs] hypotheses (plural) [hī-pōthĩ-sēz']. diagnosis (singular) [dī'æg-nō'sīs] diagnoses (plural) [dī'æg-nō-sēz']. a priori [ä' prē-ōr'ē].

Encounter. Professional interchange between a patient and (a) member(s) of a health care team. One or more episodes of care may be dealt with at an encounter. An encounter may be direct (face to face) or indirect (telephone call, letter, through a third party, or administrative).

Episode of care. A health problem from its presentation by the patient to a health care provider until the completion of the last encounter for it. It encompasses all contact elements related to that health problem; its name (diagnosis) may change over time.

A **new problem** is the first presentation of a problem; a **continuing problem** is a previously assessed problem requiring ongoing care (follow-up).

NOS. Not otherwise specified: the term to be coded cannot be classified to a more specific rubric.

Ragbag. Miscellaneous collection of symptoms and complaints of interventions or diseases not classified elsewhere.

Read-codes. The terminology used by the NHS for health service in the UK, including a wide range of objects.

Rubric. Medical phrase for designating/identifying a class in a coding system.

Age and gender matter in primary care situations, as it affects the type of conditions seen by the GP and the way patients disclose their problems. They are the markers of an unfolding (medical) life course.

Data sets are often broken down by age and gender. In the epidemiological transition from high mortality to low mortality in developed countries, the most favourable effects on survival concentrate among infants, children and women of childbearing age.

Individual lifestyle is an important factor affecting how we age.

In ageing populations degenerative diseases are extremely prevalent.

Whereas the epidemiological transition is about the emergence of chronic disease and their changing lethality, primary medical care is still dealing with an array of health problems, such as infections, that were more lethal in the past but are now manageable.

Third party – a third person involved. In our context, the two main persons are doctor and patient, so a third person may be a relative, another doctor, etc.

Continuing: persisting, that has not disappeared. **Continuous:** without interruption. A patient's chronic pain is a *continuing* problem, though the pain may have interruptions. Acute appendicitis may present with a history of a few hours of *continuous* pain in RIF (right iliac fossa).

Ongoing (=continuing): having existed or been in progress for some time and continuing to do so. Ongoing care means that the doctor (or nurse) is still seeing the patient for his (continuing) problem. Follow up is the planned ongoing care of a patients' condition. When you worry about a patient you will normally organise follow-up visits to see them again and check progress.

Otherwise in this context means "in any other place". Another use of "otherwise" is to replace "if not", e.g. "Mr. Jones, I strongly advise you to take your sugar tablets. Otherwise, you will end up in hospital again".

Gender is the sex of a person (male or female). You could also say "age and sex", but it is probably wiser to say "age and gender" to avoid confusion, as "sex" is also used to mean "sexual activity".

Disclose: reveal, tell.

Unfold: to develop and expand over time.

Life course: the course of a life.

Dataset: an organised collection of data.

Data: facts or statistics collected together for reference or analysis. In Latin, data is the plural of datum, therefore its traditionally correct form is the plural form (e.g. "data were collected"). However, use of the singular (e.g. "this is interesting data") is increasing, although whether it is correct or not is a controversial matter.

Broken down. To **break down**, in this case, is to separate in groups for analysis. It has other uses, e.g. when your car suddenly stops and you are unable to start it again, you say your car has "broken down".

Childbearing age: the age at which women may have children (approximately 15–40 years).

Lifestyle – the way we live, i.e. whether and how much we smoke, drink, have sex, exercise, eat healthily or unhealthily, etc.

To age is to grow old.

Emergence. The act or process of appearing or coming out. Do not confuse with **emergency** which means "a serious, unexpected and often dangerous situation requiring immediate action".

Array: range, collection, group, variety.

Manageable is something you can deal with or manage without great difficulty. When something gets too difficult, it becomes "unmanageable".

Nowadays: in our time (e.g. compared with the past century).

data [dā'tə].

There is a well-known difference in longevity between men and women, the latter living a few years longer.

The discussion of socio-economic health differences starts from the concept of social stratification, which layers society into bottom, representing the less-favoured members of society, and top, representing the most favoured. The term “socio-economical health differences” indicates the systematic differences in health between people with a lower position in the social stratification, on the one hand, and people with a higher position, on the other hand.

When the Sanitary Movement was established in the nineteenth century, interest in this topic arose. In 1977 a Research Working Group was appointed by the UK government to assess the national and international evidence on health inequalities and thus draw conclusions for policy. The report concluded that the poorer health experience of lower occupational groups applied to all stages of life.

The WHO put emphasis on “equity in health”, too, referring to a situation in which everyone has equal chances to reach his/her maximal potential health, rather than everyone having the same health status. It encourages improving the level of the disadvantaged nations and groups to achieve this.

Most inequalities are not biologically inevitable but reflect population differences in circumstances and behaviour that are, in the broadest sense, socially determined. Likewise, “health inequities” are inequalities that can be avoided and are therefore unfair and unjust.

In poorer countries the difference can be explained by the direct impact of material standards such as bad housing, poor diets, inadequate heating, etc. In richer countries, well-being is more closely related to relative income than to absolute income, through the psychological effects of its emotional and social meaning.

Large differences in health can be noted between the three defined social classes (lower social class, middle class, and higher class, based on profession). A man with an unskilled manual occupation is more than four times as likely to die of lung cancer than a person with a professional occupation, and twice as likely to die from coronary heart disease.

When you mention two things in a sentence, the first one is the **former** and the last one is the **latter**. Do not confuse with **later**, which means, as you know, “after a particular period or time”.

Former is also used as “occurring at or existing in an earlier time or period”. For example, when a patient moves to your practice, they will bring a list of medications prescribed by their “former GP”.

Layer: level, stratum. The **bottom** is in the lower level and the **top** is in the upper level.

Arose: past of arise. **Arise:** happen, begin, appear.

Note that you say you “**draw**” conclusions from evidence.

Policy. A program of actions adopted by an individual, group or government, or the set of principles on which they are based. Do not confuse with **politics**, which is what **politicians** (of various **political** parties) do.

Disadvantaged: with fewer advantages – in financial terms, poor. Richer people or countries are said to be “better off”, while poorer people or countries are said to be “worse off”.

Encourage: motivate, promote.

Likewise: similarly.

Housing: houses and apartments considered collectively; the provision of places to live (homes); the condition of the place where people live. A common problem seen in patient records is “housing problems”.

Heating: the equipment that produces heat to warm a room or a house.

Unskilled occupation – not requiring special training, studies or skills, e.g. porter.

Note the use of **four times as** –, and **twice as** –, followed by **likely**. According to the text, if a lawyer has 1% probability of dying from lung cancer, a builder would have 4%.

emergence [ĩ-mûr'jəns]. emergency [ĩ-mûr'jən-sē]. lethal [lē'thəl)]. manageable [mānĩ-jə-bəl]. latter [lā'tər]. later [la'tər]. encourage [ĕn-kûr'ij]. disadvantaged [dĩs'əd-vān'tijd].

The Consultation

The patient-practitioner relationship is now considered as a “partnership”. In many circumstances the doctor also acts as the patient’s “advocate”.

Something as complex as the consultation in clinical medicine requires a number of tasks to be performed within the domains of:

- *skills (competences)*
- *knowledge (which is the basis of clinical reasoning)*
- *attitudes (that enable an effective clinical process)*
- *values (that inform individual integrity, probity and purpose)*
- *performance (disciplined and appropriate application)*
- *clinical experience that informs the other five domains*

Dysfunctional consultations are likely to occur when a clinician is seriously deficient in one or more of these domains.

The first task in every consultation is for the patient to feel valued and recognised as a person. Often the few patients who are habitually offensive or difficult in clinical encounters will respond well to explicit and consistent respect for them as persons.

The second set of tasks lies in clarifying the reason(s) for the consultation so both clinician and patient understand the agenda(s). This is what Tuckett has called “meeting between experts” because the patient is the expert in describing his/her own problems, but he/she may be poorly understood. The doctor is an expert in clarifying and re-framing the patient’s problems into a format that raises therapeutic possibilities.

The third set of tasks relates to achieving a shared understanding of each problem with the patient (and their family if this is appropriate).

The fourth set of tasks involves the clinician in any ongoing clinical problems or risk factors that merit evaluation. By implication this often means that the patient has not raised the issues spontaneously, and that the clinician has a comprehensive clinical record that reveals each problem and when it was last reviewed. Sometimes the clinician will have observed a new problem of which the patient seems unaware (a suspicious mole, anxiety, etc.). This task may need to be sensitively re-scheduled to a more appropriate time, but it cannot be abandoned completely in modern primary care.

There are **partners** of many kinds: the example, it refers to a relationship between doctor and patient, but there are also dance partners, business partners (or partners in business), sexual partners, etc. Nowadays, as people do not get married as often as before, the word “partner” is used generically to name husband, wife or the equivalent in a co-habiting couple. Warning: In the UK, family doctors (GPs) own private businesses with other GPs, so when they say “my partner”, make sure you understand whether they are talking about their personal partner or their colleague at the practice!

Advocate: somebody who acts or intercedes on behalf of another to protect their interests.

Inform: to give structure or substance to something.

Domain: area, field.

Skill: the ability to do something well. You may have many kinds of skills: clinical skills, social skills (if you are good at relating to others), physical skills (if you are good at sports, etc.).

Knowledge. Facts and information acquired by a person through experience or education.

Attitude. A way of feeling about something or someone typically reflected in a person’s behaviour. For example, if your attitude towards drug addicts is negative, you may not treat them effectively.

Values: principles. **Probity.** Decency, absolute moral correctness.

Performance: the action or process of carrying out a task, action or function.

To **feel valued** is to feel that you have value, that is, to feel appreciated, respected and admired as a person or professional.

Offensive patients are those who treat the doctor and/or staff with no respect. Language can also be offensive when it contains “bad” words, and a smell can be offensive when it is very strong and unpleasant.

Lie in – consist of, is based in.

Ill understood – not well understood, poorly understood. The meaning of “ill” here is not related to any “illness”.

Re-frame: to change the way of presenting something. A “frame” is what surrounds a picture on the wall – the picture may look quite different when you change the frame!

Shared understanding implies that both parties (doctor and patient) understand the problem in a similar way.

Merit: deserve, warrant. A problem that **warrants** evaluation is a problem that has potential for benefiting from evaluation. For example, in an episode of haemoptysis, we may say “This warrants a chest X-ray” or “It is worth doing a chest X-ray”.

Unaware: not conscious of, not informed of.

Re-scheduled: change to another day or time.

deficient [dī-fīsh’ənt]. occur [ə-kûr’] schedule [skēj’ōōl]

The fifth set of tasks involves consideration of primary preventive issues or interventions of relevance to health promotion. Every person has a set of well-proven benefits that come from primary prevention, but not every person is willing or ready to make the behavioural changes or to agree to the clinical interventions that will produce these benefits. The task for the doctor is to clarify what is desirable and appropriate under the circumstances of the consultation.

What underpins the consultation tasks?

A “model” is a precise but simplified representation for a complex system. It can be used to portray form or function and can sometimes be used in training. The clinical consultation is a very complex system that has been heavily influenced by the traditional medical case-history method. It is usually reductionist and focused on the pursuit of an accurate diagnosis.

In primary care, the clinical agenda may be focused on an important diagnostic problem and the reductionist traditional model becomes relevant and helpful. But, much more commonly, the presenting problem is either undifferentiated or straightforward and the agenda is wide and person-focused rather than disease-focused. The patient with problems in an evolving life cycle and changing context is much more challenging to professionals than the patient with a disease at one point in time.

The first task is to understand the reason for the patient’s attendance. Doctors employ a variety of opening gambits such as “How are you today?”, “What can I do for you today?” or just say nothing and allow the patient to start talking. Listening to the patient’s opening statement involves communicating interest and encouragement to continue by non-verbal behaviour, such as maintaining eye contact, adopting an open posture, facial expressions of interest, and by avoiding expressions of disinterest such as looking at the notes or gazing out of the window. Verbal expressions, such as “go on”, “I see” and “Yes” also convey interest. Allowing the patient to make an opening statement without interruption minimises the risk that “hidden agendas” will be produced later. This statement will trigger a hypothesis about the nature of the problem that will require further testing or exploration.

Exploration will include totally open questions such as “How are you feeling in yourself?”, or open focused questions such as:

Tell me more about your chest pain.

Have you noticed anything that brings it on?

What thoughts have been going through your mind?

What is your worst fear?

Set: group.

Well-proven: demonstrated by (research) evidence.

To be willing: to accept to do something without being forced; to be cooperative.

Underpin. To act as a support or foundation for something. “What underpins the consultation tasks?” means “What are the basis, principles and purposes of these tasks?”

Portray: describe.

Agenda. (a) A formal list of things to be done in a particular order, especially a list of things to be discussed at a meeting; (b) the various matters that somebody needs to deal with at a given time; (c) an underlying personal viewpoint or bias. This word is very commonly used to mean “purpose or motivation”, which may be open or “secret” (“hidden agenda”). We may talk about the “doctor’s agenda” as opposed to the “patient’s agenda”. Another common expression is the “political agenda”, which is what politicians really want to do, even if they do not say so.

Helpful: useful, offers guidance or help. **Unhelpful:** useless.

Straightforward. Uncomplicated and easy to understand.

Evolve: develop, change gradually over time. The noun is ‘evolution’.

Gambit: strategy.

Opening statement: a statement with which to start a conversation or speech.

Statement. A definite or clear expression of something in speech or writing. A psychotic patient, for example, may **state** that everybody hates him and are intending to kill him. Another use of “statement” is for written documents like the monthly movements of your bank account or credit card.

Convey: communicate.

Trigger: a stimulus (event or thing) that causes something to happen. For example, the trigger of an asthma attack may be the exposure to pollens.

A **focused** question is a specific (not general) question. To **focus** is to concentrate. When you are tired or sleepy you may say you cannot study or write because you are not “focused”.

How are you **feeling in yourself?** How are you feeling generally, physically and/or emotionally?

To **bring** something **on** is to make it happen, to trigger.

What thoughts have been **going through your mind?** – What have you been thinking or worrying about?

Other approaches to exploring a patient's ideas or concerns may include more explicit legitimisation of the topic. For example, "I am interested in hearing what you think yourself", or the use of an empathic statement such as, "I can understand that it might be worrying for you" followed by an attentive silence. When silence puts pressure on a patient the doctor can break it either by a supportive statement such as "This must be difficult for you" or by moving onto another topic.

Often closed questions need to follow, such as "Does the pain go down your arm?" if the doctor needs more information.

Non-verbal communication from the patient, such as demeanour and tone of voice, may give clues to their mental state, e.g. anxiety or depression, to their social situation, and to the way they relate to other people. This can also be explored verbally, e.g. "It seems to me that you are anxious about this, am I right?" or "You don't seem your usual self today".

Another source of information are the feelings that the patient engenders in the doctor – often "patients who make me feel anxious have anxiety, patients who make me feel depressed are depressed, and patients who make me feel confused are psychotic".

At the end of this process of exploration the doctor should be developing a picture of the patient and their problems. It helps to check with the patient that this understanding is correct by offering a summary starting with "Have I got this right" or "So, in summary ...".

Usually a decision will be made during the consultation. In a paternalistic model the doctor makes the decisions, and the patient is required to "comply" with them. In the informed patient choice model the doctor provides information about treatment options, and the patients make their own decisions. In a shared decision-making model a mixture of the above is applied.

Self-efficacy is a person's belief about his/her ability to achieve specific goals, e.g. losing weight, and can be enhanced by giving information, involving people in decisions and specific skills training.

We often close the consultation with a safety-netting process, explaining what the patient should do if things do not go according to plan or any unexpected events occur, e.g. "If you get a rash with the tablets, stop them and come and see me again".

Empathy. The ability to understand and share the feelings of another.

Note “**approach** to + **ing**”. “Other approaches to exploring” – “Other ways to explore”.

Note “**interested in + ing**”.

Demeanour. Visible behaviour, manner or appearance, especially as it reflects on character. The demeanour of your patients (what they do and say, how they do it and say it) shows you what they are like. Your demeanour with your patients will also show them what kind of doctor you are and determines whether you make them feel comfortable or not.

Summary is the short version of something. To **summarise** is to produce a short version, to sum up. Also, to summarise notes is to transfer their information from the paper records of a patient to their computer records.

Comply. To obey or conform to something, for example, a rule, law, wish or regulation. A patient complies with the doctor’s instructions or advice when he **adheres** to them (e.g. he takes his tablets as the doctor told him to). “Obedient” patients are said to be compliant or have good **compliance**.

A **shared decision** is a decision made both by the doctor and patient together.

A patient with high **self-efficacy** is one who is convinced he *can* do something, e.g. lose weight or quit smoking.

Enhance: make bigger or better.

Hidden agenda is used to name those matters that are not obvious initially but are in the mind of one of the parties. A patient may not say that he wants to stop working but may insist on reporting multiple symptoms to get a doctor’s certificate.

Safety netting is to create a net for safety.

Net is a mesh such as those used for catching fish.

Safety: protection from the risk of harm or injury. Note the difference with:

Security: protection from loss or crime.

Safety and security often go together and are sometimes used interchangeably. For safety, you should not take or prescribe high doses of a drug. For security, you should not leave your money on the desk (you may lose it). You may, however, say that it is not safe to leave your money on the desk as the expression “it is not secure” is not used; or, it “is not safe to leave your money on the desk because the building is not secure”.

Security is also used to collectively name the guards employed to protect people in public places (e.g. in airports, etc.). If you feel in danger you “call security”

demeanour [dī-mē’nər] enhance [ĕn-hāns’]

The patient can take time to consider decisions and choices before they are finally made, and this process of decision making can be assisted by decision aids.

In developing and maintaining the doctor-patient relationship we need (a) personal qualities, including warmth and a non-judgemental acceptance of the patient; (b) empathy, involving being able to identify and understand patients' thoughts and feelings and to see the world as they see it, e.g. "I can understand your worries about what this might mean"; and (c) trust, which can be defined as the patients' belief that the doctor should always act in the patient's best interests. Within a trusting relationship people can disclose their personal problems and accept advice.

It is argued that doctors find a sizeable minority of patients "difficult", and that they negatively label such patients. It has been estimated that British general practitioners have an average of six "heart-sink patients" per practitioner. These figures appear conservative compared with the United States, where primary care physicians have defined almost one of every six patients seen as "difficult".

Work on "good" and "bad" patients, and patients negatively stereotyped by doctors and nurses, also contributes to the understanding of why some therapeutic encounters may be problematic. Several characteristics have been associated with "difficult", "heart-sink" and "troublesome" patients; however, the evidence is equivocal.

Some characteristics associated with "difficult" patients are:

Frequent attender; demanding; cause despair, depression, anger, frustration and helplessness

Hateful; dependent clingers; entitled demanders; manipulative help-rejecters; self-destructive deniers; masochistic

Time-consuming; dissatisfied; able to abuse and manipulate those helping them; hypochondriac; thick charts; endless complaints

Knows-it-all; uncooperative; ungrateful

Low IQ; poor hygiene

Problematic doctor-patient relationships are medically, socially, financially and legally detrimental. Many solutions have been proposed. With regard to patients, these solutions include providing brief psychiatric intervention. With regard to doctors, these solutions include training attitudes and communication skills. Organisational recommendations include a reduction in workload and strategies to increase job satisfaction.

Aid: To offer help or support. Decision aids are charts or pictures that present information about choices in a way that it is easier to make a decision. **Aids**=plural for aid. **AIDS:** acquired immune deficiency syndrome.

Warmth. Enthusiasm, affection or kindness, heat.

Non-judgemental – not making any judgements, not thinking about whether the patient is good or bad, right or wrong, not prejudiced or biased against people.

Label: to classify as. To label negatively is to classify someone as “difficult”. Once you label a patient it is not easy to change your mind about them!

Heartsink is what (or who) makes your heart sink (submerge, go down although not literally). “Heartsink patient” is a common expression used for a “difficult patient” that makes you feel depressed when you have to see them.

Per: for each.

Stereotype. To categorise individuals or groups according to an oversimplified standardised image or idea. Stereotyping results in a **label** applied to the stereotyped person. For example, you may have stereotypes about drug users being aggressive, and this may give you a defensive attitude in consultation with all drug users.

Demanding people are those who are always asking or expecting things from you. A demanding job or task is one requiring a lot of time, attention, energy or resources.

Despair: loss of hope.

Anger: a strong irritation against somebody or something.

Helplessness: the feeling that nothing can help.

Clinger. Somebody who depends upon others for reassurance and a sense of security. To cling to somebody is to be dependent on somebody.

Entitled: with rights or privileges.

Reject: say no to something.

Charts in this context are medical records.

Endless: with no end.

Ungrateful patients do not show gratitude, thanks or appreciation. When a patient is unhappy about an encounter with a doctor they may say “I was not impressed”, which really means that they got a very bad impression of that doctor and did not feel that their needs had been met. When a patient is very happy after a medical encounter they may say “I was very impressed”.

IQ ★. Intelligence Quotient, intelligence coefficient.

Detrimental: producing a negative effect.

Workload is the amount of work you have. If you have a high or heavy workload, you will need to work many hours a week, and you will probably be very tired and unable to see your friends and family.

Shared decision making has become a term used to describe the process whereby patients participate in decision-making processes about health care issues, typically in consultations, but increasingly by using other media, such as interactive technologies.

Medical sociologists have described the physician-patient decision-making process as one that has a high probability of conflict because of the different agendas brought to the encounter and the different types of discourse used to discuss health care concerns. Health economists have raised the issue of agency, the term given to the role taken when one person acts on behalf of another.

The decision may be to “do nothing”, although patients may find this difficult to accept and it is best to use a more positive term such as “watchful waiting”.

Often a prescription will be the result of the decision-making process. The model called “concordance therapeutic alliance” draws on the concept of achieving “concordance” about taking medication (an agreement between the patient and the clinician) – an alternative, less coercive term than the notion of “compliance”.

In the twenty-first century time is a precious commodity. In many health care systems in the industrialised world, time dictates the quality of care provided to patients. The length of the consultation varies around the world – ranging from 10 min in the UK to as long as 21 min in Sweden.

It has been argued that to achieve better patient satisfaction, time must be taken to “chat” about topics of a non-medical nature in order to help the patient connect with the clinician, and sufficient time must be taken when providing patients with feedback on clinical findings. Also, certain kinds of patients, such as those with psychosocial problems or the elderly, require longer consultations. Clearly, when physicians spend more time with patients they are more likely to discuss psycho-social issues and to engage patients in an explanation of the problem and the proposed management plan. An initial investment in time with the patient may well save time and resources in the future.

Many clinicians now have full electronic records and are moving towards embracing the concept of “The Paperless Practice”. With computers helping us to make clinical decisions, information technology has the potential to be the cornerstone of the delivery of evidence-based health care. Although clinicians lacking computer literacy may feel threatened by the technological revolution, there is no escape, as patients do expect their health care providers to have accurate, up-to-date and accessible medical records.

Whereby: by which.

Issue. An important topic or problem for debate or discussion. You should really learn this word – you will see it everywhere!

You do something **on behalf of** someone when what you do is not for yourself but for that other person. For example, a receptionist on the phone might say, “Hello, Mr. Smith, I am calling on behalf of Dr. Jones ...”.

Watchful waiting is what you do when you ask the patient to do nothing but wait and observe the symptoms, and come back if they persist or change.

Concordance happens when the patient does what the doctor says because he agrees with it. Compliance happens when the patient does what the doctor says for any reason, including simple obedience.

Coercion – to **coerce** is to force to do something.

Commodity. A useful or valuable thing.

To **argue** is to defend an argument or theory, or a reason for doing something. A different meaning in other contexts is to quarrel (fight verbally). When you have an **argument** with somebody you may end up being angry with them. A **discussion**, however, does not imply a disagreement, it is only an exchange of ideas.

The **length** of something tells you how **long** it is.

Chat – to chat is to simply have a conversation in an informal or relaxed way – either on the Internet or in person.

Elderly are people of old age. “Old-age pensioner” is sometimes abbreviated in writing OAP.

Embrace: adopt, accept with enthusiasm.

Is your practice “paperless”? – Do you use no paper? Do you do it all on the computer?

Cornerstone (the stone in the corner): somebody or something that is fundamentally important to something. If you remove the cornerstone, all the structure (e.g. a building) falls down.

Up-to-date: updated, containing the latest information. The opposite is

out-of-date: missing recent information. For example, a record is **updated** if it includes what happened yesterday, but it is **outdated** if there has been no information since 1998, and the patient has consulted a number of times since. You can also, as a doctor, be updated if you study regularly, but if you do not, your knowledge will become outdated.

Accurate: reflecting the exact truth.

Issue [ɪʃh'ōō] accurate [āk'yər-īt]

Diagnosis and Decision Making

Complaints that do not allow a diagnostic conclusion are often labelled as “vague”. In the patient’s view, however, complaints are rarely “vague” but quite definite and real, despite any difficulty expressing them. Such complaints, therefore, are better described as “medically unexplained”; however, it is not easy for the doctor to say “I’m afraid I cannot find the cause of your complaint” and these patients tend to be over-investigated.

Complaints are unexplained when after adequate history-taking and physical examination, taking psychological and social circumstances into account, no definite conclusion can be drawn. The Dutch guideline advises general practitioners to refrain from blood tests for at least 4 weeks after the first presentation to the general practitioner of an unexplained complaint.

In the classical taxonomy, a disease is defined as a set of (closely) related signs or symptoms, with a specific aetiological background, a plausible physiological pathway, a predictable natural history and the need for a specific therapy. In everyday general practice, however, this is rare. Symptoms presented are often non-specific, or combinations of symptoms point to more than one diagnostic direction (e.g. heart failure). Sometimes several unspecific signs or symptoms are grouped in new diagnostic entities such as chronic fatigue syndrome (ME), fibromyalgia, irritable bowel syndrome (IBS) and repetitive strain injury (RSI). Strictly speaking, none of these syndromes are diseases, and the fact that their definitions are no more than descriptive allows for the conclusion that they are as yet ill-defined.

Unexplained complaints and ill-defined syndromes together form the group of uncertain diagnoses. Uncertain diagnoses lead to uncertain management often with blind testing and treating.

The development of medical expertise is a long process, from the factual knowledge learnt in medical school to its wise application in established practice.

The three steps involved in clinical diagnosis are (a) generating diagnostic hypotheses, (b) imposing a hierarchy on them and (c) establishing a definite diagnosis by recognising diagnostic patterns, using diagnostic algorithms and ruling in or ruling out a particular diagnosis.

Complaint – In the clinical context it means “illness or medical condition, especially a relatively minor one (although not necessarily)”. When we take a clinical history we will normally write “the patient complains of ... pain ...” (often abbreviated as “c/o”); however, the more general meaning is “expression of dissatisfaction”, so a patient who is unhappy with your care may “write a complaint” and give you a hard time. Formal complaints will be addressed by the practice manager or the clinician; occasionally they may lead to legal action.

Vague: not defined.

Unexplained – no cause has been found for it.

Allow: permit.

Ill-defined: poorly defined or explained, vague.

Uncertain: in doubt.

Lead to: provoke.

Note that “**diagnoses**” is the plural for “**diagnosis**”.

Note that “**hypotheses**” is the plural for “**hypothesis**”.

Blind: unable to see.

Expertise: expert skill or knowledge in a particular field. **Experience:** practical contact with something. To develop expertise you need to have experience (as much as possible), but to have experience does not necessarily mean you have expertise. To develop expertise in medicine you need to learn from a combination of experience and study.

Hierarchy: categorisation in groups by importance. There is military hierarchy, clerical hierarchy, family hierarchy, diseases hierarchy, etc.

Factual: related to facts. Factual knowledge includes the theory about physiology, pathology, pharmacology, diseases description and prevalence, treatments evidence, etc.

Wise: sensible, good, intelligent. **Sensible** is what makes sense, what is reasonable, what sounds like the best option or course of action. **Sensitive** means very reactive, quick to respond – a test is sensitive when it easily finds abnormalities, a person is sensitive when they are easily affected by negative stimulus or when they are able to understand other people’s feelings (which is how doctors are supposed to be!).

Definite: clear, distinct and certain. **Definitive:** final and unquestionable. *A skin lesion may have definite borders; skin cancer is only a definitive diagnosis after biopsy.*

Pattern: a regular, repeated way to present.

Algorithm – Step-by-step guideline usually presented as a **flowchart** with lots of boxes and arrows where you follow a path according to the specific situation considered.

Rule out: discard, not to consider that particular option. You request an ECG and troponin levels to rule out an infarct in atypical chest pain. **Rule in** is the opposite.

algorithm [āl'gə-rĭth'əm] but rhythm [rĭth'əm]

Doctors take the evidence about the patient's problem and make judgements about its most likely diagnosis and best management. Clinical judgement is at the heart of the medical profession.

The exercise of judgement in medicine is complex, as it involves decisions to be made not just between many propositions or options but also that take into account issues involving patients' understanding, fears and desires, as well as those of the clinician and those of society (in the case of rationing).

In self-limiting illnesses, the therapeutic effect is related to the passage of time, the pathological processes and to the body's own defences and self-healing mechanisms. The role of the clinician is generally to help, ameliorating the symptoms if possible. Sometimes treatment is given for its placebo effect despite lack of evidence of its effectiveness.

Classically, the diagnostic process comprises history, examination and investigation. It has been suggested that within primary care the first two of these processes are most important, yielding around 90% of diagnoses.

Near-patient testing can be done in primary care, for example, with urine dipsticks and capillary glucose testing, using reagent strips.

A test is valid when it actually measures what it aims to measure. Accuracy refers to the degree to which the measurement of substance "X" contributes to the diagnosis. Reliability refers to how consistent the results of a test on a day-to-day basis are and how the results compare with an external standard. Precision describes the statistical variation of a series of results based on the same sample.

Primary care is generally perceived as a low-tech environment. For more complex tests a referral to the hospital or local laboratory is usually required.

Busy clinicians are caught in an information paradox: overwhelmed with information but unable to find the knowledge they need when they need it.

The enormous expansion in medical information and the drive to deliver evidence-based clinical practice make traditional approaches increasingly untenable. Computer decision support has the potential to influence and support the consultation by bridging the gaps that exist and by presenting information that can be readily shared with the patient.

At the heart: in a very central place (“core”).

Judgement: the ability to make considered decisions or come to sensible conclusions, or an opinion or conclusion. An example of the first meaning is that you may judge a patient to have pneumonia and give him antibiotics. An example of the second meaning is that you may judge a patient to be a social parasite if they do not go to work for no apparent reason.

Take into account: consider, include.

Desires: wishes.

Self-limiting illness are those which resolve without intervention, e.g. common colds.

Heal: become healthy again; or make someone or something become healthy again.

Ameliorate: make better, improve or palliate.

Despite: in spite of, even with, without being affected by. **Yield:** produce.

Near-patient testing refers to all the tests that can be done in consultation, without sending the patient somewhere else.

Dipstick: a stick or strip that you place into a liquid to measure or test it. A urine dipstick is the name of the test in which you introduce a dipstick into a bottle of the patient’s urine.

Measure: to find out the size, length, quantity or rate of something using a suitable instrument or device.

Accuracy: (technically) the degree to which the result of a measurement conforms to the correct or real value; it refers to the veracity of the measurement. In daily life, you may say that “the Internet gives patients inaccurate information”.

Reliable: consistently good in quality or performance, able to be trusted, trustworthy, able to be relied upon.

Consistent: that does not change over time or on repetition, that is always the same in a considered quality.

Low tech: low technological, as opposed to **high tech**, which refers to sophisticated and expensive technology.

Overwhelmed: inundated.

Drive. An organised effort made by a lot of people working together to achieve a particular goal.

Untenable – it cannot continue because it is useless or unacceptable.

Bridge the gap – There are gaps (distance) between what we know and what we need to know. To bridge these gaps is to “build a bridge” to reduce this distance by satisfying the need for knowledge.

Readily: easily, quickly, conveniently.

laboratory [US: lāb'rə-tôr'ē], [Brit.: lə'bɒrətɹi] please do not say lavatory [lāv'ə-tôr'ē] which means wc. busy [bɪz'ē]

Management of Individuals

The idea of patient management is about addressing the patient in their biomedical as well as social and psychological context. It is about treating patients, not diseases.

Patients expect their doctors to be knowledgeable and authoritative, yet kind and empathetic.

The patient-centred doctor will transmit information in a simple, non-judgemental and non-jargonistic fashion, and will make sure any misconceptions or misunderstandings are corrected and the patient's needs are met.

Although the term "education" may imply exerting some "power" over the patient, the same cannot be said for the terms "advice" or "counselling". These terms, at least on the surface, imply that one party holds the useful information and the other party is in search of this information. In commercial terms one is the provider and the other a purchaser. In a consultation a mixture of education, advice and counselling may well take place.

Some structured forms of counselling are used for some psychiatric disorders, but more common less structured forms are used as supportive therapy to help patients cope with their problems or change their lifestyle.

Risk is the probability that a hazard will give rise to harm. When presenting information about risk to a patient, we can present it in different ways, which may produce different decisions. Framing is defined as presenting "logically equivalent information in different ways". For example, the risk of major osteoporotic fractures is 12% in women who take HRT for over 15 years and 15% in those who do not. We could express the figures as "3% more people remaining free of fractures with HRT" (positive framing) or "3% more people suffering fractures if not taking HRT" (negative framing).

Doctors vary not only in the kind of medication they choose to prescribe, but also in the choice of initial dose and titration. Using the example of inhaled steroid therapy in asthma, some doctors would start with a low dose and titrate the dose upwards until the symptoms are controlled, and others would start with a much higher dose to gain symptom control quickly and then titrate the dose backwards to the point of breakthrough symptoms.

Authoritative. In the text it means convincing, reliable, backed by evidence and showing deep knowledge. In other uses, it means “showing that the person is used to being obeyed or expects to be obeyed”.

Yet – in spite of that.

Jargonistic: Using **jargon**: specialised language, in this case, medical language.

Fashion: (a) way, manner; (b) the prevailing (most common) style or custom, as in dress or behaviour.

Misconception. Mistaken idea or view resulting from the misunderstanding of something. **Misunderstanding.** Failure to understand or interpret something correctly. Patients may *misunderstand* you on occasion and this is why you should make sure that they understand everything you tell them. Patients may have the *misconception* that antibiotics are a treatment for a cough.

Advice: guidance, recommendation. To **advise** is to give advice, to offer somebody an opinion about what they should do. Also, to advise is used as a formal term for “say” or “inform”. “The doctor advised the patient that his results were normal”.

Counselling. The provision of assistance, guidance and support on a personal or psychological matter, usually in a professional context. In general, the term counselling refers to brief forms of psychological intervention for general psychological problems, usually by a counsellor or a clinical psychologist; however, there are also specific forms of counselling, such as the one provided before an important test (HIV serology), called pre-test counselling.

Purchase: to buy.

Cope. Deal effectively with something difficult. Typically, patients will find ways to cope **with** their diseases or problems, i.e. to live with them in the best possible way they can. When you ask a patient “How are you?” and they reply “Coping ...!” they mean they are having difficulty but they seem to be in control of the situation. When they say “Doctor, I am not coping!” they mean that the situation has become too difficult for them and they are “falling” under its pressure. You may, of course, say you are “coping” when asked “How are you?” on a busy day!

Risk: probability that something bad will happen.

Hazard: something that is potentially very dangerous.

Harm: damage, injury, destruction.

You **have a choice** when you can choose between different options; you **make your choice** when you decide which option you will take.

To **titrate** a dose is to monitor the condition, levels or side effects and adjust the dose accordingly, by increasing or decreasing it in several steps.

Upwards: in the “up” direction – increasing dose.

Breakthrough symptoms refers to the re-appearance of a symptom (typically pain) when the drug levels are low.

The problem of non-compliance (also referred to as non-adherence) is long standing, extensively documented, and largely unsolved. **Adherence** is the extent to which patients follow the instructions they are given for prescribed treatments. Typical adherence rates are about 50%. While **compliance** refers to something that patients do or not do with their medicines, **concordance** refers to a relationship between two or more parties. A patient can be non-compliant, but an individual cannot be non-concordant. Only a consultation or a discussion can be non-concordant. Concordance is a new approach to the prescribing and taking of medicines. It is an agreement between a patient and a health care professional that respects the beliefs and wishes of the patient in determining whether, when and how medicines are to be taken. General practitioners cannot force people to take medicines against their will.

The point of concordance is to identify any differences in patients' and practitioners' perspectives, whether due to doctors prescribing treatments patients are unwilling to take, or patients wanting treatments that doctors are unwilling to prescribe, so that these can be discussed and negotiated. The outcome of a concordant consultation may be an agreement to differ. The point of concordance is not necessarily to change patients' behaviour, but to bring these differences into the open for discussion and negotiation.

Continuity of care is a phrase often used to describe the extent to which patients see the same practitioner or visit the same facility from one visit to another over a period of time. Together with communication skills and the consultation, continuity of care is probably the most important tool in general practice.

Complementary medicine (CM) refers to a group of therapeutic and diagnostic disciplines that were developed and have existed largely outside the institutions where conventional health care is taught and provided. Examples of such therapies include acupuncture, chiropractic, herbal medicine, homeopathy, hypnosis, massage, and yoga. In the UK, osteopaths and chiropractors are state registered and regulated, and other disciplines are likely to follow.

The WHO defines **palliative care** as the active total care of patients whose disease is not responsive to curatives. Many doctors and nurses feel it is important that they offer a positive outlook on treatment options – in some instances so that they can maximise the potential benefits of any placebo effect; however, the issue of withholding and withdrawing treatments may be an ethical dilemma – the patient's wishes need to be taken into account. Dealing with the family is also an important role in primary care, from the management of disclosure and breaking bad news to bereavement support. **Bereavement** refers to the loss of a person. **Grief** describes the feeling resulting from loss at the time of the loss and afterwards.

Long standing – has been present for a long time.

Will. The power to make decisions.

If somebody is **unwilling** to do something, it means that they do not want to do something.

Differ: disagree; or: be different.

The point of something is the significant or essential element, often the purpose. You may say “There is no point in prescribing a higher dose if the patient is not going to take the tablets” – it is useless to do it, it is “pointless”. In a discussion, you may wish to “**make the point**” that statins are as beneficial for the elderly as they are for the younger patients, and you present an argument to support the point that you have made. You say that your colleague “**has a point**”, however, if he replies that the side effects of statins in very old patients may be greater than the benefits – you consider this to be a valid argument.

Bring into the open: uncover, make explicit.

Laud: to praise, glorify, say very good things about something or somebody.

State registered: recognised by the state, in the official lists of approved practitioners.

To follow: To go in the direction of; be guided by, to adhere to; practice, to act in agreement or compliance with; obey. Sometimes we say “to follow suit” (to do the same): *Nurses’ salaries are being increased and doctors’ salaries will follow suit.*

Outlook. A person’s point of view or general attitude to life. Another meaning is that of “prospects for the future”, e.g. the weather, “the outlook for the weekend is mainly high temperatures and sunshine”.

Withhold treatment – not to give treatment, to deny it.

Withdraw treatment – to stop or interrupt a treatment.

Disclosure. The act of making new or secret information known. To **disclose** is to reveal.

Breaking bad news: disclosing bad news for the first time. You should expect the recipient of the message to be emotionally affected. For example, you might have to tell a patient that they have cancer and this may come as a shock.

Bereavement: situation of loss due to a loved one’s death. **Grief** is the emotional reaction to bereavement, characterised by three aspects: the necessity to cry and search for the lost person; the necessity to repress crying or searching, and the necessity to review and modify internal models.

Afterwards: later. Note that you cannot end a sentence with “after”. “After” is only used between two events mentioned, e.g. “Grief is the feeling you get **after** a loss.”

bereavement [bɪ-rēv’ ment] grief [grēf]

Integrated Management

Information continuity is provided by integral medical records and longitudinal continuity is provided by a relationship with a regular or usual doctor. Cross-boundary continuity concerns coordination of a patient's care between specialists and across institutions, and involves direct mechanisms and communications (spoken or written) to supplement shared records.

The core primary care team consists of general practice, home care and perhaps social services, depending on national or local policy. The team can also include physiotherapists, speech therapists, midwives and pharmacists.

In practices with personal lists, patients need to register with one particular doctor and are only allowed to use this doctor every time. In practices with shared or combined lists, patients register with the practice (team) and are allowed to see any doctor they wish. There are pros and cons to both systems – the former facilitates access and choice, the latter ensures continuity. An intermediate option is to allow free access but encourage patients to stick to a usual doctor (or two) of their choice.

Patients may choose alternative access to primary care, bypassing the GP:
 (a) *Many A&E departments cater for primary care patients, whether attending out of hours care (OOH) or merely because access to their GP is inconvenient.*
 (b) *The development with the most apparent potential to reduce coordination is walk-in clinics. These clinics are particularly suitable for patients seeking care near their workplace where this is inconveniently far from their home GP, for example, for employees in large cities who commute to work.*
 (c) *Some countries have a comprehensive telephone advice service available 24/7. In the UK this is called NHS Direct and it is staffed entirely by specially trained nurses working from carefully designed protocols.*

With regard to coordination with the private sector, this tends to be weak in countries where most health care is delivered through the public sector, and private-sector care is reserved for small numbers of patients who are relatively well off; however, in other countries, such as the United States, there are formal mechanisms for coordination between these different health care providers.

Cross-boundary: not limited to one context but across several contexts, crossing their boundaries or frontiers.

Boundary: frontier. You may say a patient has “problems with boundaries” when he makes inappropriate demands or treats the clinician inappropriately, e.g. tries to involve the doctor at a personal level.

Concerns – refers to.

Note the use of **between** (when two elements are mentioned) and **across** when more than two elements are implied.

Speech and Language Therapist (SALT): helps patients who have problems speaking (children with developmental problems, aphasic patients) or swallowing (elderly).

Pros and cons: advantages and disadvantages, good things and bad things.

Encourage: persuade, promote.

Stick to a doctor means always seeing that doctor, and not another one. To stick to a rule means to obey that rule.

Of their choice – the one they choose. **Out of choice:** by free decision. “*Are you a doctor out of choice or because your parents wanted it?*”

Bypassing – ignoring, not using, passing by.

Cater for: try to satisfy a need or demand.

Walk-in: without the need to book an appointment.

An **employee** is a worker employed by an **employer**.

Commute. To travel some distance between home and the workplace on a regular basis. A commuter is a person who commutes, typically by train and underground, usually from the periphery of the city to the centre. Some French GPs commute from Paris to London weekly!

Note the use of “**staff**” as a verb and “**staffed**” as an adjective. “Is your practice well staffed?”

Weak: with little strength.

Deliver – take to. When you order a pizza on the phone, a person will come on a motorcycle and “deliver” it to you. Also, pregnant women, after 40 weeks, “deliver” their babies (although they do not normally give them to anybody else!).

Well off: wealthy, rich.

employee [ēm-ploi'ē] employer [ēm-ploi' er].

The majority of patients who consult a primary care practitioner are dealt with entirely within primary care. Most European countries average referrals from between 4 and 6% of consultations.

The liaison between health care workers is essential for integrated management.

Communication is often poor between GPs and specialists. Letters to specialists may not contain information about the patient's previous problems or their medication, and the specialist's response is also often poor. Advances in information systems that allow better sharing of information across the primary-secondary interface have great potential to improve care in the future. Sharing information across health sectors (including pharmacists) is an essential prerequisite for the cultural change that needs to take place if the overall care of patients is to improve.

Some countries use GPs as coordinators and advisers in hospitals. One of the tasks of GP advisers is to draw up local guidelines or translate national guidelines on the basis of equal cooperation between local stakeholders.

General practitioners with special clinical interests (GPSCIs) are primary care physicians who dedicate part of their working time to a specialised area. They are not, however, the same as specialists working in the community. An asthma GPSCI will treat an entirely different population than a hospital doctor specialising in respiratory illness; GPSCIs will generally deal with mild or moderate cases and focus on daily management and quality of life, while hospital specialists will focus on pharmacology and management of more severe cases in order to avoid disability and death.

In daily practice, most primary care professionals will have experienced the negative impact of poor communication, and some may themselves have contributed to these problems. GPs and specialists often do not communicate adequately, and sometimes they do not communicate at all. In one Spanish study, GPs received a discharge letter in only one-fourth of cases.

Possible methods of improving the standard methods of communication include: (a) standardised referral letters, containing all the information required by the specialist; (b) patient-held records, which are useful in antenatal care or home care; and (c) joint consultations by GPs and specialists.

Dealt with – managed.

Liaison. Communication or cooperation that facilitates a close working relationship between people or organisations. “I will liaise with the practice nurse to keep your blood pressure under control”.

Overall: general, considered as a totality.

If the care **is to** improve – the result expected is that the care improves.

Adviser: a post that mainly involves giving advice to specific persons or organisations. A GP adviser gives advice to hospital and practice teams. A Sexual Health Adviser gives advice to patients who require it.

Draw up: design.

Stakeholders are all that have an interest in something. If we decide to draw up guidelines on epilepsy management, we may wish to consult all stakeholders: epileptic patients, hospital specialists, primary care teams, PCT or equivalent funders, academic organisations such as the Royal College of Neurology, pharmacists, drug companies, etc.

GPSCI = GPwSI = GP with Special Interest. Note that it is pronounced similarly to “**gipsy**”, which has a very different meaning: a member of the travelling people with dark skin and hair who speak Romany and traditionally live by seasonal work, itinerant trade, and fortune-telling.

Discharge letter is what you receive (or not!) from a hospital doctor who has seen your patient while they were admitted.

Discharge is also an abnormal fluid that comes out of a bodily orifice or wound (excretion, secretion, exudate, transudate, mucus, pus, etc.).

Standardised: uniform in structure.

Patient-held: held by the patient, e.g. a record that the patient holds or keeps in their home.

Joint: done together. Both the GP and the specialist see the patient at the same time. A **joint** is also an anatomical structure between two bones.

discharge [dīs-chärj’]

-After discussing the case with the HV, the social worker, the paediatrician, the child psychologist and a few more, I am slightly concerned that there might be something wrong with this child...

LALANDA



Family Medicine

Most of the stressful life events that have been associated with poor outcomes occur within the family. On the other hand, the presence and number of living adult children are the most powerful predictors of survival in the elderly. Family support and family stress, especially bereavement, can have a powerful influence on health and mortality.

From the systemic point of view, the family is more than the sum of its parts. A change in one family member affects the other members and the family as a whole. The family physician often has to address who has the power and authority in the family, often called the family hierarchy. When a child holds too much responsibility or power in a family, he or she can be considered “parentified” and at risk for physical and mental health problems. The child might also function as a scapegoat in a family where his or her symptoms reflect problems for the family as a whole.

Individuals in enmeshed (highly cohesive) families have little separateness or autonomy and overreact to the thoughts and emotions of other family members. In disengaged families, individuals are emotionally distant and unresponsive to each other. Triangulation occurs when a family member or health care professional is drawn into a conflict between two other persons. Family members will often attempt to get their family physician to take sides in any family conflict.

Health professionals all over the world are challenged to provide appropriate care for an increasingly diverse population. Beliefs and attitudes about health and illness differ greatly among ethnic and socio-cultural groups, thus affecting therapeutic relationships, diagnosis and treatment outcomes. Clinical impasses, such as poor response to treatment, non-adherence to treatment and doctor-patient-family conflicts, are likely to occur when cultural orientations between patients and their families, physicians and/or the medical system clash. It is, however, important to avoid stereotyping.

The following case vignette highlights how family, culture and health care are intertwined realities. More specifically, it illustrates how cross-cultural differences related to values, to communication styles and also to notions about families affect the therapeutic relationship and treatment decisions:

A European-American physician in the United States approached a 65-year old woman (an immigrant from Trinidad of African descent)

Outcomes: results.

On the other hand – in contrast to what has been just said. Often, when we mention two contrasting realities we say, for example, “**On one hand**, relationship with patients may be gratifying; **on the other hand**, daily consulting may be tiring”.

Adult children. This may sound like a contradiction, but note that “children” may mean either (a) young person, or (b) son or daughter. An old man would speak, for example, about his “children”, who are married (adult children), and his “grandchildren”.

Powerful: having or capable of exerting power; full of power.

As a whole: considered as a totality, as a global unit.

Scapegoat. One that is made to bear the blame of others. In this case, when one or both parents unjustly blame a child for the problems of the family, instead of assuming their own responsibility for their own mistakes, we say they are using the child as a “scapegoat”, or they are “scapegoating” the child. Parents may make the child feel guilty by saying to him “It’s all your fault”.

Blame: assign responsibility for a fault.

Guilty: responsible for a crime, wrong action or error.

Cohesion: tendency to be or work closely together as a unit.

Overreact: react in excess. Sometimes patients become too anxious over a minor health problem, believe you have not done enough for them, file a complaint and come later saying “Sorry, I think I overreacted”, i.e. the reaction was unjustified or disproportionate.

Disengaged: emotionally detached, separate.

Drawn into: taken into.

Take sides: be in favour of one of the parties involved.

Diverse – composed of many different kinds of people.

Thus: in this way.

Impasse: a point at which no further progress can be made.

Clash. Be incompatible.

Vignette: a brief story used as an example.

Highlight: to draw attention to something; to make very evident. **Highlighter** – the fluorescent pen or marker you use to highlight words or sentences in papers or books.

Intertwined: closely inter-connected or inter-linked.

Cross-cultural differences – differences between cultures.

Approach: to speak to somebody with a view to asking for something or discussing a matter.

Descent – origin.

cohesive [kō-hē'siv]

hospitalised with terminal cancer, to tell her about her diagnosis. However, the patient was unwilling to talk about her illness, and deferred treatment decisions to her family. The physician, concerned that the patient was unaware or in denial of her condition, tried to elicit her daughter's support. To his surprise, they insisted that he not tell their mother the diagnosis.

In some ethnic or socio-cultural groups, health and illness are considered family matters, not individual issues. The family is an active participant in the treatment process and often takes charge of treatment decisions for the ill relative.

Family members are often present in the consultation. In many instances, the family member might simply accompany an ageing parent, a spouse, or an adolescent on a routine visit. Often there is one member of the family who enjoys high credibility regarding matters of health – this influential person has the ability to support or undermine the physician's recommendations.

Sometimes the doctor actively invites other members of the patient's family to attend. The following examples illustrate how one justifies an invitation to the family:

"The decision to undergo a surgical procedure is difficult and complicated. I would suggest that we all meet to discuss the pros and cons".

"My guess is that your husband would also like to know how smoking affects the children's health and what effective ways there are to help you stop smoking".

"I understand, from what you tell me, that your family is worried about you and, therefore, I believe that by meeting with them I will be able to assist them to overcome this worry".

Exploring the patient's and family's emotional response to an illness can be addressed with "functional" questions:

Is this condition temporary or a long-term problem?

How are you feeling about all this?

How has this affected each of you?

How are you each coping with this?

What will happen if there is no effective treatment right now?

Genetic disorders is an area of growing interest. Genetic counselling is the process by which patients or relatives at risk of a disorder that can be inherited are advised of the consequences of the disorder, the probability of developing or transmitting it to their offspring, and of the ways this can be prevented, avoided or ameliorated. There are many instances in current practice where primary care practitioners undertake genetic counselling without recognising it as such. It is routine practice, for example, to elicit a family history of cardiovascular disease and use this knowledge, together with other factors, to discuss cardiovascular risk with a patient.

Defer. To submit humbly to another persons' wishes. Another use is: to put off something for a later time, to postpone.

Unaware – did not know her diagnosis.

Elicit – get.

They **insisted** that he not **tell** the diagnosis – They insisted that he **avoid** telling the diagnosis – They insisted that he **hide** the diagnosis. Note that the infinitive is used: not “tells” or “avoids” or “hides”, as would be applicable to the second person singular; however, you would say “They **insisted on** him not **telling/hiding** the diagnosis”.

Take charge: assume responsibility for. Note also the use of **in charge** (of): “*Primary care nurses are in charge of chronic disease management*”. When you go to a shop and you want to speak to the boss or manager to complain you may ask “*Who is in charge here?*”

Relative. Somebody who belongs to the same family (parents, brothers, cousins, etc.). Typically, when a patient cannot speak for himself, you will ask to speak to a relative.

Spouse: husband or wife.

Note the use of the preposition: **on** a visit.

Note that the term “enjoy” does not always imply “pleasure”. In this case it refers to the “privilege” of being trusted.

Undermine: diminish or weaken.

Attend: come to the surgery, come to see the doctor.

Undergo: experience or be subjected to something (typically something unpleasant or painful).

Guess – what your intuition tells you.

Overcome: succeed in dealing with a problem. You may “overcome the obstacles” to achieve an objective.

Right now: immediately.

Familial cancers. *The inherited cancers, and in particular breast, ovarian, and colorectal cancer, provide a clear example of the potential clinical applications of research arising from the Human Genome Project. In the past decade, several genes have been identified that, when mutated, place an individual at a very high lifetime risk of developing specific cancers. These mutations are rare in the general population and account for only a small proportion of such cancers even in patients with a family history of cancer. In the future, screening in primary care for a family history of specific cancers will be appropriate once stronger evidence exists for at least one intervention for that specific cancer, be it chemoprevention, screening or prophylactic surgery.*

Family types. *In pluralistic multicultural societies, there is a broad range of diverse family forms and styles of organisation and functioning. This includes nuclear, extended, single parent, grandparent, foster, reconstituted, and same-sex family types. All of these may function in a paternalistic or maternalistic autocratic manner, or in a more democratic way, or have a laissez-faire process, where generational boundaries are eliminated.*

Disability. *The major conditions that create homebound patients are arthritis, cancer, dementia, heart disease (CHF and IHD), COPD, neurological conditions (disc and joint diseases), para- and quadriplegias and fractures in the frail or elderly. Spinal conditions (disc and joint diseases) often aggravate other conditions and lead to increased immobility. People who live alone complicate many of the above conditions and are a challenge to the health care team. A home care team would assess and review the activities of daily living (ADL – bathing, dressing, eating, toilet, mobility), instrumental activities of daily living (IADL – paying bills, preparing meals, light housework, use of the telephone) and specific functional activities such as walking and stair climbing.*

Family violence. *In families with child abuse, one can often detect wife abuse, and vice versa. Perpetrators of all types of family violence are more likely than non-perpetrators to have been victims of abuse as children.*

In many countries, physical aggression towards children is widely accepted as a method of shaping children's behaviour. Arrests for hitting children are rare, except in the most shocking circumstances. After Kempe published the landmark article on the "Battered Child Syndrome" in 1962, the United States drew the line against the most severe types of harm towards children. Sweden has banned corporal punishment of children altogether, and eight other European countries have followed suit.

Offspring: children, descendants. **Undertake:** do.

Without recognising it **as such** – without recognising it as “genetic counselling” (mentioned previously).

Routine practice: normal, usual practice.

Familial. Relating to or involving a family. In the text, it refers to genetic or inherited conditions. Note the difference with: **Familiar.** Well known, commonly seen or heard, easily recognised. “*When you come to work in the UK, it takes you some time to become familiar with the NHS system*”.

Lifetime risk – the risk in the entire life of the person.

Rare: infrequent. It also means raw (not cooked), but it does not mean “strange” as some may think.

Account for – represent.

Note the use of “**be it**” before you mention a list of possibilities.

Disabled. Referring to people who have either physical or mental impairments, which make it difficult for them to perform the basic tasks of everyday life. The impairments themselves are termed *disabilities*. Elderly patients often develop disabilities and become dependent on their family or care services.

Housebound or homebound – Restricted or confined to home due to illness. Similarly, we use the terms “chairbound” or “bedbound”. Housebound patients cannot come to the surgery and require home visits.

Bills – electricity bills, telephone bills, etc.

Housework – cleaning, cooking, ironing, etc. Do not confuse with homework, which is work given to children by their school to do at home.

You can **climb up the stairs**, then you **go down the stairs**.

Abuse. Treat with cruelty or violence, especially repeatedly or regularly. In the text it refers to serious mistreatment, especially **child abuse**. In other uses, however, we may say that a patient was “**abusive**” to the receptionists if he was disrespectful or insulting. Abuse also means “to use something to bad effect or for a bad purpose”; thus, we say a patient might have a problem of “**drug abuse**”, “**alcohol abuse**”, etc., or that they “**abuse the system**” when they always come as “urgent”, etc.

Perpetrator – the person who commits the abuse on the victim.

Shape. To cause to conform to a particular form or pattern; adapt to fit. Determine the nature of; have a great influence on.

Landmark: something that marks an important change in the history of something or a prominent identifying feature of a landscape.

Battered. Subjected to persistent physical assault, especially by a spouse, partner or caregiver. **Assault.** A violent physical or verbal attack.

To **ban** is to forbid or prohibit. To **punish:** to inflict a penalty or sanction to someone who has done something wrong.

Altogether: entirely.

Followed suit – has done the same.

abuse [ə-byooz']

Psychological theories have posited that the cause lies within the individual abuser, who must have psychological or emotional problems. Research indicates that parents who batter children have poor anger management and ineffective childrearing techniques. "Stress" is a proposed cause; abusers tend to have lower educational attainment, higher unemployment, lower socioeconomic status or more caregiver strain.

Child abuse is a broad term that encompasses many types of maltreatment: physical; emotional; sexual aggression; and neglect. "Neglect" is often defined as an act of omission, while "abuse" is an act of commission. The WHO does not make that distinction but defines all types of child abuse as acts of omission and commission. Acts include restriction of movement, belittling, scapegoating, threatening, or other non-physical forms of hostile or rejecting treatment. Unwanted children are more likely to be abused or neglected.

Intimate partner violence refers to the infliction of harm by an individual toward their spouse or intimate partner, with the intention of causing pain or controlling the other's behaviour. Some people call this act domestic violence, wife abuse or woman battering. Talking about violence in relationships requires a sensitive and confidential approach. Physicians should not wait for the patient to raise the topic but routinely screen for family violence. One can gently initiate discussions by setting a context for questions ("in my practice I am concerned about safety ..."), by asking general questions ("How would you describe your relationship?"), or by including an item on a health screening survey ("During the past 4 weeks how often have problems in your household led to: Insulting or swearing? Yelling? Threatening? Hitting or Pushing?"). Focused questions should include concrete behavioural terms ("hit" or "hurt"), not abstract words ("abuse" or "assault"). 'Common couple violence' is characterised by occasional outbursts for the purpose of winning an argument, in which both may hurt the other and neither is afraid of the other. 'Patriarchal terrorism' is characterised by a man who is extremely dangerous and controlling. Signs of this include coercion, threats, blaming, beating, choking, kicking, using fists or weapons, etc.

Elder mistreatment may take the form of physical abuse, psychological abuse, sexual abuse (molestation or forced sexual actions), financial or material exploitation or neglect. Some questions to detect it may be: Have you ever been hit, punched, kicked, slapped or otherwise physically abused? Have you been yelled at, screamed at, threatened, scolded, or otherwise verbally abused? Has anyone neglected to take care of you when you needed help? Does anyone use your money or property against your wishes? The clinician should provide a therapeutic message (helping the patient recognise mistreatment as a problem); refer to social services as well as caregiver support and respite.

Posit: use as argument for an idea.

The cause **lies within** – the cause is inside.

Batter: subject someone to physical violence. Note the difference with:

Smack: to hit someone briefly with the palm of the hand as a punishment. To smack children is a common “minor” form of punishment and whether it is right or wrong is under debate.

Rear/childrearing. Bring up and care for a child until they are fully grown.

Strain: pressure.

Maltreat = Mistreat. Treat badly, cruelly or unfairly.

Belittle. Make someone seem less good or important than they are.

Threaten: express intention to hurt.

Unwanted: not wanted. The pregnancy was not planned and the child was not wanted or welcomed.

Intention of causing = intention to cause.

Outburst: explosion.

Argument. (a) A reason that supports a point of view; (b) a disagreement in which different views are expressed, often angrily.

Beat: hit somebody repeatedly. A woman may come to your surgery, with multiple bruises, saying she was “beaten up” by her husband.

Choke: stop breathing or breathe with great difficulty because of a blockage or restriction of the throat; or make someone choke by blocking or squeezing their throat. A child may choke when he accidentally swallows a small toy. An elderly patient may choke on solids and require liquid diet.

Kick: hit using a leg.

Fist: closed hand.

Weapons – knives, guns, etc.

Elder: old person.

To molest: to assault or abuse sexually.

Punch: hit someone with the fist (closed hand).

Slap: hit someone with an open hand.

Otherwise – in any other way.

Yelling and screaming are forms of **shouting**. Note that if you speak to someone in a very loud voice (typically if you are angry) you shout **at**, yell **at** or scream **at** that person.

A mother would **scold** her child when she tells him very angrily that she does not like what he has done.

Although your **property** anything that belongs to you, the term property is commonly used to mean land, flat or house. So you live in a “property”, which may be your property or not.

Respite: a period of rest from a task. Sometimes social services can fund external care for a child or ill person while the usual carer rests.

Managing the Population

Primary care is about providing continuous, comprehensive personal health care at the first point of contact. In the UK, everyone is entitled to register with a named general practitioner who contracts within the local health authority-board to provide front-line general medical services or, when necessary, ensure that another health care professional provides the required care. The defined practice list offers a valuable opportunity to systematically offer primary and secondary preventive services to the practice population.

The positive predictive value of a symptom, sign or test is the proportion of individuals with the symptom, sign or positive test result who actually have the disease. Predictive values are useful because they reflect the underlying prevalence of the disease.

By themselves, most symptoms seen in primary care have low predictive values, especially symptoms that are ill defined or which are associated with a large number of causes. This means that in primary care there is usually little added value from undertaking an extensive history or examination.

As well as assessing presented symptoms and signs, clinicians use other risk markers of susceptibility to identify individuals with a higher probability of having a particular disease. These markers (also called risk factors) are genetic, environmental and behavioural determinants of disease found in epidemiological studies; however, risk markers are poor at pinpointing exactly who will develop the condition and when. This leads to the “prevention paradox”, whereby a large number of individuals need to be treated in order to prevent the event in a few.

The defined practice list provides an important framework in which non-responders can be readily identified and approached to maximise uptake of preventive programmes. Also, this can be discussed opportunistically when non-responders are seen in the practice.

We have known for many years that only a fraction of symptoms and illnesses occurring in the community are presented to health services. Awareness of this problem sometimes leads practices to using their practice list as a sampling frame for special initiatives such as health surveys or population-based needs assessments.

Some socio-economic and lifestyle data usually recorded in practice registers are:

Entitled to – have the right to.

Register with a GP – join that GP's list of patients. It involves going to the surgery, filling in an application form with their details, etc.

GP list: list of patients registered with a GP (usually 1000–3000).

Practice list: list of patients registered with a practice (usually 3000–30,000).

Valuable: of value, useful. When something is very valuable you may say it is “invaluable” (priceless – has no price, cannot be paid for with money).

Actually: really. Some readers may confuse it with: **Currently:** at the present moment.

Actualise: make real something that was potential. Some readers may confuse it with: **Update:** become up-to-date.

Underlying: basic; fundamental; beneath something; something that is under another one, and is more important.

By themselves – alone.

Little added value – not much extra benefit.

Extensive – long, vast.

Environment – Your surroundings. Environmental factors include all the external factors such as temperature, pollution, etc.

Pinpoint: tell exactly where something is. Sometimes patients have a diffuse pain and cannot pinpoint exactly where the pain is.

Non-responders are, in this context, those patients who do not attend for screening or checks.

Uptake – the amount of people who respond to a programme, or use something that becomes available. The uptake of the MMR vaccination was reduced after the autism scare a few years ago.

Awareness is the state of being aware, conscious about something. Many health campaigns are called Awareness Campaigns. For example, a Breast Cancer Awareness week would be organised to make everybody reflect on the importance and dangers of breast cancer and encourage women to attend screening programmes or perhaps donate money to a Cancer Research charity.

Survey. A gathering of a sample of data or opinions considered to be representative of a whole which are then statistically analysed. For example, to determine opinion, preferences or knowledge.

Note: you usually **conduct** a survey or a research study but **undertake** surveillance (see below). You may conduct or undertake screening programmes.

marital status
cohabiting status
housing tenure
ethnic group
sole adult in household
children (no.) in household
economic position
occupation
employment status
children living with sole adult

At its simplest, **surveillance** is the action of monitoring particular events or activities. In the context of health, the events are usually concerned with the incidence of disease or factors bearing on such incidence. In the context of infectious diseases, surveillance has been defined as “the continued watchfulness over the distribution and trends of incidence through the systematic collection, consolidation and evaluation of morbidity and mortality reports, and other relevant data”. In its broadest sense, surveillance in primary care means collecting information on health-related events as they interface with this environment. The direct purpose of surveillance is to prompt or plan action in order that adverse consequences can be mitigated. Surveillance is not hypothesis-driven research, although surveillance data can be used for research. Data can be used to estimate the burden of illness attributable to a particular disease.

If surveillance is primarily harnessed to prompt action, then it follows that surveillance data must be available in time for action. For some matters, timing is not as critical as others. The International Classification of diseases was generated out of a desire to compare the causes of death in differing countries with a view to planning interventions where there were unusual patterns of mortality. This sort of planning involved long-term strategic decisions. Even now in some countries annual mortality data by cause are often not available until well after the year’s end. On the other hand, surveillance of communicable diseases with implications for local spread must produce timely information if action is taken. It does not always follow that any action is possible, but at least health care providers should be prepared for the consequences. For particular diseases (especially those for which statutory notification is required) outbreak control procedures are in place, but for a wide range of less severe diseases, such as influenza, head lice, chicken pox, scabies or fifth disease (parvovirus), they do not exist in quite the same way; however, for a condition such as influenza, there are considerable public health consequences and commensurate needs for reliable surveillance information.

Marital status – whether you are single, married or divorced.

Cohabit: live together without being married.

Housing tenure – whether you own the property or are renting.

Ethnic group is much more frequently used than “race”, as it sounds more politically correct.

Occupation – job (painter, doctor, gardener, lawyer, etc.). **Occupational Health** is the health service that looks after the workers of an organisation. Some companies employ Occupational Health doctors who carry out annual checks (blood pressure, etc.) on the company staff. **Occupational Therapist (OT)** is a health professional trained to help people who are ill or disabled, learn to manage their daily activities.

