

e-Perspectives

on the Medical Transcription Profession

September 2004

Issue 49

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Hope Is On The Way!

Energy, enthusiasm, excitement . . . there is a new spirit in the air. I can feel it and I wasn't even there. The AAMT Annual Meeting in Atlanta in August was electrifying, and everyone felt it. It was like Old Home Week for many attendees who have been members of AAMT since the early 1980s. And the newer members, guests, and vendors felt positive vibes as well. It's a spirit of hope and optimism for the future of the medical transcription profession. What is responsible for this new optimistic view of our future?

Change. New leadership. New ideas. New strength in following our convictions. New respect for education and staff development. A new confidence in ourselves as healthcare professionals. A new belief in our association as more than an idea whose time has come. A belief in AAMT as an agent for positive change. One of the reasons for hope is AAMT's new commitment to quality educational programs for medical transcriptionists and its institution of an approval process for programs that meet the highest professional standards. Finally, hope is on the way!

This is the 49th issue of *Perspectives* magazine which has evolved over 14 years of publication to its present electronic format. As an e-zine, *e-Perspectives* will be available to a wider and wider audience of healthcare professionals who value the substantive original articles we publish. *e-Perspectives* will now be available worldwide to anyone with an Internet connection. The PDF articles may be downloaded and printed by those who want a print copy for reference.

In this issue of *e-Perspectives*, Sidney Moormeister leads with an inspiring article on the need for integrity in the medical transcription profession: "Would You Sell Your Soul? (and How NOT to Make a Workplace Faustian Bargain)." Randy Drake launches a new column on pharmaceuticals, "Dear Drake and Drake: Q&A Rx and OTC." Randy and Ellen Drake, authors of the annual *Saunders Pharmaceutical Word Book*, share their expertise on prescription and over-the-counter drugs. With his characteristic dry wit, Randy tells us right off the bat "Google doesn't spell anything," reminding us it is a search engine and may pull up thousands of misspellings. Renee Priest, in "The Hip Bone's Connected to the Thigh bone," delights us with her clever depiction of how dictating stations for physicians are established. Richard Lederer effectively makes the point that English is the universal language. Joe Weber comes the closest he's ever been to admitting that speech recognition is NOT going to replace medical transcriptionists in our lifetime, which he has long predicted; he describes the process of "back-end recognition" as one that makes use of medical transcriptionists as medical editors and, in some cases, may increase productivity and reduce costs.

Featured in this first issue of *e-Perspectives* is an article by John H. Dirckx, M.D., "Urines Are Cooking: Perspectives on Medical Slang and Jargon," with a two-page spread of terms, "Translation, Please! Medical Slang and Jargon." The article grew out of our recent translation efforts while producing the new course, *The SUM Program Beginning Medical Transcription*, 2nd edition. Dictating physicians use so much medical slang and jargon in their dictation that medical transcriptionists are constantly called upon to know which terms to transcribe verbatim, which ones to translate into formal terms, and which ones to flag. Dr. Dirckx offers a classification of medical slang and suggests guidelines for its management.

Rounding out *e-Perspectives* is the three-page "Update: What's New in Medicine" by Ellen Drake. These and other new terms will appear in *Vera Pyle's Current Medical Terminology*, 10th edition, to be published in Spring 2005.



Sally C. Pitman

Would You Sell Your Soul?

(and How NOT to Make a Workplace Faustian Bargain)

by Sidney K. Moormeister, Ph.D.

*The wages of work is cash.
The wages of cash is want more cash.
The wages of want more cash is vicious competition.
The wages of vicious competition is—
The world we live in.*

—D. H. Lawrence

The plight of the aged Dr. Faust touches opera goers with each performance. The story's power to enchant does not diminish as ages pass; indeed, the story of a man who sold his soul to the Devil rings truer now than ever before in the corporate arena in which we work for our living. Dr. Faust sought the solution to the riddle of life in vain, ultimately bartering his very soul in exchange for the pleasures of youth and vanity. Dr. Faust strikes a bargain with Mephistopheles that he will enjoy all of his desires for a time on earth in exchange for the forfeiture of his soul. So desperate is Dr. Faust that he quite literally makes what has become the proverbial "Faustian bargain"—a deal with the devil.

Our current economy and transcription climate frequently lead people to make what they feel are "Faustian bargains." Countless transcriptionists tell me that they fear for their very souls in the transcription workplace.

Long gone are the days of the hospital transcription department where, it seems, problems with dictators could be more easily resolved because of personal access to the physicians; gone, too, is the camaraderie that existed between fellow-workers. The home-based transcriptionist who is new to the profession has missed a whole block of our professional culture.

As the population of transcriptionists grows older, there are fewer and fewer "die-hards," as they have been called, who can mentor and pass on their wisdom to others. Some of the die-hards have literally done that—they have died. Others, having become disheartened with the impersonal atmosphere of today's milieu, have retired or gone on to second careers. Some, concerned by issues of outsourcing, have thrown up their hands in disgust and walked away.

Perhaps there are other ways to view and approach today's transcription workplace. I am not convinced that kindness, compassion, and the other "virtues" that are undefinable but very real need be abandoned. They certainly should not be. We must fight with every fiber of our collective soul to retain our humanity. But how do we do so?

Society as we have come to know it moves at warp-speed. "The bottom line" is pursued as if it were the Holy Grail. Multitasking has taken its place right up there next to kindness, compassion, and honesty as a bona fide virtue. What are our virtues, and how do we define them? What effect does the current marketplace have on our sense of ethics? How are our business ethics developed and will they survive the daily onslaught of production quotas and pressure-cooker urgencies?

Is it truly possible to remain centered in a work arena in which ever-increasing demands (with fewer and fewer rewards) are the norm? Will we attempt to do so? Should we do so? Yes! Resoundingly, yes! Not to do so is to sell our souls to an unseen devil which, while less dramatic than the Mephistopheles that beguiled Faust, is nonetheless real in its effects upon our collective psyches and well being. Not to retain our humanity is to allow ourselves to slip into a state of being in which we are robbed of our personhood and left achingly fatigued. Let us work seriously, calmly, and in an orderly manner to preserve our humanity in the rough and tumble world that is production transcription today. We must first define the challenge and then develop strategies to successfully meet the challenge—we must gird ourselves to overcome Mephistopheles, as it were.

The challenge is simply this: How do we remain human while working constantly with machines? How do we, in a high-tech world which prizes technical wizardry, speed, and gross output, manage to keep intact those qualities that make us so uniquely us? (After all, one machine looks and performs like another, and another, and another.) There is no insurance policy on earth that can indemnify us against loss of our true selves. The maintenance of one's humanity is strictly a do-it-yourself proposition, and thankfully so; uniqueness is a large part of what we are seeking to preserve.

There are plenty of technical articles out there that deal with everything from developing techie prowess to increasing transcription speed; there are few articles about preserving one's soul or inner-being. Let us focus on the issue of maintaining our humanity while working ethically and—dare I say it?—with pride and enjoyment in our work.

Virtue. It is a word that gets tossed around everywhere from Sunday school to the parking lot. What does it mean? It comes from the Latin *virtus*, which means "worth." Virtue, according to Webster, is general moral excel-

lence; a specific moral quality regarded as good. For the sake of this article, I would like to focus on kindness, compassion, honesty, and integrity as the virtues we should cultivate in our marketplace. These virtues will be coupled with ethics, which is merely the study or application of standards of conduct of moral judgment.

Let us consider four workplace “myths” in which we can apply the virtues of kindness, compassion, honesty, and integrity, and work through some strategies of application.

Myth 1: All that counts is the bottom line.

What are the characteristics of your corporate culture? Whether you work for a megaservice or one of the rapidly dwindling “Mom and Pops,” your company bears characteristics that are unique to it. Regardless of size, all companies are focused on the bottom line. This is not wrong per se; indeed, the company’s reason for existing is to make a profit. Capitalism requires and supports a production-driven workplace.

Far too many workers, be they MTs, clerks, proofers, or others on the transcription team, think and speak scornfully of “the bottom line,” as if it were something intrinsically evil. Perhaps we need to reframe our view of the need to make and show a profit. When I hear MTs speak in condescending tones about a megaservice’s concern with “the bottom line,” I remember sadly many wonderful people who were small service owners. I use the past tense because these folks are now working for university hospitals, physicians, or the megaservices because they as small-business people could not or would not acknowledge and embrace the need to keep their small companies solidly in the black. Some of them lacked people-management skills; others lacked the foresight to solicit new clients and obtain new contracts before the old ones ended. There is nothing virtuous or noble about running a business into the red! As these small businesses crumbled, people were left jobless.

We must examine the characteristics of our corporate culture as well as the role our attitudes play in it. What sort of a dynamic are we creating? How do you feel about going to work on Monday morning? One of the saddest expressions in popular culture is TGIF—“Thank God it’s Friday.” (Interestingly, this phrase expresses an international emotion. The French say, “Dieu merci, c’est vendredi,” no doubt with the same world-weary inflection as their American counterparts.)

To determine the corporate culture, it is necessary to ask a few key questions:

- Do all employees treat each other with dignity and respect in all situations?
- Do supervisors temper necessary directness with kindness and compassion?
- Are employees (or independent contractors) encouraged to give feedback, and are they taken seriously when they do so?

How do we remain human while working constantly with machines? How do we, in a high-tech world which prizes technical wizardry, speed, and gross output, manage to keep intact those qualities that make us so uniquely us?

Sufi tradition demands that three criteria be met before words are uttered:

Are they true? Are they necessary? Are they kind?

Embracing such criteria as our own might create a kinder, less stress-filled workplace while at the same time enhancing productivity.

The ideal workplace brings out the best in all individuals. The way we speak is an indicator of our willingness to embrace dignity and respect.

As a practical example, when I have occasion to call the corporate office of the team for which I work (which is many hundreds of miles away), I always take the time to ask the clerk, “How are you?” and to say “thank you” for any service the clerk performs. This takes but a nanosecond, yet it acknowledges that we are human beings, not modems, communicating with each other.

Myth 2: It’s “us” versus “them” in a workplace tug-of-war.

The failure to work collaboratively occurs on both sides of the table; management and MTs themselves often mentally position themselves as if they are standing on opposite sides of a chasm. What creates such a chasm? How can it be bridged?

Many MTs tell me that they are fearful of speaking honestly to management for two reasons: (1) Management will not take the time to listen, or (2) in the alternative, management will listen but will do so only superficially, not giving serious consideration or validation to what the MT has to offer. (As one seasoned MT told me recently, “It is as if they are thinking, ‘Shut up and type’.”)

