Podcast Transcript

# Patient-first Language- Breaking Stigmas, Building Bridges

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## Guest

### Dr. WARD, DNP, FNP-BC

Dr. Meriah Ward, DNP, FNP-BC is a family nurse practitioner pursuing a psychiatric mental health post-graduate certificate. They received an MSN, DNP, and PGC from Old Dominion University in 2020, 2021, and 2024, respectively.

They are a non-binary, autistic provider providing primary and mental health services for diverse populations. Dr. Ward's passion for primary and psychiatric care services propels them to consider an integrative approach to the co-management of medical and psychiatric conditions. Their passions include LGBTQIA+ health, sexual health, neurodivergency, multiplicity, gender-affirming care, and chronic disease management.

## Host

### Dr. Candace Pierce,

Dr. Pierce is a nurse leader committed to ensuring nurses are well prepared and offered abundant opportunities and resources to enhance their skills acquisition and confidence at the bedside. With 15 years in nursing, she has worked at the bedside, in management, and in nursing education. She has demonstrated expertise and scholarship in innovation and design thinking in healthcare and education, and collaborative efforts within and outside of healthcare. Scholarship endeavors include funded grants, publications, and presentations. As a leader, Dr. Pierce strives to empower others to create and deploy ideas and embrace their professional roles as leaders, change agents, and problem solvers. In her position as the Sr. Course Development Manager for Elite, she works as a project engineer with subject matter experts to develop evidence-based best practices in continuing education for nurses and other healthcare professionals.

## Transcript

## Episode 1 – Patient-first Language- Breaking Stigmas, Building Bridges

Candace Pierce: This is Dr. Candace Pierce with Elite Learning by Colibri Healthcare, and you were listening to our Elite Learning podcast, where we share the most up-to-date education for healthcare professionals. I want to welcome our listeners joining us for today's discussion about patient-first language. You may also hear it as person-first language. So, joining me for this discussion today is Dr. Mariah Ward, a family nurse practitioner. Dr. Ward, thank you for taking the time to join us for this discussion today.

Meriah Ward: Thanks. Yeah, I am excited to be here.

PIERCE: Can you share a little about your background and how patient-first language became an area you were interested in?

WARD: Yeah. So, I've been a family nurse practitioner for about four years. I'm currently in a postgraduate certificate program for psychiatric and mental health as well. And I am really passionate about patient-first language, because I identify with the opposite of it, which we'll talk about a little bit in the podcast. But, where I am autistic and so I don't really use person-first language, because it's so integrated into my personality and who I am. And so, I am really passionate about it from the opposite end of it. But there's lots of really great reasons as to why you would want, like, patient-first language and all of that. So, I'm kind of, like, passionate about it because of the way it falls onto to me as an individual, and kind of coming from my perspective, how that comes off. And I know that other people don't necessarily want that. So, I kind of like I'm on it from the opposite end. But I also kind of understand why, it's a necessary evil, to change that.

PIERCE: And it really seems like patient-first language is a newer health healthcare topic. But I don't think it really is, because I kind of did a little research before we met today. And I saw that in 1986, the American Psychological Association actually adopted first person language into its publications, and now we're starting to see it become more and more popular in healthcare. And I know I've seen even billboard advertisements and commercials, especially with diabetes, about patient-first language. So, I'm really interested in what you have to share with us today. So, what is patient-first language, and the origin, and the history behind the move towards patient-first language?

WARD Yeah. So, patient-first language, like you said, may be called person-first language, kind of emphasizes the person before the diagnosis like disability or condition. And so, it, it kind of humanizes, right? Instead of defining somebody by their illness like an epileptic or a schizophrenic, it focuses on the individual. So, saying a person with, whatever disorder, the approach kind of looks to reduce stigma, and highlight that a person's more than their medical status. Like you mentioned, the APA is really probably the fuel behind the fire for it, because there's a lot of stigma with mental illness. And then if we're kind of defining people by their mental illness, people are less likely to get treated. I mean, there are still people that I see who are like, I don't want that. I don’t want bipolar on my chart, because they really think that starts to define them. So, it's not surprising that the APA

kind of tied into that, and really, the movement started by advocacy efforts like by disability rights groups in the mid-20th century. So right about the time that you were kind of talking about, they argued that labels created negative stereotypes, and dehumanized people with disabilities, so it became like increasingly adopted. And it's even codified in laws like the American Disability Act of 1990 and endorsed by Style guides, which is what you mentioned, the APA and organizations in the medical and social sciences field. So, like the APA is, they are a style guide, but they're also the people who write the DSM. They're really prevalent, especially in the mental health community, and even APA guides are what we use in science. So, most nurses and medical professionals are going to be really familiar with APA, and so, when they take that, they kind of guide the practice and guide what we do, it's going to be kind of prevalent and important that we like follow their guidelines. And so, and I even think about, the most recent change, the APA, where they emphasize that using singular, they, them, for pronoun identification was appropriate clinically, it was stylistically appropriate, that really changed a lot of conversation that people were having in academia of like, okay, well, this actually is something that we could do. And it's really like this movement kind of emphasizes that it's okay to talk about, people-first and kind of like I said, it humanizes us and makes us to reduce the stigma and stuff like that. So that's really awesome.