Employment status – whether you are employed, unemployed, retired, etc.

Hypothesis-driven = **driven by a hypothesis** – done with the aim to prove a hypothesis.

It follows that – it is implied that, you can deduce that.

In time – not later than required. **On time:** punctually, at the time expected. If you are supposed to be at the practice at 8.00 every morning and start surgery at 9.00, that day when you arrived at 8.55 a.m. you were late, not **on** time, but just **in** time to start your surgery.

Timing. The choice of the best moment to do something. A woman who has just discovered she is pregnant may say, worried: “*I didn’t want a child. I have just started a new job and my partner has just lost his. It is not good timing*”.

Timely. Happening or done at the right time.

Out of a desire – because of a desire. “Out of” seems to imply that the desire is “in” the person and comes “out” to produce certain action. You may tell your neighbour: “*Out of consideration, please turn the music down!*”

Sort: type, kind.

Communicable diseases are those that can pass from person to person, e.g. infectious.

Spread: extension, distribution, expansion.

Statutory notification is the report a doctor sends to the public health authority when he detects a case of a disease listed as “notifiable” (tuberculosis, food-related gastroenteritis or “food poisoning”, etc.).

Outbreak: the start of a potential epidemic, when the first few cases occur.

Influenza is a winter viral disease colloquially called “flu”. Patients may say they feel “fluish” when they feel unwell during a respiratory infection.

Head lice: pediculosis capitis.

Chicken pox: varicella.

Commensurate: of the same size or extent.

The “disease episode incidence” is the number of new cases of disease identified within a given time period. This measure recognises that disease status may become quiescent, but there is, of course, the potential to count the same person twice. Disease episode incidence is most useful as a measure of acute diseases, which are usually short-lived.

The “annual period prevalence” is the strictest definition of prevalence and is concerned with the number of people with a recognisable disease at any one time. It is a measure of persons with disease, which is active by manifesting itself in the need for consultation or treatment in a 1-year period. Whilst this statistic underestimates the number of patients in the community with the condition in question, it allows for the comparison of data between practices and year by year.

Surveillance is needed to define the burden of illness presenting to health services, to provide an alert for contingency planning and to identify new problems or changing patterns in recognised problems. In a wider sense it is needed to monitor the equitable distribution of health care.

The international wave of psychiatric hospital closures over the past 30 years has produced the establishment of “sectorised services” which are described below:

- **Crisis management teams:** offering intensive home treatment by multidisciplinary teams for acutely unwell patients.
- **Assertive community treatment:** for patients who suffer from “severe mental illness”. The service is assertive, since staff actively seek out the patient, and team-based because the team shares the responsibility for patient care. High staff/patient ratios enable frequent contact with patients in their own environments. The programme aims to manage the patient’s illness, encourage treatment adherence, enhance a supportive environment for patients and assist them with tasks of community living.
- **Case management:** non-precise term used to describe the work of multidisciplinary community mental health services, the most common form of sectorised mental health service, in particular their assessment, care coordination and treatment activities.
- **Shared care:** between primary care practitioners and mental health services.

Examples of psychologically based interventions are:

- **Counselling:** involves a range of interpersonal interventions, provided by a range of health professionals, usually on a one-to-one basis for a relatively brief duration (6–12 sessions). It is defined as a “systematic process, which gives individuals the opportunity to explore, discover and clarify ways of living more resourcefully, with a greater sense of well-being”. Counselling in primary care is particularly important in the UK, where approximately half of all general practices employ a counsellor.
- **Cognitive therapy** is a brief structured treatment aimed at changing the dysfunctional beliefs and styles of information processing that characterise mental health disorders. It requires high levels of therapist training and is commonly practised by clinical psychologists.

Quiescent: inactive.

Concerned with – related to, referring to.

At any one time – at a specific point in time.

A **statistic** is a statistical parameter; a **statistician** is an expert in statistics.

Contingency planning – planning what to do if things go wrong.

Wave. A sudden occurrence of a repeated activity. Surfers need the waves of the sea to surf. Waving can also be an indication that you do with your hands to signal someone.

Assertive: confident in stating your position, forcefully strong. In the text, it refers to care that is very proactive. Occasionally you may say that a patient was “very assertive” when he demanded something in such a strong way that he was almost threatening.

Seeks out – goes out and actively looks/searches for the patients.

Staff/patient ratio: the number of staff per patient cared for. When it is high, patients can be visited more often.

A very popular form of cognitive therapy is cognitive behavioural therapy, commonly called CBT ★.

***Social care** includes whatever is necessary for maintaining a life that is as meaningful and as fully integrated into the community as possible. This involves having a sufficient income, employment, housing, leisure, a meaningful occupation and rewarding human relationships; however, only a small proportion of care of even the most dependent individuals is provided by professionals, the great majority by kin.*

*What is the appropriate role for primary care physicians in the overall effort to manage scarce and expensive resources wisely and allocate priority expenditures for **managing the health of defined populations**?*

The Seven Principles of Managing Health Care Resources can assist the primary care physician with this dilemma:

- 1. Prescribe medications based upon science not advertising.*
- 2. Expand non-office-based care.*
- 3. Provide access to health information and care options day and night, 7 days per week, 365 days per year.*
- 4. Integrate hospital-based physicians into primary care practices.*
- 5. Integrate behavioural health/mental health services into primary care practices.*
- 6. Build prevention into primary care.*
- 7. Create and maintain a database of patient diagnoses, utilisation, and cost patterns and share it with providers.*

It is our newly understood responsibility to manage health care resources or risk that others will do so without the best interests of our patients as a top priority.

Kin: somebody's relatives as a group. The **next of kin** (in writing, NOK) is the person closest to the patient, the one you would speak to if you cannot speak to the patient.

Scarce: available in small amount.

Resources – money, staff, equipment, time, etc.

Expenditure: amount of money spent.

Advertising – publicity, marketing.

Non-office-based: not based in the surgery.

Based in or **at** refers to where somebody or something is active, for example, “the physiotherapist is based at the hospital but comes once a week to our practice”. **Based on** refers to where somebody or something has its fundamental origin, for example, a guideline is based on research evidence.

It is common to use the expression 24/7 (“**twenty-four-seven**”) to describe something that is continuous (24 h, 7 days a week). If you ask a mother of an hyperactive child who is destroying your consulting room “Is he always like this?” she may reply: “Yes, 24/7, *doctor!*”

Top priority – first priority, most important thing.

Prevention and Health Promotion

The health gap between rich and poor nations, and between rich and poor people within nations, is shameful. Life expectancy in much of sub-Saharan Africa is now half that in northern Europe. In the UK, life expectancy is still 9 years longer for men in social class 1 than in social class 5. It is naïve to think that medicine can prevent this situation. The fundamental step in achieving good health remains the elimination of poverty, with consequent access to food, sanitation, education and shelter. But the power of medicine lies in the scientific understanding it provides of the disease process. Preventive medicine uses this understanding both to try to reduce the risk of disease and to detect and appropriately treat emergent disease before it does cause damage.

The prevention paradox means that a preventive measure which brings large benefits to the community may offer little to each participating individual. The best way to minimise this is to target preventive activity at people at high risk of disease, but this strategy is in itself paradoxical. The risk paradox means that targeting just the high-risk group will have relatively little impact on the total number of deaths.

At-risk population may be found through:

- *Registration – Most socialised health systems keep registers. These may be simply demographic (e.g. age, sex and address) or contain phenotypic or genetic details of individuals.*
- *Screening – The objective of screening is to identify early disease or high risk of disease (e.g. neoplastic dysplasia) before significant morbidity occurs; however, this can do harm as well as good. It may generate “false alarms” and detect diseases that would not otherwise present during the patient’s lifetime.*
- *Case-finding or opportunistic screening – This involves identifying at-risk individuals during routine work (normally in clinical consultations, but sometimes through contact or family tracing).*

One preventive intervention that spans primary and secondary prevention is immunisation, which has led to rapid and dramatic falls in the incidence of many diseases. In vaccination programmes, clinical benefits usually outweigh any adverse effects.

When planning preventive activities, we should ask ourselves what is achievable and what interventions work (look for evidence).

Gap: space, interval, difference.

Shameful: that produces or should produce a feeling of shame.

Shame. A negative emotion that combines feelings of dishonour, unworthiness and embarrassment.

Note that being “**ashamed**” and being “**embarrassed**” are not exactly the same. A patient may be “embarrassed” when they need to undress for an examination or report a symptom related to the genital or anal area, but they would not be “ashamed” of it. Another patient may feel “ashamed” of past infidelity to their partner, and confessing this to the doctor will probably be an “embarrassing” moment for them. Note that you are not “embarrassed” unless exposed to others, while you may feel ashamed even when you are alone.

Life expectancy. Number of years a person is expected to live, according to the average for their country and group.

Naïve: innocent, inexperienced, showing lack of experience; adjective commonly used against over-optimistic thoughts.

Sanitation. The study and maintenance of public health and hygiene, especially of the water supply and sewage systems.

Sewage: dirt, rubbish, waste.

Shelter: place to stay or live protected from danger.

Note the expression “the power ... **lies in**”.

Emergent: appearing (term not related to emergence).

Paradox: reality containing a contradiction.

Target (noun): (a) a person or thing selected as the aim of an action, (b) objective. To **target:** to choose as a target. You may say you “target high-risk groups”, or that you target an activity at high-risk groups.

Note the preposition: **impact on**.

To **trace** is to try to find other persons involved in the matter being investigated. In transmissible diseases (especially sexually transmitted infections = STIs) it is common to do “contact tracing”.

To **span:** to extend over something.

Immunisations are commonly called “imms”, and in the case of injectables, “jabs”. *From October to December we invite patients to come to the practice to have their “flu jab”.*

To **outweigh** is to have a greater weight, to be greater or more important. This expression is commonly used when explaining the advantages and disadvantages of an intervention or situation. **Achievable:** possible to achieve, feasible. You will find this term useful if you work in health care planning.

Work – function properly, be successful, produce the desired effect.

Note the “ie” in achieve, believe, etc. The “i” is always before the “e” except after “c”, e.g. receive.

hygiene [hiˈjɛn] appropriately [ə-prəˈprɛ-ɪtl̩] damage [dāmˈɪj] minimise [mɪn ɛmˈɪzə] target [tārˈɡɪt]

Key issues determining preventive programme effectiveness are:

Coverage: What proportion of the population at risk receives the intervention?

Delivery: Are factors that affect the delivery of the intervention (like the maintenance of equipment, the training of staff, and the storage of biological materials) up to scratch?

Quality control: Are standards set and monitored for key indicators of the intervention process (e.g. immune response or predictive values of screening)?

Effective prevention needs to be systematic and organised, with registered-based call and recall.

Immunisation and vaccination

The repertoire of vaccine-preventable infections has steadily increased throughout the twentieth and into the twenty-first century.

Active immunisation, or vaccination works by harnessing the mechanisms of adaptive (antigen-specific) immunity which, when successful, links the activation of innate processes which eliminate infection to pathogen-specific stimulation. The rationale is that individual immune protection is provided artificially in advance of natural exposure, at very minimal risk compared with the risks associated with naturally occurring infection, and at affordable cost.

In addition, vaccines that reduce transmission or carriage of communicable diseases contribute to population immunity. At high levels of vaccine uptake, this is very important in curtailing endemic circulation and epidemic spread. Ultimately, sustained population immunity can lead to the extinction of communicable pathogens if there are no other reservoirs of infection.

This strategy is very successful where pathogens naturally elicit immune responses which are protective against any subsequent exposure, should the individual survive acute infection; however, where pathogens have evolved to evade natural immunity, or where variants rapidly escape under immune selection pressure, the biological problems facing vaccine development are considerable.

Immunisation programmes have had spectacular success. In 1994 Finland announced the eradication of measles, mumps and rubella, 12 years after introducing the two-dose-combined MMR programme. The impact of pathogen-specific vaccines in the prevention and control of infectious diseases

Key – most important. You will find this word everywhere: key factors; key role; key points; the key to success, etc. When a clinical team looks after a patient, one of them is usually called the “key worker”, responsible for the co-ordination of that patient’s care.

To **store**: to reserve or put away for future use in a cupboard, a fridge or store room, etc.

Up to scratch: satisfactory.

Note the construction “**to set standards**”, i.e. to decide which standards we will use.

Call and recall refers to the mechanism by which we invite the population to participate in a programme (often by postal letters). Call is used for the first invitation and recall for further periodical reviews or re-testing.

Throughout – Everywhere, during the entire time or extent.

Harness. To control and make use of.

Rationale: the justification or reasoning behind an action or theory.

In advance of: before.

Take note of the word **exposure**, in case you are ever tempted to say “exposition” instead, which would not be correct for the meaning given in the text. **Exposure** is the condition of being **exposed** to something, i.e. become in contact with something. An “**exposition**” is a detailed description of a theory or issue. For example, you may present an exposition of the latest immunological theories in an international meeting. An **exhibition** is a public display of objects such as a collection of works of art.

Carriage. To **carry** or be a **carrier** of a disease is to have the pathogen in one’s body with the potential to transmit it (“pass it on”) to someone else. A typical use would be “hep B carrier”.

The vaccine **uptake** refers to how many people actually do get vaccinated.

Should the individual survive – **if** the individual survives. This is a common use of “should” that may confuse a non-native English speaker – it does not have an “obligation” but a conditional meaning.

Elicit: provoke, gain, get or extract information.

Curtail: limit.

Spread: expansion.

Measles: childhood exanthematous disease sometimes showing the typical Koplic spots in the mouth caused by a paramyxovirus. In English it may also be called **rubeola**, but it should not be confused with the “*rubeola*” of Latin languages, which denotes another exanthematous disease, caused by a rubivirus, which in English is called “**rubella**”. **Mumps**: epidemic parotiditis.

MMR ★: Measles, mumps and rubella vaccine (triple viral).

determine [dĩ-tûr'min] but undermine [ũn'dər-mĩn] repertoire [rěp'ər-twär] reservoir [rěz'ər-vwär]

was evident in the abrupt fall in incidence rates of diphtheria, polio, tetanus, pertussis, measles, and more recently, haemophilus B infection, hepatitis B and yellow fever, following the introduction of immunisation.

Outbreaks of infection occur when vaccine uptake falls precipitously. In the 1970s the uptake of the pertussis vaccine fell because of fears of a causal link with brain damage and this led to an upsurge in notified cases of pertussis. This declined again in the wake of restored confidence and increased vaccine uptake. A similar situation occurred in the UK with the “MMR scare”, when this vaccine was said to be linked with autism.

Active immunisation with either “live” or “inactive” products induces long-term immunity while passive immunisation provides short-term protection.

Rapid genetic drifts of influenza viruses leads to successive replacement of strains under antibody selection pressures.

Vaccine antigens determine the pathogen specificity and protection afforded by immunisation. Inductions of different types of immunological response are needed to protect against different types of infection.

Routine ATT boosters every 10 years are no longer recommended in the absence of clinical indications. Repeat doses of live viral vaccines do not appear to enhance adverse effects.

Primary courses of routine immunisations are offered in infancy and childhood. These vary among countries. All children should be offered the full course of immunisations unless specific contra-indications develop or parents withhold consent. Schedules can be resumed or started at other times if immune protection is incomplete, using “catch-up” schedules.

Screening. A screening test may have two desirable outcomes. Firstly, that confident reassurance can be given that a significant condition has been excluded, and secondly, that a clinically significant condition has been identified and effective treatment started; however, sometimes the outcome falls into neither of these categories. In such situations there may be an equivocal result and false reassurance may be given. A condition may be detected for which there is no treatment. The treatment instituted following the test may subsequently prove to be unnecessary, ineffective or even deleterious.

The opportunity cost of the screening programme (including testing, diagnosis, treatment, administration, training, and quality assurance) should be economically balanced in relation to expenditure on medical care as a whole (i.e. value for money).

Outbreak: sudden start of something such as an epidemic.

Uptake falls when people decide not to be vaccinated, or not to vaccinate their children.

Upsurge: increase.

Decline: decrease. It also means to say “no” to a proposal. If people “decline” to have a vaccination, then the incidence of the disease increases.

In the wake of – as a consequence of.

Note the use of the passive voice in “the vaccine **was said to be** linked to autism” – some people said that the vaccine was linked to autism.

Note that we talk about “**live**” vaccines, not “alive” vaccines.

Short-term: lasting for a short period of time. The opposite is **long-term**. When we are talking about a long-term solution to a problem, we may say that “in the **long run**, this option is the best one”.

Drift: gradual change.

Strain. A population of homogeneous organisms possessing a set of defined characters.

Note the preposition: **protect against**. We can also say “protect **from**”.

ATT: Anti-tetanus toxoid.

Booster: a repetition of the immunisation to renew or enhance the protection provided.

Withhold consent – refuse to give consent, do not give consent.

Schedule: a plan with specified times. For example, in the UK the childhood Immunisation Schedule includes DTP vaccination at 2, 3 and 4 months of age.

Resume: to continue after a pause.

Catch up: do something that should have been done earlier. A catch-up schedule is a series of vaccinations given to a child that has not had their vaccinations on time, in order to achieve similar protection despite the delay.

Desirable – good. **Outcome:** product, result.

To **reassure** is to transmit that “everything is OK”, “nothing is wrong”.

A false-negative test may give “false reassurance” and a false-positive test may produce a “false alarm”.

To **ensure** is to make sure something happens. Doctors must ensure the patient understands the treatment.

To **assure** is to say that something is surely true, to make certain. To **reassure** is to give confidence to someone. To **insure** is to arrange insurance cover. Doctors need to be insured against professional error, so that the insurance company pays compensation to any possible victim.

Deleterious: harmful, damaging, detrimental.

Expenditure: money spent. Something has good **value for money** if it is cheap compared with the benefits it provides.

withhold – double h. [wĭth-hōld"] desirable [dĭ-zĭr"ə-bəl].

The **yield** of a test is the number of people correctly identified by the test as suffering from a condition, as a percentage of the population as a whole. The sensitivity of the test is its ability to correctly identify “cases”, that is, it is the ratio between true positives and total affected. The denominator is defined by a gold-standard test, for example, biopsy, or by subsequent events, such as development of cancer within a specified period.

Specificity is the ability to correctly identify those free of disease, that is, the ratio between true negatives and total disease-free population. The pre-test probability refers to the likelihood of a condition being present before any test is done. It is equal to prevalence. The post-test probability is the likelihood of the condition once the result of a test is known. It is also called the predictive value. The likelihood ratio is the ratio between the likelihood of the condition being present if the test is positive, and its likelihood if the test is negative. In other words, it tells us how powerful the test is in determining outcome.

In establishing a **screening policy**, we have to decide upon a cut-off point above which we will carry out further assessment, and below which we will declare the test negative. By moving the cut-off point to the left, we ensure that a larger proportion of people are classified as potentially abnormal; we therefore reduce the false-negative rate but increase the false positives, with consequent costs and anxiety for the participants. By moving it to the right, we increase the risk of missing significant diseases and giving false reassurance. In the future, many screening activities that are currently seen as of doubtful value will earn their place as the evidence comes in and as test performance improves; others will be found wanting and will be rejected. Only an optimist can feel certain that all screening will be evidence based. Growth in private screening is unlikely to abate.

Changing behaviour: smoking; diet; exercise; and sexual health. Smoking-cessation advice should be tailored to the individual. Within the minority who are ready to stop, primary care workers should explore their motivation, barriers to quitting and level of dependency. They can then help the patient draw up a plan for quitting that may include further support and pharmacological treatment for nicotine dependence. Behavioural interventions aim to equip smokers with the motivation, skills, knowledge and support for quitting and avoiding relapse. Counsellors can provide general support through encouragement, information, empathy and specific techniques. Withdrawal from nicotine causes a number of unpleasant symptoms, including restlessness, difficulty concentrating, irritability, anxiety, craving for nicotine and change in appetite. The most popular treatment is the nicotine patch (NRT), which delivers a steady level of nicotine and can be worn unobtrusively.

Note the construction “**identified as having**”.

Once the result of the test is known – after the result is known.

Note the construction “the **likelihood of** the condition **being** present”.

Note the construction “how **powerful** the test is **in** determining outcome”.

In establishing – when establishing.

Note the preposition: **decide upon** a specific thing. You may also make a decision on a plan of action, or decide against doing something (e.g. having children).

Cut-off point: threshold, limit that determines what is “normal” and what is not.

To **miss** a disease is to leave cases of the disease undetected.

To **be found wanting** is to be discovered to be incomplete, deficient, or inefficient.

Abate: decrease, stop.

To **tailor** advice to the individual is to adapt it to the needs and qualities of that specific individual rather than giving standard universal advice. This way, you provide “**tailor-made**” advice. (Tailors are those who make clothes.)

Barrier: obstacle.

Quit: abandon an activity. Typically to “quit smoking” is to stop smoking.

Note the construction “**barriers to quitting**”.

Draw up: design.

Relapse. Return of the manifestations of a disease after an interval of improvement. The adjective is “relapsing”.

Recurrence. (a) A return of the symptoms in the course of a disease, following improvement or remission. (b) Relapse. The adjective is “recurring” or “recurrent”.

Withdraw: remove or take away. Withdrawal or abstinence symptoms arise when somebody suddenly stops a drug.

Restless – uneasy, agitated.

To **crave for** something is to desperately feel the need for it. This term is typically used in drug dependencies.

Steady: constant, unchanged.

Worn: past of wear. Typically you wear clothes, e.g. you wear a shirt or a hat, etc., but in this case it is a medication **patch**, adhered to the skin.

Unobtrusively: producing no inconvenience.

percentage [pər-sen“tɪʃ] withdrawal [wɪθ-drô“əl] steady [stēd“ē]

The potential benefits of the advice to “stop smoking, take more exercise, and stick to a healthy diet” are scientifically proven and well known. Nevertheless, the recommendations are usually poorly followed. Reasons why this is the case are many, but an important factor is the need for the individual to change his or her behaviour (lifestyle) – the benefits of which might only become perceptible in the long-term. A healthy diet, exercise, and avoidance of smoking are generic health-promoting factors. Accomplishment of lifestyle changes depends more on the patient than on the disease avoided.

In general, it appears that dietary intervention in general practice can be efficient and cost-effective, particularly if carried out in conjunction with a dietician. A major lifestyle-related problem is the increasing number of overweight patients in general practice, adults as well as children. To achieve long-term weight reduction, a comprehensive approach involving nutritional interventions and regular activity is needed. A mix of behavioural change methods, including goal setting and self-monitoring, may be best. Besides an unbalanced eating pattern, lack of physical activity is a major lifestyle risk factor in developing chronic degenerative diseases in the industrialised world. The benefits of physical activity are proven; despite this, only a minority of physicians advise their patients about it.

In 2001 alone, 3 million people died of AIDS. The overwhelming majority of cases of HIV are transmitted through sexual contact, reason enough to explore health promotion in the field of sexual health. Other STDs and adverse outcomes of sexual contact (e.g. complications from abortions) also cause a considerable burden of disease. Sexual health has been broadly defined as “the enjoyment of sexual activity of one’s choice without causing or suffering physical or mental harm”. Young people are at increased risk – early coitarche, for example, is associated with an increased risk of cervical cancer, and teenage pregnancies have a higher risk of hypertensive complications, premature delivery and low birth weight. Effective programmes deliver and consistently reinforce a clear message about refraining from sexual activity, using condoms or other forms of contraception. They also provide basic, accurate information for young people about the risks of teen sexual activity, and about ways to avoid intercourse or use methods of protection against pregnancy and STDs, and they provide examples of, and practice with, communication, negotiation and refusal skills. Interventions may be addressed to sex workers, gay men, young inner-city women, STD clinic attendees, etc. Outreach work may take place on the street, on mobile units that include counselling, education and even clinical facilities, or in local venues such as bars, clubs or workplaces.

Doctors **recommendations** are said to be poorly **followed** when patients do not do as advised.

Note the construction “**reasons why**”. You may wish to say “*The reason why I am studying English is to keep professionally up to date*”.

Accomplishment: completion of a task or objective. Note the difference with **compliance** (conforming to a rule or instruction) and **compliment** (something said to express admiration).

It appears that – evidence seems to show that; however, if we use the word “**apparent**”, we show more certainty: “It is apparent that dietary intervention is effective” means that it is “clearly understood” that this is true.

Overweight (*adj*) patients are those whose BMI is greater than 25. **Overweight** (*noun*) is a serious dietary problem experienced in developed countries.

Note the use of a hyphen (-) to create new words: **self-monitoring** (monitoring one’s own condition, e.g. diabetic patients checking capillary glucose levels regularly).

May be best. – May be the best thing to do or advise. You may also say “**It is best to do this ...**”. Patients will often say “The doctor **knows best**” when they trust the doctor and do not want to make a decision themselves.

Unbalanced: not evenly distributed. An unbalanced diet may contain too much fat and too little protein, for instance. Also to be unbalanced is to be mentally unstable. Note that “**imbalanced**” does not exist. **Balance** may refer not only to an equilibrium of proportions but also to the ability to keep standing without falling – patients with vertigo may “lose balance”. **Unbalance** is a lack of symmetry, balance or stability. **Imbalance** is a lack of proportion or harmony. Note that you can use the verb “**to unbalance**”, but “to imbalance” does not exist.

Overwhelming: very large.

Of one’s choice – that one chooses.

Refraining from doing – avoiding to do, not doing; to hold oneself back from doing something. To refrain from eating too much chocolate, for example.

STIs or STDs ★: commonly spoken and written abbreviations for sexually transmitted infections/diseases.

Reinforce: make stronger, give additional strength.

Inner city areas are the suburban areas of large cities generally with greater levels of deprivation (low socio-economic status) and health problems such as drug dependency or STDs.

Outreach work refers to the activities pro-actively carried out in the community.

Venue: a place where an event takes place. When you organise a meeting course or party, you need to decide on the “venue”.

major [māˈjər] premature [prēˈmə - chöör]

Practice Management

Practice Structures

In some countries, such as Italy, doctors working “single-handedly” deliver family practice services, whilst in Spain the majority are “group practices”, and in the UK there is a mix of both.

The “independent contractor status” is the most common way to deliver family medicine services throughout the world. The independent contractor is usually paid by individual patients, an insurance company on behalf of the patients or by a non-salary arrangement with the state. Some GPs are employed by other GPs either as locums or on fixed-term contracts (also called “salaried” or “non-principals”). In other countries, such as Spain or Sweden, most family doctors are salaried and work for the state.

There are several possible types of payments for “family physician” services:

- Salary for all services.
- A “salary” payment as part of income (either as a reimbursement of “average expenses” or as a base on which other payments are made).
- Item of service per consultation.
- Item of service for specific activities (e.g. cervical cytology, out-of-hours consultations).
- Capitation for each registered patient (either fixed rate or graded by age group, gender or overall list size).
- Target payments (for reaching performance indicator thresholds, e.g. 80% uptake of aspirin in secondary prevention on IHD).
- Reimbursement of expenses (for premises, staff, equipment, etc., and either total or partial).
- Payments for professional activities (such as continuing professional development, quality assurance, teaching, etc.).
- Quality and loyalty payments (including seniority and quality of care).
- Recruitment and retention payments (such as deprivation areas incentives and schemes to delay retirement).

Single-handed practices are those run by only one doctor, probably with one nurse and very few administrative staff. **Group practices** are those where two or more doctors work together.

Independent contractor status. In the UK, GPs are independent professionals who renew their contract with the state/region every year, under negotiated terms.

Locum: worker who substitutes another one when they are on leave.

Leave: period of absence from work. There are several types: annual leave (holidays, usually 4–6 weeks per year), **study leave** (to attend courses, usually 1–2 weeks per year), **sick leave** (unplanned, due to illness), **maternity/paternity leave** (for workers when they have a baby, usually 4–6 months for women), **compassionate leave** (due to the death of a close relative), etc. When somebody works extra (unscheduled) hours to meet the particular needs of the practice, they may be offered time back “**in lieu**” on some other day as compensation.

A **fixed-term contract** is one that has a defined starting and finishing date.

Salary. Also called “pay”, it is a regular sum of money paid to a worker, usually monthly, but expressed as an annual sum, e.g. £ 65,000 p.a.

Income: global amount of money earned from all sources. The GPs who are partners (owners of the practice as a business) do not have a salary – their personal income is derived from the practice’s yearly “profits” (practice income minus practice expenses). They usually, however, decide to receive part of their income in monthly amounts called “**drawings**”.

You are **reimbursed** for expenses; for example, if you buy computers on behalf of the practice with your own money, the practice will return your money on production of a receipt. This concept is different from being **refunded** (or getting a refund): if you take a new but faulty item back to the shop they will give you your money back. **Item of service** is used to refer to every single thing that gets payment, such as a consultation, a test, etc.

Capitation refers to payment per capita, i.e. an amount per patient registered with a GP, whether they come to the surgery or not.

Loyalty or seniority payments are given to those who stick to the same organisation for a long time.

Recruitment is the process of finding suitable workers for a post. When this is difficult, as it has been in the UK in recent years, GPs may be offered a “recruitment payment” consisting of an amount of money given just for signing a contract.

Retention refers to the degree to which the professionals recruited stay in post for a significant length of time. If the recruited professionals decide that the working conditions are not as good as they expected, they may go back to their original posts, and therefore the “retention” figures fall.

recruit [rɪ-krōʊtʰ]

A primary care team benefits from skill mix and teamwork where all members share their expertise. The possible membership of a primary health care team is:

In the general practice:

Family physicians

Practice nurses

Nurse practitioners

Counsellors

Receptionists

Practice secretaries

Practice manager

Based in the general practice:

Community nurses

Public health or prevention nurses

Health visitors

Community midwives

School nurses

Nursing support staff

Physiotherapists

In the local community:

Pharmacists

Dentists

Chiropodists

Optometrists

Complementary therapists

Outreach from the hospital:

Psychiatric social workers

Dieticians

Specialist nurses

– Stoma Nurses

– Respiratory Nurses, etc.

Diabetes Nurses

Palliative Care Nurses

Staff

People who deliver a service should be managed in a way that ensures that the delivery of services meets the standards set by the organisation. The needs of people providing this service, whether they be doctors, nurses, receptionists, managers, administrators, clerks or cleaners, must be met in a way that both satisfies realistic expectations and motivates them to fulfil their potential both in the delivery of care and in their own career development. The aim must be to develop primary care personnel in such a way that patient care is being provided at an optimum level by a fulfilled and stimulated team.

Personnel management in the UK is usually a task of professional practice managers. One of their functions is to recruit the staff, which involves writing the job descriptions and person specifications, advertising the post, selecting applicants for interview, and after interview, and appointing a successful candidate. Previous or current employers references may be available at the time of interview, but if not, the job offer should only be made when satisfactory references have been received. Appraisal provides the opportunity of having protected time to consider, analyse and discuss one's own performance and development needs. In an appraisal interview, the appraiser gives the opportunity to the appraisee to discuss his/her successes, failures and needs. If necessary, areas of poor performance should be tackled. Also, the appraisee should be encouraged to comment on the practice's strengths or weakness from his/her point of view. Finally, a written summary for the interview and the decisions made should be agreed upon by the appraiser and appraisee.

Skill mix is present in a team when its members have varied skills or areas of expertise – some are good or knowledgeable at certain things (e.g. organising), while others are better at other things (e.g. motivating). In a clinical team the skill mix may refer to different clinical areas of expertise (cardiology, dermatology, etc.).

Some **practice nurses** are specially trained as **nurse practitioners** and take their own clinical responsibility for clinical decisions, but with the explicit support of the family physicians in the practice.

Chiropodist: podiatrist, foot specialist.

Note that the terms **manage** and **management** are used for people, organisations, systems, etc., and even for “time”. To manage is to administer and regulate. Good managers have good “**managerial**” skills.

Personnel is a group of people employed by an organisation. Do not get confused when you meet your manager – it is not the same to say you want to talk about “personnel” matters (related to employment) or “personal” matters (related to your private life).

Fulfil their potential – develop all their qualities.

Job description: list of tasks to be developed by an employee.

Person specification: list of qualities the employee must have to carry out the tasks of their job description adequately.

Advertise: publicly announce a job vacancy through the Internet, newspaper, journals or other media.

Appoint: give the post to a selected candidate. My practice has recently appointed two new receptionists.

References are the opinions (most often in writing) of people who have previously worked with a candidate for a new post. Usually a post is offered to a candidate after an interview “subject to references”, i.e. it will be confirmed only if positive references are received.

Note the construction: “**reasons for leaving**”.

The appraisal is a regular (usually annual) process whereby each member of staff discusses their work with their managers.

Note the endings:

- **appraiser:** who appraises
- **appraisee:** who is appraised
- **employer:** who employs
- **employee:** who is employed
- **trainer:** who trains
- **trainee:** who is trained

Tackle: address, deal with, solve.

staff [stāf] personal [pûr'sə-nəl] personnel [pûr'sə-nēl].

When an employee decides to leave their post, an “exit interview” to discuss the reasons for leaving will provide useful information to the practice managers.

Equipment and Premises in General Practice

Good premises and equipment are a prerequisite for the provision of good primary care. The practice should, ideally, be situated in a place easily accessible by public and private transport, and for handicapped people and ambulances.

The entrance should, as far as possible, be welcoming and provide clear directions for the patients, including, perhaps, a map of the area with other important care facilities. The waiting room should be arranged so that it is visible from the reception desk, also so that conversations at the reception desk are not audible to others in the waiting room. The consulting rooms should ideally have a separate space for examining the patient, separated from the rest by a wall, curtain or screen. The treatment room is principally used by a practice nurse. Additional uses are injections, suturing and removal of sutures, dressings for wounds and ulcers, etc.

Organisation of Services

Five dimensions of access in primary care are recognised:

- Availability – volume and type of services*
- Accessibility – locational considerations*
- Accommodation – organisational resources*
- Affordability – financial constraints*
- Acceptability – attitudinal factors*

Over the years, there has been a downward trend in the number of patients cared for by each general practitioner, due to increased demand on community health services placed by the move towards a community-based NHS. The average list size is around 1700 patients per GP in the UK, 1030 in Italy and 1500 in Portugal. Doctors looking after smaller average list sizes have longer consultation lengths.

Booking an appointment with a GP is a complex social process in which the receptionist has an important role and which significantly determines the accessibility of care.

Triage is often done by nurses. It is a process by which management of a group of patients is prioritised or sorted according to their need for care. Triage may involve the allocation of the management of minor illnesses or patients requesting same-day appointments to nurses.

A common problem faced by patients is finding an engaged tone when they phone the practice. This would be improved by an adequate number of telephone lines and the use of answering machines when direct telephone access is not possible.

The equipment in a general practice includes clinical equipment (couches, lamps, stethoscopes, etc.) and IT equipment (computers, printers, etc.).

Premises: building.

Handicapped: disabled.

Welcoming: friendly.

Waiting room: area where patients wait before they are seen by a doctor or nurse.

It is important that the patients in the waiting room do not **overhear** (hear unintentionally) conversations at the reception desk.

Screen: a temporary wall, curtain or divide that separates two areas of a room.

Consulting room: where doctors or nurses see patients.

Treatment room: where nurses change dressings, administer injections, treat wounds, etc.

A service is **available** when it exists and is working.

A service is **accessible** when people find it easy to use.

The quality of the **accommodation** provided by a service includes furniture, air conditioning, etc.

A service is **affordable** when the cost can be paid without excessive effort.

A service is **acceptable** when it is provided in a way that does not offend users' beliefs or principles.

List size: number of patients that are registered with a GP or a practice.

Consultation length: number of minutes spent by the doctor in each consultation with a patient.

Book an appointment (or make an appointment): call or attend the surgery to reserve a time slot to see a doctor or nurse. A patient books an appointment **for** a particular day **with** a particular professional.

A **triage nurse** may receive calls or see patients first to decide whether they need to see a doctor or not.

Engaged tone: the sound you hear on the phone when you call somebody who is phoning or talking to somebody else.

triage [trē-āzh"]

The Medical Record

The medical record (MR) can be considered as the information that exists about a patient in a medical service. It can be a paper or electronic record (EPR). Records should be:

- *quickly and readily available for easy entering and retrieval of information*
- *content: legible, comprehensive, reliable, and comprehensible*
- *form: concise, accessible and well structured*
- *confidential and secure*

Examples of background information are:

- *Jehovah's witnesses will refuse blood transfusions for religious reasons*
- *Butcher: increased chance of pyodertrias; prohibited to work if suffering from Salmonella infection.*

The medical data can be divided into four categories:

- *Problem list*
- *(Progress) notes/journal*
- *Medication list*
- *Basic medical data/(diagnostic) archive (results)*

Notes taken on a doctor-patient consultation are recorded under various letters that together form the acronym SOAP. The S stands for subjective, O for objective, A for assessment (working diagnosis) and P for plan.

Time Management

Time is scarce and there are always competing ways of spending it. It is always short for a GP. Use of computers, use of ancillary staff to delegate administrative and patient-related tasks and the employment of a practice manager improves the overall efficiency of the use of time and resources. Time wasters are: unpunctuality; meetings and overlong communications; paperwork; underestimating the time required; procrastination; and unpreparedness.

Working hours vary from 35 to 65 per week in different countries. Female GPs often prefer part-time work.

The medical record (or medical notes, or patient's notes) contains the medical history of a patient and is used daily by doctors and nurses. Do not confuse it with the term **register**, which is a list of patients with a certain clinical condition.

The clinicians regularly **enter** information **on** the medical record of the patients they see.

Retrieve: recover.

Legible – clearly written and can be read and understood easily; this almost only happens in computer records, as doctors' handwriting is typically illegible!

Reliable – can be trusted as true; can be relied upon.

Background relates to the social factors surrounding the patient.

Butcher: he who sells meat.

Progress notes: a section of the medical record, where clinicians write the notes from the consultation or "news" about the patient.

Procrastination – leaving everything for later.

archive [är"kiv"]

Quality Improvement

The policy makers, patients and professionals of the health care systems in the majority of developed and developing countries have come to regard quality as a priority.

Quality improvement may be defined as a process of planned activities that have the aim of improving care. It involves the specification of desired performance, the review of actual performance and the implementation of changes in care if necessary, followed by further review of performance to check the impact of these changes. Quality may be defined as the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge. Assessment of the outcomes of care may be done through administration of quality of life scales on patients' satisfaction surveys. Assessment of the process of care is more common and usually involves measuring how much professional actions match defined good-practice criteria. Inappropriate over-use, under-use and misuse of medical procedures appear to co-exist everywhere. Doctors need to be able to assure the public that the quality of care they provide is of a high standard.

When quality assessment is required for external review, it is most frequently measured by applying quality indicators. A quality indicator relates to a specific measurable aspect of care that is sensitive to change and can be applied retrospectively to assess quality of care. Quality indicators also need to represent aspects of care that are under the control of the practitioner. Examples of quality indicators for family practice include areas such as organisation of the practice and access to care. Routine appointments with doctors and nurses should be booked at intervals of no less than 10 min.

***Quality indicators** highlight areas of performance that may require further investigation: they do not make definitive judgements about quality. They are different from guidelines, targets and standards, which is illustrated in the following examples:*

***Guidelines:** eligible women are offered routine cervical screening.*

***Indicator:** the proportion of eligible women who have had cervical screening carried out within the recommended period.*

***Target or standard:** the proportion of eligible women who have had cervical screening carried out within the recommended period should exceed 80%.*

***Evidence-based medicine (EBM)** helps to establish quality standards, by asking and answering questions that start with "What is the chance that?" ... certain outcomes will result from certain courses of action in defined groups of people. For example, "What is the chance that the MMR vaccine is just as safe as individual vaccines in children aged 2–6 months?" Such questions are usually answered with quantitative research, which gives answers in the form of probability estimates, such as "one half" or "70% as likely", or "2% more likely".*

*In evaluating evidence, the science of critical appraisal has emerged. **Critical appraisal** means reading a research paper carefully, using a structured checklist to help address two key questions: (a) Can I trust this paper? (b) Is it relevant to the question I need to answer and the patients(s) I plan to treat? The two main issues that determine whether a published paper is trustworthy are bias and internal validity.*

Policy makers: those who decide and design the policies for health care, usually following general directives from the government.

Review: re-examine. Do not confuse with **revisit:** reconsider a policy that seems to need changing; or **revise:** change a document or policy (producing a “revised version”).

Consistent. Reasonably or logically harmonious. **Consistent with:** in agreement with, in coincidence with. **Consistent over time:** unchanged, always the same.

Current: existing at the present time. **Actual:** real (not just potential).

Scale: questionnaire where the answers are graded in numbers.

Match: correspond with, agree with.

In the light of – taking certain circumstances into account.

High standard – high level. In our practice we work “to a high standard”.

Routine appointments are “normal” appointments, as opposed to “urgent” appointments.

Note the construction “as safe as”.

Likely: probable.

Paper: research article.

Checklist: list of things that you should not forget when doing something.

Pick-list: list of options that show when you click on an arrow ▼ on your computer screen.

Trustworthy: reliable – probably says the truth.

review [rĭ-vyōō] target [tär'gĭt]

Bias can be defined as “any factor arising from the design and conduct of a study that skews the data in one particular direction, either way from or towards the ‘true’ value that is being estimated with the study”. Examples of bias in quantitative research include **selection bias** (e.g. when sicker patients are allocated to active treatment and less sick ones to placebo); **observer bias** (when an assessor knows that a patient had the “real” procedure or active drug and subconsciously assesses improvement as greater than it really is); **withdrawal bias** when a high proportion of participants withdraw from a study before it is completed, especially if they differ systematically from those who continue); **measurement bias** (caused by systematic errors in instruments used to assess outcomes); and **publication bias** (authors and editors keener to publish “positive” results). One of the commonest forms of bias is **confounding**, or “left out variable bias” in which the relationship between the two measured variables (such as smoking and heart disease) is mediated by a third, unmeasured variable (such as social class).

Other tools for quality improvement. **Clinical guidelines** are another tool for quality improvement. The term “guideline” is often used interchangeably with “protocol”, “care pathway” or “practice policy”. They are defined as systematically developed statements to assist practitioner and patient decisions about appropriate health care for specific clinical circumstances. **Reminder systems** help clinicians to recall information that they already are aware of at an appropriate time in their decision-making process.

Total quality management and continuous quality improvement. While individual improvement projects begin and end, TQM/CQI (used interchangeably) is an ongoing effort to improve the whole organisation. The work required to implement TQM is broad, deep and time-consuming; not every organisation will be up to it.

Clinical governance is described in the UK as “the systematic joining up of initiatives to improve quality”. The concept is applied to both primary and secondary care and includes elements addressing: effective leadership; planning of quality; being truly patient-centred; information, analysis and insight; staff development; redesign of services and processes; and demonstrated success. The work is supported by a Clinical Governance Support Team that provides advice and training.

The patient’s role in improving quality. Patient satisfaction surveys are structured or semi-structured questionnaires, which are filled in by patients in the practice or at home, or which are answered in an oral or telephone interview.

Every health system should have adequate procedures for handling complaints expressed by patients. **Complaints** are negative evaluations of health care provision, which can signal aspects of care that need to be improved. Most patient complaints remain unnoticed, but some are expressed and handled by formal or informal complaint procedures. Formal procedures include the use of legislation and the courts. Many health care institutions have created informal opportunities to express complaints. This may be a special person or department who handles the complaints. Many complaints

are about bad communication rather than technical performance. Complaints are not necessarily representative of patients experience and not all complaints indicate physician negligence. Nevertheless, each complaint should be seen as an opportunity to learn and improve professional practice.

Bias. The distortion of a set of statistical results by a variable not considered in the calculation.

Arising from – derived from.

Skew: to make something asymmetrical.

Either way – to the left or to the right.

Withdraw from – get out of.

Keen: enthusiastic.

Note that “positive” results in research refer to results showing significant statistical differences, not “positive” in the sense of “good news”. “Negative” results mean no differences found, which is less interesting but does not mean “bad news”.

Left out – not included, not considered.

Clinical guideline: document that gives advice to clinicians on how to manage patients. A famous example in the UK are the NICE guidelines. NICE: National Institute for Clinical Excellence.

Reminder: something that helps us remember to do something.

Up to it: capable of doing something. Different from “up for it” which is to be willing to do something.

Complaint: the act of expressing dissatisfaction with somebody or something. Typically patients would “write a complaint”.

Courts/court (of law) – where the judge makes legal decisions on a case. A dissatisfied patient may want to “send a doctor to court”.

Handle: manage, deal with.

Negligence: failure to provide a reasonable level of care.

skew [skyōō] court [kôrt]

Research

Research questions should be clinically relevant and/or have the capacity to inform policy. The development of research ideas takes time and should involve careful planning, review of literature and discussion with colleagues. Clinical practice generates many questions. In seeking answers to these questions from either available research or doing research, it is helpful to ask a clear focused question. The question should adequately describe characteristics of study subjects, interventions, exposures and outcomes.

Then, an appropriate research design needs to be chosen. Cross-sectional surveys can provide information on prevalence. Case-control or cohort studies can assess the relationship between risk factors and outcomes. Randomised control trials are the most appropriate design to address questions regarding the effectiveness of treatments.

All primary care quantitative research aims to collect information from a representative group (sample) of individuals drawn from a much larger population. In order to obtain a representative sample, a complete list of the members of the population of interest is required (the sampling frame). The representative sample can be drawn from this sampling frame by selecting (a) a random sample of names using a list of random numbers; and (b) stratified random sample of names (to ensure that certain groups within the population are selected in a fixed proportion).

There are many other sampling techniques. For example, it is relatively common in primary care research to use convenience samples. Often, researchers gather data from a number of consecutive patients presenting to a general practitioner or community nurse. This involves a trade-off between the convenience and feasibility of the sampling technique and the generalisability of the sample.

Sample size depends upon the desired level of power (80% sometimes “acceptable”; 90% usually ideal), the likely or clinically important differences expected, and the pre-set significance level (usually 5% but sometimes 1%). Many randomised trials are under-powered, either in the original design or because of insufficient recruitment.

Research is a term used for systematic activity that leads to scientific conclusions, usually reflected in scientific literature. Although a research project can be described as a systematic investigation into some matter, you would not call it an “investigation project”.

Investigation is a more general term meaning a “formal process to discover and examine something to establish the truth”.

Somebody who does research may be called a “**researcher**”; however, sometimes the participants of a particular research study are mentioned as “the **investigators**”.

Researchers and investigators **conduct** or **carry out** a research study.

Research may be **qualitative** (interested in understanding and meaning) or **quantitative** (interested in significant statistical differences).

Inform: influence. **Regarding:** about.

Note the construction “**aim at collecting**”.

Drawn from – taken from.

Sample: a selection of the population that is examined to gain information about the whole.

A **frame** is a structure surrounding (around) something, such as a picture frame. The sampling frame is the whole population from which a sample is taken.

Random. Chosen or occurring without a specific pattern, plan or connection. In clinical practice, for instance, a “random glucose” is a glucose value that is not fasting (basal) or 2 h post-prandial, but tested any time during the day. In research, random means “relating or belonging to a set in which all the members have the same probability of occurrence”.

Fixed – does not change.

Convenient – easy to do.

Gather – collect and put together.

Trade off: compromise. **Compromise** – something that is not as good as you wanted, but you accept it because what you wanted is not possible.

Sometimes you may need to compromise (*verb*) generalisability in order to increase convenience and therefore feasibility.

Feasible: possible to do, realistic.

Note the use of the term “**power**” rather than “potency” when referring to the capacity of a study to detect significant differences.

Pre-set: previously decided.

To **recruit** in this case is to get participants included in a study.

qualitative [kwõl'ĩ-tā'tiv] quantitative [kwõn'tĩ-tā'tiv] design [dĩ-zĩn] technique [těk-něk]

When a study finds an association between variables, it is necessary to seek answers to the following questions:

Could it be due to chance alone? To answer this, we have tests of statistical significance, usually the p value.

Is it due to bias? For example: selection bias, in which differences in characteristics of the groups being compared can lead to apparent associations; observation bias, in which study investigators elicit or interpret information differentially (interviewer bias) or study subjects' reported events in a non-comparable manner (recall bias; e.g. parents of autistic children may be more likely to recall a history of immunisation than parents of normal infants.)

Is it due to confounding? (a third factor, which is associated with the exposure but also has an independent effect on the outcome).

If the association is real, is it most reasonably explained on the basis of a cause-effect relationship? Such attribution would be supported by the strength of the association, its biological credibility, consistency with other studies, and dose-response relationship.

Results can be presented in the forms of absolute relative benefits or as the "number needed to treat" (NNT); for example, for every 33 patients receiving nicotine replacement therapy, one additional patient will quit smoking at 1 year (an NNT of 33). Confidence intervals provide an estimate of how precise the estimate of the difference is. In the aforementioned trial, the 95% confidence interval for the odds ratio was 1.03–2.11; hence, the treatment estimate ranges from having almost no effect to more than doubling the chances of quitting.

Descriptive studies on individuals comprise cross-sectional surveys, case reports (in which individual cases which generate important research or clinical questions might be highlighted) and case series. A case series describes the experience of a group of patients with a similar diagnosis, usually highlighting an unusual aspect of a disease or history.

The two main types of **observational** studies are:

Cohort studies (other names: longitudinal, prospective or incidence studies) are generally large, population-based studies of individuals exposed to certain risk factors. Comparisons are made between exposed and non-exposed populations. The cohorts are observed over time to see which individuals experience the outcome of interest.

Case-control studies compare the frequency of a risk factor in a group of people who have the disease and a group of otherwise similar people who do not have the disease.

Seek: look for. Remember the past is **sought**.

Due to – as a consequence of.

Due for – expected to have something done. A patient may be “due for her cervical smear” this month. You may ask “When is your operation due?” and get the reply “It is due on 23 April”. If you regularly review your patients’ medication every year, you may find one who has not had it for 18 months and say “This patient’s medication review is **overdue**”.

Chance. The supposed force that makes things happen in a particular way without any apparent cause. We say that certain things happen for no reason, just “by chance”.

Chance(s): probability. “What are the chances of this factor **being** the cause of that event?” Note two uses of the same word in this sentence: “What is the chance **that** this event is due to chance alone?”

Chance: opportunity. “I had the chance **to** meet Professor Jones in an international meeting in Paris and discuss some exciting research projects”. “Sorry, I have been very busy lately, I have not had the chance to read the article you sent me”.

Apparent association – associations that seem to be true but may not be. Apparent may mean clearly seen or understood, obvious; or, seeming real but not necessarily so.

Note the endings: **interviewer** (the person who asks the questions in the interview), **interviewee** (the person who answers).

Confounding factors are those that may “confuse” the researcher and lead to false conclusions; however, note that in formal research jargon we do not say “confusing factors” or “confusion factors”.

Hence – therefore, as a consequence.

Aforementioned – mentioned before.

Doubling the chances – multiplying the probability by 2. This makes the event “**twice as likely**”. Chances may also be **tripled** ($\times 3$, three times as likely) or halved (divided by 2, reduced to half). Increases in risks or probabilities may be “**twofold**” ($\times 2$), “**threefold**” ($\times 3$), “**fourfold**” ($\times 4$), “**fivefold**” ($\times 5$), etc.

Odds. The likelihood or probability that something will occur, sometimes expressed as a ratio such as 9 to 1 (probability of the event occurring against probability of the event not occurring).

due [dyōō]

Of the **intervention** studies, the most important one is the RCT. Concealment of allocation/concealing which group the patient is allocated to, or “blinding”, can reduce observation bias.

Attrition bias occurs if patients dropping out of one study arm systematically differ from those in the other arm (e.g. due to treatment side effects).

Surveys are a common primary care research method and can be administered face to face, by mail, by telephone using a paper-based or computerised system, or via the World Wide Web. Surveys can be used to gain information from both providers and consumers of primary health care. The higher the response rate, the more likely you are to achieve a representative sample of respondents.

The transfer of research findings into routine practice is unpredictable; some interventions are implemented despite lack of evidence, while others take years to be implemented despite much evidence. **Implementation research** studies show inconsistent findings: systematic reviews indicate variable effectiveness within the same interventions. Interventions to overcome specific barriers should ideally be tailored to the nature of anticipated local problems. Qualitative research methods can also provide insights into the processes that contribute to the success or failure of interventions.

Systematic reviews, such as Cochrane reviews, look at all the published research studies on a particular topic, with the aim of minimising the risk of bias in identification and interpretation of data, and offer a synthesis of results to arrive at an overall conclusion. Increasingly, systematic reviews include statistical methods to analyse and summarise data (meta-analysis). By increasing the sample size, meta-analysis increases the power of the study. These meta-analyses or mega-trials usually clarify important questions, although sometimes they give conflicting results.

The term “health outcome” was coined in the early 1990s as a “change in the health of an individual, a group or population, which is attributable to an intervention or series of interventions”. Some health outcome measures are:

Mortality and fatality rates, morbidity, adverse events, risk factors, health literacy (the ability of the patients to gain access to, understand, and use information in ways which promote and maintain good health), quality of life and functional status measures (e.g. SF-36).

There are five key components to the evaluation of clinical and preventive services and programmes:

What is the right thing to do (**effectiveness**)?

Did we do the right thing (**appropriateness**)?

Did we do the right thing right (**performance**)?

Did it have the right result (**outcome**)?

Was the right result observed in the right people (**equity**)?

RCT ★. Randomised controlled trial.

Conceal: hide.

Blind: unable to see.

Attrition – reduction of the size of the sample because participants leave the study.

Drop out: leave, abandon something.

World Wide Web – Are you fluent pronouncing “www.”?

Inconsistent: variable – some studies conclude something, other studies conclude the opposite.

Overcome barriers – go ahead despite the barriers, find solutions to obstacles.

Insight: The capacity to discern the true nature of a situation. The capacity to look inside.

Publish(ed) – Note “publicate” or “publicated” does not exist.

Publication – research or education journal.

Literacy: (a) ability to read and write. (b) Knowledge in a specified area. Health literacy refers to the level of health education received by patients through all possible sources. “Computer literacy” is also a widely used expression. You are “**computer literate**” (or IT literate) if you are able to use a computer (not necessarily an expert or “geek”).

Right: correct or correctly, good or well. To clarify what you have heard you might say “Let me see if I have got this right”. When you prescribe a treatment and it works well, the patient may say that “the doctor got it right”; however, if you mistake your diagnosis you (or a colleague) may say that “you **got it wrong**”. Doctors are humans: sometimes they get it right and sometimes they get it wrong.

survey [sûr“vā] publish [püb“lish]

www.[double-U, double-U, double-U, dot] components [kəm“pəunənt]

Education and Professional Development

***Medical education: the contribution of primary care.** The contribution of primary care practitioners to the undergraduate education of physicians is inextricably linked with the perspective of the generalist approach to health and disease. Some particular topics and issues that are especially amenable to the learning opportunities in family medicine are communication skills, the social and community context of illness, evidence-based medicine, clinical skills and reasoning, health promotion and enhancement, exposure to common clinical conditions, etc. Evaluation/assessment in such teaching situations is a challenge. Some methods of evaluation used in family medicine clerkships in Canada are: clinical evaluation; objective structured clinical exam (OSCE); short answer management (SAM); multiple-choice questions (MCQ); academic project/research project; key features; simulated office oral; and oral examination. Evolving methods of in-training evaluation nested in a longer-term relationship between learner, teacher and patient can produce a much more complete evaluation of the skills, and particularly the attitudes, of evolving professionals.*

***Vocational and postgraduate training.** The last 30–40 years have seen mandatory training requirements spread to most developed and many developing nations, beginning with the UK in the 1950s. To refer to the doctor undergoing postgraduate training in primary medical care, we will use consistently the term **learner**, as different terms are used in different systems. For example, **registrar** is the term used for learners in Australia and the UK, **resident** is used in North America and the more generic **trainee** is still used in many places. Teachers of postgraduate learners should not be seen as teachers in a traditional didactic sense, but rather as experienced senior colleagues of the learners, capable of guiding their learners through the required learning experiences to become at least their equals, if not in time superior, practitioners. Ideally, learners are assessed against the learning objectives throughout the curriculum/assessment framework, thus ensuring that domains, presentations, age and gender issues and contextual issues, etc. are reflected in both teaching and assessment. The right balance of assessment should be delivered through a combination of formative and summative assessment, ideally including some in-training assessment that is performance based.*

Undergraduate education – The education you receive at college or university before receiving a bachelor's or similar degree.

Topic: subject, theme for discussion. **Amenable to** – susceptible to, good candidate for. **Reasoning** – process of thinking using reason to reach a conclusion. **Enhancement** – improvement.

Evaluation. To evaluate is to examine and judge carefully; to appraise. **Assessment.** The act of assessing; appraisal. Note the preposition in “assessed against”.

Clerkship: period of time spent by medical students in a clinical setting (in this case, family practice) during which they observe and practise some of the principles of family medicine.

OSCEs are becoming increasingly popular. In these exams, students are presented with “standardised patients” who are lay people trained to simulate patients' conditions and evaluate students.

Another abbreviation you should learn and practise is “MCQ” ★. These are those exams where you are given several possible answers (typically a, b, c or d) and you have to tick on the right one.

Simulated office – simulated consultation. **Nested** – included within. **Attitude:** opinion or general feeling about something. **Aptitude:** natural ability to do something. **Mandatory:** obligatory, compulsory.

Vocational training – speciality postgraduate training; typically refers to training in general practice or family medicine. In the UK, a doctor undergoing GP training is called a “GP Registrar”, while doctors undergoing training in other specialities are called “Specialist Registrars”, more commonly known as “SpR” ★.

Didactic. (a) Containing a political or moral message. (b) Tending to give instruction or advice, even when it is not welcome or not needed. Many readers may be surprised at this often negative meaning of “didactic”, as in some Latin languages its meaning is either neutral (“related to teaching”), or quite positive, referring to tools or persons that are able to teach very well and help students learn. For example, if after listening to a talk, a Spanish speaker (translating literally) says it was very “didactic”, it means they liked it, whereas if an English speaker says the same, it means they did not!

Framework: set of ideas and principles.

Formative assessment is a self-reflective process to improve student's learning. It is often done at the beginning or during a program, thus providing the opportunity for immediate evidence for student learning in a particular course or at a particular point in a program. Classroom assessment is one of the most common formative assessment techniques. It is not evaluative and does not involve grading students.

Summative assessment is comprehensive in nature, provides accountability and is used to check the level of learning at the end of the program. It often ends in accreditation test.

The Professional Development of the Family Physician: Managing Knowledge

Continuing medical education (CME) is defined as “any and all ways by which physicians learn and change”. The term emphasises the clinical nature of the content of learning and is frequently associated with a lecture or conference format.

Continuing professional development (CPD) offers a richer array of educational content and learning activities. In addition to specific clinical subject matter, CPD also encompasses “non-traditional” topics such as management skills, ethnicity and its role in practice, and ethical decision making. The word “development” implies a broader range of learning activities; not excluding the lecture as an educational medium, CPD may also utilise strategies such as self-reflection, interaction with patients and colleagues, and community-based activities, in which personal learning and growth may occur.

There are many methods that help or enable family physicians to incorporate new clinical findings into their practices, e.g. (a) practice-based workshops that provide “hands-on” experience to family practitioners have been effective in promoting the adoption of skills learned, giving the opportunity to “rehearse” the activity in the safety of a training session (e.g. sigmoidoscopy); (b) practice tools, such as flowcharts, decision aids, or toolkits, have shown relative success in promoting behaviour change.

Learning makes sense if it translates into better health outcomes for the patients. The “so what” question is needed to assess the impact of medical learning.

Personal growth and professional development. Professional practice in health care is often “messy” and deals with complex situations where uncertainty, fallibility and mystery are the norm. Often in practice there are no right answers in some absolute sense, only best ways of acting. The special kind of knowledge that enables professionals to make these judgements has been termed “practical wisdom”, and this is acquired largely through informal conversations with respected peers rather than through formal educational programmes. These informal processes occur “naturally”, and professionals engage in them automatically and largely unknowingly. There are, however, countervailing forces that prevent them occurring, and “top-down” interventions (such as many of those being introduced by governments, often linked with tighter regulatory frameworks) appear to be counter-productive.

Lecture. An educational speech on a particular subject made before an audience. Lectures are usually more formal than “talks”. They are typically given in university or national or international meetings.

Conference. A meeting, sometimes lasting for several days, in which people with a common interest participate in discussions or listen to lectures to obtain information. Scientific associations usually have annual conferences or annual meetings.

Congress. (a) A formal meeting or series of meetings between delegates. (b) A national legislative body, especially that of the United States. Because of this second meaning (which comes first in American dictionaries), the term “congress” is best avoided when referring to scientific meetings.

Workshop: (a) a gathering or training session which may be several days in length. It emphasises problem-solving, hands-on training, and requires the involvement of the participants; (b) a room or building which provides both the area and tools (or machinery) that may be required for the manufacture or repair of manufactured goods.

Hands-on. Involving active participation rather than theory. Often in life-like situations, such as clinical setting.

Flowchart: a diagram of the sequence of steps in an activity, often drawn with boxes, circles, arrows, etc.

Toolkit: a set of tools to help manage a problem, for example, a “diabetes toolkit”, may be a folder with a guideline, a flowchart, patients’ leaflets, lists of services and resources available, etc.

So what? This is an important question to be made before starting a research of educational effort. It means: even if I find the answer to the research question, or even if I learn very well what I intend to learn ... What difference will that make? What is the relevance? Will patients benefit from it?

Wisdom. The quality of being wise. **Wise:** showing experience, knowledge and good judgement (capacity to decide on the best course of action).

Peers: colleagues.

Engage: participate actively.

Unknowingly: not knowing.

Countervailing: opposing, going against.

Top-down interventions are those decided by those persons who are at the “top” of the power ladder (politicians or managers) and imposed on those persons who are below them in the power hierarchy.

Bottom-up is the opposite: processes in which the “bottom” or lower layers of workers, in this case health care professionals, influence the decisions of those in the upper layers (politicians or managers).

Tight: restrictive.

Counter-productive: producing an effect opposite to the intended one.

Re-accreditation and Re-certification

The general public expects guarantees that professional standards of all practising physicians are monitored and secured. To answer these needs, the concept of periodic evaluation of physicians' competencies has been developed.

A certain amount of confusion exists in the terminology related to the subject. Re-certification and re-accreditation are terms used interchangeably in the literature. Re-validation, re-registration and re-attestation are other terms also found in the literature, describing the issue in selected countries. Although it seems that "re-accreditation" would be more appropriately used in the context of practices rather than physicians, all the above terms may be used in relation to the process of formal recognition of previously fully licensed and vocationally trained general/family practitioners.

Some desired features of modern re-certification programmes are:

- mandatory for all practising physicians*
- based on explicit, reliable and valid standards*
- focused on physicians' performance and medical outcomes*
- accepted by physicians, patients and decision makers*
- conducted in a formative manner with an exceptional use of penalties (non-threatening manner, creating the opportunity for all doctors to better recognise and answer their educational needs).*

Multi-professional Education

Multi-professional education at the undergraduate level: Multi-disciplinary rounds and team meetings are viewed as a fundamental learning strategy for practice-based learning as are month-long rotations or electives. Multi-professional education can change attitudes and in a direction favourable to collaboration and teamwork, can break down negative stereotypes and can increase understanding about the roles and responsibilities of other professionals. Multi-professional education at the in-service level (where the students are qualified practitioners) is more likely to change clinical practice or benefit patients. Important requirements are a positive environment, student "readiness" and teacher "buy in" and commitment.

Competence = competency.

Non-threatening – non-frightening, friendly, no danger.

Rounds: tour of inspections repeated regularly (usually daily) in which the doctor checks the condition of the patients on a hospital ward; these are typically performed by a senior doctor accompanied by junior doctors.

Break down – destroy or to break in to smaller, more manageable parts.

Note the expressions “in-service” (during unsupervised practice), “in-training” (during training period), “in-house training” (at the practice or hospital, provided by staff rather than external teachers), etc.

Readiness: the status of being ready.

To **buy into** something – to be happy to accept and implement or participate in something.

Ethics and Law

Practising primary care as a family doctor can be one of the most rewarding careers in medicine. Like other clinicians, general practitioners (GPs) should pride themselves on the help that they are able to provide to others. Yet, there is a downside: Long-term relationships with patients and families, accompanied by the potential isolation of primary clinical responsibility, can create heavy burdens. Medical ethics deals with many of these problems.

Patients trust doctors when they perceive they treat them in conformity with established duties of care, which mainly are: (a) to protect the life and health of patients to an acceptable professional standard that is underwritten by expert opinion; and (b) to respect the autonomy of patients to the same standard, especially as regards the disclosure of appropriate information for informed choices about treatment options and the control of access of others to confidential information.

In its simplest terms, “autonomy” is the right of self-determination and “paternalism” is any action that reduces autonomy in the name of protecting the best interests of the patients. Traditionally, physicians have felt an obligation to make decisions on behalf of their patients, which was justified by the principle of “beneficence” – concern for patient welfare. At the other extreme the option to give in to patients’ wishes respects their autonomy but does not respect their reasoning. A “shared decision-making” model focuses on patient welfare but also enhances autonomy in a deeper sense, by providing appropriate information. The patient’s comfort with uncertainty and preference for doing rather than waiting needs to be considered. The physician might ask “Are you the kind of person who would find it very hard to just wait and see what happens, and would want us to do everything we can to get rid of this cancer even if we cannot prove that the treatment is effective? Or are you the kind of person who feels it is better to leave well enough alone unless we have good evidence that treatment will do more harm than good?”

Because patients trust and respect their family physicians, there is a danger of physicians having undue influence. It is very easy to take advantage of this power in a busy practice where it is quicker and easier to give advice than to help decide. Although the SDM model is more time-consuming, it may reduce physicians’ time in the long run. Patients are more satisfied with care, are less likely to sue their physicians, have reduced concerns, better physiological outcomes, and fewer referrals and laboratory investigations.

Pride themselves on – be proud of themselves because of something they own or have achieved.

Downside: negative side, disadvantage.

Isolated: alone, separated from the rest.

Underwritten: supported.

As regards: with regard to. Note the “s” in the first option.

Note the expression “protect the **best interest** of patients” similar to “do what is in the patients’ best interests”, which simply means “do what is best for the patients”.

