Conflict Resolution
in the Operating Theatre/Recovery

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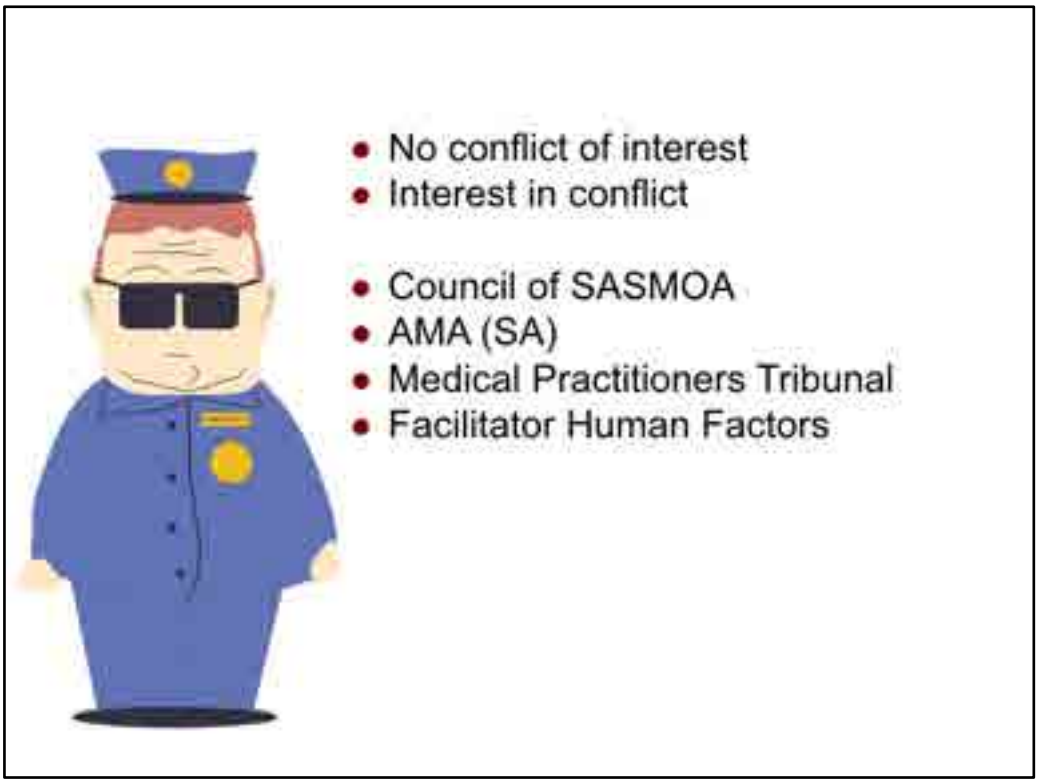


Conflict of interest statement
I am currently on the council of the South Australian Salaried Medical Officers Association (SASMOA)
And the council of the South Australian branch of the AMA.
As a result SASMOA has determined that I have a conflict of interest and am not allowed to take part in any council duties
So I know a great deal about conflict of interest!
I am also on the Medical Tribunal, that sits over the Medical board in South Australia.
Finally I lecture on conflict through a program called TeamSTEPPS and two surgical programs NOTSS and TIPS

Not About: Industrial Matters

Unions

This talk is not about industrial conflict that is correctly dealt with through Unions and industrial commissions

