"That was then, this is now":

Patient centered language for the 21st Century

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That was then: the "Old way"	***This is now***	***Examples***	***Comments***	***More resources***
Minoritized Groups				
Noting patient race or ethnicity in the one-liner of a patient case, clinical notes, and clinical presentations	Race and ethnicity are not listed in one-liner by default, but are always listed in social history. Note that race/ethnicity should always be solicited from the patient, not visually assessed.	*Old way*: 25 year old black female presents to the ED for LLQ abdominal pain. *New Way*: 25 year old woman presents to the ED for LLQ abdominal pain. Social History: Black/African American	When we include a patient's race in the one-liner, we suggest that race implies a biological difference. **Race≠ biology or genetics.** Our implicit bias may cloud judgment before we process the remaining clinical history. Our differential diagnosis may thus become limited and may impact the care specific patient groups receive. Note: When using racial and ethnic identifiers, the word should be capitalized. Example: *Black* refers to a racial group versus lowercase *black* refers to a color.	Why do doctors practice race-based medicine? Race Matters? Examining and rethinking race portrayal in preclinical medical education Are we teaching racial profiling? The danger of subjective determinations of race and ethnicity in case presentations Anti-racism toolkit for medical educators
Noting a racial/ethnic health inequity without commenting on social/structural causes	If racial/ethnic health inequities are mentioned, highlight if inequity is a result of SDOH	*Old way:* "Diabetes screening is indicated for Native American, African-American, …" New way: add -"This may be because these populations are disproportionately exposed to SDOH, which increases the risk for development of DM."	When the cause of a racial/health inequity has not been identified, we must be careful not to attribute these inequities to genetics/biology as evidence points to social/structural determinants (e.g. structural racism) as being the root causes of the vast majority of observed health inequities. Social/structural risk factors are modifiable, so attributing them to race/ethnicity eliminates possibility of intervention.	Avoiding racial essentialism in medical science curricula

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Minority Groups Ethnic Groups Racial Groups Underrepresented	(People from) minoritized racial and ethnic groups (People from) sexual/gender/linguistic/religious groups (People with/living with) mobility/cognitive/vision/hearing/independent living/self-care disabilities (People from) minoritized groups (American Indian and Alaska Native Groups are federally recognized political minority groups)	*Old:* The disease is rising among minority groups in the United States. *New:* Incidence of the disease is rising among people from minoritized racial groups in the United States.	Recognition of minoritized groups is necessary to understand how each group has been influenced by particular social determinants of health and policies. Language helps put the emphasis on systems as the root cause of the inequity, rather than placing more blame on the individual. Other suggested phrasings: "historically excluded" "populations we systemically marginalize."	Time to reconsider the word Minority in Academic Medicine
Health-Associated Person Centered Language				
Chief "Complaint" "Complains of"	Chief Concern "Has" "reports" "notes"	*Old*: Chief Complaint - 45yoF complains of pain *New*: Chief concern - 45yoF reports pain	Using words like "complains" or "denies" creates an unnecessarily adversarial dynamic between clinician and patient. Using different words supports more patient-centered care.	Person centered language
Illness first, Illness/disease case (Ex. [HIV] cases, Diabetics, Diabetic patients, Victims	Person first, People with [disease], People experiencing [chronic condition], Survivor	*Old*: Mentally ill person, Down's kid, COVID-19 case, HIV patient, Diabetic patient, Cancer victim *New*: Person with a mental illness, Child with Down's syndrome, People with HIV, People experiencing diabetes, Cancer survivor	When we use deficit-based or illness-based language filtered through a diagnostic label, this can inadvertently assign blame; we may become negatively biased and depersonalize the patient. When used as labels, terms are stigmatizing and can result in discriminatory and ineffective care. Possible exception: there are some disability communities that prefer to continue being identified with their disability - e.g. "autistic" - as they consider their disability a critical part of their identity. If in doubt, do some research about the community standards and ask the individual.	Person centered language Disability language style guide
Vulnerable populations, Marginalized Communities, High risk populations	Groups that have been socioeconomically disadvantaged, Groups that have been marginalized,	*Old:* High risk populations should be screened for XYZ. *New:* Populations at higher risk for XYZ should be screened for	These terms can be stigmatizing and imply that condition is inherent to a group rather than attributed to other causal factors. Using specific words can be beneficial in understanding some causes.	Person centered language

