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Person-first Language in Healthcare: The Missing Link in Healthcare Simulation Training

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KEYWORDS
Person-first language;
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Abstract Simulation pedagogy and training strive to adequately educate practitioners who will care for a diverse patient population. In the pursuit of protecting patients, simulation education has included a curriculum of cultural humility , diversity, equity, and inclusion that provides patient-centered best-practice. However, the missing link is person-first language essential for optimum patient/client communication. Failing to use person-first language can negatively affect patient-provider relationships. The result can adversely lead to poor patient outcomes due to mistrust, errors, decreased satisfaction, poor adherence to treatment, wasted resources, and increased healthcare costs. The use of words and how others perceive the utilization of those words matter. It is essential to acknowledge that words matter as a symbol of respect and identity in the quest towards inclusive practices. Healthcare providers carry the burden of providing quality and safe patient care. They should incorporate training strategies such as using person-first language and evidence-based resources to support an inclusive culture of diversity, equity, and inclusion.

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Introduction

Healthcare professionals can have as many as 150,000 patient interactions during a typical career (Institute for Healthcare, 2011). Patients rely on their healthcare provider to listen, synthesize healthcare data, and effectively communicate vital information related to life and death healthcare decisions. The language used by healthcare providers to communicate with patients should be examined for clarity from the patients' lens. Patient-provider communication should be respectful, inclusive, and encourage equitable participation (National Institute Health NIH National Institute on Aging, 2017 & Hashim, 2017) Additionally, effective communication is not just about the use of medical jargon but how the provider uses interpersonal communication skills to convey attentiveness and establish rapport. Person-first language is evidence-based terminology to promote human dignity by characterizing the person before the condition. For example, a person with an amputee versus a disabled person (Dunn & Andrews, 2015).

Not using person-first language can cause inadequate patient-provider relationships that lead to poor patient outcomes. Ineffective communication can cause patient mistrust, errors, decrease satisfaction, poor adherence to

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treatment, wasted resources, and increase healthcare costs (Institute for Healthcare, 2011). Some healthcare professionals not only use common medical slang/terms but use negative labels for patients. For instance, an emergency room patient with the label of "frequent flyer" is a missed opportunity to assess the unmet healthcare need that may directly cause the multiple visits (Valdez, 2021). "*Sticks and stones may break my bones, but words will never hurt me*" - Or will they? Some persistent use of stereotypes and inappropriate language can harm and result in adverse health outcomes from misdiagnosis, delays in care and unresolved healthcare needs (Valdez, 2021).

Healthcare professionals have a moral and ethical imperative to keep patients safe and advocate for patient protection. Healthcare academia and organizations emphasize putting the focus on patient safety for example, in simulation curriculum for training clinicians and continuing professional development as a strategy to enhance the quality of patient care (Agency for Healthcare Research and Quality (AHRQ), 2020; Wu & Bush, 2019). Healthcare simulation pedagogy should embed the principles of inclusive and person-first language. Using appropriate communication techniques promotes clear communication and avoids negative health consequences of poor communication (Rayner & Wadhwa, 2021). Some terms and language used in simulation scenarios reinforce stereotypes or unintentional implicit bias that do not reflect a tone of respect and inclusion for a diverse population. For example, identifying a person in the scenario as disabled, mentally ill, victim, or alcoholic does not demonstrate respect for the person's basic humanity. In the sections below, this manuscript will provide alternate language options.

Key Points

- Simulation education and training is a powerful tool that can integrate the principles of inclusive person-first language in a curriculum of cultural humility, diversity, equity, and inclusion to promote patient safety
- Healthcare language is full of harmful terms. Know the power of words, how words are used, and how others perceive the use of those words.
- Simulation education and training can be improved by incorporating appropriate terminology and inclusive language that centers on the identity and feelings of the patient.

The International Nursing Association for Clinical Simulation and Learning (INACSL) Healthcare Simulation Standards of Best Practice has emphasized "representation of equity, inclusivity & diversity" International Nursing Association for Clinical Simulation and Learning INACSL Standards Committee, 2021, pp 40–44). However, person-first language is rarely included in scenarios and case studies. Furthermore, the official *Healthcare Simulation Dictionary,* which is designed to enhance communication and clarity for healthcare education and training (Society of Healthcare Simulation, 2020) does not mention person-first language. Failure to use patient-friendly language could send unintended messages and embed implicit bias, thus creating an atmosphere of stigma, and result in actions that contribute to health inequities.

