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Date:	20-Jun-2023
Input sound file:	ARM_June13_RTP.mp3

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Sud Krishnamurthy: 00:23	[music] Hi everyone. This is Sud Krishnamurthy. Welcome back to another episode of the Anti-Racism in Medicine Series of the Clinical Problem Solvers Podcast. As always, our goal on this podcast is to equip our listeners at all levels of training with the consciousness and tools to practice anti-racism in their health profession's careers. This will be our second ever live in-person episode, and third year in a row, the Society of General Internal Medicine Conference. And so far, this is the only conference that we've been to as a podcast. So I know I speak for the team when I say that this session has become something quite special to us, especially because we get to do it live and with an audience who participate and ask questions at the end as well. This year's episode is focused on the importance of language in medicine and the role it can play in perpetuating stigma and bias. So today to talk about this with us, we have three incredible guests. I also have my amazing co-host Ashley Cooper joining us over Zoom at this live episode recording for the conference. So I'll let Ashley take it away in introducing our first guest.
Ashley Cooper: 01:45	Thank you, Sud. And I'm going to start by introducing Dr. Som Saha. Dr. Saha received his medical degree and postgraduate training in internal medicine from the University of California, San Francisco, and completed postdoctoral training in the Robert Wood Johnson clinical scholars program at the University of Washington, where he obtained a master's degree in public health. He subsequently worked at OHSU and the Portland VA for two decades before moving to Johns Hopkins University. Dr. Saha's research focuses broadly on the influence of race and racism in the doctor-patient relationship, its relation to disparities in the quality of healthcare, its implications for diversity in the healthcare workforce. He has also served as a council member and secretary of SGIM. He has been a research adviser or mentor for over 50 students, fellows, and junior faculty, over a third of whom have been from racial slash ethnic groups underrepresented in medicine and science. Thank you so much for being here with us today.
Som Saha: 02:40	Thank you.
SK: 02:41	So I'll go ahead and introduce our second guest. Dr. Mary Catherine Beach is a professor in the school of medicine with appointments in the Center for Health Equity in the Berman Institute of Bioethics at Johns Hopkins University. Dr. Beach's research focuses on humanizing healthcare by promoting respect for patients as well as improved patient-clinician communication. Much of her work has been targeted towards improving healthcare quality for patients who face systemic disadvantage and in the setting of HIV/AIDS and sickle cell disease. Her research has been funded by the National Institutes of Health, the Agency for Healthcare Research and Quality, the Robert Wood Johnson Foundation, and the Greenwall Foundation. Dr. Beach has won numerous awards for her scholarship and mentorship, including the David Levine Mentoring Award from the Johns Hopkins School of Medicine in 2015. She also is the 2017 recipient of the George L. Engel Award for outstanding research contributing to

the theory, practice, and teaching of effective healthcare communication and related skills. In 2022, Dr. Beech was elected as a Hastings Center Fellow. And in 2023, was awarded the Excellence in Ethics Award from the Society of General Internal Medicine itself. Thank you so much for joining us, Dr. Beach.

Mary Catherine Beach: 04:00 — Thank you for having me.

SK: 04:04 — Awesome. Okay. I will introduce our third guest, Dr. Pooja Lagisetty, who received her medical degree from Johns Hopkins School of Medicine and completed her internal medicine residency at Massachusetts General Hospital. Following residency, she was a Robert Wood Johnson clinical scholar and received training in health services research methodology. She's currently an assistant professor of medicine in the Division of General Internal Medicine at the University of Michigan and also a research investigator at the Center for Clinical Management and Research at the Ann Arbor VA. Clinically, she is boarded in both internal medicine and addiction medicine and practices as primary care physician and teaching hospitalist. Her research focuses on understanding how stigma impacts access to care for people living with chronic pain and opioid use disorder. She's also interested in designing multidisciplinary care models for people with comorbid pain and substance use disorders in the general medical setting. Thanks so much for joining us, Dr. Lagisetty.

Pooja Lagisetty: 05:06 — Thanks so much for having me.

SK: 05:09 — Well, just from these introductions, I know all of you know and all of our other listeners who will be listening to this on the traditional podcast platform know that this is bound to be an amazing conversation. With that, I think we can jump into it. So often, we really like to start these episodes by asking our guests what led them to the work that they do today to provide our listeners with an idea of the context. So what's the path that led you to where you are today? And can you briefly introduce some of the work you're presenting while you're here at SGIM?