PIERCE: So, you have a doctorate after, you got DNP after your name. I've got a doctorate. And so, we've written a lot using APA style guides, and I didn't realize until this conversation, until I was preparing for this, that it was that that was the reason why that change was there, that it was for that person-first patient, patient-first language. I didn't realize what it was. I just thought it was normal for formal writing. So, it's really interesting to kind of hear the history in the background of that.

WARD: Yeah, absolutely.

PIERCE: So, when I was in nursing school, condition first terminology was mainly what was used. And so, because I was so used to that, I was conditioned to that being the way, I really didn't realize the impact it had on perceptions and stigma and bias. What was the reason behind shifting from condition-first to patient-first terminology? Where did that, where did that really, where did that thinking come from?

WARD
Yeah. So, we kind of highlighted that it reduces stigma, when you put the condition first, it perpetuates these stereotypes and like creates like a sense of otherness or outsideness, and so the person-first in language acknowledges that the condition, but it emphasizes that people aren't defined by their health status. So, it's not a diabetic patient, it's a person with diabetes. So, you can take the first part of that a person and still kind of remove all of that. But like a diabetic, there's no removing that. So, you're tied indefinitely to this to this illness. It respects his individuality. So, it places a person before the condition. It humanizes the individual. It recognizes that they have life experiences and

the identity behind their diagnosis. Again, like you can't remove anything from the diabetic, right? But you can remove the person from the sentence when you say a person with diabetes. And it also empowers patients. So, it shifts the language to reflect the philosophy of disability right movements, where people with disabilities are seen as active agents, not just merely passive recipients of their labels or treatments or diagnosis. And that's really important when we're talking about long term health outcomes, because you can get better from an array of disorders and your diabetes can be controlled. That's maybe not even a fraction of what your life is. So, it's kind of important to empower the patient to remove themselves from the disorder too.

PIERCE: Absolutely. So how has the use of person-first language evolved over time, especially in the healthcare setting? Seems like it's been a very small evolving or short I mean, it's taking a long, long time.

WARD: Yeah, there's a joke in academia that, research starts and then it takes about 20 years for adoption, right? So, we research it and do all that, and then the research itself takes years and years and years. And so, and then it takes us about 20 years to adopt it. So, we're slow moving in the medical field sometimes. So, it's evolved, we've increased awareness and adoption. Person-first language has become more widely recognized as respectful and inclusive. A lot of healthcare organizations, professional bodies and educational institutions promote its use. But we still are not the best at it. The challenges of it, there's a general move towards it, but its implementation is inconsistent, like you said. Some medical terms are inherently condition first. So, there might be preferences within specific communities, like I mentioned before, autistic people like to be called autistic.

PIERCE: Yeah.

WARD: And so that kind of changes. Patient-first language continues to evolve, especially in broader conversations around disability rights and inclusive language in healthcare, and it's a dynamic process that requires sensitivity and adaptability to ensure respect for individuals. And I think, too, just having people within the community that you're in, like the medical community that are advocating, usually for themselves first, we're not just advocating for patients, because a patient sometimes seems like a distant, far off person, but, your colleague, it's a lot closer to home. And so, I think that's one of the ways right now that's really kind of helping gain momentum are people, talking about their experiences within the medical community, people who work there, not just advocating for patients who seem maybe far off a distance to some of us in the field.

PIERCE: Do you have some examples of how word order and language really impact the perception that healthcare providers or even other people might have on a patient?

WARD: Yeah. So, it's like it's a label versus a description, right? So, using the condition as a noun to define a person like a diabetic, it conveys permanence and centrality. And, like I said, you can't remove anything from that. It's there, it's permanent, right. Whereas when you say a person with diabetes, it focuses on a person, and it acknowledges that this condition is just one aspect of their identity. You can still take the “a person away” from it and that they're not attached to their diagnosis. There are negative connotations. So, things like non-compliant, difficult, they can create judgment, blame, which impacts healthcare provider’s views and treating a patient. So, like if there's anything that says non-compliant on the chart, you might be treating somebody a little differently, then if there was nothing like that on the chart. So, focusing on behavior, so having difficulty following the treatment plan, it's more neutral and opens possibilities for collaboration. It also kind of emphasizes that there's a difficulty outside of their control. Maybe that's contributing to that. Instead of saying the person's noncompliant, it's saying, oh, they're having difficulty following the treatment plan. But why are they having difficulty? So, right, you start asking more questions. and then it's empowerment versus passivity. So, phrases like “suffers from” cast the patient in a passive role. When you use a patient, like living with or managing a condition, it recognizes the individual's active role in the disease. And so, it also kind of encourages them to cope with the situation that they're in, and kind of, again, take themselves from the diabetic to a person with diabetes so that they can remove themselves from the condition, and kind of live that life a little more comfortably.

