Conflict Resolution in Emergency Medicine

Gus M. Garmel

Key Points

Conflict is the result of differing expectations, agendas, personal needs, backgrounds, and communication styles among individuals.

Conflict in emergency medicine (EM) may occur with patients, nurses, consultants, family members, residents, students, hospital administrative staff, and agents inside and outside the ED.

The goal of effective conflict resolution is to optimize immediate outcomes and to improve subsequent interactions. Success depends on being aware of one’s own communication style and the needs of the other party, along with insight into the other’s psyche and an understanding of relationship dynamics.

EPs must remember that at least two perspectives exist for each situation. “Win or lose” thinking interferes with successful conflict resolution.

Not all conflict in EM can be resolved immediately, if at all. Some resolutions require the assistance of a neutral third party, such as a mediator. The immediate goal at the time of conflict is to set up the possibility of a successful, mediated solution at a later time and at an independent site.

Successful conflict resolution requires a systematic and structured approach. It is important to recognize each participant’s principal interests and underlying positions. Whenever possible, one should try to prevent conflict before it happens.

The problem with conflict is not its existence, but rather its management.1

Conflict is unavoidable and occurs in all facets of life. The opportunities for conflict in EM are numerous because our practice involves the interaction of many individuals with varying backgrounds during times of great stress, pain, and anxiety. By nature, these interactions often result in tension and conflict. Many of these interactions occur between EPs and consultants or staff members who have differing agendas and with whom limited or no previous working relationship exists. As such, involved parties may not be able to reflect on past successful interactions that can decrease the likelihood of an intense exchange.

Controversy exists about the value of conflict. Many believe that, at its best, conflict is disruptive. Most agree that, at its worst, conflict is destructive to team harmony and patient safety. However, conflict also serves as a creative force, by providing both initiative and incentive to solve problems.

This chapter describes conflict in general, suggests many of its causes, and identifies contributing factors.
Several examples of conflict specific to EM are discussed. The role of effective communication in conflict resolution is presented, as well as its role in de-escalating, minimizing, and preventing conflict. Recommendations for decreasing conflict are offered, and this chapter guides EPs through the challenges of conflict resolution in situations in which it is necessary. The ultimate benefits of resolving conflict to the patient, staff, and EP are demonstrated, including optimizing patient care, decreasing patient morbidity, and maximizing an individual’s or health care team’s overall satisfaction. Finally, several strategies to facilitate conflict resolution are reviewed.

Communication, in the form of language and interaction, and power, in terms of how conflict is managed (or mismanaged), are tremendously important in the dynamics of groups. EM practice is all about groups, because physicians, nurses, and other staff members must consistently work well together to offer patients the best possible outcomes. Louise B. Andrew, M.D., J.D., shares how important communication is with respect to creating conflict, by stating “... conflict is often the result of miscommunication, and may be 'fueled' by ineffective communication.”

Many researchers identify three important sources of conflict: resources, psychological needs of individuals or groups, and values. Resource-based conflicts relate to limited resources, with the premise “I want what you have.” Psychological needs include power, control, self-esteem, and acceptance. These needs often exist under the conflict’s surface and may be difficult to identify and address. Finally, values (beliefs) are fundamental to conflict. “Core” values, such as religious, ethical, financial, or those involving patient care, may be difficult to change. Thus, these values generally have a large role in conflict. Value differences among people or groups (e.g., health care professionals and physicians having different training) may result in repeated conflicts. Two common examples of values serving as a source of conflict (perceived or real) in EM are the different work ethics and expectations of EPs and staff members. When conflict occurs, people feel as if their existence or integrity is being attacked. This is one reason that value-based conflicts are the most difficult to resolve (Box 208-1).

Conflict may be broken down into four general types. Intrapersonal conflict occurs when one individual has conflicting values or behaviors that cause difficulty for that individual (even though others have similar conflicting values). These are the character traits comprising personality that make conflict more likely. Interpersonal conflicts occur among individuals as a result of differences of opinion or beliefs, communication styles, or goals. These conflicts are the most common in EM and generally occur between EPs and patients, nurses, or consultants. Intragroup and intergroup conflicts occur within or among groups, when decision making is necessary (e.g., staff meetings, elections, hiring, scheduling, staffing) (Box 208-2).

It is relatively easy to understand conflict in medicine if you look at physicians’ behavior. Physicians in general do not ask others for help, and they are encouraged by their training not to do so. They may have deficits in communication skills and social maturity, as well as a tendency to be perfectionists. These attributes are highly adaptive to doctoring, reinforced by training, and rewarded by society. However, these traits may be maladaptive in terms of communicating and interacting with nonphysicians. In fact, physicians tend to avoid unpleasant confrontations and typically have not developed the skills necessary to manage conflict.

To assess interpersonal interactions in the health care environment, the responses of nearly 2100 health care providers were reported by the Institute for Safe Medication Practices in a 2003 survey on intimidating behaviors. Despite the inherent biases characteristic of survey research, 88% of respondents had been exposed to intimidating language or behavior and not just from physicians. Condescending language, voice intonation, impatience with questions, and a reluctance or refusal to answer questions or phone calls occurred far more frequently than the researchers expected. Nearly half of the respondents stated that they had been subjected to strong verbal abuse or threatening body language. Among the conclusions established by the Institute for Safe Medication Practices were that intimidation clearly affects patients’ safety and that gender made little difference.

However, not all conflict in medicine is the result of intimidation. The ED environment is particularly predisposed to conflict, and conflict occurs for many reasons. Differences in professional opinion and value systems among staff members and patients are only some of the contributing factors. EPs must interact with individuals from all areas of health care, at

---

**BOX 208-1**

General Sources of Conflict

1. Real or imagined differences in values
2. Dissimilar goals among individuals
3. Poor communication
4. Personalization of generic or organizational issues

**BOX 208-2**

General Types of Conflict

1. Intrapersonal
2. Interpersonal
3. Intragroup
4. Intergroup
all times of the day and night, and during periods of great stress. The results are often tension and conflict. Depending on the size of the hospital or medical staff, and the amount of turnover among health care personnel, it is likely that EPs will not know all the individuals with whom they must interact. This situation places a burden on EPs to identify differences in communication style preferences as well as a wide range of practice patterns among medical staff members, including personal idiosyncrasies. In many circumstances, the length of time that EPs and staff members have worked at the hospital precludes previous positive experiences among these individuals.

