Anti-racism, Equity, Diversity, and Inclusion Scenarios

Each scenario asks two general questions and one question that is specific to the context of the scenario. Before the end of the breakout session, the moderator will ask for a volunteer to speak for the group upon returning to the larger group. If no one feels comfortable doing so, the moderator will be the default speaker.

Only a few group speakers will be asked to report back to the larger group. Other groups can join in during discussion or write the highlights of their discussions in the chat.

In reporting to the larger group, focus on question 2 in each scenario:

What possible steps can you take to support the person(s) involved? Can you draw on times in the past when you have seen colleagues take effective action?

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SCENARIO 1.

A Year 3, Medical Student who identifies as a person of colour came to assess a patient in the emergency department. The patient made the assumption that the learner was a cleaner and asked “when the doctor was coming”. When the learner identified themselves as a medical student, the patient asked where they were born and complimented them on their English ability.

Discussion Questions:
1. What problematic assumptions and biases underlie the words or actions in the scenario? Focus on the implied meaning in the scenario.
2. What possible steps can you take to support the person(s) involved? Can you draw on times in the past when you have seen colleagues take effective action?
3. How might the learner be affected by these types of patient interactions over the course of their career?

SCENARIO 2.

Two faculty members were speaking about a patient on the ward who was admitted for pneumonia and who identifies as transgender. Another faculty member overheard the two of them making disrespectful jokes about the patient’s gender identity, purposefully misgendering the patient, and not using their correct pronoun. When called out, they replied that they were joking and that it “wasn’t a big deal”. This faculty member reaches out to you for advice.

Discussion Questions:
1. What problematic assumptions and biases underlie the words or actions in the scenario? Focus on the implied meaning in the scenario.
2. What possible steps can you take to support the person(s) involved? Can you draw on times in the past when you have seen colleagues take effective action?
3. How might healthcare outcomes for transgender patients be affected when their gender identity is not acknowledged or respected at a personal or institutional level?

SCENARIO 3.

A resident of Korean descent and a medical student of Chinese descent are on call in the emergency department. During the night, they are faced with treating a patient who begins making loud comments about the ‘Chinese Virus’ and ‘Wuhan Flu’. They are being subjected to increasing amounts of racist language and offensive comments. Both the resident and the student are visibly shaken.

Discussion Questions:
1. What problematic assumptions and biases underlie the words or actions in the scenario? Focus on the implied meaning in the scenario.
2. What possible steps can you take to support the learners involved? Can you draw on times in the past when you have seen colleagues take effective action?
3. While this example is overt, how might you support residents and students through less obvious incidents of anti-Asian racism?

SCENARIO 4.

The In Plain Sight report about the experience of Indigenous peoples in BC health care found widespread Indigenous-specific stereotyping, discrimination and racism that limited their access to care. Additionally, Indigenous health care workers face significant racism and discrimination in their work and study environments. During a conversation between an Indigenous faculty and a non-Indigenous faculty about the findings of the report, the non-Indigenous faculty member states that she can understand the challenges the Indigenous faculty member has faced and understands her trauma as she too “has faced discrimination as a result of being a woman.”

Discussion Questions:
1. What problematic assumptions and biases underlie the words or actions in the scenario? Focus on the implied meaning in the scenario.
2. What possible steps can you take to support the person(s) involved? Can you draw on times in the past when you have seen colleagues take effective action?
3. Are you familiar with the In Plain Sight report and have you thought about how you can acknowledge its recommendations?
SCENARIO 5.

A Year 1, medical student comes to you visibly upset. They feel they have done well so far, but have just read feedback on their end of CBL cluster WBA which says, in part, “…. needs to speak up more and not be so quiet. Seems to be too meek and shy.” They feel that this assessment is based not on their performance but on stereotypes or implicit bias.

Discussion Questions:
1. What problematic assumptions and biases underlie the words or actions in the scenario? Focus on the implied meaning in the scenario.
2. What possible steps can you take to support the person(s) involved? Can you draw on times in the past when you have seen colleagues take effective action?
3. How might implicit bias in assessment have a lasting effect on a learner and their long-term performance
Scenario 1. One form of racial microaggression follows the theme that someone is an ‘alien in their own land’. By asking questions like “Where are you from?”, “Where were you born?”, and saying something like “You speak English well” without any knowledge or context, it delivers the message ‘You are a foreigner’ or ‘You are not Canadian’ (1). Further, when a doctor or medical student who identifies as a person of colour is mistaken for a cleaner, it sends the message that people of colour are unable to occupy high-status positions.