Not About: Unsafe or Unprofessional Conduct

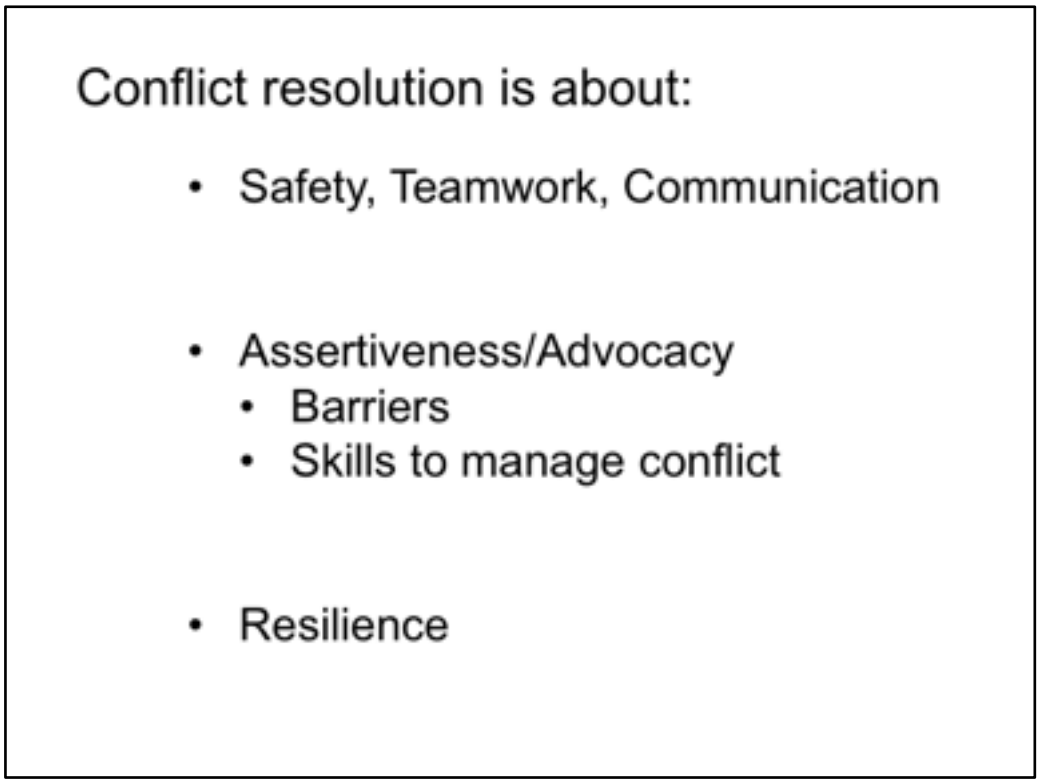
Safety Learning System report (AIMS)
AHPRA

It is not about Unsafe or unprofessional conduct that is managed through various reporting systems and ultimately the Australian Health Practitioners Regulation Agency

Not About: Bullying or Harassment

Formal reporting
Performance management

It is not about workplace bullying and harassment which is reportable and dealt with using principles of performance management.



This is about the safety of our patients.
How conflict that can arise from many sources can break up our teams resulting in poorer outcomes.
How conflict resolution is essentially about communication.

Conflict is unavoidable in a complex, high stakes, working environment like operating theatres.

Positive resolution of conflict helps strengthen our teams.

Then we will talk about assertiveness and advocacy for our patients.
Some barriers that stand in the way.

Safety, Teamwork, Communication

Assertiveness/Advocacy
- Barriers
- Scripts

Conflict
- Causes
- Methods of resolution
- Scripts

Resilience

Safety, Teamwork, Communication

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Resilience

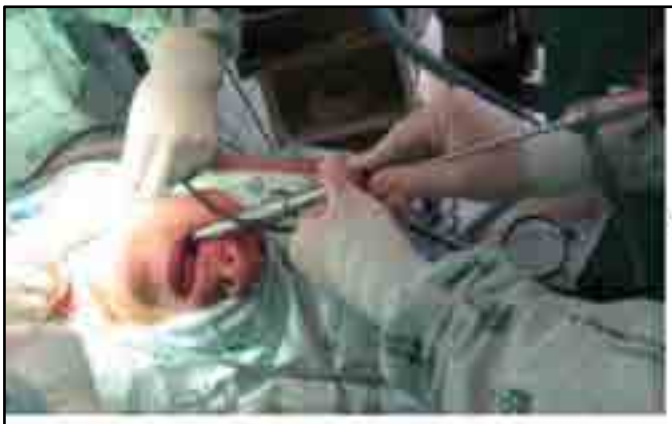
Barriers to Communication / Assertiveness

- Language difference

One of the more obvious barriers to communication and assertiveness is a simple language barrier

Search for “German coastguard video”

https://www.youtube.com/watch?v=0MUsVcYhERY



Mag ik plassen

Dutch to English: blazen:
blow; hum; wheeze; gasp; pant; puff

Dutch to English: plassen
pee; urinate; pass water

Language barriers are straight forward.
Here is an example from when I worked in Holland.
During the removal of a foreign body from the airway I asked the surgeon if I could ventilate the baby.
Blow air down the scope.
“Mag ik plassen”
Unfortunately is used a “p” instead of a “b”