**Examples of Conflict**

Conflict in EM may also result from a mismatch of expectations on the part of the patient, family member, provider, or consultant, as well as the nurse, ED staff, or ancillary staff from outside the ED. Patients and family members may have unrealistic expectations about their ED experience, not to mention the pain or fear that brought them to the ED in the first place. Nurses may have unrealistic expectations of physicians, especially those they do not know, and all participants may have widely differing cultural backgrounds. Although gender representation of EPs has become more equal, older EPs tend to be male, whereas nurses remain predominantly female. Dr. John Grey's best-selling book *Men Are from Mars, Women Are from Venus* (HarperCollins, 1992) comments on the frequency of misunderstandings and communication difficulties that exist between genders. Research also clearly describes communication challenges in the workplace among individuals of differing ages. Consultants may be frustrated by the ED staff, based on previous unsatisfying experiences. Additionally, each consultation disrupts a consultant's practice, social life, or sleep and is likely to result in time away from the office or home. This increase in workload may ignite a spark for conflict.

Numerous additional factors further explain the high likelihood of conflict in EM. Diversity in training, experience, and physicians' perspectives often result in differences of opinion between EPs and colleagues from other areas of medicine. This is true with nursing as well. For example, conflict arises simply from the fact that EPs do not want to send someone home who should not go home, whereas other specialists or hospital-based physicians prefer not to admit patients (and may be pressured not to) who do not require admission. Neither viewpoint is incorrect, but it is easy to see how these two opposing strategies create tension resulting in conflict.

EPs and ED staff members are expected to be patient advocates, although this role often creates conflict. Serving as a patient advocate may be contrary to a family member's interests or to what the patient ultimately desires from his or her ED visit. One common example from the ED occurs when a patient with chemical dependency wants narcotics for his or her addiction. How can this situation of declining to give narcotics not create conflict? Conflict is also common in EM over hospital admissions. A patient may desire admission to the hospital without a medical reason. His or her family may have this same desire. This results in conflict between the EP and the patient (or family members). At other times, an EP may believe that it is in the patient's best interest to be admitted to an inpatient medical service, even if hospitalization may not influence the ultimate outcome. This situation creates conflict between the EP and the admitting service. In other circumstances, conflict develops between two services over a patient's admission to the hospital when one service tries to influence the other to admit that patient. The EP must mediate the dispute between these two parties and must keep the patient's needs at the discussion's forefront.

Other areas in EM that predispose to conflict include the limited time and restricted availability of diagnostic testing. Conflict is inherent when a necessary test available at one period of the day is unavailable based on some arbitrary cutoff time, despite the full-service expectation of emergency care. Patients (and EPs) are frustrated by this situation and often take out their frustrations on EPs, other departments, or administrators involved in providing these tests or the decisions around their availability. Even consultative services and specialists are frustrated at these limitations, despite their own limited availability for providing patient care.

Perhaps the area most likely to create conflict centers on effective communication among involved parties. The importance of clarity in being understood, given the cultural and language nuances among patients, families, nurses, staff, and consultants, makes the cosmopolitan nature of the ED a setting primed for conflict. Frustrations and time demands, in addition to limited nursing, equipment, and testing in overcrowded spaces lacking privacy, may be overwhelming if communication is suboptimal or barriers to effective communication exist.

Because the specialty of EM is so complex and has tremendous liability associated with its challenging practice environment, many areas of potential conflict have been addressed at the federal, state, and local levels. Hospital policies and bylaws (especially those of the ED) attempt to address these issues by establishing guidelines to prevent conflict in certain areas. Despite these policies, common sources of conflict include patient care responsibilities of on-call consultants, minimum time standards for patients to be admitted and for hospital-based providers to see admitted patients, transfers of patients to or from outside hospitals, telephone treatment of private patients who present to the ED, and the use of the ED for directly admitting patients or various procedures. Many EM organizations have attempted to tackle these and other areas of potential conflict, based on the needs of emergency patients and profes-
sionals. Often, issues resulting in troublesome outcomes for patients, staff, or hospitals generate the greatest public attention and political awareness. As health policy and the specialty of EM continue to evolve, new challenges will be identified, and many more conflicting issues will require examination (Box 208-3).

As the specialty of EM has gained popularity since the 1980s, hospital administrators and medical staff members have increasingly come to recognize the importance of the ED and the EP’s role in health care delivery. Multiple factors are responsible, including mandatory EM exposure in medical school curricula, which has increased student exposure to our specialty, greater public awareness and acceptance of our specialty, based in part on well-conducted outcomes research, and popular television series that represent our specialty in a positive light. Many of the challenging situations that result from the nature of our practice are less likely to create conflict than in previous decades, because hospital administrators seem more willing to collaborate with ED leadership to prevent conflict before it occurs. Many leaders in EM are honing special administrative skills to allow them to exchange ideas with hospital leaders. Any opportunity for communication and idea sharing to discuss and solve problems in important areas prone to conflict, especially during “business hours” and non-threatening times, is in the best interest of patients, patient care, and the entire medical staff.

Effective communication is extremely important to the process of conflict resolution. For effective communication to take place, mutual respect and concern must exist among parties. This includes respect for an individual’s professional and personal choices. Whether it is work ethic, practice style, or lifestyle, many physicians have difficulty (consciously or subconsciously) interacting and communicating with individuals who do not share similar behaviors and values.

Physicians have often witnessed and learned attitudes, communication patterns, and styles of interaction with staff from mentors, role models, or other authority figures dating back to medical school or training. Yet successful conflict resolution often requires that parties demonstrate a willingness to listen fully to the concerns of the other party, without interrupting, planning a reply, or relying on old patterns of communication. Paraphrasing what is being said back to the concerned party, and expressing a willingness to find a common ground, may help to resolve conflict or at least attempt to de-escalate it.

