

Title	The importance of respectful language to enhance care. A statement of the Association of Cardiovascular Nurses and Allied Professions (ACNAP) of the ESC, the ESC patient forum and the ESC advocacy committee
Authors	Lee, Geraldine;Barisone, Michela;Dendale, Paul;Jennings, Catriona;Jones, Hwyl;Kindermans, Hanne;Kyriakou, Martha;Moons, Philip;Scheenaerts, Bart;Gibson, Irene
Publication date	2025-04-11
Original Citation	Lee, G., Barisone, M., Dendale, P., Jennings, C., Jones, H., Kindermans, H., Kyriakou, M., Moons, P., Scheenaerts, B. and Gibson, I. (2025) 'The importance of respectful language to enhance care. A statement of the Association of Cardiovascular Nurses & Allied Professions (ACNAP) of the ESC, the ESC patient forum and the ESC advocacy committee', European Journal of Cardiovascular Nursing, 24(3), pp.344-351. https://doi.org/10.1093/eurjcn/zvaf020
Type of publication	Article (peer-reviewed);journal-article
Link to publisher's version	10.1093/eurjcn/zvaf020
Rights	© 2025, the Authors. Published by Oxford University Press on behalf of the European Society of Cardiology. This article is published and distributed under the terms of the Oxford University Press, Standard Journals Publication Model (https://academic.oup.com/pages/standard-publication-reuse-rights)
Download date	2026-09-22 08:33:47
Item downloaded from	https://hdl.handle.net/10468/17345



University College Cork, Ireland
Coláiste na hOllscoile Corcaigh

Title The Importance of Respectful Language to Enhance Care. A statement of the Association of Cardiovascular Nurses & Allied Professions (ACNAP) of the ESC, the ESC Patient Forum and the ESC Advocacy Committee

Authors: Geraldine Lee^{1*}, Michela Barisone ², Paul Dendale ^{3,4}, Catriona Jennings ⁵,Hwyel Jones ⁶, Hannah Kindermans ³, Martha Kyriakou ⁷, Philip Moons ⁸⁻¹⁰, Bart Scheenaerts ⁶, Irene Gibson ^{5,11}

1. School of Nursing and Midwifery, University College Cork, Cork, Ireland
2. Clinical Epidemiology and Research Center, Humanitas Research Hospital, Milan, Italy
3. Faculty of Medicine and Life Sciences Hasselt University, Hasselt, Belgium
4. Hartcentrum Hasselt, Belgium
5. School of Medicine, University of Galway, Galway, Ireland
6. ESC Patient Forum
7. European University Cyprus, Nicosia, Cyprus
8. KU Leuven Department of Public Health and Primary Care, KU Leuven - University of Leuven, Kapucijnenvoer 35 PB7001, 3000 Leuven, Belgium
9. Institute of Health and Care Sciences, University of Gothenburg, Arvid Wallgrens backe 1, 413 46 Gothenburg, Sweden
10. Department of Paediatrics and Child Health, University of Cape Town, Klipfontein Rd, Rondebosch, 7700 Cape Town, South Africa
11. National Institute for Prevention and Cardiovascular Health, Galway, Ireland

***Corresponding author:**

Geraldine Lee, PhD, FESC, FHEA

Professor of Nursing and Chair of Health Service Research

Catherine McAuley School of Nursing & Midwifery,

Brookfield Health Sciences Complex, College Road

University College Cork, Cork T12 AK54, Ireland

Email: glee@ucc.ie

The Importance of Respectful Language to Enhance Care. A statement of the Association of Cardiovascular Nurses & Allied Professions (ACNAP) of the ESC, the ESC Patient Forum and the ESC Advocacy Committee

Abstract

The use of respectful communication is essential to establishing a good therapeutic relationship between the healthcare professional (HCP) and the patient. Negative language can adversely affect interactions between the public and HCPs. Person-centred care is advocated in cardiovascular care but there is lack of information regarding on how communication and respectful language can be applied.

The aim of this statement is to explore the concept of respectful language in the delivery of person-centred cardiovascular care and present a working definition of respectful language in the context of healthcare and HCPs. This paper outlines of the role of communication in the delivery of cardiovascular care with critical analysis of the relevant literature. Factors influencing respectful language including ethnicity and culture and the move from the term ‘patient’ to ‘person’ are explored. Digital technologies (such as remote monitoring) now play a key role in delivering healthcare and HCPs need to be mindful on how it affects communication. Another important consideration is artificial intelligence and its potential impact on respectful language. Many healthcare providers and organisations have developed plain language documents and non-technical lay summaries are available for evidence-based guidelines and research. This paper offers suggestions for ensuring best practice in the use of respectful language.

Undoubtedly, respectful language is central to delivering person centred care. Every individual HCP involved in providing cardiovascular care can make some changes to their communication. Further education and training in the use of respectful language is needed along with evidence highlighting patient-reported outcomes and experience.

Keywords: advocacy, respectful language, nurses, allied health professionals, physicians, communication

Introduction

The use of respectful communication is essential to establishing a good therapeutic relationship between the healthcare professional (HCP) and the patient. Defined as showing politeness or honour to someone, respectful communication is the cornerstone of professionalism in healthcare.¹ Language is a powerful tool that helps foster respectful communication as the words we choose can have a profound effect on individuals and how people experience their health condition. Poor communication has been shown to negatively impact patients outcomes, including reduced treatment adherence, increased stress and anxiety, decreased satisfaction with care, lowered trust in healthcare providers and diminished patients engagement in decision making.¹⁻⁴ Issues reported by people include receiving inadequate information, often delivered in a rushed manner.² not being understood by their doctors and in some cases feeling disrespected and judged.³ Feeling not understood often stems from the healthcare professionals failing to listen actively, interrupting patients or not giving them enough time to fully explain their concerns.

