Dear Dr. Jeff:

Whatever I refer to an individual in our facility as a "patient," someone corrects me to "resident." If I say this person in the hospital or in my office, he or she would be my patient, but that has somehow become a forbidden word. Staff members have claimed that this is some sort of code requirement, although no one seems to know where this is specified in the code or how conversations among the team could be regulated. What do you think?

Dr. Jeff replies:

Language does indeed have consequences. Our words convey much more than simple information. They reflect patterns of thought; they are metaphors revealing mental constructs. As such, our choice of words certainly has an effect on our audience, at times unexpected or unintended.

The Federal Requirements of Participation (aka "the Code"), which specify the regulations governing nursing homes participating in the Medicare and Medicaid programs, does not forbid medical practitioners from referring to those for whom they provide care as "patients." Although they do refer to "Resident Rights," these rights are in addition to the rights of all patients, not instead of them. Resident rights include a right to be free from verbal abuse, which could limit the words spoken in front of the resident that could insult, threaten, or humiliate them, but certainly "patient" would not fall into that category.

Many nursing homes do stress using the term "resident" for those who reside within the facility. It can be a useful construct in reminding staff members that those we serve have a dual identity as both individuals living in their own homes and individuals with self-care deficits in need of assistance. The term can serve as an ongoing reminder that these frail individuals must receive the respect that we would give anyone who has invited us as guests into their home.

This may be particularly important for those who are cognitively impaired or mentally ill, both categories that can potentially encourage violations of resident dignity and autonomy. Certainly, referring to "the patient in 212B" is dramatically better than being told "212B wants her sleeping pill renewed." Referring to a human being as a bed number is clearly demeaning, while emphasis on the medical nature of their care is not. Still, I would encourage you to try to develop a habit of using the "resident" terminology. It supports the desired message that you are a partner in the care team.

More Than Words

A recent article in Academic Medicine, the journal of the Association of American Medical Colleges, regarding language used in medical care has been widely circulated. Provocatively entitled "Seven Dirty Words: Hot-Button Language that Undermines Interprofessional Education and Practice" (an obvious tribute to comedian George Carlin’s delightful attack on the Federal Communications Commission). The author, Peter S. Cahn, PhD, is an established academic who was named as provost at the Institute of Health Professions founded by Massachusetts General Hospital; the essay represented his perspective while he was still new to the world of medical care (Acad Med 2017;92:1086-1090).

One aspect I found fascinating in his essay was several of the terms he finds problematic do not sound provocative to me, much less hot buttons. These include "patient" as well as "allied … my … Doctor … clinical … medical … interdisciplinary."

Although he proposes alternatives for each, some of these substitutes seem even more problematic or insensitive than the terms they are intended to replace. For example, he objects to "interdisciplinary" because it actually refers to discussion within a discipline rather than collaboration among different professional areas. Dr. Cahn proposes "interprofessional" as more inclusive. However, when we use interprofessional in the long-term care field (such as IDT for teams), we are often including certified nursing assistants, housekeepers, dietary aides, and unlicensed social workers, among those who bring their unique and valuable insights on patient (oops, resident) care but are not professionals as such.

The proposed alternative to "patient" is not our nursing home alternative of "resident" but rather "participant." His argument is that the word patient derives from "one who suffers," which suggests a purely passive role. The movement toward patient-centered care attempts to drive discussion toward the whole person, who has strengths and weaknesses, rather than simply addressing the disease or diseases that the person may experience. Also, much of the support provided in residential care facilities is not directly related to any cause of suffering. The intention is that the language should establish a view that encourages a partnership with the person at the center. Similarly, many consumer advocacy groups have urged terminology that centers on the person rather than the disease, such as "person with dementia" rather than "dementia patient."

Dr. Cahn’s objections might be dismissed as simply politically correct nonsense from someone who has spent too much time in the rarefied groves of academia — but we should remember that the opposite of correct is offensive. When our coworkers or our patients and their families tell us that we are being rude and hurtful, we need to listen.

Many years ago, residents’ rights regarding dignity were defined to include a right to be addressed by a preferred name. This came, in part, as a response to residents who stated that they felt demeaned when staff — often half their age, and including many they did not know or barely knew — addressed them by their first name or by nicknames. In many communities, reaching an advanced age comes with the right to the honorifics “Mr.” or “Mrs.” or “Mr.” Thirty years ago, I was the medical director at a facility where my predecessor had gone from medical director to resident within 2 years; he may have had difficulty finding his own room, but he immediately corrected any staff who failed to call him “Doctor.”

Calling an older person by their first name without their permission is treating them like a child. On the other hand, many residents do prefer to be called by a less formal name; if they express that preference, then it is perfectly fine. Similarly, many members of the medical community still have problems addressing transgender individuals with their preferred pronouns — but, again, this relates to simple respect.

The "Doctor" is In

The same respect should be extended to the members of our teams, although the use of the descriptor “doctor” in particular has become increasingly confusing. Professional membership organizations often have difficulty defining their membership due to the combination of other professionals who have advanced degrees, and the bewildering array of different professionals who may be working within the world of long-term care compounds the difficulty of our situation. Besides MDs and DOs, DPsMs and DMDs and DDS degrees are all routinely called doctor, as are PhDs and clinical psychologists. Newly minted occupational and physical therapists are now required to achieve doctoral degrees, but licensed professionals in these fields who trained in the past may not have that diploma.

A small number of social workers have a DSW, although master’s or bachelor’s level training is much more common. Senior nursing administrators may have a DNS or DNP or even a PhD in nursing, whereas advanced practice nurses and nurse practitioners typically have a master’s degree, as do other nursing personnel who may have master’s level training without practitioner status. Thus, a doctor of nursing could pick up an order (another word many find offensive) from someone with a master’s degree.

The DNP degree has added even more confusion as some programs are designed as additional training for master-trained nurse practitioners, while some offer executive or public health training for non-practitioner nurses. A few schools offer both as separate tracks. Columbia’s program actually offers a year of “residency” after the formal didactics.

Physician assistants may be bache- lor’s-level trained. Bachelors of optometry were grandfathered into doctors of optometry, but some older pharmacists with pharmacy degrees were not retroactively elevated to PharmD status.

Medical staffs are frequently spoken of as “our doctors” in language that excludes half or more of the practitioners in the building. Given the profusion of degrees and the tendency of some nurse practitioners to introduce themselves as “Dr. So-and-So,” some facilities have tried to regulate which staff members can introduce themselves as “doctor” to minimize resident confusion.

Nearly half of all medical visits in long-term care are now made by nurse practi- tioners, and they have certainly suffered from dismissive or minimizing language. References to “mid-levels” or “physician extenders” are still common in discus- sions, suggesting a hierarchy with physi- cians on top and nurse practitioners at least one level below. This is more than simply a residual sexist reflex left over from when MDs were overwhelmingly male and nurses overwhelming female — it persists in a world where the nursing home administrators, medical directors, geriatricians, and other physicians com- ing into our buildings are increasingly overwhelmingly female as well.

Our residents (not our patients) require the assistance of an entire team, and our language needs to be inclusive, accurate, and above all clearly understandable. Words are tools, and like all tools should be used carefully. If your language is clear and demonstrates respect for everyone, there should be no need to worry about political correctness.

Dr. Nichols is past president of the New York Medical Directors Association and a member of the Caring for the Ages Editorial Advisory Board.