BMC Medical Education

RESEARCH Open Access

"You're not taught to think about the words you use and then it just perpetuates"—a qualitative examination of medical students' perspectives of stigmatising language in healthcare

Saakshi Daswani[1*], Elizabeth Gorecki[1] and Lisa Mellon[2]

Abstract

Background Stigmatising language is used commonly in healthcare, affecting healthcare providers' perceptions of patients and care delivery. Using person-first language is best practice, however, it does not reflect reality.

Method This study examined medical students' perspectives on stigmatising language in healthcare. Twenty-one medical students at the RCSI University of Medicine and Health Sciences participated in four focus group interviews; a thematic analysis of the data was conducted.

Results Seven themes were identified: prevalence of stigmatising language, its impact on students and patients, being sensitive versus medically accurate, evolving nature of recommendations for language use, barriers to changing practice, power dynamics and cultural context influencing language use, stigmatising language being a societal issue. Participants provided recommendations for improving language use in healthcare: open discussions and student feedback on language in the learning environment, lecturers signposting person-first language, training workshops on person-first language for clinicians and lecturers, and social intelligence skills training.

Conclusion Study findings highlight the impact of stigmatising language in healthcare. To address this issue and inform guidance for future generations of professionals, medical students recommended more open dialogue and improved social intelligence.

Keywords Language, Inclusivity, Healthcare, Stigmatising words, Stigma

*Correspondence:
Saakshi Daswani
saakshi.daswani@gmail.com; SaakshiDaswani20@rcsi.com
[1]Graduate Entry Medical Programme, School of Medicine, RCSI University of Medicine and Health Sciences, Dublin, Ireland
[2]Department of Health Psychology, School of Population Health, RCSI University of Medicine, Dublin, Ireland

Background

Person-first language in healthcare prioritizes respect for the patient, acknowledges patient autonomy, and promotes positive, collaborative patient-provider relationships [1, 2]. Though considered best practice, it is not always implemented. Terms centering medical conditions over the person (e.g. "addict," "schizophrenic," "demented," "paraplegic," "obese") are frequently used to describe patients [3]. Words such as "defect" [4], "disorder" [5], "presenting complaint" [6], have negative connotations in society and in healthcare.

The use of stigmatising language in healthcare may be unintentional [7] and hold a functional meaning in the clinical environment. However, there is consensus that stigmatising language used in healthcare settings is a problem [8]. It can be disempowering and serve to belittle and shame patients, infer to patients that they are to blame for their conditions, or that they are passive recipients of care with minimal role in making treatment decisions [6, 9]. Stigmatising language can affect patient outcomes. For example, patients with obesity who experience stigmatising language have poorer outcomes in weight management treatments, increased psychological distress, and reduced healthcare utilisation [10].

Language use also influences healthcare professionals' perceptions of patients [11]. Medical students and resident doctors who read medical notes of a patient with sickle cell disease written using stigmatising language had more negative attitudes towards the patient compared with those who read a neutral version of the note. Resident physicians who read the stigmatising note were less likely to prescribe pain medication, highlighting how bias can be transmitted through language use and directly impact patient care [12].

The goal of using person-first language is to empower patients and facilitate better therapeutic relationships between the patient and healthcare provider. Doctors and medical educators need to appreciate the power of their words and realise their role in leading change in the medical lexicon to foster an ethos of person-first language [13]. Language biases can be perpetuated in clinical training; the effectiveness of language interventions in medical education settings is unknown [6].

Problem formulation/purpose

To understand the scope of the problem of stigmatising language within medical education and identify what types of interventions medical students and lecturers would value, medical students were interviewed in this study. They shared their experiences of stigmatising language in healthcare and education settings and recommendations for change.

Method

Study design

An inductive qualitative study approach was used for an in-depth understanding of the language complexities in healthcare from a constructivist research paradigm [14, 15].

Participants and procedure

Ethical approval was granted by the RCSI University of Medicine and Health Sciences Research Ethics Committee on February 22, 2022. All students, regardless of year or course of study, were invited to participate via a general information post on the university's Virtual Learning Platform and directed to a Microsoft Forms link to view the participant information sheet and anonymously indicate availability for one of four pre-selected interview dates and times. There were no exclusion criteria for participation.