As we move into the global economy and our world becomes smaller, it will pay rich dividends to treat each individual in the workplace with dignity and respect. We need to learn from cultural differences. What is acceptable and permissible in one culture may not be so in another. Even in our own culture, there are differences and boundaries that must be respected. Everyone has something valuable to add. When I became an associate dean of a major forensic sciences program during the eighties, I once asked my secretary for her opinion on something. Amazed, she replied, “But I am only a secretary! Why do you care what I think?” I told her that I never again wanted to hear her refer to herself as “just” a secretary and that I honestly felt that if all of the secretaries went on strike, the university would quickly close. She got the point.

Employees stand on one side of the economic chasm while management maintains its guard at its own border. Differences,

however small, are magnified when there is no communication. An MT friend of mine who works for a megaservice relates that their CEO last year was awarded a \$4 million bonus. While this is not a particularly outstanding bonus when compared to what other CEOs earn, it offended my friend mightily. Bitterly she asked one of her fellow MTs how much her bonus had been. Neither MT had received a bonus at all, nor had there been any acknowledgment during the holiday season. While I realize that we live in perilously politically correct times and that Christmas cards are not appropriate in the workplace, could not the company have sent out a generic end-of-year card thanking the employees and contractors for a job well done and wishing them well in the coming year? I know of no one who would have been offended by that. It would have been a wonderful opportunity to build a sense of team and cooperation; it could have even been a chance to bridge the chasm; yet it was not done. The employees noticed, and many made cynical comments to the effect that machines do not need to be sent holiday greetings. The chasm was not bridged, but reinforced. Perhaps something can be learned from this story.

Myth 3: It's personal.

One of the most pervasive yet most dangerous workplace myths is that any issue is personal. Feelings are hurt and the embers of temper are fanned by our all-too-human tendency to personalize workplace conflicts. Many times we use the phrase, "Oh, it's just a personality clash" to excuse ourselves from resolving interpersonal problems.

The most helpful thing I learned while in academia is that we all see issues from our own unique perspective. We all have developed an idea of what is "right." Because we are human, we sometimes have firmly entrenched beliefs that something is right even when logic and reason tell us it is not so. (Witness my persistent love of drinking Coca-Cola with breakfast, years of dental bills notwithstanding.)

It has been helpful to me to realize that even though I may be dismayed by a viewpoint or approach taken by another, that person feels and acts the way she does because it is right from her point of view. (In the immortal words of Bob Dylan, "You're right from your side and I'm right from mine.") The other person's viewpoint and behavior have nothing to do with me personally but rather are the result of the sum total of that person's experience, ethics, values, and beliefs. When I let go of my own desire to be "right," I can more objectively analyze the issues at hand. In any conflict, three questions are helpful:

1. What is the single issue that leads to disagreement?
2. How does this conflict affect my individual behavior and productivity?
3. What part of the conflict can I take responsibility for transforming?

Perhaps the only thing that can be transformed is your attitude toward the problem. Perhaps you need to speak up (politely) for yourself and others. Communicating honestly and clearly

Employees stand on one side of the economic chasm while management maintains its guard at its own border. Differences, however small, are magnified when there is no communication.

signals to the other party that you respect them and that you expect them to respect you.

Myth 4: The Golden Rule has been rewritten.

"Do unto others before they do unto you" seems to be the transmogrification of the classic Golden Rule of doing to others as you would have them do unto you. This change to Holy Writ is unofficial but it appears to be very real in some quarters, and it is part of the sad legacy of the Yuppie movement of the 1980s. Over the past three decades, there has been the evolution of what I will call the "Me First Generation." Membership in this group has nothing to do with age and everything to do with attitude. I know very altruistic 20-somethings and greedy 60-year olds—and vice-versa.

"Me-Firstism" is a fear-based behavior that occurs because people believe that there is not enough—not enough work, not enough money, not enough time. A belief in scarcity drives this behavior. Many MTs working for large services feel that the human part of them has been lost. They do not see themselves as members of the team. Some of this has to do with being home-based; more of it has to do with the exclusive focus on technical skills with little interpersonal interaction or acknowledgement. There is a perception, even among the nontranscriptionists in the transcription industry, that anyone who can type can do this job. The late, wonderful Vera Pyle contended that transcriptionists would never have professional respect because their tool is a keyboard. How sad.

There is also the constant quest for increased production. Some—mostly inexperienced—managers push production-based workers to and beyond the breaking point. This is not a new problem. I well remember an incident that occurred in the 1970s in a well-known hospital where I worked. A transcriptionist, tired of the constant struggle for more lines, picked up and single-handedly threw her brand-new self-correcting IBM Selectric against the wall of our transcription department. (For this she won herself a trip to the psychiatric ward.) Under such pressures, it is little wonder that the Golden Rule and other forms of civility lie broken and bloodied on the battlefield of production.

What is the solution? The Moody Blues sum it up neatly in one phrase: It's a *question of balance*.

To keep production finely tuned is a challenging proposition. MTs frequently tell me that they are afraid of being turned into machines, and rightly so. On management's side is the complaint that MTs (especially those who are classified as statutory employees) have become so individualistic and so con-

This brings me to the number one problem in today's transcription workplace—a simple lack of integrity. My definition of integrity is simple: Integrity means doing what you say you will do.

cerned with their own convenience that their attitudes toward work are downright cavalier. Production agreements are not kept, schedules are disregarded, and accounts are ultimately endangered. Management and MTs stand at an impasse.

I have personally witnessed situations in which a transcription company had to offer its employees bonuses to work on the weekend. I have a real problem with this. While I like a good bonus as much as the next person, I find it unfortunate and improper that workers need to be bribed into doing the work that they have already contracted to do.

This brings me to the number one problem in today's transcription workplace—a simple lack of integrity. My definition of integrity is simple: Integrity means doing what you say you will do. That transcriptionists must be "invited" to do their work makes me sad. What has happened to professionalism? What has happened to keeping one's word?

Transcriptionists who fail to "deliver the goods" hurt not only themselves but also put their fellow MTs at risk. Accounts are jeopardized because MTs do not produce what they have agreed to produce. One of the reasons for acting without integrity is that MTs feel that the company's immediate and ongoing needs for production supersede the MT's needs—needs for time off, time for a personal life, time to be human. I often wonder if the reason some MTs do not keep their word is sort of a passive-aggressive approach to their own dissatisfaction. Such an approach does not work. Just as MTs need feedback, so do supervisors. If there is one weakness in the megaservice model, it is that feedback is always one-way. Almost never is there provided a pathway through which the MT may communicate with management on key issues. This is demoralizing. It also robs the company of valuable information from seasoned "in the trenches" workers.

What if? Ask yourself "What if?" What if you embraced the company's goals as your own? If you view your job as only a means of obtaining a paycheck, try visualizing yourself as part of a team. This may be especially difficult for people who work from home; paradoxically, people who work from remote sites may be those most in need of this exercise. What can you do to serve the client and ultimately the patient? Frequently the patient gets lost in our need to master technical skills and in the remoteness of our workplace. But never should we forget that

we are part of a team whose opportunity is service and that the patient is our main concern. We provide unseen but invaluable service.

Margaret Mead said, "The best possible work has not yet been done." The transcription world of this new century is an exciting one. We face more challenges and more opportunities than ever before. Let us redefine our workplace as a place in which we will get and give support; let us remind ourselves that transcription is a service business, and that the person we serve is the patient. Let us approach our colleagues with a sense of collaboration rather than of competition. Let us reframe our attitudes and re-embrace integrity. Let us develop virtues and exercise ethics. Let us create a new workplace in the new century. In so doing, we will defeat Mephistopheles.

I would be interested in exploring questions of ethics, virtue, and the preservation of humanity in the transcription workplace. Please let me know your thoughts at: slcwarthog@earthlink.net.

Resources for Further Reading

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The Hip Bone's Connected to the Thigh Bone

by Renee M. Priest, CMT

“The dictation line’s connected to the transcriber’s ear.”

A simple concept to an MT, but some days I think the folks who actually decide where dictation stations are placed have no idea at all where the sound really goes.

Darth Vader strides confidently through the emergency room door, pointing here, there, and with rasping voice: “Maximum nursing traffic, high-volume patient pass-throughs, nice echo effect of the ambulance sirens. Put that phone set right here in the middle of the room.”

Try deciphering actual spoken words against the backdrop of those noises all day long and you quickly understand why my mental vision of what these folks look like is less than favorable. My imagination conjures up something along the lines of the Gestapo agent from the first *Indiana Jones* movie, with a little sprinkling of the warden from *Cool Hand Luke* thrown in for good measure: “What we have here is a failure to communicate.” It is obvious to me that somewhere in that placement process the all-important fact that MTs must be able to HEAR the dictation in order to transcribe it was zapped with the light saver!

I bet it is sort of like watching a swarm of ants armed with automatic roll-up tape measures and industrial-strength headphones that block out the merest whisper of sound. Clutching blueprints under their arms, the sound engineers probably only separate long enough to measure the distance of dictation station location to patient bed. Then, punching those coordinates into PDAs, they instantly uplink to some central data bank for “where to place dictation stations” maintained on the Internet. Once updated, it is a done deal. From then on, in every single hospital that is built, the dictation station will be in the exact same noisy place! Judging by the sounds coming from my headset, I don’t think that is such a far-fetched assumption.

It is just as obvious to me that these instructions were created when the hospital was utterly deserted. “Sound whispered in the microphone, against the background noise of a patient in pain is connected to . . .” Well, it sure is not connected to the transcriptionist’s ear because what I am hearing bears no relationship to words.

I suspect the hospital may have had a patient visitation day from Hooters on the day these folks were doing calculations because it is pretty evident that whoever was in charge of the measuring tape was a bit ... errr ... distracted the day the nurse’s station dictation line was mapped out. How else to explain the fact that I can hear the doctor and nurse discussing the lunch menu in the cafeteria, but absolutely nothing about the medications the patient is supposed to be receiving stat? How else to explain the sound of charts being slammed down on the desk; the clanging and clinking noises of desk drawers opening and shutting; the incessant ringing of the telephone that no one is answering. Somewhere in that cacophony of sound is a

dictator’s voice and I can’t shake the feeling that if I just listen hard enough, I will be able to discover it! Sort of like mining for gold, swirling the water and the mud around over and over again until the gold nugget falls out.

“The microphone is connected to the phone line ...” Somewhere in those PDA downloadable placement directions there must be an entire chapter on just how far from the dictator’s mouth the microphone should be placed and exactly where that sound is going when it is sent off-site. I am, however, beginning to think it is written in ancient Greek because many of the dictators I encounter seem to have skipped over that chapter entirely. I suspect that some of them really do think that a tiny person is sitting inside the Dictaphone waiting to spring into action the moment sound activates the machine! “Hello, hello,” BAM, BAM, BAM, the sound of a finger tapping on the microphone ... “just making sure this is turned on and someone is listening.”