	Under resourced communities, Populations at higher risk for [condition]	the condition [+ provide culturally aware or patient-reported context for why they are being considered a member of this population].		
Noncompliant	Nonadherent	*Old*: Patient was non-compliant with meds. *New*: Ms. X was non-adherent to medications because of cost.	Noncompliance suggests the patient must obey orders of the physician. Nonadherent offers reasoning as to why patients may not be able to follow the recommended medication regimen.	What's in a name? Compliance, adherence and concordance in chronic psychiatric disorders
Differently abled, Disabled Suffers from, victim of, afflicted by Handicapped Wheelchair-bound Mental retardation Normal, able-bodied	Has/lives with physical disability, Uses a wheelchair Intellectual disability, developmental disability, Non-disabled/ without disabilities, Neurodiverse	*Old: Wheelchair-bound patient suffers from being disabled. Patient suffers from mental retardation but is able-bodied.* *New: Patient lives with physical disability and uses a wheelchair.* *Patient has intellectual disability without physical disabilities.*	Medical model of disability: -Negative -Deficiency or abnormality -Characteristic of an individual's body -Treatment is through intervention by medical professionals Social model of disability: -Neutral -Difference or identity -A function of how an individual interacts with society -"Treatment" by advocating to make society more accessible Note: CDC recommends patient first model; although individual patient preferences may opt to be disability first; follow patient preferences	Disability language style guide
Pregnant Women, Mothers-to-be	Pregnant patient, expectant parents	*Old: All pregnant women; 30yo mother-to-be* *New: All expectant parents; Patient is a 30yo pregnant woman*	Terms addressing pregnant patients should be inclusive of all genders	
Person committed suicide, Person killed themself	Person died by suicide	*Old:* 35yo male committed suicide *New:* 35 yo man died by suicide	Recognition that as society we are not villainizing those who have taken their own life	

The elderly, the aged, seniors, Geriatric (to refer to people), Frail, fragile	Older adults, older people Ages ## and older	Old: The elderly are at higher risk for XYZ. Geriatric male patient presents for XYZ. New: People ages 65 and older are at higher risk for XYZ. 86yo man presents for XYZ.	Words like (the) aged, elder(s), (the) elderly, and seniors should not be used because such terms connote discrimination and certain negative stereotypes that may undercut research-based recommendations for better serving our needs as populations age.	When It Comes to Older Adults, Language Matters
LGBTQ+ + Gender Identity				
Addressing a patient based on clinician's assumption of gender - Mr / Mrs / Ms Assume binary gender (male or female)	Greet each patient by first & last name as listed in the medical chart to confirm we are seeing the correct patient, then ask how the patient would like to be addressed. If relevant, and if patient provides this information,, specify "cis", "trans" or non-binary in the one-liner.	*Old*: Hello, Mrs. M. *New*: Hello, may I ask your name? How would you like to be addressed, and do you have a title of respect you would like me to use? What pronouns do you use? (document in SH) *Old: way*: 35yo female presents with abdominal pain. *New Way*: 35yo cisgender woman presents with abdominal pain.	By addressing a patient as Mrs/Ms/Mr, we may be inaccurately assuming gender identity. Patients should be given the opportunity to express their identity to the physician. Note that this is a statement of gender, not of gender "preference." The patient does not "prefer" to be called a woman, she IS a woman. Also, be aware that our society -including healthcare settings- have a long history of discriminating against the gender diverse patient population. Patients may not want to have this preference stated in their medical record.	Pronoun guide LGBTQ-inclusive language DOs and DON'Ts Good practices: Inclusive language
"M to F" "Born a [boy/girl]" "Biologically…" Sex change surgery Sex reassignment surgery Identifies as [a man/woman/non-binary] Hermaphrodite	Assigned male/female at birth Gender confirmation surgery, [specific surgery] **Is** a transgender man/woman Intersex	*Old*: MTF presents with XYZ. *New*: 42 year old transgender woman (assigned male at birth) presents with XYZ.	If a patient has undergone gender reassignment or is transitioning, we should specify their appropriate gender in the one liner.	A language guide: Trans and Gender Diverse Inclusion

