COMMENTARY

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Rethinking the Language of Bedside Rounds

INTRODUCTION

Bedside rounds call for the presentation of clinical information to a patient and a medical team simultaneously. This approach engages patients, improves rounding efficiency, increases patient satisfaction, and extends the opportunity to observe learners' communication skills, when compared with clinical presentations done outside a patient's room.[1-5] However, when the presentation shifts from the hallway to the bedside, the discussion is no longer solely among clinicians, and the language of the presentation must also shift. Language adjustments are not always intuitive and must be intentional.

Furthermore, the presenting clinician juggles several different tasks during bedside rounds. First, they need to provide clinical information effectively to other team members. Second, they would like to demonstrate to the patient that they understand the larger context of the patient's presentation (eg, the emergency department course, for a newly admitted patient; or events in the intensive care unit, for a patient transferred from another service). Third, they want to engage the patient and their family in understanding the diagnosis and the plan of care. Finally, the presenting clinician hopes to convey compassion and concern, to avoid introducing unnecessary anxiety, and to steer clear of giving offense. Additionally, other elements may add complexity to the encounter—use of an interpreter, high illness acuity, struggling learners—and need consideration.

Achieving all these aims requires strategy and practice. In this piece, we focus on one essential component of communicating effectively during bedside rounds: making deliberate language choices within the case presentation. We describe 4 categories of words to avoid when presenting at the patient's bedside. We discuss the rationale for each recommendation and provide examples in each category.

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WORDS TO AVOID

First, we explore *medical words and phrases that can be misconstrued when interpreted in lay English*. These are words or phrases commonly used by medical professionals, often as shorthand. But because they each have a different meaning in everyday speech, it is easy for them to be misunderstood, potentially creating confusion or giving offense.[2,5,6] For example, a trainee might report to the team that "the rest of the patient's exam was not impressive." The other physicians would understand that the trainee had examined the patient and, that, outside of what had already been mentioned, everything else in the examination was normal and did not stand out as providing additional information to the clinical decision-making process. The patient, however, might hear that the doctor was not impressed by something related to their physique, and wonder if the team were judging their appearance in some way.

Other examples in this category:

- Ready for the floor
- Patient endorses
- Patient failed treatment
- Tachy ("tacky")

A related category is *words and phrases commonly used by clinicians that might inadvertently cause anxiety when misinterpreted* by patients. Many common turns of phrase are not reassuring, even when the news is good.[6] For example, a presenter might mention that the patient's "creatinine is down" and might even try to clarify saying, "that's a test that measures how your kidneys are doing." The team would understand that the renal function was improving, but the patient might worry that the kidneys themselves were "down."

Other examples in this category:

- Grossly normal
- Test was negative
- Bugs in the blood
- Exam was nonfocal

Third, there are a number of words with *negative or stigmatizing connotations in any context*. Researchers have looked at the impact of these words in the medical record[7-9] and how their presence negatively influences the physician's own perception of the patient,[10] and the perception

of other clinicians and medical staff involved in the patient's care.[11,12] Many patients themselves are offended by certain commonly used words when they review their own medical record.[13] While research exploring the impact of using these words and phrases verbally in front of the patient is less robust, this category of language should be avoided regardless of the clinical context.[14]

For example, clinicians understand that saying a patient "complains" of symptoms such as knee pain does not mean that they find the patient whiny or unreasonable. It instead identifies the patient's main concern by referencing the phrase "chief complaint." Using "complain" at the bedside, however, may offend patients.[15] Similarly, physicians understand that when they say a patient "denies" a symptom, that means that they asked the patient about that particular symptom, and the patient let them know the symptom was not present. However, a patient might hear the word "denies" and wonder if the physician suspects them of lying.[13,16]

Other examples in this category:

- Patient refuses
- Noncompliant
- Patient claims
- Urine looked dirty

Finally, there are words that are simply *medical jargon and are likely to be incomprehensible* to anyone without professional training.[6] These words are useful for hallway rounds, discussing cases with other clinicians, and in the chart, but they do not help engage the patient during bedside presentations.[2,5] An example is using the word "dyspnea" to describe shortness of breath. Some words in this category may even cause confusion among clinicians, such as referring to a troponin elevation as "troponemia."

Other examples in this category:

- Diaphoresis
- Leukocytosis
- Lower extremity
- Transaminitis

RECOMMENDATIONS

Adapting medical language for bedside presentations may not be intuitive and requires clinicians to intentionally modify years of training and communication practices.[6,16,17] Medical students spend a lot of time learning the correct terms to describe pathology, but most medical schools do not spend a commensurate amount of time teaching students explicitly how to translate those terms into ones that patients will understand.

We suggest the following to improve the language of bedside presentations:

1. Integrate bedside presentation skills into existing clinical skills curricula on communication and oral presentations
2. Evaluate communication skills used during bedside rounds using an Objective Structured Clinical Exam format
3. Incorporate training for all team members at the start of a rotation, if applicable, and include common words and phrases to avoid, as well as alternatives
4. Assign a specific team member to listen for language used and then debrief after bedside encounters, with the team member providing examples of potentially confusing terminology
5. Ask the patient for feedback on the language used by the team during bedside communication
6. Use teach-back (ie, when a clinician asks a patient to explain in their own words what the clinician said) to illustrate what was not conveyed effectively by the team

CONCLUSIONS

Rounding at the bedside requires multiple lines of attention: to the patient, to their family, to the rest of the clinicians, and sometimes to other care team members. It can be challenging to speak to all of these groups simultaneously and effectively. Integrating bedside language into existing medical school communication curricula can help students learn how to translate the language of pathology to the language of the patient. Residents, fellows, and attendings have the opportunity to strengthen their skills and to role-model their approach with every encounter at the bedside. Language matters—reflecting on the potential impact of commonly used words can help our patients understand more, worry less, and connect with the team who cares for them.

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