

The American Medical Association (AMA) and the Association of American Medical Colleges (AAMC) have issued a document, *A Guide to Language, Narrative and Concepts*.

This comprehensive guide presents a new perspective from these Associations and describes the need, rationale, and clear information to address these important topics. The title appropriately identifies the three areas of focus.

Part 1. Health Equity Language: Oft-used words and phrases can have limitations and harmful consequences. This section reviews these terms and offers “equity-centered alternatives” (p 7). These terms evolve over time, but the importance of context is stressed, e.g., the term Latinx is appreciated by some to describe the ethnic identity of people with Latin American or Spanish ancestry. However, for others, the term lacks meaning and Latina/Latino or Hispanic is preferred. There is a table of terminology that has heretofore been used and that has negative roots. These are explained and useful alternatives are presented. Overall, this section’s guidance is reflected by this list:

1. Avoid use of adjectives such as “vulnerable” and “high-risk.”
2. Avoid dehumanizing language. Use person-first language instead.
3. Remember that there are many types of subpopulations.
4. Avoid saying “target,” “tackle,” “combat” or other terms with violent connotation when referring to people, groups or communities.
5. Avoid unintentional blaming.

Part 2. Why Narratives Matter: Narratives are collective stories that are intertwined in everyday life and are widely circulated and integral in the psyche of the nation. These shape our language, thinking, and actions and are largely taken for granted – and accepted. There are dominant narratives that reflect the values and power of “the dominant group”, i.e., “white, wealthy, hetero-, able-bodied, male, Christian, US-born” (p 18). An example of narrative change from conventional about Native Americans is that they have the highest mortality in the US. This implies that the individual’s behavior and choices are the cause; alternatively, if the description is of the dispossession of land and culture, Native Americans have the highest mortality rate in the US. In **race-based medicine**, the meaning of race is poorly defined and implies biological significance. In **race-conscious medicine**, race is defined as a “social and power construct” (p 21). The former led to biologized concepts that led to biased and exclusionary research, education, and clinical practice. The latter reframes race such that research studies the effects of structural racism; education, and clinical practice reflect the understanding the need for recognition of consequences and to the support to overcome these structural health barriers.

Part 3. Glossary of Key Terms: This extensive and comprehensive glossary provides more than just definitions, but also a broad perspective and potential approaches to improve health equity.

It is critical to address all areas of marginalization and inequity due to sexism, class oppression, homophobia, xenophobia and ableism. Yet conversations about race and racism tend to be some of the most difficult for people in this country to participate in for numerous reasons, including a lack of knowledge or shared analysis of its historical and current underpinnings, as well as outright resistance and denial that racism exists. Given the deep divides that exist between groups in the United States, understanding and empathy can be extremely challenging for many because of an inability to really “walk a mile in another’s shoes” in a racialized sense. Collectively, we have an opportunity and obligation to overcome these fissures and create spaces for understanding and healing. (p 3)

This is an important document provides clear validation from a recognized and well-respected authority, which would help advance research, education, and clinical practice.



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Advancing Health Equity: Guide on Language, Narrative and Concepts. <https://www.ama-assn.org>