What`s up, Doc?

A Medical English course for medical students in clinical semesters SS 2006

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What´s up, Doc?

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Introduction

What would you do if a pregnant woman consulted you and told you that her water had broken? Would you try to calm her by giving her the telephone number of a plumber (telling her about the fine bathtub he installed in your flat lately)? Or would you glibly smile at the elderly gentleman who talks about his bowel movement and chat about those terribly high costs of moving house (...with all this stuff and furniture, you know...)?
Obviously you did not get acquainted with an important part of your daily routine as a student in a foreign hospital: you have neglected the specific language when you react like that.
You will also be puzzled by the "natural" way physicians deal with the information when clerking a patient: whereas in Germany you can rely on the most important questions being part of the medical form already, in the United Kingdom you might be forced to take a medical history and write it down on a blank piece of paper since everybody of course knows about it.

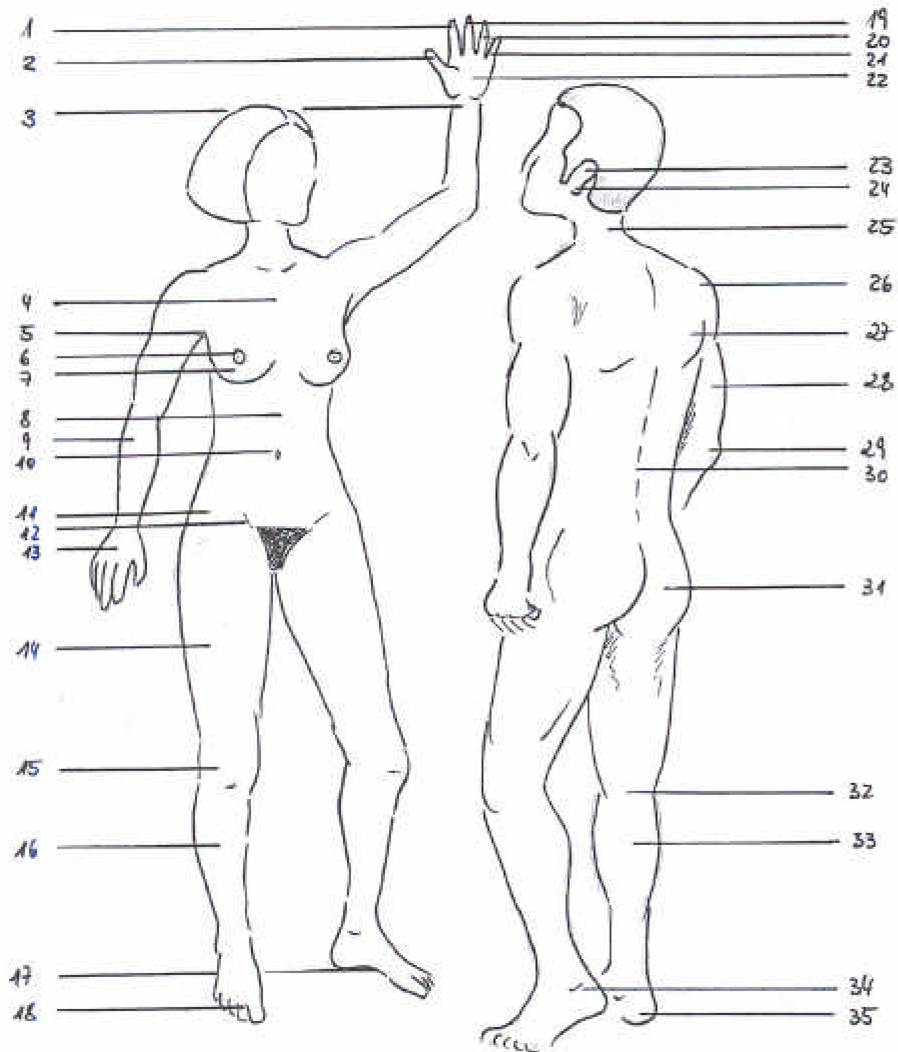
There are the difficulties of daily life on a ward, such as the lack of sentences you can use in a conversation with a patient when English is not your mother tongue. By the way - how would you translate: "Was macht die Kunst?", when informally talking to a patient?
Idiomatic expressions and technical terms, the way of taking medical histories according to the British scheme and the conversation with patients are the main topics of the course. This script serves as a reference book and should provide you with the basic information. Apart from that there will be role-plays and handouts in some of the meetings. Further, you will find some useful hints and copies for your application at an English-speaking hospital and a list of the most important abbreviations to put into your pocket when on the ward.
The concept of the course is based upon *your* lively participation you`d rather not stay seated – bored to death – while an even more boring lecturer explains his amiable but (again) boring theories. You should take this opportunity and really *learn* something within a group of students reaching at the same target: find out about the mysteries of English as a medical language and become competent for your clerkship by training your communication skills.

We are looking forward to the term!

Prof. Dr. H.-P. Kröner and Davinia Talbot

The Parts of the Body

The human body



1 = index
2 = thumb
3 = wrist
4 = chest
5 = armpit
6 = nipple
7 = breast
8 = stomach ("tummy")
9 = forearm
10 = navel ("belly button")
11 = hips
12 = groin
13 = hand
14 = thigh
15 = knee (-cap)
16 = shin
17 = sole
18 = toes
19 = middle finger
20 = ring finger
21 = "pinkie"
22 = palm
23 = ear
24 = earlobe
25 = neck
26 = shoulder
27 = shoulder blade
28 = upper arm
29 = elbow
30 = vertebral column (spine)
31 = buttock (backside)
32 = hollow of knee
33 = calf
34 = ankle
35 = heel

The human face

1 = forehead
2 = wrinkle (to frown)
3 = bridge of nose
4 = nostrils
5 = moustache
6 = upper lip
7 = lower lip
8 = chin

9 = skull
10 = temple
11 = eyebrows
12 = eyelids
13 = eyelashes
14 = eyeballs
15 = cheek
16 = jaw
17 = beard

Organs and structures

German	English
Gehirn	brain, encephalon
Grosshirn	upper brain, cerebrum
Kleinhirn	cerebellum
Stammhirn	brain stem, encephalic trunk
Hirnhaut	meninx (plr. meninges)
Rückenmark	spinal marrow, spinal cord
Schädelbasis	base of skull, cranial base
Liquor	fluid, liquor
Zunge	tongue
Gaumen	palate (hard/ soft)
Rachen	throat, pharynx
Kehlkopf	voice box, larynx
Stimmbänder	vocal ligaments/ cords
Luftröhre	windpipe, trachea
Bronchien	bronchi
Lunge (nlappen)	lung, pulmo (lobe of lung)
Schilddrüse	thyroid (gland)
Thymus	thymus (gland)
Herz	heart, cor
Vorhof	atrium (of heart)
Kammer	chamber of the heart, ventricle
Segelklappe	atrioventricular valve
Taschenklappe	semilunar cusp/ valve
Aorta	aorta (ascending~, aortic arch, desc.~)
Speiseröhre	gullet, esophagus
Zwerchfell	midriff, diaphragm
Magen	stomach, abdomen, belly, tummy
Zwölffingerdarm	duodenum
Bauchspeicheldrüse	pancreas
Dünndarm	small bowel/ intestine
Dickdarm	large bowel/ intestine
Blinddarm	blind gut, appendix
After	anus
Milz	spleen
Leber	liver
Gallenblase	gall bladder
Niere	kidney, ren
Harnleiter	ureter
Harnblase	(urinary) bladder
Harnröhre	urethra
Scheide	vagina, (sheath : auch `Kondom`)
Gebärmutter	womb, uterus
Eileiter	(fallopian) tube, salpinx
Eierstock	ovary, ovarium
Penis	penis, (member)
Hodensack	scrotum
Hoden	testicle, orchis
Prostata	prostate (gland)

