CHAPTER 8

CONFLICT MANAGEMENT

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Peace is not the absence of conflict but the presence of creative alternatives for responding to conflict–alternatives to passive or aggressive responses, alternatives to violence.

–Dorothy Thompson, journalist (1894-1961)

Wherever people coexist, conflict exists. Frequently, a difference exists between what people desire and their current conditions. This discrepancy is especially true in a crisis-oriented environment like the emergency department (ED), where rapid and high-pressure interactions occur among individuals. In the ED, conflict is intensified as a natural consequence of urgency, the pursuit of incompatible objectives, individuals under stress, and unmet expectations.[1,2]

CONFLICT IS INEVITABLE

Examples of conflict in the ED include the following:

- An emergency medical technician (EMT) arrives in the ED with a patient and expects that staff will immediately attend to the new patient respectfully. Instead, the EMT finds an overwhelmed and somewhat agitated health-care worker who angrily responds, "Can't you see we're busy?"
- A patient with chronic back pain expects immediate treatment and dramatic relief. The busy, perhaps overwhelmed health-care worker arrives 30 minutes later to assess the patient and finds a sarcastic and disdainful patient who claims, "I thought you forgot about me."
- A cardiologist arrives in the ED after leaving his busy office, demanding that a nurse attend to his needs immediately.
- An emergency physician becomes increasingly frustrated because it seems that nothing is getting done and patients are languishing. He loudly calls out to a nurse who just picked up a phone call, "That's great! You're on the phone while patients are sick and waiting!"
- The mother of a crying child walks up to the triage nurse after waiting for more than an hour and is told, "Ma'am, we have sicker patients than your child . . . you'll just have to go back to your seat and wait!"
- An emergency nurse refuses to give a physician-ordered treatment because the nurse believes it may be inappropriate.

Benefits of Conflict

Although the foregoing examples demonstrate negative aspects of conflict, conflict is often beneficial. High-functioning organizations are not conflict-free; rather, they recognize conflict as an opportunity to address unresolved issues and make improvements. The benefits of conflict include the following[3]:

- ***Improved solutions***: A disagreement voiced and examined allows a deeper investigation into the problem, perhaps incorporating a perspective not yet considered. Attention to alternative views may create more nuanced solutions addressing several perspectives.

- ***Improved efficiency***: A poorly introduced process change may lead to resistance, delayed implementation, and perhaps failure. Effective leaders recognize that change is fluid and requires "after-action reviews" and "tweaking." Reviewing what worked and what did not opens the process to fine-tuning by those responsible for and affected by its implementation. Identifying conflict and encouraging feedback on process changes fosters buy-in and early adoption.
- ***Enhanced morale***: Poorly managed or ignored conflicts may lead to brooding and unwillingness to participate in current and future solutions. Addressing concerns or conflicts early decreases resistance to new ideas, programs, and processes and is more likely to result in the successful implementation of those new ideas. Individuals recognize they are respected and their ideas can contribute to the solutions of complex problems. Addressing the issues of people within the group strengthens relationships and enhances morale.

When a patient, family member, or colleague's dissatisfaction is acknowledged, caregivers have an opportunity to make a change to better meet the needs of those they serve. Quality service can only be sustained in organizations that care about the people delivering those services and those to whom the services are delivered.

Costs of Conflict

Although conflict in the ED is unavoidable—and can have benefits, as previously noted—it is vital to understand its associated costs (especially when conflict is not handled early and productively).[4] Unresolved conflict interferes with patient satisfaction, throughput, quality of care, and patient safety. Staff morale and pride are likely to decline with high levels of conflict, resulting in greater turnover from dissatisfaction with the work environment.[5] In high-conflict EDs, leaders will likely spend more time hiring for open staff positions and addressing an increasing number of complaints from patients, medical staff members, and other hospital units.

In the ED, a stressful, noxious work environment negatively affects the staff. In a toxic work environment, poor communication is more likely, which directly affects patient care through increased errors. Some staff members may avoid work by calling in sick, leaving the department understaffed. Repeated conflict and professional dissatisfaction may lead to frustration, anger, family strife, substance abuse, and chemical dependency in staff members. Furthermore, patients can recognize conflict among staff members, which may reduce their satisfaction.

ORIGINS OF STRESS AND CONFLICT IN THE ED

Stress is widespread in EDs for practitioners, patients, and their family members. Clinicians confront numerous situations for which there are few or no positive solutions. Many patients waiting to be seen believe their problems are emergent in nature and require immediate attention; most of them are anxious and in pain. They or their family members may be standing in the hallway or waiting area with arms folded, glaring at the staff while waiting for attention. Overwhelmed staff who are too busy to adequately respond to meet their patients' expectations may avoid these individuals, creating even more conflict.

The Health-Care Setting

Keeping up with the changing health-care setting and expanding numbers of regulatory mandates generates ongoing stress among ED leaders and staff. Health-care reform brings

with it pressures to provide nearly perfect care, eliminate pain, address patients' service needs in a timely manner, and ensure quality. Managed care organizations, insurance providers, hospitals, and accountable-care organizations critically review resource use in the ED and advocate limiting the battery of tests and procedures performed. Conversely, specialty training, peer-review organizations, patients and their families, and malpractice fears create pressure to leave no stone unturned when providing emergency care to the public. Furthermore, the lack of historical clinical perspective that exists in an established patient relationship often results in emergency caregivers using additional resources.

Organizational Climate

The hierarchical structure of the ED creates additional tension. Significant inequality of status and pay exists among physicians, nurses, technicians, and clerical staff. Physicians outrank each other in terms of seniority, partnership, leadership, training, or skill set, and they outrank the nursing staff. Some nurses outrank other nurses. Technicians and secretaries are often (incorrectly) considered less significant than clinical staff members. Intensifying this stress is the traditionally held "captain of the ship" mentality—the belief that one person must be in charge of all patient care decisions. When a speaker has power over the listener and the situation is stressful, the potential for conflict is far greater.

