England has no legally constituted official language, but English is the de facto official language. However, Welsh does have legal official status in Wales. In Scotland, Gaelic has official language status and in Northern Ireland the de facto language is English, and Irish Gaelic and Ulster Scots are two recognised regional languages (Mac Sithigh, 2018). In terms of sign language, British Sign Language (BSL) and Irish Sign Language (ISL) are the preferred form of sign language for UK residents, depending on background and location.

Language is complex at the best of times but when countries within the UK have all these differences it can lead to greater complexity.

After these languages, the most common spoken language in the UK is Polish. For example, the 2011 England and Wales census recorded that 546 000 people spoke Polish; the next most common languages being Punjabi and Urdu. And around 4 million people reported speaking a main language other than English or Welsh (Office for National Statistics, 2013).

Medical terminology includes Greek and Latin phrases, but also includes the language of the country where it is being used (Lysanets and Bieliaieva, 2018). Yet the UK's population is often expected to understand the terms we use in health care, regardless of their first language. Nurses have a responsibility to bridge the gap between this terminology and their patients (Fage-Butler et al, 2016). However, there are other barriers to communication in health care, such as regional dialects, colloquialisms, idioms and euphemisms (Hansen et al, 2016; Gu and Shah, 2019). Using local dialects can, in some instances, make the terms used easier for patients to understand, but they can be an added layer of complexity for those with English as an additional language (EAL).

Medical terminology sits within this rich linguistic ecosystem, although it is often not understood by the population who have English as their main language. It could be argued that parallel forms of language have developed, with medical terminology in one stream and common vernacular in another. For example, a myocardial infarction (MI) is a medical term that is often translated into the vernacular as ‘heart attack’. But imagine a patient with EAL entering the discussion. Without the nuances developed through long-term language immersion, this person may consider this term to be more violent in nature and possibly linked to an autoimmune condition. Perhaps a more literal term would be ‘heart ache’ considering the most common symptom of an MI is pain in or around the heart but, as we know, that is a term referring to emotional pain or anguish.

An example of a common colloquialism used within health care is ‘waterworks’ instead of urinary system. Consider the effect and the possible confusion of asking a patient who has EAL about the condition of their ‘waterworks’. An example of an idiom would be saying a person has ‘gone to a better place’, which is open to several interpretations, rather than the person has died.

If we cannot effectively tailor our language to reduce or remove idioms, colloquialisms and euphemisms from our discussions, are we not putting more barriers in the way of our patients, particularly those with EAL? With effective communication and knowledgeable professionals, channels previously closed can be opened and all patients can receive the support and care they deserve. If we consider our own language choices carefully, then we could empower our patients to make their own informed healthcare choices.

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