Canadian Medical Education Journal

Reviews, Theoretical Papers, and Meta-Analyses

Disagreeing respectfully: embracing complexity facilitates civil discourse

Exprimer son désaccord avec respect : accepter la complexité facilite le dialogue civil

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Published ahead of issue: Sept 22, 2025; published: Nov 6, 2025. CMEJ 2025 Available at https://doi.org/10.36834/cmej.82086

Abstract

Polarization and incivility are on the rise, negatively affecting collegiality, workplace relationships, morale, and performance at work. The authors argue for the need for civil discourse in medicine and for embracing complexity as an essential component of that civil discourse, facilitating nuanced thinking, respectful dialogue, and greater understanding of other perspectives. This principle of embracing complexity is congruent with the attitude of physicians, who are trained to tolerate uncertainty and to hold and appreciate multiple perspectives in making diagnoses and choosing and proposing treatment plans. This understanding of civil discourse does not amount to moral relativism, whataboutism, or an embracing of both sides of an argument universally, nor does it serve as a cudgel to silence or to perpetuate hegemonic power. Instead, the principles of civil discourse clarify multiple aspects of the boundaries of professional conduct, outlining how physicians can engage in advocacy for patients and communities while maintaining collegial relationships and the perception that they will be safe providers for all patients. The rights of citizens in democracies, including to engage in peaceful protest and to say anything within the bounds of their country's laws governing free speech, do not extend unabbreviated into the lives of professionals, who are limited by the privileges afforded to them and by the responsibilities they have to their patients and colleagues. By embracing complexity and nuance over simplism and slogans, physician colleagues who disagree with one another can communicate respectfully, advocate professionally, and be safe and effective care providers to all patients.

Résumé

La polarisation et l'incivilité sont en hausse, ce qui a un impact négatif sur la collégialité, les relations de travail, le moral et les performances professionnelles. Les auteurs plaident en faveur de la nécessité d'un discours civilisé en médecine et de l'acceptation de la complexité comme élément essentiel de ce discours civilisé, facilitant une réflexion nuancée, un dialogue respectueux et une meilleure compréhension des autres points de vue. Ce principe d'acceptation de la complexité est conforme à l'attitude des médecins, qui sont formés à tolérer l'incertitude et à considérer et apprécier de multiples points de vue lorsqu'ils établissent des diagnostics et choisissent et proposent des plans de traitement. Cette conception du discours civil n'équivaut pas à un relativisme moral, à une contre-attaque (« whataboutism ») ou à une acceptation universelle des deux côtés d'un argument, ni ne sert de bâton pour faire taire ou perpétuer un pouvoir hégémonique. Au contraire, les principes du discours civil clarifient de multiples aspects des limites de la conduite professionnelle, en décrivant comment les médecins peuvent s'engager dans la défense des patients et des communautés tout en maintenant des relations collégiales et l'image de prestataires de soins sécuritaires pour tous les patients. Les droits des citoyens dans les démocraties, notamment celui de participer à des manifestations pacifiques et de s'exprimer librement dans les limites des lois de leur pays régissant la liberté d'expression, ne s'étendent pas sans restriction à la vie des professionnels, qui sont limités par les privilèges qui leur sont accordés et par les responsabilités qu'ils ont envers leurs patients et leurs collègues. En privilégiant la complexité et la nuance plutôt que le simplisme et les slogans, les collègues médecins qui ne sont pas d'accord entre eux peuvent communiquer de manière respectueuse, défendre leurs intérêts de manière professionnelle et être des prestataires de soins sécuritaires et efficaces pour tous les patients.

Introduction

We are having more trouble speaking with each other on challenging subjects than ever before.[1] Partisanship, ideological loyalty, and absolutism on both sides of the political divide explain some of our radical discomfort engaging in meaningful discussions with those who disagree with our opinions.[2] We are faced with a world in which "polarization" was chosen as Merriam-Webster's 2024 "word of the year."[3] This polarization, the driving of our opinions "toward the ideological poles,"[4] is increased by exposure to incivility from those with whom we disagree.[5] The rise of incivility has impacted workplaces in myriad ways: increasing stress, decreasing morale, damaging collegiality and workplace relationships, and affecting performance and employee attrition.[6] As in broader society, incivility within medical schools and hospitals is increasingly common and underreported;[7] endangers physicians' ability to provide care; and, is "a potent threat to professionalism."[8] As such, physicians and health system institutions need an approach to fostering civil discourse and addressing incivility so that individuals with differing beliefs can work and learn together in ways that promote communication, productivity, and wellbeing.

