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INVITED EDITORIAL

Adopting Inclusive Language as Part of Patient-Centered Care

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Communication is critical to ensure equitable health outcomes and a positive care experience for our patients. The words we choose and the way we communicate hold power and send a signal about our own understanding, comfort, and openness to diversity. Sometimes communications lead to an environment of distrust, causing our patients to withhold information and potentially impacting our ability to provide quality care. Taking the time to develop an inclusive language practice demonstrates an interest in meeting our patients where they are and signals our desire for a truly patient-centered care environment.

Inclusive language is not just about avoiding certain exclusionary words or phrases. It's also about being "…respectful, accurate, unbiased, and consistent with the preferences of the individuals and communities who are being discussed."[1] Inclusive language requires empathy and a willingness to adapt to a patient's needs, regardless of the providers comfort or communication preference.

There have been numerous studies on empathy and its correlation with outcomes.[2] The more empathic a provider is toward their patient, the better satisfaction and clinical outcome. It is challenging to empathize in an environment that stigmatizes. When we stigmatize, either in writing or in discussing a case with colleagues, we remove empathy and connection from the patient. By viewing a patient through stigma, we reduce their humanity and personal experiences, making it harder to empathize or provide a patient-centered experience. Adopting inclusive language helps keep the patient centered and allows us to demonstrate greater compassion and understanding of the unique needs of each person who comes into our care.

Inclusive language isn't about carrying a list of what to say or not say, and it isn't about always getting it right. Our patients, like every human being, are diverse, and the guides available are suggestions to help us.[3] A person who is deaf or hard of hearing, for example, may identify as Deaf (capital "D"), preferring identity-first language and rejecting person-first language. To them, being Deaf is part of their culture and identity. It is a part of their experience that carries pride and isn't something that needs to be fixed. This preference is why it's impossible to carry a list and get it right. We must get to know our patients, listen to and observe how they identify, and communicate in a way that demonstrates that they were heard and are respected.

It is common to feel uncomfortable adopting inclusive language. Many people worry about making a mistake or being offensive. It can be hard to adapt our language, especially when language is deeply connected to our own values and experiences. Personal insecurity and fear of embarrassment can lead to avoidance rather than compassion. For example, avoiding a patient's pronoun or not asking a patient their ethnicity gives the provider temporary comfort at the expense of the patient's needs and potentially their clinical outcome. We must be willing to feel slightly uncomfortable while learning to practice inclusive language.

Inclusive language is not the only tool in our Diversity, Equity, and Inclusion toolkit. We must also reduce our biases and continue to develop our awareness and cultural-linguistic competency. Adopting inclusive language is a step we can immediately take while we are advancing our Diversity, Equity, and Inclusion efforts. If we consider inclusive language as part of patient-centered care and necessary for positive outcomes, it shifts the dialog from something that is uncomfortable and could be avoided to something that is imperative and must be implemented. We will not always get it right, but if we approach the process with humility, apologize when we make a

mistake, and do our best to avoid mistakes in the future, we will earn the trust of patients who are most vulnerable.

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