Medical Terminology

Medical terminology is a standardized language used by healthcare professionals to precisely communicate about the human body, health conditions, procedures, and treatments of patients under their care.

Importance of medical terminology in healthcare

Medical terminology serves several critical functions in healthcare:

- **Precision and Clarity**: Enables accurate communication between healthcare professionals, eliminating ambiguity that could lead to medical errors.
- **Efficiency**: Technical terms often express complex concepts concisely, saving time in both verbal and written communication.
- **Standardization**: Creates a common language across healthcare settings, specialties, and even internationally.
- **Documentation**: Supports accurate medical records essential for continuity of care, billing, and legal purposes.
- **Data Analysis**: Enables consistent coding for research, epidemiology, and healthcare management.

Importance of medical terminology in RTT Validation specifically

Medical terminology plays specific important roles in RTT validation:

- **Pathway Identification**: Accurate medical terms help correctly classify patient pathways (e.g., cancer, cardiac, orthopedic) to ensure appropriate waiting time targets are applied.
- **Clinical Prioritization**: Terminology helps define urgency levels based on condition severity, ensuring resources are allocated appropriately.
- **Clock Start/Stop Events**: Precise terminology defines what constitutes a referral, first appointment, diagnosis, or treatment for accurate pathway timing.
- **Coding Accuracy**: Proper terminology ensures clinical conditions are coded correctly when validating RTT pathways.
- **Exception Reporting**: Terminology helps define valid exceptions to standard pathways (patient-initiated delays, DNAs, clinical decisions to defer).
- **Audit Trail**: Standardized terminology creates clear audit trails for RTT validation processes, essential for governance and compliance.
- **Cross-department Communication**: Enables accurate information transfer between referring departments, diagnostic services, and treatment providers.

Incorrect or inconsistent use of medical terminology in RTT validation can lead to:

- Misclassification of pathways
- Inaccurate waiting time reporting
- Inappropriate prioritization
- Compliance issues with national standards
- Financial implications due to incorrect coding

Essential Medical Terminology

The essential medical terminology relevant for this training will be discuss from three perspectives. They include Anatomy, disease classification, and from procedural dimension to give a clear understanding of the context.

- ✓ **Anatomy Terms:** Anatomical terminology is used to precisely describe the human body and its parts. They include the following system; Cardiovascular system (heart, blood vessels), Respiratory system (lungs, airways) Digestive system (mouth to rectum) Urinary system (kidneys, bladder) Nervous system (brain, spinal cord, nerves) Musculoskeletal system (muscles, bones, joints) Integumentary system (skin, hair, nails) Endocrine system (hormone-producing glands) Lymphatic/immune system (spleen, lymph nodes) Reproductive system (sex organs).
- ✓ **Disease Terminology**: Diseases are classified in several ways, either as Etiology or Pathology.
    - **Etiology:** talks about (cause) of a disease or condition it could either be Infectious, genetic, autoimmune, metabolic, idiopathic (unknown cause).
    - **Pathology:** Talks about the (disease process) which include Inflammation (The body's response to injury or infection, causing redness, swelling, and pain), Infection (The invasion and multiplication of microorganisms in the body), or Tumor (An abnormal growth of tissue, which can be benign or malignant.
- ✓ **Surgical and Procedural Terms:** They are used to describe medical intervention offered to patient by clinicians through surgical and procedural processes, and they include:- ectomy (surgical removal (appendectomy, tonsillectomy), -otomy (cutting into (tracheotomy, laparotomy) -ostomy (creating an opening (colostomy, tracheostomy) -plasty (surgical repair/reshaping (rhinoplasty, angioplasty) -scopy (viewing with an instrument (colonoscopy, bronchoscopy) as well as some relevant Surgical approaches like Laparoscopic (small incisions), endoscopic (through natural openings), open (traditional).
- ✓ **Diagnostic Test Terminology:** Talks about the Tests used to diagnose conditions; they include:
    - **Imaging studies**: X-ray, CT (Computed Tomography), MRI (Magnetic Resonance Imaging), ultrasound, PET (Positron Emission Tomography).
    - **Laboratory tests**:
        - FBC/CBC (Full/Complete Blood Count)
        - U&Es (Urea and Electrolytes)
        - LFTs (Liver Function Tests)
        - TFTs (Thyroid Function Tests)
        - CRP (C-Reactive Protein) - inflammation marker
    - **Specialized tests**:
        - ECG/EKG (Electrocardiogram) - heart
        - EEG (Electroencephalogram) - brain
        - EMG (Electromyogram) - muscles
        - Spirometry (lung function)

✓ **Medication Terminology:** Talks about Terms related to drugs:

- **Administration routes**: PO (oral), IV (intravenous), IM (intramuscular), SC/SQ (subcutaneous)
- **Dosing terminology**: PRN (as needed), OD (once daily), BD (twice daily), TDS (three times daily), QDS (four times daily)
- **Drug classes**:
  - Analgesics (pain relievers)
  - Antibiotics (fight bacteria)
  - Anticoagulants (prevent clotting)
  - Antihypertensives (lower blood pressure)
  - NSAIDs (non-steroidal anti-inflammatory drugs)