PL: 05:48 — Yeah, great. Thank you so much for having me. It's really exciting to be able to discuss this issue today. So what I've been presenting at SGIM has been focused on thinking about stigmatizing language, particularly in the context of patients presenting with chronic pain and how that impacts their downstream care within the healthcare system. And I'd say that my interest in this is largely rested in the broader context of how stigma affects care, not just language, but also provider biases, treatment biases, etc, and so the written bias. I think we've all experienced those potentially clinically when patients present to the emergency room or to our primary care offices and have notes in the electronic medical record that says something along the lines of patient has chronic pain and is potentially, let's say, quote, 'drug seeking,' or patient is only requesting a specific pain medication. And we know how these interactions can potentially impact the way providers foresee that patient even before entering the patient room. And so we've been really kind of thinking about how this impacts access barriers for the specific patient population.

MCB: 07:07 — Thanks for that. So it's funny that you say that because I also got interested in the topic of stigmatizing language through an earlier project looking at quality of pain management for people with sickle cell disease. So at the time, I was very interested in trying to demonstrate that we could measure provider attitudes towards patients and demonstrate that they had an impact on the quality of care given. And so we had developed a scale for clinicians to rate their attitudes towards patients with sickle cell

disease. And we were going to then try to see if we could correlate that with quality of pain management in medical records. But we didn't have a great measure of the quality of pain management. So we decided we were going to go and develop one based on our hospital guidelines like if a person comes in, they're supposed to have their pain recorded. And then given a certain dose of medication, and then reassessed at a certain interval. And then if they didn't have a response, have an increased dose of medicine. So we were looking for all of those measures. And I would look at a note and see the patient has a 10 out of 10 pain, but there would be something in the note to indicate, to me, that the clinician writing it didn't think that the patient really had 10 out of 10 pain. And so it was at that point that I started thinking we convey a subtext to other clinicians. And that was where I started getting interested in stigmatizing language.

MCB: 08:43

And so at that point, it was around, "Do we not believe someone?" But there were other types of signals in the record to suggest there was other types of biases besides just not believing a person. So we subsequently looked at that. And then fast forward to-- you asked also what we're here presenting. So the abstract that I presented yesterday focused on looking at three different types of language in medical records where we might see that demonstrated bias. And one of them is, again, that negative disbelief that we saw in those early notes. A second one was a group of words indicating that the person is difficult to interact with. And then a third type of language that hasn't been looked at to my knowledge is what we call positive language. So when people get marked as being pleasant or delightful. And then we were interested to see, can we demonstrate bias in who gets appraised as being in positively, as being pleasant to interact with. So that was our abstract that we did yesterday.

SS: 09:57

Yeah. So most of my research sort of focuses on how racism affects clinical care. And within that space, people talk a lot about unconscious race bias. It's hard to study the effect of unconscious race bias on clinical care because it's sort of invisible. It doesn't happen in explicit ways because it's implicit. And so the reason that I got very interested in this work, and full disclosure I got interested because my partner in crime here, Dr. Beech, was doing this work. And so I sort of tagged along. But the reason that I was really interested in it is that when we started to look at the language and medical records and seeing that there is a racial tilt in the types of words and the types of sentiments we convey, I realized that the medical record, it was like a smoking gun. So basically, if you watch an episode of CSI, and they go in and they spray that stuff they spray, and they see the blood spatter. That was what the medical record was. It was like, "Oh, my gosh, this is where the unconscious bias is actually evident." We actually called our grant hidden in plain sight because we realized that it's been in front of us all the time, this sort of manifestation of race bias in medicine, and we just hadn't looked. And so then when we started looking, we started seeing it over and over again.

SS: 11:28

Now, the abstract that I'm presenting later today looks at how we talk about patients following our recommendations. So the language around adherence and acceptance of our recommendations, words like refuse and adhere and comply. And so we've tried to dissect this out because people might argue that any racial differences in documentation of nonadherence might be due to true nonadherence. So we've tried. And I'm not going to spoil it because I want you to come to my abstract. But we basically looked to see, is this really a manifestation of race bias, or can someone defensively argue? And I think that's an important thing. As, Dr. Beach, anybody who

went to her presentation yesterday will know that the things that are sort of kind of egregious language that kind of denigrates a patient, we don't really see it that much. It's much more subtle. And often, very defensible people, you could probably-- there's plausible deniability in the use of this language. So you really have to very carefully sort of dissect out and kind of pick apart the underlying reasons so that you can confidently conclude, yes, we're seeing bias.

AC: 12:53 Thank you. Dr. Saha, you begin to discuss some of your work in this realm, and we've talked about stigma and bias separately. So I'm wondering if you would be able to distinguish between these two concepts and discuss how language may affect them differently. And in your work, how does the use of language differ based on the race of the patient, both in the clinical encounter and in the medical record?

