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Shared Language Builds a Foundation for Health Equity

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Abstract

Achieving Health Equity requires developing a shared language that allows people to understand diversity in various contexts. For instance, shared language allows us to discuss diversity issues concerning gender identity, just as much as it allows us to discuss diversity issues concerning citizenship, race, or sexual attraction. This article sets out five key terms that form the foundation of a shared language: Diversity, Equity, Inclusion, Cultural Humility, and Cultural Responsiveness. The five key terms provide a solid foundation for efforts to further expand our shared language around diversity, such as a glossary defining terms like gender identity, race.

Keywords

Shared Language, Equity, Diversity, Inclusion, Social Determinants, Cultural Responsiveness, Cultural Humility

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No known conflicts

EDITORIAL

Shared Language Builds a Foundation for Health Equity

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Abstract

Achieving Health Equity requires developing a shared language that allows people to understand diversity in various contexts. For instance, shared language allows us to discuss diversity issues concerning gender identity, just as much as it allows us to discuss diversity issues concerning citizenship, race, or sexual attraction. This article sets out five key terms that form the foundation of a shared language: Diversity, Equity, Inclusion, Cultural Humility, and Cultural Responsiveness. The five key terms provide a solid foundation for efforts to further expand our shared language around diversity, such as a glossary defining terms like gender identity, race.

Keywords: Shared language, Equity, Diversity, Inclusion, Social determinants, Cultural responsiveness, Cultural humility

Achieving Health Equity requires developing a shared language that allows people to understand diversity in various contexts. An ability to communicate with others and express we is a basic human need. A shared language allows us to discuss diversity issues concerning gender identity, just as much as it allows us to discuss diversity issues concerning citizenship, race, or sexual attraction.

The potential impact of cultural differences can lead to health care disparities. Introducing a shared language is one way to enrich an inclusive and equitable work environment, since it removes barriers to understanding one another. Shared language is critical to collaboration, and collaboration is critical to better understanding.

This article sets out five key terms that form the foundation of a shared language: Diversity, Equity, Inclusion, Cultural Humility, and Cultural Responsiveness. The five key terms provide a solid foundation for efforts to further expand our shared language around diversity, such as a glossary defining terms like gender identity, race.

1. Diversity, equity and inclusion

Diversity, equity and inclusion (DEI) are basic terms embedded within the culture of a healthcare organization. An organization can improve communication effectiveness when all employees recognize and bridge cultural differences that may contribute to misinterpretation and miscommunication. The Centers for Disease Control and Prevention (CDC) *Health Equity Guiding Principles for Inclusive Communication* emphasize the importance of addressing all people inclusively and respectfully: “Achieving health equity requires focused and ongoing societal efforts to address historical and contemporary injustices; overcome economic, social and other obstacles to health and health care; and eliminate preventable health disparities”.¹ Shared language is a key element to moving DEI work forward in this area.² A lack of shared language and understanding can directly impact DEI initiatives and adversely affect patient health outcomes and quality of life.

Diversity, equity, inclusion, cultural humility, and culturally responsiveness are the five foundational

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terms used to move organizational efforts forward. Shared language helps to avoid misunderstanding and misinterpretation and will stabilize dialogue to support DEI efforts. A shared language offers a standard of health care definitions. This paper presents case studies in health care to illustrate the importance of shared language and its impact on DEI efforts to drive health equity as patient populations change and evolve.

2. Background

The 2020 U.S. census discussed current changing populations in the U.S. “The Two or More Races population (also referred to as the Multiracial population) has changed considerably since 2010. The Multiracial population was measured at 9 million people in 2010 and is now 33.8 million people in 2020, a 276% increase.”³

3. Awareness

“Language not only expresses ideas and concepts but actually shapes thought.”⁴

Increasing awareness and knowledge about language that applies to treating people with respect and dignity is critical to achieve DEI.

The CDC's *Health Equity Guiding Principles for Inclusive Communication* suggests: “Using a health equity lens when outlining information about health disparities; Considering the key principles, such as using person-first language and avoiding unintentional blaming; Using preferred terms for select population groups while recognizing that there isn't always agreement on these terms; Considering how communications are developed and looking for ways to develop more inclusive health communications products; Exploring other resources and references related to health equity communications”.¹ As the world becomes more global and the presence of many new cultures grows, it's crucial that organizations create and nurture a DEI community where everyone feels safe, valued and heard. Fundamental constructs are the basis for DEI.