Limited resources place further pressure on ED staff. Downsized staffs (in both the ED and the hospital), limited budgets for facility and equipment upgrades, and prolonged "holding" of patients waiting for disposition contribute to suboptimal service.[6] The limited resources severely challenge staff members as they strive to meet patients' needs and provide quality service.

Unhealthy Work Environment

The stresses of delivering emergency care can create symptoms of post-traumatic stress disorder (PTSD)—depression, anxiety, stress, and anger—in many health-care staff. Emergency physicians are more than twice as likely to suffer from PTSD than those in the general public.[7,8] One 2005 study described seven emergency medicine residents who "reported sufficient symptoms to meet the *DSM-V* criteria for PTSD."[9] Those who develop PTSD-like symptoms work in environments with these characteristics:

- ***Intensive***: The work is exhausting.
- ***Dangerous***: Emergency care is often a matter of life and death. The margin for error is slim and mistakes, which are inevitable, must be kept to a minimum. Contagious diseases and increasing violence in the ED environment also carry personal risk to health-care providers.
- ***Litigious***: The fear of malpractice is pervasive among most emergency practitioners.
- ***Unpredictable***: There is always a pending sense of the unknown. One moment the ED may be empty; an hour later, it may be overwhelmed by injured and critically ill patients.
- ***Unmet expectations***: When the patient or private attending arrives, the ED staff member's complete and immediate attention is required.
- ***Uncontrollable***: There is often a sense of crisis and inability to address urgent demands.[10]

In addition to the effects of environmental stress, ED staff have little opportunity to recover or rest. Shifts are often without breaks; meals are always rushed and often missed. Sleep patterns are irregular because of shift work and 24-hour coverage mandates, despite an increasing body of knowledge that describes the biologic and physiologic stresses of changing sleep habits.[11-13]

In describing stress and burnout among emergency care providers, emergency physician Debra Roberts Slapper notes that "individuals prone to burnout are high achievers who have intense schedules, do more than their share on every project, and don't admit their limitations. As we age, our bodies tolerate the physical stresses less well. Twelve-hour shifts, eating on the run, no time for breaks, and sleep disturbances make us feel 70 when we are only 35."[14,15] Given the lack of control over patient volume, job insecurity, challenges with professional and patient relations, the mountain of knowledge and skill that must be maintained (often at one's fingertips), and the emotional roller coaster of "routine" practice, it is understandable that many emergency providers struggle with full-time clinical practice.[16,17]

The Four Cs

Patients arrive at the ED with certain expectations about the attention they will receive. These expectations are numerous, sometimes unrealistic, and often difficult to achieve.[18-20] **Box 8.1** lists the Four Cs, or general expectations, of patient satisfaction.

Convenience (expeditious care): Convenience and time are crucial to most patients seeking emergency care. Longer wait times are associated with lower patient satisfaction.[21] When patients have a choice about emergency care, they generally choose the place that will see them immediately and get them out most quickly. Patients place time-pressure on ED providers, particularly when they have (or think they have) a true emergency. After all, rapid assessment is the *sine qua non* of emergency care.

Caring (concern and kindness): Of equal or greater importance to many patients is provider caring. Rapport and trust must be established rapidly. Initially, patients judge the staff and their experiences not by the level of care, but by the level of *caring*. The responsibilities of ED caregivers are to take care of the patients' needs, both physical and emotional.[13] Caring goes beyond providing a high standard of care. Most patients prefer a warm, friendly, and concerned health-care provider who delivers "good" care to an unfriendly and distant provider practicing on the cutting edge.

Care (quality): Because the actual quality of care is quite difficult for the patient to assess, this expectation is generally considered only when there is no improvement or something goes wrong. Patients take for granted that emergency care is exceptional.

Cost (acceptable or not): Patients who are treated expeditiously with caring and quality tend to be somewhat less concerned about the cost of their care. This is especially true when the outcome of their care is favorable, and they feel better (or relieved) after their experience. Conversely, cost may be an issue for patients who experience provider-in-triage models during which patients may be evaluated, treated, and released quickly yet receive a large bill. Furthermore, cost is more likely to become an issue when a patient perceives that any aspect of care is absent, substandard, inadequate, or does not meet their expectations.

BOX 8.1 ■ THE FOUR Cs OF PATIENT SATISFACTION

- Convenience
- Caring
- Care
- Cost

BOX 8.2 ■ MEHRABIAN'S COMPONENTS OF PERSUASION

Component	Weight
Verbal content	7%
Vocal expression	38%
Visual cues	55%
Total	**100%**

PROVIDER COMMUNICATION: SKILLS, BIASES, AND RESPONSE TO STRESS

To be successful, ED personnel must move rapidly from situation to situation, communicating effectively in each. For example, a provider may be required to resuscitate a critically ill patient, admit a patient to a reluctant staff member, and put a fearful child at ease, with each situation requiring a different skill set with respect to conflict management. Regardless of the situation, skillful communicators recognize the importance of words, tone, and body language when trying to persuade others and manage conflict.

Components of Communication

The three classic components of communication are verbal content (words), vocal expression (tone), and visual cues (body language). Some may be surprised to learn that verbal content plays a relatively small role in persuasion. In fact, in some situations, less than 10% of persuasion may be the result of the actual words used.[22] Success in swaying one's perception or opinion is often the result of other forms of communication—the tone, posture, expression, and movement of the communicator.

Albert Mehrabian, one of the foremost communication experts of his time, performed experiments to demonstrate the importance of verbal and nonverbal communication (**Box 8.2**).[22] He examined the contribution of verbal content, vocal expression, and visual cues to persuasion and believability when trying to convince others of something they did not currently believe. Mehrabian found that only a small percentage of communication in that setting relates to the words used; instead, persuasion relies heavily on vocal expression and visual cues. However, in a pressured environment, it is typical to communicate with attention to the words only, ignoring other aspects of communication. This focus on words only may result in verbal incongruence, which Mehrabian described as incongruity between the spoken words and the manner in which they are delivered (vocal tone and body language).

