Derogatory Language in Charting: The Domino Effect

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"Dr. Smith" is meeting with a patient in Room 3 who has been admitted for abdominal pain and nausea. He suspects the patient may have appendicitis and will need her appendix removed. Dr. Smith begins to chart, "Ms. Dorian is a 34-year-old female; has a history of abusing alcohol; and is here to be consulted for an appendectomy upon admission for nausea, vomiting, and abdominal pain."

The Room 3 nurse sits down at the computer to review Dr. Smith's note on her patient. "Hmmm, maybe a consult for substance use would be helpful for this patient," she thinks. The nurse puts in an electronic consult request for a social worker to meet with the patient in Room 3.

A few hours later, a unit social worker knocks on the door of Room 3. "Hello, I'm here to conduct an assessment for substance use and discuss alcohol-use resources." The patient is holding her abdomen while she looks with wide eyes at the social worker. "I have been sober for 15 years. Why are you here?"

No matter your background and expertise in healthcare, it is still possible for you to be impacted by stigmatizing language through reviewing a chart. Medical documentation is used to coordinate and communicate care plans from provider to provider and with members of a patient's care team. In reality, a patient's history and plan of care is not the only thing that can be passed through. An important theme of this article is exposing the fact that bias can be passed from provider to provider through stigmatizing language in clinical documentation.

Is Stigmatizing Language Actually a Patient Safety Issue?

Yes, indeed, it is. Creating assumptions based on documentation is dangerous for many reasons. When we make assumptions that a patient knows what they don't know, this leaves room for error and places the patient at risk. Let me explain further.

For example, labeling a patient as a frequent flyer can be a barrier to appropriate follow-up care, by means of the assumption that a patient will be back, impacting staff's efforts in creating a sustainable care plan for the patient to follow through with. If we act on our bias, believing a patient will be back, documenting the patient will be back, we assume we don't need to take further steps at preventing them to come back. This is the cycle that can be perpetuated by stigmatizing language and its effect on bias and further treatment of patients.

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What does stigmatizing language look like?

Stigmatizing	Person-first
Patient refuses	Not tolerating
Substance abuser	Substance use
Sexual assault victim	Individual that experienced sexual assault
Schizophrenic	Patient with schizophrenia
Clean or dirty	Testing negative or testing positive
Addicted baby	Neonatal symptoms of withdrawal
Opioid addict	Person with substance use disorder, specifically opioid use
Hospital slang such as "frequent flyer"	

A further example is provided by a research study at Johns Hopkins School of Medicine published in 2018, which was conducted to observe the impact of bias in documentation on medical provider bias. In order to assess pain management and attitudes toward patients, the study provided two different chart notes describing the same hypothetical patient: one note with derogatory language, the other note with neutral language. When staff reviewed stigmatizing language regarding the hypothetical 28-year-old patient with sickle cell disease, the effects were significant. The study revealed that with the chart notes exposing stigmatizing language to staff, there was less comfort in managing the patient's pain and more negative attitudes toward the patient based on surveys completed by medical providers.

When there are different modes of care and engagement with patients, this most definitely is an issue of patient safety.

Interestingly, the study also showed that after reviewing stigmatizing language, experienced medical providers showed more of a change in their attitude toward the patient than less experienced providers did.

Further studies have shown that medical professionals' attitudes have impacted patients' feelings of empowerment and action-oriented tasks. This makes it even more essential for healthcare workers to increase an inner awareness around personal bias in regard to the patient's safety and overall care, no matter your length of time in the medical field or your expertise.

"No one really reads my notes, does it actually matter?"

It can be helpful to visualize documentation as a domino effect in this regard. You knock the domino down whenever you chart bias, misinformation, or criminalizing language, which in essence knocks your domino down, and then the next, and the next, and so on and so forth.

Look around: Everyone is a domino, including medical assistants, nurses, physical and occupational therapists, phlebotomists, lab technicians, X-ray technicians, pharmacists. When you chart, it is not just you reading the chart, it is every healthcare worker accessing the information you provide.

What Do We Do? Steps to Take: The Person Before the Diagnosis

Using person-first language in clinical documentation allows for patients to be seen and described as human beings. Centering the patient in the documentation versus clinical behaviors, diagnosis, or medical histories is critical.

Some providers find it helpful to include space in documentation to list a patient's hobbies, meaningful relationships, and desire for medical interventions or care. For example, "John is hopeful that engaging in physical therapy will increase his chances of rejoining his bowling league this fall." This honors the patient and can serve as a kind reminder to staff that the individual you are working with is a person, not just your patient.

Substance Use and Mental Health

Mental health diagnoses give us information that can impact a care plan but are not meant as adjectives or labels to describe a person. More often than not, mental health diagnoses have been used as adjectives to describe patients in medical documentation. For example: "depressed patient" vs. "patient with history of depression." This is faulty in the sense that this takes away from the person-first language approach, which can aid to risk of bias upon reading documentation in a chart.