Specialties

SPECIALITY	SPECIALIST	ADJECTIVE
▸ anaesthetics	anaesthesist	▸ anaesthetic
anatomy	anatomist	anatomical
bacteriology	bacteriologist	bacteriological
biochemistry	biochemist	biochemical
cardiology	cardiologist	cardiological
dermatology	dermatologist	dermatological
embryology	embryologist	embryological
endocrinology	endocrinologist	endocrinological
epidemiology	epidemiologist	epidemiological
gastroenterology	gastroenterologist	gastroenterological
▸ geriatrics	▸ geriatrician	▸ geriatric
▸ gynecology/ obstetrics!	gynecologist/ obstetrician	gynecological/ ▸ obstetric
haematology	haematologist	haematological
histology	histologist	histological
immunology	immunologist	immunological
microbiology	microbiologist	microbiological
neurology	neurologist	neurological
oncology	oncologist	oncological
ophthalmology	ophthalmologist	ophthalmological
▸ orthopaedics	▸ orthopaedic surgeon	orthopaedic
otorhinolaryngology	otorhinolaryngologist	otorhinolaryngological
▸ paediatrics	paediatrician	▸ paediatric
parasitology	parasitologist	parasitological
pathology	pathologist	pathological
pharmacology	pharmacologist	pharmacological
▸ pharmacy/ pharmaceutics	pharmacist	pharmaceutical
▸ physics	▸ physicist	▸ physical
physiology	physiologist	physiological
psychiatry	psychiatrist	▸ psychiatric
radiology	radiologist	radiological
rheumatology	rheumatologist	rheumatological
surgery	▸ surgeon	surgical
urology	urologist	urological
virology	virologist	virological

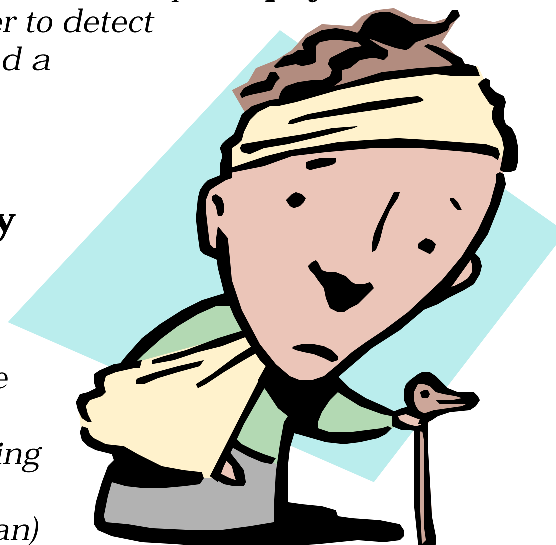
▸ = pay attention!

All of these specialists deal with

illnesses / ailments / diseases / disorders / complaints / maladies / troubles / sicknesses / sufferings

Clerking a Patient

Admitting a patient to hospital includes two major steps: on the one hand the doctor has to take the patient`s* ***medical history****, where he is given the opportunity to report his complaints and to answer the doctor`s questions. On the other hand a (complete) ***physical examination*** *should be done in order to detect certain physical symptoms and to find a diagnosis.*



Part one: **Taking a Medical History**

A typical medical history usually follows a defined scheme. Of course one should know that scheme well, but obviously gathering the relevant data from an English-speaking patient (not to mention the typical Glaswegian or the Yorkshire dalesman) can be a problem in itself.
In general British people tend to be more polite than people on the "continent". The language is full of phrases that might appear strange or even exaggerated to a foreigner. As a physician (to be) you are obliged to have the patient`s trust and the use of an adequate style of language is important to reach that aim. So this lesson includes some useful common phrases of conversation.

0) Introducing oneself/ Specific Greetings

Good morning, Mr. Bradford, my name is Anne Golding. I am a medical student (*you may say*: "student doctor") doing a clerkship on this ward.[1] I heard about the problems you have with your heart. Would you mind if I examined your chest again?

Hello, Mrs. Rutherford, my name is Robert Weiss. I am a Senior medical student. The doctor will be here shortly, may I ask you a few questions meanwhile?

Good morning Mr. Hewling, it's nice to see you. Please come in and have a seat. What has brought you along today? What seems to be your problem? Could you describe it for me, please?

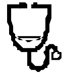
Good afternoon, Mrs. Johnson. I see from your chart that you came to us complaining of pain in the stomach. Is there anything

[1] For details about your status see „British Health System" in the appendix

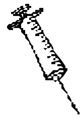
else you want to tell me before we look at your stomach more closely?

Hello, Mr. McLeod. We met last week, didn`t we? Well, I have been going over some of the results of your tests with a colleague of mine and we are pleased with your progress.

Good morning, you are Christopher, aren`t you? I heard a lot of nice things about you. But your Mum told me you have a tummy ache. Is that right? Now, Chris, I want you to tell me all about it.



Hello, Mr. Smith. Could you please roll up your sleeve and let me take your blood pressure?



Hello again, Mr. Wright, I have come to take a blood sample. Could you please roll up your sleeve? It might be a bit uncomfortable. It is like a sharp scratch.

GATHERING INFORMATION

I) Personal Data: Time of assessment (!)

Name (surname/ Christian name) ***Age*** (DOB)
Sex ***Occupation*** ***Marital Status***[2]

II) c/o (= complaining of = Chief Complaint)

Try to find a short phrase describing the patient`s problem. Do not give a diagnosis!

III) HPC (= History of the presenting complaint)

When did the problem begin?
How long has it been bothering you? **DURATION**
How did it start? (gradually/ suddenly)
MODE OF ONSET
How often does it come on? **FREQUENCY**
Have you ever had anything like this before?
What brings it on?
Does anything make it better/ worse?
Does it occur in certain positions?
RELIEVING/ AGGRAVATING FACTORS
Does anything go along with it? E.g. Are you feeling sick, are you sweating?
ASSOCIATED SYMPTOMS
Where does it hurt?
Is it a constant pain/ does it come and go?
Does it interfere with your daily activities? **PAIN**

[2] e.g.: single, married, divorced, separated, widowed

- <u>What is the pain like?</u> Is it ...