PIERCE: When you were kind of going through the word order just now, I was thinking about when I was at the bedside, and I would take report. You would take a report from your peers, your coworkers, and specifically they would say, well, this person is really hard to handle, or this person is noncompliant with what I'm telling them to do. And so, I feel like it kind of switched my thinking about that person before I even met them, and I tried really hard not to walk in there with a judgment of this patient is going to be hard to deal with today. And I really recall a situation where I was in ICU and this person was getting ready to go out to the floor, and they're like, they've been on the call like a million times tonight. I keep having to go into their room. And so, I walked in there, and I introduced myself, and I asked them what they needed. And then when I left, I told them when I was coming back, and not once did they hit the call. Because I came back when I said I was going to come back. But it could have been somebody else and we're like, oh, this is a really difficult patient. And you walk in there, and you see them treating someone differently because in your head that's who they are. What are your thoughts on that?

WARD: Yeah, I think it's like, we take away from the person by saying things like that where it's like, they've been on the call light all night, I'm not sure what's going on with them. When you humanize them, it gives them a little bit of that, it gives you that touch of empathy and sympathy. It's like, yeah, so you've had a challenging night with them, but you're not really sure why, right? So, it's not just blaming the patient. It's just saying, something's not right. Something's amiss, because like you said, that can set the tone for how you walk in and how you provide care to the person. And so, you want to avoid that

as much as possible. And too, sometimes it's just like it's we're not, often times when we use condition-first language or, where we use.

PIERCE: Problem-first language.

WARD: Yeah. Problem-first language, yeah. Well, when we use that we kind of like, set these patients up for failure, because we are just, we're blaming them. And the reality is that oftentimes it's not them that's causing the issue. It's that it's them living with that condition, right. Like we have this dementia, demented, agitated patient, right. Like if we say they're demented, and we say that they're agitated, it kind of puts the blame on them. Whereas if we were like, this person with dementia is experiencing agitation, we kind of tie it more into the dementia, right. It’s more of the dementia fault that they're agitated, and less the person's fault that they're agitated. They have no control that they're agitated, like they don't, and not saying that patients can't have control, but that it's that sometimes it's not, there's other outside factors that we need to think about first.

PIERCE: Absolutely. And especially with patients who maybe, it's not about a condition, it's just about the fact that we're, as a nurse that day taking care of them, or a physician that day taking care of them, we didn't do what we said we were going to do, or they didn't know. So, because I would tell this patient when I was coming back, if they needed something and it could wait, they would wait until I came back rather than be on the call light every time, they needed something. So, it was a change in what I was doing that had a change in what they were doing, because they knew they could depend on me, and I was coming back, and I was going to fulfill their needs. But I think that when we label them, oh, this is a hard patient to take care of, then the next nurse that comes in, and the next nurse that comes in, it can affect the care that they receive and how they're thought of.

WARD: Yeah, absolutely. Yeah, I agree I think too, it's when we put the emphasis on them, it kind of empowers them to take back some of that control over it, right. They're not just succumbing to whatever condition that they feel like they're in. So, I think it's a good thing when we focus on putting them first.

PIERCE: Absolutely. And then maybe evaluating ourselves to make sure that we're not part of the problem as well.

WARD: Absolutely.

PIERCE: So how does first-person language reflect respect for the individual, and acknowledge that humanity that you were talking about beyond their medical condition?

WARD: Yeah. So, kind of like we've hit on it focuses on the person, right? So, we're putting person-first. We're emphasizing that they're more than just their diagnosis. It reinforces

that they have hopes, dreams, relationships and experiences that extend way beyond their condition. It also avoids dehumanizing them, kind of again, like we talked about, condition- first language can feel reductive. Defining somebody entirely by their illness. whereas person-first language helps counter that. And recognizing the complexity and the wholeness of the person and also separates identity from the condition. So, it acknowledges that while the medical condition is part of someone's life, it doesn't entirely define who they are. So, it helps preserve individual identity and dignity and to continue to utilize that kind of idea of like, well, I am an individual, I have this, but I still, I also like to hike, I also like to crochet, I like to do all those other things. So, they can also be a person who crochet, a person, whereas like a diabetic you can't really have much. You can't have other hobbies, rights, and interests, when you're kind of in that area.

PIERCE: Absolutely. And there's so many dimensions to who we are as a person, and what we have to offer and bring to the world, rather than just being stuck on a condition or even a label, combative or annoying. That's one, "oh, they're annoying," so I think it even goes beyond just condition, but also how we label them when we give report or when we send them out of the hospital to the nursing home It really does bring us a stigma and a bias as well, not even just the condition.

WARD: Absolutely.

PIERCE: So, I know that there's some ongoing debates around person-first language, which I was really surprised whenever we were kind of talking about this, I didn't realize that there were arguments. So, what are some of the ongoing debates around this and arguments from both sides? What are the sides?

