A fair maid plundered

And when at last we do come to that fair maid statistics we observe with sorrow that she has been plundered and pillaged to provide a terminology that varies from the pretentious to the erroneous—or, in the case of *parameter*, both. No observation can now be recorded without saying that it is *significant*. “His liver was significantly enlarged,” “the hand was significantly swollen,” the “tongue was significantly red,” and so on ad infinitum. An author (and I speak for myself) is indeed often haunted by the question, Does this work really add up to anything? Surely it must have some significance in the judgment of posterity, or in the opinion of his colleagues, or finally in his own conscience. All right; let there be no misunderstanding then. Everything observed, described, reported, compared must be significant. After all, the thing looks more different than mere chance would allow.

Another term borrowed from statistics, where like “significant” it has a more restricted sense than in common usage, is *population*. No longer does an author report on a series of patients, or a group of them, or a sample; he reports on a *population* of them or even, as I have seen, a *selected population* of them. It sounds like something big, and authors know that big science is better than small science. It is all-embracing too, so that if an author’s results are derived from a “population” they apply to pretty well everyone, not just his series of “subjects.” And, as there is really nothing much beyond the population, that makes the results definitive as well.

On *parameter* I need not labour the lesson. Except in statistical texts, its proper place, the word is now dead, that is, it is used in so many different senses it has lost all meaning and become that characteristic end product of the hieratic mode, mumbo-jumbo.

During the past couple of years I have noted it doing duty as: an indicator in general of disease, a criterion of the severity of disease, a test for the existence of a lesion, a measure of a drug’s effect, the limits or boundary of a syndrome, and the pathognomonic symptom of a particular disease. Farewell, *parameter*.

In this hieratic language such homely prepositions as “before” and “after” are too commonplace. They have now given way to *prior to* and *following*. Likewise “by,” “with,” and “from” have been thrown away and an entirely new preposition has been created from the participle *using*, which is generally (in entire disregard of correct grammar) in the state called *unattached*. Thus we see this prepositional linchpin holding up sentence after sentence—for example, “The patient was studied using immunofluorescence,” “the results using that test were positive,” and “surgery was undertaken using a split-level approach.” This nonsensical abuse of language often results in sentences that are as ambiguous as they are barbarous.

Stop pretending

Why do they write in this hieratic mode? My plea is not that they should write better English, with their grammar logical and their vocabulary precise, though I wish they would. Nor is it that in their clinical practice they should scorn the numinous power to comfort and heal that a good doctor has; I wish there was more of that. What I do ask of them is that they should stop pretending they are administering a sacrament when they are simply addressing their professional colleagues. Such people must be disquieting to meet in the flesh—if indeed they ever are incarnate.

Medspeak made simplifax

JAMES ROBB

Medspeak is here to stay. Its continued use is to be encouraged as a method of communication between doctors, though obfuscation often results when it is used with patients. Until recently, Medspeak was a lingua franca, at least among doctors in the English-speaking world. Diversification, however, has inevitably occurred, so that British and American Medspeak are no longer identical. Ideally, a common language such as Mid-Atlantic Medspeak should fuse the two, but until then guidelines are sorely needed for speaker and learner in the interpretation of Medspeak.

On both sides of the Atlantic doctors regularly use prefix and suffix to change word meaning. The frequent use of the prefix *de-* probably began as an easy means of deriving an exact opposite. Now its use is automatic, saving busy doctors the effort of thought to find a better alternative. In this way medical language that was interesting in the past is now being replaced by ersatz Medspeak. Recent examples from the United States include *demystify*, *de-emphasise*, *decolostomise*, and *dephenomenalise*.

The use of the suffixes *-ise* and *-isation* are also a common method of neologising. In America the words *splenectomise*, *colostomise*, and *capsulise* have been used to their best advantage in statements such as “the subject was colostomised” and “the

authors have capsulised the topic.” The economy of American Medspeak is apparent. Perhaps the pedestrian British equivalents are “the patient had a colostomy fashioned” and “the authors have provided a comprehensive review of the topic”—more flowing but less succinct.