Patients are a common source of microaggressions and racist behaviour is encountered at all levels of training but is rarely discussed. Physicians frequently feel like they are ‘on their own’ when dealing with racism at work and there is little guidance that helps them acknowledge and deal with incidents (2).

Scenario 2. Accessing health care is the most common setting where transgender people experience discrimination, more than even housing or employment (3). Not being able to disclose gender identity has been associated with diminished care and transgender individuals report difficulty balancing their need for medical care with their fear of experiencing discrimination or violence. In addition to this fear, transgender individuals are often faced with a healthcare system and providers who lack basic knowledge about the physical and mental care of transgender people resulting in people choosing to delay care (3).

Despite an increase in the last 10 years of the publication of literature addressing transgender health, there is still an overall lack of research that addresses transgender-specific health and health education. In undergraduate and post graduate medical education, there is little curricular space reserved for transgender-specific education and it is usually under the umbrella of LGBTQ2S education.

Scenario 3. According to the Center for the Study of Hate & Extremism, anti-Asian prejudice and hate crime increased by 164% in the US in the first quarter of 2021 (4). The increase in Canada was starker: a 532% increase in 2020. Though the definition of a hate crime is wider in Canada compared to the US, it has remained consistent and in Vancouver, for example, they reported a jump from 12 reported incidents in 2019 to 98 in 2020. The study also looked at Google and Twitter trends related to stigmatizing language and saw large increases and spikes at various points over the last year.

Scenario 4. The In Plain Sight report carefully outlines Indigenous-specific forms of racism and discrimination in health care in BC, showing that pervasive negative stereotypes of Indigenous people lead to less access to care, and, ultimately, worse health outcomes (5). While these stereotypes can result in health care workers having conscious or subconscious biases, interpersonal racism is only one aspect (6). Going beyond looking at just the existence of the problem, the report examines the rich history of Indigenous health and wellness that was intentionally undermined through colonialism and how that still colours Indigenous experiences in health care to this day.
The combination of interpersonal and systemic racism shapes negative and inequitable health outcomes for Indigenous people (6). Trying to identify with and be an ally to Indigenous people by highlighting discrimination one may have also faced minimizes the nature and scope of discrimination against Indigenous people.

**Scenario 5.** Meaningful assessment is critical to competency-based medical education. One large study examined 33,456 resident evaluations and found that, while there was no difference in level ascribed to male and female residents at the beginning of training, by post graduate year 3, faculty ascribed higher levels in all 23 ACGME Milestones to male residents compared to female residents and male residents had a 12.7% higher rate of milestone attainment than female residents (7).

Another analysis showed that gender bias or gender-based stereotypes can affect a student’s or resident’s assessment. Women were attributed as having too much compassion, enthusiasm, and sensitivity. Conversely, men were seen as having too little of these qualities (8). Men were given more credit for being ‘quick learners’ than comparable women. The amount of this bias was correlated to level of proficiency, so the most proficient women experienced the greatest amount of bias.

**References**


2. Vogel L. Doctors on their own when dealing with racism from patients. CMAJ Sept 2018;190(37)E1118-E1119.


Inclusive Language Guide

INTRODUCTION

UBC is committed to supporting teachers in implementing inclusive course design and teaching practices. This inclusive language guide is developed by the Office of Faculty Development & Educational Support, and the Office of Respectful Environments, Equity, Diversity & Inclusion, and is designed to support those teaching in lecture, small group, and clinical settings.

The guide introduces complex inclusive language approaches, distilled into principles and examples to contextualize their use. The guide was developed through consultation with academic leadership, faculty, and students, and focuses on key areas where language could be more inclusive.

Please consider these inclusive principles as you prepare to deliver materials and facilitate student learning in Health Professions education. Those wishing to learn more can access additional resources included at the end of this document.

Thank you for your dedication to teaching.

WHAT IS INCLUSIVE LANGUAGE?