A study by Shore *et al.*, 2024 shows that most patients with advanced heart failure demonstrated a poor understanding of their prognosis. Patients and care partners described ineffective communication of prognosis with physicians, common barriers to understanding prognosis, and similar suggestions for improving communication of prognosis. Barriers to understanding prognosis included avoidance of conversation by physicians, inconsistency of information between different physicians, distractions during communication of prognosis, and confusion related to the use of medical jargon.⁵ Therefore, respectful communication is a fundamental skill that HCPs must acquire and develop to enhance patient engagement in decision-making, improve adherence to medication and treatment plans and overall perceptions of quality of care.¹ Importantly, a multicultural society requires communication that is sensitive to culture and ethnicity. However, cultural differences including language and

communication barriers, together with economic aspects, significantly limit the ability of different ethnicities to control the burden of CVD risk.⁶ These cultural differences can make the communication process difficult, especially where there is limited training and resources for HCPs.⁴⁻⁹ Person-centred care (PCC) focuses on “*understanding the patient as a human being*”, a concept which is shaped by the person’s context, values, preferences, needs and beliefs and as such is central to an optimal therapeutic relationship.^{10,11} PCC is associated with positive perceptions on quality care and highlights the move away from ‘the patient’ to ‘the person’.^{1,12} As such, global organisations across non-communicable diseases such as diabetes, obesity and cancer recommend the use respectful, person-centred language across all communications including publications in academic journals.¹³⁻¹⁷ However, to date there has been little emphasis on cardiovascular disease (CVD).

This statement aims to explore the concept of respectful language in the delivery of person centred cardiovascular care. An outline of the role of communication, education and training and digital technologies in the use of respectful language will be presented. Implications for clinical care and research will be discussed and suggestions for practice will be provided. **Table 1** provides practical examples for use of respectful language by health care professionals working in cardiovascular care.

Background

Despite healthcare professionals and the public’s interest in communication and PCC, gaps remain on how respectful language should be applied and its impact on the patient-clinician relationship. Before exploring the issues, it is important to describe what we mean by respectful language. Use of language may be unidirectional or bidirectional, synchronous or asynchronous, and it requires a communication channel, whether it be oral or written, and more

recently digital that may include a visual component that allows observation of body language. Specific circumstances influence the use of language, for example the moment of the communication, the amount of time available and the physical environment. In **text box 1**, we propose a working definition of respectful patient language in the context of healthcare and HCPs. What is evident from recent literature, is the importance of person-first language, avoidance of dehumanising labels or terms that suggest personal blame (i.e. the obese patient) and any language that can have psychological ramifications.^{18,19} An awareness of the negative effects of language on patients has emphasized how language is central in PCC, particularly in those with chronic conditions where there has been a history of blame in relation to lifestyle choices (smoking and poor diet for example).²⁰ It is possible that respectful language will increase shared decision-making and improve relationships between HCPs and patients which could be measured using Patient-Reported Outcomes Measures (PROMs) and Patient-Reported Experience Measures (PREMs). If we are to successfully deliver PCC, advocate for our patients and improve satisfaction with care, we need to ensure the language and communication we use is respectful.

Text box 1: Working definition of respectful language in the context of healthcare and HCPs:

Respectful language is the use of person-centred language in all forms of communication, that is intentionally empathetic and takes into account the person's values, orientation, condition, beliefs and culture whilst also being non-judgemental, impartial and free of stigma.

Effective communication is critical when talking about a diagnosis, a prognosis, a treatment or a life-threatening situation with patients and families and between HCPs. The literature shows that the language used about patients can depersonalise individuals, particularly when it refers to them according to their diagnosis, for example 'the heart attack in bed 8'.¹⁹ The emphasis has now moved to respectful communication and a guarantee that there

are opportunities for patients and their families to ask questions and be partners in their own care using shared decision-making. Thus, the clinical HCP-patient dynamic has substantially changed.

More recently, there has been a move to acknowledging how language affects individuals and to recognising the need for clinicians to be mindful of their spoken and written language. A language guide for people with lung cancer emphasized the importance of using language that respects the dignity of the patient and raised the important point that language and meaning may vary depending on the context.¹³ Some authors have called for improved therapeutic relationships and avoiding language that belittles patients or has negative connotation such as 'patient denies chest pain' or using the term 'poorly controlled'.²⁰ They acknowledge that some language is now out-dated (for example 'patient denies' or 'patient claims') and that narratives in clinical notes need to be person focussed with a clear need for collaborative relationships between clinician and patient.^{21,22} Bajaj et al. echo this whilst highlighting the use of dehumanising language that reinforces stigma and highlights the possible psychological ramifications with the use of labelling.¹⁷ Patient engagement is now widely advocated, and this will help determine what language is preferable for patients and also identify what language is stigmatising or upsetting. The authors recommend working with health communication experts to map out the effect of language on patient and clinician perceptions.²³ The debate has clearly moved on with a recent editorial considering the move towards 'dignity-based practice'.²⁴

It has been suggested that a communication framework would be useful to measure patient- related outcomes - for example did a patient directly respond to something they were told in a consultation about medication or a lifestyle risk factor.²⁵ One hypothesis is that a good therapeutic relationship can result in improved diagnosis with improved treatment adherence, improved satisfaction and a reduction in decisional conflict where shared-decision making is

used.²⁵ There is some evidence that report the causal effects of communication in relation to physicians.²⁶ It may be that the process (i.e. good communication) and outcomes (i.e. satisfaction) are probably of greater importance than the framework applied. The following section will provide an overview of areas where we need to develop, namely: communication; training and education; and practice and culture.