Non-straight, homosexual, queer Sexual preference, lifestyle choice, sexual identity Husband, wife Mother, Father	LGBTQIA*, Lesbian, gay, bisexual, pansexual, asexual [for identity] Sexual orientation Spouse, partner Parent Men who have sex with men, women who have sex with women [for behavior]***AI Edit	*Old:* 47yo homosexual male; Wife agrees with the husband about their child's treatment plan. *New:* 47yo gay man; Both parents agree with their child's treatment plan.	LGBTQIA* is utilized to be a descriptor to the community's diversity. When referencing a specific person, utilizing their specific preferences are more appropriate. Note: term "Men who have sex with men" is utilized as a behavior descripitor not to define a person in a particular way.	See above
More social history				
Homeless in the one-liner	Experiencing homelessness / houseless. In SH instead of one-liner	*Old*: One-liner - 60yo homeless male presents to ED with chief concern of dizziness. *New*: Patient is a 60yo man presenting to ED with chief concern of dizziness. … in SH, patient is experiencing homelessness.	More accurate and respectful to describe homelessness as a set of circumstances rather than a blanket label	Is homeless the right word?
At-risk, Needy, Disadvantaged, The poor, Poverty-stricken, Uninsured, Underserved, Hard to reach, Disparity or inequality	Low-income (people), People experiencing poverty, People who are underserved, People without health insurance, Historically and intentionally excluded, Disinvested, Inequity	*Old:* 50yo low-income, uninsured female. Patient is underserved and struggling due to health disparities. *New:* 50yo woman experiencing poverty is without health insurance. Patient lives in an historically and intentionally excluded population and is experiencing health inequities.	Note: When a particular aspect of lower socioeconomic status is specified the term underserved is not interchangeable. The term "underserved" refers to access to particular resources, which is different from "disproportionately affected". Disparity refers to differences but health inequity refers specifically to the differences that are avoidable and unjust. Equality refers to each person getting the same amounts and types or resources among all populations without consideration of generations	Conscious style guide

			of disvestment and discrimination. Equity offers a framework in which individuals get the resources they require to meet their needs.	
Inmate, criminal offender, ex-convict, parolee, felon	Patient who is incarcerated or detained, person who is in pre-trial or with charge	*Old:* Patient is a 27 yo male prison inmate. *New:* Patient is a 27 yo man who is incarcerated	Recognition of the person of the patient's health exposures while keeping patient first. In the new terms we remove the legal judgements on the patient.	An Open Letter to Our Friends on the Question of Language
Aliens, Illegal Immigrants, illegals Immigrant (Not to be used when specifically referring to undocumented immigrants)	People who are undocumented, undocumented immigrants, non-status immigrants	*Old:* Patient is an illegal immigrant. *New:* Patient is an undocumented immigrant.	Newer terms recognize the humanity of the patient outside of the lack of legal documentation.	Health Care for Undocumented Immigrants
Third-world vs First world, Global South vs Global North	Patients from high income versus lower or medium income countries (LMIC)	*Old:* Patient was raised in a third-world country. *New:* Patient lived in a lower or medium income country from birth to age 18.		
Tackle community health issue, Target community for intervention, Stakeholder	Engage, Prioritize Consider/Tailor needs of Population of focus Partner, collaborators, allies	*Old:* We must tackle lack of access to diabetes care in at-risk communities. *New:* We must prioritize access to diabetes care in populations at high risk for the condition.	Terms with violent connotations including tackle, target, and combat should be avoided. The term "stakeholder" can be viewed in Urban Native communities as a violent term.	
People who do not seek healthcare Workers who do not use PPE	People with limited access to (specific service/resource) Workers under resourced with (specific service/resource)	*Old: Healthcare* workers who do not use PPE. *New:* Healthcare workers under resourced with N95 masks and face shields.	Consideration of the context is important to avoid language that could lead to negative assumptions, stereotyping, stigmatization or blame.	