Endless possibilities

Another way of creating Medspeak neologisms is to combine the prefix *de-* with the suffix *-ise* or *-isation*. One word can thus burgeon into a whole new range of meanings: noun, verb, and their opposites—for example, *emphasis*, *emphasise*, *de-emphasis*, *de-emphasise*. The possibilities are virtually endless. The advantages of this system to the neophyte neologiser are flexible word-power, economy of thought, and rapid mastery. The disadvantages are turgidity and inelegance. Nevertheless, Medspeak’s continued development is assured because neologising is always fun, and medicine requires an increasingly complex private language to maintain its charisma.

Medspeak, however, can turn fickle as the more advanced Medspeaker faces syntactical niceties such as whether or not to follow common usage. In the United States, for instance, there is an increasing tendency to drop the affix *-al* from the end of adjectives such as *anatomical*, *histological*, *pathological*, which results in such phrases as *the histologic diagnosis*. And in Britain the superfluous use of the affix *-at* still occurs in *preventative* and *dilatation* with surprising regularity.

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Johnson deplored the combination of *subject matter* as gratuitous. This usage has become commonplace. In Britain *mode* and *modality* are creeping into Medspeak descriptions such as *treatment modality*, which is especially popular in the United States. *Modality* adds nothing to *treatment*.

Further scope is offered to Medspeakers by the use of "non words" such as *context*, *situation*, *basically*, and *essentially*. One often sees on a haematology report "essentially normal film"—a type of Haemspeak. Does this mean that the film is "perfectly normal," or "more or less normal"? Liberal larding of phrases with *basically* adds nothing but a suspicion that all is not what it purports to be. Although Medspeak's widespread use of *situation* and *context* is relatively meaningless, they may be used to relieve linguistic monotony—on the one hand the Medspeak context and on the other the Medspeak situation.

Depersonalisation in Medspeak is inevitable. Patients become *clinical material* or *bed number six*. Doctors and nurses are *health care professionals*, their work being *health care delivery*. As Medspeak becomes too terse these stacked nouns (a useful Germanic technique) restore the balance between economy and prolixity.

Syntactical choice and linguistic dilemmas

So in erudite circles where advanced Medspeak is used syntactical choices and linguistic dilemmas exist. What should the British Medspeaker do? Resist temptation, or follow his

American cousin by ceasing to be logical and becoming logic? The final solution to this ongoing Machiavellian Medspeak dilemma situation will be the eventual fusion of British and American Medspeak.

Not the least pleasure of a living language is borrowing words from other disciplines and distorting their meaning. Naturally confusion can result when the non-initiate tries to panhandle the difference between the Medspeak meaning and the Real meaning of a word. *Parameter* to the scientists means a constant factor, but to the Medspeaker a variable. To the zoologist a *monitor* is a lizard but to the Medspeaker either a machine or a verb.

Medspeak humour is also largely derived from unintentional abuse of medical jargon by the non-medical world: the Medspeak malapropism. Statements such as "the Government's schizophrenic attitude towards the railways" would have undoubtedly interested Freud. Patients are a good source of Medspeak malapropisms when they talk of their *deferred pain*, their *prostrate gland*, their *mother's discalated hip*, and their *infested surgical wound*. Similarly, secretarial mishaps can cause delight or horror as *cerebral spondylosis*, *serous anguinous fluid*, *senile dimension*, or *pseudex atrophy* rattle off the typewriters—all, no doubt, the result of a dysarticulating doctor on his dictaphone.

Medspeak is unlikely ever to become boring for the user. It will continue to evolve. And it does not matter what we say among ourselves, provided that we layspeak properly to the patients.

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An anachronistic treatment for asthma

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Abstract

Dry cupping is an ancient practice that died out in England over a hundred years ago. In certain cultures it survives and if not recognised can lead to a little diagnostic confusion.

Introduction

We saw two Russian girls who had been unsuccessfully treated for their asthma by cupping. This ancient practice survives in many cultures, and can result in unusual bruising, which in children may lead to an erroneous diagnosis. Because of this point, and its interesting history, we report the following cases.

Case histories

Case 1—A 14-year-old Russian girl presented with acute asthma. Examination showed many fresh bruises on her back. Her mother

explained that these were due to the application of cups to treat her dyspnoea (fig).

Case 2—A 6-year-old girl also presented with several bruises. Her mother thought that cupping "drew the congestion out of her chest, and made the blood flow faster." As the casualty officer commented, unless one had seen a similar case before it would have been easy to assume, purely on the appearance of the bruises, that this was a case of child abuse.

Bruises caused by cupping in a 14-year-old girl.

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