Stigma in Medicine: The Power of Language

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Whole group discussion

Instructions: Review this case, noticing any stigmatizing language. Be prepared to share your findings.

CC: tried to commit suicide

HPI: Mr. W is an elderly Hispanic alcoholic veteran who presented to the hospital last night after he ran into traffic after what he claims was a “2-week” bender. He admits to being noncompliant with anti-depressant medication he gets from his provider at the VA, and had unfortunately relapsed on alcohol after being clean for almost 6 months.

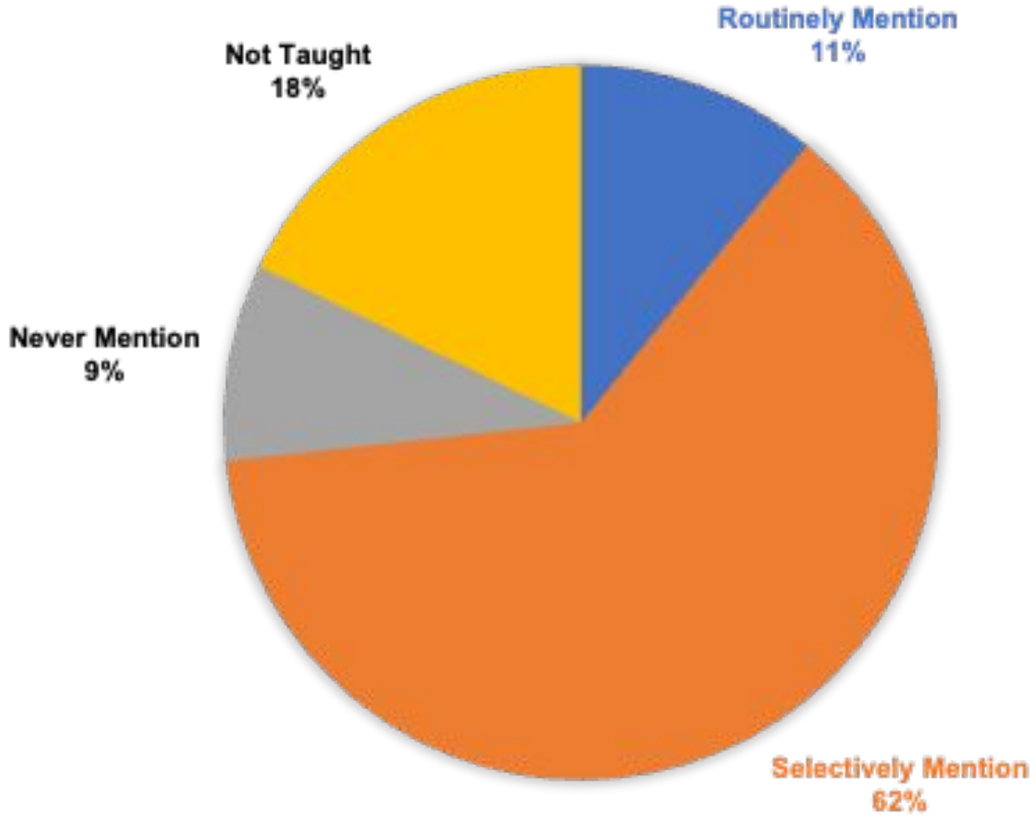
In Zoom: click “Annotate.”
Circle or underline stigmatizing language.

CC: tried to commit suicide

HPI: Mr. W is an elderly Hispanic alcoholic veteran who presented to the hospital last night after he ran into traffic after what he claims was a “2-week” bender. He admits to being noncompliant with anti-depressant medication he gets from his provider at the VA, and had unfortunately relapsed on alcohol after being clean for almost 6 months.

