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Patient-centeredness and inclusive language use in health care – pedagogical considerations

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Inclusive language use is part of patient-centered communication, but only if applied in a sensitive, personalized, adaptive manner because its purpose is to support diversity, create an open and inclusive environment, and promote equal rights and opportunities to all interlocutors in a healthcare situation. However, if inclusive language use recommendations are considered rules to follow, it can easily backfire and may even cause harm to both patients and healthcare providers. The most problematic part of implementing inclusive language use recommendations is that it touches on the core belief systems of each participant in a healthcare situation. Therefore, several issues must be addressed when teaching inclusive language use to healthcare providers or students. A supportive environment must be created for students where they can be open to other people's beliefs and explore their own. Accordingly, students may have to face that they are not as sensitive as they think and their own vulnerabilities may surface as well. These tasks require a holistic approach, simultaneously engaging students' intellects and emotions. Furthermore, it must be noted that change and development in these intellectual and emotional processes take time and do not happen at the same pace and level due to students' individual differences.

Keywords: *inclusive language use, healthcare communication, cultural humility, intercultural competence, patient-centeredness*

Introduction

Patient-centered communication elicits and aims to understand patients' perspectives (Naughton, 2018) through a respectful attitude toward patients, which helps support patients' decision-making in the healthcare process along with their values, needs, and preferences (Jiang, 2017). Such communication can be realized in an inclusive environment, which appreciates and acknowledges patients' individual perspectives, experiences, and whole selves (APA, 2021). Therefore, by aiming to use and let the patient use inclusive language, their capacity to make medical decisions can be enhanced (APA, 2021).

In intercultural healthcare communication, which is characterized by cultural diversity, there is an increased need for patient-centered communication and, thus, inclusive language use. However, the healthcare professional-patient dynamic is often compromised due to communication and behavioral barriers caused by various sociocultural mismatches, usually due to the provider not being aware of their patients' beliefs and experiences (Tervalon–Murray-García, 1998). Additional and ruinous barriers can occur as a result of the providers' unintentional and intentional actions of racism, classism, ableism, homophobia, sexism, ageism, and sizeism, among others (Hosseinabadi-Farahani et al., 2021).

Accordingly, it is crucial that healthcare providers are prepared to communicate with patient-centered, inclusive language use when engaging in intercultural communication. A common approach is designing and implementing programs for achieving intercultural competence (ICC), however, not in its narrow dimension with the assumption that it is a unit of knowledge that can be easily demonstrated and assessed, but as *"a commitment and active engagement in a lifelong process that individuals enter into on an ongoing basis with patients, communities, colleagues, and with themselves"* (Tervalon–Murray-García, 1998:118). Therefore, ICC should be understood as the ability to collaborate effectively with individuals

from different cultures, which has been found to improve experiences and outcomes in health care, consultations with clients, and work with students and trainees in a variety of disciplines (Nair–Adetayo, 2019).

Furthermore, it must be underlined that the aim of improving ICC is not to know about every group's health beliefs, but to make providers conscious of how patients' health experiences are affected by a great number of factors, such as race, ethnicity, religion, class (Tervalon–Murray-García, 1998). In order to realize this, providers must engage in continuous reflection *"to be aware, responsive, and accountable to the communities one is serving or working with"* (APA, 2023, n.d.), which was termed cultural humility and was proposed to be expanded to the concept of intercultural humility (Bilbus–Koh, 2019) to emphasize the diversity of the cultures meeting in social contexts.

In line with the above, we propose that preparing healthcare providers for intercultural communication with patients, intercultural humility, patient-centeredness, and inclusive language use are key within the framework of developing ICC.

Steps to Improve Intercultural Competence

Step 0 – developing intercultural humility

Any training aiming to ensure the lifelong process of committed and actively engaged healthcare communication must take intercultural humility as a fundament. In this process, healthcare providers must function with self-reflection and challenge their biases (Tervalon–Murray-García, 1998). Especially so, as they need to be aware of and negotiate the inherent power imbalances in the dynamics of provider-patient communication (Joseph-Williams et al., 2014). Engagement in healthcare communication with such humility encompasses acknowledging the complexity of patients' identities, uniqueness, and diversity and consequently redressing the inherent and added intercultural power imbalances of healthcare situations (APA, 2023).

Furthermore, providers also need to ensure that through their patients, they create mutually respectful partnerships with traditionally marginalized communities (Tervalon–Murray-García, 1998). Intercultural humility creates a climate establishing the *"degree to which community members feel included, affirmed, or excluded in the work group, organization, or community"* (APA, 2021). Climates are shaped by organizational practices, interactions among members of the work group, organization, or community, and objective characteristics of the setting (Nishii–Rich, 2014).

