

Call to Action: Prioritizing the Use of Inclusive, Nonstigmatizing Language in Scientific Communications

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The language we use in our scientific communications can either empower or stigmatize the people we study and care for. *Clinical Infectious Diseases* is committed to prioritizing the use of inclusive, nonstigmatizing language in published manuscripts. We hereby call upon submitting authors, reviewers, and editors to do the same.

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The language we choose reflects our attitudes and can influence others. As scientists, researchers, clinicians, and advocates for the patients and populations we serve, we have a responsibility to learn about and employ the use of inclusive language in all communications. Doing so may be challenging and will require us to eschew old habits and intermittently review guidelines to ensure that we are up to date with the literature. Yet, doing so is imperative. As noted in the rationale for the 2021 updates to the *AMA Manual of Style*, a resource used by scientific authors, editors, and publishers worldwide, “Inclusive language supports diversity and conveys respect. Language that imparts bias toward or against persons or groups based on characteristics or demographics must be avoided.” [1].

One effective way to make language inclusive is to utilize person-first language. Person-first language seeks to communicate with respect for individuals, acknowledging their equal and inherent value before attaching other descriptors to them. In other words, it describes conditions or diseases as something an individual *has*, not something an individual *is*. References to person-first language date back to the 1960s when psychologist Beatrice Wright referenced studies from the field of semantics that “show that language is not merely an instrument for voicing ideas but that it also plays a role in *shaping* ideas” [2]. Person-first language is familiar to those of us in the field of infectious diseases. The Denver Principles, written by human immunodeficiency virus (HIV) advocates in 1983, called for the use of respectful person-first

language in the opening words: “We condemn attempts to label us as ‘victims,’ a term which implies defeat, and we are only occasionally ‘patients,’ a term which implies passivity, helplessness, and dependence upon the care of others. We are ‘People With AIDS.’” [3]. The term “person-first language” was officially coined in 1988 in a congressional act [4] in support of people with disabilities and has since been adopted by the *AMA Manual of Style* as well as the National Institutes of Health and the Centers for Disease Control and Prevention [5–7]. Additionally, the People First Charter was launched in July 2021 during the Berlin International AIDS Society Conference to promote person-first language by creating and regularly updating terminology guidance and encouraging policymakers, researchers, conferences, journals, clinicians, and allied care providers to follow the guidance [8].

Although the field of infectious diseases has largely adopted and endorsed person-first language without controversy, it is important to acknowledge the nuances in preferred language within the disability community [9]. Person-first language (eg, people with disability) has been endorsed by the American Psychological Association and is currently the recommended approach in many North American scholarly journals because it aims to empower individuals with disability by placing emphasis on their humanity rather than their impairments [10]. However, many disabled people prefer identity-first language because they take pride in this aspect of their identity [11]. Identity-first language recognizes that disability is part of the person rather than a derogatory term, and portrays disability as a human attribute as opposed to a medical problem that requires treatment [10]. For these reasons, some groups in the field of disability have expressed a preference for identity-first language (eg, “disabled people”). While this nuance may be confusing for clinicians and researchers, the appropriate action should always be to (1) acknowledge this nuance while using the preferred language of the people being described, (2) not label people as their

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Table 1. Commonly Used Terminology to Avoid and Suggested Alternatives

	Term to Avoid	Alternative
Person-first terminology	Addict	Person with a substance use disorder, person recovering from substance use disorder
	Alcoholic	Person with alcohol use disorder
	The disabled	People with disabilities or disabled people
	Drug user	Person who injects (or uses) drugs
	HIV-infected, HIV patient	Person with HIV (PWH)
	Mentally ill	Person with mental illness
	Midget	Person with dwarfism
	Non-compliant/non-adherent	Person who faces barriers to adherence
	Obese person	Person with obesity
Terminology to use when reporting on race, ethnicity, and structural inequities	blacks	Black people
	Caucasians	White people
	hispanics	Hispanic people*
	Latinos	Latino, Latina (if referring to women only), or Latinx (gender neutral term) people**
	Hard-to-reach populations	Describe the specific barriers that are limiting the population's access to or information about health care options
	Minority	Historically marginalized or under-represented may be appropriate, depending on what the author is trying to communicate; can be appropriate as part of a more informative term such as "racial minority population" or "sexual minority population". Where possible be as specific as possible about which group is being referenced.
	Poor, poverty-stricken, poverty-ridden, third world	Resource-limited
Terminology to use when reporting on sex, gender and sexuality	Biologically male/female	Assigned male/female at birth
	Cisgendered/transgendered	Cisgender/transgender
	Homosexual men	Men who have sex with men (MSM)
Other	deaf	Deaf (capitalized)***
	Handicapped parking	Accessible parking

NOTE: This table is by no means exhaustive but is meant to be used as an aid and general guidance. Additionally, some of the terms to avoid are potentially offensive and being used for illustration only.