Focus groups were conducted in-person on the university campus in April 2022, facilitated by at least one student researcher and a staff researcher. A semi-structured interview schedule was designed to explore student experiences of stigmatising language during their medical training. This allowed the researchers flexibility when questioning whilst using prompts as needed to explore three key areas: the experience of stigmatising language use and effect of stigmatising language in healthcare; experiences of stigmatising language use and the effect of stigmatising language in medical education; and recommendations for improving person-first language in medical education and healthcare settings. Focus groups lasted approximately one hour. Participants were provided with food and beverages.

Data collection and analysis

Interviews were audio-recorded by Dictaphone and the Microsoft OneDrive transcription function was used to transcribe interviews. Transcripts were checked for accuracy and de-identified by researchers. Data was organised using NVivo Version-12.

Demographic information pertaining to the participants' university course, age in bands (1 [9]-25; 26–35; 36–45; 46+), and primary language was recorded to contextualise the sample. This data was collected using an anonymous questionnaire at the focus group and analysed using Stata Version-12.

Twenty-four participants responded to the recruitment post. Twenty-one participants took part in 4 focus group interviews, ranging in size from 2 to 11 participants. Participants ages ranged from 18 to 25 (57%) and 26–35 (43%). 90% reported English as their primary language and 33% reported having a chronic health condition.

Reflexive inductive thematic analysis (TA) was conducted following a six-step guideline [16]. Two study

Table 1 Examples of stigmatising language reported and suggested person-first alternatives

Stigmatising language examples observed by participants in medical education	Person-first language alternatives
Wheelchair bound	Wheelchair user Person who uses a wheelchair
Junkie	Person who uses drugs Person with drug dependence
'Rotten' lungs	Lung condition
Diabetic	Person with diabetes (*Note: diabetic person may be preferred - it is recommended to ask the person which term they use)*
Chronic psychotic	Person with psychosis Person with mental illness
Schizo	Person with schizophrenia
Heart defect (in utero)	Congenital heart disease
Drunks	Person with alcohol use disorder
Autistic	Person with autism (*Note: autistic person may be preferred - it is recommended to ask the person which term they use)*

researchers (SD, EG) individually read transcriptions and made notes of early impressions. Initial themes were generated using a theoretical TA approach [17, 18], and an open coding process using semantic coding was applied [19]. SD and EG separately coded each transcript, modifying and developing themes through regular group discussions of semantic code content. Disagreements were solved through discussion with the third researcher LM until a group consensus was reached.

Initial themes were broad and predominantly descriptive (i.e. describing semantic patterns in the data relevant to the research question). These were collated and grouped into sub-themes ensuring agreement between SD, EG, and LM. Final themes (i.e. numbered 1 through 7 in Results) were refined through group discussions. Reflexive practice was central to the analysis as the student researchers were classmates with some participants, and all focus group participants had interacted with the staff researcher during their medical education. Open dialogue and consideration of personal assumptions was engaged throughout.

Results

Seven themes were identified and are outlined below with supporting quotes. Additional quotes are included in Appendix 1. Participants were assigned pseudonyms. Person-first language examples of stigmatising terms observed by students are outlined in Table 1.

1) Prevalence of stigmatising language

Observing stigmatising language use was a common occurrence in medical education and healthcare settings with the feeling that it is *"absolutely everywhere… used flippantly among health professionals to students."* Participants observed that stigmatising language is *"especially damaging"* in mental illness, where it was described as *"almost like a bonding"* between colleagues when words such as *"alcoholic, drug addict, schizophrenic, [and] chronic psychotic"* are used. Participants noted that health professionals often did not correct their language, even when patients highlighted it was incorrect.

> *One of the doctors was like "you're wheelchair bound" and the patient specifically said to them "I'm actually a wheelchair user" and the consultant is like "yeah… you're wheelchair bound." The word bound suggests that the wheelchair is something that they are unfortunately forced to use, which sort of flips the whole idea that the wheelchair is…a mobility aid… it allows people to get around….*

In teaching settings, participants recognised that lecturers did not correct students' language, viewing this as a missed learning opportunity.