WARD: Yeah. So, like I mentioned, kind of at the beginning is like, there is this identity versus stigma. So, like some advocates of identity-first language, specifically like in autistic communities or deaf communities, the argument is that conditions like autism, deafness, blindness, we're inseparable from that personal identity. And so, we are trying to embrace it versus distancing ourselves from it. Person-first language can sometimes minimize or hide a core aspect of who they are. So, like that that's a really big, especially in the autistic community, that's a big argument that I see even from just patient perspectives, not even from a healthcare provider perspective. So then, there's also individual choice. So like, so sometimes the choice between person-first and identity-first language should be up to the individual, and imposing one style over the other kind of takes away some of that autonomy from the person, so, both terms can be valid depending on personal preference, and the context too, right. And so, the other arguments can be a medical necessity. So sometimes condition-first language is unavoidable for clarity, precision in the diagnosis, and treatment discussions. This debate centers around finding balance between these practicalities and respect for individual preferences. So, amongst colleagues you may be sharing, this is a diabetic patient whose, it's a lot shorter than a person with diabetes. So sometimes, brevity is important, especially when we're trying to

convey something in an urgent manner. And then, there are nuances within the community. So different communities have different preferences. Much of the disability rights movement for favors person-first language. But like I said, the deaf and autistic communities really prefer identity first language. And that's, a lot of that is just because we can't take ourselves from that. We can't fray those edges like, I'm autistic all of the time. Like, it impacts every aspect of what I do. And the same thing for somebody who's deaf, a deaf person is always going to be deaf, and it impacts every aspect of their life. And so sometimes, it's more about, this doesn't take away from me, but when we when we try to take me away from it, that doesn't make sense, right. So, it's really important to ask for individual preferences too. And like go with the safe rather be safe than sorry. And I always just call the person by their name, and, and if I'm going to talk about them, I usually do it in contexts where they're not going to be listening to it, and that. It's really important for me, it's like, I'm going to call you by your name, and if you want me to call you an autistic person at some point in the conversation, that's totally fine, but I'm going to start by calling your name. And that's I think that's really the first part of it, right, is that we humanize people by just giving them stripping down every label and just calling them by their name.

PIERCE: So, when you were talking, I was trying to pick up on the context where person where actual condition-first language is more preferred, and I got it with like the blind and deaf community and the autistic community. But what about within that healthcare conversation, like with our healthcare team? Can you kind of help break that down for me a little bit?

WARD: Yeah. So, I think that when we're talking to our colleagues, we want to optimize our time together, right. Because maybe we, like especially a nurse in nursing, when we're calling a physician and asking for orders. We may not really be able to say a whole lot of words. So, we're going to say this is a diabetic patient, blood sugar is 40, we've done XYZ. And so, we're going to simplify the language for brevity purposes. And also, clarity. It doesn't, there's not a lot of extra words. You're getting the most important part across. The patient's diabetic, they are experiencing XYZ, we need XYZ. And so, it shortens the amount of time that you're, not wasting, but like occupying for that provider, or for whoever you're speaking to. And this is really important too, like during Rapid response team measures, if you're transferring a patient from one section of the hospital to another, if you're trying to communicate with another healthcare provider about needs, and then even coordinating care between individuals, right. So, you're going to sometimes shorten that language to make it short and sweet and concise and really emphasize brevity, so that you are optimizing both your time and the other individuals time. And it's not really about, it sounds harsh, but it's not about the patient in that moment, right? It is, but it's really about what's going on with the patient.

PIERCE: Getting the information to the person that needs it immediately.

WARD: Yeah, absolutely. And so, I think it's a lot easier, and it just saves us time and effort and energy when we're communicating in that way versus just taking all of the time for person-first language. Not saying that we shouldn't do that, especially in patient facing interactions, but in provider-to-provider interactions, it's going to be a lot simpler to err the side of brevity and conciseness.

PIERCE: Absolutely. I want to talk a little bit about stigmas. Are there are certain stigmas associated with certain medical conditions when it comes to language?

WARD: Yeah, I think, we kind of hit on this when we talked about the APA being who kind of initiated this change in the community. Mental health is really heavily stigmatized to terms like crazy and psycho, which are used really casually, usually in a derogatory way. This perpetuates harmful stereotypes, and creates an environment where people are hesitant to seek out help and disclose their diagnosis due to a fear of judgment. Addictions are kind of similar in that way. Substance use disorders can be termed like addict or junkie, and that carries this heavy moral judgment and dehumanizing of the individuals, and it can act like a barrier to seeking treatment, contributes to negative attitudes towards these people in recovery. And the other, especially infectious diseases too so, diseases like HIV and AIDS, carry these significant stigmas, terms that are associated, they can be weaponized, to shame and ostracize individuals. And even though in the medical field, people with HIV have a ton more of a life quality. And so that's kind of one of the things like, it kind of takes away from those individuals. And then, too, disabilities, it's like, both visible and invisible, stigmatizing language exists and outdated terms and languages that focus on the deficits rather than the ability really undermines the person's sense of self and perpetuates these ablest attitudes. And so, I think it's just about moving into a safer kind of place for most of these individuals, and kind of emphasizing that they are separate from their diagnosis.