On behalf of: in the interests of, as a representative of.

Welfare. The physical, social and financial conditions under which somebody may live satisfactorily.

Give in: stop fighting, surrender, submit. To give in to a patient’s wishes is to decide to do what the patient wants, even if we do not agree with it.

Reasoning: intelligence, capacity to reason.

Rather than: instead of, as an alternative to, as opposed to.

Get rid of. Take action so as to be free of. In the example, do something to be free of the cancer.

Undue. Going beyond the limits of what is proper, normal, justified or permitted. “Undue influence” is an influence that the doctor should not have over the patient.

The opposite is **due**, referring to something that should happen. “*With all due respect, sir, I must say ...*”. “*I will review the patient in due course*” (at an appropriate time, not specified) – very typical expression found in letters from hospital doctors.

SDM: Shared decision making.

Long run: long term.

Sue. To take legal action against somebody in order to obtain something, usually compensation for wrongdoing. It is also said “to take somebody to court”. Do not confuse with “sew” (pronounced the same) which means to make or repair clothes with needle and thread.

Concerns: worries.

Isolated [i'so-lāt'ēd] undue [ün dyōō] sue [sōō] reasoning [rē'zo-nĩng]

Truth telling in family medicine. As a guiding principle, physicians should be truthful with their patients; however, there are numerous qualifications of this general rule. The practice of disclosure by physicians in different parts of the world varies significantly, with physicians generally disclosing less to patients in Italy and Japan, compared with the United States. Physicians may consider withholding a serious diagnosis, misrepresenting it, or limiting discussions of prognosis or risks out of fear that a patient will develop severe anxiety or depression or refuse needed care. The amount, manner and timing of truth telling or truth withholding are crucial factors for which there is no ready formula. To know how much the patient wants to know, the physician may ask: "Is there anything else you want to ask me about, that we haven't already discussed?" or "I am sure you have lots of questions ...".

Confidentiality. Of course, everybody knows that what you say to the doctor is confidential. The problem is – Does it really work that way? Most patients would probably choose optimal treatment including disclosure of necessary private information but in the context of confidentiality. We work on the basis that there is a cordon of confidentiality around those who need to work within medical teams. The law imposes the duty of confidentiality on clinicians (and others); but the public interest in disclosure may override it (e.g. if a psychiatric patient reports an intention of killing somebody).

Ethics of research. Ethical issues in medical research include consent, confidentiality, risk of harm, value and quality of the research (Are the aims worthwhile? Is the methodology appropriate?) and justice (Are inclusion/exclusion criteria appropriate?). Consent should be obtained in writing, and should ensure that no coercion has been exerted on the subjects recruited to the study – they should feel free to decline. A Research Ethics Committee needs to approve any research project before it is carried out. Liability for compensation in the event of harm occurring to the research participants has led to most institutions to purchase insurance against such liability. The researcher needs to ensure that the information collected is stored in a secure manner. When information is requested by external researcher too, consent is needed; otherwise, confidentiality would be breached.

Ethics of resource allocation. Clinicians, as well as managers, have an ethical responsibility to ensure that resources are allocated fairly and used wisely. As well as striking a balance between risks and benefits, doctors are also required to balance the needs and wishes of individual patients against the needs of society as a whole.

To be **truthful** – to tell the truth.

To **disclose** is reveal or make visible something that was hidden or secret.

To **withhold** is not to give, to hide or keep secret.

To **misrepresent** is to present it in a way that is not completely true.

Out of fear – because of fear.

Timing of truth telling – when we tell the truth.

Ready-made: pre-made (by someone else). “Ready meals” are those you buy in big supermarkets to heat up in the microwave oven.

“**It does not work that way**” is what we say when a theory is far from the practice.

Cordon of confidentiality: group of staff around the doctor who have access to a patient’s health information and have a duty of keeping it confidential (nurses, receptionists, secretaries, students, etc.).

Override: to be more important and take priority, cancelling a previous rule.

Worthwhile: beneficial enough to justify the effort made.

Consent: permission, agreement to do something.

In writing – in written form.

Coercion: pressure.

Decline – say no.

Liability. Legal responsibility for something, especially costs or damages.

Sorted – organised.

Stored – kept.

Breach: to break, to fail to obey a principle, rule or law.

Resources are the supply of money, equipment, staff, etc., available.

Allocation of resources refers to the decisions made to provide health care to some and therefore not to others due to the limitation of resources.

Fair = just. **Fairly** = with justice; however, **fair** has another meaning when assessing the quality of something – it means “between poor and good”. Also, **fairly** has another meaning when we use it to describe quantity. “I am fairly sure” means that “I am moderately/reasonably sure”.

Striking a balance – obtaining a balance.

Whole: total.

consent [kən-sənt] fair [fâi] whole [hōl]

End-of-life decisions. *The laws of most countries are relatively permissive regarding how physicians manage care at the end of life. There may be significant differences, such as the legal acceptance of euthanasia in the Netherlands but nowhere else, and the legalisation of physician-assisted suicide in Oregon alone in the United States. The dying patient may be unable to make decisions about treatment, so one should then appeal to the patient's previous autonomy. Sometimes the patient has given "advanced directives" about the medical treatment he/she would or would not wish to receive, either verbally or in writing ("living will"). Sometimes the patients designate the person or persons they most trust to make such decisions (power of attorney for health care). Futility may be an issue – in most countries, however, treatment not considered to be effective would not be brought up as an option.*

Medico-legal Issues

Law impinges on medicine most visibly when things go wrong. Primary care errors are multifactorial and associated with poor communication, prescription errors, failure to diagnose, investigate, monitor or to refer patients in a timely fashion. In 2000 there were 23,000 outstanding clinical negligence claims associated with an estimated liability of over £ 4 billion in the UK. Around 3.6% of GPs faced legal action as a result of work undertaken in the previous 12 months.

Negligence is "a want of attention to what ought to be done or looked after". To prove negligence in a court of law, a plaintiff (complainant in the UK) – the person bringing the action – must show that: (a) the defendant doctor owed the plaintiff a duty of care; (b) the doctor breached this duty of care by failing to provide the required standard of medical care; and (c) on the balance of probabilities this failure actually caused the plaintiff harm. A doctor will not be guilty of negligence if he/she has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art.

Medical errors may be divided into those caused by problems with physical execution – such as slips, lapses, trips and fumbles, usually associated with attention or memory failures – and mistakes related to bad planning or problem solving. Many errors have the potential to harm but sometimes luckily do not ("near misses").

Appeal to – use as basis.

Advanced – given in advance, given beforehand, in anticipation.

Living will. A document, typically signed in advance while in good health, in which somebody declines to be kept alive artificially by life-support systems in case of a terminal illness.

Will. A statement of what somebody wants to happen to his or her property after death, or a legal document containing this statement.

Power of attorney. The legal authority to act for another person in legal and business matters.

Futility. Lack of usefulness or effectiveness.

Bring up: present for discussion.

Things go wrong when the process or results are bad.

When a patient had a condition that you did not diagnose, you **missed** the diagnosis or **failed to** diagnose.

Timely – at the right time, perfect timing.

Outstanding: pending, not solved yet. A very different meaning for “outstanding” is “extraordinary” or “extremely good”.

Face. To accept the reality of a difficult or unpleasant situation.

A want of – a deficit of.

Complainant. A person or organisation that takes legal action against another.

The action of taking someone to court is also called “**litigation**”. Fear of litigation is unfortunately shaping modern medical practice, particularly in Anglo-Saxon countries.

Owed a duty of care – was obligated to provide care.

If you repeatedly fail to provide the required **standard** of medical care, it may be said that your performance “falls below standards”.

Slip: an oversight, failure to see something.

Lapse: a momentary fault.

Trip. A fall or stumble caused by catching the foot on something.

Fumble. To do something clumsily, hesitantly, inefficiently.

Luckily: fortunately.

- Yeah, I have this kind of, you know, sort of thing, yah' know what I mean like? I took the stuff, right? but basically didn't sort of actually work, I mean... I know my body, like. I am, know what I say, sort of, yeah, actually, OK..., basically, kind of, you know what I mean, don't yah'?



Unit VIII The Language of Clinical General Practice

This unit is a general overview of the language used in daily clinical practice. More detailed teaching is offered by specialised clinical areas in the next unit.

The Consultation

Meeting the Patient

When a patient enters the consulting room, you can greet them in many ways. A typical example is:

- Good morning, Mr. Jones. Please have a seat.

The *times of the day* in English speaking countries may be different from those in yours. 'Good morning' applies until 12 noon, 'good afternoon' until 5 p.m., and 'good evening' thereafter. Do not greet with a "good night" as this is only said when you go to bed.

The *title* of the person you greet reflects their gender and/or age or marital status:

• Mr. = male adult	[mɪs'tər]
• Master = male child	[mās'tər]
• Miss = female not married	[mɪs]
• Mrs. = female married (followed by husband's surname)	[mɪsɪz]
• Ms. = female unspecified	[muz]

After this, you ask about the presenting complaint (PC):

- How can I help you today?
- What can I do for you?
- What seems to be the problem?
- What brings you here today?

Taking a Clinical History

So, now the patient has replied to your initial question and you are listening to the patient's complaint(s). They will mainly use colloquial expressions which will require translation into medical language (see Table 1).

When listening to the patient, note that they may use many “**gap fillers**”, which do not mean anything but may confuse you if you try to find them a meaning. Some gap fillers are:

Right?/Yeah/You know/You see/Actually/Basically/Didn't I?/I mean/Like/Sort of/Kind of ...

Next, you want to know more about their complaint:

- How long have you had this for?
- Did it start suddenly? Or gradually, over a few days/weeks/months/years?
- How long does it last?
- What makes it better? What makes it worse?
- Do you get anything else with it?

Specifically for the symptom *pain*, you may need to ask:

- Could you show me exactly where it hurts?
- Does it spread anywhere? (radiate)
- What brings on the pain? (triggers)

Other questions about symptoms and their possible answers are shown in the next unit by clinical areas.

If details are not available from the records, you may need to ask about the patients past medical history (PMH), family history (FH), social history (SH) and drug history (DH).

PMH:

- Do you have any other medical problems?
- Have you had any illnesses in the past?
- Have you ever been admitted or operated on?

FH:

- Do/did any of your close relatives have any medical problems?
- Do you know if there are any diseases that run in the family?

SH:

- Who do you live with?
- What is your occupation?
- On average, how much do you drink in a week?
- Do you smoke? How many cigarettes per day?

DH:

- Are you taking any medications?
- Are you allergic to any medications?

Table 1. Common phrases used by patients, and their meanings

When a patient says ...	The doctor understands ...
I can't breathe or my chest is tight	Dyspnoea
Everything is spinning or I am dizzy	Vertigo
It itches or I'm itching	Pruritus
It stings when I pass water	Dysuria
I can't eat or I've lost my appetite	Anorexia
I don't feel like doing anything	Asthenia
Headache	Cephalalgia
I have a runny nose	Rhinorrhoea
I've vaginal discharge	Leukorrhoea
I'm on my period	Menstruation
My hair is falling out	Alopecia
I can't remember a thing	Amnesia
My skin looks yellow	Jaundice
I can't move (a limb)	Paralysis
I can't see anything	Blindness
Bad breath	Halitosis
I've a cavity	Caries
It hurts when I swallow	Odynophagia
Food gets stuck in my throat/chest	Dysphagia
I bring up phlegm	Sputum
I am coughing up blood	Haemoptysis
My stomach aches	Epigastralgia
I am wheezy	Wheeze
I've got pins and needles	Paraesthesia
I have heartburn	Pyrosis
I feel sick	Nausea
I pass a lot of water	Polyuria
I always feel like I have to pee	Tenesmus
I'm always thirsty or I'm always dry	Polydipsia
I've a rash	Erythema
My ... is swollen	Oedema
My skin looks blue	Cyanosis
I have the runs	Diarrhoea
My mouth is always watering	Sialorrhoea
I can't breathe when I lie down	Orthopnoea
My stools are black	Melaena
My stools are white	Acholia
My urine is dark	Choluria
I have trouble sleeping	Insomnia
I can't go to the toilet	Anuria or constipation
Bruise	Haematoma
Toothache	Odontalgia

Examining the Patient

Now you may need to *examine* the patient. (Note that in English you do *not* “*explore*” a patient. You may explore the patient’s feelings, for instance, but not the patient themselves.)

- Please could you take off your shirt and sit on the couch.
- Please could you take off your trousers and lie on the couch.

The names of several clothing items are given in the next section for your reference.

When asking a patient to position themselves on the couch, you might say:

- Please lie on your back (with your back against the couch, face up).
- Please lie on your chest or front (with your chest against the couch, face down).
- Please lie on your left side (e.g. facing the wall).

When the examination is over, you may tell the patient:

- That’s it, thanks, you can now get off the couch and get dressed.

Explaining Diagnosis and Management

If you feel that an investigation is required, you can address the matter by saying:

- I suspect you have a urine infection, and I would suggest that you take a urine sample so that we can check for that.
- I am not sure why you have this cough, so I would like to send you for a chest X-ray.
- There are many reasons why you may be feeling so tired. I think the best would be to start the investigation by taking some blood tests.

You would normally add to any of these proposals:

- Would that be OK?

If you already have some results for the patient:

- Your urine test has come back positive for infection. I would recommend that you take a course of antibiotics.
- Your X-ray is clear, and as your cough is better, I don’t think there is anything for you to worry about.
- Your blood test shows that you are anaemic. I think this needs further investigation at the hospital. They will probably require you to have an endoscopy (a tube passed through your mouth to see your stomach). How would you feel about that?

Checking Understanding

It is vital that you make sure you have understood the patient well, and they have understood *you*, too.

- So, let me see if I have got this right: you have had this pain for 3 months, which starts in your back and goes to your leg ...
- What do you mean exactly by ...?
- Do you mean that ...?
- So, in other words ...
- Is everything clear to you?
- Is there anything you have not understood?
- Would you like me to explain it to you again?
- Are there any questions you would like to ask?

Closing the Consultation

When the patient senses that the consultation is over, they may ask:

- Is that it? or: Are we done?

Meaning:

- Is that all? Have we finished?

To which you may reply:

- Yes, that's it/we are done, if that's OK for you.

Unfortunately, some patients do not sense this and show no intention of leaving the consulting room. You can then say:

- Good, Mr. Jones. It was nice to see you. You are free to leave now.

Recording the Consultation

This is where doctors use and abuse abbreviations! Besides the abbreviations discussed in Unit VI, you will find another 3 common types:

- **slash** abbreviations
- **time** abbreviations
- **x** abbreviations

Some of the most popular abbreviations contain a slash (/). English speakers (or writers, in this case) are very fond of slashes, and use them profusely to invent abbreviated ways to write things:

C/O: complains of

H/O: history of

O/E: on examination

D/W: discussed with

F/U: follow up

R/V: review

C/S: culture and sensitivities (antibiogram)

Another peculiarity is the way they note the time. They use an interestingly complicated system: As there are 12 months in a year, 1 month is 1/12; as there are 52 weeks in a year, 1 week is 1/52; as there are 7 days in a week, 1 day is 1/7. Fortunately, they do not use this system for hours and minutes!

You may also see a simpler method using letters (which I am trying to promote in my practice), with the equivalences shown below:

3 seconds	3 sec	
3 minutes	3 min or mn	
3 hours	3 h	
3 days	3 d	3/7
3 weeks	3 w	3/52
3 months	3 m	3/12
3 years	3 y	

A third attraction for English speakers (sorry, writers!) is the letter “x”. They use it next to the main initial of a word to create another type of abbreviation:

Sx symptoms

Ix investigation

Dx diagnosis

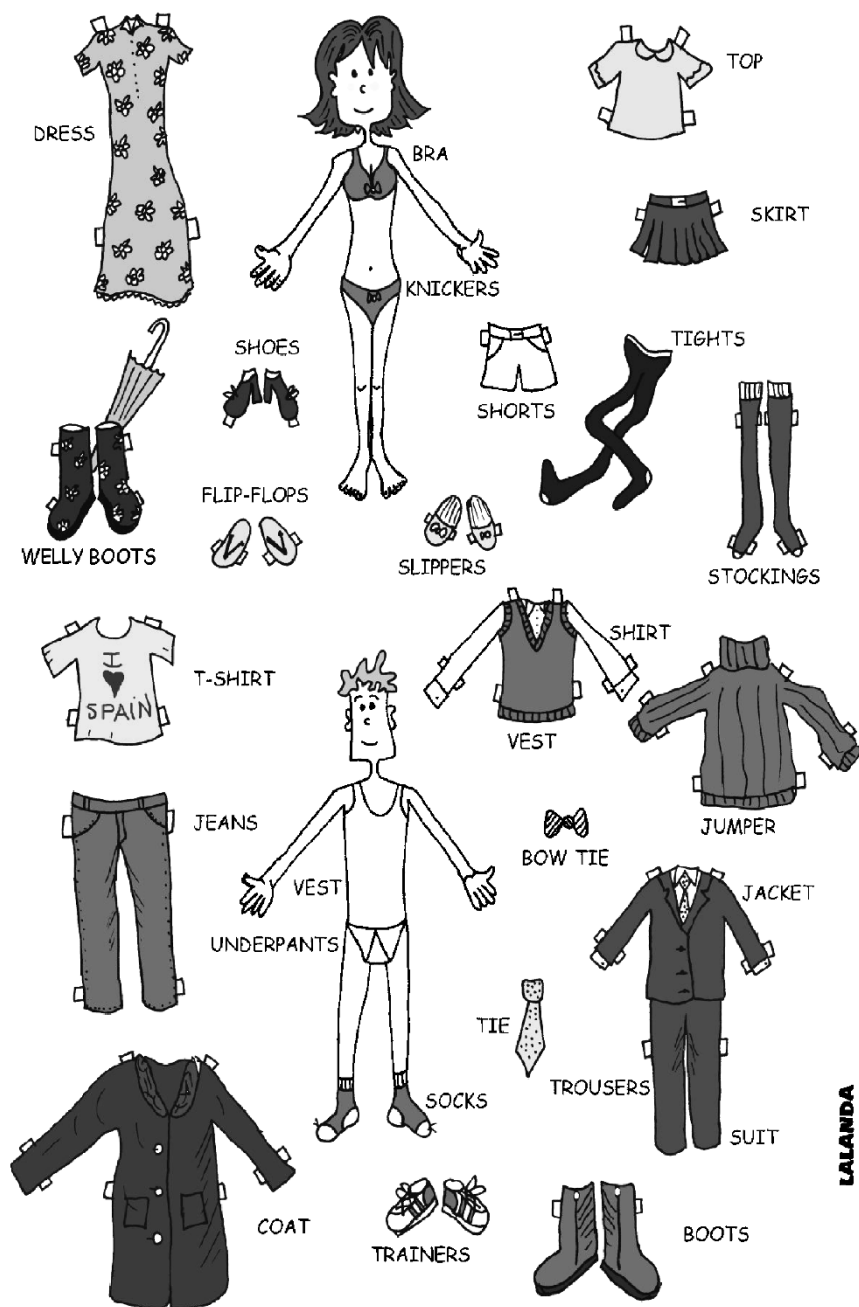
Rx prescription ... etc. (Do not confuse with XR for x-ray)

Note that a plural of an abbreviation is sometimes indicated with ‘s, as in *U&E’s* (*urea and electrolytes*).

Left and right are often abbreviated as L and R, sometimes encircled as ®.

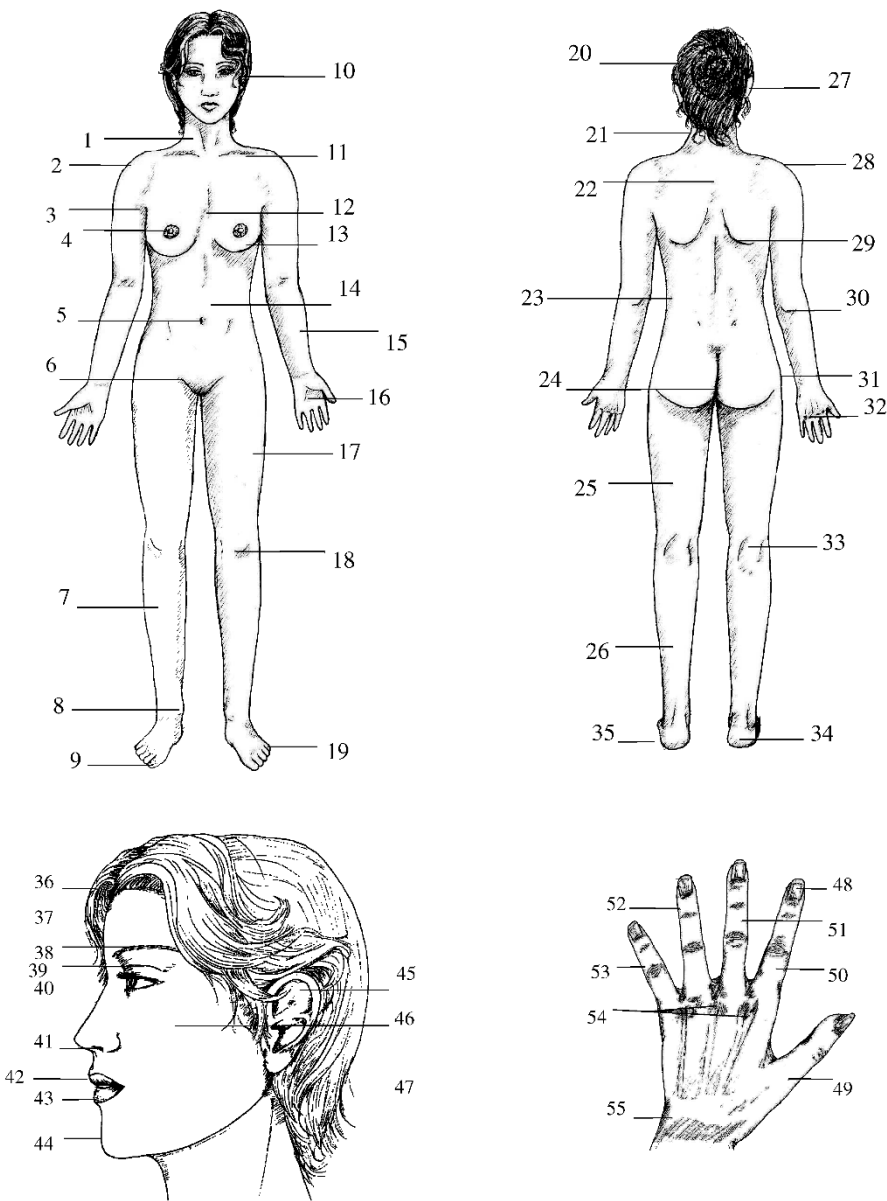
Clothes

Illustrations by Monica Lalanda



The Human Body

Illustrations by Nadia Sultan



The parts of the body may be expressed in three “languages”:

- (a) medical terms
- (b) lay (non-medical) terms
- (c) colloquial (informal) terms

1. throat	20. hair; under the hair: scalp
2. shoulder	21. nape
3. axial (a) underarm, armpit (b)	22. back: posterior area of the trunk = thoracic spine/area + lumbar spine/area or low back
4. nipple	23. waist
5. umbilicus (a) navel (b) belly button (c)	24. gluteal area (b) buttocks (b) bottom (c) bum (very informal)
6. inguinal area (a) groin (b)	25. thigh
7. shin (the front of the lower leg below the knee)	26. calf (plural: calves)
8. ankle	27. earlobe; inside: ear
9. great toe (big toe/1 st toe)	28. shoulder
10. head	29. scapula (a) shoulder blade (b)
11. clavicle (a) collar bone (b)	30. elbow
12. thorax (a) chest (b)	31. hip
13. breast	32. dorsal aspect of the hand (a) back of the hand (b)
14. abdomen (a) stomach (b) tummy, belly (c) Note that in lay terms 'stomach' is the front part of the body between the chest and the thighs.	33. popliteal space (a) back of the knee (b)
15. forearm	34. heel
16. volar aspect of the hand (a) palm (b)	35. sole (b) volar aspect of the foot (a)
17. thigh	
18. patella (a) kneecap (b) (anterior bone of the knee)	
19. little toe (5 th toe)	

36. hairline	48. nail
37. forehead	49. thumb (1 st hand digit)
38. eyebrow	50. index finger (2 nd h.d.)
39. eyelid	51. middle finger (3 rd h.d.)
40. eyelashes	52. ring finger (4 th h.d.)
41. nostril	53. little finger (5 th h.d.)
42. upper lip	54. knuckles
43. lower lip	55. wrist
44. chin	
45. earlobe	
46. cheek	
47. jaw	

Anatomical Terms

A review of all anatomical names is beyond the scope of this book; instead, let us just highlight some interesting points:

- **Skull** is more widely used in daily practice than **cranium**; however, the adjective for “related to the skull” is **cranial**.
- **Brain** is the part of the central nervous system contained within the cranium. **Cerebrum** refers to the largest portion of the brain, mainly the cerebral hemispheres. **Cerebral**: related to the cerebrum or the brain. In practice, “**brain damage**” is preferred to “cerebral damage”.
- **Mental**. (a) Related to the mind; (b) related to the **chin** [Latin: *mentum*, chin]. **Chin**: the prominence formed by the anterior projection of the mandible, or lower jaw. (Do not confuse with **shin**: anterior aspect of the lower leg over the tibial shaft).
- **Scalp**: the skin and subcutaneous tissue, normally covered by hair, covering the neurocranium.
- The **spine** is the structure formed of cervical, **thoracic** and lumbar **vertebrae** and the sacrum. Each **vertebra** is abbreviated as C1, C2, etc., T1, T2, etc., L1, L2, etc., S1, S2, etc.
- The **ribcage** is the structure formed by all the **ribs**. The adjective for “related to ribs” is **costal** (e.g. lower costal margin, subcostal nerve).
- You may say **kidney** disease or **renal** disease, **liver** problems or **hepatic** problems, **heart** failure or **cardiac** failure. In practice, the first options are more common.
- **Ulna** is preferred to **cubitus**, and **ulnar** to **cubital**.
- **Fibula** is the name of the lateral bone of the lower leg; however, the adjective for “related to the fibula” is **peroneal**.
- **Patella** is the anterior bone of the knee. The adjective is **patellar**.
- **Hip bone** = **pelvis** = ileum + ischium + pubis.
- **Pelvis** may also refer to all organs contained in the part of the abdomen enclosed by the pelvis. In practice, **pelvic pain** usually refers to pain in the pelvic organs (although this could be called *hypogastric* pain or pain in the *hypogastrium*, such expressions are not used in practice).
- Note that the inflammation of the (urinary) **bladder** is a **cystitis** and the inflammation of the **gallbladder** is a **cholecystitis**.
- The lungs, liver and brain have subdivisions called **lobes**. Smaller subdivisions within the lobes are called **lobules**.
- The adjective for “related to the **spleen**” is **splenic**.
- **Node** is a circumscribed mass of differentiated tissue, especially a **lymph node**. A **nodule** is a small node, or in practice, a small protruding lump that is usually palpable.
- **Vena cava**. Note that it is not “caval vein”.
- In the heart, the adjective for “related to the **atrium**” is **atrial**, and the adjective for “related to the **ventricle**” is **ventricular**.

Reader's Notes

Clinical Equipment and Stationery

Illustrations by Francesca Chen

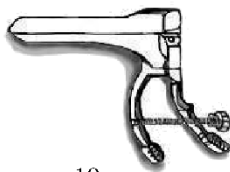
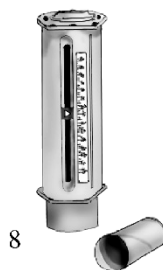
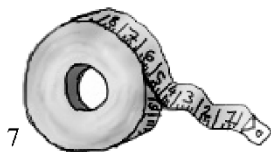
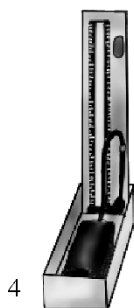
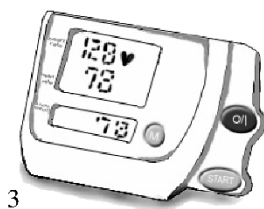
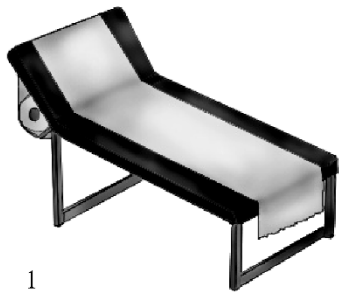
Sometimes the simplest things are the ones we have most difficulty with. You may know the names of diagnoses, symptoms, signs, tests and treatments ... but do you know how to ask the nurse for a spare BP cuff or the secretary for a stapler?

Here are the names of the most common objects present in a consulting room.

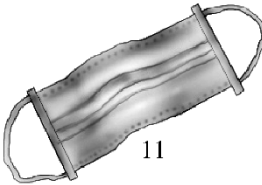
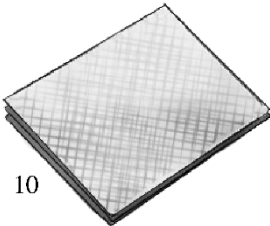
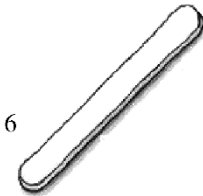
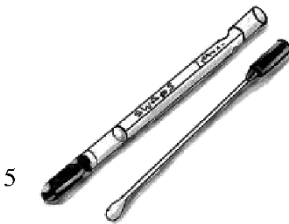
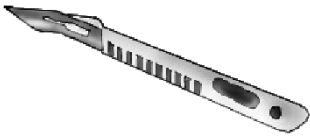
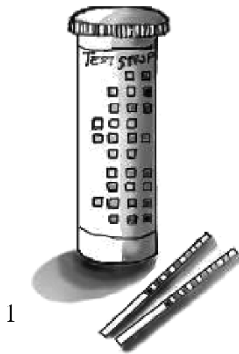
1. **Couch.** [kouch] Do not confuse it with a *coach* [kōch], which is a bus. Practise these pronunciations repeatedly: in *couch*, the vocals are pronounced as is “mouth” or “shout”; in *coach*, the vocals are pronounced as in “coat” or “boat”.
2. **Scale** [skāl], or **weighing scales.**
3. **BP digital monitor.**
4. **Sphygmomanometer.** Classic mercury “sphygmom” are now becoming old-fashioned.
5. **(BP) Cuff.** [küf] This is the part of the BP measuring equipment that connects the monitor or sphygmo to the patient’s arm and inflates around it. They come in several sizes (paediatric, standard, large).
6. **Reflex hammer.**
7. **Measuring tape.** [mězh'ərīng tãp]
8. **Peak flow meter** and **mouthpiece.** Mouthpieces can be re-usable (plastic) or disposable (cardboard).
9. **Sharps box.** Yellow container for sharp material (needles, etc.).
10. **Speculum.** Plural: “specula”.
11. **Gloves.** [glŭv]



12. **Stethoscope.**

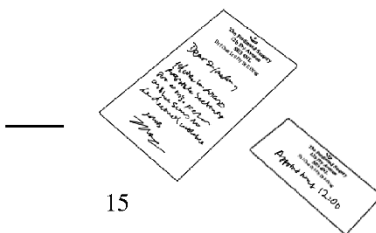
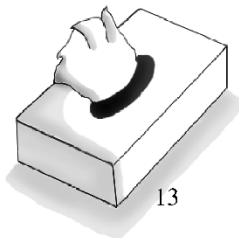
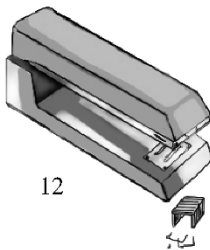
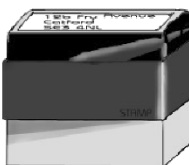
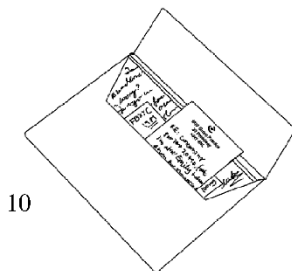
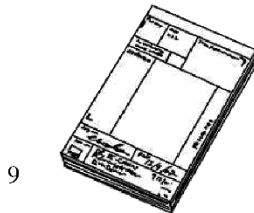
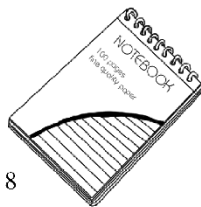
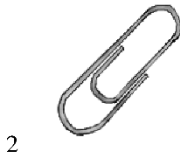


1. **Test strips.** Strips that are dipped inside a fluid to test for something make up part of a “dipstick” test. Typically, we will have test strips in our surgery for a “urine dipstick” test or urine testing.
2. **Stitch cutter.** These are used to cut stitches. Stitches are the pieces of thread that the surgeon leaves in the skin to close a wound.
3. **Tongs, tweezers, forceps.** Note that all these are always in plural, either mentioned alone or as “a pair of” (a pair of tongs, a pair of tweezers, a pair of forceps).
4. **Cytology brush.** For cervical smears.
5. **Swabs.** To take specimen samples from wounds or the vagina, etc., for microbiology tests. “Charcoal Swabs” are the most common.
6. **Tongue depressor.**
7. **Specimen bottle.** There are different types for urine, feces, sputum, etc.
8. **Surgical tape.** Adhesive tape used to fix dressings.
9. **Dressings.** Of various types, used to dress (cover and treat) wounds. A **bandage** is a long strip that is wrapped around an injured part of the body.
10. **Gauze.** [gôz] A dressing made of loosely woven material, such as cotton, that is applied in many layers to wounds. In practice however, they are simply called “dressings”. The simplest version you can prescribe is “NA dressing” (non-adhesive).
11. **Surgical mask.**
12. **Plaster.** Adhesive strip to protect small wounds. Note that “plaster” is also the hardened material used to immobilise fractures.
13. **Syringe.** [sə-rɪnj]
14. **Needle.**



Stationery is the collective name given to writing and other office materials. Do not confuse with “*stationary*” which means “not moving, not changing”. A patient in ICU (intensive care unit) may be said to be in a stationary condition.

1. **Battery/batteries.**
2. **(Paper) clip.**
3. **Eraser or rubber.** [ĩ-rā'sər or rüb'ər]
4. **Drawing pin.**
5. **Highlighter.** [hĩ'lĩ'tər]
6. **Adhesive tape.** [ād-hě'siv tāp]
7. **Rubber band.**
8. **Notebook.** In this case, ring-bound notebook.
9. **Prescription pad.** Containing about 50 prescription forms.
10. **Envelopes.** A flat paper container usually used for sending a letter by post, usually sealed by a gummed flap. **Folders** are usually A4 size or larger, made of cardboard or plastic, and are used to contain many sheets of A4 paper, sometimes in a classified way, with or without ring binders.
11. **Stamp.** Device used with ink to stamp instantly on paper, for example, the name and address of the Practice. The stickers used on envelopes to send a letter by post are also called “stamps” (postage stamps).
12. **Stapler,** which is loaded with many **staples** and used to bind things together (to staple).
13. **Tissues** to offer to tearful patients.
14. **Calculator.**
15. **Headed paper** is any sheet that has a header printed on it, usually with the name and address of the Practice and the names of the doctors.
A **compliment slip** is small piece of headed paper (about a third of A4) that is used to write a brief note or to accompany something you send by post (a report, a book, etc.). It often has the printed phrase “with compliments”, as a greeting to the person who receives whatever is enclosed.



Tests and Diagnoses

Most test names will probably be very similar to those in your language as they have a common origin. The tests most frequently mentioned in primary care are:

Blood Tests

Haematology:

- FBC.** Full blood count, with:
 - RBC.** Red blood cells or erythrocytes
 - WBC.** White blood cells or leucocytes
 - Platelets.**
- ESR ★.** Erythrocyte sedimentation rate.

Biochemistry:

- Glucose.**
- U&Es ★.** Urea and electrolytes. Kidney function tests including creatinine, Na, K, eGFR (estimated glomerular filtration rate).
- Lipids.** Triglycerides and cholesterol (with or without HDL/LDL fractions).
- LFTs ★.** Liver function tests including AST, ALT, ALP (alkaline phosphatase) and bilirubin (with or without direct/indirect fractions). Gamma-GT may need to be requested separately.
- TFTs.** Thyroid function tests (TSH, T4).

Blood tests are sometimes generically called “**bloods**”. You would often say that you have “**sent** a patient **for** bloods”, meaning that you have arranged blood tests to be done for them. In the clinical notes you may summarise this in the “Plan” section by simply writing: “for bloods”.

The **blood sample** may be taken at the practice or elsewhere by a nurse or a **phlebotomist**, a person who is specifically trained to do phlebotomy (extract blood from patients).

You will need to **fill in** a **request form**, either on paper or electronically. If on paper, you will probably have to **hand** it in to the patient to take with them to the phlebotomy clinic.

The form may have several **boxes** where you can **tick** to choose the tests you want done (☑).

Once the blood sample is taken, it is sent to the **laboratory** for analysis (often at the hospital). Please pay attention to the pronunciation of the word *laboratory* [lāb'rə-tôr'ē] and note that in British English the stress is on the first “**o**”; avoid stressing the first “a” as it may sound like “*lavatory*” [lāv'ə-tôr'ē], which means WC! in London (in American English, however, the stress at the first ‘a’ is common).

A few days later you will receive a **report** with the **results**. You may then say that they have “**come back normal**”, or that the ESR is “**raised at**” (or increased at) 50 mm/h or the sodium is “**low at**” 122 mEq/l.

If you do not receive the report and you can ask a receptionist to **chase the results**, i.e. to contact the lab to request a copy of the report. Hospital doctors’ reports or follow-up appointments can also be “chased” when they seem to be missing.

Microbiology

Serologies may need to be requested in blood tests to check for infections or immunological state (viral hepatitis, syphilis, etc.)

Other specimens may need to be taken for microbiological examination, such as:

Urine. Typically you would write on the request form:

- Specimen/sample: **MSU**. Mid-stream urine.
- Test requested: **C/S**. Culture and (antibiotic) sensitivities.

Vaginal discharge (exudate).

- Specimen/sample: **HVS**. High vaginal swab.
- Test requested: mycology, bacteriology, *Chlamydia*, etc.

Other specimens: wound or ulcer, sputum, ear discharge, etc., usually require “C/S”.

Imaging Tests

X-rays and **scans** are the two main options here.

X-rays (radiograph, Roentgen rays) are often abbreviated:

- CXR.** Chest X-ray.
- AXR.** Abdominal X-ray.
- KUB.** Kidneys, ureters and bladder.

Scans may be of three major types:

- USS.** Ultrasound scan
- CT scan.** Computerised tomography.
- MRI scan.** Magnetic resonance imaging.

Other Tests

- Many invasive tests end in “**oscopy**” (endoscopy, bronchoscopy, laparoscopy)
- Many function tests end in “**ometry**” (spirometry, manometry)
- Many analytic tests just have the name of the specimen (saliva test) including or not the substance analysed (urea breath test) or reflect the procedure (**exercise test** for screening of ischaemic heart disease).

Diagnoses

Note that the plural for diagnosis [dī'æg-nō'sis] is diagnoses [dī'æg-nō'sēz] (as hypothesis/hypotheses, crisis/crises).

A patient is said to be “**diagnosed with**” a disease or condition, or “**diagnosed as having**” a disease or condition. You may also say that they **suffer from** a health problem, which may be a diagnosis (e.g. duodenal ulcer) or a symptom (e.g. indigestion).

English-speaking doctors do not use the technical Latin- or Greek-derived names for diagnoses, signs or symptoms as much as the Latin-language speakers do. They would prefer to say or write *chest infection* rather than bronchitis or pneumonia, *shortness of breath* rather than dyspnoea, *pain on swallowing* rather than odynophagia, *low back pain* rather than lumbalgia, etc. You can use them, but some may find it a bit pedantic!

Medication and Prescription Language

I am a good patient, doctor, I take all my tablets. Patients often refer to all types of solid oral medication as “tablets” or “pills”, whether they are tablets, capsules or lozenges. **Tablets** are made of compressed powder, **capsules** have a gelatine container, and **lozenges** dissolve in the mouth (especially for sore throats). When we prescribe “**soluble**” tablets, patients dissolve it in water first and then drink the solution. Most tablets are **swallowed** (down the throat), but others are to be **sucked** (with movements of the tongue) or **chewed** (with the teeth).

I cannot swallow tablets, can't I just take medicine? Although **medicines** or **medications** are terms used to refer to any form of therapeutic drug, when a patient refers to “medicine” they often mean a drug in its liquid form, i.e. solutions and syrups. These are often dispensed with a 5-ml oral syringe or spoon. Other forms of administration of drugs are: intramuscular (i.m.), subcutaneous (s.c.), intravenous (i.v.), transdermal (**patch**) or **syringe driver** (device for continuous subcutaneous infusion).

Are there any natural remedies for this? I am not a pill taker. **Pills** is another collective name for oral medication or prescribed medication in general. “**The pill**”, however, refers to the contraceptive pill. People who do not like to take prescribed medication tend to seek “**natural remedies**” or “complementary/alternative medicines” including “**herbal medicines**” such as those offered in Chinese medicine.

You can buy paracetamol over the counter when needed. Medicines that are obtained without prescription (some can be bought in supermarkets) are called **over-the-counter (OTC)** medicines. Medicines that can only be obtained with a prescription are “prescription only medicines” (POM).

Judicious prescribing is very important. A **prescription** is a written order by a physician or other qualified practitioner that authorises a pharmacist to dispense a particular medication for a particular patient, having made such decision after the appropriate clinical judgement. To **prescribe** is to **issue** a prescription, and the person who issues it is the **prescriber**. Prescribers who are not doctors (e.g. nurses) are called **supplementary** prescribers.

This patient is on 10 repeats. Patients on chronic medication usually receive **repeat prescriptions** (informally called “**repeats**”) prepared regularly by administrative staff and signed by the prescriber. The physical piece of paper signed by the doctor may also be called a **prescription form** or **script**. This may be handwritten or computer-issued. The patient takes this script to a pharmacy or a chemist where a pharmacist will **dispense** it.

I have taken two packs of these tablets and I still have the pain. Tablets usually come in “**packs**”, which consist of a number of tablets in a container or **package** (e.g. a box).

I will look it up in the BNF. The British National Formulary (BNF) is the standard reference guide for prescribers (vademecum) in the UK, and is present on every GP’s desk. To learn more about medication language you can visit www.bnf.org. There you will find information about indications, cautions, contraindications, dosage, side effects, etc.

Doctor, these tablets are a different colour! **Generic** titles are also called “non-proprietary” (e.g. diclofenac) as opposed to “proprietary” titles, which have a **brand** name (e.g. Voltarol). European Law requires use of the Recommended International Non-proprietary names (INN), which can be found at www.who.int/druginformation. **Compound** medication has more than one drug component, and modified-release medication (“retard”) is abbreviated **MR** (e.g. Diclofenac MR).

I have come to collect my methadone script. **Controlled drugs (CD)** are those with a potential for abuse or misuse, and therefore have special requirements for their prescription (methadone, amphetamines, etc.).

Be careful if you need to drive: these tablets may cause drowsiness. Medications may have **side effects** which occur in many patients, e.g. drowsiness with sedatives. Some patients may suffer less common symptoms, which may lead to stopping the drug: these are called **adverse reactions**.

The dose of ramipril should be titrated according to patient's tolerance and renal function. To **titrate** is to increase or decrease (adjust upwards or downwards) sequentially a dose of a drug according to a number of factors (target, tolerance, etc.), in order to finally find the optimal dose.

You need to increase the dose of your BP tablets – I will prescribe you tablets with double strength. The **strength** is the quantity of drug present in each tablet (e.g. 5 mg); the **dose** is the quantity of drug that the patient takes at any one time (e.g. two tablets together = 10 mg) or at regular intervals; the **dosage** is the determination of the size of the dose and the intervals between them. When patients need to take the dose every 6 h, or every 8 h, etc. (e.g. antibiotics), we advise them to “*take the dose at regular intervals*”.

I prescribed the patient penicillin q.d.s. (spelt abbreviation). The following Latin abbreviations are used when prescribing:

o.d.	omni die	once a day (or once daily)
b.d.	bis die	twice a day
b.i.d.	bis in die	twice a day
t.d.s.	ter die sumendum	three times a day
t.i.d.	ter in die	three times a day
q.d.s.	quarter die sumendum	four times a day
q.q.h.	quarta quaque hora	every 4 h
p.r.n.	pro re nata	when required
o.m.	omni mane	every morning
o.n.	omni nocte	every night
a.c.	ante cibum	before food
p.c.	post cibum	after food
stat	immediately, now	

This patient overdosed last week. An **overdose** is a dangerously high dose of a drug, taken either accidentally (e.g. children) or intentionally (in a suicide attempt).

Letters, Reports and Certificates

The family doctor's clinical workload has two major components: what we call strictly “clinical” work (seeing patients) and what we call “**admin**” (administrative) work, which includes signing repeat prescriptions, checking results of tests, writing certificates and reports, and reading or writing letters. This is also called “**paperwork**”, although nowadays much of it tends to be done electronically. In this section we are going to look at:

- Letters
- Reports
- Certificates

Letters

There are various kinds of letters a GP may need to write. When communicating with other medical specialists or third parties about a patient, the general structure would be the following:

(Addressee)

Name and Address

Of the person you are writing to

(Sender)

Practice Name

Practice Address

Date

Re: Name and address of the patient
D.O.B. (*date of birth*)

Dear Dr./Mr./Ms./Sir/Madam ...

[Text of the letter]

Yours sincerely,

Your signature

Your name

The date in British English is expressed day/month/year; in American English it is expressed as month/day/year.

The “**Re:**” (Regarding) line indicates the matter you are referring to in your letter. When writing to a third party, the ‘matter’ is often ‘a patient’. When writing to a patient this line may not be necessary.

“**Dear**” is always used in formal letters without necessarily expressing affection. In any other context, to say that someone is “very dear” to you means that you love them.

Referral Letters

A referral is the act or process of asking a specialist to see a patient. Sometimes it is done over the phone, but most of the time it is done in the form of a letter. Nowadays, there is an increasing tendency to send referrals electronically, so the traditional referral letters are seen less frequently. Electronic referrals allow you to create a more summarised version of the traditional letter, which is usually typed in the “Reason for Referral” section of the computer system.

If you know the name of the doctor you are referring the patient to, you would write it in the Addressee space and after “Dear” (e.g. *Dear Dr. Starke*). If you are referring generically, you may write “*Consultant Cardiologist*” in the Addressee section and “*Dear Doctor*” further down.

In the UK, doctors who are surgeons are addressed as *Mr.* or *Miss* before their names (and would not like you to address them as *Dr.*!). Female surgeons are professionally *Miss* regardless of their marital status. Married female doctors in general may keep their maiden (pre-marriage) surname professionally – that is, they may be Mrs. White at home and Dr. Black at the practice, or Mrs. Green at the club and Miss Brown at the hospital.

The body of the letter will contain a summary of the patient's complaint, examination, investigations, diagnostic impression and reason for referral.

Examples

- *This 46-year-old hypertensive man is reported as having possible LVH and lateral ischaemia on routine ECG. He is asymptomatic and his blood pressure is now 169/98, on Bendrofluazide 2.5 mg daily. He does not tolerate Felodipine because of oedema or Enalapril because of erectile dysfunction. He does not have any other medical problems. I wonder if you would consider investigating these findings further. Thank you very much.*

LVH. Left ventricular hypertrophy.

- *This 46-year-old woman has no history of dyspepsia but has been suffering from low odynophagia for the past month. This has become worse in the past week and she describes it as a tight pain on the lower part of her sternum appearing on solids and liquids and lasting 1–2 h after intake. She finds some relief with co-proxamol and reports some subjective weight loss, which I have not been able to confirm. She suffers from a number of medical conditions and is on many medications – the list of which I enclose. Examination is unremarkable. I wonder if she suffers some degree of oesophageal spasm or oesophagitis. I would be grateful for your assessment.*

Intake – eating or drinking.

Unremarkable – no significant findings, essentially normal.

Enclose – attach, include in the paperwork you are sending.

- *This 35-year-old woman complains of vaginal bleeding on intercourse for the past 5 months. It has occurred a total of around seven or eight times, and she reports a good amount of blood, sometimes together with pain. She attended the sexual health clinic in November and was told she had thrush only. I took vaginal swabs, which were reported as positive for Candida; however, treatment with Clotrimazole has made no difference in the bleeding. I would be grateful for your assessment.*

Intercourse: sexual intercourse, coitus.

- *This 44-year-old patient has been diagnosed as having Helicobacter gastritis after serology, endoscopy and biopsy. He was prescribed triple therapy in October 2004, which improved his dyspepsia but did not resolve it completely. I wonder if you would consider arranging a urea breath test to check for persistent infection.*
- *This 89-year-old woman has a history of essential hypertension, LVH on ECG and LVF in 2002. There is also a history of high cholesterol recorded but no values available. Unfortunately, we cannot repeat a blood test because of her complete lack of cooperation. Likewise, she has a history of high glucose levels. The staff at her care home have managed to check her BMs occasionally and this has fluctuated from 5 to 15. At present she is only on treatment with diet and the enclosed medication. As she suffers from vascular dementia, it is not easy to take a history from her. She does not seem to have any chest pain or dyspnoea. Chest examination was unremarkable and there was no oedema. Her BP was 140/72 and pulse 81. I wonder whether an echocardiography to assess ventricular function would be helpful. I would be grateful for your advice.*

LVF. Left ventricular failure.

- *Thank you for sending us the results of the MRI for this lady with ulnar nerve pain. I note that this is normal, so we do not have a diagnosis yet. The patient has not received an offer of a follow-up appointment. She is still complaining of persistent pain to right side of the neck, shoulder and arm up to the fourth and fifth finger which often does not let her sleep. I would be grateful if you could review her and give me your opinion and advice.*

Sometimes we write to request that an appointment be brought forward:

- *This patient was referred to you in August by Dr. Shaw. Thank you for offering her an appointment for December; however, her symptoms are worsening and the patient and myself are getting increasingly concerned. I enclose the details of our last consultation. I wonder if there is any chance of fitting her in earlier.*

Bring forward: move to an earlier date.

Fit her in – include her in the list of patients to see.

Or to request information:

- *Thank you very much for the care of this 60-year-old woman with bipolar disease. I understand you are arranging regular blood tests for her to monitor her Lithium. I would be most grateful if you could routinely send copies of these results to me.*

Hospital Letters

The bulk of clinical letters received by the GP are often called “hospital letters”, although many of them do not come from the hospital but from other community specialists (mental health teams, social workers, etc.).

A hospital doctor signing a letter to the GP may be a:

- **Consultant:** a fully trained specialist who practises independently.
- **Specialist Registrar (SpR):** a doctor in the higher levels of specialist training. Also called *middle-grade* doctor.
- **Senior House Officer (SHO):** a doctor in the lower levels of specialist training. Also called *junior* doctor.

Non-consultant doctors would sign with their names followed by their Consultant’s name as follows:

Dr. Young, SpR to Dr. Old
Dr. Child, SHO to Mr. Knife

Discharge letters are sent to the GP when a patient leaves (is discharged from) hospital. These state:

- The date when the patient was admitted or the **admission** date, and the date when the patient was discharged or the **discharge** date.
- The consultant who has looked after the patient. It is said that a patient is **under the care of** a consultant. Informally, you may say that “Mrs. Pain is **under** Dr. Balm”.
- The **Ward** where the patient has stayed. A ward is a section of the hospital building with a number of beds for patients with similar types of condition. Interestingly, in Britain, hospital wards are often named after important individuals, e.g. the “John Smith Ward” rather than “Cardiology Ward”. Britons also like to give names rather than numbers to the buildings, and to give names to services according to their location (e.g. “Ladywell Unit” rather than “Psychiatric Unit”).
- The reason for admission, progress in ward, tests, diagnosis, treatment and medication on discharge.
- Any plans for **follow-up**, i.e. whether an **outpatient appointment** has been given for review at the hospital or elsewhere.

Outpatients letters are sent to the GP whenever a patient is seen at an outpatient clinic; these inform the GP of the outcome of hospital reviews, investigations and diagnostic conclusions, and provide management suggestions.

Examples

- *I am glad to say Mr. Turp's upper-GI endoscopy showed no major abnormality. There was a small polypoid lesion in the duodenum, which is almost certainly a leiomyoma. The biopsies from the polyp surface showed no abnormality whatsoever.*

I think it would be reasonable to repeat the UGI endoscopy in 12 months to make sure that the lesion is stable. I do not believe it requires any additional intervention at this stage.

If Mr. Turp's reflux symptoms are not settled with full-dosage proton pump inhibition therapy, please let me know and I will arrange for him to have pH studies and oesophageal manometry.

Whatsoever. Used to emphasise a negative statement, after words such as "none" or "anyone".

- *This 52-year-old patient was seen at the clinic on 21 March. She has been complaining of localised pain in the right iliac fossa since May 1996. She was quite a difficult historian, but I gather that her periods are regular and normal and she has no intermenstrual or postcoital bleeding. She has been investigated before at Benenden Hospital under the care of Dr. Bright and Mr. Handy and was diagnosed as possibly having a functional bowel disorder or irritable bowel syndrome. She had a hysteroscopy in 1996 performed at her local hospital, which revealed no abnormality. She also admitted to frequency and urgency but no stress incontinence.*

Abdominal examination revealed tenderness over the right iliac fossa in the appendix area. Vaginal examination revealed an anteverted normal-size mobile uterus with a normal-looking cervix. I do not think that the cause of her RIF pain is gynaecological, but I am organising a pelvic ultrasound for her and a urodynamic assessment. I will review these results and if both are negative I will arrange for her to see one of my colleagues here at Benenden to rule out chronic appendicitis as a cause of the pain.

A difficult historian is a patient that does not express himself/herself well, usually because they give contradictory or unclear accounts of their symptoms.

I gather that – the information available to me indicates that.

Admitted to – admitted having.

- *Thank you for referring this 62-year-old diabetic gentleman who has a 1-year history of bilateral painful shoulders especially on movement.*

On examination, he has a nodule in his left fourth finger consistent with a trigger finger, and decreased active and passive movement of both his shoulders consistent with bilateral frozen shoulders.

This condition is quite common in diabetes. It is not very responsive to corticosteroid injections; therefore, at the moment, I do not feel that the corticosteroids are appropriate.

I have referred him to the physiotherapist and I have given him a booklet to read and some specific exercises to do for his shoulders. Should his symptoms not improve, I would be quite happy to see him again for an injection.

For the moment I have not given him a further appointment.

Trigger finger: syndrome produced by stenosing tenosynovitis of the flexor of the thumb.

- *I reviewed this lady today at the request of the dermatologist. I am glad to report that the lymph node in her neck has settled and she requires no further intervention.
I have therefore discharged her back to your care.*

Letters to Patients

General practitioners may write to patients to remind them to come for health checks, to give results and advice or to respond to a patient's complaint.

Examples

- *I have received a letter from the mental health team suggesting you would be interested in acupuncture and social services referral. If you would like to discuss this, please make an appointment to see me.*
- *Your recent results show that your cholesterol is still high at 6.54. I would advise you to increase the strength of your Simvastatin tablets to 40 mg. I enclosed a prescription. You could still use the 20 mg tablets if you have them at home, taking two together at night. If you have any queries, please do not hesitate to contact me.*

Reports

A **medical report** is a document signed by a doctor providing information to a third party, and sometimes an opinion, on a patient's medical condition(s). **Insurance** companies may ask GPs for comprehensive reports on all the patient's medical conditions, in order to decide whether they will accept them as a client, or may ask for short reports to confirm the truth of a **claim** made by an insured patient who seeks compensation for harm covered by their policy (e.g. after an accident). **Solicitors** (lawyers) may also request reports from the GP to support the case of their client.

Some reports consist of a form with printed questions and some space to answer them. Other reports are free text, usually written on the Practice's

headed paper; most will have the format of a letter, although sometimes they may be a non-addressed document with the title “Medical Report” or “Statement of Truth”.

Examples

- *Thank you for your letter dated 15 May 2007 requesting a medical report for the above patient. Ms. Arch suffers from hypothyroidism for which she requires Thyroxine 100 µg daily. I enclose a letter from Kings College Hospital where she was last seen in October of last year. Her thyroid function has been very stable and she has been taking her medication regularly. Ms. Arch also suffers from raised cholesterol levels, which has been treated by diet alone. She has successfully reduced her cholesterol level from 7.08 in October 2005 to 5.7 in January 2006. At the moment she has declined medication but this will be reviewed in 6 months. She is also taking Omeprazole 20 mg once a day for gastritis. She will need to remain on the Thyroxine for life. We will continue to monitor her cholesterol level.*

If you require any further information, please do not hesitate to contact us.

I enclose an invoice for this report. Thank you.

Invoice: a written request for payment for a service provided. (In the UK, the NHS does not cover most reports to third parties, so GPs are able to charge for them as a private service).

- *Thank you for your letter of 1 October 2007 with reference to the above patient requesting information on his well-being. I apologise for the delay in replying.*

Mr. Groves initially presented back in July 2006 with bilateral leg pain and swelling. He was referred in September 2006 to a rheumatologist at Lewisham Hospital. After intensive investigation, he was diagnosed with Pes Planus or flat feet. He is currently receiving treatment through the podiatrist in the community. A referral for physiotherapy has also been made.

More recently he has been able to omit his crutches; however, he reports that he is unable to walk long distances and a journey for a court appearance would be too stressful for him.

I hope this information is sufficient for you and the court. I also enclose letters from the rheumatologist and the podiatrist.

- *I have seen Miss Bassi today for a medical examination. In reply to your questions:*

1. *Date of operation 12 October 2006, open myomectomy at Lewisham Hospital. Average recovery time is 6–12 weeks.*
2. *Miss Bassi has fully recovered from her operation and I have signed her fit to return to work.*
3. *She will be well enough to look after a 2-year-old child.*

I enclose an invoice for this report.

- *Thank you for your letter dated 10 April 2007 requesting a further report regarding the above patient.*

Ms. Watson's diagnosis is that of depression, which appears to be mostly work related. Ms. Watson has undergone intensive treatment including cognitive behavioural therapy (CBT), which is ongoing. She is also still taking antidepressant medication. I am only aware of work-related issues, i.e. grievances and disputes that may affect Ms. Watson's ability to undertake work tasks; however, I am not in a position to advise you or the employer as to what could be done to accelerate recovery and her return to work. I am also not in a position to comment on her ability to return to work or the estimated duration of her current condition. Given that depression could be either of a chronic or a relapsing nature, the long-term prognosis of Ms. Watson is somewhat difficult to estimate.

When I last met with Ms. Watson her mood had stabilised. She will continue with her ongoing treatment and we shall continue to review her on a regular basis. I hope this information is sufficient.

- *Thank you for your letter regarding the above patient. I can confirm that he suffers from the following:*

1. *Essential hypertension, on treatment with nifedipine 10 mg o.d.*
2. *Diabetes type 2, on treatment with metformin 500 mg t.d.s.*
3. *Low back pain, on treatment with physiotherapy.*

I hope this information is useful.

Or:

MEDICAL REPORT

RE: Mr. William Williams

I can confirm that the above patient suffers from the following medical conditions:

1. *Essential hypertension*
2. *Diabetes type 2*
3. *Low back pain*

He is on treatment with:

1. *Nifedipine 10 mg o.d.*
2. *Metformin 500 mg t.d.s.*
3. *Physiotherapy*

Signed

Dr. Mary Mars

Certificates

Patients request “certificates” from their GP in a number of situations:

I hurt my back and I need a certificate for work. In the UK, the patient’s employer would usually require the patient to provide a doctor’s **certificate** or **sick note** when they need to be **off** (absent from) work for more than a week. This is a document signed by the GP (a printed form that is filled in) stating the patient’s diagnosis and the period of time they are advised to refrain from work. This kind of certification is what patients normally call “a certificate”. The opposite kind is the “**fitness**” certificate, which states that the patient is **fit** to do something (able to do something without risk to themselves or others): fit for work; fit to travel; fit to drive, etc.

I haven’t gone to work today and my employer wants a doctor’s note. In the UK, by law, workers have the right to be absent from work due to illness for up to 1 week without requiring a doctor’s sick note. Workers themselves would usually sign a **self-certificate** for the employer, declaring that they have been sick; however, some employers may insist on the employee getting a certificate from the doctor – in these cases the GP can sign a **private certificate** for which the patient or employer would pay a fee.

Doctor, I need a paper from you to get free prescriptions. “**Exemption certificates**” are given to some patients (diabetics, etc.) so that they do not need to pay (they are exempted from paying) for their prescriptions. The “maternity certificate” is required by pregnant women and states the expected date of delivery (or confinement).

The relatives of the deceased will collect the death certificate from the practice. When a patient dies, a doctor is called to **certify the death** (declare that the person is dead). Then, their usual GP is asked to issue a **death certificate** stating the cause of death. If the GP does not know the cause of death, they need to refer the case to the **coroner** who will decide whether a post-mortem examination (autopsy) is needed. If the deceased is to be cremated (incinerated), a **cremation certificate** will be requested from the GP as well, stating further details of the circumstances of the death.

Meetings

Most family doctors attend regular meetings within their practice. These are essentially of two kinds: clinical or organisational.

Clinical Meetings

The purpose of clinical meetings is usually to discuss cases or topics.

Presenting a Case

*I first saw Mrs. Caroline James 6 months ago. She is a 63-year-old woman who **presented with** a 3-month **history of** severe joint pains. She also **complained of** a burning pain on passing urine for the past 2 weeks. She has no past medical history or family history **of note**. She lives alone. She does not drink or smoke. **On examination**, she had notable deformities in her hands and feet. Chest and abdominal examination was **unremarkable**. I **requested** blood tests, which **showed** raised rheumatoid factor at 178, and an MSU which **came back positive for** infection to E. coli sensitive to cefadroxil. The UTI **responded to** antibiotics but the pain was only partially relieved by NSAIDs. I **referred her to** the rheumatologist who **started her on** methotrexate last month. Unfortunately, she has developed significant neutropenia and this medication had to be stopped, with the pains worsening again. She is **due to be seen** again tomorrow at the hospital. Her daughter came to see me yesterday. She is very **concerned** that her mother is no longer able to look after herself and would like social services to **arrange** a home care package.*

Discussing the Case

- Would it be **worth trying** opioid type painkillers?
- I **would suggest** you phone the social worker ...
- I **wonder** if she has ...
- I wonder why ...
- I wonder if you should ...

Note that the expression “I wonder” makes everything softer and polite: asking for a favour or proposing an action (it makes it less authoritarian), giving an opinion (it makes it more humble), expressing doubt (it sounds less insecure), etc. It is used for everything with extreme frequency. I wonder if you use it enough?

Organisational Meetings

There are many kinds of organisational meetings in a general practice. Two major types are **practice meetings** and **management team meetings**. The former is attended by all members of the practice team and the latter by the members of the management team (in the UK: the practice managers and the GP partners).

In all cases, meetings contain the following elements:

Agenda. The written list of **items** or program of things to be done or considered during the meeting, which is circulated to all the attendees before the meeting takes place. The first item is usually the *Apologies*, where those who have been unable to attend are noted. The last item on the list is usually *AOB: Any Other Business*, referring to any new matters that may arise during the meeting.

Discussion. Polite expressions help a constructive atmosphere:

Agreeing:

- I agree with that.
- That's a good point.
- I couldn't agree more.

Disagreeing:

- I am not sure about that.
- I do not think that would be a good idea.
- I am not keen on that.

Proposing:

- I wonder if we could do this instead ...?
- I wonder if we should consider ...
- Is there any chance we could ...?
- What about doing this ...?

Concluding:

- I think the best option would be ...
- I would go for that.
- Are we in agreement?

Minutes. The written document summarising what has been discussed, what opinions were expressed and what decisions were made. This is usually done by the practice manager.

Chair. The member of the team who presents the items for discussion during the meeting and makes sure the time is kept. This may be **rotational** (a different one each time).

-It hurts here. It is a dull ache. More of a throb than a pain. It burns and sometimes it feels like a cramp. I would say it is a discomfort but at times it becomes sharp, like a stabbing pain. It can go from being sore to be excruciating. It is also very tender.



Unit IX The Language of Clinical Areas

Including adapted texts from
The Oxford Textbook of Primary Medical Care
Vol. II
(R. Jones et al., 2004)

In this unit I have worked together with 17 contributors, all of whom are foreign doctors currently practising or who have recently practised in the UK. As non-native English speakers, we have all been through the arduous and challenging process of learning and improving our medical English *hands on*, while seeing patients. This is why we are able to offer you that kind of teaching that really helps, that is, teaching based on real life, on our own mistakes and our own successes, inspired by our own learning.

Each chapter presents a working day in the life of a General Practitioner, focusing on one of the major clinical areas. We have blended our experience with our knowledge and imagination to create these stories and extract from them as much language teaching as possible.

The idea is that you are transported to this reality as a close observer, able not only to hear what is going on in a GP's practice from the inside, but – most importantly – able to understand everything, as we take you by the hand and explain all the smallest details. We know what questions you would be likely to ask if you came to see us work, so ... here are some answers.

Similarly to Unit VII, the pages on the left contain the stories and the right pages offer linguistic comments and explanations. The punctuation code used is:

A dot (.) following the expression means a formal or general definition.

A colon (:) means an informal or contextual definition.

A dash (–) is used when a phrase is replaced by another one with a similar meaning.

A dash and dot (–.) is used when an expression is not followed by a definition but by a comment.

Abbreviations commonly used in spoken language are marked ★. These are spelt type abbreviations (read letter by letter) unless specified differently.

Welcome to real “GP-land”. Enjoy your reading!

Cardiovascular System

with Meritxell Atxa

Dr. Atxa had had a lovely weekend, and was looking forward to starting her surgery. She was fully booked and there were two extra patients waiting for any cancellations. Surprisingly, she was running on time when her eighth patient arrived. He was a 53-year-old man, with well-controlled high blood pressure on two drugs, with a family history of CVD.