Communication is often difficult, for various reasons. Many physicians do not have good listening skills. Data consistently demonstrate that physicians interrupt patients early and often; these patterns are likely present during communication with colleagues and team members, especially during stressful situations. However, this style of communication may be necessary for high-acuity situations. In the ED, time pressures make communication challenging, as does the fact that most communication occurs in a public area. Often this communication occurs by telephone, during which visual cues are not part of the equation. Furthermore, individuals often have unique or differing agendas that make it even more difficult to communicate efficiently, let alone effectively. Past interactions have a role in future communication attempts; previous negative interactions are far more likely to be remembered than are positive ones. The personalities of individuals practicing in different specialties are also likely to clash, which contributes to the likelihood of conflict.

Communication skills of physicians are not always developed with these concepts in mind. In fact, the Model of the Clinical Practice of EM, originally published in 2001 and updated in 2005, included an administrative section on communication and interpersonal issues that lists “conflict resolution” as one important subheading. A subsequent publication by multiple educators in EM similarly described the importance of integrating communication and interpersonal skills as defined by the Accreditation Council for Graduate Medical Education competencies in the education of EM residents. These essential documents guiding the training of future EPs emphasized the importance of acquiring and mastering these key skills.

A well-done three-part series of articles that focused on physician-patient communication in EM shared many pearls and problems inherent to our practice. Other excellent references described the importance of the physician-patient relationship and EP communication. The Association of American Medical Colleges, for instance, included communication in medicine as a central aspect of its Medical Schools Outcomes Project, which is intended to guide curricula in all U.S. medical schools. In 2004, the National Board of Medical Examiners began requiring all U.S. medical students to be evaluated in their communication skills as well as their clinical skills. The Accreditation Council for Graduate Medical Education now requires all U.S. residency programs to provide instruction in interpersonal and communication skills. Medical licensing bodies have identified the importance of physician communication. As a result, instruction in this area (and that of conflict resolution) is now required in EM training programs.

In clinical practice, physicians characteristically spend much of their time listening and responding to patients’ concerns. Studies have consistently found that clinicians’ interpersonal skills are not always as good as patients or nurses desire. Research has demonstrated that poor communication skills and the lack of team collegiality and trust lead to lower patient satisfaction and worse patient outcomes. Interestingly, when physicians and critical care nurses were surveyed to examine these behaviors, nearly all physicians did not consider their collaboration or communication with nurses to be problematic, whereas only 33% of nurse respondents rated the quality of these behaviors high or very high.
1. The commitment to patient satisfaction is prone to create conflict. Limited resources and lack of consultant availability increase the likelihood of conflict. Additionally, patients’ expectations for antibiotics, narcotics, or other drugs with abuse potential generate conflict. Conflict arises in emergency medicine when patients make unrealistic demands for medications, tests, consultation, return to work notices, or dispositions that are not appropriate. Additionally, long wait and throughput times often generate frustrations for patients and their families, because their time is valuable and the conditions are stressful. As a result, despite efforts to satisfy patients, conflict is common.

2. Final patient disposition may result in substantial disagreement between EPs and consultants or primary care physicians. Disposition is one of the most common areas for conflict among professionals in the ED setting. In EDs in which the final disposition is determined by hospital-based consultants who evaluate the patient in the ED, ill feelings may be generated on both sides: the EP feels powerless and unimportant, whereas the consultant feels as if he or she is doing the EP’s work. The converse is true at hospitals in which the EP makes all final disposition decisions, as generally occurs in teaching institutions.

3. Occasionally, private physicians or specialty consultants mistreat EPs by not recognizing their vital role in health care delivery and its safety net. This situation may occur when these physicians do not acknowledge the knowledge base or skill set specific to an EP’s training and experience. Conflict is likely when private physicians and consultants treat EPs as “extensions” of their own practices during evening, weekend, and holiday hours.

4. Timing of follow-up care for patients who are not admitted to the hospital, including the timing of necessary outpatient tests, often leads to disagreement between EPs serving as patient advocates and primary care or consultant physicians who may have limited access to subsequent testing.

5. In the ED, important telephone conversations about patient care often occur when one or both parties are not fully listening because of distractions, external noise, or interruptions. This unfortunate but common circumstance often leads to frustrations or conflict.

6. Conflict is likely to occur in emergency medicine as a result of differences in education, backgrounds, values, belief systems, and interpersonal styles of communication between EPs and nurses, consultants, patients, and their families, and administrators. Often these interactions are deemed adversarial, simply by the nature of the patient’s needs that the EP is trying to meet.

7. EPs are advocates for patients and for the medical staff. However, conflict is likely to arise if an EP is expected to be an advocate for both at the same time. Clearly, EPs have the primary duty of patient advocacy and not for staff physician or consultant advocacy if these outcomes are contradictory. Otherwise, this dual advocacy sets up a conflict of interest that may jeopardize patient safety.

8. Conflict between attending staff members and house staff members is prominent in teaching institutions. The attitudes toward patients or the ED of this training staff, the temporary nature of their positions (some for as little as 1 month or 1 year), and the fatigue, work demands, and personal difficulties that house staff members exhibit during training all contribute to conflict and interpersonal relationship difficulties. Furthermore, some house staff members in every institution take little pride in the manner of interaction they have with others. These same individuals may not feel that they are part of the hospital, they may not demonstrate hospital or patient “ownership,” and they may have interpersonal conflict about their career choice, thereby making conflict with others even more inevitable.

9. Conflict is common with respect to transfers and emergency care of patients with limited or no insurance (or ability to pay). Especially at hospitals that do not care for indigent or uninsured patients (unless the clinical situation mandates), arranging for transfer, consultation, and follow-up care may be extremely difficult. Often, it is downright contentious. Because differences of opinion are certain to exist, such situations almost always result in some form of disagreement or conflict.

