Frequently Misused Medical Terms
(Or – How to Improve Your Credibility)

1. **AAOX3**
   - The first “A” means “Awake”.
   - The second “A” means “Alert”.
   - The “O” means “Oriented”
   - Don’t use these letters if the patient is not alert and oriented.

   **X1** means “oriented to self or person” – patient knows own name, significant others.
   **X2** means “oriented to person and place” – knows where he/she is.
   **X3** means “oriented to person, place, and time” – knows the date/day.

   If the patient is not alert and oriented, use another way to describe the mental status: AVPU or more descriptive terms.

   **DO NOT USE “AAOx3” TO DESCRIBE A PRE-VERBAL CHILD!**

2. **Responds to Pain**
   - State **HOW** the patient responds. There is a great difference between:
     - Moans
     - Localizes pain
     - Generalized movement
     - Posturing

3. **“Upon arrival”**
   - This is very over-used. It implies that you will be doing an update on the patient’s condition some time after arrival by comparison (“On our arrival, the patient was alert, but became unresponsive almost immediately”). Otherwise, this falls into the rule that you should write as few “filler words” as possible. Read physician’s history and physicals, they never say, “Upon arrival in the ER, I found this patient . . .”. Another common filler word is, “Patient” . . . to begin each sentence, “Patient c/o tenderness in RUQ abd, patient denies diarrhea, patient denies vomiting, etc.” Space is limited, save room for words that give good information. “Upon exam” is another. Use the word “upon” about as often as you use it in normal conversation. (*Never?*)

4. **“Tenderness”** - means that you elicit pain when you touch, or palpate. So, “Pain on palpation” means exactly the same thing as “tenderness”. No need to say, “Upon palpation, patient complains of tenderness”.

5. The lungs are divided into **lobes**, which we can **see** in surgery, on autopsy, or xray. We cannot **hear** LOBES. When auscultating, use terms like: “bibasilar”, “left or right base”, “scattered” (wheezes or rales), “inspiratory” or “expiratory” wheezes, “rales ¾ way up”, etc.
6. Don’t use EKG terms like, “NSR” unless patient is on monitor. Say “regular”, “irregular”, “tachycardia”, etc. Only name a rhythm if you see it on the monitor.

7. Don’t evaluate ST segments on a monitor, unless you specifically put it into “diagnostic” mode. The filters in a monitor can alter ST segments, causing them to elevate falsely or not elevate when they are elevated on a 12-lead EKG. The 12-lead EKG is the only accurate way to evaluate ST segments!

8. We are not trained to evaluate patients for abdominal masses. Patients can have all kinds of abd. masses and we will be unaware of them. If you suspect an abdominal aortic aneurysm, it is okay to say, “No obvious abd. mass”, or, “palpable pulsating mass to left of midline in LLQ of abd”. Don’t write, “No masses in abdomen”.

9. Keep learning about pathophysiology. What you absorb in class is not enough. Your assessments will be more pertinent to each patient if you understand the disease. Your use of terminology will improve, also. Learn to spell medical terms. Your credibility will suffer if you can’t spell.