The following examples illustrate verbal incongruence:

- A parent with tight lips, tense body, and threatening posture attempts to verbally reassure a child, "I'm not angry with you!"
- An ataxic patient staggers into the ED with a strong odor of alcohol on his breath and slurs, "I only had a coupla beers."
- On learning of his wife's death, a grieving husband begins shaking uncontrollably with tears streaming down his cheeks. When a caring health-care provider offers solace, he continues to say, "I'm fine! Really, I'm just fine!"

Communication skills, both verbal and nonverbal, play a major role in the development or resolution of conflict. Poorly developed skills often heighten discord and dissent, especially in an environment prone to high stress and miscommunication.

Personal Response to Stress and Conflict

Individuals respond to stress and conflict by habit, that is, learned patterns of behavior. In general, habits are advantageous because they allow people to perform activities and tasks without thinking. People perform thousands of minor tasks every day without conscious effort. For example, when driving a car, habits allow the driver to accelerate, turn the steering wheel, watch the scenery, and listen to the radio at the same time.

In a calm environment, individuals exhibit routine behavior patterns. However, when under substantial stress, a person typically responds with a consistent and individualized pattern of behavior known as a "crisis pattern." Some people confront stressful predicaments with maladaptive behavior patterns—provocation, accusation, anger, withdrawal, or disdain—that exacerbate the situation. These behaviors may be particularly ineffective (and often disruptive) in an environment that requires decisive, collaborative, and articulate communication and responses, such as the ED.[23,24]

Implicit Bias

Discrimination, although sometimes subtle, exists in all areas of the hospital, especially the ED. This creates further inequities and conflict. Because waiting times and level of caring by practitioners are key factors in patient satisfaction, biases that prolong waiting and decrease practitioner compassion seem particularly unfair and inappropriate. Biases that exist among staff members may further undermine care. Common types of inherent bias include gender, generational, ethnic, financial, and educational. In health-care settings, "presenting complaint" bias can also influence perception and compassion.

- ***Gender bias***[25-28]**:** It is well-documented that female patients presenting with cardiac illnesses are approached, evaluated, and treated less aggressively than male patients with similar complaints. Women presenting with abdominal pain or chronic pain syndromes experience a similar type of bias. Another form of gender bias occurs when patients request that the evaluating practitioner be of the same gender.
- ***Ethnic and cultural bias***[29,30]**:** Patients of non-white ethnicities are more likely to perceive and report caregiver bias than their white counterparts. Differing ways of responding to pain and language barriers may frustrate staff members and lead to ethnic bias.
- ***Financial or socioeconomic bias*:** Emergency providers may exhibit bias against uninsured or homeless patients who have few options for urgent or ongoing care. Conversely, emergency staff may treat patients who are well dressed or appear to have financial means with greater courtesy and respect.
- ***Educational bias*:** Closely associated with financial and socioeconomic bias, providers may demonstrate bias against patients with less education. These individuals may be less articulate and less able to understand or follow written or verbal instructions in accordance with the health-care provider's intent. Furthermore, health-care workers may react negatively to patients who use "street" grammar, slang, or idioms because they may be perceived as indicators of educational status.
- ***Presenting-complaint bias*:** Most practitioners prefer straightforward presenting complaints, and they may avoid patients who present with vague or confusing complaints that are difficult to assess, choosing to see "easier" cases first. Typical presentations that lead to presenting-complaint bias include chronic back pain, fibromyalgia, constipation, generalized weakness, confusion, and behavioral issues.[31] Presenting-complaint bias may lead to caregivers forming opinions about the patient prior to evaluation.

Implicit biases may lead to health-care disparities by affecting clinical judgment and decision-making. As such, it is incumbent on ED personnel to recognize and thoughtfully reflect on how these stereotypes and prejudices may affect their patient care.

CONFLICT MANAGEMENT: GENERAL PRINCIPLES AND FRAMEWORKS

Several conceptual frameworks are useful in managing conflict. These include shared governance, leadership choices, and taking personal responsibility for behavior change.

Shared Governance

Instituting shared governance programs (SGPs) is an excellent method of reducing intradepartmental conflict. Unlike traditional quality processes that emphasize blaming outliers, SGPs emphasize collaborative improvement of processes by generating broad participation. Staff members are encouraged to give input, requesting their feedback acknowledges their expertise in and direct responsibility for system efficiency. Shared governance programs decrease departmental stress and increase accountability, both of which are critical elements in creating a team approach to problem-solving and, ultimately, decreasing conflict.

Leadership Choices

In an organization committed to SGPs, leaders may choose to regularly meet one-on-one with employees (i.e., Studer's "rounding for outcomes") to identify evolving problems.[32,33] Judgments about who is right or wrong are de-emphasized; instead, staff members are empowered to work with leaders to initiate solutions in a timely manner. Creating an open environment, seeking critical feedback, and avoiding blame all decrease stress and may prevent conflict before it occurs.

Personal Responsibility for Behavior Change

The first step in behavior change requires individuals to recognize they have no control over anyone's behavior but their own. Some individuals think, "It sure seems like there are a lot of difficult people out there. I don't do anything to provoke them." However, the most difficult people often don't realize they're triggering stressful interactions. A person who regularly becomes frustrated during times of stress may significantly contribute to the frustration of others, further increasing conflict. That person's conduct and communication skills merit review and self-reflection (i.e., "What is my role in this?").

Behavior patterns are extremely difficult to change. People frequently repeat previous behaviors whether successful or not; they don't always learn from their mistakes. If we extrapolate from the experiments of the psychologist Guthrie, responses to stimuli tend to become habitual.[34] Thus, it is likely that if a person has an ineffective response to a stressful situation, that same response will recur when that person is confronted with similar circumstances. In fact, in times of crisis, most people tend to repeat an individualized, consistent pattern of behavior they developed in childhood. Reflecting on one's own response to stress can lead to adaptation and more appropriate responses. Consider the admonition, "When angry, count to ten before you speak." While a somewhat simple intervention, it is an example of placing "time and space" between the stimulus and the response.