Encountering incivility decreases healthcare professionals' psychological welfare and engagement with their work and their institutions.[9] Healthcare professionals must also be able to provide safe care for all potential patients, while also collaborating with diverse groups of colleagues. Engaging in incivility, even outside of the hospital walls, compromises providers' therapeutic relationships with patients and collaborative relationships with colleagues, thus compromising the practice of medicine. However, efforts to address this incivility have been made more difficult by ambiguity regarding healthcare professionals' roles in advocacy.[10]

In the current educational paradigm of competency-based medical education, the knowledge, skills and attitudes related to arguing for individual patient's needs, the needs of a group of patients, or a specific health policy or political change is described as health advocacy.[11] Some physician competency frameworks (e.g., CanMEDS) have a specific "Health Advocate" role,[12] whereas others embed advocacy in other roles (such as Systems-Based Practice within the ACGME Competencies),[13] but the idea that physicians should be "advocates" is widespread. However, scholars have long noted a lack of clarity in how advocacy should be operationalized and what the bounds of such advocacy should be.[14,15] Advocacy is sometimes misconceived as a single pursuit. However, advocacy, defined as "helping patients navigate health care…and engaging in system and policy-level activism,"[16] comprises two separate activities: "agency" and "activism."[17] The former focuses on individual patients and works to help patients navigate the existing health care system, while the latter is concerned with population health and aims to disrupt the status quo and change existing systems.[18] It is activism, which has more recently been called resistance,[15] that carries significant risks that demand careful attention[15] and that can engender emotion-laden conflicts.

Patient care, professionalism, and professional reputation can all be endangered by engaging in resistance.[15] For example, trying to make change by refusing to provide care to specific individuals or in general (such as in the case of a strike) hurts patients and contravenes professional codes, even if the ends purport to justify the means.[15,19] Similarly, since professional resistance involves drawing on one's authority as a physician which is granted by one's participation in the self-regulated professions' organizing bodies, resistance that "dismantles or disavows state-sponsored self-regulation" is "inconsistent with the principles of a profession" and can thus not claim to be "professional."[19]

Using dehumanizing language towards detractors, vilifying opponents, and over-simplifying complex issues may make an activist-physician an unsafe provider to potential patients. Ironically, a patient may fear that they won't receive adequate advocacy for their own health needs from a doctor whose activism manifests in this way. Similarly, since a physician's ability to practice medicine partly depends on their relationships with colleagues, resistance that marginalizes and vilifies some of a physician's colleagues harms those colleagues and damages that physician's relationships with them, putting their collective ability to practice medicine effectively in jeopardy.

A proposed solution: the principle of civil discourse

We propose adopting civil discourse, or respectful dialogue,[20] as a core component of professionalism. Civil discourse as an idea arises from Aristotle's concept of *dialectic*, reasoned exchange between two people seeking understanding,[21] a tradition that threads into contemporary political philosophy via John Locke's 17th century principles of tolerance for differing beliefs and rejection of coercion in political discourse.[22] It is different from civility, which is often understood as politeness and courtesy in communication. Indeed, someone can be civil

as it relates to being polite while simultaneously being disrespectful, dehumanizing, or threatening. Civility, therefore, is a personal behaviour, while civil discourse is a relational activity. For two people to engage in civil discourse on a topic about which they disagree, there are a few preconditions that must be met (Table 1). They must act respectfully of each other as human beings and uphold each other's right to have differing views. They must be willing to listen and reflect upon the other's point of view.[23] They must be reasonably confident that they will not be vilified for their beliefs or put themselves or their social standing at risk by engaging in the discussion. And they must both treat the other person as well-meaning, which we specifically define in this context as motivated by a desire to do good.[24] This mandate to treat the other person as well-meaning does not mean that we have to believe that each person we talk to is necessarily making good decisions or acting in others' best interests. Rather, by treating the other person as virtue-motivated, as trying to do the right thing, we have an opportunity to understand even those whose actions we vociferously condemn. For example, one of us (AL) teaches a course on Lessons for Physicians from the Holocaust to the medical students at the University of Toronto,[25] in which an understanding of the perspectives of Nazi physicians is sought not to justify their horrific actions but rather to understand how humans who believe themselves to be motivated by a desire to do good can come to internalize harmful beliefs and carry out atrocities.[26]

