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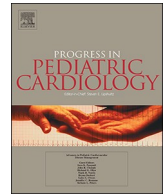
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The hard talk: Managing conflict in the cardiac intensive care unit

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ABSTRACT

Conflict between parents and providers is common in the cardiac intensive care setting, particularly in patients with prolonged length of stay. Poor communication is the most commonly cited reason for conflict and is exacerbated when providers and families cannot find common ground and develop mutual trust. It is critically important that healthcare providers learn strategies to better partner with families in order to optimize patient medical and psychosocial outcomes. This requires providers to avoid falling prey to their own implicit (or unconscious) biases, including those towards families labeled as “difficult”. Building a healthy family-provider relationship is part of a healthcare provider's duty to treat, has a measurable effect on patient outcomes, and sets up a foundation for the provider-family dyad to more easily navigate any conflicts that do develop. Once a relationship is built, providers and families can talk through their conflicts. They are more likely to have open and transparent communication and are more able to give each other the benefit of the doubt when navigating difficult situations and/or behaviors, rather than labeling each other as intrinsically “difficult” people.

1. Introduction - scope of the problem

Up to 60% of patients and/or families are considered “difficult” by their healthcare providers [1,2]. In the adult population, family-provider conflict has been studied most robustly related to decisions about end-of-life care, perhaps because the patient may be too sick or incapacitated to make their own independent medical decisions without family input [3–6]. Not unexpectedly, conflict in such cases is extremely common; in some studies, conflict is a factor in nearly 80% of cases [5,7].

In the pediatric population, the necessary focus on family-centered care means parent-provider conflict may arise during everyday decision-making. To look at this more closely, Studdert et al. devised a study of pediatric ICU patients with a prolonged length of stay (> 8 days). In this population nearly 50% of families experienced conflict, most commonly related to problems with communication or disagreements about the general plan of care [8]. These issues are particularly relevant in the cardiac intensive care unit (CICU) because of the critical nature of care provided and the often longitudinal nature of the relationships formed between providers and families. Children with complex palliated congenital heart disease or who are waiting for heart transplantation can spend weeks to months in the CICU either consecutively or over recurrent admissions throughout their childhood.

Any encounter between a parent and provider is not solely an isolated incident but is built upon a foundation of numerous previous interactions and experiences – both positive and negative. While many providers enter medicine with a desire to provide psychosocial support in addition to medical care, the urgent nature of decision making in the CICU can make it challenging to stop and dive deeper into each family's personal story. These families are typically experiencing significant psychosocial stress – disruptions to family routine, job insecurity, out-of-pocket healthcare expenditures, social isolation, caregiver burnout, loss of control, and even psychiatric disturbance including higher rates of anxiety, depression and post-traumatic stress disorder [9–14]. These cumulative stressors are associated with decreased parental satisfaction with care delivered and can exacerbate conflict by leading to anger, frustration, fear, and despair [15,16].

While these emotions may be perfectly normal reactions to the stressors these families have faced in the past, experienced in the present, and anticipate in the future, they may also interfere with collaborative decision making [17]. Perhaps underappreciated is the fact that healthcare workers embedded in these high-intensity environments may also be manifesting maladaptive responses to their own daily stressors in and out of the hospital. Healthcare provider burnout has received increasing attention in the past several years. Conflict has been shown to be a major driver of burnout amongst healthcare workers and

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can lead to erosion of empathy over time [18,19]. While implicit bias affects everyone, it particularly thrives in the setting of burnout. In fact, physicians who score lower on validated scales measuring empathy are more likely to label their patients as difficult [2]. But this label is an oversimplification. In the words of Sylvestre Quevedo, “behind each label lies a real person with a very particular, indeed unique, story” [20].