To standardize documentation, the following terms will be used to describe a patient's race/ethnicity:

Asian
Black
Latina/Latino/Latinx
Indigenous, American Indian or Alaska Native; Identify persons or groups with specific tribal affiliation
Native Hawaiian or Other Pacific Islander
White
Multiracial; people who identify with more than one race/ethnicity
(Other - specify)
Note: Each "racial" category (e.g. Asian, Black, White) can be accompanied by the "Latina/Latino/Latinx" identifier if the patient identifies as such; any categorization of race, ethnicity or gender is based on the patient's self-identification.
Note: Be mindful of utilizing terms including "communities of color" and "racial and ethnic minority groups" in circumstances where racial and ethnic groups other than non-Hispanic White must be addressed. In other circumstances avoid these terms as the resources and disease experience varies greatly across different groups

Overarching Framework Language:

This document has been created with the mindset that Language holds power. In the power we yield daily in health care, we must strive to ensure we use language to empower our patients and communities we work with to both provide the best care possible. Below are some overarching framework ideas to retain as you work through this document.

1. **Influence of structural inequities leading to health disparities**
    a. Recognition that health disparities have not occured in a vacuum is essential to furthering health equity. Due to specific governmental policies and other long-standing societal structures particular groups are at increased risk of particular conditions through no fault of their own. Health disparities can be further understood by the social determinants of health **(Insert link).
2. **Health equity must be considered through an intersectional lens**
    a. An intersectional lens is one that recognizes that a person may belong to different racial/sexual/socioeconmic/gender/ability minoritized groups facing differing types of discrimination. Therefore, we must recognize the individual experiences and barriers to accessing care to ensure further health equity. In this work we must be careful to avoid generalizations about particular communities.
3. **Communities are not a monolith**

a. As we work to build health equity and recognize the diversity amongst communities, we also must recognize the diversity within each community. While some may prefer a particular term, others may not find the word to represent themselves. Thus, while this document will provide a broad framework on how we can approach different communities, as providers asking patients what they prefer can also be helpful.

4. **Striving for Cultural Humility versus Cultural Competence**
    a. Previously, cultural competence has been sought after in graduate medical education. Cultural competence describes the framework striving for "cultural sensitivity" by identifying cross-cultural expression of health and illness. A common criticism of cultural competence is that it often offers too simplistic or reductionist of a view. As a result, communities can frequently be treated as a monolith. Cultural humility describes a growth process that revolves around self-critique and recognition of each patient's individual experience. Another term, "cultural safety" developed in New Zealand in the 1980s refers to a concept under which clinicians are called upon to create spaces that are responsive to a patient's social, political, linguistic, economic and spiritual realities.

In the interpretation of racial/ethnic differences, all conceptually relevant factors should be considered, including: racism & discrimination, SES, social class, personal or family wealth, environmental exposures, insurance status, age, diet/nutrition, health beliefs/practices, educational level, lanuage spoken, religion, tribal affiliation, country of birth, parents' country of birth, length of time in the country of residence, and place of residence.

An excellent overview of the recommended changes can also be found in this guide:
Race and Culture Guide for Editors of Teaching Cases.
A Checklist for Assessing Bias in Health Professions Education Content.

Why are we doing this?

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Other References

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CDC Preferred terms for select population groups and communities

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Conscious Style Guide
Inclusive Language style guide
A Progressive's Style Guide
Kaplan JB, Bennett T. Use of Race and Ethnicity in Biomedical Publication. *JAMA.* 2003;289(20):2709–2716. doi:10.1001/jama.289.20.2709
"Race Conscious Medicine: A Reality Check"

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