The directions for “mouth is connected to microphone” placement must include detailed “how to’s” for everything from swallowing the word in mid syllable to throwing the words at the microphone like spit balls. I guess the theory is that the speed of trajectory will force that word to land on the microphone, ending up in the transcriptionist’s ear by default. These seem to be behavior patterns that the process of downloading stamps into the dictator’s mind permanently, sort of like the collective consciousness of the Borg from *Star Trek*, because these dictation patterns are inevitably cross-institutional!

“The cafeteria is connected to ...” Actually I don’t know why anyone could have thought the cafeteria was connected to the dictation system, but obviously someone did. Recently a newspaper in Seattle offered the useful advice (“Return the dictation untranscribed.”) to an MT who had written a letter to the help column, bemoaning the “mouth full of food connects to clearly spoken dictation” theory. “If you or your company calmly returned these tapes to physicians, they might fire you and find people more willing to be abused. They might also cooperate. If you know or believe you cannot afford to risk a job no matter how much abuse is involved, realize this job will entail transcribing through mealtimes.”

I am trying to track down the author of that advice and find out how he/she managed to tap into the “dictation station placement” PDA master file. I know a couple of MT hackers who would love to get hold of those placement files and do a little “sound is connected to ...” rewriting!

Renee Priest, CMT, is the moderator for the Hot Zone at MT Desk, www.mtchat.com. As on off-site acute care MT for more than 10 years, she believes that humor is her most effective tool in dealing with the stress inherent in this profession. E-mail: pithy@millenicom.com.



Dear Drake and Drake

Q&A: Rx and OTC

by Randy Drake

QI was looking up a medication in the *Saunders Pharmaceutical Word Book*, and found that you have it spelled Lanacane. Google has it spelled Lanacaine. Which is correct? —J.S.

AThe short answer is that Lanacane is correct; Lanacaine is not. See: www.lanacane.com

Please note that Google doesn't spell anything; Google is a search engine that indexes words found on Web pages. The main problem is that Google finds and indexes everything that appears everywhere on the Wild, Wild Web (what do you think "www" stands for?). And yes, there are 294 pages on the Web that have the product misspelled as Lanacaine, which Google indexes right along with the 10,400 pages that have it spelled correctly.

If you use the Web as a reference source, you can usually find multiple ways to spell just about anything. The problem is that you can't tell which is right and which is wrong. Misspellings of drug names abound. You can find "Levothyroid" all over the Web, for example, but "Levothyroid" does not exist—anywhere in the world, either now or in the past. The correct spelling is *Levothroid* (without a "y"), as you will find it listed in our book. There are Google hits on "zithromycin" and "zithromicin" and "azithromicin" also; they're all misspelled variants of "azithromycin"! The Internet can be a wonderful source of entertainment, but if you want to find the correct spelling of medical words, you should stick to high-quality medical reference books that have a reputation for accuracy.

QI have come across a medication in transcription spelled by a physician as Zellnor 0.6 mg. I am aware of a medication called Zelnorm. I am not sure Zelnorm is what he wanted, however. Can you please advise regarding this unfamiliar medication? Thank you. —D. C.

AThe good doc probably meant *Zelnorm*. Physician spellings are famously unreliable, so we'd take his spelling with a grain of salt. The best way to double-check it is by the dosage and indication. If he actually said "zero point six milligrams," that would give us pause, since Zelnorm comes in 6 mg strength, not 0.6 mg. If he said "point six" we'd wonder if he was making a mistake in the dosage also. That leaves the

indication. Zelnorm is specifically indicated for irritable bowel syndrome (IBS). If the "mystery medicine" is being prescribed for IBS, we'd feel pretty confident that it's Zelnorm. If you have access to the chart, you could verify the medication there; if not, we'd probably flag it with "D: Zellnor 0.6 mg. T: Zelnorm 6 mg. OK?" If it's not for IBS, we'd leave a blank before typing a drug we couldn't verify.

As a point of interest, the FDA would not allow a company to name a prescription drug "Zellnor" because the name is too close to Zelnorm. Several years ago they started disallowing soundalike and lookalike names to already-existing Rx drugs, to prevent mixups in the pharmacy when the script is being filled. The first name they disallowed was "Celebra" (too close to Celexa), which the manufacturer then changed to Celebrex. Years before that, the manufacturer changed the anticonvulsant Clonopin to Klonopin so that the bottle would not sit next to the antihypertensive clonidine on the pharmacist's shelf. All this is to say that it's very unlikely that there is a prescription drug named "Zellnor." Herbal and natural products are not subject to FDA review, however, so anything goes when naming them.

QI have received conflicting feedback from QA and was told to take up this issue with you. According to the QLEDB, Pen-Vee K has been discontinued. In a recent report, I flagged the occurrence of this drug, indicated this fact, and asked the editor if I should type "pen VK" (which I understand is the generic name) instead. I was specifically told by the editor "Pen-Vee K should now be pen VK." However, on a subsequent report, the editor changed my notation of "pen VK" to "Pen-Vee K." Please let me know which one of these forms should be used. Thank you. —A.

AWe should first address the misconception that "pen VK" is a generic name. It's not. The official generic name for this drug is penicillin V potassium. Any other form is either a brand name or slang.

Pen-Vee K is Wyeth-Ayerst's registered brand name for penicillin V potassium. In 2002 the company went through a major reorganization—some divisions spun off, others merged, etc.—and they became known as simply Wyeth. In the transition, several drugs were discontinued or sold to other manufacturers. Pen-Vee K bit the dust in the transition, probably

because most people now use the generic version instead of paying a premium for the brand.

There are a few brands of penicillin V potassium still around: Penicillin VK and Veetids in the U.S., others in Canada. Interestingly, a half dozen other brands were discontinued in 1997–98, probably because the other manufacturers (Lederle, Parke-Davis, etc.) couldn't compete with Pen-Vee K and the widely-available generics.

As far as “Pen VK” goes, we cannot find a manufacturer that makes this brand. Nu-Pharm (Canada) makes Nu-Pen-VK, Novopharm (Canada) makes Novo-Pen VK, Apotex (Canada) makes Apo-Pen VK, but nobody makes Pen VK, domestically or internationally. Pen VK can be found all over the Web, of course, along with misspellings of many other drugs. We suspect that this rendering is simply a phonetic spelling of Pen-Vee K, which was the most popular brand in the U.S. (Wyeth's Mexican brand was Pen-Vi K, but it, too, dropped during Wyeth's restructuring.)

Once doctors get a name in their head, they tend to use it forever. For example, doctors still dictate “AZT” (for azidothymidine), even though the generic name was changed to zidovudine (ZDV) many years ago. And many people still refer to RU-486, even though its official generic name, mifepristone, replaced that investigational code name over ten years ago.

So what to do? Our advice is this: If a doctor dictates “pen vee kay” in a historical sense, we'd type the brand name Pen-Vee K, since it was historically the most popular brand. If the doctor is prescribing “pen vee kay” today, we'd type the generic, penicillin V potassium, since he didn't specify a brand that's available today. It's highly likely that the good doctor will continue to dictate “pen vee kay” (and write scripts for Pen-Vee K) until he retires since it's an ingrained habit. It is up to the alert transcriptionist (and pharmacist) to recognize what he is saying (or writing) and transcribe (or fill the script with) the current form of the drug.

Q Why do you have Qvar in your book, when the manufacturer's Website clearly states it is QVAR? This makes Quality Assurance difficult when you have a transcriptionist doing it the correct way, and a QA editor “correcting” it to the incorrect version using your book as a reference. —B.H.

A You've made an assumption that the only “correct way” to render a drug name is to follow the manufacturer's capitalization scheme and, therefore, every other way to render the name is “incorrect.” That would be fine if you were typing the reports for yourself, and if there were no standardization authorities in existence.

The short answer on the drug in question is that either rendering is correct.

On page xiii in the front of our book, the first two paragraphs of “A Brief Note on the Transcription of Drugs” discusses capitalization schemes that may vary from institution to

institution. An institution's formatting preference supersedes all other formats, including the one found on the manufacturer's Website and the one found in our book. As a transcription service, you may be asked to render drug names different ways for different clients. Do you ask your clients for their preference on the transcription of drugs? Lacking specific instructions from the client, we suggest that the AMA and AAMT standards be followed.

Many manufacturers “shout” the name of their products, as if to make them more important, which they accomplish typographically by putting them in ALL CAPS. Before we published our first edition in 1993, we made an editorial decision not to follow the “all caps” scheme that manufacturers are so fond of. Therefore, any all-cap rendering by the manufacturer is changed to an initial cap in our book, as supported by the AMA and AAMT.

We try to follow a manufacturer's capitalization scheme unless it is rendered in all caps. A reader recently brought to our attention that Welchol should have a cap “C” in it. In going to the manufacturer's Website (www.welchol.com), we noted that it is displayed with a cap “C” throughout, including in the official prescribing information. We do follow a manufacturer's unusual capitalization scheme if it is consistent, so we changed “Welchol” to “WelChol” in the 2004 edition. It becomes a problem only when a manufacturer registers a drug name two different ways, such as as “femhrt” for the U.S. market and “FemHRT” for Europe; we use the U.S. rendering in our book.

Q When will the next edition of *Saunders Pharmaceutical Word Book* be available? Can you ship one and bill me, or should I send you a check?

A Each new edition begins shipping the first week of December. You can pre-order the 2005 edition now, but not from us. We are the authors; all book sales are made by the publisher.

The best way to order our books is directly from the publisher's representative in your area. To get the contact information for your local rep, go to our Web site, spwb.saunders.net, and click on the “Order” tab. Follow the link to the Sales Rep Locator page, scroll down about half way to “Professional Sales Force” and enter your zip code.

Or you can use the publisher's toll-free order line (800-545-2522) to order from them directly. You don't need to pre-pay; they'll bill you.

Randy Drake has been involved in the medical transcription profession for 18 years. He is the coauthor (with Ellen Drake) of 16 books in the *Saunders Pharmaceutical Word Book* series. He has spoken at national pharmacists' meetings, AAMT Annual Conventions, state and local chapter meetings, as well as at several seminars for teachers. Contact him at spwb@saunders.net.

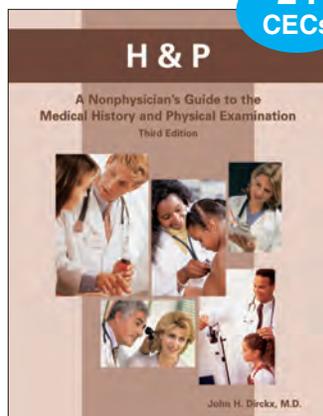


H&P: A Nonphysician's Guide to the Medical History and Physical Examination, 3rd ed., by John H. Dirckx, M.D.