Patients can have multiple diagnoses listed in documentation, and when a patient is admitted, that does not mean every diagnosis listed is the reason for an admission or care. This is the same for substance use and mental health: Those two markers should not deter from the possibility that patients can have a wide range of health concerns outside of those two factors. Information about mental health and substance use can be useful with treatment plans and preventative care, but it may not necessarily need to be the guiding clinical markers of care. This inappropriate guidance of care can impact clinical documentation, drifting away from why a patient is seeking care in the first place.

It is vital that we increase our awareness around language in medical documentation, for just as the impact of any diagnosis is great, so too is the impact of bias surrounding that diagnosis and how we respond. Instead of criminalizing the patient and personalizing the individual to the concern, we remember that people have problems, but are not the problems. Oftentimes, a patient may exhibit behaviors as a symptom of what they are being seen for. Recognizing this, it is our responsibility as healthcare workers to acknowledge our bias in order to prevent perpetuated mistreatment and misunderstanding of a patient, regardless of their behaviors. Make no mistake, you can hold a gentle awareness to your bias and also adhere to appropriate boundaries when it is necessary and request staff support when safety is being questioned.

When healthcare workers can see a person before the diagnosis, it assists in adhering to treating patients and not providing judgement or a mindset of punishment. Of note, studies have shown that bias and judgement have substantially increased with terms such as "abuser" versus "patient with a history of substance use" in clinical documentation. You can be a long-standing physician or equipped mental health professional and still have habits in documentation that may unintentionally impact another provider's mindset before they walk into the room. Lax, derogatory language in clinical documentation is detrimental to the patient you have been charting on.

When we use awareness in charting, we are not only being accurate, but also honestly advocating for patients and their authentic selves, with a person-first approach.

Reflection Questions for Charting

Grab that cup of coffee, take a breath. As you sit at the computer, ready to document your encounter with a patient, here are some helpful questions to check in with yourself:

- What am I trying to say about this patient?
- Is this information relevant to what the patient is being admitted and seen for?
- Why am I saying it like this? What are my intentions here at a clinical level?
- Is this symptom or behavior I am documenting based on evidence given by the patient or personal witness, or could it be feelings I am having?
- Is there any piece of information I am leaving out? Why might I be leaving it out? What is coming up for me?

Empowering Patients through Electronic Health Record Access

Further data has shown that giving patients education and electronic health record (EHR) access—where they can review chart notes from their providers and the listed diagnosis—helps ensure ongoing consistency of care and adequate treatment. An open line of access for a patient to their health information not only

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prevents misinformation from being shared with medical teams, but also is a substantial and sometimes underrated opportunity for patients to be engaged in their care, their responsibility to themselves, and their health, and an opportunity for them to continue asking questions and giving information as it pertains to their diagnosis and care plan. If a patient is unaware of lab results, diagnoses, or a treatment plan they may be unsure of what to look for.

Encouraging patients to get connected to your hospital system's patient record through a computer portal system is vital in maintaining patient-care team communication and to allow for open dialogue around diagnosis, treatment plans, lab work, and medications prescribed.

We know that words are powerful, and we know that information matters. How we give and filter that information is up to those who are holding it and sharing it on behalf of the patient for the sake of their well-being and safety. Using information to open access rather than limit access to healthcare depends on how we choose to document diagnoses, histories, behaviors, and results. As healthcare workers, you have an opportunity to build bridges instead of roadblocks just by the words you use. We see results when we are in tune with how our actions and bias can come into play with documentation and interpreting that documentation. This is your chance—don't miss it. Make your words count.

The Johns Hopkins study mentioned earlier also revealed implications that bias in a chart can be maintained throughout the life of a patient, which is frankly very concerning. In a patient's lifetime, every visit, check-up, lab work, procedure, and admission can be impacted by the language that each staff member uses in documentation. The sense of permanency in medical documentation and the impact of documentation on patient care mandates the healthcare community to take documentation seriously.

Overall, if there is less patient engagement and less empathy because of stigma and misinterpretation through derogatory language, this is a problem of patient safety, period. This is a great opportunity for the medical community to build awareness around systemic gaps and the impacts of documentation—both the impact of documentation on bias and of bias on patient treatment.

Any room for misinterpretation of information needs to be evaluated.

Any room for assumptions made due to stigmatizing language needs to be rewritten.

"Speech has power. Words do not fade. What starts out as a sound, ends in a deed." -Abraham Joshua Herschel

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Further Resources

Webcasts: "The Power of Language and Portrayals: What We Hear, What We See" https://www.samhsa.gov/power-language-portrayals

Mental Health Guide to Reporting https://www.cartercenter.org/resources/pdfs/health/mental_health/2015-journalism-resource-guide-on-behavioral-health.pdf

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