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Conflict Resolution: Practical Principles for Surgeons

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Abstract Historically, surgeons have had little formal training in conflict resolution; however, there has been an increasing body of evidence that poor conflict resolution skills may have an adverse impact on patient outcomes and career advancement. Furthermore, the Accreditation Council for Graduate Medical Education has recognized the importance of conflict resolution skills in resident training by mandating the training of communication skills and professionalism. These skills have often been taught in other professions, and surgeons may need to acquaint themselves with the literature from those fields. Conflict resolution techniques such as the 7-step model or principle-based conflict resolution can be applied to conflict in the operating room, wards, and among colleagues. We propose a model for conflict resolution by using the basic tools of the history and physical exam, a process well known to all physicians.

Introduction

Conflict is defined as "a state of disharmony between incompatible persons, ideas, or interests" [1]. Although there are many different forms of conflict, most conflict is intrapersonal or interpersonal in nature. Intrapersonal conflict is defined as conflict that occurs within oneself, whereas interpersonal conflict occurs between individuals [2, 3]. Interpersonal conflict is normal in the workplace. Conflict between individuals occurs commonly in any workplace, but it may become more apparent in settings where teams of people are needed to perform or execute a task. Surgery, like most fields in medicine, is a specialty where the "team concept" is vital for patient care. The responsible surgeon is always the leader of a medical team that works together to oversee a patient's journey safely from the evaluation process, to the operating room, and through the postoperative course. As future team leaders, surgeons in training need to develop the necessary leadership and conflict resolution skills to succeed in the workplace.

Surgeons have often been criticized for being difficult to work with because of their poor interpersonal skills that lead to conflicts with nurses, operating room staff, and even patients[4–6]. Even more concerning, though, is a lack of self-awareness about failures in communication. A recent article by Makary et al. [4] demonstrates a large discrepancy between the perceptions of operating room nurses and operating surgeons concerning collaboration and team communication. Surgeons reported good collaboration with the nurses 85% of the time, whereas the nurses reported a favorable collaboration only 48% of the time [4].

Interpersonal conflict is not only distressing to the principals, it can have a significant impact on patient care because it often leads to miscommunication and poor team interaction. A study by Gawande et al. evaluated adverse surgical events that resulted from errors of management and found that 43% of the errors were related to breakdown of communication between personnel [7]. Within the critical care setting, poor collaboration has actually been shown to lead to increased length of stay within the ICU

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and increased patient mortality [8, 9]. In support of these findings, root cause analysis by the Joint Commission on Accreditation of Healthcare Organization identified breakdown in communication as the leading cause of wrong-site operations and other sentinel events [10]. Heightened awareness of miscommunication and its detrimental effect on patient care, has provided the impetus for integrating communication, interpersonal skills, and professionalism into the surgical training curriculum [11].

Unfortunately, current medical education rarely offers formal training in conflict resolution, communication, and leadership skills needed to improve team communication and function. Other professions, however, have studied and implemented formal curriculum in conflict resolution. For example, conflict resolution and teamwork principles have been the cornerstones of teaching and improving productivity in the business model. This review presents different methods and principles of conflict resolution that may be applied to some of the challenges that surgeons encounter on a daily basis.

Conflict resolution

The first formal conflict resolution theories were developed in the 1950 s in response to the Cold War. Pioneers from various disciplines saw the value of studying conflict and applying approaches from management, social work, psychology, communications, and systems theory to its resolution. However, the field did not experience acceptance and growth until the 1980 s. Today, the work of such notable figures as Herbert Kelman, Roger Fisher, William Ury, Adam Curle, and Elise Boulding continues to advance the field of conflict resolution [12]. The effectiveness of conflict resolution in the twentieth century was evident from the examples set by great social leaders such as Mahatma Gandhi and Dr. Martin Luther King, Jr. Gandhi was a British-educated lawyer who championed the cause of Indian independence from foreign domination [13]. His philosophy was *satyagraha*, asserting truth with nonviolence. He used this basic philosophy to resolve conflicts such as civil rights for Indians in South Africa and, most importantly, for Indian independence from British rule. The philosophy of *satyagraha* as a method to peacefully resolve conflict was later used by Dr. Martin Luther King, Jr., to propel his vision of equality for all men and women [14].