2. The trouble with labels

Implicit bias is the tendency to process information based on unconscious associations that may even conflict with one’s conscious (explicit) beliefs. Recent world events have elevated awareness of the dangers of implicit bias based on race and ethnicity, but labels of any kind can lead to bias. The human mind must process an incredible amount of information each minute and is designed to use labels to help us categorize and then rapidly act on that information [21]. This is particularly necessary in the high-stakes world of cardiac intensive care. Unfortunately, these unconscious biases influence the way information is organized and can lead to assumptions that change the way relationships are managed and ultimately the way care is delivered [22,23]. Ethnic and racial minorities and families from disadvantaged socioeconomic backgrounds are even more susceptible to such bias, which has been shown to affect both provider behavior and patient/family perception of the care delivered [22,24]. Underlying assumptions can bias providers’ interpretation of difficult situations and the people involved. This may lead to labeling which perpetuates further bias. It is critical that providers label the encounter rather than the family as difficult or risk succumbing to the biases such labels inevitably perpetuate [1,25,26]. The application of the “difficult family” label becomes a self-fulfilling prophecy such that every encounter is viewed through a difficult lens and the family then responds in kind [17]. This vicious cycle further erodes the relationship. As trust deteriorates, conflicts will continue to escalate in a predictable way. Forbat et al. have created a framework outlining the predictable phases of parent-provider conflict escalation [27]:

- Mild conflict begins with recurrent misunderstandings
 - Using language in an insensitive manner
 - Mixed messages
 - Real or perceived patient management concerns
 - Reaction to previous unresolved conflict
- Moderate conflict is characterized by deterioration of trust
 - Avoidant behaviors
 - Micromanagement of care
 - Separation into opposing camps
 - Development of entrenched positions
- Severe conflict results in disintegration of the therapeutic alliance
 - Shift in focus from the child to the conflict itself
 - Physical and verbal threats and/or abuse

In order to avoid escalation of conflict past the point of no return, providers must recognize early warning signs of a relationship at-risk and intervene accordingly.

3. Power differential

Although there is a shared responsibility between provider and family for maintenance of the therapeutic alliance, the greater ethical responsibility lies with the clinician [17,28]. Physicians have taken an oath to use their knowledge and skills to improve the health of their patients and families. Patients and families have taken no such oath. A well-functioning family-provider relationship is a powerful driver of positive health outcomes, in some studies showing greater effect than aspirin for preventing myocardial infarction or smoking cessation for improving mortality [7,28–30].

In addition to a direct association with patient outcomes, dysfunctional family-provider relationships may affect patients indirectly via the effect on parental coping. Parental stress and mental health is an important driver of neurodevelopmental and psychosocial outcomes in children with congenital heart disease [10,31]. Parental stress has been shown to be strongly associated with a worse long-term neurodevelopmental and quality of life outcome in children with chronic cardiac conditions, in some cases a more potent predictor than the severity of the medical condition [32,33]. These family stresses occur despite the best efforts and intentions of the healthcare team to create a collaborative environment characterized by shared decision-making. The reality is that any encounter between a healthcare provider and family takes place in the context of a tremendous power differential, even for the most medically savvy families [28,34,35]. The hospital is a foreign experience filled with strange sights, sounds, and smells. This is exacerbated in families facing language, health literacy, or cultural barriers that do not align with “hospital culture”.

4. A complex game of chess

Hospitals are a metaphorical game of chess and healthcare providers are like the chess pieces. Each member of the healthcare team has a different role and works together to accomplish the task of “winning the game” (i.e., improving the patient outcome). The team functions collaboratively under a set of shared expectations for conduct and behavior. As part of medical education, hospital orientation, and cultural indoctrination, the rules are clearly laid out [36,37]. As providers gain experience within the healthcare system, they become increasingly comfortable in those roles and operate seamlessly within the framework of those “rules”. They spend innumerable hours in the healthcare setting. They speak a shared language. They build relationships with their colleagues and the hospital eventually becomes a natural habitat. And while friction does sometimes occur within the team, these conflicts proceed predictably within the framework of the previously established shared principles. We are still playing the same game of chess.

Providers traditionally underrepresented in medicine may have a unique perspective on this chess game. As an African American pediatric cardiac intensivist, I have spent the majority of my professional life as one of only a few underrepresented minority physicians in any given room. This is particularly notable in gatherings with a high proportion of senior physicians in leadership roles. While I believe it does not always affect me moment to moment, I admit that I do count the number of other underrepresented minorities at a conference, a lecture, a work dinner, or an administrative meeting. As the only African American physician in my unit, I have become the go-to resource for and mediator between racially and ethnically marginalized families and staff. I have provided counsel on myriad issues, including how to wash and style African American patients’ hair when their parents were not around, to intervening when security is called on minority families for being “too loud” or “too aggressive”.