...biting?	*beißend*
...stabbing?	*stechend*
...pinlike?	*nadelähnlich*
...sharp?	*scharf*
...pinching?	*kneifend*
...cramping?	*krampfartig*
...throbbing?	*pochend*
...blistering?	*sehr heiß,*
...burning?	*brennend*
...sore?	*brennend*
	wund
...wrenching?	*ziehend*
...stinging?	*stechend*
...numb?	*taub*
...gnawing?	*nagend*
...dull?	*dumpf*
...excruciating?	*unerträglich*

Þ mnemonic „pain“[3]

S ite
O nset
C haracter
R adiation
A ssociations (nausea, sweating)
T iming of pain/ duration
E xacerbating/ alleviating factors
S everity (e.g. scale from 1-10)

IV) PMH (= Past medical history)

Apart from your present complaint how is your general health?
What previous illnesses have you had?
Do you remember any childhood diseases?[4]
Have you ever been seriously ill?
Have you ever been hospitalised/ had an operation?
What about broken bones?
Do you suffer from any chronic disease?

[3] **Longmore/ Wilinson/ Török.** *Oxford Handbook of clinical Medicine.* Oxford: Oxford University Press, 2001; p 32

[4] see „Common Illnesses“ and remind the patient of some possibilities

V) Med (= Medications)

Are you taking any medicines/ tablets?
Are you on the pill?
Do you need sleeping tablets?

VI) All (= Allergies)

Have any medicines ever upset you?
Are you allergic to penicillin, contrast agents, foods or anything else?
Have you been immunised against tetanus/ polio/ influenza/ hepatitis A, B/ pertussis / diphtheria?

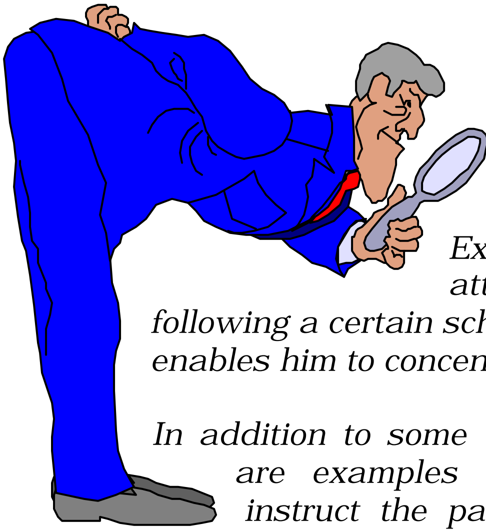
VII) FH, SH (= Family history, social history)

Does anyone in your immediate family suffer from a chronic disease?
Are your parents (other members of the family) alive and well?

Ask for the circumstances of the patient's accommodation, education, job, leisure interests.
Ask whether he is married/ has children.

VIII) Alcohol, tobacco, recreational drugs

Do you smoke?
How often do you drink alcohol?
Do you take any kind of drugs?



Part two:
The Complete Physical Examination

Examining a patient requires some attention and practice. So again, following a certain scheme frees the physician's mind and enables him to concentrate on his five senses.

In addition to some useful questions given below there are examples of sentences one might need to instruct the patient during the examination. It is vital that the instructions you give are simple and clear. Do not use technical terms the patient probably won't understand.
If you wish to do a thorough physical examination it is usual to say:

"Would you mind taking off your clothes except your pants (men)/ except your panties and bra (women)? Lie on the couch and cover yourself with a blanket."
"Please get undressed, but keep on your underwear."

General Survey

Before beginning a physical examination you make a survey of the patient's general health. You should evaluate the following:

1. gait[5], posture[6], appearance[7], hygiene[8], mental state.
2. vital signs, including:
   - height
   - weight
   - pulse
   - temperature
   - respiratory rate
   - BP
3. a possible way to proceed during an examination is according to the scheme

IPPA = **I**nspection
Palpation
Percussion
Auscultation

---

[5] e.g. slow/ lame/ spritely
[6] e.g. upright/ sunken
[7] is he well nourished/ well developed/ well hydrated?
[8] e.g. normal standard hygiene/ low standard hygiene

Cardiovascular System

QUESTIONS	INSTRUCTIONS
Do you have any pain in the chest, especially after exertion? Are you breathless at any time (on exertion/ at rest/ in bed)? Do your ankles swell up? Do you freeze often and quickly? How far can you walk before the pain in your leg stops you going (intermittent claudication)? Have you recently lost consciousness?	I would like to listen to your heart. Please lie down on your back. Now roll over to your left side. Try to take short rapid breaths. Lean forward with your hands on your knees and hold your breath for a few seconds.

Respiratory System

QUESTIONS	INSTRUCTIONS
Are you short of breath? Have you noticed any wheezing when you breathe? Do you cough up any sputum/ phlegm/ spit? What colour is it[9]? Have you coughed up any clots of blood?	Could you please undress to your waist? I`d like to exam your chest and lungs. I would like to listen to the sounds in your chest; sorry if the stethoscope is a bit cold. Now breathe through your mouth. Take a deep breath, hold your breath for a few seconds and let out the air again.

Ear/ Nose/ Throat (incl. Head/ Neck)

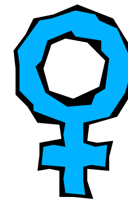
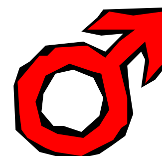
QUESTIONS	INSTRUCTIONS
Have you noticed any swollen glands or lumps in your throat? Do you suffer from chronic headaches? Are they steady, one-sided?	I'm going behind you to feel your neck. Could you please open your mouth? Try not to squint when I shine the torch into your eye. When I press on your cheek bone please, tell me if it hurts. I want to check your ears (nose) now; please lean forward with your face to the side.

[9] e.g. whitish, green, yellow, brown, red

Gastrointestinal System

QUESTIONS	INSTRUCTIONS
Do you have any pain in your abdomen? Have you lost your appetite? Do you have any difficulty in swallowing? Did you feel sick recently? Have you lost/ put on weight? Do you have regular bowel movements? How often do you open your bowels/ go to the toilet? Are they hard/ soft? Have you noticed any blood in your stools?	Please lie down on your back and rest both arms along side your body. Now I want to tap on your belly. When I push here and let loose suddenly, does it hurt? Please relax and try to let your belly go soft.

Genitourinary System

QUESTIONS	INSTRUCTIONS
Do you have any trouble passing water? Do you have any trouble with your waterworks? Is there any pain or burning when you urinate? Do you ever leak urine? Do you suffer from incontinence? How often do you have to spend a penny during the night?	
F E M A L E When did you start your last menstrual period? Does it come regular? How often? How heavy is the flow? How many days would you bleed? Have you experienced painful periods? Are you in the change of life? Are you on the pill? Do you have any pain on intercourse?	
M A L E Have you noticed any sores or swellings on your penis? Do you have any discharge from your penis? Any swellings or pain in the scrotum? How often do you have intercourse? Do you use condoms? Do you belong to a high risk group for AIDS?	

Neurological System CNS LOC

QUESTIONS	INSTRUCTIONS
Could you please frown? Can you whistle for me, please? (…always look on the bright side…) Could you open your mouth and show me/ stick out your tongue?	You should just try to relax, I am going to test your reflexes, now. This hammer looks more dangerous than it actually is: so, do not be afraid; I won`t hurt you.

When you have finished the examination, you should not leave your patient unsure about what to do next.

"You can get dressed now and then come out to me. (you might add) Do not hurry, take your time."