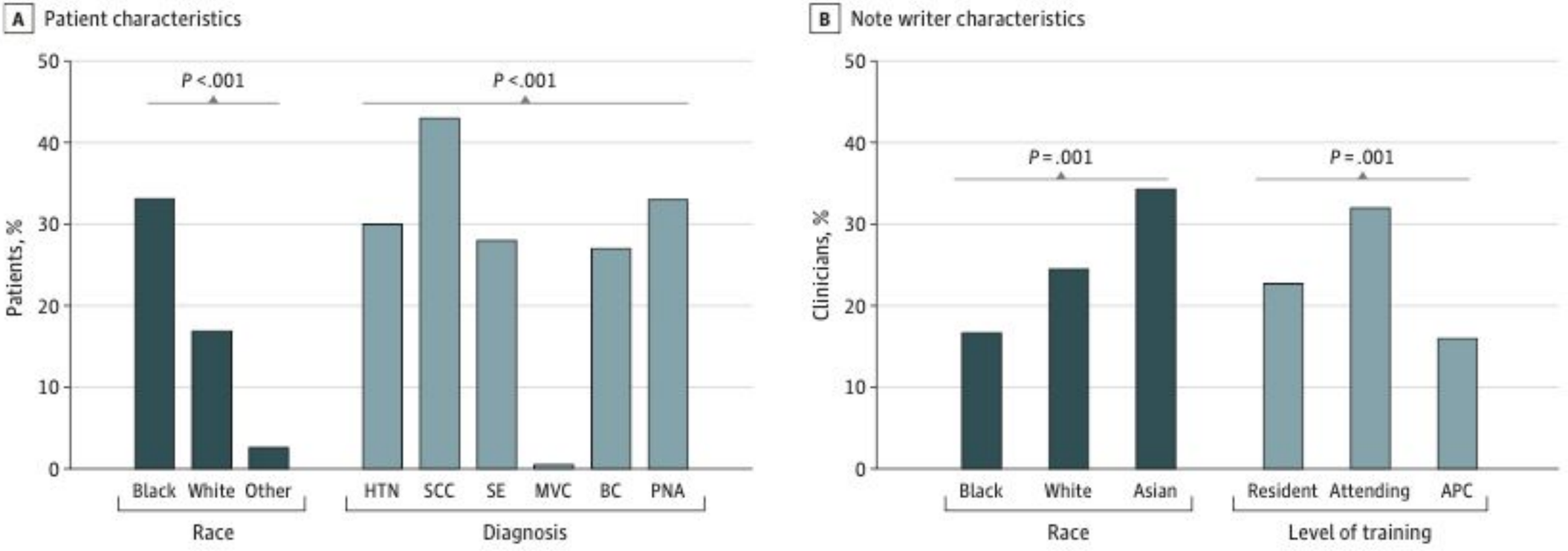
Have you received any explicit teaching on the use of social identities (i.e., race/ethnicity) and/or stigmatizing language in medical documentation?

What are students being taught about race in clinical presentations and documentation?



Nawaz et al. Medical Education 2009: 43: 146–154

Figure. Race Documentation by Patient Characteristics and by Note Writer Characteristics



A, Race documentation by patient characteristics; B, Race documentation by note writer characteristics. APC indicates advanced practice clinician; BC, breast cancer; HTN, hypertensive emergency; MVC, motor vehicle collision; PNA, pneumonia; SCC, sickle cell crisis; SE, status epilepticus.

Balderston et al., JAMA Internal Medicine, 2021

Racial Bias in Presentation of Cases

THOMAS E. FINUCANE, MD, JOSEPH A. CARRESE, MD

JOURNAL OF GENERAL INTERNAL MEDICINE, *Volume 5 (March/April), 1990*

Testimonial Injustice: Linguistic Bias in the Medical Records of Black Patients and Women

Mary Catherine Beach, MD, MPH[1,2,3,4], Somnath Saha, MD, MPH[2,5,6], Jenny Park[2,7], Janiece Taylor, RN, PhD, FAAN[8], Paul Drew, PhD[9], Eve Plank[10], Lisa A. Cooper, MD, MPH[2,3,4], and Brant Chee, PhD[11]

A linguistic content analysis of 600 clinical notes:

1. **Evidentials** – indicates the source of one's knowledge
   - Example: "The patient has a headache" vs "The patient reports that she has a headache."
   - allows the reader to be agnostic about whether the statement is true

2. **Judgement Words** – questions credibility more directly
   - Example: "The patient is adamant that she has a headache." or "The patient apparently says she has a headache."