> *Human freedom involves our capacity to pause between stimulus and response and, in that pause, to choose the one response toward which we wish to throw our weight.*
>
> —Rollo May[35]

BOX 8.3 ■ CONCEPTUAL MODELS OF CONFLICT

- Thomas-Kilmann conflict mode
- DISC personality profile
- Meyers-Briggs
- *Getting to Yes* by Fisher and Ury

MODELS FOR ASSESSING AND RESPONDING TO CONFLICT

By adopting a conflict management framework, leaders can take a broader view of conflict, thus facilitating resolution. There are several ways to view conflict; four methods are listed in **Box 8.3**.

Thomas-Kilmann Conflict Mode

Thomas and Kilmann defined a matrix illustrating five distinct styles of negotiation (that is, responses to conflict) that fall along two axes (**Figure 8.1**).[36] One axis, assertiveness, describes the extent to which individuals attempt to satisfy their own concerns. The other axis, cooperativeness, identifies the extent to which an individual attempts to satisfy another person's concerns.

The five styles of negotiation are:

- ***Competing***: assertive, uncooperative
- ***Avoiding***: unassertive, uncooperative
- ***Accommodating***: unassertive, cooperative
- ***Compromising***: intermediate assertiveness, cooperativeness
- ***Collaborating***: assertive, cooperative[37]

Each style may be useful in a particular situation; for example, competing may be best when the outcome is more important than the relationship. Simultaneously, certain styles

FIGURE 8.1 ■ Thomas and Kilmann's Five Conflict-Handling Styles

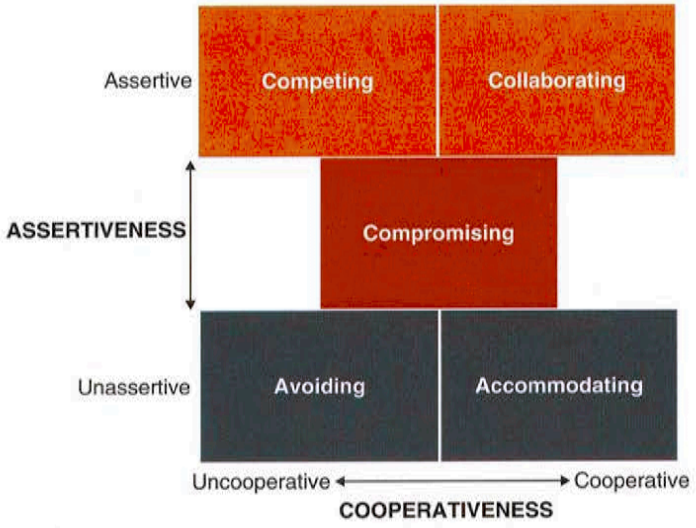


TABLE 8.1 ■ Negotiation Response Styles

Response	Assertiveness Level	Cooperation Level	Use When	Avoid When
Avoiding	Low	Low	Relationship and outcome are unimportant	Relationship or outcome are important
Accommodating	Low	High	Relationship is more important than outcome	Outcome is important
Competing	High	Low	Outcome is more important than relationship	Relationship is important
Compromising	Moderate	Moderate	Outcome and relationship are somewhat important	
Collaborating	High	High	Outcome and relationship are very important	Relationship or outcome is unimportant

should be avoided when the goals or outcomes are important; for example, the avoiding style should not be used when the outcome is important (**Table 8.1**).

The collaborating style is the most complex style of conflict resolution; yet, it is the best method to adopt when the relationship is long term and the outcome is important to both parties. The style has a "win-win" goal—both parties achieve desired, acceptable outcomes. Collaboration is characterized by high assertiveness and high cooperativeness; it integrates perspectives. Exploring the issues in depth and confronting differences are integral components of this strategy. This style often results in increased commitments and improved relationships among parties.

DISC Personality Profile

The DISC personality profile is a model based on observable behaviors. First introduced by William Marston in 1926, DISC describes four distinct traits of behavior: dominance (or drive), influence, steadiness, and compliance.[38] The intent of the profile is to help individuals understand their own and others' traits so they can avoid, reduce, or manage conflict while working with others (**Table 8.2**).

TABLE 8.2 ■ DISC Traits

Trait	Description
Dominance	Achievers and self-starters. They are direct, decisive, driven, and push themselves and others.
Influence	Enjoy people and attention, life of the party. They are motivators, fun, and persuasive.
Steadiness	Understanding, supportive, and good listeners. They are loyal and steady.
Compliance	Neat and organized. They are analytical, systematic, detailed, and accurate.

The DISC model identifies an individual's primary trait, although people may display additional traits or styles when interacting in different roles (e.g., department chair, clinician, spouse, parent, etc.). DISC profile tests are available online, providing immediate results that offer detailed personality assessments. With the newer "Everything DISC" profiling system, the test-taker responds to several phrases using a Likert scale to identify the degree to which the phrase describes the individual.

The profile may be used to help an individual work more effectively with others; many businesses use it to enhance teamwork, improve relations, and decrease work conflict.[39] Residency training programs have had success using this tool with residents and residency administrators.

Myers-Briggs Type Indicator

The Myers–Briggs type indicator (MBTI) is adapted from Jungian theory of personality types.[40,41] Although initially created to help individuals determine the job best suited for their personality type, the MBTI is currently the most widely used personality assessment tool. The MBTI categorizes people by attitudes, functions, and lifestyles (**Table 8.3**). The Myers–Briggs test is intended to help people understand how they perceive the world and make decisions. Its advantages include its widespread use and depth of evaluation. However, its interpretation is complicated and difficult to apply in daily activities.