Communication

From an historical perspective, a top-down authoritarian model of communication between patients and doctors has been evident in clinical practice with the literature referring to ‘the patient’. However, within the past three decades, there has been a shift in the patient-doctor encounters with patients now expressing their preferences, engaging in decision-making, and asking questions about their condition, health or treatment.²⁷ As well as good communication between HCPs, good communication between clinician and patient is important. As described by Timmermans, the most powerful tool in healthcare is the conversation between the clinician and the patient as it is the foundation for discussing diagnosis, treatment and prognosis.²⁷ Clinical engagement should, therefore aim to facilitate and support the active involvement of persons in their own care. Central to this is avoidance of language that belittle or blames the person. For instance, the term ‘*poorly controlled diabetes*’ can be stigmatising and make people feel judged.²⁸ Furthermore, language needs to emphasise that patients are no longer passive recipients of care and that the doctor or HCP is not in the position of power. For instance, there can be an authoritarianism around what an individual should or should not do in relation to their lifestyle in terms of modifiable risk factors. This implies that the HCP knows better and if the individual does not follow instructions, they are being un-cooperative.²⁰ It also fails to acknowledge the person’s experience of living with the disease. Therefore, suggesting options that emphasise individual choice and autonomy is preferred. There is also evidence to show that the language used by doctors can influence the

relationship they have with their patients.¹⁹⁻²¹ In a study by Puhl et al. 19% of participants reported that they would avoid future medical appointments if made to feel stigmatised about their weight.¹⁹

There is a wealth of published literature on communication theories. Lazare proposed a three-function model: 1) to determine and monitor the nature of the health problem, 2) to develop, maintain and conclude the therapeutic relationship, and 3) to carry out patient education and implementation of treatment plans.²⁹ Epstein and Street's model proposed six core functions for patient-clinician communication: 1) fostering relationships, 2) information exchange, 3) making decisions, 4) enabling self-management, 5) responding to emotions, and 6) managing uncertainty.³⁰ Despite these models providing core functions for effective communication, the language utilised is not identified specifically as a core function and there is a lack of consensus across the models in the core functions. More recently, a scoping review identified 53 different tools to measure communication satisfaction highlighting the importance of communication within a healthcare consultation whilst also highlighting that it is difficult to capture.³¹ Undoubtedly, good communication as part of the therapeutic relationship is essential but use of respectful language is not overtly evident in the models described.

Factors influencing use of respectful language

Despite the extensive literature on communication within healthcare settings, there is a paucity of information on factors affecting respectful communication. Respectful patient language encompasses multiple challenges to take into account to reach its intent. An article by Aycock *et al.*, proposed the concept of language sensitivity and the use of words that are respectful, supportive and caring.³² One aspect is changing from using 'medical-symptom first' to 'person-first' language. This helps to emphasise that the disease is only one part of the whole person. For example, rather than referring to 'the aorta dissection in room 15' it is better to talk about

“Miss or Mr (surname) or the person with the aorta dissection in room 15 ”. Linked to this, is the question, should we use a different word for patient? The term “patient” can imply that people are little more than their diagnosis and it also conflicts with the idea that the patient is an equal partner with their HCP. However, in the absence of research regarding peoples’ perspectives of the word “patient”, it has been suggested that efforts should be focused on improving practice to ensure that connotations of the patient are holistic and positive.³³ There is also a difference in appropriateness of language when talking about patients with medical colleagues on the one hand and talking directly with patients on the other hand. This also extends to other areas such as medical education, research and the media. Therefore, what is required is the ability to adapt our language to differing contexts.

Another important factor is the health systems focus on task centred care.¹ With shortages of HCP staff, increased workload, burnout and limited time, it may be easier for HCPs to become task oriented. While adding the human factor to the technical nature of the job is not a trivial task, it has been argued that it is the quality of HCP-patient interactions that matter versus the quantity of time spent with patients.³⁴ For example, a HCP greeting asking the patient how they would like to be addressed is an opening to create a therapeutic relationship, thus positively impacting on the person’s experience of care.³³

Studies show that ethnic and cultural factors play a key role in how patients like to be addressed. For example, in countries such as Iran and Israel and in African Americans in the US, formal address by title and surname is preferred, whereas in Ireland, UK and Australia patients prefer first name and informal address.³⁵ To ensure patients are addressed in accordance with their preference, a simple approach may be to enquire and document their preferences and personal pronouns on initial contact with the health service.

Digital technologies

Nowadays, digital communication has become a part of our daily life. Next to physical interactions between HCPs and patients, digital means are rapidly becoming a viable and efficient alternative. Digital communication goes further than adding digital means to human interaction: new development in Artificial Intelligence (AI) technologies predict a huge impact on contemporary healthcare- an example is the Gartner hype cycle.³⁶ This will further increase in the years and decades to come. Natural Language Processing (NLP) is an AI branch that pertains to interfacing computers and human language.³⁷ Whereas NLP was initially conceived to process and analyse copious language data, contemporary large language models are adept at crafting texts that emulate human natural language.³⁸ Since many large language models are trained on massive amounts of internet texts, biases and discrimination loom inherently. AI lacks contextual understanding, especially as algorithms are not trained on medical texts.³⁹ Specific “medically trained” algorithms are still being developed. Currently, AI systems cannot fully grasp the nuanced context of healthcare interaction, including cultural norms, individual patient preferences, and non-verbal cues such as body language. Despite these risks, AI could serve to enhance respectful language employment, if the models are suitably trained. For instance, developing bespoke AI algorithms to analyse exchanges between HCPs and patients to identify patterns of respectful or disrespectful language add value to digital communication. Integrating such AI systems into hospital information systems furnishing real-time feedback regarding disrespectful language, while HCPs are drafting their notes.⁴⁰ Another avenue could involve the development of chatbots for training and educating HCPs. Tools to simulate patient interaction and immediate feedback on language usage, then aid HCPs in developing skills in respectful communication within a controlled setting before applying it in real-life. It is worth noting that such bespoke AI systems, specialized in cardiology, are yet to be developed.

It is important to be mindful of using an appropriate form of digital communication. Application in medical settings pre-Covid was often unidirectional, hence transactional by nature. Using short messages between the HCP and the patient should only occur when there is

a high degree of trust in the relationship and the message is transactional. E.g. “*INR is 2.0. Warfarin dose 4mg.*” In most circumstances, digital communication implies specific formalities to the written text. The communication style should be genuine, personable and empathetic (as suggested in our working definition) and the intent should be that the patient keeps faith in their relationship with the HCP. As patients now have access to their online records in many countries, it can be challenging for the HCP to interact with patients trying to understand medical and technical language.^{41,42}

Training and education

Education and training in all levels of the health curriculum, spanning from undergraduate studies to continuing education, play a pivotal role in shaping HCPs who are attuned to PCC and competent communicators. In the context of respectful patient language, there are several crucial (intertwined) communication skills that can be identified in literature: (i) effective shared decision making (SDM), (ii) relational communication skills, (iii) informational skills, (iv) prevention of bias and (v) written information. A review of curricula at medical schools indicates that training of such skills is brief and variable and students as well as professionals probably do not value person-centered care enough.⁴³⁻⁴⁵ Yet, Education and training, even short-term, directed at transferring patient-centered skills to HCPs are found to be effective and interpersonal training of undergraduate students can improve their overall communication skills and empathy.^{46,47} Therefore, acknowledging the barriers and increasing efforts towards the inclusion of the following learning objectives is needed.