Inclusive language values and honors identities and experiences, addresses inequities, helps to establish respectful learning environments, and fosters interactions welcoming to all. Using inclusive language means avoiding expressions or words that stereotype, stigmatize, trivialize or exclude individuals or populations based on their race, ethnicity, gender, sexual orientation, disability or ability, class, age, etc. Using inclusive language requires open-mindedness, flexibility, and continuous learning around language to respect and connect with those around us.

Inclusive language fosters a safer and more open learning environment where people know they will not be dismissed, silenced, or looked down upon for being who they are, or for characteristics they have no control over.

WHY DOES IT MATTER?

As educators, we have a responsibility to create respectful and inclusive learning environments, and use language in a way that promotes effective learning for all. Studies in medical education show that language is a powerful tool that helps students develop their identity and a sense of belonging as health professionals. Non-inclusive language, on the other hand, can leave a student or learner with residual embarrassment, confusion, fear, or anger that could impact their performance and experience in medical education.

Language can also have a significant impact by influencing attitudes and behaviours towards patients. Stigmatizing language has been shown to influence medical student and resident attitudes to be more negative about a marginalized patient, and negatively affected the quality of care. Impacts on patient safety and the perpetuation of health care and health outcome disparities are critical reasons language matters in medical education.
Challenge assumptions and judgments, and preserve dignity and autonomy by using appropriate language.

Thinking critically about the assumptions, biases, and judgements in our teaching, give us the opportunity to make our materials and presentations more inclusive. Language choices impact how groups of people are perceived by learners both positively and negatively. Ensure the people referenced in your teaching are represented in a respectful way that preserves their dignity and autonomy, by calling them by their self-identified terms.

5 THINGS YOU CAN DO!

- Recognize assumptions, biases, and judgements about groups or people reflected in language
- Use inclusive terminology that does not favor or cast judgements on, stigmatize or stereotype groups of people
- Ensure you are not attributing blame for poor health to people with certain conditions
- Respect people's humanity by speaking of them as people not as objects of learning or statistics
- Use the person's self-disclosed identity when possible (treat others as they wish to be treated)

Examples:

<table>
<thead>
<tr>
<th>Instead of this...</th>
<th>Consider this...</th>
<th>Why is this important?</th>
</tr>
</thead>
<tbody>
<tr>
<td>This patient typically practices unconventional treatments.</td>
<td>This patient typically practices Traditional Chinese Medicine.</td>
<td>Labelling culturally-based practices as unacceptable or unconventional implies a negative judgement. Instead, use the actual term describing their cultural practice, as it is just one factor in the case you would be presenting.</td>
</tr>
<tr>
<td>This patient practices an alternative lifestyle.</td>
<td>This patient has described that they have multiple sexual partners.</td>
<td>Considering the history and implications around word choice will help you find different descriptions that do not cast a negative judgement on the person. An “alternative lifestyle” is a subjective term that can delegitimize a person’s sexual practice as abnormal or ‘other’. Instead, use the patient’s self-described orientation or practice.</td>
</tr>
<tr>
<td>This patient abuses drugs periodically.</td>
<td>This patient uses substances periodically.</td>
<td>There are negative connotations and implications of choice associated with the words abuse or addiction. Use language that describes the patient’s experience without judgement.</td>
</tr>
</tbody>
</table>
**PRINCIPLE 2**

Use people-first language when appropriate.

People-first language focuses on people as individuals first and the condition or disability second to respect an individual's autonomy, agency, and humanity.

**2 THINGS YOU CAN DO!**

- Introduce the person first and then the condition or disability second
- There are exceptions where certain groups and individuals prefer identity-first language (e.g. a hearing-impaired person); when in doubt, ask the person\(^9\)
- Do not use stigmatizing language in any medical education materials, in interactions with patients, medical and academic records, and when speaking about patients\(^4\)

