Inclusive Language Guide

The University of British Columbia's Faculty of Medicine (FoM) is committed to supporting teachers in implementing inclusive course designs and teaching practices. Developed by the Offices of Faculty Development and Respectful Environments, Equity, Diversity & Inclusion, and in consultation with FoM leadership, faculty, and learners, this guide advises how faculty can apply inclusive language in large group, small group, and clinical settings.

These five principles include best practices, strategies, and examples for applying them, but as language is always evolving, the guide is not all-encompassing. It is important that we remain adaptable with the language we use, in order to preserve all individuals dignity and autonomy through inclusion. This resource is intended to support faculty to be thoughtful and conscious about how to incorporate inclusive principles in teaching. This guide is updated regularly; those wishing to learn more can access additional resources included at the end of this document.

Thank you for your dedication to teaching.

WHAT IS INCLUSIVE LANGUAGE?

Inclusive language values and honors identities and experiences, addresses inequities, helps to establish respectful learning environments, and fosters interactions welcoming to all.[1,2] Using inclusive language means avoiding expressions or words that stereotype, stigmatize, trivialize or exclude individuals or populations based on their race, ethnicity, gender, sexual orientation, disability or ability, class, age, etc.[3] Using inclusive language requires open-mindedness, flexibility, and continuous learning around language to respect and connect with those around us.[2] Inclusive language fosters a safer and more open learning environment where people know they will not be dismissed, silenced, or looked down upon for being who they are, or for characteristics they have no control over.[3]

WHY DOES IT MATTER?

As educators, we have a responsibility to create respectful and inclusive learning environments, and use language in a way that promotes effective learning for all.[4] Studies in health education show that language is a powerful tool that helps learners develop their identity and a sense of belonging as health professionals.[5] Non-inclusive language, on the other hand, can impact learner performance and experience in a negative way, resulting in feelings such as embarrassment, confusion, and fear.[6]

Language can also have a significant impact by influencing attitudes and behaviours towards patients. Stigmatizing language has been shown to influence student and resident attitudes to be more negative about a patient, and negatively affected the quality of care.[4] Impacts on patient safety and the perpetuation of health care and health outcome disparities are critical reasons language matters in health education.

PRINCIPLE 1

Challenge assumptions and judgement by using appropriate language.

Thinking critically about the assumptions, biases, and judgements in our teaching, give us the opportunity to make our materials and presentations more inclusive. Language choices impact how groups of people are perceived by learners both positively and negatively. Ensure the people referenced in your teaching are represented in a respectful way that preserves their dignity and autonomy, by calling them by their self-identified terms.

4 THINGS YOU CAN DO!

- Recognize assumptions, biases, and judgements about groups or people reflected in language.
- Use inclusive terminology that does not favor or cast judgements on, stigmatize or stereotype groups of people.
- Respect people's humanity by speaking of them as people, not as objects of learning or statistics.
- Use the person's self-disclosed identity when possible (treat others as they wish to be treated).

Examples:

Instead of this...	Consider this...	Why is this important?
"This patient typically practices unconventional treatments."	"This patient typically practices Traditional Chinese Medicine."	Labelling culturally-based practices as unacceptable or unconventional implies a negative judgement. Instead, use the actual term describing their cultural practice, as it is just one factor in the case you would be presenting.
"This patient practices an alternative lifestyle."	"This patient has described that they have multiple sexual partners."	Considering the history and implications around word choice will help you find different descriptions that do not cast a negative judgement on the person. An 'alternative lifestyle' is a subjective term that can delegitimize a person's sexual practice as abnormal or 'other'. Instead, use the patient's self-described orientation or practice.

*The **BCCDC Public Health Language Guide** provides additional inclusive language examples for editing specific content.

PRINCIPLE 2

Use people-first language when appropriate.

People-first language focuses on people as individuals first and the condition or disability second to respect an individual's autonomy, agency, and humanity.

2 THINGS YOU CAN DO!

- Introduce the person first and then the condition or disability second.
- There are exceptions where certain groups and individuals prefer identity-first language (e.g. a hearing-impaired person); when in doubt, ask the person.[9]
- Do not use stigmatizing language in any health education materials, in interactions with patients, health and academic records, and when speaking about patients.[4]

Examples:

Instead of this...	Consider this...	Why is this important?
"They are wheelchair-bound."	"They are a person who uses a wheelchair to assist with mobility."	Disability is only one part of that person's life, so emphasize their personhood first. Using terms like 'bound' imply the person is trapped, when in fact they are just using assistive technologies.[10,11]
"Mrs. X is a known alcoholic..."	"Mrs. X has been in the clinic before seeking treatment for alcohol use."	Use language that preserves the dignity of the person and most accurately describes their experience and relevant medical history.
"Go see 'the chest pain' in room 2."	"Please assess Mr. C in room 2. He is experiencing chest pain."	Use language that respects humanity rather than speaking of people as objects or identifying them by their symptoms or condition.