This edition—in workbook format with comprehensive exercises—explains the history and physical report step by step, demystifying the elusive language of physicians. It aids both novice and experienced transcriptionists in deciphering difficult dictation and can be used as a study aid for credentialing exams.

Earn 24 CECs from AAMT!

Softcover, 336 pp., 2001.
Item Code: H&P3. \$32.



Human Diseases by John H. Dirckx, M.D.

Human Diseases, 2nd ed., contains the latest information on the diseases most commonly encountered in dictation, including causes, symptoms, diagnostic tests, diagnoses, and treatment regimens. The systematic, self-contained topical organization of the book makes *Human Diseases* an ideal, easy-to-use desk reference for medical transcriptionists, coders, and other allied health professionals.

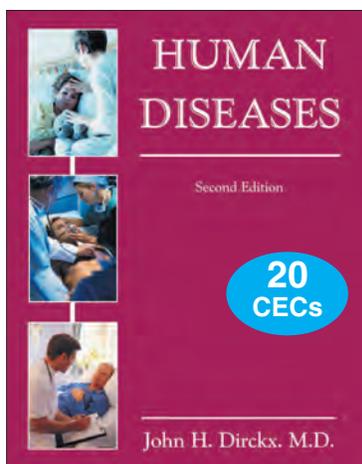
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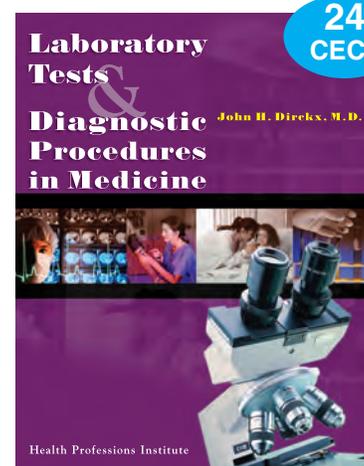
Laboratory Tests and Diagnostic Procedures in Medicine, by John H. Dirckx, M.D.

The latest addition to our SUM Program curriculum, this entirely new book, **in workbook format**, is like having two books in one! It provides critical information for understanding laboratory tests and diagnostic procedures. It answers the “what, when, why, and how” of laboratory and diagnostic medicine, promoting more accurate transcription, editing, and coding of health records and chart analysis.

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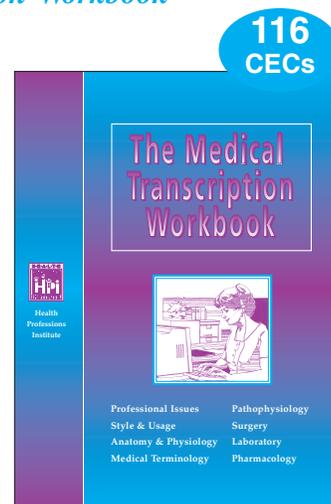
The Medical Transcription Workbook

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- Pathophysiology
- Laboratory
- Pharmacology

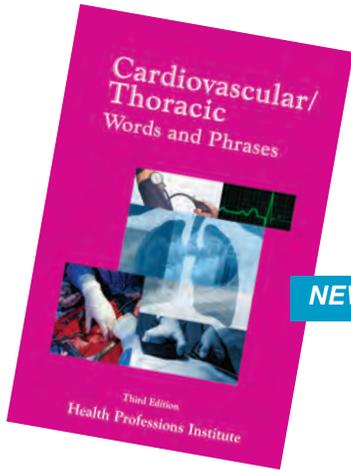
Earn 116 CECs from AAMT!

Softcover, 462 pp, 1999. Item code: MTWB. \$40.



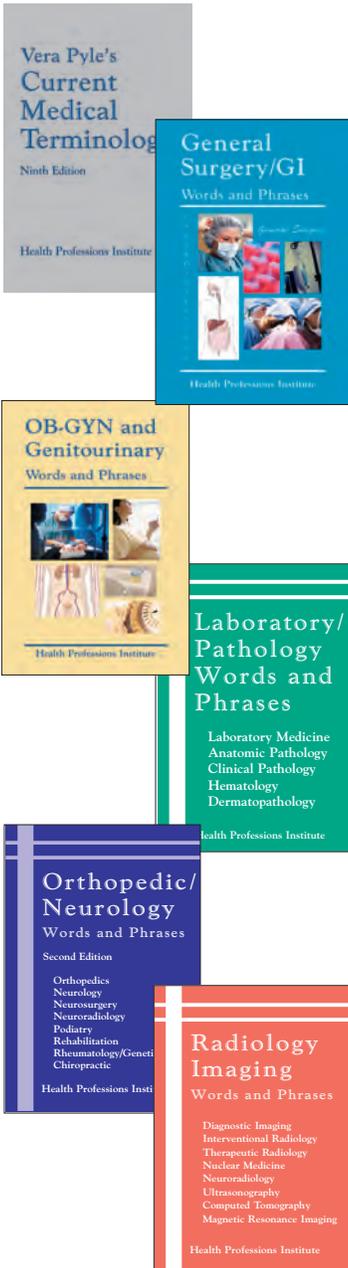


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Looking at Language

Doing a Number on English

by Richard Lederer, Ph.D.

Recently, some organizations in Germany joined forces to compile a list of the hundred words that best reflect the twentieth century. AIDS, beat, bikini, camping, comics, computer, design, Holocaust, image, jeans, pop, single, sex, star, stress—English words that became part of the German language during the past hundred years—are featured in the list. That's just one piece of evidence that English has become the closest thing that humankind has ever had to a universal language.

"I think that language is a mirror of history, and these words reflect that," said Karin Frank-Cyrus, head of the Society for German Language. "The English language has become a lingua franca, a language that the whole world understands."

It is said again and again these days that there are lies, damnable lies, and statistics. Nonetheless, Americans are fascinated with and by statistics and take a special interest in facts that can be quantified. Here are some essential facts about our English tongue, expressed statistically:

Number of languages in the world: Approximately 6,800, 50 to 90% of which will be extinct in a hundred years.

Number of people around the world who can be reached by English in some form: 1.5 billion.

Percentage of those people who learned English as a second (or third or fourth) language: 51.5. China and India each have more English speakers than the United States.

Number of countries or territories in which English has official status: 87.

Percentage of the world's English speakers who live in the largest English-speaking country, the United States: 20.

Percentage of world English that is American English: 66.

Percentage of world English that is British English: 16.

Percentage of students in the European Union studying English: 83.

Percentage of people in the European Union who are fluent in English: 75.

Percentage of non-native speakers around the world who are fluent in English: 25.

Percentage of all books in the world printed in English: 50.

Percentage of international telephone calls made in English: 52.

Percentage of radio programs worldwide broadcast in English: 60.

Percentage of global box office from films in English: 63.

Percentage of global e-mail in English: 68.

Percentage of international mail and telexes written and addressed in English: 70.

Percentage of global computer text stored in English: 80.

Percentage of the 12,500 international organizations in the world that make use of the English language: 85.

Percentage of those international organizations that use English exclusively: 33.

Percentage of all English words throughout history that no longer exist: 85.

Number of words listed in the *Oxford English Dictionary*, not counting its supplements: 616,500.

Average number of words added to English each year: 1,000.

Number of words in the largest dictionaries of German, the world's second largest language: 185,000.

Number of words in the largest dictionaries of Russian, the world's third largest language: 130,000.

Number of words in the largest dictionaries for French and Spanish, tied for the world's fourth largest language: 100,000.

Borrowed words in English versus native (Anglo Saxon) words, expressed as a ratio: 3:1.

Number of borrowed languages in the English vocabulary: 300.

Percentage of English words made from Latin word parts: 50.

Number of words the average English speaker actually recognizes: 10,000-20,000.

Percentage of the average English speaker's conversation made up of the most frequently used 737 words: 96.

See next page for a list of Lederer's books and ordering information.

Richard Lederer, Ph.D., is the author of more than 3,000 books and articles about language and humor. His syndicated column, "Looking at Language," appears in newspapers and magazines throughout the United States. E-mail: richard.lederer@pobox.com.



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Speech Recognition Is Here At Last!

by Joe Weber

The technology we've all been anxiously awaiting has finally arrived. *There are now several major hospitals across the country that have implemented enterprise-wide speech recognition. At each of these hospitals, all the physicians are dictating into PCs so that powerful software can instantly display their spoken words. The physicians then review this recognized text, correct the very few mistakes, and electronically sign the report immediately. No transcription delay. No transcription cost. The hospital executives are thrilled, and the word is just beginning to spread. Within a year or two, this will surely be the way clinical documentation is handled everywhere.*

Just kidding. I figured this was an effective way to get your attention, albeit personally hazardous, given the readership of this magazine. That whole first paragraph is a lie, except for the first sentence. I do hope you're chuckling rather than gritting your teeth or clutching your chest because we will now turn our attention to a speech recognition approach that actually is appealing to the medical transcription industry.

The Reality

The simple reality is that most physicians refuse to correct the mistakes made by a speech-recognition engine, even when there's only a 2-3% error rate. Therefore, the primary users of what we shall call "front-end" recognition are only those physicians who are both progressive thinkers and would otherwise be paying for transcription out of their own pockets. And there are just not that many progressive physicians.

The vast majority of physicians want to keep doing exactly what they've always been doing, and nothing more. They also won't embrace structured/codified input, which is arguably the most powerful weapon available to us for advancing the science of medicine as well as increasing both the quality and cost effectiveness of healthcare. But that's a discussion for another day.

The Physician-Friendly Approach

There is a way to implement speech recognition that is actually quite palatable for physicians. It's palatable because they don't even have to know that it's going on, and they don't have to change their dictation behavior at all. Physicians love innovation but they hate change. So if you want to stay friends with physicians, don't force them to change anything. This stealthy approach, happily, is also friendly to transcription folks. It's not the Holy Grail, but it is beginning to make a significant impact on the industry.

We shall refer to this approach as "back-end" recognition. Physicians dictate as they always have, typically over the tele-

phone into a digital dictation system. The resulting digital-voice file is routed through a speech-recognition engine to produce a draft of the text report. This draft is transmitted to a medical editor, who listens to the playback while reading the draft and corrects any mistakes observed. Dictation can also occur via portable digital recorder or PDA, uploaded to a PC, or physicians can dictate directly into a PC. In these cases, the voice file is digitally transmitted to the server for recognition.

What's the Payoff?