4. Building shared language

“Shared language between patients and health care providers enables gathering information to arrive at diagnoses, explaining treatment strategies, and ensuring understanding and joint decision-making.”⁵

Shared language will help health care workers recognize their diverse colleagues, a precursor to better understanding their patients.

5. Shared language terms: diversity, equity, inclusion, cultural humility, cultural responsiveness

5.1. Diversity

“Diversity is one of the foremost foundations of quality health care. Diversity does not happen by wishful thinking or symbolic gestures. It requires a sustained focus and informed effort to embed inclusion and equity as organizational values and practice.” Eric J. Bieber, M.D., President and CEO, Rochester Regional Health.

Diversity is an interpersonal concept that appears in the composition of teams and organizations. “Diversity refers to “difference” within a given setting,” and refers to a wide range of identities such as: race, ethnicity, gender, age, national origin, religion, disability, sexual orientation, socioeconomic status, education, marital status, language, veteran status, physical appearance.⁶ Diversity can also involve different ideas, perspectives and values. “People are continually adapting to one another and to organizational resources and requirements.”⁷

5.2. Dimensions of diversity

In our expanding, diverse world of many cultures, values and ways of interacting with one another demand awareness. Not everything about a person is visible, some things remain below the surface (see Fig. 1). Dimensions of diversity can help us recognize how we respond to those around us. Dimensions of diversity are important as people bring their whole selves to work and to individual or group encounters. Even when we can't see someone's religion or faith, values, or life experience, we are still interacting with those dimensions of diversity in our encounters with anyone, as they are with us (see Fig. 2).⁸

Individual identity distinguishes us as different from others and social or group identity recognizes us as members of society; *Primary dimensions* “shape self-image, worldview and identity or how we define ourselves” and “they exert primary influences on our own identity”; *Secondary dimensions* “reflect other differences acquired throughout life” and can be “modified or discarded” based on our life choices; *Organizational dimensions* are “attributes



Fig. 1. Not everything is above the surface.

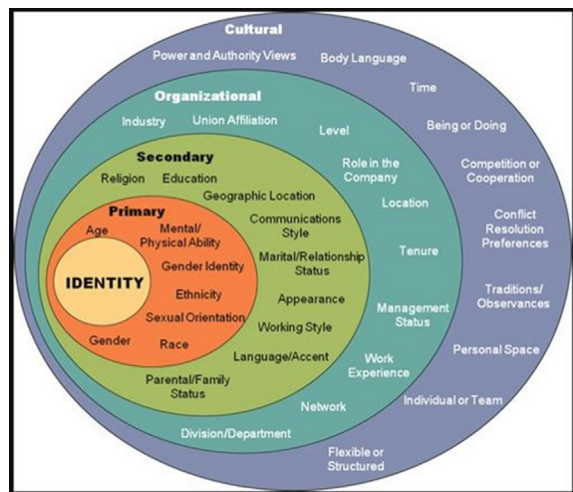


Fig. 2. Dimensions of diversity.

that define or pertain to the workplace”, and are “associated with past and present experiences”; *Cultural dimensions* are “traits, behaviors or values that are shaped by culture” (See Fig. 2).⁸

Image repurposed from Workforce America⁸

We know the benefits of diverse groups more broadly. Take, for example, Barack Obama's October 2016 Presidential Memorandum Promoting Diversity and Inclusion in the National Security Workforce: “Research has shown that

diverse groups are more effective at problem solving than homogenous groups, and policies that promote diversity and inclusion will enhance our ability to draw from the broadest possible pool of talent, solve our toughest challenges, maximize employee engagement and innovation, and lead by example by setting a high standard for providing access to opportunity to all segments of our society.”^{9,10}

5.3. Example of diversity

A large multi-site healthcare system pursued initiatives to improve the way they addressed diversity throughout the demographic area of the organization. Leadership instituted Community Conversations when the COVID-19 pandemic began to affect all populations. The organization identified various populations most at risk: communities of color, deaf and hard of hearing groups, LGBTQ populations, veterans, disabilities, WNY Farmer Workers, Teens & Parents, Healthy Moms, and Internal groups (LTC, EVS, FNS). The organization then worked with community leaders to reach into these communities in an effective way.