SS: 13:15 Yeah. So just this business of stigma versus bias, I think it seems wonky, but it's very important to separate the two concepts. So things can be stigmatizing in the medical record but not reflect any particular bias because those things are socially stigmatized. So when we document that a person has a sexually transmitted infection or is using illicit substances, those are stigmatizing because as a society, we stigmatize those things. But the clinician who's recording it may not have any bias. They're just recording clinically relevant information. So those are things that might be stigmatizing but not biased. On the other hand, there are things, like Dr. Beach referred to, of positive language. That's not stigmatizing in any way to say that someone's lovely or delightful. But when we look at it, it's biased. So we use that language more for white patients than for black patients. So these are different things, sort of bias and stigma. And I think the reason that I think it's important to sort of separate those two things out is that often when we do our presentations on stigmatizing language, when we talk about it, people immediately sort of think of, how are we going to get rid of this stigmatizing language? And that leads to a place where we start to think about sort of word policing. And it gets to a very sort of difficult place where we think we're going to sort of micromanage the way people write.

SS: 14:55 And it's important to remember that stigmatizing language is a symptom of an underlying illness. And let's just say that underlying illness is racism in this case. But the pathway by which stigmatizing language shows up might come from different things. So it might come from structural inequalities that give rise to a greater prevalence of certain conditions or behaviors in one population versus another, or it might come from actual clinician race bias. And it's important to remember that sometimes treating the symptom, actually addressing the problem of stigmatizing language, sometimes there's a role for treating symptoms. But what we really are trying to accomplish is treating the underlying condition. And sometimes those symptoms of stigmatizing language should lead us to sort of investigate what is the underlying condition that's giving rise to the symptom. I don't know if I answered your question.

SK: 15:55 No. You absolutely did. I think that was an incredible analogy of that, especially probably appeals to people in medicine. So I appreciate that. Dr. Beach, I guess what types of stigmatizing language have you observed in clinical settings yourself, whether that's in the medical record or in oral presentations and such? What impact do you think that language also has on the care of the patients that you receive?

MCB: 16:28 Yeah. So we've talked about a couple of types of language like language indicating you don't believe someone and language indicating you think someone's difficult to interact with, language indicating that people are refusing or not following medical

advice, and then this positive language. A lot of times, we-- well, right now we have the technology to search for those specific terms and see whether they're being used in context or out of context. If you say someone's aggressive, did you use the word aggressive to say that you're going to do aggressive treatment for this disease, or were you referring to the person as aggressive? So you have to be careful when you're using those term discovery things that you're actually doing enough natural language processing that you're accurately capturing them. But for a second, put the terms aside because I think that the stigmatizing language that we see most commonly that is really hard to detect are microaggressions that don't use those terms. So if you think about it, every interaction we have with a patient, we get a ton of information, and then we decide what's relevant to put in the note. And I think what's really important to look at is, what details do we include about people that are potentially stigmatizing but maybe accurate? So we did this vignette study where we show that if you have-- we give a medically identical circumstance with somebody with sickle cell disease who comes in with pain, and you put stigmatizing language in it, and then you rewrite it with a neutral version that if you randomize clinicians to see one or the other version, that if you see the version with stigmatizing language, the clinician had more negative attitudes towards that hypothetical patient and prescribed lower doses of pain medicine.

MCB: 18:33

So the stigmatizing language has a subsequent impact. And just to further the point on the distinction between stigma and bias, I think the reason we have become drawn to calling it stigmatizing, it's that stigmatizing is focused on the subsequent impact that the language has, whereas when you talk about bias, then you're talking about the clinician who wrote it. And in many cases, the clinician who wrote it is biased. But the more persuasive point is to say it's stigmatizing, meaning it has an adverse impact moving forward. And so that is what we've shown. But I think one of the details in that vignette, and this is where I was coming to, is that the person was hanging outside of McDonald's. And in the whole conversation you have with someone, I'm sure it was accurate. And it wasn't flagrantly stigmatizing. In the sense it was like it wasn't morally wrong to include it. But if you think about it for a second, why, why include it? Especially, I think if we could anticipate how other people are going to think of the person when they read the note, put the details in that are going to personalize the patient. And this I'll steal from Som. What his point was, I think, at one point when we were reading all these notes and looking at this language and debating among ourselves, is it wrong to put in the detail that the last meal they had was they eat Swedish fish at 3:00 AM? Is it wrong? And the thing is, is that like necessarily wrong, except why? Don't put it in if somebody is going to look at that, a clinician is going to look at that.

