



Inclusive Language Guide

INTRODUCTION

UBC is committed to supporting teachers in implementing inclusive course and clinical designs, and teaching practices. This inclusive language guide is developed by the Office of Faculty Development & Educational Support, and the Office of Respectful Environments, Equity, Diversity & Inclusion, and is designed to support those teaching in lecture, small group, and clinical settings.

The guide introduces complex inclusive language approaches, distilled into principles and examples to contextualize their use. The guide was developed through consultation with academic leadership, faculty, and students, and focuses on key areas where language could be more inclusive.

Please consider these inclusive principles as you prepare to deliver materials and facilitate student and resident learning in Health Professions education. 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 students develop their identity and a sense of belonging as health professionals.⁵ Non-inclusive language, on the other hand, can leave a student or learner with residual embarrassment, confusion, fear, or anger that could impact their performance and experience in health education.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 marginalized 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 judgments, and preserve dignity and autonomy 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.

5 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
- Ensure you are not attributing blame for poor health to people with certain conditions^{7,8}
- 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.
This patient abuses drugs periodically.	This patient uses substances periodically.	There are negative connotations and implications of choice associated with the words abuse or addiction. Use language that describes the patient's experience without judgement.

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 person⁹
- Do not use stigmatizing language in any health education materials, in interactions with patients, health and academic records, and when speaking about patients⁴

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 to be inclusive.

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 **Diagram 1**.¹²

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
- 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; follow their lead

Examples:

Instead of this...	Consider this...	Why is this important?
<p>"This female patient complained of pain in her abdomen."</p> <p>(the patient had self-identified as a trans man, but you thought it was not relevant to the case)</p>	<p>"This patient, who is a trans man who has been on hormones for 5 years, but still has his uterus, complained of pain in his abdomen."</p>	<p>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 this may have since changed.</p> <p>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 most appropriate for that person.</p>
<p>Their wife will pick them up after discharge from the hospital.</p> <p>(The person talked about their kids, so you assumed they were married)</p>	<p>Their support person will pick them up after discharge from the hospital.</p>	<p>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.</p>

PRINCIPLE 4

Attend to the social and structural determinants contributing to disparities in health, especially when discussing epidemiology and risk factors.

While generalizing risk factors 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 causes, and pathologize the population group.¹³ Differences in health outcomes are often construed as non-modifiable, biological differences (for example, between racial and ethnic groups). Populations are labelled as 'at risk' for conditions based on their race, implying there are inherent biological differences and that their bodies and identities are inferior. When race is presented as a risk factor, it teaches students heuristics to apply, using racial identity to inform diagnostic reasoning and management.

4 THINGS YOU CAN DO!

- Reframe findings in health research to explain why disparities in health exist between certain population groups to help learners understand the determinants of health, rather than associating pathologies as inherent in certain populations or over-attributing differences caused by oppressive forces (such as racism) to genetic differences.^{7,8}
- Highlight that patient-centered care involves thinking of patients as individuals first who may or may not fit into general demographic epidemiological categories.
- Consider the impact of associating genetic factors with terms representing different populations, and explicitly acknowledge its limitations to your learners.
- Recognize race as a social, not biological, construct. When discussing genetic susceptibility, avoid using race as the sole reason for differences in health outcomes. To approximate genetic ancestry, use granular terms which may better reflect shared genetic origins (e.g., ethnicity, genetic ancestry, and/or country of origin rather than race).¹⁴

Examples:

Instead of this...	Consider this...	Why is this important?
Indigenous people are a vulnerable population in Canada.	Indigenous people are a marginalized population in Canada.	Using 'vulnerable' insinuates personal weakness and obscures the role of social and structural factors in contributing to inequities. Using the term 'marginalized' draws attention to how disparities are the result of power imbalances. ¹⁵
Indigenous people are at higher risk of diabetes.	Prevalence of diabetes among Indigenous people living off-reserve (10.3%) is disproportionately higher than the general population (5.0%).	Using epidemiologic terms are better than more value-laden terms of risk. The 'at risk' label creates a 'deficit discourse' which situates responsibility for problems with the affected individuals or communities, overlooking the larger socio-economic structures in which they are embedded. ^{16,17}
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. ¹⁸

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.¹⁹

5 THINGS YOU CAN DO!

- Review presentations to ensure examples and images are diverse and do not only represent a singular experience or identity.
- Be cognizant when using stock images. Try 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.¹⁴

Examples:

Instead of this...	Consider this...	Why is this important?
Using an example of a 56y/o Black patient ... is diagnosed with Sickle Cell Disease.	Using an example of a 56y/o patient of southern Italian ancestry is diagnosed with Sickle Cell Disease.	When representing diversity be careful to avoid using racial or ethnic identifiers to reinforce ideas of race-specific conditions. This creates a race-based diagnostic bias when specific identifiers are only used when talking about specific diseases. ¹⁴
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, people from all other groups have also been affected by this condition. If the only examples of HIV are in gay men, it reinforces the stereotype that all gay men have HIV and/or that only gay men 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 homelessness 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.

CONSIDERATIONS FOR...