10. Because of time limitations and the urgency of most interactions of EPs on behalf of their patients, disagreements among hospital colleagues often require EPs to move “up the ladder” and speak with higher authorities about patient care. In teaching hospitals, this means contacting an attending or teaching physician responsible for supervising a resident. These higher authorities also include specialty consultants, chiefs or chairpersons of divisions or departments, and nursing or hospital administrators. Contacting a house staff’s supervisor or a staff member’s superior results in unavoidable conflict with that initial individual, whether immediate or delayed. EPs who serve as passionate patient advocates therefore do not always have positive interactions with the entire medical or nursing staff.

Continued
Interacting with consultants is equally challenging in terms of communication and other areas likely to result in conflict. A multicenter survey from London of 171 newly appointed senior house officers demonstrated the frequency and importance of communication problems, especially with reference to consultations in the ED. These authors concluded that senior house officers serving in EDs could benefit from consultation skills training in which they are taught communication skills. It is not clear from this article how much communication training these individuals had before taking on their roles as senior house officers, or how much training or the type of training they would require. The challenges of interacting with consultants and the difficulties evaluating these interactions are described in the EM literature.[18,19]

A new era of patient care and physician training has developed. These changes are in part a response to the call by several medical organizations for improved training and competence in communication skills of physicians. The Patient’s Bill of Rights, resident work hour (duty) restrictions, and the Institute of Medicine’s Report on Medical Error released in 1999 all raised awareness of the importance of physician communication, interpersonal skills, and effective team functioning to improve patient safety. Although difficult to study, it will be interesting to see whether patient care outcomes and satisfaction within the medical profession improve over time as a result of these changes.

Many issues challenge communication in EM. Time urgency seems ubiquitous to all communication in the ED, even though many physicians and health care professionals are unaccustomed to this challenge. Disrupted sleep patterns, difficulties with challenging patients, and the uncertainty of high-risk presentations make simple communication even more difficult. As previously described, these interactions often occur over the telephone, thus obscuring facial expressions and body language that would otherwise reveal more accurate representations of events or “hidden agendas.” As a result, telephone communications are often much more difficult to manage. Multiple distractions, frequent interruptions, background noise, concerns about other patients, and frustrations with the ED or the consultation process often result in fractured communication. This situation is likely to create strain in the relationships of colleagues and consultants over time, if not immediately. Therefore, an established communication style and rules (when possible) for unavoidable telephone consultations are integral to the smooth operation of the ED.

Rosenzweig defined emergency rapport as a “working alliance between two people,” including recognizing each other’s needs, sharing information, and setting common goals. He went on to write “. . . rapport implies mutuality, collaboration, and respect, and is built upon a groundwork of words and actions.”[12] Although the rapport Rosenzweig referred to describes physician-patient interactions, it can just as easily (and perhaps more importantly) be used to describe interactions among physician colleagues or health care workers.

Finally, the role of stress on physician communication must not be overlooked. It is stressful for EPs to contact physicians about patient care issues, particu-
larly in the middle of the night. It is especially difficult for EPs to contact physicians who have hospital leadership roles, reputations of demeaning behavior, or senior positions that may affect partnership opportunities or future employment. These situations may directly or indirectly result in less than optimal patient care when an EP’s desire to avoid conflict becomes the first priority.

Costs of Conflict

With these issues in mind, what are the costs associated with conflict in EM? Some may be surprising, whereas others are likely intuitive. First, staff morale and staff retention are likely to be low in EDs with high levels of conflict. Staff turnover and dissatisfaction with the work environment are also likely to be high. Management must address an increasing number of complaints, not only from within the ED but also from other areas of the hospital. This takes up valuable administrative time that could instead be used for improving conditions in the ED. If conflict interferes with patient satisfaction, throughput, and efficient care, reimbursement may decrease, which affects salaries for ED staff members. Pride in the ED may decline, thus further reducing morale and creating a potentially debilitating negative spiral. Research has also shown other costs of conflict. In 1986, Knaus and associates demonstrated that predicted and observed patient death rates appeared related to the interaction and communication among physicians and nurses. In this prospective study from intensive care units at 13 tertiary care medical centers, controlled for APACHE II (Acute Physiology and Chronic Health Evaluation II) scores, patient mortality appeared related to the degree of intergroup conflict. The authors concluded that the “degree of coordination of intensive care significantly influences its effectiveness.” Although not studied directly, interpersonal or intergroup conflicts also likely result in decreased patient safety.

The impact of conflict (and poor conflict resolution) on EPs and ED staff members is also important. In addition to making the ED an unpleasant place to work during an EP’s shifts, increased stress and decreased job security for the EP are possible. Reduced reimbursement compared with peers may occur, thus causing even greater professional dissatisfaction. These conditions may lead to isolation, withdrawal, or depression. Substance abuse and alcohol or chemical dependency are possible, as are marital strife and family or other personal difficulties common in physicians who repeatedly generate conflict with others. Not all stress is perceived or experienced in a similar manner; this is particularly true of staff members of different gender, culture, training, and generations. Medical errors are likely to occur more frequently, a situation that may compromise patient care and reduce patient care outcomes. Patients are likely to identify conflict among staff members, and the result may be lower patient satisfaction. The emotional and financial costs to patients, staff members (especially nurses), consultants, managers, and administrators are immeasurable if an EP frequently creates conflict and does not possess the skills to minimize it or to resolve it promptly.

Conflict Resolution

If conflict is a disruptive force in EM, conflict resolution and the skills necessary to achieve it are key factors for successful patient care. Simply stated, conflict management depends on effective communication among parties. In his popular book, People Skills: How to Assert Yourself, Listen to Others, and Resolve Conflicts, Robert Bolton offers a simple three-step method for conflict resolution:

1. Treat the other person (party) with respect.
2. Listen until you “experience the other side” (reflect content, feelings, and meanings by restating the other parties’ views to their satisfaction).
3. State your views, needs, and feelings.

Several additional methods specific to the practice of EM are described in this section, although Bolton’s method breaks down this exigent process into these three essential components.