MCB: 20:25

That's all they're going to remember. It's a memorable detail, Swedish fish, McDonald's. I mean, we see so many medical terms that it's those things that you're going to remember, and that's how you're going to associate the patient. Why not put in that they're a grandmother and they work on the weekends at whatever, and they take care of their grandkids during the week? Put that in if you're going to put in extra details.

AC: 20:51

Absolutely. Thank you both so much for sharing on this topic. And, Dr. Lagisetty, your work has focused on how language affects care for patients with pain and substance use disorder, specifically. I'm wondering if you could share with us some examples of stigmatizing language you have heard or seen in medical records, and the patients of yours that have been most impacted by the use of this language. I'm also wondering if

there are any alternatives that you might have in mind. And, Dr. Saha and Dr. Beach, feel free to jump in here after with some language that you might use instead as well.

PL: 21:20

Yeah. It's an interesting space, especially in the opioid use disorder world. There's been a lot of advocacy efforts in the past couple of years around Words Matter. You can even kind of search wordsmatter.com. And it's all about the words that we use to describe people with substance use disorder, avoiding words such as clean or dirty or addict and saying a person with a substance use disorder or a person in recovery. And so there's been a lot of movement around this. And to Dr. Saha's point, this might just be treating the symptom, and, hopefully, it does potentially impact health outcomes a little bit. But it's hard to determine whether that in itself will be what we need in order to improve outcomes for people with substance use disorders, and how can we actually impact the clinical care decisions that are happening as a result of this. And so one of the things that I've been really trying to think about is the intersectionality of different types of stigma that particularly in the case of, let's say, opioid use, that patients with pain and opioid use disorder interact with, right? We've talked a lot about disbelief of pain and how words manifest with respect to disbelieving whether pain is real versus organic or if they're texting while they're having pain and things like that that kind of indicate this idea of disbelief. But now we also have clinicians who have a lot of opioid phobia in general, right?

PL: 22:53

Any mention or thought around opioid as a treatment option can be potentially perceived biased or stigmatizing as well, both on the patient and on the provider end too. We often hear patients say, "If I even say I'm in pain, or if I even ask for an opioid, they will automatically think that I am just a person with an addiction." And so there's the opioid phobia. That's another type of stigma that we're experiencing. And then also just the stigma that people with addiction also deal with as well. And so when you kind of put this disbelief of pain, addiction, and opioid phobia together, you get a lot of different types of language in the medical record. And one other place that we haven't explored yet is that clinicians also have biases, specifically in the case of opioid use disorder around medication-based treatment. And so there might be clinicians who view it as substitution therapy. And so there's potential to even explore biases around treatment options and not just about patient behaviors. And that probably also manifests in the medical record.

MCB: 24:13

So I think I may have forgotten the question. But I think when the question came or when the question was asked, I remember thinking I wanted to bring this up. So hopefully, this is in response to the question. One thing I think we should think very hard about and potentially remove most of from the record is quoting patients. Because I think that we are taught to quote patients as being this patient-centered way of introducing the patient's voice and letting their story be told in their record, in their note. But I don't see it used in that way very often. I see the quotes used to-- they feel like they're mocking the patient because they've taken some bad grammar or a mistake in the way someone describes something. And they'll put that in quotes. And so we use quotes as scare quotes, meaning we convey disbelief. They say their pain is, quote, 'still a 10, or I take my medicine every day,' end quotes. There are just things that where even if I don't even know if the person writing it intended to cast doubt on what the patient was saying. But we used to scare quotes so much in society right now to cast doubt or make fun of or call out someone's words as being incorrect that I'm afraid that the way we use them in the records even if we didn't intend it to be this way is going to make it seem like we don't believe the person, or we think that what they said is wrong or embarrassing, or we wouldn't ourselves say it. So we

couldn't possibly write in the record and have someone think we would say it that way. So I think we should really get rid of a lot of the quoting that we do.

SS: 26:16

So I think the one point I wanted to make about this is that it matters not just what we say in the records but where we say it. So I will see a lot-- I precept in resonant clinic. And I'll see a lot of cases where the identifying information, which I often just copy and put into my little attestation, will say something like, 45-year-old polysubstance abuser. And sometimes I'll go back and see where did that start. And it started like 10 years ago. And it's been in there identifying information ever since. There is no denying that when any doctor or nurse that sees that in the identifying information is going to shape an opinion about that patient based on that terminology. And the same thing goes for-- there's history of gonorrhea in the identifying information for no good reason. The gonorrhea may have happened 10 years ago, but it still it just carried forward and forward and forward as if this is an important aspect of this person's history. And I think we should think carefully about how these things that are stigmatizing that aren't necessarily inaccurate, but stigmatizing, do they belong in the record anymore? Is it really that relevant to their clinical care? And does it really belong in the identifying information where we basically say this is who this person is? I had a patient once who said, "It said in my note because I had copied and pasted from the last clinician that took care of this person. The past medical history, it said polysubstance abuse. And I had just blindly ignorantly sort of copied and forward these." And he basically said, "I haven't used drugs or alcohol for 20 years. But I think that everybody that sees me sees that and thinks of me differently." And I took it out of his note. But it took him telling me that to sort of recognize there's no clinical utility to this information anymore. The harm is greater than the good.