In the first place, effective SDM requires the willingness and openness of the physician/HCP towards active participation of the patient in the diagnostic and therapeutic process, which is not always the case^{48,49} SDM may wrongfully be perceived as too time-consuming.⁵⁰ Therefore emphasis in training should also be directed at developing positive

attitudes and tackling misconceptions. Next, physicians themselves reported a need for knowledge and skills on SDM to address patient barriers such as lack of trust or low health literacy.⁴⁸ It is known that patient-related barriers can be compensated for by the experienced quality of the patient-physician relationship which underscores the need for relational communication skills on the side of the healthcare provider.⁵¹ Continuing education can support HCPs on improving their relational communication skills. Third, informational skills are at the core of effective SDM. Independent of patients' level of health literacy, they should understand what is going on and of the options to participate in shared decisions. This is often not the case.⁵² To increase patient understanding, physicians and HCPs need to be educated in tailoring the level of complex information to the individual patient and reducing the use of medical jargon. This in turn can improve the patient-clinician relationship.^{53,54} A full guidance on the content of SDM is beyond the scope of this paper (see Elwyn and colleagues, for example, who have provided a useful outline of steps in a SDM conversation).^{55,56}

Another important aspect is to ensure that respectful patient language involves the prevention of bias. Biases are mental processes that can involve negative or positive attitudes towards someone from a social group based on particular qualities. Biases can be implicit (i.e. one is not aware of their bias) or explicit and both affect perceptions and behaviors such as the use of biased (body) language even if it is unintentional.⁵⁷ In individuals with cardiovascular disease, several types of bias might be apparent such as sex and gender bias where females/women are disadvantaged or body weight bias.^{58,59} Currently, there is no generally accepted evidence-based strategy to tackle implicit bias. Moreover, putting much emphasis on informing people not to stereotype can have the opposite effect and even increase implicit bias.⁶⁰ Yet, implicit bias is typically addressed by increasing knowledge and heightening awareness through reflexive exercises at an individual level or campaign-like information on a group level. To reduce weight bias for example, providing knowledge of non-behavioral contributors of

obesity to students can tackle negative beliefs such as ‘being overweight is one’s own fault’.⁵¹ Overall, providing counter stereotypical examples has been identified as one of the interventions with the most potential.^{15,60} In addition, HCPs should be educated on the usage of neutral words such as talking about ‘unhealthy weight’ instead of obesity with their patients.⁶¹

Language matters in direct verbal communication with patients but also in indirect ways through written language. Language used in medical records could also, unintentionally and unconsciously, be stigmatizing and biased.^{62, 63} Moreover, respectful patient language is also a point of interest in scientific publications.⁶⁴ As many healthcare practitioners are also involved in academic research, familiarization with inclusive language should take part early in and throughout education.⁶⁵ A recent scoping review noted that negative clinician attitudes and stigmatizing language has a negative impact on patient perception and potentially health outcomes.⁶⁶ To change practice, it is important to ensure that training and education of HCPs includes raising awareness of bias in how patients are viewed and guidance on how to record notes fairly.³

So, educational efforts towards PCC should focus on the cultivation and reinforcement of attitudes (i.e. personal values and beliefs) in addition to knowledge and practical skills. Yet, besides what is being taught, consideration should also be given to who is teaching. A large part of learning takes place in practice and implicitly by the observation of others so especially the effect of role models such as supervisors in training should not be neglected.^{67,68} Finally, patients themselves can play a valuable role in teaching and have a demonstrated beneficial effect on students’ empathy levels.^{69,70}

Changing practice and culture

Improving the language we, as HCPs, use when delivering cardiovascular care, requires a heightened awareness and willingness to change.²¹ The use of problematic language is deeply

ingrained in clinical practice and the need to change is not just a matter of political correctness, but rather, should be viewed as a catalyst for changing the way HCPs approach patients, deliver PCC, and establish collaborative relationships with patients.^{20,71} Collaborative relationships can take different forms and the choice will depend on several factors. However, whichever type of collaboration is selected, focusing on the words we choose across all communication mediums (written, verbal and digital) will help to actively engage patients living with CVD in their own self-care. To help support the use of respectful language, we have provided examples of suggested changes to terminology in **table 1**. The examples presented are not intended to be an exhaustive list but reflect our own experiences as well as those described in the literature.

Table 1. Examples of suggested changes to terminology related to CVD

Try this...	Instead of this..	Rationale
Reports no chest pain	Denies chest pain	Use of the term “deny” suggests untrustworthiness and casts doubt on the validity of the patient’s experiences
Difficulty taking medication due to...	Non-compliant	Use of the term non-compliant, can imply that the person is uncooperative, especially when used as adjective to describe the person rather than the behaviour.
Person who smokes	Smoker	Categorising a person by their health behaviour, has a negative connotation and perpetuates stigma
People with or living with heart disease	Heart patient	The term “heart patient” defines the person as their health condition. It is important to recognise that the patients we care for are more than just their diagnosis. Emphasising

		the person's ability to live with heart disease has a more positive connotation
Patient declined treatment	Patient refused treatment	Use of the term "refused" has a negative connotation and disregards the beliefs, preferences and other constraints on the individual, including the wider determinants of health
Treatment was not effective for the patient	Patient failed treatment	The connotation with the term 'fail' is that blame lies with the patient for the treatment not working. Patients do not fail treatments, treatments fail patients. Language needs to be empathic and non-judgemental
Is x (heart valve surgery, pharmacological or behavioural etc) the most appropriate intervention for this patient?	Is this patient suitable for xx intervention (medical or surgical) ?	This puts the intervention before the person.
Participants, people, individuals or patients depending on the context	Research subjects	The term "subject" is passive and does not acknowledge the active and vital role of individuals participating in research.