PIERCE: Right. And we know that stigma is carrying. But I mean, when we think about carrying the stigma, is it the patient, the provider, both, the community, who's carrying that?

WARD: I think it's both. So, when we use person-first language, it avoids labeling people by their condition, it promotes more nuanced understanding of like those individuals. It humanizes them. So, they're more than just the illness, we emphasize their humanity and experiences, and it fosters empathy and understanding instead of judgment and pity. It also empowers them, to the person's strengths and agency, combating these feelings of helplessness that the stigma can create. And we kind of talked about it where providers may hold unconscious bias or even conscious bias influenced by this stigmatizing language. So non-compliant, where we kind of already have that idea of what the patient is going to be like, and what they're going to experience, and so, I think it's really, it's on both. But I do think the provider carries, not the provider, the patient carries most of that

burden, but the providers do too. And we kind of hit on that earlier about, it changes the way we view a patient if we just change that language around a little bit.

PIERCE: Right. I think it's not even our view. But I mean, go back to HIV and Aids, and what you were talking about with that, and a stigma is carried with healthcare providers. You see that on a chart, and you kind of get a little anxious if you're the one taking care of that patient, but does it change anything that we do?

WARD: No. Not usually.

PIERCE: Right. It really shouldn't because all of our standard precautions that we already have. Yeah, that shouldn't change at all really, other than we just are we become more hyperaware of the of the potential, I think. Had we not known, we would still be doing the same thing, we wouldn't be hyper aware. And so, you definitely see that stigma and that bias in that moment, which is hard. It's hard to not have that as a healthcare provider to know that. But yeah, absolutely. Well, Mariah, we've come to the end of our first episode. There is a lot of information to unpack and this first episode around first-person language, but it was really good insight for information. So, thank you so much for sharing with us.

WARD: Yeah, absolutely. Thank you for having me.

PIERCE: To our listeners, I hope you will join us for episode two, where we will be discussing how first-person language really affects that patient-provider relationship.

Patient-first Language- Breaking Stigmas, Building Bridges EP 02
Podcast Transcript
https://players.brightcove.net/2619222696001/Lzde9xbxz_default/index.html?videoId=6348023466112

Candace Pierce: Welcome to episode two of our series on patient-first Language. With me to continue this discussion is Dr. Mariah Ward. Dr. Ward, thank you for continuing this discussion with me.

WARD: Yeah, absolutely. I'm excited to be here.

PIERCE: To our listeners, if you have not already, I really encourage you to listen to episode one of the series. Dr. Ward really walks us through the history and the origins of patient-first language and so far, our focus for this episode is going to be application and how we can improve that patient provider relationship, while also communicating medical specifics in a really respectful way. So, I really want to start our discussion around cultural competence. Does cultural competence play a role in using person-first language, and then how we adapt communication to these diverse backgrounds of people that we take care of? And if it does, how?

WARD: Yeah, absolutely. Cultural competence plays a role in almost everything we do, right? There's a reason that it's integrated into almost every single one of our courses in nursing. So, it’s important because it's about respecting preferences, right? Different cultures and communities have varying preferences for how they want to be referred to, especially regarding their health conditions. So cultural competence involves understanding and respecting these differences. Also, different cultures have different amounts of stigma associated with particular diagnoses or conditions. And so, it's really important to kind of understand where that individual may be coming from when you say something like, oh, I think you have depression. There's a lot of cultural stigmas that comes along with that. And then sensitivity, and awareness, right, so being culturally competent knows how language, terminology, and even person-first versus identity first can be perceived against differently across cultures. And so, if you say to someone, I'm thinking about like an experience I've had, I had an African American patient, older probably in her 80s or 90s, and just some of the stuff that that she was saying was like, this is depression. And but like, immediately her family was like, oh, she's not depressed, like she doesn't want to kill herself. And it's like, so even just the word, the condition instills this like sense of stigma of like her family immediately jump to suicidal ideation. It's not it's not always suicidal ideation that's problem, and depression, she was saying, oh, I don't want to wake up, like I go to sleep, and I don't want to wake up. Well, that's a little that's a touch, so just even changing that language of saying, okay, depression is a condition that has multiple factors. It's not just suicide. And so, a lot of the times, cultural expectations are already strongly embedded, and they negate treatment efforts and stuff. So, it just picking away at that is really helpful to know, like so as soon as they like jump to that I was like okay, let me rewind and kind of define what I think depression is. And kind of like define what I am referencing, in that situation. And they were more apt to get treated at that point. So, it's really important to be culturally aware and especially even if you like, go to say something right. And you see immediately that the response just navigating that knowing, okay, let me rewind, and touch base back on what actually is being feared here, what's actually being said by this person, when they're communicating this like fear and they're adamant that this is not what's going on. So, what are they communicating to me?

PIERCE: And I can see too, I lived in Japan for a few years and, how we look at different medical conditions versus how other cultures look at medical conditions is not the same. And it's really hard to navigate that. Would you say that a way to help navigate cultural competence in how we talk, would be to know your community, to become familiar with your community?