Conflict resolution is most likely to succeed in an environment built on leadership principles, communication skills, and flexibility. Leadership in conflict resolution can take on a variety of styles, which can be thought of as autocratic, laissez-faire, or democratic [15]. Autocratic leaders directly delegate all orders to the people below them and leave little decision making to the team. Laissez-faire leaders give little guidance to the team and expect team members to be self-directed and self motivated. Finally, democratic leaders actively participate in decision making, but will consider the suggestions and ideas put forth by all group members.

There is a time and place for each of these leadership styles. As one can imagine, the autocratic leader role may be more appropriate in emergency situations where the surgeon should give orders and maintain tight control over a clinical situation. The laissez-faire leadership style is not likely to succeed when there is a conflict. Most experts suggest that the democratic style of leadership is the most effective in times of conflict. The democratic leader has open channels of communication and is concerned about the feelings and thoughts of others.

Resolution of conflict can occur only when communication is open, unemotional, and honest. The importance of communication in the professional development of physicians has been recognized by the Accreditation Council for Graduate Medical Education (AGME). One of the six core competencies mandated by the ACGME for resident education is the development of communication skills [11]. Three practical communication principles that may be used for conflict resolution are described by author Sam Horn: (1) allow only one person to speak at a time, (2) the opposing parties can only speak once on the problem until each side has expressed an opinion, (3) limit the time each side can speak to prevent rambling and repetition of issues [16]. These tools can be used to help resolve interpersonal conflict and effectively manage teams in the operating room and on the wards.

To effectively resolve conflict, surgeons must be flexible enough to see each point of view objectively. Historically, the surgical discipline has been viewed as a specialty the problems are most difficult to deal with once conflict has arisen. Difficulty in resolving conflict often arises from the sense that surgeons are unwilling to be flexible [17]. In a recent leadership article on the “willingness to lead” and the “willingness to learn,” Brunicardi et al. describe the need for flexibility. These two “willingness: principles may guide a surgeon toward being flexible enough to negotiate and compromise in a conflict situation [14]. For example, if the nursing staff is in conflict with the resident staff, as a leader, the attending surgeon will need to spend the time to carefully understand the position of both groups. This may entail learning the exact protocols that the nurses have to abide by, hospital policies, and also to whom the grievance is directed. The idea of flexibility in leadership has also been stated in a recent review by Rogers et al. in which the authors outline six principles that surgeons may use for conflict resolution [18]. Even though the need for “flexibility” is never directly stated, the basic understanding of problem solving,

negotiation, and compromise requires that surgeons in leadership positions be willing to be flexible when it comes to identifying and resolving conflict. [18].

Models of conflict resolution

7 step model

A popular method of conflict resolution has been described by Stewart Levine [19], who proposes a seven-step approach to moving from conflict to resolution. The steps are listed in Table 1. The first step is to develop the attitude to resolve the conflict. In other words, recognize that there is a conflict and, therefore, there are two opposing views. This step also assumes a desire to resolve the conflict, rather than dictate the outcome. The second step is to tell your story and to truly listen to the other person's story. The third step is to be open to a preliminary vision of resolution. During this step, one should try to develop an initial resolution that would allow for both parties to "win." The fourth step, after agreeing that resolution is possible and determining that both parties are committed to the resolution, is current and complete disclosure. This entails full disclosure of all aspects of the conflict and is often the most difficult step. The fifth step involves reaching an agreement based on principle after all of the issues have been discussed. The sixth step is to craft the agreement based on a detailed blueprint for the vision. The seventh step is to make your resolution a reality.

Principle-based model

In their book titled *Getting to Yes* [20], Fisher and Ury describe another method for conflict resolution based on principled negotiation. Therein they discuss four principles that should be held firm during any conflict resolution: (1) maintain objectivity by not making the discussion personal, (2) focus on interests not positions, (3) be flexible for multiple solutions to the issue, and 4) use objective criteria (Table 1).