The benefit of this back-end approach is simple: increased productivity, resulting in reduced cost. But does it really have this impact? There are a number of vendors offering back-end recognition solutions. They claim productivity improvements ranging from about 30% to 100%. The latter figure represents a doubling of output, which is big! With the lower figure, however, it doesn't seem worth going through the process change, not to mention that it's not worth the cost. The most advanced speedtyping software, i.e., Stedman's Smartype and Instant Text, averages about a 40% productivity boost for less than \$200, one-time cost per transcriptionist. It's rather foolish to pay thousands of dollars per transcriptionist each and every year to achieve less than that. [Disclosure: Stedman's Smartype is my company's product.]

So, for the sake of our argument, let's assume that we're only interested in this technology if it approaches an average of 100% productivity increase. Let's run the numbers from the perspective of a medical transcription company. If the company now pays 9 cents per line (cpl) to its transcriptionists for straight transcription, and it can promise them a doubling of productivity, then its transcriptionists should be willing to accept 5 cpl. If the technology costs less than 3 cpl, and actually does double productivity, it makes sense to implement it.

Unfortunately, there have been implementations where the cost is 2-4 cents per line and productivity is increased by just 30-40%. There's no value proposition in that scenario. If you're considering implementing a back-end recognition solution, it's critically important to come up with a reasonably accurate estimate of productivity increase (through a controlled test), determine what that's worth in cost savings, and then match that to the price being charged by the technology vendor. If the latter is not at least 1 cent per line, preferably more, lower than the former, walk away. Run away.

The Total Solution

Most of the vendors of this application technology provide a total solution. This means that you place your entire dictation/transcription operation on their platform. If you're looking to purchase a new dictation system, transcription software,

and document-distribution system, then this is a reasonable course to evaluate. The cost for this total solution, however, is likely to be rather high, potentially requiring some up-front dollars plus maybe 3-4 cents per line.

There are two major basic-technology providers of speech recognition: ScanSoft (Dragon) and Philips (SpeechMagic). The accuracy of their engines is rather close. Each one does certain things better than the other, but, overall, there is not a substantial difference. I believe that one is a little better, but in this article I'm not going to tell you which one that is.

The application providers use technology from one of the technology providers, ScanSoft or Philips, or they utilize a proprietary technology. Remember that while accuracy is an important contributing factor, the only variables that really count are productivity increase and cost per line. Make sure you know the magnitude of both and how they compare before you sign any agreement that requires a substantial investment.

The Other Approach

If you have a workflow which makes you happy, and prefer not to go through the process-change and expense to change it, then you should consider speech-enabling your existing platform. This means that you acquire just the speech engine and the toolkit to integrate it. It will require some work but you won't have to go through a major platform shift, and you should save many thousands of dollars. The only observable difference from what happens today is that your transcriptionists will receive a draft text report, along with the synchronized voice, and will now be editors rather than typists.

In order to maximize productivity, you will need to incorporate some complementary software, such as automatic formatting. If the editor needs to format the report as well as correct misrecognitions, there is not likely to be a speed advantage over straight transcription. If all they have to do is make the corrections, this will have a profound positive impact on overall productivity.

It is also important to optimize the acoustic and language models of the speech-recognition engine. The acoustic model represents how each dictator pronounces the sounds (phonemes) of the English language. The language model determines what words the dictator uses and how s/he puts them together in context.

In front-end recognition, the acoustic model is initially customized by having the dictator read displayed text for 5-20 minutes. But in this back-end approach, the dictator is kept in the dark. So the acoustic model is formed by matching the words in prior voice dictations to the words in the associated transcribed text. The language model is put together by analyzing a relatively large number of prior reports for each work-type for each dictator. There is no need for any effort on behalf of the dictating physicians. Lucky for us! Because we know exactly how cooperative physicians can be when asked to make any effort to improve clinical documentation. Nonetheless, it doesn't hurt to ask the physicians to be a little more careful with their dictations. You'll probably have to incent them with money or doughnuts.

The accuracy, naturally, will vary by dictator. Those who enunciate most clearly will achieve the highest accuracy. The systems do surprisingly well with accents as long as the dictator doesn't mumble or manifest substantial dysfluency. Some physicians are such bad dictators that it will be years before the technology advances enough for it to make sense to even attempt to edit their drafts generated by these recognition engines, but the majority of dictators should qualify immediately.

To get started on this process, it seems advisable to acquire some outside expertise to help assure an elegant integration into your workflow and to optimize your abilities to construct the best acoustic and language models, which are critical for maximizing accuracy and thus productivity. Make sure that the consultants will transfer their skills and knowledge to your staff, once the process is running smoothly and effectively. [Disclosure: My company provides autoformatting and other software, as well as implementation expertise for speech-enabling existing workflows.]

If you choose to go this route, you are likely to find the pricing extremely attractive. The software, when amortized over 3 years, can come out to well less than 1 cent per line. If you can double productivity for that price, you don't need complex math to recognize the value proposition.

Is It Really Here?

Since 1982, when I sat in the living room of the founders of Dragon Systems excitedly observing their initial alpha software run on an 8086 IBM PC (anyone remember those?), I've been watching this technology very, very closely. Starting in the mid-1980s, lots of folks fell prey to the rolling 3- to 5-year window: In 3-5 years, the first paragraph of this article will be reality. Well, that window rolled for a couple of decades, and that reality is still not here. But what is here, as described in this article, is something rather powerful. And it is something that should resonate with the souls of everyone in the medical transcription industry.

If transcription productivity can be doubled for 1 cent per line, the entire face of the transcription industry should be transformed overnight. In any industry related to healthcare, nothing ever happens as fast as we think it will, but the handwriting is on the wall. Or, in more apropos verbiage, the words are appearing on the screen. If you can save several cents per line for most of your dictators, that's an opportunity you should grab sooner rather than later. As stated in that first true sentence of this article, "The technology we've all been anxiously awaiting has finally arrived."



Joe Weber is CEO of Lexicore, provider of software and consulting services to optimize speech recognition applications for medical transcription companies and healthcare organizations. E-mail: joweber@alum.mit.edu.

Update

What's New in Medicine

by Ellen Drake, CMT

abnormal bowel wall enhancement—a finding on CT possibly indicative of ischemia (also seen in hypotensive shock bowel).

Acorn cardiac support device

(ACSD)—a ventricular containment device designed to treat heart failure by containing the heart to prevent further dilation.

Allgower-Donati technique—a suturing technique used in orthopedic procedures. (Allgower appears in some references, but not coupled with Donati.)

angel wing—a figurative term for a portion of an A-P bevel resection guide, shaped like an angel wing, used in joint replacement surgery. Also may refer to a *Miller resection guide*.

aortomyoplasty—a treatment for heart failure in which the latissimus dorsi muscle is wrapped around the aorta and stimulated to contract during diastole to provide chronic diastolic counterpulsation. In one technique, the latissimus dorsi muscle (LDM) is wrapped en bloc around the aorta and secured to itself (*circumferential wrap*). In a second technique, a 4–5 cm wide strip of the lateral portion of LDM is isolated and wrapped as a helical coil around the descending thoracic aorta. A newer third technique is called a *wringer wrap*, in which the oblique transverse portion of the LDM is wrapped clockwise around the superior portion of the descending thoracic aorta, coupled to the lateral portion of LDM, which is wrapped in a counterclockwise direction distal to the oblique-transverse portion.

Bead Block—a polyvinyl alcohol (PVA) embolic microsphere used for the treatment of hypervascular tumors and arteriovenous malformations. PVA beads are also being used to treat uterine fibroids.

Blinkeze external lid weights—a treatment for lagophthalmos; the weights, made of tantalum, have adhesive backs and are placed on the upper lids.

bone morphogenetic protein—a protein involved in the formation of bone and cartilage. Bone morphogenetic protein 2 (BMP2) belongs to a superfamily called transforming growth factor beta (TGF-beta). BMP2 is an indication of osteoporosis risk.

BPM (bioabsorbable polymeric material)—a new embolic agent incorporated into Guglielmi detachable coils, used in treating aneurysms.

Cardioblade XL—a surgical ablation pen.

CD Horizon M8 multiaxial screws for lumbar fixation.

Collect graft preparation device—a bone marrow aspiration technique for iliac crest cell harvest, used to obtain osteogenic graft material that is rich in cells that can be prepared by surgeons without subjecting the patient to an iliac crest graft harvesting procedure. The Selective Retention process can be quickly performed intraoperatively and delivered to the patient at a reasonable cost.

colostomy shift en masse—a novel technique in which the colostomy is shifted along with a rim of skin and abdominal wall tissue. This provides additional length of distal bowel if needed during pull-through anastomosis.

Concentric retriever system (CRS)—a small metal wire with a loop at the end that removes clots from arteries and thereby restores blood flow to the brain.

DAVF (dural arteriovenous fistula) (Neuro).

D blood typing and antibody screening—formerly Rh blood typing. Related terminology includes D incompatibility (when a D negative woman is pregnant with a D positive fetus); D hemolytic disease; D antibody; administration of D immunoglobulin or Rho(D) immune globulin; weak D; and D isoimmunization.

EDR (extreme drug resistance) assay—a test performed prior to chemotherapy.

Embol-78—a liquid embolic material used for vein embolization.

embolotherapy—a coined word denoting embolization treatment.

embryo biopsy—a procedure performed when an in vitro fertilized embryo has reached the 8-cell stage in which a laser is used to make a hole in the envelope surrounding an IVF embryo and a single cell removed using a pair of tiny pipettes for the purpose of genetic diagnosis. The 7-celled embryo that remains is just as viable as the 8-celled one and remains in the petri dish while the biopsied cell is being studied genetically.

EVOH (ethylene vinyl alcohol copolymer).

Gill laminectomy—a procedure for spondylolisthesis, which consists of removing the involved loose lamina and decompressing the exiting nerve roots by removing hypertrophic fibrocartilage in the pars defect. Because of the risk of slip progression, a concurrent fusion procedure in adults to prevent late symptomatic instability, especially in the setting of degenerative disk disease has been recommended. (Note: *Not Gil*.)

Gimmick elevator—used in otologic surgery. “When opening posterior fossa dura, put a Gimmick in and

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cut with Belucci scissors over the top, always pulling outward to look for vessels.”

Goodwin sound—a sound used in the endoscopic treatment of obliterated membranous urethral strictures.

GUARD—saphenous vein graft intervention using AngioGuard for reduction of distal embolization.

Gynecare Gynemesh PS—a polypropylene mesh indicated specifically for pelvic floor repair in cases of cystocele, rectocele, and vaginal vault suspension.

hepatoprotection—a coined word denoting factors that protect the liver against toxicity.

high-dose-rate (HDR) brachytherapy—a treatment for prostate cancer in which very tiny plastic catheters are placed into the prostate gland. A series of radiation treatments are given through these catheters. The catheters are then easily pulled out, and no radioactive material is left in the prostate gland. This temporary brachytherapy is in contrast to the usual permanent seed placement.