Also helpful for health professionals is the RESPECT model, outlined in detail in a paper from Alcock and colleagues.³² This model acronym (Rapport, Environment/Equipment, Safety, Privacy, Encouragement, Caring/Compassion, and Tact) serves as a prompt for health professionals to consider the sensitivity of their approach in their use of language.

Changing culture and practice in any organisation or institution has its challenges. Health services with their complex mix of health professionals, administrative, managerial and support staff are no exception. Good training and continuing education, raising awareness of the consequences of poor practice at the top, praising and rewarding good practice, role modelling, allowing time for the process of change and adjustment are all important. Essential to good practice and a culture that supports it is good leadership and leading by example. HCPs' use of language when they interact with patients and families and how they record their interactions with patients is influenced by all of these factors. What is practiced and accepted by those senior members within an organisational culture will be mimicked by those newly appointed employees. So, for example, what junior health professionals from any discipline whether it be physicians, nurses, pharmacists or other, see as the norm when looking at medical notes from seniors will influence the way they record notes themselves. Therefore, demonstration of good practice is essential to show leadership.

How can research help to improve the use of respectful language in health care communications?

At the start of this section, we referred to the need to heighten awareness of HCPs' choice of language when communicating with or about patients in health care and the need for a willingness to change. While we have insight into patient perspectives of respectful language and its impact, there is little data on HCPs' attitudes and whether this influences their behaviour. In addition, we need to investigate what barriers exist to using respectful language and, equally, facilitators that could be applied to change our use of language as these do not appear to have been systematically reviewed.

In addition, it is not clear from the current literature whether changing our use of language will improve patient satisfaction with the care delivered for the best.²⁰ Whilst some studies establish the benefits of good communication between clinicians and patients, they do not specifically investigate the use of respectful language.^{72,73} We should aim to adopt language that engenders trust and balance, that empowers and supports SDM as this will at least be positive in promoting a healthy dynamic between patients and professionals and improve collaboration for better outcomes, especially PROMs and PREMs.

Cox and colleagues suggest that we still need research to investigate and ‘map out’ how language affects outcomes either positively or negatively.²⁰ In addition, we need to assess the impact of interventions, including training and education that are designed to promote the use of respectful language. One study demonstrated a lasting impact of communication skills training for oncologists, but again this was not specifically focussed on the use of respectful language.⁷⁴ An interesting area for research would also be to disentangle whether we should only focus on training communication skills or if we should focus on changing attitudes (that in turn will affect communication). That is, we can teach HCPs about not using stigmatizing language but if they keep a stigmatizing attitude, we have not been successful. Interventions to change attitudes may lead more easily to improvements in communication and make it more effective.

Take home messages

To help ensure best practice in the use of respectful language we have developed some suggestions based on the key messages of this statement (see text box 2).

Text box 2. Suggestions for ensuring best practice in the use of respectful patient language

- Reflect on your own use of language and be mindful of the potentially negative words or phrases that you use. Be aware that your words may not be interpreted the way you intend and that the meaning and acceptability of words can change over time.
- Discuss with your colleagues, how you can promote the use of respectful language to create a positive, person-centred environment.
- Encourage the use of respectful language at conferences, and in research publications. Many journals now require that articles submitted for publication use person first language.
- Avoid the use of medical jargon. Listen to the words that individuals living with CVD use and reflect that language. Where possible check assumptions and the effect your language has on individuals
- Be a role model and use all opportunities to demonstrate good practice, acknowledging respectful language when you hear and see it.
- Aim to make person first language the standard for respectfully addressing all individuals living with CVD.
- Eliminate 'blame' language by being empathic and non-judgmental. Many patients will struggle to manage their CVD health for reasons beyond their control.
- Adopt an individualised approach, avoid using the term 'patient', acknowledging that individual preferences, culture and ethnicity will influence the language you use.
- Engage patient groups by asking them how we can improve the use of respectful language across clinical care, education, research and in the media.

Conclusion

Despite the move to place the person at the centre of their cardiovascular care, there is a paucity of evidence demonstrating this. However, the evidence highlighting the importance of respectful language in the delivery of care is increasing and has the ability to not only transform individual care but systemic practices in healthcare. Each HCP can make some changes to their communication but further education and training in the use of respectful language is needed along with evidence highlighting patient-reported outcomes and experience.

Conflict of interest: Catriona Jennings is deputy editor and Philip Moons is Editor-in-Chief of the European Journal of Cardiovascular Nursing. Hence, in line with the journal's conflict of interest policy, this paper was handled by Jeroen Hendriks.

References

1. Kwame A, Petrucka PM. A literature-based study of patient-centered care and communication in nurse-patient interactions: barriers, facilitators, and the way forward. *BMC Nurs.* 2021; 20: 158. <https://doi.org/10.1186/s12912-021-00684-2>
2. Berman AC, Chutka DS. Assessing effective physician-patient communication skills: "Are you listening to me, doc?" *Korean J Med Educ.* 2016; 28(2):243-9. doi: 10.3946/kjme.2016.21.
3. Kee JWY, Khoo HS, Lim I, Koh MYH. Communication Skills in Patient-Doctor Interactions: Learning from Patient Complaints. *Health Professions Edu* 2018; 4 (2): 97-106. doi.org/10.1016/j.hpe.2017.03.006.
4. Taylan C, Weber LT. "Don't let me be misunderstood": communication with patients from a different cultural background. *Pediatr Nephrol.* 2023; 38(3): 643-649. doi: 10.1007/s00467-022-05573-7.
5. Shore S, Harrod M, Vitous A, Silveira MJ, McIlvennan CK, Cascino TM, Langa KM, Ho PM, Nallamothu BK. Prognosis Communication in Heart Failure: Experiences and Preferences of End-Stage Heart Failure Patients and Care Partners. *Circ Cardiovasc Qual Outcomes.* 2024;17(6):e010662. doi: 10.1161/CIRCOUTCOMES.123.010662.
6. Bamoshmoosh M. Cardiovascular diseases in European ethnic minorities: Beyond the traditional cardiovascular risk factors. *World J Cardiol.* 2024;16(3):98-103. doi: 10.4330/wjc.v16.i3.98.
7. Rechel B, Mladovsky P, Ingleby D, Mackenbach JP, McKee M. Migration and health in an increasingly diverse Europe. *Lancet* 2013; 381:1235-1245. [https://doi.org/10.1016/S0140-6736\(12\)62086-8](https://doi.org/10.1016/S0140-6736(12)62086-8)

