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MEDICAL COLLEGE OF WISCONSIN

Anesthesia Care Provision & Conflict with a Colleague …or Worse… a Parent

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Disclosures & Acknowledgements

- **No disclosures**

- **A grateful thanks to my colleagues who volunteered for the video role plays** (Dr's Duncan-Wiebe, Scott, Strong, Troshynski, Vandrovec)

Goals

1. Be able to explain the 5 common modes of conflict resolution and some "times for use "

2. Recognize impacts of conflict.. on –our teams, our selves-our patients

3. Reflect-- better identify conflict and de-escalate one…or support a team member.. next week

(my goal-dissemination **sstaudt@mcw.edu**)

Why Expertise in Conflict Management?

CASE: A 3 yo w/giant neuroblastoma ..severe intraop bleeding resuscitation fails ..*why?* ineffectual resuscitation? embolism? PE? anaphyaxis? transfusion rxn ? (pt *minimally responsive to fluids, blood products, pressors ,inotropes, CPR and finally open cardiac massage and atrial line*)

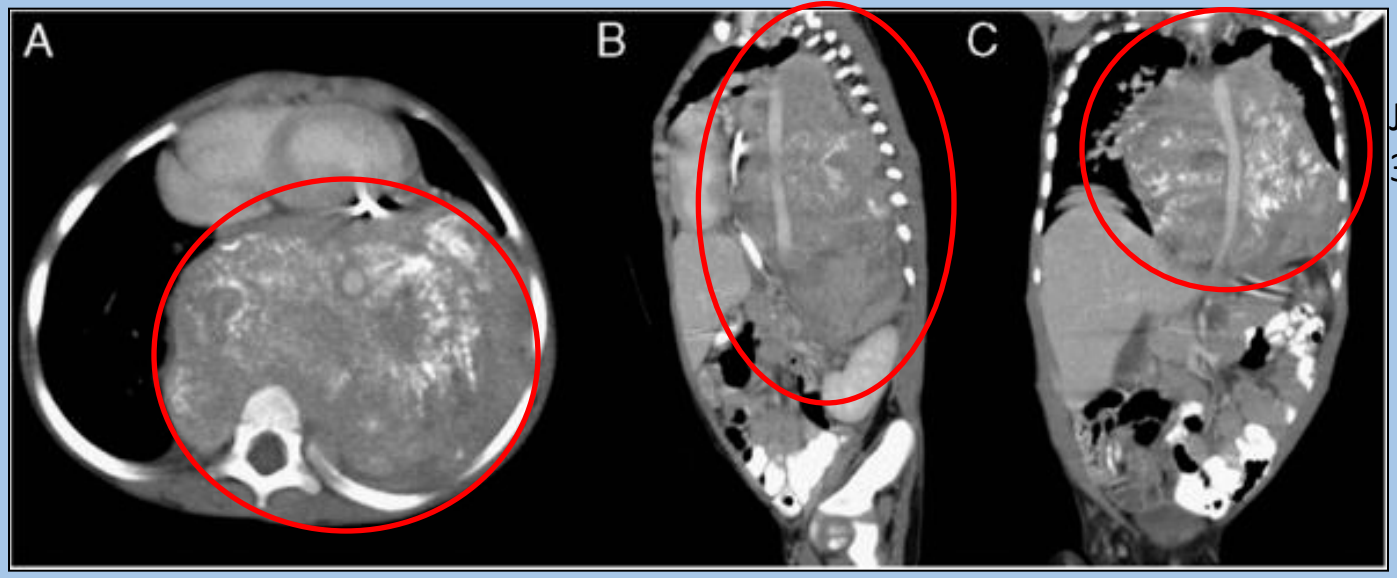


photo from Pappas, L; et al J Ped Hematology/Oncology. 32(2):163-166, March 2010.