> *Someone said 'I've never seen so many junkies before'.. And the lecturer didn't say anything. … we are sitting with knowledge, learning about drug addiction and one of your students has just said junkie in a professional setting and you are not going [to do anything]… that's not an acceptable [response].*

2) Impact of stigmatising language

Students shared instances where fellow students were personally affected by language used by lecturers. In one instance the students had a lecture on serious respiratory illness. *"They [the lecturer] didn't use stigmatising language per se, but they described the lungs as rotten… and it happens to be that one of the students in our class has… [the condition being discussed]."* Whilst it was noted that lecturers cannot be expected to know the situation of every student in the room, general consideration is required. Such language is often unintentionally used with negative impact.

From a patient perspective, participants felt that stigmatising language use can make "*patients feel as if they're defined by the condition… it can make the professional sometimes think well, I'm just dealing with this condition, not the patient…*" The more stigmatised patients feel, the less likely they are to speak about their concerns; this may preclude them from seeking medical care.

I'm already being judged for this condition that I have, and the doctor has a preconceived notion about the fact that it is a disease or disorder or defect and that I am somehow a problem… so, I'm not going to provide them with any more ammunition to carry that….

3) Being sensitive versus medically accurate

Participants acknowledged that there is a counterargument regarding the use of sensitive language; "*Do you change the actual scientific lexicon to accommodate cultural trends?"* One participant noted that if a patient is overweight and doctors try to *"censor that… we're masking from the patient what we think, right? That's sort of wrong."* Caution must be taken against the cost of losing transparency.

4) Language as constantly evolving

Participants felt it is *"hard to keep up"* with appropriate language. Some felt *"there's never going to be [a] clear demarcation as to what's appropriate and what's not… [as the] lines and the goal posts are always shifting…"* Rapid evolvements in language can act as a barrier to language progression.

5) Barriers to change

One reason for the perpetuation of stigmatising language use in healthcare was highlighted as the ability to *"become desensitised to the language you use."* Stigmatising words *"roll off your tongue… you don't typically think of the impact of that certain word on the actual patient…"* Additionally, practicing medicine is stressful. "*There is so much to already think about, it's kind of -as bad as it sounds- I think sometimes it's the last thing you're thinking about it, even though we're told constantly how… communication is key in medicine…"* The demands of providing medical care impairs language awareness.

6) Influence of power dynamics and cultural context

Language cannot be analysed in isolation. Participants advised the consideration of power dynamics as "*…medicine is either taught or administered from a place of power… this person whether they're my doctor or my professor, they know better than me… you sort of defer to them…*" Participants referenced a hierarchy in medicine, noting that if a student's superior felt a stigmatising word was *"appropriate to use"* they felt *"…quite uncomfortable standing up to that…"*.

Additionally, modern healthcare is diverse, and "*culturally you can have different words that you use…*" For example, some "*might think that it [one word] is not a bad word but other people would."* Cultural sensitivities are difficult to integrate.

7) Stigmatising language as a broader societal issue

Participants highlighted that *"this isn't a problem we can solve just in medicine…it is a broader societal issue."*

Recommendations for improving language use in medical education and healthcare settings

Creating an environment where feedback to lecturers from students is welcomed would foster an ethos of person-first language. Open discussion and debate on issues in medical language should be encouraged. Lecturers can use their position to make a difference. To help students develop the practice of using sensitive language, lecturers should routinely signpost person-first language in relation to the topic being taught because "*if it's integrated into the slides in the same way that every lecture slide has the COVID information on the very front… you see it all the time, you just know it…"*.