8. Agaronnik N, Campbell EG, Ressalam J, Iezzoni LI. Communicating with Patients with Disability: Perspectives of Practicing Physicians. *J Gen Intern Med*. 2019; 34(7): 1139-1145. doi: 10.1007/s11606-019-04911-0.
9. Hasannejadasl H, Roumen C, Smit Y, Dekker A, Fijten R. Health Literacy and eHealth: Challenges and Strategies. *JCO Clin Cancer Inform*. 2022; 6: e2200005. doi: 10.1200/CCI.22.00005.
10. Balint E. The possibilities of patient-centered medicine. *J R Coll Gen Pract*. 1969; 17(82): 269-76.
11. Ekman I, Swedberg K, Taft C, et al. Person-centered care--ready for prime time. *Eur J Cardiovasc Nurs*. 2011;10(4):248-251. doi:10.1016/j.ejcnurse.2011.06.008
12. Kyriakou M, Samara A, Philippou K, Lakatamitou I, Lambrinou E. A qualitative meta-synthesis of patients with heart failure perceived needs. *Rev Cardiovasc Med*. 2021;22(3):853-864. doi:10.31083/j.rcm2203091
13. International Association for the study of cancer, 2021. Language Guide. [IASLC Language Guide | IASLC](#)
14. Diabetes Australia. Position Statement.
<https://www.diabetesaustralia.com.au/position-statements/#:~:text=Diabetes%20Australia's%20position%20statement%20Our,reflect%20reality%3A%20they%20create%20reality.>
15. Diabetes Ireland. Talking about diabetes. 2022. <https://www.diabetes.ie/wp-content/uploads/2024/02/talking-about-diabetes.pdf>
16. Asteggiano R, Dent SF, Jaarsma T, Lee G, Lopez-Fernandez T, Lyon AR, Stephens R, Szmit S, Thavendiranathan P. ESC Clinical Practice Guidelines on Cardio-Oncology: What Patients Need to Know. <https://www.escardio.org/Guidelines/guidelines-for-patients>
17. Bajaj SS, Tu L, Stanford FC. Respectful language and putting the person first with obesity. *Eur Heart J*. 2022; 43; 430.

18. Harrigian K, Zirikly A, Chee B, Ahmad A, Links AR, Saha S, Catherine Beach M, Dredze M. Characterization of Stigmatizing Language in Medical Records. *PhysioNet* 2023; 2: 312–329. <https://doi.org/https://doi.org/10.13026/n938-2385>
19. 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:-9. doi: 10.1038/ijo.2012.110.
20. Cox C, Fritz Z. Presenting complaint: use of language that disempowers patients. *BMJ* 2022; 377; e066720.
21. Dickinson JK, Maryniuk MD. Building therapeutic relationships: choosing words that put people first. *Clin Diabetes* 2017; 35:4.
22. Ferandez L, Fossa A, Dong Z et al. Words matter: what do patients find judgemental or offensive in outpatient notes? *Gen Intern Med* 2021; 36. 8
23. Chou CL, Cooley L. *Communication Rx: transforming healthcare through relationship-centred communication*. Mc Graw-Hill Education. 2021.
24. Abimbola S. The art of medicine: When dignity meets evidence. *The lancet* 2023; 401: 340-1.
25. De Haes H & Bensing J. Endpoints in medical communication research, proposing a framework of functions and outcomes. *Patient Educ Couns*. 2009 ; 74: 287-294.
26. Howe LC, Goyer JP, Crum AJ. Harnessing the placebo effect: Exploring the influence of physician characteristics on placebo response. *Health Psychol*. 2017 Nov;36(11):1074-1082. doi: 10.1037/hea0000499.
27. Timmermans S. The Engaged Patient: The Relevance of Patient–Physician Communication for Twenty-First Century Health. *J Health Soc Beh*. 2020; 61(3): 259-273. <https://doi.org/10.1177/0022146520943514>
28. Dickinson JK. The experience of diabetes-related language in diabetes care. *Diabetes Spectr* 2018;31:58-64. doi: 10.2337/ds16-0082

29. Lazare A, SM Putnam SM, M Lipkin M. Three functions of the medical interview. *The medical interview: Clinical care, education, and research*, 1995. Springer
30. Epstein RM, Street RL. Patient-centered communication in cancer care: promoting healing and reducing suffering. 2007. psycnet.apa.org
31. Wollney EN, Vasquez TS, Fisher CL, Armstrong MJ, Paige SR, Alpert J, Bylund CL. A systematic scoping review of patient and caregiver self-report measures of satisfaction with clinicians' communication. *Patient Educ Couns*. 2023;117:107976. doi: 10.1016/j.pec.2023.107976.
32. Aycock DM, Sims TT, Florman T, Casseus KT, Gordon PM, Spratling RG. Language Sensitivity, the RESPECT Model, and Continuing Education. *J Conti Edu Nurs*. 2017;48(11):517-524. doi:10.3928/00220124-20171017-10
33. Neuberger J, Tallis R. Education and debate- Do we need a new word for patients? Let's do away with "patients" Commentary: Leave well alone. *BMJ*. 1999;318 (7200):1756-8.
34. McCabe C. Nurse–patient communication: an exploration of patients' experiences. *J Clin Nurs*. 2004;13(1) : 41-9.
35. Parsons SR, Hughes AJ, Friedman ND. 'Please don't call me Mister': patient preferences of how they are addressed and their knowledge of their treating medical team in an Australian hospital. *BMJ open*. 2016; 1;6(1):e008473.
36. Gartner Research. Hype Cycle for healthcare data, analytics and AI 2024.
<https://www.gartner.com/en/documents/5687119#:~:text=Summary,guide%20their%20strategic%20planning%20decisions>.
37. Van Bulck L, Couturier R, Moons P. Applications of artificial intelligence for nursing: has a new era arrived? *Eur J Cardiovasc Nurs*. 2023; 22(3): e19-e20. doi: 10.1093/eurjcn/zvac097.