The health system representatives learned that people from many cultures with English as a second language needed a way to hear and understand critical health care information in their native language. The issue was critical and presented a barrier to accessing, understanding, and using information to make vital health care decisions. The results of the Community Conversations led to further initiatives within the healthcare system that addressed ease of translation and understanding.

5.4. Equity

Equity is what happens when all members of a diverse population of employees have equal opportunities and support to succeed and grow. Equity provides access, opportunity and advancement for all people and the elimination of barriers that prevent the full participation of some groups.

The “Principles of Equity” acknowledge that there are historically underserved and underrepresented populations and that fairness regarding these unbalanced conditions is necessary to provide equity for all.¹¹

As shown in Fig. 3, equity is creating opportunities for and giving equal access to underrepresented groups, not by giving them equal resources, but by giving them the same opportunities (see Fig. 3).¹²

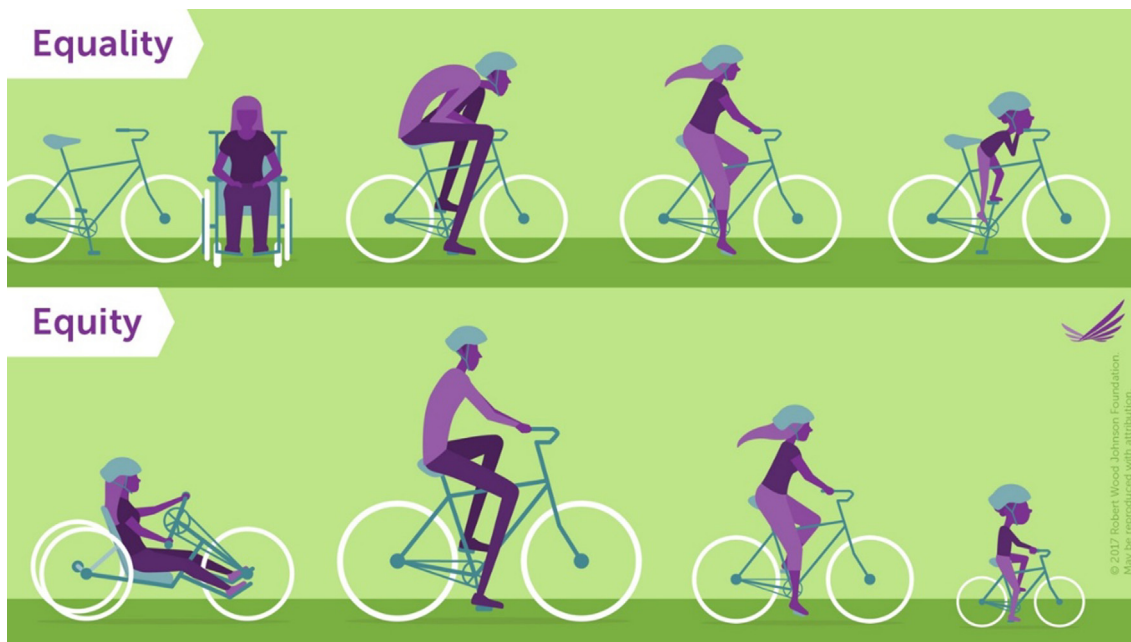


Fig. 3. Equality vs. Equity: One size does not fit all.¹² Robert Wood Johnson Foundation¹²

5.5. Health Equity

According to Braveman, “pursuing Health Equity means striving for the highest possible standard of health for all people and giving special attention to the needs of those at greatest risk of poor health, based on social conditions.”¹³

Health Equity is achieved when every person can “attain his or her full health potential” and no one is “disadvantaged from achieving this potential because of social position or other socially determined circumstances.”¹⁴

Health Equity as outlined above aligns with the integrated health system's mission: “to enhance lives and preserve health by enabling access to a comprehensive, fully integrated network of the highest quality and most affordable care, delivered with kindness, integrity and respect.”^[Anonymized]

Social factors have as much, or even more impact on health as the medical care system. A significant proportion of health inequalities can be attributed to

social determinants and can affect health outcomes including mortality, morbidity, life expectancy, health care expenditures, health status, and functional limitations (see Table 1).¹⁵ “Social determinants of health are the conditions in which people are born, grow, live, work and age.” Social determinants can influence health in positive and negative ways.¹⁶

5.6. Example of equity

The feedback from the health system's Latinx Community Conversations led to a collaboration between DEI and Communications to enhance the health system website by including a translation tool that would be accessible to all and offer many options for multi-cultural groups within the health system demographic area.

