Letters to the Editor

Clear English is healthy

Felicity Savage and Peter Godwin gave good advice in their article "Controlling your language; making English clear" in the March 1996 issue. We should, in our efforts to educate English as a Second Language health professionals, keep in mind that English is the second (or third or fourth) language and make allowances accordingly. On the other hand, those health professionals seeking higher degrees or more advanced medical training need to be able to process that lovely language we can call "Medicalese". This seems to be considered the Lingua Franca of the higher education class. Are we seeking to impart on our students the ability to write sentences that, while breaking no grammatical rules, are difficult to interpret even for those who use "Medicalese" on a daily basis? I hope not. We are, after all, educating.

Whether we are training health care workers with very limited English proficiency, or those who have studied well past the secondary school level, we should follow those 17 rules Savage and Godwin discussed. We should use "clear" English. We should keep our sentences short. We sometimes confuse lengthy, grammatically correct sentences with "clarity". Clarity is ably demonstrated when we read the introductory sentences of a few of the papers (chosen at random when the journal falls off my table) presented in that same March issue:

"Diet plays a central role in the development of dental caries." (Page 15, paragraph 1)

"The negative effects of motor vehicle accidents (MVA) are increasing." (Page 25, paragraph 4)

"Fractures of the facial bones are relatively common in western societies." (Page 54, paragraph 1).

All these sentences are short and sweet (all are less than twelve words long). They present clear ideas; all make positive statements; they are unimpeded by excessive terminology, nothing is compounded, no unnecessary relative clauses exist. They are also easy to understand. These sentences are employing Savage and Godwin's advice quite well.

Working with the Pacific Basin Medical Officer's Training School (PBMOTP), I have come across students who misjudge the importance of clear simple English and seek to jump to "Medicalese" in the mistaken belief it better demonstrates their ideas. Students struggle to learn phrases like "multivariate analyses","substantial variation of survival" and "engraftment". While these phrases have succinct meanings, it takes a great deal of study and language experience to learn how to decode such phrases. We do not encourage this type of writing. Students are encouraged to develop, through their Self Directed Research Project, clear writing to discuss their research.

The following are examples of students' introductory sentences:

"This project is a study to evaluate the extent of dental disease, particularly caries, in preschool-aged children in Pohnpei." (Lemuel, 1992)

"The status of the Pohnpei State Hypertensive Cohort was investigated in a retrospective evaluation study during the last semester of 1992." (Skilling, 1992)

"This paper talks about a case-control study on low birth weight babies in Chuuk which was done in April of 1991." (Mori, 1992)

Here students (all English as a Second Language users) provided clear ideas on topics of their own choosing. They used imperatives, precise words and all have avoided difficult constructions. Their English is clear; we know what they are saying.

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As educators we must bear in mind the needs of our students, whether health workers in the field or health education students in the classroom. Students need practice at learning how to write clearly. They need to be warned away from "Medicalese" and shown that good clear simple English is developed through practice. Often times trial and error will do the job for them. As educators we must lead students to clear English usage, and keep it simple. Using clear English will help our students learn communication skills they can impart to others. Using clear English is a healthy idea.

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Postgraduate training

In the last issue of the Pacific Health Dialog, Stephen Kinnear *et al* outlined the history of postgraduate medical training in the Pacific and the recommendations from the WHO meeting in late 1995 at Yanuca Island. This brought together representatives from many of the Pacific Islands, experts in medical education, faculty from the Fiji School of Medicine (FSM) and partner agency observers. The objectives of the meeting included "designing postgraduate medical education in major specialties appropriate to the regional situation" and "preparing a work plan and timetable for the implementation of postgraduate medical education in Fiji." The recommendations included an emphasis that "all programmes run by the FSM, at both the undergraduate and postgraduate level, be appropriate and responsive to identified health and workforce needs in the Pacific Island countries." It was recommended that Diploma/Masters courses be established initially in the following disciples: Medicine, Surgery, Obstetrics and Gynecology, Pediatrics/Child Health, Anesthetics, Population health/community health/public health" and that "at a later date programmes be offered in family medicine, oral health and allied health areas."

As an educator and pediatrician at the University of Hawaii Pacific Basin Medical Officers Training Program (PBMOTP). I applaud the development of postgraduate training programs within the Pacific. Medical School takes students through basic sciences, problem solving techniques and gives them a superficial overview of the disciplines of pediatrics, surgery, internal medicine and ob-gyn. Experience and supervised postgraduate training however is needed to solidify a physician's knowledge base and develop the skills needed to practice good medicine, especially in isolated island settings so common in the Pacific.