*Hispanic people—from a Spanish-speaking country

**Latino/Latina/Latinx people—from Latin American country (e.g., Brazilian people are Latinx but not Hispanic)

***Deaf people have reclaimed the term Deaf and prefer identity-first language to emphasize the culture of the Deaf community

disability (eg, “the disabled” or “a paraplegic”), and (3) avoid using pictorial metaphors (eg, “wheelchair bound”) or condescending euphemisms (eg, “differently abled”) to describe disability [9, 10, 12, 13].

Clinical Infectious Diseases is committed to prioritizing the use of inclusive, nonstigmatizing language in published manuscripts. We encourage submitting authors, reviewers, and editors to do the same. Recognizing the aforementioned nuance with disability language, manuscripts should aim to use person-first language where people are described as having a condition or disease, experiencing a circumstance, or engaging in a specific behavior rather than presenting the condition, disease, circumstance, or behavior as part of their identity [6, 7]. For example, authors should use the terms “people with obesity,” “person with HIV,” “person who injects drugs” and so forth, rather than “obese people,” “HIV patient,” “HIV positive,” or “IV drug user.” Please refer to Table 1 for additional (nonexhaustive) examples.

When reporting on race and ethnicity, we recommend following the guidance outlined in the *AMA Manual of Style*, an

excellent resource [5]. Above all, it is important to acknowledge that race is a social construct and not defined by genetics or biological differences. If demographics such as race and ethnicity are needed, authors should be consistent, listing all of the racial and ethnic groups represented in the sample, not just one group, and avoid creating aggregated groups centering whiteness as a “default vs other” (eg, “White vs non-White”). Further, authors should indicate how participants’ race and ethnicity were determined. Self-identification is the most accurate and preferred method for collecting race and ethnicity data. All race and ethnicity terms should be capitalized and, in accordance with person-first language, used as modifiers (eg, Black patients, Hispanic participants) rather than nouns (eg, Blacks, Hispanics). Similarly, “minority” and “minorities” should not be used as nouns but, rather, accompanied by another descriptor (eg, racial and ethnic minority groups). The reporting of race and ethnicity (and disparate outcomes) should not be considered in isolation—it should be accompanied by reporting other sociodemographic factors and social determinants of health with interrogation of the upstream influence

of structural racism (not race) as the risk factor for the disparate outcomes [14, 15].

When reporting on sex and gender, it is important to note that these terms have different meanings and should not be used interchangeably. Sex refers to “biological differences between females and males, including chromosomes, sex organs, and endogenous hormonal profiles” [16]. The traditional categorization of sex is dichotomous and includes the terms male or female. Occasionally, other response options may be appropriate (eg, intersex, other). “Gender refers to socially constructed and enacted roles and behaviors which occur in a historical and cultural context and vary across societies and over time” [16] and is often categorized as male, female, and nonbinary. Gender identity is a person’s own internal sense of self and their gender. Cisgender is the term used for people whose gender identity aligns with their sex assigned at birth, whereas transgender is the term for people whose gender identity is different from their sex assigned at birth. As with race and ethnicity reporting, the methods used to obtain sex and gender information should be clearly outlined, and self-reporting is preferred. It is also recommended to explicitly designate information about the gender identities of participants (ie, use cisgender men instead of men unless men is inclusive of all male gender identities). Terms regarding a person’s sexual orientation and gender identity (eg, bisexual, cisgender, etc) may be utilized as adjectives when appropriate.

The guidance and suggested terminology in this call to action are not final and will require updates as the science evolves; this change reflects an iterative process and may not always be straightforward. As such, we recognize that contributing authors and *Clinical Infectious Diseases* editors may continue to make errors in usage and terminology, based on lack of awareness of these principles, language barriers, or simply force of habit. Through feedback about these mistakes—feedback that is emphatically welcomed—our goal is to continue learning and improve how we communicate.

Several academic journals have committed to the use of inclusive language, setting a precedent that others may follow. Infectious diseases funding agencies, conference organizers, and medical societies should pledge to use inclusive, person-first language in all scientific communications so that this practice becomes the norm.

