

Current Guidance on Inclusive Language for Medical and Science Journals

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• **Why?** “Terminology, usage, and word choice are critically important, especially when describing people and when discussing race and ethnicity. 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.”

Figure. Rationale for updating AMA guidance

“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 This session focused on inclusive language updates from the *AMA Manual of Style*, a resource used by scientific authors, editors, and publishers worldwide.

Stacy Christiansen opened the session by explaining the rationale behind updating the *AMA Manual of Style* so soon after the last update (February 2020): They believe it is imperative for medical and scientific journals to use consistent, equitable language when describing the race and ethnicity of patients or in articles that discuss health disparities in healthcare, research, and education (Figure).

The AMA Manual of Style Committee began reassessing the guidance for reporting race and ethnicity in spring of 2020. After 8 months of research, updates, and external review, the revised guidance was published as an editorial in the *Journal of the American Medical Association (JAMA)* in February 2021 with an invitation for wider review and feedback. The guidance was revised following comments from numerous reviewers and those with expertise in diversity, equity, and inclusion. After another round of peer review, the updated guidance was published in *JAMA* in August 2021.

The following key principles are included in the updated guidance:

- An acknowledgment that race and ethnicity are social constructs—race is a created concept, not defined by genetics or biological differences. These terms provide limited utility in understanding medical research practice and policy but may be useful in studying racism, disparities, and inequities in health, health policy, education, and research

- It is paramount that writers and editors are clear, precise, fair, and consistent in the terms they use to describe race and ethnicity
- Race and ethnicity should be reported with other sociodemographic factors
- The origin of racial and ethnic categories should clearly indicate what categories were used and how study participants’ race and ethnicity were determined, with preference for self-identification
- The guidance is not final—discussion will continue, and updates will be made as needed

A summary guide for appropriate reporting of race and ethnicity was presented and included the following preferences:

- Capitalize all race and ethnicity terms—this is the most fair, sensitive, and consistent approach
- The term “race/ethnicity” was changed to “race and ethnicity”—using a slash can be confusing, since race and ethnicity both have numerous subcategories
- List race and ethnicity categories in alphabetical order instead of by prevalence, but list “other” and “unknown” last
- Following patient-first language, race and ethnicity should be used as modifiers (e.g., Asian patients; White populations), not nouns (e.g., Asians; Whites)
- Compound racial and ethnic terms should not be hyphenated (e.g., Asian American; African American)
- Avoid “mixed race” unless this term was used in data collection; “multiracial” or “multiethnic” is preferred

Annette Flanagin spoke next and continued:

- Abbreviations (e.g., AANHPI [Asian American Native Hawaiian Pacific Islander]) should be avoided as they may not be understood by a global audience. If such abbreviations must be used, they should be expanded and reserved only for complicated tables

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- “Minority” and “minorities” should not be used as nouns; rather, they should be used with another descriptor (e.g., racial and ethnic minority groups). “Underserved” or “underrepresented” can be used but have different meanings—“underserved” refers to health disparities among groups, while “underrepresented” refers to a disproportionately low number of individuals in a workforce or educational program
- “People of color” should be avoided—this is inclusive to the point that it erases differences between groups. The preference is to list specific racial or ethnic categories
- Terms such as “Black, Indigenous, and people of color (BIPOC)”, “Black, Asian, and minority ethnic (BAME)”, and “Black and minority ethnic (BME)” should be avoided as they disregard individuals’ identities, may not include all groups, eliminate differences among groups, and may imply hierarchy. Preference is to list specific racial or ethnic categories
- If collective terms are used, ask for definitions of groups included and expand at first mention. In practice, *JAMA Network* journal manuscript editors will follow up with authors who use collective terms that are vague or nonspecific
- Avoid use of colors (e.g., brown and yellow) to describe individuals or groups. These terms may be less inclusive than intended, or considered pejorative or a slur
- Avoid “other” without explanation as it is vague. Authors should state which groups are included in the term “other” and why “other” was used (e.g., numbers in some categories were too small for meaningful comparative analysis)
- Avoid biological explanations for healthcare disparities or inequities between racial and ethnic groups and recognize the intersectionality of many sociodemographic and systemic factors that may be associated with such disparities and inequities
- Don’t use “non-White”—specific groups should be indicated. If there is a reason for classifying this way, authors will be asked to justify and explain

Christiansen then spoke again, this time about updates to *JAMA Network* journals’ instructions for authors regarding the collection and reporting of demographic data on race and ethnicity. The methods section should identify who determined participant race and ethnicity, what classifications were used, and how this was done, as well as why race and ethnicity were assessed.