Participants suggested that students should be encouraged to seek out patient preferences in communication-based classes such as "*Is it OK if I address you this way? Or how would you like to be addressed?"* It is also vital that lecturers and clinicians are aware of recent guidance regarding appropriate language use. However, as one participant noted, caution should be taken as "*if you're policing that [language] in their place of work and the people they interact with every single day, I don't know if it will have the best outcome."*

Training workshops would ensure clinicians and lecturers remained up-to-date. Presentations at Grand Rounds or forums accessible to staff was highlighted as a method to promote person-first language. Social intelligence in healthcare was further stressed since "*learning how to read a room is very important in medicine."*

Discussion

Findings of this study demonstrate the problem of stigmatising language use in medical education and healthcare, across disciplines, levels of seniority, and patient cohorts. Medical students feel that it impacts their education and patient care, and often feel limited to drive change for fear of impacting their relationships with lecturers and clinicians who have influence over their educational progression. Stigmatising language is further perpetuated by fear of exclusion, awareness of the power dynamics in healthcare as a junior doctor, and lack of awareness of evolving guidance on use of person-first terminology.

Students offered examples to improve the use of person-first language in medical education. Fostering an

environment where students can highlight instances of stigmatising language use and engage in discussions with lecturers and clinical staff without fear of personal or academic consequences would allow students to develop confidence in using person-first language with patients. It was highlighted that medical educators also have a responsibility to educate themselves on person-first language in their areas of expertise and provide appropriate signposting for students to up-to-date language and terminology. Additionally, lecturers have a responsibility to be self-aware of the impact of their terminology on students.

Participants highlighted that policing language in medical education and clinical practice may restrict one's intuitive communication style and detract from the focus on optimal care delivery [20]. The euphemistic treadmill refers to replacement of potentially offensive, emotionally laden words with "polite" words that, over time, also become offensive, perpetuating a need for newer replacement words. This phenomenon highlights the constantly evolving nature of language and the difficulty of keeping informed on emerging developments in person-first language. In the setting of the competing demands of clinical practice, this phenomenon does not harbour an easy path [21].

The role of the hidden curriculum in medical education must be acknowledged [22]. The French philosopher Michel Foucault developed the concept of the 'medical gaze', which describes how doctors objectify the patient's story through a biomedical lens and thus only focus on pertinent clinical information [23]. The use of medical slang may serve a dual purpose in developing camaraderie whilst serving as a way to distance oneself from seeing illness and death regularly, through the process of filtering out the patient's subjectivity [7]. Slang most commonly begins in third year of medical school and peaks in internship and junior years as a way to relieve stress and burnout from considerable professional responsibilities and long working hours [24].

Working with patients from a biopsychosocial paradigm which integrates clinical objectivity with the patient's subjective experience involves social intelligence when working with patients is a critical skill as a doctor but often overlooked in medical training. Consequently, improving social intelligence and awareness of the power of words was highlighted in the findings as a recommendation for change in medical education.

Current teaching strategies to improve person-first language in healthcare education and amongst health professionals have employed various methods. The use of patient videos has been used to help clinicians identify their unconscious biases [25], along with receiving feedback from patients and carers [26]. The RESPECT Model, developed with nursing professionals, promotes Rapport, Environment/Equipment, Safety, Privacy, Encouragement, Caring/Compassion, and Tact when communicating with patients [27].

A number of condition-specific guidelines can be an essential resource; for example, Obesity UK provide guidelines on communication with patients with obesity, including a focus on: avoidance of labelling and language that implies blame and generalising; collaboration; awareness of the power of language and non-verbal communication; noticing the language patients use about their own conditions; communicating evidence-based information. The International Network of People who Use Drugs provide a reference guide that emphasises avoidance of language that diminishes the person's value and assumptions about the person's identity; it stresses the use of empowering language and valuing the perspective of the person who uses drugs.

Participants in this study raised the issue of stigmatising language as a broader social issue, particularly in areas of disability, race, ethnicity, gender identity, and sexual orientation. Efforts to address stigmatising language are evident in public-facing sectors including journalism [28], communications and marketing [29], and academic writing; this may serve to bring awareness and education to society [30].