Table 1. Conditions for Civil Discourse

Conditions for Civil Discourse
Respect each other as humans with the right to disagree
Be willing to listen and reflect on the other's point of view
Be reasonably confident of not being vilified or risk social standing by engaging
Treat each other as well-meaning (motivated by a desire to do good)

Civil discourse requires a tolerance of complexity. Simplicity is appealing, and putting things into simple dichotomized categories—healthy and sick, useful and useless, good and evil—can help people learn.[27] However, it is precisely this tendency that can lead to Manichean thinking, in which someone comes to believe that their perspective is entirely correct, that opposing views are wrong, and that those that hold opposing views are evil.[28] This helps explain why over-simplification of complex political ideas drives polarization.[29] By embracing complexity over simplism, people may see the humanity in those with whom they disagree[29]—which is a precondition to civil discourse. As physicians, we are even more obligated to see the humanity in those whom we perceive to be our ideological opponents, given our professional and ethical mandates to treat everyone we encounter with full dignity and care. Individuals and institutions in health care and medical education have a professional imperative to embrace complexity as essential for civil discourse and functional collegial relationships (and indeed for the provision of excellent care for all).

However, it is just as important to state what this embracing of complexity is *not*—it is not a universal embracing of both sides of every argument, it is not whataboutism, and it is not moral relativism. Admitting the possibility of being wrong and that complex issues cannot be reduced to a catchy slogan is different from claiming that there is no right and wrong because everyone is partly correct. Rather, it is an argument against sweeping absolutism and for an understanding of the diversity of human perspectives. Understanding those with whom we disagree as well-meaning, as heroes of their own stories, helps us avoid dehumanizing those with differing beliefs as cartoonized moustache-twirling evildoers. We would want our own ideological detractors to do the same for us when they speak of our intentions.

Another useful conception of civil discourse is captured by Margaret Gilbert's notion of "walking together." Gilbert writes that exploring the dynamics of the social dyad of two people on a walk together deepens our understanding of how to practice civility.[30] She describes how those two people are "participating in an activity of a special kind, one whose goal is the goal of a plural subject, as opposed to the shared personal goal of the participants."[30] According to Gilbert, this sort of social dyad forms the core of civil discourse, giving rise to an approach of gratitude, humility, curiosity, perspective-taking, reflection, and, ultimately, compassion. In medicine we necessarily participate in a particular kind of dyadic activity: patient care. Whether on an individual or a system level, every meeting of two health care professionals forms a plural subject with a shared goal—excellent patient care. This dyad mirrors that created by the physician and patient, who together engage in meaning-making of the patient's illness and find a plan for treatment that arises from the patient's perspective and the dyad's relationship and interactions.[31] The logical consequence of sharing this goal of excellent patient care is that every two health care professionals therefore share other goals—for example, that every medical student should have the opportunity to become a skilled physician,[32] that every doctor should have adequate resources to care for their patients,[33] and that every patient should receive excellent care.[34] This does not mean that such a dyad will always agree on the best ways to

achieve their goals. They are free (and likely) to disagree at times. But two people on a walk, according to Gilbert, recognize each other's rights and obligations in sharing that activity, and, in sharing a "we" that pursues a shared goal, pledge to disagree with respect and with recognition of mutual good intention.[30] Civil discourse, therefore, must be regarded as a core principle of professionalism; when two health care professionals "walk together," their shared goals necessarily fuse them into this social dyad.

The boundaries of civil discourse do limit what we can say. For discourse to be civil, it must not dehumanize others or promote violence.[20] For example, the phrase "Punch a Nazi" began to trend on social media in 2017 after Richard Spencer, an "alt-right" figure who embraces white supremacist views, was punched in the face during an interview on camera.[35] There were many individuals online who suggested, in jest or not, that it was always okay to punch a Nazi.[36] This constitutes uncivil discourse. While fighting against Nazi ideas is indeed a worthy cause, and while engaging in violence may be warranted when engaging in self-defence or coming to the aid of another person under attack, advocating for violence against people who do not agree with our views is not acceptable (and contravenes free speech laws in many jurisdictions). People who hold odious ideas do not forfeit their human rights, and we would not want to hear others say that we deserve to be physically attacked for the beliefs we hold. Institutions should hold those who flout this principle accountable, as allowing such speech is dangerous both to others' ability to feel safe engaging in civil discourse and, potentially, to their physical safety.

