PROVIDING HEALTH CARE IN A TIME OF POLARIZATION

A BRAVER ANGELS WORKSHOP FOR CLINICIANS

William Doherty, Ph.D.
University of Minnesota and Braver Angels
bdoherty@umn.edu
braverangels.org

Goals

- **More understanding of political polarization and how it affects clinical relationships.**
- **Increased skills in managing clinical relationships affected by polarization.**

Principles

1. Being clear about responsibilities: patients are responsible for what they do about their health in their own lives; clinicians are responsible for their medical advice and choices; clinic administrators are responsible for policies.
2. Maintaining respect for patients even if you see their ideas as wrongheaded or they treat you poorly.
3. Preserving the relationship and the possibility of future conversations

The Big Picture of Polarization

- Historic levels of political polarization, which have been rising since the 1980s.
- Not just polarization on issues, but "affective" polarization characterized by
    - Othering: Seeing people who differ politically as essentially different or alien from
    - Aversion: Holding dislike and distrust for them as persons
    - Moralizing: Seeing them as bad people

  Ref. Finkel et al. (2020). "Political Sectarianism in America"
- Data point example: "inter-party marriage"
- Many sources of this polarization, and happening in other countries
- Politics has become part of core values and personal identity (red/blue)
- Polarization has entered nearly every sector of life.
- The pandemic and George Floyd's killing intensified polarization pressures.
- If the political "Other" is seen as not just wrong, but deluded at best and evil (or abetting evil) at worst, how people maintain their personal integrity and their relationships, personal and professional, with political "Others?"

Discussion Question: How has polarization shown up in your practice or workplace? What is a specific example that you have found challenging to handle?

Different Levels Where Disagreement Occurs (Benson, 2019)

- Is it true? (facts/information, the "head")
- Is it meaningful? (values/preferences, the "heart")
- Is it useful? (practical outcomes, the "hands")

Each level has its own forms of evidence and implications for conversations.

Each is personal ("what do I believe?") and social ("what does my community believe?)

Implication for clinicians in polarized conversations:

Listen and respond at the *meaning level* in addition to the truth level. For example, if the patient's belief is based on autonomy threat or group loyalty, include those concerns in your response rather than dealing only with medical facts. The skills that follow can help you do that.

Skills

Overall strategy: Connect first, then share your perspective in personal ways.

Specific Skills: ASAP-C (Acknowledge, Seek to Understand, Agree, Perspective—Closure)

1. **Acknowledge/paraphrase back**
    - Focus on underlying concerns, not "truth" beliefs.
      "You are concerned about/worries about" rather than "You believe the COVID vaccine makes people sicker."
2. **Seek to understand**
    - "I'm interested to know how you came to see it this way."
    - "What sources of information have you looked at?"
    - "What do people you trust say about this (family member, community leader)?
    - "Do you know people who have been harmed?"
    - NOTE: At this point, do not comment on the sources of patient's views.
3. **Agree with something (if possible). Examples:**
    - Vaccines can have side effects.
    - Medical advice has been changing.
    - Health care leaders have made mistakes in some areas.
4. **Perspective**
    - Sometimes it's helpful to signal you want to shift the conversation from listening to sharing your perspective. "I'd like to offer my own thoughts about this now. Is that okay?" This is the communication skill of "pivoting."
    - I-statements rather than truth-statements. "This is where I've come down on…." rather than "here are the facts."
    - Mention your sources of information, based on the medical community you are a part of, and acknowledge that these differ from the patient's sources.
    - Ground your perspective in your clinical experience with patients.

- Try to fold the client's concerns into your perspective sharing. "I hear you on not wanting to put things in your body that can harm you. From my perspective, it's likely that either the virus will enter our body and do serious harm to vulnerable people, or the vaccine enters our body with a lot less risk."
- Affirm the patient's autonomy before offering counter-advice. "It's going to be up to you what you decide to do with my advice."
- Express your concern for the patient in personal terms.
    - "I'm concerned for you right now because you have risk factors that could make COVID really damaging."
    - "I'm concerned that you may be relying on sources that are not helpful for you. Some people make statements for political or financial reasons rather than health reasons. I'm not interested in the political parts of this right now—just what's best for your health."
    - "Again, I know it's up to you, and I will be here for you no matter what you decide."

5. Closure

- Ask where the patient is in terms of your input.
- Briefly clarify any miscommunication about your input
- If still disagreement:
    - Express appreciation that the patient was frank with you and listened to your perspective and concerns.
    - Ask if it's okay for you to mention your concerns in the future.

6. Skills for Handling Verbal Attacks

Principles:

1. Don't be either a victim or a counter-attacker.
2. Don't stoop to defending your character or integrity.
3. Stay calm and firm.
4. Give the patient the opportunity to soften and reboot the conversation.

Scenarios: (assumes you have a clinical relationship)

1. An indirect attack ("Doctors these days are just doing the bidding of…."). Response: firmly ask for clarification ("Joe, are you saying that I am looking out for myself or ( ) and not for you?") If the patient apologizes or clarifies that it's not personal to you, accept and move on. Don't give a speech about always putting your patients first.
2. A direct attack ("You're lying…You're in bed with…You're only saying this because…."
   Potential Responses:
   a) "Whoa! That's a very strong thing you just said. Do you believe that or are you just really upset right now?" (Give the patient a chance to back away from attack mode.)

b) If patient reaffirms the attack, then raise the question about whether to continue the conversation. “I don’t know where that leaves us right now. I see myself as trying to be helpful to you, and you see me differently.” (If the patient apologizes, you can acknowledge the stress and confusion the patient is experiencing, and then try to go with the visit.)
c) If the patient digs in or escalates, exit the visit without defending yourself or criticizing the patient (“I think we should stop now. You’ll have to decide at some point whether you want to continue to see me as your doctor. And then we would have to have another conversation.”)
d) The patient will probably say something further. Unless it’s a softening and retraction, then exit with something like “I hear you. Let’s stop at this point.” Then leave the room.