Study limitations and directions for future research

Analysis of medical students' perspectives from a single institution may limit the representativeness of findings presented; however, RCSI has a student cohort from over 69 countries. Additionally, the examples provided are paraphrased from the students memory of what a clinician or lecturer said and may not be verbatim. Future research examining the lecturer's perspective on stigmatising language use in healthcare and the perspectives of students representing other healthcare disciplines (e.g. nursing) would provide a broader context. To address this research gap, we have conducted a similar study containing focus groups with staff medical lecturers at our institution; preliminary analysis indicates concordance with student views on the breadth of this problem in healthcare and strategies for change. The Lancet Commission on ending stigma and discrimination in mental health states that recognition of the lived experience of the patient is an essential part of any anti-stigma programme, and patient inclusion in training initiatives is imperative [31]. Thus, future research examining patient experiences is essential to developing initiatives to improve person-first language in healthcare.

Conclusion

Stigmatising language in healthcare is an evolving topic with little guidance. This qualitative study was the first to examine medical students' perspectives on stigmatising

language in medical education and healthcare. Stigmatising language use was identified as prevalent across medical disciplines and amongst diverse patient cohorts; it has an impact on medical education and clinical practice. There is a need for inclusion of person-first language training in core medical curricula to address the perpetuation of stigmatising language use in healthcare. Further, medical educators have a responsibility to educate themselves and role model appropriate person-first language in their given disciplines. Fostering a culture of open dialogue between students and medical educators on the impact of stigmatising language on patients and healthcare delivery can bolster student confidence to challenge stigmatising language in healthcare settings, engage in effective communication with patients, and serve as exemplary future medical professionals.

Supplementary Information

The online version contains supplementary material available at https://doi.org/10.1186/s12909-025-06690-1.

Supplementary Material 1

Supplementary Material 2

Acknowledgements
We would like to acknowledge the participants of the study who openly shared their perspectives and experiences on stigmatising language in healthcare and medical education. The funding from RCSI University of Medicine and Health Sciences was of invaluable support to the study.

Author contributions
SD and LM conceptualized and designed the study. SD, EG, and LM were involved with conducting the study and collecting and analysing the data. All authors contributed to the development of the manuscript and have read and approved the final version of the article.

Funding
The study was funded by an RCSI Student Engagement and Partnership Award (Saakshi Daswani and Elizabeth Gorecki), and RCSI Research Summer School funding (Saakshi Daswani and Elizabeth Gorecki) in 2022.

Data availability
The qualitative data collected through the focus group interviews is shared within the Results section of the manuscript and supplementary file Appendix 1. Due to the potential of identifying participants through qualitative data, the entirety of the data has not been shared. Relevant, de-identified quotations have been shared after obtaining participant consent.

Declarations

Ethics approval and consent to participate
Ethical approval for this study was granted by the RCSI University of Medicine and Health Sciences Research Ethics Committee on February 22, 2022. Informed consent to participate in the study was obtained from all student participants. All participants provided consent for their quotes to be published anonymously.

Competing interests
The authors declare no competing interests.

Received: 1 March 2024 / Accepted: 9 January 2025
Published online: 24 January 2025