The translation tool enables users to translate from English to over 100 languages at the click of one button. The tool removes barriers to providing critical health care information in native languages

Table 1. Social determinants that influence health equity.

Determinant	Conditions
Economic Stability	Employment, income, expenses, debt, medical bills, support
Neighborhood and Physical Environment	Housing, transportation, safety, parks, playgrounds, walkability
Education	Literacy, language, early childhood education, vocational training, higher education
Food	Hunger, access to healthy options
Community and Social Context	Social integration, support systems, community engagement, discrimination
Health Care System	Health coverage, provider availability, provider linguistic and cultural competency, quality of care

Repurposed from Artiga and Hinton.¹⁵

and allows all populations to access and understand personal health information and make informed health decisions about their own care.

5.7. Inclusion

Inclusion is the act of creating an environment in which any individual or group will be welcomed, respected, supported, and valued as a fully participating member. An inclusive and welcoming climate embraces and respects differences. Inclusion is the practice of active, intentional, and ongoing engagement with the many dimensions of diversity mentioned earlier.

5.8. Examples of inclusion

A large multi-site health system offered implicit bias awareness training to more than 400 medical staff in the OBGYN department. The objective of the training was to build awareness of unconscious bias and support the development of cultural humility towards patients and colleagues leading to better maternal health patient outcomes and a more inclusive workplace culture.

The health system also introduced a program Because We Care, to address all dimensions of diversity. The program emphasized the importance of identifying and using personal pronouns with patients, visitors, and healthcare employees. Employees were encouraged to ask patients to identify their personal pronouns. The goal of the Because We Care program was to ensure a welcoming and inclusive workplace culture. Posters were displayed throughout the health system's reception and treatment areas. The posters explained to patients why they were being asked to identify their pronouns, to familiarize them with the process and make it more comfortable.

6. Cultural Humility

DEI work has evolved just like the people it seeks to serve. In this evolution, DEI practitioners have moved away from "cultural competence", which suggests that we could take a course, read a book, or listen to a podcast and know all we need to know about DEI/cultural differences.

The work has evolved and is grounded in the philosophy of Cultural Humility: "a humble and respectful attitude toward individuals of other cultures that pushes one to challenge their own cultural biases, realize they cannot possibly know everything about other cultures, and approach learning about other cultures as a lifelong goal and process."¹⁷

Cultural humility encourages everyone to be an active participant to learn about a patient's or client's personal, cultural experiences.¹⁸

"Cultural humility pushes us to challenge our assumptions, judgments, and prejudices; it encourages experts to become students when interacting with individuals of other cultures."¹⁷ Cultural humility leaves room for continuous growth.

6.1. Example of cultural humility

Jennifer, a white American nurse from New England accepted a job offer at a hospital in El Paso, Texas (this example is adapted from Gonzalez & Levitas¹⁷). Because of the proximity of El Paso to Mexico, she knew that many of her patients would be of Mexican descent, so she spent several weeks before her move to El Paso reading literature about Mexican culture before her relocation to feel confident before beginning her new job.

After working with Mexican patients for a while, Jennifer felt confident in her understanding of their culture. She learned from her reading that many Mexicans are Catholic, so she went ahead and requested a priest for one of her patients. But the patient was Jewish and felt offended by Jennifer's assumption.

If Jennifer had taken a cultural humility approach, she would not have assumed that her patient was Catholic. Instead, she would not have acted on an assumption and would have asked her patient questions to better understand her patient's values and beliefs, leading to a better patient experience and possible outcome.

We note that in each of the above cases, cultural humility applies. Providers assumed a certain cultural group (Chinese, Mexican) were a certain way. If cultural humility or better knowledge of cultures was in place, these missteps would not have happened.