A Medical Form: Version–A-

Time of
assessment
Name First Name Date of
Birth
Sex Marital Status
Occupation

Present Complaint
c/o

O/E
General Condition
CVS
RS
ENT
GIT
GUS
CNS
(LOC)

Immediate Past History

Points of note

Investigations

Diagnosis

Management

A Medical Form: Version –B-

Time of
assessment
Name First Name Date
of Birth
Sex Marital Status
Occupation

Present Complaint
c/o

HPC

S/E
CVS
RS
ENT
GIT
GUS
CNS
(LOC)

PMH

DH

All

FH

SH

O/E
General Condition
CVS
RS
ENT
GIT
GUS

Part three:
Letters of referral

Communication is an important part of a physician's daily routine. It is obvious that several different specialists might have to be consulted before a suitable treatment can be guaranteed. Usually it is the GP (General Practitioner) who has the closest contact with the patient and who refers him to the specialists. Thus written communication providing sufficient information is indispensable with.

I) Example of a GP`s letter referring a patient to hospital

47 Elm Terrace
London N14

26 July 2004

Consultant Physician
Hammersmith Hospital
Du Cane Road
London W12

Dear Dr

Re: Steven Richmond 26 3 42 (m) 42 Liverpool Way N14

This man has c/o backache on and off for two years. Recently he has also complained of vague discomfort in the left side of his abdomen. This is not related to food intake. Micturitation and bowel normal. O/E limitation of the movements of his spine. Abdomen NAD. Perhaps the abdomen pain originates in the spinal column and I should appreciate your opinion of him.

Yours sincerely
Helen Winterbottom (Dr)

II) Example of a letter from a Consultant to a GP

Whittington Hospital
Highgate Hill
London N19
11 August 2004

Dr S Farnon
10 York Raise
London N6

Dear Dr Farnon

Pamela Layton 7 6 68 (f) 53 Park Close N6

Thank you for referring this patient who gives an interesting history of frequent urinary infections occurring about every 4 months since marriage 6 years ago. However, there is no clear-cut relation to intercourse nor is there any other precipitating factor. Each attack seems to respond rapidly to treatment and there is nothing to suggest permanent renal damage. There is an interesting family history with her mother and sister having similar symptoms. Her mother is on long-term prophylaxis and she has relapses if she ever stops taking the tablets.

I could not find any significant signs on general and rectal examination apart from slight tenderness over the sigmoid colon. I have ordered IVP and other relevant investigations to exclude any underlying cause.

Should nothing be found, it might be advisable to treat her in the same way as her mother with long-term chemoprophylaxis.

Yours sincerely
John Hamilton
Consultant Physician

Usually those letters of referral include the following information:

1) Patient's name, age, sex, address.
2) Presenting symptoms (reminding the physician of the relevant data).
3) Any further information from taking the history.
4) Findings from physical examination.
5) Tests required.
6) Provisional/ firm diagnosis.
7) Treatment required (e.g.: none/ medical/ hospitalisation/ surgical/ psychiatric).
8) Prognosis.
9) What information one has given the patient.
10) Keep contact open and future arrangements.

Common Illnesses (& Lay Terms)

You should keep in mind that the patient might need a sick certificate to show his employer.

Childhood Diseases

GERMAN	DOCTOR`S TERM	LAY TERM
Windpocken	Varicella zoster virus	chicken pox
Röteln	rubella	German measles
Masern	rubeola	measles
Mumps	epidemic parotitis	mumps
Scharlach	scarlet fever	-
Keuchhusten	pertussis	whooping cough
Kinderlähmung	poliomyelitis	polio/ infantile paralysis

Common Illnesses and other conditions

GERMAN	DOCTOR`S TERM	LAY TERM
<u>*Chronisch:*</u>		
Arteriosklerose	arteriosclerosis	hardening of the arteries
Arthrose	arthrosis	joint disease
Asthma bronchiale	asthma	-
Adipositas	adiposity	obesity
Depression	depression	-
Diabetes mellitus	diabetes	(sugar)
Gelbsucht	icterus	(yellow) jaundice
Hämophilie	hemophilia	-
Hepatitis	hepatitis	-
Hypertonus	hypertension	high blood pressure
Krebs	cancer	-
Rheuma	rheumatism	-
saisonale Rhinitis	allergic rhinitis	hayfever
Tinnitus	tinnitus	ringing in the ears
Ulcus ventriculi	peptic ulcer	-

<u>*Akut :*</u>		
Erkältung	coryza	cold
Grippe	influenza	flu
akutes Abdomen	acute/ surgical abdomen	-
Bauchschmerzen	abdominal pain	belly ache
Übelkeit	nausea	sickness
Erbrechen	vomiting	throwing up
Kopfschmerz	migraine	headache
Halsschmerzen	-	sore throat
Mandelentzündung	tonsillitis	-
Myokardinfarkt	myocardial infarct	heart attack
Lungenembolie	pulmonary embolism	-
Apoplex	apoplexy	(apoplectic) stroke
(gastrointest.) Blutung	(gast.) hemorrhage	(gast.) bleeding
Schock	shock (psy.: trauma)	-
Hörsturz	apoplectiform deafness	sudden deafness
Aortenaneurysma	aortic aneurysm	-
Krampfanfälle	convulsions	fits (to throw a fit)
Gastroenteritis	gastroenteritis	-
(akutes) Glaukom	glaucoma	-
Konjunktivitis	conjunctivitis	pink eye
Tetanus	tetanus	lockjaw

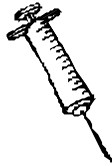
<u>*Chirurgisch:*</u>		
Schenkelhalsfraktur	femoral neck fracture	-
Appendizitis	appendicitis	-
Varizen	varicose veins	-
(inkarzerierte) Hernie	(incarcerated) hernia	-
Ileus	ileus	intestinal obstruction
Cholezystolithiasis	cholelithiasis	gallstone (disease)
Struma	goitre	thyroid
Verbrennung	burn injury/ wound	-
Schädelverletzung	head trauma, skull injury	-

Medical Environment

Instruments and Materials

THINGS A DOCTOR MIGHT HAVE	
white coat	*Kittel*
plaque/ name tag	*Namensschild*
beeper/ bleep	*Piepser*
stethoscope	*Stethoskop*
⇨ (membrane/tubing/earphones)	⇨ *(Membran/ Schläuche/ Hörteil)*
tongue depressor	*Zungenspatel*
tourniquet	*Stauschlauch*
torch (UK)/ flashlight (USA)	*Stablampe*
reflex hammer/ tendon hammer	*Reflexhammer*
scissors	*Schere*
scalpel	*Skalpell*
sharp / dull blade	*scharfe/ stumpfe Klinge*
(sterile) gloves	*(sterile) Handschuhe*
tape measure	*Bandmaß*
cannula/ i.v.-line/ i.v.-access	*Braunüle*
adhesive plaster/ tape	*Pflaster*
swab	*Tupfer*