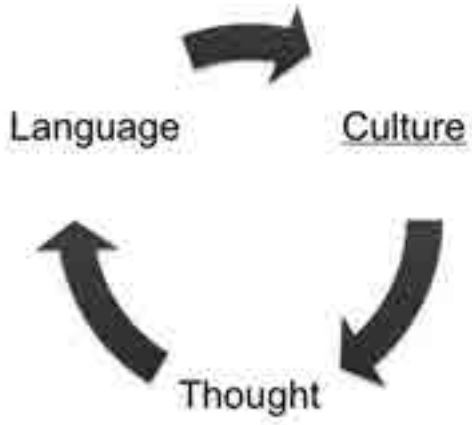
Dutch as a second language

I was preoccupied translating the words,
so I heard what people said
but I did not always
understand what they meant.

Ik versta je wel,	maar,	ik begrijp je niet
I can translate,	but,	I do not understand

Barriers to Communication / Assertiveness

Intonation
Body language



A closely related barrier to communication and assertiveness is culture. When I was working in Holland they had real difficulty understanding my sense of humour and took everything that I said literally.

It was very hard to work out if this was culture or language
Did they have a different sense of humour?
Or did they have difficulty in "reading" the cues in tone or language when the language was not their own.

I have been told that it is especially difficult to understand the Australian accent, and in particular when we wear masks.

They not only mask our words but also facial expression.

Culture is closely related to language in generating conflict.

Language and culture: problems

- We assume that 'yes' means 'I agree'
  - The Asian 'yes' is a habitual response.
  - Like "yeah I am listening", not necessarily "I understand"
- It may be an acknowledgement that you have asked a question NOT the answer to the question
- "Yes, (I will do that)" does NOT necessarily mean "Yes, (I know how to do that)"
- Risk of losing face (yours or theirs)
  - May pretend to understand your meaning.
  - Do not want to suggest that you are not being clear

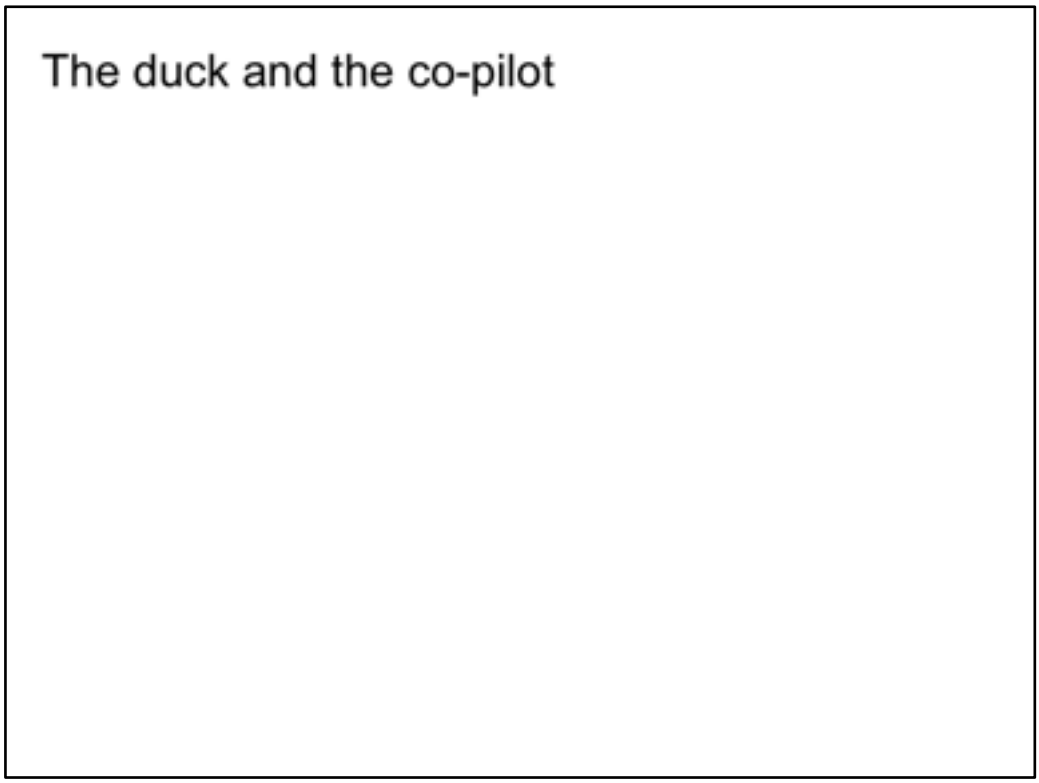
Language and culture: Suggestions

- Do not ask closed questions,
  - "Do you understand?"
  - Condescending
  - Another "yes", "no" question.
- Rather ask open questions,
  - "What do you understand?"
  - "What are you going to do?"
  - "Please let me know if my mask makes me unclear"