MCB: 28:19

And that actually came up this morning, you guys, in the plenary. I think it was Monica Lipson who asked why in the first line was incarcerated included. And I think the speaker had an interesting and reasonable rationale for it. But we have to question why are these things in the first line. Why is a history of signing out AMA sitting in the identifying information?

SK: 28:46

No, I think all of your responses have been incredibly informative. I think also this very specific anecdotes with words and quotes that you've seen in the medical record is helpful for clinicians who are listening to this, hopefully, later to also keep that out. We'd love to open to the audience for questions. So if you have a question, you're more than welcome to come up. We'll turn this mic around so you can be heard for the podcast as well. Until everyone gathers their questions, I can ask a question that I was thinking of. So I recently learned of the concept of the euphemism treadmill here at SGIM this year. So essentially, this describes the process of replacing words that have taken on a stigmatizing pejorative or derogatory connotation with new words that are more humanizing and how this is kind of an iterative process. So I'm wondering with stigmatizing language, do you all envision something like the euphemism treadmill with kind of the consistent learning and unlearning process when it comes to clinical settings?

PL: 30:03

Yeah, this is a great question. It obviously comes up a lot in substance use. Even if you kind of think about the history of DSM diagnoses for substance use disorders, we just went from use and abuse as part of our terminology to now saying a use disorder to remove the word abuse. There's a big push even with the National Institute onf Drug Abuse to remove the word abuse there. And it does feel like perhaps we are getting in this path of substituting a different word that potentially is less stigmatizing. And I question that a lot as well to wonder which path we're going down. And then it gets

tricky as well. In the opioid use world, we are also now trying to distinguish people who are on, let's say, prescribed opioids for chronic pain versus those who are taking non-prescribed opioids. And when you kind of create a lots of different terminology to describe different people, it could potentially further stigma because it continues to further the other groups. And so it's a tricky situation. I don't know what the solution is. But I think we're constantly looking for terms that can decrease our biases against certain healthcare conditions. And it does kind of-- I like to use of the word treadmill. It does sort of feel like a treadmill.

MCB: 31:43

That's right. I've never heard that term. I feel like the person who coined the term euphemism treadmill couldn't possibly think it was a good idea to be on the euphemism treadmill. I mean, I think that there is a-- I think that the attempts to change language to evolve with our evolving understanding of what the meaning is behind whatever term we're using and the adverse impact that the previous term can have, I think, obviously, it's well intended, and I think it's largely a good idea. I think that there is a risk that we will get maybe too fixated on the fact that someone who trained in an era where we called it substance abuse who continues to do that because they just learned it, that we're now focusing on criticism on that person when they never intended it to be stigmatizing. So I think I would want to separate out, let's think about replacing old outdated terminology with terminology that better reflects respect for the person that we're describing. But I would be careful that we just not necessarily blame people who learned a different word and are use that word because that's what they learned.

SS: 33:17

I mean, I think I'm trying to come up with things that are truly euphemism treadmill where we just substitute one for the other and the same stigma applies. But I think language has power. And I think studies have shown that the transition to using the term substance use disorder from substance abuse has real impact. So randomized trials have shown that people have less stigmatizing attitudes towards people when you use the term substance use disorder because you're recognizing it as a disorder as opposed to a failure of personal responsibility. And so terms that reorient people's mindset towards a condition or a patient, I think, have real salience. I think that was the intent of transitioning from compliance to adherence, that adherence gives a little more agency to the person to adhere as opposed to comply to the orders that they're given. I think there's been a drift such that nonadherence is now not that fundamentally different from noncompliance in our minds. So that might be a little bit of a euphemism treadmill. But I think the intent was right. And I think the shift from compliance, which is very paternalistic, to adherence, which is maybe a little less, maybe a little less paternalistic, was well intended. And then I think that-- but I think this is the issue is that if we have attitudes that stigmatize a certain behavior, it doesn't matter what terminology you use. It's our societal stigmatization of that thing that's going to drive it. You can put in whatever term you want. But if we can reorient in the way that I think substance use disorder does, if we can reorient how we look at that condition, then it's very powerful.