USEFUL INSTRUMENTS	
sphygmomanometer	*Blutdruckmeßgerät*
⇨ blood pressure cuff	⇨ *Blutdruckmanschette*
ophthalmoscope	*Augenspiegel*
otoscope	*Ohrenspiegel*
thermometer	*Thermometer*
tuning fork	*Stimmgabel*
(sterile) gown	*(steriler) Kittel*
face mask	*Mundschutz*
disposable cap	*Einmalhaube*
paper towels/ tissues	*Papiertücher*
syringe	*Spritze*
cannula/ needle	*Kanüle, Hohlnadel*
stretcher	*Trage*
ointment	*Salbe*
pincers/ (pair of) tweezers/ forceps	*Pinzette*

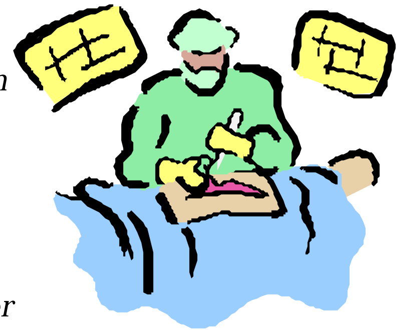


Objects in a patient`s room

bedsheet	*Bettlaken*
blanket	*Bettdecke*
pillow	*Kopfkissen*
rails	*Bettgitter*
handgrip/ trapeze	*Bettgalgen (-handgriff)*
bell push (UK)/ signal cord (USA)	*Klingel*

light switch	*Lichtschalter*
bedside table	*Nachtschränkchen*
tray	*Tablett*
bedpan	*Steckbecken*
emesis basin/ vomit bowl	*Nierenschale*
crutch	*Krücke*
plaster of paris	*Gips*
elastic bandage	*elastische Binde*

Different Rooms



consulting room	*Behandlungsraum*
waiting room	*Wartezimmer*
theatre	*Operationssaal*
A & E (accident & emergency)	*Notaufnahme*
delivery room	*Kreißsaal*
sick room	*Patientenzimmer*
nurses` room	*Schwesternzimmer*
ward	*Station*
laboratory (infml.: lab)	*Labor*
corridor	*Flur*
dining hall/ canteen	*Kantine*

Special clinical tests and procedures

For further details please consider English textbooks.

Blood

Full blood count (FBC)/ Complete blood count (CBC)	*Grosses Blutbild*
White blood count (WBC)	*Leukozytenzahl*
Urea and electrolytes (U&E)	*Harnstoff und Elektrolyte*
Clotting screen	*Gerinnungsfaktoren*
Arterial blood gasses (ABG)	*Arterielle Blutgasanalyse*
Blood cultures (BC)	*Blutkulturen*
Liver function tests (LFT)	*Leberfunktion (GOT, GPT, Bilirubin, alk. Phosphatase)*

Radiology

Chest X-ray (CXR)	*Röntgen-Thorax-*
Abdominal X-ray	*Röntgen- Abdomen-*
CT-scan	*Computertomographie*
Electrocardiogram (ECG)	*selbstredend…*

Procedures

venipuncture	*Venenpunktion*
lumbar puncture	*Lumbalpunktion*
paracentesis (e.g. of ascitic fluid)	*Punktion (z.B. von Aszites)*
Ultrasound scanning	*Ultraschalluntersuchung*
angiography	*Angiographie*
gastric lavage	*Magenspülung*
Dilatation and curettage (D&C)	*Kürettage*

Case Histories

Case History I: A Patient with Abdominal Pain[10]

The patient was a 33 year old salesman, who came to the emergency room because of "bellyache".
He had been in good health until the previous evening, when he went to a party. There he had several bottles of beer. He sampled the chili and ate custard. About an hour after the meal of chili he suddenly felt an excruciating abdominal pain, accompanied by nausea. The pain appeared to arise from the area under his belly button. He broke out in a sweat and had to lie down. After about 5 min the pain was completely gone and he felt fine again. He even engaged in a match of volleyball later that evening. When playing in the front row close to the net he jumped and stretched for the ball. Immediately thereafter, the abdominal pain recurred. Since then he had been restless; his pain never let up completely. In the last 2h he had not had any desire for food; he had been nauseated 6 times and vomited 4 times. Each attack was accompanied by worsening of his sharp abdominal pains. The pain was now located in the left abdomen and under the umbilicus. It worsened after coughing or sneezing. The patient`s last bowel movement had been 2 days ago.

Physical examination

The patient appeared to be in acute distress on account of his abdominal discomfort. He was diaphoretic, the oral temperature was 100°F (38°C), the pulse was 104 beats/min, and the blood pressure was 100/70 mmHg. The patient rested motionless on his stretcher. He had his knees pulled up and apparently tried to avoid any movements. The abdominal examination showed tenderness to gentle palpation in the left upper quadrant, the epigastrium, and the area of the umbilicus. This was accompanied by guarding in these respective areas. Palpation of McBurney`s point was unremarkable. There was no rebound tenderness in any abdominal area. The bowel sounds were diminished or even absent. There was no costovertebral angle tenderness and the rectal examination was normal.

Questions

What diagnostic possibilities would you consider at this point and what would you do to work them up?

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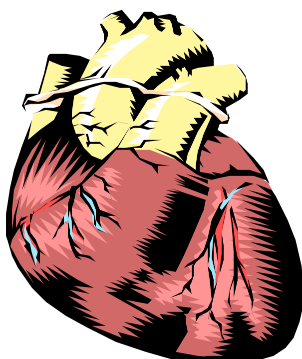
[10] taken from: **Gross, Peter.** *Medical English.* Stuttgart: Thieme, 2000. pp 66-73

Case History II: A policeman with chest pain[11]



A 47 year-old policeman was taken to the emergency room because of substernal chest pains. The attack began 45 min before admission, while he was on the phone. The pain radiated to his back and did not budge until admission. It was accompanied by shortness of breath, dizziness, and nausea; he vomited once.
The patient`s wife reported that he had had a similar attack 2 hours before while lifting a case of beer. Furthermore, on the morning of this day the patient had had a fainting spell, followed by palpitations and restlessness. The patient had a past medical history of high blood pressure. Family history: his father died suddenly at 51 years of age.

Physical examination
In the emergency room the patient was in acute distress from severe chest pain. He moaned and groaned continually and was profusely diaphoretic and cyanotic. The temperature was 97°F (36,8°C). The patient was an obese male (148 lbs/5`2``) = (67kg/1,55m) looking much older than his stated age. During his exam he temporarily lost consciousness. The BP was 70/40 mmHg, the pulse rate was 134/min and irregular. The physical exam of heart, skin, lung, abdomen and extremities was unremarkable. Cardiac auscultation was also unremarkable.

Lab
ECG was normal.

Question
What possible diagnoses do you think of and what would you do to confirm them at this point?

[11]taken from: **Gross, Peter.** *Medical English.* Stuttgart: Thieme, 2000.

Case History III: A Dying Adolescent[12]

Lucy was fifteen years old and one of four children. Her mother was a registered nurse and her father a machine operator in a local factory. She was admitted to the hospital with a two- day history of nausea, vomiting, and persistent abdominal pain. A gastrointestinal X-ray series and a gastroscopy confirmed an obstruction in the initial portion of the small intestine. Exploratory surgery revealed a large tumor which appeared to arise in the pancreas and had penetrated the intestine. The tumor had also spread to regional lymph nodes, the liver, and one kidney. Pathological examination of specimens removed at surgery confirmed the diagnosis of carcinoma of the pancreas.