Barriers to Communication / Assertiveness

- Language
- Culture
- Status, Hierarchy
  - Don't want to look stupid
  - Not sure I'm right
  - Not my place, what do I know?

Another cultural is status or hierarchy.
It is one of the commonest reasons that staff do not speak up



Search “duck copilot video”

https://www.youtube.com/watch?v=KPpPjEd3yUY&list=PLoDNk7TM96wGfZ1mM6Ejmod4glkOsg6Ef

Safety, Teamwork, Communication

Assertiveness/Advocacy
- Barriers
- Skills to manage conflict

Resilience

In spite of these barriers we have a responsibility to speak up on behalf of our patients

To err is human: Building a safer health system. Washington, DC: National Academy Press. Preston, P. (2003, October).

Inquiry/Advocacy/Assertion.

These behaviors relate to crewmembers' promoting the course of action that they feel is best, even when it involves conflict with others.

Behavioral Markers.

(1) Crewmembers speak up and state their information with appropriate persistence until there is some clear resolution.

(2) "Challenge and response" environment is developed.

(3) Questions are encouraged and are answered openly and nondefensively.

(4) Crewmembers are encouraged to question the actions and decisions of others.

(5) Crewmembers seek help from others when necessary.

(6) *Crewmembers question status and programming of automated systems to confirm situational awareness*.

In Zen they talk about beginners mind.
It is a mind that may have the wisdom of experience
But it is a mind that is free from prejudice or bias.

We should tell our students to speak up, because they will see things that we do not.
Not everyone agrees.

"Junior team members should be able to question the decisions made by senior team members"

AGREE	
Pilots	97%
ICU Consultants	94%
Consultant anaesthetists	84%
Nurses	70%
RMOs	60-70%
Consultant surgeons	55%

Now we know what advocacy is, do we practice it?

The results for this survey speak for themselves

(Sexton et al. BMJ 2000;320:745-9)

This video about a failed intubation highlights the importance of speaking up on behalf of patients.

The nurses tried to to get the doctors to realise the patient needed a tracheostomy and a bed in intensive care.

They used the principle of “hint and hope” but they were ignored.

This video also shows that you can have all the experts and fancy equipment for difficult intubations,
But,
It can be the non technical aspects that determine the outcome.

The video can be found online, just search Elaine Bromiley.

http://www.dailymail.co.uk/health/article-421989/Blunder-killed-wife.html

Now we have outlined some of the barriers to getting our message across and ensuring understanding.
There are some methods we can use to ensure our concerns are heard.
These can be described a scripts, a recipe or formula that is agreed upon.
When the issue is a matter of fact such as an allergy, or operating on the wrong side, we can use something called the 2 challenge rule.

It is important to voice your concern by advocating and asserting your statement at least twice if the initial assertion is ignored (thus the name, "Two-Challenge rule").
These two attempts may come from the same person or two different team members.
The first challenge should be in the form of a question.
The second challenge should provide some support for your concern.
Remember this is about advocating for the patient.

The "two-challenge" tactic ensures that an expressed concern has been heard, understood, and acknowledged.
There may be times when an initial assertion is ignored.
If after two attempts the concern is still disregarded, but the member believes patient or staff safety is or may be severely compromised, the Two-Challenge rule mandates taking a stronger course of action or using a supervisor or chain of command.
This overcomes our natural tendency to believe the medical team leader must always know what he or she is doing, even when the actions taken depart from established guidelines.
When invoking this rule and moving up the chain, it is essential to communicate to the entire medical team that additional input has been solicited.

There are a number of ways to repeat the message

Curious (Concerned)

That cystic duct looks big – could you show me the anatomy?

Unsure (Uncomfortable)

I'm not sure that it is the cystic duct

Seriously concerned

I'm really worried that it's not the cystic duct

Second Pair of Eyes

Perhaps we could get another opinion

Stop (for Safety's Sake)

Please stop the dissection

There are numerous methods/models of graded assertiveness.
Here is the surgical method.
It is slightly less confrontational.