Getting to Yes by Fisher and Ury

Getting to Yes is a popular book written by the cofounders of the Harvard Negotiation Project, Roger Fisher and William Ury. It advocates the concept of principled conflict resolution that

TABLE 8.3 ■ Myers-Briggs Personality Types

INTJ THE ARCHITECT IMAGINATIVE STRATEGIC PLANNERS	INTP THE LOGICIAN INNOVATIVE CURIOUS LOGICAL	ENTJ THE COMMANDER BOLD IMAGINATIVE STRONG-WILLED	ENTP THE DEBATOR SMART CURIOUS INTELLECTUAL
INFJ THE ADVOCATE QUIET MYSTICAL IDEALIST	INFP THE MEDIATOR POETIC KIND ALTRUISTIC	ENTJ THE PROTAGONIST CHARISMATIC INSPIRING NATURAL LEADERS	ENFP THE CAMPAIGNER ENTHUSIASTIC CREATIVE SOCIABLE
ISTJ THE LOGISTICIAN PRACTICAL FACT-MINDED RELIABLE	ISFJ THE DEFENDER PROTECTIVE WARM CARING	ESTJ THE EXECUTIVE ORGANIZED PUNCTUAL LEADER	ESFJ THE CONSUL CARING SOCIAL POPULAR
ISTP THE VIRTUOSO BOLD PRACTICAL EXPERIMENTAL	ISFP THE ARCHITECT ARTISTIC CHARMING EXPLORERS	ESTP THE ARCHITECT SMART ENERGETIC PERCEPTIVE	ESFP THE ENTERTAINER SPONTANEOUS ENERGETIC ENTHUSIASTIC

BOX 8.4 ■ FISHER AND URY'S *GETTING TO YES* SOLUTIONS

- Separate people from the problem.
- Focus on interests, not positions.
- Generate options for mutual gain.
- Insist on objective criteria.

seeks "win-win" solutions similar to Thomas–Kilmann's collaborating style.[42] By being "hard" on concepts and "soft" on people, principled conflict resolution clarifies problems, validates emotions, discusses and explores interests, and develops objective criteria for solutions. Advantages of the approaches described in this book include their universal appeal, applicability of concepts, and utility for multiple situations (**Box 8.4**).

CONFLICT MANAGEMENT: SPECIFIC SKILLS

When used properly, many techniques can help manage and resolve conflict. However, even correct strategies may exacerbate disagreements when applied inappropriately. Conflict management begins with creating trust and listening effectively.

Creating Trust

It is difficult to negotiate where neither will trust.

–Samuel Johnson[43]

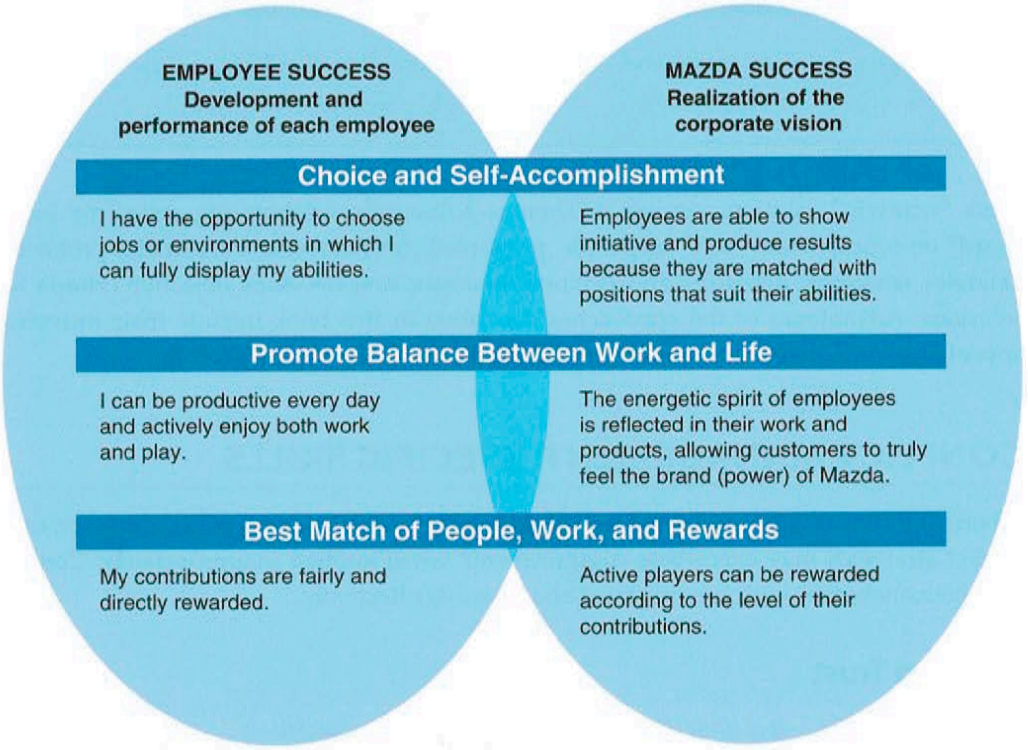
Effective communication occurs most easily in an environment of trust and respect. Supervisors who live in their offices except when criticizing staff or mandating new programs create an environment of apprehension and distrust. Leaders must get close to the people providing the services so they can understand the issues and conflicts first hand. Criticism of the night or weekend staff by ED leaders who never work nights or weekends often falls on deaf ears.

Alternatively, workers are more likely to listen to compassionate leaders with whom they identify. Leaders who listen to and acknowledge team members' issues are more likely to be perceived as understanding and more likely to be heard by the other side. The Mazda Way, for example, demonstrates a corporate-wide approach that hinges on a commitment to seven basic principles: integrity, flawless execution, continuous "Kaizen," challenger spirit, self-initiative, "Tomoiku," and "One Mazda." Each principle recognizes that *people* are the company's most important asset (**Figure 8.2**).[44]

Effective Listening

Although effective ED care requires rapid identification of problems and immediate response, staff members may move too quickly in some situations. Some health-care providers interrogate patients and staff in hurried and impatient tones, interrupting responses to their questions with further questions. When rushed, people may gloss over subtleties. Obtaining nuanced information depends on building trust and rapport. When people believe the other person is not listening, they may become frustrated, reserved, and vague, resulting in a breakdown in communication and withholding of sensitive information. Effective listening, a first step toward resolving the problem, is critical to improving trust, patient satisfaction, and outcomes. It is also one of the key qualities that minimizes litigation and conflict.