**Examples:**

<table>
<thead>
<tr>
<th>Instead of this...</th>
<th>Consider this...</th>
<th>Why is this important?</th>
</tr>
</thead>
<tbody>
<tr>
<td>They are Wheelchair-bound.</td>
<td>They are a person who uses a wheelchair to assist with mobility.</td>
<td>Disability is only one part of that person's life, so emphasize their personhood first. Using terms like 'bound' imply the person is trapped, when in fact they are just using assistive technologies.(^{10,11})</td>
</tr>
<tr>
<td>&quot;Mrs. X is a known alcoholic...&quot;</td>
<td>&quot;Mrs. X has been in the clinic before seeking treatment for alcohol use.&quot;</td>
<td>Use language that preserves the dignity of the person and most accurately describes their experience and relevant medical history.</td>
</tr>
<tr>
<td>&quot;Go see 'the chest pain' in room 2.&quot;</td>
<td>&quot;Please assess Mr. C in room 2. He is experiencing chest pain.&quot;</td>
<td>Use language that respects humanity rather than speaking of people as objects or identifying them by their symptoms or condition.</td>
</tr>
</tbody>
</table>
PRINCIPLE 3

Be flexible and willing to adapt your language to be inclusive.

We all have the responsibility to adjust our language when we learn more inclusive terms. Adapting your language to be more inclusive is often an iterative process requiring us to be open to feedback. Terminology is not one-size-fits-all because specific language is dynamic, changing as people and society learn and evolve. See the response and adaptation framework in Diagram 1.

5 THINGS YOU CAN DO!

• Be willing to hear and accept feedback when non-inclusive or outdated language is identified in your presentation or conversation, and be willing to adapt language when needed
• Prepare to revisit language and its meaning regularly
• Stay humble when approached by someone affected by language you have used
• Reflect on your word choice and research anything you are unsure about using
• Ask people what language they prefer; follow their lead

Examples:

<table>
<thead>
<tr>
<th>Instead of this...</th>
<th>Consider this...</th>
<th>Why is this important?</th>
</tr>
</thead>
<tbody>
<tr>
<td>“This female patient complained of pain in her abdomen.”</td>
<td>“This patient, who is a trans man who has been on hormones for 5 years, but still has his uterus, complained of pain in his abdomen.”</td>
<td>Always refer to patients in ways that affirm their gender identities, including using the correct names and pronouns. There may be times when their current anatomy is relevant to their care – knowing what sex a person was assigned at birth will be insufficient, since this may have since changed. Even when gathering this medically relevant information, you should continue to refer to the patient using the name, pronouns and other gendered language that is most appropriate for that person.</td>
</tr>
<tr>
<td>(the patient had self-identified as a trans man, but you thought it was not relevant to the case)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Their wife will pick them up after surgery.</td>
<td>Their support person will pick them up after surgery.</td>
<td>Moving away from assumptions about a person’s sexual orientation and relationship status, and instead using gender-neutral terms (unless the person has self-identified), can make the scenario more inclusive of many gender identities, sexual orientations, and familial/relationship structures.</td>
</tr>
<tr>
<td>(The person talked about their kids, so you assumed they were married)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

2021-05-19 Version 1
Attend to the social and structural determinants contributing to disparities in health, especially when discussing epidemiology and risk factors.

While generalizing risk factors of certain population groups is a common practice for healthcare providers in narrowing differential diagnoses, over-generalization can discourage individualized care, over-attribute health disparities to genetic differences rather than social and structural causes, and pathologize the population group. Differences in health outcomes are often construed as non-modifiable, biological differences (for example, between racial and ethnic groups). Populations are labelled as ‘at risk’ for conditions based on their race, implying there are inherent biological differences and that their bodies and identities are inferior. When race is presented as a risk factor, it teaches students heuristics to apply, using racial identity to inform diagnostic reasoning and management.

4 THINGS YOU CAN DO!

- Reframe findings in medical research to explain why disparities in health exist between certain population groups to help learners understand the determinants of health, rather than associating pathologies as inherent in certain populations or over-attributing differences caused by oppressive forces (such as racism) to genetic differences.
- Highlight that patient-centered care involves thinking of patients as individuals first who may or may not fit into general demographic epidemiological categories.
- Consider the impact of associating genetic factors with terms representing different populations, and explicitly acknowledge its limitations to your learners.
- Recognize race as a social, not biological, construct. When discussing genetic susceptibility, avoid using race as the sole reason for differences in health outcomes. To approximate genetic ancestry, use granular terms which may better reflect shared genetic origins (e.g., ethnicity, genetic ancestry, and/or country of origin rather than race).

