Six Easy Things We Can Do to Help Create a Positive Learning Environment

1. **Be welcoming and inclusive:** Simple suggestions for starting off on the right foot!

Welcoming phrases:
"Welcome, I look forward to working with you."
"I'd like to introduce you to the to the staff members, so you know the team. I'd like you to feel part of the team."
Consider setting the stage for students to bring you any concerns in real time by saying something like: "I am here to help you have a great experience in (name of clerkship/rotation). We want to meet the expectations for this rotation and prepare you for your career in medicine, regardless of your specialty choice. If you have concerns about the rotation, student expectations, learning environment or how best to improve, I'd be happy to meet with you or direct you to the appropriate person. The best way to reach me is…"
Respectful inclusive phrases:
"What would you like to be called?" Remember to learn and use student names!
"What do you want to take away from this rotation?" "What are your expectations and goals for the month?"
"You look as if you might have something to say. Please share, even if your ideas aren't fully formed."
"That's a really good point."

2. Demonstrate enthusiasm: Learning is enhanced when learners encounter enthusiastic role models

Introduce yourself and describe why you are excited and passionate about learning and patient care "It's going to be hard work, but we will have fun and see interesting cases."
Embody a positive and optimistic attitude toward the team and learning

3. Be a team player: Don't denigrate other specialties or complain about appropriateness of a consult from a peer

Provide appropriate space and trust based on trainees' level of training and competency
Invite learner's insights, thoughts and opinions
Encourage questions and independent thinking; "I want you to feel that you can ask me any questions."
"We can learn from each other as we work together."

4. Show empathy: Put yourself in your learner's shoes. Be supportive of their uncertainties.
If you are concerned about a student who appears to be disengaged or withdrawn, consider reaching out: "You seemed a little quiet/distracted/upset today on rounds. Is everything OK?"
Acknowledge personal struggles; "It's really challenging when a patient…. (receives devastating news, dies…) how are you doing with this?" "I've struggled with XYZ as a learner myself."
Consider communicating to students at the beginning of the rotation not to hesitate to let you know should they ever feel the need to take a moment to reflect after a difficult patient encounter. Students might otherwise find it hard to ask.
Consider circling back after rounds; "I know rounds can be an intimidating setting so I wanted to check back with you and see what questions you may have about your patients."

5. Model humility
Admit your own limitations, errors, concerns; "I don't know all the answers."
Think aloud and invite learners to do the same
Acknowledge insecurities, fear of harming patients and desire to know more
Be open to learning from your students - They have a heightened awareness and understanding of how social determinants of health impact patient outcomes and, when given the opportunity to participate, can be valuable contributors to the health care team

6. Balance, challenge, AND support*
High challenge + high support = progression through a positive environment – trainee is given specific and challenging targets with adequate opportunity to meet them.
High challenge + low support = trainees feel discouraged
Low challenge + low support = trainee believes they have reached the level required
Low challenge + high support = previous misconceptions by the trainee are cemented instead of challenged

Acknowledgements:
Mayo Clinic "Resources for Creating a Positive Learning Environment"
Penn State "Faculty Scripts to Help Improve the Learning Environment"
Yale "ERASE" Program
*Gavriel, G, Gavriel, J, Br J Gen Pract. 2011 Oct; 61(591): 630–632.

How to Avoid Mistreatment:

First the basics: here are the behaviors the AAMC defines as mistreatment:

- Being publicly humiliated
- Threatened with physical harm or physically harmed
- Required to perform personal services
- Subjected to offensive sexist, racial, ethnic, or sexual orientation remarks
- Based solely on gender, race, ethnicity, or sexual orientation
    - Denied opportunities for training or rewards
    - Received lower evaluations or grades
- Subjected to unwanted sexual advances
- Asked to exchange sexual favors for grades or other rewards

Here are some tips for how to avoid behaviors that may not meeting AAMC criteria for Mistreatment, but are nonetheless commonly reported:

1. **Being ignored or feeling excluded from participating in patient care**
    - Consider the following general statement to help introduce students to patients (particularly in the outpatient setting):
        - *"A medical student is working with Dr. X as part of the health care team today. The student will be in shortly to help XYZ (i.e., clarify your history, ask you a few questions, listen to heart and lungs, etc.)."*
    - If the clinical situation requires your full attention and you don't have time to teach, set expectations for the learner:
        - *"This patient requires my full attention at this time. I will address teaching points once the patient is stable."*
        - *"I have a packed schedule in clinic today and will likely not have time to address questions between patients. Keep track of your questions and let's plan to regroup at the end of the day."*
        - *"I'm sorry I can't address your questions at this moment. We will get to them later when I have the time to give them the attention they deserve."*
        - *If a patient is reluctant to have a medical student involved in their care, consider advocating on behalf of the student. See link below to "Supporting learners when patient declines student involvement in their care."*
2. **Not knowing expectations**
    - As much as possible, communicate explicit expectations early
        - Discuss goals (yours for the students, the students for themselves, overall clerkship goals)
        - Getting going: When should the students start seeing patients, which patients should they see (or not see)?
        - How much and how long: What should the students do in the room, how much time should they spend alone with the patient, what should they focus on? Try to be specific about what they should do, learn or review.

- Questions: Make the times students should ask questions predictable. For example, “At the end of rounds, we will go back through the patients with the resident and you can ask your questions.”
- Help clarify to students where they should physically be during the day (i.e., work room, library, on a laptop on certain floor)
- Set expectation for how students should spend their “downtime” or time in between rounds or cases (i.e., There’s not much going on right now, why don’t you go to the library and meet up with the team again at x time”)
- Be clear about when students are dismissed for the day.