PRINCIPLE 3

Be flexible and willing to adapt your language.

We all have the responsibility to adjust our language when we learn more inclusive terms. Adapting your language to be more inclusive is often an iterative process requiring us to be open to feedback. Terminology is not one-size-fits-all because specific language is dynamic, changing as people and society learn and evolve. See the response and adaptation framework in **Appendix 1**.

5 THINGS YOU CAN DO
- Be willing to hear and accept feedback when non-inclusive or outdated language is identified in your presentation or conversation, and be willing to adapt language when needed.
- Prepare to revisit language and its meaning regularly (unpack slang and idioms, and avoid culturally appropriated language).
- Stay humble when approached by someone affected by language you have used.
- Reflect on your word choice and research anything you are unsure about using.
- Ask people what language they prefer, and how they would like to be addressed; follow their lead

Examples:

Instead of this...	Consider this...	Why is this important?
"This female patient complained of pain in her abdomen." (the patient had self-identified as a trans man, but you thought it was not relevant to the case)	*"This patient, who is a trans man who has been on hormones for 5 years, but has a uterus, complained of pain in his abdomen."*	Always refer to patients in ways that affirm their gender identities, including using the correct names and pronouns. There may be times when their current anatomy is relevant to their care – knowing what sex a person was assigned at birth will be insufficient, since their anatomy may have since changed. Even when gathering this medically relevant information, you should continue to refer to the patient using the name, pronouns and other gendered language that is gender-affirming for that person.
"This is the mother's first pregnancy."	Instead of limiting pregnancy to female identifying patients, we can also include: *"This is the birthing parent's first pregnancy."*	It is important to consider the various identities of patients who may present with pregnancy or fertility related issues. Remember that gender identity will not always coincide with the patient's physiology/anatomy. Best practice is simply to use the language the patient uses themselves.
"Their wife will pick them up after discharge from the hospital." (the person talked about their kids, so you assumed they were married)	*"Their support person will pick them up after discharge from the hospital."*	Moving away from assumptions about a person's sexual orientation and relationship status, and instead using gender-neutral terms (unless the person has self-identified), can make the scenario more inclusive of many gender identities, sexual orientations, and familial/relationship structures.

PRINCIPLE 4

Attend to the social and structural determinants contributing to disparities in health.

While generalizing characteristics of certain population groups is a common practice for healthcare providers in narrowing differential diagnoses, over-generalization can discourage individualized care, over-attribute health disparities to genetic differences rather than social and structural influences, and may negatively stigmatize the population group.[12] While the literature and clinical practice are at different stages of addressing language issues, we acknowledge that educators are instrumental in adjusting language in health education. This principle is based on current literature and the new Canadian Medical Association Journal (CMAJ) guidelines.[13]

The recognition of the difference between genetic ancestry, ethnicity and race is important to prevent over-generalization.[13,14] Although there may be times that using race and ethnicity as influences for certain health outcomes is valid (especially when considering social determinants of health including access barriers to health care and treatment) caution must be exercised when interpreting data using these labels to prevent oversimplification, unfairness, and potential harm.[13] Although race and ethnicity align in some cases as a surrogate for genetic ancestry, the clinician must be aware of the pitfalls of such an approach.

Populations are labelled as 'at risk' for conditions based on their race/ethnicity may experience stigma and generalized discrimination. How language is used in these circumstances can make a difference in how an individual sees themselves, and how others interpret the genetic information being provided. When race is generalized to being a 'risk factor', it wrongly prompts heuristics to suggest racial identity informs diagnostic reasoning and management.[15] Remember that race and ethnicity are social and cultural constructs, and also that racism may be reflected within health data.[13] It is important to critically appraise health data that is categorized by race and ethnicity.

