Conflict is inevitable. Opportunities for conflict in emergency medicine (EM) are numerous because individuals with different backgrounds and divergent agendas interact over important concerns (e.g., patient care or resource use). By nature, these interactions take place under time constraints, which often exacerbate conflict. Many interactions between emergency physicians (EPs) and patients, family members, staff members, or consultants occur with limited or no previous working relationship or when prior interactions have been problematic. As such, involved parties may be unable to reflect on prior successful interactions, an approach that often decreases the likelihood of 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 outcomes. However, conflict also serves as a creative force, providing both initiative and incentive to solve problems.

This chapter describes conflict in general, identifies contributing factors, and offers several examples specific to EM. The importance of effective communication in conflict resolution is presented, as well as its role in de-escalating, limiting, and preventing conflict. This chapter offers strategies to facilitate successful conflict resolution. Conflict resolution ultimately benefits patients, staff, and EPs by optimizing patient care, decreasing patient morbidity, improving patient safety, and maximizing an individual’s or health care team’s overall satisfaction.

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 is very much about group dynamics because physicians, nurses, and other staff members must consistently demonstrate successful teamwork to offer patients the best possible outcomes. Louise B. Andrew, MD, JD, stated “… conflict is often the result of miscommunication, and may be ‘fueled’ by ineffective communication.”

Three important sources of conflict have been identified: resources, psychological needs of individuals or groups, and values. Resource-based conflicts relate to limited resources, common in EM. Psychological needs include power, control, self-esteem, and acceptance. These needs often exist under the conflict’s surface and can be difficult to identify or address. Values (beliefs) are fundamental to conflict. Core values, such as religious, ethical, financial, or those involving patient care are difficult to change and therefore generally assume a large role in conflict. Value differences among people or groups (e.g., health care professionals and physicians with different training) may result in repeated conflicts. The expectations that EPs have of hospital and emergency department (ED) staff regarding work ethic or efficiency, for example, often result in conflict (perceived or real). Under these circumstances, people feel as if their integrity is being questioned, and this is one reason that value-based conflicts are extremely difficult to resolve.

Conflict in medicine is relatively easy to understand if one considers physician attributes, such as a tendency toward perfectionism and delayed social development. These characteristics are highly adaptive to doctoring, reinforced
by training, and rewarded by society. These traits may be maladaptive when it comes to communicating and interacting with nonphysicians, however, with resulting conflict and poor conflict management.

The ED environment is particularly predisposed to conflict for many reasons. Differences in professional opinion and value systems among staff members and patients are contributing factors. EPs must interact with individuals in all areas of health care, at any time of day or night, and during periods of great stress. EPs are unlikely to know everyone on every service with whom they must interact. This challenges EPs because they are not familiar with each medical staff members’ idiosyncrasies, preferred practice pattern, or communication style. These interactions create even greater difficulties for new EPs, who lack histories of favorable reputations or successful relations with hospital staff, thus significantly increasing the likelihood of conflict.

EXAMPLES OF CONFLICT

Conflict in EM results from a mismatch of expectations among patients, family members, providers, or consultants, as well as among nurses, ED staff, or ancillary staff 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. Nurses may have unrealistic expectations of physicians and generally have widely differing backgrounds. Although gender representation of EPs has become more equal, older EPs tend to be male, whereas nurses are predominantly female. Misunderstandings and communication problems exist in the workplace between genders and age groups. Additionally, each time a consultant is contacted, his or her practice, social life, or sleep is disrupted. This added workload alone may ignite conflict.

Numerous additional factors further explain the high likelihood of conflict in EM. Diversity in training, experience, and perspective often result in differences of opinion between EPs and colleagues from other areas of medicine, including nursing. For example, conflict arises simply because EPs do not want to send someone home who should not go home, whereas hospital-based physicians or specialists may prefer not to admit (or may be pressured not to) patients who do not require admission. These two opposing “forces” create conflict.

The responsibility of patient advocacy assumed by EPs and ED staff often creates conflict because it may not coincide with the interests of the patient or family members. If a patient’s decision-making capacity is impaired or their legal advocate is not present, EPs have the duty to act in the best interest of the patient, state, or society, regardless of the patient’s wishes. One common challenge occurs when a patient with a history of substance abuse and chemical dependency demands narcotics for “pain.” An EP’s refusal to prescribe narcotics is certain to create conflict. Conflict also occurs when a patient or family member desires admission to the hospital without medical justification, a test that is not indicated or available (or may be harmful), or consultation with a specialist that is medically unnecessary or inappropriate at that time. 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, and this creates conflict with the admitting service. Conflict may also develop between two services over which service will admit a patient. The EP must mediate this dispute while keeping the patient’s needs and interests at the discussion’s forefront.