3. **Negative comments about other specialties or other broad groups of health professionals**
    - At times, the practice patterns of other units, specialties or teams may frustrate us. That said, be especially careful about making any broad negative general statements about others such as, “Why would anyone be an X?” or, “This drives me crazy; the nurses here always do XYZ.”
    - Instead, try to model a collegial approach. For example: “I had thought the team would follow our consult recommendations to do X, but they did Y instead. I’m sure there’s a good reason. Let’s call them to get more information so we’re all on the same page.”
4. **Comments or jokes regarding diverse populations such as those concerning race, ethnicity, religion, gender identity, and sexual orientation**
    - Many mistreatment complaints concern faculty who thought they were making a joke or an innocent observation, but in reality, they were unwittingly propagating a *microaggression*. Be especially careful about comments about any aspect of diversity, including race, ethnicity, gender or gender identity, religion or sexual orientation. For your benefit and for the benefit of others, you should avoid making disparaging comments or jokes based on another person’s aspect of diversity.
    - Instead: Inquire. If you think knowing more about a student’s aspects of diversity could help you to improve the learning environment, consider something like: “I know you mentioned that you will not be here Saturday so you can observe the Sabbath. Would it be OK with you if I asked you to tell me a little more about your scheduling needs so that we can work together to develop a schedule that maximizes your learning without interfering with your other obligations?”
5. **Comments about student appearance**
    - Unless there is a breach of the *General Guidelines for Medical Student Appearance Policy*, avoid all comments about students’ appearance. Seeming compliments or comments about appearance, attractiveness or other irrelevant characteristics can feel demeaning to learners.
6. **Distributing opportunities based on the gender of your medical students**
    - Medical students want to participate in real clinical medicine. Try to equally distribute opportunities to your learners. Especially avoid giving males or females different opportunities.
    - For examples, see above: “Being Ignored or Feeling Excluded from Participating in Patient Care”
7. **Giving constructive feedback in front of others**

- Giving constructive feedback in front of other people can be challenging, and complaints from students who felt humiliated when given feedback publicly are common.
- Set the stage for your teaching by saying something like this:
    - *"I am going to be asking everyone questions. I am not trying to embarrass you, or anyone. Knowing the edges of your knowledge helps me match my teaching to your knowledge level."*
    - *"If I give you a list of specific things to read up on during the clerkship in front of other people, it isn't to humiliate you, it's to round out your knowledge of our specialty and I do this commonly. Expect me to give assignments. Sometimes I'll follow up and ask you to tell me what you learned, and other times I won't. If I ask you to read on something and tell us about it the next day, don't wait for me to remember to ask you about it. Sometimes I may get distracted and forget. Feel free to initiate a discussion about the best time to present your topic."*
- Remember to provide specific, constructive behavior-based feedback
- For more information, check out these quick guide:
    - *Six Common Pitfalls of Feedback Conversations*
    - *Giving and Receiving Feedback*

8. Supporting students with disabilities
    - Providing a welcoming, inclusive environment for all students acknowledges the importance of including disability in our diversity and inclusion efforts.
    - Here are some tips for contributing to an inclusive environment for students with disabilities:
        - Consider including a supportive statement in your course syllabus or orientation materials, directing students who require accommodations to the OMSE Office of Academic Achievement.
        - For examples of statements, see Appendix "A" (p.91) in the AAMC publication: "*Accessibility, Inclusion, and Action in Medical Education*"
        - Convey a willingness to collaboratively implement ADA accommodations approved by the UVM Student Accessibility Services
        - Acknowledge that students with disabilities may experience new challenges when transitioning into the clinical learning environment.
        - Promote an open-door policy for students to reach out to you with any questions or concerns early in the rotation/course.
        - Remain sensitively aware to the reality that some clinical students may have an undiagnosed or hidden disability, or may not have chosen to seek ADA accommodations.
        - Creating an active culture of disability inclusion will remove barriers and encourage students to proactively seek the resources they may need for equal access to educational experiences.
    - For additional resources, including 20 minute educational modules, see Appendix "B" (p. 96) of the AAMC publication: "*Accessibility, Inclusion, and Action in Medical Education*"

We are all human. If you inadvertently snap at a student, or raise your voice, consider a simple apology:

- "I am sorry I raised my voice. Practicing medicine can be very challenging sometimes. I wasn't upset with you; I was just worried about xyz."
- I realize I was harsh when I said xyz. I apologize and I shouldn't have said it that way."

If you witness a colleague inadvertently behave in a way that is unprofessional:

- Consider sharing your concern with your colleague. Often, we are simply unaware of how our behaviors are perceived by others and we can depend on one another for assistance.

For more information, check out this quick guide: *Is it Mistreatment? Practices for Productive Teacher Learner Interactions.*

Thank you for your dedication to and engagement in our educational mission and for all you do to support a positive learning environment for our trainees.