Hiss, angle of—anatomic site encountered in laparoscopic gastric bypass procedure. “The root of the left diaphragmatic crus was exposed by caudad traction on the stomach fundus by the assistant to the patient’s left, and the phrenogastric ligament was incised at the level of the angle of Hiss.” Do not confuse with *His bundle of the heart*.

implantable gastric stimulation (IGS) system—a relatively new approach of electrical gastric stimulation to treat obesity. The operative technique is relatively simple and the system does not alter gastrointestinal anatomy.

keel and wing—phrase used in joint replacement procedures.

keel punch—a bone punch.

Kiwi vacuum extraction cup—a device consisting of a rigid plastic,

Malmström-type cup attached by a wire to a unique combined handle/pump, especially useful for cases involving cranial deflexion/malpositioning.

latissimus dorsi demand dynamic wrapping—an aortomyoplasty technique in which the latissimus dorsi muscle wrap is stimulated to provide active systolic assistance. See *aortomyoplasty*.

long-edge medullary nail (Ortho).

MACE (major adverse cardiac events).

maze procedure—a procedure performed on the left and right atrium for treatment of atrial fibrillation. Its name is based on the concept of a puzzle. The incisions made create barriers and several blind alleys allowing for only one major route for an electrical impulse to travel from the top to the bottom of the heart.

Merci Retriever—a wire with a corkscrew-like twist in the middle, the first medical device cleared by the FDA to remove blood clots from the brain in patients experiencing an ischemic stroke. The device was evaluated in the MERCI (mechanical embolus removal in cerebral ischemia) trial. The Merci Retriever is also used to remove foreign bodies in the peripheral, coronary, and neuro vasculature.

MIVAT (minimally invasive video-assisted thyroidectomy).

MOST (trademarked) **options system rotating hinge revision knee**.

n-butyl cyanoacrylate (n-BCA)—a permanent liquid embolic material and tissue adhesive for use in cerebral arteriovenous malformations.

Neuroform microdelivery stent system—a device used for the treatment of intracranial aneurysms.

Nichols-Condon bowel prep.

Novoste Beta-Cath system (brachytherapy).

Onyx—an experimental nonadhesive liquid embolic agent (ethylene vinyl alcohol copolymer [EVOH]) used for treatment of spinal dural AV fistula (DAVF) where penetration into the proximal radicular vein is required and for cerebral aneurysms.

passive girdle effect (adynamic-girdling)—an aortomyoplasty technique in which the latissimus dorsi muscle is used for passive restraint of the ventricle. See *aortomyoplasty*.

percutaneous nephrolithotripsy (PNL)—a technique for removal of large, dense stones and staghorns via a port created by puncturing the kidney through the skin and enlarging the access port to 1 cm in diameter. There is no surgical incision. The procedure is done under anesthesia and real-time live x-ray control (fluoroscopy). Because x-rays are involved a super-specialist in radiology (interventional radiologist) may perform this part of the procedure. The endourologist will then continue to insert instruments via this port into the kidney, break up the stone, and remove most of the stone debris.

Powerline catheter—a low-profile rapid-exchange PTCA catheter that provides better trackability for tortuous vessels and crossability for tight lesions.

preimplantation genetic diagnosis (PGD)—a therapy-oriented embryonic screening procedure using a procedure called *embryo biopsy*.

rainbow coverage—the use of sliding scale insulin coverage for inpatient glucose control. However, this method does not work well. Sliding scale methodology dates to diabetes monitoring by urine glucose levels. The tape that was used for the test would change colors, depending on how much glucose was in the urine. Insulin was then given based on the change in color. This was called

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“rainbow coverage.” Unfortunately, whether urine or plasma glucose is used, there is no physiologic basis for this form of insulin therapy. Patients therefore tend to have “roller coaster glucose control.” Under this protocol, the patient would not receive insulin when their glucose level is normal. A few hours later their glucose level increases because no insulin had been given. Insulin is then administered for the elevated glucose level and a few hours later the glucose level returns to normal. This cycle is repeated again and again.

retrograde intrarenal surgery (RIRS)—a procedure in which a fiberoptic endoscope is placed through the urethra into the bladder and into the ureter and kidney. The stone is seen through this optical instrument and can be manipulated, crushed by ultrasound probe, evaporated by laser probe, grabbed by small forceps, pushed back into the kidney (for subsequent ESWL).

roller coaster glucose control—see *rainbow coverage*.

sedentary death syndrome (SeDS)—a condition which is linked to syndrome X, dysmetabolic syndrome, obesity, increased rates of type 2 diabetes, and childhood obesity.

sentinel clot—a mesenteric hematoma or a focal area of higher density clotted blood seen on CT suggestive of vascular injury.

SonoSite portable ultrasound.

SprayGel absorbable adhesion barrier system—an adhesion barrier that can be delivered laparoscopically or via laparotomy to form a strongly adherent hydrogel film to prevent adhesions in gynecological surgery.

SST (stainless steel rod).

S-Stent—a new-generation smaller stainless steel corrugated ring stent with a proprietary Quadrature Link system allowing for easier maneu-

vering in smaller, more tortuous vessels.

stress Myoview—noninvasive nuclear imaging technique for patients unable to undergo traditional stress testing.

suction-bubble technique—an easily visualized movement of air bubbles in attached tubing caused by the vacuum created by hip-joint distraction, thereby verifying intraarticular needle placement for hip aspiration and arthrography.

SutureGroove gold eye weights—weights of 99.9% pure gold used for the treatment of lagophthalmos. A small incision is made in the eyelid, just above the lashes, and a small pocket created. The weights are secured to the lid with sutures placed through small channels or grooves in the weight, and the incision closed. Placement of the eyelid implant may be septal, mid pretarsal or low pretarsal.

Syed template—an interstitial gynecologic brachytherapy. Previously, the technique required blind insertion of the interstitial needles, potentially risking inaccurate placement of the radioactive sources and viscus perforation. These concerns arise particularly in the management of anterior vaginal tumors where difficulties in negotiating the pubic arch can prevent optimal needle placement. In answer to this problem, a technique utilizing an open retropubic approach for Syed template interstitial implants in anterior vaginal tumors under direct visualization has been developed.

TG-60 dosimetry parameters—dosing protocol for Novoste Beta-Cath 90Sr/Y source trains for intravascular brachytherapy.

ThinProfile eyelid implants—see *SutureGroove gold eye weights*.

THRIVE (T1 high resolution isotropic volume examination) technique—a powerful new imaging sequence

that combines a 3-D T1-weighted TFE sequence with SPIR fat suppression and SENSE, enabling fast, high-resolution imaging with large FOV coverage and excellent fat suppression in as short as a single 20-second breath hold.

transscrotal extratunica vaginalis procedure—a technique for bilateral varicocele repair using a single scrotal incision that can be performed on an outpatient basis. Key terminology: “The veins of the anterior and posterior pampiniform plexus were ligated and sectioned bilaterally.”

Trufill—a brand name of n-butyl cyanoacrylate (n-BCA).

vacuum phenomenon, spontaneous—a finding on x-ray of the lateral compartment of the knee, possibly related to traction on a joint or the absence of an effusion. The presence of this finding on a plain radiograph, or of artifacts associated with it on magnetic resonance imaging, is said by some to create the false impression of a meniscal tear, especially in the medial compartment. Others consider it a true indication of meniscal degeneration with tearing.

Ventrex mesh—a mesh patch used in hernia repair.

ventricular containment device—see *Acorn cardiac support device*.

wringer wrap—see *aortomyoplasty*.

X-10 Crosslink plates—a spinal plate system that allows surgeons to convert a dual-rod construct into a frame to improve both axial and torsional stiffness, reduce motion at the bone-implant interface, and decrease the risk for fatigue breakage.

Xomed dacryocystorhinostomy (DCR) drill.

“zomed”—phonetic for *Xomed*.

Urines Are Cooking: Perspectives on Medical Slang and Jargon

by John H. Dirckx, M.D.

It has been truly said that slang is something like pornography: even though the experts can't agree on a definition, we all recognize it when we see it. And the essential character of slang, like that of pornography, resides not so much in the topic under discussion as in societal attitudes toward the way in which that topic is treated.

The adjective that most often comes to mind when we attempt to define slang is *unconventional*. Slang can be thought of as a sort of eccentric or irregular dialect that exists in parallel with the more formal vocabulary that we find codified in dictionaries. We all use dozens of slang expressions and understand hundreds more when we hear them. But we also recognize that slang is inappropriate in some settings, such as a resumé or a letter of sympathy. Some slang expressions are objectionable because most people don't understand them; others because they are too brash, flippant, or frivolous for formal discourse, or perhaps are even offensively vulgar.

Since the language of medicine is full of slang and all dictators use it, the competent medical transcriptionist must develop the ability to judge which expressions to transcribe verbatim, which ones to translate into formal terms (and what terms to use), and which ones to flag. This article offers a classification of medical slang and suggests guidelines for its management by the transcriptionist.

Some day I hope to compile a book-length glossary of medical slang. That day hasn't come yet.

When we try to analyze slang as a linguistic phenomenon, we find that it actually encompasses several overlapping vocabularies, each with its own origins, motivations, and flavor.

Informal or colloquial language includes a huge number of **short forms** that have been cut down from longer words or phrases just to save time and effort. Shortened versions of single words can be subdivided into those that have

(1) lost their beginnings, such as [*colono*]scope, [*electro*]lytes, and [*hemato*]crit;

(2) lost their endings, such as *consult*[ation], *met*[astasis], and *retic*[ulocyte];

(3) lost both beginnings and endings, such as [*diver*]tic[ulum], [*in*]flu[enza], and [*pre*]script[ion]; and

(4) lost something out of the middle, such as *app*[endectomy], *cath*[eteriz]ed, and *prep*[are](p)ed.

The same patterns can be identified among shortenings of phrases:

(1) [*adrenocortical*] steroid, [*anabolic*] steroid, [*lymph*] node, [*sinoatrial*] node;

(2) *local* [*anesthetic*], *pectus* [*excavatum*], *pelvic* [*examination*], *portio* [*vaginalis*];

(3) [*plasma*] cholesterol [*concentration*], [*pulsed*] Doppler [*sonography*];

(4) *genitourinary* [*tract*] infection, *Pap*[*anicolaou*] smear, *sed*[*imentation*] rate, *white* [*blood cell*] count.