Within two weeks after surgery, an intensive six-week course of chemotherapy with three drugs was undertaken. After this course, there was a marked regression of the tumor in the pancreas. All other tumor had disappeared entirely. A second six-week cycle of treatment was initiated, but by the end of this course, X-ray and physical examination revealed that the tumor was again growing rapidly and metastases were appearing.

Throughout the early period of treatment, the patient was very interested in how treatment was going. She was also very cooperative through a series of difficult procedures. She often expressed to the nurses a concern about the impact of her illness on her parents and siblings. However, she was also usually very reserved in interchanges with hospital staff members, and she never initiated discussions of her condition. In addition, the patient's mother was very protective of the child and, as the health professional in the family, assumed the decision-making role. At all times, the family, particularly the mother and the patient, appeared to be very close-knit and loving.

After failure of the first regimen of chemotherapy, a different anticancer drug therapy was attempted. However, two weeks later the patient was admitted to the hospital with acute gastrointestinal bleeding. Endoscopic examination revealed bleeding in three sites in the initial portion of the small intestine, suggesting that the tumor was eroding blood vessels. Over the next three days the gastric bleeding continued, and the patient occasionally vomited large clots of blood. The patient's blood volume was kept stable by daily administration of red cells. Generalized abdominal pain was controlled with a moderate dose of intravenous morphine.

The physician visited the room each day to discuss the patient's condition with the family. These discussions were held at the bedside and were focused on day-to-day changes in her condition.

[12] taken from: **Ackerman, T. and C. Strong.** *A Casebook of Medical Ethics.* New York, Oxford: Oxford University Press, 1989; pp 50-53

The patient remained awake and alert during this period, but she was always very quiet. She did not ask whether she might soon die, and the issue was not raised with her. On a couple of occasions, the mother expressed a concern outside the room about conducting discussions of her daily condition in the patient's presence. But in private conversations with the nurse practitioner, the child said that she was aware that she might not become well enough to return home, although she would like to do so. She expressed further concern about her parents. She also said she believed God would make her well again.
One week after hospitalization the patient's prognosis was discussed privately with her mother. The mother inquired about the availability of other chemotherapeutic agents. She was told that no other drugs with established dosages or effectiveness were available for the treatment of pancreatic cancer, although some experimental agents might be tried. It was emphasized that the chance for regression of the tumor was slight, and at best life could be prolonged only briefly. At any rate, chemotherapy could not be administered until the bleeding abated and the physician said that it would probably not be possible to stop the bleeding. He suggested that it might be appropriate not to send the patient to the intensive care unit should her condition worsen; doing so might subject her to needless discomfort. He also raised the possibility of discontinuing the blood transfusions. The mother was unprepared to accept either suggestion, asked that the transfusions be continued at their present rate, and held out the hope that additional chemotherapy might be possible. Finally, the question raised about involving the patient in the decision-making process. But the mother also firmly resisted this possibility, indicating that she did not wish to intensify the anxiety and suffering of her daughter.

Question

Point out the physician's dilemmata and try to evaluate the options he has.

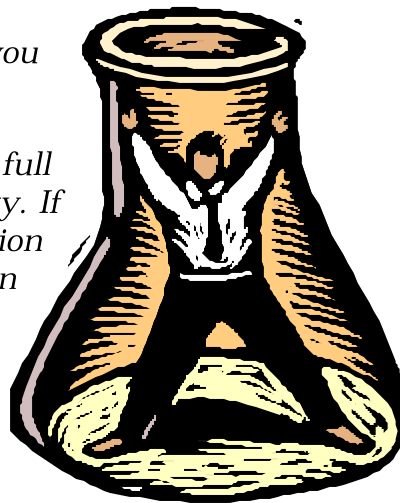
Appendix

How to write an Application

Before you can start practising your new abilities in a British hospital you have to apply for a clerkship. A list of addresses of hospitals (Teaching or District Hospitals) can be obtained by

- Links der Fachschaft Medizin (auf den Serviceseiten im http://www.klinikum.uni-muenster.de/fachschaft/ausland.html)
- Deutscher Famulantenaustausch (dfa) http://www.dfa-germany.de/index2.htm (dort über „Service“ und dann „Krankenhäuser“)
- British Council (umfangreiche Info zu UK) http://www.britishcouncil.de/pdf/medi.pdf
- Hospitals worldwide (except US) http://adams.mgh.harvard.edu/hospitalwebworld.html
  Hospitals US
  http://adams.mgh.harvard.edu/hospitalwebusa.html

Usually you send your letter of application directly to the desired hospital, optionally you might add your CV and a reference, where somebody (the dean/Prof. Nippert) ensures the foreign hospital that you are a full time medical student at Muenster University. If you do not include that additional information the hospital will surely ask you to hand it in before definitely accepting you. There are examples of the three types of documents given below:



Letter of Reference

This is an example of a recommendation the Dean of the Ruhr-Universität Bochum gives his students.

To whom it may concern

Mrs Annette Kloppstock, born on August 28th 1977 in Münster, is enrolled as a medical student at the Westfälische Wilhelms-Universität Münster. Her study follows the requirements of the Licensing Regulations for Physicians in the Federal Republic of Germany. At present she is in her 3rd year of a 6 year program.

In personal and critical discussions about scientific problems as well as on common medical and social issues Mrs Kloppstock has proved to be critical and intelligent. She is known as a hard-working student and is in good standing with our university.
Her knowledge of written and spoken English is excellent.

Mrs Kloppstock would like to do a clinical clerkship at your institution. I recommend this plan as very useful for her medical education. She is approved to take this clerkship for credit.

Yours truly,

Dean of the faculty of medicine

Letter of Application

Annette Kloppstock
Waldeyerstasse 27
48149 Muenster
Germany

Tel.:0049-251-8355291
e-mail: kloppstock@uni-muenster.de

To the Head of the
Department of Cardiac Surgery
Bromsgrove Hospital
14 Kendal Close
G66 1EL Glasgow
Scotland

November 28th, 2002

Dear Madam, dear Sir,

I would like to apply for a clinical elective[13] at your department.
I am a German medical student in the third year of a six- year medical training at Muenster University. In partial requirement for my medical degree a clerkship must be performed in a non-university-related hospital or with a private practitioner. The minimum required time for such a clerkship is 30 days. It is the purpose of the clerkship to acquaint the student with the medical milieu in general and the specifics of the department or ward in which he is working, including learning basic medical skills. Our clerkship is called "Famulatur" and is not equivalent to a third year medical clerkship, internship or elective.

I am very interested in obtaining information concerning the possibility of performing a medical clerkship in your department as my dissertation deals with a cardio-surgical topic ("T I T L E").

I have enclosed my curriculum completed to date in medical school and a letter of recommendation by the dean of the faculty (the supervisor = Doktorvater). If there are any more details you should require please inform contact me.
Thank you for your kind consideration in this matter.