- **Critical incident review-explain what happened?**

Case (cont'd)

- Young peds surgeon in 1st year of practice
- Young peds anesthesiologist 2nd yr of practice
- Case bumped to off hours - " just a biopsy"
- Pt a difficult airway (SVC syndrome)-anes focus
- Access-2 saphenous (LE) iv's-discussed by both MD's

Senior surgeon scrubs in – takes charge through bullying and power - gradually revises plan via silent action-- to resection–

no OR team discussion

- Anesthesiologist focused on art line under drapes; massive transfusion
- Young Surgeon forgets about access issue (***sr. surgeon unaware***)
- *Surgeons X clamp IVC for bleeding control*- anesthesia unaware
- Sr surgeon "assumes" anes knows what is happening in the field –anes "assumes" he'd be told of field events relating to no LE venous access

A sad real example of communication failure in the OR

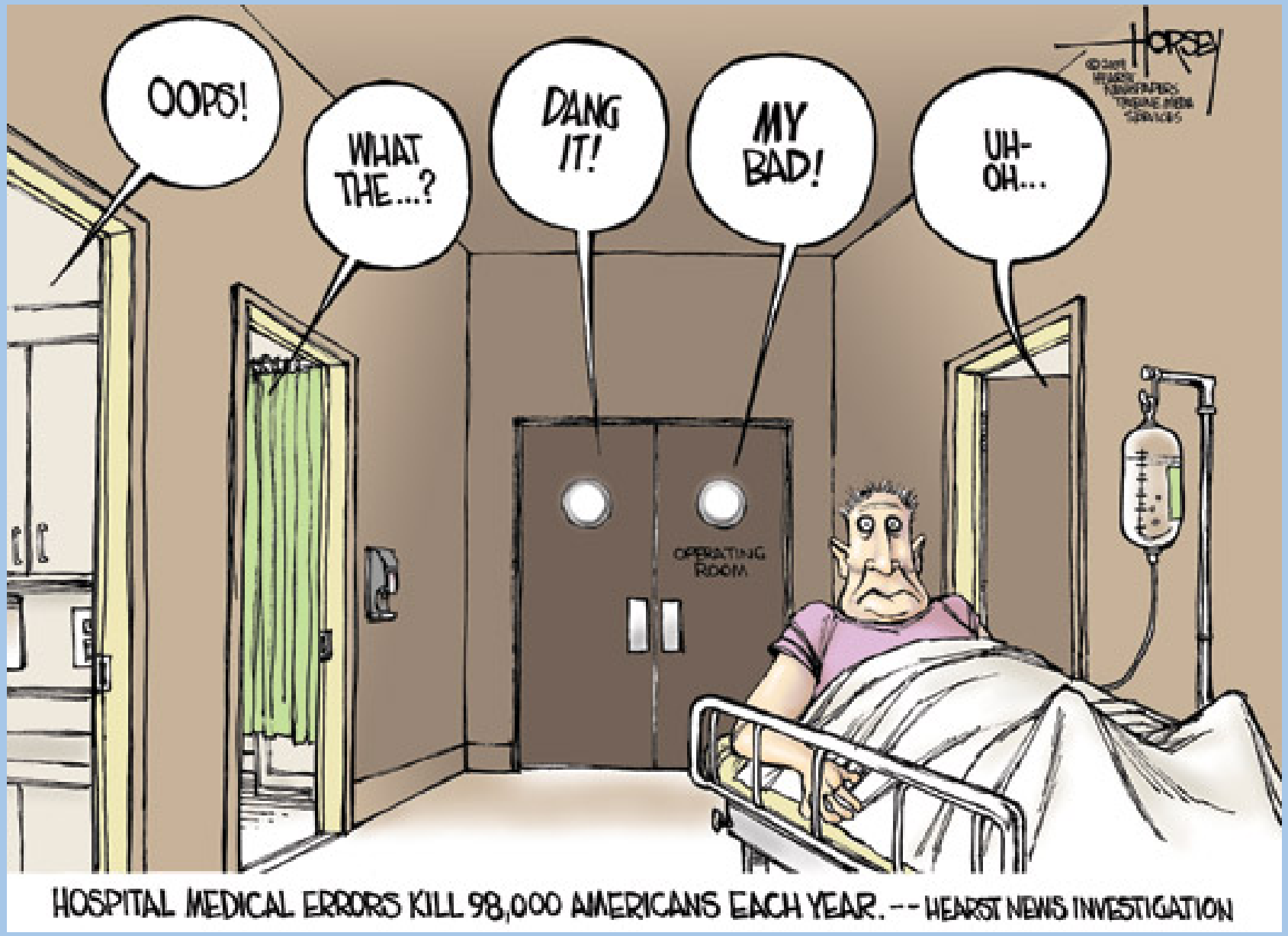
Communication Failures in the Operating Room: an observational classification of recurrent types and effects Lingard, L Espin S et al Qual Saf Health Care, 2004 13:330-4