3. **Quotes**
   - While quoting patients are often encouraged to convey that the words have been spoken but can be an indication that the words are to be doubted.
   - Example: When physicians make the choice to write, "the patient reports she had a 'reaction' to the medication," they may be trying to indicate that they do not necessarily believe that the reaction occurred

Table 2 Prevalence of Linguistic Features Used in Medical Records by Race and Gender

Linguistic feature	Race		Gender		Unadjusted Black-White difference	Adjusted† Black-White difference	Unadjusted female-male difference	Adjusted† female-male difference
	White	Black	Male	Female				
	Mean (SD)	Mean (SD)	Mean (SD)	Mean (SD)	β (95% CI)		β (95% CI)	*p*-value
Evidentials	3.29 (3.66)	4.81 (3.74)	4.41 (3.89)	4.56 (3.70)	1.52*** (1.33, 1.70)	0.32*** (0.17, 0.47)	0.15 (−0.01, 0.31)	0.10 (−0.02, 0.22)
	N (%)	*N* (%)	*N* (%)	*N* (%)	OR (95% CI)		OR (95% CI)	
Judgment words	403 (21%)	2164 (29%)	1037 (29%)	1530 (27%)	1.56*** (1.38, 1.75)	1.25* (1.02, 1.53)	0.93 (0.85, 1.02)	0.96 (0.82, 1.11)
Quotes	572 (30%)	3337 (45%)	1470 (41%)	2439 (43%)	1.94*** (1.74, 2.16)	1.48*** (1.20, 1.83)	1.12** (1.03–1.22)	1.22* (1.05, 1.44)

*$p<0.05$
**$p<0.01$
***$p<0.001$
†*Mixed-effects modeling to account for clustering of notes within patients and patients within clinicians*

Key Points

- Clinicians systematically describe patient accounts, and use stigmatizing language in documentation (and oral presentations), **differently** based on the identity of the patient; such that, clinicians disproportionately cast doubt and stigma towards minoritized patients.

So what?

Stigmatizing language in the chart and oral presentations has deleterious consequences for minoritized patients

Do Words Matter? Stigmatizing Language and the Transmission of Bias in the Medical Record

Anna P. Goddu, MSc[1], Katie J. O'Conor, BA[1], Sophie Lanzkron, MD, MHS[2], Mustapha O. Saheed, MD[3], Somnath Saha, MD, MPH[4,5], Monica E. Peek, MD, MPH, MSc[6], Carlton Haywood, Jr., PhD, MA[2], and Mary Catherine Beach, MD, MPH[1]

413 physician-in-training

Randomized

Neutral language chart note

Section 1
Mr. R is a 28-year old man with sickle cell disease and chronic left hip osteomyelitis who comes to the ED with 10/10 pain in his arms and legs. He has about 8–10 pain crises per year, for which he typically requires opioid pain medication in the ED. At home, he takes 100 mg OxyContin BID and oxycodone 5 mg for breakthrough pain. Over the past few days, he has taken 2 tabs every 4–6 hours. About 3 months ago, he moved to a new apartment and now has to wheel himself in a manual wheelchair up 3 blocks from the bus stop.

Stigmatizing language chart note

Mr. R is a 28-year old sickle cell patient with chronic left hip osteomyelitis who comes to the ED stating he has 10/10 pain "all up in my arms and legs." He is narcotic dependent and in our ED frequently. At home he reportedly takes 100 mg OxyContin BID and oxycodone 5 mg for breakthrough pain. Over the past few days, he says that he has taken 2 tabs every 4–6 hours. About 3 months ago, patient states that the housing authority moved him to a new neighborhood and he now has to wheel himself in a manual wheelchair up 3 blocks from the bus stop.

