

# Medical Terminology Fundamentals

Medical terminology is the specialized language used by health-care professionals to describe the human body, its functions, diseases, procedures, and equipment. Mastery of this vocabulary is essential for anyone working in a medical office, because accurate communication reduces errors, improves patient safety, and supports efficient documentation in electronic health records (EHRs). The following sections break down the fundamental components of medical terminology, provide clear definitions, illustrate practical applications, and present challenges that learners may encounter.

Root words form the core meaning of a term. They often refer to a body part, organ system, or disease process. For example, the root *cardi* means “heart,” while *hepat* refers to the liver. When a root appears alone, it is usually combined with a vowel, most commonly *o*, to create a combining form (e.g., *Cardi-o*, *hepat-o*). Understanding roots enables learners to decipher unfamiliar words by recognizing familiar patterns.

Prefixes are added to the beginning of a root to modify its meaning. Common prefixes indicate location, number, or negation. For instance, *hyper-* means “above normal” or “excessive,” as seen in *hyperglycemia* (high blood sugar). The prefix *hypo-* conveys “below normal,” such as *hypotension* (low blood pressure). The prefix *brady-* denotes “slow,” while *tachy-* denotes “fast.” Recognizing these prefixes helps staff quickly assess the severity of a condition when reviewing charts or lab reports.

Suffixes appear at the end of a root and often indicate a procedure, condition, or specialty. The suffix *-itis* denotes inflammation, as in *appendicitis* (inflammation of the appendix). The suffix *-ectomy* indicates surgical removal, such as *tonsillectomy*. The suffix *-logy* identifies a field of study, for example *dermatology* (the study of skin). By learning common suffixes, office staff can accurately code procedures and generate appropriate billing entries.

Combining forms consist of a root plus a vowel that links it to another root, prefix, or suffix. The vowel, typically *o*, facilitates pronunciation. For example, *cardi-o-vascular* combines “heart” and “vessel” to describe the circulatory system. When a combining form ends in a vowel and the next element begins with a vowel, a linking vowel may be omitted, as in *oste-arthritis* (bone + joint inflammation). Mastery of combining forms is essential for constructing and deconstructing complex terms used in patient records.

Anatomical directional terms describe locations on the body relative to other structures. These terms are indispensable for recording findings in a systematic way. *Superior* (or *cranial*) means “above,” while *inferior* (or *caudal*) means “below.” *Anterior* refers to the front of the body, and *posterior* to the back. *Medial* indicates a position toward the midline, and *lateral* indicates a position away from the midline. *Proximal* and *distal* describe points nearer to or farther from the trunk, respectively. In a medical office, using these terms correctly in progress notes ensures that clinicians and ancillary staff share a common reference frame.

Body planes and sections are another set of spatial descriptors. The *sagittal plane* divides the body into left

and right halves; a mid-sagittal cut produces equal halves, while a parasagittal cut is offset. The coronal (or frontal) plane separates the front (anterior) from the back (posterior). The transverse (or horizontal) plane divides the body into superior and inferior sections. Knowledge of these planes is crucial when interpreting imaging studies, such as CT or MRI scans, and when documenting findings in radiology reports.

Body cavities are spaces that house organs and provide protection. The two primary cavities are the ventral (or thoracoabdominal) cavity and the dorsal cavity. The ventral cavity includes the thoracic cavity (containing the heart and lungs) and the abdominal cavity (containing digestive organs). The dorsal cavity includes the cranial cavity (housing the brain) and the spinal cavity (housing the spinal cord). When scheduling diagnostic procedures, staff must know which cavity a test targets, because preparation instructions differ (e.G., Fasting for abdominal ultrasound versus no special preparation for a chest X-ray).

Organ system terminology groups structures that work together to perform a function. Common systems include:

- Cardiovascular system – heart and blood vessels.
- Respiratory system – lungs, trachea, bronchi.
- Gastrointestinal (GI) system – mouth to anus, including stomach and intestines.
- Urinary system – kidneys, ureters, bladder, urethra.
- Musculoskeletal system – muscles, bones, joints, connective tissue.
- Nervous system – brain, spinal cord, peripheral nerves.
- Endocrine system – glands that produce hormones.
- Integumentary system – skin, hair, nails.

Understanding these system names helps office personnel route patient calls to the appropriate department, schedule specialist appointments, and code services accurately.