- *Good morning, Mr. Brown.*
- *Good morning, doctor.*
- *Please, take a seat. What can I do for you today?*
- *Well, I do not want to waste your time, doctor, but for the past 2 weeks I have been suffering with some kind of discomfort in my chest.*
- *OK, Mr. Brown. How often do you suffer with it?*
- *Not very often. You know, my grandchildren's school is just up the hill, and every time I go there to pick them up I feel this ... [The patient was not sure how to describe it properly] pain in my chest. I have no problems at any other time. But you know, doctor, my back went just 3 weeks ago, so it could probably just be old age, or maybe lack of exercise?*
- *Well, Mr. Brown. I am just going to ask you a few more questions to see if I can find out the root cause of the problem. Can you describe the pain, please?*
- *Well ... it's like a pressure over this bone here [pointing to the sternum].*
- *It feels like someone is sitting on my chest and I feel short of breath, too. But as soon as I stop, the pain goes.*
- *Have you had this pain before?*
- *Not that I can remember, doctor. It has only been like this for the past 2 weeks.*
- *Does the pain move to any other parts of your body, or does it stay there all the time?*
- *As I said, it only lasts a few minutes and then stops, but occasionally it goes to my neck and I can feel something in my throat, like somebody is squeezing it and I cannot breathe properly. And for the past few days I've been clammy and quite anxious when I've had the pain. My wife is very worried about it, too.*
- *Mr. Brown, is there a history of heart problems in your family?*
- *Yes, doctor. My father died of a heart attack. He passed away when he was 64. As far as I can remember he was on some kind of medication for this, but he was very bad at taking pills and he did not like coming to the surgery.*
- *Does the pain wake you up at night?*
- *No, doctor, not at all. In fact, I can sleep very well.*

She was fully booked – her 15 appointments were taken; 15 patients had booked an appointment for that clinical session and no more patients could be booked.

Cancellations: When a patient cannot attend their appointment, they should call the Practice and explain that they will not be attending, so another patient can use that slot.

She was running on time – she was not late, she was not delayed, she was seeing each patient at the time they had booked. Rarely happens!

High blood pressure is more widely used than the medical term “**hypertension**”.

Antihypertensives are also called “BP-lowering tablets”, or by the patients, “BP tablets”.

BP ★. Blood pressure. Very commonly used abbreviation among professionals and patients. “*I’ve come for my BP check, doctor*”.

White-coat hypertension is a BP artificially raised in a patient that feels anxious when visiting the doctor or nurse. This term is still used in the UK, even though GPs and practice nurses do not wear white coats!

Family history is the health background of his direct relatives, mainly his parents and brothers and sisters.

CVD. Cardiovascular disease.

My back went – I felt a sudden pain in my back that seriously limited my physical capability.

It may be lack of exercise – This may happen because I do too little exercise.

The root of the problem – the origin, the ultimate cause of the problem.

Short of breath – He feels he has difficulty breathing and cannot get enough air.

Squeeze: to press something firmly in the hand or between two other objects.

Clammy: profuse sweating resulting in a cold, damp feeling.

Sweat. The clear salty liquid that passes to the surface of the skin when somebody is hot or as a result of intense activity, fear, anxiety or illness.

Heart attack: Myocardial infarction.

MI ★. Myocardial infarction. Very widely used abbreviation, in writing and orally.

To pass away: To die.

He was very bad at taking pills – He did not take his pills regularly or did not take them at all.

Pills or tablets are the terms used by the patients to refer to any medication taken by mouth in a solid form.

antihypertensive [ān'tē-hī'pər-tēn'siv] sweat [swēt] anxious [āngk'shəs] myocardial [mī'ō-kär'dēōl] throat [thrōt] heart [härt]

- *And have you taken your pills today?*
- *Sure, doctor. It is the first thing I do as soon as I wake up.*
- *Good. I can see here that in your last blood test the cholesterol level was OK. This test was done 5 months ago, so it might be worth doing another test to make sure there are no recent changes. Is this OK with you?*
- *Yes, sure. No problem at all.*
- *I will need to check your blood pressure today and do some more examinations.*
- *Uhhmm ... what kind of examinations?*
- *Well, as I told you I will need to check your blood pressure [putting the BP cuff around his arm], and I would also like to check your breathing, heart beat and then I need to do an ECG.*
- *An ECG? What is that?*
- *I am sure you have had one before. We just need to put some cables onto your chest and limbs which will give us an idea of the state of your heart.*
- *OK, that sounds alright. Go ahead.*

Dr. Atxa performed the physical examination and everything was entirely normal. Heart sounds (HS) and respiratory sounds (RS) were normal and the heart beat was regular at 70 bpm. Blood pressure was 133/80 mmHg. He was asymptomatic now. At that point the doctor had spent the 10 min available for each patient.

After asking the patient to wait outside the consulting room Dr. Atxa spoke to the Practice Nurse. She asked her if she had time to do an ECG for Mr. Brown now. Fortunately, her last patient had not turned up and she had had two DNAs on that day. Five minutes later, the doctor had the ECG results and the patient was back in her room.

- *Well, Mr. Brown. The ECG results look good and your blood pressure is fine, so ...*
- *Thank goodness for that! So can I go home now?*
- *Well ... I can let you go home now but I need to do a referral to the hospital.*
- *Do I need to go to the hospital now?*
- *Not now, but I am pretty sure that you are in the early stages of angina. I will try to arrange an appointment for you within the next 3–4 days in the outpatient's clinic at the local hospital. They will contact you in 1–2 days to give you the exact date. I will also need to give you more medications. Firstly, you will now need to add to your daily medications a 75 mg dose of aspirin to be taken once a day. I will also give you a spray which should ease your pain. Every time you feel the pain again, you need to apply the spray under the tongue and wait for 1–2 min. The pain should go. But if you do not feel better do it again and wait another 2–3 min; if it is still not helping after repeating a third time, call 999. But listen to me carefully, this is very, very important: if you begin to have this pain more*

BT. Blood test.

It might be worth doing – It might be useful or of benefit.

The **BP cuff** is what inflates around the patient's arm when checking the BP.

Breathing: respiration. To ask about dyspnoea, we may ask "*Do you have trouble breathing?*". To check for orthopnoea we may ask: "*How many pillows do you sleep on?*"

ECG ★. Electrocardiogram. We use this abbreviated form almost always, both in writing and orally.

Alright = All right.

Go ahead: expression used to give permission to proceed.

HS. Heart sounds. When they are normal we may write I + II. Sometimes we may hear abnormal sounds such as a **murmur** produced by a valve anomaly (stenosis or incompetence). Murmurs may be heard in systole or diastole. They may be soft or loud, aspirative, harsh, etc. A "click" may be heard in patients who had a valve **replacement**.

RS. Respiratory sounds.

BPM. Beats per minute.

Heart **rhythm** may be regular or irregular. When it is abnormal we say there is an **arrhythmia**.

A BP of 133/80 mmHg is read: "133 **over** 80".

In the cardiovascular examination you may also check for finger **clubbing** (also called acropachy = thickening of peripheral tissues).

Had not turned up: Did not come to her appointment after booking it.

DNA ★: abbreviation in initials: "Did Not Attend". But colloquially has become a word. "This patient has had three DNAs in the past 3 months".

Thank goodness – thank God.

Pretty sure – quite sure, considerably sure, very sure.

Early stages: initial stage of development, not yet advanced; beginning of a process.

Angina: angina pectoris.

Ease your pain – relieve, improve your pain.

Arrange: to make a plan for something to happen. In this case it is a consultation with the specialist at the local hospital.

The doctor who will see the patient in the outpatients' clinic is a heart specialist or **cardiologist**.

999 ★: The UK and Ireland's emergency telephone number for all the emergency services: Police, Fire Brigade, Ambulance. In the rest of Europe: 112. When you call you will be asked "*Police, Fire or Ambulance?*".

available [ə-vā'lə-bəl] asymptomatic [ā'simp-tə-māt'ik] angina [ān-jī'nə] spray [sprey] arrhythmia [ə-rīth'mē-ə] rhythm [rīth'əm] but algorithm [āl'gə-rīth'əm]

frequently than normal, or the pain wakes you up at night, or does not disappear whilst you are at rest, please call 999 immediately. Do you have any questions?

Dr. Atxa started to feel a bit under pressure as there were three patients waiting in the waiting room.

- *So ... should I be worried? Is this a heart attack?*
- *Well, in my opinion it looks like you are suffering from angina. You will need an appointment at the hospital for more investigations just to be sure. When you go to the hospital they will ask you to walk or run on a treadmill under supervision. This will monitor your blood pressure and ECG again but this time while you are exercising. If this is angina, they will give you more medications and a follow-up appointment. I will contact the hospital now, if that's OK with you.*
- *Yes, doctor. Go on.*

Dr. Atxa now had four patients waiting in the waiting room. She phoned the local hospital but it was engaged. Ten minutes and three more attempts later, she was about to lose her temper when, finally, someone answered the phone! She asked to be put through to the RACPC. Eventually, another lady answered the phone. The doctor explained the situation and the lady arranged an appointment for the patient in 2 days time and, very kindly, advised to send a fax with the request to their clinic. Dr. Atxa added this to the growing "to do" list that she had on her desk. She explained everything to Mr. Brown again to make sure that he had understood. Then, she took a deep breath and pressed the button to send her next patient in.

After her morning session, around 12:30 p.m. whilst she was checking her paperwork, she received a telephone call; it was the Practice manager reminding her to attend the weekly clinical meeting. The agenda was quite full, as usual. That day, the district nurse had something urgent to say:

"Hello everyone. I saw Mr. Nicholson, one of our housebound patients today. I think that he needs a doctor's visit urgently. He is 68 years old, diagnosed with heart failure (NYHA class IV); with quite a lot of cardiovascular risks factors. This gentleman is a very obese ex-smoker. He was diagnosed with type-2 diabetes 10 years ago and currently requires insulin on a daily basis. He had his last echocardiogram less than a year ago, which showed LVSD. He had a CABG 8 years ago following acute myocardial infarction. He needs to take a lot of tablets daily and he is on domiciliary oxygen too, 16 h/day (as per cardiologist). For the past 18 months he has been on iron tablets for this chronic anaemia, probably due to a mixture of factors (poor diet, chronic renal failure, high doses of diuretics, etc.). He spends all day on the sofa,

At rest: not moving. The opposite is **on exercise**.

Treadmill: an exercise machine, typically with a continuous belt, that allows one to walk or run in place.

Follow-up appointment: new consultation planned to review the patient.

Go on: term used when you want to encourage somebody to do something.

The telephone line is **engaged** when it is being used in another call.

Put through to – pass the telephone line to someone else on another extension.

RACPC: abbreviation of “Rapid Access Chest Pain Clinic”, a specialist clinic allocated in most of the hospitals where you can refer patients with possible cardiac chest pain who do not need immediate admission.

“to do” list – list of tasks to be completed after finishing with the patients.

Make sure: – confirm.

Agenda. A list or programme of things to be done or considered. In this case it is the list of items to be discussed during the meeting. This list is often produced beforehand and then circulated so that everyone attending the meeting knows what will be discussed.

Heart failure: condition derived from the incapacity of the heart to function normally pumping the blood to the rest of the body. “**Cardiac failure**” is also used, but not “heart/cardiac insufficiency”.

Risk factors: conditions, traits and lifestyle habits that can cause a deterioration in health if not altered. The alteration of these factors can play a main part in preventing some fatal diseases.

On a daily basis – every day.

Echocardiogram: Ultrasound examination (by echography) of the heart. Interestingly, in practice, when we speak of “an echo” we refer to a heart echography or ultrasound scan, while the same kind of test in other parts of the body is called “ultrasound scan of ...” (e.g. “abdominal USS” but not “abdominal echography”).

LVSD. Left ventricular systolic dysfunction.

CABG ★. Coronary artery bypass graft. Pronounced “cabbage”.

Cabbage: a type of vegetable.

As per: according to, following somebody else’s instructions.

Iron tablets: Ferrous sulphate tablets.

Oedema. Swelling due to fluid collection.

Echo [ɛkˈo] cabbage [kəbˈɪʃ] iron [ɪˈɜrn] oedema [iˈdɛmə] anaemia [ə-nɛˈmɛ-ə]
failure [fælˈjər] diuretics [dɪˈə-rɛtˈɪk]

only moving to stand up and walk few steps to go to bed at night time. He was diagnosed with varicose veins ages ago and has been stable with chronic oedema in both legs for the past 2 years. As a result of his poor circulation in both legs, and the limited response to compression hosiery, in the past 6 months he has developed a pressure ulcer on his right ankle with two episodes of cellulitis in the right leg. As you can see, he has an impaired quality of life. His wife has been taking care of him, and although she is very supportive, his condition has deteriorated significantly in the past 24 hours. His breathing has become worse and the swelling has extended to his upper legs and his scrotum. Dr. Hussein (GP) increased his diuretics 5 days ago but he has not responded to medication. He has been quite lethargic all morning and his wife has rung saying that he is quite poorly and she is very worried. I visit the patient on a daily basis, but I would be very grateful if any of the doctors could go to assess him as soon as possible”.

There were three GPs in the meeting today and Dr. Smith was on call. Dr. Smith decided to visit Mr. Nicholson straightaway, as he was expecting a very busy afternoon surgery. The practice manager would pass him the minutes of the meeting afterwards.

Ten minutes later, Dr. Smith arrived at Mr. Nicholson's place. Mrs. Nicholson reported that her husband had been stable for the past 2–3 h but she was still quite worried about him. Mr. Nicholson had difficulty speaking due to his shortness of breath. His blood pressure was fine, but the oedema had extended to his upper legs and genital area and was very obvious. His lips were cyanotic. On examination there were crackles on both hemithoraces and his heart rate was irregular at 130 bpm. His JVP was up and a soft systolic murmur was audible on mitral focus. Dr. Smith felt that Mr. Nicholson was exhibiting signs of a rapid deterioration of his advanced heart failure, and a recent onset AF, so he called 999. Whilst they were waiting for the ambulance, Dr. Smith called the Medical Admissions Unit at the local hospital to let them know that Mr. Nicholson was on his way.

Varicose veins: dilated, tortuous, or lengthened veins due to valve failure and weakness in its wall, causing circulatory problems: aching on feet and calves, itching of skin, heaviness, tension and swelling in lower legs.

Ages ago – a very long time ago, in the past.

Compression hosiery: medical stockings or tights prescribed to treat venous insufficiency. The patient must put them on in the morning, before getting up from bed, and wear them all day. There are three compression classes: 1 (light support); 2 (medium support); and 3 (strong support).

In severe cases, nurses apply **compression bandages** after testing with echo Doppler.

Bandage. A long narrow strip of thin or elasticised fabric that can be wrapped around a wound or injured part of the body to protect or support it.

Pressure ulcer: area of skin that breaks down when you stay in one position for too long with restricted movements. It is most common over bony prominences.

Take care. To look after.

Supportive: understanding, caring and helpful.

Deterioration: worsening of the patient's condition.

Upper legs = thighs: part of the leg from knee to groin.

Scrotum: part of the male external genital area that protects the testicles.

Lethargic – in a low level of consciousness.

Poorly: informal way to say that someone is very ill.

Assess: to do a medical evaluation.

On call: Person who is available for a period of time to attend to all the unexpected patients who need immediate attention.

Straightaway: immediately.

Minutes: an official record of the proceedings of a meeting. These notes are often circulated around those who attended/could not attend afterwards as a reminder of what was discussed.

In the patient's place – in the patient's home.

Cyanosis: bluish discoloration of skin and mucous membranes due to not enough oxygen in blood.

Crackles: crepitations.

Murmur: abnormal sound detected on auscultation produced by the blood at its passage through the heart valves.

Focus, plural foci – The four sites of cardiac auscultation are the aortic, tricuspid, pulmonary and mitral foci.

Hemithorax: One side of the chest. Plural: hemithoraces.

JVP ★. Jugular vein pressure. When the jugular vein is prominent, we say the "JVP is up", which is a sign of heart failure.

Medical Admissions Unit. Special ward in the hospital in charge of receiving and assessing all patients with a medical condition that require immediate medical care.

AF ★. Atrial fibrillation.

Impaired [ĩm-pârd"] hemithorax [hẽm"ĩ-thôräks"] hemithoraces (plural) [hẽm"ĩ-thô"äsẽs] murmur [mũr'mər] aortic [ã-ôr'tĩk] mitral [mĩtrəl]

Respiratory System

with Meritxell Atxa

A 33-year-old man came to see his GP. He had attended the surgery 3 months before, when he had been diagnosed with a URTI. He lived alone and worked occasionally as a labourer. He complained of a cough that was harsh and dry, and had been going on for 3 weeks. He was requesting treatment for it and said that he always felt better after a course of antibiotics. He was late for his consultation and breathless on arrival, as he had been running to the surgery to get to his appointment on time.

- *Hello, Mr. Adams. Take a seat, please. What can I do for you?*
- *Hello, doctor. It is this cough again. I have made it much worse by running here today, but I am sure I will be fine! It is always the same after I have been exercising. All I need is a course of antibiotics and a bit of rest and I will be fine again.*
- *Well, Mr. Adams. How long have you been coughing like this?*
- *Oh ... I've had it for ages! Probably years, but I can cope quite well with it. I think I just need some antibiotics or maybe some cough mixture.*
- *Do you sleep OK at night?*
- *Not really, doctor. I have this dry cough at night, too, so sometimes I have problems getting to sleep, but I am used to it. The only thing is that sometimes I have periods of really bad sleep and I have trouble getting up for work the next day.*
- *Any other symptoms? Malaise, chest pain, sore throat, any phlegm?*
- *Lately, when I exercise, I have been feeling some tightness in my chest.*
- *Do you smoke?*
- *Smoke ... uhmm? Tobacco you mean?*
- *Yes, well ... anything. Tobacco, cannabis ...?*
- *Yes, I smoke around 20 cigarettes a day and very occasionally cannabis, but just to help me relax.*
- *Any alcohol?*
- *Yes ... only beer when I go to the pub.*
- *How many pints a week?*
- *Well ... around 20 pints a week.*
- *Is there anybody in your family who is diagnosed with asthma?*
- *No ... I don't think so. But when I was a child I did have one of those blue devices to help me breathe properly. It didn't really help much so I stopped it after a while.*
- *OK, Mr. Adams, if you don't mind I would like to examine you?*
- *Sure, doctor. No problem.*

URTI: Upper respiratory tract infection. **LRTI:** Lower respiratory tract infection. The respiratory system is composed of the **airways** and the lungs. The hospital doctor who specialises in respiratory conditions is the **chest physician**.

Labourer: Person who does a job which involves a lot of hard physical work.

Harsh. Unpleasant or uncomfortable. Difficult to deal with.

Breathless: breathing with difficulty, gasping. A **breath:** an inhalation or exhalation of air from the lungs. **To breathe:** take air into the lungs and then expel it. Note below the difference in “th” and “ea” pronunciation between the noun and the verb.

In practice, the technical terms **dyspnoea** or **dyspnoeic** are not commonly used. A patient would usually be said to be **breathless** or **short of breath**, or have **breathlessness** or **shortness of breath**.

SOB. Short(ness) of breath. Common abbreviation used in medical notes (not orally).

SOBOE. Short(ness) of breath on exertion.

Dry cough: a non-productive cough, a cough with no **sputum**.

Sputum: substance, such as mucus or mucopurulent matter, expectorated by mouth in diseases of the air passages. A more colloquial term for “sputum” is **phlegm**, used both by patients and doctors. When the cough is productive, patients would say they “**bring up phlegm**” or “**cough up phlegm**”.

When patients feel noises or secretions in their chest, they say they are “**chesty**” or their cough is “**chesty**”.

I have had it for ages – I have had it for a very long time.

I can cope well – I am able to live with it. When patients are not coping well with a symptom they may say they are “**fed up**” with it.

Cough mixture: solution to relieve the cough that can be bought in most shops and chemists. **Malaise.** A general feeling of illness or sickness without any specific diagnostic significance.

I have a **sore throat** – My throat is painful. “Sore throat” is a very common expression used by patients and doctors to refer to the pain that is usually due to pharyngitis. Patients may distinguish “**it is sore**” (diffuse discomfort, often of a burning nature) from “**it is painful**” (more localised and defined) or “**it aches**” (diffuse pain, usually dull and not severe, most often musculoskeletal).

Chest tightness: a feeling of restriction, as if the lungs cannot move inside the chest. Patients may say “my chest is tight”.

respiratory [rēs"pər-ə-tôr"ē] labourer [lā"bər] cough [kôf] sputum [spyōō'təm]
phlegm [flēm] course [kôrs] antibiotics [ān'tī-bī-ōt"īks]
breath [brēth] breathless [brēth'lis] breathe [brēth] breathing [brēth ing] malaise [mā-lāz"] device [dī-vis"] examine [ig-zām"īn]

On examination, he had dry skin and reported having had “a bit of eczema” when he was younger. He had been coughing whilst in the consultation room. On auscultation his chest was wheezy but there was no respiratory distress. He was tachypnoeic at 30/min. Pulse was 102, BP: 130/80, PEFR 450, with no fever.

On reviewing her notes, Dr. Atxa noted that he had presented with a dry cough on several occasions, with shortness of breath and wheezing about twice a year for the past 4 years. He had always been diagnosed with a chest infection or URTI. This had been treated differently each time with a variety of antibiotics and cough medicines. A peak-flow reading had never been recorded. He had never had a CXR.

The doctor decided that Mr. Adams appeared to be suffering from asthma. The diagnosis of asthma is a clinical one; there are no confirmatory diagnostic blood tests or radiological or histopathological investigations. In some people, the diagnosis can be corroborated by suggestive changes in lung function tests. One of the main problems in asthma is that it is often misdiagnosed as chest infection, so we need to keep in mind that a patient who has a prolonged dry cough following URTI may well have asthma. Another problem is that patients often tolerate significant symptoms for a long time before mentioning anything to the doctor, and they may even become used to the symptoms as part of their normal life.

Dr. Atxa sent the patient to see the practice nurse to check his peak flow and Mr. Adams was prescribed a course of short acting inhaled bronchodilators (relievers).

Many patients who have asthma neglect to take their treatment, so a further 5 min were spent explaining to the patient how to follow the treatment properly.

Mr. Adams went to see the practice nurse again the next day to learn how to use the peak flow meter, how to record the results and how to use an inhaler.

Changes in peak flow correlate with changes in severity of asthma. The peak-flow measurement is very useful, not only to confirm the diagnosis but also to check how well the medication is working. The patient is usually capable of checking and recording their own peak flow readings which improves patient confidence and reduces medical admissions.

The practice nurse also prepared a written personal asthma action plan for him. He was offered smoking cessation therapy, but he refused it.

Pint. A unit of liquid measure equal to one half quart or 0.473 litre in the United States and 0.568 litre in the United Kingdom. *UK:* a pint of a liquid, especially of beer or milk (informal).

Device: apparatus.

Wheezy: with wheeze or wheezing. **Wheeze:** to breathe with difficulty and noisily.

Respiratory sounds on auscultation:

- **Wheeze:** a whistling, squeaking, musical or puffing sound made by the air passing through narrowed airways. In a moderate asthma crisis we may hear wheeze everywhere in the chest – we would write in the notes “widespread wheeze”.
- **Rale** is used by some to denote rhonchus and by others for crepitation.
- **Rhonchus** (plural: **rhonchi**): sound with a musical pitch occurring during inspiration or expiration, caused by air passing through bronchi that are narrowed by inflammation, spasm or presence of mucus; if low-pitched, it is called **sonorous rhonchus**, if high-pitched, with a whistling or squeaky quality, **sibilant rhonchus** (wheeze). Well, all this is the technical theory, but in practice we just use the terms “rhonchi” (sonorous) and “wheeze”.
- **Crepitant** or **crepitant rale:** a fine bubbling noise produced by air entering fluid in lung tissue; heard in pneumonia, heart failure and other conditions. Often abbreviated “creps” in the notes.
- **Crackle.** In theory: short, sharp or rough sound often heard in pleurisy with fibrinous exudates. In practice, “crackles” are used as synonymous of “crepitations”.
- **Pleural/pericardial Rub:** sound produced by friction, heard in some pleuritis/pericarditis.
- **Stridor.** A high-pitched, noisy respiration, like the blowing of the wind; a sign of respiratory obstruction, especially in the trachea or larynx.

Tachypnoeic: breathing rapidly.

Note the expression “tachypnoeic at 30/min” to specify the respiratory rate. Similarly we say, for example, “the glucose was raised at 10 mmol/l” to specify the value.

RR. Respiratory rate (number of breathing cycles per minute).

CXR: Chest X-ray. Very common abbreviation used in medical notes (not orally).

He appeared to be – he probably was, it seemed that he was.

Misdiagnosed: diagnosed incorrectly.

Keep in mind: remember constantly.

eczema [ɛk'sə-mə] tachypnea [tæk'ɪp-nē'ə] radiology [rā'dē-ōl'ə-jē] radiological [rā'dē-ōl'j'ī-kəl] suggestive [səg-jēs'tiv] bronchodilator [brōŋg'kō-dī-lā'tər] inhaler [ɪn-hāl'ər] measurement [mēzh'ər-mənt] capable [kā'pə-bəl] improve [ɪm-prōv] rub [rüb]

- Well, Mr. Adams. One of the main points with asthma is the follow up of the condition and for this we need your cooperation.
- Absolutely, I am really keen to improve. What do I need to do?
- Most importantly, you must make sure that you continue with the treatment. I also think that you should try to cut down on your smoking as this can seriously aggravate your asthma. I am going to introduce you to a new device (peak flow meter) which will allow you to check how you are doing at home. Before each use you must make sure that the arrow on the peak flow meter is at the bottom of the numbered scale. You need to stand up straight. Remove any chewing gum or any food from your mouth. Take a deep breath, as deep as you can. Put the mouthpiece of the peak flow meter into your mouth making sure that you close your lips tightly around the mouthpiece. Be sure to keep your tongue away from the mouthpiece. In one breath, you must blow out as hard and as quickly as possible. Blow a “fast hard blast” rather than “slowly blowing” until you have emptied out nearly all of the air from your lungs. The force of the air coming out of your lungs causes the marker to move along the numbered scale. Note the number on a piece of paper. You will need to repeat the entire routine three times, and record the highest of the three ratings. If that sounds OK, we could do some practice here in the room now.
- Yes, sounds fine.

Mr. Adams did some practising in the room with the practice nurse until he got used to it.

- Well, try to do it at around the same time each day, and come back to see me in 3 weeks.
- Yes, I will. Thanks. See you in 3 weeks.
- Three weeks later, Mr. Adams returned to see the practice nurse. He had written down all of his peak flow readings on the chart as instructed and he had also noted down the days on which he did some exercise.
- Hello, Mr. Adams, how are you?
- Hello. I feel better now with the inhaler the doctor gave me.
- Good. Have you experienced any difficulty sleeping because of your asthma?
- Oh, yes. I have been waking up like I used to.
- Well, can you remember how many times a week?
- Yes. I have everything written down. It has been approximately two times a week. I woke up breathless and I could hear some wheezing in my chest.
- Have you had your usual asthma symptoms during the day?
- Just occasionally. But after taking the inhalers I felt much better. I needed them only once or twice a day.

I am really keen to – really interested in, really enthusiastic about, really wanting to ...

Cut down: reduce gradually.

Aggravate: make worse.

Arrow: this symbol →.

Straight: with no flexion.

Chew: masticate.

Instructions to patients

- **Take a deep breath in** (deep inspiration)
- **Hold your breath** (no inspiration nor expiration)
- **Breathe out completely** (full expiration).
- **Breathe deeply, in and out, with your mouth open.**
- **Breathe normally.**
- **Lean forward** (incline thorax anteriorly).

PFER. Peak flow expiratory rate. The device to measure this is the **Peak flow meter** (informally called “peak flow”). It is an inexpensive, hand-held device designed to monitor small changes in breathing capacity.

Hand-held – you can hold it in your hand.

Blow out. To expel a current of air from the mouth.

Blast: explosion.

Get **used to:** become accustomed to. “Used” is an adjective here.

Used to do something: did something frequently in the past. “Used” is a verb here (past of “use”).

Reading: result of a measurement such as BP readings, glucose readings, etc. A reading is a value (134/86 mmHg, 5 mmol/l, etc.).

Chart: an organised way to present data.

Note you may say ‘three times **daily**’, ‘three times **a day**’, or ‘three times **per day**’; ‘three times **weekly**’, ‘three times **a week**’, or ‘three times **per week**’.

arrow [āʀ"ō] reading [rēd ing]

- *Good. Has your asthma interfered with your usual daily activities at home or work?*
- *Not really. But I have been feeling an uncomfortable tightness in my chest and I start to cough whenever I have been exercising. It was always triggered by exercise.*
- *OK, Mr. Adams. I want to check you are managing with the medication the doctor gave you. Can you show me how you take the inhaler?*
- *Sure. When I feel short of breath, I put the inhaler in my mouth, I take a deep breath and at the same time I press down, like this. Then I hold my breath for a few seconds. I normally do this twice every time I need it.*
- *Good. You are doing it just right. What about smoking? Have you managed to cut down?*
- *Yes! I am really proud of myself. I am only smoking 10 a day now and I feel much better for it. I am determined to stop completely within the next few weeks, hopefully before my birthday.*
- *That is very good. You are doing very well. But as you are still having sleepless nights and as the symptoms persist whenever you exercise, your asthma does not appear to be completely under control. I think we need to move one step forward in the treatment. That means that I need to add a new inhaler to your treatment. Is this OK with you?*
- *Sure, whatever it takes.*
- *The new one is called a “preventer”. It contains an inhaler steroid called beclomethasone 200 µg. You need to take it twice a day, so it’s one puff in the morning and another one in the evening. This should help you to avoid waking up at night and it should reduce the symptoms you experience whenever you practise any sport. I need to see you again in another 3 weeks. Please carry on checking the peak flow and using the other inhaler as much as you need it.*
- *Thank you. See you in 3 weeks.*

Interfered. Action that hinders the progress of another person or event.

Trigger. An event that precipitates another event. Asthma triggers are pollen, exercise, smoke, etc.

Whatever it takes – the patient means that he would do anything that is necessary to improve his asthma.

You are **determined** when you have made a firm decision to do something, for example, to **give up** smoking (stop smoking).

Move a step forward – progress to a more advanced point in a plan.

Inhalers

Inhaler. Medical device use for delivering medication to the body via the lungs. The standard metered-dose inhaler (MDI) on activating releases a fixed dose of medication in aerosol form. There are also dry powder devices.

Puff: A short gentle burst of air. In this case a puff from the inhaler, a puff of medication.

We often explain to patients that inhalers are of two major kinds:

- a. Relievers:** they directly improve breathing (bronchodilators).
 - **Short acting** – their effects lasts for a short time (e.g. salbutamol).
 - **Long acting** – their effects lasts for a long time (e.g. salmeterol).

- b. Preventers:** they indirectly improve asthma control (steroids).

Inhaler devices come in many forms such as MDI (metered dose aerosol inhaler), turbohaler, breath-actuated, etc. A **spacer** is often prescribed for children or the elderly; it is attached to the inhaler to facilitate inhalation.

Auscultation: lung zones

RUZ. Right upper zone.

RMZ. Right medium zone.

RLZ. Right lower zone.

LUZ. Left upper zone.

LLZ. Left lower zone.

Chest X-ray: lung lobes

RUL

RML

RLL

LUL

LLL

tightness [tīt'nēs] determined [dī-tūr'mīned] control [kən-trōl] beclomethasone [bēk lō mēth'ə-zōn]

Ear, Nose and Throat

with Cristina Melchor

Dr. Cristina Melchor was wondering how many home visits she would have to do in the afternoon when her final patient of the morning, Mr. Moody arrived with a knock on the door. Mr. Moody was a very pleasant 75-year-old gentleman.

- *Good morning, Mr. Moody!*
- *Good morning, doctor.*
- *Please have a seat. How can I help you today?*
- *Well, my Mrs. sent me to see you because she thinks that I am getting hard of hearing! She says I keep ignoring her, I listen to the TV too loud and I never hear the doorbell or the phone ring!*
- *And what about you, Mr. Moody? How do you feel about your hearing? Have you noticed any difficulties yourself?*
- *Well, I don't like to admit it but ... yes. Lately, I have had trouble using the telephone; I always have to listen with my right ear. Also, when we go shopping it sounds as though everyone is mumbling when they speak ... mind you, youngsters nowadays really don't speak clearly, do they?*
- *OK, Mr. Moody, have you experienced any other problems such as dizzy spells?*
- *Well, I do feel a bit giddy sometimes.*
- *Right, can you tell me any more about that?*
- *Well, sometimes I get a bit off balance.*
- *What do you think triggers these "off balance" episodes?*
- *Mainly when I try to reach for something on a high shelf, or if I turn my head too quickly I get dizzy and I have to hold onto something, just for a few seconds, until it stops.*
- *Do you have neck stiffness as well?*
- *Oh yes! Plenty of it! My neck clicks a lot ... sometimes I think I am falling apart, doc!*
- *Well, we don't grow any younger, do we, Mr. Moody?*
- *No, I'm afraid we don't.*
- *OK. Have there been any other symptoms such as earaches or discharge from the ear?*
- *Nope.*
- *What about headaches?*
- *Not really, just the odd one, now and again.*
- *Any ringing or buzzing noises in your ears?*
- *Oh yes, now that you mention it, I do get this buzzing noise in my ears sometimes, especially when I am in bed and it is quiet.*

ENT ★ or otorhinolaryngology is the medical speciality that deals with ear, nose and throat problems. The specialist doctor in this area is called ENT specialist or ENT surgeon.

My Mrs. – My wife or girlfriend (colloquial). **Hard of hearing** is said of someone who cannot hear very well.

When taking a clinical history we may ask: *Do you have any trouble with your hearing?*

Deaf is someone who cannot hear at all, or can hear little. **Mumbling** – not speaking clearly. **Youngsters** – Young people, usually used by elderly people in reference to teenagers. **Dizzy spell**: short episode of dizziness.

Dizziness. Many different terms are often used to describe what is collectively known as **dizziness**. Common descriptions include words such as light-headed, floating, woozy, giddy, confused, helpless or fuzzy. **Pre-syncope**, **vertigo** and **disequilibrium** are the terms in use by most doctors. Dizziness is sometimes a symptom of a balance disorder. It may be part of the condition called **motion sickness** or **kinetosis**, which many people suffer when travelling, especially in a boat.

- **Pre-syncope** is most often described as feeling light-headed or **feeling faint**. **Syncope**, by contrast, is actually fainting, or having a **faint** (losing consciousness).
- **Vertigo** is a specific medical term used to describe the sensation of **spinning** or having the room spin around you. Most people find vertigo very disturbing and often report associated nausea and vomiting.
- **Disequilibrium** is the sensation of being off balance, and is most often characterised by frequent falls in a specific direction.

Off balance. Suffering from unsteadiness or loss of balance when standing or walking. When Mr. Moody feels “off balance” he may fall.

Stiffness: rigidity. **Falling apart** – colloquial expression for something that is disintegrating, breaking up into fragments, often used by patients when they feel their health is deteriorating in many ways.

Earache. Ear pain, otalgia.

Discharge: fluid coming out.

Nope. Colloquial for “no”.

The odd one – occasional, very infrequent headaches.

Now and again – occasionally, infrequently.

Ringing and **buzz**ing – onomatopoeic words for certain noises.

Mrs. [mɪs ɪz] dizzy [dɪzˈi] faint [faɪnt] earache [ɪrˈæk]

- Yes, we call that “tinnitus”. Mr. Moody, I would just like to examine your ears if that is all right?
- Yes, that would be fine, doctor.

Dr. Melchor reached for her auroscope and began the examination.

- Could you just tilt your head for me, Mr. Moody?

She inserted the auroscope into the patient’s right ear and after having a good look said:

- Well, Mr. Moody, there is a significant amount of wax in your right ear. I could hardly see the drum! I’ll just take a quick look in your left ear now.

Dr. Melchor moved round to the other side of the patient, gently tilted his head and inserted the auroscope into the left ear.

- Yes, hmmm, this one also has a lot of wax inside. Well, Mr. Moody, first of all we need to get your ears syringed by our nurse and then we will send you for an audiogram at the ENT department at the Hospital.
- An audiogram?
- Yes, that’s right. Nothing to worry about. It is a hearing test to check the degree and type of hearing loss you are experiencing.
- And will they help me if I am going deaf doctor?
- Hopefully yes! If the hearing tests show an age-related deafness, which is what I suspect you have, then they will be able to fit you with a hearing aid. How would you feel about wearing one of those?
- Well, if it helps me to hear and if it keeps my Mrs. happy then I will go for it!
- Good, OK, I will organise for you to have your ears syringed and in the meantime I would like you to use some olive oil drops. These will soften the wax and facilitate shifting it; I’ll just write you a prescription.
- Don’t worry doc! I’ll get them over the counter; I don’t want to keep you!
- Fair enough; is there anything else I can do for you today, Mr. Moody?
- No, thank you doctor, that was all.
- OK, then ... give my regards to Mrs. Moody!
- I will! Thank you very much.
- My pleasure. Have a good day, Mr. Moody!

As there were no visits requested, Dr. Melchor could have a good half hour break for lunch. Her afternoon surgery started at 2 p.m.

After some regular attenders who brought their usual complaints, Dr. Melchor saw Tommy, a 4-year-old boy who came with his Mum, Mrs. Williams.

Tinnitus. Perception of inexistent ringing or other noises in the ears or head.

Auroscope = auriscope = otoscope: medical instrument for examination of the ear.

Tilt: move laterally to one side or the other.

Wax – cerumen: a modified serum of the external auditory meatus. **Ear syringing** is a procedure whereby ear wax is removed by injecting warm water into the ear with a large syringe.

Eardrum. Tympanic membrane, often abbreviated TM.

Deafness. A partial or total hearing impairment in one or both ears. The person with such an impairment is said to be **deaf**.

Hearing aid. Electronic device worn by a deaf or partially deaf person for amplifying sounds. The specialist who does hearing tests (audiograms) and fits hearing aids is the **audiologist**.

To go for it – to accept it, to take it, to choose it.

To shift: to move.

Over-the-counter medicines are those that can be purchased without a doctor's prescription. Abbreviated as OTC.

To keep you – to take up your time (as I know you are very busy).

Fair enough – expression used to agree with a proposal.

Other expressions of interest:

Presbycusis: loss of the ability to perceive or discriminate sounds as part of the ageing process.

Pinna: cartilage and skin prominence of the external ear. Some of its anatomical parts are tragus, helix, antehelix and lobule (ear lobe).

Sinusitis: inflammation of the paranasal sinuses.

Halitosis: bad breath.

Gums: gingivae.

Gingivitis: inflammation of the gums.

Tooth decay: dental caries.

tinnitus [tɪ-nɪtəs] auriscope [ôr ĭ-skōp] audiogram [ô"dē-ə-grām] syringing [sə-rɪnj"ing] aid [ād] fair [fâr]
sinus [sɪ"nəs] gum [gŭm] decay [dɪ-kā"]

- Good morning, Mrs. Williams! Hello, Tommy! Please take a seat.
- Good morning, doctor, sorry to trouble you again, but Tommy, and myself, have been up all night again with one of his earaches. This is the third one in a short period since Christmas and antibiotics only seem to help for a short while ... he cannot continue like this ... we need to do something about it! ... It was the same last winter.
- So sorry to hear that, Mrs. Williams. So, Tommy, how are your ears now?
- OK ... I got a cold.

Mrs. Williams continued:

- He had some paracetamol medicine at 5 o'clock this morning and it seemed to calm him down.
- OK! Lets have a look at this troublesome ear, then ... shall we, Tommy?

As Dr. Melchor grabbed her auroscope, Tommy did not look happy and decided to cry in an attempt to get away without being examined. But after playing the old game that Dr. Melchor was very familiar with of examining the old Teddy bear's ears, Tommy seemed a bit more convinced and allowed the doctor to examine him, although still a bit reluctantly. Dr. Melchor finished the examination by looking into Tommy's throat and sat back saying:

- Well, Mrs. Williams, Tommy has quite a red eardrum so it's no surprise he was in pain, but I also noticed that the other ear has a dull and in-drawn drum which is very suggestive of glue ear ... has there been any concern about his hearing?
- Well, he seems to ignore me at times and the nursery has commented that sometimes he does not answer when called ... I just thought he was naughty, but do you think it may be his hearing, doctor?
- Possibly ... is his speech developing well otherwise?
- Yes, I think so, but sometimes he confuses words that sound alike, like tummy and dummy.
- Well, this may be a sign of hearing loss caused by his glue ears and the adenoids are very likely responsible for that.
- Does Tommy snore at night?
- Oh, yes! He snores quite loud like an old man! And it seems to get worse when he has a cold, like now.
- Have you noticed any problems with his breathing during sleep?
- Yes! ... Now that you mention it, sometimes he seems to stop breathing for a few seconds while he is asleep. It is a bit frightening, especially because he has been doing it more often recently.
- Yes, we call that sleep apnoea and it is a sign, together with the snoring, of enlarged adenoids.

Cold: also called “head cold” or a “chill” meaning a viral illness causing runny nose, blocked nose, headache, etc.

Runny nose: rhinorrhoea. To have a runny nose is to produce abundant nasal discharge.

Medicine: popular expression meaning a drug given in a liquid/syrup form instead of tablets.

Troublesome: that gives trouble.

Get away with – be successful in doing something without punishment. For example, some people commit crimes and get away with it, because they are not discovered. Of very bad doctors it is said that they “get away with murder”.

Teddy bear: a stuffed toy bear.

Reluctant – not wanting to do something.

Dull: not shiny, light reflex lost.

Indrawn: moved towards the inside.

Drum – eardrum. It is also a percussion musical instrument.

Glue ears: expression often used by doctors to describe secretory otitis media allusive to the sticky nature of the effusion produced by the otitis.

Nursery: a kind of school for babies or very young children (under 5 years), used by parents who cannot look after them during the day because they need to work.

Naughty: badly behaved.

Speech: language, articulation, elocution.

Adenoids: collection of lymphoid tissue in the posterior part of the nose which is often enlarged and infected in young children.

Snore: snorting sound made during sleep.

Sleep apnoea: temporary cessation of breathing during sleep.

Other expressions of interest:

Tonsils: areas of lymphoid tissue on both sides of the throat.

Tonsillitis: inflammation of the tonsils.

Tonsilectomy: surgical excision of the tonsils.

Odynophagia: pain on swallowing.

Dysphagia: difficulty in swallowing.

reluctant [rɪ-ˈlʊkˈtənt] naughty [nɔˈtɛ] apnoea [ˈæpˈnɛ-ə]
tonsillitis [tɒnˈsə-lɪˈtɪs] odynophagia [ɒ-ˈdɪnˈə-fəˈjə]

- *Can anything be done for this, doctor?*
- *Yes, certainly! I will need to refer Tommy to the ENT surgeons for a tympanogram to confirm his glue ears and then he may be a good candidate for grommet insertion and possibly adenoidectomy if these sleep apnoeas keep recurring ...*
- *Thank you, doctor. If Tommy needs an operation how long do you reckon the waiting list would be?*
- *I am not sure, but I will request for him to be seen soon, as it is important to sort out his hearing before he starts school next year.*
- *Great! Thank you very much for your help, Dr. Melchor.*
- *You are welcome! ... Bye, Tommy, get better soon!*
- *Yes, I will.*
- *Say thank you to the doctor, Tommy.*
- *Thank you, doctor.*
- *You are very welcome, Tommy. Come to see me again if you are not well!*

Dr. Melchor made a note to remind herself to do Tommy's referral and pressed the button for her next patient. This was Andrew, an 18-year-old young man.

- *Good afternoon, Andrew!*
- *How are you doing, doctor?*
- *Very well, thank you. What can I do for you?*
- *Well ... I don't know really. My Mum says I've got hay fever.*
- *Is that so?*
- *Well, I got this cold that I cannot get rid of ... I keep sneezing and my eyes are itching like mad and it seems to be worse when I play football with my mates.*
- *Do you get wheezy also?*
- *Yes ... I am using my asthma pump more often.*

Dr. Melchor got hold of her stethoscope and said:

- *Let me listen to your chest, please, Andrew. [Auscultates] That sounds clear. Let's do a peak flow.*

After finishing the examination, Dr. Melchor said:

- *Well, Andrew, everything looks fine. I think your Mum was right in saying you've got hay fever, so I am going to give you a prescription for anti-histamines and hopefully that will do the trick ... OK?*
- *Cool, doc! Ta!*

Spring had already started. Many more like Andrew would follow soon.

Tympanogram: a commonly used test of impedance audiometry particularly useful in evaluating children with otitis media with effusion.

Grommet: tympanostomy tube.

Reckon – to have an opinion on something.

Waiting list: list of patients awaiting surgery, treatment or assessment.

Sort out – solve a problem.

Hay fever: seasonal allergic rhinoconjunctivitis.

Get rid of: eliminate. Patients also say “*I cannot shake it off*”.

Sneeze. A sudden involuntary expulsion of air through the nose and mouth, caused by irritation of the nasal passages. It typically happens with colds and allergies.

Itch: pruritus.

Mates: friends.

Pump: popular name for the inhaler devices used by asthmatic patients.

Clear – normal.

Do the trick – be effective in solving the problem.

Cool: popular expression among youngsters meaning agreement, okay, fine

...

Ta: informal exclamation to say thanks.

Other expressions of interest:

Blocked nose: nasal obstruction.

Anosmia: no sense of smell.

Epistaxis: nose bleeding.

Hoarseness: dysphonia.

hay [hā] fever [fē'vər] hoarse [hōrs]

Digestive System

with Paula Alba and Gonzalo Moreno

Dr. Moreno worked as a salaried GP at a rural surgery in Yorkshire. It was a Tuesday morning and he was on call. Two of the partners were on holiday and the registrar was on study leave. In addition, the IT system had been down for about 20 min. Dr. Moreno sighed; it was going to be a hard day. He was just about to enter his room when Joan, a receptionist, approached him.

- *Good morning, doctor. Would you like a cup of tea?*

The doctor smiled as he noticed some papers in Joan's hands.

- *Erm, yes, please, tea with two sugars would be nice.*
- *Doctor, I just have a couple of messages for you. Mrs. Higgingbottom has just called the surgery; she's a little worried about the ibuprofen you gave her for the back pain. She has read in the leaflet that it is not good for people with asthma and she says it is giving her heartburn and upsetting her stomach. She wonders if you could prescribe her something else.*
- *Well, Joan, tell her to have some paracetamol instead. She doesn't need a prescription for that and it's cheaper over the counter. She can have up to two q.d.s. See how it goes.*

Dr. Moreno had a quick look at the patients' list. His first patient had only just registered at the practice. Dr. Moreno called him in and found himself talking to a man aged about 40 who was dressed in old clothes, had a long beard and smelled like a bottle of brandy; but the most important thing was that his skin was a yellowish colour.

- *Good morning, Mr. Daniel, have a seat, please. I'm Dr. Moreno. Very nice to meet you.*

They shook hands, and Dr. Moreno noticed a little tremor in both of Mr. Daniel's hands.

- *Mornin' doc ... Nice to meet you. The thing is, I feel totally run down, really under the weather.*
- *OK, Mr. Daniel. Before we go on, I notice you are new at the practice, and as we haven't received your clinical notes yet, I would like to ask you two or three questions. Firstly, are you taking any medication?*
- *Nope.*

Digestive system – gastro-intestinal system and liver.

The gastrointestinal tract, abbreviated **G-I** or **GI ★**, is divided into **upper GI** tract (stomach and small bowels/intestine) and **lower GI** tract (colon or large bowels/intestine).

A specialist in this field is a **gastroenterologist**.

Study leave: days of leave you use to do courses.

IT ★ system: the computer system. When the **IT system goes down** it means the computer system has stopped working.

A couple of: two.

Heartburn: a burning sensation in the oesophagus, caused by stomach acid. “Heartburn” is used both by doctors and patients; the more technical term “**pyrosis**” is rarely used.

Upset the stomach – produce dyspepsia or abdominal discomfort such as pain, nausea or vomiting. “Upset” can be verb or noun. A patient may say “I have a bit of a stomach upset”.

She wonders if – she asks herself whether ... Polite way to ask for something.

Over the counter (OTC ★): without prescription.

2 q.d.s ★: two tablets four times a day.

See how it goes – let’s try this and wait and see if she gets better.

He had only just registered – he was new to the practice.

Yellowish: a colour similar to yellow. Note you can add the suffix “**ish**” to almost anything, to mean “approximately”.

Leaflet: the information that accompanies the medication, usually found on a piece of paper inside the box.

See how it goes: To wait for the progression of something.

Have a seat: Polite way of telling the patient to sit in the chair.

Shake hands: a way to greet (say hello to) somebody by pressing their hand. You say you “shake somebody’s hand” or you “shake hands with” somebody.

Tremor: repetitive regular oscillatory movements. To have a tremor is to tremble.

Run down: tired, exhausted.

Under the weather – not very well ... slightly ill, sick or depressed.

Clinical notes = medical records: all the written medical information about the patient. Note that this is different from the “clinical history” which is taken from the patient by asking them questions.

Firstly, ... – “What I am going to ask or say first is ...”. Then you may also say “secondly, ...” “thirdly, ...”, etc.

Nope. Informal for “no”. **Yep** is the informal for “yes”.

IT [I.-T] paracetamol [pä-rä” sëtä möl] beard [bîrd], seat [sēt] sit [sīt] nope [nōp]

- *Do you have any important illnesses?*
- *Nothing important, doc, only I broke some ribs a fortnight ago when I fell on the stairs at home. That's the main reason why I am here today.*
- *I see.*
- *Since I fell, I have had an awful pain in my stomach, and the co-codamol they gave me at A&E is not helping at all. They just make me feel sick and it's hard to go to the toilet.*
- *Do you mean that you are constipated?*
- *Yeah, and bloated as well. I feel like a pregnant woman, even my belly button is pushing out. Also my legs are aching, I'm having very bad chills and all my joints are tender.*
- *Do you have a temperature?*
- *Yeah, I'm sweating all the time.*
- *All right, I will need to examine you. Would you like to get onto the couch and lie on your back, please? Thank you. I'm going to examine your chest and your belly. Could you undo your shirt and trousers, please?*

Dr. Moreno examined the patient.

- *Mr. Daniel, have you noticed that your skin looks yellow?*
- *Well, I've noticed it today.*
- *What about your urine? Is it a strange colour?*
- *Not at all.*
- *White stools?*
- *Nope.*

Then he wrote a few notes into his computer:

First appt.

C/O: RUQ pain for 2/52, increased abd perimeter and constipation, with chills and jaundice since yesterday. No melaena or coffee-ground vomit. No white stools, no dark urine. Had a fall 2 weeks ago. On co-codamol. O/E: T 100 F. Alcoholic breath, tremor, jaundice, spiders, parotid hypertrophy. CVS: p 84, reg. BP 100/70, oedema up to both knees, no raised JVP. RS: NAD. GIS: generalised distension, tender RUQ, hepatomegaly, ascites, no guarding, no rebound. CNS: no flapping tremor.

- *What do you think, doctor? Is it something serious?*
- *Mr. Daniel, I'm thinking that you've probably got a problem with your liver: it may be inflamed. One of the things that can inflame the liver badly is alcohol. How much do you drink on average?*
- *I'm not drinking so much now, but I used to drink a lot.*
- *That has probably been the cause: alcohol has damaged the liver. I think you need to be admitted to hospital for investigation.*

Ribs: thoracic long curved bones. The **ribcage**, composed of 24 ribs, is the bony structure that protects the heart and lungs.

Fortnight: Two weeks.

My stomach – my abdomen. Note that patients use the word “stomach” to indicate any anterior part of the body between the ribs and the pubis levels. Even a pelvic pain can be introduced as a “pain in my stomach”. Informal terms for abdomen are “**tummy**” and “**belly**”.

Co-codamol: commercial name for codeine plus paracetamol.

A & E ★: Accident and emergency.

To feel sick is to feel **nausea**. **To be sick** may be to be ill, or to **vomit** (also to “**throw up**”).

Many patients would say “I feel I am going to be sick ... but I haven’t actually been sick” when they report nausea but no vomiting. Or they may say “I was sick three times yesterday” meaning that they vomited three times.

Constipation, to be constipated. Difficult, incomplete, or infrequent evacuation of dry hardened faeces from the bowels.

Bloated. Swollen with fluid or gas.

The **belly button** is the **navel** or umbilicus, a round depression in the centre of the abdomen.

Ache: constant dull pain. We use the word **tender** when something is unusually sensitive when touched or pressed.

Chill: a feeling of cold with shivering and pallor that accompanies fever.

Shiver: to tremble because of cold or fear.

Joint: junction between bones.

Undo your shirt – undo the buttons of your shirt in order to take it off.

Not at all: 0%.

Stools: faeces. To defecate is to “pass stools”.

Sweat. To excrete perspiration through the pores in the skin; perspire.

RUQ. Right upper quadrant (of the abdomen). Liver and gallbladder area.

Gallbladder: organ next to the liver that may develop **gallstones** (**cholelithiasis**).

Jaundice: yellow coloration of skin and mucosae.

Melaena: black stools, produced by gastro-intestinal bleeding. Another possible manifestation of **GI bleeding** is **coffee-ground vomiting**.

Guarding: reflex contraction of the abdomen when you press it with your hands. **Rebound** is the increase of pain in the abdomen after removal of pressure. **Tenderness** is pain on palpation; an area of the body is said to be **tender**.

On average – if he drinks sometimes two beers a day and sometimes four, he probably drink three beers on average.

stomach [stŭm"ək] abdomen [āb"də-mən] tummy [tŭm"ē] bloated [blōted] navel [nāvəl] ache [āk] temperature [tēm"pər-ə-chöör"] fever [fēvər] faeces [fē"sēz] sweat [swēt] jaundice [jôn"dis] melaena [mā'lā'nä] guarding [gärd ing] rebound [rē"bound"]

- *No way, doc, I've got a little dog and I have no one to take care of him.*
- *I do understand the problem, Mr. Daniel, but I'm very worried about you, I think if we leave this, it could become something very dangerous, even life-threatening. I would rather admit you as soon as possible. You will need an ultrasound or CT scan.*
- *Do you mean today?*
- *Yes, I would phone the bed bureau and find out when they have a bed available. What I would suggest is that you go home and try to find a neighbour to take care of your dog and in the meantime I will sort out getting you a hospital bed.*
- *OK, doc, I do agree with you it's better to go to the hospital: better safe than sorry.*
- *Yeah, I'll sort everything for you, just wait at home, they'll phone you from the hospital. If you hold on a moment I'll give you a referral letter to take with you.*

Dr. Moreno wrote:

RE: Mr. Jack Daniels

Letter for admission to Medical Ward

Dear Colleague,

I would be most grateful if you could see this 40-year-old patient who has been complaining of abdominal pain and jaundice. He has no PMH of note and he is not taking any medication at the moment, except co-co-damol for costal pain after a fall. He has a long history of high alcohol intake. My clinical examination confirms ascites, hepatomegaly and marked jaundice. I suspect he is suffering a first episode of alcoholic hepatic decompensation.

Thank you very much.

Yours sincerely,

Dr. Moreno

The Alba Practice

Dr. Moreno called the receptionist to ask her to phone the bed bureau while he kept seeing patients. His next patient was Mrs. Dawn, an 87-year-old woman who was very fit and usually only came because of her osteoarthritis. She was probably going to need some NSAIDs.

- *Morning, doctor.*
- *Good morning Mrs. Dawn, what can I do for you today?*
- *It's a little embarrassing, doctor. I'm having problems down below.*
- *I see ... Do you mean when passing water?*
- *No, with my back passage. I went yesterday for a number two and there was blood in the toilet.*

Appt. appointment, **C/O** Complains of, **Abd** abdomen, **O/E** On Examination, **T** temperature, **CVS** cardiovascular system, **p** pulse, **reg** regular, **JVP** jugular vein pressure, **RS** respiratory system, **NAD** no abnormalities detected, **GIS** gastrointestinal system, **CNS** central nervous system.

To admit someone: to get a bed in the hospital for a patient in order to have further investigation or for treatment.

No way – impossible.

Life-threatening – could result in the death of the patient.

Bed bureau: management centre for hospital beds in the area.

Sensitive: easily damaged. Note that it is different from “sensible”, which is the quality of having good judgement.

Better safe than sorry: an English phrase to say that it is better to be safe by acting upon something than sorry by not acting upon it.

To sort something for someone – to solve a problem for someone.

To hold on: to wait for a short period of time.

re: Regarding.

Medical ward: the part of the hospital where the patients are admitted with a non-surgical illness.

Long-standing: a condition that has existed for a long period of time.

Intake: amount eaten or drunk. **Amount:** quantity.

Keep seeing patients – continue seeing patients.

To see patients: A patient is seen by a doctor when they attend a consultation at the surgery. A doctor visits the patient when he has to see them at home, hence the expression “home visit”.

To be fit: to be healthy, capable of activity. It may be used more specifically, e.g. to be “fit for work” after recovering from an illness. **Fitness** generally refers to physical health and ability to do sports, etc., but can also be used more specifically, e.g. a “fitness to drive” certificate is required to get a driving license.

Osteoarthritis: degenerative disorder of the joints characterised by loss of cartilage. It is a misnomer as it is not an inflammatory condition, and although it is also called, more correctly, **arthrosis** or **osteoarthrosis**, these terms are not used in common practice. Inflammatory conditions of the joints are called **arthritides** (plural of **arthritis**).

NSAIDs ★. Non-steroidal anti-inflammatory drugs.

Embarrassing: cause some sense of humiliation.

Down below: euphemistic way of mentioning the perineal area. People may also say **down there**.

Passing water: urinating.

amount [ə-mount] NSAID [en-es-eɪd]

- *Was there a lot?*
- *No, I wouldn't say that, but it was quite painful. For the past 2 weeks I've been having trouble opening my bowels, and I think my piles have started again, I can feel something down there. It is also very itchy.*
- *When you say "trouble", what do you really mean? Diarrhoea?*
- *No, doctor, no loose stools, the problem is the pain.*
- *OK, I am going to have a look at you there. I can call Jane, the practice nurse to sit with you if you would like.*
- *Yes, doctor, that would be nice, I'll wait.*

Dr. Moreno went to call Jane. She was running the breath test clinic on that day. While he was on his way to the treatment room the receptionist told him she had the bed bureau on the phone.

- *OK then, I'll come and talk with them, if you can tell Jane that I need her as a chaperone.*

He picked the phone up.

- *Good morning, I'm Dr. Moreno, from The Alba Practice. I am calling regarding a patient I would like to admit.*
- *Good morning, doctor. Medical or surgical?*
- *Medical.*
- *Could I have the name and DOB.*
- *Jack Daniel, 15/04/57.*
- *OK, and the diagnosis?*
- *Ascites with jaundice.*
- *Can the patient wait a couple of hours? We are really busy at the moment.*
- *Two hours is okay, thank you.*

Dr. Moreno returned to the consultation room, where Jane was waiting near the couch, while the patient was lying on her side, having taken off her underwear in preparation for the rectal examination.

- *OK, Mrs. Dawn, I'm back. Let me see your belly first ... OK ... Now I need to do a rectal examination ... I'll need to put my finger inside the anus. It will be a little uncomfortable, but not painful ... Is this OK? ... Let me just put the gloves on.*

After the examination Dr. Moreno asked the patient to get dressed and wrote on the computer:

C/O: pr bleeding for the last few days, red blood, no big amount, anal pain, itchy. Recurrent problem. O/E: ABD NAD, external pile at 12 o'clock, no fissure, pr normal. Adv cool baths and topical steroid. No red flags.

Back passage: the anus.

Number two: defecate. **Number one:** urinate.

To have trouble with: To have a problem with.

To open bowels: to defecate.

Bowels: lay term for intestine.

Piles: haemorrhoids.

Itch: pruritus. To itch is to be itchy or suffer a pruritic sensation. The natural reaction is to **scratch** the skin.

Loose stools: diarrhoea. Also called “**the runs**”. Patients may say also that their **motions** are loose.

To run a clinic: to see patients with a specific condition at specific regular times (e.g. Diabetes Clinic on Thursday mornings).

(Urea) Breath test: used to check for the presence of *Helicobacter pylori* in the stomach.

To have someone on the phone – someone is waiting to talk with you on another telephone line.

Chaperone: a person (usually female) asked to accompany the patient (usually female) when the doctor (usually male) performs a medical examination on intimate areas of the body.

Pick the phone up: take the phone in the hand to answer a call.

DOB. Date of birth. When saying numbers, note that “zero” may be called “o” (as the letter). When giving telephone numbers, note that repeated numbers would be dictated as “double 3” (33) or “triple/treble 4” (444), etc.

Presumptive diagnosis: unconfirmed diagnosis. Sometimes it is called a **diagnostic impression**, and abbreviated IMP.

Couch: bed for medical examination. Do not confuse with **coach** which is (a) sports trainer or (b) bus. Check the different pronunciation below.

To lie (a): assume horizontal position. Past: **lay**. Gerund: **lying**. Example: “the patient was lying on the couch.”

To lie (b): to say something that is not true.

To lay: to put something down. Past: **laid**. Gerund: **laying**. Example: “the doctor laid a clean blanket on the couch.”

Blanket: piece of cloth used to cover the examination couch.

Get dressed: to put on the clothes. “To dress” is also correct but less used in this setting. To **dress up** is to get dressed particularly well, for example, when you go to a party.

bowels [bouˈəl s] piles [pɪls] pylori [pɪ-lôrɪ] lie [li] lay [lā] couch [kouch] coach [kōch]

Finally, he coded in the summary: Haemorrhoids – not complicated.

- *Mrs. Dawn, have you lost your appetite lately?*
- *No, doc, in fact I've put half a stone on, I can eat for England ...*
- *OK. I'm going to give you a prescription for a cream. You should apply it with a wet piece of cotton wool, use cool water. I think it's your piles that are giving you problems, but anyway, Jane is going to take some bloods today, and see if everything is OK. If you keep having this problem, we'll have to think about a referral to the consultant to check it with the tube.*

When Mrs. Dawn left, Dr. Moreno glanced at his watch; he was running 45 min late. In the hope that the next patient was going to be an easy one, he checked the list. Unfortunately, it was Mr. Brown, a 53-year-old patient, very well known to the doctor. He had a history of anxiety and GORD for the past 2 years. He had been taking PPIs intermittently for a long time and had come 2 weeks before complaining of dysphagia to solids for the past 3 months. He denied loss of weight or loss of appetite. Dr. Moreno had requested a blood test and an urgent barium meal. The patient probably came for the results. Before calling the patient in, the doctor checked the results on the computer:

The blood test included: FBC, ESR, CRP, LFT, U/E, TFT, Clotting screening and Alb, everything in the normal range. The barium swallow report read: "Upper oesophagus normal. The cardia is fairly lax. A sliding hiatus hernia with gastro-oesophageal reflux demonstrated irregularity of the distal oesophageal mucosa, indicating reflux oesophagitis. There is a distinct step deformity on the right posterolateral aspect of the oesophagus. Possibility of a Barret's/early malignancy of the oesophagus needs to be considered. Examination of stomach, duodenal cap and loop did not reveal any significant abnormality. Urgent endoscopy recommended."

Dr. Moreno thought he should have probably referred for endoscopy in the first instance. He nodded and called Mr. Brown:

- *Hello, Mr. Brown, have a seat please.*
- *Hello, doctor. I'm here for the results.*
- *Yeah, I have just received the swallowing test. Have you had any further symptoms?*
- *Yes, doctor, I still have this burning sensation in the chest, feeling sick and belching a lot. The choking sensation keeps coming on and off,*

PR bleeding: Per rectum bleeding; rectal bleeding.

PR ★. Per rectum; rectal examination.

Fissure: break in the skin or mucosa; linear erosion.

Adv: advised.

Steroids: preferred to “corticosteroids”.

Red flags: alarm signs that require urgent action.

To code: to introduce information on the computer as a code, in order to be able to find it later.

Summary: a short version of the clinical notes containing only the main diagnoses.

Lately: in the last few days, weeks or months.

Cotton wool: soft balls of cotton used to cleanse delicate areas.

Blood test: common investigation in medicine that consists of analysing a small quantity of blood. The employed material is a tube of plastic to contain the blood (called a **syringe**) and a sharp piece of metal called a **needle** that is used to make a little puncture in the skin.

Keep having – continue having.

Tube: colloquial for endoscopy.

Pleasure: My pleasure: one possible response to “thank you”.

GORD: Gastro-oesophageal reflux disease.

PPI ★: Proton pump inhibitor (omeprazole, lansoprazole, etc.).

Barium meal or swallowing test: It is a radiological examination that consists of swallowing a liquid that is radio-opaque, in order to see the gastrointestinal system from the mouth to the duodenum.

FBC: Full blood count. When you ask for the FBC you receive the information of the quantity and percentage of erythrocytes, leucocytes and platelets. **ESR:** erythrocyte sedimentation rate. **CRP:** C-reactive protein. **LFT:** Liver function test. **U/E:** Urea and electrolytes, it also includes creatinine levels. **TFT:** Thyroid function test. **Clotting screening:** Coagulation test. **Alb:** albumin.

In the normal range: within normal limits.

Fairly: Considerably, to a considerable degree.

Lax: Not tight or tense.

Sliding: When something slips over a surface, moving easily from one place to another.

Distinct: Clearly differentiated.

Loop: A circular shape formed by a line or something such as a piece of string that curves back over itself. Furosemide is a “loop diuretic”.

Reveal: Show, expose.

syringe [sə-rɪŋʃ] reveal [rɪ-vēl] intermittently [ɪn'tər-mɪt'nt] dysphagia [dɪs-fə'jə] appetite [əp'i-tɪt] blood [blʊd] hiatus [hɪ-ā'təs] hernia [hɜr'nē-ə] reflux [rē'flʊks]

- *it seems sometimes that the meal gets stuck in my chest. Is there anything wrong in the tests?*
- *Well, the blood tests have come back normal, we have checked liver, kidney, blood cells, and everything is all right. In the barium swallow there seems to be a small lesion in the oesophagus, near the stomach. I think that is causing all the trouble. The problem is that it is not really clear if that area is inflamed because of the reflux or something else ... they do recommend doing an endoscopy.*
- *The tube?*
- *Yes, it's the only way to see that lesion ...*
- *Could it be something nasty?*
- *We won't really know until we do the endoscopy, so we are going to do a "fast track" referral for that, if that is OK with you. In the meantime you need to keep taking the stomach tablets I gave you.*
- *Do you know how long it will take to get an appointment?*
- *No more than 2 weeks.*

Mr. Brown agreed and left rather worried. Dr. Moreno was running an hour late and starting to develop a throbbing headache ... it was going to be a long, hard day.

