How doctors describe patients matters — even in their notes

The language and labels that some physicians use to describe patients in medical records often fly under the radar, but they can provide a window into bias in health care.

A recent study of the medical records of 18 459 Americans published in *Health Affairs* found that Black patients were 2.54 times more likely than white patients to have at least one negative descriptor such as "resistant" or "non-compliant" in their files. Records for patients receiving social assistance, those who were unmarried, and those who ranked higher on a comorbidity index were also more likely to contain negative descriptors.

Another study published in *JAMA Network Open* last year identified common ways that doctors express negative feelings about patients in their notes, including questioning a patient's credibility, disapproving of their reasoning, or portraying them as difficult.

"Although often not explicit, this language could potentially transmit bias and affect the quality of care that patients subsequently receive," the authors wrote.

Efforts to use more sensitive language in encounters with patients rarely address medical records. "Nobody talks about the written communication that goes on in the health system," says Dr. Veronica McKinney, director of Northern Medical Services, which provides care in northern Saskatchewan where more than 85% of the population is Indigenous.

Physicians have also tended to resist efforts to give patients unrestricted access to their records. Some argue that greater transparency would lead to unnecessary conflict with patients who might be confused or upset by what they read in their files. Others don't want to complicate already onerous paperwork.

"Examining why we are writing or using the terms that we do — that makes physicians feel uncomfortable," says McKinney, who has Cree and Métis ancestry. Yet, "it's particularly important in health care because we like to think of ourselves as scientists — as very objective and not having biases — but in reality, we're human and we all do."

Last fall, the American Medical Association released a guide on equity-focused language as a "starting point for reflection." The guide lists terms to use and avoid and unpacks why language matters in medicine.

"Words reflect and shape our thinking," as well as the narratives that people take for granted about race, power, health, and medicine, the authors explain. Unexamined narratives that uphold the status quo limit the questions clinicians ask, the solutions they develop and how they describe problems.

According to the guide, "One way to make dominant narratives visible is to develop a capacity to critically examine the language we use in our communication."

Rewriting the narrative

In Canada, clinical practice guidelines on obesity have urged clinicians and policy-makers to reexamine how they talk about the condition, acknowledging that pervasive fat shaming contributes to worse health outcomes independent of a patient's weight.

Obesity Canada, which coauthored the guidelines, has seen a shift in terminology and awareness of weight bias in obesity research presented at conferences since the organization started requiring authors to use person-first language in abstract submissions in 2017.

"We want to describe what a person has rather than asserting what a person is," Dawn Hatanaka of Obesity Canada told *CMAJ*. The language physicians use in their notes matters too, even if patients don't see it, because of doctors' influence in the health care hierarchy.

Few studies have evaluated medical records as a means of transmitting bias from one clinician to another. One randomized vignette study published in 2018 found that medical trainees who read stigmatizing notes on a hypothetical patient's chart were more likely to express negative attitudes toward the patient and less likely to treat pain aggressively.

Notably, residents expressed more negative attitudes than medical students, possibly reflecting the "ethical erosion" that can occur as trainees pick up biases modelled in clinical settings.

Alexandra Holtom of the Canadian Association of People Who Use Drugs would like to see more people from stigmatized groups involved in the development and delivery of medical education so that their preferred language can be built into training.

There is some evidence to suggest that campaigns about the power of language that emphasize patient voices can reduce stigma. One recent randomized trial in *JAMA Network Open* found that a combination of visual campaigns and patient narratives about the harms of judgmental language can reduce negative attitudes among health workers about people with opioid use disorder.

"Hiring and integrating people with lived experience into the health care professional workforce is a contact-based

approach that may also be an effective stigma-reduction strategy," the authors suggested.

Canadian efforts to specifically address physician bias in medical records appear to be limited.

Melissa Nisbett of the Royal College of Physicians and Surgeons of Canada said the organization is generally "working on embedding equity, diversity and inclusion competencies in our work to support physicians practising cultural safety and unbiased care." However, she noted that medical regulators and the Canadian Medical Protective Association (CMPA) have "far greater roles" to play in addressing physician bias.

According to Noëlla Leblanc of the CMPA, the organization doesn't offer training related to cultural biases but "learning will be a key element" in a strategy the organization is developing to "advance equity, diversity and inclusion in all our services to members."

Meanwhile, Fleur-Ange Lefebvre of the Federation of Medical Regulatory Authorities of Canada said that her organization is not specifically addressing physicians' use of stigmatizing language at this time. In a 2021 statement on Indigenous-specific racism, the organization committed to recognize all forms of racism as professional misconduct.

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