Lingua Franca and Beyond

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Lingua Franca and Beyond–working together

Knowing that the main theme of this issue of *Medical Writing* is writing for the lay audience, I was thinking hard about what would be the most relevant topic to discuss in the *Lingua Franca and Beyond* section. My thoughts went to a topic that bridges the lay audience with medical and regulatory writers (regardless of native language). A couple of months ago, I attended an investigator meeting; at the end, one of the Danish investigators congratulated the organisers, and said: 'The meeting was just perfect; the only remark, we couldn't really follow all acronyms'. This made it clear for me that abbreviations and acronyms widely used in clinical development language and in medical publications are something that must be a problem for the lay audience, if it was a problem for medically educated people. Here we go – I have an excellent topic! Therefore, I asked Art Gertel to share with us his views on the use of abbreviations and acronyms. Many of us know that Art is an expert in regulatory affairs, medical writing, and bioethics; he was also President of AMWA (the American Medical Writers Association). Art naturally presents the American point of view but, at the same time because of his close connections with EMWA, he understands very well the European, multi-language perspective. In his very interesting overview, he also draws our attention to this multi-language perspective and the fact that acronyms and abbreviations don't always translate into other languages. This reminds me of a family story. I used to spend quite a lot of time in Warsaw together with my husband, who does not speak Polish. When he needs to take a taxi, and no person with a good command of English and Polish is around, I write down the address … just to be on the safe side. Once, he was to go to the office of the Technical Institute; the well-known acronym of this Institute was NOT (**N**aukowa **O**rganizacja **T**echniczna), and everybody knew it! Obviously, my husband didn't. So I gave him a piece of paper with the text: 'NOT Czacki Street'. What happened? Guess? He considered me to be completely insane. 'There are hundreds of streets in Warsaw, and she wrote down one of them I should *not* go to, instead of writing the one I should go to. On top of everything in capital letters' – he thought. Well, acronyms do not translate into other languages and are not obvious for foreigners.

I had the pleasure of attending John Carpenter's excellent classes in medical writing and will never forget his examples of the overuse of acronyms – some of them even to the point that they make whole sections of text impossible to understand. A parody of such overuse was published more than 15 years ago in the *New England Journal of Medicine*. Read and try to understand what Steven Mann wrote and the Editor answered:

Steven Mann's letter to the Editor:

"There is a recent trend (RT) in the medical literature (ML) to abbreviate previously unabbreviated phrases for the sake of efficiency (PUPSAE). Although it makes good sense (GS), the frequency with which it is used can tax the inexperienced reader (IR). Sometimes repetition can actually be beneficial (RCABB) by allowing the reader to retain words he does not constantly have to refer back to (WOHCREBT).

I would like to suggest to the *Editor* (ED), that for the IR who doesn't wish to have PUPSAE, he have the GS to change the ML so that RCABB and he can eliminate WOHCREBT."

Steven G. Mann
NEJM, April 27, 1989

The Editor's reply:

"We agree with Dr. Mann, but protest our innocence (POI). We do not ordinarily abbreviate PUPSAE because we also believe RCABB and we know that the IR needs WOHCREBT. But it makes GS to allow some previously abbreviated phrases (PAPS) when they are in widespread use (WU), and we occasionally even allow abbreviations of PUPSAE when repeatedly spelling them out would be unusually cumbersome (STOWBUC). We admit, however, that WU of PAPS and PUPS in the ML, even when

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STOWBUC, often raises the IR's and the ED's BP and HR."

NEJM, April 27, 1989[1]

Finally, I would like to invite you to check your familiarity with acronyms and abbreviations – see the short quiz. Do you know what the following acronyms and abbreviations stand for? AERS, CHMP, CORE, CTA, CTD, DSMB, DSUR, EEA, EMA, GCP, GLP, GMP, IND, IRB, MAH, MR, NDA, PRO, SmPC/SPC, SUSAR.

If you don't know, don't worry; you will find the answers on page 253; but if you know at least half of them, you are very well equipped for the regulatory world.

Enjoy! HAINRE – MKH
HAINRE – HAve an INteresting REad

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Acronyms and abbreviations — enigma machine required?

As someone who came of age in an era before Twitter, Short Message Service (SMS), emoticons, and even (GASP!) the Internet, I have an inherent bias against overuse of acronyms and abbreviations. That being said, I am also part of a culture (the Pharmaceutical Industry) that thrives on the use of these short-cuts. As the vectors of communication continue to place pressure on us to convey concepts using fewer and fewer characters, and when speed is of the essence, we tend to fall back on the use of these time-and-space savers. Unfortunately, their use may actually result in message confusion and longer elapsed time, given the need for the recipient to figure out what the sender meant.