Examples:

<table>
<thead>
<tr>
<th>Instead of this...</th>
<th>Consider this...</th>
<th>Why is this important?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indigenous people are a vulnerable population in Canada.</td>
<td>Indigenous people are a marginalized population in Canada.</td>
<td>Using ‘vulnerable’ insinuates personal weakness and obscures the role of social and structural factors in contributing to inequities. Using the term ‘marginalized’ draws attention to how disparities are the result of power imbalances.</td>
</tr>
<tr>
<td>Indigenous people are at higher risk of diabetes.</td>
<td>Prevalence of diabetes among Indigenous people living off-reserve (10.3%) is disproportionately higher than the general population (5.0%).</td>
<td>Using epidemiologic terms are better than more value-laden terms of risk. The ‘at risk’ label creates a ‘deficit discourse’ which situates responsibility for problems with the affected individuals or communities, overlooking the larger socio-economic structures in which they are embedded.</td>
</tr>
<tr>
<td>Black race is a risk factor for Sickle Cell Disease.</td>
<td>Those with genetic ancestry from areas where malaria is endemic are at higher risk for Sickle Cell Disease.</td>
<td>’Race’ is not the risk factor, but being from an area where malaria is endemic is the risk factor for Sickle Cell Disease. Conflating race with genetic ancestry implies an essentialist, biological, view of race. Students who think of race as biological are more accepting of racial disparities, seeing them as “natural” and unlikely to change from societal efforts.</td>
</tr>
</tbody>
</table>
Be Intentional about representing diversity.

Educational materials should reflect the diversity of students, and those they will serve in their future practice. Teaching sessions, case studies, and clinical cases should address a diversity of presentations so students can recognize signs and symptoms in different people.

The visual tools we use to emphasize and convey meaning in the content (text, images, visual recordings, etc.) are all part of the discussion around inclusive language. 19

5 THINGS YOU CAN DO!

- Review presentations to ensure examples and images are diverse and do not only represent a singular experience or identity.
- Be cognizant when using stock images. Trying changing your search key words, or use stock image vendors that intentionally include a diversity of people.
- Be aware that representing diversity is not the same as mentioning a patient’s identity only for diagnostic significance. To consider identities only when it relates to medical decision-making medicalizes that identity and can lead to generalizations and stereotyping.
- Recognize how the pairing of certain identifiers with certain conditions may harmfully perpetuate stereotypes or negative perceptions about groups of people.
- Avoid portraying/framing certain identities (white, cisgender, heterosexual, etc.) as the ‘default.’ Use identifiers in all case examples, otherwise do not mention them at all. 14

Examples:

<table>
<thead>
<tr>
<th>Instead of this...</th>
<th>Consider this...</th>
<th>Why is this important?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Using an example of a 56y/o Black patient … is diagnosed with Sickle Cell Disease.</td>
<td>Using an example of a 56y/o patient of southern Italian ancestry is diagnosed with Sickle Cell Disease.</td>
<td>When representing diversity be careful to avoid using racial or ethnic identifiers to reinforce ideas of race-specific conditions. This creates a race-based diagnostic bias when specific identifiers are only used when talking about specific diseases. 14</td>
</tr>
<tr>
<td>Only showing videos or testimonials from gay men when discussing HIV.</td>
<td>Showing videos and testimonials of different people, from different sexual orientations and ethnic backgrounds when discussing HIV.</td>
<td>While the gay and bisexual community has been disproportionately affected by HIV, people from all other groups have also been affected by this condition. If the only examples of HIV are in gay men, it reinforces the stereotype that all gay men have HIV and/or that only gay men are affected by HIV.</td>
</tr>
<tr>
<td>Including an image of a person who does not have access to stable housing to represent the effect of ongoing substance use.</td>
<td>Consider whether you need an image of a person to convey your lesson.</td>
<td>Linking homelessness with substance use perpetuates a stereotype. Avoid visual associations which may negatively stereotype marginalized groups. Instead, consider imagery that helps reinforce other aspects of the condition you are trying visualize.</td>
</tr>
</tbody>
</table>
CONSIDERATIONS FOR...