6 THINGS YOU CAN DO!

- Reframe discussions about findings in health research to include why health disparities might exist between certain population groups to help learners better understand the determinants of health, rather than automatically associating pathologies as inherent in certain populations.[7,8]
- When discussing genetic susceptibility, avoid attributing differences in health outcomes solely to race and ethnicity, and instead use more precise terms such as, genetic ancestry or country of origin to approximate shared genetic origins.[19]
- Avoid using comparative terms that imply a hierarchy among different "races". When listing racial or ethnic data in tables, order them based on empirical rationale to prevent unconsciously creating a hierarchy (e.g., avoid listing white patients first or comparing white vs. non-white population groups without a valid context).[13]
- Consider grammatical adjustments to improve respectful representation of groups, such as capitalizing tribal, racial, or ethnic groups, and using ethnic and racial terms as adjectives instead of nouns.[13]

continued...

- When using names of racial or ethnic groups, be appropriately specific as possible for the context (e.g. Korean instead of Asian). If there is insufficient data for more specific categories, identify the gaps and the impact of excluding data. Using broader racial and ethnic groups can be justified when necessary, but it should be explained, and whenever possible, individual groups within those broader categories should be used.[13]
- Though preferred names may change over time, use the most contemporary or preferred racial groups (i.e. White instead of Caucasian) by checking literature, research, or guides (such as the **UBC Indigenous Peoples: Language Guidelines**).[13]

Examples:

Instead of this...	Consider this...	Why is this important?
"Indigenous people are a vulnerable population in Canada."	*"Indigenous people are historically and currently marginalized and underserved by the Canadian health care system."*	Using 'vulnerable' insinuates personal weakness and obscures the role of social and structural factors contributing to inequities. Draw attention to how disparities are the result of past and current power imbalances by being specific about what system/ institutions are affecting the population.[20]
"Indigenous people are at higher risk of diabetes."	*"Prevalence of diabetes among First Nations peoples living off reserve (10.3%) is disproportionately higher than the general population (5.0%)."*	Be specific about the population and context you are speaking of so they are not over-generalized. If the data describes First Nations patients, then using Indigenous would be incorrect as it would not apply to Inuit of Metis individuals. Using epidemiologic terms are better than more value-laden terms of increased likelihood. The 'at risk' label creates a 'deficit discourse' which situates responsibility for problems with individuals or communities, overlooking the larger socio-economic structures in which they are embedded.[18,19]
"Black race is a risk factor for sickle cell disease."	*"Those with genetic ancestors from areas where malaria is endemic are at higher risk for sickle cell disease."*	'Race' is not the risk factor, but being from an area where malaria is endemic is the risk factor for sickle cell disease. Conflating race with genetic ancestry implies an essentialist, biological, view of race. Students who think of race as biological are more accepting of racial disparities, seeing them as 'natural' and unlikely to change from societal efforts.[20]

PRINCIPLE 5

Be intentional about representing diversity.

Educational materials should reflect the diversity of students and those they will serve in their future practice. Teaching sessions, case studies, and clinical cases should address a diversity of presentations so students can recognize signs and symptoms in different people. The visual tools we use to emphasize and convey meaning in the content (text, images, visual recordings, etc.) are all part of the discussion around inclusive language.[21]

5 THINGS YOU CAN DO!

- Ensure examples and images are diverse but not stereotypical, presenting multiple experiences and identities.
- Be cognizant when using stock images. Trying changing your search key words, or use stock image vendors that intentionally include a diversity of people.
- Be aware that representing diversity is not the same as mentioning a patient's identity only for diagnostic significance. To consider identities only when it relates to healthcare decision-making medicalizes that identity and can lead to generalizations and stereotyping.
- Recognize how the pairing of certain identifiers with certain conditions may harmfully perpetuate stereotypes or negative perceptions about groups of people.
- Avoid portraying/framing certain identities (white, cisgender, heterosexual, etc.) as the 'default.' Use identifiers in all case examples, otherwise do not mention them at all.[19]

Examples:

Instead of this...	Consider this...	Why is this important?
Using lecture slides portraying various skin presentations (rashes, cancer, etc.) in only light skinned patients.	Adding images to show how conditions clinically present in dark skinned patients, and addressing any different characteristics.	By visually showing and addressing various skin presentations, we are training students to recognize conditions amongst our diverse patient population. For example, pigmentation for rashes appears grey in dark skin, and red in light skin, and presentations of cancers like basal cell carcinoma and malignant melanoma differ between light and dark skin.[22]
Only showing videos or testimonials from gay men when discussing HIV.	Showing videos and testimonials of different people, from different sexual orientations and ethnic backgrounds when discussing HIV.	While the gay and bisexual community has been disproportionately affected by HIV, many different people are affected by this condition. If gay men are the only group shown in HIV examples, it reinforces the stereotype that all gay men have, or are affected by, HIV.
Including an image of a person who does not have access to stable housing to represent the effect of ongoing substance use.	Consider whether you need an image of a person to convey your lesson.	Linking being unhoused with substance use perpetuates a stereotype. Avoid visual associations which may negatively stereotype marginalized groups. Instead, consider imagery that helps reinforce other aspects of the condition you are trying visualize.

