English for overseas doctors

While the medical profession contemplates the language problems of overseas doctors and the high failure rate in the new TRAB examination for would-be practitioners from abroad, it is good to know that help is at hand from another profession. Many universities, polytechnics, and colleges of further education in Britain have departments that specialise in teaching English as a foreign language. With English more in demand as a second language than any other in the world these institutions are gradually transforming their language lessons, using techniques based on the scientific observation and recording of how language is actually used and learned. They are now beginning to turn their attention to the special problems of foreign workers in medicine.

At Lancaster University a team led by Christopher Candlin of the department of linguistics has completed a study of about 2000 consultations in the casualty departments of 18 hospitals. Analysing the language used in these consultations has helped the team develop teaching methods which have already been successfully used on a pilot course for overseas doctors in South London. The team presented their material at a recent conference on "Breaking the language barrier," held at the King's Fund Centre, which already helps with courses for foreign ancillary staff in British hospitals.

There are none of the turgid grammatical exercises or translation passages which used to glut language textbooks. The emphasis is on spoken English—on spoken *lay* English. Patients depicted in the lessons use real-life language like: "Well you know I kind of fell doctor, well not exactly fell . . ." Some of the examples seem uncannily naturalistic, as if Pinter had replaced Milton as a model for discourse. But this is surely right, if stories about foreign doctors correcting their cockney patients' English are ever to become obsolete.

Doctors are discouraged from speaking the arrogant gobbledegook of research papers, a practice familiar enough among medical natives of Britain. Exercises require medically qualified language students to explain to lay teachers the meaning of terms such as "intramuscular tetracycline." Much work is devoted to the subtle tricks of vocabulary, syntax, and intonation by which we indicate sympathy, reassurance, or optimism. A successful graduate of the course would know why "Could you just take off your shirt, please" is preferable to "Take off your shirt."

Though discussion at the King's Fund Centre was necessarily limited to the language problems of one group of doctors, the edges of this topic shaded off into vaster problems of doctor-patient relationships, sociology, and semantics. Nevertheless, even within its small area the discussion raised so many issues that another conference is likely to be held soon. One familiar difficulty faced by the people who arrange language courses is that commonly overseas doctors do not recognise their own language deficiencies when these are evident to colleagues and patients. Even if they do, they are unlikely to find time or official encouragement to attend a course. While there is no shortage of enthusiasm and skill—or at least the willingness to learn the special skill of teaching medical English—among the teachers who could make our overseas doctors fluent, there seems to be a notable lack of initiative among the institutions which could provide students and help to finance courses. Some local education authorities already provide heavily subsidised courses in specialised types of English; most would be prepared to do so if a clientele could be guaranteed.

Doctors who are worried about a problem which has recently attracted—and deserved—so much publicity should find out whether English language training is available in their districts. They should encourage colleagues and their juniors to attend courses when this is obviously necessary. They should consider organising courses for overseas graduates in their specialties in conjunction with trained language teachers (this has already been done at the Royal College of General Practitioners). There may soon be an urgent need for centralised language training schemes for overseas doctors, and it would be sensible for the medical authorities to enlist the help of linguistic specialists sooner rather than later.

More on liver tumours and the pill

An association between hepatic neoplasia and the contraceptive pill was first suggested in 1973 by Baum et al., who described seven women with benign adenoma; since then at least 46 similar cases have been recorded. Most of these have been in women who had been taking oral contraceptives for over two years, but in a few cases exposure had been for less than six months. The tumours are usually solitary, but in one patient two separate foci were present. The variable histological appearances of these tumours and the difficulties in terminology have recently been discussed in detail by Sherlock, who emphasised their prominent vascularity, which may amount to so-called peliosis hepatis—large blood spaces without an endothelial lining. Not surprisingly, therefore, about two-thirds of these tumours first presented with acute intraperitoneal haemorrhage; in others the leading clinical feature has been right upper quadrant abdominal pain or a palpable mass. The diagnosis may be strongly suspected before laparotomy from the arteriographic appearances. Liver scanning will usually show a filling defect if the diameter of the tumour is over 2 cm, but while this has great value as a screening test it does not help with the differential diagnosis. The results of liver function tests are usually
normal, and liver biopsy is contraindicated because of the risk of haemorrhage.

Because of the danger of fatal internal bleeding surgical excision of the adenoma is usually recommended, and this advice has now been reinforced by the description at page 496 of apparent malignant change in one patient. One case of primary hepatocellular carcinoma and one hepatoblastoma, both occurring in young women taking oestrogens, have been reported, and the possible mechanisms by which oral contraceptives might produce hepatic neoplasms have also been discussed: either the oestrogen or the progestogen component might be responsible. The anabolic steroids (which are closely related to the synthetic progestogens) have also been implicated in causing hepatocellular carcinoma, and recently a patient with an adenoma has been described. No causal link between oral contraceptives and liver tumours has yet been proved, for the prevalence of such tumours in women of childbearing age is unknown. Reassuringly, in view of the millions of women who have been taking the pill over the past 20 years the risk must be extremely small. Nevertheless, doctors should be alert for the possibility of the development of a hepatic adenoma in any young woman who presents with right upper quadrant pain or hepatomegaly, and surgeons may meet the tumour during emergency laparotomy. Clearly all further cases should be reported; and the establishment of a central registry for the clinical and pathological data would greatly help the evaluation of the nature and size of the problem.