- “field research”-observed 90 periop hours in complex OR procedures
- Tracked every communication (**421**)
- Categorized as successful or failed (**129**)
- Analysis of reasons for failures
- Attached consequences to each in terms of any patient harm or risk

Conclusions-Lingard

- **1/3 communications failed** in a university OR
- Failures could be classified as
    1. **Occasion** (timing or context-46%)
    2. **Content** (insufficient or inaccurate 36%)
    3. **Audience** (wrong team members- 21%)
    4 **Purpose** (unclear, not achieved – 24%)

1/3 of the failures jeopardized patient safety via delays once GA initiated, procedural error, need for workaround, routine disruption, increased team tension and missing further team critical communications


OOPS!
WHAT THE...?
DANG IT!
MY BAD!
UH-OH...
OPERATING ROOM
HORSEY
HOSPITAL MEDICAL ERRORS KILL 98,000 AMERICANS EACH YEAR. -- HEARST NEWS INVESTIGATION

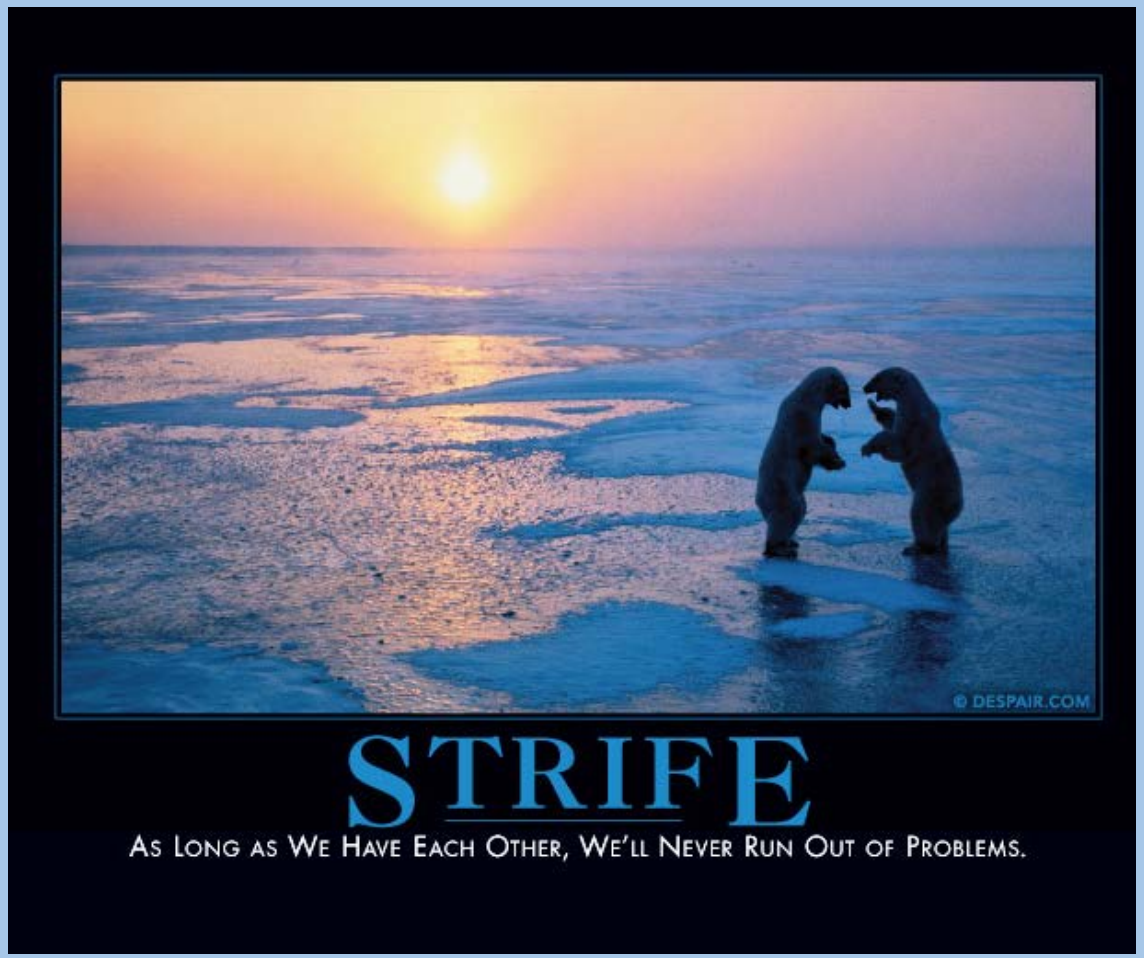
Common Barriers to Communication and Collaboration (agency for healthcare quality and research)