The development of postgraduate training programs however, must be done with caution. Western countries, especially the United States, over the last 10 years have come to realize postgraduate specialty training has become expensive and out of touch with the health care needs. It has become clear that in many countries the physician workforce is sorely off balance with too many physicians concentrated within urban areas and too many specialists unable to meet the health care needs of the general public. There is now great demand in both urban and rural practices for the family practitioner who is able to take care of a patient of any age, assess his or her needs, deliver treatment and communicate clearly with the consultants for advice when the problems become too complex. Again and again, the conclusion has been reached that the most practical and logical approach to health care is through the development of good primary health care services. The family practitioner, the physician well trained in primary health care, is the cornerstone to this system. Medical schools and postgraduate training programs are now shuffling to meet these needs.

As we develop health training programs within the Pacific, we too must remain practical and clear in our efforts to improve the health care of the region. Most of the population in the Pacific is from small island nations which do not have the population base to support many specialists. It is well known that the greatest users of health care systems are children, women of child-bearing age and the elderly. Whether they are comfortable with this or not, most physicians end up seeing an assortment of patients, especially as our resources diminish and health care cost escalate. Our greatest contribution as health care educators will be developing a physician workforce which will meet the demands of these diverse patients - the high risk pregnant woman, her malnourished child and her elderly parents who have hypertension and diabetes.

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The family practioner is definitely not the unskilled physician who has never specialized or attended postgraduate training. Rather, he or she is the physician who completes an intense training program which provides supervised experience in all the basic fields of medicine and allows the practioner to be comfortable with the patients of all ages who have a wide variety of problems. He or she must, in many ways, be the "best and the brightest" of all physicians.

The postgraduate training programs in operation at FSM currently are the Diploma in Anesthesia, Child Health and Obstetrics and Gynecology. A diploma in Orthopedics has been affiliated with the school. Immediate plans include the development of a Masters in Surgery. I support the development of these specialties but feel that an urgent priority must be given to a postgraduate family practice/primary care program in the Pacific. The training program does not need to be in a large urban setting but rather may be more appropriate in a rural environment. It must be practical and allow the physician to gain hands-on supervised experience with a wide variety of patients. The Pacific do need to address their own workforce needs by developing appropriate and practical postgraduate training. The development of a family

practice/primary health care program may be one of the most important components to this effort.

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PBMOTP, Pohnpei, FSMOctober 1996

Tobacco in Namoluk

I found PHD's recent issue on non-communicative diseases in the Pacific of great interest, especially the several articles on smoking prevalence and tobacco control, since I have recently completed research and a report on these subjects to the Federated States of Micronesia (FSM) Department of Health Services. I expect to publish the results of this work soon, but in the interim I thought your readers might be interested in a few of my findings to add to those from other areas of the Pacific already covered in PHD Volume 3, Number 1.

Cigarettes are a major import to the FSM in dollar value, and they amounted to US$25.5 million for the 10-year period from 1984-1993 inclusive. Smokeless tobacco products have become much more popular in the FSM over the past decade, with moist snuff use now a matter for public health concern. Betel chewing has spread from Palau, Yap and the Marianas—where it has been common for centuries—to those areas of the FSM where formerly it did not occur. Most who chew betel add tobacco to the quid, typically 1/4 to 1/2 of a cigarette.

A cross-sectional prevalence survey of tobacco smoking was conducted with 293 persons over age 12 years whose home community is Namoluk Atoll, Chuuk State, FSM. Survey results showed 84 % of males and 27 % of females had ever tried smoking, and that 47 % of males and 6 % of females were current smokers in April 1995. Eighty-six % of the male current smokers smoked daily, as did 78 % of the small number of female smokers. Men not only were more likely to smoke than women, but they also smoked much more heavily: close to 60 % of the male daily smokers consumed 16 or more cigarettes per day; only one woman smoked this much. Men on the atoll smoked as frequently and as heavily as those located in urban areas of Chuuk or on Guam; however, smoking was nearly nonexistent among women in the rural atoll community (only one woman smoked). Those women who smoked resided in town on Chuuk or outside Chuuk State in places such as Guam.

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It is no surprise to find a gender difference in smoking prevalence in the Namoluk population, as this accords with findings from much of the Pacific and most of the developing world. While women (as well as youth) have been targeted by the tobacco multinationals as potential future customers (addicts), public health professionals in the Pacific should work with women's groups as important allies in maintaining the current gender difference, preventing youth from beginning to smoke, and encouraging the men in their lives to quit.

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" Love of knowledge is like an arranged marriage. First you do it then fall in love! "

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