In many respects, the use of these acronyms and abbreviations (let's call them '*A&As*') represent admission into a 'Secret Society', comprising only the *cognoscenti*.

First, some definitions:

An **acronym** is an **abbreviation** formed from the first letter or the first few letters of each word in a phrase. Usually these components are individual letters (such as sonar, created from '**SO**und **N**avigation **A**nd **R**anging'), or parts of words or names (as in *Benelux*–the customs union formed by Belgium, the Netherlands, and Luxembourg.).[1] The American Medical Association (AMA) *Manual of Style* further cites a distinction regarding the latter as an initialism: 'a name or term formed from the initial letters of a group of words and pronounced as a separate word.'[2]

An **abbreviation** may be any type of shortened form, such as words with the middle omitted (for example, 'Rd' for Road or 'Dr' for Doctor).

Fowler's *Modern English Usage*[3] appears to take a dim view of *A&As*, categorising them as 'curtailed words'. 'Some of these establish themselves so fully as to take the place of their originals or to make them seem pedantic; others remain slangy or adapted only to particular audiences.' Going further in seeming to disparage American usage, Fowler states: 'Another way of forming curtailed words is to combine initial letters, a method now so popular, especially in America, that a word – *acronym* – has been coined for it.'

Likewise, the editors of the AMA's scientific publications discourage the use of abbreviations, acronyms, and initialisms in their journals, with the exception of internationally-approved and accepted units of measure and some well-recognised clinical, technical, and general terms and symbols. '*Overuse of abbreviations can be confusing and ambiguous for readers – especially those of another culture or those outside a specific specialty. However, since abbreviations save space, they may be acceptable to use when the original word or words are repeated numerous times.*'[2]

Use of *A&As* has become so ubiquitous that users often are unaware of the source term. When asked what the letters stand for, too often the response is a blank stare and a shrug of the shoulders.

There are several classes of *A&As*:

- Those that are used across general society: e.g. FYI, FAQ
- Those that are used across the medical and scientific community: e.g. therapeutic areas: CNS, CV, OB-GYN; diseases and associated measurements: AML, MS, HIV, HbA1c, LFT, ALK PHOS, SGOT; measures of frequency: BID, QD, QID (which, by the way, may or may not separate each letter with a period); diagnostic technology: PET Scan, CAT Scan
- Those that are used in a regulatory context: e.g. FDA (United States **F**ood & **D**rug **A**dministration), EMA (**E**uropean **M**edicines

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Agency), EudraCT (**Eu**ropean **C**linical **T**rials **D**atabase), PMDA (Japanese **P**harmaceuticals and **M**edical **D**evices **A**gency)

- Those that are used across the pharmaceutical industry: e.g. NDA, IND, ISS, ISE, ICH, CTD
- Those that are used within a particular pharmaceutical company, including research programs:
  - **TOPCAT-G** (A **T**rial of **O**ptimal **P**ersonalised **C**are **A**fter **T**reatment for **G**ynaecological cancer)
  - **EURECA** (**E**uropean **R**esearch on **E**lectrochemotherapy in head and neck **CA**ncer)
  - Including those where they couldn't even get the acronym correct: **PROTECT** (**P**redicting **R**esponse to Standardized Pediatric **C**olitis **T**herapy)

But, of course, there are not universal standards of use, either across institutions or in terms of rules of usage:

Examples of non-standard use across institutions include:

- Clinical Study Report (CSR) vs. Clinical Trial Report (CTR)
- Institutional Research Board (IRB) in the USA vs. Ethics Committee (EC) in Europe vs. Research Ethics Board (REB) in Canada

Examples of inconsistent rules of usage include:

- When a multiple-letter abbreviation is formed from a single word, periods are in general not used, although they may be common in informal usage. *TV*, for example, may stand for a *single* word (*television*), and is, in general, spelled without punctuation (except in the plural). Although *PS* stands for the single word *postscript* (or the Latin *postscriptum*), it is often spelled with periods (*P.S.*).