38. Woo B, Huynh T, Tang A, Bui N, Nguyen G, Tam W. Transforming nursing with large language models: from concept to practice. *Eur J Cardiovasc Nurs*. 2024; 23 (5): 549-552. doi: 10.1093/eurjcn/zvad120.
39. Boonstra MJ, Weissenbacher D, Moore JH, Gonzalez-Hernandez G, Asselbergs FW. Artificial intelligence: revolutionizing cardiology with large language models. *Eur Heart J*. 2024;45(5):332-345. doi: 10.1093/eurheartj/ehad838.
40. Barcelona V, Scharp D, Moen H, Davoudi A, Ilday BR, Cato K, Topaz M. Using Natural Language Processing to Identify Stigmatizing Language in Labor and Birth Clinical Notes. *Mat Child Health J*. 2023; 28: 578-586. <https://doi.org/10.1007/s10995-023-03857-4>
41. Tapuria A, Porat T, Kalra D, Dsouza G, Xiaohui S, Curcin V. Impact of patient access to their electronic health record: systematic review. *Inform Health Soc Care*. 2021; 46(2):192-204. doi: 10.1080/17538157.2021.1879810.
42. Bärkås A, Hägglund M, Moll J, Cajander Å, Rexhepi H, Hörhammer I, Blease C, Scandurra I. Patients' Access to Their Psychiatric Records - A Comparison of Four Countries. *Stud Health Technol Inform*. 2022; 294:510-514. doi: 10.3233/SHTI220511
43. Anderson NN, Gagliardi, AR. Unclear if future physicians are learning about patient-centred care: content analysis of curriculum at 16 medical schools. *Med Teacher*. 2021; 43(9): 1085-1091.
44. Bejarano G, Csiernik B, Young JJ, Stuber K, Zadro JR. Healthcare students' attitudes towards patient centred care: a systematic review with meta-analysis. *BMC Med Edu* 2022; 22(1): 324.
45. Pollard S, Bansback N, Bryan S. Physician attitudes toward shared decision making: a systematic review. *Pat edu counsel* 2015; 98(9): 1046-1057.
46. Dwamena F, Holmes-Rovner M, Gaulden CM, Jorgenson S, Sadigh G, Sikorskii A, Lewin S, Smith RC, Coffey J, Olomu A, Beasley M. Interventions for providers to promote a

patient-centred approach in clinical consultations. In *Cochrane Database of Systematic Reviews* 2012 (12). John Wiley and Sons Ltd.

<https://doi.org/10.1002/14651858.CD003267.pub2>

47. Gilligan C, Powell M, Lynagh MC, Ward BM, Lonsdale C, Harvey P, James EL, Rich D, Dewi SP, Nepal S, Croft HA, Silverman J. Interventions for improving medical students' interpersonal communication in medical consultations. *Cochrane Database Syst Rev*. 2021; 2(2):CD012418. doi: 10.1002/14651858.CD012418.pub2.
48. Lindeboom JJ, Coylewright M, Etnel JRG, Nieboer AP, Hartman JM, Takkenberg, JJM. Shared Decision Making in the Heart Team: Current Team Attitudes and Review. *Structural Heart*. 2021; 5(2): 163–167. <https://doi.org/10.1080/24748706.2020.1859660>
49. Pollard, S., Bansback, N., & Bryan, S. (2015). Physician attitudes toward shared decision making: A systematic review. *Patient Educ Couns*, 98(9), 1046–1057. <https://doi.org/10.1016/j.pec.2015.05.004>
50. Veenendaal, H. van, Chernova, G., Bouman, C. M., Etten – Jamaludin, F. S. van, Dieren, S. van, & Ubbink, D. T. (2023). Shared decision-making and the duration of medical consultations: A systematic review and meta-analysis. *Patient Educ Couns*. 2023; 107. <https://doi.org/10.1016/j.pec.2022.11.003>
51. Keij SM, Lie HC, Laidsaar-Powell R, Kunneman M, de Boer JE, Moaddine S, Stiggelbout AM, Pieterse AH. Patient-related characteristics considered to affect patient involvement in shared decision making about treatment: A scoping review of the qualitative literature. *Pat Edu Counsel*. 2023; 111: 107677. <https://doi.org/10.1016/j.pec.2023.107677>
52. Sarkar U, Schillinger D, Bibbins-Domingo K, Nápoles A, Karliner L, Pérez-Stable EJ. Patient–physicians’ information exchange in outpatient cardiac care: Time for a heart to heart? *Pat Edu Couns*. 2011; 85(2): 173–179. <https://doi.org/10.1016/j.pec.2010.09.017>

