

2012 SAEM ETHICS CURRICULUM

Module 5: Interpersonal Relationships

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ACGME EM Milestones:

- ICS2: (*Team management: assuring clear communication, difficulties with consultants*)
- ICS1 (*Patient centered communication*)
- PROF1: (*Professional values*)

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5.1 Colleague Interactions (Schaninger, Otten)

5.2 Interpersonal conflicts (Asher)

5.1 Colleague Interactions (Schaninger, Otten)

Objectives:

1. Understand the aspects of EM that are unique in conflict generation.
2. Recognize the importance of conflict resolution skills in EM.
3. Understand the use of a conflict resolution skill set as it applies to EM.
4. Gain a framework for resolving disagreements and conflicts in the ED.

Case Study 5.1.1 – consultant refusing pain medicines:

A 24-year-old female presents to the Emergency Department with RLQ abdominal pain. After ordering routine labs you consult with a general surgeon to request an evaluation. The surgeon tells you, “I’ll be there in 2 hours, and don’t give the patient any pain medicine; I need to get a good exam.” After informing him that the literature indicates that pain medication is indicated and has not been shown to interfere with clinical exam, you are told, “I am the only one who will have to take the patient to the operating room and I don’t want my exam messed up.”

5.1.1: Questions

1. What are the strategies for avoiding conflicts with specialist consultants?
 2. How would you resolve the conflict in the case?
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Case Study 5.1.2 – Interaction with nurses:

You are working a busy shift on a day when the nurses are understaffed. A 60-year-old male with a history of hypertension and previous stent placement is brought back to a room from triage complaining of severe substernal chest pressure that radiates to his left arm, and you are concerned about acute coronary syndrome. The patient's nurse appears very busy trying to manage five patients when you ask him to get an EKG. As he is on his way into another patient's room he replies, "I will get to him as soon as I can. First I have to put in this Foley on a patient who has been waiting for a while and call up report for my admitted patient who now has a bed."

Case Study 5.1.2 Questions

1. What aspects of EM make it likely to generate conflict?
 2. What would you do in this instance? How could you do so while avoiding conflict? Ask another nurse or tech? Provide redirection about priority/acuity of care?
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Background Information:

The specialty of emergency medicine involves multiple interpersonal and interdisciplinary interactions. Perhaps no other specialty forces the physician to interface directly with such a wide spectrum of professionals with various levels of training. During a shift, an EM physician may need to cooperate with police, social workers, EMTs, nurses, respiratory therapists and a variety of medical specialty physicians. All of these professionals bring diverse training and perspectives to their contribution to patient care. With such a wide array of personnel interaction in patient care, conflicts can be anticipated.

Such conflicts can be disruptive to patients and staff members, can erode pathways of communication, and can compromise patient safety and quality of care. In one recent survey of ED nurses and physicians by Rosenstein et al., approximately one third of respondents felt that disruptive behavior could be linked to the occurrence of adverse events, medical errors, and poor quality of care.

Because Emergency Medicine involves constant interaction with others, EM physicians must be skilled mediators and problem solvers. Traditional problem solving involves both partners expressing their perspectives and coming to a face to face mutual agreement. This is not always possible in the fast paced environment of the ED or when initial contact with other providers is over the phone, such as with consultations. In one recent study about consultation in the emergency department by Kessler et al., conflict between emergency physicians and consultants was "managed through concessions, compromise, and negotiation in addition to climbing the seniority ladder". The authors also presented a model for consultation requests aimed at avoiding interpersonal conflicts. The "5 C's Consultation Model" involves contact, communication, asking a core question, collaborating on a plan, and closing the loop. The ED physician initiates contact with the consultant by providing her full name, rank, service and supervisor and then asks whom she is speaking with to build the relationship. She then gives a

concise story and asks a focused question of the consultant before mutually agreeing on a plan prior to the consultant's arrival and a timeframe for the consultation. This is then briefly summarized at the end of the consultation phone call. The authors note that the three components that are critical to a successful consultation are organizational skills, interpersonal and communication skills, and medical knowledge.

Resolving conflicts in the ED involves all of the specific skills already mentioned, but perhaps what is most important is understanding the perspective, values and training of the person with whom one disagrees. The explanation of one's rationale in resolving conflicts with members of each of these professions should be different. EM physicians should have developed the skill of communicating with patients and family members of various educational and socioeconomic backgrounds. Those skills can be used in conflict resolution in a wide variety of interdisciplinary settings.

The practice of EM creates opportunities for conflict with medical specialists. The inconvenience, reimbursement issues and nature of some ED patients can serve to heighten the conflict. When working on conflict issues with other physicians it is paramount to keep the patient's best interest at the forefront of any decision-making. EPs must also strive to avoid 'specialty bashing' by implying that certain specialties are deficient in specific areas and must avoid generalizing the practices or behaviors of one practitioner to that of a specialty or group. The best way to do this is to gain an appreciation of the knowledge base, practice patterns, and decision making of consultants of various specialties. If one understands the knowledge base and perspective of other professionals and is willing to listen to dissenting opinions from one's own, it is possible to frame a patient-centered discussion to resolve conflicts.

Patient management differences may result in physicians from different services acting in a hostile manner to those working in the ED, particularly nurses and medical residents. Procedures exist for addressing these clinical management differences, such as writing letters describing points of dispute to the chairperson or medical director when conventional means of discussion have yielded inadequate results. When those procedures are ignored, and other physicians attempt to use intimidation to express their anger, staff physicians and nursing administration in the ED should feel a proprietary interest in their staff and should zealously advocate for those in their department. The most senior person present should deal with these kinds of breaches of procedure or human decency on an immediate basis.