- Complexity of care
- Concerns regarding clinical responsibility
- Differences in accountability, payment, and rewards
- Differences in language and jargon
- Differences in requirements, norms of professional education
- Differences in schedules and routines
- Disruptive behaviors
- Emphasis on rapid decision making
- Fears of diluted professional identity
- Gender, cultural, generational differences
- Historical interprofessional and intraprofessional rivalries
- Personal values and expectations
- Personality differences
- Varying levels of preparation, qualifications, and status

Source: O'Daniel M, Rosenstein AH. Professional communication and team collaboration [online].

Internet:http://www.ahrq.gov/qual/nurseshdbk/docs/O'DanielM_TWC.pdf.

Conflict is…



"I know it when I see it"

" a dispute, disagreement or difference of opinion"

" a PROCESS OF SOCIAL INTERACTION involving power, status, beliefs, claims to resources, where those involved have disparate preferences or desires"

Communication failures = CONFLICT

Analysis and Classification of Perioperative Conflicts Duncan Wiebe, Staudt, Farber, et al

ASA 2008 Abstract # 951309

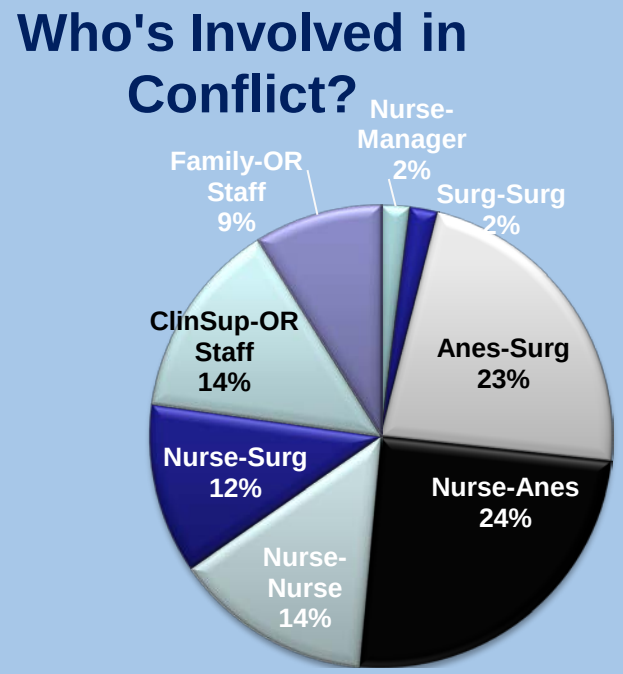
- Describe a recent conflict you encountered at work
- Who was involved in the conflict?
- What happened?
- Was there any resolution?
- At any time did this conflict become personal-(more about you/your team- relationships) than the situation? (describe)
- Did any negative consequences reach the patient? (describe)
- Have you encountered this conflict situation before?
- How stressful was this conflict for you? (scale)

Analysis and Classification of Perioperative Conflicts

- Collected surveys from surgical services team- 42 completed fully (30% response)

- Conflicts in all areas
- Most common between contiguous roles;
- Anes involved in almost 50%

- In addition:
- Poor concordance on whether conflict is present; (severity, type)



Analysis and Classification of Perioperative Conflicts

Duncan-Wiebe, Farber, Staudt ASA, 2008

PROCESS/TASK

- Miscommunication/absent communication
- Supplies and equipment availability
- Personnel availability/timeliness
- Disagreements about the plan of care

RELATIONSHIP

- Criticism in public forum
- Misuse of team role or authority position
- Team - family conflicts

Analysis and Classification of Perioperative Conflicts

1. *Unresolved* conflicts were more stressful *(was there a resolution to this situation?)*

2. *Personalized* conflicts were rated more stressful with negative "vibe" and anger in the tone of the report – *to reviewers clear these morphed from initial process or task conflicts*