Disease process terminology classifies conditions based on etiology (cause), pathology (structural change), and physiology (functional change). Common categories include:

- Infections – caused by bacteria, viruses, fungi, or parasites (e.G., pneumonia, cellulitis).
- Neoplasms – abnormal tissue growths, benign or malignant (e.G., carcinoma, adenoma).
- Inflammatory disorders – characterized by redness, swelling, heat, pain (e.G., arthritis, dermatitis).
- Degenerative diseases – progressive loss of function (e.G., osteoporosis, Alzheimer's disease).
- Congenital anomalies – present at birth (e.G., cleft palate, spina bifida).
- Traumatic injuries – result from external force (e.G., fracture, laceration).

When entering a diagnosis into an EHR, staff must select the most specific term available in the system's drop-down menu. Using broad terms can lead to inaccurate coding and reimbursement delays.

Diagnostic procedure terminology includes words that describe tests used to identify disease. Some key terms:

- Biopsy – removal of tissue for microscopic examination.
- Electrocardiogram (ECG or EKG) – records the heart's electrical activity.

- Magnetic resonance imaging (MRI) – uses magnetic fields to create detailed images.
- Computed tomography (CT) – cross-sectional X-ray imaging.
- Ultrasonography (ultrasound) – uses sound waves to visualize soft tissues.
- Endoscopy – direct visual examination of interior organs via a flexible tube.
- Laboratory panel – collection of multiple lab tests, such as a complete blood count (CBC).

Practical application: When a patient calls to confirm a scheduled MRI, the receptionist must verify the correct body part (e.G., "Brain MRI") and any preparation instructions (e.G., "No metal objects").

Miscommunication can result in an incomplete study or the need to reschedule.

Laboratory terminology is another essential area. Common lab prefixes and suffixes include:

- Hemato- (blood) – hemoglobin, hematocrit.
- Leuko- (white blood cells) – leukocytosis (high WBC count).
- Gluco- (glucose) – glucose tolerance test.
- Urea (blood urea nitrogen, BUN) – indicator of kidney function.
- Creatinine – another kidney function marker.
- Electrolyte – includes sodium, potassium, chloride, bicarbonate.
- Enzyme – e.G., alkaline phosphatase, AST, ALT.

When entering lab results, staff must ensure units are correct (e.G., Mg/dL, mmol/L). Errors in unit entry can cause clinicians to misinterpret a patient's status, potentially leading to inappropriate treatment.

Medical abbreviations are shortcuts widely used in charts, prescriptions, and communication. While they increase efficiency, they also pose a risk of misinterpretation. Some widely accepted abbreviations include:

- BP – blood pressure.
- HR – heart rate.
- RR – respiratory rate.
- PRN – "as needed."
- PO – by mouth (per os).
- IV – intravenous.
- q – every (e.G., Q4h = every 4 hours).
- STAT – immediately.
- Dx – diagnosis.
- Tx – treatment.

Practical tip: When entering medication orders, always expand abbreviations in the patient's medication list for clarity, especially for patients who may view their own records. Many institutions now discourage ambiguous abbreviations such as "U" for units or "QD" for daily, because they have been linked to medication errors.

ICD-10-CM coding (International Classification of Diseases, 10th Revision, Clinical Modification) provides a standardized system for classifying diagnoses. Each code consists of a letter followed by numbers, with optional decimal points for specificity. For example, I10 denotes essential (primary) hypertension, while

E11.9 denotes type 2 diabetes mellitus without complications. Accurate coding is essential for reimbursement, quality reporting, and public health surveillance.

CPT coding (Current Procedural Terminology) is used to describe medical, surgical, and diagnostic services. A CPT code such as 99213 represents an established patient office visit of moderate complexity. Proper selection of CPT codes depends on documentation of time spent, decision-making complexity, and services provided. Front-office staff may need to verify that the provider's notes contain the required details before submitting claims.

Electronic Health Records (EHRs) have transformed how medical offices store and share information. In an EHR, terminology is often linked to drop-down menus, auto-complete fields, and decision-support alerts. For instance, when a provider selects "chest pain" from a symptom list, an alert may suggest ordering an ECG based on clinical guidelines. Understanding the underlying terminology helps staff navigate these systems efficiently, troubleshoot errors, and train new users.

Patient documentation terminology includes sections commonly found in a medical record:

- Chief complaint (CC) – the patient's primary reason for the visit, expressed in their own words.
- History of present illness (HPI) – a chronological description of the current problem.
- Review of systems (ROS) – a systematic inquiry of symptoms across organ systems.
- Physical examination (PE) – documented findings from the provider's inspection, palpation, percussion, and auscultation.
- Assessment – the provider's interpretation of the problem, often a diagnosis.
- Plan – the intended course of action, including tests, medications, referrals, and patient education.