WARD: Yeah, absolutely. So, like you said, if I'm in Japan practicing, I'm going to be doing a totally different thing than if I'm in Mexico practicing. And different cultures have different ideas, especially surrounding mental health. That's a big, big deal. Mental health has got a lot of stigmas. And, and when you tell somebody like they have a mental health condition,

certain cultures think that you're possessed by demons, right? So, they're going to start doing a totally different thing or, thinking about how we, not just how we treat them as healthcare providers, but how do their community treat that? Like if somebody is told that they have depression, their culture is that they believe like they've got to be like put on an island by themselves, and they got to do this, like giving them that diagnosis is going to snowball into other things within their community. So, we got to also think about being culturally competent. In terms of knowing your community, it’s not just what is the reaction going to be to you, but what is the reaction once they go home, and they tell their loved ones in their support system that maybe this is something that they have. And so, it kind of gives you an idea too, of how the community is going to respond to somebody having this and, and stuff like that. So, it's very important to kind of know your community and, and sometimes you're going to be exposed still to people that are in your community that you're like, I have no idea. But the best way to do that is really just to be direct and ask and talk, be candid. But kind of try and learn how to navigate that in real time, which comes with time and practice.  As a new grad, you're probably going to struggle a little with that. But, ten years into the game, you're probably going to be a little better at navigating it in real time.

PIERCE: I hope so!  So how can healthcare providers balance that the respectful language but also like really clearly communicating medical specifics.

WARD: Yeah, I think having an open dialog. So, asking the patient directly what they prefer.  This fosters collaboration and ensures that we're respecting their wishes. You want to combine approaches. So, person-first language can be used in most communication, but you want to utilize precise medical terms when it's necessary for clarity and diagnosis and treatment discussion. So that may be in charting. That may be in conversations that you have with other healthcare providers. Also, explain when necessary. So, if you're using condition-first terminology, maybe explaining why, what's the medical context, briefly explain why you're using it that way. This shows that you're aware that the patient may have a response to it, but you're also ensuring to them that you want to communicate accurately. And that's really fosters like a sense of rapport and trustworthiness when you're actively explaining what am I going to do, why am I doing it this way? When you emphasize collaboration, like let's talk about how to manage your condition. So, it again focuses and respects individual and also kind of like focuses on their perspectives. And their involvement in their own care. And obviously I think as a perpetual learner, staying informed about evolving language preferences, and best practices like that is the key to maintaining cultural competence, and maintaining that connection with your patients. It is just being open to learning, and kind of like what we're doing here, talking about it, engaging in education that focuses on that so that we can really emphasize the benefits of this person-first language.  So, ongoing education. So is a big one.

PIERCE: So, when we were talking in episode one, one of my takeaways was that patient-first language really contributes to effective and compassionate care for our patients. So, as a nurse listening to this podcast, what is important to know about the nurse's role in patient communication?

WARD: So, I think your choice of language really impacts how patients feel seen, respected and empowered in their care. It's also a powerful tool to reduce stigma, build trust and rapport, like I kind of mentioned. And also, when you stay informed about these respectful communication practices, it includes that you're being attentive to cultural nuances. And it's a crucial part of knowing patient-centered care. So, person-first language is such an integral part of patient-centered care. And we all have heard patient-centered care, because that's really where our healthcare model is going in terms of reimbursement and payment. And so patient-first language is one of those key features of patient centered care. And so, kind of just knowing how to navigate that is going to be essential, to emphasizing that patient-centered, patient-focused care.

PIERCE: For sure. What advice do you have for all healthcare workers, who are trying to use language sensitively when they're interacting with patients?

WARD: So, I think you should prioritize the person. So, you want to remember the person behind the diagnosis, and try to use person face first language as a default. You want to ask and listen. So, don't assume somebody preferences, inquire about how they want to be referred to regarding their condition. You want to avoid judgment, right? So, being mindful of terms with negative connotations of blame like addict or junkie, and you want to focus on neutral descriptive language that fosters collaboration. So really just kind of saying a person with diabetes. So, the person's there, and the condition is there. You want to stay aware. So, you want to commit to ongoing learning about inclusive language practices and recognize that this is going to evolve, and cultural sensitivity and cultural competence is essential in order to really navigate this with other people in your community.

PIERCE: Can you take this a step further? And not just about like, medical specifics, but can you talk a little bit about, I'm throwing you in the spot here, it's kind of a rabbit hole. And it was going back to like when we give report about somebody, and we label patients, we label them combative or annoying. Can you talk a little bit about how using that language really affects the care that a patient could receive?