Conflict resolution has been defined many ways, but each definition comments on the importance of the present interaction and its impact on subsequent interactions during inevitable future conflict. The 2005 Nobel Prize in Economic Sciences was awarded to two researchers of Game Theory (a branch of applied mathematics) and its role in studying interactions and managing conflict among groups or people. This theory relates that the actions of one party in a conflict affect its adversaries’ subsequent behavior. John Nash (the subject of the book A Beautiful Mind) and two other scholars brought public awareness to the concept of Game Theory when they received the Nobel Prize in Economics in 1994.

Individuals, groups, and organizations employ many responses to conflict (Fig. 208-1). Interestingly, styles of response have been described as related to
This style is characterized by low assertiveness and high cooperativeness, and it can be either an act of selflessness or one of obeying orders. The goal of this method is to yield or give in, typically by ignoring or neglecting one’s own concerns to accommodate those of the other party. It may be useful for issues of little importance, or for creating good will and demonstrating reasonableness. Unfortunately, the accommodator can harbor ill will if this style becomes dominant and is abused by others. In the extreme, this style may result in poor patient outcomes.

In the compromising style of conflict resolution, both parties “win some and lose some.” Made famous by television personality Monty Hall, “Let’s make a deal” best describes this style’s philosophy. This method has moderate assertiveness and cooperativeness and involves negotiating or splitting any differences of opinion. The goal is to find some middle ground, often expeditiously, and to exchange concessions, unlike the more time-consuming style of collaborating. The compromising method may be helpful in issues of moderate importance, especially when time constraints exist.

In the competing style, a contest within the contest is the goal of the competitors. This style results in someone’s winning and someone’s losing (“my way or the highway”). High assertiveness and little cooperativeness dominate this interaction. This style may have utility when making unpopular decisions, especially for a leader or manager. This style tends to create quick results, and it may be used when bargaining is not an option or the position you support is undeniably correct. This style is, however, very one sided and is likely to be unpopular with others.

Collaborating, although the most complex style of conflict resolution, is ultimately the method to adopt when possible. Its outcome generally causes both sides to win. Collaboration is one of the main tenets of “win-win” negotiations, by taking on the philosophy that “two heads are better than one.” Characterized by high assertiveness and high cooperativeness, this style is best used for learning, integrating solutions, and merging perspectives. Digging into the issues, exploring them in depth, and confronting differences are components of this method to manage conflict. This style often results in increased commitments and improved relationships among involved parties.

The distinct advantages to using the collaborating approach are that relationships are preserved for future interactions, and substantive outcomes may be achieved. This approach to dealing with conflict is the most challenging and perhaps takes the longest to negotiate. As such, the collaborating approach may be difficult in the time-pressured setting of the ED. However, ideal outcomes can be obtained if the willingness and the resources exist to pursue the collaborative method.

In the book Gandhi’s Way: A Handbook of Conflict Resolution, Mahatma Gandhi examined the principles...
of moral action and conflict resolution, with the goal of finding satisfying and beneficial resolutions to all involved.\footnote{Gandhi used the term satyagraha, which means “grasping onto principles” or “truth force.”} The basic premise to Gandhi’s approach to conflict is to redirect the focus of a fight from persons to principles. He assumed that behind any struggle lay a deeper clash, a confrontation between two views that were each in some measure true. Every fight, according to Gandhi, was on some level a fight between differing “angles of vision” illuminating the same truth.

A contemporary phrase used when dealing with two perspectives is that “the truth lies somewhere in the middle.” Considering this concept, it is relatively easy to see why conflict is so prevalent in society, because opposing opinions are likely to exist in politics, health care, and interpersonal interactions, to name a few, and little effort is expended on finding the middle ground.

Conflict resolution in EM has a significant role with respect to effective patient care, as well as positive interpersonal and intragroup relations. Successful communication is integral to promoting positive interactions among individuals, in an effort to prevent (or minimize) conflict before it becomes detrimental. However, poor communication among individuals may provide the potential for ongoing conflict and misunderstanding.

Building alliances with colleagues may reduce the potential for and the amount of conflict. As a visitor to the internationally renowned Centre for Conflict Resolution in Capetown, South Africa, I learned that team building and the promotion of constructive, creative, and cooperative approaches to the resolution of conflict are key elements of this institution’s success. Off-site exercises encourage input from the entire staff (at all levels) about their experiences. These meetings (referred to as “growth sessions”) are regularly scheduled, yet they may occur when a particular need is present. These exercises allow all team members not only to be heard, but also to feel valued.

One team-building exercise done in our ED included a mandatory off-site meeting that included food, programs, and exercises. Led by non-EM professionals and supported by hospital administrators, this collaborative activity allowed ED staff members the opportunity to interact with each other outside the workplace in a relaxed setting. Throughout the day, opinions were solicited, voices were heard, hierarchies were eliminated, and friendships were kindled. Although the session was expensive, group dynamics improved dramatically following this event, including a reduction of animosity between staff members and a greater desire to work together and to solve problems to meet common workplace goals. It is difficult to measure the costs (direct and indirect) that resulted from interpersonal conflict in our ED on a daily basis, but staff members who remain years after this activity remember its value. It was wise of hospital administrators to recognize the importance of such a mandatory exercise to reunite the ED staff and to reestablish its patient-centered philosophy.

**Challenges to Conflict Resolution**

EPs interact with numerous individuals of varying backgrounds, interests, and goals on such a regular basis that this is part of our hospital experience. It is one we take for granted and generally do not find particularly difficult. However, other physicians on staff may not have a similar comfort level with these frequent interactions with such a diverse group of people. Successful EPs must be leaders within the ED (with respect to their clinical responsibilities), yet other staff members may not feel comfortable with their leadership style. This is particularly likely during stressful situations, when EPs gravitate toward the competing style of conflict resolution. Individuals who seldom use the ED (patients, families, consultants) may have even more difficulty being comfortable with the environment and the interactions related to it, because these “guests” of this unusually challenging environment are not familiar with its structure. Unfortunately, the ED does not always offer the kind of treatment that other health care professionals have come to expect. For example, in the operating suite, a surgeon is handed instruments in exactly the way he or she prefers by a designated individual who caters to that surgeon’s personal style. This is done in both the patient’s and the surgeon’s best interests. In the ED, however, as a result of staffing shortages or more pressing cases, there is often no one available to cater to the consultant’s needs. This situation often results in problems for staff members, who may inappropriately take their frustration out on EPs or the ED. Conflict is likely to result, and the patient and the ED staff members suffer. ED staff members may feel frustrated that they cannot do better in the eyes of the medical staff, but they are also frustrated by the challenges of staffing, the needs of patients, and the demands of multitasking that prevent them from being more accommodating.

