Activity Guide: Sensitive, Accurate Patient Chart Language

Activity Goal:

- Help pre-med and medical students understand why and how to use sensitive, person-first language when writing patient charts

Estimated Time to Complete Activity: 40 minutes

Activity Instructions:

1. Give each student a printout of the Original Patient Record.
2. Ask students to work individually to identify any stigmatizing, inflammatory, or biased language within the fake patient chart on their sheet.
3. After students are done individually marking their sheets, ask them to get into small groups (2 or 3 students each). Within each group, students should share the problematic language they each identified, and work together to replace those words and phrases with more sensitive, accurate, and person-centered terms.
4. Hand out the Improved Patient Record, with more sensitive, appropriate language. In their small groups, students can discuss why this version is better and share ideas on how they can further change the language to be more accurate, objective, and person-centered.
5. A large group de-brief is encouraged, in which groups share the terms they decided were problematic, and their suggestions for better alternatives. After several examples are shared, the instructor can use any of the following discussion prompts:
    - What do you notice between the Original Patient Record, and the Improved Patient Chart? (Instructor prompt – answers can and should include the following):
        - Avoiding subjective, emotion-based opinions ("Patient indicates regularly consuming between 4 and 9 drinks per day" versus "heavy drinker").
        - Using the "patient's" first name throughout the chart, to humanize him.
        - Using third-person language and full explanations of actions ("Following institutional policy regarding escalating agitation, security was requested for staff safety. " vs. " I called hospital security to address patient."), tells the story without interjecting your opinions.
        - Reporting things in the patient's own words, rather than your interpretation of the story ("Patient says he does not use Atrovent inhaler regularly" versus "Patient refuses to use Atrovent inhaler properly.")
        - Using full yet concise sentences leads to a more thorough big-picture view for other professionals.
    - Why is it important to use person-centered, non-biased language on a patient chart, if the patient himself/herself won't ever *see* the actual chart?
    - If you received the first patient chart with its original language, what would your impressions of the patient be before you met him or her? How would you prepare yourself before going into that follow-up appointment?

Activity Handout– Original Patient Record (1 page)

Review the patient chart and identify any stigmatizing, inflammatory, or biased language.

PATIENT VISIT RECORD – Urgent Care Visit

CHART NO.		DATE
2443-JL34-225		August 25, 2020
PATIENT NAME	**PATIENT AGE**	**PATIENT GENDER**
Bingham, Charles Jr.	35	Male

NOTES

CENTRAL COMPLAINT	Presented with breathing issues, "heaviness" in chest.		
MEDICAL HISTORY	Diagnosed with asthma "a couple" years ago, but refuses to use Atrovent inhaler regularly. Known heavy drinker.		
FAMILY HISTORY	Unknown		
PHYSICAL EXAM	Tachycardia (heart rate 110 bpm). Hypoxemia, with pulse oximetry results showing $Sa0_2$ = 84%. Respiratory rate ~20, wheezing upon exhalation, and BP 125/85 (Last visit 145/90). Patient has lost 10 pounds since last medical encounter 5 weeks prior. Eyes are bloodshot, patient is sweating excessively.		
ALLERGIES	None known	MEDICATIONS AND DOSAGES	Flovent HFA 110mcg 1 puff BID (Per 2020 GINA Guidelines for initial treatment), and Ventolin HFA, 2 puffs every 4 to 6 hours as needed for wheezing and shortness of breath. Patient does not use inhaler properly.
IMPRESSIONS	Patient is manic—talking too fast and very loudly, using unnecessarily large hand gestures. Patient is disheveled, with dirty clothing and skin. Mentions that he has not gone to work for the past several days, and has spent the past several nights drinking at a bar, where he has started "a bunch of" fights with other patrons. Patient had a hard time answering my questions and was very easily distracted. After several minutes, patient became agitated, and I was concerned for my safety. I called hospital security to address patient.		
PLAN	Patient's asthma symptoms were stabilized and patient was given instructions on properly using an inhaler. A visit with the patient's primary care doctor has been scheduled in 8 days, for follow-up assessment. I encourage PCP to complete a psych eval due to patient's obvious cognitive degradation, potentially due to heavy drinking.		

Activity Handout– Improved Patient Record (2 pages)

Problematic language is ~~struck out in red text~~. More objective, sensitive, and person-centered language is suggested in **bold text.**

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Bingham, Charles Jr.	35	Male

NOTES

CENTRAL COMPLAINT	Presented with breathing issues, "heaviness" in chest.		
MEDICAL HISTORY	Diagnosed with asthma "a couple" years ago, but ~~refuses to~~ **says he does not** use Atrovent inhaler regularly. ~~Known heavy drinker.~~ **Patient indicates regularly consuming between 4 and 9 drinks per day.**		
FAMILY HISTORY	Unknown		
PHYSICAL EXAM	Tachycardia (heart rate 110 bpm). Hypoxemia, with pulse oximetry results showing $Sa0_2$ = 84%. Respiratory rate ~20, wheezing upon exhalation, and BP 125/85 (Last visit 145/90). ~~Eyes are bloodshot.~~ **Eyes showing red conjunctiva**, patient is sweating ~~excessively~~ **profusely.**		
ALLERGIES	None known	MEDICATIONS AND DOSAGES	Flovent HFA 110mcg 1 puff BID (Per 2020 GINA Guidelines for initial treatment), and Ventolin HFA, 2 puffs every 4 to 6 hours as needed for wheezing and shortness of breath. ~~Patient does not use inhaler properly.~~
IMPRESSIONS	~~Patient is manic~~ **Mr. Bingham displays signs of mania**—talking ~~too~~ fast and very loudly, ~~using unnecessarily large hand gestures~~. ~~Patient is disheveled, with dirty clothing and skin.~~ **Upon further review of systems, patient displayed increasing signs of agitation, including increased pace of speech and heightened affect.** ~~Mentions that he has not gone to work for the past several days, and has spent the past several nights drinking at a bar, where he has started a bunch of fights with other patrons.~~ **Mr. Bingham related "spending the past several nights drinking at a bar" and "has gotten into several fights."** ~~Patient had a hard time answering my questions and was very easily distracted. After several minutes, patient became agitated, and I was concerned for my safety. I called hospital security to address patient.~~ **Following institutional policy regarding escalating agitation, security was requested for staff safety. It was not possible discuss the condition with Mr. Bingham at this time.**		

PLAN	A visit with the patient's primary care doctor has been scheduled in 8 days, for follow-up assessment. ~~I encourage PCP to complete a psych eval due to patient's obvious cognitive degradation, potentially due to heavy drinking.~~ **Assessment for substance use including alcohol, prescription and nonprescription drugs, and tobacco is recommended. Patient's behavioral patterns and significant weight loss may be indicative of mental health opportunities. I recommend psychiatry referral for additional assessment.**