Emergency medicine faces many challenges and opportunities with respect to interpersonal and professional conflicts. By keeping the patient's best interest first, understanding the perspectives of co-workers and consultants, and maintaining the ability to compromise, the EP can lead the conflict resolution process.

5.2 Interpersonal conflicts (Asher)

Objectives:

1. Discuss and understand how interpersonal conflict with patients and caregivers can adversely affect patient care.
 2. Outline techniques for diffusing an interpersonal conflict between physician and patient and between physician and other caregivers.
 3. Define appropriate and inappropriate romantic relationships in the context of a residency training program.
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Case Study 5.2.1: Interpersonal Conflict with Patients and Caregivers

A young adult patient presents with vague abdominal pain, and after thorough evaluation including urine, labs, and imaging, no specific diagnosis can be found. The patient has been experiencing this pain intermittently for the last two years, and states that he “will not leave until there is an answer.” He becomes belligerent when told that you will not be able to give him an answer in the ED and that he will have to pursue outpatient follow up with his established primary care doctor.

Case Study 5.2.1: Questions

1. What is the likely issue underlying the patient’s unwillingness to leave the ED?
 2. What techniques can you employ to diffuse conflict in the ED between physician and patient?
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Case Study 5.2.2: Interpersonal Conflict with Members of the Healthcare Team

A patient presents to the ED with a complaint of acute exacerbation of chronic back pain. A nurse refuses to administer narcotic pain medication as ordered “because he’s here all the time and he’s a drug seeker.” A lively debate ensues between the resident and nurse regarding the appropriate management of patients with chronic pain.

Case Study 5.2.2: Questions

1. What should be the primary goal for both the resident and the nurse in this scenario?

2. What techniques can you employ to diffuse conflict in the ED between physician and nurse? Between physician and physician?
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Case Study 5.2.3: Relationships Within a Training Program

Early in an academic year, it becomes apparent that a junior faculty member has become romantically involved with one of the new interns. At first there are rumors, and although neither person has publicly admitted the relationship, later it becomes increasingly a source of gossip in the ED. A few of the other residents have been overheard making comments about the intern “getting special treatment” from the faculty member. The intern in question is doing well academically, and the faculty member is not in a designated position of administrative authority (assistant residency director, etc.).

Case Study 5.2.3: Questions

1. In the above case, if you were the chairperson of the department, would you approach the faculty member concerning the relationship? How would you approach it?
 2. Should residencies have written policies forbidding romantic relationships or fraternization between faculty and residents?
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Background Information

Interpersonal relationships are a reality in the emergency department as in almost every work environment. These interactions are the means of communication with our patients and fellow caregivers and add to the enjoyment of the job. At times, however, these relationships can be a source of conflict and can adversely affect patient care, resident and student education, and workplace morale.

Patient-physician relationships can be a challenge in a busy ED. A physician has a very brief period of time in which to meet the patient and associated family/friends, establish rapport, perform an appropriate history and physical exam, form a differential diagnosis and diagnostic/therapeutic plan, and discuss this adequately with the patient and family, while answering all questions in an appropriate manner. In situations where this line of communication breaks down or is difficult to establish, it is important for the emergency physician to remember that most patients feel powerless and frightened when placed in this environment. Patience and a caring approach will go a long way toward breaking this barrier of fear and distrust in even the most demanding and abrasive patients. In the end, the investment of a few extra minutes to develop the patient-physician relationship and assuage the patient’s anxieties may make the difference in a patient’s agreement and compliance with the proposed plan of care.

Professional relationships (physician-physician, physician-nurse, etc.) are another potential source of conflict in the ED. Limited time and resources, differences in treatment goals (emergency physician vs. consultant or primary care physician), poor communication and personality clashes can all contribute to conflict between caregivers. In these situations, it is important to remain focused on the needs of patient care. One ought to approach these situations with the question, “What is in the best of interests of this patient?” Many of these conflicts can be resolved with a return to this basic premise. All caregivers, though they approach it from different perspectives, have the same fundamental goal: high quality medical care for the patient. When an impasse arises regarding the best interest of the patient, one can go back to the source (the patient) to address their needs. When the patient’s best interests are not clear, an impartial third party can often mediate a reasonable solution.

Romantic relationships are another potential source of ethical conflict within the emergency department. Clearly, a romantic relationship between a caregiver and patient can lead to exploitation of the patient and can be detrimental to that individual’s physical and mental health. Additionally, in a residency training program, as in any academic hierarchy, there is a potential conflict of interest if two individuals on different levels of the academic ladder establish a romantic relationship. Residents or students in training are vulnerable to coercion in such relationships. Whenever there is a difference in level of power between participants, whether it be faculty-resident, resident-student, or faculty-student, there is potential for conflict or abuse by the individual with greater power. Most academic institutions forbid relationships between teachers and students during periods of active instruction/grading (i.e. while students are taking an instructor’s class). As residency represents an ongoing process of education and evaluation, it is most prudent to avoid any relationship between faculty and resident that may develop into a real or perceived conflict of interest. However, these relationships sometimes do exist. In those circumstances it is important to assure that the faculty member is not involved on evaluation of the resident and that mechanisms are in place to assure that both the individual resident and all other residents are treated fairly. In addition, it can be difficult to navigate the perceptions on the part of other students or residents that there is no unfair treatment, even if precautions are put in place.

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