When entering data, staff should avoid "copy-and-paste" errors that can propagate outdated or inaccurate information. Regular audits of documentation can identify patterns of misuse and provide opportunities for targeted training.

Medication terminology includes drug classes, routes of administration, and dosing conventions. Key concepts:

- Analgesic – pain-relieving medication (e.G., Acetaminophen, ibuprofen, morphine).
- Antibiotic – medication that kills or inhibits bacteria (e.G., Amoxicillin, ciprofloxacin).
- Anticoagulant – prevents clot formation (e.G., Warfarin, apixaban).
- Topical – applied to the skin surface.
- Intramuscular (IM) – injection into muscle.
- Subcutaneous (SC) – injection under the skin.

Practical challenge: Patients often bring medication bottles with abbreviations that differ from the office's standard. Staff must verify the exact drug name, strength, and dosage frequency before entering it into the medication list. Mislabeling can lead to adverse drug events.

Allergy documentation is a critical safety component. Allergies can be categorized as:

- Drug allergy – immune-mediated reaction to a medication.
- Food allergy – reaction to specific foods (e.G., Peanuts, shellfish).
- Environmental allergy – pollen, dust mites, animal dander.
- Adverse reaction – non-immune side effect (e.G., Nausea from chemotherapy).

When entering an allergy, the staff should include the allergen, type of reaction, and severity (e.G., "Penicillin – rash – mild"). This information is used by the EHR to generate alerts that prevent prescribing contraindicated medications.

Radiology terminology includes imaging modalities and positioning terms. Common modalities:

- X-ray – uses ionizing radiation to produce 2-dimensional images.
- CT scan – cross-sectional X-ray images compiled by a computer.
- MRI – uses magnetic fields and radio waves; no ionizing radiation.
- Ultrasound – sound-wave imaging, often used for obstetrics and abdominal studies.

Positioning terms are essential for technologists and for documenting the view taken:

- AP (anteroposterior) – beam passes from front to back.
- PA (posteroanterior) – beam passes from back to front; preferred for chest X-rays because it reduces heart magnification.
- Lateral – side view.
- Oblique – angled view.

When scheduling a radiology appointment, staff must confirm the correct view (e.G., "PA chest X-ray") and any patient preparation (e.G., "Fast for 4 hours before abdominal ultrasound").

Cardiovascular terminology is frequently encountered in both outpatient and inpatient settings. Key words include:

- Arrhythmia – abnormal heart rhythm (e.G., Atrial fibrillation).
- Myocardial infarction (MI) – heart attack; death of heart muscle due to blocked blood flow.
- Angina – chest pain caused by reduced blood flow to the heart.
- Hypertension – high blood pressure; often classified as primary (essential) or secondary.
- Hyperlipidemia – elevated blood lipids, a risk factor for atherosclerosis.

Practical example: A patient's lab results show LDL cholesterol of 190 mg/dL. The office staff should flag the result for the provider, who may order a lipid panel repeat and discuss lifestyle modifications. Accurate terminology ensures that the patient's chart reflects the correct risk factor.

Respiratory terminology includes words describing airway anatomy and disease processes:

- Bronchitis – inflammation of the bronchi.
- Pneumonia – infection of the lung parenchyma.
- Dyspnea – shortness of breath.
- Apnea – temporary cessation of breathing.

- Spirometry – a test measuring lung volumes and flow rates.

When a patient reports “shortness of breath” during a telehealth visit, the nurse should document the symptom as “dyspnea” and note any associated factors (e.G., Exertion, wheezing), because precise terminology guides the provider’s assessment and potential need for a pulmonary function test.

Gastrointestinal terminology covers the digestive tract and related disorders:

- Gastritis – inflammation of the stomach lining.
- Esophagitis – inflammation of the esophagus.
- Colitis – inflammation of the colon.
- Hepatitis – inflammation of the liver; may be viral (e.G., Hepatitis B) or toxic.
- Pancreatitis – inflammation of the pancreas.

Procedures often have “-scopy” suffixes indicating visual examination with an endoscope: colonoscopy (colon), gastroscopy (stomach), sigmoidoscopy (sigmoid colon). When a patient is scheduled for a colonoscopy, the front-desk staff must ensure bowel preparation instructions are clearly communicated and that the patient’s medication list is reviewed for anticoagulants that may need temporary discontinuation.

