Interprofessional jousting and medical tragedies: Strategies for enhancing professional relations

In 1990, the AANA Council for Public Interest in Anesthesia (CPIA) in conjunction with Anesthesia Professional Liability Services Inc. and the St. Paul Fire and Marine Insurance Company surveyed AANA members to identify stressors that have the most impact on performance, health, and the risk of a lawsuit. The results were presented that year in the AANA Annual Meeting’s keynote address. Among the most significant findings was dysfunctional CRNA/physician relationships. In light of this finding, the CPIA and The St. Paul developed and sponsored a one-day enhancing professional relations workshop which has been offered at the past five annual meetings. This article summarizes the activities and key learnings from that workshop.

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Effective collaboration among healthcare professionals is not only “nice to have,” it is a “must have” when it comes to provider satisfaction and patient safety. With the changing healthcare environment and consequent increase in stress, the importance of this topic has escalated. Coupled with this and the finding that dysfunctional professional relations were a major source of stress for CRNAs, the Council for Public Interest in Anesthesia, in conjunction with the AANA and the St. Paul Fire and Marine Insurance Company, sponsored a one-day workshop, “Enhancing Professional Relations,” at the last five Annual Meetings. This article summarizes the activities and key findings from the 1995 workshop.

Over the years, the goals of this workshop have remained the same—to identify factors that shape healthcare professionals’ interactions and enhance participants’ awareness and effectiveness in identifying and improving dysfunctional relations. To meet these goals, the workshop was designed to provide a “virtual reality” experience for participants. Case scenarios were developed to focus the discussion. These scenarios were a synthesis of actual cases and for many participants elicited an element of familiarity. In addition, a multidisciplinary program faculty was selected to reflect the
relationships that exist in the clinical/administrative setting. Two cases were presented at last year's AANA Annual Meeting.

**Case I**

The first case involved a schedule add on cholecystectomy of a diabetic patient who had presented the prior evening in the emergency room. During the procedure, the patient's blood sugar and pressure became critically elevated. Although the clinical outcome of this case was positive, the experience for the providers certainly was not.

This case provided a backdrop for discussing providers' interpersonal relations from three perspectives: (1) systems, (2) professional perspective, and (3) communication.

**Systems**

Using systems theory and principles of total quality management, one fundamental source of conflict among providers exists in ineffective systems. When unclear guidelines, ambiguous rules, and discrepant or conflicting procedures exist, positive professional communication and effective relationships are hampered. Our first task was to identify the systems issues in the case that inhibited effective relations among the providers (e.g., Why was this an add on procedure for a patient presenting nearly 12 hours prior?).

We also analyzed the case using an iceberg model with three layers of understanding (Figure 1). The visible tip of the iceberg is the event level which defines "what happened." Beneath this visible tip of the iceberg are the patterns and trends that emerge when looking across time. The third level contains the forces and pressures at work or the structure which has an impact on why something has been happening. Elements of structure include such things as hierarchy, compensation and incentive systems, work processes and flow, rules and regulations, and physical layout. Many of the conflicts among providers are imbedded in ineffective systems or structure.

**Professional perspective**

A second source of conflict is professional perspective. Individuals view the world and events not simply as they are, but use their own perceptual filters of values, expectations, and experiences. When one person's perspectives clash with another's, this can cause conflict. Understanding differences in backgrounds, biases, and preferences will help to minimize the conflict arising from these differences. An example would be the differences in perception between professionals compensated on an hourly basis versus those paid on a case basis. Additionally, to achieve effective collaboration, it is imperative to strive for professional respect, trust, and mutual understanding.

**Communication**

A third source of conflict is communication. Verbal and nonverbal communication will either enhance or interfere with the effectiveness of the interaction. The specific choice of words exchanged between individuals, as well as the tone, inflection, style of delivery, and other nonverbal behaviors, have an impact on the message received. In fact, only a small portion of a message is communicated through words, with most of the message interpreted through tone and nonverbal behaviors. When verbal and nonverbal messages conflict with one another, people tend to believe the nonverbal message. Often, heightened levels of stress and anxiety will spark witticism and wisecrack remarks. Humor certainly does have a welcome place when used to diffuse a tense or otherwise overwhelming situation, but sarcasm and jokes are inappropriate when they are consistently directed at the expense of one person or one group of people. The key is to communicate with others in a way that empowers.