What might be called **syntactic shortening** occurs when, for example, a verb is formed from a noun or adjective without change of form: *to biopsy*; *to code* 'call for help in cardiopulmonary resuscitation'; *to gross* 'perform gross examination and description of pathology specimens'; *to guaiac* 'test a stool specimen for blood with guaiac'. **Back formation** is the creation of a new word (such as *beg*) that seems as if it should have been the origin of another word (such as *beggar*), but wasn't. Medical examples include *to diurese* from *diuresis*, *to lase* from *laser*, and *to torse* from *torsion*.

A special form of shortening is the **letter abbreviation**, in which the initial letters of the words in a phrase are used instead of the full phrase. Thus, *H and H* 'hemoglobin and hematocrit', *D/C'd* 'discontinued'. Although most abbreviations are not truly slang, they may share some of the objectionable features of slang words and phrases: unintelligibility, ambiguity, and informality.

Another way of compressing or shortening language is **contraction**, whereby two or more words are run together and some internal sounds are omitted. In writing, the dropped sounds are indicated by apostrophes: *can't*, *he'll*, *I'd've*, *she's*, *they're*. Most contractions are colloquialisms rather than true slang. Although they may be considered inappropriate in the most formal speech and writing, they sound and feel much more natural in speech than the full expressions. The speech of a person who always says *he will*, *she is*, and *they are* instead of using contractions seems stiff and pedantic, even foreign. Dictators who are native speakers of English naturally use many contractions.

An important source of slang terms besides the desire to shorten or simplify language is whimsy or a sense of **humor**. Examples are light-hearted variations on standard terms such as *orthopod* for *orthopedist*, *preemie* for *premature infant*, and *Western blot*, a modification of the *Southern blot*, which was named for its developer, E. M. Southern. Here we might also mention comical expressions such as *chandelier sign*, which implies that a diagnostic procedure is so painful that the patient leaps into the air and hangs from the chandelier.

Some slang is **pejorative**, that is, uncomplimentary or even abusive. Examples in medical language include *croak* and *gomer*, both referring to tiresome, difficult, or hypochondriacal patients. Slang can also be **euphemistic**, replacing an awkward or offensive word with one that seems more acceptable. Familiar examples of such expressions are *confused* ‘demented’; *inappropriate*, often denoting behavior that is grossly objectionable; and *poor historian*, sometimes referring to a patient whose memory is virtually blank. Among euphemisms one might also include the abbreviation *FLK*, which sounds better than the full expression, *funny-looking kid*.

The terms **argot** and **jargon** refer to special, often secret vocabularies used by practitioners of certain trades or professions to discuss their activities or their equipment and its use. One reason behind the development of such special “shop talk” is the desire for a shared, exclusive language as a source or symbol of solidarity, somewhat like the vestments and rites of a secret society or a religious sect. This aspect of medical jargon appeals particularly to medical students and physicians in training, who are quick to appropriate and perpetuate esoteric expressions heard from instructors.

A second motive for the development of a trade jargon is the need or wish to communicate by means of a code that cannot be understood by outsiders. (Another meaning of *jargon* is ‘unintelligible language, gibberish’.) This feature also has its application to medicine. At one extreme we have a gang of criminals plotting robbery and murder in the presence of their unsuspecting victim and at the other a team of physicians on rounds discussing a grave prognosis in the presence of the patient.

The jargon of medicine, like most other jargons ranging from thieves’ cant to the highly technical vocabularies of international law and nuclear physics, can be divided into two broad categories: specially coined terms and ordinary words to which special meanings have been assigned.

In one sense the first of these categories encompasses the whole vast lexicon of the healing professions, containing arcane tongue-twisters such as *esophagoduodenoscopy*, *pseudohypoparathyroidism*, and *spondylolisthesis*. But although words like these may in some sense be called jargon, they are certainly not slang.

In contrast, terms such as *benign neglect* ‘withholding fruitless and potentially harmful treatment’, *bleed* (noun) ‘hemorrhage’, *high index of suspicion* ‘particular alertness to a given diagnostic possibility’, *left shift* ‘increase in the proportion of immature neutrophils in the circulation’, *natural history of a*

disease ‘expected clinical course’, *retrospectoscope* (a mythical instrument with which the physician is supposed to achieve “20/20 hindsight”), and *workup* ‘thorough diagnostic evaluation’ are all slang, at least by origin.

A large part of medical jargon consists of ordinary English words to which special meanings have been assigned. Many of these expressions hover on the borderline between slang and formal language. Consider the italicized terms in the following phrases:

The chest is *clear*; the ears are *clear*; the suture line is *clear*. The deep tendon reflexes are *intact*; the tympanic membranes are *intact*; the pulses are *intact*. The history is *remarkable* for tonsillectomy at age 12; findings on examination were *consistent with* acute bronchitis; lab studies are *compatible with* metabolic alkalosis. The patient *presented* to the emergency room *in* atrial fibrillation. He *spiked a temperature*. His liver function studies are *elevated*. She *failed* outpatient therapy; he was *seen for* recurrent bronchitis; the patient was *started on* ciprofloxacin; she was transferred to Mental Hygiene *secondary to* increasing disorientation. *Acute abdomen*, *renal panel*, *blood chemistries*, *generous biopsy*, *documented lymphoma*, *looks toxic* . . .

Most or all of these words and phrases may have become so familiar to the experienced medical transcriptionist that they seem like strictly formal technical language. Yet each usage exemplified here represents a deviation, peculiar to medicine, from the conventional meaning of the word or words involved. These are some of the very terms that, by their strangeness and apparent incongruity, present the greatest challenge to the beginning transcriptionist.

One form of medical jargon owes its prevalence to the fondness of many physicians for abstract language, pretentious circumlocution, and obscure prolixity. Such physicians seemingly consider it a mark of intellectual superiority and linguistic sophistication to prefer *intervention* to *care*, *medication* to *medicine*, *modality* to *treatment*, *morphology* to *shape* or *appearance*, *pathology* to *disease*, *symptomatology* to *symptoms*, and so on.

The fledgling physician absorbs massive doses of medical jargon from the speech of professors and peers and often puts some of it to use like so many formulas or incantations without clearly reflecting on its exact meaning. Hence we hear such oddities as “status post falling off his tricycle” and, in operative reports, the endlessly recurring and wholly superfluous phrase, “The patient was taken to the operating room.” *Albuminuria* is not an acceptable synonym for *proteinuria*, nor is *blood sugar* an exact equivalent of *plasma glucose*. Although *bilirubin* may appear in the urine, *bile* does not. *Decompensation* cannot logically denote a deterioration of function when no compensation has previously taken place.

Much medical jargon violates English idiom or common sense: “At risk *for* [why not *of*?] metabolic syndrome.” “Extensive ecchymosis of the left [side of the] face.” “Auscultation revealed absent breath sounds [?] over the left base.” Jargonistic formulas may embody terms or concepts that

have been obsolete for decades. *Flat plate* still means ‘a radiographic study of the abdomen with the patient supine’ even though probably no physician living has ever seen a glass plate used to record an x-ray image. A stool examination for occult blood is apt to be called a *guaiac test* regardless of what reagent is used.

Granted that scarcely a paragraph of dictation is ever entirely free of colloquial or unconventional expressions, what are the implications for the medical transcriptionist? How far may slang, medical or general, diverge from the beaten track of formal language before it becomes taboo in a medical record? What kind of slang can be transcribed just as it is dictated, what kind needs to be altered to something more formal, and what kind must be rigorously excluded?

Only a few absolute rules can be laid down on this tricky topic. One is that **profane, vulgar, obscene, scurrilous, defamatory, uncouth, or otherwise crassly offensive language is always out of place in a medical report.** Inclusion of such material detracts from the sober and objective nature that should characterize a serious technical document. It can raise doubts as to the credibility or validity of the document and the competence or good faith of the dictator, and may even lead to litigation.

An important exception to this rule pertains to slang that is quoted by the dictator from the speech of a patient or some third party. Generally the dictator indicates this by saying “quote . . . unquote” or “quotation marks”: *The pros and cons of surgery were presented to the patient but he stated that he didn’t “want any damned butcher messing with” his “gizzard.”*

Quotation marks may also appropriately be used to set off less inflammatory remarks (*The patient’s mother says she “freaked out” the last time she had a pelvic examination*), including slang expressions deliberately employed by the dictator (*Recently most of our therapy sessions have evolved into “bull sessions”*).

Another rule of general application is that **any extremely unconventional expression should be replaced by a translation.** Thus, a *wicked-looking appendix* might be more appropriately described as *severely inflamed*, and *Reports of urine cultures and sensitivity studies are pending* looks and sounds better than *Urines are cooking*. If there is doubt as to the intended meaning, the transcriptionist would of course flag such a passage instead of making a wild guess.

A corollary or footnote to this rule is that a term that looks like slang but appears in medical dictionaries and word books can generally be transcribed verbatim. Examples might be *Coca-Cola urine*, *lumpectomy*, and *sweaty feet syndrome*.

The very general guidelines given above must be interpreted in the light of the transcriptionist’s judgment and experience, aided perhaps by institutional or agency directives or individual dictators’ preferences, if known. Style manuals typically offer broad rather than detailed advice regarding the handling of slang and jargon in medical reports, and any specific recommendations they make are apt to be arbitrary. For

example, the *AMA Manual of Style* prefers *reference range* to *normal range*, *therapy for cancer* to *therapy of cancer*, and *treatment of cancer* to *treatment for cancer*. I must confess that the rationale behind such choices escapes me.

A few fairly standard conventions regarding the handling of short forms may be mentioned here. Most letter abbreviations, as mentioned earlier, are not genuine slang. Indeed, it is standard practice to transcribe dictated units such as “centimeters” and “milligrams per deciliter” as abbreviations: *cm*, *mg/dL*. But, like slang, initialisms and acronyms can be obscure or ambiguous. *D/C* can mean either *discharge* or *discontinue*; *HS* can mean either *half-strength* or *bedtime*; *MS* can mean either *morphine sulfate* or *magnesium sulfate* (as well as *Master of Science*, *multiple sclerosis*, *medical student*, *millisecond*, and who knows what else?).

A letter abbreviation should therefore be expanded on its first appearance, with the abbreviation following the full expression in parentheses. Thus, “Emergency IVP showed . . .” should be transcribed as “Emergency intravenous pyelogram (IVP) showed . . .” If the same abbreviation is dictated again later in the document, only the abbreviation is transcribed.

Most authorities recommend similar treatment of binomial taxonomic terms (genus and species). Thus, “Cultures were negative for toxigenic *E coli*” would be transcribed as “Cultures were negative for toxigenic *Escherichia coli* (*E coli*).” Note that in contemporary practice the period is omitted from the abbreviation of the genus name. In no case should true jargon such as *H flu* or *Strep pneumo* be transcribed verbatim.