53. Allen KA, Charpentier V, Hendrickson MA, Kessler M, Gotlieb R, Marmet J, Hause E, Praska C, Lunos S, Pitt MB. Jargon Be Gone – Patient Preference in Doctor Communication. *J Pat Exper.* 2023; 10. <https://doi.org/10.1177/23743735231158942>
54. Schillinger D, Duran ND, Mcnamara DS, Crossley SA, Balyan R, Karter AJ. Precision communication: Physicians' linguistic adaptation to patients' health literacy. *Sci. Adv.* 2021; 17; 7(51): eabj2836. doi: 10.1126/sciadv.abj2836
55. Elwyn G, Dehlendorf C, Epstein RM, Marrin K, White J, Frosch DL. Shared decision making and motivational interviewing: Achieving patient-centered care across the spectrum of health care problems. *Ann Fam Med.* 2014; 12(3): 270–275. <https://doi.org/10.1370/afm.1615>
56. Elwyn G, Durand MA, Song J, Aarts J, Barr PJ, Berger Z, Cochran N, Frosch D, Galasiski D, Gulbrandsen P, Han PKJ, Härter M, Kinnersley P, Lloyd A, Mishra M, Perestelo-Perez, L., Scholl I, Tomori K, Trevena L, Van Der Weijden T. A three-talk model for shared decision making: multistage consultation process. *BMJ.* 2017; 359: 4891. <https://doi.org/10.1136/BMJ.J4891>
57. Patil M, Patil, V, Katre U. Unspoken science: exploring the significance of body language in science and academia. *Eur Heart J.* 2024; 45(4): 250–252. <https://doi.org/10.1093/EURHEARTJ/EHAD598>
58. Kim I, Field TS, Wan D, Humphries K, Sedlak T. Sex and Gender Bias as a Mechanistic Determinant of Cardiovascular Disease Outcomes. *Can J Card.* 2022; 38(12): 1865–1880. <https://doi.org/10.1016/j.cjca.2022.09.009>
59. Rubino F, Puhl RM, Cummings DE, Eckel RH, Ryan DH, Mechanick JI, Nadglowski J, Ramos Salas X, Schauer PR, Twenefour D, Apovian CM, Aronne LJ, Batterham RL, Berthoud, H. R., Boza C, Busetto L, Dicker D, De Groot M, Eisenberg D, Dixon JB. Joint international consensus statement for ending stigma of obesity. *Nature Medicine.* 2020; 26(4): 485–497. <https://doi.org/10.1038/s41591-020-0803-x>

60. Fitzgerald C, Martin A, Berner D, Hurst S. Interventions designed to reduce implicit prejudices and implicit stereotypes in real world contexts: A systematic review. *BMC Psych*. 2019; 7(1): 1–12. <https://doi.org/10.1186/S40359-019-0299-7/TABLES/1>
61. Talumaa B, Brown A, Batterham RL, Kalea AZ. Effective strategies in ending weight stigma in healthcare. *Obes Rev*. 2022; 23 (10): e13494. <https://doi.org/10.1111/OBR.13494>
62. Healy M, Swyrn M, Strand N, Dingman, DA. The “Our Words Matter” Campaign to Reduce Stigma and Bias in Clinical Communication: A Case Report. *CASE REPORT*, 2023; 4(1): 1–10. <https://doi.org/10.15367/ch.v4i1.542>
63. Park J, Saha S, Chee B, Taylor J, Mary M, Beach C. Physician Use of Stigmatizing Language in Patient Medical Records Key Points. *JAMA Network Open*. 2021; 4(7): 2117052. <https://doi.org/10.1001/jamanetworkopen.2021.17052>
64. Lee G. Taking the patient on the scientific journey: making research findings patient friendly and inclusive. *Eur J Cardiovasc Nurs*. 2022; 21(6): 517-518. doi: 10.1093/eurjcn/zvac059.
65. Freedman-Cass, D. A., Fischer, T., Alpert, A. B., Obedin-Maliver, J., Kunz, P. L., Koh, W. J., & Carlson, R. W. (2023). The Value and Process of Inclusion: Using Sensitive, Respectful, and Inclusive Language and Images in NCCN Content. *JNCCN J Nat Com Cancer Network*. 2023; 21(5): 434–441. <https://doi.org/10.6004/jnccn.2023.7025>
66. Barcelona V, Scharp D, Ilday BR, Moen H, Cato K, Topaz M. Identifying stigmatizing language in clinical documentation: A scoping review of emerging literature. *PLoS One*. 2024; 19(6): e0303653. doi: 10.1371/journal.pone.0303653.
67. Holmes SM. Learning Language, Un/Learning Empathy in Medical School. *Culture, Med Psych*. 2023. <https://doi.org/10.1007/s11013-023-09830-8>
68. Oerlemans AJM, Knippenberg ML, Olthuis, GJ. *Learning shared decision-making in clinical practice*. 2020; 104 (5): 1206-1212. <https://doi.org/10.1016/j.pec.2020.09.034>

69. Boshra M, Lee A, Kim I, Malek-Adamian E, Yau M, LaDonna K. When patients teach students empathy: a systematic review of interventions for promoting medical student empathy. *Can Med Ed J*. 2022; 13 (6): 46-5. <https://doi.org/10.36834/cmej.73058>
70. Hearn J, Dewji M, Stocker C, Simons G. Patient-centered medical education: A proposed definition. *Medical Teacher*. 2019; 41(8): 934–938.
<https://doi.org/10.1080/0142159X.2019.1597258>
71. Anderson RM, Funnell MM. Patient empowerment: reflections on the challenge of fostering the adoption of a new paradigm. *Patient Educ Couns* 2005;57:153–157
72. Riedl D, Schübler G. The Influence of Doctor-Patient Communication on Health Outcomes: A Systematic Review. *Z Psychosom Med Psychother*. 2017; 63(2) : 131-150.
doi: 10.13109/zptm.2017.63.2.131.
73. Street RL Jr, Makoul G, Arora NK, Epstein RM. How does communication heal? Pathways linking clinician-patient communication to health outcomes. *Patient Educ Couns*. 2009;74(3):295-301. doi: 10.1016/j.pec.2008.11.015.
74. Fallowfield L, Jenkins V, Farewell V, Solis-Trapala I. Enduring impact of communication skills training: results of a 12-month follow-up. *Br J Cancer*. 2003; 89(8):1445-9. doi: 10.1038/sj.bjc.6601309.

The importance of respectful language to enhance cardiovascular care



The use of respectful communication is essential to establishing a good therapeutic relationship between the healthcare professional (HCP) and the patient

Proposed working definition of respectful language in the context of healthcare and HCPs



“ Respectful language is the use of person-centred language in all forms of communication, that is intentionally empathetic and takes into account the person's values, orientation, condition, beliefs and culture whilst also being non-judgemental, impartial and free of stigma. ”

Factors that may influence respectful language



Previous education and training of HCPs



Ethnicity and culture



HCPs' communication skills



Digital technologies & artificial intelligence