Yet even when I stand alone as an underrepresented minority, I still generally feel as though I am a piece of the larger whole. I understand the hospital. I understand the rules. I understand my role and I know what is expected of me. I may be a plastic chess piece amongst wooden chess pieces, but I still generally feel at home on the chessboard.

For our patients and families, being in the hospital is more like being a checker piece on a chessboard. The game board looks like the checkerboard the family is used to, but the rules are somehow different. The codes of conduct and expectations may be different from what they experience in their own families, neighborhoods, and cultures. They are far from home, friends, and other outside sources of support - all made worse by the forced physical isolation of the COVID-19 pandemic. Even those who speak English as their primary language don’t speak medical jargon. Worst of all, they did not actually agree to play this game in the first place. Except, it is not a board game but rather their sick child, and they are not a checker piece but rather a family in crisis.

The cultural isolation of the hospital itself is exacerbated for those who are unable to find a sense of “sameness” in the providers around them. Specifically, studies show providers from four populations are significantly underrepresented in medicine compared to the general population: women, racial and ethnic minorities, sexual and gender minorities, and people with disabilities [38]. Families from these and other marginalized groups may struggle to find commonalities with the healthcare team.

5. Provider responsibilities

It is the job of the healthcare providers to facilitate families' adaptation to this new environment and to find common ground. Helping parents to feel safe and welcomed as part of the collaborative healthcare team is a critical component of family-centered care [14,39]. Active participation on the part of parents and “good communication” on the part of the healthcare team have both been shown to reduce parental stress and decrease tension in the parent-provider relationship [40]. Alternatively, implicit bias has been shown to have a negative effect on communication which may in turn erode parent-provider trust. Families labeled as “difficult” often detect the negative nonverbal behaviors providers unintentionally display in this setting [41], despite best intentions. The result is further disempowerment of the patient and family. This means physicians have a special responsibility to ensure the therapeutic alliance is not further threatened by their own implicit biases and misperceptions [28]. As time in the hospital stretches on, relationships with staff exert an ever greater influence on the patient and family experience as the specifics of the child's medical condition may even start to fade into the background [42]. Thus, despite the challenges, providers must find ways to repair the relationship, or better yet, to prevent the escalation of conflict in the first place.

6. Strategies for building healthy relationships

While providers in both the ambulatory and intensive care setting often describe reluctance to tackle major psychosocial issues in their healthcare encounters, both patients and physicians report lower levels of satisfaction when communication is limited to the purely biomedical aspects of care [2]. Interventions focused on returning the healthcare provider to their role as a holistic caregiver may both reduce the number of difficult encounters and improve provider job satisfaction [2,43]. Unfortunately, many providers feel ill-equipped to navigate these scenarios and medical education does not routinely include in-depth training in interpersonal interactions or conflict resolution [44].

“Difficult families” are a syndrome, not a species. Under the right circumstances, anyone can manifest difficult behaviors. Unfortunately, by the time the syndrome is diagnosed, we have missed the accumulation of symptoms which led up to that particular moment – the often unintentional but insensitive use of language, mixed messages and miscommunication on the part of the healthcare team, and care management concerns (whether they be actual mismanagement or just a mismatch between parental expectations and outcomes). For parents of children with prolonged length of stay or serious chronic cardiac disease, these initial “frictions” may stretch back weeks, months, or even years. They may not even involve any of the current members of the healthcare team. But looking back, there is all too often a trail of breadcrumbs leading back to the various prior unaddressed issues that have been swept under the rug. Tackling these conflicts in real time before they can accumulate is the best way to prevent the creation of a family that might not otherwise be difficult.

So... what can providers do to combat conflict? Identifying shared principles, clearly explaining consequences, applying the principles fairly and consistently, taking ownership of one's own role in helping or hurting the family-provider relationship, and getting to know patients and families on a personal level are the best ways to keep reasonable families from getting infected with difficult behaviors.

1. Create a shared agreement regarding the rules of engagement for both providers and families.

We have already established that families are navigating a foreign environment where they are not comfortable, and providers are relatively comfortable. These rules of engagement, which define the culture, are often unspoken and may not be as obvious for families unfamiliar with life in the hospital. The first step in helping families to successfully navigate the difficulties of a prolonged stay in the cardiac care unit is to explore the needs of parents and providers alike. This requires the creation of a system of shared principles that ensures all parties are playing the same game and understand the rules.