WARD: I think that when we label a patient, we are, there's just going to be implicit and explicit bias that we're then going to demonstrate. So, I think about oftentimes, I worked on a pulmonary unit as RN before I became a family nurse practitioner, and we would often get patients who had substance use disorder. And the way they were kind of communicated about was like, well, this is an active addict. They're in their 20s, and they're noncompliant. They're really challenging to deal with, and they've got vegetation

on their heart. So, I feel like it reduces the amount of compassion we have for that individual. To be honest, it's kind of challenging to go into a patient's room when the way they're described is just like, addict is not it is not a good word, right, that's not a positive thing. Whereas substance use disorder is kind of neutral. It's like, okay, well this person has this condition, and I feel like especially from, our perspective as caregivers, like maybe we're less likely to go in there, we're less likely to have compassion, and, understanding and patience.  When I don't have that stigmatizing language, I have more patience with the person, because I have more empathy and understanding for them. And I think that when we use words like noncompliant and stuff like that, we were talking about this in the first episode, where it's like that it makes me not want to interact with them. It makes me not want to talk to them about what's actually causing them to be noncompliant. And so instead of saying this patient is non-compliant or non-adherent, like, well, they have difficulty accessing their treatment plan. Well, okay. Well, it's like, oh I can't afford my medicine. That's not noncompliance, that's a very different situation than noncompliance. Noncompliance says I've got the pill bottle in front of me, and I just refuse to take it. And granted, we still don't want to call somebody non-compliant in that sense, but that's what noncompliance is. And so, when somebody uses that word, we already have that instant thought of, okay, this person has the medicine, just doesn't want to take it. Instead of saying things like this, patient's unable to access their medicine. Oh well that's actually different. And we can maybe we can get you signed up with this program and, and all of that stuff. So again, it leads to more empathy and understanding and empowerment, too, on the provider's part. So, if somebody is like I just can't access my medicine, we're more likely to give them resources in the community to kind of advocate for them to be able to access it. And then, when you look at it and the noncompliance rates are lower, you're like, oh, well, this isn't them. This is an access issue. It broadens our empathy and understanding when we use person-first language over using condition-first language, I think we just lack compassion and empathy and understanding. and not everybody but the majority of us.

PIERCE: But I've also seen how when we as the nurse, we label that patient with something like that, it continues to follow them through every report, until they get discharged and it does start to affect the care that they receive on that floor, because they can't shake that label. And maybe they were just having a bad day.

WARD: Yeah, absolutely. And we all have bad days. So, you want to treat people like you want to be treated.

PIERCE: Absolutely. And you started touching on it. But how is that person-first terminology can really improve that patient-provider relationship and that quality of care. Can you kind of go a little bit deeper into that?

WARD: So, I think it helps build trust and respect, right. So, patient-first language shows that you see them as a whole person, not just their illness or whatever particular,

adjective that you're using. And it fosters trust and a sense of respect, which is really crucial for a patient-provider relationship. It improves communication. So, patients who feel respected are more likely to be open and honest about their experiences and concerns. This leads to better communication, which is essential for accurate diagnosing and effective treatment planning. It also empowers the patient, so it focuses from deficits to strengths, and empowers patients to participate actively in their care, improving adherence to treatment plans, and ultimately better health outcomes. And it reduces stigma. So, it helps eliminate that harmful stigma surrounding various medical conditions. And it creates this more welcoming and compassionate healthcare environment, which just encourages people to seek care without that fear of judgment or misunderstanding. I think when we use patient-first language, it instills a sense of understanding which just is the foundation to a good provider-patient relationship.

PIERCE: Absolutely. I remember when I went to a doctor's office, and I said that my stomach was hurting, and I was labeled. My labels were female, military, spouse, young. And so, I was told that I needed to go see this to see the mental health for anxiety. And so, they didn't check why my stomach was hurting, and actually ended up in the ER the following weekend with a severe infection, and so I can definitely see how some of those labels affect the care that we receive, where I was automatically like, oh, she's female. She's just anxious. Her husband's gone. She's young. Can you provide examples of how first-person language really helps in healthcare scenarios? I wonder how I could have gotten through to the doctor to say, no there really was something wrong with my stomach.

WARD: Yeah, absolutely. In terms of medical charting, instead of saying noncompliant, diabetic, patient, maybe saying patient with diabetes, who is having difficulty managing blood sugar levels. You and I talked about this especially, in the first, and we've kind of hit on it in the second episode, where it kind of emphasizes that the difficulty may not actually be on the patient. So maybe it's again, going back to is the meds accessible? Is the treatment accessible? So, it kind of like emphasizes that there may be another reason that's not patient fueled that may be causing some issues. In terms of patient interactions, instead of saying, are you taking your meds, you can say, how are you doing managing your medication schedule? Sometimes it's like, well, I skipped my lunch dose because I've got to take medicine five times a day. And so, I just end up skipping that. Well, then it helps you create and curate a treatment plan that's more accurate and helpful for the patient, especially once they're discharged from the hospital or once they're out in the outpatient setting when you know they're not going to take that morning or that second dose of that medication, maybe you can find a way to navigate it so that they still get what they need without that being a burden. I think that says a lot about how we care for the patient. And again, it kind of gives us more sympathy and empathy for them. And context matters. So, there are times where you're going to say a condition first. And like I mentioned earlier, just making sure that the patient understands that there will be times where you use condition-first language and that if they need clarity on why you're using it

at that time, just to give you a heads up and you can absolutely explain it and giving them that sense of ease while also kind of still promoting the benefits of, of, patient-first language.