Step 1 – reflecting on identity

In truly intercultural and patient-centered healthcare training, educators need not only to overcome but also to openly oppose the clinically disconnected, intellectual practice of thinking about and describing patients in an objectified, scientific way. At the heart of medical education should be the facilitation that healthcare trainees feel encouraged and supported in the enfolding, continuous, courageous, and honest practice of self-reflection and self-awareness. Educators must become role models and guides for students in the process of investigating and identifying their own patterns of unintentional and intentional racism, classism, ableism, homophobia, and so on. Tervalon and Murray-García identified two ways to initiate this constructive process, one being to *"have trainees think consciously about their own, often ill-defined and multidimensional cultural identities and backgrounds"*, and the other is to awaken trainees *"to the incredible position of power health care professionals potentially hold over all patients"* (Tervalon–Murray-García, 1998:120). This process is particularly critical concerning

the members of traditionally marginalized communities, of those *"excluded from dominant social, economic, educational, and/or cultural life"* because of, for example, *"age, gender, gender identity and expression, race, ethnicity, religion, national origin, immigration status, language, disability, sexual orientation, size, neurodiversity and socioeconomic status"* (Sevelius et al., 2020:2009).

If not already members of these communities, medical professionals and teachers should become, firstly, so-called *"allies"*, who *"recognize the unearned privilege they receive from society's privileging of Whiteness, male gender, Christianity, heterosexuality, ableism, and other identities and take responsibility for advancing equity"* (APA, 2023). An ally needs to be authentic, transparent, and willing to step out of their comfort zone in order to use their privileged position to center marginalized voices (APA, 2023). Secondly, trainers should also become *"accomplices"*, who aim *"to tackle injustices, such as racial injustices on an institutional level"* (Schafranek, 2021). Accomplices strive to identify and challenge the inappropriate structures and policies that create marginalization. Healthcare and medical training institutions that aspire to provide interculturally sensitive and person-centered care and education are obliged to use the very same self-reflection and self-criticism, which they promote to their workers, also at the institutional level. By doing so they demonstrate an inclusive approach towards their students and staff members. Consequently, medical professionals and teachers must take up the roles of allies and accomplices simultaneously, and one way to achieve this is by implementing and promoting inclusive language usage.

Step 2 – reflecting on language use

As Zimman pointed out *"language is not just an auxiliary to identity, but it is the primary grounds on which identity construction takes place"* (Zimman, 2017:85). The lack of linguistic awareness of these questions results in people from marginalized communities remaining vulnerable to verbal harassment and discrimination in health care. Normative language usage recognizes certain identities as "*natural"*, "*normal",* and "*good"*, while other identities are categorized as "*unnatural"*, "*abnormal"*, and "*bad"*. As one of the most essential ways to construct identity is by language, the recognition, understanding, and dismantling of normative language are crucial for creating inclusivity.

In addition to the openly and directly antagonistic expressions, such as transphobic and racist epithets, there are less obvious ways to impose normality by linguistic means. There are other commonly occurring brief, *"verbal, behavioural, and environmental indignities, whether intentional or unintentional, that communicate hostile, derogatory"* attitudes (Sue et al., 2007:273). These microaggressions are called 'micro' not because they are considered small, but because they take place on an interpersonal level and thus cause harm in the long run as they accumulate over time (APA, 2023). Types of microaggressions include microassaults, microinsults, and microinvalidations (Sue et al., 2007:273). Microinsults are often unconscious insensitive remarks and comments; microassaults are usually conscious, deliberate, and derogatory; and microinvalidations are mainly unconscious and exclude and negate the thoughts, feelings, or experiences of a marginalized group (Sue et al., 2007).

A set of practices was founded on the reclamation of stigmatizing words, so it is also important that lexical resignification becomes a central subject of analysis. The discussion of person-first (e.g., *alcoholic person*) versus identity-first (e.g., *a person with alcohol use disorder*) language is crucial to be kept in focus, but in practice, if possible, terms that honor both perspectives should be identified. But it is advised to ask the person's preference first and foremost. In person-first language, the person is emphasized, while identity-first language allows the individual to choose their identity for themselves rather than allowing others to select terms with negative implications (APA, 2023). Identity-first language is often used as an

articulation of cultural pride and a reclamation of what was once presented as a negative identity (APA, 2023). Using the preferred approach to language, *"whether that be person-first language, identity-first language, or a mix of both—treats people with respect and helps reduce bias in practice, research, and educational setting."* (APA, 2023).

Pedagogical considerations

Based on our experience, teaching inclusive language usage in Hungary, where it is not widely known and supported by society, requires courage, risk tolerance, and patience. The learning process can become an upward spiral when students are getting inspired by the empowering feeling of professional development, by the evolving supportive and protected environment of the classroom, and by their own growing sense of self-improvement, compassion, and pride. However, a downward spiral can equally occur when students feel overwhelmed by the complexity of the inclusive approach; they perceive it as far too cumbersome and time-consuming to implement in the settings and conditions of the Hungarian healthcare system.