Nancy Denizard-Thompson: 35:09

Hi, I'm Dr. Denizard-Thompson from Wake Forest. I was really intrigued by your concept of the positive language. I've had my patients now for about 17 years. So I love them. I'm very attached to them. And then I see them go to other parts of the healthcare system. And I read the notes. And sometimes I just cringe inside because this is the patient that's brought me cookies and cake and ask me about my kids. Yet, they go to the ER to the hospital. And what I read in the chart is very different than the person that I've known for 10, 15 years in my practice.

AC: 35:44 So I have a question for you just back to clarify. So what's your opinion of positive language? Do you want to offer that? Because I suspect it's valuable.

NDZ: 35:56 I mean, I haven't really used it. But I do see that some of my patients when they go see subspecialists or what have you, I'll see you in the note this lovely 65-year-old woman, what have you. I mean, I guess it makes me feel good because I know that. And I do think that that changes the trend. I mean, that has always been one of my big soapbox with students and learners is that term noncompliant. And nonadherent is really one of those terms that I've really tried to have people avoid using. I do think it changes a little bit of the narrative. Just like you all mentioned, that first-line statement is so powerful. I don't want to falsely just be adding all of these adjectives to my notes. But I do feel like perhaps infusing a little bit more of that humanism to some of my patients could be impactful when they go to other parts of the healthcare system.

AC: 36:47 Thanks.

MCB: 36:49 Yeah. So this is an interesting debate. And I've had people come down on either side of whether, does the word pleasant have any place in a record? People are like, "Well, sometimes I've heard of patients who are upset by it because they think, why would they even be assessing my personality?" But I kind of also agree with you that it's protective. I think it does protect people in the health system because it's the opposite of stigmatizing. So it's like an example, right, of something that's not stigmatizing. It's protective against stigma. But at the same time, we are using it in a biased way. And so I don't fully have a strong solution to that.

SS: 37:43 Yeah. I think this goes beyond just the positive words, but any kind of language that kind of shows that there's a little personal relationship. Let's be clear that we do not advocate at all depersonalizing the medical record because I think there is value in adding who this person is-- who this patient is as a person. So we've done beyond stigmatizing language. We've done studies of personalizing and viewing a patient as a person and knowing their personal narrative. And that has strong power to actually combat implicit bias because if you see a person as a person as opposed to a member of a racial group, you are less likely to have bias against that patient. You're less likely to stereotype that patient. So we don't want to depersonalize the record. However, we have this problem of more positive personalizations in the records of white patients than black patients. So I think the real issue is to sort of just bring up this issue. By the way, you might have-- in our society because we know the way that racism works is that most clinicians are white. Clinicians are likely to have more lovely delightful interactions with other white patients because of the way racism works. And that then gets into the record.

MCB: 39:06 So it's a, I think, greater consciousness of the fact that this exists that when you use the word pleasant or lovely, you are likely stacking more cards on the decks of the white patient population compared to the black patient population. And this is the same with both negative and positive language. Just beware that when you record things about this visit, they may be racially biased. And when you read things from prior medical records, you may be shaping opinions that emanated from unconscious or conscious racial bias, and step back and put it aside for a second so that you can see this patient without whatever opinions you've formulated.

Colin Washington: 39:56 Colin Washington from Emory University. Just kind of to continue on on this topic of positive language. I think I would love to hear your opinion about using this language

to try and counteract maybe a negative image of patients. Sometimes patients had an episode where they were upset and yelling at a previous hospitalization, get a safety alert, and then they get labeled as verbally abusive or something for the rest of their time coming to the hospital. And can this positive language be used to try and, I guess, get somebody back to a normal baseline so that they stop continue to be, I guess, visualized in what happened at one time in the past?

MCB: 40:42

I mean, I think that's a great point. I feel like I have done that in the past myself in the records of patients. I know that because I work in sickle cell disease in respect and thinking about the inner personal tension and bias against people with sickle cell disease, I would often write pleasant or something like that in the note. People have pointed out that that could also be viewed as racist because people are like, "Well, why would you think that--" It's like calling Obama articulate, right? It's that sort of microaggression. But in the case, it was a deliberate attempt on my part to make sure that anyone reading that note because I know they're going to have bias that they're going to think, "Oh, this is a really good person." Yeah, I think I had something else to say, but I can't remember now. Yeah. Yeah.

PL: 41:47

I almost kind of want to follow up with a question to you, Dr. Beach, on that same point. And I think it gets to who is on the whole-- the example of Obama's articulate would be potentially racist to Obama himself. But in the setting of a provider reading a provider note, who the intended audience is, and how this language affects two different audiences in two different ways. I'm curious what your thoughts are there.