Acknowledgements:
Mayo Clinic "Resources for Creating a Positive Learning Environment"
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"Take 5" Learning Environment Video Series- courtesy of The Mayo Clinic

Videos

Microaggressions in the Learning Environment

Professionalism Pivot

Supporting Learners When a Patient Refuses Care

Supporting Learners Seeking Help

Reducing Stereotype Threat in the Clinical Learning Environment

Click here to view the full Library of The Mayo Clinic's “Take 5 Videos”

Resources

Interactive Film Based UVMLCOM Learning Environment module

User Name: psychmod

Password: UVMmodules@#

For Navigating Specific Challenges, follow links to guides below:

- *What is a microaggression and how can I avoid it?*
- *Supporting learners when patient declines student involvement in their care.*
    - *Take 5 Takaways: Supporting the Learners when a Patient Refuses Care*
- *Supporting learners when patients make an inappropriate (racist, sexist) request or comments.*
    - *Take 5 Takeaways: Patient Bias Encounters*
- *More on use of pronouns and navigating gender identity*
- *Twelve Tips for Interfacing with the new generation of medical students: iGen (GenZ)*

The University of Vermont

LARNER COLLEGE OF MEDICINE

Inclusive Language Glossary for the Learning and Practice Environments

An Accompaniment to the Winter 2022 Snow Season Retreat workshop: 'The Evolving Landscape of Language: Inclusion and Belonging in Medical Education'

This resource was compiled by Luke Higgins, Mahima Poreddy, Richard Brach, Dr. Nathalie Feldman, and Dana Kramer of the University of Vermont Larner College of Medicine.

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I. Learning Objectives:

After reviewing this glossary, readers should be able to:

- Define intent and impact and relate each term to the restorative justice framework.
- Recognize common examples of non-inclusive language in the learning and practice environments and explain why each example is not considered inclusive.
- Describe and demonstrate person-first, identity-first, and anatomy-based language in educational and clinical contexts.

II. Introduction:

Language is both complex and dynamic, and conceptual approaches to language are nuanced. With increasing awareness of the importance of diversity, equity, and inclusion across all facets of medical education, supporting language practices that are inclusive and reflect the diversity of our communities is an important aspect of individual and institutional efforts. Language has received increased attention nationally, including the development and publication of the resource 'Advancing Health Equity: a Guide to Language, Narrative, and Concepts' by the American Medical Association (AMA) and the Association of American Medical Colleges (AAMC).

Language is also an important part of our engagement with one another as teams in the learning environment. Study of leaders' language demonstrates increased team engagement across a hierarchy when leaders utilize inclusive phrases.[1]

In this guide, we present a resource that both provides examples of language that is not considered inclusive and contextualizes and examines these examples in broader conceptual frameworks. We provide suggestions to use in place of these phrases. This guide is not intended to be comprehensive, and language may continue to evolve after its completion. We aim to be practical, succinct, and provide consensus-driven guidance.

Intent and Impact

Intent and impact are important concepts in approaching inclusive language. Despite the best intentions, sometimes the language we use has a negative impact on another individual, including discussions of a third party with whom one identifies. These intent-impact gaps are difficult to navigate for both parties and can be detrimental to the learning and practice environments. Impact is often given more weight than intent when addressing harm, including AAMC metrics that are student-reported and focused on the impact on learners.[2]

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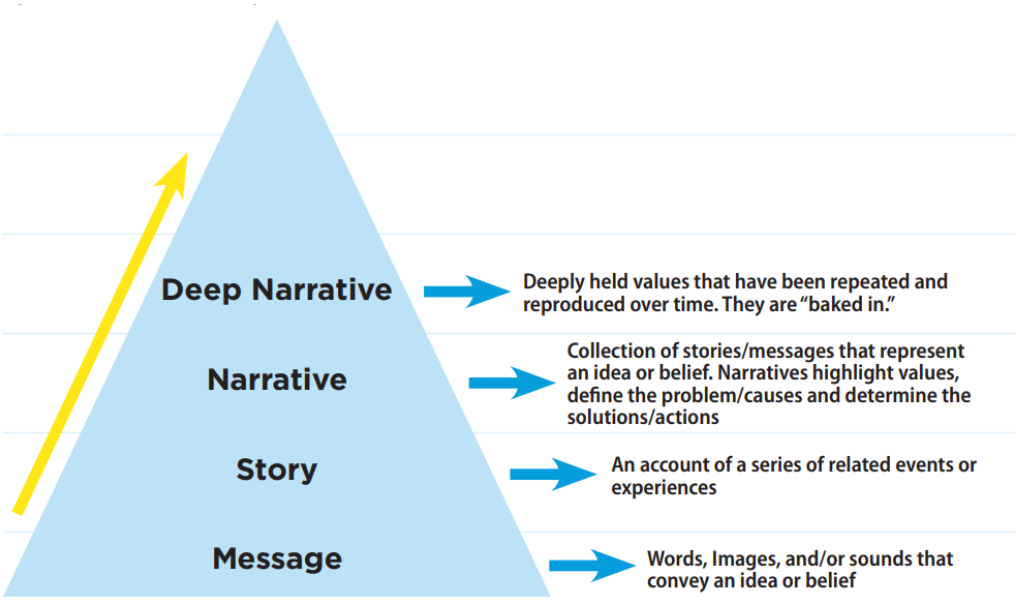
[1] Weiss M, Kolbe M, Grote G, Spahn DR, Grande B. We can do it! Inclusive leader language promotes voice behavior in multi-professional teams. *The Leadership Quarterly*. 2018;29(3):389-402.