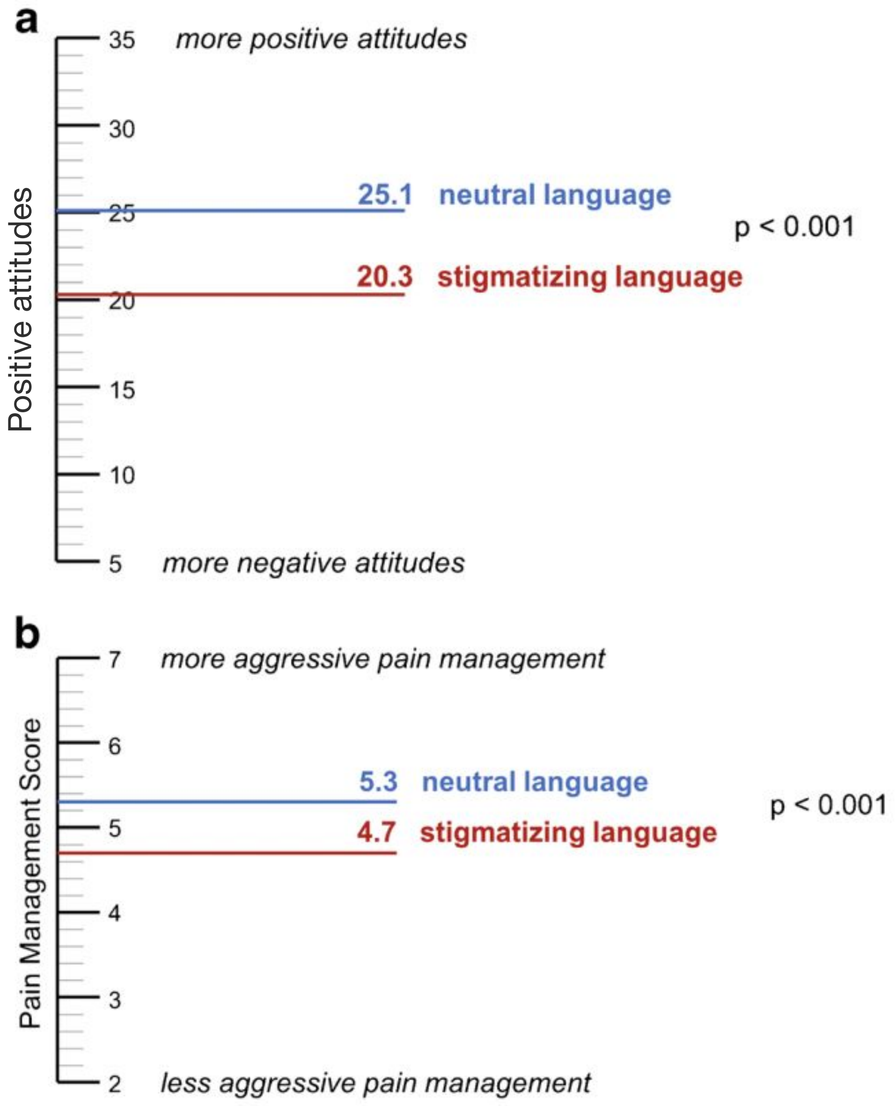


Figure 1 Effect of stigmatizing language on attitudes (Panel A) and on pain management (Panel B).

Table 3 What Did Participants Notice about Each Chart Note? Examples from the Vignettes and Frequency of Mentions by Participants

Feature of chart note	Stigmatizing chart note Negative attitude perceived (score < 9)*
Narcotic dependent	34
In our ED frequently	29
Girlfriend on bed with shoes on	24
Girlfriends requests bus token	20
"Stressful situations"	16
Use of quotation marks	15
Cursing at nurse	14
Insisting pain is "still a 10"	10
McDonald's	8
Refuses to wear his oxygen mask	7

Special Article

THE EFFECT OF RACE AND SEX ON PHYSICIANS' RECOMMENDATIONS FOR CARDIAC CATHETERIZATION

KEVIN A. SCHULMAN, M.D., JESSE A. BERLIN, SC.D., WILLIAM HARLESS, PH.D., JON F. KERNER, PH.D., SHYRL SISTRUNK, M.D., BERNARD J. GERSH, M.B., CH.B., D.PHIL., ROSS DUBÉ, CHRISTOPHER K. TALEGHANI, M.D., JENNIFER E. BURKE, M.A., M.S., SANKEY WILLIAMS, M.D., JOHN M. EISENBERG, M.D., AND JOSÉ J. ESCARCE, M.D., PH.D.