There are also documents that serve the same purpose; however, they may have a different name and structure:

- Investigational New Drug application (IND) in the USA *vs.* Clinical Trial Application (CTA) in Europe and Canada

Perhaps this speaks more to the issue of a lack of a global standard. While we certainly have much conformance in *structure* in the context of the ICH (International Conference on Harmonisation) CTD (Common Technical Document), there are still many differences among nations and languages, with respect to how *A&As* are accepted and used. In addition, these variations in standards often result in 'reinventing the wheel' forcing creation of multiple documents to meet the requirements of multiple authorities when a single, universal, document should suffice.

One of the problems with using *A&As* is that they quickly become jargon. I have experienced the disorientation upon changing jobs within the industry and finding myself in my first meeting at the new company, completely baffled by the *A&As* used by the meeting participants. I felt as if I had forgotten to bring my decoder ring! I clearly remember a situation when, back in my graduate school days, I was working in the pathology/toxicology laboratory and, when reviewing one of the necropsy reports, came upon the notation: '*MDYPPT*'. Having no idea what that represented, I tracked-down the laboratory technician who had submitted the report and he stated that it was obvious that it stood for 'Moderate Dark Yellow Precipitate', with an expression on his face that implied that even an idiot should have known that.

I recently saw a road sign directing drivers, as follows:

S.I. Thwy Nxt Rt

Even for a *native speaker*, it was not intuitive that the sign meant: *Staten Island Thruway Next Right*

The same is true for documents. It is now standard practice to include a list of acronyms and abbreviations in documents such as protocols and study reports. These are usually provided early in the document. This is especially valuable when the terminology used is esoteric and may not be readily known to the reader. In addition, I would never use an acronym or abbreviation without spelling-out the term at first use. Thereafter, it is acceptable to use just the acronym or abbreviation, without the 'decode'.

Another complication is that *A&As* don't always readily translate into other languages. Unfortunately, their use often represents arrogance on the part of the *native speaker*, conveying the assumption that anyone who is competent and reasonably intelligent should readily understand their secret code.

One should also consider whether there is a difference between using *A&As* in written vs. spoken language. Is it any more or less confusing when one uses them in speech? I would say that it

is more confusing, as there is greater potential for confusion associated with accent, pronunciation, and letters that may sound alike (e.g. 'c' and 'k') which, when spoken, do not allow clear association between the letter and its source word.

Use them or lose them?

In reviewing the pros and cons of *A&As*, I find it difficult to identify too many advantages in unbridled use. While *A&As* certainly present opportunities to save space, the benefits are quickly outweighed by increasing potential for confusion and, worse, misinterpretation. These, in turn, result in increased time to comprehension, and obfuscation. I tend to agree with the AMA editors in selective use of *A&As*. I would also encourage anyone who is attending a meeting where there may be participants who are not familiar with company-specific *A&As* to deliberately define the terms when using them in the meeting conversation. I have prepared 'decoder sheets' for distribution to new employees when they first join the company or department. The sheets are a valuable aid in making these colleagues more comfortable with the culture of their new environment and avoiding the embarrassment of having to ask for a 'translation'.

As long as definitive publications and documents associated with our profession (e.g. peer-reviewed journal articles and filings to regulatory authorities) are less driven by saving incremental space and time, I would reserve frequent use of *A&As* for those media that ARE so-restricted (e.g. TWEETS). At least we haven't regressed to using emoticons ☺!

References

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2. American Medical Association. Manual of style; a guide for authors and editors. 9th ed. Philadelphia: Lippincott Williams & Wilkins; 1998. p. 275.
3. Fowler HW. A dictionary of modern English usage. 2nd ed. New York, Oxford: Oxford University Press; 1965. p. 116–17.

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Abbreviations & Acronyms – Quiz answers

Question	Answer
AERS	Adverse Event Reporting System (FDA)
CHMP	Committee for Medicinal Products for Human Use
CORE	Clarity and Openness in Reporting: E3-based
CTA	Clinical Trial Application (Canada and EU)
CTD	Common Technical Document
DSMB	Data and Safety Monitoring Board
DSUR	Development Safety Update Report (ICH)
EEA	European Economic Area
EMA	European Medicines Agency
GCP	Good Clinical Practice
GLP	Good Laboratory Practice
GMP	Good Manufacturing Practice
IND	Investigational New Drug Application (USA)
IRB	Institutional Review Board (USA)
MAH	Marketing Authorisation Holder
MR	Mutual Recognition
NDA	New Drug Application (USA)
PRO	Patient Reported Outcome
SmPC/SPC	Summary of Product Characteristics
SUSAR	Suspected Unexpected Serious Adverse Reaction