Large Group

Large group contexts (whether synchronous or asynchronous) are a learning environment where individuals may be less likely to speak out in the moment. Learners could contact you after the presentation to express concern over non-inclusive language used. Others may stay silent, unable or unwilling to share their concerns with you. In some cases, you may only do a presentation once per year, making it essential to add inclusive language and imagery as a consideration during your annual quality improvement cycle.

What can you do?

- Up front, address any past aspects of the lecture, week or course that has been contentious, 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.
- Invite feedback from learners throughout the academic year using appropriate tools for large groups, such as polls or through emails, can help you preemptively address non-inclusive language.

Small Group

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 students and residents 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, a resident, or a student, it should be addressed (consider using, or guiding the other person through the process in **Diagram 1²**).
- 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

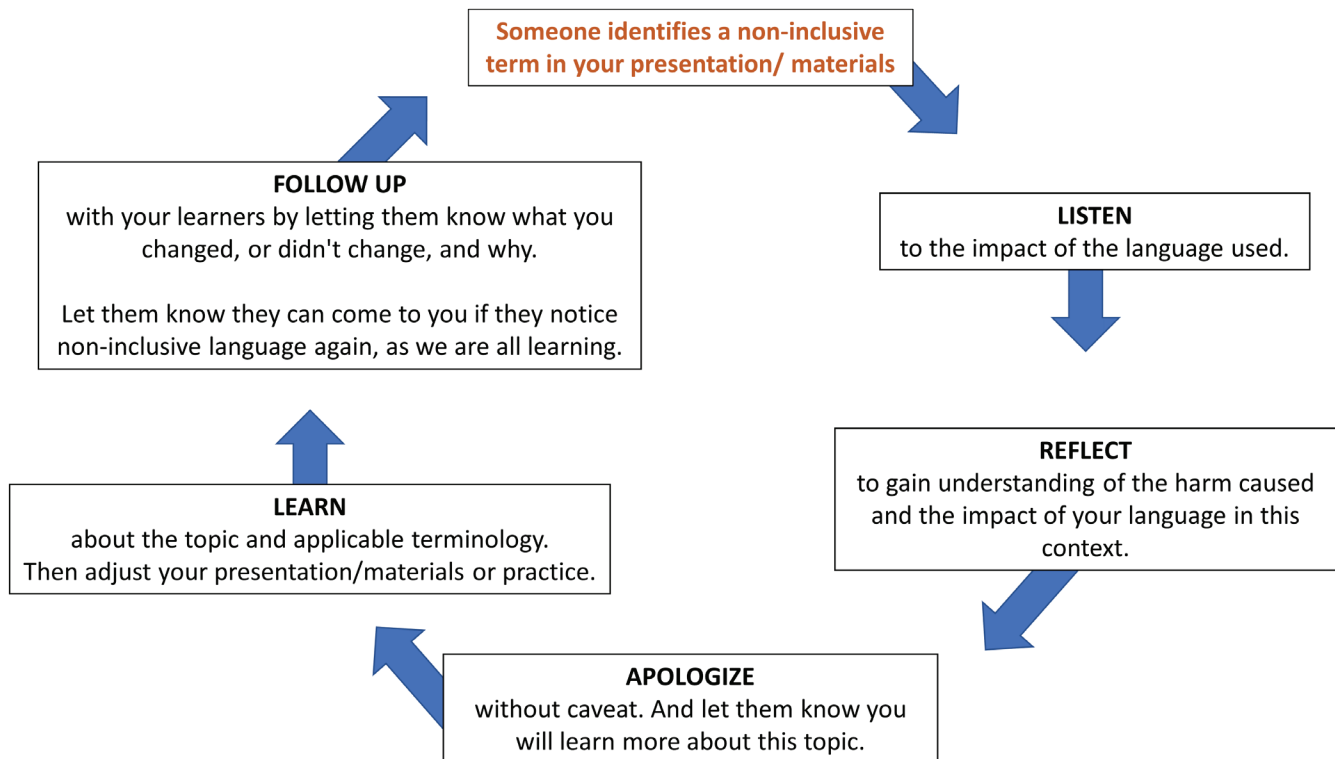
Clinical environments take learning into a professional context, where faculty, residents, students, patients, and other health professionals are working together. Balancing patient needs and learner needs when non-inclusive language has been used is a challenge specific to this context. Though time 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, a resident, or a student, it should be addressed (consider using, or guiding the other person through the process in **Diagram 1²**).
- 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

Diagram 1: Response and adaptation framework¹²



Visit the [Inclusivity in the Learning Environment](#) for more information on responding when non-inclusive language is used. This foundational online module is intended for faculty, staff, residents, and students.

ADDITIONAL RESOURCES

Visit the [Office of Respectful Environments, Equity, Diversity & Inclusion](#) for more information and assistance.

For questions about using the guide, contact the Office of Faculty Development & Educational Support at fac.dev@ubc.ca.

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.

[Rider University, Using Inclusive Language: Guidelines and Examples](#)

Though developed within an American context, we recommend reviewing the sections on **Age, Class, Disabilities** (Including **Person-First Language** and **Identity-First Language**), **Gender & Sexual Orientation**, and **Size** (body habitus).