Urinary system terminology includes:

- Nephrology – the branch dealing with kidneys.
- Urology – the branch dealing with urinary tract and male reproductive organs.
- Cystitis – bladder inflammation.
- Pyelonephritis – infection of the kidney pelvis.
- Hematuria – presence of blood in urine.

When a lab report indicates “proteinuria,” the staff must recognize it as a sign of possible kidney disease and alert the provider for further evaluation, such as a urine protein-to-creatinine ratio.

Musculoskeletal terminology covers bones, muscles, joints, and connective tissue:

- Osteoporosis – reduced bone density, increasing fracture risk.
- Arthritis – joint inflammation; subtypes include osteoarthritis and rheumatoid arthritis.
- Myopathy – muscle disease.
- Ligament – fibrous tissue connecting bone to bone.
- Tendon – fibrous tissue connecting muscle to bone.

When a patient presents with “knee pain,” the nurse should document the location, quality (e.G., “Sharp,” “dull”), and any aggravating factors. This precise language assists the provider in deciding whether imaging (e.G., X-ray, MRI) is warranted.

Neurological terminology includes:

- Seizure – abnormal electrical activity in the brain.
- Stroke – interruption of blood supply to the brain (ischemic or hemorrhagic).

- Neuropathy – nerve damage, often peripheral.
- Ataxia – lack of coordination.
- Synapse – junction between nerve cells.

In a neurology clinic, documentation of “motor strength 4/5 in the right upper extremity” provides a quantifiable measure that can be tracked over time. Staff should be comfortable entering such standardized assessments into the EHR.

Endocrine terminology involves hormone-producing glands and metabolic disorders:

- Hypothyroidism – underactive thyroid, often treated with levothyroxine.
- Hyperthyroidism – overactive thyroid, may present with tachycardia and weight loss.
- Diabetes mellitus – chronic hyperglycemia; type 1 (autoimmune) and type 2 (insulin resistance).
- Adrenal insufficiency – inadequate cortisol production.
- Insulin resistance – reduced cellular response to insulin.

When a patient’s fasting glucose is 130 mg/dL, the staff should note “prediabetes” and schedule a follow-up hemoglobin A1c test, following the provider’s protocol.

Integumentary terminology focuses on skin, hair, and nails:

- Dermatitis – inflammation of the skin.
- Eczema – a type of dermatitis, often chronic.
- Psoriasis – autoimmune skin disease with plaques.
- Urticaria – hives, an allergic skin reaction.
- Melanoma – malignant skin cancer.

When a patient presents with a new mole, the nurse should document its size, color, border, and any changes, using the “ABCDE” criteria (Asymmetry, Border, Color, Diameter, Evolution). This language informs the provider’s decision to biopsy.

Reproductive system terminology differs for male and female anatomy but shares many common prefixes and suffixes:

- Gynecology – female reproductive health.
- Obstetrics – pregnancy and childbirth.
- Andrology – male reproductive health.
- Menopause – cessation of menstrual cycles.
- Infertility – inability to conceive after 12 months of regular intercourse.

When scheduling a prenatal visit, the front-desk staff must verify the gestational age, which influences the type of screening tests ordered (e.G., First-trimester ultrasound, nuchal translucency measurement).

Pathology terminology provides a framework for describing tissue changes:

- Necrosis – cell death.

- Hyperplasia – increased cell number.
- Metaplasia – transformation of one differentiated cell type to another.
- Dysplasia – abnormal cellular development, often precancerous.
- Carcinoma – malignant tumor arising from epithelial cells.

When a pathology report states “moderate dysplasia of cervical epithelium,” the provider may recommend a colposcopic exam and possible excisional procedure. Staff must ensure that the patient receives the appropriate follow-up instructions.

Immunology terminology includes concepts related to the body’s defense mechanisms:

- Antibody – protein that binds to specific antigens.
- Antigen – substance that triggers immune response.
- Autoimmune – immune system attacks self (e.G., Lupus, rheumatoid arthritis).
- Allergy – hypersensitivity reaction to an external antigen.
- Vaccination – administration of antigen to develop immunity.

When a patient receives a flu vaccine, the staff should document the vaccine name, lot number, and administration site, as these details are required for reporting to public health agencies.