Burning: hot feeling as if produced by fire.

Belch: or **burp**. Emit gas noisily from the stomach through the mouth.

Choke. Stop breathing, or breathe with great difficulty, because of a blockage in or restriction of the throat.

On and off: intermittent.

Stuck: adhered, fixed, inseparable.

The tests have come back normal – the results received are normal.

Kidneys: the two organs that depurate the body's blood-producing urine.

Nasty: very bad, in this case: malignant.

Fast track: a quicker way for specific cases.

Many people don't remember the names of the medication, so they name them according to the name of the problem they treat, for instance: water tablet for diuretic, **stomach tablet** for **antacids**, etc.

To run late: to be delayed.

Throbbing: pulsatile.

Other expressions of interest:

Change in bowel habits – when, for example, a patient who normally opens their bowels twice a day, starts opening them twice a week, or vice versa.

Stomach/abdominal cramps: colic type of pains, typical of gastroenteritis or constipation problems.

Wind: colloquial for flatulence.

Antacid –. NOT anti-acid.

Groin: inguinal area.

Loin: renal or lumbar fossa.

IBS ★: Irritable bowel syndrome.

IBD: Inflammatory bowel disease.

Worms: certain parasites of the bowels and anal area.

Parts of the anterior abdominal wall:

RUQ Right upper quadrant is preferred to right hypochondrium

LUQ Left upper quadrant is preferred to left hypochondrium

RIF Right iliac fossa

LIF Left iliac fossa

Others: epigastrium; umbilical area; suprapubic area; however, a suprapubic pain is most often recorded as a “pelvic” pain.

lesion [lē'zhən] tube [tyōōb] swallow [swŏl'ō]

Metabolic System

with Benjamin Desserre

Michael was an obese 44-year-old IT consultant in the City. Dr. Desserre was seeing him for the first time as the practice nurse had suggested he see a doctor during his registration checkup.

- *Good morning! What can I do for you?*
- *Good morning, doctor! I was asked by the nurse to come and see you about my diabetes.*
- *I see ... Let's just have a chat about it, for me to get to understand your case. Tell me, how long have you been diabetic?*
- *For 3 years now.*
- *OK and how did you find out?*
- *I was feeling tired all the time, I kept going to the loo, passing lots of water, always thirsty, and I had trouble sleeping, so my previous GP ordered a blood test. He then called me in to double check whether I had fasted correctly and as I had, he ran some more tests. You know he sent me for that blood test, the one where you have to fast for 12 hours and then drink a sweet drink?*
- *You mean an OGTT?*
- *That's the one! That is how they found out I was diabetic.*
- *Do you have any family history of any kind? I mean, are there any other diabetics in the family, any history of heart attacks or strokes?*
- *No, not really, except an uncle on my dad's side who had a heart attack when he was about 60. Well, and maybe a tendency to overweight, as you can see is also my case!*
- *Are you taking any medication?*
- *No, I am on a diet. I also gave up smoking and drinking.*
- *Really? And have those lifestyle changes worked for you?*
- *Yes! I lost some weight by improving my diet and by going to the gym on a regular basis.*
- *Well done!*
- *It was hard, believe me, but I lost 2 stone! I am also proud to say I am not a couch potato anymore!*
- *So your sugar must be well controlled. Are you self-monitoring? What are you aiming for?*
- *Yes, I have my own machine. I am now only checking it once a week. The target I was given was under 7 before breakfast and under 11 after a meal. Is that right?*
- *Yes, though I would be stricter in your case as you are young. I would rather rely on the HbA1c anyway. Have you heard about it?*
- *Are you talking about my six-monthly blood test?*

City – the financial area of Central London.

Type-2 diabetes was called in the past “non-insulin-dependent diabetes mellitus”, so you may still see the abbreviation NIDDM. The person suffering from diabetes is a **diabetic**.

TATT. Tired all the time. Common abbreviation used in medical notes for patients who come frequently reporting fatigue.

Under the weather. Slightly unwell or in low spirits.

Polyuria: increased diuresis.

Polydipsia: increased thirst and liquid intake.

Fasting glucose is the basal glucose or glucose taken before breakfast. The patient is asked to **fast** for 8 h before the test, i.e. not to eat or drink anything (except water) for the previous 8 h.

The finger tip test is called **BM** (blood monitoring), and is taken with a **lancet** (the device to pierce the skin of the fingertip). The blood drop is then put on a **strip** and into the **glucometer** (or glucose reader, or BM machine) and the reading shows after a few seconds.

IFG. Impaired fasting glucose.

IGT. Impaired glucose tolerance, diagnosed with an **OGTT**: Oral Glucose Tolerance test.

To **run** some more tests – to conduct further investigation by ordering more tests.

Dad's side – paternal side of the family.

Stroke: Cerebro-vascular accident (CVA ★) or a transient ischaemic attack (TIA ★), which patients may call “mini stroke” or “slight stroke”.

Obesity. BMI > 30.

Overweight. BMI > 25.

BMI ★. Body mass index (kg/m²).

English patients still use **stone** and **pounds** to measure their weight. A pound is 16 ounces or 454 g. A stone is 14 pounds or 6.356 kg. Note that the plural of stone is equal to the singular: Michael says he “lost 2 stone”.

Lifestyle changes – changes in diet, physical activity, alcohol and tobacco use, etc.

Couch potato – a stereotypical term used to describe a lazy individual. Usually an overweight, inactive man sitting on his couch in his living room watching TV, holding a beer and eating crisps. (“Couch” here means “sofa”.)

Self-monitoring – most diabetics check their own blood sugar level with a BM machine that gives a capillary reading of the glycaemia.

diabetes [dī'ə-bē'tis] diabetic [dī'ə-bēt'ik] glycemia [glī-sē'mē-ə] fatigue [fə-tēg'] obese [ō-bēs']

- Yes. Your previous GP must have given you a yearly “MOT” which includes a kidney function, a liver function, a thyroid function and a cholesterol check. This “MOT” also includes a urine sample, doesn’t it?
- Yes, the whole lot! I think my sugar had gone up last time. I think I am due a blood test anyway. My last one was a bit more than 6 months ago.
- Here is the form for you. Come and see me a week after you have it done, so we can discuss the results. When was your last DECS eye check?
- I am due now. Will it be in the local area or do I have to go to the hospital?
- I am afraid you will have to go to the hospital for that, but it is only once a year; however, we do have an in-house dietitian if you ever need any further advice on dieting or healthy eating.
- I think I am fine with that for the time being, but who knows ...
- So far, we have gone through how you have been diagnosed, your lifestyle changes and the monitoring of your diabetes. I know you are not taking any medication for your diabetes but what about your cholesterol and blood pressure?
- Well, I am not on medication but I am not quite sure how I am doing with that ...
- Let’s check your blood pressure then, [taking a standard cuff] 152/92 ... This is quite high for a diabetic patient.
- Really? Do I need to go on tablets then?
- You may need an antihypertensive if it is persistently high over the next three readings. It could just be white coat syndrome, in which case, it will depend on the urine sample and kidney function. If there are proteins in the urine, then the BP target for you will be much lower.
- Oh dear!
- Anyway ... Let’s do the blood and the urine test first and we will take it from there.
- OK, then. Thank you, doctor.

Two weeks later, Michael came back and consulted Dr. Desserre again for his blood results but also for a sore foot.

- Hello again! Thank you for coming in. We have your results ...
- And?
- Well, I am afraid you do have high cholesterol or hypercholesterolemia. Your cholesterol is 5.5. Guidelines are telling us we should start you on lipid-lowering treatment and also on aspirin.
- Hold on ... How many tablets will I have to take then?

Well the aspirin is once daily and so is the cholesterol tablet but better taken in the evening; however, you do have to keep in mind that if diet

MOT ★. Test – Ministry of Transport test is an annual test of car safety for every car over 3 years old. Patients often come to surgery asking for an “MOT” when they want a “full health checkup”.

FBC. Full blood count (of blood cells).

ESR ★. Erythrocyte sedimentation rate.

TFT ★. Thyroid function tests.

LFT ★. Liver function tests including usually AST, ALT, GGT, ALP and bilirubinaemia.

U&E ★. Urea and electrolytes, sometimes referred as to as **kidney function** as it includes urea, creatinine, Na, K and now **eGFR** (estimated glomerular filtration rate).

ACR ★. Albumin–creatinine ratio or microalbuminuria check.

Lipids. This check includes total cholesterol, triglycerides, HDL fraction and estimated LDL.

DECS. Diabetic eye complication screening. Diabetic patients go to this clinic specifically for their retinal screening for retinopathy and laser treatment if necessary.

I am due now – it was planned that I have them now.

In-house: in the same surgery building.

Dietitian. A specialist in dietetics.

For the time being – for now. (We may change our mind later.)

So far – until now.

Lifestyle changes – changes in diet, exercise, smoking, etc.

How I am doing with that – how good or bad my progress is with regard to that.

Go on tablets – start oral medication.

Target: objective, value we aim to achieve.

Take it from there – decide after and according to results.

Proteinuria: presence of protein in the urine.

Sore foot – painful foot.

Cholesterol. NICE guidelines recommends lower target for diabetic patients <5 mmol/l. Total cholesterol can be abbreviated as TC.

Lipids-lowering treatment – referred to as “cholesterol tablets” by patients. Primary prevention for a diabetic patient without coronary heart disease (**CHD ★**) is recommended to patients with a 10-year-risk of coronary heart disease greater than 15%.

Hold on – wait a minute.

HbA1c ★

thyroid [thīˈroidˈ] U & E [u and e]

and increasing physical exercise are not enough, then we will have to add an oral agent to achieve good glycaemic control, and in the long run to reduce your risk of vascular disease.

- *I have been taking over-the-counter aspirin for 2 years ...*
- *Good. Here is a prescription for your cholesterol tablets along with a blood test which will enable you to check your cholesterol and liver function in one month's time. Is there anything else I can do for you?*
- *Well ... actually ... can I quickly show you my sore foot?*
- *What is wrong with your foot?*
- *I have an excruciating throbbing pain and it is all swollen ...*
- *Let's have a look ... Ah yes, your great toe is all red ... Looks like gout. Have you suffered from gout before?*
- *I've never had this kind of pain before. Isn't gout an old person's disease? What is it anyway?*
- *It is often associated with diabetes, obesity and high blood pressure. Gout is produced by urate crystals precipitating in the joint. That is why it is so painful. This precipitation happens when there is a high level of uric acid in the blood. But anyway ... Let me give you a prescription of NSAIDs and strong analgesics. I'll add "uric acid" on the follow up blood test form I have just given you. NSAIDs need to be taken with food, never on an empty stomach as it can give you a stomach ache.*
- *How long is the course for?*
- *Until it settles, but by all means get back to us if it has not settled within 2 weeks!*
- *I am very much obliged, doctor!*
- *Bye for now!*

In the long run – looking into the distant future.

Over the counter: bought without prescription.

Pain can be throbbing (pulsatile), excruciating (extreme), dull (not sharp), burning, nagging (dull continuous, not severe), stabbing (like a knife stab).

Swollen: from the verb to swell/swelled/swollen, to become larger (e.g. ‘swollen ankles’ for oedema of the legs or ‘swollen glands’ for enlarged lymph nodes).

Gout: a disease typically experienced by middle aged or elderly people whereby uric acid crystals precipitate in a joint. Usually presents with **hyperuricaemia**. Often reported on blood test results as “serum urate”.

Great toe – first toe is also the big toe; little toe is the fifth toe.

NSAID ★. Non-steroidal anti-inflammatory drug, as opposed to steroidal anti-inflammatory drugs such as prednisolone.

Analgesics. Painkillers, medication providing pain relief; some can be bought over the counter.

Follow up: review of patient’s improvement (or lack of it), often abbreviated f/u. Review is sometimes abbreviated r/v.

To be obliged – to be grateful.

Settle – subside, disappear.

By all means – expression used to emphasise that the listener should have no hesitation in doing something.

Within 2 weeks – included in the period starting today and ending in 2 weeks.

Other expressions of interest:

Goitre. A chronic enlargement of the thyroid gland, not due to a neoplasm, occurring endemically in certain localities, especially where the soil is low in iodine, and sporadically elsewhere.

Hypothyroidism is a condition where the thyroid gland is **under-active**; hyperthyroidism is a condition where the thyroid gland is **over-active**. Patients may say they have an “under-active thyroid”.

gout [ɡaʊt] hyperuricaemia [hiˈpər-yōrˈiːsēmia] obliged [ə-blɪd]
goitre [ɡɔɪtˈər]

Genito-urinary System

with Marcus Martin Hassemere

Dr. Marcus circled around the usual traffic congestion on his scooter. He pitied those who were stuck in their cars on such a wonderful sunny day. When he entered the surgery the receptionists were already busy trying to calm down angry patients who could not get an appointment for the day. There are never enough appointments on a Monday for all patients, but thanks to the 10-min appointment system, Dr. Marcus only sees 6 patients per hour – and no more. When he opened EMIS on his PC, many urgent patients were already piling up on his screen. The first booked patient was Mr. Agarwal, aged 62.

- *Hello, Mr. Agarwal, nice to see you, what can I do for you?*
- *Well, doctor, I feel so tired in the morning and I can't hold my water, I have to rush to the loo and sometimes I don't make it and I end up wetting myself.*
- *So how often do you pass urine?*
- *At night, I have to get up about four or six times, more if I have a beer. And during the day ... Ah, that is the main problem. I am a taxi driver and I have to stop every 20–30 min. It's very difficult during rush hour, and sometimes I am still leaking urine even after going to the loo.*
- *Can you remember when your symptoms started?*
- *Around 6 months ago.*
- *Right, and how about your urine flow? Is it quite a strong flow?*
- *It has become quite slow.*

Dr. Marcus made a note here as he thought that impotence could also be an additional problem to address in another appointment.

- *I think the best thing to do would be for me to carry out a physical examination. Would you mind if I examined your tummy, genitals and feel for your prostate?*
- *That's alright.*
- *OK, if you would like to get undressed and lie on your back on the couch, please.*

Mr. Agarwal undressed behind a curtain whilst Dr. Marcus put on his gloves. He palpated the suprapubic area and could not feel a distended bladder. The penis was circumcised, there were no lumps in either of his testicles and his spermatic cords were normal. Dr. Marcus applied some KY Jelly to his fingertips.

To pity: feel pity for, feel sorry for.

EMIS. Egton Medical Information System. One of the most frequently used clinical software in English surgeries.

Pile up: accumulate.

Rush: hurry, speed up.

Loo: toilet, lavatory.

I don't make it – I don't reach the toilet on time. To “make it” may be applied in other contexts, e.g. if you are asked to come to a meeting, you may need to say: “Sorry I can't make it for that date, I will be on a course”.

My water – my urine. Patients normally refer to their urine as “water”.

I can't hold my water – I cannot wait to go to the toilet; if I do, I wet myself.

Wet oneself – suffer an episode of urine incontinence.

Rush hour: (or **peak hour**) busiest time of day for traffic on the roads. When there is heavy traffic you may get stuck in a “traffic jam” and be unable to advance for a long while. “Stuck in traffic” is a typical excuse for patients who arrive late to appointments and for doctors who arrive late to meetings.

Leak: to escape accidentally.

Flow: the movement of liquid; **stream.**

Carry out: perform.

Tummy: colloquial informal term for abdomen. Patients also call it “stomach”.

Lie on your back – lie down with your back against the couch and your face looking up. The opposite would be “lie on your stomach”.

Couch: examination bed used in consulting rooms. Also, sofa used at home to watch TV.

Distended: dilated, swollen, oversized.

Bladder: pelvic organ where the urine is stored between mictions.

Circumcision: removal of foreskin when a child is young. Very common in Muslim and Jewish cultures.

Foreskin: prepuce; a fold of skin that covers the end of the penis.

Jelly: any substance of semisolid consistency. In this case we refer to a lubricant used for rectal examinations. “K-Y Jelly” is a common brand in England.

EMIS [ēmɪs] urgent [úr'jənt] loo [lōō] stream [strēm] impotence [ɪm'pə-təns]
prostate [prös'tāt] couch [kouch] penis [pē'nɪs] do not confuse with pennies
[pɛn'ɛ]

- *All seems fine Mr. Agarwal, could you now turn onto your side, facing the wall and bring your knees up to your tummy. I am going to have to insert my finger into your back passage.*
- *Yep, go on doctor.*

Dr. Marcus felt two large soft lobes of the prostate gland and normal sulcus.

- *Well that's all, thank you! I hope that was not too bad. You can now get dressed again.*

After dressing, the patient came back to his chair.

- *I think you suffer from an enlarged prostate, which makes it difficult for your urine to pass out of the bladder. The bladder tries to push it out instead. I would suggest we start with a tablet, which will shrink your prostate. I would also like to send you for some blood tests and refer you to a waterworks specialist for further investigation. You will pass urine in a flow device, which should indicate how severe the obstruction is and they may use a camera to look into your bladder.*
- *Is this something very serious?*
- *Well, I don't think you should worry too much about it.*

Dr. Marcus explained that a benign prostate enlargement was not a precursor for prostate cancer.

- *Please call me if you have any further questions or if you experience any side effects from the medication; otherwise, I will see you in four weeks!*
- *Thank you for being so thorough, Doctor.*

Dr. Marcus wrote in his notes:

P: Suspected BPH

H: Since 6 months ago, obstructive and irritative sx gradually getting worse, nocturnal frequency up to 6x and every 30 min daytime, terminal dribbling, weakness of urinary stream.

E: s.p. area soft, testicles normal, no lumps, normal penis. PR: Enlarged smooth prostate lobes with normal sulcus, palpation not painful, no nodules, ampulla empty.

C: Possible associated erectile dysfunction – will address this next time. For bloods with PSA, see 4/52.

Rx: Tamsulosin trial.

When the PSA result arrived, slightly raised, Dr. Marcus dictated a letter to Mr. Stone, Consultant Urologist and Specialist in BPH:

Turn onto your side, facing the wall – move your body so that only your side (usually left) is against the couch and your face is in front of the wall.

Back passage: colloquial for anal area. **Bottom** is the general colloquial term for **buttocks** (gluteal areas).

Yep: informal for “yes”.

I hope that was not too bad – I hope the examination has not been too uncomfortable for you.

Shrink: make smaller.

Waterworks specialist: urologist.

Enlarged: bigger than normal; **has enlarged** – has got bigger.

Camera – rigid or flexible cystoscopy.

Sx: symptoms.

Obstructive symptoms:

- **Weakness** of urinary **stream** – the urine comes out slowly.
- **Hesitancy** – the urine takes time to start coming out.
- **Dribbling** – urine drops keep falling after micturition.
- **Straining** – the patient needs to apply voluntary muscle force to push the urine out.
- **Intermittency** – the urine stream is interrupted.

Irritative symptoms:

- **Urgency** – the patient feels an urgent need to pass urine, with discomfort in the bladder.
- **Frequency** – the patient urinates more times than usual. “Frequency” is the short version of “increased frequency of micturition”.
- **Nocturia** – the patient gets up at night to urinate.
- **Incontinence** – the patient cannot control bladder function and wets himself.

Thorough: exhaustive, careful, complete.

Frequency “**up to**” **6x** – the night frequency of micturition was variable with a maximum of six times per night. The “x” is often used in notes to mean “times”. For example, “vomiting x3, diarrhoea x7”.

Daytime – during the day, not including the night.

BPH ★: Benign prostate hyperplasia.

PR ★. Per rectum, rectal examination.

Smooth: with no lumps or interruptions, soft and even.

PSA ★. Prostate-specific antigen.

Erectile dysfunction: impotence.

Trial – course of medication to see if it helps.

Mr. Stone – Note that any surgical specialist in the UK is addressed as “Mr.” rather than “Dr.”.

tummy [tũm"ē] passage [pās"ij] benign [bĩ-nĩn"] thorough [thũr"ũr]

Dear Mr. Stone,

Thank you for seeing this 62-year-old gentleman who has been suffering from obstructive urinary symptoms for more than 6 months which are gradually getting worse. He seems quite bothered by his symptoms as he has to get up more than 4–6x at night and approximately every half hour during the day. This interferes severely with his job as a taxi driver. O/E: prostate feels enlarged and smooth. He is not on any regular medication. I would be grateful for your assessment.

Just as he put the dictaphone down, the telephone rang. It was Shanine, one of the receptionists, smiling as usual.

- *Hi, Dr. Marcus, Mrs. Money Penny is on the phone, her son has a pain in his testicles, and she says it is urgent, she is on line 601.*
- *Hello, it's Dr. Marcus speaking.*
- *Doctor, you need to see James, he is in terrible pain with his testicle, and I don't know what to do!*
- *When did the pain start?*
- *It started suddenly, just before breakfast. I gave him some ibuprofen but it is no better.*

Dr. Marcus had a free urgent slot, so he asked Mrs. Money Penny to bring the boy in to surgery. On his PC screen a request for an urgent home visit appeared, but the next patient had already been waiting for more than 20 min. It was Mrs. Amir, a Muslim Bengali lady.

- *How can I help you, Mrs. Amir?*
- *It's my water. It has been burning very badly since yesterday, and I hardly got any sleep. I never had such pain before.*
- *This sounds like a urinary infection. I will need you to give me a urine sample ... the toilet is just around the corner.*

The dipstick showed signs of a UTI and Dr. Marcus advised her to take a short course of antibiotics. He also recommended that she drink plenty of fluids. He filled in a laboratory form, crossed MCS, labelled the urine bottle and stored it in the refrigerator. He wrote in his notes: "Dysuria for 1 day, UTI, 3-day course of Trimethoprim, send for MCS".

James, the 9-year-old foster son of Mrs. Money Penny was already in the waiting area. Dr. Marcus called them into the consulting room.

- *OK, James, would you mind showing me exactly where it hurts so I can have a look?*

He is quite bothered – he is very affected, uncomfortable and/or worried.

Interferes with – has a negative impact on, is an obstacle for.

It is no better – it is not better, it is not getting better.

Slot – An assigned place and time in a schedule, e.g. for an appointment.

I hardly got any sleep – I didn't sleep much during the night.

Sample – specimen.

Around the corner – turn left and then left again, or turn right and then right again.

UTI ★. Urinary tract infection (of kidney, ureter, bladder, urethra).

Dipstick: quick urine test for leukocytes, nitrites, proteins, density, pH, blood, ketones and glucose. A well-known brand is the Combur test.

Crossed MCS – wrote an “X” in the box by “MCS” in the form.

MCS. Microscopy, culture and sensitivity.

Label. You need to write the name and DOB (date of birth) of the patient on the specimen bottle. If you do not, the lab may not analyse the sample but send you this message back: “sample not processed – sample unlabelled”.

MSU ★. Mid-stream urine. It is common to ask the patients to take a mid-stream morning sample to send to the lab. We would instruct the patient to wash the perineal area first, pass the first part of the urine stream outside the specimen bottle, then the pass middle part of the stream inside the bottle, and finally discard the last part of the urine stream. We would often write in the notes: “sent for MSU”.

Dysuria: pain on micturition, pain on passing urine (sometimes written as “pain on PU”). Mrs. Amir had “burning dysuria”.

Foster child –. Foster care is a system by which adults care for children or young people who cannot live with their parents.

9-year-old boy –. Remember it is NOT “9-years-old boy”. You may say, however, that “the boy was 9 years old”, or “the boy was 9”.

urinary [yöör"ə-nër"ē] urine [yöör"īn] dysuria [dīs-yöör"ē-ə] hurt [hûrt]
interfere [īn'tər-fīr"]

Colloquial terms:

For testicles: balls.

For penis: willie (children).

For urinating: to pass water, to do number one, to wee-wee (children).

Both Mrs. Moneypenny and James agreed and with some help from mum, James got undressed from the waist down and lay down on the couch. Dr. Marcus gently touched the painful testicle as it was slightly lifted upwards. He was convinced that this was a possible testicular torsion and that James would need to be admitted to hospital.

- OK, James, I will have a word with the children's specialist at the hospital. It looks to me that one of your testicles is a bit twisted and it will need to be brought back into its normal position.

Dr. Marcus dialled the GP line of the hospital.

- Hi, could I speak to the Paediatric Surgical doctor on call please.
- Dr. Rashnal here, how can I help you?
- Hello, it's Dr. Marcus here. I'm a GP from The Mission Practice. I have a 10 year old boy with severe left testicular pain. The pain started suddenly approximately two hours ago, it looks like a testicular torsion.
- Okay, send him to Paeds A&E with a letter – keep him NPM.

Mrs. Moneypenny was happy to take her son to the hospital herself. In theory Dr. Marcus should have a break after seeing several patients. However, this is rarely the case as he needs the spare time to catch up with any outstanding work. He dialled the number given for the urgent home visit. The district nurse was still with Mr. Grunsch and explained that his catheter was blocked by clots of blood and that he was suffering from severe abdominal discomfort. Mr. Grunsch had had a Redo TURP 2 days before and was discharged from the hospital with a catheter. A trial of micturition was planned for him for the following week as an outpatient. His notes documented:

Regular medication: 3 mg Warfarin od, Detrusitol 2.5 mg bd, Zopiclone 3.75 mg nocte, PRN: 2 cocodamol if necessary qds. PMH: AF, Insomnia, Irritable Bladder, TURP 1995, Urethral Stricture 1996. Allergies: Penicillin.

Mr. Grunsch was very pleased to see Dr. Marcus and the district nurse left him her mobile number just in case. Before she left she also took a blood sample for his INR. Mr. Grunsch was in severe agony and so grateful to see the doctor. On examination Dr. Marcus found that the bladder was distended and extremely painful. Dr. Marcus decided to change his catheter to a size 18 Ch Foley. The old catheter was quickly removed and the new one inserted. With the bigger catheter size the clots came out and the patient's pain was immediately relieved. Within 5 min the bladder drained 800 ml of urine. Mr. Grunsch was delighted and Dr. Marcus, satisfied, went back to the practice to go on with his busy day. No wonder he was a GPWSI in Urology.

Got undressed from the waist down – took off his underpants, trousers, socks and shoes.

Lay down: past of **lie** down.

Lifted upwards – had moved up, was displaced to a higher level than normal.

Twisted: rotated.

Dial: to press the telephone keys to call.

GP line: some hospitals have a telephone line dedicated to GP calls only.

On call: this hospital doctor has to answer GP calls. The receptionist will usually ask “Medical or Surgical?” and “Adults or Paeds?” For advice you would ask to speak to the **Registrar** or **SpR** ★ (doctor in training for a certain specialty).

NPM – Nil per mouth. The patient should not eat or drink anything, as he may need surgical intervention.

Paeds: short for paediatric(s).

Was happy to – agreed to, was OK with, had no objections. Obviously, she didn’t really “feel happy” as it was not a happy situation.

A break – a short rest.

This is rarely the case – this almost never happens.

Spare – free, not used.

Outstanding work – pending work, work waiting to be done, work you still have to do. Note that “outstanding” also means very good compared with the rest: for instance, a brilliant student would get “outstanding” marks in his medical studies.

Clot: piece of coagulated blood.

TURP: Trans-urethral resection of the prostate.

Redo TURP: repeated TURP when it has not been possible to remove all prostate tissue with the first one.

Trial of micturition: attempt to remove the catheter to see if the patient can pass urine normally.

As an outpatient – without being admitted to hospital; not as an **inpatient**.

Do not confuse “inpatient” (patient admitted to hospital) with “impatient” (unable to wait) – although these two may coincide!

PMH. Past medical history.

In agony – suffering a lot with the pain.

Urethral: related to the urethra. **Ureteric:** related to the ureter(s), e.g. “ureteric colic” in urolithiasis.

No wonder – it is not surprising that.

GPwSI (or GPSI): GP with a Special Interest. These GPs provides some specialist services that are normally been provided within the secondary care setting.

SpR [es pee ahr] catheter [kāthˈɪ-tər]

-Well doctor, what happened is, I went to see a man about a dog and there was a lot of blood. The wife told me to come and see you, like.



LALANDA

URINATE, TO: to pass water, to do number one, to go round the corner, to go to see a man about a dog, to wee-wee, to pee, to go to see one's aunt, to have a run-out, to spend a penny (women only), to tinkle

DEFAECATE, TO: to have the bowels opened, to do a big job, to do number two, to do a rear, to crap, to do a pooh (children), to do one's business, to go to the ground, to have a clear out

Women's Health

with Fausto Plana

Dr. Fausto Plana checked the last blood test results on the computer. Taking a glance at his watch, he noticed that it was already 9 o'clock. He opened up the list of patients booked in for his morning session. Unsurprisingly, he was fully booked with 15 routine 10-minute appointments. The first patient, Mrs. Audrey North, had been waiting for 5 minutes so he called her into his office.

- *Good morning, Mrs. North, please take a seat. I can see that you are an early bird, what can I do for you today?*
- *Well doctor, I think I am going through the change ... you know, the menopause.*

Dr. Plana glanced at her medical record and noticed that she was 49 years old.

- *What makes you think that, Audrey?*
- *Well, I have been very emotional lately. I cry at the silliest things, even for no reason sometimes! My husband has also said that I have been very moody lately and that I keep losing my temper. You know me, doc, I'm not usually like that!*
- *Tell me, Audrey, do you think you may be a bit depressed? Have you had any bereavement in the family or had any bad news?*
- *Not at all, doctor. My husband is very understanding; the business is going well; Michelle, my daughter, has just started at Uni. I was even considering taking up a part time job to keep busy but with the way I am feeling right now, I don't think that would be a good idea.*
- *Have you experienced any hot flushes?*
- *Well, now that you mention it, yes. I often wake up in the middle of the night feeling hot and sweaty. We have to sleep with the window open now. Do you think we should check my hormones?*
- *Yes, we will check that just to be certain, but from what you have told me it definitely sounds as though you are going through the menopause. Have your periods stopped?*
- *Yes! I am 2 weeks late this month. And I missed one back in November.*
- *Well, I don't think you are pregnant, Audrey! [laughing]*
- *No, [laughs in agreement] that's not likely doc! My husband had the snip. Don't you remember?*

Glance: quick look.

Patients booked in – patients booked, patients who had an appointment reserved for them.

Routine –. Routine (non-urgent) appointments are currently 10 min long to ensure an acceptable quality of the consultation and minimise patient waiting times.

Fully booked – all appointments booked, no appointments left.

Early bird – from the phrase “the early bird catches the worm” – meaning that she wakes up and arrives early.

Going through – experiencing.

The Change: colloquial term for the menopause.

To be emotional: to have an unusually high tendency to express emotions, especially to cry.

Silly – not important. To be silly is to lack common sense. You may say or do something silly. Mrs. North's husband probably said to her “Oh, don't be silly, don't cry for this ...”.

For no reason – without a reason; cannot say why.

Moody. Tending to change mood unpredictably, e.g. from cheerful to bad-tempered.

Mood swings: changes of mood, e.g. from happy to sad.

Cheerful: happy and optimistic.

Temper. An emotional condition or predisposition of a particular kind.

(Bad) temper: tendency to get angry easily and suddenly.

Lose my temper: get angry.

Bereavement: death in the family or amongst close friends.

Uni – short word for university.

Take up: accept.

The way I am feeling – how I am feeling.

Right now – at this precise moment. Often used to give orders, e.g. “Come here right now!”

Hot flushes: intermittent hot feeling and facial redness, especially at night with sweats; typical vasomotor symptoms of the menopause.

Period: menstruation.

It sounds as though – it seems that; it looks like.

Missed a period – did not have a period.

Back in November –. The “back” only emphasises the “past” occurrence of the event – it can be omitted. Also, let us take the opportunity to remind you that the names of the months and days of the week in English start in capital letters. And a reminder about prepositions: **on** Monday; **in** November; **in** 2007; **on** 5 November 2007.

The snip: colloquial expression for a vasectomy. Literally, snip is to cut with scissors.

menopause [mɛnˈə-pôz] idea [ī-dēˈə] hormone [hôrˈmôn]

- *Oh, yes, how could I forget? I referred him to the urologist myself. OK, I am going to request some blood tests to confirm our suspicions but I would also like to know your views on HRT.*
- *I am not very keen on pills, doctor. I have read so many bad things in the press. I don't really know, what's your advice?*
- *I'll tell you what, Audrey, let's just have the blood tests done and then you can come back and see me in a couple of weeks and we will have another chat.*
- *That's great, thanks! I'll make an appointment on my way out.*
- *OK, bye, Audrey!*

Mrs. North left the room and Dr. Plana entered some notes on his computer.

C/O menopausal symptoms: moodiness and vasomotor mainly. Also irregular periods.

LMP 6/52, husband had a vasectomy. Lipids, FBS, LH-FSH and TFT requested. Review 2/52.

Two weeks later, Mrs. North returned to see Dr. Plana for a follow-up appointment. It was a fine afternoon and Dr. Plana was in good spirits.

- *Good afternoon, Audrey. It's lovely out there now that winter is over! How are you feeling today?*
- *Not very well, I'm afraid to say. Two days after I saw you, I had a period and it was incredibly heavy. I was flooding! I had such bad stomach cramps and clots too.*
- *Oh dear, that sounds awful! I have your tests back and I can confirm that you are going through the menopause. Before we go any further I would just like to ask you a few more questions. First of all, have you got a family history of breast cancer or heart conditions?*
- *No, doctor, although my granny passed away when I was quite young.*
- *OK and are your smear tests up to date?*
- *Yes, I had one a few weeks ago.*
- *Excellent. I am just going to check your blood pressure and I am afraid I will have to do an internal examination to see if you could have any fibroids on your womb as these can cause heavy periods like the one you just described.*
- *All right, doctor, if you have to.*
- *I will call a chaperone, if you like to sit with you during the examination.*
- *Oh yes, that would make me feel more comfortable.*

Dr. Plana called through to reception to see who was available and a couple of minutes later, Sharon, one of the Practice's health care assistants, knocked on the door and entered the room.

I referred him myself – it was me who referred him.

Not keen on pills – dislikes taking oral medication, preferring to avoid it altogether.

Altogether: completely.

Press – newspapers and magazines.

I'll tell you what – I propose this plan.

Chat: informal conversation.

On my way out – as I go out, when I pass through reception.

Mainly: essentially, most importantly.

C/O. Complaining of.

LMP. Last menstrual period.

FBS. Fasting blood sugar (as opposed to RBS or random blood sugar).

TFT. Thyroid function tests.

Follow-up appointment. A second consultation with a patient regarding the same complaint.

In good spirits: feeling good, optimistic.

It's lovely out there – it is a very nice day, the weather is good.

Winter is over –. Briefly commenting on the weather is a good conversation starter and it helps to make the atmosphere less formal.

I'm afraid – expression often added to any bad news. It does not mean one is frightened.

Heavy period – large amount of bleeding; **menorrhagia**. The opposite is a **light period**. Periods may be **regular** (e.g. **menstrual cycle** 4/28) or **irregular** (e.g. 4/25–40). **Period pain** is called dysmenorrhoea.

Flood. A very large amount of water that covers a previously dry area, e.g. when it rains too much and a river overflows and inundates a town.

Clots. Coagulated blood.

Cramps – colicky pain.

Granny: grandmother or grandma.

Awful: very bad or very ugly.

Before we go any further – before we advance more in this process.

Pass away: die.

Smear test. Cervical cytology. In England these tests are carried out every three years on women over the age of 25 years and every 5 years over the age of 50 years.

Up to date – not late, not overdue. **Overdue.** Late or after the scheduled time, especially in arriving, occurring, or being paid.

Internal – Vaginal examination. Often abbreviated as VE or PV (per vagina).

Fibroids: Benign tumour of the uterus arising from myometrium. The more technical term “myoma” is rarely used except in “myomectomy”.

Womb: lay term for uterus.

Suspicion [sə-spɪʃən] smear [smɪr] fibroid [fɪˈbroid] menorrhagia [mɛnˈə-rāˈjē-ə] awful [ɒˈfəl] overdue [ōˈvər-dyōō] womb [wōōm] uterus [yōōtər-əs]

- *Hello Mrs. North, I'm Sharon, Dr. Planar asked me to sit with you.*
- *Hello Sharon, call me Audrey!*

Sharon helped Mrs. North to undress and lie down on the couch. Dr. Plana finished the examination and Sharon, smiling, went back to her clinic.

- *Well, Audrey, I hope that wasn't too uncomfortable!*
- *No, it was fine, you know what they say ... "lie down and think of England!"*

Both patient and doctor laughed and then Dr. Plana continued in a more professional tone.

- *As far as I can see there is no medical reason to stop you from taking HRT if you wish to do so.*
- *I am still undecided, doctor. I would like to have your opinion.*
- *Well, I can't make the decision for you, but from a strictly medical point of view you don't have to be on HRT. Furthermore, there is a slight risk of breast cancer, stroke, heart attack and lung clots in those ladies who do use HRT. Having said that, in your particular case I would judge those risks to be very small. Should your menopause symptoms get worse I would be happy to prescribe it for you, providing we keep a close eye on your blood pressure and check your breasts regularly. You are very medically fit at the moment so you should be fine on HRT.*

There was a short pause until Mrs. North resumed the conversation.

- *I suppose it's all about pros and cons at the end of the day. As I said before, I am not very happy with popping pills. I think I would like to try some natural remedies first and if all else fails ...*
- *That sounds fine, Audrey, there is something on the market called Black Cohosh that might help with your hot flushes, but just beware of the pricey stuff!*
- *Yes, I know what you mean, doctor! Thank you, you have been most helpful.*
- *Well, keep me posted and let me know if you have any problems.*
- *Will do! Bye.*

Dr. Plana filled in the HRT template on the computer and closed down the consultation.

Three months later, Mrs. North started on HRT, as she was unable to cope with the stress of Michelle starting her exams at Uni. Two months after that, she got a part-time job as a PA in a law firm.

As far as I can see – according to what I am seeing.

To stop you from taking HRT – to make me advise you not to take HRT.

HRT ★: Hormone replacement therapy. Consists of oestrogens with or without progestogens.

If you wish to do so – if you wish to do it.

Point of view: perspective.

Furthermore, ... – There are even more reasons, ...

Stroke: Cerebrovascular accident.

Lung clot: Pulmonary embolism (PE).

Who do use HRT – compared to those who do not.

Having said that – in spite of what I have just said, I will now say something that is contrary or compensatory to what I have just said.

I judge them to be – I believe they are (in my professional opinion).

Should they get worse – if they get worse.

Happy to prescribe – agree to prescribe with no objections.

Providing – with the condition that; only if.

Keep a close eye – monitor closely. **Keep an eye:** observe vigilantly.

Resume: start again.

To pop pills – to swallow many pills. People who love to take medication are “pill poppers”.

Natural remedies: alternative medication such as herbal medicines.

If all else fails – if nothing else works.

Beware: be conscious of.

Pricey: expensive.

Stuff: informal for “things”.

Keep me posted: update me on your progress, let me know any news.

Template: pre-made structure in the clinical software where you enter coded data in specific boxes or lines. There is a template for asthma, diabetes, hypertension, HRT, etc.

Close down – close a computer program or a part of it, or turn off the computer.

PA ★. Personal assistant. A high-profile secretary. Not many GPs have one (I wish!) but some hospital consultants do.

Law firm. A group of lawyers who sell legal services.

Other expressions of interest:

Thrush: lay term for candidiasis (oral or vaginal). It usually presents with a white cheesy discharge.

Quadrants of the breast

UEQ. Upper external. **UIQ.** Upper internal.

LEQ. Lower external. **LIQ.** Lower internal.

uncomfortable [ʊn-kʊmˈfər-tə-bəl] oestrogens [esˈtrə-jən] progestogens [prə-jesˈtə-jən] resume [ri-zōm] beware [bi-wâr] stuff [stʌf] staff [stäf]

Conception, Pregnancy and Childbirth

with Emilia Negrin Brito

Dr. Emilia Negrin arrived a bit late for her surgery that morning. She had had to drop the kids off at school and the traffic was very bad. She already had two patients waiting when she walked through reception. She quickly logged onto her computer and pressed the key to call her first patient.

Miss Anna Wilson, a student in her early twenties, was not frequently seen at the practice and indeed she had failed to attend her last two appointments.

- *Come in, please. Take a seat.*
- *Thanks, doctor.*
- *I'm sorry I have kept you waiting, what can I do for you today?*
- *I think I am in trouble, doctor. [Her cheeks flushed.]*
- *Would you like to tell me about it?*
- *Well, I think I might be pregnant ... I did a pregnancy test at home and it was positive. I am not sure how reliable they are. Can you double-check?*
- *I see. When was your last period?*
- *I finished, let me see ...*
- *No, I mean the first day of your last period, when did you start bleeding last?*
- *Oh, I see ... That was on the 2nd of April. I normally have my period at the beginning of the month, so I had a test this weekend, when I realised I was over a week late. It was one of those you buy at the chemist, but I would like to have one done here. They are more reliable, aren't they?*
- *The pregnancy tests we use here are similar to the ones you can buy at the chemist, and they are both quite reliable.*
- *Oh, are they really?*
- *How do you feel about being pregnant?*
- *Not too good, doctor. It is not the right time, I have only been with this guy for 6 months and I am still in college. My parents will kill me. I don't think I can keep it.*
- *You should not let what others think influence your decision. It is a very important step and you should take your time to think about it. Don't rush it.*
- *I have thought about it long and hard and I still want to have a termination.*
- *Have you thought about other options, like adoption?*

Drop the kids at school – (informal) take the kids to school.

Log in or log on: enter a computer system or program in order to be able to use it. It often requires typing in a username and password.

Log out or log off: exit a computer program or system.

Keys are each of the buttons of the computer's keyboard that you use to type words or perform computer functions. Most of them are "letter" keys (Q W E R ...).

Failed to attend – missed the appointment. Often abbreviated DNA (did not attend), e.g. "This patient has DNA's twice".

I have kept you waiting – I have made you wait. Doctors often apologise if they are running late. Patients are also very apologetic if they are late for an appointment. **Sorry to keep you waiting** is a common phrase you will hear if you deal with commercial companies or official institutions on the phone.

Cheeks flushed. To turn red, as from fever, embarrassment, or strong emotion; to blush.

Pregnant. Denoting a gestating female. The expression "expecting a baby" is also often used. You also say that a woman "is carrying" a baby.

Reliable is what you can trust because it works well or says the truth.

Double-check: re-check, check or test again to be absolutely sure.

Period – menstrual period, also referred to as **menstruation**.

When did you start bleeding last – When was the last time that you started bleeding?

Over a week – more than a week. "Over" may also be used to mean "during", e.g. "The patient bled 2 litres over 24 hours."

Guy: man. However, when it is used in plural to address a group of people, it may include men and women. For example, you may say "You guys are lucky in Britain because you can organise your own practices."

College: institution of higher education after standard school studies, usually for short degree courses.

Keep the baby – not to abort. **Don't rush it** – don't make a decision too quickly. **I thought about it long and hard** – I dedicated time and effort to think about it before making a decision.

Termination. Provoked abortion. To end (a pregnancy) before term by artificial means. Another use of this word is "to terminate a contract"; or "this train terminates at Stanford" (last station). You do NOT say, however, that you "terminate" things like a meal or a piece of work, you "finish" them, or they "end".

flush [flʊʃ] reliable [rɪ-lɪ'ə-bəl]

- *Oh, no! I could not carry a baby for 9 months to just give it away after. That is definitely not an option!*
- *What I can do, Anna, is to refer you to an Advisory Centre where they can discuss your options with you so that you are certain you are making the right decision.*

Dr. Negrin filled in the referral forms and asked:

- *Have you had a termination or a miscarriage before?*
- *No, this is the first time I've been pregnant, doctor.*

She also wrote a quick referral letter on the computer:

*Dear colleague,
Many thanks for assessing this 21-year-old student who is requesting a TOP. There are no significant events in her past medical history. There are no known allergies and she is a non-smoker.
Her LMP is 2 April and she had a home pregnancy test positive on the 10 April. Her GA is 6/40 and her EDD is 6 Jan.
Yours sincerely,
Dr. Emilia Negrin
General Practitioner*

Dr. Negrin printed the letter out and instructed Miss Wilson about what she should do next.

- *This is the form that you have to take down to reception. They will book the appointment for you. On the day of your appointment, take this other letter with you and give it to the receptionist at the clinic there. You will still have to go through some counselling with one of the nurses there and then you will see a doctor. They should explain the whole procedure to you and you will be given plenty of time to ask questions. But remember, you can still change your mind at any time, OK? It might also be a good idea for you to start thinking about long term contraception. You can come and see me right after the termination to discuss it if you like. That way you can avoid pregnancies until you are ready.*
- *OK, doctor, I will. Can I ask you one more question?*
- *Of course, what is it?*
- *My parents won't know about this, will they?*
- *No, not unless you tell them. This consultation will remain completely confidential.*
- *OK, that's what I wanted to hear. Thanks a lot.*
- *Take care, bye.*

Miscarriage is the spontaneous expulsion of the product of a pregnancy before the middle of the second trimester. Patients, however, use this term for any pregnancies interrupted naturally at any stage. After a miscarriage, women often undergo dilation and curettage, commonly known (even by patients) as **D & C**. The external evacuation of the product of conception can also be written as **EEPC**.

TOP ★ Termination of pregnancy.

No significant events – this may be used in referral letters when the referring doctor wants to note that the past medical history is not relevant to the case.

LMP ★ Last menstrual period.

GA. Gestational age. It is usually written in the format 31/40 (31 weeks pregnant out of the total 40 that is considered full term).

EDD. Estimated date of delivery. It is also called estimated date of confinement. Patients will talk about this using the expression **due date**. For example: “**When is your baby due?**”

Due for my period – my period is expected. “I was **due** 14 days ago, so I am now nearly 2 weeks **overdue**” – my period should have come 2 weeks ago, but it has not.

Print out: (verb) print a document that normally stays on the computer; (noun) the printed version of such document. When you go for a home visit, you normally take a “summary print-out” of the patients records.

Counselling. To give professional help and advice to (someone) to resolve personal or psychological problems.

Change your mind – change your opinion or decision to a different one.

Long-term contraception or long-term reversible contraception, to differentiate from those permanent methods such as a vasectomy.

Remain – keep.

Take care: common expression to say good-bye, expressing a wish for the other person to keep well.

Unwanted pregnancy – a pregnancy the woman wants to end. If she does not, she would have an unwanted child. A pregnancy may, however, be “**unplanned**” but not necessarily “unwanted”.

miscarriage [mɪsˈkɑːrɪj] remain [rɪˈmān] sincerely [sɪn-sɪr] procedure [prəˈsɛːjər]
due [dyʊ] trimester [triˈmɛsˈtər]

Then Dr. Negrin turned to her computer and wrote:

P: Unwanted pregnancy

H: LMP 2 April, pos preg test at home

C: options discussed, decided TOP, referred. Pt TCB for long term contraception.

Dr. Negrin called in the next patient. She knew Miss Morgan very well. She was a 19-year-old single mother to Sam (2 years) and Millie (10 months).

- *Hi, please take a seat. What can I do for you today?*
- *I had a little accident on Saturday, doctor. I need the morning after pill.*
- *I see, what happened?*
- *The condom split.*
- *Was that with your regular partner?*
- *Yes, of course.*
- *I am asking you this because when something like this happens with a casual partner, we need to consider testing for sexually transmitted infections. I don't mean to be nosey!*
- *Oh, no, I know you don't.*
- *When was your last period?*
- *25th of April, if I remember correctly.*
- *Are your periods regular?*
- *Yes, they usually come every 30 days or so. I should come on again around the 25th of May.*
- *So you are due in about 2 weeks, then?*
- *Yes.*
- *Any other accidents since your last period?*
- *No, I have been very careful really.*
- *Are you taking any medication at the moment?*
- *No, nothing.*
- *Any allergies?*
- *Not that I know of.*
- *Any history of liver problems?*
- *No, never.*
- *OK, you have two options here. You can either take the morning after pill, as you suggested, or I could arrange for you to have a coil inserted. The coil can be useful as emergency contraception but it can also be left inside, thereby acting as long-term reversible contraception. That way you won't have to worry about unplanned pregnancies for years. What do you think?*
- *Oh, no, I don't like the idea of having something left inside there, it gives me the chills just thinking about it. I think I'll take the pill.*
- *OK, if you feel so strongly about it ... You have been on the pill before, haven't you?*

Pt. Patient.

TCB. To come back. There is a similar abbreviation TCI that means to come in. Both express that there is a plan to see the patient again.

Single mother: a mother who does not have a husband or partner. We would call this one a “single parent family”.

Mother to – mother of.

Morning after pill (MAP) – the commonest form of **emergency contraception (EC)**, usually levonorgestrel in one or two doses.

The condom split – the condom broke. To **split up** means to end a marriage or other relationship. (“We split up last month”.)

Regular partner – consistent sexual partner, i.e. husband/wife or long-term partner. The only or main person with whom someone has sexual intercourse.

Casual partner – an occasional sexual partner, person with whom someone has sexual intercourse only once or from time to time, not in a romantic relationship. To have “casual sex” is to sleep with one or more non-regular partners.

Sexually transmitted infections/diseases (STIs ★ or STDs ★). In Britain, there are dedicated clinics where STIs are specifically diagnosed and treated. Those based in the hospital are called **GUM ★ clinics** (Genito-urinary Medicine clinics). Patients usually like them because they can refer themselves (self-referral) and the details of the consultation do not necessarily go to their GPs. Some patients even use false names!

Nosey: someone who is too inquisitive or intrusive about other people's affairs; someone who wants to know too much about other people's lives.

Come on – start the menstrual period.

Coil: informal way to refer to the **IUD ★** (intrauterine device). Many gynaecologists prefer to use the term IUCD that stands for intrauterine contraceptive device. That is slightly different to the IUS (intrauterine system) with a hormonal component.

Thereby – in this way.

To have the chills – to be frightened.

Feel strongly about something: to have a very clear opinion or wish and defend it firmly.

The pill – or the “contraceptive pill”, or “birth control pill”, are names given by patients to the **oral contraceptives**. Note that we talk about “**contraception**”, not “anti-conception”.

The mini-pill: informal term to refer to the progesterone-only pill (**POP ★**).

To breast-feed: give maternal milk to the baby. The mother is breast-feeding when she offers breast milk to the baby, and the baby is breast-feeding when he takes it. Breast-feeding is highly recommended.

- *I was on the minipill after I had Millie, but it was so hard to remember to take it ... I am not a good pill taker. I was also breast-feeding and I was told that the minipill was the only thing I could take then. But I stopped breast-feeding 2 months ago, so I guess I can have other things now, can't I? Although with my history of migraines I was told once that the conventional pill was not for me. Is that true?*
- *Yes, with your history of migraines you should not take any contraception that contains oestrogen. So, the "normal pill" is not something I would recommend for you. Apart from the fact that it was hard to remember, did the minipill agree with you?*
- *Oh, yes, I had no problems with it.*
- *There is a new pill that you might like to try. It is similar to the one you have taken in the past, but this one has a 12-hour window if you forget to take one pill. Or if you prefer not to have to think about pills at all, a similar hormone can be given to you in the form of an injection every 12 weeks. There is also the option of an implant that can be inserted under your skin and will last for 3 years.*
- *I think I have heard about that. Is that the one they put in your arm?*
- *Yes, it is about the size of a matchstick.*
- *Mmm, does it hurt?*
- *You will be injected with a little bit of local anaesthetic to numb the area; you should not feel any pain.*
- *Mmm, maybe the other pill you mentioned will be better for me.*
- *Well, it is up to you. I will give you some information leaflets on the types of contraception that we have discussed, please take some time to read them at home and come and see our nurse with a decision in the next few days. She will get you sorted in time for your next period.*
- *OK, I will do, thank you.*
- *Now, here is your prescription for the emergency contraception; there are two tablets for you to take all at once as soon as possible. Please read the instruction leaflet that comes with it for more detailed information.*
- *OK, I will.*
- *There are a few things you need to know about this pill. Most importantly, it is more effective the sooner you take it, but in the unlikely event that it fails and you become pregnant, there is a small risk that you will have an ectopic pregnancy. This is when the pregnancy is not in the womb, but in the tubes, and that would be a medical emergency. So if you have any abdominal pain, just give me a call. In any case, if you haven't had your period in 3 weeks time or if your next period is lighter than usual, you should do a pregnancy test to exclude pregnancy.*
- *I understand.*
- *Good, anything else I can help you with today?*
- *No, that's it. Thanks, doc.*
- *You are welcome. Bye.*

The medication did not agree with me – I suffered intolerable side effects from the medication.

Window – margin.

Injectable / the injection. In this case, it refers to “**the Depo**” medroxyprogesterone acetate (DMPA) injection.

Implant: device containing a slow release progestogen, inserted under the skin.

Anaesthetic: substance that produces anaesthesia. The related medical speciality is **anaesthetics** or **anaesthesiology** and a doctor who specialises in it is an **anaesthetist** or **anaesthesiologist**.

Numb: with no power of sensation.

It is up to you – you decide.

Leaflets: brief, printed material providing essential information on a wide range of topics for the patients.

Get you sorted – organise everything needed for you.

In time for your next period – with enough time to be ready before your period.

At once: in one single event, not in stages or parts, all at the same time.

In the unlikely event – if such a rare thing happens.

Fails – does not work, is not effective.

Ectopic pregnancy. The development of an impregnated ovum outside the cavity of the uterus.

Womb: uterus.

Lighter period – with less blood than usual.

That's it – that's all. At the end of a consultation a patient may ask you “**Is that it?**” to know if you have anything else to say.

Other terms of interest:

In recording obstetric history, one would write:

Gravida	3	(has been pregnant three times)
Para	2	(has had two deliveries)

Sometimes labour needs **induction** with drugs – **induced labour**.

Termination of pregnancy may be also called **induced abortion**.

migraine [mī"grān"] implant [īm-plānt"]

Dr. Negrin turned to her computer again and wrote:

P: Emergency contraception

H: UPSI approx 36 hours ago, usual partner, LMP 25 April.

C: EC given, advised re failure rate and risk of ectopic; discussed long term reliable contraception, COCP not recommended due to PMH of migraine, discussed implant, IUD, POP, leaflets given. Pt TCB to see nurse before next period.

Now Dr. Negrin picked up one of her messages. It read: "Had baby 10 days ago, seen by midwife today, told has mastitis and needs antibiotics, please call". So she picked up the phone and dialled.

- *Hello?*
- *Hello, may I speak to Mrs. Walker, please?*
- *Yes, speaking.*
- *Hi, this is Dr. Negrin, from the practice, returning your call, how can I help?*
- *Hi, doctor, thanks for calling back. I saw the midwife today and she thinks I have mastitis. So she said I had to ring you to get some antibiotics.*
- *OK, when did you give birth?*
- *Ten days ago.*
- *How did it go?*
- *Quite well I think. I started to show on the evening before and then my waters broke in the morning. I talked to the midwife and she advised me to stay at home and call her later that day, but by lunchtime the contractions were so strong and frequent that I had to ring again. She told me I had to go to hospital because I was in labour. I was a bit worried because I had had a C section with my previous child, but luckily it wasn't needed this time, just a little bit of gas and air. I was going to ask for the epidural, but there was no time for that, by 4 p.m. I had Louise in my arms. I can't complain.*
- *Fantastic, I am so glad for you.*
- *How are you coping?*
- *I am still a bit tired but not too bad I guess. I have my mother around most of the day, and my husband is still on paternity leave, so I have plenty of help.*
- *Oh, that's good to hear.*
- *And how is the baby?*
- *She is doing well; putting on weight already ... She is OK.*
- *Are you breast feeding?*
- *Yes, but I am finding it very painful with the mastitis.*
- *When did the symptoms start?*

UPSI. Unprotected sexual intercourse; unprotected coitus.

COCp. Combined oral contraceptive pill, also known as the “combined pill”.

It read – there was this written on it.

Midwife: a specialised nurse qualified to assist women in childbirth.

Told has mastitis – the patient has been told by the midwife that she has mastitis.

Yes, speaking – Mrs. Walker is speaking with you, I am Mrs. Walker.

Returning your call – calling you as requested, after you called me.

Give birth: deliver the baby.

How did it go – how good or bad was the process or the outcome.

The show: colloquial for the expulsion of the “**mucous plug**” (a small amount of mucus with blood that was filling the cervical canal during pregnancy) which is a sign of impending labour.

My waters broke – the amniotic sac broke.

Labour: process of expulsion of the foetus and the placenta from the uterus. It has three stages: dilation, expulsive, placental. The **labour ward** is the hospital area where women deliver their babies. The normal position of the foetus during labour is the head or **vertex presentation**; sometimes, however, the foetus may be in **breech presentation** (buttocks).

Delivery is the passage of the foetus and the placenta from the genital canal into the external world. It is part of the second stage of labour. The term “delivery” generally is used for the whole event of bringing a baby to the world. A normal delivery is a spontaneous vaginal delivery, abbreviated **SVD**. In a **full-term** pregnancy, delivery occurs around the 40th week. A baby born before the 37th week is **premature**. A **stillbirth** occurs when a baby is born dead (stillborn).

Post-partum is the period after delivery.

C ★ section. Caesarean section, as opposed to vaginal delivery.

Gas and air – form of pain relief used in labour. It consists of an equal mixture of nitrous oxide and oxygen.

Epidural. An injection into the epidural space of the spine to reduce the feeling of pain in childbirth.

I guess – I suppose.

Around – present at home.

Putting on weight – or gaining weight, they both mean increasing the weight.

Breast-feeding, instead of bottle feeding, in which case formula milk is used.

Mastitis. Inflammation of the breast.

mastitis [mā-stī'tis] epidural [êp'ĩ-dyöör'əl]

All endings in “itis” are pronounced [ī'tis].

- *About 2 days ago. It is very painful and there is an area where it is very red and hot. The midwife said it might have been because of the cracked nipple I have, and we have been talking about how to latch her better to avoid that.*
- *Yes, very often bacteria use the cracked nipple to get into the breast and cause the mastitis; by improving the latching technique you can reduce the risk of nipple cracks and therefore the risk of developing mastitis. But you can carry on breast-feeding.*
- *Do you feel feverish?*
- *I did feel a bit unwell yesterday so I checked my temperature, but it was normal.*
- *OK, I will leave a prescription for you in reception. You can send someone to pick it up. Give me a call if you are not better in the next few days and don't forget to book your appointment for the postnatal check at 8 weeks.*

Dr. Negrin then received a message from the receptionist. It was from Miss Wilson, whom she saw earlier that morning. She was having second thoughts about terminating her pregnancy and wanted another appointment to discuss other options. Dr. Negrin was pleased to read that and instructed the receptionist to give her an appointment as soon as possible.

Crack – fissure.

Latch her – the way of attaching the child to the breast during breast feeding.

Carry on: continue.

Feverish – to feel unwell with a fever (or believing one has a fever), usually hot and sweaty.

Pick up: collect.

Postnatal check – routine follow-up exam performed between 6 and 8 weeks after delivery.

Having second thoughts – a change of opinion or resolve reached after reconsideration.

Other expressions of interest:

Sub-fertility is the inability to conceive after 1 year of intercourse with the same partner without contraception. Most couples who present have relative sub-fertility (reduced chance of conception) rather than absolute infertility. Causes include drugs, infections, tubal blockage, polycystic ovaries, etc.

Tests include:

Male partner: semen analysis (sperm count, motility and morphology)

Female partner: baseline endocrine profile, rubella status, Chlamydia swab, cervical smear, USS pelvis, HSG, laparoscopy and dye test.

USS. Ultrasound scan.

HSG. Hysterosalpingogram.

PCO. Polycystic ovaries.

bacteria [bāk-tîr'ē-ə] feverish [fē'vər-īsh] fissure [fīsh'ər]

Mental Health

with Delphine Sekri

Dr. Sekri's first patient of the afternoon was Mrs. Taylor.

- *Good afternoon, doctor, I need my repeat prescription, I have run out.*
- *OK, which one do you need?*
- *The sertraline. I take one a day, but it doesn't really do the trick. Maybe I should change.*
- *How has your mood been lately?*
- *Low, I have no interest in my usual activities, I don't enjoy things anymore.*
- *How have you been sleeping?*
- *A lot!*
- *Have there been any changes in your appetite or weight?*
- *I have put on a bit of weight. I have a sweet tooth and I have bad chocolate cravings. I am going through "the change" which doesn't help!*
- *Have you noticed a decrease in your energy levels?*
- *Yes, for sure, I feel tired all the time, I could fall asleep anywhere and I'm really slow. At work, everything seems to take ages; I used to be much more efficient and concentrated. At home, it is even worse. My partner pushed me into coming here; he can't stand me anymore! I don't want to go out to see anyone ... I have no sex drive ... I used to be in charge of all the housework, but if you see my house now, everything is falling apart. It used to be spotless. I have not cleaned it properly for a while, the mail is piling up and the funny thing is that I don't even care. I am not usually that kind of person.*
- *Have there been times when you thought you'd rather not carry on?*
- *To be honest, sometimes I think that life is not worth living.*
- *Do you have any thoughts about ending things?*
- *I do sometimes, but I wouldn't really do such a thing.*
- *So, from what you're telling me, your depressive symptoms seem to have become worse. It might be a good idea to increase your tablets to two daily for a few weeks. They have worked fine for you so far; it is not worth changing to another medication just yet. What do you think about that?*
- *I don't know ... you're the doctor.*
- *Fair enough. Would you mind making another appointment with me for the end of the month?*
- *Will do. Thank you, doctor.*

I have run out of tablets – I have no more tablets left.

Mood. Internal emotional state (happy, sad, anxious, depressed, angry, etc.). **Low mood:** sadness. You may be in a **good mood** – feeling positive, or a **bad mood** – getting angry easily.

Lately: recently.

To enjoy. To take pleasure in something.

To put on weight: to gain weight, to get fatter. The opposite is **to lose weight**.

Sweet tooth: to love sweet things (chocolates, sweets, cakes, ice cream ...).

To crave. To have an intense desire for something. A drug addict craves or needs to take drugs to feel well again.

A decrease: a drop, a fall. **An increase:** a rise.

To take ages: to take a long time.

I used to be efficient – I was usually efficient in the past.

Partner: A partner in this sense means the person with whom you are currently sharing your life. This could be your husband, wife, boyfriend or girlfriend.

To stand: to bear, to tolerate.

Sex drive: libido, the desire to have sex.

Housework – washing up, cleaning, ironing, keeping the home neat and tidy.

Falling apart – in a disastrous state.

Spotless: (no spots) extremely clean and tidy.

Properly: well, to do something in the correct manner.

A while: a long time.

To pile up: to accumulate.

The funny thing – the strange thing about this.

I do not care – I am not affected or worried by these disasters I have mentioned.

You would rather not – you would prefer not to.

To carry on: to continue, to keep on doing something. To keep going.

Life is not worth living – there is no benefit in living.

To end things: indirect way of saying you wish to end your life or commit suicide. A polite and gentle way for the doctor to bring this matter into the consultation.

Daily: per day, a day. **Monthly** is every month and **yearly** every year. Every 6 months is “6-monthly”.

To work fine: to help, to be effective.

So far: until now.

It is not worth changing – there is no benefit in changing.

Will do: I will do it.

appetite [äp[~]ĩ-tīt[~]] decrease [dĩ-krēs[~]] ages [ājiz] suicide [sōō[~]ĩ-sīd[~]]
suicidal [sōō[~]ĩ-sīd[~]l]

The next patient was Ms. Lee, a lovely 50-year-old Chinese lady. She owned a Chinese take-away restaurant, but she had to stop working since she had heart failure due to a valve problem a few months previously. She was on the waiting list for heart surgery.

- *Good afternoon, Ms. Lee! How are you today?*
- *I'm fine. But I can't sleep properly. I am very worried, you know. Can you tell me when I am going to be able to go back to work?*
- *Well, I am afraid that as long as your heart condition remains unstable you won't be able to go back.*
- *But this is not possible, I am running the take-away on my own, 7 days a week, and if I don't work, I am losing money everyday! I think about it all night long. I really can't afford this kind of trouble.*
- *Can you tell me more about your sleeping habits?*
- *I go to bed at about 11 p.m., it is very difficult to fall asleep, and if I do, I wake up very often throughout the night. In the morning, I feel very tired.*
- *Have you ever had similar symptoms prior to your heart problems?*
- *No, doctor, I was all right.*
- *How do you feel during the daytime?*
- *I feel exhausted ... and my daughter keeps on telling me that I am very irritable.*
- *Have you tried to use anything to help?*
- *No, I don't know what to take. As I am taking so many medications, I don't want to buy anything over the counter without telling you.*
- *I think that the first thing to do is to try to create favourable conditions for sleeping, meaning that you should go to bed at the same time every night, not going to bed until you feel sleepy and not staying in bed if you're not asleep. You should avoid coffee, tea and alcohol, try to engage in relaxing activities in the evening and, even if you're tired in the daytime, you should still avoid naps. The main thing, which seems to cause you all these troubles, is the money issue. We have a benefits advisor who comes to the surgery every week. I would advise you to make an appointment with her to discuss your problems. I am pretty sure that once the take-away is sorted out, you'll feel much better.*
- *Can I have some sleeping tablets?*
- *Well, if you follow my advice, your sleep quality and sleep time have a great chance of improving on their own. If it does not get better within 2 weeks, we'll discuss sleeping tablets. I understand that you have had a hard time this year and you probably feel very stressed. I would be happy to see you again in 2 weeks to see how things are going.*
- *OK, doctor, see you then.*

The next patient was Mr. Jones, a 26-year-old man. He came to the surgery only occasionally. Dr. Sekri called him into the consulting room.

To own: to have, to be the proprietor of something.

Take-away: a restaurant that serves food that you can take home with you rather than eat on the premises.

Go back to work – return to work.

As long as – while; during all the time that.

A few: several, some. It is different from **few** which means a little, not much.

To run something: to be in charge. In this case she is in charge of the restaurant, she is the boss and the only employee at the same time.

All night long: during all the night.

Afford: to be able to cope financially.