The Institute for Healthcare, 2011 the application of patient-centered communication competencies using evidence-based practices that could include inclusive language to effectively collaborate with the patient to enhance patient safety (Institute for Healthcare, 2011; Wu & Bush, 2019). In simulation scenarios and case studies participants can be encouraged to practice an inclusive dialogue that does not contribute to unconscious or implicit biases. This approach involves the learner synthesizing and integrating what has been taught in relation to the real-life clinical environment from the patient perspective. Learners can develop a new awareness and change behaviors that contribute to a system where discrimination and inequities occur. The purpose of this article is to discuss the importance of inclusive language within the healthcare or health professions for inclusion of all healthcare provider professionals and provide examples and resources for practitioners in their journey to creating an inclusive environment in their practice.

The Power of Language

The words used, how those words are used, and how others perceive the use of those words matter. In the quest towards inclusive practices, it is important to acknowledge that words matter because they are a symbol of respect and identity. Admittedly, it can be difficult to know what person-first terminology is appropriate and generally accepted terminology may shift over time. To add to the complexity within groups of people and cultures, there are disagreements of what is acceptable. In healthcare, the term "patient" has been identified as the least objectionable term when compared to a client, consumer, or customer (Deber, Kraetschmer, Urowitz, & Sharpe, 2005). Additionally, patients desire to have a relationship with their healthcare provider that resembles friendship (Magnezi, Bergman, & Urowitz, 2015). To this end, it is important to ask patients what they expect from the healthcare provider relationship and how they wish to be referred. By asking this simple question it communicates that you care and want to get it right for your patient regardless of race, ethnicity, gender identity, sexual orientation, or ability. The following sections discuss inclusive language around person-first language, race and ethnicity, sex, gender identity, sexual orientation, ability, and agism, used in healthcare.

Person-first Language

Using person-first language puts the emphasis on the person instead of their disability, illness, social class, race, or other characteristics. By using person-first language, a healthcare provider avoids conscious or subconscious dehumanization or marginalization of their patients in and out of the healthcare setting. Consider the following example: "*the diabetic patient needs to alter their diet*" In this example, the statement centers on diabetes where the patient is defined by their disease. Alternatively, a provider could say "*The patient with diabetes needs to alter their diet*." The second example identifies what the person "has" as opposed to what the patient "is." Consider the following examples of person-first language:

- A person with a disability versus a disabled person (APA, n.d. A).
- A person with a substance use disorder versus "junkies," "crackheads," (Botticelli & Koh, 2016)
- A person experiencing homelessness versus a homeless person (Valdez, 2021)
- A person with bipolar disorder versus a bipolar person (Valdez, 2021)
- A kid or teen in the foster care system versus foster care kid (Dunn & Andrews, 2015)

By changing to person-first language, there is a sense of empowerment for the patient. The person has control, or autonomy, not the disease. Generally, using person-first language will be most correct, however, as will be discussed in relation to ability, there are some groups where person-first language is not preferred.

Ability and Ageism

Individuals with disabilities and older adults face similar issues of mis-labeling and harmful commonly used terms. The term "disability" is a broad term that encompasses physical, psychological, intellectual, and socioemotional impairments (World Health Organization, 2011). A person's disability or ability affects people of all ages and could be a lifelong issue or a temporary impairment. It is important to avoid, categorize or judge based on diagnoses or perception of diagnosis. As with other groups, practitioners need to use language that demonstrates respect because there is a wide range of abilities that should be accounted for when practitioners work with these populations. Generally, person-first language is most appropriate when referring to ability or disabilities except for most in the Deaf or Deaf-Blind community. They prefer to be called Deaf or Deaf-Blind with the letters capitalized (Dunn & Andrews, 2015).

Ageist terms such as senile, demented, and aged were once commonplace and should be discontinued in our spoken and written language because they perpetuate stereotypes through generalization of older adults (Avers, Brown, Chui, Wong, & Lusardi, 2011). What it means to be "old" has shifted over time as medical advances have allowed people to live longer and experience a greater quality of life. For example, a Marist poll found that adults under 30 largely consider 65 considered to be "old" while older adults consider 65 to be "middle-aged" (Miringoff, Carvalho, & Griffith, 2016). For people with disabilities, older adults, and people who may not speak English fluently, there is a tendency to speak differently by exaggerated articulation and speaking slower (Uther, Knoll, & Burnham, 2007). This practice is insulting and patronizing because it generalizes these groups as hard of hearing and/or not able to communicate well (Mclaughlin, 2020). Table 1 provides additional examples of language alternatives using appropriate terminology.