Pharmacology terminology covers drug actions, classifications, and interactions:

- Analgesic – pain relief.
- Antipyretic – reduces fever.
- Beta-blocker – blocks beta-adrenergic receptors, used for hypertension and arrhythmias.
- ACE inhibitor – inhibits angiotensin-converting enzyme, used for heart failure.
- Drug interaction – when one medication alters the effect of another.

Practical challenge: A patient on warfarin reports starting over-the-counter ibuprofen for back pain. The staff must alert the provider because NSAIDs can increase bleeding risk, prompting a possible INR (International Normalized Ratio) check.

Diagnostic coding challenges often arise from ambiguous documentation. For example, a note that simply states “pain” without specifying location, duration, or severity cannot be accurately coded. The coder may need to request clarification, which can delay claim submission. Training staff to ask targeted follow-up questions (e.G., “Where is the pain located? How long has it been present? What makes it better or worse?”) Reduces ambiguity.

Documentation best practices for medical office software include:

- Use full, standardized terms rather than colloquial abbreviations.
- Enter data in the correct fields (e.G., Medication name in the medication field, not in the allergies field).
- Verify patient identifiers (name, date of birth, medical record number) before entering new information.
- Check for duplicate entries, which can cause confusion in medication reconciliation.
- Review alerts generated by the EHR for potential conflicts (e.G., Duplicate orders, drug-allergy



interactions).

Patient communication terminology is also vital. When explaining a procedure, staff should use plain language while still incorporating correct medical terms when appropriate. For instance, "We will perform a colonoscopy, which is a camera that looks inside your colon. You will be sedated so you won't feel discomfort." Balancing technical accuracy with clarity improves patient compliance and satisfaction.

Insurance and billing terminology often intersect with medical vocabulary:

- Primary diagnosis – the main condition responsible for the encounter.
- Secondary diagnosis – additional conditions that affect care.
- Modifier – a two-character code that provides extra information about a service (e.G., "-25" For a significant, separately identifiable evaluation and management service).
- Denied claim – a reimbursement request that was not approved, often due to coding errors or lack of medical necessity documentation.
- Prior authorization – approval required before a service is rendered, common for high-cost imaging or specialty medications.

When a claim is denied, the billing specialist must review the provider's documentation, ensure that the correct ICD-10-CM and CPT codes were used, and submit an appeal with supporting evidence. Clear terminology in the clinical note is essential for a successful appeal.

Quality improvement terminology relates to ongoing efforts to enhance patient care:

- Key performance indicator (KPI) – a measurable value that demonstrates how effectively a practice is achieving key objectives (e.G., Average wait time, patient satisfaction score).
- Root cause analysis (RCA) – systematic process for identifying underlying reasons for an error.
- Plan-Do-Study-Act (PDSA) cycle – framework for testing changes in practice.
- Adverse event – any incident that results in harm to a patient.
- Just culture – organizational environment that encourages reporting of errors without punitive action.

Practical example: If a patient receives the wrong medication due to a transcription error, the office can conduct an RCA, identify that the error stemmed from an ambiguous abbreviation, and implement a policy to eliminate that abbreviation, thereby improving safety.

Telehealth terminology has expanded rapidly. Key concepts include:

- Video visit – real-time visual interaction between patient and provider.
- Store-and-forward – asynchronous transmission of images or data (e.G., A photo of a rash sent for review).
- Remote patient monitoring (RPM) – collection of health data (e.G., Blood pressure, glucose) from the patient's home using connected devices.
- HIPAA compliance – ensuring that electronic communications protect patient privacy.
- Consent – documented patient agreement to participate in telehealth, often captured electronically.

When scheduling a video visit, the receptionist should verify that the patient has a compatible device,

provide instructions for logging into the secure portal, and confirm that the patient has signed the telehealth consent form.

Health information exchange (HIE) terminology refers to the sharing of patient data across different health-care entities:

- Interoperability – ability of different information systems to exchange and use data.
- Continuity of care document (CCD) – standardized summary of a patient’s health information.
- FHIR (Fast Healthcare Interoperability Resources) – a modern standard for exchanging health data electronically.
- Data stewardship – responsibility for ensuring data accuracy, privacy, and security.

In practice, a primary-care office may receive an HIE feed containing recent lab results from an external laboratory. The staff must reconcile these results with existing records, noting any discrepancies and alerting the provider if values fall outside expected ranges.