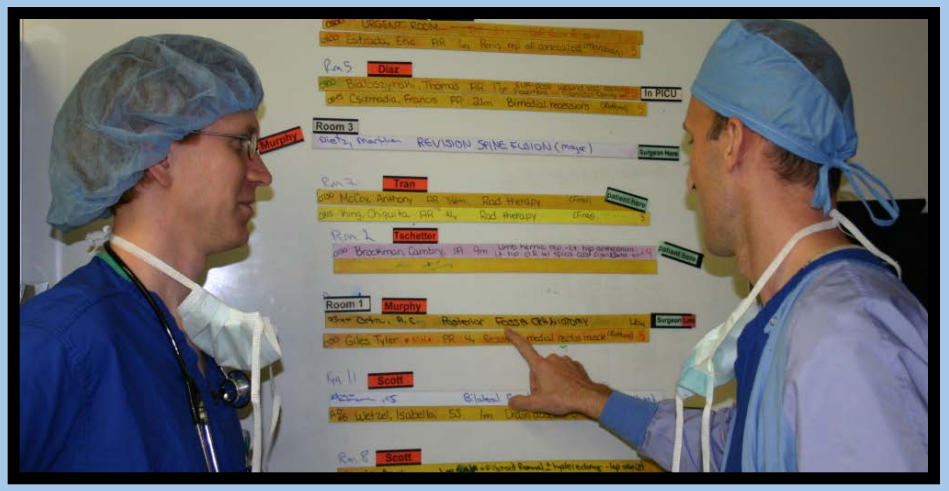
3. Age, experience level, team role NOT associated w/degree of stress reported

4. Conflicts where (perceived) a negative impact reached a patient were deemed more stressful

Variants on 2 Common Conflicts…

TWO ANESTHESIOLOGISTS

At the OR board-staffing : balancing case coverage & a complex add- on case with non- clinical duties