Table 1 Examples of Ability and Ageism Language

Problematic Language	Preferred Language
Disabled person	Special needs
Mentally challenged	Person with intellectual disabilities
Hard-of-hearing person	Person with hearing loss
Blind person	Person with blindness
Older adult, person/people, individual	Elderly, Senior citizen, Retiree, Grandmotherly
Advanced maternal age, Geriatric Pregnancy, Elderly primigravida/multigravida	Pregnant person

Note. This list is not exhaustive and was adapted from the APA Disability writing guide (APA, n.d. A).

Race and Ethnicity

Knowing the correct terminology to say or write related to race and ethnicity can be difficult. The authors of this article recommend reviewing widely accepted style guides for guidance not only in your writing but for social interactions. For example, the American Psychological Association (APA) style guide (7th Edition) provides a robust examination of Race and Ethnic terminology (APA, n.d. B). When writing and speaking related to issues of race and culture it is important to consider the following:

- *Use generally accepted terminology.* A rule of thumb when using terminology related to Race, Culture and Ethnicity the more specific you can be, the better. For example, using the term "*Asian*" is acceptable, however, using regional descriptors such as "*Southeast Asian*" is better, but it is best to refer to a specific nation or region of origin when possible (ex. Vietnamese).

- *When in doubt, capitalize.* Racial and ethnic groups are proper nouns and should be capitalized. For example, when Black is referring to an ethnicity, it is a noun the "B" should be capitalized.
- *Avoid using colors to describe race.* Generally, White, and Black are the most universally accepted colors used to describe race. Other colors historically used are frequently seen as offensive and demeaning. When writing using colors as a racial category capitalize the B when writing about people who identify as Black. There are debates of whether to capitalize the "W" in white, however the APA style guide advises to use the capital "W" when using it to describe the white racial group because it is considered a proper noun (APA, n.d. B).
- *Avoid nonparallel designations.* For example, writing or saying "*African Americans and Whites*" is incorrect because African Americans are a specific group of people who are Black, while "*Whites*" is a broader term associated with many groups of people. Instead use "*Blacks and Whites*" or "*African Americans and European Americans*."
- *Consider power dynamics.* Avoid phrasing that minimizes the diversity of racial minority groups such as saying or writing "*white Americans and racial minorities*." Be more specific when describing groups of people such as "*white Americans, African Americans, Mexican Americans, and Asian Americans*."
- *Avoid essentialism.* It is important to avoid phrases such as "*the Black race*" and "*the White race*" because it can perpetuate stereotypes by putting all people of a certain color into a singular group.

Sex, Gender Identity, and Sexual Orientation

Like race and ethnic terminology, terminology related to sex, gender identity, and sexual orientation can be complicated. Data suggests that asking about and using appropriate gendered terminology creates a welcoming environment for LGBTQIA+ patients to engage with the healthcare provider (Eisenberg et al., 2020). Missing or failing to use terminology may cause distrust in the healthcare provider which may result in hesitancy to seek care (Eisenberg et al., 2020). Practitioners should also avoid language such as "*Dear,*" "*hon,*" "*sweetie*" and other similar terms of endearment (National Institute Health NIH National Institute on Aging, 2017). As identified above, when in doubt use neutral language, and ask patients how they prefer to be called.

When in doubt of someone's preferences it is best practice to use gender neutral terminology (Rosendale, Goldman, Ortiz, & Haber, 2018). For example, instead of saying "*His test came back positive*," gender neutral options include using the patient's name or using the generic term "*patient*." To help navigate some of these complexities Table 2 provides examples of gendered and gender-neutral language. Similarly, using correct pronouns is equally important. Using correct pronouns is another way to create an inclusive environment by demonstrating personal respect, Table 3 provides examples of commonly used pronouns. To take a deeper dive into pronouns check out www.mypronouns.org (Buchanan & O'Connor, 2020; MyPronouns.org n.d.), the website goes into detail of why pronouns are important including examples of how, and when to use pronouns. It is important to ask patients what their preferred labels are related to pronouns and gender. Importantly, be sure to document their preferences so the practitioner will use correct terms in future interactions.

Table 2 Examples of Gender Neutral and Gendered Language

Problematic Language	Preferred Language
Pregnant women/woman	People who are pregnant, pregnant person
Biologically male/female	Cisgender
Biologically male	Assigned male at birth
Biologically female	Assigned female at birth
Mother/Father	Parent
Breast, breastfeeding	Chest, chest feeding
Female reproductive organs	Internal reproductive organs

Note. This list is not exhaustive and was adapted from Krempasky, Harris, Abern, & Grimstad, 2020.

Incorporating Person-first Language Simulation Education

There is currently not an International Nursing Association for Clinical Simulation and Learning (INACSL diversity standard of best practice. Below is a list of recommendations for best practices to encourage diversity, equity, and inclusion.