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TABLE 4. REFERRAL FOR CARDIAC CATHETERIZATION ACCORDING TO EXPERIMENTAL FACTORS.

EXPERIMENTAL FACTOR AND CATEGORY	MEAN REFERRAL RATE	ODDS RATIO (95% CI)*	P VALUE
	%		
Sex			
Male	90.6	1.0	
Female	84.7	0.6 (0.4–0.9)	0.02
Race			
White	90.6	1.0	
Black	84.7	0.6 (0.4–0.9)	0.02
Age			
55 yr	89.7	1.0	
70 yr	85.6	0.7 (0.4–1.1)	0.09
Risk level			
Low	88.9	1.0	
High	86.4	0.8 (0.5–1.2)	0.31
Type of chest pain			
Nonanginal pain	83.8	1.0	
Possible angina	90.0	1.7 (1.0–3.0)	0.04
Definite angina	89.2	1.6 (0.9–2.7)	0.08
Stress-test result			
Inferolateral ischemia	86.3	1.0	
Anterolateral ischemia	86.7	1.0 (0.6–1.6)	0.89
Multiple ischemic defects	90.0	1.4 (0.8–2.5)	0.20

*CI denotes confidence interval.

TABLE 5. PREDICTORS OF REFERRAL FOR CARDIAC CATHETERIZATION.*

MODEL AND VARIABLE	ODDS RATIO (95% CI)†	P VALUE
Race and sex as separate factors		
Sex		
Male	1.0	
Female	0.6 (0.4–0.9)	0.02
Race		
White	1.0	
Black	0.6 (0.4–0.9)	0.02
Interaction of race and sex		
White male	1.0	
Black male	1.0 (0.5–2.1)	0.99
White female	1.0 (0.5–2.1)	>0.99
Black female	0.4 (0.2–0.7)	0.004

*Both models included all experimental factors as covariates, as well as the probability of coronary artery disease as estimated after the results of the stress tests were known. The first analysis included only the main effects. The second analysis explored a race–sex interaction.

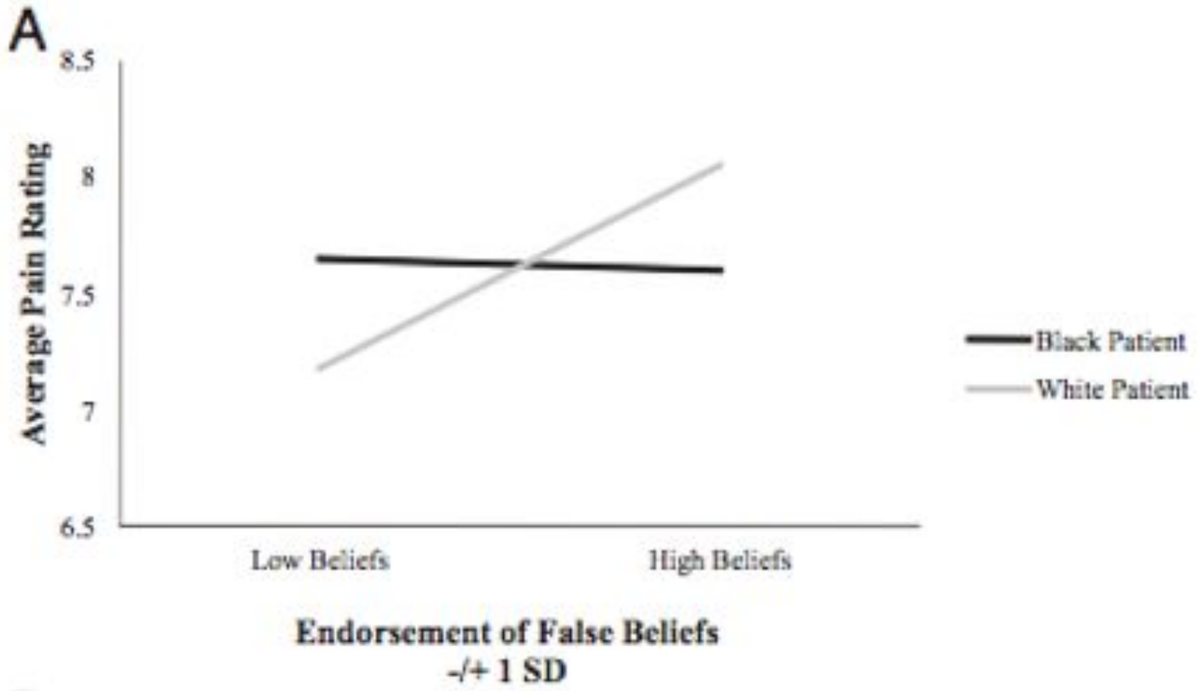
†CI denotes confidence interval.