Professional Coach Steve Chandler counsels against using the terms “limits” or “expectations” and instead encourages teams to consider the use of “co-agreements” [45]. Co-agreements are mutually agreed upon arrangements between the key stakeholders created out of mutual respect. They allow those involved to maintain a sense of autonomy and ownership by expressing the what, how, when, and why of their needs from the other party. Unlike expectations or contracts, this avoids external blame and one-sided enforcement of rules. It allows families to clearly communicate what they need from the healthcare team and vice versa. Some of these shared principles are generalized hospital values and some are individualized to a particular family. In order to be successful, families require a hospital orientation and cultural indoctrination similar to the one that providers receive as they integrate into the medical world. Just as important, the healthcare team needs to build a longitudinal relationship with the family that includes an orientation and cultural indoctrination into the family's culture and values. Co-agreements help to guide both parties through these discussions and set the foundation for a more collaborative partnership moving forward. Incorporation of education on mediation, communication, and de-escalation techniques may further reduce conflicts and improve both parent and provider satisfaction [46]. While these conversations and educational initiatives take time, they may actually save time in the long term by preventing escalation of mild conflicts to a breakdown of the therapeutic alliance [47].

2. Set up clear consequences for deviation from these shared principles for both the family and the healthcare team.

Once the shared principles have been established, it is important for both parties to be held accountable. In the words of author Brené Brown, “clear is kind” [48]. Failure to transparently discuss the consequences for deviation from the shared principles in an effort to avoid tough conversations is not just cowardly but also unkind. Many a family meeting has been held to discuss a parent's failure to “follow the rules” without acknowledging the ways in which the healthcare team has not lived up to its end of the bargain. All too often these issues are left unaddressed by parents and providers alike in an effort to avoid conflict only to lead to a larger conflict down the road. As conflict escalates, both parties may become avoidant which exacerbates the problem [27]. Creating a safe space for open and honest communication allows both families and providers to address and de-escalate any issues head on while they are still minor misunderstandings.

3. Frequently re-explore the needs of both parties and apply the shared principles consistently and fairly.

The needs of families navigating a prolonged stay in the cardiac care unit frequently evolve over time [42]. As parents acclimate to the hospitalization, they may be increasingly involved in medical decision making and daily cares at the bedside, or they may have been forced to step back in order to manage life outside the hospital. In either case, their needs from the healthcare team may change as their circumstances change. Co-agreements must be frequently re-examined to ensure the needs of all parties are still being met. The shared principles

and the associated consequences should be rooted in equity. Families will require different levels of support at different stages in their journey. It is the job of the healthcare team to meet them where they are and provide the support needed to promote success. For example, most providers recognize that a parent who has just received devastating news may not behave in the same way or require the same support as a parent whose child is improving. Equitable delivery of care, meaning providing each family with what they need, may require us to approach an explosive outburst during a moment of despair with forgiveness and understanding rather than immediately focusing on “setting limits”. The necessity of this approach may be clear to the healthcare team in that moment. It is important to remember, however, that providers are often not privy to the full story of what may be going on with a family outside the hospital. If the relationship has been properly cultivated and there is sufficient trust, providers may know a family well enough to know the full details of the various psychosocial stressors at play. In other circumstances, providers may need to approach the situation with grace and patience and give the family the benefit of the doubt. Sometimes de-escalation techniques, rather than taking a hard line, are the best way to re-engage a family without further eroding trust [44].

4. Take responsibility for your own role in a breakdown of the relationship.

Despite our best intentions to deliver quality care to every patient and treat each family with respect, our biases (yes, we all have them) sometimes lead us to behave in opposing ways. The negative impact of implicit biases on patient treatment and patient outcomes has been well established. It is now our responsibility as providers to uncover our own biases and how they influence our behaviors. How do you do this?