With all this conflict occurring in the ED, what are some methods used by EPs to reduce or resolve it, to maintain the best possible patient and provider satisfaction, without compromising patient care? Drs. Marco and Smith developed 10 principles of conflict resolution in EM.\footnote{These principles seem quite reasonable to adopt into practice. On closer inspection, some are similar to the principles described by Robert Fulghum in his popular book (in its 15th edition) entitled *All I Really Need to Know I Learned in Kindergarten* (Ballantine Books, 2003) (Box 208-4). Marco and Smith’s last principle (be pleasant) is good to keep in mind during high-stress situations, when conflict is especially likely. Remember that kindness is contagious. Everyone benefits from a pleasant disposition, regardless of previous negative interactions. Dropping to a lower level of unpleasant or unprofessional interactions has no benefit; EPs.}

Marco and Smith’s last principle (be pleasant) is good to keep in mind during high-stress situations, when conflict is especially likely. Remember that kindness is contagious. Everyone benefits from a pleasant disposition, regardless of previous negative interactions. Dropping to a lower level of unpleasant or unprofessional interactions has no benefit; EPs.
should make it their “standard of care” to refrain from this behavior and to rise above it during conflict.

In a similar, well-written article, O’Mara focused on the interrelationship between communication and conflict resolution. She stated that “each relationship presents its own potential for ongoing communication dynamics, which may include conflict and misunderstanding.” She added that “appreciating alternative viewpoints and a willingness to adapt are prerequisites for managing interpersonal conflict.” Competent EPs are experts at adapting to many situations, and they should consider good communication a fundamental part of their skill set.

**Relationships in the Emergency Department**

Certain unique aspects of the EP-patient interaction may lead to conflict. First, the nature of this interaction is new, intense, unexpected, brief, and unselected. Neither the patient nor the EP chooses the other; instead, they become “connected” by schedule and circumstance. This is the nature of emergency care. Furthermore, despite how EPs at times may seem powerless and without control, the balance of power in any doctor-patient relationship is unequal. Each “side” has a different perspective on the nature of the emergency condition. Not only is the anxiety associated with the condition itself of great concern, but other concerns exist as well, including work, family, finances, disability, morbidity, and mortality. Furthermore, the timing of care—how long is appropriate to wait for tests, results, consultants, an admission bed, or discharge instructions—creates conflict and, often times, animus. In these situations, mismatches between patient and EP expectations and perspectives often result in conflict that can be intensified by social, cultural, ethnic, and language differences.

Perhaps the most intense interactions EPs have are with the nursing staff, not only because of the need for successful interaction at any given moment, but also because these interactions recur daily. Poor interactions between physicians and nurses are often remembered during subsequent interactions. Nurses are likely to interpret words, communication, and body language in the context of prior less than ideal interactions. The doctor-nurse relationship has been examined for years, because the ability of these two groups to communicate has a definite impact on patient care. In ground-breaking research examining these relationships, Stein and colleagues determined that one of the greatest negative influences on patient outcomes occurred when the nursing profession lacked the opportunity to communicate with physicians. EDs that inadvertently encourage authoritarian behavior and attitudes in their EPs are at risk for lower morale among nursing staff. This appears to be true in EDs with training programs, in which the hierarchic nature of training may extend to communication efforts. Enhanced relationship building between nurses and EPs includes improved communication styles and techniques aimed at conflict resolution.

Conflict resolution between EPs and consultants may be difficult to achieve, given the episodic nature of consultation, often occurring during inopportune times for both individuals. Although the immediate outcome of the interaction may seem appropriate to the EP (serving as patient advocate), the “scars” from this interaction may be deep. Suboptimal interactions may result in several responses, such as avoiding each other, harboring ill feelings toward that individual or department, sharing these feelings with others (“professional slander”), or reporting to administrators of respective departments. In all cases, the earlier that problem interactions are addressed, and the more directly, the better future outcomes are likely to be. Addressing these difficulties with the goal of conflict resolution is best done in a non-threatening collegial environment. Taking the “personal” out of the problem is always wise, and seeking assistance from skilled, unbiased “outsiders” is a good idea if these problems are not easily handled. Given physician’s temperaments and busy schedules, outside resources may be difficult to schedule, but they are necessary. These resources include chiefs or chairs of respective divisions or departments, ambassadors or communication experts selected by hospital administrators who specialize in interpersonal problems, ombudspersons, mediators, human resource managers, social workers, licensed therapists, and psychologists and other mental health professionals.

Effective communication among colleagues has been demonstrated to improve patient outcomes at
many levels, and it is certain to improve subsequent interactions. Every effort should be made to have face-to-face meetings with consultants when they come to the ED. Shared educational activities with consulting colleagues are also important, whether it be journal review, didactic sessions such as Grand Rounds or other lectures, or question-and-answer opportunities, as long as there is a clear goal of education and not criticism. These opportunities allow colleagues with different training to communicate patient care principles, to discuss areas of changing or unclear practice, and to resolve potential conflict before it occurs. These interactions allow consultants the opportunity to recognize our knowledge and to see that EPs are interested in gaining skills to provide better patient care and to accommodate specialty consultants more readily. Furthermore, it is important for EPs to attend social activities within or outside the hospital, where they can get to know the medical staff members. Having positive personal interactions with non-EM colleagues away from the stressful environment of the ED is a wonderful opportunity for building alliances that may reduce the amount and intensity of conflict. This approach is also more likely to ensure faster conflict resolution in the future.