Trouble: problem, worry, concern.

Throughout the night: during the night.

Prior to: before.

The daytime: during the day. **Night time** is during the night.

Meaning – this means.

Sleepy: feeling the need to sleep.

Asleep: sleeping.

To avoid: to try not to do something.

Engage in – participate regularly in something.

Naps: brief period of sleep during the day. English speakers do use the Spanish word “siesta” when the nap is long and/or enjoyable enough.

The main thing: the most important thing.

Issue: problem, subject, matter.

Benefits advisor: a person who can help patients deal with financial problems, especially when they are unable to work and may be entitled to benefits (money given by the state to people in need).

To be pretty sure: to be quite sure, very sure. It is different from **to be pretty** which means to be physically attractive.

To sort out a problem: to solve a problem, to make it better.

Sleeping tablets: medication prescribed to help the patient sleep.

Have a great chance – have a great probability.

To improve: to get better.

To have a hard time: to experience difficulties.

See how things are going – see how you are progressing.

Occasionally: from time to time.

- *Good afternoon, Mr. Jones, long time no see. How are you today?*
- *Not too bad, thank you.*
- *What can I do for you?*
- *I am not too sure ... I started this new job 6 months ago and I feel terrible. I don't think I can cope any more ...*

Mr. Jones burst into tears. Dr. Sekri kindly offered him a tissue.

- *What does your new job involve exactly?*
- *Well, I am a trainee solicitor in one of the top-three City law firms.*
- *Sound's good, what's wrong, then?*
- *Basically, every morning, I struggle to get out of bed; I start crying at the thought of going to work. Once I am there, I can't concentrate or make decisions. When someone asks me my opinion, my mind is blurred; I start sweating, shaking and blushing, which makes things even worse. I try to put on a brave face, but I am quite sure that everyone has noticed it; I even think my colleagues make fun of me.*
- *Have you ever had these symptoms before starting your new job?*
- *Not really. I have always been a worrier, but it has never got to that extent. Now, I feel overwhelmed. I went back to my parents' home because I could not bear staying on my own anymore.*
- *How do you feel when you're not at work?*
- *Slightly better. My parents encourage me to go out with friends but I can't be bothered. When I get home, I have a few drinks and just go to bed.*
- *What do you mean by a few drinks?*
- *A couple of beers after work, a bottle of wine with my parents for dinner ... one or two whiskies to sleep.*
- *Do you mind if I ask you some more questions about that?*

Dr. Sekri ran through the CAGE questionnaire. She began to suspect a degree of alcohol misuse as Mr. Jones answered "yes" to three out of four questions. She emphasised that Mr. Jones' drinking habits seemed harmful. Dr. Sekri gave him some advice on changing his behaviour, and tried to increase his awareness on alcohol-related problems in the long term.

- *You know, doctor, this job has affected my whole life. I feel powerless. Sometimes, I fear I am going crazy.*
- *You are not there yet but you definitely look very anxious. There are a few things we can do about that. Discussing your issues with the CPN would help. She runs counselling sessions but has been trained for CBT as well. If your symptoms get worse, we might need to step up and start you on antidepressant tablets.*
- *I am not very keen on taking tablets, I don't want to be hooked on anything. They make you feel drowsy and that's the last thing I need. Do you think counselling would really make a difference?*

Long time no see – I have not seen you for a long time.

To burst into tears: to start crying suddenly.

Tissue: paper handkerchief; the most famous brand is Kleenex. Tissues are also the organic materials of which the body is made (muscular tissue, subcutaneous tissue, etc.).

Trainee solicitor: someone who is training to become a solicitor.

Solicitor: lawyer.

One of the top three – one of the best three.

To struggle: to progress with difficulty.

At the thought of – when I think of.

My mind is blurred – I am confused, I cannot focus, things are unclear to me. Vision can also be “blurred” in ophthalmological conditions.

Shaking: repetitive movement (in this case, of the body). You may find on bottles of juice or deodorants the advice “shake before use”.

To blush. To become red in the face, especially from modesty, embarrassment or shame; flush.

To put on a brave face: to appear brave and strong even in times of hardship when you may be struggling.

To make fun of someone: to laugh at someone because of their problems or deficiencies.

A worrier: someone who always worries, who tends to be anxious about things.

To get to that extent: to go that far, to be so important.

To be overwhelmed: to feel something is too big for you.

To bear: to stand, to tolerate.

On my own: by myself, alone, with no company.

Encourage: try to persuade or convince to do something.

I can't be bothered – I don't feel like doing it; I am not motivated.

CAGE questionnaire:

- *Have you ever felt you should **cut down** (on reduce) your drinking?*
- *Have people ever **annoyed** (irritated) you by criticising your drinking?*
- *Have you ever felt bad or **guilty** (responsible for a bad behaviour) about your drinking?*
- *Have you ever had a drink first thing in the morning to **steady** (stabilise) your nerves or **get rid of** (eliminate) a **hangover** (headache and malaise after having drunk too much)?*

Three out of four – of a total of four, the affected ones are three.

Behaviour. The way someone behaves. **Behave.** To act in a particular way that expresses general character, state of mind or response to situations or other people.

Awareness: consciousness.

Alcohol-related problem: a simple way of describing the source of a problem. You can use this method of expression to describe anything, e.g. work-related injuries, family-related stress, smoking-related illness.

To affect. To have an influence or effect a change in something or someone. Do not confuse with **effect** which is something brought about by a cause or agent.

Powerless: without power, helpless.

- *There is evidence that CBT is very effective for anxiety. I'll print you a patient information leaflet, I hope you will find it useful; however, I'll be happy to see you again in 2 weeks.*
- *Fine, I'll book an appointment straightaway. Thanks a lot, doctor.*

While Dr. Sekri was making a cup of tea, Jenni the CPN stopped by.

- *Hi, Jenni! I have just referred a young chap to you. He is completely stressed out. He has been anxious since starting his new job and is drinking a bit too much. Is there anything I can do before he sees you?*
- *You could recommend him a self-help book; it has a very good feedback. I'll drop the references in your tray.*
- *Thank you for the tip. Let's get back to work now, see you later.*

Dr. Sekri returned to the consulting room and noticed that Ms. Khan, a patient who suffered from obsessive compulsive disorder, was the last patient on the list that afternoon.

- *Hi, doctor, I asked for my medication at the counter last week but the receptionist said I had to see you.*
- *That's right, you are due for your medication review.*
- *How have you been feeling lately?*
- *Not great ... This week, I have been taking four baths a day and I cleaned the kitchen cabinets twice. My hands are really bad. The skin is all dry and cracked, even though I apply cream each time after washing them.*
- *How often do you wash them?*
- *Three times per hour ...*
- *How are things going otherwise?*
- *I have not been able to leave the house for the past 2 weeks. I have missed work ... I need a sick note by the way ... Before leaving my flat, I need to make sure that all the doors and the windows are locked. By the time I have managed to check everything, I am late for work. That's why I have not been in recently. My sister has been at home with me to help with the children as I find it very difficult to do it on my own. She told me I was going mental ... the children don't even listen to me anymore. She said I should see the consultant again.*
- *When did you last see him?*
- *Quite a long time ago, I haven't seen him since I moved here. I was discharged just before moving house, and he thought I was fine. He told me I should contact my GP if anything got worse.*
- *I am going to refer you to the mental health team. I will write them a letter and arrange for the CPN to see you this week. In the meantime you should keep on taking your medication.*
- *OK, that's fine. I'll stay in touch.*
- *Dr. Sekri wrote a referral letter to the mental health team:*

Anxious: nervous. **Anxiety:** clinical psychological syndrome characterised by fear of danger, restlessness, tension, dyspnoea and other adrenergic symptoms.

CPN ★. Community psychiatric nurse. This nurse belongs to the community mental health team (CMHT) where there are also psychiatrists, psychologists and social workers.

CBT ★. Cognitive behavioural therapy. A very popular kind of psychotherapy.

To step up: to go to the next stage.

Hooked on – addicted to.

Drowsy: sleepy, dozy, light-headed, tired.

Make a difference – have a significant effect.

Straightaway: immediately. **A chap:** a man, a guy, a bloke.

Stressed out: very stressed, anxious.

A self-help book: a book used to help the patient to learn more about their condition and to deal with it on his or her own.

Feed-back: allows people to comment on the service that they have received.

A tip is a short practical piece of advice. Also, it is the bit of money you give to the waiter in the restaurant if the service has been good.

In your tray – in a specific box with your name where your correspondence and messages are left. There is one for each member of staff, usually in the reception area. Also called “pigeon holes”.

The counter: the reception desk.

Medication review: a consultation in which the doctor checks all the medication the patient is taking and reassesses the suitability of the treatment.

Not great – not very well.

Cracked skin: cuts in the skin due to extreme dryness.

To miss work: not to go to, not to attend work. Another meaning would be to feel the need to go back to work ... but this is rare!

A sick note: a doctor's certificate to justify that the patient should not go to work for medical reasons.

Locked: closed with a key.

To go mental: to become crazy, mentally unstable.

Consultant: the specialist.

To move house: change from one house to another one to live in.

A specialist doctor **discharges** a patient when he decides to stop seeing them because a specialist care is not needed.

To arrange: to organise, to make sure.

To stay in touch/ to keep in touch: to keep in contact with someone.

behaviour [bɪ-hāv"yə] behavioural [bɪ-hāv"yə ɒl] psychiatry [sɪ-kɪ"ə-trē] psychological [sɪ"kɒ-lɒj"i-kəl] fear [fɪr] CAGE [kāj] reassesses [rɪ ə-sēs"]

Dear Colleague,

Thank you for seeing this lady. She has been suffering from OCD since her early twenties. She is currently on SSRI. She was under the care of Dr. Johnson and was discharged when she moved house as she was well controlled. Recently, her symptoms have become worse. She cleans and checks things a lot. Her daily activities take a long time to finish. These problems trouble her because she cannot arrive on time for work and has therefore missed 2 weeks. She cannot cope with her children and had to ask her sister to come and help.

I would be grateful for your assessment and management advice. I have asked our CPN to see her this week and to get in touch with you as soon as possible. Do not hesitate to contact me if you need any more information.

*Yours sincerely,
Dr. Sekri*

The phone rang. Carol the receptionist was on the line:

- *Hi, doctor, Miss Silva is on the line, and she says it's urgent.*
- *OK, put her through.*
- *Hi doctor, Louise Silva speaking. Sorry to disturb you in the middle of your surgery but my boyfriend is going mental. I went out shopping this morning and when I came back, he would not let me in. He said I had brought contaminated food to poison him and if I tried to come in, he was ready to take care of me. I don't know what he means but his tone was frightening. He has been acting funny lately. Since he spends his nights smoking grass with friends. He is not himself. I tried to talk to him through the door but nothing he said made sense. He was talking about cleaning the place with fire. I looked into the house through the window. It is a total mess. I know he was seeing a psychiatrist before moving to the UK, but he has always been reluctant to discuss it with me.*
- *Hold on, Miss Silva, I will come over right away.*

Before leaving, Dr. Sekri called the mental health team.

- *Hi, Dr. Sekri speaking, from the Park Surgery. One of my patients seems to be having paranoid delusions. I have just received a distressing call from his girlfriend saying that he threatened to set fire to the house. He might need to be sectioned. I am heading there straight away. Can you send someone urgently as well? I think I am going to need your help.*

OCD ★. Obsessive compulsive disorder.

Early twenties – 21, 22 or 23 years old.

SSRI ★. Selective serotonin re-uptake inhibitors.

To be under the care of a consultant: to be seen and assessed by a consultant. Patients may say “I am under Dr. Parker”, meaning that Dr. Parker is the main doctor who sees them for a particular condition.

Daily activities: activities done everyday (shopping, cleaning, eating, washing, etc.).

To trouble: to cause problems.

To get in touch with someone: to contact someone.

On the line: on the phone.

Put her through – pass the call to my line.

Funny: strange, weird, unusual.

Grass: slang term for cannabis.

To be himself: to be the way he is normally.

To make sense: to have a meaning, to be reasonable or sensible.

A total mess: a great disorder.

Reluctant: not keen on doing something.

Come over – go to where you are.

Right away: immediately.

Delusion. A false belief. A **deluded** patient cannot be convinced that they are wrong.

Hallucinations are false perceptions (auditory or visual).

A distressing call – a call that has left me worried.

Set fire to the house – burn the house with fire.

To be sectioned: to be sent to psychiatric hospital by force, without consent. It usually happens when there is a risk of the patient self-harming or harming those around them.

Heading there – going there.

Alcohol dependence

The symptoms of alcohol dependence are: craving; withdrawal symptoms (early morning shakes, morning nausea and vomiting or generalised anxiety state); stereotypic drinking (the drinking pattern follows the same routine irrespective of the context); compulsion to drink. The process of recovery is likely to involve many relapses, the ultimate goal being abstinence.

Crave: to feel a strong desire for something you have stopped taking (e.g. alcohol).

Withdrawal: event or process of stopping (a drug).

Compulsion: a strong force that makes somebody do something (drink).

Recovery: process of getting better from an illness.

Relapse: return of the problem after recovery.

Inhibitor [ɪn-ˈhɪbɪ-tər] compulsion [kəm-pʊlʃən] delusion [dɪ-lōʊˈzʃən] poison [pɔɪˈzən]

Child Health

with Carmen Ribes Bautista

Dr. Carmen Ribes was on duty on Friday evening before her well-deserved holidays. Being on duty often means seeing more children than usual. You know, mothers always worry. On that particular Friday, Dr. Ribes saw a lot of them. The first Mum came with her 30-week-old baby and lots of questions. She was a new mother and therefore very anxious.

- *Hello, Mrs. Johnson, I see you brought little Tom with you. What seems to be the problem?*
- *Many problems, doctor. To start with, he has a terrible cough.*
- *I see. How long has this cough lasted?*
- *All week. He sounds very chesty, and he also has a runny nose and a temperature. And I think he's got an ear pain because he holds his ear sometimes. He's keeping me up all night!*

Dr. Ribes quickly assessed parental coping:

- *Yeah, it must be tiring. Do you find it hard to cope with?*
- *Well, fortunately my mother is at home helping so I can usually rest during the day if I need to. Martin, my husband, is also quite good and helps a lot.*

Dr. Ribes was satisfied with this and looked at the records. Tom had already been brought to surgery eight times in his short life. Most of the problem titles read: "URTI".

- *Children do get colds quite often. What in particular are you concerned about?*
- *I think it's coming down to his chest.*
- *OK, let's have a look at his chest, then. Could you please take him to the couch and undress him.*
- *Including the vest?*
- *Including the vest, please.*

The doctor stopped Tom's brief attempt to crawl on the couch. The baby showed no opposition to being auscultated, but struggled when the doctor examined his ears and cried energetically when she attempted to see his throat.

- *I think it would be best if you held him on your lap while I examine him. [Mum did as told.] Yeah, cradle him against your chest. That's great.*

The doctor **on duty** (or on call) is usually the one to be called for urgent matters. On another line, the **duties** of a doctor are all the tasks a doctor is expected to perform in his or her working role.

Deserved – because she had worked hard and “gained the right” to go on holidays.

Mum [*Am. Mom*] is used more often than “mother” in daily clinical settings.

Therefore: as a consequence.

Terrible means very bad. Not to be confused with “terrific”, which means very good!

Chesty is an expression used by patients when they feel a cough is originated in the chest rather than the throat.

A **temperature** is a fever, according to the mother of course.

Hold: take with the hand(s). Note that the past is **held**.

Keep me up: not let me sleep. **Being/staying up** all night means not sleeping.

Parental coping is the ability of the parents to cope with the situation, that is, the capacity to deal successfully with something difficult. Note the question ending in **cope with**.

URTI: Upper respiratory tract infection.

Do is sometimes used to emphasise another verb – “**do** get colds” is said stressing the accent on the “do”.

Concerned about: worried. To express a concern is to express a worry; however, **concerned with** means related to, and **of concern to** means of interest to.

Vest: undershirt (underwear garment used under the shirt). It is also used for a garment with no sleeves used on top of the shirt. Garment: item of clothing.

Attempt: try.

Crawl is what babies do on the floor moving their hands and knees to get from one place to another when they are too young to walk.

To **struggle** is to make violent efforts to get free of something. It may also mean to try to achieve something with a lot of effort (e.g. struggle to finish on time) or to have difficulty handling or coping with something (e.g. *I’m struggling with my English*).

Note the expression “**it would be best if**” + verb in the past.

Lap. The flat area between the waist and knees of a seated person. Now you know why they call portable computers “laptops”.

To **do as told** is to obey.

Cradle in the example means to hold gently and protectively. As a noun, it is the infant’s bed or **crib**. **Cradle cap** is a skin condition sometimes seen in babies caused by excessive production of sebum, characterised by areas of yellowish or brownish scales on the top of the head.

duty [dyōō’tē] deserved [dī-zûrv’d] brought (past of bring) [brôt] cough [kôf]

crawl [krôl] couch [kouch] auscultate [ô’skæl-tât’] cradle [krād’l]

The stress in “**F**ortunately” and “**t**emperature”.

When she finished, Mum put his dummy back in his mouth to silence him.

- *His chest is fine, Mrs. Johnson. No reason to worry at present. If he develops any breathing trouble, or a high fever, please come in again or give me a ring. Most probably, however, he will be quite well in a few days.*
- *Oh, good, thank you, doctor. But I am also worried because I don't think he is putting on weight.*
- *Mmm ... let's check his Growth Chart. Have you got his Red Book?*
- *Yes, here it is. The Health Visitor said it was fine, but I think he is very small.*
- *He is at the thirtieth centile for weight, which means 30% of all children of his age have a lower weight than him. This is normal. He has always kept on this centile, so that's fine. It is when a child crosses centiles downwards, I mean when measurements drop below the previous percentile lines, say, from 60 to 30, that we say there is a failure to thrive; otherwise, we are happy.*
- *Ah ... and what about his height?*
- *His length is also fine, at percentile 50. Looks good. Is he breast-feeding or bottle-feeding?*
- *Half and half. When he is left hungry after the breast feed, I give him a top up with a bottle.*
- *So, is he feeding well?*
- *Generally, but sometimes not. This afternoon he's been off his food. He only had two feeds this morning.*
- *Is he wetting his nappies as usual?*
- *Yes.*
- *Does he cry in an unusual way, like moaning, or a high-pitch cry?*
- *I don't think so.*
- *Has he lost interest in what is going on around him or has he been drowsy?*
- *Well, he was quite lively yesterday, but a bit sleepy today.*
- *If he loses sleep at night with the cough, he should be able to make it up by napping during the day. Just let him relax in the crib and comfort him when necessary. By the way, are his jabs up to date?*
- *Yes, he's got all his jabs.*
- *[Looking at Tom who is smiling at her]. He's a lovely baby, and very healthy. You are doing very well with him.*
- *Thank you, doctor. [Getting up from the chair] Sorry for taking up so much of your time. I just wanted to be sure.*
- *No problem. Now you know you can expect this again from time to time and you don't need to worry. He may be a little more prone than others to get colds, but within normal limits.*
- *[Relieved] OK, doctor, it's good to hear that.*

Dummy: A rubber or plastic teat for a baby to suck on. In another meaning, it is also a model or replica of a human being, used to help students learn anatomy.

Give me a ring: call me using the telephone.

Quite, which means “a lot”, is not to be confused with **quiet**, which means silent.

Put on weight: gain weight, get fatter.

Chart: A sheet of information in the form of a graph, table or diagram. The **growth chart** or growth grid shows the normal curves of weight and height/length for children. Note the expression “to **cross** percentiles” (commonly called centiles).

Failure to thrive (FTT) refers to children who do not gain weight at the speed they should. When the height is normal it may also be called **lagging weight**.

Drop: fall, move downwards. In other uses, you may also say “drop me a line” when you ask someone to write to you.

Happy: satisfied – not necessarily cheerful or smiling or full of joy.

Note a baby may be **breast-fed** or **bottle-fed**. A **top-up (feed)** is an “extra” feed given when the baby is **left** hungry with the initial one, to complete it.

To be off one's food: not eating.

Nappy (plural **nappies**) or **diapers** are pieces of absorbent material that wrap babies' bottoms. A baby **wets** his nappy when he passes urine. **Nappy rash** is a common form of dermatitis in irritated bottoms.

Moan. Cry expressing suffering.

A soprano is a woman able to sing in a **high-pitched** voice (usually more pleasantly than babies!)

Drowsy: Sleepy and lethargic. **Lively:** the opposite of drowsy, i.e. very alive.

What is going on?: What is happening?

Make it up in this case means recovering what was lost, but in other uses it may mean lying (inventing a story to deceive others).

Nap is a little time of sleep during the day.

Jab is a colloquial term for injections, usually referring to vaccinations/immunisations. A child is **up to date** in his jabs when he is following the standard **immunisation schedule**.

Do well: progress or deal with something satisfactorily.

From time to time means with relative frequency. **Every now and then** is used for lower frequency.

Prone to: with a tendency to (have). Different from **prone position** (face down).

growth [grōth] height – please do not say hate! (despite spelling similarity with weight) [wāt]. thrive [thrīv] moan [mōn]. drowsy [drou"zē]. lose [lōōz] loss [lōs]. comfort [kūm"fōrt]. comment [verb] but comment [kōm"ēnt, noun].

Dr. Ribes said good-bye to Mrs. Johnson and showed her to the door. Then she came back to her desk and wrote in her computer:

P: URTI

H: 1/52 cough, runny nose, temp, eating less.

E: alert, active, smiling; chest clear, tm nad, throat nad, t 36.5C.

C: advised and reassured.

Then she turned to her new registrar, Alex, who was sitting in with her on his first day at the practice, and commented, in her experienced teaching style:

- *As you know, children under 4 years have the highest consulting rate for minor illnesses of any patient age group, five times a year on average. It is important, though, that we leave parents feeling their concerns have been addressed and confident to deal with their child's illness.*
- *Babies are almost always fine, aren't they?*
- *Almost! Occasionally not, and your task is to rule out or identify any serious illness. You have to be unhurried, listen to parents attentively and examine methodically.*
- *I always worry about meningitis.*
- *Sure. Remember the baby with meningitis is typically unhappy, febrile, and may be irritable or drowsy. There may be prolonged or high-pitch crying even when cuddled. In young babies, the classical neck stiffness is usually absent, and a bulging fontanelle is a late sign. So, you need to look for any degree of tension of the anterior fontanelle. Observation of the baby's interaction and level of consciousness is the most helpful touchstone. Is the baby alert and responsive? Can he make sustained eye contact or is he staring vacantly into space? Is he smiling, reaching for things (e.g. the pen you offer) and playing with toys? Can he be consoled, at least temporarily, when held?*
- *I've never seen a meningococcal rash. What's it like?*
- *[Taking some laminated pictures from the shelf to show him]. It's a non-blanching purpuric or petechial rash. It does not disappear on pressure. It is the key clinical sign in diagnosing meningococcal disease, a life-threatening illness as you know. The child may be well until late in the illness, so seeking the early signs of circulatory shock (tachycardia, peripheral vasoconstriction with pallor, cool peripheries, and mottling) is key to recognition.*
- *Infants end up in hospital quite easily for minor problems, though.*
- *They do, but when you see any possible sign of a serious illness in an infant, you should have a low threshold for referral, especially in the first month or two of life, when they can deteriorate very quickly. There should be no hesitation in referring a sick neonate to hospital.*
- *Right.*

1/52. One week. I am, however, trying to get Britons to write 1w instead!

TM: tympanic membrane.

NAD: no abnormality detected.

Advised: given suggestions on what to do.

Reassured: made them feel that there is no reason to worry or fear.

Sit in: observe in a consultation for learning purposes.

Note that to tell the age we may use only a number, not necessarily followed by “years” or “old”. A child may say “I am 4”. Young children are referred to as the “**under-fives**” and senior adults as “over 65s”.

Address: pay attention to some problem or issue in order to solve it.

Confident: feeling sure of their own capabilities to succeed. It is also used to describe feeling certain about a truth.

Deal with: take action about something or someone.

Unhurried: with no hurry, not trying to finish quickly, taking your time.

Cuddle. Hold close in one’s arms as a way of showing love or affection. Typically done by parents with children, and children with teddy bears.

The fontanelle is **bulging** when it is swelling or protruding outside the skull – it can be felt as a lump or mass.

Touchstone: A standard or criterion by which something is judged or recognised.

Staring vacantly means looking fixedly without moving the eyes and with no interest.

Reach for something is to move your body or part of it to get something that is at a short distance.

To **console** is to comfort, to give relief or calm someone down.

Laminated. Covered in protective plastic.

Non-blanching: it does not turn white (on white skin) when you press on it with your finger.

Seek. Look for. Note the past is **sought**.

Pallor: whiter colour of the skin in certain pathological states such as anaemia or shock.

Cool means with a low temperature. In completely different contexts it may be used as “very good” in a very modern way/slang (e.g. this book is cool!).

Note the use of “**though**” at the end of a sentence. It is similar to using “however” at the beginning.

To have a **low threshold** for referral means not to require too much to make a decision to refer, i.e. to refer at the minimal concern or doubt. The opposite is, obviously, to have a high threshold.

Hesitation: doubt as “to do or not to do”.

Neonate. Newborn, baby younger than a month in age.

parents [pâr"ənt] parental [pə-rĕn"tɪ]. febrile [fĕb"rəl] fever [fĕ"vər].

petechial [pə-tĕ"keĕəl]. absent [āb"sənt]. fontanelle [fŏn"tə-nĕl"]. alert [ə-lûrt"].

threatening [thrĕt"ng]. pallor [pāl"ər]. threshold [thrĕsh"hŏld"].

Dr. Ribes checked her appointments screen. Her next patient had not turned up so she had a few more minutes to spare.

- *Are there any other aspects of paediatrics you would like to discuss?*
- *Crying. What to do with the crying baby, who is otherwise well?*
- *Let's look it up. [Passing him a book.] What does the book say?*
- *[Opening the book and finding the page.] "He may have hunger, wind, a noisy temperament or discomfort (e.g. soiled nappies/diapers, clothing, colic). Crying is often attributed to teething. Crying that accompanies feeding and burping may indicate reflux oesophagitis. Commonly, there may also be parental anxiety, family or other environmental stress in the home to which infants are sensitive. Assessing parental coping followed by explanation, reassurance and support will be important." Then there is a section on infantile colic-paroxysmal crying that resolves by 4 months of age.*
- *There you are!*

A new "A" appeared on screen. The next patient had arrived. Dr. Ribes picked up the phone to call reception and said:

- *Would you mind sending Salim Patel in, please?*

In the meantime, she checked the records and spoke to the registrar:

- *I first met this child last month. He is 4 years old. The family is new to the practice, so we don't know them well. I understand they came from India 3 years ago. I find their accent rather difficult to understand.*
- *I can help you out, then. I am half Indian myself.*
- *Well, that's handy!*

The whole Patel family came into the consulting room. The father, mother and three children filled the space. The registrar stood up and gave up his chair to Mrs. Patel and her baby. Mr. Patel preferred to stand and keep some control over the other two little children, especially the eldest, who was running around and trying to play with all the clinical equipment.

- *Hello, Mr. and Mrs. Patel. This is my registrar, Dr. Cutts, who is sitting in with me today. He will be working with us for 6 months.*

After an exchange of greetings, Mrs. Patel went straight to the point.

- *I am very worried, Dr. Ribes. Salim is driving me insane!*
- *Really?*

Turn up: attend/arrive.

Time to spare or spare time: free time.

Otherwise well – well except for the crying problem.

Wind: gases produced in the stomach, intestines or in the bowels during digestion, which produces discomfort.

A child with a **noisy temperament** is one who simply cries because he likes to make noise.

Nappies get **soiled** when they fill with faeces/stools (colloquially **poo**).

Children usually refer to urinating as needing “to **pee**” or to do a “**wee-wee**”. You should be able to recognise the phrase “mummy, I wanna wee-wee!”

Teething is the process of growing one’s teeth, especially milk teeth. **Teething problems** is also used in other contexts to refer to problems arising at the start of a new project or system.

Burping. Noisily release of air from the stomach through the mouth.

Sensitive: Susceptible to the attitudes, feelings, or circumstances of others. Do not confuse with **sensible** which means reasonable or wise (and which babies are not!).

Infant: baby younger than a year old.

Send in a patient is to ask them to come in from the waiting room to the consulting room.

First met. Met (past of meet) for the first time. You can use it to indicate how long you have known somebody.

Help you out: (colloquial) give you a hand, to make it possible or easier for someone to do something by doing part of their work.

Handy. Convenient and useful.

Stood up. Past of “stand up”.

Give up your chair means to kindly let it be used by someone else.

Eldest. Oldest (used for people only).

Greetings. Polite words or signs of welcome or recognition.

Straight to the point: directly, with no preparatory or indirect talk.

Drive someone insane: make someone go crazy or mad because of desperation and frustration. We also say that to keep our **sanity** or mental health we need regular breaks in our work (holidays, weekends, coffee breaks).

poo [pōō, slang]. pee [pē, slang]. “wee-wee” [wē wē, slang]. faeces [fē’sēz]

- *I think he's got ADHD. He behaves very badly, never pays attention to what he is told, and destroys everything he finds. Now he has started bed-wetting as well.*

Dr. Ribes attempted to greet Salim several times, but she was completely ignored.

- *Mmm. Has he done anything dangerous?*
- *He pushed a chair against his little sister yesterday. Fortunately, it fell in another direction.*

Dr. Ribes continued taking the history by enquiring about previous behaviour, perinatal history, etc.

- *I think we might need some help from the Child Mental Health Team. Would you agree to have him referred?*
- *[Desperate] Yes, please, as soon as possible.*

Dr. Ribes wrote a referral letter to the local child psychiatrist:

Dear Dr. Peterson,

I would be grateful if you could see this 4-year-old boy with behavioural problems. His mother says he is very disruptive at home and requires constant vigilance. He is more destructive and aggressive than we would expect for a normal child. I am also concerned about his younger siblings who he could potentially harm. He tends to push heavy objects against them. Mother also reports recent onset enuresis, despite being toilet-trained since the age of 2 1/2.

He has no other medical history of note. He was born by SVD at 39 weeks and his delivery and neonatal period was uneventful.

He did not engage at all when I tried to converse with him. I could confirm his hyperactivity in the surgery, where it was difficult to keep him from handling medical stationery and surgical equipment.

The parents are understandably very anxious and would like a specialist assessment as soon as possible.

Thank you very much for your help.

Yours sincerely,

*Dr. Carmen Ribes
General Practitioner*

ADHD ★: Attention deficit hyperactivity disorder. All mums suffering with bad boys think their boys have it. Children can be **well-behaved** or **badly behaved**, or, most often, something in between. Children (and adults) who behave badly (but not seriously bad) are said to be **naughty**.

Pay attention to – Remember this construction. “Pay” involves no payment here. You also **pay a visit** to someone when you go and see them where they usually are (e.g. their home), most often for social reasons.

Bed-wetting. Wetting the bed (with urine). Colloquial for **enuresis**.

Enquire. Ask in a process of investigation. **Enquiry** is a formal investigation process, usually for legal purposes, not in medical contexts. **Query** is a question to check about the validity or accuracy of something, e.g. the pharmacist may call you to query [verb] the dosage you have prescribed for an infant, as he may think it is too high. If he doesn’t find you, he may speak to your receptionist who will pass the query [noun] to you.

ASAP ★. As soon as possible. It is extremely commonly used in writing, especially when you are asking someone to do something for you, e.g. “Please can I have this report done ASAP”? Sometimes people even say it orally, pronouncing the names of each letter: A, S, A, P.

Local: living or working in the same area. If a patient asks you “Are you local?” they want to know whether you live in or close to the practice area, or you come to work every day from a longer distance.

Disruptive: producing disruption, altering the normal or natural way of things, in this case, altering the normal functioning of the family.

Siblings. Brothers and/or sisters.

Recent onset indicates that a condition or symptom started a short time ago.

A child is **toilet-trained** when he does not need to wear a nappy, as he is able to recognise when he needs to pass urine or faeces and goes to the toilet to do so. During the process of learning this, a child is said to be “toilet-training”.

Uneventful: nothing special happened – in medical settings this means “with no problems” (events in Medicine tend to be bad news ...).

Engage in this case is to establish a connection or relationship. If you say the child did **not engage at all**, you mean his level of engagement was zero, nothing, not even a little bit. If you ask “did the child engage **at all**”? You mean “did the child engage, at least a little bit?” In another meaning, a couple is ‘engaged’ when they have decided to get married.

The parents are **understandably** anxious: I can understand why they are anxious; their anxiety is understandable; I would probably be anxious myself in the same situation.

Naughty [nó'tē] **Natural** [nāch"ər-əl] but **Nature** [nā"chər] **National** [nāsh"ə-nəl] but **Nation** [nā'shən] **Enquire** [ən-kwīr"] **Query** [kwīr"ē] **Aggressive** [ə-grēs"iv] (note doubles) **Enuresis** [ən"yə-rē' sis] **Engage** [ən-gāj"] **Understandably** [ün'dər-stān'də-bəle]

Now it was the turn for the little sister, Jasmine, a pleasant toddler who looked rather passive compared with her brother. Mum was worried she could have some developmental delay.

Dr. Ribes had a quick look at her Table of Child Development “Red Flags”:

<i>2 months</i>	<i>Inability to lift head, smile or respond to noise</i>
<i>4 months</i>	<i>Inability to grasp rattle, no vocalisations</i>
<i>6 months</i>	<i>Inability to roll over or reach for toys</i>
<i>9 months</i>	<i>Inability to sit without support or self-feed finger food</i>
<i>12 months</i>	<i>Unable to stand briefly unsupported, no jabbering</i>
<i>15 months</i>	<i>No words</i>
<i>18 months</i>	<i>Not walking</i>
<i>24 months</i>	<i>Unable to remove clothing or combine two words; vocabulary <50 words</i>
<i>Any age</i>	<i>Loss of previously attained milestones</i>

After the relevant questions and examinations, Dr. Ribes concluded:

- *Mrs. Patel, Jasmine is doing well for her age.*
- *So you think she is normal?*
- *Yes, she is only slightly running behind on language, but that’s probably because of her ear problem, now sorted with the grommets she had inserted. I am sure she will catch up soon. If she doesn’t, or if you have any further concerns, you may discuss them with the Health Visitor who will be able to advise you.*

A number of adult patients followed, and another mother whose pre-school child had OSA and was paranoid about SIDS since she had had a second baby.

At six o’clock, after reading the hospital correspondence and checking some lab results, everything seemed sorted. Dr. Ribes sighed and smiled:

- *That’s all for today, Alex. Have a nice weekend. I’m off to the airport!*

Toddler. Child 1–2 years old who is just beginning to walk.

So the age groups are in chronological order: newborn; infant; toddler; pre-school; school age (5–12 years); adolescent or teenager (12–18 years); adult.

Developmental delay is what children have when they are not progressing in their skills as they should for their age, e.g. not walking at 2 years of age. In the UK the Community Paediatricians are the specialists who care for developmental problems in children.

Red flags are signs that should alert you to consider that a problem is present or that there is a serious cause for a certain problem.

Lift: make it go up.

Grasp. Seize and hold firmly. It is also used to mean “understand fully”, e.g. the child could not grasp the severity of the situation.

Rattle. A baby’s toy consisting of a container filled with small pellets that makes a noise when shaken.

Roll over. Move by turning over and over.

The baby sits without **support** when you don’t need to hold him in order to prevent him from falling back.

Self-feed is to eat without needing help. **Finger food** is any food you can eat with your fingers (e.g. chips – fried potatoes as you would have them at McDonald’s).

Briefly: for a very short time. To explain something briefly is to summarise.

Jabber. Talk rapidly and excitedly but with little sense.

Attained: achieved.

Milestones. An action or event marking a significant change or stage in development.

Slightly: just a bit.

Running behind: delayed, not yet at the level of progress they should be. You are running behind when at 8.45 a.m. you are still in the shower, have not had breakfast or ironed your shirt, and need to be at work by 9.00 a.m. However, you can **catch up** if you go very fast and reach the desired stage, recovering the time lost.

Sorted: solved.

Grommets: tympanostomy tubes.

Further concerns would be other concerns that arise after this one.

OSA: Obstructive sleep apnoea.

SIDS: Sudden infant death syndrome.

Sigh. Emit a long, deep, audible breath expressing relief, tiredness, sadness or a similar feeling.

I’m off to ...: I will disappear from this place to go somewhere else. You can also be off to a visit (to see a patient).

development [dī-vēl"əp-mənt] but developmental [dī-vēl"əp-m ē nt'tl]
 paediatrician [p'dēə-trishən] but paediatrics [pē'dē-āt'rīks] size [siz]
 clothing [klōth ing] adolescent [ād'l-ēs"ənt] adult [ād"ült] sigh [si]

Nervous System

with Yann Lefevvre

Dr. Yann Lefevvre was doing a Wednesday evening session. His next patient was a middle-aged man named Michael Norris. He was walking with a walking stick and his back was slightly bent.

- *Hello, Mr. Norris. Come in and have a seat. What can I do for you?*
- *Well it is my missus who asked me to come down; I don't want to waste your time, doc. I need a medical certificate.*
- *What is the reason for this certification, Mr. Norris?*
- *Oh well, it must be to do with what happened last Friday. I was having a drink with my old man at the pub when two blokes just jumped on me for no reason, out of the blue! Can't understand it; one minute we were having a good time and then that!*
- *I see, and what happened then?*
- *I went to A&E; I had to wait 3 hours there before they saw me. They did some X-rays and gave me some tablets and I went home at 3 a.m.*
- *And how do you feel now, Mr. Norris? It looks like you are in quite a bit of pain. Can you pinpoint where it hurts exactly?*
- *Well, I am still in agony, aching all over, and stiff as a stick. I was pushed to the ground, kicked in the head; I've got bruises all over and I ache in the chest, but the main thing is that I have still got a massive backache.*

The doctor asked Mr. Norris to stand up to examine his back. The first step was to determine whether the patient did have evidence of clinical consequences of the fight. Dr. Lefevvre tried to distinguish muscle bruising with potential nerve compression syndromes from a much commoner lumbar disc syndrome, as his main concern was the lower back pain. Once the clinical history had been taken, the doctor performed a basic neurological examination: the presence and distribution of weakness, the pattern of tendon reflexes and responses to pain were measured.

- *OK, Mr. Norris, let's have a look at your back. Could you lift up your shirt for me and stand with your hands by your sides please?*

Dr. Lefevvre examined Mr. Norris whilst he was standing.

- *You have a big bruise on your lower back and your muscles are very stiff. Could you possibly lean forward? Keep your knees straight, how far down can you go?*

Walking stick: stick used for support by someone who is unsteady on their feet. A **walking frame:** is a slightly more complex device with four legs to help the elderly walk. A **crutch** is a long stick used as walking support under the axilla, often after trauma of the legs.

The way somebody walks is their **gait**. Gait is impaired in many neurological disorders (e.g. ataxia, lower limb paralysis) and in trauma of the legs. A **slow gait** in small steps is typical of Parkinson's disease, together with a **cog-wheel** sign (arm rigidity) and a **coarse** (not fine) **tremor**.

Bent: flexed. Having a curved, twisted or angled shape. Past of "bend".

Mrs. or "missus": an informal but personal way for a man to refer to his wife or female partner. Also "my other half".

Medical certificate: a sick note; doctor's certification of temporary incapacity to work.

To do with – in relation to.

Old man: informal way of referring to your father.

Bloke: man.

Out of the blue: unexpected and for no reason.

A & E. Accident and emergency.

Quite a bit – quite a lot. Paradoxically, although "a bit" means "small amount, little", "quite a bit" means "considerable amount". Similarly, "a few" means "a small number of", while "quite a few" means "a considerable number of".

Pinpoint: tell exactly what or where something is. Often used to highlight the exact location of the pain, usually showing with a finger.

In agony: suffering terribly, usually with pain.

Aching all over – with pains in all parts of the body.

Stiff: rigid, unable to move easily.

Bruises: haematomas.

I ache in the chest – my chest aches or is aching, I have a chest ache.

Backache: back pain.

Weakness: reduced strength or power.

Lift up your shirt – pull up part of the shirt to see the chest. For a more complete uncovering you can ask to "slip off your top things" – to remove the clothing that covers your upper body.

Lower back: lumbar area.

Lean forward – incline your body towards the space in front of you. To lean forward, to lean over backward or sideways, bending down are all expressions that can be used during the examination to test a patient's range of movement.

Limb: arm or leg.

Keep straight: keep in extension, do not flex, do not bend.

ache [āk] reflex [rē"flēks"]

Mr. Norris could not bend further than his knees.

- *OK, could you stand up straight, now lean over backwards, now sideways, good. Could you please raise both arms and move your legs?*

Dr. Lefevre observed the range of movement in Mr. Norris' limbs throughout the examination. He noticed that there was no limitation and no disability.

- *Do you have any pins and needles in your legs? Any numbness?*
- *I am in a mess, doc, I ache all over; I haven't slept for two nights with it. I can't feel my toes; I can't go to the toilet because it hurts.*
- *I have to check for any focal weakness or numbness and your reflexes. I will use a reflex hammer to see if there has been any neurological damage following the assault.*

There is no evidence of neurological disorder on the limbs.

- *Tell me a bit more about the pain and not being able to go to the toilet. On a scale of 0 to 10, with 10 being the most painful, how bad is it at the moment?*
- *It's around 8 to 9.*
- *How about your difficulty going to the toilet?*
- *It is mainly the sitting down, doc ... I can't for some reason, and every time I try I am in agony. I haven't done a number two since last Friday. My legs are giving way with the pain.*
- *I see, so it is the pain that is preventing you from going to the toilet. OK, try pinching your thighs. Can you feel the pinch on one thigh more than the other?*
- *No, it feels the same in both legs, doc. Doctor, the tablets the hospital gave me ... they are doing nothing for me. Here they are.*
- *Diclofenac and paracetamol. Thanks, Mr. Norris. I would like to reassure you, the assault has caused serious bruising and muscle pain but nothing too serious. I suggest taking the diclofenac three times a day and I will give you some co-codamol to help with the pain. It should control the pain during the next few days and you should get better afterwards. I will give you a certificate for 1 week.*
- *Thanks, doc, I am going to the police now to make a statement.*

Dr. Lefevre said good-bye to Mr. Norris and showed him to the door. Then he came back to the desk and wrote on the computer.

P: Assault

H: alleged kick in the head and lower back last Friday.

Further than – beyond, at more distance than.

Backwards: towards (in direction to) your back.

Raise: lift, move up.

ROM. Range of movement.

FROM. Full range of movement. We write this abbreviation in the notes when on examination we find normal amplitude of movement of a limb or joint.

Disabling: producing functional impairment or inability. A “disabling pain” is a pain that leaves the person unable to lead their normal life by partaking in everyday activities.

Pins and needles: tingling and other symptoms of sensory loss and abnormal sensations technically called **paraesthesias**.

Numbness: sensory loss (anaesthesia), which indicates a sensitive impairment. A motor impairment is shown by a loss of muscle **power** in any of the limbs.

I am in a mess – I am in a disastrous state.

Toe: foot digit. The first toe or big toe is also called “great toe”. Note that the foot does not have “fingers”, only the hand has “fingers”. The hand has four fingers and a thumb.

Going to the toilet is defecating or urinating.

Assault: physical attack or aggression. An unlawful threat or attempt to do bodily injury to another.

Jerk reflexes examination

I am going to test your reflexes by tapping you with this little hammer. It won't hurt. Let me hold your knee; let it go quite relaxed – try not to tighten up, let it go quite floppy.

*Could you kneel on the chair so that your feet are just slightly hanging over the edge? I am going to tap them behind your heel with the hammer; this is a method of testing for your **ankle jerk**. Now I would like you to sit with your legs dangling over the edge of the couch so that I can test your **knee jerks**.*

*Could you lie down on the bed with your legs stretched out in front of you? I am going to stroke the sole of your foot with this pin to see which way your big toe is going, this is called the **plantar reflex**. This is not painful it will just tickle a little.*

Jerk – sudden movement that is provoked when examining the reflexes.

Number two: defecate.

Legs give way – the legs are unable to support the weight of the body.

Pinch. To squeeze between the thumb and a finger.

Doing nothing for me – not helping me.

Make a statement – declare the details of the assault.

Alleged: reported but not proven yet. We often talk about “alleged assault” as we don't really know if the patient is telling the truth.

assault [ə-sòlt]

E: bruises on lower back L4/5 on the right side, bump on the head occipital area, no cut no wound. Med3;1/52.

T: Co-codamol 30/500 tds 30 tablets.

Mr. Norris came back a couple of days later.

- *Hello, Mr. Norris. What can I do for you today?*
- *Well, doc, I am sorry to waste your time but since I saw you on Wednesday I have had this splitting headache! Sometimes my vision is blurred, too, so I thought I'd better come back and have it checked over.*
- *Tell me a bit more about your headache, Mr. Norris. Have you always had them or have they just started since the fight?*
- *I've been getting them for the past 2 or 3 years, actually, since the last one was born.*
- *How often do you have these headaches and how long do they last?*
- *I get them every day and feel all dizzy. They last for hours on end; it's like a dull ache, like a toothache.*
- *I see, are these headaches on one side or both sides of the head? How do they start? Progressively and gradual? Do you wake up with them?*
- *Both sides, doc, and in the neck, usually. It starts as soon as I wake up and lasts pretty much all day; nothing touches it, nothing.*
- *Do you think that there are any precipitating factors, Mr. Norris?*
- *Well, doc, you know, since the fight I have been a bit stressed out.*
- *Do you feel sick with these headaches?*
- *Not really.*
- *Do they feel worse on bending or coughing?*
- *No.*
- *Have you felt that your thinking has been affected lately?*
- *What do you mean, doc, have I lost my marbles?*
- *Well, sometimes, headaches can affect people in different ways, Mr. Norris. I am just trying to work out how yours have arisen.*
- *Of course ... sorry, doc, I'm on a bit of a short fuse at the minute, since being beaten up.*

The doctor then explained that he needed to perform a clinical examination. He started off by using a thermometer, which showed a temperature of 37.2°C. The sphygmomanometer showed a blood pressure of 135/67 mmHg, the pulse was regular at 67/mn. Then Dr. Lefevre palpated the facial and neck muscles, the cervical spine and sinuses and looked for signs of meningeal irritation.

- *I will use a pen torch to test the reactions of the pupils; there you go. I would like you to follow the light.*

The doctor tested the eye movements and then checked for papilloedema.

Bruise: haematoma.

Wound: injury producing a break in the skin.

Med 3: type of medical certificate (sick note) in the UK.

Splitting headache – a headache that seems to split my head in two.

Blurred vision – seeing things unclear, with borders of objects undefined.

Dizziness/feel dizzy: feeling bewildered or confused, or experiencing a whirling sensation (vertigo) with a tendency to fall over. Other similar terms are **giddy** and **light-headed**. A pre-syncope state is usually described as **feeling faint**.

Faint: to lose consciousness, often falling down as a consequence.

Syncope in lay terms is “to faint”, “to collapse”, “to pass out”, or “to black out”.

For hours on end – for many hours.

Dull: boring.

To check over. To verify or control.

Nothing touches it – nothing relieves it, nothing makes it better.

Feel sick – have nausea.

Your thinking – your capacity to think.

Losing one's marbles – going mad, crazy or “losing it”.

Work out: find out, discover the answer to a question after a process of reasoning and investigating. Also, you “work out” if you go to the gym to develop your muscles.

Arise: appear. Past participle: arisen.

To have a short fuse: short-tempered, irritable.

At the minute: at the present moment, now.

Beat: to hit or knock repeatedly. Past participle: beaten. To be **beaten up:** to receive repeated knocks, to be subject of serious physical aggression.

mn: min: minute.

Torch: instrument to give light.

There you go –. This phrase does not really mean anything, it is used after completion or confirmation or something, as if saying “this is done” or “that is how I thought it would be”; and also when you give something to someone.

Other expressions of interest

Epileptic crises are called “fits” or “seizures” by doctors and patients. If they are motor crises they may also be called **convulsions**, mainly by doctors.

facial [fə'shəl] sinus [sɪ'nəs] meningeal [mənɪn'jē-əl]

- *I am just going to ask you a few more basic questions. What is the day today?*
- *Friday.*
- *Have you been feeling tearful or upset lately?*
- *That's what my mates keep telling me, I am not the same, it ain't me. I snap at everything and when I watch TV, I am very emotional and crying when I did not use to.*
- *Mr. Norris, I can assure you that I am not too worried about your headaches; we call them tension-type headaches or muscle contraction headaches. You said that they occur on both sides of the head, which is a common feature of a tension-type headache.*
- *Yes that's it, doc.*
- *I would like to reassure you that there is nothing sinister going on. I gave you some painkillers for your back on Wednesday. How are you doing with those?*
- *That's alright, doc; the back is much better.*
- *That's great. What I think you should do, as your back is feeling better, is just take paracetamol or aspirin for the headaches. You might also like to try something to help you reduce your stress levels. We are currently running relaxation groups in our surgery. Perhaps you would like to come along and join the group so that you could learn some coping strategies to deal with stressful situations? Perhaps you could try to reduce your intake of tea or coffee, as we know these can aggravate existing headaches.*
- *I will have a think about it, doc, it would be great if you could give me a prescription like last time and if they don't work, I will definitely think about joining that group.*
- *OK, Mr. Norris, I would like to see you again in a few weeks, please.*
- *Yes, doc, I will come back in a couple of weeks if I am no better. Bye for now.*

Mr. Norris left the consulting room and the doctor went back to his desk to enter the new information on the computer.

P: Tension-type headaches

H: Ongoing headaches described as daily and gradual onset bilateral radiating towards the cervical area.

E: Oriented, cervical muscles tension, bilateral mid-position reactive symmetric pupils. Consciousness not altered. No meningeal irritation or papilloedema. No nystagmus. No skull wound. No red flags.

C: Reassurance and advice given, review if not better. Consider amitriptyline as stressed.

Tearful: with a tendency to cry because of a state of sadness.

Being upset means feeling offended or emotionally disturbed. It covers a wide range of possibilities: shocked; angry; sad; etc. “To be upset”, “to get upset” and “to upset somebody” are expressions very commonly used.

Mates: friends.

Ain't – isn't.

Snap. To say something or reply in anger or irritation. Also, to break something suddenly with a sharp cracking sound.

To be emotional: to feel emotions intensely.

I did not use to – I never used to be emotional – I was not an emotional person before this happened – **I used to** be a very calm person.

Assure: tell with conviction, being sure of what one says.

Feature: characteristic.

Sinister: dangerous, serious, malignant.

Painkillers: analgesics.

Have a think about it – think about it.

No better – not better.

Ongoing: persistent.

Red flags: clinical signs that require immediate action.

Reassure: to make somebody feel that there is nothing to worry about.

Common neurological abbreviations:

PERLA. Pupils equal and reactive to light and accommodation.

AJ. Ankle jerk.

CNS. Central nervous system.

CSF. Cerebrospinal fluid.

CVA ★. Cardiovascular accident. Commonly called **Stroke** (Latin: ictus).

TIA ★. Transient ischaemic accident.

LP. Lumbar puncture.

MS ★. Multiple sclerosis.

SAH. Subarachnoid haemorrhage.

LOC. Loss of consciousness.

Professionals

The doctor specialising in neurology is called a **neurologist**.

The doctor specialising in neurosurgery is called a **neurosurgeon**.

neurology [nyöő röľ'ə-jē] neurosurgeon [nyöör" ö-sûr"jən]

Eyes

with Ana Garaikoetxea

It was a very chilly morning and, as Dr. Ana Garaikoetxea approached the main door of Moorfields Eye Hospital, she could feel the butterflies in her tummy. Ana was a GP registrar at Down Street Surgery and as part of her training scheme she had agreed with her primary care tutor to work for a month at the eye hospital. Once inside, she asked at the information desk for Mr. Smith and was sent down an unending labyrinth of badly lit corridors. Eventually, she found herself in front of Mr. Smith's door. She hesitated, took a deep breath and gave a nervous knock. From the other side of the door a jolly voice called her in. Behind a large dark wood desk sat Mr. Smith. As his voice suggested, he was a chubby, distinguished looking, grey-haired man in his late fifties wearing a woollen jacket, light shirt and a bow tie.

- *Ah, you must be Ana; please do take a seat.*

Ana thought how nice it was that Mr. Smith had taken the trouble to find out her name.

- *What seat? She muttered to herself, unable to see one.*

Noticing the lack of a chair, Mr. Smith said: – Oops, terribly sorry! – He jumped up to get her one, knocking a pile of books off his desk onto the floor as he did so.

- *There you are. Make yourself comfortable; although that might be difficult, these old chairs are awfully hard – puffed Mr. Smith cheerily whilst bending down to pick the books up with not a small effort.*

Ana couldn't help feeling relaxed by Mr. Smith's old-fashioned appearance, absent-minded manner and soft, posh accent.

- *I thought you might like to sit in with me for a couple of days. Then I will leave you to your own devices.*
- *That sounds fine, Mr. Smith.*
- *I am on duty today, so let's see what's in store for us, eh?*

With that Mr. Smith stood up, grabbed a couple of folders from his desk and was out of the door in a flash, with Ana following behind almost running to keep up with him. First they went to take the records of the patients who had been registered as urgent visits at the hospital's admissions desk.

Chilly: (colloquial) cold.

To have butterflies in your tummy: to feel nervous.

Butterflies are those pretty insects with colourful wings.

Tummy: colloquial for abdomen.

Registrar: a doctor who is training in order to become a specialist in a particular medical subject. For example: primary care.

Scheme: programme.

Mr. Smith is an **ophthalmologist** (specialist in ophthalmology). He is of course a doctor, but because his specialty includes significant surgical activity, in Britain he is considered a surgeon and therefore his title is “Mr.” rather than “Dr.”. The same thing applies for ENT specialists, urologists, gynaecologists, etc.

Unending: endless.

Lit: illuminated with light.

Knock on the door: to make a “knocking” sound with the hand against the door so that somebody comes and opens it to let you in.

Jolly: (colloquial) cheerful, happy, extrovert.

Chubby: (colloquial) a bit overweight.

Distinguished looking – of distinguished aspect.

Late fifties: 57, 58 or 59 years old.

Take the trouble: to make a special effort to do something.

Seat: chair. “Seat” is the noun, “sit” is the verb.

Mutter: to speak in very a low voice (no-one would hear).

Jump up: standing up very quickly.

Get her one – get one for her.

To knock (something) off: to cause something to fall.

Puff: to exhale strongly after or during effort.

Cheerily: colloquial for happily.

Bend down: flex the trunk so as to let your hands reach the floor.

Couldn't help – couldn't avoid, couldn't resist.

Absent-minded: a tendency to be forgetful.

Posh: (colloquial) aristocratic or upper middle class origin or aspect.

Sit in: observe in consultation with learning purposes.

Leave to your own devices: leave you alone, on your own, with your own resources.

In store: what is waiting for you.

Grab: take something quickly with the hands.

In a flash: quickly.

Keep up with: to follow or maintain equality with, to be at the same level.

Note the 2 “h” in **Ophthalmology**. Scheme [skēm] labyrinth [lāb"ə-rĩnth] lit [līt]
light [līt]

They also checked their alarmingly long patient list on the computer.

- *Let's get to work, Dr. Garaikoetxea, I think we are going to be quite busy this morning.*
- *Yes, I can see that.*
- *Would you mind calling our first patient?*
- *No, not at all.*

Ana took the list and walked towards the waiting room to call the first patient, a woman in her late thirties, Ms. Newton; who was holding her 7-year-old daughter's hand and looking rather distressed.

- *Good morning, Miss Newton.*
- *Ah, "Ms.", actually.*
- *Right, of course, terribly sorry. Now, how can I help you today?*
- *My GP has sent me here because I have been having some trouble with my left eye.*
- *What sort of trouble?*
- *Everything seems a bit blurred, you know, and kind of shadowy.*
- *Could you be more specific?*
- *I'll try. Wherever I look, I see spots of shadow that move when my eye moves and also sometimes I see sparks of light.*
- *Flashes and floaters, said Mr. Smith confidently, this time talking to Ana. What eye conditions should we exclude, doctor?*
- *Retinal detachments, migraines ... – ventured Ana shyly trailing off to a whisper.*
- *Correct, Dr. Garaikoetxea, and some other possible, but rarer causes are posterior uveitis and neoplasm – added the older doctor discreetly.*
- *Which, in English, means what? Like, is it serious? I mean, am I going to go blind? – interrupted Ms. Newton anxiously. Mr. Smith gave Ms. Newton a warm smile and then said gently:*
- *Let us find out what you've got first, Ms. Newton. Then we will discuss your options.*

After a brief pause, Mr. Smith quickly changed the subject and asked the patient if she had ever suffered from migraines.

- *No, never.*
- *Are your current eye symptoms accompanied by headaches?*
- *No.*
- *In that case, we will need to have your eyes checked after using some special drops that will dilate your pupil. This test is called a fundoscopy. We use it to get a good look at your retina.*
- *Will it hurt?*

Distressed. Extremely upset, anxious or unhappy.

Ms.: usually used as a politically correct form that doesn't specify marital status of a woman. "Miss" assumes an unmarried state and "Mrs." a married state.

Sort: kind, type.

Sort of, kind of: something similar to; approximately.

Blurred: not well defined.

Shadowy: like a shadow. **Shadow:** dark silhouette projection of an object when illuminated by an external light source.

You know: (colloquial) "filler" phrase widely used with or without a reason, such as when someone can't find the right word to describe something.

Spot. A small defined area that is different in colour, material or texture from the surrounding area, especially one that is more or less circular. Patients also call the skin papules or furuncles "spots".

Sparks: small, intense flashes of light.

Flashes and floaters: medical term that describes a very specific visual disturbance where the patient sees shadows in his/her visual field and intermittent flashes of light. **Vitreous floaters** are those specifically produced by disorders of the vitreous body, sometimes described as "flying flies" (insects).

Venture: to offer a suggestion without total confidence.

To trail off: to decrease in volume until becoming inaudible.

Like: (colloquial) "filler" word or tag widely used when someone can't find the right word to describe something.

Blindness: inability to see.

Gently: softly.

Find out: to discover.

Fundoscopy: test performed with an ophthalmoscope in order to examine the fundus or retina.

Other common tests used to check the eyes are:

- **fluorescein stains** to look for corneal ulcers.
- **conjunctival swabs** to determine the cause of an infection.

Swabs and scrapings are specimens taken from a lesion or specific site for microscopic examination.

blurred [blûrd] floaters [flō'tərs] uveitis [yōō'vē-ṛ'tīs] blind [blind] scraping [skrāp ing] fluorescein [flōō-rēs"ē-īn]

- *No, not at all. But your vision may be a little bit more blurred in the next 24 hours. Just until your pupil goes back to its normal size.*

Both doctors performed the test, which showed an area of retina ballooning into the vitreous, confirming their first choice diagnosis.

- *Ms. Newton you have got what is known as a retinal detachment. Potentially it's quite a serious eye condition, but it usually responds well to laser therapy. You will need the therapy within 24–72 hours, so I will go and arrange for you to be treated as soon as possible. Is that OK with you?*
- *Yes, but first I will need to call my mum so that she can take care of Sophie.*

She smiled at the little girl who looked scared.

- *Don't worry, sweetheart. Mummy will be okay, whispered Ms. Newton whilst kissing her on the forehead. Would it be possible to make the call from here?*
- *Of course. Dr. Garaikoetxea will accompany you to the information desk in order to help you with your arrangements.*
- *By the way, one last request before I leave: Do you mind taking a look at Sophie's eyes? I have noticed that they look red and sticky. That's why she didn't go to school this morning.*

Sophie was a very neatly dressed pretty girl who seemed calmer after her mummy's comforting words.

- *Has she mentioned that her eyes are bothering her? Ana asked Ms. Newton. But it was Sophie who answered in a sweet high-pitched voice:*
- *Yes, it's as if I've had something in my eye for a couple of days.*
- *Sorry, Sophie – said Ana whilst smiling apologetically – I should have asked you instead of asking your mummy. You are a big girl now and sometimes we doctors forget that.*

Mr. Smith stood up and said:

- *Right, Dr. Garaikoetxea, Sophie is all yours. I will go and sort out your therapy arrangements in the meantime.*
- *Sophie, do you suffer from allergies, eczema or asthma? continued Ana.*
- *No – answered Ms. Newton quickly.*
- *Do you wear contact lenses?*
- *No – replied Sophie.*

Ballooning: making a balloon shape.

Scared: very frightened.

Sweetheart: colloquial term that expresses affection – used by adults to children or between closely related adults.

Whisper to: to talk in a low and almost inaudible tone of voice.

Take a look: have a look.

Sticky eye: colloquial way to describe the cohesive effect of a discharge on the eyelashes. Other relatively common and very unspecific eye symptom that patients complain of is the term “**sore eye**”, meaning that it is painful.

Neatly: smartly, cleanly and tidily.

Bothering her: causing physical distress.

Apologetically: in apologising tone.

Sweet: (colloquial) very pleasant.

High pitched: high, sharp tone of voice.

Sort out: to resolve.

Contact lenses –. Sophie was asked about wearing contact lenses. Patients also wear **prescription glasses** (also called spectacles) to correct **refractive errors**. GPs or **opticians** check patients’ **visual acuity** using different charts, such as the Snellen chart.

Other expressions of interest

Stye. An inflamed swelling of the edge of an eyelid, caused by bacterial infection of the gland at the base of the eyelid.

Chalazion. A chronic inflammatory granuloma of a meibomian gland.

Squint. Strabismus.

Gaze paresis: impairment of the oculomotor function.

laser [lāˈzər] serious [sɪrˈɪ-əs] vitreous [vɪtˈrē-əs]

- *Have you been playing with something that could have got stuck in your eye, or have you had any recent history of trauma?*
- *I don't think so.*
- *Does it itch?*
- *No.*
- *Is the discharge watery?*
- *Looks more like pus, especially in the morning. This time it was Ms. Newton who had answered.*
- *In that case, let me take a look at your eyes.*

Ana examined her and confirmed that Sophie's eyelashes were sticky, and she also had a mild oedema around her eyelids. The anterior chamber showed a slightly red and superficial vasodilatation.

- *Sophie, you have got a bacterial conjunctivitis. Sounds like a dinosaur's name, doesn't it? I will prescribe you some eye drops and you might need to be off school until it gets better. Also you need to clean your hands every time you touch your eyes so that nobody around you catches it as well.*
- *Thanks very much, doctor.*
- *You are a very sweet little girl. I hope you and your mummy get better.*

Dr. Garaikoetxea handed Sophie a sugar-free sweet.

Mother and daughter left the room and Ana couldn't help feeling sorry for them both. She really hoped Ms. Newton's laser therapy would be a success. Then, remembering suddenly that she had to take them to reception to make the phone call she rushed out of the room. It was just the start of what was going to be a very busy first day ... and she had left her butterflies far behind!

To get stuck: adhered, difficult to be removed. Also: to be unable to progress.

To be aware of: to notice something, to be conscious of it.

It itches – it makes me feel itchy. **Itch:** pruritus. “To itch” is not followed by pronoun, so do not ask “does it itch you?” but simply “does it itch?”

Eyelashes: hair of the eyelids.

Eyelids: skin that covers the eyes when they are closed.

Discharge: any abnormal fluid that emanates from the body. Other medical term used to describe a very specific type of discharge that patients with blepharitis have is the “greasy scales” that appear in the lid margins.

Watery: aqueous.

Be off school: do not go to school. You can also be “off” work, usually when you are sick or on holiday.

To catch an illness – to acquire an illness, especially through contact with an ill person.

Feel sorry – feel pity.

Rush: to do something quickly.

Leave something far behind: to stop feeling, remembering or doing something.

Some abbreviations used in ophthalmology:

PDR: proliferative diabetic retinopathy

OAG: open-angle glaucoma

ACG: angle-closure glaucoma

RAPD: relative afferent papillary defect

ARMD: age-related macular degeneration

PVD: posterior vitreous detachment

pus [pūs] vasodilatation [vā"zō-dī-lā'shən] conjunctivitis [kən-jŭngk'tə-vī'tis] blepharitis [blēf'ə-rī'tis] greasy [grē'sē]



Mr Potter: and I just hoped that you could come and see me.

Dr Garcia: Sure, no problem. I am going this afternoon.

Mr Potter: So you are not coming to see me.

Dr Garcia: Of course I am going

Mr Potter: But where are you going then?

Dr Garcia: To see you

Mr Potter: You are coming, then?

Dr Garcia: Yes Mr Potter, I've just told you I am going

Mr Potter: But if you are going, you won't be able to come and see me then

LALANDA

Musculoskeletal System

with Emilia Negrin Brito

Mr. McDonald is originally from the USA but is now living and working in London. He is not familiar with the UK NHS system and occasionally makes some inappropriate requests. He managed to get to the doctors' surgery on time after rushing off from his last meeting in the morning. He had moved to London from New York only two months before. He reported his arrival to the reception staff and was told that Dr. Negrin was running late due to some unexpected emergencies, but that he would be seen as soon as possible.

Mr. McDonald did not know what to expect: "In New York they are always on time", he thought. "I'd better reschedule my next meeting just in case", he said to himself while taking a seat and getting his Blackberry out of his pocket. At the same time, inside the consultation room, Dr. Negrin pressed the "next patient" key on her computer and a few seconds later she could hear a knock on the door.

- *Come in, please!*
- *Good morning, doctor. Thank you for seeing me at such short notice.*
- *Good morning, Mr. McDonald, it's my pleasure. Please take a seat. What can I do for you today?*
- *I think I've done my back in, doctor. I've had this pain for two weeks now ... it's killing me!*
- *When did the pain start?*
- *I'm not sure, I was doing some work in the garden last weekend ... Then that evening I started feeling the pain. I've put it down to something I must have done whilst gardening.*
- *I see. Can you pinpoint where the pain is?*
- *Yes, all across here. [He points across his lumbar area.]*
- *Does it spread down your legs?*
- *No, it just sits there.*
- *Any pins and needles in your legs or toes?*
- *No, not at all, just the pain there.*
- *When do you get the pain?*
- *It is mainly when I am walking or if I try to bend. Also, sometimes if I twist my back I get the pain, too. But if I lie down in bed I am fine.*
- *Do you feel any stiffness in the mornings?*

He is not familiar with – it is unfamiliar to him, he does not know how it works.