LARGE GROUPS

Synchronous and asynchronous large group learning contexts are less conducive to receiving learner feedback in-the-moment. Instead, learners could contact you after the presentation to express concern over non-inclusive language used, or they may communicate these concerns directly to the site lead, week lead, course lead, or other faculty leadership. Others may stay silent, unable or unwilling to share their concerns with you or faculty leadership for fear of repercussions. It is therefore helpful and important to incorporate inclusive language and imagery in your session.

What can you do?

- When applicable, address up-front any past aspects of the lecture that may have been contentious in previous years, what has been done to address it, and how this is part of the iterative quality improvement process.
- If non-inclusive language is identified in pre-recorded lectures, follow up with learners and let them know if there will be changes to the content in the future.
- Create a safe space at the beginning of your lecture by inviting feedback from learners. Let them know they are welcome to reach out to you after your session with any feedback about your lecture. If you feel comfortable, share your e-mail with the learners so they can reach out via e-mail after the session.

SMALL GROUPS

Small group learning environments, and the relationships built within them, provide opportunities for learners and faculty to discuss inclusive language together. In this setting, consider the possibility that learners who are unusually quiet may be experiencing discomfort created by the use of non-inclusive language.

What can you do?

- When non-inclusive language is used, whether by yourself, a fellow faculty member, or a learner, it should be addressed (consider using, or guiding the other person through the process in *Appendix 1*).
- Role model the importance of being inclusive by speaking up or suggesting alternate terms if you notice non-inclusive language being used.
- Intervene so other learners are not put in a position of either having to confront their peers or remain silent.
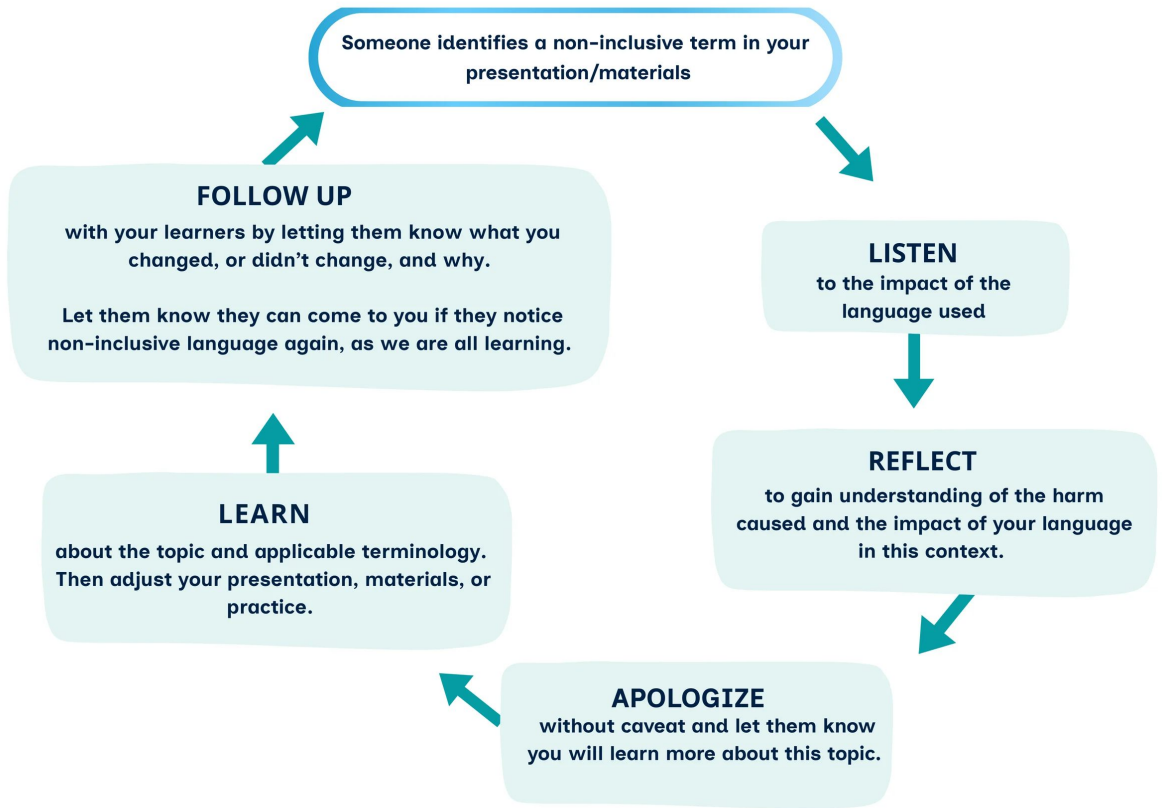
CLINICAL