Some of the best-known writings about conflict resolution are from the business world. The Harvard Negotiation Project found that a working relationship depends on the ability to balance reason and emotion, and on the ability to understand each other’s interests or position. Positive working relationships also require good communication, dependability, the use of persuasion rather than coercion, and mutual acceptance of each other’s differences. In the seminal works Getting to Yes and Getting Past No, the authors discussed negotiation in terms of its being an everyday experience or a fact of life. These resources described the method of principled negotiation, which decides issues on their merit rather than through a haggling process focused on what each side says it will and will not do. This method suggests looking for mutual gains whenever possible. When interests conflict, individuals should insist that the result of negotiation be based on some fair standards independent of the will of the other side. This method of principled negotiation is therefore “hard on the merits, soft on the people.”

In his book You Can Negotiate Anything, Herb Cohen (self-proclaimed to be the world’s best negotiator) offered three crucial variables for negotiations: power, time, and information. Power is in the hands of the EP in the sense that he or she may use the phrase “I am not comfortable with that (advice),” or “I would like you to come in and see the patient now (let’s discuss this at the bedside).” Power may, however, undermine negotiation and conflict resolution. Those with power have less to gain from negotiation, and they often walk away from the process (avoidance style of conflict resolution), because withholding participation may maximize their power (or at least not result in its loss). Many authors believe that a collaborative approach to conflict resolution minimizes the role of power in negotiations.

Time is not always on the side of the EP, and it may shift the balance of power to the consultant. Again, the EP must serve in the role of single advocacy for the patient; dual advocacy for both the patient and the consultant may result in a conflict of interest, thus jeopardizing patient care.

Information may be shared among parties. The EP has information about the patient’s condition at the bedside in real time, and the consultant often has a special knowledge base or skill set to offer the patient or the EP. Parties may exchange information that benefits themselves, patients, or both, and it must be considered in the conflict resolution “equation.”

Cohen’s mantra for successful bargaining is to “be patient, be personal, (and) be informed.” Preparation, an important element before negotiations, is sometimes difficult or impossible in EM. However, several opportunities exist to increase preparation before consultation (which should be considered a negotiation). Efforts such as having the patient’s identifying information immediately available at the time of the conversation, reviewing the laboratory and radiographic results before the call if possible, and clearly defining the specific goals of the contact (“I need you to come in and evaluate this patient,” or “I need your input on testing, treatment, or follow-up care strategies for this patient”) help to reduce conflict.

Fisher and colleagues’ book Getting to Yes recommends that negotiators develop their best alternative to a negotiated agreement, which can serve as the basis for exploring and evaluating options. This approach involves thinking carefully about what will happen if the parties cannot reach a negotiated agreement, and it simultaneously serves as an impetus to engage in a process to try to reach such an agreement (Box 208-6).

Several specific skills are effective in resolving conflict. Feedback and communication begin with
General Principles of Conflict Management

1. Creating trust: This occurs by understanding and being perceived as understanding the other party’s issues.

2. Effective listening: This is the first step toward understanding the problem. Be careful not to project your understanding of the situation based on your experiences; the present situation and experiences are those of the individual. Successful responses after careful listening are neutral and without criticism. They allow concerns to be expressed, accepted, clarified, and perhaps validated. Empathy is a wonderful response to integrate at this stage of effective listening.

3. Eye communication: This allows the speaker to feel heard and to feel that what he or she is saying matters.

4. Focus on the issue, not the position: It is always best to bring the discussion or negotiation back to a level playing field by concentrating on the issue, not on the position.

5. Separate the individual or group of individuals from the problem: Effectiveness in dealing with conflict in part depends on this ability. Success requires the recognition that most people are not trying to create problems, but in fact are trying to meet their own needs. The key is to remember that others have different perceptions of reality from ours, and these perceptions are equally valid. Therefore, understanding their underlying or preexisting perceptions is important to resolving conflict.

6. Responding to emotion: Responding emotionally to an emotional situation reflects a loss of control. Maintaining composure and continuing to focus on the issue enhance the resolution process. Silence is an effective alternative response to an emotional interpersonal conflict. The power of silence is profound, and it often de-escalates heated situations.


careful, empathic listening. Avoiding negative comments or ridicule (especially public) and depersonalizing the conflict are healthy approaches to its management. This method allows the other party to maintain self-esteem and self-respect. Remaining objective while focusing on the issues is the best approach to dealing with the conflict.

Louise Andrew, M.D., J.D., an EP who is also an attorney-mediator, suggests “paraphrasing the communication back to the complainer” and “expressing a willingness to find a common ground.” This approach is of critical importance because conflict is often generated (and many times escalated) as a result of one side’s fear that their concern will be neither heard nor validated. Andrew described four As to make her point:

1. Acknowledge the conflict (“I understand your concern. I can tell you are not pleased with what has taken place.”).
2. Apologize (blamelessly) for the situation (“I’m sorry this situation occurred.”).
3. Actively listen to the concern (“Please go on. I want to hear more about this.”).
4. Act to amend (“I promise I will act to fix this situation and [try] to make certain it doesn’t happen again to someone else.”).2

Working together with others can create community, which affords the opportunity to develop creative solutions to resolve conflict. In this manner, conflict can be productive, rather than destructive. When possible, an attempt at solutions acceptable to all involved parties should be made. Addressing value differences resulting in the conflict (or making resolution difficult), establishing effective styles of communication (including active listening without interruption), and having all parties commit to the mutually satisfying resolution of these concerns are key factors to success. Given the challenging dynamics of EDs, and the instability of work groups, prompt conflict resolution is vital to the health of the system. It is especially important to acknowledge shared responsibilities for problems (and solutions) within the ED environment. In this manner, stakeholders have ownership, pride, and incentive to correct the situation. Prevention of potential conflict remains the superior approach to conflict resolution. When that is not possible, early intervention by trained and respected individuals in a safe haven for discussion is the next best approach.

Several models for conflict resolution exist in the literature, thus providing evidence that it is a much-needed skill. Box 208-7 combines ideas and protocols resulting in a detailed, logical, and multifaceted approach to conflict resolution.