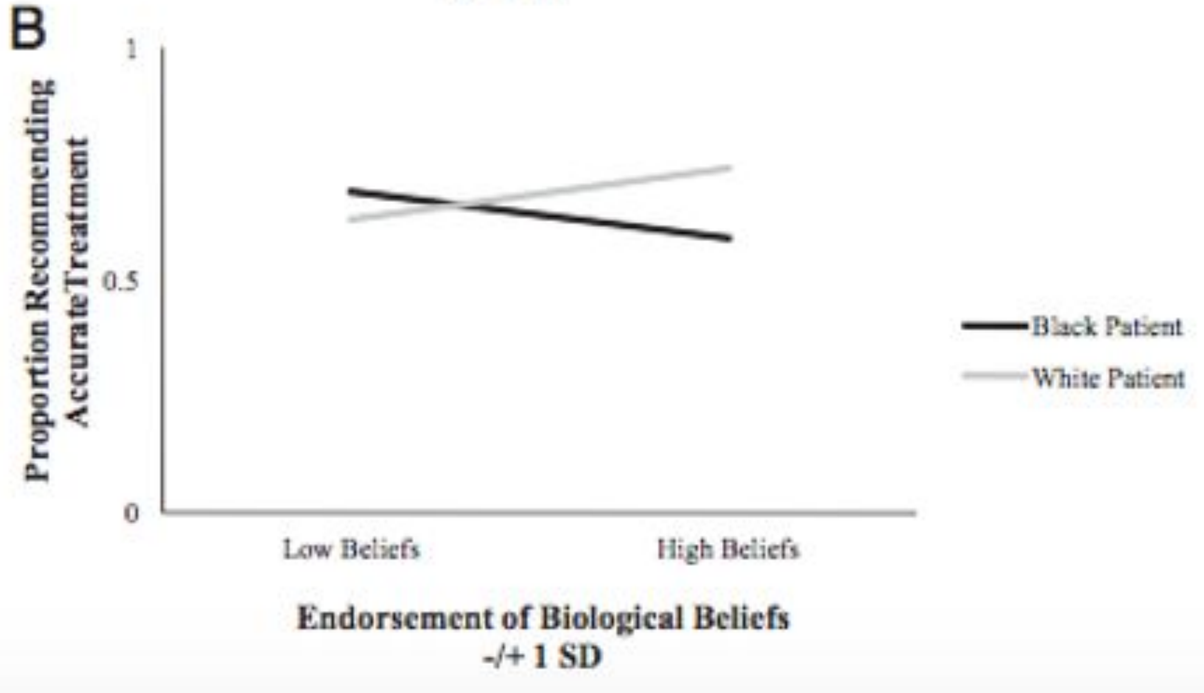
Racial bias in pain assessment and treatment recommendations, and false beliefs about biological differences between blacks and whites

Kelly M. Hoffman[a,1], Sophie Trawalter[a], Jordan R. Axt[a], and M. Norman Oliver[b,c]

Table 1. Percentage of white participants endorsing beliefs about biological differences between blacks and whites

