Person-First Language in Anesthesiology Care

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Do words matter? The language with which we refer to our patients can affect the way they feel about themselves, the success with which they are treated and adhere to clinical recommendations, and the way that clinicians make treatment choices. "Person-first language" is a linguistic construct that attempts to assiduously avoid referring to patients *as* their diseases, disabilities, or conditions, but rather a *person with* such attributes. Thus, one would not refer to a "substance abuser" (much less "user" or "addict"), but rather a "person with substance use disorder," or a "person with diabetes," not a "diabetic." Even more benign-sounding constructions such as "CHF patient" would be avoided, by literally putting the person rather than the disease first. In the purest instantiation, terms such as "suffering from," "burdened with," or "afflicted with" (a condition) are also avoided, as are terms such as "complaint" (reason for seeking care), "compliant" with a treatment recommendation, and "poorly controlled," or "failed" a therapy. All of these terms may be best not used to avoid stigmatizing the patient by the association with the condition or treatment result.

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Person-first language

Many medical schools and other professional educational institutions teach person-first language. The AMA Manual of Style dictates use of such constructs in scholarly writing, and the *ASA Monitor* generally adheres to such use (AMA Manual of Style: A Guide for Authors and Editors. 11th ed, 2020). Still, no matter how vigilant we are in our communications with others, it takes conscious, deliberate, and consistent effort to avoid nonperson-first language and the potential adverse effects it may engender.

Without a doubt, nonperson-first language is common in clinical practice, particularly in clinician-to-clinician communication, where it may be a sort of shorthand for describing patients to one another. By modeling this suboptimal use of language, attending physicians may prompt students and graduate trainees to abandon person-first language to "fit in" to the perceived culture of the hospital ward, office, or OR. Conversely, by respectfully calling out such lapses, more senior clinicians can encourage others around them to use preferred terms.

Some may view attention to such linguistic details as unnecessary, cumbersome, or even politically motivated. Indeed, the careful use of person-first and other aspects of patient-sensitive language requires deliberate attention and practice and resistance to social pressures of commonly used medical shorthand terminology. I would suggest, however, that this sort of language choice is not merely political correctness or "wokeness," but rather a desire to keep our patients' interests at the forefront of our care.

So, is person-first language objectively superior to nonperson-first language? An increasing body of research suggests that it is. Many of the diseases and conditions frequently used to stand in for a person with the condition are those in which there is an unstated or even explicit implication that lifestyle choices are responsible for the condition (alcoholic, addict, diabetic, cirrhotic) or otherwise telegraph shame directed at the patient with the diagnosis (obese, epileptic, smoker). Using person-first language promotes respect and dignity for patients. Describing someone as "a patient with diabetes" rather than "a diabetic" acknowledges that the person is more than just their illness and recognizes their individuality. Using person-first language also helps to avoid stigmatization and discrimination, which can have a negative impact on a patient's mental and physical well-being (*Diabetes Spectr* 2018;31:58-64). This may be especially true for mental health conditions, substance use disorders, painful syndromes, eating or body image-related conditions, and in obstetric care (*Int J Drug Policy* 2010;21:202-7).

Second, person-first language may improve communication and understanding between health care providers and patients. By using person-first language, health care providers can convey empathy and understanding, which can help to build trust and rapport with patients. This, in turn, can lead to better adherence to treatment plans and overall better health outcomes (*Patient Educ Couns* 2009;74:295-301). Moreover, use of stigmatizing terminology has been shown to reduce provider empathy toward their patients (*J Bioeth Inq* 2017;14:31-42). For anesthesiologists and anesthetists, the abbreviated but critical preoperative moments require rapid development of such trust. This time-sensitive imperative further supports using the most compassionate terminology possible. Furthermore, emotional detachment by health care providers is one of the hallmarks of the epidemic of clinician burnout, so any maneuvers to strengthen emotional connections should be welcomed.

Finally, person-first language may promote inclusion and accessibility for patients with disabilities or diseases. By using person-first language, health care providers can help to reduce barriers and promote equity for patients with disabilities. This can include using terms such as "a person with a mobility impairment" rather than "a wheelchair-bound person," or "a person who is deaf" rather than "a deaf person" (although the latter is controversial; see below). These same effects may even have an impact on health care research and policy. By using person-first language, researchers and policymakers can help to ensure that the voices and perspectives of patients are represented and respected in study design and conduct and in policy formation (Crossing the Quality Chasm A New Health System for the 21st Century. 2001).

Not all patients or patient groups prefer person-first language. Identity-first language refers to the person's condition first, rather than in a secondary fashion, with the expressed intent to demonstrate that the condition is a fundamental part of their identity. A notable example is in the Deaf community, which rejects "person with deafness" and prefers Deaf person (noting the capital "D"). In this perspective, the Deaf view themselves as members of a community and proudly use the name of the condition as an identifier. Some in the neurodiverse/autistic community also feel this way, though many do not. In general, best practice is to be guided by the patient's desires, and when in doubt to use person-first language until otherwise directed.

Anesthesiologists rightfully consider themselves defenders of the patient's welfare during the perioperative period. In addition to providing technically expert care, attention to our language when addressing our patients is an important component of clinical excellence. ■