Tip Sheet: Language and OUD

Stigma within the healthcare environment limits access to treatment for opioid use disorder (OUD), even as OUD results in significant morbidity and mortality worldwide.[1] Provider language in the electronic health record (EHR) can affect both patient experience and future care through the transmission of stigma or positive regard.[2,3]

In our recent chart review for patients with OUD, we found that stigmatizing language was nine times more frequent than positive/affirming language per patient. Many instances stem from standard documentation practices that can be stigmatizing in the context of discussing a sensitive issue like OUD. By modifying the language we speak and document in the EHR, we can hopefully positively impact our patients' experiences with the health care system.

Quick Fixes: This for That

Current Language	Alternative Language
Substance Abuse	Opioid Use/Misuse, Opioid Use Disorder
Relapse	Return to Use
IV Drug User	Uses Substances Intravenously, Patient Who Injects Drugs
Clean/Dirty	Abstinent, Current Use, UDS + or – for [substance]
Denies/Admits to Substance Use	Reports, Discloses, Shares, States
Treatment/Medication Compliance	Adherence, Is taking or not taking medication
AMA Discharge	Self-Directed Discharge
Complaint	Reason for Admission, Current Symptoms

System Generated Language

Just over one-third of stigmatizing language appeared in system generated language such as diagnostic codes and drop-down menu options. While you are limited to the options available to you in the system, here are a few questions to consider when updating a patient's social history and problem list, the primary areas where we noted stigmatizing language flows through into templates.

Question	Notes
Have I updated the patient's social history?	We do not always update this section during hospital admission, although we ask many of these questions. Drop downs in the Social History sometimes include identity first language. While you are not able to change those options currently, remove any free-text options with stigmatizing language.
Have I updated the patient's problem list?	Some diagnostic codes in the problem list contain stigmatizing language, such as abuse. While you cannot change the options available to you, you may be able to select an accurate option that contains preferred language or change what is displayed in the problem list. Consider the following when documenting problems related to substance use: Have I selected the accurate qualifiers, such as severity and remission status? Does the diagnosis code use abuse or identity first language? If so, is there another option I can select that is accurate?

Reflection Questions

Language and stigma are both highly subjective and context dependent, making it challenging to issue clear guidance for every situation. Below are a few questions to consider when documenting patient encounters. Remember just one key question:

Would I want this written about me or somebody that I love?

Initial Question	Follow-Up Questions
Is a direct quote necessary to convey the patient's meaning or understanding?	Does the quote include slang, grammar, or pronunciations that may stereotype a patient? Can the patient's statement be summarized in an accurate, factual way without quotes?
Am I unintentionally expressing judgement for a patient's behavior?	Am I exploring the reasons for a patient's behavior, like being in withdrawal, anxiety over hospital admission, prior trauma?
Am I indirectly implying that a patient is to blame for their current situation?	Am I exploring the reasons for a patient's behavior, such as not taking prescribed medication? Have I looked at the systemic context of the patient's behavior, such as lack of financial resources or access to transporation?
Am I conveying information needed to keep other staff members safe?	If a patient is escalated, violent, or threatening towards you, other staff need to be aware. Do not be afraid to include a factual account of this experience in your documentation.
Would I include these details about all patients?	Is it standard practice to ask patients about these topics? Is the information germane to their care or understanding of their needs?
Have I copied over language written by someone else into my note?	Does what I copied include stigmatizing language? Can I edit or paraphrase what the previous author said, or is it necessary to keep it as written?

References

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