Perhaps the area most likely to create conflict is ineffective or incomplete communication between or among two or more parties. Given cultural and language differences among patients, families, nurses, staff, and consultants, communication challenges prime the ED for conflict. Frustration, unmet expectations, time constraints, and limitations on staffing, equipment, space, and 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 practice environment, many areas of potential conflict have been addressed at federal, state, and local levels. Hospital policies and bylaws have established guidelines addressing these issues, in an attempt to prevent conflict before it occurs. Despite these policies, conflict still occurs. EM organizations are addressing these and other areas of potential conflict, based on the needs of emergency patients and professionals. As health policy and the specialty of EM evolve, new challenges will be identified, with more issues requiring resolution (Box 209.1).

### BOX 209.1 Areas of Conflict Related to Emergency Medicine

1. Differences in education, background, values, belief systems, and interpersonal styles of communication between EPs and others
2. Commitment to patient satisfaction
3. Final patient disposition (and who determines this)
4. Timing of follow-up care and outpatient tests for released patients
5. Telephone conversations required for patient care issues
6. Lack of professional respect from primary physicians or consultants
7. Dual advocacy expected by others for the EP
8. Teaching hospitals with house staff who may lack communication and conflict resolution skills, have less commitment to the hospital, patients, or ED staff because of temporary scheduling at that hospital or ED, and sense a lack of input, ownership, and control over patients’ (or their own) lives
9. Patient transfers to or from the ED
10. Time limitations and urgency
11. Practice variability, including patient hand-offs
12. High patient acuity and volume
13. Space issues and patient privacy
14. Federal or hospital reporting mandates
15. EM practice, such as caring for multiple patients with limited information, with risk of great morbidity and mortality
16. Threat of litigation related to high stakes, clinical challenges, and patient’s lack of previous personal relationship with EPs

ED, Emergency department; EM, emergency medicine; EP, emergency physician.
Many challenging situations that result from the nature of EM 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 EM leaders are sharpening administrative skills to allow them greater success when exchanging ideas with hospital leaders. Opportunities for communication, education, and problem solving in areas prone to conflict, especially during “business hours,” are in the best interest of patients and the entire medical staff.

**IMPORTANCE OF COMMUNICATION**

Effective communication is extremely important to the process of conflict resolution. For effective communication to occur, mutual respect and concern must exist between parties. This includes respect for an individual’s professional and personal choices. Many physicians have difficulty interacting with individuals who do not share similar values, such as work ethic, practice style, or lifestyle.

Communication is difficult for various reasons, especially because many physicians are poor listeners. Physicians interrupt patients early and often; these patterns are likely present during communication with colleagues and team members, especially during stressful situations. In the ED, time constraints make communication challenging, as does the fact that most communication occurs in a public area. Communication often is done by telephone or electronically, which eliminates visual cues. Furthermore, individuals may have unique or differing agendas that make it even more difficult to communicate efficiently, let alone effectively. Past interactions affect future communications. Previous negative interactions are far more likely to be remembered than are positive interactions. The personalities of different specialists often clash, thus contributing to the likelihood of conflict.

The role of stress on physician communication must not be overlooked. Besides patient care stressors, contacting physicians about patient care issues, particularly at night, is stressful for EPs. It is especially difficult for EPs to contact physicians with hospital leadership roles, with reputations of demeaning behavior, or in 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 takes priority. Fortunately, instruction in communication and conflict resolution is required not only in EM training programs but also by medical schools and other residency training programs.

**COSTS OF CONFLICT**

What are the costs associated with conflict in EM? Staff morale is likely to be low in EDs with high levels of conflict. Staff turnover and dissatisfaction with the work environment are likely to be high. Management will probably need to address an increasing number of complaints about the ED from it and other areas of the hospital, and that takes up valuable administrative time. Conflict interferes with patient satisfaction, throughput, quality of care, and patient safety. Pride in the ED may decline, thus further reducing morale and creating a potentially debilitating negative spiral.

Conflict (and poor conflict resolution) increases the likelihood that the ED is an unpleasant place to work; this increases stress and decreases everyone’s job security. Reductions in physician reimbursement, staff salaries, and positions may result, causing even greater professional dissatisfaction. Medical errors are likely to occur more frequently, errors that further compromise patient care and reduce patient outcomes. 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 identify his or her contribution, to minimize it, or to resolve it promptly.