FIGURE 8.2 ■ The Mazda Way



Many effective listening styles and techniques have been described in the literature.[45,46] In general, effective responses are neutral, without criticism or judgment, and often validating. Accepting the speaker's concerns creates the opportunity for clarification and further exploration (see **Box 8.5** for listening styles).

Consider the responses to the following comment by a staff member: "I just can't stop thinking about the child from the accident."

Impatient response: "You're overreacting, and you're getting too emotional about it. I would just put it out of my mind if I were you."

Although perhaps well meaning, this advice ignores the feelings of the staff member. This response inadvertently communicates criticism, dismissal, and lack of concern for the staff member's distress.

Passive response: "Hmmm."

Passive listening requires the listener to be quietly attentive. This behavior may encourage the speaker to continue discussing the issue and possibly get to the crux of the problem. Difficult issues take time to divulge and, like onions, may require peeling away layers before getting to

BOX 8.5 ■ LISTENING STYLES

- Passive
- Reflective
- Empathetic
- Validating

the center. A passive type of response can also help defuse angry reactions. To feel comfortable revealing a problem, people often need time and, at the very least, a safe environment.

Reflective response: "It seems like it's difficult to get him out of your thoughts."

Reflective listening involves providing objective feedback to the person expressing a concern. In its most rudimentary form, this response involves repeating the words back. This technique encourages the speaker to elaborate.

Empathetic response: "It sounds like you're worried about him."

This listener has decided to try to understand the speaker to get on the same side of the table. The listener has suspended a personal frame of reference and attempted to rephrase content and reflect feeling. This type of nonjudgmental and concerned listening allows speakers to address their feelings about the problem.

Sympathetic response: "I understand what you're going through. The same thing happened to me."

Sympathizing should be used with caution. Insincere sympathy may seem patronizing. Furthermore, the recipient of the "sympathetic" response may not believe that the person offering the sympathy really understands.

Acknowledging and validating response: "Yes, it is difficult to see a child suffer. Would you like to talk about it?"

When done correctly, acknowledging and validating responses allow the speaker to know the listener has heard and is substantiating the concern. Frequently, the speaker confirms the response by saying something like, "Yes, that's it exactly," or nodding in affirmation.

Eye Communication

Skilled communicators maintain good eye contact when listening to and speaking with others.[47] The pattern of eye contact (minimal, intermittent, or continuous) used by one person in a conversation will generally be copied unconsciously by the other person. Looking into another's eyes while listening (and speaking) demonstrates interest and attentiveness. Conversely, avoiding eye contact may be interpreted as a lack of interest. The listener can create an even greater sense of apparent interest by facing the other person and giving occasional nods of affirmation, a form of acknowledgment.

Focus on Interests, Not Positions

Positions are generally driven by underlying interests. As an example, consider two chefs who both insist on using the one remaining orange to create a dessert.[48] Positional bargaining would lead to an argument and perhaps one winner and one loser. However, once the underlying interests were understood (Chef A needed the rind, while Chef B needed the juice), both could be satisfied. Some of the most difficult people exhibit positional bargaining, as shown in the following example:

Admitting resident: "That's the third sick patient you've asked me to admit in the last hour. I won't do it." The position is "NO!"

Responding to the position is "taking the bait" and getting hooked into a win-lose situation. *A positional response might be:* "Oh, yeah? Well, you have to—and now! If you don't, I'll call your attending!"

BOX 8.6 ■ DISCREPANCY BETWEEN WORDS AND INTENT

The actual words spoken:	The thoughts underlying the words:
A: Did you discharge the patient yet?	I have some free time, so if it isn't done yet, I can do it.
B: I told you I would do it when I get the chance, and I will! Don't keep bugging me about it!	I have been incredibly busy doing more important things, and now you're criticizing me for taking five minutes for myself to get a cup of coffee.
A: Well, never mind!	That is what I get for offering to help.

Positional bargaining may, in fact, get the desired result. However, it generally creates a winner and a (resentful) loser. Furthermore, if these two parties work with each other again, the loser typically remembers and may try to get even.

The effectiveness of interest-based rather than position-based bargaining is evident in successful conflict management, negotiation, and complaint management. Continuing to concentrate on the interests of both parties often mitigates difficult situations. By focusing on the interest of the admitting resident, a solution may become clear immediately. A good interest-based listener will interpret the underlying message from the admitting resident as:

> *I'm tired, overwhelmed, and feeling out of control. I don't think I can handle another patient right now.*

Responding to the message rather than the words would lead to a more effective reply:

> *Yes, your night has been difficult. I can hold the patient here for another 45 minutes until 3 A.M., while you catch up. Can you commit to being here by 3 A.M.?*

Avoiding a direct response to the resident's position and instead responding to the resident's interests and needs may require minor compromise, but it allows both sides and the patient to get their needs met—everybody wins.

Separating the People From the Problem

Everyone has irritating behaviors. Although most people seek mutually satisfying and trusting relationships, they may quickly become suspicious and angry when someone is offended. In a stressful and hurried environment such as the ED, communication is often truncated and may inadvertently aggravate a situation. Under duress, stressed health-care professionals may not take the time to be polite ("Please . . ." or "When you get a chance, could you . . ."). Instead, they use verbal shortcuts ("Get the . . . now!"). Such communication may result in or increase conflict, especially between individuals without a history of positive exchanges. Successfully separating the person from the problem requires recognizing that people generally try to satisfy their own needs and obligations. To successfully resolve conflict, it may be necessary to discern the other person's underlying intent. Note how differently the scenario in **Box 8.6** would conclude if the underlying intent were recognized.[49]

When someone perceives a person's intentions as dishonorable, future actions tend to be interpreted in that same light. To avoid a conflict, a participant must examine the other

person's motivations in a sincere and noncritical way. This may be accomplished by simply asking, "What was your reason for asking me if I had discharged the patient yet?" Or, "Why did you react negatively when I asked if you had discharged the patient yet?" Eventually, by continuing to explore each other's intentions, a positive outcome can be achieved, and miscommunication can be averted.