MCB: 42:24

Yeah. I mean, I think that for each of those times where that would have happened, it was really I was really only thinking about, how do I protect this person from the bias that they're going to encounter with so many other providers? So the audience was very specifically other providers who I was concerned would be biased against that person because of their sickle cell disease. I have seen other things besides just putting in the pleasant, etc. But your example, Dr. Washington, of the person who got angry, and then they have that behavior alert or something in their chart. I've seen people record encounters like that where they say the person has become understandably frustrated at the length of delay. And I think that is so perfect, right? It's very understandably frustrated. Everything that happens to people in the health system is understandably frustrating.

SS: 43:36

Yeah, I mean, I think that intent is important. And if pleasant is coming from, "I didn't expect this person to be pleasant, but lo and behold they are," that's the sort of Obama's articulate thing, where it's kind of a form of racism. But then I think if a patient has been misunderstood, it is undoubtedly true that because of the way that racism works in healthcare, there are probably more interracial than non-interracial conflicts that happen. People get upset because they're waiting longer than other people. And then they're sort of recorded by the staff as being abusive. And then they get a flag in their medical record. The first thing you see is that this person is-- and it may have all arisen from a misunderstanding. And then actually, marking that that patient is perfectly delightful and pleasant is, to some degree, antiracist. It's a way of sort of setting the record straight. So the way we use our language can be racist, and it can be antiracist. And I think it's important to sort of make people conscious of how they're using this language. Because in the end, people think like, "Oh, we're just talking about wordsmithing, right?"

SS: 45:03

But the medical record lasts forever. I mean, and it follows you all over the place. If you've ever seen the Seinfeld episode where Elaine is sort of complaining that every

time she goes, she's been marked as a difficult patient. I mean, that really happens. And the medical record is like a rap sheet. It's basically like, "Okay, what do I think of this person?" before I ever even walk into the room. So it is a powerful tool that we use to communicate to each other and has the ability to really elevate or denigrate a patient.

Gabrielle Bromberg: 45:37 — Thank you so much. My name is Dr. Gabrielle Bromberg. I'm a hospitalist from Mass General and see this on a daily basis. And I guess one, perhaps, pivoting towards hope question is, have you seen successful interventions at a system level if this is at the point that it is really systemic bias embedded in the chart that follows people everywhere at undoing it, whether it's an ICD-10 billing or in our documentation?

MCB: 46:07 — Yeah, thanks. So I think the most hopeful thing that I've experienced - and this is not exactly a health system intervention, but it could start to be one - is that when we've presented our findings to groups of clinicians, there has been a lot of acknowledgment of owning this problem of recognizing that it is a problem. And it feels like a desire to change it. So I actually have encountered rooms full of people. There's some pushback for sure. The person did refuse the vaccine. What's the problem with that? Or maybe sometimes people do lie. So what are we supposed to do in that case? There's a little pushback. And I think we have to have good responses for that. But I have been very hopeful that clinicians want to make it better.

SS: 47:17 — Another full disclosure, we have a grant to do a system-level intervention. But we're not quite there yet. But I think that it is true that I think most clinicians, not all-- there are some who will push back against us and say, "You're policing our language." But most clinicians will, I think, own the issue that they don't think that carefully. Even in the era of open notes, they don't think that carefully about what they write. We don't think that carefully about what we write in notes. And when you show clinicians this is the impact that your note could possibly have on the future care of this patient forever because of copy and forward, that clinicians, well-mind, well-intentioned clinicians will sort of say, "Okay, this is actually a serious thing. I really should pay more attention." And so something Dr. Beach does to audiences that I'll just steal right now is when people say these are accurate statements I'm making. She will say, let's say your goal was to preserve the dignity of the patient going forward. That was your goal. It was at least one of your goals. You're going to document this patient's behavior. But let's say that one of your goals was to preserve the dignity of this patient and give that patient a fighting chance the next time they see a clinician, how would you document? How would you write your note? Imagine this was your child who was being seen. How would you want that clinician to write a note about that? Even if your child was--

AC: 48:59 — Angry.

SS: 49:00 — --angry and irritated and combative, how would you want your child to be recorded? How would you want that behavior to be recorded knowing that this is going to affect the way your child gets their care for a long time? And clinicians, I think, respond to that positively.