The CUSS approach allows the trainee to phrase their concerns within a learning mode.
You can see how it starts off with a question which is less confrontational.
It avoids 'you must' or 'you will' statements.

Then unsure
Finally seriously concerned

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Causes of Personal Conflict

- Hierarchy
  - Power
  - Control
- Personality Type

- Low resilience
  - Hungry
  - Angry
  - Late
  - Tired

Sometimes the conflict is not just about information.
It has a more personal flavour.

It might involve hierarchy or power.
It may be a result of different personality types.

It might be due to a decreased resilience of the team from fatigue or time pressures

Disagreement and Aggression in Theatre

Source of aggression	n	%
Register nurses/ODP	256	65.6
Consultant surgeon	209	53.4
Consultant anaesthetist	131	33.5
Surgical registrar	124	31.7
Anaesthetic registrar	55	14.1
Line manager	52	13.3

Disagreement and aggression in the operating theatre

Coe, R. 2008

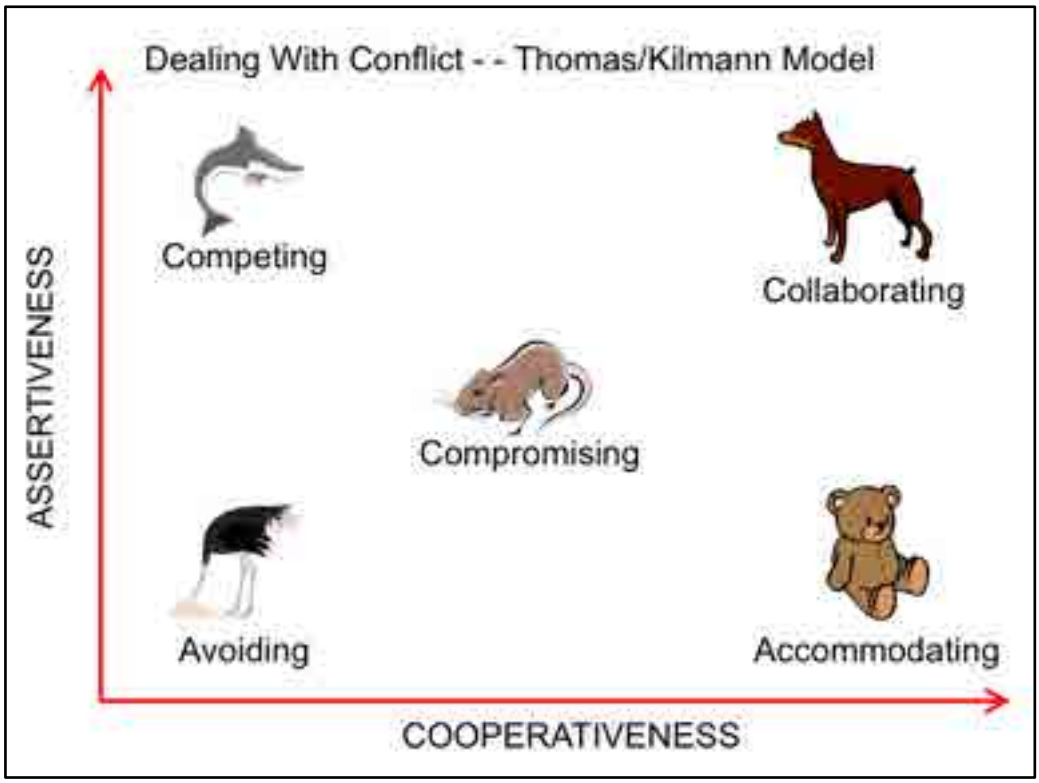
Main source of disagreement concerned operating list management.
Over-running of lists 90%
Daily occurrence 55%

Survey of OR staff in NHS
disagreement = parties involved in the exchange held conflicting views which could not be immediately reconciled
Aggression = rudeness, bullying, shouting, malicious gossip, refusal to speak and purposeful ignoring