- Develop clear objectives and outcomes that encourage a change in knowledge, skills, and attitudes towards issues related to diversity, equity, and inclusion.
- Include a better representation of diverse populations in simulation activities and have them consult on patient dialog. Reframe from using specific ethnic groups in a negative, overgeneralized stereotypical patient roles.
- Enhance partnerships to assist with content development. Work with local college diversity or student disability offices, hospital patient relation offices, and ethnic/social communities in your area, including churches, unions, fraternities/sororities, and clubs.
- Address relevant topics that promote use of inclusive language to assist learners in reflective learning during debriefing sessions.

Table 3 Commonly Used Pronouns

Subject Pronoun	She	He	They	Ze
Object Pronoun	Her	Him	Them	Hir
Possessive Pronoun	Her/Hers	His	Their/Theirs	Hir/Hirs
Reflexive Pronoun	Herself	Himself	Themselves	Hirself

Note. This is not an exhaustive list and was adapted from https://www.mypronouns.org/how

Table 4 Examples of Biased Hurtful Language and Neutral Language and Considerations

Problematic Language	Preferred Language
Drug seeker	Document patient's description of pain, i.e., characteristics, pain level, and effect on function.
Frequent flyer	Describe the patient's history, present concerns, and assessment findings. *"Patient presents with a history of intermittent abdomen pain, intermittent over two months with tenderness on palpation in the lower quadrant."*
Dirty or clean specimen	*"Patient reports using opiates or being in sustained recovery from oral pain killers over the last six months."*
Homeless patient	Person who is unhoused or experiencing homelessness
This patient is crazy	Objectively state the patient's diagnosis and findings. *"Patient complains of hearing voices when no one is around."*
Prisoner or Convict	Person who is incarcerated.
The patient is a "Gomer"	Objectively state the patient's name, condition, diagnosis, and findings.
A term describing a non-responsive patient who is terminal.	
Non–compliant	Describe the patient's clarification or cause of the failed treatment plan.

Note. This list is not exhaustive and adapted from Valdez, 2021.

In addition, consider problematic labels that are used in scenario scripts. This language can be riddled with prejudice, subjective observation, judgment, implicit bias and assign blame to the patient (Botticelli & Koh, 2016; National Institute Health NIH National Institute on Aging, 2017; Valdez, 2021). Tables 1-4 represents examples of biased problematic language used within the healthcare system and preferred language considerations to be used in the simulation curriculum (Valdez, 2021).

Making Mistakes

Making mistakes is inevitable, especially if you are beginning the journey of breaking habits ingrained from childhood. When mistakes happen, it is important how you respond. Based on our own research, scholarship, and lived experiences consider the following when a mistake is made:

- *Apologize.* Simply saying "*I'm sorry*" is enough. By saying "*I'm sorry*" you are acknowledging the error happened and you did not mean any harm.
- *Keep apologies brief.* Do not go into detail about the mistake or draw more attention to the mistake. Do not over apologize by doing the following: "*Oh my goodness! I am so sorry, I didn't mean to use the wrong words, I know it's wrong, that is not who I am, please forgive me!*"
- *Correct yourself.* If you used "*he*" to refer to someone but they prefer "*they*", simply say "*I meant 'they,'*" and move on.
- *Do better.* People are generally forgiving for mistakes, but when mistakes are repeated, the implicit message is that you do not respect that group or person enough to put in the necessary effort to change.
- *Center their feelings.* Being aware of the feelings of others, being sympathetic, and empathetic is important in relationship building. If the language used upsets the person or people you are talking to it is appropriate to follow-up in private. As stated above, keep the apology brief, and keep the conversation focused on what you can do to best support them. This follow-up will help regain trust.

Conclusion

Communication between patient and provider should convey mutual respect and eliminate barriers, misunderstand-

ings, stereotypes, shame, and preconceived judgments. Healthcare providers should consider implicit bias associated with using stereotypes and insensitive terminology. The consequences of poor communication, negative labeling, and the absence of person-first language cost time and resources because effects are harmful to the patient, erode trust, blame the patient, and perpetuate poor patient outcomes. No one is perfect and making mistakes is part of learning. Learn from these errors and take steps to do better. "*Sticks and stones may break my bones, but words will never hurt me"* - is a myth because words are harmful and have a long legacy of prejudice and pain, especially in the healthcare industry. The good news is a simulation curriculum that incorporates person-first language could strengthen the patient-provider relationships and enhance healthier patient outcomes. Nurses are the largest healthcare professionals (AACN, 2019) and most respected (Saad, 2020). They can be the change agent by modeling person-first language.

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