[2] Mavis B, Sousa A, Lipscomb W, Rappley MD. Learning about medical student mistreatment from responses to the medical school graduation questionnaire. *Acad Med*. 2014;89(5):705-711. doi:10.1097/ACM.0000000000000199

Microaggressions, which are often subtle and unintentional, are also defined by impact and are an important focus of work to improve language inclusivity in medical education and clinical practice.[3,4]

Intent-impact gaps are frequently driven by differences in identity and lived experience. The words we use are interpreted by the recipient in the context of the 'Narrative Ecosystem,' as demonstrated in the following figure:[5,6]



For example, "pimping," a common phrase in medical education, is used to describe Socratic teaching methods but also carries narratives of intent to shame and humiliate, and deep narratives of imposter syndrome, capability, belonging, and fairness in the medical hierarchy.[7]

Pursuing awareness of deep narratives is imperative for recognizing injustice and developing cultural humility. However, translating this awareness into the language we use requires intentionality and practice with reproducible and methodical frameworks. While we include some information on deep narrative in our glossary of terms, we will first introduce several

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[3] Young K, Punnett A, Suleman S. A Little Hurts a Lot: Exploring the Impact of Microaggressions in Pediatric Medical Education. *Pediatrics*. 2020;146(1):e20201636. doi:10.1542/peds.2020-1636

[4] Sue DW, Capodilupo CM, Torino GC, et al. Racial microaggressions in everyday life: implications for clinical practice. *Am Psychol*. 2007;62(4):271-286. doi:10.1037/0003-066X.62.4.271

[5] Advancing Health Equity: Guide to Language, Narrative and Concepts. https://www.ama-assn.org/system/files/ama-aamc-equity-guide.pdf. Published 2021. Accessed January 3, 2022.

[6] Race Forward. Guide to Counter-Narrating the Attacks on Critical Race Theory. https://www.raceforward.org/practice/tools/ bannedwords/guide-counter-narrating-attacks-critical-race-theory. Published 2021. Accessed January 3, 2022.

[7] Kost A, Chen FM. Socrates Was Not a Pimp. *Acad Med*. 2015; 90 (1): 20-24. doi: 10.1097/ACM.0000000000000446.

concepts and frameworks that will provide a 'toolkit' for transforming awareness of deep narratives into navigating and using inclusive language.

Restorative Justice

Restorative justice, a framework that has been proposed for addressing mistreatment in the medical education learning environment, focuses on building accountability and responsibility for gaps in intent and impact through efforts aimed at directly addressing and repairing harm to individuals or groups and mitigating the possibility of repeated instances of negative impact.[8] The application of restorative justice extends beyond formalized processes and can be integrated into navigating individual instances of a gap in intent and impact. We suggest utilizing this framework when addressing intent-impact gaps to promote understanding, humility, and accountability in the learning environment.

Person-First Language

Person-first language is a framework designed to simultaneously add humanization and precision to language practices. It avoids defining a person by a single attribute, diagnosis, or identity. While this is a common framework that is mandated in many academic publications, and much has been accomplished since the framework was developed by the disability community in 1974, person-first language is not the norm in the clinical setting.[9]

The framework is simple and formulaic: "the person" or "the persons" is placed first and then any descriptors second. For example, rather than saying "the diabetic" one may say "the person with diabetes." We include many examples of person-first language in our guide and annotate examples of person-first language in the 'additional notes' column of our glossaries.

Most of the terms we include can be addressed through the implementation of person-first language, and after completing your review of this glossary, we expect you will be familiar with and able to apply this framework to everyday language practices. Many resources document specific applications of person-first language and may be of interest for further reading.[10,11,12,13]

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[8] Acosta D, Karp DR. Restorative Justice as the Rx for Mistreatment in Academic Medicine: Applications to Consider for Learners, Faculty, and Staff. Acad Med. 2018;93(3):354-356. doi:10.1097/ACM.0000000000002037, 10.1097/ACM.0000000000002037

[9] Crocker AF, Smith SN. Person-first language: Are we practicing what we preach? Journal of Multidisciplinary Healthcare. 2019;12:125-129.

[10] Bedell P, So M, Morse D, Kinner S, Ferguson W, Spaulding A. Corrections for Academic Medicine: The Importance of Using Person-First Language for Individuals Who Have Experienced Incarceration. Academic Medicine. 2019; 94 (2): 172-175. doi: 10.1097/ACM.0000000000002501.

[11] Granello DH, Gorby SR. It's Time for Counselors to Modify Our Language: It Matters When We Call Our Clients Schizophrenics Versus People With Schizophrenia. Journal of Counseling & Development, 2021;99(4):452-461. https://doi.org/10.1002/jcad.12397

[12] Jensen ME, Pease EA, Lambert K, et al. Championing person-first language: a call to psychiatric mental health nurses. J Am Psychiatr Nurses Assoc. 2013;19(3):146-151. doi:10.1177/1078390313489729

[13] Crocker AF, Smith SN. Person-first language: are we practicing what we preach? Journal of Multidisciplinary Healthcare. 2019;12:125-129. doi:http://dx.doi.org/10.2147/JMDH.S140067.

Person-first language is not without critique. Some have criticized the framework's utilization of singularly focused identifying language, especially language historically associated with significant stigma, as maintaining reductive and dehumanizing elements of other language frameworks.[14,15] This added nuance is important to consider and these criticisms highlight the importance of work to address broader injustice and stigma. These criticisms are relevant to and within the scope of clinical practice and learner engagement.

Identity-First Language

An alternative framework to person-first language is identity-first language. This framework, much like person-first language, is straightforward: to utilize identity-first language, you first state the descriptor and then "person" or "people" to whom the descriptor is applied. For example, to describe someone who has a disability, you would say "disabled person," compared to the person-first framework which would be "person with a disability."