This past year, I had the opportunity to participate in an Equity Coaching Program (i.e., executive coaching with a diversity, equity, and inclusion lens) to learn what I did well and what areas might need improvement. My Equity Coach, Audra Davis, helped me identify my blind spots and how to correct them to provide more equitable treatment and care. My overall leadership with regards to diversity, equity, and inclusion has also improved as a result. In preparation for this article, my coach had the following advice for providers who want to tackle their own implicit bias head on:

- The Harvard Implicit Association Test (IAT) [49] is a good starting point for understanding implicit biases across several different topics. It is a free online test that has been taken by millions of people over the past 20 years. Within a few minutes, you can identify and quantify your implicit bias with regards to skin tone, different racial and ethnic groups, gender, age, and many other areas. I took several of them and learned a lot about myself. In preparation for the TED-style talk version of this manuscript presented in February of 2019 at CHOP Cardiology Update in Orlando, FL, I searched for images of “angry parents” with which to draw in the audience. On review of the talk afterward, I discovered all of my “angry parent” images were representations of angry fathers. In this case, my personal bias was reinforced by society’s bias. In my Google Image search for “angry person”, 8 of the 10 images produced by the search engine were men. While I was absolutely blind to it at the time, my implicit bias training is now helping me to be more aware of my own unconscious mental associations and the ways in which they affect how I conduct myself personally and professionally. Besides the images I select for presentations, the language I intentionally choose now is a good example of my evolution (using co-agreements versus expectations, and no longer describing families as difficult).
- To see how implicit biases may be impacting patients, Davis recommends providers obtain data on their patients’ satisfaction and outcomes by different diversity dimensions (e.g., race/ethnicity, gender, socio-economic status). I did this and saw differences for the

patients in my unit. You, too, may be surprised at the disparities and inequities you find across your patients. This may be a good time to take a step back and reflect on the causes of these differences and how your behavior may have contributed to them. Additionally, Davis recommends providers solicit objective feedback on nonverbal and verbal behaviors which may be linked to their implicit biases. Your colleagues know you and, if asked, will gladly share what you need to improve on from a diversity, equity, and inclusion lens. Perhaps you spend less time with families deemed too demanding, do not share as much information with families you perceive as having low health literacy or avoid eye contact with some families who look very different. Perhaps you demonstrate microinequities such as interrupting certain families when they speak (and not others) or over-simplifying the depth and detail of the medical discussion with parents who require interpreter services. Perhaps you use language that is judgmental or conjures up negative associations when discussing families with staff. While these behaviors may be unintentional, they have a cumulative effect that nonetheless affects care. Taking time out to learn about your biases and how they manifest in your interactions with patients and families is critical to providing appropriate treatment.

5. Get to know your patients and families.

Combatting implicit bias requires a strengthening of skills in empathy and social cognition [43]. This can be accomplished by two relatively obvious strategies for viewing the parent’s behavior within the framework of their own unique circumstances – individuating and perspective-taking [22]. Individuating is the conscious effort to focus on an individual rather than their social category. Similarly, perspective taking is the deliberate attempt to view the situation from the parent’s point of view.

In the end, both of these strategies combat bias by consciously taking stock of our tendency to fall prey to automatically activated judgments and to replace these judgments with individual information that allows us to better relate to the other party [23,50].

Building relationships is the answer to the “difficult family”. By committing to building relationships with the individual members of the individual families, healthcare providers can often arrest the cycle of conflict before it becomes severe. Once a relationship is built, providers and families can talk through their conflicts, are more likely to have open and transparent communication, and are more likely to give each other the benefit of the doubt.

7. Conclusion

Children with complex cardiac disease and their families are often forced to navigate prolonged hospitalization in the cardiac care unit. Unfortunately, conflict between parents and providers is common in that setting despite the best intentions of both parties. Poor communication is the most commonly cited reason for conflict and is exacerbated when providers and families cannot find common ground and develop mutual trust. For parents, this may be more difficult in the face of significant psychosocial stressors in and out of the hospital overlaid on previous negative experiences with the healthcare team and feelings of isolation. For providers, job-related stress, burnout, and implicit bias may make it harder to see past difficult behaviors and relate to families on an individual level. By proactively engaging with families, looking past labels to see parents as individuals, and approaching difficult situations with empathy and self-reflection, providers can help de-escalate conflict - before it leads to a breakdown in the relationship and further exacerbates staff burnout, parental stress, and negative patient outcomes. This is not just a strategy for conflict resolution. As providers, we need to be more proactive in our attempts to engage families early and often in order to arrest the cycle of conflict before families receive a difficult label in the first place.

Declaration of competing interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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