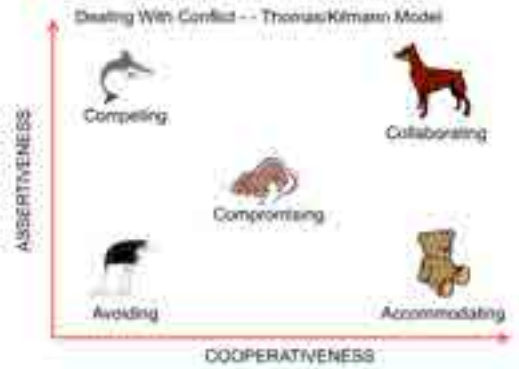
Sample –

nurses/op dept practioner	227
consultant surgeons	24
junior surgeons	14
consultant anaesthetists	39
Junior anaesthetists	17

COE R. & GOULD D. (2008) Disagreement and aggression in the operating theatre. Journal of Advanced Nursing 61(6), 609–618



There are a number of styles for dealing with conflict.
This is the Thomas Kilmann Model



Everyone has a preferred method of resolving conflict

Each one has its advantages & disadvantages

Competing: High assertive, low cooperative

You want to get your way no matter how it affects the other party.

What are situations where you have seen the competing method work well?
What are the problems with this method?

Competing

+ve

When a quick decision is needed.

-ve

Loss of resilience, ("money in the bank")

Collaboration: High assertive, High cooperative

You are concerned with fully satisfying both sides.

Collaboration seems like a good idea.
When is it most useful?
What are the problems with collaboration?

Collaborating

+ve

Provides sustainable solutions.
When gaining commitment.

-ve

Time consuming.
80:20

True collaboration is a process, not an event

Avoidance: Low assertive, Low cooperative

You don't want to deal with conflict so you delay, minimise or ignore issues

Avoidance seems like a poor choice on all occasions.
When is it useful?

Avoiding

+ve

When one or more parties need time to calmdown or consider a situation

When issues are of low importance.

-ve

Loss of resilience

Opportunity cost

Accommodating: Low assertive, High cooperative

Lets agree to respect each others views
No matter how wrong you are

Accommodating seems like a good way to build teams.
Or is it?

Accommodating

+ve

You are learning a new skill.

The issue is of low importance.

-ve

Your voice is not heard

In compromise everyone gets some of what the want.
But no-one is fully satisfied.

Compromising

- -+ve
  Quick agreement
  The decision is a temporary solution.
  The issue is of moderate importance..
- -ve
  No-one gets what they want

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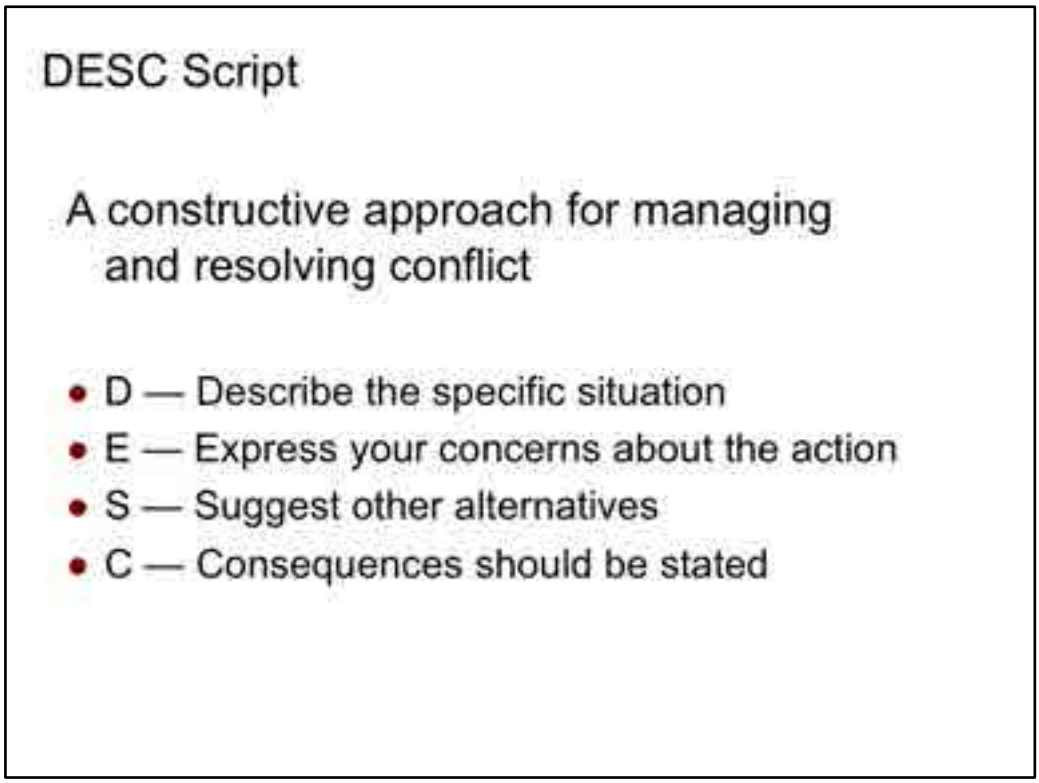