The AMA Manual committee is also reviewing and updating the rest of the chapter on inclusive language, including sections on sex and gender, sexual orientation, age, socioeconomic status, ability, and persons with

diseases, disorders, or disabilities. Updated guidance will be made available online once completed.

Tracy Frey spoke next about current guidance and recent changes to the inclusive language section regarding sex and gender. Current guidance includes using “sex” for biological factors and “gender” for identity or psychosocial/cultural factors and defining the different terms used; explaining the methods used to obtain information on sex and gender; reporting the distribution of study participants or samples; and reporting data for all participants, not just the category representing the majority of the sample. In research reports, all main outcomes should be reported by sex (or gender, if appropriate) wherever possible. Choose sex-neutral terms for nonresearch reports.

Frey then spoke about new guidance being discussed as part of the AMA update:

- Use pronouns when known; inclusive pronouns are acceptable
- Binary terms may be acceptable, depending on context
- Using LGBTQ/LGBTQ+ (lesbian, gay, bisexual, transgender, queer [or questioning]) and LGBTQIA (lesbian, gay, bisexual, transgender, queer [or questioning], intersex, asexual [or allied]) is acceptable, if defined
- Terms regarding sexual orientation and gender (e.g., bisexual, cisgender, gay, etc.) are acceptable as adjectives
- When reporting on pregnancy, avoid “pregnant women” or “women of childbearing potential”—“pregnant individuals”, “pregnant patients”, or “pregnant people” are preferred
- Be specific when referring to people by age group (“neonate/newborn” or “infant” rather than “baby”; “older adults” rather than “seniors”, “the elderly”, or “the aged”); avoid ageist terms
- Do not label people, populations, or countries by socioeconomic status—avoid general terms that are archaic or insensitive, such as “homeless” or “poor” (“people without housing” and “low-income” are preferable)
- Use person-first language when referring to conditions, diseases, disabilities, and abilities (e.g., “patients with diabetes” is preferable to “diabetics”). Avoid describing patients as victims or with terms that imply helplessness (e.g., “afflicted with”, “suffering”). In some cases, such as with autism or deafness, identity-first language may be more appropriate

Annette Flanagan then spoke about an analysis of 688 studies published in *JAMA*, *Lancet*, and the *New England Journal of Medicine (NEJM)* between 2015 and 2019 to determine changes in the reporting practices of demographic variables, including race, sex, and socioeconomic status.² The authors of the analysis concluded that limited progress

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was made in the reporting and representation of race and socioeconomic status in medical research between 2015 and 2019, while the reporting of sex was high. The authors also concluded that the impacts of systemic racism in medicine are being acknowledged, but that it is imperative to address and improve the way we represent, report, and include race, socioeconomic status, and sex or gender in medical research.²

Flanagin shared an example of what one journal is doing to improve the reporting of diversity in research studies: *NEJM* guidance states that reports of clinical trials must include a supplementary table providing background information on the disease, problem, or condition studied and the representativeness of study participants.

There was some discussion about postpublication name changes from the Joint Commitment for Action on Inclusion and Diversity in Publishing (of which all session speakers were part of). As a result, *JAMA* Network developed a policy about postpublication name changes, recognizing that authors can change their names for personal reasons (e.g., changes in identity or marital status) without requiring rationale. This may be done as a silent correction, meaning the correction will be made and the article redeposited in PubMed without a formal notice, or through the usual correction process that results in a published notice. *JAMA*

Network will notify indexers and databases of the name change but cannot guarantee that they will make updates on their end.

JAMA Network also introduced a statement on potentially offensive content in regard to previously published content.³ There is a plan to link to this statement in articles that have been identified as potentially offensive, with a notice similar to the way corrections or retractions are handled.

Patty Baskin then spoke about a new toolkit for equity from Coalition for Diversity & Inclusion in Scholarly Communication, debuting in summer 2022. The kit will include 12 sections on various topics and aims to set an industry standard promoting inclusive writing. Attendees were encouraged to sign up for the email list by contacting c4disc@gmail.com.

References and Links

1. Flanagin A, Frey T, Christiansen SL, Bauchner H. The reporting of race and ethnicity in medical and science journals: comments invited. *JAMA*. 2021;325:1049–1052.
2. Alegria M, Sud S, Steinberg BE, Gai N, Siddiqui A. Reporting of participant race, sex, and socioeconomic status in randomized clinical trials in general medical journals, 2015 vs 2019. *JAMA Netw Open*. 2021;4:e2111516.
3. *JAMA* Network. [accessed June 1, 2022]. <https://jamanetwork.com/pages/offensive-content-statement>.