



The art of medicine The beauty of medical language

One of the pleasures of editing *Bellevue Literary Review* for the past 20 years is the opportunity to indulge in the aesthetics of writing. Creative writing, particularly poetry, places a premium on language for pleasure, words for beauty. For all of us trained in the scientific world, it is a secret indulgence, a private ice-cream sundae.

This all grinds to a rasping halt when I push aside the poetry and fiction to crack open my journals for the latest research advances in medicine. The clinical language is so dry that it sticks in my throat like the grits they used to serve in our hospital cafeteria. It handily abides by our hospital's infection control guidelines; the writing is so sterile that nary a staphylococcus could hope to achieve mitosis in its midst. It is as though the practitioners of the scientific literature of medicine reached a covert agreement to ban even the slightest hint of creativity, the slimmest suggestion of beauty.

Of course, it was not always that way. A century ago, purveyors of the stethoscope were also men of letters—and they were, largely, men. They penned florid descriptions of pathology, waxed poetic over the musicality of murmurs. But as our diagnostic imaging offers ever crisper renditions of human pathology, there is less and less need for language to employ its vast metaphorical repertoire to render illness onto the page.

Case reports will never again read like Sir William Osler's description of endocarditis lesions:

“For the great majority of the cases of the primary form, the term ‘ulcerative’ hardly expresses the precise anatomical condition. The expression used by French writers is more correct, ‘*endocardite vegetante ulcereuse*,’ for there are both loss of substance and vegetative

outgrowths. The affected valve presents irregular nodular excrescences of a greyish-white colour, often fissured, cauliflower-like; the surface either quite smooth and covered with a thin fibrinous lamina or granular from exposure of the texture of the mass.”

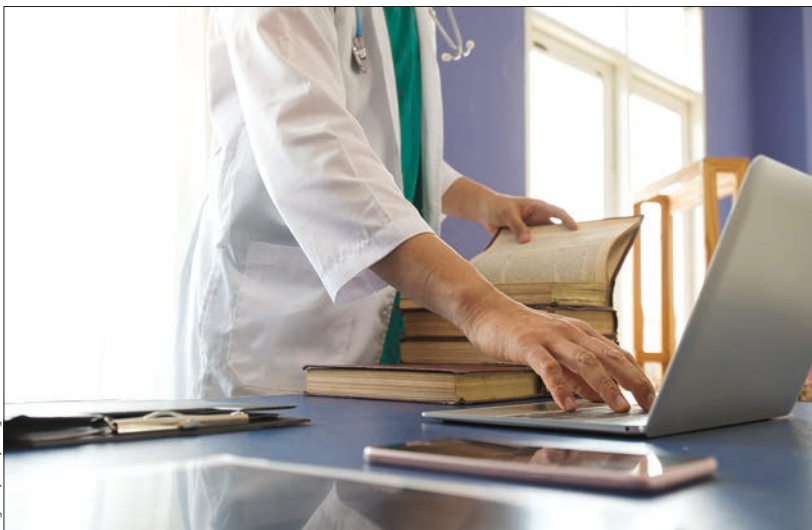
Nor need they. An echocardiogram delivers the relevant information in a way that is more practical for everyday clinical practice. The era of creative writing in the scientific literature of medicine is over. But, luckily, that era has left enough imprints in the language of medicine to offer the occasional pearl of beauty in our otherwise arid linguistic landscape. Every time I stumble across one, especially within the workaday clinical grind, it is like someone has slipped me a spoonful of that ice cream. Just when I need it.

Some of my favourites come from the physical examination, the extended kind performed by earnest medical students who are still blissfully unyoked to 15-minute visits. Whenever these students report on fremitus, egophony, or whispered pectoriloquy of the lungs, I feel like I have been momentarily transported. It is not a medical history they are reciting; it's a Keatsian poem.

Those pulmonary terms, however—lovely though they are—have largely reached their sell-by date. These manoeuvres are no longer part of the routine physical examination, except in teaching settings or in remote medical settings without easy access to radiology. Most patients I see have been x-rayed or CTed before a stethoscope—much less a palm—has even sidled up to the chest. By contrast, some of the mellifluous words of gastroenterology remain in current use. You will easily come across odynophagia and choledocholithiasis in medical charts, even an occasional sialadenitis, all shimmering with onomatopoeia. And there is always borborygmi, ideal technical cover to keep us far from the madding crowds. What self-respecting doctor would risk their high-brow credentials by penning “stomach grumbling” when a perfectly good sesquipedalian is available?

Rheumatology has always offered a trove of words that roll luxuriously off the tongue. Polymyalgia rheumatica tops the list for me, followed closely by the heliotrope rash. Then there is migratory arthritis and ankylosing spondylitis, which both offer the added bonus of conveying action and movement—always a plus in the literary world.