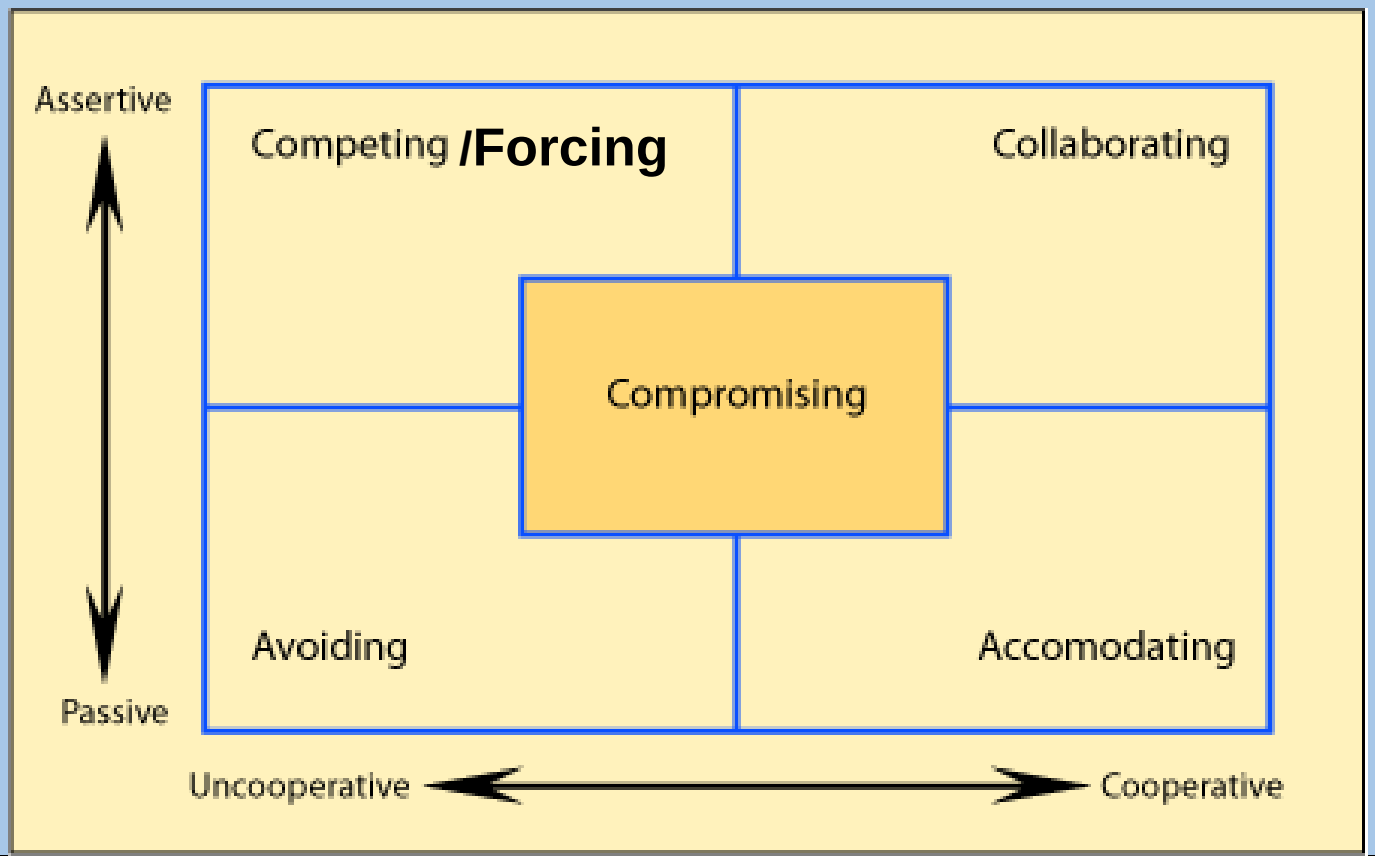
ANESTHESIOLOGIST & SURGEON

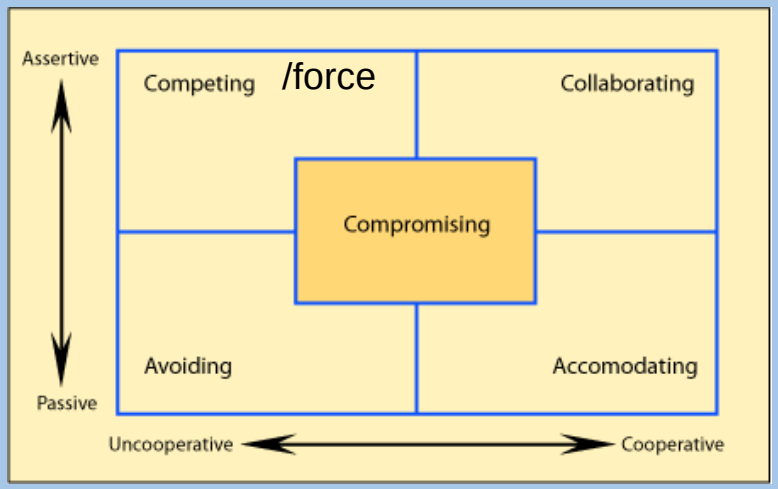
A complex case (ex-preemie with difficult vascular access) leads to conflict over presurgical case preparation time (epidural placement) vs. surgical start

- VIDEO_TS.IFO

The TKI Conflict Resolution Style Grid

- TKI most widely utilized tool; intuitive terminology
- 2 Axes for response: **assertiveness** and **cooperativity** Mouton and Blake
- All approaches have utility and potential for downside consequences
- Individuals have *preferred* approaches; we can/ ?need to utilize all styles



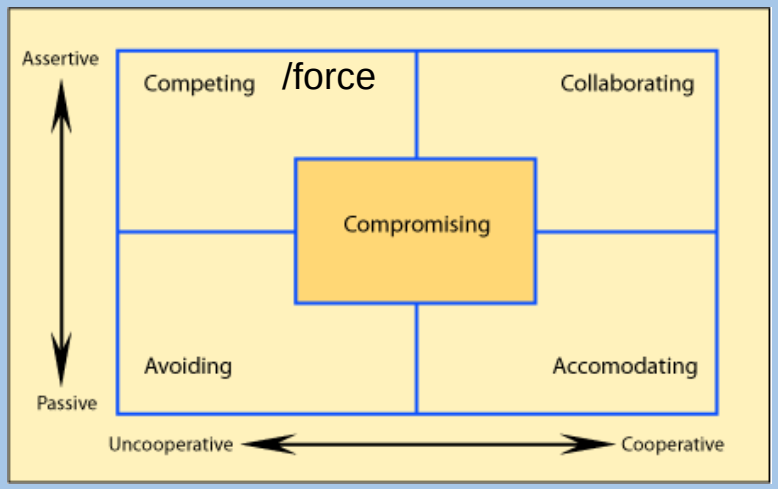


AVOID

- **Issue is of minor importance**
- **Insufficient information**
- **<u>When emotions are too high</u>**
- **If others can better resolve**
- **If your power /role p is too unequal *(MODERATOR-3RD PARTY***
- ***BUT-disengaged, negative***