What if a conflict has become personal in nature?
The DESC script can be used to communicate effectively during all types of conflict, and is most effective in resolving personal conflict.
The DESC script is used in the more conflicting scenarios in which good behaviours aren't practiced, hostile or harassing behaviours are ongoing, and safe patient care is suffering.

DESC is a mnemonic for—
D = Describe the specific situation
E = Express your concerns about the action
S = Suggest other alternatives
C = Consequences should be stated

Ultimately, consensus should be reached.

DESC Script

- Timely
- Frame problem in terms of your own experience and observation. Use "I" statements
- Depersonalise: Focus on the patient, safety

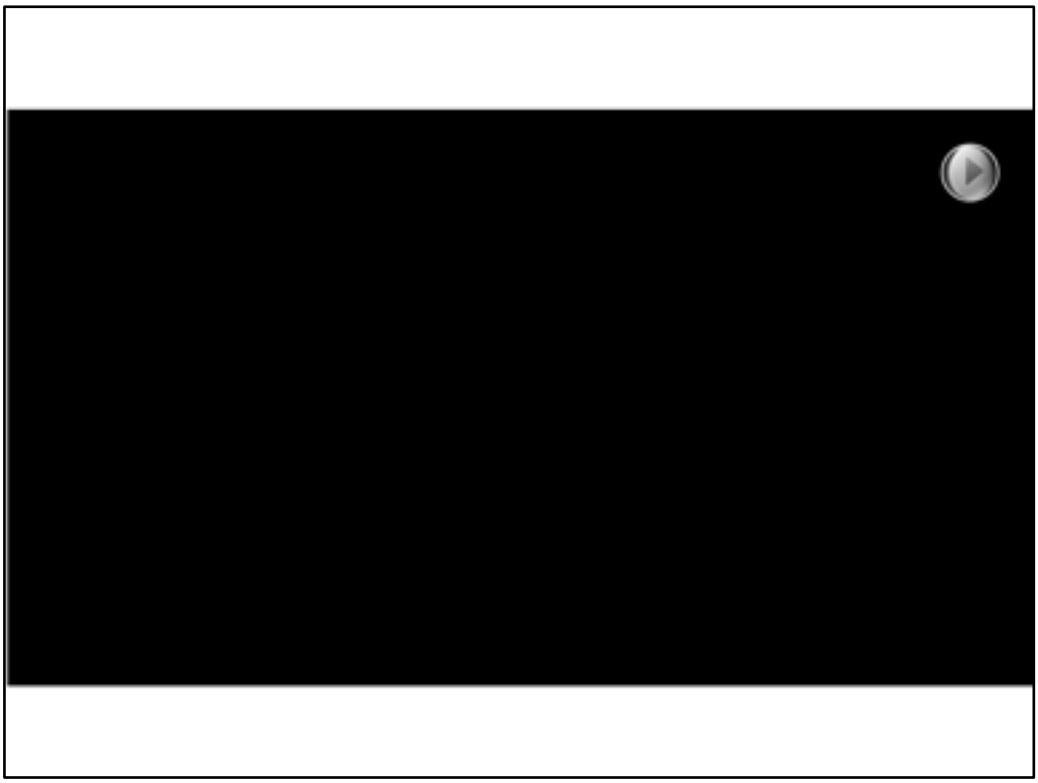
Its not about you (or me)

There are some crucial things to consider when using the DESC script:

Time the discussion
Work on win-win— Despite your interpersonal conflict with the other party, team unity and quality of care are dependent on coming to a solution that all parties can live with
Frame problems in terms of personal experience and lessons learned
Choose the location—A private location that is not in front of the patient or other team members will allow both parties to focus on resolving the conflict rather than on saving face
Use "I" statements rather than blaming statements.
Critique is not criticism
Focus on what is right, not who is right

DESC script in the operating room

In the following video you can see how the DESC script is used.
There is a combination of conflict resolution styles involved.



