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DISSOLVING THE US AND THEM DIVIDE:

By Elizabeth Morrison, LCSW, MAC
Contributing Authors: Mary Rainwater, Steph Sharma and Kori Joneson

In the context of a global pandemic:

This paper was written months before the pandemic began. There is no question we are in an unprecedented time of fear, uncertainty and social isolation. Even after the threat of the virus itself is lifted, the economic suffering it will leave in its path is going to be with us for a long time. These challenges also provide an opportunity for change and real transformation, if we seize the moment and act upon the learnings from this tragedy. The pandemic has illuminated with great clarity the artifice of the "us" and "them" divide, as the concern about infection of health care workers, staff and patients amalgamate. Let's work harder than ever with this new-found awareness, or remembering, of our interconnectedness and shared experiences, to build the systems in our society that will enable all of us to thrive and share equitably in all the human kindness and good that exists in our world.

Us and Them

The division between "us" (care providers) and "them" (patients) is expressed explicitly and implicitly in health care. It is conveyed when we act out the provider-patient dyad and in the way we discuss "them" - using a diagnosis in place of a name ("she's schizophrenic"); talk about "those" with addictions and chronic pain; or when we refer to people as an entire category ("high utilizers"), as if they have a cluster of homogeneous characteristics or symptoms. This inadvertently gives rise to "othering" - seeing those we serve as fundamentally different from "us" and as one dimensional, not wholly human.

The Divide

The divide is largely driven by good motives: most of "us" were acculturated in nonprofit settings that stressed a mission to help "the poor" and "the underserved." The focus on "others" was, in many ways, born out of a well intended, service-minded, ethic. Even the term "patient-centered" aimed to ensure the focus was on the patient, as opposed to the system.

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However, the primary problem with the divide is the process of "othering". As providers well versed in motivating and empowering people to engage in their care, we know that our words shape our thinking and, subsequently, our actions. When we divide "us" from "them," it becomes easy to believe that there are actually significant and meaningful differences between "us" and "them". This divorces our professional actions from contemplating the experience of the people we work with. We might develop referral protocols we ourselves would never follow, give recommendations we ourselves haven't been able to do, or institute rules in our clinics that we ourselves wouldn't endure.

This lays fertile ground for implicit and explicit bias to take hold and reinforces the culture of hierarchical, directive, relationships with those we serve. It is subtle, leading to stereotypes such as, "our patients don't use the internet", or "those without stable housing didn't have cell phones" or "my patients won't know how to read that". When we hold these beliefs, we sell our patients and our entire health system short. In the process, we sell ourselves short too. We forget that all of us are patients and family members of those receiving health care somewhere too. Likewise, our patients are also sometimes health providers and, certainly, spouses, children, parents, employees, educators, or church members too. When we think in "us and them" terms, we forget that we are all whole people who occupy multiple, fluid, and constantly changing roles.

Dissolving the Divide

When we dissolve the divide and prioritize seeing everyone in our healthcare system as simply human, with needs, wants, strengths, and limitations, we make people-centered decisions that benefit all of us. For example, if we know that fluorescent overhead lighting is stressful for patients, we know it is also stressful for us when we work under it for 8 hours a day. When we invite our patients to share their concerns with living in an unsafe neighborhood or their son's anxiety, and build our systems to respond to those concerns, we can also do the same for our staff. Instead of creating service lines for patients, we strengthen and fortify an environment where everyone feels valued and heard, where wellness and health of all humans who are in the eco-system of our organization is prioritized.

The binary distinction between "us and them" mirrors the deep separation of mind and body that we have fought so hard to combat in healthcare over the last decades. By framing each

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part as discrete and disconnected, we lose the wisdom that comes from accessing both. To dissolve the divide, we can work in the following ways:

Language

- **Limit talking about "those with" or "patients with" certain conditions** and instead see how often the use of "we" and "our" can be used. For example, instead of "1 in 10 patients has an addictive disorder", try "1 in 10 of us have an addictive disorder".
- **Limit the use of binary language** when possible (such as patient/provider or provider/staff) and experiment with using "people" or "persons".
- **Limit "othering" language** that defines people by role or conditions, such as "diabetic", "receptionist", and increase the use of person-first language, such as "person with diabetes" or "reception staff" or simply use names.

Congruency:

- **Implement the "do we do this ourselves?" approach** to all initiatives directed toward "patients". For example, if an organization would like to roll out Trauma Informed Care practices, consider including the organization itself in the roll out. As the organization focuses on addressing health disparities and health equity for those served, consider also addressing racial, gender, and other inequities within our organizations.
- **Use the "how would we respond" test.** Before instituting late policies that refuse to see people after being 15 minutes late, discharge patients for multiple no-shows, bar food or drinks from the waiting room, we can ask ourselves "how would this feel to us, if we were in the patient role?"
- **Assess external partnership with vendors or consultants** based on their level of congruency with this principle, of dissolving the divide. Use an assessment or create an interview case review where you invite ideas for reducing the divide and see how progressive they are in their thinking.

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Equivalence

- **Advance equivalence in all relationships, especially those historically defined by hierarchy**, for example, providers and staff. If hierarchical practices continue within the health care team and organization, dissolving the divide between us and them will challenged.
- **Consider the implications** of mandated use of titles.
- **Consider the implications** of clinical encounters that do not elicit patient preferences, beliefs, values or experiences.
- **Adopt an "urgent transformation" mindset** to include whole-scale learning and development activities designed to support equivalence in employee and patient relationships.

We all have different histories, families, ethnicities, ages, and life experiences. We can be conscientious that in our striving to dissolve the division between "us and them", we do not go too far the other way in generalizing us all as one in the same. When we generalize our own experiences to be true for others, it can result in overlooking others' uniqueness, or their personal thoughts and beliefs. It can impact our ability to understand why someone might need a prescription for Tylenol instead of buying it over the counter, or why a seemingly healthy young person may find it impossible to work, or even why someone might hide the truth about their substance use from their doctor.

Dismantling the "us" and "them" divide is critical to transforming our healthcare system. It can increase, not decrease, our genuine curiosity about others, support and honor individual differences, and enhance our ability to serve one another.

People First Health Collective exists to facilitate system transformation to put people first. We believe this builds relationship-centered systems, empowering the context in which all true and sustaining healing occurs.

People First Health Collective brings a depth of over 100 combined years in catalyzing change. We do this by research, facilitation and support in the deep, transformative work of developing relationship centered practices.

Who we are:

Mary Rainwater, Kori Joneson, Holly Hughes, Jennifer Brya, Elizabeth Morrison, Steph Sharma and Karen Linkins.

What we do:

1. CONSULTING:

Facilitate and support transformation of health and social care systems, enhancing people centered practices that support whole health.

2. ADVOCACY:

Engage in social justice-related advocacy, as it relates to the health equity, health access and health care for all people.

3. ADVISING:

Provide clear, concise problem definition with relationship centered solutions to local, state level and national health concerns

4. THOUGHT LEADING:

Author and promote articles to challenge, shift and create dialogue about the dominant discourse in health care, to catalyze bold thinking needed for change.

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