**CONFLICT RESOLUTION IN EMERGENCY MEDICINE**

If conflict is a disruptive yet inevitable force in EM, conflict resolution and the skills necessary to achieve it are key factors for favorable patient care. Conflict management starts with effective communication among parties. Successful conflict resolution therefore requires parties to demonstrate a willingness to listen fully to the concerns of each other, without interrupting or planning a reply. Expressing a willingness to find common ground may help resolve conflict or at least de-escalate it. A healthy approach to conflict resolution includes treating the other person with respect, active listening (e.g., paraphrasing, demonstrating understanding), and clarifying one’s own needs and perspective.

Conflict resolution for today’s interactions is crucial to tomorrow’s triumphs because future conflict is inevitable. Individuals likely adapted their approach to conflict management based on what “worked” for them in childhood, or from observing mentors. Conflict itself is not necessarily problematic, but how individuals (or organizations) deal with it may be. Five distinct responses to conflict can be plotted using the axes of assertiveness (the extent that individuals attempt to satisfy their own concerns) and cooperativeness (the extent that individuals attempt to satisfy the concerns of others) (Fig. 209.1). Each of these responses to conflict or approaches to resolving it has advantages and disadvantages and circumstances when it may prove effective or ineffective. For example, an EP preferring the accommodating style (low assertiveness and high cooperativeness) may have poor patient outcomes over time. The competing style employed by many EPs may create quick results necessary for patient care, but it is unpopular.

Although most complex, the collaborating style is the method to adopt whenever possible. Its outcome generally causes both sides to win. Collaboration is one of the main tenets of principled negotiation. Characterized by high assertiveness and high cooperativeness, this style is best used for learning, integrating solutions, and merging perspectives. Exploring issues in depth and confronting differences often result in increased commitments and improved relationships among involved parties. Despite the time constraints of EM, the collaborating style can be integrated into patient care activities by an EP and used successfully in conflict resolution.

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if understood and practiced. This approach generally preserves relationships for future interactions while achieving appropriate outcomes.

Conflict resolution in EM has a critical role with respect to patient care, as well as positive interpersonal and group relations. Successful communication is integral to promoting positive interactions among individuals, in an effort to prevent (or minimize) conflict before it becomes detrimental. Poor communication among individuals may potentiate ongoing conflict and misunderstanding. Building alliances with colleagues may reduce the likelihood and amount of conflict. Team building within the ED and hospital, to promote constructive, creative, and cooperative approaches to conflict management, is vital to success.

**CHALLENGES TO CONFLICT RESOLUTION**

EPs take for granted that difficult interactions occur as part of their daily experience. Some EPs may not find conflict particularly challenging or stressful. Successful EPs must be leaders within the ED, even if outside staff members are uncomfortable with their leadership style. This may be particularly true during stressful situations, when EPs gravitate toward the competing style of conflict resolution. Individuals who seldom use the ED (e.g., patients, families, consultants, hospital administrators) may not be comfortable with the environment or its interactions because its structure and culture are “foreign” to them. Unfortunately, the ED does not always provide the kind of service that health care professionals have come to expect. For example, a surgeon in the operating room has instruments handed to him or her in exactly the way he or she prefers by a designated individual. This is done in both the patient’s and the surgeon’s best interests. In the ED, however, staffing shortages or more pressing cases may cause a consultant to be “ignored.” This situation often results in problems for everyone because consultants may take their frustration out on EPs or ED staff. Conflict within the ED is the likely outcome.

**STRATEGIES FOR SUCCESSFUL CONFLICT RESOLUTION**

With all this conflict occurring in the ED, successful EPs apply strategies to reduce or resolve it, to preserve the best possible patient and provider satisfaction without compromising patient care. Drs. Marco and Smith described 10 reasonable principles for conflict resolution in EM (Box 209.2). EPs should make it their “standard of care” to refrain from hostile communication and instead persuade others using kindness and intellect, focusing on patient advocacy and safety.

O’Mara focused on the interrelationship between communication and conflict resolution. She wrote that “each relationship presents its own potential for ongoing communication dynamics, which may include conflict and misunderstanding” and added that “appreciating alternative viewpoints and a willingness to adapt are prerequisites for managing interpersonal conflict.”

**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 chose the other. Furthermore, the balance of power in any doctor-patient relationship is unequal. Each participant has a different perspective on the nature of the emergency condition. Anxiety, pain, cost of care, lost wages, disability, morbidity, and mortality are of great concern to patients. Furthermore, the timing of care—how long is appropriate to wait for pain relief, test results, consultants, an admission bed, or discharge instructions—creates conflict (and at times open hostility). In these situations, mismatched expectations and perspectives between a patient and an EP result in conflict that can be intensified by stress, pain, and social, cultural, and language differences.