Responding to Emotion

Emotional actions breed emotional reactions. When one person is behaving obnoxiously, it is tempting to reciprocate with anger or respond emotionally by yelling, crying, door-slamming, or stomping. An emotional response may provide a momentary feeling of relief; however, this type of response will almost always make resolution and subsequent interactions more difficult or impossible. Silence is a powerful alternative response to difficult emotional interpersonal conflicts because escalation is less likely when one party avoids emotional engagement. Furthermore, those who can maintain composure and continue to focus on the interests of the other party (or parties) are more likely to enhance the resolution process.

THE MANDATE FOR BEHAVIORAL FEEDBACK

In the stressful ED environment, leaders may find it necessary to provide feedback to individual staff members. To encourage change, leaders should provide feedback. Behavioral feedback is mandated in Accreditation Council for Graduate Medical Education training programs, which evaluate behavior using the competencies of "professionalism" and "interpersonal and communication skills."[50]

Because inappropriate behavior can undermine the culture of safety, The Joint Commission mandates that "[institutional] leaders create and implement a process for managing disruptive and inappropriate behaviors."[51]

Structuring Feedback

Although feedback may be mandated or a consistent part of a program, behavioral commentary is often met with resistance unless structured in a manner that encourages receptivity. Feedback is accepted most readily when it is presented with positive, instructive, or constructive language and without blame, criticism, or judgment. The best environments for process improvement are those in which bidirectional feedback is encouraged, establishing a culture of feedback.

The "I" Message

The word "criticism" connotes judgment and disapproval; it should be avoided when commenting on behavior. Terms such as "input" or "feedback" are more readily accepted because they connote more objective and helpful consideration. Additionally, feedback is received more favorably when it is internally focused (on the person giving the feedback) rather than externally focused (on the person receiving the feedback) because it allows the feedback recipient to maintain self-esteem. Finally, labeling, personal attacks, and generalizations should be avoided. For example, the following comment voiced in an attempt to create positive behavior change is likely to be rejected:

"You are always too argumentative!"

BOX 8.7 ■ THE THOMAS GORDON MODEL

- When we/you . . .
- I feel . . .
- Because . . .

When giving feedback, emphasizing a point by using terms such as "always" and "never" will be poorly accepted because the recipient will likely perceive the comment as an unwelcome exaggeration. Furthermore, the term "argumentative" is a label describing a personal trait; it is unlikely to lead to a helpful insight or resolution. Conflict resolution expert Thomas Gordon suggests a more effective alternative for providing behavioral feedback: using "I" statements.[52] He advocates structuring feedback in three parts, with a clear description of the behavior and how it affects the person offering the feedback (**Box 8.7**).

- ***When I/we***: The "when" statement should be specific, concrete, and observable. Simply and objectively recount the occurrence with a statement such as "When we argue. . . ." Avoid attacks and labeling, such as, "When you argue with me." Specific and objective words will be more easily accepted. For example, avoid a statement such as, "When you act the way you do . . .," which is too vague, or "When you behave like a jerk . . .," which attacks the person receiving feedback by labeling them.
- ***I feel***: The "I feel" statement should express a sincere feeling that is consistent with the situation, such as "I feel angry (frustrated, upset, embarrassed)." Avoid phrases that are blaming or do not describe a feeling, such as "I feel like a child," (how does a child feel?) or "I feel like you don't care" (accusatory).
- ***Because***: The "because" statement provides an opportunity to share motives and the desired outcome. A good example is, "I feel frustrated because it seems my ideas are not considered." Again, blaming should be avoided. Speakers should focus on the way the behavior affects them and their perception.

Effective "I" Statements

Using the Gordon model, the person providing feedback can effectively share the concern without blaming the other person, labeling, or exaggerating. In **Box 8.8**, the examples in the first column will probably be ineffective because the recipient of the feedback is likely to perceive blame and disapproval. The "I" statements in the second column are more likely

BOX 8.8 ■ EXAMPLES OF EFFECTIVE "I" STATEMENTS

Blaming	Constructive
You are always too argumentative!	When we argue, **I feel frustrated** because it seems my ideas are not respected.
I am furious with you because you always ignore me!	When I am ignored, **I feel upset** because my ideas aren't considered.
You are so disrespectful; I can never count on you!	**I feel frustrated and resentful** when you arrive late for a shift because it disrupts my plans and I do not know whether to take care of waiting patients.

to be met with receptivity, resulting in an effort to further examine and resolve the issue. Constructive feedback clarifies the problem, describes the resulting feeling, and defines the underlying issue to address. When done well, there is no blaming. This technique allows both parties to objectively examine ways to resolve the problem.

CPR: Content, Pattern, Relationship

In *Crucial Accountability* and *Crucial Conversations*, Patterson et al. promote the mnemonic CPR—content, pattern, relationship—as a way to appropriately respond during a confrontation without avoidance or aggression.[53,54] First, the leader identifies the *content*, or problem, in the current situation and then relates the present situation to a history of similar events, the *pattern*. Finally, the leader addresses their continuing interactions and trust of the parties, that is, the *relationship*. The CPR approach may be used to move toward a fair solution for all parties, and it is particularly valuable when a habitual pattern is noted. For example:

Content:	A practitioner might say to a colleague who takes multiple long breaks, "Janet, I've noticed that you have taken five or six long breaks during the shift today."
Pattern:	"I've noticed the same pattern when we've worked together recently."
Relationship:	"Janet, I must be able to rely on you when we are working together. This pattern leads me to question whether or not I can."