6.2. Cultural Responsiveness

"Cultural responsiveness, like the term 'cultural competence,' promotes an understanding of culture, ethnicity, and language. The difference between the two is that 'responsiveness' does not imply that one can be perfect and have attained all the skills and views needed to work with culturally diverse clients. It assumes one just has the openness to adapt to the cultural needs of those with whom they work."¹⁹

Cultural responsiveness is the ability to learn from and relate respectfully with people of your own culture as well as those from other cultures.¹⁷

Because of the increasing global diversity, and the intermixing of different cultures, the importance of cultural responsiveness in the health care professional world is significant.

Cultural Responsiveness in Health Care.

1. *Tailor care engagement*: Meet people where they are; one size does not fit all; listen to understand, not to respond.
2. *Create an environment of acceptance*: “I’m not here to judge, I’m here to address your needs.”; “Without your help, I can’t provide the best care for you.”
3. *Evaluate*: Engage in institutional review. Does diversity currently exist?
4. *Seek and share*: Look for information on treatment advances and share information with patients.

6.2.1. Examples of cultural responsiveness

“A culturally competent healthcare system is one that acknowledges the importance of culture, incorporates the assessment of cross-cultural relations, recognizes the potential impact of cultural differences, expands cultural knowledge, and adapts services to meet culturally unique needs.”²⁰

Case 1. An Irish woman was hospitalized and scheduled for surgery. The woman complained of pain to her family but did not inform her nurse or doctor about the pain, so the date of the patient’s surgery was not moved up. For some reason the woman did not want to discuss her pain with her nurse or doctor. She may have felt uncomfortable complaining or it may have been a cultural trait of Irish women. During the surgery, the woman’s condition worsened, and she died.

If a culturally responsive nurse or physician had intervened, the Irish woman may have had an entirely different outcome.

Case 2. A Chinese patient was showing respect to a physician by avoiding eye contact; however, the physician knew that in American culture, a lack of eye contact can be considered rude or an indicator of depression. The physician felt uncomfortable with the Chinese man because he had no information about Chinese culture. In both Muslim and Navajo cultures, eye contact has other distinct meanings as well.

Understanding the nuances between cultures and how language has different meanings for different people—to the extent that body language we assume to be very basic and simple differs between

cultures—is crucial when treating patients with backgrounds that differ from one’s own background.

7. Discussion

The influence of language and the potential to help or harm health care and health outcomes is very potent. The future impact of an increase in multi-cultural differences can result in health care disparities if steps are not taken now to achieve better health equity. Shared language allows health care workers to improve communication with patients of different cultures by better understanding the patient in front of them and fully address their needs. Effective communication can be a significant driver for health equity.

Diversity, Equity, Inclusion, Cultural Humility, and Cultural Responsiveness are the foundational terms that move health care organizational efforts forward. A shared language stabilizes dialogue to achieve these efforts.

When equity and inclusion are lacking, so are innovation and creative thinking, which can impede critical observations surrounding a patient’s diagnosis, medical history, or other socioeconomic factors that could influence patient care. In the absence of cultural humility, bias may not be explicitly expressed but it can still impact decisions made for patients when it is embedded in the policies and procedures of a healthcare organization. Implicit bias (unconscious bias) and its destructive effects can often be mitigated in patient care when equity, inclusion and cultural humility are present.

A UCLA study examined the link between medical school diversity and educational benefits. As an example, white students who attended racially diverse schools “felt better prepared than students at less diverse schools to care for patients from racial and ethnic groups other than their own.” These students learned that inclusion and cultural humility prepared them to endorse access more likely to adequate health care as a societal right rather than a privilege (although they were not more likely to work in under-served areas).⁹

Unfortunately, health disparities became forefront during the COVID-19 pandemic when marginalized communities were suffering because of a lack of health equity, inclusion and cultural humility that resulted in poor health care access for these populations. A shared language would have enabled a better understanding of health care choices and led to better health outcomes.

8. Conclusion

A collective grasp of basic health care terms can provide the foundation for understanding between health care staff and the community they care for. Achieving health equity through a shared language leads to improvement in health care disparities and improved health care access for marginalized populations.

Conflict of interest

No known conflicts.

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