EPs have numerous interactions with nursing that must be successful as often as possible even though they occur under stress. Positive or negative exchanges between physicians and nurses are likely remembered during subsequent interactions; nurses typically interpret an EP’s words, communication style, and body language in the context of prior interactions. Research clearly demonstrates that the doctor-nurse relationship has a significant impact on patient care.

Conflict resolution between EPs and staff members may be difficult to achieve, especially if interactions occur infrequently. In almost all situations, the earlier and more directly problem interactions are addressed, the more likely it is that future interactions and outcomes will be positive. These difficulties should be addressed in a nonthreatening, collegial, and supportive environment, in addition to removing personal issues from the problem. If this approach is neither possible nor successful, a skilled, unbiased outsider may be needed (particularly if differences in age, gender, cultures, ethnicity, rank, or position exist).

Additional strategies to foster successful conflict resolution in EM include social or educational meetings with colleagues and staff outside the ED. EPs who participate in medical staff affairs or who serve on hospital committees share time with colleagues when stress is not maximal. Positive interactions and sharing of common interests during these activities are likely to build alliances that may reduce the amount and intensity of conflict. This strategy will almost certainly improve conflict resolution in the future.

The book Getting to Yes describes using principled negotiation, which decides issues on their merit to resolve conflict, 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 fair standards, independent of the will of the other side.

Preparation is an important element before negotiations begin, although this is sometimes difficult in EM. Several opportunities exist to increase preparation before consultation (which is a negotiation). Making efforts to have the patient’s identifying information available at the start of the conversation, reviewing the laboratory and radiographic results before the call if possible, and clearly stating specific goals of the contact help reduce conflict before it occurs. Communicating in the consultant’s language and refraining from making suggestions (even obvious ones) unless asked are excellent strategies.

Getting to Yes recommends that negotiators develop their best alternative to a negotiated agreement (BATNA), which serves as the basis for exploring and evaluating options. This approach involves thinking carefully about what would happen if a negotiated agreement cannot be reached, while simultaneously serving as an impetus to engage in a process with agreement as the outcome. Communication that begins with careful, empathic listening helps resolve conflict and allows the other party to feel heard. Avoiding negative comments or ridicule (especially public) and depersonalizing the conflict are healthy approaches to its management. This allows the other party to maintain self-esteem and self-respect. Remaining objective and maintaining composure while focusing on the issues are important. One must be careful when responding to emotions; silence can be powerful and may de-escalate conflict.

**BOX 209.3 Positive Outcomes of Conflict Resolution**

1. Improved communication with patients and colleagues
2. Reduced stress levels and improved staff morale
3. Increased workplace productivity (and possibly reimbursement), with reduced expenditures related to conflict
4. Promotion of healthy relationships with colleagues and staff
5. Improved patient, staff, and physician satisfaction
6. Decreased staff turnover (increased staff retention)
7. Improved recruitment
8. Prevention of future conflict, or at least resolution of future conflict more effectively and expeditiously
9. Decreased medical error with improved patient safety
10. Improved overall patient care

**BENEFITS OF CONFLICT RESOLUTION**

Dr. Andrew recommended “paraphrasing the communication back to the complainer” and “expressing a willingness to find a common ground.” These recommendations are critical because conflict is often generated (and many times escalated) by the fear that a concern was not heard or validated. Dr. Andrew described four A’s that assist with conflict resolution:

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.”).

Skillful negotiating techniques embody an empowering, active, constructive, and positive approach to resolving difficulties and often yield successful outcomes or incremental change over time. Numerous benefits result from successful conflict resolution, with short- and long-term impact (Box 209.3).
SUMMARY

Conflict has been described as a natural consequence of incompatible behaviors and unmet expectations. The preferred strategy to manage conflict is to prevent its occurrence, which is not easy in EM. Effective communication among individuals and within groups in which parties are respected and heard produces an environment of trust. This results in the likelihood that conflict will be resolved more effectively. EPs should be aware of their behaviors and styles of interaction that increase conflict in an environment predisposed to conflict. Furthermore, EPs must strive to understand principles of conflict and conflict resolution, including effective communication, strong interpersonal and listening skills, and the tenets of professionalism because they may help achieve successful EM practices (Box 209.4).

REFERENCES

References can be found on Expert Consult @ www.expertconsult.com.
REFERENCES