Here we will watch a scene between a surgeon and an anaesthetist.
The anaesthetist described the specific situation ("D"),
expressed her concerns about the action ("E"),
suggested other alternatives ("S"),
and stated the consequences ("C").
Ultimately, consensus was reached.

Note the anaesthetist Avoided the confrontation in front of the patient, a helpful form of avoidance.
The surgeon was Denying there was even a problem, an unhelpful form of avoidance.
The surgeon was initially competing and very assertive.
Later he was accomodating, "you are right, it is not good practice"
The anaesthetist compromised by saying that "there were problems with over-runs" and she would bring it up at the next meeting,

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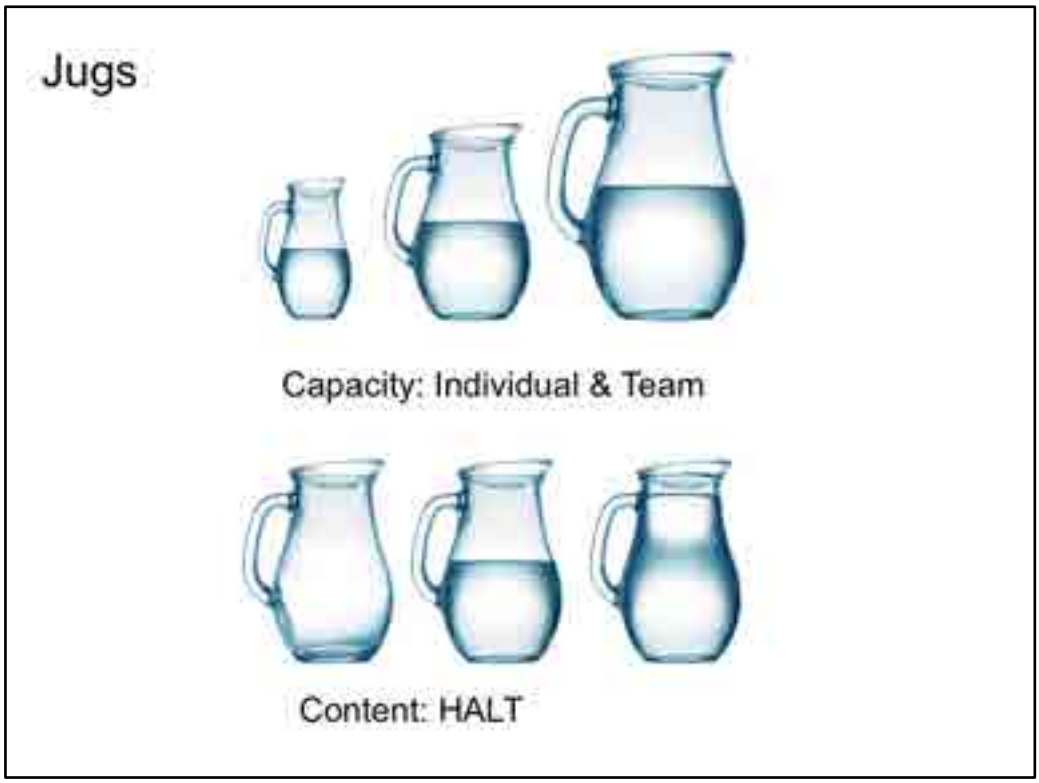

We all have different capacities of resilience.

And at any particular time our resilience "jug" can be relatively full or empty

Hungry

Angry / **A**nxious

Late / **L**onely

Tired

The sorts of things that wear us down are included under HALT

Dimensions of Resilience

- Fitness and stamina
- Nutrition for energy
- Rest and recovery

- Calming and focussing
- Impulse control
- Emotional regulation
- Positive emotion
- Realistic optimism

- Self belief
- Outlook & perspective
- Thinking traps
- Sustained focus
- Causal analysis
- Control controllable

- Values and beliefs
- Empathy
- Reaching out

In short conflict resolution is about communication and ultimately patient safety
We have looked at a couple of scripts to practice: CUS and DESC

And finally underlined the importance of looking after ourselves.