REFERENCES

1. University of Michigan Center for Research on Learning & Teaching. Overview of Inclusive Teaching at Michigan [internet]. University of Michigan; 2021 [cited 2021 May 4]. Available from: <https://crlt.umich.edu/overview-inclusive-teaching-michigan>
2. Kovach-Galton K. Say This, Not That: A Guide for Inclusive Language [internet]. The Diversity Movement; 2020 September 9 [cited 2021 May 4]. Available from: <https://thediversitymovement.com/say-this-not-that-a-guide-for-inclusive-language/#:~:text=Inclusive%20language%20is%20not%20the,focused%20on%20honoring%20people's%20identities>
3. Rider University. Using Inclusive Language: Guidelines and Examples [internet]. Rider University; 2021 [cited 2021 May 4]. Available from: <https://online.rider.edu/online-bachelors-degrees/liberal-studies/guide-to-using-inclusive-language/#:~:text=Inclusive%20language%20is%20defined%20as,or%20underprivileged%20groups%2C%20such%20as>
4. Goddu AP, O'Connor KJ, Lanzkron S, Saheed MO, Saha S, Peek ME, Haywood C, Beach MC. Do words matter? Stigmatizing language and the transmission of bias in the medical record. *Journal of general internal medicine*. 2018 May;33(5):685-91.
5. Monrouxe LV. Identity, identification and medical education: why should we care? *Medical education*. 2010 Jan;44(1):40-9.
6. Acholonu RG, Cook TE, Roswell RO, Greene RE. Interrupting microaggressions in health care settings: a guide for teaching medical students. *MedEdPORTAL*. 2020 Jul 31;16:10969.
7. Baah FO, Teitelman AM, Riegel B. Marginalization: Conceptualizing patient vulnerabilities in the framework of social determinants of health—An integrative review. *Nursing inquiry*. 2019 Jan;26(1):e12268.
8. Sharma M, Pinto AD, Kumagai AK. Teaching the social determinants of health: a path to equity or a road to nowhere?. *Academic medicine*. 2018 Jan 1;93(1):25-30.
9. Ferrigon P, Tucker K. Person-First Language vs. Identity-First Language: An examination of the gains and drawbacks of Disability Language in society. *Journal of Teaching Disability Studies*. 2019.
10. Association of University Centers on Disabilities. Portrayal of People with Disabilities [internet]. Silver Spring, MD: Association of University Centers on Disabilities; 2011 [cited 2021 May 4]. Available from: <https://www.aucd.org/template/page.cfm?id=605>
11. BC Centre for Disease Control. BC CDC COVID-19 Language Guide: Guidelines for inclusive language for written and digital content [ebook]. BC Centre for Disease Control; 2020 July [cited 2021 May 4]. Available from: <http://www.bccdc.ca/Health-Info-Site/Documents/Language-guide.pdf>
12. Office of Faculty Development and Educational Support. Inclusivity in the Learning Environment [e-learning module]. Vancouver, BC: University of British Columbia; 2020 [cited 2021 May 4]. Available from: https://rise.articulate.com/share/pQs-Kukedlwu7ECX-xQ_2nzO6WHxuAMg#/
13. Woo E. The Significance of Race-Based Generalizations in Canadian Medical Education. *UBC Medical Journal*. 2019 Apr 1;10(2).
14. Amutah C, Greenidge K, Mante A, Munyikwa M, Surya S L, Higginbotham E, Jones D S, Lavizzo-Mourey R, Roberts D, Tsai J, & Aysola J. Misrepresenting Race — The Role of Medical Schools in Propagating Physician Bias. *New England Journal of Medicine*. 2021 March 4;384:872-878.
15. Katz AS, Hardy BJ, Firestone M, Lofters A, Morton-Ninomiya ME. Vagueness, power and public health: use of 'vulnerable' in public health literature. *Critical Public Health*. 2020 Oct 19;30(5):601-11.

16. Fogarty W, Bulloch H, McDonnell S, Davis M. Deficit discourse and Indigenous health: How narrative framings of Aboriginal and Torres Strait Islander people are reproduced in policy. *Deficit Discourse and Indigenous Health: How Narrative Framings of Aboriginal and Torres Strait Islander People Are Reproduced in Policy*. 2018:xii.
17. Pica-Smith C, Veloria C. "At Risk Means a Minority Kid:" Deconstructing Deficit Discourses in the Study of Risk in Education and Human Services. *Pedagogy and the Human Sciences*. 2012;2(1):33.
18. Williams MJ, Eberhardt JL. Biological conceptions of race and the motivation to cross racial boundaries. *Journal of personality and social psychology*. 2008 Jun;94(6):1033.
19. Massie JP, Cho DY, Kneib CJ, Burns JR, Crowe CS, Lane M, Shakir A, Sobol DL, Sabin J, Sousa JD, Rodriguez ED. Patient representation in medical literature: are we appropriately depicting diversity?. *Plastic and Reconstructive Surgery Global Open*. 2019 Dec;7(12).