This framework addresses criticisms of person-first language by centering community and cultural identity and recognizing how each element of a person, including a disability, are part of their whole person.[16,17] Proponents of this model appreciate the attention of this model to both the social and medical definitions of disability, although it is not universally agreed that identity-first language better captures the social definition compared to person-first language.[18] Identity-first language is the preferred model for many Autistic people and Deaf people.

There is debate within many communities regarding the use of person-first compared to identity-first language, and this may lead to intent-impact gaps with some community members. When approaching such gaps, centering restorative justice facilitates building trust and demonstrating respect for people even after a gap between intent and impact is identified.

Anatomy-Based Language

Anatomy is often gendered through our care systems. For example, OBGYN centers are often called "women's care centers," which is exclusive of trans, nonbinary, or intersex people with a uterus, cervix, etc. Much of our language is cis-normative and represents dominant discourse about gender that can be harmful to trans, nonbinary, and intersex people. Qualitative research conducted with trans and nonbinary youth demonstrated a preference for language that is

[14] Collier R. Person-first language: what it means to be a "person". *CMAJ*. 2012;184(18):E935-6. doi:10.1503/cmaj.109-4322, 10.1503/cmaj.109-4322

[15] Gernsbacher MA. Editorial Perspective: The use of person-first language in scholarly writing may accentuate stigma. *J Child Psychol Psychiatry*. 2017;58(7):859-861. doi:10.1111/jcpp.12706, 10.1111/jcpp.12706

[16] Why Person-First Language Doesn't Always Put the Person First. https://www.thinkinclusive.us/post/why-person-first-language-doesnt-always-put-the-person-first. Published 2021. Accessed January 4, 2022.

[17] I am Disabled: On Identity-First Versus People-First Language. https://thebodyisnotanapology.com/magazine/i-am-disabled-on-identity-first-versus-people-first-language/. Published 2015. Accessed January 4, 2022.

[18] People first vs identity first: a discussion about language and disability. https://www.croakey.org/people-first-vs-identity-first-a-discussion-about-language-and-disability/. Published 2016. Accessed January 4, 2022.

anatomical but not gendered or based in self-determination (the latter of which will be covered under "mirroring language").[19]

For example, the term "woman's body" is a gendered term associated with a reproductive tract including a uterus, ovaries, cervix, and vagina and secondary sex traits including breasts. Not all people with this anatomy identify as women. Using anatomical terms can reduce gender dysphoria associated with medical care for organs discordant with gender identity.

Mirroring Language

Mirroring language is a strategy to use self-determined language demonstrated by another individual. None of the inclusive language strategies we discuss are one-size-fits-all; rather, they are consensus-driven. Listening to the terms used by people to discuss their own identity, anatomy, etc. may provide their individual preferred terminology.

As discussed above, trans and nonbinary people may experience gender dysphoria with their anatomy, and anatomy-first language is a standard approach to avoid gendering organs. However, if a person were to refer to their uterus as "my box" or another colloquial phrase, this may be their preferred term for this anatomy, and you can either mirror this language or ask if they would prefer you use the modeled language.

In other instances, reclaimed or reappropriated terms may be used by community members and may not be appropriate for people outside the community to use.[20,21] It is best to avoid terms that have historically been derogatory unless you are a member of the identity group.

III. Describing Individuals and Identity

When describing individuals or communicating about an aspect of their identity, person-first and organ-based language can be important frameworks to utilize, and we have provided many examples below that demonstrate how to transform non-inclusive language to inclusive language utilizing the person-first and organ-based frameworks.

Notably, not all people of an identity group prefer the same language, which can result in intent-impact gaps even with the best of intentions and the most carefully selected language. In these situations, relying on restorative techniques and mirroring language can be useful.

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[19] Tordoff DM, Haley SG, Shook A, Kantor A, Crouch JM, Ahrens K. "Talk about Bodies": Recommendations for Using Transgender-Inclusive Language in Sex Education Curricula. *Sex roles*. 2021; 84:152-165. https://doi.org/10.1007/s11199-020-01160-y

[20] Coles G. The Exorcism of Language: Reclaimed Derogatory Terms and Their Limits. *College English*. 2016; 78(5):424-446.

[21] Galinsky AD, Wang CS, Whitson JA, Anicich EM, Hugenberg K, Bodenhausen GV. The Reappropriation of Stigmatizing Labels: The Reciprocal Relationship Between Power and Self-Labeling. *Psychological Science*. 2013;24(10):2020-2029. doi:10.1177/0956797613482943

Diagnoses and ability

Several of the terms below discuss drug use and addiction. For more information and a CME (Continuing Medical Education) opportunity, see this resource developed by the National Institute of Drug ~~Ab~~use.[22]

Many other terms address (dis)ability. For more examples and information, see the National Center on Disability and Journalism's Disability Language Style Guide.