Inappropriate requests – requests for things that the NHS or the doctor is not supposed to provide.

Manage to: finally achieve something after effort or against probability.

Rush off: leave a place in a hurry. Also remember the expression “**rush hour**” which is the time at the start and end of the working day when traffic is at its heaviest. Also, somebody could have **been rushed to the hospital** if taken in quickly for a major emergency.

Report arrival to/at Reception –. Patients usually have to let Reception know that they have arrived so the receptionists mark them as such on the computer and the doctor knows he/she can call them.

Running late – delayed, running behind schedule.

Due to: because of.

Unexpected. Something not expected or regarded as unlikely to happen.

On time: punctual.

Reschedule. To change the time of a pre-planned event.

Blackberry: mobile phone with PDA and Internet capabilities.

At short notice–. The patient had booked the appointment a very short time before, perhaps only minutes. It is not uncommon for the patient to thank the doctor for the appointment, especially if it was a last minute booking. The opposite would be to book the appointment **well in advance** (days or weeks before). **Notice period** is the time given to an employee or employer to notify the termination of a contract. **To take no notice of** – Quite often a patient will mention a symptom felt in the past and say “... but I took no notice of it” to mean that he or she paid no attention to the symptom or discomfort at the time.

I’ve done my back (in) – [informal] I have hurt my back during an activity, such as lifting a heavy object.

I’ve put it down to – I’ve attributed it to ... or I think it was caused by ...

To **pinpoint:** to find or locate exactly. A pinpoint means a tiny dot or point and also it is used to define something as absolutely precise.

Across – reaching from one side to the other.

Does it spread down your legs? – Does it extend (radiate) down to your legs?

The pain just sits there – the pain is in one place and does not spread or extend to other any areas.

Pins and needles: patients will very often use this expression to talk about their paraesthesias.

To twist my back – To turn or bend my back in a particular way.

Stiffness. Unable to move easily and without discomfort or pain.

Reschedule [rē-skěj”ōōl] spread [sprěd]

- *No, not really ...*
- *Any trouble with your bowels or waterworks?*
- *No. That seems to be OK.*
- *Have you tried any painkillers since the pain started?*
- *Yes, I tried something I bought over the counter back home in New York. I wrote down the composition ... let me see ... here we are ... it is called acetaminophen ... but it hasn't helped that much, to be honest.*
- *How many have you been taking?*
- *I've taken up to eight tablets a day, as it says on the box.*
- *Have you had back problems in the past?*
- *I had something similar two years ago, when we moved house ... I put it all down to the lifting and carrying ... then my GP, back in the USA, referred me for some physiotherapy sessions and that sorted it out. I was going to ask you if I could be referred again. I have private insurance.*
- *Well, that is certainly an option, but I would like to take a look at your back first, if that is OK with you.*
- *Yes, sure. Do you want me up on the couch?*
- *Yes, please.*

Dr. Negrin examined the patient carefully and came to the conclusion he had non-specific low back pain.

- *All right, finished! Everything appears to be fine. You can take a seat on the chair again if you wish.*
- *OK ... Oh, it is sore now [Mr. McDonald gave a long sigh]. What do you think doctor, should I have an MRI scan or something?*
- *Well as I said, everything looks fine and I don't think that an MRI scan is necessary at this moment in time. You probably had a contracture of some of your lower back muscles whilst gardening and that is what is causing the pain.*
- *I thought so ...*
- *I would recommend a different kind of painkiller you can take to help with the pain, and, if you want, I can give you a letter so you can see a physiotherapist.*
- *Oh yes, that would be great, I can't really afford to be off sick for long.*

After checking for allergies, interactions, and contraindications, Dr. Negrin decided to prescribe some ibuprofen. She wrote the relevant details on the patient's record:

P: Low back pain without radiation

H: 2/52 back pain, no red flags, no relief with OTC paracetamol, no CI for NSAIDs

Trouble with bowels – a way to enquire about intestinal movements.

Waterworks: colloquial way of referring to the urinary system.

Painkillers: colloquial way of referring to any analgesic medication.

Back home –. Often used when a patient refers to their country of origin.

Acetaminophen: paracetamol (as known in America).

To sort something out. To resolve a problem or difficulty.

Lifting and carrying – activity including taking heavy objects from the floor or alike and moving them to another place. You do this, for example, when you move house and transport your own bags, boxes and furniture. It typically ends up in a back pain.

Couch: examination bed.

Low back pain is a term more frequently used by doctors, rather than “lumbalgia”.

Sore: painful.

MRI ★. Magnetic resonance imaging.

I cannot afford to – it would be a luxury that I cannot allow myself.

To be off sick – to stop going to work because of illness. On the other hand, “skiving” or “bunking” are used when somebody could be pretending to be ill when he or she really is not.

Radiation –. Note that a pain is or can be “**radiated**” (extended from one point to another); however, a patient undergoing radiotherapy is “**irradiated**” (exposed to radiation). Take note of the difference.

2/52: two weeks.

Red flags are signs that should alert you to consider that a problem is present or that there is a serious cause for a certain problem. “**Yellow flags**” are risk factors for developing a condition. In our example, yellow flags for persisting chronic pain and long-term disability are any psychosocial barriers to recovery, like: emotional problems such as low or negative mood, depression, anxiety, stress; problems and/or dissatisfaction at work, overprotective family, lack of support, etc.

CI. Contraindications. This is a common abbreviation in clinical records.

NSAIDs ★. Non-steroidal anti-inflammatory drugs.

physiotherapy [fɪz’ē-ō-thēr’ə-pē] insurance [ɪn-shōōr’əns] couch [kouch] sore [sôr] sigh [sī]

E: FROM, NAD.

C: *Ibuprofen, private physio referral.*

Mr. McDonald had been checking the time of his next meeting. He lifted his head and said:

- *So ... how about going to see a physio? A work colleague recommended one to me, but my insurance company requires a referral letter from my GP in order to cover me for the treatment.*
- *That's OK. Do you have the name of the physiotherapist?*
- *Yes, let me see, her name is Jane Smith, she is based in a private clinic near Cannon Street, let me see [fiddling with his Blackberry again].*
- *[Dr. Negrin interrupted] That's OK; her name is all I need, thank you.*

Dr. Negrin proceeded to write a referral letter on her PC:

Dear Ms. Smith,

Many thanks for seeing Mr. McDonald.

He attended today complaining of a 2-week-history of lower back pain following gardening activities. He has tried paracetamol with no relief. He had a similar episode 2 years ago that was resolved with physiotherapy. His examination today is unremarkable, except for mild pain in the lower lumbar area when bending forward. I have recommended that he take some ibuprofen for the pain and try and keep as active as usual.

I would be very grateful if you could see him at your earliest convenience and give us your valued opinion.

Yours sincerely,

Dr. Emilia Negrin

General Practitioner

Dr. Negrin then turned to Mr. McDonald and said:

- *For the time being I would like you to try ibuprofen for the pain [She took a prescription from the printer]. You can also get this over the counter; it will be probably cheaper than on prescription. And, this is your referral to Ms. Smith. I believe you may need to contact your insurance company in order to get authorisation before you book the appointment. Let me know how it goes. But remember, try to stay active as much as you can.*
- *OK, great!*

When Mr. McDonald left, Dr. Negrin had a quick sip of her coffee. Her next patient was Mrs. Brown, very well known to her. She attended regularly with her young children and occasionally consulted for herself.

FROM. Full range of movements.

NAD. Nothing abnormal detected.

Lift: move up.

How about ... ? – Suggesting an alternative course of action or idea, “How about we try this instead?”

Cover – pay for.

Is based in – works in.

Is based on – has its origin or fundamentals itself in. Evidence-based medicine is based on research.

Fiddling: playing with something in your hands, usually due to nervousness.

PC ★. Personal computer.

Many thanks for seeing ... –. Although the physiotherapist has not seen the patient yet, many doctors would start the letter by thanking them in advance for seeing the patient.

Complaining of –. A way to express the reason for the consultation.

A 2-week history of –. A way to describe the duration of the complaint.

Unremarkable: nothing significant to say.

Mild – not intense, not severe.

Bend forward: flex the upper part of the body to a position ahead of the lower part.

At your earliest convenience – as soon as you can do it without inconveniencing yourself (without much trouble for you).

Valued opinion – an opinion I give value to, an opinion I think has great value, an opinion that I trust.

For the time being – for now. Used to mean “this is what we can do in the present, but then we can change it in the future”.

Sip – a very small amount of liquid taken into the mouth.

Well known to me – I know them well.

Questions to ask

Back pain

Is the pain confined to the back or does it radiate to the upper or lower limbs?

Is the pain exacerbated by coughing or sneezing?

Did the pain begin suddenly or gradually?

Knee pain

Do both knees hurt or only one? [systemic disease]

Have you noticed swelling of the joint? [arthritis]

Does the knee lock in certain positions? [meniscal disease]

Does it give way on occasion? [meniscal disease]

authorisation [ô'thər-ĩ-zā'shən] meniscus (singular) menisci (plural)

- *Hello, Mrs. Brown, what seems to be the problem?*
- *Hi, doctor, I am not too bad I guess ... It is just my hand, the left one, I don't know what's wrong with it. I have pins and needles all over it. At the beginning it used to be only at night and I put it down to a funny position while sleeping. In fact, I used to wake up with it and then after stretching my hand and sometimes shaking it a bit, I was fine again. But for the last couple of weeks it has also been giving me trouble during the day ... it is so annoying!*
- *I see ... and where in your hand did you say you felt the pins and needles? Is there a particular area of your hand where it feels worse?*
- *Well, now that you ask, it seems to be worse in these three fingers ... [She said this while gently rubbing her other hand over the volar surface of her thumb, index and middle fingers.]*
- *Have you had any trouble with the rest of your arm?*
- *No, up here is all fine.*
- *Have you noticed if you have been dropping things or felt that your hand is weaker?*
- *Well, sometimes it feels weird, as if I don't have a good grip, but then I haven't dropped anything ... not yet!*
- *How long have you been feeling like this?*
- *Probably about 3 months, but as I said, at the beginning the symptoms were only at night, I was absolutely fine during the day. I guess I should have come earlier instead of letting it get to this stage, but you know, I am always so busy with the kids, school runs, preparing meals and all that, that I don't seem to have much time left to look after myself.*
- *Well, you have to look after yourself in order to be able to look after others, you know that. But the most important thing is that you are here now; let me have a look at that hand.*

Dr. Negrin took Mrs. Brown's hands and carried out a careful inspection looking for any obvious deformity or swelling; she also compared both hands checking for any atrophy; then she performed a few manoeuvres in order to support her diagnostic impression.

- *I am going to gently tap here on your wrist with my hammer and I would like you to tell me if you feel anything in your fingers while I do it. OK?*
- *OK doctor, that's fine.*

Dr. Negrin lightly tapped Mrs. Brown's wrist over the median nerve. The patient quickly said:

- *Oh yes, I feel like a tingling sensation in these three fingers. It is very similar to what I feel at night.*

Funny – strange, unusual.

Stretching – to extend one's body or a part of one's body to its full length. To **stretch one's legs** means to go for a short walk.

Shaking: move up and down or from side to side with rapid movements. Shaking can also be an uncontrollable trembling experienced with strong emotion. **Shake hands (with someone)**: clasp someone's right hand in one's own at meeting or parting, in reconciliation or congratulation, or as a sign of agreement.

Annoying: irritating.

Rub: to apply firm pressure to (a surface): with a repeated movement along the surface.

Volar aspect: surface of the palm of the hand or the sole of the foot. The opposite side is the **dorsal** aspect.

The hand

The digits of the hand are the thumb and four fingers.

Thumb: the first digit on the radial side of the hand.

Index finger: second digit of the hand.

Middle finger: third digit of the hand.

Ring finger: fourth digit of the hand.

Little finger: fifth digit of the hand.

You drop things – things that you are holding fall from your hands.

Weaker: less strong.

Weird: strange, unusual.

Grip. An act of taking or keeping a firm hold on something. In the example, the capacity to hold something with the hand without dropping it.

Earlier – before.

School runs: trips back and forward from school to drop or pick up children at the beginning and at the end of the day.

Look after myself – take care of myself, protect or improve my health.

Carry out – do, perform.

Swelling. An increase in size of part of the body. It may be caused by inflammation, mass or oedema.

Support – provide evidence in favour of.

Tap: to hit lightly and repeatedly against something.

Wrist: area of junction between arm and hand.

Reflex hammer: instrument to test neurological reflexes.

Tingling sensation – pins and needles or paraesthesia.

shake [shāk] rub [rüb] swelling [swēling] atrophy [āt'rə-fē] manoeuvres [mə-nōōvər] median [mē'dē-ən]

Dr. Negrin carried on for a few more minutes until she was satisfied with the examination. Then she talked to Mrs. Brown.

- *Well, I think your symptoms are due to a trapped nerve here in this area of your wrist [pointing at her own carpal tunnel area]. In most cases the reason is not known, but on occasion it can accompany other conditions. I would like you to have some blood tests done to make sure that this is not the case with you. I don't want you to worry too much at this stage. I can see on your records that you had normal blood test results just over a year ago so there is not much reason for concern. In the meantime, I would like to suggest that you use a splint over night and even when you can during the day. This will help to keep your hand in the right position, which will minimise the symptoms. This is the prescription and the blood test form. Are there any questions you would like to ask?*
- *Mmmm ... Is this serious, doctor?*
- *As you said, it is annoying, but I think it is very unlikely to be anything serious.*
- *OK, do I have to come and see you with the blood test results?*
- *Yes, please, book an appointment with reception once the results are back from the hospital and we can discuss them.*
- *I will do doctor, thanks for your time.*
- *You are welcome, bye.*
- *Bye.*

Dr. Negrin wrote in her computer:

P: CTS

H: 12/52 left hand paraesthesias, symptoms worsening, no relevant PMH

E: Tinel's and Phalen's positive, no evidence of atrophy, grip preserved

C: BT requested, splint, TCB with results

Dr. Negrin checked her computer again and was relieved to see that her last patient had cancelled his appointment. So she started getting ready for her home visit. As she walked out through reception she said to one of the receptionists:

- *Bye, Sue, I'm off to a visit, but you can call me on my mobile if there are any problems. I'll be back just before my evening surgery.*

Carry on: continue.

Trapped nerve: colloquial for compressed nerve.

On occasion: occasionally.

This is not the case with you – your carpal tunnel syndrome does not accompany another condition.

No reason for concern – no need to worry.

Just over a year ago – a little bit more than a year ago.

Splint. A strip of rigid material (usually plastic) for supporting a broken bone or injured joint. A more rigid immobilisation used for fractures is a **plaster cast**, which is applied as warm wet strips, which dry hard.

Minimise: reduce to a minimum.

Note the differences:

Is this serious? – Is this an important/dangerous problem?

Are you serious? – Are you telling the truth or joking?

Are you a serious person? – Are you normally quiet, thoughtful, not laughing or making jokes very often, and always sensible?

With reception – with the reception team; it could be done in person at the desk or on the phone.

In reception – it is understood that you will be physically there to make the appointment.

CTS. Carpal tunnel syndrome.

PMH. Past medical history.

Preserved: conserved, not affected, not lost, not impaired.

BT. Blood test.

TCB. To come back (to come to surgery again).

Get ready: prepare.

Be off to a visit – going to do a home visit.

Be back – have returned.

Professionals

A doctor specialising in trauma and orthopaedics is an **orthopaedic surgeon**. Sometimes referred to as “orthops”.

A physician specialising in rheumatology is a **rheumatologist**.

A health professional trained in physiotherapy is a **physiotherapist**, short-named “physio”.

A health professional providing **foot care** services is a **chiropodist** or **podiatrist**.

paraesthesia [pār'is-thē'zhə] minimise [pār'is-thē'zhə] serious [sîr'ē-əs] mobile [mō'bîl]

Emergencies and Trauma

with Monica Lalanda and Juan Antonio Alonso

Dr. Lalanda had the day off. She had not planned to do anything special; she just wanted to chill out all day. She slept in and woke up feeling good. As she was having breakfast, Dr. Lalanda thought that it would be nice to have some friends over for dinner, so she sent a few text messages to some of her friends:

- *R u free 4 dinner 2nite?*

To her delight, they all accepted her invitation. They would call in at around 7 p.m. Dr. Lalanda decided to pop into the local supermarket and buy a few things. She didn't particularly like shopping but she loved cooking and she had a reputation for being an excellent cook. One hour later, Dr. Lalanda was getting some fish from the fishmonger:

- *May I help you, madam?*
- *Oh, yes, please. Can I have four of those salmon fillets over there?*
- *There you go!*
- *Lovely, cheers!*

As she was putting the fish in her shopping trolley, she heard a big commotion nearby. She didn't pay much attention to start with; maybe it was just a toddler having a tantrum. A few minutes later, there was a call alerting the supermarket First-Aider. At this point, Dr. Lalanda decided to approach the small crowd to find out if she could be of any help. There was a woman on the floor; she was unconscious and looked very pale. She was elderly, probably in her late seventies. A shop assistant was kneeling next to her but she looked almost as pale as the patient. She seemed to be in a bit of a panic. Dr. Lalanda stepped in,

- *Hello, I am a doctor. Can I help?*
- *Oh, yes please, thank you very much! This lady collapsed as she was pushing her trolley. I think she's passed out.*
- *OK, please go and get some more help and bring all your first aid kit.*

Dr. Lalanda got down on her knees and quickly assessed the woman, who was quite overweight. Then she heard the soft tearful voice of an elderly man just behind her.

Day off: a day you are not working.

To chill out: to relax, to enjoy yourself. **To sleep in:** to sleep longer than usual. It can have a negative connotation if it makes you late for work in which case you can refer to it as "I overslept".

Have friends over – have friends coming to your house as guests.

Dinner. The main meal of the day, usually eaten in the evening or sometimes in the early afternoon. **Supper.** A light meal taken in the evening, or the main meal of the day when taken in the evening.

R U free 4 dinner 2nite – Are you free for dinner tonight?

To call in: to visit. The term "call" has many uses. It is common to see signs that read "thank you for calling" or "Please call again, soon" in supermarkets or petrol stations. It doesn't involve a telephone call but a physical presence. It probably derives from the need to call on the door when you arrive at a house.

Pop into: go to somewhere for a short time with a specific purpose.

Cook –. Note that the **cooker** is the kitchen appliance and the **cook** is the person that cooks (against all logic!).

There you go –. Common expression used when handing something over to someone else.

Cheers! An informal expression for "thank you".

Nearby –. You cannot finish a sentence with "near". You may say "Monica heard a commotion near the supermarket" or "Monica was in the supermarket and heard a commotion nearby".

To start with – at first, initially.

First Aid: basic urgent care given to a sick or injured person until definitive medical treatment can be accessed. Although anyone can provide first aid, a "first-aider" is a person trained to provide it.

At this point – now, at this time, at this point in time.

Crowd: large group of people gathered in one place.

Tantrum: An uncontrolled outburst of anger and frustration. It is mainly used for small children but it can be useful to describe the behaviour of some surgeons!

Late seventies: 77, 78 or 79 years old.

Kneel: put one or two knees on the floor.

Step in. Become involved in a difficult or problematic situation especially in order to help or prevent something from happening.

Oh yes, please. Thank you very much –. Politeness applies in every single situation, even in the middle of a cardiac arrest. Using please, thank you and sorry all the time will make you sound like a proper English speaking person.

Collapse: fall suddenly.

Pass out: faint, lose consciousness.

Kit: group of tools or instruments prepared for a particular purpose.

Tearful: crying.

messages [mə'sɪʒ] delight [dɪ-lɪt] crowd [krouɪd] aid [aɪd] tearful [tɪr'fʊl]

- *She said she had chest pain, I told her we could come shopping any other day. My Mary wouldn't listen ... she's so stubborn. I knew she wasn't well, doctor. She has had angina everyday this week. She was breathless ... Oh, Mary!*

Luckily, a young woman who was standing next to him tried to comfort him. Dr. Lalanda smiled at her. It was hard enough to deal with an ill person in the middle of a supermarket! Having to deal with a distressed relative would make it even more difficult. Dr. Lalanda gently shook the woman's shoulder,

- *Mary, Mary, can you hear me?*

There was no response. Dr. Lalanda realised that it was a long time since she did her ALS; luckily she could still remember the basics. She had always been very keen on Emergency Medicine; she even did some locums at her local A&E every now and again; however, she had not treated a cardiac arrest for quite some time. She bent close to the patient's face and looked, listened and felt for 10 seconds. There was no breathing. At that moment the shop assistant arrived with the First Aid trolley. Dr. Lalanda quickly grabbed a mask to give safe mouth-to-mouth. She gave three rescue breaths. She now looked for a pulse in the woman's neck for 10 seconds. There was no pulse. Dr. Lalanda thumped her chest, reassessed and then commenced chest compressions. A middle-aged man approached and introduced himself,

- *Hello, love. Can I give you a hand? I am an ICU nurse. Let me take over the airway.*

Dr. Lalanda was really pleased to get some assistance. She now turned around and asked a young man whether he had a mobile phone. He nodded.

- *Please call 999. Tell them where we are and just say that we have a woman in cardiac arrest with ongoing CPR.*

She turned to the shop First Aider and asked her if she could do chest compressions.

- *Yes, I am trained to do that, but I have never done it on a real person.*
- *Not to worry, I'll take you through it.*

Dr. Lalanda demonstrated what to do and she quickly agreed with the ICU nurse to use the old ALS guidelines as they were not very familiar with the new ones; therefore, they were doing 15 compressions to two ventilations. Dr. Lalanda could now concentrate on the automatic defibrillator from

She wouldn't listen – She refused to listen.

Stubborn: Showing determination not to change one's attitude. It usually has negative connotations.

Distressed: extremely anxious.

Relative: a person connected to you by blood or marriage. It is useful to know the expression “next of kin” (NOK). This is the person that is closest to you and the one you want to be contacted in case of an emergency.

Shook: past of shake.

ALS: Advanced life support (course).

She has always been keen on – She has always been very enthusiastic or very fond of something.

Locum: temporary work.

A & E ★. Accident and emergency. This has recently changed to **ED** (Emergency Department). Most people still use the expressions “A & E” or “Casualty” (“Cas”) which is an even older name.

Every now and again – sometimes, but not very frequently.

For quite some time – for a long time.

A draw that said ... – or a draw that read means that it had something written on it. In this case was “Airway”.

He grabbed a mask: To grasp the mask suddenly and roughly, in a hurry.

Rescue: save.

A middle aged man – a useful description for the age of a person. A man between 35 and 55 years.

Thump. Hit heavily with the fist (closed hand).

Re-assess: assess again.

Hello, love – Very common expression mainly used by people in the North of England. It is an informal way of addressing female strangers.

Can I give you a hand –. A genuine way to offer help.

ICU ★. Intensive Care Unit.

Take over: to replace, to substitute, to take somebody's place, to continue doing a job or task that was previously done by somebody else.

To nod: to say “yes” by moving one's head up and down.

Call 999: British telephone number for emergency calls.

CPR ★. Cardio-pulmonary resuscitation. Resuscitation is informally called “resus” but this should not be confused with “Rhesus” (antibodies).

Take you through it – guide you through the process.

Not familiar with – they did not know about it in depth. Generally, when somebody says “I am not familiar with that”, it means “I don't know anything about that and I don't want to look silly in front of you by making a mistake!”

rescue [rɛsˈkyōō] resuscitation [rɪ-sʊsˈɪ-tāː-shən] “resus” (short name for resuscitation) [rɪ-sʊs] Rhesus [rɛˈsəs]

the First Aid trolley. They had one at her surgery but they had never used it. She knew that this piece of equipment was very user-friendly. She opened the defibrillator case and switched it on. A female voice told her where to stick the soft-wired pads on the patient's chest. After a few seconds the voice said,

- *Non-shockable rhythm. Continue CPR for 3 minutes.*

Dr. Lalanda asked the other two if they were tired but they just shook their heads. At that moment, they all heard (with great relief) the arrival of a blue-light ambulance. Two paramedics ran in. They carried two big bags on a stretcher. Dr. Lalanda sighed and then gave them a brief hand-over.

- *Hi, guys, great to see you! I am a local GP. This is Mary. She is known to suffer from IHD. Chest pain today prior to collapse. Witnessed cardiac arrest. Ongoing CPR since. Non-shockable rhythm. She has been down for about 15 minutes now.*
- *Thanks, doc. Let's attach her to our cardiac monitor and see what we have.*

The CPR continued. One of the paramedics dealt with the monitor and the other one attempted to gain IV access. She succeeded with a cannula on the first attempt. She now opened the bag which contained the drugs and started to set up for intubation, too.

- *Please stop CPR. Let's see what the rhythm is like. That looks like bradycardia. Is there any output?*
- *No output.*
- *OK, then. This is PEA. Let's give some adrenaline. Please continue CPR, you are doing a great job, guys. Are you happy to tube, Jenny?*
- *I'm ready.*

Jenny (one of the paramedics) intubated the lady with some difficulty due to the patient's size. She used a laryngoscope and a size 7 ETT. She attached it to the bag and oxygen and checked the position of the tube. Jenny looked pleased. The husband had been gently moved aside and somebody had provided him with a chair. Dr. Lalanda felt very sorry for him. A younger man was standing next to him and he had his arm over the old man's shoulder. They looked alike. He was probably the son. The paramedics gave Mary some IV adrenaline and took over the CPR. They attached the ETT to the portable ventilator and lifted Mary onto the stretcher. They were now ready to go.

- *Thanks, doctor. We are taking her to the Infirmary. Would you mind dealing with the relatives?*

User-friendly: easy to use, self-explanatory.

Case: box.

Switch on: turn on. Generally used for lights or electrical equipment. The “switch” is the button you need to press to switch it on/off.

Wired: with wires (thin metallic cables).

Pad. A piece of soft material used to protect something or give it shape, or to absorb moisture. Different kinds of pads are used for incontinence, periods, etc.

Shake one’s head: say “no” by moving the head from left to right and right to left. **Blue-light ambulance:** an ambulance that drives at high speed with a loud noise (siren) and blue flashing lights so that everybody gives it right of way.

Paramedics: Members of an ambulance crew who are trained to perform various emergency medical procedures.

Stretcher: framework (kind of bed) with wheels to carry patients who are lying down or “stretched”. When you book a non-urgent ambulance for patient transport they normally ask you “chair or stretcher?”

Hand-over: in a medical environment, a brief communication between health professionals about patients to transfer information and responsibility from one to another. Do not confuse with “hangover” which is what you feel the morning after a night of too much alcohol!

Guys –. Informal way to refer to a group of people in a friendly manner.

She is known to suffer from – she is diagnosed with.

IHD ★: Ischemic heart disease.

Witnessed – seen by someone. There were people there when it happened.

She has been down for 10 minutes – Expression used during the hand over of resuscitation to explain how much time has passed since the patient arrested.

IV ★. Intravenous.

To gain IV access: To insert an intravenous cannula or to **cannulate**.

To set up – to get the equipment ready.

Is there any output? – Can anybody feel a pulse?

PEA. Pulseless electrical activity. Some people still refer to it as EMD (electro-mechanical dissociation).

Are you happy to ... ? –. This common expression has nothing to do with happiness. It means “do you know how to do this, and more importantly, do you feel comfortable doing it?”

ETT. Endotracheal tube.

He felt sorry for him –. A different use for “sorry” different to the apology. It means that he felt sad because of what was happening to him.

crew [krōō] urgent [ûr"jənt]

- *No, of course not. Leave it to me, and thank you for your help.*
- *No, thank you. You've done a good job.*

Dr. Lalanda approached the family. They both looked very anxious.

- *You are Mary's husband, aren't you? ... And you are? [Addressing the younger man:]*
- *I am his son.*
- *My name is Dr. Lalanda. Mary has been taken to the hospital. She is critically ill. The paramedics will be doing their best to look after her on the way to the hospital. I think you should follow them. Have you got transport?*
- *Yes, doctor, thank you for your help.*

Dr. Lalanda watched them as they went towards the exit. The old man was dragging his feet. She just wondered how he would cope with all this. She turned around to look for the two people that helped with the resuscitation. They were talking to each other:

- *Well, mate; I don't know how you can do this for a living. To be honest with you, I wouldn't last a day!*
- *It's one of those things, isn't it? At the end of the day, somebody has to do it and it is not that bad, honestly.*

Dr. Lalanda joined the conversation:

- *Are you OK? You must be pretty tired after all that exercise.*
- *I am fine. It's only ... well, you know. It is not very nice ...*
- *Yes, it is hard but you have done well. Get a little break and get yourself a cuppa.*

Dr. Lalanda continued with her shopping. Her mind was not on the evening dinner anymore, though. Dealing with a pre-hospital cardiac arrest was not what she expected for her day off. Dr. Lalanda rang the hospital later on. Unfortunately, Mary did not make it after all. She was pronounced DOA.

The story was the subject of conversation during dinner that night, and again at work the following morning. Tuesday morning was Dr. Lalanda's "admin" session, which she used to catch up with her paperwork. When she was reading reports from the hospital lab, the practice nurse entered the room and asked her:

Infirmary –. Many hospitals in Britain maintain this old-fashioned term for hospitals. From the Latin “infirmus”, ill; however, the modern term “hospital” is more commonly used.

Leave it to me – pass the responsibility to me, I will do it, you don’t need to worry about it. The kind of phrase you always like to hear ...

Looked very anxious –. In this case, “look” refers to “aspect” or “appearance”, not to the act of looking with the eyes. You may ask “How did the patient look (or look like)?”

Critically ill: the highest level of being unwell.

Doing their best –. Despite the difficulty they will try to achieve the best possible result. Another example could be, “I am not sure I can help you, but I will do my best”.

Dragging his feet: walking slowly, with difficulty, without lifting the feet from the ground.

To cope: to deal effectively with something difficult.

Mate: friend. It is more common for male friends. It is also commonly used by young people. A flatmate or roommate is someone with whom you share a flat (or apartment) or a room, usually temporarily.

To do this for a living – To do this as a job. You can ask patients: “What do you do for living?” or “What is your occupation?”

It is one of those things ... – It is one of those things you cannot avoid ...
– It is just life!

At the end of the day – After all, in spite of everything, what really matters is, the end result is ...

Well, you know – These words are commonly used as gap fillers (they do not mean anything).

It is not very nice –. The use of “nice” and “not nice” is very extensive. It can be applied to anything from a good meal to a house on fire.

Do well: progress or perform satisfactorily.

Cuppa – A cup of tea. It is also important to know how to politely offer a cup of tea. (“Would you like a cup of tea? Sugar and milk?”)

Did not make it – did not survive.

Pronounced dead – confirmed and certified dead.

DOA. Dead on arrival.

Infirmary [ɪn-fûr'mə-rē] arrest [ə-rĕst']

- *Can I pick your brains for a minute, please? This patient caught his finger on a gate at his farm 2 days ago he has a pretty big cut.*

They went into the treatment room, where Dr. Lalanda asked the patient:

- *So, when did it happen?*
- *Day before yesterday. I couldn't be bothered to go to the hospital, but this morning when I saw my finger with this boggy swelling I thought there was more to it.*
- *I'm afraid you are right. You have an infection, and we may need to lance it. You also need an X-ray, if you have a fracture, it can be tricky, as the infection can go to the bone. I'm sending you to the hospital with a letter for the doctor in Casualty.*

Mr. Conan went to the hospital with the letter from his GP. When he arrived at the Emergency Department the receptionist asked him to wait in the waiting area. Soon, a triage nurse invited him into one of the cubicles. There was a sign on the door reading "minors". After reading the letter from the GP, the nurse picked up the phone and rang the switchboard:

- *Can you bleep the orthopaedic surgeon on call, please?*

A few minutes later a doctor entered into the cubicle and said:

- *Good afternoon, Mr. Conan, my name is Mr. Daniels and I am the orthopaedic registrar on call. Can I see your finger, please? [Examines the finger.] I think your doctor was right. We have to keep you in. I'll organise an X-ray and we'll start you on antibiotics tonight. We will operate on you tomorrow morning. Our SHO will speak to you later on and he will ask you sign a consent form. I'll review you first thing in the morning during the ward round.*

Mr. Daniels scribbled in the notes "septic finger. Needs I+D. TCI orthopaedics. Start iv AB. NBM from 24:00". Mr. Conan underwent surgery and the orthopaedic registrar went to see him.

- *Everything went very well. The X-ray showed no fracture. We'll keep you on antibiotics through this drip until tomorrow. After that, the nurse in your GP surgery can change the dressings as needed. You can take the discharge summary to your doctor yourself. Will you need a sick note?*
- *No, thanks. I'm OK with that.*

Mr. Conan's finger healed fine and two weeks later he was well enough to go back to work.

Pick your brains – (very informal) ask for your opinion to make a decision.

Caught his finger – trapped his finger.

Pretty big cut – not necessarily nice, but quite a big cut.

Treatment room: dedicated room to carry out minor procedures.

Couldn't be bothered: didn't want to take the trouble to do something.

Boggy: soft and watery.

There was more to it: to realise that a situation has more serious implications.

To lance: familiar for incision and drainage.

Tricky: difficult, problematic.

Casualty: old term for Emergency Department, but still very popular.

Minors: term used in the Emergency Department for small injuries.

Switchboard operator: a person whose job is to receive telephone calls and connect them to other numbers.

Bleep: radio device to contact doctors in a hospital.

On call: doctor on duty for non-routine work.

Mr.: in hospital terms Mr. is applied to surgeons (qualified members of the Royal College of Surgeons).

Registrar (Specialist Registrar or SpR): senior doctor in training in any hospital speciality.

Your doctor: normally used to refer to your General Practitioner (GP).

SHO ★. Senior House Officer: junior doctor in training.

Consent form: legal requirement to perform any surgical intervention.

Ward round: brief visit to every patient in the hospital under a particular team.

I+D: incision and drainage.

TCI: to come in (due to be admitted).

IV AB: intravenous antibiotics.

NBM: nil by mouth. To keep fasting – not to eat.

Drip: device to provide intravenous fluids.

Discharge summary: details of the admission episode given to the GP after the patient leaves the hospital.

Note that **discharge** has two meanings:

- ending the care of a patient
- abnormal fluid coming out of a body orifice

Sick note: document signed by a doctor to justify absence from work because of illness.

Fine: not thin, but OK.

registrar [ə-rĕst"] discharge [dĭs-chärj"]

Skin and Soft Tissues

with Ana Viejo Casas

Dr. Viejo had just arrived at work after a long weekend. She had looked forward to resting during the bank holiday after three working weekends in a row. She had done so much out-of-hours in the past few months that she could not even remember the last time she spent the whole weekend with her husband.

She switched on her computer and saw her appointments for that day. She had 15 patients in the morning. It wasn't too bad. Nadia was her first one. She had been seeing her regularly to check her thyroid levels as they had been borderline in the last two blood tests results. She called her in.

- *Good morning, Nadia, how can I help you today?*
- *Morning doctor, I've come to see you today because I've got this itch all over that it's driving me mad!*
- *How long have you had it for?*
- *I've been getting it on and off for the past couple of weeks. I've tried to use some moisturising cream but honestly, it doesn't make any difference.*
- *Have you got a rash at all?*
- *No, it's only the itchiness.*
- *Do you mind if I have a look?*
- *Of course not!*

Nadia rolled up her trousers so Dr. Viejo could see her legs, and they were clear.

- *I need to do something about it, as I can't stand this any more!*
- *I understand. I've checked it on the computer and you are not on any medication at the moment, is that right?*
- *Yes, that's right.*
- *OK then, I'm going to prescribe you some antihistamines to treat the symptoms and I recommend you to use a moisturising cream twice a day.*
- *Thanks, I appreciate it.*
- *And we'll need to repeat your bloods in order to review your thyroid levels. I would like to see you again in 10 days time with the blood results. Is that OK with you, Nadia?*
- *Yes, that's fine. I'll see you then.*
- *Bye-bye, then. See you.*

Bank holiday – a weekday when the banks are closed and which is also a public holiday; legal holiday in Britain; these include Christmas, Good Friday, Easter Monday, etc.

In a row – consecutive.

Out of hours (OOH): primary care emergency work, done outside normal working hours, i.e. weekends, bank holidays, and between 7 p.m. and 8 a.m. on weekdays.

Borderline: on the limit.

Itch or itchiness: lay term for pruritus; irritating sensation in the skin. “Itch” is used by patients and professionals. “Pruritus” is rarely used in practice.

All over – everywhere, any part of the body.

Driving me mad – making me go mad or crazy.

On and off: intermittently. Also “coming and going”.

Couple of weeks – two weeks.

Moisturiser – body milk, emollient, product to improve hydration of the skin.

Honestly: frankly.

Rash: lay term for cutaneous eruption, commonly used by professionals as well.

At all? – any, big or small?

To roll up – (trousers, sleeves) to fold several times to uncover the limb in question.

Can’t stand – cannot tolerate.

Is that OK with you? –. Polite way to confirm the patient is happy with what we decide.

I appreciate it – I am grateful.

In order to – for, with the purpose of.

In 10 days time – in 10 days.

Nadia left the room and Dr. Viejo wrote on the computer:

P: Pruritus

H: 2/52 no rash, used moisturising, not improved

E: o rash, o erythema

C: Rx antihistamines, emollient, repeat TSH, review 2/52. Advised and reassured.

She didn't mind seeing patients with skin problems, as she was very keen on dermatology. She had attended an update course on dermatology 3 weeks before so everything was very fresh in her mind. A few minutes later the telephone rang.

- *Hello?*
- *Sorry to interrupt you, Dr. Viejo. This is John McDonald, a GP locum. I'm working at the practice this week. Have you got a minute?*
- *Hi there! Yes, sure. How can I help you, John?*
- *I've got a query. I've got this patient who is in her mid-twenties and has mild acne. She's got closed and open comedones in her face and pustules on her upper back. She has tried all sort of topical treatments for the past 5 years and oral antibiotics for the past 9 months. But it seems to flare up every time she stops them.*
- *I see. Is she on the pill?*
- *Yes, she has been on it for two years. She is happy to see a specialist and she has private cover.*
- *She can have a private referral, then.*
- *How shall I do it? I have no experience of private referrals in this practice and I don't know what your policy is.*
- *You should tell her to arrange an appointment with the private dermatologist and you'll have to do a GP referral letter for her insurance company.*
- *Does she need to collect it or can we fax it through?*
- *No, she would need to pop in and collect the letter before going to the appointment.*
- *Thank you very much for your time, Dr. Viejo.*
- *You are welcome. See you!*

She continued with the surgery and half an hour later the telephone rang again. It was Lou from Reception.

- *Dr. Viejo, sorry to bother you, but I've got Mrs. Smith here requesting an emergency appointment for her child, Master Joseph Smith. I know you are not duty doctor today but she insists on seeing you.*
- *My next patient is a DNA. Fit him in, please.*
- *OK, doctor. I'll call him in then.*
- *Yes, thank you, Lou.*

To be keen on: to be interested in or enthusiastic about something.

GP locum: general practitioner employed temporarily to replace another GP who is on leave.

Hi there: friendly way to say hello.

Query: question, doubt that needs solving.

Mid-twenties: 24, 25 or 26 years old.

Mild acne – acne can be mild or severe.

Comedones: the essential pathological unit for acne. They can be open, also called “**blackheads**”, or closed, called “**whiteheads**”.

Papule: elevated lesion that can be palpated above normal skin. It is less than 1 cm in diameter.

Pustule: a vesicle with a cloudy appearance due to the presence of leucocytes. May indicate infection but not always.

All sorts of – all kinds of. She has tried all types of preparations.

Topical: directly on the skin. Do not confuse with “**topic**” which is the subject of a talk or discussion.

To flare up – to have a new sudden episode with new lesions (spots). A “flare up” is one of such episodes.

To be on the pill: to take oral contraceptives.

Private cover: private medical insurance.

Private referral: referral to a private specialist by the GP.

Policy – strategy, principle, rule. A defined course of action adopted by the practice.

To arrange: to plan, to come to an agreement.

GP referral letter –. In the UK, patients usually need a letter from the GP to be seen by the specialist. This could be on the NHS or privately.

Insurance company: company that sells insurance products (in this case medical insurance).

Fax it through – send a document via fax.

To pop in – (informal) visit briefly and unexpectedly.

Sorry to bother you – sorry to interrupt you.

Master: title given to a boy, as Miss is used for single women, Mrs. for married women and Mr. for men.

Insists on seeing –. Remember the preposition and gerund here.

Emergency appointment – urgent consultation. Although the term “emergency” may sound “life-threatening” to some non-native English speakers, in practice it really means “urgent for the patient”, which very rarely is a real medical emergency.

Duty doctor – doctor on call. They usually deal with urgent patients.

DNA ★. Did not attend.

Fit her in – put her in a slot available between patients. Also “squeeze her in” (implying there is not much room available).

Mrs. Smith came into the room with the push chair. She struggled to get in, as the door couldn't open completely due to the couch behind it. Doctor Viejo's was a small consulting room.

- *Thanks for seeing us, doctor.*
- *Let me help you in.*
- *Sorry to be a pain, but here we are again. I don't know what to do with Joseph anymore. I can't bear his eczema!*
- *Tell me what happened.*
- *He has new patches all over his body! I have been giving him all the usual creams and emollients but nothing works! He keeps on scratching all day long!*
- *Let's have a look at them, OK?*
- *Sorry for my behaviour but I'm getting very anxious about it. Shall I undress him?*
- *Yes, please, the nappy as well.*

Mrs. Smith undressed the toddler completely. Dr. Viejo saw the rash Sylvia was complaining about. There was a papular rash with scratching lesions and erythema in Joseph's neck and trunk.

- *This doesn't look like eczema.*
- *Really? What is it then?*
- *Did it start on the neck and then move down to his chest?*
- *That's right. Is it dangerous?*
- *It looks like chicken pox to me.*
- *Oh my gosh! How could I not recognise it?*
- *It's not that easy. Both chicken pox and eczema can flare up as an itchy rash but with eczema you get these scaly dry patches on top of red skin and with chicken pox they are spots or blister lesions that are smaller in size and get dry and crusty on top. You can also have patches at different stages at the same time which you won't find with eczema.*
- *And how do you know it is not another kind of skin infection like scabies?*
- *Because scabies lesions look different, they are spots localised mainly on the wrists and between fingers and they are very itchy.*
- *I see. What should I do then? How are you going to treat it?*
- *Emollients and an itchy relief cream like calamine lotion will do the trick. You should also be aware of the alarm signs and come back if he gets a high temperature or if he is lethargic and weak.*
- *Thank you, doctor. Is it contagious?*
- *Yes, you should keep him at home and not allow him to spend time with other children for at least 5 days.*
- *That sounds reasonable to me.*

Push chair: a chair on wheels for transporting babies and young children.

Struggled to get in – entered the room with difficulty.

Help you in – help you enter the room.

Sorry to be a pain – sorry to disturb you repeatedly.

Can't bear – can't tolerate, can't stand.

To calm down – to relax.

Scratch – rub the skin with the fingers to relieve the itch.

Toddler: a young child learning to walk.

It looks like ... to me – I think it is ...

Chicken pox: lay term for varicella, used by patients and professionals. Nobody says “varicella” really.

Oh my gosh! – “Oh my God!”

It is not that easy – it is not as easy as you may think.

Scaly: with scales. **Scale:** flake of dead skin. Scaly patches are typical of eczema and psoriasis.

Patch: flat non-palpable lesion greater than 2 cm in diameter.

Crusty: with a crust. **Crust:** dried serum or pus on the surface of a ruptured blister or papule.

Scabies: parasitosis by *Sarcoptes scabiei*.

To do the trick – to achieve the desired effect or result.

To be aware of – To be informed, to be alert. In this case, to know or to look for any differences or changes in the skin.

Lethargic: drowsy, sleepy.

That sounds reasonable to me – she agrees with the doctor's recommendation. Also “that sounds OK to me”, “that is OK with me”.

Other expressions of interest:

Alopecia: hair loss or hair thinning. Age-related or familial lack of hair, particularly in men, is called **baldness**. People with no hair are **bald**.

Vitiligo: patches of depigmented skin (discoloration).

Felon. A purulent infection involving the bulbous distal end of the finger.

Paronychia. Suppurative inflammation of the nail fold surrounding the nail plate.

Lay terms:

Shingles. Herpes zoster.

Ringworm. Dermatophytosis.

Dr. Viejo wrote on the computer:

P: Rash

H: rash for 48 h, from neck to torso, itchy, no temp.

E: happy child, macular and papular rash on trunk. Scratching lesions.

C: ?chicken pox. Emollient advised, alarm signs given and reassured.

- *Dr. Viejo, while I'm here I would like to ask you something about myself. It will be just a minute.*
- *What is the matter, Sylvia?*
- *I'm very worried about a mole on my belly. It has changed colour lately. I've heard so many horrible stories about melanomas that I'm very scared! My best friend, Miranda, had a sort of skin cancer last year.*
- *Let me have a look at it ... How long have you had it for?*
- *It's been there forever but changed just recently.*
- *It looks quite regular in shape and colour. Has it ever bled? Is it itchy?*
- *No, doctor. It just looks different to how it used to.*
- *It seems to be a common melanocytic naevus or pigmented lesion with no malignant signs. That doesn't mean you should forget about it; in fact, you will need to keep an eye on its size, colour and border irregularity. How much time do you usually spend under the sun during the year?*
- *I go on holidays twice a year, usually to Spain. But I always take the sun cream with me!*
- *That's OK, then. If any of the signs that I mentioned before occur, then you should come back. Sometimes a diagnosis of a melanoma cannot be ruled out and a biopsy should be performed.*
- *I will do. Cheers!*

When she had finished with her last patient of the morning, someone knocked on the door. It was Mike, the practice nurse.

- *Have you got a minute, Ana?*
- *Sure, what is it about?*
- *I know you are good with dermatology and I would like to double-check something with you.*
- *OK, go on.*
- *I've seen a patient with some red flaky lesions on his elbows and knees for a fortnight. I suspect it could be psoriasis, but I am not sure. Could you have a quick look?*

?chicken pox. Note the “?” sign at the left of an uncertain diagnosis. This is read “query chicken pox”.

What is the matter? – What is wrong?

Mole: lay term for naevus.

Bled: past of bleeding.

To keep an eye on it – to follow up.

To rule out: exclude.

Go on: continue.

Flaky: with thin crisp fragments called “flakes”.

Fortnight: two weeks.

Localised skin lesions

Lay terms

Flat lesions

Macule < 1 cm

Patch > 1 cm

Spot; if pigmented: **mole**

Patch

Raised (palpable) lesions

Papule < 1 cm

Plaque > 1 cm flat surface

Wheal: urticarial lesion

Nodule > 1 cm

Spot

Patch

Spot

Lump

Fluid-filled lesions

Vesicle < 1 cm

Bulla > 1 cm

Pustule: papule with pus

Furuncle

Blister

Blister

Infected spot

Boil

Other lesions

Crust (dried tissue on excoriation)

Verruca

Scab

Wart

Scales are flakes of dead epidermic tissue; you may see a **scaly rash** or a scaly scalp, for example.

A **wound** is a break in the skin due to injury (trauma or surgery). After healing, it may leave a **scar**.

A **scratch** is a superficial linear wound. A **laceration** or **tear** is a deeper one.

Sore is a common term used for **erosions** and **ulcers** of the skin.

Pressure sore: decubitus ulcer.

Cold sore: herpes simplex.

Dr. Viejo went to the treatment room and saw the patient's lesions on the extensor aspects of elbows and knees. They looked like thick scaly plaques with a well-defined border.

- *I think these are typical psoriasis plaques.*
- *So that confirms my suspicions.*
- *Have you checked the nails for "pitting"?*
- *Yes, but they are clear.*
- *[Addressing the patient] Is there family history of psoriasis?*
- *Yes, my mum has it as well, so I am familiar with it.*
- *You will know then that a wide range of treatments are available nowadays. We should start with the topical medication but phototherapy and systemic therapy could also be used, mainly when the condition is too extensive for topical therapy alone.*
- *What shall I try first then?*
- *Let's start with moisturisers twice daily and tar ointment q.d.s.*
- *And if it is not effective?*
- *Then we will add the high-potency topical corticosteroid. But be patient and persevere with the emollients.*

The doctor printed a script and arranged a follow-up appointment in 10 days time.

- *We'll see how it goes. Good-bye, Mr. Plack. See you later, Mike.*
- *Thank you for your time, Ana.*

The morning was over. Dr. Viejo had a couple of referral letters to dictate and one telephone call to make before going to lunch. She was pleased with her first morning after the holidays. Not bad, it could have been worse ...

Extension aspects – the extension areas of elbows and knees.

Plaque: elevated lesion. It has a flat top and edges are either distinct or blend into surrounding skin. They are larger than 1 cm in diameter.

Pitting: little holes or cavities on nails.

They are clear – they have no lesions.

Wide range of treatments – many different treatments.

Tar ointment: thick ointment used for the treatment of psoriasis. Tar is a thick black liquid obtained through coal distillation.

Stuff – It is a very informal way to say “things”. In this case it means creams.

Script – a very common way to say prescription (the physical paper).

The morning was over – the morning ended. It was finished.

Professionals and equipment

The medical specialist in skin problems is the **dermatologist**.

The specialised surgeon is the **plastic surgeon**.

Some general practitioners perform **minor surgery** procedures to treat some skin or soft tissues lesions, such as incision and drainage of abscesses, cryotherapy for warts, curettage, excision of sebaceous cysts, skin biopsies or joint injections. Some instruments used are:

- For cutting: **scalpel**, suture scissors.
- For holding: dissecting **forceps**, artery forceps, needle holder, retractors.

When suturing a non-continuous surgical wound, the doctor ties several knots leaving the patients with several **stitches**, which will be removed a few days later by the nurse using a stitch-cutter.

Dressings may be used to cover and protect a wound and **bandages** may be used to wrap the dressing around a part of the body to keep it in place. Some strips of adhesive **surgical tape** may be needed to secure the dressings or bandages.

Dressings are often square shaped and made of a gauze material with or without substance to help the healing (e.g. antibiotics). Dressings may have adhesive borders (brand name Mepore) or may be non-adhesive (abbreviated N-A dressings).

bald [bôld] vitiligo [vīt'l-ī'gō] erythema [erythema] impetigo [īm'pī-tī'gō]

Old Age

with Amaia Foces

After a busy morning in the surgery, Dr. Amaia Foces popped into reception to find out how many home visits were requested. Looking at the visits book, she noticed at first sight that Mr. Jones' daughter, Shelley, was requesting a home visit for her dad. Mr. Jones was an 80-year-old patient living on his own. He was usually in good health and only visited the surgery for coughs and colds; he was not currently on medication. As he used to say "he didn't like to bother the doctors" or "make a fuss over nothing". Dr. Foces knew him socially as she lived close to the sheltered flat that he owned. So she decided to visit him on her way home. Shelley, Mr. Jones' daughter, was supposed to be waiting there until Dr. Foces arrived, but she gave the receptionist her dad's key code just in case.

- *Good afternoon, Shelley. How is your dad? I was surprised to see that he needed a visit.*
- *Oh, sorry to bother you. I know you are very busy.*
- *Not at all, it's always a pleasure to see your dad. What can I do for him today?*
- *Well, he has been getting down a lot recently, more so than usual. At first I thought he was a just little bit under the weather as it's close to the anniversary of my mother's death and he always gets a little low around this time. But now I'm really worried. For the past week he has been having silly falls and now he finds it very hard to get out of bed. I even think that he does not recognise me sometimes.*
- *Does he have a temperature?*
- *I wouldn't know, I haven't got a thermometer but he does seem hot.*
- *Has he opened his bowels at all? Are his waterworks OK?*
- *Funny you should ask that, doctor, I have noticed that he leaks urine now and again.*
- *Let's have a look at him, then.*
- *I don't know if he'll speak to you, doctor. He seems particularly confused today.*

Dr. Foces went into the bedroom and found Mr. Jones in bed.

- *Good afternoon, Mr. Jones. It's Dr. Foces here.*

She didn't get a reply, as Mr. Jones appeared to be sleeping and couldn't keep his eyes open for long. He just mumbled a few words and closed his eyes again.

At first sight: with only a quick initial look.

Living on his own – living alone. These patients often require a **care package** from Social Services consisting of regular visits, help with meals, etc. Other patients live with a relative or friend who acts as a **carer**. Caring may be hard so carers are sometimes offered **respite**: somebody else cares for the patient while the usual carer has a rest or holiday.

Still, caring for a very dependent person may become so hard that the carer cannot cope any longer (informally called “carer(s) acopia”). The patient may then need to move to a **care home**, of which there are two types in the UK: **nursing homes**, staffed with nurses, and **residential homes**, staffed with professional carers. Elderly patients may be **unsettled** in the first weeks of their move (confused, depressed, aggressive, etc.) but will usually **settle** gradually.

To bother: to disturb.

Make a fuss: protest exaggeratedly. A “fussy” person is someone who easily complains about things. Do not confuse with “fuzzy”, which is applied to something unclear, blurred, not sharp enough to be seen, heard or understood properly.

Sheltered: protected. **Sheltered flat** –. Some elderly people live in apartments that have a warden or guardian that checks on them every day and does a few tasks for them, if needed. They might have communal areas to watch TV and for residents to meet each other if they want.

Key code –. Many elderly patients living on their own are not mobile enough to open the door to health professionals. They have a tiny safety box outside the door that contains the key for the house. It can be opened with the key code.

Get someone down: to depress someone. **Under the weather:** feeling a bit sad or unwell.

Low: sad, depressed. **Silly:** stupid. **Temperature:** fever.

I wouldn't know – I don't know, I can't know. “Would” is used in practice in more varied ways than you learn from English textbooks.

Open bowels (“number two”): pass stools. **Pass water (“number one”):** pass urine.

Funny can have several meanings: (a) amusing, fun, which has a positive connotation; (b) strange, unusual, generally with a negative connotation; (c) curious, interesting. Do not confuse with **fanny**, a not very elegant name for the female genitals.

You should ask – that you ask. The word “should” is used in practice in more varied ways than you learn from English textbooks.

Leak: escape of fluid. **Leaking:** mild urine (or stools) incontinence.

Now and again: sometimes, but not very often.

Mumble. To speak or utter something quietly and unclearly without opening the mouth very much.

carer [c âr ûr] respite [rës'pīt] fuss [fūs] pleasure [plëzh'ər] thermometer [thər-möm'ī-tər] particularly [pər-tīk'yə-lər-lē]

Dr. Foces proceeded to examine him and wrote down in her notes:

Call via daughter – c/o functional decline, recurrent falls for the last 2/52. Worsening for the last 2/7. Confusion. Normal bowels. Occasional urine incontinence.

O/E – Well hydrated, confused, afebrile. BP-100/6

CNS – Difficult examination as poor cooperation. PERL. Grossly intact.

HS – I+II+0

Chest – clear

Abd – NAD

Urine dipstick (from pad) – Leucos ++, Nitrates +ve, Prot +ve.

After the examination, Dr. Foces explained her thoughts to Shelley:

- *He might just have a water infection, as it's very common in elderly people to get confused and be prone to falls; however, I wonder if he might have had a mild stroke or whether there is something neurological going on. I would like the district nurses to come in to do some blood tests and to try to collect a proper water sample. Meanwhile, I'll start him on a course of antibiotics and we'll review him in 2 days time. Feel free to ring me earlier if you are worried or if he deteriorates further. Is that alright with you?*
- *Yes, doctor, thanks for calling in.*

Dr. Foces wrote down:

Dx: ?UTI. ?CVA

Plan: 1 – MSU

2 – FBC, BS, TFTs, U&E

3 – Rx TMP 200 mg 1 bd×7/7

4 – F/U 2/7.

Dr. Foces received the test results 2 days later. She noticed that the MSU was negative and the blood tests were normal. She rang Shelley:

- *Good morning, Shelley, it's Dr. Foces here, how is your dad?*
- *Not very well, doctor. To be honest I can't see any improvement.*
- *I've got the test results back and they look normal. There is no evidence of a water infection or any other abnormality in the test to help me with the diagnosis; however, antibiotics can mask the results and as we started your father on antibiotics before collecting the water sample this may have influenced the test somewhat. From what you have said about his lack of improvement there is a possibility that there might be something neurological going on as he should have*

C/O. Complains of. **2/52:** two weeks. **O/E.** On examination. **BP.** Blood pressure. **CNS.** Central nervous system. **PERL.** Pupils equal reacting to light. **HS- I+II+0:** heart sounds normal. **Chest clear:** normal lung sounds. **NAD.** No abnormality detected. **+ve:** positive. **-ve:** negative.

Pad. Soft material used to protect something (the underwear in this case). Elderly patients often use **incontinence pads**.

To be prone to: to have a tendency to, to have increased probability of.

Mild: of little severity.

Stroke. Word used commonly for **CVA ★** (cerebro-vascular accident). The noun “stroke” in this case is related to the verb “**strike**”, which means “to hit”. Paradoxically, the verb to “**stroke**” is to gently move your hands over somebody’s skin or hair, usually with affection. **Stroke** therefore can have two very different meanings: (a) a CVA; or (b) a caressing gesture.

A CVA may present with limb weakness (**hemiparesia**), impaired speech: inability to find words (**dysphasia**) or to articulate them, resulting in **slurred speech (dysarthria)**, impaired **gait** (ataxia), etc.

Patients sometimes call a “mini-stroke” what doctors call **TIA ★** (transient ischaemic attack).

A **confused** patient is disoriented and often incoherent. Confusion may be due to a number of causes including infections and **iatrogenia**. Cognitive impairment or **cognitive decline** may be the start of dementia. Some demented patients present with **agitation** and **restlessness** requiring tranquilisers.

Whether: if. Do not be confused with **weather:** climate or meteorological conditions. Both words are pronounced in the same way.

Further – more.

Calling in: visiting.

UTI. Urinary tract infection. **MSU.** Mid-stream urine.

FBC: Full blood count. **BS.** Blood sugar. **TFTs.** Thyroid function tests. **U&E.** Urea and electrolytes. **Rx.** Prescription. **TMP.** Trimethoprim. **b.d.** twice a day. **F/U:** Follow up. **2/7:** two days.

Somewhat: a little, a bit, in some way.

Lack of improvement – no improvement.

Going on – happening.

By now is used when something should have happened before the time we are speaking. It can also be used for the past (it should have happened by then) or the future (it needs to happen by ...). For example, “the blood test results should be back by Monday”.

improvement [ɪm-prōv'mənt] antibiotics [ant-i-bī-ät-iks] dysphasia
[dis-'fā-zh(ē-)ə] Alzheimer [Awlz'hī mēr]

started responding to the antibiotics by now. I would like to speak to the registrar on call at the hospital to see if they can run another test and an MRI scan. Are you happy for him to go to the hospital?

- *Of course, doctor, whatever you think is best.*
- *As he was such a healthy chap before, I think that is the proper thing to do. I'll speak to the registrar and try to get your dad admitted today.*
- *Thanks, doctor.*

Dr. Foces spoke to the registrar, who was happy to see the patient:

- *Sure, just send him to the EMU.*

Then, Dr. Foces rang the ambulance service to arrange the transport:

- *Is it a Blue-Light ambulance doctor?*
- *No, said Dr. Foces, it can wait 1–3 hours.*
- *Chair or stretcher?*
- *Stretcher, please.*

Mr. Jones was diagnosed with a subdural haematoma probably as a consequence of one of his falls, which were attributed to a UTI. The haematoma was drained and he quickly recovered and was sent back home.

Chap: informal way to say man.

EMU. Emergency Medical Unit.

The Blue-Light Ambulance: Emergency service attending within the hour.

Stretcher: couch.

Drained: evacuated.

Other expressions of interest:

The *Barthel ADL Index* (Activities of Daily Living) gives an idea of how independent an elderly person is by taking into account the following factors:

- *Bowels* – whether they are **continent** or incontinent. **Faecal incontinence** may be due many reasons including faecal **impaction**.
- *Bladder* – whether it is continent, incontinent or **catheterised**. Urine incontinence may be due to many causes including **unstable bladder** and retention with **overflow**. A **commode** may be used by elderly persons who cannot reach the toilet on time. It is a chair with a toilet as seat.
- *Grooming* – whether they need help with personal care (face, hair, shaving, teeth).
- *Toilet* – whether they need help or not, e.g. **wiping** (cleaning themselves using **toilet tissue**).
- *Feeding* – whether they need help to eat their meals.
- *Transfers* – whether they can sit and stand up **unaided** (without help).
- *Mobility* – how mobile or immobile they are. They may need assistance from someone or the help of a walking aid (walking stick or walking frame) or a wheelchair. We may say that mobility is “good”, “fair”, or “poor” in decreasing order. Patients with impaired mobility may have **recurrent falls** with possible **hip fractures**. Patients who stay in bed may develop **pressure sores** (ulcers). A special **mattress** (bed’s soft platform) may be used to avoid them.
- *Dressing* – whether they are able to dress themselves, including fastening buttons and **zips**.
- *Stairs* – whether they are able to climb or **negotiate** stairs.
- *Bathing* – whether they can bathe or shower unsupervised.

Elderly –. An elderly person is a person of old age. “The elderly” are all these persons considered collectively. Nowadays, the expression “old age” is starting to be preferred to “elderly”.

Professionals. The medical specialist in **geriatrics** is the **geriatrician**. **Community teams** of health professionals provide care at home and may include chiropodists, occupational therapists (**OT** ★), physiotherapists, etc. The audiologist performs hearing tests and **fits** hearing aids; the optician performs eye checks and provides prescription glasses (e.g. for **presbyopia**) or suggests surgery for **cataracts**, for example.

subdural [səb- dyöör“əl] haematoma [hē“mə-tō“mə] faecal [fē“kəl] catheterised [kāth“-ī-tə-rīz“] wipe [wīp] tissue [tīsh“ōō] bath [bāth] bathe [bāth] bathing [bāth ing] geriatrician [jēr“ē-ə-trīsh“ən]

Palliative Care

with Concha Gonzalez Prieto

Dr. Concha Gonzalez was catching up with her clerical work at lunchtime – a rushed sandwich and lots of paperwork, when one of the receptionists called her to tell her that Mrs. Rae was on the phone “wanting a word”. Although Dr. Gonzalez knew that taking the call might mean finishing the paperwork at the end of the day, she knew that Mrs. Rae was struggling to cope with her husband’s illness. Mr. James Rae was an 84-year-old man suffering from terminal lung cancer and, although the Palliative Care team plan was in place, his wife was becoming increasingly anxious.

- *Hello, Mrs. Rae, what’s on your mind?*
- *Oh, good, Dr. Gonzalez, the district nurse told me to call you “cos Jim isn’t managing to get his tablets down and he’s getting sleepier and sleepier. I’m worried that maybe his time is up and I’m not sure what to do.”*

Dr. Gonzalez sensed carer anxiety and genuine coping difficulties especially from her previous dealings with Mrs. Rae. She had had last been to their house 10 days before and, although Mrs. Rae was still sharp, she was not physically strong and her husband’s illness was taking a heavy toll on her health, too. Dr. Gonzalez replied:

- *OK, don’t worry, it sounds like we will just need to make some changes to Jim’s medication to help him feel more comfortable.*
- *Oh, I see, doctor, so how long do you think he has got?*
- *It’s impossible to say, Mrs. Rae, it sounds like the illness is progressing, but all this is expected and manageable and it will still take a little time.*

As Dr. Gonzalez knew that Mrs. Rae was the sole carer, she asked:

- *Have you got any family or friends close at hand?*
- *Yes, my neighbours are always in and out, doing the shopping and keeping me company, you know.*
- *Well, that’s good to hear. Now, don’t worry and I’ll talk to the nurse at the hospice and arrange a visit to see you tomorrow and we can talk it all through and I can have a look at how Jim’s getting on. Together we can make sure that we make him as comfortable as possible.*

Palliative care: the treatment and care/support offered when an illness is terminal.

Catching up: completing and updating a task left incomplete.

Clerical work – papers dealing with administration, letters dealing with test results, writing or responding to referral letters and, in general, anything that is not face-to-face clinical work.

Wanting a word – wanting to speak to.

Struggling to cope – finding difficulties to manage or deal with the problems or challenges.

Palliative Care team: the group of professionals who contribute to the care of the dying patient and his/her carers and immediate family. It includes nurses, hospice staff and doctors with this special training.

Increasingly – more and more.

Anxious: worried, nervous, preoccupied. **What's on your mind?** – What is the problem worrying you?

"cos": because.

District nurses – nurses who attend homes to see patients who cannot leave home, e.g. elderly or house-bound.

Isn't managing to get his tablets down – cannot swallow/ take the medication.

Sleepier and sleepier – more lethargic, less awake or less conscious.

His time is up – he is going to die.

Sensed – noticed, recognised.

Carer anxiety: the feelings of panic/worry felt by the person looking after a patient.

Dealings – contact/meetings/conversations.

Sharp – intellectually healthy, no signs of dementia (also: with all her/his marbles).

Taking a heavy toll – having a negative effect, with a high cost (not financial but on emotional and/or physical health).

How long do you think he's got? – How much time is there until death?

Sole: the only one.

Close at hand – near (to offer help).

In and out – frequently visiting as they live near.

Hospice – specialist Palliative Care unit within a hospital or a small separate unit.

Talk it all through – discuss the details together.

... how Jim's getting on – what condition the patient is in. In other contexts it means progressing.

palliative [pāl"ē-ā'tiv] struggle [strüg"əl] manageable [man-ij-ə-bəl] hospice [hös"-pīs]

What time will that be, do you think? You know I like to have everything looking ship-shape.

- *I can't say for sure, but it'll be after morning surgery, so around lunch-time.*
- *Lovely. Thanks, doctor, see you then.*

Mrs. Rae did not hang up straight away and Dr. Gonzalez was aware that she was not completely reassured. She said:

- *Remember that you can call the hospice any time, day or night.*
- *But you don't think I'll lose him today, do you?*
- *It seems unlikely, but I'll ask the district nurse to pop in and see you this afternoon.*
- *Thanks so much, doctor. I'll see you tomorrow then.*

Dr. Gonzalez hung up and pulled up Mr. Rae's case notes on the computer, abandoning all hope of completing the clerical work until after the afternoon surgery.

