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Moving from Stereotyping Language to Neutral Language in Clinical Practice and Teaching

Medicine is a vast discipline and there is no "one size fits all" approach. As such, it is commonplace to see labelling and grouping of patients, based on race, gender, culture, sexual orientation, socioeconomic status, weight and disability to name a few examples. However, when this categorisation extends into stereotyping language in practice and in teaching, this can become pathological. Though the initial justification may be that these are epidemiologically informed groupings, it is vital to consider the following; Firstly, the implications of stereotyping language on patient care and whether these risks are justifiable, and secondly, how we can mitigate these risks to minimise the negative impact upon those in our care.

There is a well-established school of thought which dictates that language holds the power to guide consciousness [1], and thus, the way in which language is used has the power to inform how we view the world. When stereotyping language is used, particularly on an institutional scale, this can have an astronomical compound effect on the way that individuals perceive themselves and others. In the context of medicine, it has been established that stigmatizing wording choices, such as blaming or doubtful language, can affect patient's perception of their own condition, and indeed impact the ways in which health care workers view and even treat the people in their care [2,3]. It is thus reasonable to consider that widespread conditioning with stereotyped language can lead to implicit biases which can in turn feed into the way we treat the individuals that fall under these "othered" labels [4]. There is little doubt that this is a contributing factor to the repeated findings that individuals within minority groups fare poorer outcomes within healthcare systems. [5,6].

Throughout my time at medical school, I have increasingly recognised the use of stereotyped language in medical education and clinical practice. There is seemingly a conceptual "default" demographic of patient, that minority groups are framed as straying away from. This is reflected in our teaching, where demographics such as race, gender or sexual orientation are frequently employed as a defining factor to hint at a diagnosis. I have been advised by mentors and peers to recognise leading traits for ease of answering single best answer questions – if a gay man attends with fever, the question is most certainly leading towards STI or else his orientation wouldn't be placed in the question; If a woman attends with non-specific symptoms, always consider anxiety; If a black woman attends with a dry cough, it is most likely to be sarcoidosis and so on. Our question banks often reward this kind of decision making, and so this behaviour becomes positively reinforced. Not only are these simplifications othering, but they put real patients at risk of being failed by their healthcare practitioners, who have been actively trained to contextualise them in stereotyped settings. It comes as no surprise that this can invite mistreatment of common conditions in these individuals.

One devastating instance where I witnessed this phenomenon in practice was when an older female patient with myocardial infarction was initially misdiagnosed with anxiety because she presented "atypically", with nausea, dizziness and shortness of breath. Upon dissecting this case, we can see that there was an implicit bias at play in the initial diagnosis based on gender, which had the potential to be fatal. This misdiagnosis evokes the commonly stereotyped misinformation that MI is typically a male disease, along with the preconception that women presenting with vague symptoms are often anxious. Moreover, we can observe the use of an exclusionary semantic choice ("atypical") to describe a presentation that is far from atypical in women [7]. Notably, it is thought that the "atypical" label of this presentation is brought about by a data gap, in which the underrepresentation of women in the data for cardiovascular health leads to biased conclusions [7,8]. This is an important example of a feedback loop at play, where language informs perception, and perception informs data collection, which in turn reinforces language.

Moving forwards, we must reflect on what aspects of normalised practice may be stereotyping or exclusionary. A critical area of development is of course medical education. Rather than creating stereotyped cases as proxies to aid learning, only to unlearn them for safe practice, it would be beneficial to move towards a model where our learning materials provide diverse representation and visibility, to minimise learnt bias. Moreover, learning resources such as Osmosis.org have consulted experts to review and adapt existing materials to reflect neutral language[9]. This approach translated to medical curricula could be transformative for standardising language in a conscious and informed way. Finally, encouraging students to consult resources such as the NIH style guide at an early stage when learning how to document has the potential to encourage standardisation of language that reflects best practice, whilst also combatting the development of implicit bias through promoting conscious linguistic choices to describe patients.

Fundamentally, through recognising the compound risks brought about by seemingly unconscious automations in linguistic choice, and how stereotyped language can perpetuate outdated narratives and biases, we begin to appreciate the importance of conscious action to achieve neutrality of language. Further, through appreciating the power that language holds to shape the world around us, we can acknowledge the role of updating and standardising language, as a seed with the potential to decondition healthcare systems from implicit biases.

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1. Searle, J.R. *Consciousness and language*, (Cambridge University Press, 2002).
2. Cox, C. & Fritz, Z. Presenting complaint: use of language that disempowers patients. *Bmj* **377**, e066720 (2022).
3. Park, J., Saha, S., Chee, B., Taylor, J. & Beach, M.C. Physician Use of Stigmatizing Language in Patient Medical Records. *JAMA Network Open* **4**, e2117052-e2117052 (2021).
4. Shepherd, S.M.*, et al.* Racial and cultural minority experiences and perceptions of health care provision in a mid-western region. *International journal for equity in health* **17**, 1-10 (2018).
5. Dayo, E., Christy, K. & Habte, R. Health in colour: Black women, racism, and maternal health. *The Lancet Regional Health–Americas* **17**(2023).
6. Chauhan, A.*, et al.* The safety of health care for ethnic minority patients: a systematic review. *International journal for equity in health* **19**, 1-25 (2020).
7. Woodward, M. Cardiovascular Disease and the Female Disadvantage. *Int J Environ Res Public Health* **16**(2019).
8. Desai, S., Munshi, A. & Munshi, D. Gender Bias in Cardiovascular Disease Prevention, Detection, and Management, with Specific Reference to Coronary Artery Disease. *J Midlife Health* **12**, 8-15 (2021).
9. Osmosis. Words Matter: The Power of Inclusive Language in Medicine. in *Osmosis blog* (2021).