ACCOMMODATE

- **<u>To defuse a tense situation</u>**
- **To facilitate team if issue can be handled alternate ways**
- **When a generosity can be given (a minor issue for you)**
- **Excess of this is insecurity, can fail the patient as their advocate**

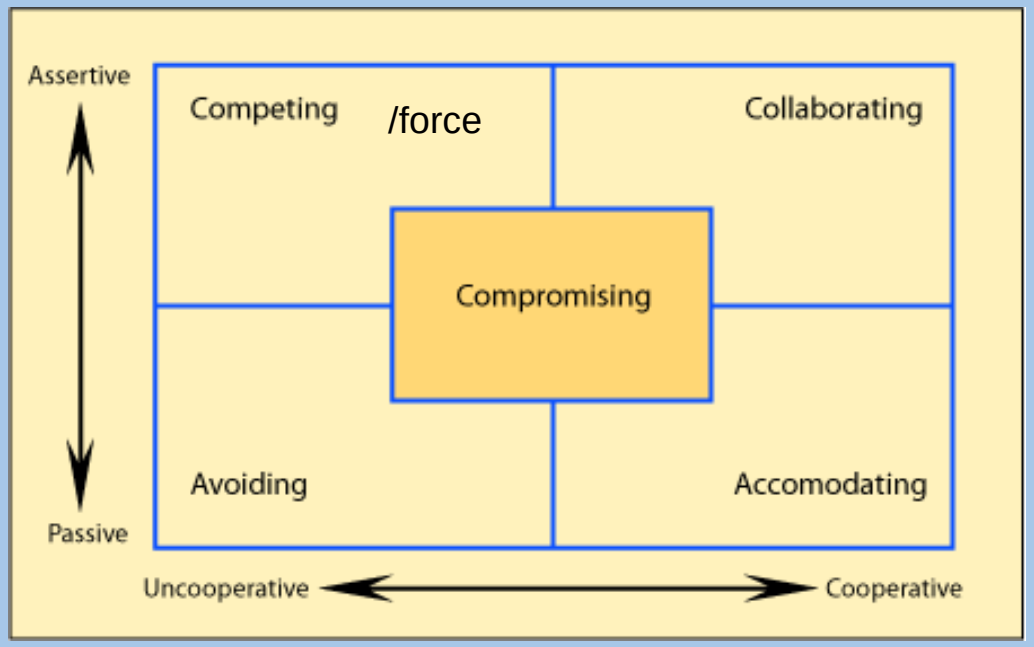


FORCE/COMPETE

- In emergencies (a code)
- In a tight situation if you are sr. expert & little time to explain
- Expect some push back or consequences; *DEBRIEF*

COLLABORATE

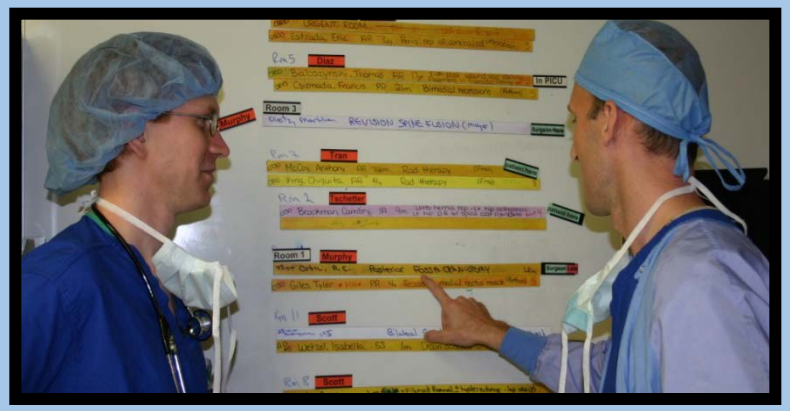
- When cooperation is normative
- If mutual benefits
- Takes organizational support
- If there are high stakes
- DOWNSIDE =(time consuming to get win win)



COMPROMISE-the middle

- **When its worth taking time for a partial solution**
- **When a complete win is impossible**
- **When there are conflicting goals**
- **When time doesn't permit more negotiation-common in OR**
- ***Repeated compromise hurts relationships over time (always give up something)***

CONFLICT RESOLUTION TAKE HOME?



Accomodation is not always good… (? Collaboration, compromise?)