Term	Suggested Replacement	Additional Notes
the diabetic / the cirrhotic / the epileptic / the paraplegic / Sickler / etc.	person diagnosed with _____ / person with _____	Examples of person-first language. This language model is precise, humanizing, and promotes inclusivity.
alcoholic / addict / junkie / drug abuser / user	Person with substance use disorder / Person who uses _____	
Former Addict	Person in recovery / person who previously used _____	
Dwarf / little person / midget	Person with dwarfism	
Mentally Retarded / Slow	Person with intellectual, cognitive, or developmental disability	
Crazy / insane / nuts / psycho / loony / deranged	Person with mental illness / Person with psychiatric disability / Person living with _____	
Handicapped / the disabled	People / person with disabilities	
Invalid / cripple	People / person with disabilities	
Brain damaged	Person who has a traumatic brain injury	
The blind	People who are blind	
Wheelchair bound	Person who uses a wheelchair	

[22] We included this strikethrough purposefully to highlight the institutional integration of terms that do not follow inclusive language standards. By their own guide, 'abuse' is not a preferred term.

Obese / morbidly obese /overweight	Person with unhealthy weight / Person with high BMI	These examples use person-first language. Note, that "fat" has become a reclaimed term that may be appropriate to mirror when used by people. Avoid discussing weight singularly. Focusing on exercise, diet, etc. rather than weight may reduce stigma felt by patients/individuals.
Autistic	Autistic person / neurodivergent person	The use of identity-first language is overall preferred to person-first language in these communities, although there is no universal agreement.
the *d*eaf	**D**eaf people / **D**eaf person	
Afflicted with / stricken with / suffers from / victim of _____	The patient has _____	Switching to person-first language reduces connotations of pity
Able-bodied	Person without a disability	This language others people with disabilities or medical diagnoses.

Sex and Gender

Gender pronoun use is an important part of inclusive language practice. Sharing and asking for personal pronouns is an important part of introductions to colleagues, students, and patients. This is an affirming practice that promotes inclusivity of trans and nonbinary persons. Sharing pronouns is important in both individual interactions and large group spaces. Notably, pronouns may evolve over time as an individual's dynamic identity evolves and introductions may not be the only time that you ask for someone's pronouns.

When introducing yourself to another person, one might say, "My name is Alex and I use They/Them pronouns, what pronouns should I use to address you?" In situations where you might mistakenly address another person by pronouns that are not congruent with their identity, a quick apology and correction are typically the best approach. For example, after using the incorrect pronoun, one might say "I'm sorry I used the incorrect pronoun," and then continue the conversation with effort to utilize the individual's pronouns.

Many resources are available for further information on pronoun use and sex/gender:

- A video generated by Osmosis.org in collaboration with UVM LCOM discussing the concepts of sex, gender, and sexual orientation.

- A peer-generated video designed by UVM LCOM students focused on pronoun use in the learning environment.
- GLSEN Pronoun Guide
- NPR: A Guide to Gender Identity Terms
-

Example term	Suggested Replacement	Additional Notes
Chairman, manpower, etc.	Chairperson, people power	Gender neutrality in common phrases can increase inclusivity and validate the presence of cisgender women, transgender, and nonbinary individuals.
"Hey guys" / "Ladies and gentlemen"	Folks / y'all / colleagues / friends / attendees / everyone	
"Boys and girls"	Children / kiddos	
"Husband" / "wife"	Spouse / Partner	
"Mom and dad" or "mother and father"	Parents / Guardians	
"Women's care"	Gynecologic Care / Obstetric Care / Breast care	Adding specificity provides organ/system-based, rather than gender-based, language and is inclusive of trans or nonbinary people with those organs.
"Preferred pronouns"	"Personal pronouns" / "pronouns"	Pronouns reflect gender identity, utilizing "preference" insinuates choice.
transvestite / transsexual / Hermaphrodite	They are transgender / a transgender individual / they identify as transgender (adj.) Some people accept the reclaimed word "queer" as an umbrella term.	Trans and nonbinary gender identities exist on a spectrum. "Transgender" is one of many identities on this spectrum and other adjectives may be preferred. Pay attention to language modeled or ask if uncertain.
they are "a" transgender (n.) / they are "transgendered" (v.)		

they "transgendered" a few years ago (v.)	They "transitioned" a few years ago.	Transitioning is the preferred term for this complex and individual process including social, medical, and other components. The process of transitioning, including identity in medical records, does not follow the same timeline as the development of identity. Try to avoid language that invalidates identity prior to transition.
they "changed genders" a few years ago		
Is "actually" …, Born as….	"Assigned at birth"	
"Before he was a boy"	"Before he transitioned"	
"de-transitioned"	"transitioned" / "they identify as ____"	Gender is a dynamic identity on a spectrum, and people may or may not identify the same way throughout their lives.
"Sex change" operation / "opposite sex hormones"	Gender-affirming care	Gender-affirming care includes hormone therapies, procedural interventions etc. Not all trans and nonbinary people will pursue medical intervention, but for many this is live-saving care that affirms their identity.
"Biological sex" or "Biological gender"	Sex traits	People are born with sex traits, including chromosomes, genitals, and reproductive organs, but these may not line up neatly into what most people think of as one "biological sex."
"Born with ambiguous gender" or "ambiguous genitalia"	"Born with genitalia outside of the typical male/female binary"	"ambiguous" implies seeking to place an individual within a binary definition of sex which is not inclusive of intersex people.