Yours sincerely

Annette Kloppstock

Enclosures/ Attachments: Curriculum Vitae
Letter of reference

[13] The magazine „Via Medici" advises students to use the term `clinical attachment`. (*Via Medici.* Verlag Georg Thieme, Stuttgart. Heft Okt. 2000, S.7)

Curriculum Vitae

Name

Date and place of birth

Address/ e-mail

Marital status

Parents

University career (University attendance in anti-chronological order)

Military service/ Social service/ Voluntary social year

Education (School attendance in anti-chronological order)

Electives in (give specialities and duration)

Professional Experience (if applicable)

Publications (if applicable)

Leisure interests (give one or two items)

References/ Referees (give names, titles, addresses, tel-no of **two** referees)

Place, Date, Signature

ABKÜRZUNGSVERZEICHNIS

- A = Anaemia
- A&E = Accident & Emergency
- A&W = Alert and well
- AAA = Abdomin. aortic aneurysm
- AB = Asthma bronchiale
- ABG = Arterial blood gases
- AC = Air conduction
- AF = Atrial fibrillation
- AI = Aortic insufficiency
- AJ = Ankle/Achilles jerk
- All = Allergies
- APB = Atrial premature beat
- APH = Antepartum haemorrhage
- ARF = Acute renal failure
- aROM = active range of movement
- AS = Aortic stenosis
- ASAP = As soon as possible
- AXR = Abdominal X-ray
- BBB = Bundle branch block
- BC = Blood culture or Bone conduction
- BJ = Biceps jerk
- BMA = British Medical Associat.
- BP = Blood pressure
- BPC = Biparietal circumference
- BS = Breath sounds
- BUN = Blood urea nitrogen
- Bx = Biopsy
- c = cum (lat.), with
- C = Cyanosis
- C&S = Culture and sensitivity
- c/o = complaining of
- CABG = Coronary art. bypass graft
- CAD = Coronary artery disease
- CAT = Computed axial tomograp.
- CBC = Complete blood count
- CBD = Common bile duct
- CCF = Congestive cardiac failure
- CCU = Coronary Care Unit
- CDH = Congenital disloc. of t. hip
- CF = Cystic fibrosis
- CHF = Congestive heart failure
- Cl = Clubbing
- CN = Cranial nerves
- CNS = Central nervous system
- COAD = Chronic obstructive airways disease
- COPD = Chronic obstructive pulmonary disease
- CPR = Cardiopulm. resuscitation
- Crea = Creatinine
- CRF = Chronic renal failure
- CS = Caesarean section
- CSF = Cerebrospinal fluid
- CV = Curriculum vitae
- CVA = Cerebrovascular accident
- CVS = Cardiovascular system
- CXR = Chest X-ray
- D&C = Dilatation and curettage
- D&V = Diarrhoea and vomiting
- D/C = Discharge, discontinue
- D/W = Discussed with
- DD = Differential diagnosis
- DH = Drug history
- DM = Diabetes mellitus
- DNR = Do not resuscitate
- DOA = Dead on arrival
- DOB = Date of birth
- DOE = Dyspnoea on exertion
- DSS = Depart. of Social Security
- DUB = Dysfunct. uterine bleeding
- DVT = Deep venous thrombosis
- e&s = erect and supine
- e.g. = for example
- ECG = Electrocardiogram
- ECT = Electroconvulsive therapy
- EDC = Expected date of confinement
- EDD = Expected date of delivery
- ENT = Ear, Nose, Throat
- Ep = Epilepsy
- ESR = Erythrocyte sediment. rate
- EUA = Examinat. under anaesthe.
- (F) = umgangssprachl., familiär
- F/U = Follow up
- FBC = Full blood count
- FD = Forceps delivery
- FH = Family history
- fl.oz. = fluid ounce
- FOB = Faecal occult blood
- ft. = Foot, feet
- FTND = Full term normal delivery
- FUO = Fever of unknown origin
- G&S = Group and save
- GIT = Gastrointestinal tract
- Glc = Glucose
- GMC = General Medical Council
- GP = General practitioner
- GUS = Genitourinary system
- Gyn = Gynaecology
- h., hrs. = hour, hours
- HCSW = Health care support worke.
- HO = House Officer
- HPC = History of presenting complaint
- HS = Heart sounds
- HVS = High vaginal swab
- Hx = History
- ICP = Intracranial pressure
- ICU = Intensive care unit
- IDDM = Insulin-dependent DM
- in. = inch
- IRDS = Infant respirat. distr. syndr.
- IUCD = intra-uterine-contraceptive-device
- IVI = Intravenous infusion
- IVP = Intravenous pyelogram
- IVU = Intravenous urogram
- J = Jaundice
- JHO = Junior House Officer
- JVP = Jugular venous pulse
- Krkhs = Krankenhaus
- KUB = Kidney, ureters, bladder
- L = left
- LAD = Lymphadenopathy
- lb. = pound
- LE = Lower extremity
- LFT = Liver function tests
- LIF = Left iliac fossa
- LMN = Lower motor neurone
- LMP = Last menstrual period
- LOC = Locomotor system
- LP = Lumbar puncture
- LPN = Licensed practical nurse
- LSCS = Low segm. Caesarian sect.
- LUQ = Left upper quadrant
- LVF = Left ventricular failure
- LVH = Left ventric. hypertrophy
- m = Mile
- mane = in the morning
- MI = Myocardial infarction
- MOS = Mitral opening snap
- MPS = Medical Protection Societ.
- MR = Mitral regurgitation
- MS = Mitral stenosis or Multiple sclerosis
- MSQ = Mental score questions
- MSU = Mid stream urine
- N/A = Not applicable
- NAD = No abnormality detected
- NAI = Non-accidental injury
- NB = nota bene (lat.), note well
- NBM = Nil by mouth
- NGT = Nasogastric tube
- NHS = National Health Service
- NI = National insurance
- NIDDM = Non-insulin-depend. DM
- nocte = at night
- NOF = Neck of femur
- NSAID = Non-steroidal anti-inflammatory drug
- O = Oedema
- O/D = Overdose
- O/E = On examination
- OA = on admission, osteoarthr.
- Obs = Obstetrics
- OCP = Oral contraceptive pill
- od = once daily
- OD = Overdose
- ODA = Operating depart. assistant
- OPA = Outpatient appointment
- Ortho = Orthopaedics
- oz. = ounce
- Paeds = Paediatrics
- PC = Presenting complaint
- PCB = Post-coital bleeding
- PCV = Packed cell volume
- PE = Pulmonary embolus
- PERLA = Pupils equal and reactive to light & accommodation
- PID = Pelvic inflammat. disease
- PJ = Patellar jerk
- Pl = plantars = Babinsky
- PM = Postmenopausal or postmortem
- PMB = Post-menopausal bleeding
- PMH = Past medical history
- PND = Paroxys. noct. dyspnoea
- PO = per os
- PPH = Postpartum haemorrhage
- PPP = Peripheral pulses present
- PPs = Peripheral pulses
- PR = per rectum
- PRN = pro re nata (lat.),as needed
- pROM = passiv. range of movement
- pt. = pint
- PTE = Pulmonary thrombo-embolism
- PUO = Pyrexia of unknown origin
- PV = Examination per vaginam
- PVD = Peripheral vascular disease
- qid = Four times a day
- R = right
- RA = Rheumatoid arthritis
- RBC = Red blood count
- RF = Rheumatic fever
- RIF = Right iliac fossa
- RL = Reversed Lasègue
- ROM = Range of movement
- RoS = Review of Systems
- RS = Respiratory system
- RTA = Renal tubular acidosis or road traffic accident
- RUQ = Right upper quadrant
- S/B = seen by
- S/E = Systematic Enquiry
- SAU = Sieve all urine
- SBE = Subacute bact. endocarditis
- SCBU = Special care baby unit
- SH = Social history
- SHO = Senior House Officer
- Sibs = Siblings
- SIDS = Sudden infant death syndr.
- SJ = Supinator jerk
- SL = Sublingual
- SLR = Straight leg raising = Lasègue
- SOB = Short of breath
- SOL = Space occupying lesion
- st. = stone
- STD = Sexually transmitted disea.
- SVT = Supraventric. tachycardia
- SXR = Skull X-ray
- TB = Tuberculosis
- tds = Three times daily
- TFT = Thyroid function tests
- TIBC = Total iron binding capacity
- TJ = Triceps jerk
- TLC = Tender loving care
- TOP = Termination of pregnancy
- TPR = Temperature, pulse and respiration rate
- Tx = Treatment
- U&E = Urea and Electrolytes
- U/S = Ultrasound
- UE = Upper extremity
- UMN = Upper motor neurone
- URTI = Upper respirat.tract infect.
- UTI = Urinary tract infection
- +ve = positive
- -ve = negative
- VD = Venereal disease
- VE = Vaginal examination
- VQscan = Ventilation-perfusion scan
- VR = Vocal resonance
- VT = Ventricular tachycardia
- W/R = Ward-round
- WBC = White blood count
- Wd = Ward
- wk. = week
- WNL = Within normal limits
- x/12 = number of months
- x/24 = number of hours
- x/40 = number of gestation. weeks
- x/52 = number of weeks
- x/7 = number of days
- y. = Years of age
- yd. = yard, yards