Item	Study 1: Online sample (n = 92)	Study 2			
		First years (n = 63)	Second years (n = 72)	Third years (n = 59)	Residents (n = 28)
Blacks age more slowly than whites	23	21	28	12	14
Blacks' nerve endings are less sensitive than whites'	20	8	14	0	4
Black people's blood coagulates more quickly than whites'	38	29	17	3	4
Whites have larger brains than blacks	12	2	1	0	0
Whites are less susceptible to heart disease than blacks*	43	63	83	66	50
Blacks are less likely to contract spinal cord diseases*	42	46	67	56	57
Whites have a better sense of hearing compared with blacks	10	3	7	0	0
Blacks' skin is thicker than whites'	58	40	42	22	25
Blacks have denser, stronger bones than whites*	39	25	78	41	29
Blacks have a more sensitive sense of smell than whites	20	10	18	3	7
Whites have a more efficient respiratory system than blacks	16	8	3	2	4
Black couples are significantly more fertile than white couples	17	10	15	2	7
Whites are less likely to have a stroke than blacks*	29	49	63	44	46
Blacks are better at detecting movement than whites	18	14	15	5	11
Blacks have stronger immune systems than whites	14	21	15	3	4
False beliefs composite (11 items), mean (SD)	22.43 (22.93)	14.86 (19.48)	15.91 (19.34)	4.78 (9.89)	7.14 (14.50)
Range	0–100	0–81.82	0–90.91	0–54.55	0–63.64
Combined mean (SD) (medical sample only)			11.55 (17.38)		


A
8.5
8
7.5
7
6.5
Average Pain Rating
Low Beliefs
High Beliefs
Endorsement of False Beliefs
-/+ 1 SD
Black Patient
White Patient


B
1
0.5
0
Proportion Recommending
Accurate Treatment
Low Beliefs
High Beliefs
Endorsement of Biological Beliefs
-/+ 1 SD
Black Patient
White Patient

Key Points

- Stigmatizing language in documentation (and oral presentations) can activate and propagate bias from one clinician to another, informing diagnostic and treatment decisions

- There needs to be anti-racist, anti-oppressive approaches to documentation (and oral presentations) to de-stigmatize historically stigmatized populations, which will enhance the care the patient.

Anti-Oppressive Language: Guiding principles

Person-first

Non-stigmatizing

Non-judgmental

Anti-Oppressive Language: Mindful Language Toolkit

Consider:

- ❑ Does it cast blame?
- ❑ Does it reinforce a stereotype?
- ❑ Does it include extraneous information?
- ❑ Does it contain pejorative language?
- ❑ How would my patient feel if they read this?

Raney J, et al. (2021) Words Matter: An Antibias Workshop for Health Care Professionals to Reduce Stigmatizing Language

Anti-Oppressive Language: People first

- Literally put the person first and then their illness
  - "psychotic patient" → "person with psychosis"
  - "diabetic" → "patient with diabetes"
- Avoid using identifying information or descriptors as nouns
  - "alcoholic" → "person with alcohol use disorder"
  - "a female" → "a woman"
  - "a veteran" → "a patient or person who served in the military"
- Avoid undermining the patient's validity
  - "claims/admits" → "endorses" or "states"
  - Use quotes judiciously

Adapted from: Christina Girgis, M.D., Loyola University Stritch School of Medicine, *June 2020*

Anti-Oppressive Language: Substance use disorders

- Non-judgmental, non-stigmatizing
  - "substance abuser" → "person with a substance use disorder; actively using X"
  - "junkie", "habit" → "substance use disorder", "illness"
  - "narcotics" → "opioids"
- Promote recovery
  - "noncompliant" → "declines treatment", "had [barrier] to maintaining compliance"
  - "relapsed" → "experienced recurrence", "returned to use"
  - "detox" → "withdrawal management"
- Avoid slang
  - "dirty/clean" UDS → "positive/negative" UDS
  - "convict", "felon" → "person with a history of incarceration", "was convicted", "patient has a history of felony charges"

Adapted from: Christina Girgis, M.D., Loyola University Stritch School of Medicine, *June 2020*