"Born both a man and a woman"	"Born intersex" or "born with different sex traits"	With most people's binary understanding of sex, this could imply a person was born with two sets of genitalia, which is not possible. It also assumes being a man or a woman depends on sex traits at birth (and implies these are the only two options!).
"Female/Male Chromosomes"	XX/XY chromosomes	Chromosomes do not determine gender identity. Also, intersex people can have chromosome patterns that are not XX or XY.
"Women's/Man's Genitalia"	Vagina/Penis	Body parts don't have genders. Organ-based language is inclusive of intersex and transgender people with sex traits often associated with a different gender.
"Both sexes/genders"	Multiple sexes/genders	There are more than two genders, and many combinations of sex traits
Frequently referring to physicians with he/him pronouns	Diversify your example physicians. Use she/her or they/them	"They" can be used as a non-binary or gender-neutral pronoun

Sexuality

Term	Suggested Replacement	Additional Notes
Homosexual	LGBTQ+ (Lesbian, Gay, Bisexual, Transgender, Queer/Questioning, and more)	Homosexual is viewed as pathologizing and reinforces a binary gender construct.
Promiscuous	Engages in ____ with ____ partners	Person first language that is precise and non-judgmental
Sexual preference	Sexual orientation / sexuality	Sexual preference connotates choice

Other identity-based terms

Example Term	Suggested Replacement	Additional Notes
"Elderly people" / "old people"	Older adults / adults / People over the age of ____	Person-first or language with reduced stigma.
"minorities"	"underrepresented"	This language recognizes systemic barriers. Furthermore, it is important to be general when discussing general topic and precise when discussing a specific identity group.
"marginalized"	"groups facing systematic oppression"	
Vulnerable	Oppressed / disenfranchised	
Victim	Person who has experienced / person who has been impacted by _____	These examples utilize person-first language. Some people may prefer the term "survivor" or "survivor of ____" to person-first language in this situation.
"Choice" / "lifestyle" / "preference"	A person who is _____ / people who are _____	Person-first language, with emphasis on identity recognition.
"normal"	A person who is not _____	Less "othering" and avoids centering privileged identities as "defaults"
Person who does not seek care	Person with limited access to (specific service/resource)	Avoid unintentional blaming
Homeless	Person experiencing homelessness / unhoused person	Person-first language
Prisoner / Convict	Person who was/is incarcerated	Person-first language
Prostitute	Person who engages in sex work / Sex worker	Person-first language and less stigmatizing.
Child Prostitute	Child who has been trafficked	Person-first, recognizes power dynamics
Caucasian	White	The term Caucasian has a white supremacist origin.[5]

Latino/Latina/Latin@ (when referring to multiple people)	Latine / Latinx	Gender neutral and non-binary. Note that Latine originated in Spanish-speaking populations and is generally preferred over Latinx.
Illegal immigrant / illegal alien	Undocumented Immigrant	"illegal" and "alien" are dehumanizing and othering terms
Indians	Native peoples / Indigenous peoples / American Indian & Alaska Native	The term "Indian" is rooted in colonization, which resulted in genocide of the native people of North America.
"Orientals"	Person of Asian ancestry	Person-first replacement of outdated language. Ancestry may be preferred to "Asian-American," as this term can be interpreted as othering and is sometimes inaccurate.
African Americans / Black**s**	Black (use a capital B) / Black people (plural)	Note, this is not universally agreed upon and different people may prefer different terminology. "African-Americans" has been seen as othering by some who have been in the US for generations or inaccurate for those who identify as Caribbean Islanders, etc.
"People of Color"	Black and Indigenous People of Color (BIPOC)	When discussing oppression, this is a more precise representation of racial groups disproportionately affected by violence and discrimination. Note that this is an umbrella term and more precise discussions warrant more precise language.

IV. Clinical Vocabulary / Terms

Example Term	Suggested Replacement	Additional Notes
"harvesting" or "procuring" organs	Organ "recovery"	Reduces transactional language to respect donor.
Non-compliance	Non-adherence	Non-compliance does not recognize additional factors (structural barriers, mistrust, poor communication) and places blame on the patient
Refused care	Declined _____ option/ selected to _____	Centers patient autonomy and shared decision-making
Dirty / Clean	Testing negative or positive / in remission / not actively using drugs	Clinically accurate and non-stigmatizing
Habit (in reference to substance use)	Substance use (disorder) / Drug addiction	Habit implies the ability to stop and minimizes the seriousness of the disease.
Committed/successful/completed suicide	Died by suicide / Took their own life	Removes framework of criminality or achievement and attached judgement
Failed / unsuccessful / attempted suicide	Took steps to end their life	
Chief Complaint	Chief Concern	Complaining has negative connotations for patients
"Red Man Syndrome"	Vancomycin Infusion Reaction	White male standard has led to gender and race related bias. Also "Red Man" has been used as racist language towards Native people.
Mongolian Spots	Dermal melanocytosis	The former term is racialized.
Wegener's Granulomatosis / Reiter's syndrome / Clara cell / Asperger Syndrome	Granulomatosis with polyangiitis / reactive arthritis / Club cell / Autism Spectrum	Avoid medical eponyms which have been associated with Nazi human experimentation.
Conceptualizing race as a biological construct	Race is a social construct and is distinguished from ancestry.	There's no genetic basis for race. Biologic race has been used to support white supremacy and ignore social sources of disparities, such as racism.

Sickle Cell Crisis	Acute painful episode	"Acute painful episode" preferred because patients shouldn't have to be at a point of true crisis for appropriate analgesia.