Regulatory terminology includes laws and standards governing medical documentation:

- HIPAA (Health Insurance Portability and Accountability Act) – federal law protecting patient privacy and security.
- HITECH (Health Information Technology for Economic and Clinical Health) Act – promotes adoption of EHRs and strengthens HIPAA enforcement.
- OSHA (Occupational Safety and Health Administration) – regulates workplace safety, including exposure to bloodborne pathogens.
- Joint Commission – accrediting body that sets standards for patient safety and quality.
- CMS (Centers for Medicare & Medicaid Services) – federal agency that administers Medicare, Medicaid, and enforces documentation requirements for reimbursement.

Compliance with these regulations often requires staff to use specific terminology in documentation (e.G., “Patient education provided regarding infection control”) and to follow audit trails within the EHR.

Clinical decision support terminology refers to embedded tools that aid providers in making evidence-based choices:

- Order set – pre-configured group of orders for a specific condition (e.G., Heart failure order set includes diuretics, labs, and discharge instructions).
- Alert – pop-up notification for potential medication interactions or allergies.
- Best practice guideline – recommended clinical pathway based on current research.
- Smart phrase – templated text that auto-populates with patient-specific data.

When a provider selects the “diabetes management” order set, the system may automatically suggest a hemoglobin A1c test, foot exam, and retinal screening. Understanding these terms helps staff anticipate the resources needed (e.G., Scheduling a retinal photographer).

Patient safety terminology emphasizes practices that reduce harm:

- Never event – a shocking error that should never occur (e.G., Surgery on the wrong site).
- Time-out – a pause before a procedure to verify patient identity, procedure, and site.
- Double-check – verification by two qualified individuals (e.G., Medication preparation).
- Incident report – documentation of an unexpected event, used for analysis.
- Standard precautions – infection-control measures applied to all patients (e.G., Hand hygiene, gloves).

A common challenge is ensuring that all staff consistently perform the “time-out” before each invasive procedure. Regular training and visual reminders can reinforce compliance.

Data entry challenges often arise from system limitations or human error:

- Free-text entry – allows narrative input but can lead to inconsistent terminology.
- Pick-list selection – standardizes terms but may not include every possible condition.
- Autocomplete errors – system may suggest an incorrect term that the user accepts inadvertently.
- Duplicate records – multiple entries for the same patient, leading to fragmented data.

To mitigate these issues, offices should establish data-validation rules, conduct routine audits, and provide ongoing training on proper use of the EHR’s terminology libraries.

Clinical documentation improvement (CDI) is a specialized field focused on enhancing the quality of provider notes to support accurate coding and reimbursement:

- Query – a clarification request sent to the provider when documentation is ambiguous.
- Specificity – level of detail (e.G., “Left lower quadrant pain” versus “abdominal pain”).
- Medical necessity – justification that a service is clinically appropriate.
- Documentation audit – systematic review of charts for compliance.

A CDI specialist may notice a note that reads “patient with infection” and query the provider for the organism, site, and severity, thereby ensuring the correct ICD-10-CM code is applied.

Professional communication terminology includes language used in inter-disciplinary interactions:

- SBAR (Situation, Background, Assessment, Recommendation) – structured handoff technique.
- Handoff – transfer of patient information between providers.
- Consult – request for specialist input.
- Referral – direction of a patient to another provider or service.
- Follow-up – scheduled revisit or test.

When a nurse reports a change in a patient’s vital signs, using SBAR ensures that the provider receives concise, relevant information, reducing the likelihood of misinterpretation.

Ethical terminology in medical documentation includes concepts such as:

- Informed consent – patient’s agreement to a procedure after understanding risks and benefits.
- Advance directive – patient’s preferences for future medical care.
- Do-not-resuscitate (DNR) – order to withhold CPR.

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- Beneficence – acting in the patient’s best interest.
  - Non-maleficence – “do no harm.”

Accurately recording a patient’s DNR status in the EHR prevents unwanted resuscitation attempts and aligns care with the patient’s wishes.

Learning strategies for terminology mastery are essential for office staff:

- Use flashcards with root, prefix, and suffix combinations.
- Practice building new terms by mixing known components (e.G., “Hyper- + tachy- + cardi- + -ology” → hyper-tachy-cardiology, meaning an overly fast heart condition).
- Apply terms in real-world scenarios, such as writing mock progress notes.
- Engage in peer quizzes to reinforce recall.
- Utilize EHR’s built-in glossaries to familiarize with system terminology.

Regular exposure and active usage promote long-term retention, which translates into more efficient charting and fewer documentation errors.