While it appears simple, CPR can be difficult to put into practice when there is strong emotional content. With practice, CPR helps transition conflict from confrontation to resolution by avoiding blame or emotional finger pointing and, instead, objectively describing what has happened and what the speaker would like to see happen.

Averting Public Ridicule

Occasionally, an angry person may verbally abuse another person in a public space. This behavior makes most observers uncomfortable, and the unfortunate recipient of the ridicule will likely feel humiliated by this exposure. The person expressing discontent may not even recognize the inappropriateness of their behavior.

If a patient, coworker, or medical staff member is publicly expressing emotion in a loud or disruptive manner, the dysfunctional communication should be interrupted. The following process may help resolve the situation. The intervening person can:

1. Walk up to and stand in front of the speaker.
2. Gain the person's attention, and establish eye contact.
3. Quietly and firmly say, "I see you're upset. I'd like to talk with you about this issue over here."
4. Move to a more private space.
5. Address the issue.

Most angry people will go with the person who has offered to address the problem. Physically moving will itself begin to decompress the situation. (Note: This technique should not be used if there is any potential danger.)

Responding to a Complainer

In a busy ED, patients' expectations often go unmet. The two most common complaints from patients are "It's taking too long!" and "Nobody cares!" People who wait for a prolonged period and are treated rudely may be particularly vocal or hostile when expressing their discontent.

Habitual blamers tend to be angry and believe they should get their way; anything less may feel unacceptable. They may even believe they have not gotten what they deserve because people are insensitive and purposefully obstinate. Blamers often use personal pronouns, generalizations, and extreme language to make their point. They tend to be dramatic in both tone and gesture. Blamers may shake their finger, pound their fist, and be verbally threatening. The blamer, in essence, tries to place the responsibility for his or her problem on someone else. For example, a blaming patient who is tired of waiting might exclaim, "Why is it that every time I come here, I always have to sit around and wait for hours and hours? Don't any of you people care about anyone? Can't you see that I'm in agony?" But what the patient means is, "I want to be taken care of now!"

A placating patient is, in many ways, like a blaming patient.[55] The placater acts as if he or she or the system is personally responsible for the problem. The placater, like the blamer, uses many personal pronouns, generalizes, and places emphatic stress on words. However, instead of aggressively placing the responsibility for the problem on others, a placater is apologetic and appears to assume responsibility. A placater who is frustrated because of a prolonged wait might say, "I don't know why it is that I always seem to come when it is so busy. I don't like to complain, and I know that you doctors and nurses are so busy and my problem is so insignificant," when what they really mean is, "I want to be taken care of now!"

There are many ways to respond to complainers. Before choosing a response, recognize that a verbal assault is not necessarily directed at the unfortunate recipient. Although tempting, one should avoid taking the bait. An opportunity is created to address concerns when a complaining person confronts or blames someone.[54,55] An effective response may lead to immediate resolution, whereas an ineffective or defensive response may exacerbate the problem. Blaming the blamer will likely exacerbate the conflict, whereas placating, offering a blameless apology, or acknowledging and validating the patient's concerns might help resolve the issue.

Blaming a Blamer

If the health-care professional takes complaints personally, a blaming professional might blame the blamer and respond by saying, "Can't you see that we're busy? We're working as fast as we can! Your constant interruptions are delaying our getting to you. If you will just sit quietly and wait, we'll take care of you when it is your turn. There are people here who are really sick!"

Blaming a blamer puts the responsibility back on the original blamer. Joining this mudslinging contest gets everyone dirty; there are no winners. Inevitably, blaming back leads to escalation of the conflict. When the opportunity arises, the blamer will take his or her frustrations to the next level, with a letter to the CEO or an editorial to the local newspaper.

Placating

Professionals in a service industry such as health care commonly placate to resolve conflict. The placating professional apologizes and either assumes personal responsibility or apologizes for the inadequacy of others, such as, "I'm very sorry, I wish I could have been here sooner. You must be upset. It's been so busy and one of the x-ray machines is broken. I'm very sorry." What they really mean is, "It's not my fault."

Placating in response to conflict works—to some degree. Generally, it avoids escalation and allows the other side to blame the obliging apologizer. This behavior, however, causes the placater to feel inept and impotent. Furthermore, it does not substantially improve the situation.

Blameless Apology

An effective alternative to placating is the blameless apology: "I am sorry you've had to wait so long." This approach is reassuring and expresses concern for the perceived issue without assuming responsibility for the problem. It demonstrates that the provider cares and is listening.

Acknowledge and Validate

A particularly effective way of responding is to acknowledge and validate the expressed complaint. Ideally, the provider addresses the underlying concern. This approach eliminates blame, deals directly with and validates the patient's concern, and provides the complainer with what she really wants—attention, empathy, and responsiveness. This technique avoids "biting the hook" by assuming responsibility or blaming others. For example, "Yes, it's frustrating to wait when you're in pain. I'm here to take care of you now."

Objectively repeating the complaint from the complainer's perspective demonstrates an understanding of the issue. When possible and appropriate, the provider should immediately offer complainers the care and caring they want. If unable to provide a solution now, then it is appropriate to let the complainer know when to expect one.

CONCLUSION

Conflict is inevitable and it has both benefits and costs. To effectively manage conflict, the parties must treat each other respectfully, recognizing that the other participants have real interests and needs that are important. Active listening and empathy may be the most important skills necessary to achieve satisfactory resolution. The other parties should not be considered adversaries to be overcome because winning at the expense of others does not bode well for future collaboration.

The process of developing collaborative solutions—satisfying their needs while achieving your goals—takes time and skill. The focus should be on creating an environment of mutual respect. Even when a conflict must be addressed immediately and unilaterally, such as in the emergent management of a critically ill patient, real-time input should be encouraged and respected.

When dealing with conflict, consider and respect the needs of others without neglecting your own. A culture of collaboration is essential to achieve the goal of providing high-quality care and caring in an ED environment.

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