Clinical environments take learning into a professional context, where faculty, learners, patients, and other health professionals are working together. Balancing patient needs and learner needs when non-inclusive language has been used is a challenge specific to this context. Though time to debrief a non-inclusive language encounter may be limited, it is important to support learners and go over how the situation can be navigated.

What can you do?

- When non-inclusive language is used, whether by yourself, a fellow faculty member, another health professional, or a learner, it should be addressed (consider using, or guiding the other person through the process in *Appendix 1*).
- If non-inclusive language is used by a patient, consider how and when to address it, and follow up with learners during or after the encounter (whether they were targets or witnesses).

Appendix 1: Response and adaptation framework

Someone identifies a non-inclusive term in your presentation/materials

FOLLOW UP

with your learners by letting them know what you changed, or didn't change, and why.

Let them know they can come to you if they notice non-inclusive language again, as we are all learning.

LISTEN
to the impact of the language used

LEARN

about the topic and applicable terminology. Then adjust your presentation, materials, or practice.

REFLECT

to gain understanding of the harm caused and the impact of your language in this context.

APOLOGIZE
without caveat and let them know you will learn more about this topic.

Reminder

Learning can often feel uncomfortable, so consider reaching out to a colleague to debrief and for support.

Visit **Optimizing the Learning Environment** for more resources on inclusive teaching approaches.

INFORMATION & TEACHING RESOURCES

Visit **Optimizing the Learning Environment** for more resources on inclusive teaching approaches. For questions about using the guide, contact the Office of Faculty Development at **fac.dev@ubc.ca.**

Visit the **Office of Respectful Environments, Equity, Diversity & Inclusion** for more information and assistance.

ADDITIONAL RESOURCES

Language & Terminology Guides

BC Centre for Disease Control COVID-19 Inclusive Language Guide

Provides specific inclusive language and non-stigmatizing terminology, examples covering a broad range of areas in the context of health professions, and explains the difference between racial, ethnic, and cultural identities. For more examples extending from topics in this guide, we recommend reading the sections on **Racial, Ethnic & Cultural Identities, Substance Use, Sex, Gender, Sexual Identities, Pronouns & Gender Inclusive Language, and Sexuality & Bodies.**

Reviewing sections on **Disease Basics, Relationship, Family Status & Pregnancy**, and **Age & Ability** can also benefit faculty looking to expand their inclusive language vocabulary.

UBC Center for Teaching and Learning Accessibility and Inclusivity Guidelines for Facilitators.

Guidelines for facilitators on designing and presenting materials, focusing on **Inclusive Language, Accessibility, Pronouns, Chosen Names,** and **Cultural Considerations**. We recommend referencing the extensive **Accessibility** section.

BC Public Service, Words Matter, Guidelines on using inclusive language in the workplace.

Relates inclusive language to the BC Human Rights Code, provides **general principles** and **examples of language to use**, and **how to promote respect in the workplace.**

UBC Equity & Inclusion Office, **Equity & Inclusion Glossary of Terms** and **Positive Space Language.**

Provides **definitions** and **information** on many terms referenced in this guide. The Positive Space guide specifically references **Sexual Orientation** and **Gender Identity** terms.

Government of Canada, Department of Justice, Gender-neutral Language

Though written with a law-context in mind, provides recommendations on **Gender-Neutral Language** that can be applied in other settings.

UBC Indigenous Foundations, Aboriginal Identity & Terminology and **Indigenous Peoples: Language Guidelines**

Provides guidance and history on perceptions of **Indigenous Identity** through language.

Beyond the Binary

Beyond the Binary Canada states their goal is to provide nationally relevant, community informed guidance that enables researchers to conduct gender inclusive health research for cisgender women, trans, non-binary, Two-Spirit, gender non-conforming, gender creative, and additional gender divergent identities.

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WE WANT TO HEAR FROM YOU!

Use the QR code or email us at fac.dev@ubc.ca to provide feedback or comments on this Inclusive Language Guide.