V. Medical Education Terms

In the medical education space, providing and receiving feedback is an important part of learner development and is also an area in which bias can be present. In both written and oral feedback, descriptors such as "confident," "compassionate," "quick learner," "scholarly," "natural leader," and "needs to smile more," are used in a gendered way that perpetuates inequities within medical education.[23,24,25] The following graphic demonstrates domains that tend to be evaluated using gendered language:[26]

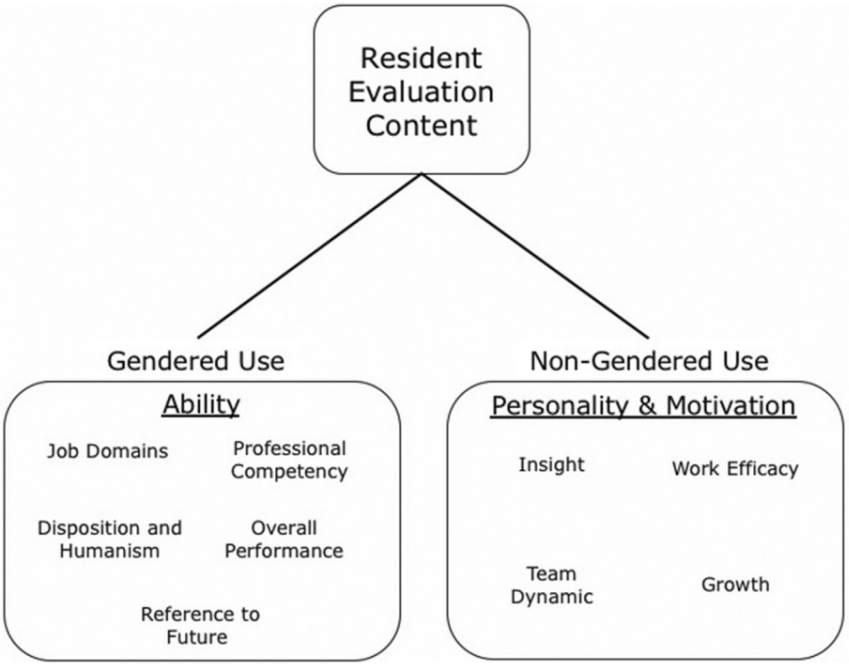

Fig. 2. Conceptual model of how people write differently about men and women surgical trainees.

[23] Brewer A, Osborne M, Mueller AS, O'Connor DM, Dayal A, Arora VM. Who Gets the Benefit of the Doubt? Performance Evaluations, Medical Errors, and the Production of Gender Inequality in Emergency Medical Education. *American Sociological Review*. 2020;85(2):247-270

[24] Blanch DC, Hall JA, Roter DL, Frankel RM. Medical student gender and issues of confidence. *Patient Educ Couns*. 2008;72(3):374-381. doi:10.1016/j.pec.2008.05.021

[25] Gerull KM, Loe M, Seiler K, McAllister J, Salles A. Assessing gender bias in qualitative evaluations of surgical residents. *Am J Surg*. 2019;217(2):306-313. doi:10.1016/j.amjsurg.2018.09.029

[26] Ibid.

The impact of evaluations utilizing biased language is most often misaligned with their impact. Deep narratives that influence the impact of feedback are also intersectional, meaning they are informed by the intersections of multiple identities held by one person. For example, if a woman was to be provided feedback that she was “abrasive” or “aggressive” this would carry additional deep narratives for a Black woman compared to a White woman, because the language is both gendered and racialized. We hope that our emphasis on precision, intentionality, and attention to deep narratives is evident and helpful for crafting evaluations using inclusive language.

Example Term	Suggested Replacement	Additional Notes
"pimping”	“quizzing” / “putting you on the spot”	References position of power and exploitation in sex trade and human trafficking, carries narratives of learning environment mistreatment.
Freshman	First-year student	Gender-neutral
Walk-in	Drop-in	Assumes the ability to walk
Trigger warning	Content note	Prepares learners for content without assumption of reaction / impact, leading to learner autonomy and kindness to learners.

VI. Other Terms

Example Term	Suggested Replacement	Additional Notes
Hysterical	Upset	Derived from gendered language and historically used in medicine to describe women in a sexist way.
"Powwow”	Meeting, gathering, check-in	This language appropriates native culture.
“Totem poll”	Hierarchy, organizational structure	
“gypped” / “jewed”	“ripped off” / “haggled down”	Originates from slurs directed at Romani/Gypsy and Jewish people.

"Killing it"	"Great job!"	Avoids violent language
Take a shot at / take a stab at	Give it a go / give it a try	
"grandfathered in"	I was able to retain _____ / I got an exception because _____	References "grandfather clause" used to disenfranchise black voters during reconstruction.
"Long time no see"	I haven't seen you in a while	These idioms are derived from phrases to mimic "broken" English
"No can do"	I can't do that	
Third world country	Low-income country, Low resource country	Recognizes systemic barriers for states with low resources.

VII. Additional Resources:

The following resources are available to further inform inclusivity in the learning and practice environments. While some sources cited in our glossary are included below, many additional resources can be found in our citations.

- UVM Resource: Creating a Positive Learning Environment (and Avoiding mistreatment!)
- UVM Resource: What is a Microaggression and How to Avoid Committing Them
- UVM Resource: Supporting Learners When a Patient Makes and Inappropriate (Racist, Sexist) Request or Comment.
- UVM Resource: Use of Pronouns and Navigating Gender Identity
- AAMC Guide: Advancing Health Equity: A Guide to Language, Narrative, and Concepts
- AAMC Guide: Accessibility, Inclusion, and Action in Medical Education Lived Experiences of Learners and Physicians with Disabilities
- NASPA: Brave Spaces and Safe Spaces