The use of inclusive language in our scientific communications is only one step towards achieving truly equitable healthcare and research, and additional measures are urgently needed. Engaging historically excluded and underrepresented groups (including racial and ethnic minorities, cisgender women, transgender individuals, and economically disadvantaged populations) in clinical research is critical to reduce healthcare disparities. Funders and publishers can also encourage the incorporation of analyses by race, ethnicity, sex, and gender in

study designs, when feasible, and then indicate when findings apply to only one race, ethnicity, sex, or gender.

A subset of *Nature* portfolio journals began asking authors to report sex and gender analyses in their submissions in June of 2022, and the editors described compelling reasons for this policy. “The new measures are needed because research is still mostly failing to account for sex and gender in study design, sometimes with catastrophic results. Between 1997 and 2001, ten prescription drugs were withdrawn from use in the United States; eight of these were reported to have worse side effects in women than in men (we recognize that not everyone fits into these categories). These differences had probably been missed, in part, because of insufficient or inappropriate analysis of data on sex differences during clinical trials.” [17].

We urge all readers, reviewers, and editors of *Clinical Infectious Diseases* to promote inclusion and equity in scholarly work by using inclusive and nonstigmatizing language. Our ultimate goal is to make scientific communications a reflection of more inclusive study designs and more accurate findings that can be applied to all the patients we study and care for.

Notes

Acknowledgments. The authors acknowledge the work many others are doing to make the language we use more inclusive and less stigmatizing.

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References

1. Flanagin A, Frey T, Christiansen SL, Bauchner H. The reporting of race and ethnicity in medical and science journals: comments invited. *JAMA* 2021; 325: 1049–52.
2. Wright BA. Physical disability: a psychological approach. New York: Harper & Row, 1960.
3. The Denver Principles. 1983. Available at: https://data.unaids.org/pub/externaldocument/2007/gipa1983denverprinciples_en.pdf. Accessed 27 November 2022.
4. US Congress Subcommittee on Housing and Community Development of the Committee on Banking, Housing, and Urban Affairs. Supportive housing needs of elderly and disabled persons: hearings before the Subcommittee on Housing and Community Development of the Committee on Banking, Housing, and Urban Affairs, House of Representatives, One Hundred First Congress, First Session. Washington, DC: US Government Printing Office, 1989.
5. American Medical Association. AMA Manual of Style: a guide for authors and editors. 11th ed. Oxford University Press, 2020. Available at: <https://www.amamanualofstyle.com/>. Accessed 27 November 2022.
6. NIH Style Guide. Available at: <https://www.nih.gov.nih-style-guide>. Accessed 9 December 2022.
7. Centers for Disease Control’s Inclusive Communication Principles. Available at: https://www.cdc.gov/healthcommunication/Health_Equity.html. Accessed 9 December 2022.
8. People First Charter. Available at: <https://peoplefirstcharter.org/>. Accessed 27 November 2022.
9. Andrews EE, Powell RM, Ayers K. The evolution of disability language: choosing terms to describe disability. *Disabil Health J* 2022; 15:101328.
10. Dunn DS, Andrews EE. Person-first and identity-first language: developing psychologists’ cultural competence using disability language. *Am Psychol* 2015; 70: 255–64.
11. Best KL, Mortenson WB, Lauzière-Fitzgerald Z, Smith EM. Language matters! The long-standing debate between identity-first language and person first language. *Assist Technol* 2022; 34:127–8.

12. Shakespeare T, Iezzoni LI, Groce NE. Disability and the training of health professionals. *Lancet* **2009**; 374:1815–6.
13. Pierce LL. Flattening the learning curve: notable updates in the publication manual of the American Psychological Association 7th edition. *Rehabil Nurs* **2020**; 45: 309–10.
14. Marcelin JR, Fadul N, Cawcutt KA, Abdul-Mutakabbir JC. Diversity in probiotics and diversity in clinical trials: opportunities for improvement. *Infect Control Hosp Epidemiol* **2022**; 43:1508–9.
15. Boyd RW, Lindo EG, Weeks LD, McLemore MR. “On racism: a new standard for publishing on racial health inequities.” *Health Affairs* blog, 2 July 2020. Available at: <https://www.healthaffairs.org/doi/10.1377/forefront.20200630.939347/>. Accessed 9 December 2022.
16. NIH Office of Research on Women’s Health. Sex & gender. Available at: <https://orwh.od.nih.gov/sex-gender>. Accessed 27 November 2022.
17. *Nature* journals raise the bar on sex and gender reporting in research [editorial]. *Nature* **2022**; 605:396.