References

1. Dickinson JK, Maryniuk MD. Building Therapeutic relationships: choosing words that put people first. Clin Diabetes. 2017;35(1):51–4.
2. Lala A, Mentz RJ. Language matters: understanding barriers to Medication Adherence to Better Tailor Heart Failure Care. J Card Fail. 2021;27(8):825.
3. Crocker AF, Smith SN. Person-first language: are we practicing what we preach? J Multidiscip Healthc. 2019;12:125–9.
4. Mai CT, Petersen EE, Miller A. Public perception of birth defects terminology. Birth Defects Res Clin Mol Teratol. 2012;94(12):984–9.
5. Johnson EK, Rosoklija I, Finlayson C, Chen D, Yerkes EB, Madonna MB, et al. Attitudes towards disorders of sex development nomenclature among affected individuals. J Pediatr Urol. 2017;13(6):608. e1- e8.
6. Cox C, Fritz Z. Presenting complaint: use of language that disempowers patients. BMJ. 2022;377:e066720.
7. Fox AT, Fertleman M, Cahill P, Palmer RD. Medical slang in British hospitals. Ethics Behav. 2003;13(2):173–89.
8. Leopold SS, Beadling L, Gebhardt MC, Gioe TJ, Potter BK, Rimnac CM, Wongworawat MD. Editorial: words hurt–avoiding dehumanizing language in orthopaedic research and practice. Clin Orthop Relat Res. 2014;472(9):2561–3.
9. Abbasi K. Mind your language to catalyse the patient revolution. British Medical Journal Publishing Group; 2022.
10. Puhl R, Peterson JL, Luedicke J. Motivating or stigmatizing? Public perceptions of weight-related language used by health providers. Int J Obes (Lond). 2013;37(4):612–9.
11. Raney J, Pal R, Lee T, Saenz SR, Bhushan D, Leahy P, et al. Words Matter: an Antibias Workshop for Health Care Professionals to reduce stigmatizing Language. MedEdPORTAL. 2021;17:11115.
12. O'Conor APG, Lanzkron KJ, Saheed S, Saha MO, Peek S. Do words Matter? Stigmatizing Language and the transmission of Bias in the medical record. J Gen Intern Med. 2018;33(5):685–91.
13. Donnelly WJ. The language of medical case histories. Ann Intern Med. 1997;127(11):1045–8.
14. Park YS, Konge L, Artino AR. Jr. The Positivism paradigm of Research. Acad Med. 2020;95(5):690–4.
15. Lee C-jG. Reconsidering constructivism in qualitative research. Educational Philos Theory. 2012;44(4):403–12.
16. Braun V, Clarke V. Using thematic analysis in psychology. Qualitative Res Psychol. 2006;3(2):77–101.
17. Maguire M, Delahunt B. Doing a thematic analysis: a practical, step-by-step guide for learning and teaching scholars. All Irel J High Educ. 2017;9(3).
18. Braun V, Clarke V. One size fits all? What counts as quality practice in (reflexive) thematic analysis? Qualitative Res Psychol. 2021;18(3):328–52.
19. Wæraas A. Thematic analysis: making values emerge from texts. Researching values: methodological approaches for understanding values work in organisations and leadership. Springer International Publishing Cham; 2022. pp. 153–70.
20. Pinker S. The blank slate: the modern denial of human nature. Penguin; 2003.
21. Botha M, Hanlon J, Williams GL. Does language matter? Identity-first versus person-first language use in autism research: a response to Vivanti. J Autism Dev Disord. 2023;53(2):870–8.
22. Hafferty FW, Franks R. The hidden curriculum, ethics teaching, and the structure of medical education. Acad Med. 1994;69(11):861–71.
23. Misselbrook D, Foucault. Br J Gen Pract. 2013;63(611):312.
24. Coombs RH, Chopra S, Schenk DR, Yutan E. Medical slang and its functions. Soc Sci Med. 1993;36(8):987–98.
25. Altilio T, Groninger JH, Kelemen A, Leff V. Watch your mouth: expanding awareness of Clinical Language to promote Quality Care and Culture Change (SA523). J Pain Symptom Manag. 2018;55(2):651.
26. De Souza CM, editor. Editor Pediatric Somatization: incorporating Family Feedback to inform Education and Care. 2020 virtual meeting. AACAP; 2020.
27. Aycock DM, Sims TT, Florman T, Casseus KT, Gordon PM, Spratling RG. Language sensitivity, the RESPECT model, and continuing education. J Continuing Educ Nurs. 2017;48(11):517–24.
28. Silverman A. National Center on Disability and Journalism: Disability Style Language Guide Arizona State University2021 [updated 2021; cited 2024 20/01/2024]. Available from: https://ncdj.org/style-guide/#D
29. Marketing CC. Inclusive Language Guide.
30. Gernsbacher MA. Editorial Perspective: the use of person-first language in scholarly writing may accentuate stigma. J Child Psychol Psychiatry. 2017;58(7):859–61.

31. Thornicroft G, Sunkel C, Alikhon Aliev A, Baker S, Brohan E, El Chammay R, et al. The Lancet Commission on ending stigma and discrimination in mental health. Lancet. 2022;400(10361):1438–80.

Publisher's note