PL: 49:23 — Yeah, I don't have much to add. I think that there's still-- I think this field is still new enough that we don't have a lot of great interventions. But I think we can lean on other decision science tools that have happened before us. When you think about thinking fast and slow and audit and feedback type interventions and things like that seem to make a lot of sense in this space. Because I think what we do when we

document quickly is we're in a rush, didn't encounter. That probably influences the speed that we are thinking about some of our own biases. And so there may be some mechanisms to kind of build on prior literature about other cognitive biases and think about similar interventions in this space.

Francois Rollin: 50:07

Thank you so much for this. This is Francois Rollin. I'm at Emory University. And one thought generally which doesn't need an answer is, should we treat a pleasant or unpleasant patient differently? And so maybe we should never have it because you should be allowed to be unpleasant perhaps. And are they equally worthy of care? But a question related to what you were just talking about is, is there any evidence of either real-time or retrospective feedback on language use by providers? I would love for someone to tell me like, "Hey, you keep using this in your note. Maybe switch to this." Or the way that in the HR currently doesn't let you say, for example, MS for morphine sulfate instead suggests something else. Is there anything like that if you're going to use abuser just for, "Hey, think about person-first language, Instead of a diabetic, someone with diabetes"? So it seems like a very simple switch in any HR. Thank you.

SS: 51:04

Yeah, that's a great point that you made about the fact that, of course, they deserve the same care. Let's just say that outright. But then the question is, if you put pleasant in the record, we're all emotional. We're all emotional beings. We will likely treat that person better if we think they're pleasant than if they're unpleasant. So it makes us a strong argument for, at least, some consideration of not using that kind of language. So in terms of these interventions, so one thing that we are planning is using our NLP algorithms to create scorecards. But first, we have to really get a tight kind of scoring system of what counts. And we view this in the vein of other quality improvement. The goal is not zero because the sort of never language is hardly ever used. So it's about, "How often are you using this compared to everybody else? And could you be using this kind of language less knowing that you're going to use it sometimes?" You're going to use-- some of these terms that we use are appropriate. If you're using them all the time, then-- so that is something that I think could be useful. The spell checker thing, we've been round and round about it. I mean, there's no faster way to get clinicians to hate what you're doing than to make their lives miserable. So I mean, if they start seeing the little Microsoft paper clip, you're dead in the water. But I think that we've sort of talked about the fact that there could be AI algorithms that could just correct your language as you write. And you don't have to actually do any more work with it. So it's a possibility, but it needs to be explored.

MCB: 53:04

Yeah. I mean, and it would have to be really smart because then you'll have notes that say on the physical exam, the person with diabetes foot ulcer, right? You don't want it to be replacing words incorrectly. Yeah.

SK: 53:20

We'll end the audience questions with that. Thank you so much to all of the audience members who came up and asked questions. We usually like to end our episodes with a short clinical takeaway. And this is obviously extremely clinically relevant. And like someone else had mentioned and Dr. Hicks had mentioned in his plenary yesterday, we want to end with hope. And so for our listeners who will finish this episode and kind of return to their healthcare professions, what are some practical applications that they can interweave into their work to help destigmatize the language used in the medical record and in the clinical setting in general?

SS: 54:11

So I think most of us don't want to do harm to patients through our language. So I think one thing is that we can just be more conscious both as readers and as writers.

So I think if we can sort of tell clinicians, "By the way, there's lots of studies to show that our language is biased and that it affects clinical care," when you read a note, before you sort of walk in and straight into the room, think about maybe kind of going tabula rasa and giving this patient a shot at not being the person that you just read about. And then when you are writing your note, think about the goal of not just documenting the interaction but preserving the dignity of the patient going forward. And if you do that, you might write a little bit differently, and we might make small changes that might have large effects.

MCB: 55:11 That was a good thing to end on, but since I haven't gone, now I have to go after that. But I think if the intent is to end with some very practical clinical suggestions, I think be very careful. Don't use quotes as much as we do. Be very careful when you decide to quote a patient and include, I think, personalizing details that would make the next clinician see that patient as a person.

PL: 55:41 Yeah. And I think just in the spirit of being at SGIM, I think a lot of us in the room are educators. And I do this when I'm on the teaching awards. I provide kind of a reset before every time I am taking over a new team to remind them of some of these biases in the way our language impacts care. And I think the more we can start to do this with our learners, the more it'll become part of, hopefully, their habits moving forward.

SK: 56:13 That's incredible. Thank you all so much for taking the time to talk with us today and for really imparting a great deal of wisdom. I think we've talked about kind of from the starting of what inspired you to do this work to the differences between stigma and bias and some examples that we've encountered along with the euphemism treadmill, and then answered a couple of great audience questions. So we're so thankful that you were able to join us. And thank you to all of the audience members that engaged with this so really well. We'll wrap up with that. And thank you all for coming today. [music]