Failure of Real-Time Conflict Resolution

When it is not possible to resolve conflict in real time, it may be necessary to have an outside mediator work with the parties. A well-written article on this topic in the Canadian Journal of Emergency Medicine reported that “... while early intervention through negotiation between conflicted parties is often the most desirable option, there may be situations where a dispute involves power imbalances, in which case resolution may be more achievable using the neutral facilitative approach provided by a third party media-
Dr. Andrew defined mediation as a “process that takes negotiation to its highest level, employing a neutral party to help hurt and angry people communicate effectively and draft collectively a solution that is greater than the sum of the problems.”

Mediation should be nonadversarial. Typically, it is scheduled at an unbiased location, away from the ED, at a time convenient for all parties. Scheduling the session takes time, and a good mediator meets with both parties privately before arranging a joint meeting. It is important that rules be established and agreed on before the meeting. Such rules may include treatment of the other party with respect, an agreement not to interrupt or use negative nonverbal communication, confidentiality, and allowance of time for each party to process ideas and information, because the conflict and this process are likely to create emotional intensity that may interfere with the ability to process information. Even if the parties do not like or respect each other, they should at least accept that they have different value systems. This seemingly small concession has a tremendous impact on resolving conflict. Finally, agreeing ahead of time to consider all ideas as valid, even if these ideas are not implemented, offers both parties more confidence that their ideas will be heard (see Fig. 208-1).

**Benefits of Conflict Resolution**

Skillful negotiating techniques embody an empowering, active, constructive, and positive approach to resolving difficulties and, as such, may yield successful outcomes or incremental change over time. Numerous benefits result from the successful resolution of conflict. Many of these are obvious, whereas others may not be readily identified (Box 208-8).

These positive outcomes of conflict resolution also have a definite long-term impact. Professional satisfaction increases, as do overall personal satisfaction and workplace harmony. These improve physician and staff longevity, patient safety, clinical outcomes, and cost savings, because less money will need to be diverted to grievance assistance, staff rehiring and retraining, medical-legal risk prevention, and litigation. The ultimate benefit of successful conflict resolution is the production of a more collaborative work environment, in which the ED runs more efficiently, with fewer frustrations and problems resulting from ineffective communication and inappropriate interpersonal or intragroup interactions.

**Red Flags Associated with Conflict and Inadequate Conflict Management**

In several areas, conflict may result in problems for patients and staff. Some of these “red flag” areas of conflict and poor conflict management are described in Forte’s article “The High Cost of Conflict.” Not all problems can be described in economic terms, however. Notably, the provision of suboptimal patient care, in part the result of decreased communication...
and teamwork related to fear of approaching or interacting with staff members, is a tangible concern borne out in the literature. An EP’s desire to avoid conflict may place patients at risk by causing specific delays or inadequacies in care. For example, an EP may not consult a specialist based on some unrelied conflict with that consultant in an area outside his or her expertise. Clearly, this behavior jeopardizes patient care, and it does nothing to improve subsequent interactions (see Red Flags box).

**Summary**

Conflict has been described as a natural consequence of incompatible behaviors and unmet expectations. The best way to manage conflict is to prevent it from occurring, which is not an easy task. Experts agree it is best to take action before these inevitable clashes spread beyond the source. Effective communication among individuals and within groups, in which parties are respected and listened to, produces an environment of trust. This situation is worth striving for because everyone, especially the patient, benefits.

A conflict resolution process should be in place before conflict occurs. Although stressful, conflict should not be considered a threatening situation if the environment has established rules, known to staff members, by which this process occurs. EPs should be aware of their behaviors and styles of interaction that increase conflict in an environment predisposed to conflict. Furthermore, EPs should strive to understand the principles of conflict management that may help them to achieve resolution. When neutral, outside parties are needed to address conflict, added time and stress are likely for the parties involved. When possible, mediators should encourage parties to agree to collaborate and should reach consensus decisions using interest-based negotiations that promote greater workplace harmony. If this process fails, arbitrators may be needed to make a unilateral decision, which may or may not afford mutual gain.

In their article on “Professionalism in Emergency Medicine,” Finkel and Adams described the commitment that EM physicians must make to our profession: suspension of self-interest, honesty, authority, and accountability. These elements are also essential for successful conflict resolution. These authors concluded that “... medicine can never succeed as a transaction; it can only succeed as a partnership, a trusting exchange with patients, which is the hallmark of professionalism.” Attitudes of and behaviors by EPs that enhance trust through placing the patient’s needs above other interests serve as the operative definition of professionalism. This philosophy, extended beyond patients to hospital staff members and consultants, suggests the approach physicians should take to resolve conflicts in EM. Effective communication and interpersonal skills promote a culture of teamwork, which, with professionalism and conflict management techniques, are essential components of successful EM practice.

Taoism has as its quintessential ideas guidelines for conflict resolution, which it describes as realizing harmony with one another and achieving consonance with nature. The Art of War, written 2400 years ago by the Chinese military philosopher Sun Tzu, is considered one of the most highly appreciated strategic texts in today’s business world. Many translations of this work share important philosophic points, such as “winning without fighting” (no conflict) and “knowing your enemies and yourself” (to prevent conflict, or, if inevitable, to be more successful in its resolution). In conflict, one must consider the other party an equal, with real issues and needs, and not an adversary to be overcome. Winning at another’s
expense does not work if future collaboration is necessary, as is generally the case in EM practice. Successful conflict resolution requires collaboration in which both sides have at least some of their needs met, even if to varying degrees. If one side does not respect the other, or if judgment is passed, confrontation will continue and conflict will not likely be resolved. Truly collaborative solutions, such as those in which both parties feel supported, respected, and satisfied that their needs were met, should be the focus behind the resolution of any conflict.

Acknowledgments

I am grateful to Lou Binder, M.D., for generously sharing his materials, and Laura K. Kerr, M.S., M.A., Ph.D., for her thorough review of this chapter. I would also like to thank Doris Hayashikawa and Kandi Praska of the Kaiser Permanente Medical Center Health Sciences Library, Santa Clara, California, for their help in assembling literature for this research.

REFERENCES