There are those who argue that mandating civility is a way to shut down free speech, pointing to a history of the use of the term civility as a "cudgel" to perpetuate oppression and hegemonic power.[37] This argument posits that the medical establishment uses an archaic conception of professionalism to silence dissent by admonishing anyone who dares to protest the inequitable status quo. Certainly, there is a history in medical culture and medical education of seeking to "neutralize" those in medicine, castigating forms of self-expression that deviate from the norm and marginalizing those who are different, particularly women and racialized people. [38] This is, however, a mischaracterization of the mandate of civil discourse, which, as discussed above, is different than mandating civility. We can engage in free self-expression, including promoting equity in medicine, while engaging in civil discourse.

How to teach, practice, and mandate civil discourse

Teaching civil discourse

Integrating civil discourse into our understanding of professionalism provides a context and a framework in which it can be taught. Best practices in teaching professionalism can be adapted to teaching civil discourse, including understanding the specific challenges to civil discourse in the particular cohort of learners being taught and engaging with them in ways appropriate to their career stage, role-modelling by faculty by training faculty first or simultaneously, and "defining expectations as observable behaviours."[39] Exemplars of civil discourse on challenging, charged, and controversial issues, such as the one outlined in Box 1, can aid learners in understanding how to apply the principles of civil discourse in practice. Educators can also capitalize on the parallels of civil discourse and clinical reasoning, as its philosophy of embracing complexity should resonate with physicians given the contexts in which we learn and work. Occam's Razor may entice doctors with the promise of a straightforward unifying diagnosis but, fundamentally, the practice of medicine requires healthcare professionals to tolerate uncertainty, complexity, nuance, and the possibility of being mistaken.[40] As such, medical education aims to teach students how to accept uncertainty as inevitable, to hold multiple perspectives simultaneously, and to make reasoned decisions in the face of uncertainty.[41] We can harness physician skills for tackling complex data analysis and uncertainty in clinical care by using it to reorient our understanding of other complex issues. We can recognize contentious issues as necessarily complex, choose to start from the assumption that every person who believes something has come to their belief as a human who is trying to do good in the world, and acknowledge that our own beliefs may be mistaken. In doing so, we can, with humility and curiosity, avoid the pitfalls of simplism. This attitude is something that individuals can foster in themselves and that medical schools can set out to teach, just as they teach clinical reasoning.

Box 1. Example of Civil Discourse

Two psychiatrists hold different beliefs about whether patients with depression and no other underlying condition (depression as the 'sole underlying medical condition') should be eligible for Medical Assistance in Dying (MAiD). How can they engage in civil discourse on this topic? We present an example of this to guide the education and enactment of the principle of civil discourse:

Each physician comes to the conversation with curiosity and a willingness to hear the other's perspective. One physician shares their belief that patients with severe refractory depression should have the right to receive MAiD, just like patients with other grievous and irremediable conditions, and that a blanket prohibition on MAiD in this population infringes on their autonomy, perpetuates stigma by delegitimizing psychological suffering, and may prolong irremediable suffering. The other physician shares that they oppose offering MAiD for this indication because they have concerns around decisional capacity in patients with severe depression requesting to die, and because they believe that the focus should be on improving access to care and removing stigma around mental health. Each physician learns about the other's position and gains a greater understanding of the complexity of the issue and that multiple perspectives can have validity. Neither of them feels vilified for the differences in their beliefs, and neither feels that they were threatened or that their social status or livelihood was at risk. They also recognized that both of them share a common goal of doing the best they can do for their patients, and this gives them a feeling of safety that allows them to engage with the other's perspective more readily, as they don't feel like they are with a person who is intentionally malicious or who perceives them as intentionally malicious. They gently correct one another when one or the other inadvertently uses disparaging language about those who disagree with their position, and they are able to take the feedback with grace and with a growth mindset. After they leave, one or the other may still feel passionately about the issue enough to engage in activism, such as giving money to organizations advocating for their position or writing an editorial advocating for their viewpoint, but neither posts anything on social media that suggests that people who disagree with them are villains or less than human. The first physician does not post something like: "All psychiatrists who oppose MAiD for the mentally ill should lose their jobs." The second physician does not post: "Doctors who provide MAiD to the mentally ill are murderers." Each feels that they can disagree with their ideological opponents without ascribing them malice, and from this experience, they feel more ready to have challenging conversations on other tough subjects.