She wrote on the computer:

P: Lung Cancer

*H: Signs of deterioration, diff. in swallowing meds, ^^confusion
Wife anxious of imminent death.*

C: Plan – home visit with Pall Care nurse mane, to probably change to sbc medication and assess carer's needs.

Dr. Gonzalez (DG) then rang Mrs. Holland (MH) (Palliative Care nurse from the local hospice) who was involved in the case to arrange a visit together the following lunchtime.

The next day they arrived at the Raes' home, a small council flat on the ground floor.

DG – Hello, Mrs. Rae, what sort of night did Jim have?

MH – Hello, Bessie, how are you doing today?

Mrs. Rae – Oh, it was an awful night! He was fighting for his breath all night, shouting and getting all hot and bothered and not making any sense. I was scared and I don't think I slept a wink.

DS – Right, then, let's go in and have a look at how Jim is now.

Doctor Gonzalez and Mrs. Holland went in to see Mr. Rae. Mrs. Rae came in, too. He was sleeping, drifting in and out of semi-consciousness and groaning as if in pain. Dr. Gonzalez examined him and noticed that his skin was a bit dry and his tummy was hard and felt loaded. She asked Mrs. Rae:

Ship-shape – tidy, clean and organised.

Note that if the patient asks *Are you coming to visit me?* You should respond *Yes, I am coming* – not *Yes, I am going*, as ‘going’ may be understood as ‘going away’ if you do not specify where you are going.

I’ll lose him – the patient will die. When you **lose** [verb] something or somebody you suffer a **loss** [noun], and when you don’t know where you are you say you are **lost** [adjective]. Do not confuse lose with **loose**, which means not enclosed, not fixed, free to move, relaxed, with no restrictions.

Loose trousers are those that are too big for you.

To pop in – to visit for a short time.

To hang up – to finish a phone conversation.

Pulled up – to access the computer medical record of the patient on the screen.

Notes on the computer are often in abbreviated forms:

Diff – difficulty.

Meds – medication.

^^ – increased/more.

mane – tomorrow morning.

sbc – subcutaneous.

A person who has **died** [past participle of to **die**] is said to be **dead** [adjective] or **deceased**. Do not confuse “to **die**” with “to **dye**” [pronounced the same] which is to give colour to something using a colouring substance such as a tint for the hair. Do not confuse **diseased** and **deceased** [pronounced differently]: the former means ill, the latter means dead.

Council flat – housing supplied by the state, rent and bills paid by the tenant (occupant).

Fighting for breath – having difficulty breathing.

All hot and bothered – upset, nervous, agitated.

Not making any sense – confused in what he was saying.

Slept a wink – no sleep at all (a wink is a quick opening and closing of the eye) (also **40 winks** – a siesta).

Drifting in and out – semi-conscious, no control over consciousness.

Groaning – low sounds indicating suffering or discomfort/pain.

Tummy – stomach area/abdomen.

Loaded – with a palpable mass of faeces felt in the colon showing constipation.

deteriorate [dĭ-tĭr"ē-ə-rāt"] death [dĕθ] died [dīd] dead [dĕd] die [dī] dye [dī]
diseased [dī-zēzd"] deceased [dī-sēs'd] awful [ô"fəl] scared [skârd]

- *How long has it been since he opened his bowels?*
- *I'm not sure, ... about 4 days ago.*
- *Has he been drinking anything at all?*
- *He hasn't had much for the last couple of days, and he hasn't eaten anything either. He won't take anything.*
- *Don't worry about that, Mrs. Rae, it's perfectly normal and he doesn't need to eat at this stage. The body doesn't need much energy as it is slowly shutting down. I'm sure he'll be more comfortable if we give him some fluids under the skin and some more medicine at the same time to help with any pain that he may be having.*

Doctor Gonzalez and Mrs. Holland had discussed the case on the phone and decided to start Mr. Rae on a syringe driver. Dr. Gonzalez then explained this to Mrs. Rae:

- *What we're going to do is put a syringe in, which will stay put for 2 or 3 days and then we can give him fluids and medicine without him needing to swallow them. This is called a syringe driver. Nurse Holland is just going to check him over.*

On examination she noted that he had two pressure sores on his lower back. She explained:

- *We'll get the district nurses to dress these sores and I'll also ring the Social Services to get Jim a hospital bed.*
- *Oh, dear, do you mean he's got to go into hospital again?*
- *No, no, I mean that we will get a bed brought here and set up to help make him more comfortable.*

Dr. Gonzalez asked:

- *Has Jim talked about whether he would prefer to die at home, Mrs. Rae?*
- *Oh, yes, doctor, he has always said that he didn't want to go in some big, empty place. I'm sure he'd prefer to quietly slip away in our own house.*
- *That's fine, Mrs. Rae. All I need to do is to make sure that you've got all the contact numbers you might need in case you need any additional help. Do you have a list of numbers at hand?*
- *Yes, I've got everyone's number ... eh the surgery, the district nurse, the hospice on a piece of paper in the kitchen next to all the medicines. But whom do I phone when he goes?*

When this happens, don't panic. Phone the surgery if it's during the day and if it's at night just ring the Out of Hours Service. You can, of course, ring family or a friend, too. The doctor will come to certify the death and then you can contact the funeral directors afterwards to start the arrangements. Remember not to call for an ambulance as they will take Jim to hospital and we know that he would prefer just to be here at home.

- *Oh, right, I think I've got it. I should just call the doctor, then.*

Open bowels – to excrete faeces. Other expressions include: **to poo**, **to do a number 2**, **to go (to the toilet)**.

Shutting down – closing down, stopping, organ function is slowing towards death.

Syringe driver – a small battery-operated infusion pump to deliver medication to subcutaneous tissue.

Check him over – to have a look, to give a quick examination.

Pressure sores: a painful ulceration or area of extensive subcutaneous destruction to the tissue due to uninterrupted pressure on the area.

Dress: to cover and treat ulcer or skin lesions (in this case, NOT to put clothes on).

Hospital bed – a special bed used in hospitals. Here the confusion is caused by the fact that Mrs. Rae thinks that they are talking about organising a bed for her husband IN hospital. It is explained that the bed will be delivered to the house.

Get a bed brought – to arrange for people to bring a bed to the house.

To set up – to prepare for use.

He didn't want to go ... – (here) to go means to die.

To slip away – to quietly die.

At hand – nearby, easily accessible.

Don't panic – Do not do anything without thinking.

Out of Hours Service – the service offered after 6.30 p.m.; a team of deputising GPs offer this service to the patients of several local surgeries. Also offered at weekends.

To ring – to telephone.

Principles of drug prescribing in advanced disease

- *Prescribe drugs proactively for persistent symptoms.*
- *Each new drug should be perceived to have benefits that outweigh potential side effects (burdens) in the context of the patient's condition.*
- *Consider drug interactions.*
- *Appropriate route of administration.*
- *Avoid polypharmacy – stop medications that are no longer appropriate or have not worked.*
- *Regular review.*

couple [kʊpˈəl] either [ēˈthər, ɪˈthər] comfortable [kʊmfəˈtə-bəl]

Mrs. Holland added:

- *Remember, Bessie, we'll be in and out every day to check how he's doing and I'll leave you a note of what to do so you can look at it before you phone.*
- *Oh, lovely, thanks so much, both of you, I think I know who to turn to now and as long as Jim's not in any pain then it should be alright. It's just that he's not been at all himself these last couple of days and I didn't know if that meant I was going to lose him any minute.*

Dr. Gonzalez and Mrs. Holland said their good-byes and Dr. Gonzalez added:

- *Well, Mrs. Rae, we'll leave you now, but the district nurse will be back later today to fit the syringe driver we talked about and that should mean you will both have a quieter night.*
- *Thanks again.*

Dr. Gonzalez and Mrs. Holland talked, as they left the house, about the imminent bereavement. They agreed that it would not be difficult as it was expected and all the support was in place. Hopefully, the support of family and friends would make her husband's death less stressful. Although Mrs. Rae was in generally good health, they talked about the need to keep an eye on her during the months following the bereavement in order to avoid any decline in both her physical and emotional well-being.

Dr. Gonzalez went back to the surgery and completed the following notes on the home visit.

P: Cancer care plan

H: Decline in health, poss v near death, bed sores

C: Arrange for syringe driver to be set up, hospital bed to be supplied, instructions given to carer on action to take in case of death. Reassured and supported.

Dr. Gonzalez had a quick cuppa before starting her afternoon surgery.

Certify the death – the attending doctor must complete a death certificate listing the cause of death when this was expected. If not expected, the case will go to the Coroner's Office (legal office) to recommend a PM (post-mortem)/autopsy to find the cause of death.

Funeral Director – the companies who offer the service of preparation for funeral/cremation.

I've got it – I understand.

Who to turn to – who to contact for help.

He's not been himself at all – he has not been acting normally/not been well.

Bereavement: the death of a loved one, family or friend.

To keep an eye on – to monitor, check.

Grief: the process of pain following the death of a loved one when changes have to be made to adapt to the new situation. The affected persons are said to be **grieving**, or grieving the death of the loved one. Also referred to as **mourning**. Note the difference between mourning and **morning** (pronounced the same, which means the part of the day before 12 noon).

Decline: to get worse. In other contexts it can mean to say no/refuse.

Well-being – health in a wider, more general sense.

Poss – possibly

v. – very

tb – to be (will happen in the future)

A cuppa – a quick cup of tea (or coffee).

What is a good death?

- *To know when death is coming, and to understand what can be expected.*
- *To be afforded dignity and privacy.*
- *To have control of what happens; to have control over pain (and other symptoms) relief; to have control over who is present and who shares the end.*
- *To choose where to die.*
- *To have access to information and expertise of whatever kind is necessary; to any spiritual or emotional support required; to hospice care in any location, not only in hospital.*
- *To be able to issue advanced directives which ensure wishes are respected.*
- *To have time to say good-bye and control over other aspects of timing.*
- *To be able to leave when it is time to go, and not to have life prolonged pointlessly.*

ambulance [āmˈbyə-ləns] bereavement [bɪ-rēvˈ mɛnt] grief [grɛf]

- Are you happy to see patients with cancer?
- Happy??!!! Oh, no, certainly not! I feel very sorry for them



LALANDA

Unit X Applying for a Job in General Practice

If you want to work abroad and have found an *advert* for a post you are interested in, you may, according to the instructions in the advert:

- Send your CV; or:
- Request from the recruiter an *Application Pack*, which usually contains a *Job Description*, *Person Specification*, *Practice Profile* and an *Application Form*.
Next, you would send them your completed *Application Form* and CV.

If, on the basis of this documentation, the recruiters decide to **short-list** (select) you, they will invite you to attend a *Job Interview*. If you are successful in the interview, your potential employer will offer you the post. If you accept, the practice **appoints** you (as GP salaried, for instance) **to** their team.

Advert

A typical advert for a GP vacancy in the BMJ (British Medical Journal) could read:

<i>Salaried GP required</i>	(1)
<i>5–6 sessions</i>	(2)
<i>£ 70K pro rata</i>	(3)
<i>Leading to possible partnership</i>	(4)
<i>List size 10,200</i>	(5)
<i>No OOH</i>	(6)
<i>Modern premises across two sites</i>	(7)
<i>EMIS Paperlight</i>	(8)
<i>High QOF achievement</i>	(9)
<i>MDU subscriptions paid</i>	(10)
<i>Five weeks' annual leave and 1 week study leave</i>	(11)
<i>Diverse ethnic patient mix</i>	(12)
<i>Inner-city area</i>	(13)
<i>Job share considered</i>	(14)
<i>For more information or to arrange an informal visit, contact manager@practice.org.uk</i>	(15)
<i>Closing date: 30 June 2008</i>	(16)

1. **Salaried:** the *partners* of the practice will employ you and pay you an agreed salary.
2. **Sessions:** number of half-days to be worked per week. Each session is approximately 4–5 h.
3. **K**=1,000; therefore, £ 70 K=£ 70,000. **Pro rata:** this is the salary per year for the equivalent full time post. *Full time* usually means nine sessions per week, but it could also be eight or ten. In this example, if the practice considers ten sessions as full time, then they would pay £ 35,000 per year to a five-session salaried GP.
4. **Leading to a possible partnership** – After a successful period of working as part of the team, your partner colleagues may offer you a *partnership*. If you accept you will be able to participate in the management of the practice and have a share in the yearly profits (if any).
5. **List size**=practice population=number of patients registered with the practice.
6. **OOH:** Out of hours: primary care “on call” services between 6.30 p.m. and 8.00 a.m. and weekends.
7. **Premises:** building. **Two sites** (or branches) – two buildings in separate locations. (This means that you may need to work in different places on different days.)
8. **EMIS:** clinical software. **Paperlight** – A practice may try to use as little paper as possible doing most of their work on computer.
9. **QOF:** Quality-indicators framework. The practice has good results in the yearly audit of clinical indicators.
10. **MDU:** Medical Defence Union: a British professional insurance organisation. Another one is **MPS** (Medical Protection Society). They pay for any legal consequence of your medical errors – and also advise on how not to make them.
11. **Annual leave:** holidays. **Study leave:** days off for courses, etc.
12. **Diverse ethnic patient mix** – the patients are of different ethnic groups.
13. **Inner city:** suburban area, usually of low socio-economic level.
14. **Job share** – the six sessions could be done by two salaried GPs, e.g. three sessions each.
15. **@** –. When reading E-mail addresses, the symbol @ is pronounced “at”. This symbol is also used informally to mean “at” in other contexts, for example, “*we are meeting @ 2 p.m. @ the practice*”.
16. **Closing date**=deadline for applications=the last day you can present your application or CV.

Application Pack

Job Description

This document contains the characteristics of the job, aims, tasks, working conditions, etc.

Person Specification

This is a list of skills and attributes that are required for the job, or that the employers want from the person they intend to employ. Some of these attributes would be “essential” and others would be “desirable” (preferred but not essential).

For example:

	<i>Essential</i>	<i>Desirable</i>
<i>Qualifications</i>	Certificate of Vocational Training in General Practice	MRCGP
<i>Clinical experience</i>	Minimum 5 years in General Practice	Emergency Services
<i>Clinical skills</i>	Competent to work without supervision as a GP	Family Planning
<i>Personal skills</i>	Good communication skills in English	Other languages
	Flexibility	Evening availability
	Good team-worker	Good team leader
	Stamina	

Stamina: lasting energy that makes you able to do something for a long time. You have a lot of it if you are a hard worker.

Practice Profile

This lets you know what kind of practice it is: the practice population, the staff, the organisation, aims and style.

Application Form

This form contains the details that your potential employers want to know from you, in order to decide whether they will short-list you or not, i.e. whether they will interview you or not. It provides spaces for you to write all answers. It may include CV information or you may need to attach your CV separately.

Curriculum Vitae

The curriculum vitae (CV) should be clear in appearance and concise in content. There are many ways to do it. The following is a structure suggested by the British Department of Health:

Personal details: Name (separate: forename; surname), nationality, date of birth, family details, address, telephone number and E-mail address.

Qualifications: Primary and specialist qualifications and any others, which are relevant to your clinical practice. Details of which academic or professional body awarded your qualifications.

Current Employment: Details of your current post. This should specify where you work, who your employer is and in what speciality you are practising.

Medical Registration: With whom are you licensed to practice (Approbation). If you are registered with the GMC, you should provide your GMC number and whether or not you are on the specialist register.

Previous Employment: Indicate all posts held since graduation, in table format and reverse chronological order.

Training: Detailed information of your speciality training, identifying which posts were training posts, their speciality content and the names of your supervising General Practitioner. If you have kept a logbook during your training, you should forward a photocopy with your CV and application form. Your logbook is likely to record details of practical procedures carried out by yourself, seminars and courses attended. If you were appraised as to your progress during training, include details in this section.

Experience: It is important to give as much information as you possibly can. Include, wherever possible, information on the following:

1. Surgeries/Clinics per week
2. Special interests, e.g. Family Planning, Child Health Surveillance, Diabetes
3. Minor surgery
4. Primary care prevention, e.g. cytology screening
5. Home visits
6. Number of patients seen per week
7. Describe case-mix of your patients (prevalent problems)

Courses and Conferences attended.

Teaching Responsibilities: Medical undergraduates and postgraduates, also include other health care professionals. Describe subjects covered both at formal and informal teaching sessions (include details of classroom and bedside teaching).

Research and Publications: Describe briefly all of your research projects during your career to date. Document the outcomes of your research projects. List your publications and identify those published in peer-reviewed journals.

References: Details of three referees who can be contacted to confirm the details on your CV. One of the references must be from your current employer. Referees will only be asked to provide a reference if you are selected for interview.

Other common headings are:

Career Intentions: whether you want to develop in a clinical area, research, teaching, management, etc.

Social Interests: sports, music, literature, travel, etc.

Cover Letter

Sometimes the CV is sent with a cover letter. Here you would introduce yourself and express briefly why you are interested in the post and why you think you are a good candidate.

Qualifications

Qualifications are academic degrees, which English speakers like to add after or under their names in abbreviated form, for example:

Dr. Peter Peterson MB MD PhD MRCGP DFFP

In the UK and Commonwealth countries the first professional degree is a Bachelor of Medicine and Surgery (**M.B., B.S. or M.B., Ch.B.**), earned with typically 5–6 years of study and training at university. The **MD** (Medicinae Doctor) degree is a further academic degree that involves either a number of publications or a thesis, and is examined in a similar fashion to a **PhD** degree. There are many other qualifications derived from courses and/or research activity, such as **MSc** (Master in Sciences) or **DFFP** (Diploma of the Faculty of Family Planning). A very common and desired qualification for a GP to possess is an **MRCGP** (Member of the Royal College of General Practitioners), earned after a comprehensive exam.

In the United States, the **M.D.** degree is the first professional degree (not a research doctorate) held by all medical practitioners (physicians and surgeons), after 4 years of training in a school of medicine.

You will need to find out how your qualifications are officially “translated” into English in both full and abbreviated forms. For example, the Spanish degree *Licenciado en Medicina y Cirugia* is translated as *Licence in Medicine and Surgery* (**LMS**). In the UK, you will be informed of this when you register with the General Medical Council (**GMC**), which is a necessary step to be allowed to practise in this country.

Note the prepositions:

Degree, Certificate or Diploma **in** ... Family Planning (or **of** the Faculty of Family Planning)

Course or conference **on** ... Family Medicine (or **of** the National Association of Family Medicine)

Registered **with** ...

SHO **in** ...

* Note that in English we usually speak about attending medical *conferences*, not medical congresses.

Types of Posts

A post is a position of employment. During post-graduate training, posts typically last 6 months. In the UK, GPs may go through the following posts during their career:

Hospital Posts

PRHO. Pre-registration House Officer.

SHO. Senior House Officer.

General Practice Posts

GP Registrar. Three years of vocational training (VT) in General Practice.

GP salaried. Employed indefinitely by GP partners in a practice.

GP partner. Self-employed, independent contractor.

GP retainer. Special kind of salaried contract partially paid by the NHS, for doctors who wish to work no more than four sessions a week with protected time for learning.

GP locum. Employed temporarily to cover a GP who is on leave or has not been appointed yet.

Induction Posts

Induction is the general name given to a period of adaptation to a new post or kind of job. It can occur in the same place where you will continue working, or in separate one where it is often arranged by a teaching organisation.

Clinical attachment is a period of time where foreign doctors are attached to a clinical unit with a named supervisor with the aim of becoming familiar with the system and style of clinical practice of the country where they intend to work.

Teaching Posts

University teaching posts in the UK are, in ascending hierarchic order:

Lecturer

Senior Lecturer

Professor

Head of Department

A GP with a post-graduate training responsibility (i.e. who supervises GP Registrars) is a **GP trainer**.

CV Example

CURRICULUM VITAE

PERSONAL DETAILS

FULL NAME: SANDRA LAM
ADDRESS: 35, SAUGHTONHALL DRIVE, EDINBURGH EH12 5TP
TELEPHONE: 0131
NATIONALITY: SPANISH (MARRIED TO A U.K. NATIONAL)
DATE OF BIRTH: 3/03/1959
G.M.C. FULL REGISTRATION: **4009 (14/6/93) LMS 1985 CANTABRIA T(GP)**
DRIVING LICENCE: FULL, CLEAN U.K. LICENCE

UNIVERSITY EDUCATION AND QUALIFICATIONS

10/77 to 7/85: DEGREE IN MEDICINE
(LICENCIADA EN MEDICINA Y CIRUGIA) (L.M.S.)
UNIVERSITY OF SANTANDER, SPAIN
1/4/94 REGISTERED GENERAL PRACTITIONER:
CERTIFICATION FROM THE SPANISH MINISTRY OF HEALTH

POSTGRADUATE QUALIFICATIONS AND REGISTRATIONS

31/8/03 DIPLOMA OF THE FACULTY OF FAMILY PLANNING (**DFPP**)
04/03 REGISTERED ON THE LOTHIAN HEALTHCARE SUPPLEMENTARY MEDICAL LIST
04/03 INCLUSION ON THE LOTHIAN CHILD HEALTH SURVEILLANCE LIST

U. K. WORK EXPERIENCE

3/2004 to DATE REGISTERED FAMILY PLANNING LOCUM
DEAN TERRACE FAMILY PLANNING CLINIC, EDINBURGH
9/2001 to DATE: **GP RETAINER (4 SESSIONS)**

- INCLUDING ANTE-NATAL CLINICS, FAMILY PLANNING AND SEXUAL HEALTH

WESTER HAILES HEALTH CENTRE, EDINBURGH

- 6,200 PATIENT LIST, DEPRIVED AREA, YOUNG POPULATION, HIGH UNEMPLOYMENT. HIGH RATES OF DRUG,& ALCOHOL RELATED HEALTH PROBLEMS, TEENAGE PREGNANCIES, MENTAL ILLNESS.

7/2000 to 7/2001: **GP REGISTRAR (part-time 60%)**
SIGHTHILL HEALTH CENTRE,
CALDER ROAD, EDINBURGH
1/2000 to 15/5/00: **SHO IN OBSTETRICS AND GYNAECOLOGY**
(FLEXIBLE TRAINING)

- ANTE-NATAL AND GYNAECOLOGY CLINICS

ST. JOHN'S HOSPITAL, LIVINGSTON

CURRICULUM VITAE (S. LAM)U.K. WORK EXPERIENCE (continued)

- 2/99 to 31/12/99: **S.H.O. IN E.N.T. , (FULL TIME)**
 • E.N.T. CLINICS AND PRE-OPERATIVE ASSESSMENTS
 CITY HOSPITAL, EDINBURGH
- 8/98 to 2/99: **S.H.O. IN GERIATRIC MEDICINE (FULL TIME)**
 ROYAL VICTORIA HOSPITAL, EDINBURGH
- 2/98 to 8/98: **S.H.O. /LOCUM S.H.O. IN GERIATRIC MEDICINE,**
 (HONORARY CONTRACT)
 ROYAL VICTORIA HOSPITAL, EDINBURGH
- 8/97 to 2/98: **CLINICAL ATTACHMENT IN GERIATRICS
 AND GENERAL MEDICINE,**
 • STROKE ASSESSMENT AND REHABILITATION, ACUTE GENERAL
 MEDICINE RECEIVING UNITS
 ST. JOHN'S HOSPITAL AT HOWDEN, LIVINGSTON

WORK EXPERIENCE (continued)

- 8/92 to 8/97: IN THIS TIME I HAD OUR SECOND CHILD AND
 LOOKED AFTER BOTH WHILE IMPROVING MY
 ENGLISH. I ALSO DID COURSES TO PREPARE
 FOR A RETURN TO THE MEDICAL PROFESSION.
- 8/92: WE MOVED TO THE U.K. TO SETTLE IN A
 MORE SECURE AND PROFESSIONALLY
 STABLE ENVIRONMENT.
- 10/90 to 8/92: I STOPPED WORK TO START OUR FAMILY AND
 TO LOOK AFTER OUR DAUGHTER.
- 1/90 to 9/90: TEACHER OF BIOLOGY AND CHEMISTRY,
 ALBA ACADEMY, SANTANDER, SPAIN
- 1/89 to 3/89: LOCUM GP
 GENERAL DAVILA HEALTH CENTRE
 SANTANDER, SPAIN
- 12/88: DOCTOR IN CHARGE OF MEDICAL CHECK-UPS
 COLLEGE OF PHYSICIANS, SANTANDER, SPAIN

PROFESSIONAL COURSES SINCE GRADUATION

- 11/03 MINOR SURGERY FOR GENERAL PRACTICE
 LISTER POSTGRADUATE INSTITUTE, EDINBURGH
- 09/02 SEXUALLY TRANSMITTED INFECTIONS (FOUNDATION COURSE)
 LISTER POSTGRADUATE INSTITUTE
- 09/02 FAMILY PLANNING COURSE
 LISTER POSTGRADUATE INSTITUTE
- 05/02 MUSCULOSKELETAL MEDICINE FOR GPs
 LISTER POSTGRADUATE INSTITUTE
- 28/2/02 UPDATE GP DERMATOLOGY COURSE
 LISTER POSTGRADUATE INSTITUTE

CURRICULUM VITAE (S. LAM)

PROFESSIONAL COURSES SINCE GRADUATION (continued)

24/4/01:	DRUGS AND H.I.V. FOR GPs LISTER POSTGRADUATE INSTITUTE UNIVERSITY OF EDINBURGH
21/11/00:	OPHTHALMOLOGY FOR GPs LISTER POSTGRADUATE INSTITUTE UNIVERSITY OF EDINBURGH
17/8/00:	CARDIO-PULMONARY RESUSCITATION PERFORMANCE TEST (FULL PASS) ROYAL COLLEGE OF GENERAL PRACTITIONERS
8/12 – 10/12/99:	PSYCHIATRY FOR GPs LISTER POSTGRADUATE INSTITUTE UNIVERSITY OF EDINBURGH
27+28/10/99:	DERMATOLOGY FOR GPs LISTER POSTGRADUATE INSTITUTE UNIVERSITY OF EDINBURGH
23/8 – 27/8/99:	DEVELOPMENT SURVEILLANCE MODULE SCHOOL OF COMMUNITY PAEDIATRICS UNIVERSITY OF EDINBURGH
9/98:	FAMILY PLANNING COURSE FACULTY OF OBSTETRICS & GYNAECOLOGY UNIVERSITY OF EDINBURGH
10/96 to 7/97:	CERTIFICATE IN FORENSIC MEDICINE FACULTY OF MEDICINE UNIVERSITY OF EDINBURGH
1/97:	MEDICAL/ACADEMIC ENGLISH (ADVANCED) INSTITUTE OF APPLIED LANGUAGE STUDIES UNIVERSITY OF EDINBURGH
10/93 to 12/93:	RESEARCH TECHNIQUES OPEN STUDIES, UNIVERSITY OF EDINBURGH
12/91:	THE GP AGAINST CANCER MINISTRY OF HEALTH, SANTANDER, SPAIN
7/87:	INTERNATIONAL CONFERENCE ON AIDS MENENDEZ PELAYO UNIVERSITY, SPAIN

REFERENCES:

DR ; ASSOCIATE POSTGRADUATE DEAN LISTER POSTGRADUATE INSTITUTE 11, HILL SQUARE EDINBURGH EH8 9DR	DR G.P. SENIOR PARTNER SIGHTHILL HEALTH CENTRE 380, CALDER ROAD EDINBURGH EH11 4AU	DR G.P. SENIOR PARTNER WESTER HAILES HEALTH CENTRE 7, MURRAYBURN GATE EDINBURGH EH14 2SS
TEL. 013 0000 0000	TEL. 013 0000 0000	TEL. 013 0000 0000

ADDITIONAL DETAILS

Please state what in particular attracted you to this post, how it fits into your career plans and why you consider yourself to be a suitable candidate. Please continue on a separate sheet, if necessary.

AS I AM MOVING TO SOUTH-EAST LONDON IN THE SUMMER DUE TO MY HUSBAND'S NEW JOB, I AM KEEN TO GRASP THE OPPORTUNITY TO FURTHER MY G.P. CAREER BY QUICKLY TAKING UP A NEW POST IN THE AREA.

AT PRESENT I AM WORKING AS A G.P. RETAINEE (4 SESSIONS) IN EDINBURGH AND I HAVE 4 YEARS U.K. G.P. EXPERIENCE AS WELL AS 3 PREVIOUS YEARS HOSPITAL WORK. I AM RELIABLE AND HARD-WORKING AND HAPPY TO BE PART OF A TEAM WITH A VARIED PATIENT LIST. MY PRINCIPAL INTERESTS LIE IN WOMEN'S WELL-BEING, FAMILY PLANNING AND CHRONIC DISEASE MANAGEMENT (DIABETES). I HAVE BEEN INCLUDED ON THE LOTHIAN CHILD HEALTH SURVEILLANCE, MINOR SURGERY AND OBSTETRICS LISTS AS WELL AS ON THE SUPPLEMENTARY MEDICAL LIST. I HAVE COMPLETED THE DIPLOMA OF THE FACULTY OF FAMILY PLANNING AND I HAVE GAINED VALUABLE EXPERIENCE OF ALL OF THESE AREAS AND MORE DURING MY WORK IN EDINBURGH.

I HOPE THAT I CAN OFFER A DIFFERENT SET OF EXPERIENCES WHICH HELP ME TO UNDERSTAND AND RELATE TO PATIENTS FROM A VARIETY OF BACKGROUNDS. AS A SPANISH CERTIFIED G.P., I WAS GRANTED ACQUIRED RIGHTS BY THE G.M.C., BUT I FELT THAT IT WAS IMPORTANT TO UP-DATE MY TRAINING AND KNOWLEDGE, SPECIFICALLY WITHIN THE U.K. HEALTH SYSTEM. I CONTINUE THIS PROCESS BY ATTENDING COURSES AND TRYING TO ACHIEVE RELEVANT KNOWLEDGE OF A VARIETY OF AREAS OF GENERAL PRACTICE.

MY ENTHUSIASM IS FURTHER STRENGTHENED BY THE FACT THAT I RETURNED TO MEDICINE SEVEN YEARS AGO AFTER A BREAK DUE TO PERSONAL CIRCUMSTANCES, AND ALTHOUGH THIS HAS AT TIMES BEEN TOUGH, I FEEL THAT I HAVE ACHIEVED A GREAT DEAL AND I AM KEEN TO MAKE THE MOST OF THE NEXT STAGE OF MY CAREER AS A G.P..

I confirm that the above statements are true and correct and I understand that any misrepresentation will invalidate my application and/or my contract/employment with the Rushey Green Group Practice.

SIGNATURE: Sandra

... DATE: 21/03/2004

Where did you see this advertisement? B.M.J. 13/3/04

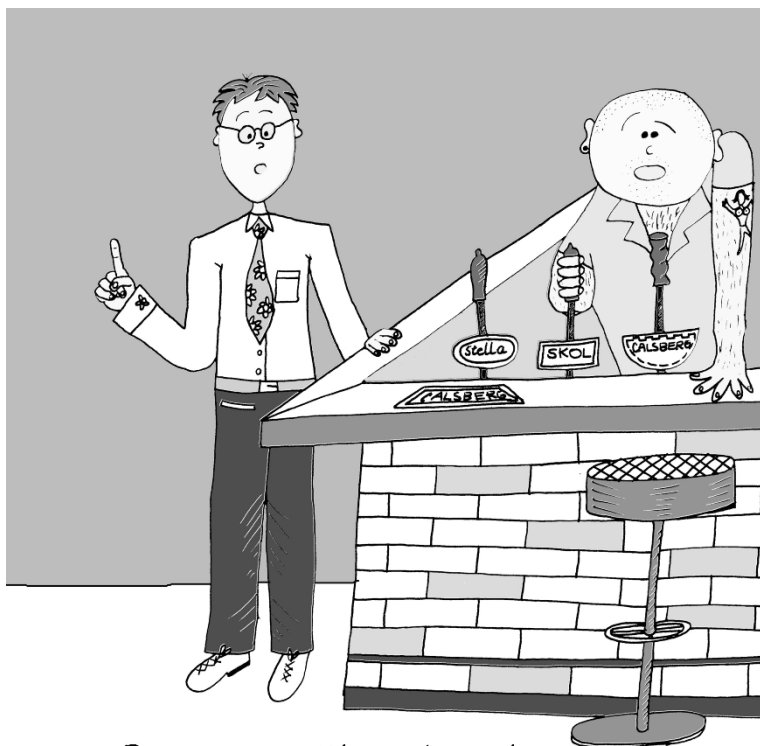
Job Interview

adapted from www.medical-interviews.co.uk

Some of the questions you may be asked in an interview for a GP post are:

- Tell me about yourself.
- Talk us through your CV/Application Form. (Remind and comment on each section.)
- Tell us about your background (your education, training, experience).
- What made you go into General Practice?
- What is your career ambition?
- Where do you see yourself in 5–10 years?
- What attracted you to this post?
- What do you have to offer us?
- Give us three adjectives that describe you best.
- What would your friends say about you?
- What kind of feedback would I obtain from your patients if I asked them?
- What are your main strengths?
- What are your main weaknesses?
- What skills have you gained that will make you a good GP?
- Name two skills that you would like to improve over the next 2 years.
- What skills do you need to develop most?
- What job have you particularly liked/disliked?
- Why should we recruit you rather than any other candidate?
- What have you done that is different to anyone else?
- What makes you a good candidate for the job?
- What concerns you about this job?
- What do you think will be your biggest challenge in this job?
- What are your hobbies? How have they influenced your medical practice?
- What experiences outside medicine have you found useful in your medical career?
- What sort of practice would you rather work in and why?
- How would you rate your communication skills?
- Give us an example of a situation where your communication skills made a difference to the care of a patient.
- Give us an example of a situation where you failed to communicate appropriately.
- What skills have you acquired that make you a good communicator?
- Do you work better as part of a team or on your own?
- What leadership skills have you acquired during your training?
- Tell us about your experience of managing a team of people.
- How would you motivate others?
- Tell us about a situation where you showed leadership.

- Tell us about a situation where you showed initiative.
- What makes you angry?
- Have you ever been in a situation where you have had a conflict with a colleague?
- Give an example of a situation where your work was criticised.
- How would you cope with criticism or a complaint being made against you?
- What is your approach to resolving conflict?
- What would you do if a patient disagreed with your treatment approach?
- How do you handle stress?
- How do you normally cope with pressure?
- How do you recognise when you are stressed?
- What difficult decisions have you made in a clinical setting?
- Tell me about your research experience.
- Tell us about your teaching experience.
- How do you identify your training needs?
- What is the biggest mistake that you have made in a clinical setting?
- How do you keep your skills up to date?
- Tell us about a NICE guideline relating to primary care.
- What would you do in the following clinical case scenario ...?



- Excuse me, may I have a beer, please?
- Pint of lager?
- Mmmm, eerrrr.... a beer?
- You mean bottled?
- ...well, or in a glass, maybe?
- Half pint or a pint?
- eeerrrr, mmmm, I think I'll have a coke then.
- Sorry, mate. We only serve beer here.

LALANDA

Unit XI Conversation Survival Guide

Introduction

Fluency gives self-confidence, and its lack undermines you.

The intention of this unit is not to replace conversation guides; on the contrary, we encourage you, according to your level, to use them.

Do not be ashamed of carrying and reading a guide, even in public; they are the shortest way to fluency in those unfamiliar scenarios that sporadically test our English level and, what is more important, our self-confidence in English.

Whenever you have to go out to dinner, for example, review the key words and usual sentences of your conversation guide. It will not take more than 10 min, and your dinner will taste even better since you have ordered it with unbelievable fluency and precision.

Greetings and farewells

- Hi.
- Hello.
- Good morning.
- Good afternoon.
- Good evening.
- Good night.
- How are you? (Very) Well, thank you.
- How are you getting on? All right, thank you.
- I am glad to see you.
- Nice to see you (again).
- How do you feel today?
- How is your family?
- Good-bye.
- Bye-bye.
- See you later.
- See you soon.
- See you tomorrow.

- Give my regards to everybody.
- Give my love to your children.

Presentations

- This is Mr./Mrs. ...
- These are Mister and Missis ...
- My name is ...
- What is your name? My name is ...
- Pleased/Nice to meet you.
- Let me introduce you to ...
- I'd like to introduce you to ...
- Have you already met Mr. ...? Yes, I have, we met at

Personal Data

- What is your name? My name is ...
- What is your surname/family name? My surname/family name is ...
- Where are you from? I am from ...
- Where do you live? I live in ...
- What is your address? My address is ...
- What is your E-mail address? My E-mail address is ...
- What is your phone number? My phone number is ...
- What is your mobile phone [*Brit*]/ cellular [*Am.*] number? My mobile phone/cellular number is ...
- How old are you? I am ...
- Where were you born? I was born in ...
- What do you do? I am a GP/ family doctor.
- What do you do? I do general practice/ family medicine.

Courtesy Sentences

- Sorry to bother/trouble you.
 - What can I do for you?/May I help you?/How can I help you?
 - Would you please ...?/I would like .../Can I have ... (the course programme), please?
 - Sure, no problem.
 - Thank you very much.
 - You are welcome.
- Would you like something to drink?
 - Yes, please. Some tea would be nice.

- Milk or sugar?
 - No milk, two sugars please.
 - Here you are.
 - Thanks, you are very kind/It is very kind of you.
 - My pleasure/It's OK.
 - Cheers! [informal for thank you/bye-bye].
- Would you like something to drink?
 - No, thank you. I'm OK.
 - Excuse me. (Where are the toilets?)
 - Sorry/I apologise/I am really sorry/I do apologise/Pardon me ...
 - It's OK/No problem/Don't worry/It doesn't matter/Never mind.
 - Congratulations!
 - Good luck!
 - Have a nice day.

Speaking in a Foreign Language

- Do you speak English/Spanish/French ...?
 - I do not speak English/Only a bit/Not a word.
- Do you understand me?
 - Yes, I do/No, I don't.
- Pardon/I beg your pardon/Sorry, can you repeat that?/Could you please repeat that?/Sorry, what did you say?/Sorry, I didn't get that/Sorry, I do not understand you/Say that again?
- I can't hear you.
- Sorry, my English is not very good/Could you speak slowly, please?
- How do you write it?/How do you spell it?/Could you write it down?
- How do you pronounce it?

At the Restaurant

“The same for me” is one of the most common sentences heard at dinner tables around the world; however, a simple look at a guide a few minutes before the dinner will provide you with enough vocabulary to ask for whatever you want. Do not let your lack of fluency spoil a good opportunity to taste delicious dishes or wines.

Preliminary Exchanges

- Hello, have you got a table for three people?
- Hi, may I book a table for a party of seven at 6 o'clock?
- What time are you coming, sir?
- Where can we sit?
- Is this chair free?
- Is this table taken?
- Waiter/waitress, I would like to order.
- Could I see the menu?
- Could you bring the menu?
- Can I have the wine list?
- Could you give us a table next to the window?
- Could you give us a table near the stage?

Ordering

- We'd like to order now, please/We are ready to order.
- Could you bring us some bread, please?
- We'd like to have something to drink.
- Could you recommend a local wine?
- Could you recommend one of your specialties?
- Could you suggest something special?
- What are the ingredients of this dish?
- What is there for dessert?
- Is the halibut fresh?
- I'll have a steamed lobster, please.
- The same for me.
 - How would you like your meat, sir?
 - Rare/medium-rare/medium/well-done.
- Anything else, sir?
 - No, we are fine, thank you.
 - Enjoy your meal, sir.
- How was everything, sir?
 - The meal was excellent/The sirloin was delicious.

Complaining

- The dish is cold. Would you please heat it up?
- The meat is underdone. Would you cook it a little more, please?
- Excuse me. This is not what I asked for.
- Could you change this for me?
- The fish is not fresh. I want to see the manager.
- I asked for a sirloin.

- The meal wasn't very good.
- The meat smells off.
- This wine is off, I think ...
- Waiter, this fork is dirty.

The Bill [Am. The check]

- May I have the bill, please.
- Would you bring us the bill, please?
- All together, please.
- We are paying separately.
- I am afraid there is a mistake, we didn't have/order this.
- This is for you.
- Keep the change.

City Transportation

- I want to go to the Science Museum.
- Which bus/tram/underground line must I take for the Science Museum?
- Which bus/tram/underground line can I take to get to the Science Museum?
- Where does the number ... bus stop?
- Does this bus go to ...?
- How much is a single ticket?
- Three tickets, please.
- When must I get off for ...?
- Is this seat occupied/vacant?
- Where can I get a taxi?
- How much is the fare for ...?
- Take me to ... Street.
- Do you know where the ... is?

Shopping

Asking About Store Hours

- What are your opening hours?
- When are you open?
- How late are you open today?
- Are you open on Saturday?

Preliminary Exchanges

- Hello Sir/Madam, may I help you?/Can I help you with something?/Can I help you find something?
- Thank you, I am just looking.
- On which floor is the Leather Goods Department?
- On the ground floor (on the mezzanine, on the second floor ...)
- Where can I find a mirror?
- There is a mirror over there.
- I just can't make up my mind.
- If I can help you, just let me know.
- Are you looking for something in particular?
- I am looking for something for my wife/husband/child.
- It is a gift.
- Hi, do you sell ...?
- I am looking for a ... Can you help me?
- Can you tell me where the Music Department is?
- Please would you show me ...?
- Where are the changing rooms?
- The changing rooms are over there.
- Only four items are allowed in the dressing room at a time.
- Where are the toilets?
- Have you decided?
- Have you made up your mind?

Buying Clothes/Shoes

- Please, can you show me some natural silk ties?
- I want to buy a long-sleeved shirt.
- I want the pair of high-heeled shoes in the window.
- Could you show me the pair in the window please?
- What material is it?
- Of what material is it made? Cotton, leather, linen, wool, velvet, silk, nylon, acrylic fibre?
- What size, please?
- What size do you need?
- Is this my size?
- Do you think this is my size?
- Where is the changing/fitting room?
- Does it fit you?
- I think it fits well, although the collar is a little tight.
- No, it doesn't fit me, it's too small.
- May I try a larger size?
- I'll try a smaller size. Would you mind bringing it to me?
- I'll take this one.

- How much is it?
- This is too expensive.
- Oh, this is a bargain!
- I like it.
- May I try this on?
- In which colour? Navy blue, please.
- Do you have anything to go with this?
- I need a belt/a pair of socks/pair of jeans/pair of gloves/pair of slippers ...
- I need a size 38.
- I don't know my size. Can you measure me?
- Do you have a shirt to match this?
- Do you have this in blue/in wool/in a larger size/in a smaller size?
- Do you have something a bit less expensive?
- I'd like to try this on. Where is the fitting room?
- How would you like to pay for this? Cash/credit
- We don't have that in your size/colour.
- We are out of that item.
- It's too tight/loose
- It's too expensive/cheap.
- I don't like the colour.
- Is it in the sale?
- Can I have this gift wrapped?
- I'd like to return this item, it is the wrong size/it is damaged/it is the wrong colour. I have the receipt here.
- Sorry, Sir/Madam, the shop policy is only to refund or exchange goods within 28 days of purchase/Certainly, would you like to exchange it or would you like a refund?

At the Shoe Shop

- A pair of shoes, boots, sandals, slippers ..., shoelaces, soles, heels, leather, suede, rubber, shoehorn.
- What kind of shoes do you want?
- I want a pair of rubber-soled shoes/high-heeled shoes/leather shoes/suede slippers/boots/dressy shoes/sandals/flip flops/trainers, etc.
- I want a pair of lace-up/slip-on shoes good for the rain/for walking.
- What is your size, please?
- They are a little tight/too large/too small.
- Would you please show me the pair in the window?
- Can I try a smaller/larger size, please?
- This one fits well.
- I would like some shoe polish.
- I need some new laces.
- I need a shoehorn.

At the Post Office

- I need some (first class) stamps, please.
- First class, please/Air mail, please.
- I would like this to go express mail.
- I would like this recorded/special delivery.
- Second class for this, please (UK).
- I need to send this second-day mail (US).
- I need to send this parcel post.
- I need to send this by certified mail/registered mail.
- Return receipt requested, please.
- How much postage do I need for this?/to send this air mail?
- Do you have any envelopes?
- How long will it take to get there?
- It should arrive on Monday.
- The forms are over there. Please fill in a form and bring it back to me.

Going to the Theatre

- Sorry, we are sold out tonight/Sorry, there are no tickets available.
- Sorry, these tickets are non-refundable.
- Would you like to make a reservation for another night?
- I would like two seats for tonight's performance, please.
- Where are the best seats you have left?
- Do you have anything in the first four rows?
- Do you have matinees?
- How much are the tickets?
- Is it possible to exchange these for another night?
- Do you take a cheque (UK)/cheque (US)/credit cards?
- How long does the show run?
- About 2 h.
- When does the show close?
- Is there an interval?
- Where are the toilets?
- Where is the cloakroom?
- Is there anywhere we can leave our coats?
- How soon does the curtain go up?
- Did you make a reservation?
- What name did you reserve the tickets under?
- Where can we buy refreshments/drinks/ice cream.
- Where can I get a programme for tonight's performance?

At the Chemist/Pharmacy [US: Drugstore]

- Prescription, tablet, pill, cream, suppository, laxative, sedative, injection, bandage, sticking plasters, cotton wool, gauze, alcohol, thermometer, sanitary towels, napkins, toothpaste, toothbrush, paper tissues, duty chemist.
- Fever, cold, cough, headache, toothache, diarrhoea, constipation, sickness, insomnia, sunburn, insect bite.
- I am looking for something for ...
- Could you give me something for ...?
- I need some aspirin/antiseptic/eye drops/foot powder.
- I need razor blades and shaving foam.
- What are the side effects of this drug?
- Will this make me drowsy?
- Should I take this with meals?

At the Cosmetics Counter

- Soap, shampoo, deodorant, shower gel, hair spray, sun tan cream, comb, hairbrush, toothpaste, toothbrush, make up, cologne water, lipstick, perfume, hair remover, scissors, face lotion, cleansing cream, razor, shaving foam, hand cream, sanitary towels/tampons, hair dye, hairbands, tweezers, nail files, etc.

At the Bookshop/Newsagent

- I would like to buy a book on the history of the city.
- Has this book been translated into Japanese?
- Have you got Swedish newspapers/magazines/books?
- Where can I buy a road map?

At the Photography Shop

- I would like a 36 exposure film for this camera.
- I need new batteries for my camera.
- Could you develop this film?
- Could you develop this film with two prints of each photograph?
- How much does developing cost?
- When will the photographs be ready?
- My camera is not working, would you have a look at it?
- Do you take passport (ID) photographs?
- I want an enlargement of this one and two copies of this other.

- Have you got a 64-megabyte data card to fit this camera?
- How much would a 128-megabyte card be?
- How many megapixels is this one?
- Has it got an optical zoom?
- Can you print the pictures on this CD?

At the Florist

- I would like to order a bouquet of roses.
- You can choose violets and orchids in several colours.
- Which flowers are the freshest?
- What are these flowers called?
- Do you deliver?
- Could you please send this bouquet to the NH Abascal hotel manager at 47 Abascal Street before noon?
- Could you please send this card too?

Paying

- Where is the cash machine?/Is there an ATM near here?
- How much is that all together?
- Will you pay cash or by credit card?
- “Next” in line (queue).
- Could you gift-wrap it for me?
- Can I have a receipt, please?

At the Hairdresser

We recommend, before going to the hairdresser, a thorough review of your guide so that you get familiar with key words such as scissors, comb, brush, dryer, shampooing, hair style, hair cut, manicure, dyeing, shave, beard, moustache, sideburns, fringe, curl or plait, straight, straighteners, curling tongs etc.

Men and Women

- How long will I have to wait?
- Is the water OK? It is fine/too hot/too cold.
- My hair is greasy/dry.
- I have dandruff.
- I am losing a lot of hair.
- A shampoo and rinse, please.
- How would you like it?

- Are you going for a particular look?
- I want a (hair) cut like this (take a picture with you).
- Just a trim, please.
- However you want.
- Is it OK?
- That's fine, thank you.
- How much is it?
- How much do I owe you?
- Do you do highlights?
- I would like a tint, please.
- Just a wet cut please.
- I'd like a cut and blow dry please.

Men

- I want a shave.
- A razor cut, please.
- Just a trim, please.
- Leave the sideburns as they are.
- Trim the moustache.
- Trim my beard and moustache, please.
- Towards the back, without any parting.
- I part my hair on the left/in the middle.
- Leave it long.
- Could you take a little more off the top/the back/the sides?
- How much do you want me to take off?

Women

- How do I set your hair?
- What hairstyle do you want?
- I would like my hair dyed.
- Same colour?
- A little darker/lighter.
- I would like to have a perm (permanent wave).
- Can you blow dry and straighten it?

Cars

As always, begin with key words. Clutch, brake, indicators [*Am. blinkers or signal lights*], boot [*Am. trunk*], tank, gearbox, windscreen, wipers, engine, (steering) wheel, unleaded petrol [*Am. gas*], etc.

- How far is the nearest petrol station? Twenty miles from here.
- In what direction? Northeast/ Cambridge.

At the Petrol/Gas Station

- Fill it up, please. (Most petrol stations in the UK are self-service, however.)
- Unleaded, please.
- Could you top up the battery, please?
- Could you check the oil, please?
- Could you check the tyre [*Am. tire*] pressure, please?
- Do you want me to check the spare tyre too? Yes, please.
- Pump number 5, please.
- Can I have a receipt, please.
- I'd like to have my car washed and waxed.

At the Garage

- My car has broken down.
- What do you think is wrong with it?
- Can you mend a puncture [*Am. flat tire*]?
- Can you take the car in tow to downtown Oxford?
- I see ..., kill (turn off/stop) the engine, please.
- Start the engine, please.
- The car goes to the right and overheats.
- Have you noticed if it loses water/gas/oil?
- Yes, it's losing oil.
- Does it lose speed?
- Yes, and it doesn't start properly.
- I can't get it into reverse.
- The engine makes funny noises.
- Please, repair it as soon as possible.
- I wonder if you can fix it temporarily.
- How long will it take to repair?
- I am afraid we have to send for spare parts.
- The car is very heavy on petrol.
- I think the right front tyre needs changing.
- I guess the valve is broken.
- Is my car ready?
- Have you finished fixing the car?
- Did you fix the car?
- Do you think you can fix it today?
- Could you mend a puncture?
- I think I've got a puncture rear offside.
- The spare's flat as well.
- I've run out of petrol.

At the Car Park

- Do you know where the nearest car park is?
- Are there any free spaces?
- How much is it per hour?
- Is the car park supervised?
- How long can I leave the car here?
- Is it pay and display?
- Is it park and ride?
- Where is the ticket machine?

Renting a Car

- I want to rent/hire a car.
- For how many days?
- Unlimited mileage?
- What is the cost per mile?
- Is insurance included?
- You need to leave a deposit.

How Can I Get To ...?

- How far is Lewisham?
- It is not far. About 12 miles from here.
- Is the road good?
- It is not bad, although a bit slow.
- Is there a toll road between here and Wales?
- How long does it take to get to Manchester?
- I am lost. Could you tell me how I can get back to the toll road?
- Can you give me directions?

Having a Drink (or Two)

Nothing is more desirable than a drink after a hard day at work. In such a relaxed situation embarrassing incidents can happen. Often, there is a difficult counter-question to a simple “Can I have a beer?” such as “Would you prefer lager?” or “Small, medium or large, sir?” From my own experience, when I was a beginner, I hated counter-questions and I remember my face flushing when in a pub in London, instead of giving me the beer I asked for, the barman responded with the entire list of beers in the pub. “I have changed my mind, I’ll have a Coke instead” was my response to both the “aggression” I suffered from the barman and the embarrassment resulting

from my lack of fluency. “We don’t serve Coke here, sir.” These situations can spoil the most promising evening so ... let’s review a bunch of usual sentences:

- Two beers, please, my friend will pay.
- Two pints of bitter and half a lager, please.
- Where can I find a good place to go for a drink?
- Where can we go for a drink at this time of the evening?
- Do you know any pubs with live music?
- What can I get you?
- I’m driving. Just an orange juice, please.
- A glass of wine and two beers, please.
- A gin and tonic.
- A glass of brandy. Would you please warm the glass?
- Scotch, please.
- Do you want it plain, with water, or on the rocks (with ice)?
- Make it a double.
- I’ll have the same again, please.
- Two ice cubes and a teaspoon, please.
- This is on me.
- What those ladies are having is on me. (I will pay for their drinks.)
- I’ll buy the next round.

On the Phone

Many problems start when you lift the receiver. You hear a continuous purring different from the one you are used to in your country or a strange sequence of rapid pips. Almost immediately the words “What the hell am I supposed to do right now” come to mind, and we face one of the most embarrassing situations for non-fluent speakers. The phone has two added difficulties: firstly, its immediacy and, secondly, the absence of images. (“If I could see this guy I would understand what he was saying”.) Do not worry; the preliminary exchanges in this conversational scenario are few. Answering machines are another different, and tougher, problem and are beyond the scope of this survival guide. Just a tip: do not hang up. Try to catch what the machine is saying and give it another try in case you are not able to follow its instructions. Most messages are much easier to understand and less mechanical than those given by “human” operators.

- Where are the public phones, please?
- Where is the nearest call-box?
- This telephone is out of order.
- Operator, what do I dial for the USA?
- Hold on a moment ... number one.

- Would you get me this number please?
- Dial straight through.
- What time does the cheap rate begin?
- Have you got any phone cards, please?
- Can I use your cell/mobile phone, please?
- Do you have a phone book (directory)?
- I'd like to make a reverse charge call to Korea.
- I am trying to use my phone card, but I am not getting through.
- Hello, this is Dr. Vida speaking.
- The line is engaged.
- There's no answer.
- It's a bad line.
- I've been cut off.
- I would like the number for Dr. Vida on Green Street.
- What is the area code for Liverpool?
- I can't get through to this number. Would you dial it for me?
- Can you put me through to Reception?

Emergency Situations (999)

- I want to report a fire/a robbery/an accident.
- This is an emergency. We need an ambulance/the police.
- Get me the police – and hurry.

In the Bank

Nowadays, the spread of credit cards makes this section virtually unnecessary but, in my experience, when things go really wrong you may need to go to a bank. Fluency disappears in stressful situations, so in case you have to solve a bank problem, review not only these sentences but the entire section in your guide.

- Where can I change money?
- I'd like to change 200 Euros.
- I want to change 1000 Euros into pounds/dollars.
- Can I have it in tens, please?
- What's the exchange rate?
- What's the rate of exchange from Euros to Sterling?
- What are the banking hours?
- I want to change this travellers' check.
- Have you received a transfer from Rosario Nadal addressed to Fiona Shaw?

- Can I cash this bearer cheque?
- I want to cash this cheque.
- Do I need my ID to cash this bearer cheque?
- Go to the cash desk.
- Go to counter number 5.
- May I open a current account?
- Where is the nearest cash machine?
- I am afraid you don't seem to be able to solve my problem. Can I see the manager?
- Who is in charge?
- Could you call my bank in France? There must have been a problem with a transfer addressed to myself.

At the Police Station

- Where is the nearest police station?
- I have come to report a ...
- My wallet has been stolen.
- Can I call my solicitor [*Brit*]/lawyer?
- I have been assaulted.
- My laptop has disappeared from my room.
- I have lost my passport.
- I will not say anything until I have spoken to my solicitor/lawyer.
- I have had a car accident.
- Why have you arrested me? I've done nothing.
- Am I under caution [*Brit*]?
- I would like to call my embassy/consulate.



Mrs Chinga seemed happy during her baby check-up. Baby Lily had been nearly eight pounds at birth and now she was a stone. Mrs Chinga explained that Lily's dad was six foot five so she wasn't at all surprised.

Appendix 1

Personal Bilingual Dictionary

Here is a suggestion to help you make the most of your learning:

Create your own Bilingual Dictionary

1. Take a notebook and divide it into two halves: the first half will be a dictionary from English to your language and the second one will be a dictionary from your language to English.
2. Within each half, label pages in alphabetical order. For example, page 1 will feature all those words and terms under the letter A, page 2 will feature all the terms and words under the letter B, and so on.
3. Now you can start noting down expressions that you want to practise, or that you think you may forget and would like to be able to check easily.
 - If you have learnt an expression in English that you want to note the meaning of, write it down in the first half of the notebook and note its translation as shown below.
 - If you would like to note down how to say something in English for future reference, do so in the second half of your dictionary as shown below.
4. You may use your dictionary to do exercises, by covering the right columns and guessing their contents.
5. Remember, it is not only about individual words, you may also note phrases that are of interest to you, such as how to ask certain questions, etc.
6. Take your notebook everywhere!

First Half

A	
ENGLISH	⇒ YOUR LANGUAGE
<i>In this column write the word or phrase in English.</i>	<i>In this column translate the word or phrase into your own language.</i>
EXAMPLES:	
Arrhythmia	
ASAP	
As per	 etc

B	
ENGLISH	⇒ YOUR LANGUAGE
.....	
.....	
.....	
.....	
.....	
.....	
.....	 etc

Second Half

A	
YOUR LANGUAGE	⇒ ENGLISH
<i>In this column write the word or phrase in your own language.</i>	<i>In this column translate the word or phrase into English.</i>
.....	
.....	
.....	 etc

B	
YOUR LANGUAGE	⇒ ENGLISH
.....	
.....	
.....	
.....	
.....	 etc

Appendix 2

Unit Conversions

with Emilia Negrin and Nick Jarrett

In medicine, understanding numbers is as important as understanding words. Values' measures vary in different countries, creating different "languages" that we need to learn. In the UK, the following systems are used:

- *Weight.* Although professionals are adopting the international system (kilograms), patients most often speak in **pounds** (for babies) and **stone** (for adults). A mother may say her baby weighed "6 pounds" (2.721 kg) at birth and an obese patient may say that he has "lost 2 stone" (12.7 kg) in the past year. Note that stone have no 's' in plural.
- *Height.* Although professionals are adopting the international metrical system (cm), patients most often speak in **feet** and **inches**. A "6-foot" man (a man who is 6 feet high) is not a short one (183 cm).
- *Temperature.* The **Celsius** scale is now predominant but the **Fahrenheit** scale is still used sometimes. A fever of 38°C is 100.4°F.
- *Biochemistry.* **Glucose** and **lipids** values are expressed in millimoles per liter (**mmol/l**) rather than mg/dl, so you may find numbers are smaller than in your country. The diabetes cut-off level of 7 mmol/l is approximately 125 mg/dl, and the cholesterol cut-off level of 5 mmol/l is approximately 200 mg/dl. For creatinine, however, you may find numbers are bigger than you are used to, as they are expressed in micromoles per liter (**μmol/l**). A **creatinine** value of 100 μmol/l is approximately 1.15 mg/dl.

We offer below some equivalence tables of interest, including the conversion factor and a range of values for easy reference.

× 0.4536		× 2.205	
Pounds (Lbs)	Kilograms (Kg)	Kilograms (Kg)	Pounds (Lbs)
1	0.454	1	2.205
2	0.907	2	4.410
3	1.361	3	6.615
4	1.814	4	8.820
5	2.268	5	11.025
6	2.721	6	13.230
8	3.628	8	17.640
10	4.535	10	22.050
12	5.442	12	26.460
14	6.349	14	30.870
16	7.256	16	35.280
18	8.163	18	39.690
20	9.070	20	44.100
22	9.977	22	48.510
24	10.884	24	52.920
26	11.791	26	57.330
28	12.698	28	61.740
30	13.605	30	66.150
35	15.873	35	77.175
40	18.141	40	88.200
45	20.408	45	99.225
50	22.676	50	110.250
55	24.943	55	121.275
60	27.211	60	132.300
65	29.478	65	143.325
70	31.746	70	154.350
75	34.014	75	165.375
80	36.281	80	176.400
85	38.549	85	187.425
90	40.816	90	198.450
95	43.084	95	209.475
100	45.351	100	220.500

×0.63503		× 0.1575	
Stone	Kilograms	Kilograms	Stone
7.00	44.452	35.00	5.513
8.00	50.802	40.00	6.300
9.00	57.153	45.00	7.088
10.00	63.503	50.00	7.875
11.00	69.853	55.00	8.663
12.00	76.204	60.00	9.450
13.00	82.554	65.00	10.238
14.00	88.904	70.00	11.025
15.00	95.255	75.00	11.813
16.00	101.605	80.00	12.600
17.00	107.955	85.00	13.388
18.00	114.305	90.00	14.175
19.00	120.656	95.00	14.963
20.00	127.006	100.00	15.750
21.00	133.356	105.00	16.538
22.00	139.707	110.00	17.325
23.00	146.057	115.00	18.113
24.00	152.407	120.00	18.900

×0.3048	
Feet (Ft)	Metres (m)
5	1.52
10	3.05
15	4.57
20	6.10
30	9.14
40	12.19
50	15.24

×3.2810	
Metres (m)	Feet (Ft)
5	16.40
10	32.81
15	49.21
20	65.62
30	98.43
40	131.23
50	164.04

×2.5400	
Inches	Centimetres
10	25.40
15	38.10
20	50.80
30	76.20
40	101.60
50	127.00

×0.3937	
Centimetres	Inches
10	3.94
20	7.87
30	11.81
40	15.75
50	19.69
60	23.62
70	27.56

×1.6090	
Miles	Kilometres
5	8.05
10	16.09
15	24.14
20	32.18
30	48.27
40	64.36
50	80.45

×0.6214	
Kilometres	Miles
5	3.11
10	6.22
15	9.32
20	12.43
30	18.65
40	24.86
50	31.08

F = (C × 1.8) + 32	
Fahrenheit	Celsius
30	−1.1
32	0.0
34	1.1
36	2.2
40	4.4
45	7.2
50	10.0
55	12.8
60	15.6
65	18.3
70	21.1
75	23.9
80	26.7
85	29.4
90	32.2
95	35.0
96	35.6
97	36.1
98	36.7
99	37.2
100	37.8
101	38.3
102	38.9
103	39.4
104	40.0
105	40.6
106	41.1

C = (F − 32) / 1.8	
Celsius	Fahrenheit
10	50.0
15	59.0
20	68.0
25	77.0
30	86.0
35	95.0
36	96.8
36.5	97.7
37	98.6
37.5	99.5
38	100.4
38.5	101.3
39	102.2
39.5	103.1
40	104.0
40.5	104.9
41	105.8
41.5	106.7
42	107.6

×0.0555		×88.4		×0.0259	
Glucose (mg/100 ml)	Glucose (mmol/L)	Creatinine (mg/100 ml)	Creatinine (μmol/L)	Total Cholesterol (mg/100 ml)	Total Cholesterol (mmol/L)
30	1.665			100	2.59
40	2.220	0.5	44.20	110	2.85
45	2.498	0.6	53.04	120	3.11
50	2.775	0.7	61.88	130	3.37
55	3.053	0.8	70.72	140	3.63
60	3.330	0.9	79.56	145	3.76
65	3.608	1	88.40	150	3.89
70	3.885	1.1	97.24	155	4.01
75	4.163	1.2	106.08	160	4.14
80	4.440	1.3	114.92	165	4.27
82	4.551	1.4	123.76	170	4.40
84	4.662	1.5	132.60	175	4.53
86	4.773	1.6	141.44	180	4.66
88	4.884	1.7	150.28	185	4.79
90	4.995	1.8	159.12	190	4.92
92	5.106	1.9	167.96	195	5.05
94	5.217	2	176.80	200	5.18
96	5.328	2.1	185.64	205	5.31
98	5.439	2.2	194.48	210	5.44
100	5.550	2.3	203.32	215	5.57
110	6.105	2.4	212.16	220	5.70
120	6.660	2.5	221.00	225	5.83
125	6.938	2.6	229.84	230	5.96
130	7.215	2.7	238.68	235	6.09
135	7.493	2.8	247.52	240	6.22
140	7.770	3	265.20	250	6.48
150	8.325	3.5	309.40	260	6.73
160	8.880	4	353.60	270	6.99
170	9.435	4.5	397.80	280	7.25
180	9.990	5	442.00	290	7.51
190	10.545	5.5	486.20	300	7.77
200	11.100	6	530.40	310	8.03
210	11.655	6.5	574.60	320	8.29
220	12.210	7	618.80		
230	12.765				
240	13.320				
250	13.875				
260	14.430				
270	14.985				
280	15.540				
290	16.095				
300	16.650				

Appendix 3

Pronunciation Guide

The pronunciation of terms in this book is indicated in brackets [] with letters of the English alphabet rather than with proper phonetic symbols, for consistency with the system used in Stedman's Concise Dictionary for the Health Professions:

The following key shows the sounds represented by these letters.

Vowels

ā as in baby; before **r** as in care
a as in cap
ă as in abortion, abulia, hepatitis
ah as in father
aw as in law, cause
ē as in be; before **r** as in here
e as in bed
ě as in system
ī as in lie, my
i as in lip, sit

ĩ as in pencil, utensil
ō as in go
o as in got
õ as in occult, collect, bottom
oy as in oil, boy
oo, as in boot, **ū** as in neural
ow as in cow, hour
ũ as in pull, put, foot
u as in cup
yu as in cube, urine

Consonants

b as in baby
ch as in church
d as in do
dh as in rhythm, this, mother
f as in fall
g as in go
h as in house
j as in join
k as in keep, action, cataract
l as in lie
m as in make

n as in no
p as in pain
r as in red
s as in so
sh as in shoe
t as in take
th as in thing
v as in vein
w as in we
y as in yes
z as in zoo
zh as in pleasure

A stressed syllable is indicated by an accent mark (') *following* the syllable. For example: weather [wě'thər].

Alphabet

A	[ā]
B	[bē]
C	[sē]
D	[dē]
E	[ē]
F	[ěf]
G	[jē]
H	[āch]
I	[ī]
J	[jā]
K	[kā]
L	[ěl]
M	[ěm]
N	[ěn]
O	[ō]
P	[pē]
Q	[kyōō]
R	[ār]
S	[ēs]
T	[tē]
U	[yōō]
V	[vē]
W	[dūb'əl-yōō]
X	[ěks]
Y	[wī]
Z	[zěd]