Competition is not working …becoming personal (more about the people involved than the patient in the here and now)
(see next slide)

MODIFIERS OF CONFLICT RESOLUTION STYLES (see also patient family conflict)

To De-Fuse Strong Emotions…

1. **VERBAL**
    1. Try an I Message
    2. Use 1st name-acknowledge the frustrations as shared, propose a solution
    3. Emphasize Common Goals “We both want…I know we are both concerned about…”

2. **NON-VERBAL** Avoid mirroring anger, frustration (in tone, stance)

Conflict with Patients/Families

- 2005 ethics panel polled members for top 10 challenges -- #1:

“Disagreement between patients/families and health care professionals…”

- Scant literature -few studies

(Most =end of life, medical futility- focus in ICU’s)

Causes of Conflict with Families

- Misunderstandings
- Expectations not met
- Parties differ over goals
- Goals aligned; disagreement about how to achieve them (process)
- Distrust (? Prior experiences)
- Values, cultural bias
- Guilt, grief, anger
- Secondary gain
- Unacceptable behavior

An ICU survey of MD-family conflict

Schuster RA, Hong SY, et al: Investigating Conflict in ICUs—Is the Clinicians' Perspective Enough? *Crit Care Med* 2014; 42:328–335

- physicians report less conflict than families
- concordance was extremely poor.
- *agreement between physicians and family on presence of conflict approached "the accuracy of a coin flip".*
- No different when focus only on high level conflict (> 5 /10)
- If we fail to ID conflict, how can we resolve it?

Steps in Managing Family Conflict

- **Active listening** Encourage via prompts, nonverbal cues. Avoid “you” questions /statements “why are you angry?" Summarize with I messages “ I hear you saying..”
- **Shared goals/Agreement** are imperative- start with facts to agree on: "You are right. I did not order the MRI you requested”
- **Acknowledging the family’s feelings.** "I can see this is frustrating.“- show empathy
- .

Steps in Managing Family Conflict

- **Apology** "I am sorry ..that was not my intent."
- **Acting as a team -working together without blame or judgment.** Statements that demonstrate a partnership establish collaboration in the doctor-patient relationship.
- **Demonstrate respect** attribute positive intent. "I'm impressed at your determination …. That's a great quality and I'm going to help you get that explanation"

Challenges in Anes-Family Relations

- No prior or long term relationship
- Family perceptions ≠ reality
- Unrealistic desires /expectations

Assistance

- Speak to a provider who knows family
- Case Swap-will a different anesthesia provider be in the best interest
- Mediator-Use a family care representative (Ombudsman, social services, chaplain)

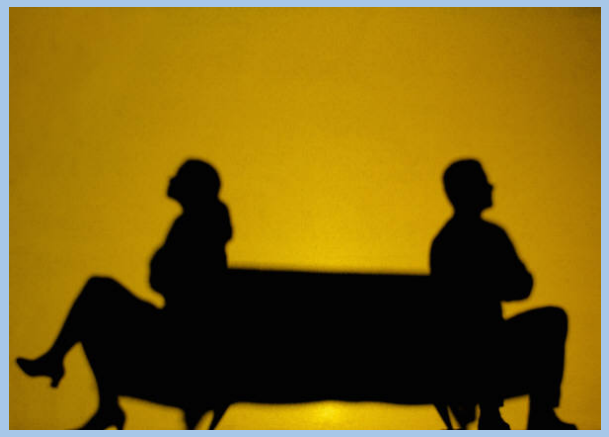
Delivering Anesthesia following colleague or patient conflict

- Conflict is ubiquitous - occurs at any time
- Conflicts that become *personal -create anger and stress*- impact participants& team beyond the conflict duration
- As with adverse events, the <u>WORK CULTURE</u> must promote:
    1- PREVENTION
    2- SAFE REMOVAL-REGROUP
    3- NON PUNITIVE DEBRIEF
    4- TEAM RELATIONSHIP BUILDING

At its most destructive, Conflict leads to

- Absent communication
- Mistimed communication
- Stress
- Job dissatisfaction
- Team errors
- Inefficiency and delays
- PATIENT CARE SAFETY AND QUALITY ISSUES

SUMMARY- CONFLICT RESOLUTION (adapted from Katz)



1. Anticipate conflict
2. Develop communication skills, styles
3. Establish shared goals; commit to a resolution
4. Acknowledge shared frustration
5. Start from non-judgemental perspective
6. Keep difficult conversations private
7. Utilize a 3rd party when necessary
8. Transfer care to uninvolved colleague if irreconciliable “now” issue

Thank you!