Large Group

Large group contexts (whether synchronous or asynchronous) are a learning environment where individuals may be less likely to speak out in the moment. Learners could contact you after the presentation to express concern over non-inclusive language used. Other students may stay silent, unable or unwilling to share their concerns with you. In some cases, you may only do a presentation once per year, making it essential to add inclusive language and imagery as a consideration during your annual quality improvement cycle.

What can you do?

• Up front, address any past aspects of the lecture, week or course that has been contentious, what has been done to address it, and how this is part of the iterative quality improvement process.

• If non-inclusive language is identified in pre-recorded lectures, follow up with learners and let them know if there will be changes to the content in the future.

• Inviting feedback from students throughout the academic year using appropriate tools for large groups, such as polls or through emails, can help you preemptively address non-inclusive language.

Small Group

Small group learning environments, and the relationships built within them, provide opportunities for students and faculty to discuss inclusive language together. In this setting, consider the possibility that students who are unusually quiet may be experiencing discomfort created by the use of non-inclusive language.

What can you do?

• When non-inclusive language is used, whether by yourself, a fellow faculty member, or a student, it should be addressed (consider using, or guiding the other person through the process in Diagram 1).

• Role model the importance of being inclusive by speaking up or suggesting alternate terms if you notice non-inclusive language being used.

• Intervene so other students are not put in a position of either having to confront their peers or remain silent.

Clinical

Clinical environments take learning into a professional context, where faculty, students, patients, and other health professionals are working together. Balancing patient needs and student needs when non-inclusive language has been used is a challenge specific to this context. Though time to debrief a non-inclusive language encounter may be limited, it is important to support students and go over how the situation can be navigated.

What can you do?

• When non-inclusive language is used, whether by yourself, a fellow faculty member, another health professional, or a student, it should be addressed (consider using, or guiding the other person through the process in Diagram 1).

• If non-inclusive language is used by a patient, consider how and when to address it, and follow up with learners during or after the encounter (whether they were targets or witnesses).
Visit the Inclusivity in the Learning Environment for more information on responding when non-inclusive language is used. This foundational online module is intended for faculty, staff, residents, and students.
ADDITIONAL RESOURCES

Visit the Office of Respectful Environments, Equity, Diversity & Inclusion for more information and assistance.

For questions about using the guide, contact the Office of Faculty Development & Educational Support at fac.dev@ubc.ca.

Language/terminology Guides

**BC Centre for Disease Control COVID-19 Inclusive Language Guide**

Provides specific inclusive language and non-stigmatizing terminology, examples covering a broad range of areas in the context of health professions, and explains the difference between racial, ethnic, and cultural identities. For more examples extending from topics in this guide, we recommend reading the sections on Racial, Ethnic & Cultural Identities, Substance Use, Sex, Gender, Sexual Identities, Pronouns & Gender Inclusive Language, and Sexuality & Bodies.

Reviewing sections on Disease Basics, Relationship, Family Status & Pregnancy, and Age & Ability can also benefit faculty looking to expand their inclusive language vocabulary.

**UBC Center for Teaching and Learning Accessibility and Inclusivity Guidelines for Facilitators.**

Guidelines for facilitators on designing and presenting materials, focusing on Inclusive Language, Accessibility, Pronouns, Chosen Names, and Cultural Considerations. We recommend referencing the extensive Accessibility section.

**BC Public Service, Words Matter, Guidelines on using inclusive language in the workplace.**

Relates inclusive language to the BC Human Rights Code, provides general principles and examples of language to use, and how to promote respect in the workplace.

UBC Equity & Inclusion Office **Equity & Inclusion Glossary of Terms** and **Positive Space Language**

Provides definitions and information on many terms referenced in this guide. The Positive Space guide specifically references Sexual Orientation and Gender Identity terms.

**Government of Canada, Department of Justice, Gender-neutral Language**

Though written with a law-context in mind, provides recommendations on Gender-Neutral Language that can be applied in other settings.

**UBC Indigenous Foundations, Aboriginal Identity & Terminology**

Provides guidance and history on perceptions of Indigenous Identity through language.

**Rider University, Using Inclusive Language: Guidelines and Examples**

Though developed within an American context, we recommend reviewing the sections on Age, Class, Disabilities (Including Person-First Language and Identity-First Language), Gender & Sexual Orientation, and Size (body habitus).
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