The most common scenario at the beginning of conflict resolution is for each party to stake its claim and then advocate for that position. This can jeopardize the ability to resolve the conflict as each party becomes more committed to its position. The more ego becomes identified with one's position, the more one tends to defend that position in order to "save face." The conflict becomes a "battle of wills," and limits to flexibility interfere with open discussion. This danger can be avoided by separating the people from the problem, focusing on basic and shared interests and principles instead of position, and exploring a few possible solutions before deciding on the ultimate solution. The first principle, maintaining objectivity, is often one of the most difficult to carry out. All human beings are subject to emotional responses and because of this, conflict is easily perceived as a personal threat, when it usually is not. To combat this tendency, it is critical to consciously seek to understand the data and to keep communication open. This is done by listening as well as discussing, while keeping emotions, particularly anger, in check while looking for principle-based, shared outcomes. The second and third principles are related and focus on the objective issue at hand and not the positions of each person. The third principle is where some creativity may come into play, because many problems may have multiple solutions. The goal of conflict resolution is to identify principle-based options for resolving the conflict at hand. The last principle of conflict resolution involves the use of objective criteria to assess the outcome of the shared outcome [20].

History and physical model

For physicians, another model that has great application in solving conflict and teaching conflict resolution, is to apply the tools used in obtaining a history and physical exam. The history and physical exam is a tried and true method for initiating a problem-solving process and coming to a

Table 1 Models of conflict resolution

7-step model	Principle based	History and physical
Develop the attitude	Maintain objectivity	History
Listen	Focus on interests	Physical exam
Preliminary vision	Be flexible	Differential diagnosis and plan
Disclosure	Use objective criteria	Preoperative preparation
Principle-based agreement		Informed consent
Craft the agreement		Time out
Execute the agreement		Operation
		Postoperative care

resolution with a treatment plan. This same format may be applied to conflict resolution (Table 1).

History

The history portion consists of obtaining information about the conflict by listening. Just as in taking a past medical history from a patient, this step includes a discussion of the history of the conflict, for example why the conflict has arisen and what has specifically resulted from the conflict. It is often the case that by the time a conflict arises, negative emotions such as anger and a sense of injustice are in play [21]. The key element of the history portion of conflict resolution is to allow the other party to describe such feelings, listening in a calm manner, keeping an open mind, and trying to empathize with the speaker.

Physical exam and laboratory review

The second step of this method continues to examine the conflict with objective data, much as occurs in the clinical setting. As a physician would collect data by performing a physical exam and reviewing laboratory data, this step allows each party to collect objective data that pertains to their position. For example, in a conflict between anesthesiology and start times for the operating surgeon, the data would consist of patient time into room, incision time, time out of the operating room, and reason for delay.

Differential diagnosis and assessment/plan

The third step of this method is assessment and planning, which entails formulation of the possible reasons for the conflict (i.e., differential diagnosis) and an outline for a plan to resolve the conflict. Just as in evidence-based medicine, the resolution of the conflict should be principle based instead of emotion based [19].

Preoperative preparation and informed consent

After the two sides have discussed the outline for a plan of action, then the next step would be pre-implementation preparation. Much like preoperative preparation and informed consent, possible problems are identified early, consensus is built on all aspects of the plan, and a final review is done by both parties prior to execution.

Time out

Similar to the "time out" that is performed prior to the start of an operation; conflicting parties also need to be in constant communication to prevent errors. Just as in the operating room when the surgical team communicates with the anaesthesiology team and the circulating nurse, the importance of constant communication between parties is essential to guarantee that expectations are met and that any possible complication during the execution of the plan is averted.

Operation

The "operation" step of this conflict resolution model is the implementation of the plan. As in any operation, there are multiple steps that need to be performed and these steps should have been laid out during the assessment and plan step of the conflict. Furthermore, the concept of team communication is a fluid and active process that also enables efficient implementation of the plan. Just as in any operation, once the goal is achieved the next portion involves postoperative assessment and care.

Postoperative care

The final aspect of this conflict resolution model involves continuing assessment and evaluation of the results of the "operation." Just as we take care of patients in the postoperative setting, the importance of follow-up for conflict resolution cannot be downplayed. With changing circumstances, follow-up is essential to ensuring that conflicts stay resolved. This occurs when both parties feel validated, respected, and involved [21].

Conclusions

As surgeons, we have devoted our lives to caring for patients, and this is one of the unique perspectives that can be brought into medical conflict resolution. There are a number of different conflict resolution models, all of which share the basic principles of good communication, flexibility, leadership, and empathy. The "history and physical" method of conflict resolution is easily understood and is a common framework for all physicians, allowing this method to be easily implemented and taught in the workplace. Conflict resolution is an important component of patient safety and professional quality of life. By openly discussing conflict and how to resolve it, our patients and colleagues directly benefit.

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