Anti-Oppressive Language: Suicide

- Avoid “commit suicide”
  - “died by suicide”, “ended their life”, “attempted suicide”, “took their own life”
- Avoid “completed suicide” / “successful suicide” / “failed attempt”
  - “suicide” or “suicide attempt”
- Avoid “passive” suicidal ideation
  - “wishes to die”, describe, or just “suicidal ideation”

Padmanthan, et al (2019) Language use and suicide: An online cross-sectional survey.
Adapted from: Christina Girgis, M.D., Loyola University Stritch School of Medicine, *June 2020*

Anti-Oppressive Language: “Provider”

- implies uniformity of expertise and knowledge
- creates confusion
- implies transactional relationship

AAFP (2018) Provider, Use of Term (Position Paper)
Goroll (2016) Eliminating the Term Primary Care “Provider”: Consequences of Language for the Future of Primary Care

Anti-Oppressive Language: What do patients find offensive?

- “Chief compliant” → “primary concern” / “reason for visit”
- “Obese” → document BMI / document condition, not as adjective
- “Diabetic” → document diagnosis of diabetes, not as adjective
- “Uncontrolled diabetes” → “High A1c” / “A1c is above X goal”
- “Denies” → “does not” or “has not”
- “Elderly” → “X years old”
- Incorrect gender/pronouns → ask and match

Fernández, et al (2021) Words Matter: What Do Patients Find Judgmental or Offensive in Outpatient Notes?

Anti-Oppressive Language: Race or other identity

- Generally, do not use in HPI
- If relevant and explicitly ascertained, explain why (contextualize), in:
  - Structural formulation
  - Or social history

First Impressions — Should We Include Race or Ethnicity at the Beginning of Clinical Case Presentations?

Allan S. Brett, M.D., and Christopher W. Goodman, M.D.

Adapted from: Christina Girgis, M.D., Loyola University Stritch School of Medicine, *June 2020*

Small Group Breakout (5min)

1. Revise the previous case

2. One member to paste revision into chat upon return

Share your revised version.

Whole group discussion

Instructions: Revisit this case, noticing any stigmatizing language. Be prepared to share your findings.

CC: tried to commit suicide

HPI: Mr. W is an elderly Hispanic alcoholic veteran who presented to the hospital last night after he ran into traffic after what he claims was a “2-week” bender. He admits to being noncompliant with anti-depressant medication he gets from his provider at the VA, and had unfortunately relapsed on alcohol after being clean for almost 6 months.

Suggested revision (not perfect!)

Primary concern / Reason for admission: suicide attempt

HPI: Mr. W is a 57-year-old with alcohol use disorder who presented to the hospital last night after he tried to kill himself by running into traffic after experiencing a recurrence of his alcohol use. He has been unable to fill prescribed anti-depressant medication (due to cost) and had resumed using alcohol in the last 2 weeks after not using for almost 6 months.

Turn and talk (5min)

1. Discuss revisions you would make to the case
2. Be ready to share

CC: tried to commit suicide

HPI: 17 year old marijuana using Hispanic boy who presents to the ED last night after he ran into traffic after what he claims was a “2 week” bender. He admits to being noncompliant with antidepressant medication which he gets from his pediatrician, and had unfortunately relapsed on marijuana after being clean for almost 6 months.

Whole group discussion

Instructions: Revise the case together…

CC: tried to commit suicide

HPI: 17 year old marijuana using Hispanic boy who presents to the ED last night after he ran into traffic after what he claims was a “2 week” bender. He admits to being noncompliant with antidepressant medication which he gets from his pediatrician, and had unfortunately relapsed on marijuana after being clean for almost 6 months.

Revise…

CC: Suicide attempt

HPI: 17 year old with cannabis use disorder ~~marijuana using Hispanic~~ spanish speaking boy who presents to the ED last night after he ran into traffic after a 2 week intoxication state. He ~~admits to being~~ has been nonadherent with fluoxetine prescribed by his pediatrician, and had returned to use of cannabis after maintaining sobriety for for almost 6 months.

Commit to change

What is one area of your documentation that you will try to change, in order to reduce bias / stigma and enhance patient care?

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Q&A

National Anti-racism in Medicine Curriculum Coalition:
www.namcc.net