

# Editorial

## CONFLICT MANAGEMENT IN THE INTENSIVE CARE UNIT

By Richard H. Savel, MD, and Cindy L. Munro, RN, PhD, ANP



**C**onflict is common in the intensive care unit (ICU). Experiences in critical care are often intense, involving high stress and high stakes, but learning to appropriately manage a circumstance that might otherwise lead to conflict should be a measure of personal success. Many examples come to mind: intra-team conflict, conflict between the ICU team and consulting services, and conflict between the ICU team and the patient/family unit, to name a few.<sup>1,2</sup> This editorial addresses the issue of conflict in the ICU, including how to recognize it, how to manage it, and how to turn conflict into an opportunity for improvement.

### Conflict Between the ICU Team and Other Teams

Emotions often run high in the ICU, and the environment can be fertile ground for conflict. One example is tension between the critical care clinical team and the primary surgical team. Such conflict can take place in any kind of surgical ICU. In this case, conflicts can arise about the timing of an extubation or about whether certain kinds of therapeutic interventions (such as antibiotics or diuretics) are

needed. The perspectives of the primary ICU team and surgical team often differ on such matters.

There are also medical-legal issues that lead to conflict, specifically the question of which attending physician is the “attending of record” during a particular patient’s hospital stay. This is essential to determine because the physician who is the attending of record has the final decision on matters relating to the patient—not a trivial issue and not one to be worked out “on the fly” in the open ICU. Instead, such an important decision should be agreed upon by all parties working in tandem with hospital administration beforehand in the relative calm and quiet of an administrative session.

The point here is not that we should abdicate *all* decision making authority so the attending physician is the only one to “calls the shots.” That would make for an unpleasant work environment. The point is that conflict management is the foundation for good clinical outcomes. A better way to handle such a situation would be to define and acknowledge the attending physician of record but still permit reasoned discussion of complex clinical issues between the critical care and surgical teams. That kind of positive experience takes time to develop because it is built on trust and requires a high level of maturity on the part of both teams. What often works best is development of a shared

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sense that there are particular areas where the intensivist team is best qualified (eg, resuscitation and evaluation for readiness to extubated) and areas where the surgical team is best qualified (eg, concerns that the patient needs to be returned to the operating theater). Although both teams are clearly interested in the patient as a whole, development of “areas of expertise” encourages a give-and-take collaborative approach that works well.

Along these lines, however, the intensivist team should still be thought of as coordinating care. Deciding which areas of care are even worthy of discussing with the primary surgeon is important. If every decision the surgeon seeks to implement—no matter how trivial—becomes a point of discussion or argument with the ICU team, unnecessary rancor between the teams will inevitably result. On the other hand, if the critical care team is working hand-in-hand with the primary surgical team and infrequently has disagreements with management about what they feel are highly important and crucial issues (eg, whether it is unsafe to extubate a patient, whether a patient should begin antibiotics), the surgeons are much more likely to take the recommendation seriously and implement the modified plan.

### Conflict Between the ICU Team and Consulting Services

In managing conflict between critical care teams and other consulting services, open verbal communication is key. We both have seen numerous misunderstandings and miscommunications take place when a consulting team makes a recommendation that the primary team does not follow. Unfortunately, consulting clinicians may well perceive such a thing as insulting.

Our recommendation is that, in general, actual conversations should take place between the critical care team and the consulting team, either in person or via telephone. These dialogues can mitigate hurt

feelings and conflict, and, more often than not, completely resolve the issue. For example, conciliatory phrasing might sound like this: “I see that you did not approve the antibiotic we asked for. I would like to go over with you again why we feel so strongly about this.” Or, similarly: “I see you recommended these 3 medications for blood pressure control for this patient. We just discovered that the patient had a very severe adverse reaction to one of those medications in the past. Would you prefer if we just gave the other 2 medications, or would you like to try a different agent?” Such language sends a clear and important message of mutual respect and leaves all involved feeling appreciated and heard.

Similar circumstances occur in a teaching hospital when, for example, some procedure or medication is given routinely without evidence, the value and importance of which may take on a life of its own. If the critical care team disagrees with this practice, it may be impossible to change the practice at the level of the resident or even that of the attending physician. But resolving such a conflict could offer a valuable learning opportunity for the entire surgical department or division.

We recommend setting up some kind of educational session, such as grand rounds, to share with the primary team (preferably not in the ICU setting itself) why the critical care team feels the current practice ought to change, what current evidence supports the recommendation, and the plan for implementation of the recommendation. More often than not, this approach is highly effective, but one should remember to give the surgical group a little time to digest the presentation.

### Conflict Within the ICU Team

This area is worthy of discussion because it can be a very delicate and sensitive issue.<sup>3-7</sup> We believe the relationship between doctors and nurses in the ICU should be based on a foundation of healthy mutual respect. If an environment of mutual respect is established, conflict and disagreement can exist without becoming acrimonious. From the perspective of ICU leadership, an ICU in which the voices of all members of the team can be safely heard is a good one, and people will feel comfortable sharing their opinions. Such an environment decreases the likelihood of burnout and moral distress.

One thing we strongly recommend is to establish some kind of monthly ICU staff meeting. There

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are many ways to do this. We recommend a monthly nursing staff meeting in which the clinical bedside nurses could meet with the unit's nursing leadership (and perhaps one level of nursing leadership higher, if need be) so issues and challenges could be aired and there could be some follow-up about ongoing issues raised in previous meetings. We cannot emphasize enough how important it is for nurses to have a forum in which their voices are heard, preferably in front of people who can truly make a difference and affect change. Of course, not everyone agrees whether physician leadership ought to be present at such meetings. On the one hand, it would be good for physician leaders to hear directly from nurses about what their challenges are; on the other hand, nurses might be more comfortable sharing and airing obstacles in a forum without physicians present.

We also believe that a second, multidisciplinary, monthly ICU staff meeting should be held. Nurse and physician leadership and other key members of the multidisciplinary team, including representatives from respiratory therapy, pharmacy, nutrition, and infection control, should attend this meeting. Sticking to a formal agenda so the meeting can remain organized and issues from previous meetings can be followed up appropriately is important, but leaders ought to strike a balance, creating an informal “feel” so attendees will be comfortable making their ideas heard. Such a balance may be difficult to find, but it is vital for the long-term benefits of all parties involved. Follow-up on previously discussed action items is a top priority so that members of the staff take the meetings seriously and believe that change is achievable.

## Conclusion

Conflict in the ICU will not go away anytime soon. However, we critical care professionals must begin to see conflict not as something to be avoided, but as something to be managed. We should recognize conflict as a potential opportunity for improvement—as a chance to hear the ideas of others and ensure they're brought to light.<sup>8,9</sup> Although emotions can run high in the ICU, such tension is probably a sign that people care about their jobs and care about their patients.

Leaders at the local, regional, and national levels ought to channel passion in a positive way.<sup>10</sup>

They must continually hone their listening skills and respect and consider ideas that come from others. In order for new ideas to keep coming, environments must be nurtured that respect other points of view, encourage them to rise to the surface, support them, and give them life. Because such an environment is more conducive to change, and change is sometimes met with resistance, the process can be long and arduous. However, managing conflict and using it as an opportunity to improve conditions for our patients ultimately must be our guiding light in the high stress and high stakes ICU environment. We owe it to ourselves—and to our patients.

The statements and opinions contained in this editorial are solely those of the coeditors.

## FINANCIAL DISCLOSURES

None reported.

## eLetters

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