2 Sherlock, S, Gut, 1975, 16, 793.
7 Brugueret, M, Lancet, 1975, 1, 1295.

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**Risks of amniocentesis**

Diagnostic amniocentesis is being used ever more widely in three main sets of circumstances. Firstly, to detect fetal abnormalities, best done at 16 weeks gestation, with a view to abortion—indeed it is essential to have established that abortion would be wanted or such amniocentesis is pointless. Secondly, it aids assessment of the severity of fetal erythroblastosis by allowing the measurement of the bilirubin level in amniotic fluid. Thirdly, when induced delivery is contemplated to overcome risks to the life of the fetus amniocentesis may be used to predict the likelihood of the respiratory distress syndrome in the neonate by determining the lecithin/sphingomyelin ratio in amniotic fluid. Here again, amniocentesis should be done only if its result determines the timing of delivery.

Amniocentesis is safely performed only through the abdominal wall. With standard aseptic care a 20-22 gauge spinal needle with stylette is introduced at right angles through the skin, which may or may not be anaesthetised. In slim patients disposable 21-gauge 40 mm needles are often used, but there is a risk of these being lost if broken at the base. No more than 10 ml of amniotic fluid is ever needed. This procedure is virtually free of risk to the mother in early and late pregnancy, though occasionally transient febrile reactions occur, possibly due to intravasation of amniotic fluid or fetal blood. Amniocentesis occasionally results in abortion, premature labour, or infection, but these risks are small, being together less than 1%. It has now also become clear that the placenta is frequently damaged by the needle and the resulting fetomaternal haemorrhage must increase the risk of rhesus sensitisation, though the actual risk has never been measured. Furthermore, there have been several isolated but disturbing accounts of fetal exsanguination due to puncture of the placenta or umbilical cord and of various fetal injuries, some permanent, caused directly by the needle. Thus the safety of amniocentesis needs to be improved before the advantages of the information to be gained clearly outweigh the potential disadvantages.

In early pregnancy the fetus is well protected by the surrounding amniotic fluid; but the placenta is relatively large, making it more susceptible to injury than in late pregnancy. The placenta covers the whole of the anterior uterine wall in a third of cases at 16 weeks gestation, but if localised by ultrasonography it can be avoided by introducing the needle above it. Thus it may be possible to reduce by 90% the incidence of bloody taps, which indicate placental puncture. Nevertheless, any fetoplacental haemorrhage resulting from puncture of the placenta may easily be measured with a view to administering anti-D globulin to counteract its effect, and in early pregnancy is likely to be so small as to carry little risk of rhesus sensitisation.

To protect the fetus in late pregnancy amniotic fluid is usually sought in the pools between the fetal parts, which lie beneath the central or “periumbilical” areas of the anterior uterine wall. Unfortunately more commonly the placenta is situated anteriorly than elsewhere. In one study of 39 periumbilical amniocenteses done between 22 and 40 weeks gestation and observed but not guided by ultrasonography the placenta was punctured in at least 18 (46%), and 9 of these were associated with appreciable increases in fetomaternal blood transfusion. In a recent review of 552 periumbilical amniocenteses done to determine the lecithin/sphingomyelin ratio two fetal deaths resulted from exsanguination as a direct result of the procedure; emergency caesarean section was done in both these cases and one other. When these complications are set against the possibility that determination of the lecithin/sphingomyelin ratio prevented death from the respiratory distress syndrome in only five babies the risk is unacceptable. In this series placental damage (evident at delivery) had nearly always been preceded by failed attempts at amniocentesis; clearly when the procedure has failed it is better not repeated. Factors predisposing to failure were anterior placenta and small-for-dates fetus (presumably due to oligohydramnios); obesity presented no technical problems.

An alternative technique of amniocentesis in late pregnancy is the suprapubic or “isthmic” approach. In this the needle is aimed below the fetal presenting part after it has been raised manually; the method should thus reduce the risk of damage to the fetus as well as to the placenta. The approach is through the lowest part of the upper uterine segment, where in late pregnancy the placenta has been found to be present in only about 3%, of cases. Comparing 308 suprapubic with 57 periumbilical amniocenteses, Gordon and Deukmedjian found that the incidence of bloody taps and failed attempts (so often associated with placental puncture) was greatly reduced with the suprapubic approach, and that there was no increased incidence of premature rupture of the membranes or of premature labour. These findings confirm several other reports. The commonest causes of failed suprapubic amniocentesis are premature (11-fold higher before 30 weeks gestation than after 34 weeks), oligohydramnios, and extended breech presentation. The suprapubic technique appears to offer a real advantage in the safety of amniocentesis in late pregnancy and merits particular application in obstetric units without ultrasonic facilities.