Weights and Measures

Heights

1 **inch**	2,5 cm
12 inches = 1 **foot**	30 cm
3 feet = 1 **yard**	90 cm (about 1 metre)
6 feet	180 cm
5 ft 7 inches (“five seven”)	170 cm
5 ft 3 ½ inches	160 cm
4 ft 1 inch	124 cm (child)

Temperature

C E L C I U S	F A H R E N H E I T
0°	32°
20°	68°
30°	86°
37°	**98,6°**
38°	**100,4°**
39°	**102,2°**
40°	**104°**
100°	212°

A useful hint (?!):
To convert degrees Fahrenheit (°F) to degrees Celsius (°C) substract 32 and multiply the remainder by 5/9.

Weights

1 **ounce**	28,3 grams
16 ounces = 1 **pound (=lb** `libra`)	453,59 grams (~ 450 g)
14 lbs = 1 **stone**	6,3 kg

To transfer kg to **lbs** multiply by 2,2!
1 kg = 2,2 lbs

Abbreviations of time

3/24	3 hours
3/7	3 days
3/52	3 weeks
3/12	3 months

Some facts about the British Health System

The information provided in this chapter is meant for you to become acquainted with the education of British medical students and to explain most of the common titles within the "hierarchy". The text is based upon details given by the British Council.

Doctor or Mister?
Once upon a time there was something wicked persons might have called `animosity` between members of the surgical and of the non-surgical fields of medicine. Either of them had their special abilities, but only the latter were authorised to call themselves ***doctors****. The surgeons proved to be neither dumb nor dull and proudly used `**Mister**` as a title.* *If you stick to that rule you (and they) will live happily ever after….*

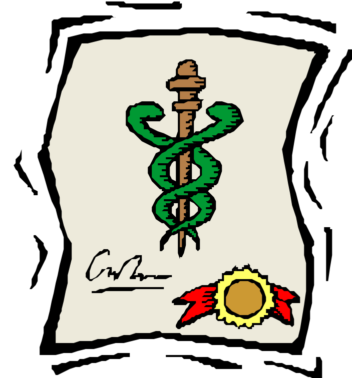
It takes five years to study medicine in Great Britain. There are actually no strict rules and regulations as in the German `Lehrplan`, so the education of medical students is not the same at different universities. But of course the education has to be in accordance with the statutes of the profession that are made by the British Medical Council.

Candidates that have passed the final exam are called `Bachelor of Medicine` which includes their pre-registration.

After that they work as **Junior House Officers (JHO) / Pre-Registration-Officers (HO).** This position is similar to the German `AiP` and includes clerking patients, getting the daily work on the ward organised and -of course- doing nightshifts. There are two six-month sections called internship.

At this point of their education British physicians start their (Basic and Higher) Specialist Training. As **Senior House Officers (SHO)** they are supervising the JHO`s. They can be regarded as German `Assistenzärzte` and work quite autonomously. After two or three years of work within and rotations to other hospitals as well as further training they might get the opportunity of becoming a **Registrar** (similar to `Oberarzt` but without a special exam yet) If a registrar does not desire to become a specialist registrar/ consultant he/she remains in "**staff grade**".

The registration as a specialist requires some more effort: after another 4 to 6 years the **Senior Registrar/ Specialist Registrar** usually has to pass several exams which are held by the particular medical Royal College (e.g.: Royal College of Surgeons of England, London). The document he obtains is called Certificate of Completion of Specialist Training (CCST). He/ she is authorised to add his/ her name to the Specialist Register, then.



A **Consultant** is a specialist on his/ her field, the position is that of a German `Chefarzt`.

You might also find **Loccums** (of all grades) in the department, who have a limited contract.

Considering the nursing members of the hospital we find the **Head Nurse** or **Sister** who can be regarded as the chief of the ward. **Staff Nurses** (or just **Nurses**) have undergone a three-year training and thus are similar to German "examinierte Pflegekräfte". In contrast to that **Auxiliary Nurses** (or just **Auxiliaries**) fulfilled a one or two year training and are responsible for the basic work on patients like washing, feeding, etc. **Student Nurses** are trainees and are under the Head Nurse`s surveillance. There is further staff such as the **Health care support workers** doing the administrative work on the ward and the **Orderlies/ Domestics** who do the cleaning.
In the delivery room you will find the **midwives** taking care of the women in labour and their babies. Surgical instruments during operations are managed by the **theatre nurse**.
Sooner or later you will depend upon the **porter`s** help as he knows a lot about the hospital you work in.

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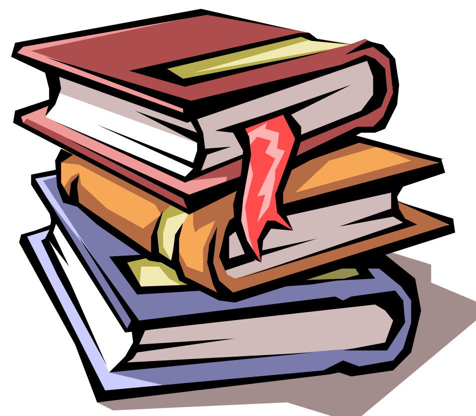

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