PIERCE” Absolutely. And I see person-first language as being more than just being about a disease process, but also being about the labels that we give our patients, as we've kind of talked about before, and like I mentioned, the label of being a female, the label of being young, the label of, you were talking about, drugs. How can we move away from the labels? How do we advocate for that?

WARD: Yeah, I think it kind of depends. In terms of healthcare organizations, you want to have a lot of clear policies that kind of promote using patient-first language and all patient interactions, documentation, and educational materials. So, you want to provide the rationale for that. And clear examples. You want to do ongoing training and education. So, you want to provide staff with regular training on person-first language, focusing on like why it matters, how to use it effectively, how to navigate nuanced situations, and addressing the evolution of language and respect for that individual preference.  That's really important. You want to incorporate it into your system. So, if your standard forms, templates, and EMR says don't encourage person-first language, we're less likely to adapt that technology that process into our practice and, holding people accountable and giving feedback. So, establishing mechanisms for patients to provide feedback on language that they experience and offering non-punitive guidance to staff if disrespectful language is noted. So just even like small corrections from the individual level like even challenging that person. Well, this person is non-compliant. Well, why are they non-compliant? I don't know, like they're just being, it's like well challenging them kind of helps that to move forward and there are other things too, where we have to start with our training programs too. So, how do we integrate that into our curriculum? You want to make it a foundational element of communication courses, and do we even have communication courses in our training programs?

PIERCE: I know.

WARD: Yeah, it's such a huge, such an integral part of, not just nursing, but all medical field is, is communication. But we don't really learn how to communicate well, at least in my experience. And doing that, starting there, and emphasizing the impact. So how does it impact a patient's experience, stigma, healthcare outcomes. You want to do simulations, right, and role play. So, offer opportunities for students and for active RNs, nurses to practice person-first communication, because that's going to be how we get comfortable with it. And then also, collaborating interdisciplinary with interdisciplinary teams, including perspectives from disability advocates, including your patients in that communication efforts. Those are going to be really key ways that we do it. It's going to be kind of hard, but, emphasizing how and are and why, saying this is how we're going to do it, but this is why we're doing it. And kind of really having real life experience kind of tied into that. I

think it's such a huge component of it. And, just knowing that, like that shift in language can change an entire patient's outcome is really like a crucial aspect of, kind of how we focus on patient-first language.

PIERCE: Absolutely. So, when I think of person-first language, it really ties into it being a part of cultural competency. It ties into also that implicit and explicit biases, understand what your biases are, because person-first language is also going to play into that. It's going to play into how we treat our patients. It's going to play into the treatment plan, which is also going to be where we get our patient outcomes. So, it really all ties together and is very intricate and to each other. So, as we come to the end of our series, Meriah, what would you like to emphasize or leave our listeners with to think about when it comes to patient-first language?

WARD: Yeah, I think just the shift in and emphasizing the person-first and saying, this person is experiencing difficulties, or this person has diabetes, that kind of emphasizes that they're there still as a person. Sometimes we can really get stuck in treating individuals as a cluster. If you work on a neurology unit, you're going to be dealing with stroke patients, right? So, remembering that this is a person who had a stroke can help you kind of break up that monotony of your work and kind of change to like the approach that you take. Not every patient's going to be ready to walk by day two. So, making sure that we understand that treating it kind of like we do children like, I know that sounds wild, but not all children at two can say four words. And that's okay. They're going to be other, and we will give them the tools, right. So, if you go and you see a pediatrician and your kid isn't saying the number of words that they're supposed to, we're going to give them the resources to get that. So, I think it's really crucial, to kind of treat it like that, right. Everybody has different needs. And yes, most two-year-olds should be doing this. So, most patients who have diabetes should be compliant with medications. But why aren't they compliant? So, we really look at the why, and break down those barriers and stigmas. And I think that's really just, that's how we really start. And kind of utilize patient-first language is just understanding that not everybody is going to be the same. And treating them like individuals is crucial.

PIERCE: Absolutely. Thank you so much. This has been a really great discussion. Through our conversation today, I made a note of three things there that really stood out to me, specifically about the use of person-first language. And the first one was it can enhance patient satisfaction. Number two is it can improve trust. And number three was when used compassionately, it can really promote a better patient provider relationship. Would you say that those are kind of the top three things that come out of person-first language?

WARD: Yeah. Absolutely. Yeah. And especially the outcomes you want to highlight that, because unfortunately that's how we're driven by reimbursement and payment. And that's how we have jobs as nurses is that patient outcomes drive it. It's a huge driver. and so, better patient outcomes don't just benefit patients. They do benefit us too. And it

highlights the uniqueness of being a nurse. Like we are so exposed to everyday interactions with patients that, we are an integral part in shifting patient outcomes. And if we can do that by just changing a little bit of our language, that's amazing.

PIERCE: Absolutely. Thank you, Meriah, for spending time with me on this topic and sharing so much insight into patient-first language. To our listeners, I encourage you to explore many of the courses that we have available on Elitelearning.com to help you grow in your careers and earn CEs.