In contrast to the acceptive atmosphere of the class in the fortunate situation of the upward movement, in a downward spiral, the discussions and reflective tasks do not result in a space where opinions can be openly expressed, but escalate into a hostile milieu where students are withdrawing from real interactions and are getting ashamed of expressing their opinions. Naturally, it is much more likely that there is a continuous fluctuation of upward and downward spiral movements, and the real pedagogical aim is to achieve a final overall upward tendency. This might seem a doubtful and questionable outcome of a teaching process, and it may well be the case if the goals were merely aimed at developing intercultural competence and skills. However, tutoring a flexible, inclusive language usage adaptive to real medical situations requires a fundamental attitude change from students, which cannot be achieved through the overly beaten and secure paths of traditional language courses for specific purposes. In the following, we propose approaches that can foster the development of a patient-centered and inclusive attitude.

Creating a supportive environment

The very first step of any course is to establish mutual acceptance of the ground principle of showing respect for each other and the topic at hand (Lloyd, 2008). Experimenting with inclusive language use can be attempted only if students feel assured that their opinions, feelings, and identity are going to be respected. The consistent usage of inclusive language demonstrates to students that this principle is taken seriously and has practical implications. Also, from the very beginning, striving for transparency is vital (Leary, n.d.) and can be accomplished by acknowledging the complexity and inherent difficulties of inclusive language use. However, establishing a baseline for inclusivity by showing the fundamental theoretical principles and practical guidelines employed by various institutions can also increase transparency and help students recognize clear boundaries of solicitous communication. Paying so much attention to inclusivity builds community, while devoting so much time and effort promotes belonging to the group. Students also enjoy the sensitivity directed toward all participants' physical, mental, emotional, and spiritual well-being. Interrogating social and professional norms and practices openly emancipates students from the restrictions of the overwhelmingly hierarchical healthcare education system.

Incorporating inclusive language use

Beginning every course by enquiring about students' preferred names and, if they wish to tell, about their pronouns allows them to discuss their emotions and opinions about identity, the significance of naming, and also about gender assignment based on appearances and real gender identifications. Teachers have to tread very carefully here since these are very sensitive subjects and many students need much more time to trust the environment and community surrounding them to be able to share. They can also experience how individual preferences, sometimes as minor as being called Patricia or Pat, are respected in the class. Finding out individual preferences is also crucial when the issues of ethnicities, nationalities, cultures, abilities, religions, beliefs, and many more dimensions of diversity come up in group discussions. Tolerance of ambiguity and change is naturally encouraged as the result of actively listening to other perspectives, acknowledging differences, and finding common ground and empathy in order to keep up the dialogue and cooperation (Haley et al., 2017). During these processes, empathy and circular reflection are inherently developed.

Downs – Problems and solutions

Though students on occasion consider inclusive language usage a minority issue, which is irrelevant to them, we still have to make them understand that everyone, including them, is affected. If nothing else, just becoming ill makes each of us vulnerable and marginalized, so in class, reflective tasks on personal memories of exclusion from the majority help students realize their own humanity (TCLIP, 2024). However, while inclusivity, especially in health care, has been promoted as a norm in Europe (Inclusion Europe, 2018), in Hungary, it is still a novel and often dismissed subject, so students frequently find it confusing and shocking. Therefore, as much time as necessary to process and accept the phenomenon of inclusivity needs to be devoted to it. Another objection that might arise is that it is not a healthcare issue, though exploring the holistic approaches to care can help people comprehend the falsity of this perspective. Some trainee professionals go in the opposite direction and take the concepts in hand personally and get offended. As per our experience, the conflicting situations arising in the classroom can be overcome by shifting the focus to the overall perspective. Many find inclusive language use far too challenging, complex, and overwhelming and want to give up even before starting. These rightful concerns can be balanced with acknowledging difficulties and emphasizing that attitude matters and mistakes can be made.

Conclusions

Healthcare communication can only be effective if patients receive thoughtful and personalized care, which can be ensured with heightened awareness in communication. The main drive of communication and information exchange is language, and therefore, the words selected when addressing an individual largely influence the quality of care and the patient's adherence to it. Inclusive language use is not a controlling guideline, and it is definitely not about policing the language, but it creates the foundation of an honest and respectful dialogue between the patient and the healthcare professional, just as much between teachers and students. During the training of future professionals, their educators should become role models whose own motivation and attitude towards their students count, and whose responsibilities expand to sharing their perspectives respectfully and always considering students' sensitivities.

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