Medical educators should also teach trainees the goals and bounds of advocacy and activism which are, as we have argued above, challenging components of being a physician. It is reasonable for medical students, as students in an academic institution and as those not yet part of a profession, to believe that they can express any perspective on any issue in any forum. However, educators can use the standard of civil discourse to educate on how to practice activism without breaching professional standards. Specifically, activism must be enacted with respect towards people and local communities, such that a physician's activism does not compromise their ability to be seen as a safe physician for all patients. This implies more than a simple requirement for a physician to provide care to those who hold views they find odious. Physicians must also avoid public discourse that makes certain groups of patients feel that they will not receive good care from that physician. They must also avoid vilification of current and future colleagues, as this will also compromise the physician's ability to practice within a health care community. The rights of citizens in democracies, including to engage in peaceful protest and to say anything within the bounds of their country's laws governing free speech, do not extend unabbreviated into the lives of professionals, who are limited by the privileges afforded to them and by the professional responsibilities they have to their patients and colleagues.[19]

Civil discourse in practice

In a conflict over clinical decision-making or the navigation of patients through the health care system, we can draw on the principle of civil discourse by treating each person as someone who aims to provide good care for patients. Even if we disagree with their conclusion on the best course of action, we must recognize that the other person's opinion is based on their own experience and understanding, and this not only facilitates civil discourse but helps mitigate incivility, because we are kinder to those whom we understand as well-meaning.[42] Making this explicit in conversation can defuse elevated emotions and help resolve interpersonal conflicts.[42]

It is trickier when political topics arise among colleagues, at work or online. Moral judgments, feelings of fear and insecurity, and societal polarization fuel emotional reactions and can lead to the sorts of absolutist language and vilification discussed in the first section of this article.[43] Training ourselves in the principle of civil discourse can help us and those around us navigate such conflicts. When we feel strongly about an issue, we can, with those skills in hand, fight passionately against ideas without fighting against *people*. Suppose we encounter a colleague who is simplifying complex issues and vilifying those who disagree, either in person or online. We can use the language of civil discourse to express how this language contravenes professional obligations and engage them in a discussion to attempt to gain mutual understanding and a recognition of the complexity of such issues. Failing that, we can approach our institution for help, citing civil discourse as the principle being broken.

How institutions and leaders should use civil discourse

Institutions, leaders, and regulatory bodies all have an opportunity to engage in culture change and reverse the trend of polarization and incivility in medicine. By mandating civil discourse and explicitly integrating its

principles into institutional value statements, institutions can lead by example and promote embracing complexity. In this way, institutions can break silences on taboo subjects and foster collegiality between members who disagree. It also offers a blueprint on how to grapple with discourse that violates these principles. Institutions already have approaches to unprofessional behaviour;[44] if we identify civil discourse as a fundamental feature of professional conduct, then institutions can use their existing protocols to address "controversial" behaviour that previously they may have struggled to label. Language that dehumanizes and alienates specific people compromises a physician's ability to practice, and identifying it as such allows leadership to intervene, remediating or sanctioning those who violate the principle of civil discourse.

Conclusion

The stakes are high. Our ability to communicate as colleagues, to work together within hospitals and faculties of medicine, and to function as a profession—and in so doing to maintain the trust of all patients—depends on us working to foster civil discourse in our trainees, in ourselves, and in our institutions. This means eschewing reductionism and embracing and seeking to understand multiple perspectives, forsaking catchy slogans and pithy epithets, and working towards an understanding of our ideological opponents. Institutions and professional regulatory bodies must define not just a plan to uphold the principle of civil discourse, but also an approach to addressing uncivil discourse—how to identify it, the consequences for those who engage in it, and what steps must be taken to mitigate its damage to the community and to prevent it from spreading. Within society, we disagree with each other on so much—hopefully within medicine we can agree to strive to disagree with each other peacefully, insightfully, and with a pledge to seek understanding, nuance, and recognition of each person's humanity. Our ability to practice as physicians who care for all patients depends on it.

Conflicts or competing interests: The authors report no conflicts or completing interests.
Funding: The authors report no external funding source for this article.
Acknowledgements: The authors would like to thank Rebecca Stovel, MD for her valuable review of an earlier version of this manuscript.
Disclaimers: The views, interpretations, and conclusions expressed in this article are solely those of the authors and do not necessarily reflect the opinions, policies, or positions of their affiliated institutions or any other associated roles with organizations.
Edited by: Marco Zaccagnini (senior section editor); Marcel D'Eon (editor-in-chief)

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