When I began internship, I was initially bound for neurology. Although I eventually settled on internal medicine, I have retained an attachment to the melodious terms of neurology, and remain convinced that this was part of the initial attraction. Who wouldn't want to be immersed in the soft sibilants of meningismus and nucleus pulposus, or the cool elegance of anisocoria? Then there's



the gentle tilt of the antalgic gait and the sophisticated clip of dysdiadochokinesia (not to mention the smug self-satisfaction if you manage to pronounce it correctly on the first go-around).

The doctors of yore evinced a well known fondness for culinary descriptors—the nutmeg liver of chronic venous congestion contrasting with the anchovy liver of amoebic infection. And what better way to distinguish cholera from typhoid than by examining the brothy output? If you're producing rice-water diarrhoea, you've got cholera. Pea soup? Start antibiotics for typhoid.

Certain foods, such as the humble currant, extend liberally across more than one organ system. Currant jelly stool is a hallmark of paediatric intussusception, whereas currant jelly sputum indicates *Klebsiella pneumoniae*. During autopsies, there are currant jelly clots, which sediment at a brisker clip than their more languorous counterparts, the chicken-fat clots. And, of course, there remains the unswerving devotion to food as a medical measuring tool, despite precise millimetre readings available on our MRI and CT scans. Palpable lesions in the breast are pea-sized. Enlarged lymph nodes may be grape-sized (walnut-sized if larger and harder). Abdominal tumours retain a specificity for being grapefruit-sized.

These meaty metaphors, alas, evanesce when we open the electronic medical record (EMR) for the decidedly pedestrian task of chronicling patient care in the 21st century. The computer is distinctly unsentimental, eschewing the profligacy of prose for check-boxes that can be efficiently tallied into megadata. Trying to corral the vividness and variety of the human condition into cramped carriage of the EMR is endlessly frustrating.

Despite our modern technologies—many of which offer impressive benefits, but a good deal of which do nothing but obfuscate—much of clinical medicine is still talking, listening, observing, palpating, and reflecting. Clinical medicine is a human interaction that does not distil easily into the EMR straightjacket.

Yes, there are a few remaining free-text fields, but free-wheeling composition is clearly frowned upon. Once, in an earlier iteration of our EMR, I reached the character limit when trying to elaborate a patient with a knot of cardiac, endocrine, renal, and pulmonary conditions, all of which had reached a severe stage. I had already pared down this complex case to a degree that would crimson the cheeks of Strunk and White, but I still kept hitting up against the EMR's limit. In desperation, I called the help desk (an oxymoron perhaps better left undiscussed) and was told sharply, "Well, we can't have you doctors rambling on."

I am thankful that my predecessors were not so constrained. Yes, perhaps it was the very paucity of viable medical treatments that offered them the luxury of time, space, and ink. Luckily, their floridity of description, indulgence of metaphor, and liberal lifting from Latin,

Greek, and French, have left us traces of beauty in the lingua medica.

With whatever shrinking free-text allotments clinicians are still permitted, we can slip in the café-au-lait spots, the port-wine stains, and the palpable thrills (the G-rated cardiac kind), and appreciate the honeyed syllables of cystocoeles and cyanosis.

And we can find relief in the renewed acknowledgment of medical humanities. The Association of American Medical Colleges (AAMC) released a 2020 report, *The Fundamental Role of the Arts and Humanities in Medical Education*, advocating for humanities as a crucial tool for the "cultivation of practical wisdom". It is easy to be smart—students who enter the health professions are already smart and access to electronic databases makes us even smarter. But it is far harder to be wise. "Human suffering and illness arise within complex contexts", notes the AAMC report, and good medicine requires the "ability to integrate one's deep fund of knowledge, ethical sensibilities, and emotional intelligence to know how to do the right thing in *this* circumstance, with *this* patient". Humanities offer rigorous grounding in nuance and ambiguity—practical wisdom for the everyday clinician.

It makes perfect sense that the crispness of Anton Chekhov, the veracity of Lucille Clifton, and the abandon of Walt Whitman should reside in the curriculum alongside the diagnostic algorithm for adrenal insufficiency and the preoperative cardiac risk assessment. I keep my office well stocked with copies of our literary magazine so that when the EMR threatens to flatline me, I can always reach for a poem. When the suffocating diction of algorithmed medicine gives me acute borborygmi, a dose of luscious metaphor is the perfect Rx.

I also hand out copies to my patients. For patients, who have to put up with even more bureaucratic blarney than their doctors and nurses do, literary language can be a true balm. In our frenetic, fractured medical world that treats patients as objects upon which health care will be "delivered", literature and poetry burrow deeper into the planes of vulnerability that illness engenders. The language is encompassing and humanising; the metaphors resonant and grounding. And unlike the other things I routinely hand out to my patients, this doesn't cause constipation, vertigo, nausea, or flattened libido. I wish I could say the same about the language of our politicians these days; but that is a whole other story.

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Further reading

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