✓ **Symptoms and Conditions:** Talks about Terms describing patient experiences:

- **Common symptoms**:
  - Dyspnea (difficult breathing)
  - Pyrexia (fever)
  - Dysuria (painful urination)
  - Nausea (feeling sick)
  - Vertigo (spinning sensation)
- **Symptom descriptors**:
  - Acute (sudden onset)
  - Chronic (long-term)
  - Intermittent (comes and goes)
  - Referred (pain felt away from source)

UK Medical Codes

Medical coding is a standardized way of recording diagnoses, procedures, and other healthcare-related information that translates clinical information from patient records into alphanumeric codes and they are used for:

- **Clinical management**: Tracking patient conditions and treatments.
- **Billing and funding**: Ensuring hospitals and trusts are reimbursed (e.g., via NHS payment systems like the National Tariff).
- **Research and epidemiology**: Analysing health trends and outcomes.
- **Interoperability**: Enabling data sharing across healthcare systems.

The most primarily ones used by the UK health sector are:

- **SNOMED CT**
- **ICD-10**
- **OPCS-4.**

- **SNOMED CT (Systematized Nomenclature of Medicine Clinical Terms):** SNOMED CT is clinical terminology used by NHS as the standard for recording clinical information in electronic patient records (EPRs). It's a comprehensive, multilingual system maintained internationally by SNOMED International and customized for UK use via the **UK Edition**, for Capturing detailed clinical information (e.g., symptoms, diagnoses, procedures, medications) in real time. Primarily use by the GP system in Recording patient health information that is shared with hospitals.

- **ICD-10 (International Classification of Diseases, 10th Revision):** ICD-10 is a global standard developed by the World Health Organization (WHO) for classifying diseases and health conditions. In the UK, it's used primarily in secondary care (hospitals) to code diagnoses for statistical and reimbursement purposes. The major purposes for this coding system is tracking mortality rate, Supports NHS funding via Healthcare Resource Groups (HRGs)and enables international comparison of health data.

- **OPCS-4 (Office of Population Censuses and Surveys Classification of Interventions and Procedures, Version 4):** OPCS-4 is a UK-specific system for coding surgical procedures and interventions, maintained by NHS Digital for specifically Records what procedures are performed in hospitals (e.g., surgeries, diagnostic tests) and Links with ICD-10 for funding and resource allocation.

RTT Terminology

- **RTT:** Referral to Treatment
- **PTL:** Patient Tracking List – a list of patients who need to be treated by given dates
- **Nullify:** To cause something to have no value or effect
- **DNA:** Did Not Attend (e.g., OP appointment)
- **Patient Cancellation:** Activity cancelled by the patient
- **Hospital Cancellation:** Activity cancelled by the hospital
- **IPTMDS:** Inter-Provider Administrative Data Transfer Minimum Data Set
- **Ad-hoc:** Administrative events that happen outside hospital setting
- **PBL:** Partial Booking List - list of patients waiting for the first appointment (OPA)
- **OPA/OPD:** Outpatient Appointment
- **WL:** Waiting List (for patients who are added to the list to have diagnostic test or treatment)
- **TCI Date:** To Come In Date (date for surgery or diagnostic)
- **WL Active:** Waiting list that is active
- **PL:** Planned Waiting List
- **OP Reg Date:** Outpatient Registration Date
- **OP Discharged Date:** Outpatient Discharged Date
- **N:** New Appointment
- **F:** Follow-Up Appointment
- **Pathway:** A folder where the journey of a patient is recorded from when the clock start (when patient is referred) till when the patient is discharged.
- **Pathway Number:** Unique number to identify each pathway or folders open for the patient.
- **Referral to Treatment Period Start Date:** Clock start date.
- **Referral to Treatment Period End Date:** Clock end/stop date

RTT National-=; Status Codes and Their Meanings

❖ Clock start codes:

- 10: The first activity in a pathway
- 11: The first activity after active monitoring end/or watchful wait ends
- 12: First activity following a consultant or AHP referral for a new condition

❖ Clock ticking codes

- 20: Subsequent activity in an RTT period
- 21: Transfer to another healthcare provider

❖ Clock stop codes

- 30: Start of first definitive treatment
- 31: Start of active monitoring initiated by the patient
- 32: Start of active monitoring initiated by the hospital
- 33: DNA – patient did not attend the first care activity
- 34: Decision not to treat or no further contact required
- 35: Patient declined offered treatment
- 36: Patient died before treatment

❖ Non RTT codes

- 90: First definitive treatment occurred previously
- 91: Care activity during active monitoring
- 92: Diagnostics only (not yet referred for treatment)
- 98: Activity not applicable to RTT periods

Summary: *Accurate use of medical terminology and RTT codes as discussed above is essential for effective patient care and management within the NHS.*