Some very basic abbreviations occur so frequently in certain settings that they can safely be transcribed as dictated. Examples are *S₂* (denoting the second heart sound) in a report of a cardiac examination; the *L₅-S₁ interspace* (the interspace between the fifth lumbar and the first sacral vertebrae) referring to spinal findings on physical examination or imaging studies or at surgery; and *WBC/hpf* (white blood cells per high power field) in a report of microscopic examination of urine.

By contrast, certain other abbreviations have recently been outlawed by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) because of the high risk of misinterpretation, with potentially lethal consequences, when they are hand-written. For example, *cc* ‘cubic centimeter(s)’ can be mistaken for *U* ‘unit(s)’ or the numeral *4*, and *µg* ‘microgram(s)’ may look like *mg* ‘milligram(s)’. Even though the danger of error may be virtually nil when the forbidden abbreviations appear in a transcription, the prohibition issued by JCAHO extends to all uses of them, even including printed forms.

The decision whether to transcribe or reinflate contractions such as *hasn’t* and *we’ve* depends on local standards. So does the choice between *exam* and *examination*, *lab* and *laboratory*, *postop* and *postoperative*. By and large, however, even clipped forms that are universally understood throughout the medical community, such as *alk phos*, *cathed*, *labs*, *multip*, *procto*, *pro time*, *quad-strengthening*, *rehab*, *strep*, *urines*, and *V tach* should be transcribed in full: *alkaline phosphatase*, *catheterized*, *laboratory tests* (or *reports*), *multipara*, *proc-*

toscopy, prothrombin time, quadriceps-strengthening, rehabilitation, streptococcus (or streptococci), urine specimens, and ventricular tachycardia.

Regardless of any other considerations, an ambiguous abbreviation or short form should always be expanded: *AV (arteriovenous/atrioventricular), crypto (cryptococcosis/cryptosporidiosis), histo (histology/histoplasmosis)*. And an expression that obviously distorts reality, such as a urine specific gravity of 1.012 dictated as “ten-twelve,” should always be rendered in its correct form.

When in doubt about a piece of jargon, ask yourself whether a more suitable, even though perhaps longer, term is readily available. On those grounds, *CABG'd (“cabbaged”), cyanosed, necrosed, and seized* should be rejected in favor of *underwent coronary artery bypass grafting, cyanotic, necrotic, and had a seizure.*

By contrast, your own good sense will probably tell you that standard phrases like *oriented times three, two-diopter choke, and two-pillow orthopnea* can be transcribed word for word unless local precepts dictate otherwise. And probably few service managers would expect a staff member to recast “a couple of skin bleeders were boved” as “two or more severed and hemorrhaging cutaneous arteries were coagulated with a Bovie electrosurgical pencil.”

It may help to keep the issue of slang and jargon in perspective if you recall that every single word, meaning, and pattern of usage in every language ever spoken on earth was at some past time an innovation—either a brand-new addition to the language or a departure from some previous usage. Many of our most solemn and sacrosanct words and phrases got their start as puns or flippant variations on existing terms.

In other words, what makes an expression slang is not its origin but rather the degree of acceptance it has attained in the formal speech and writing of educated and cultivated people. Clipped forms and jargon expressions that haven't made it yet could still become part of the standard language of medicine tomorrow. Skill in medical transcription requires experience, discretion, taste, and an intimate familiarity with both the formal lexicon of medicine and that other, slightly disreputable vocabulary we call slang or jargon.

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Translation, Please!

Medical Slang and Jargon

A&W alive and well
 albuminuria proteinuria
 absent breath sounds absence of breath sounds
 afib atrial fibrillation
 alk phos alkaline phosphatase
 amp ampule
 anchovy rolled-up piece of fascia lata (that looks like an anchovy)
 appy appendectomy
 appy tape small laparotomy tape used in appendectomy
 AV arteriovenous *or* atrioventricular
 bagged ventilated by hand using an Ambu bag
 banana bag a detox “cocktail” given IV to alcoholics
 beaver fever hikers’ and canoeists’ “affectionate” term for giardiasis
 benign neglect withholding fruitless and potentially harmful treatment
 bicarb bicarbonate
 bili bilirubin
 bili lights bilirubin (fluorescent) lights for infants with hyperbilirubinemia
 bleed (noun) hemorrhage
 blown pupil dilated pupil unresponsive to light in a brain-damaged patient
 blue bloater emphysema patient with cyanosis and peripheral edema due to right ventricular failure
 bug any infectious agent
 CA carcinoma
 CABG’d underwent coronary artery bypass grafting (“cabbaged”)
 cardioplege (v.) to administer cardioplegia
 cath’d, cathed catheterized
 cauliflower ear external ear deformed by repeated or severe trauma, as in boxers and wrestlers
 coags coagulation studies
 code black emergency department jargon for a patient who has died
 confused demented
 consult consultation
 crank street drug methamphetamine which is snorted or injected
 crit hematocrit
 crock difficult patient
 crypto cryptococcosis, cryptosporidiosis
 cyanosed cyanotic
 cysto cystoscope, cystoscopy
 D/C, D/C’d discontinue(d), discharge(d)
 decels decelerations
 diff differential
 dig (“dij”) digoxin, digitoxin, or digitalis
 Doppler pulsed Doppler sonography

drip intravenous infusion
 D-stix Dextrostix
 duck male urinal
 dunk, dunked inversion of the appendiceal stump before tying the pursestring suture
 embolotherapy embolization treatment
 epi, Eppy epinephrine (Adrenalin)
 e-stim electrical stimulation
 euboxic said of a laboratory test whose result falls within the normal box on the automated report printout
 ex-fix external fixator, external fixation
 fat doctor bariatrician; specialist in treating obesity
 fecalogram an imaging study in an improperly prepared patient, showing stool in the colon
 fem-pop femoral-popliteal
 flatliner patient whose EEG shows no cerebral activity
 FLK funny-looking kid
 flu influenza
 fudge factor arbitrary adjustment of quantitative test result to support a desired interpretation
 gomer difficult patient (“get out of my ER”)
 gram cardiogram, sonogram, electroencephalogram . . . or gram
 H flu *Haemophilus influenzae*
 H&H hemoglobin and hematocrit
 histo histology, histoplasmosis
 HS half-strength; bedtime
 I’d’ve I would have
 IMax or IMAX internal maxillary artery
 in the magnet said by radiologists working in MRI unit
 inappropriate displaying grossly objectionable behavior
 jargon unintelligible language, gibberish
 joker operating room instrument
 labs laboratory studies
 lap laparotomy
 lap appy laparoscopic appendectomy
 lap chole laparoscopic cholecystectomy
 lap tape laparotomy sponge
 left face left side of the face
 left shift increase in the proportion of immature neutrophils in the circulation
 local local anesthetic
 LOL little old lady
 lytes electrolytes
 meds medications
 met, mets metastasis, metastases
 Metz Metzenbaum scissors
 MS morphine sulfate, magnesium sulfate, multiple sclerosis, millisecond

Translation, Please! Medical Slang and Jargon

multip	multipara, multiparous	skinny needle	a 22-gauge needle used in percutaneous biopsy or aspiration cytology
necrosed	necrotic	slow code	CPR efforts carried out perfunctorily and with little expectation of success
nitro paste	nitroglycerin ointment	soft-passed	passed without resistance
node	lymph node, sinoatrial node	spill	excrete inappropriately in urine, as glucose or protein
OD'd	overdosed	stat or STAT	immediately
orthopod	orthopedist	steroid	adrenocortical steroid, anabolic steroid
Pap smear	Papanicolaou smear	Strep pneumo	<i>Streptococcus pneumoniae</i>
peanut	small sponge used in surgery	strep	streptococcus, streptococci
pectus	pectus excavatum	subcu	subcutaneous, subcuticular
pelvic	pelvic examination	sublux (v.)	subluxate
pimping	relentless quizzing of a medical student or resident on arcane topics by a senior physician, chiefly to establish or maintain superiority	sundowner	moderately demented, usually elderly patient, who becomes more severely disoriented in the evening
pink puffer	emphysema patient with dyspnea but no cyanosis	surf test	surfactant test of amniotic fluid
pollywogs	cotton balls, pledgets, or sponges used to absorb blood or fluids at the operative site	sweetheart	Harrington retractor
poor historian	patient with a blank memory	T and C	Tylenol and codeine
portio	portio vaginalis	TBP	total body pain; referring to a patient with numerous severe complaints
post	postmortem examination, autopsy	T'd ("teed") (v.)	extension of an incision in a T shape
preemie	premature infant	tet spell	spell typical of tetralogy of Fallot
prepped	prepared	tib-fib	tibia-fibula
procto	proctology, proctoscopy	tic	diverticulum
pro time	prothrombin time	tincture of time (TOT)	watchful waiting
Q sign	a moribund patient, with gaping mouth and lolling tongue	T-max	temperature maximum (formerly, renal tubular clearance threshold)
quad-strengthening	quadriceps-strengthening	to biopsy	perform a biopsy
red flag	a condition or laboratory value ("panic level") indicating severe or urgent condition	to code	call for help in CPR
rehab	rehabilitation	to diurese	to induce or experience diuresis
retic	reticulocyte	to gross	perform gross exam and description of pathology specimens
retrospectoscope	a mythical instrument with which the physician is supposed to achieve 20/20 hindsight	to guaiac	test a stool specimen for blood with guaiac
ROMI, romied	rule out myocardial infarction, myocardial infarction ruled out	to lase	to use a laser
sats	(oxygen) saturation	to torse	to experience torsion, as a cyst or testicle
scalpel safari	trip to a third-world country for cosmetic surgery	tokos or tocos	tocodynamometer; tocolytics
scope	colonoscope, endoscope, etc.	triple A	AAA (abdominal aortic aneurysm)
scrim	speech or auditory discrimination	Tyco #3	Tylenol No. 3 (Tylenol with Codeine No. 3)
script	prescription	uncooperative	negative, disobedient, defiant
sed rate	sedimentation rate	urines cooking	reports of urine cultures and sensitivity studies are pending
seized	had a seizure	urines	urine specimens
sharps	suture needles, scalpel blades, hypodermic needles, cautery blades, and safety pins	V tach	ventricular tachycardia
sharps count	count of sharp instruments at end of operative report	wastebasket diagnosis	a vague or general diagnosis, such as chronic fatigue or nonspecific back pain
shotgun therapy	treatment with several drugs so as to cover all diagnostic possibilities	wee bag	urine collection bag
sickler	patient with sickle cell anemia	wet reading	stat radiology report
sink test	sham lab test, in which the unexamined specimen is discarded "down the sink"	white count	white blood cell count
		wicked-looking appendix	severely inflamed appendix
		workup	thorough diagnostic evaluation
		Zandy bars, Zannies, Z-Bars	Xanax