**Case II**

The afternoon session focused on the CRNA manager and his or her role in a case involving a high profile civic leader. This patient underwent a selective routine laparoscopic bilateral tubal ligation. As the surgeon inserted the trocar, the patient bucked. In response, the anesthesiologist and CRNA deepened the anesthetic. Surgery was completed without further complication. Unfortu-

![Figure 1: Iceberg model](Image)
nately, the patient's vital signs began to slowly fail. She was taken back to the operating room where extensive retroperitoneal bleeding was found. The patient suffered cardiac arrest and did not respond to exhaustive resuscitation efforts, resulting in her death.

This case stimulated discussion about (1) the impact of such a tragedy on the providers and their ability to maintain effective working relations, (2) needed risk management procedures, and (3) public relations and media coverage concerns.

**Emotional impact and working relations**

When untoward outcomes occur in an otherwise healthy individual, the tragedy seems even more significant. The emotional reactions elicited can be overwhelming, and, if not appropriately addressed, may interfere with the providers' ability to work effectively together in the future. Traumatic incidents tend to reemphasize and cruelly remind us of our own lack of control, fallibility, and mortality.

There is no one correct way to respond to trauma. Individual differences dictate how any one person will respond. Individuals may respond with shock, anger, feelings of guilt, uncontrollable crying, violent outbursts, finger pointing, humor, or they may become withdrawn, depressed, or even suicidal. The scope, nature, and intensity of the emotional reactions depend on the incident itself, an individual's personal experience and coping ability, the team's history and experience, the extent of personal identification with the patient ("that could have been me"), and the supportive-ness of the organization. Teams represent more than just the conglomerations of individuals' reactions. The ability of members to forgive and to regain one another's trust is critical for effective future interactions.

There are many things a manager or director can do to facilitate effective coping and to encourage prompt return to a high-functioning, effective team:

- Do not wait until tragedy occurs to learn about your organization's policies or procedures for coping with a traumatic event or workplace crisis. Procedures will vary depending on the size of the organization and the type of crisis that occurs. For the case described above, a debriefing session or case review where emotions and other concerns can be discussed may be appropriate. Sometimes this can occur in the operating room with only the members involved present. Other times it may be prudent to include a minister, a crisis intervention specialist, or a clinical psychologist.

- Understand that individuals may need to go through a grieving period. Saunders and Valente offer a task model of bereavement that may prove helpful for individuals in this situation. Their model contains four main goals that need to be met after such a tragedy: reclaim meaning, restore integrity, manage affect, and realign relationships.

- Do not provide counseling services yourself, rather make the appropriate referrals to an employee assistance program or other counseling services when necessary.

- Provide opportunities for skill development or enhancement (e.g., bereavement, aggression control techniques, conflict resolution, active listening, interpersonal communications, etc.).

- Initiate quality improvement reviews or other systems evaluations and follow other risk management guidelines.

**Risk management**

After a serious incident like this, effective risk management becomes extremely important. There are a number of issues requiring careful consideration:

- **Notification** — Is there a procedure that articulates who needs to be notified in administration? Who is responsible for calling the insurance agent and the insurance company?

- **Collecting facts** — Who is responsible for assembling the details of the incident? A list of people involved and their roles will assist a claim handler in a thorough review.

- **Instructions to those involved** — Who is responsible for explaining to the people involved the inappropriateness of finger pointing and speaking to plaintiff attorneys? Controlling this kind of behavior is critical to limiting exposure created by the incident.

- **Preserving evidence** — Who is responsible to ensure that records, broken equipment, logs, etc. are preserved?

- **Altering records** — Occasionally, records need to be amended. Any time records are altered, the plaintiff's attorney will carefully scrutinize the changes. It is critical that providers understand the appropriate method for amending records. Changes should be made on a separate page, along with an explanation, and be signed and dated.

- **Contact with the family** — Meet with the family as soon as possible. All the known facts should be disclosed. Do not speculate. Qualifying words such as "error" and "mistake" should be avoided. Any written apologies or other materials should not be given to the family. This includes the medical record unless it is formally requested.
Media relations

This case also stimulated a discussion of how to handle media interest when tragedy strikes. The healthcare institution’s, as well as providers’, credibility and reputation can be severely challenged if not completely ruined with such a tragedy. The ability to effectively interact with the media is critical to regaining the public’s trust. There are several issues to keep in mind:

- Understand how reporters in your city work. Appreciate deadlines and be aware that electronic and print media reporters have different needs.
- Who is your facility’s identified spokesperson? He or she should be prepared to communicate the message you want to deliver. Simply reacting to media questions is not an effective strategy.
- Do not say “no comment.” Even if the response is “we are presently investigating the incident and will discuss it later,” it is better than having a reporter suggest you “refused to comment.”
- What format will be used to communicate your message? You might choose a paper question and answer, or, if there are inquiries, a news conference might be appropriate.
- Control your message. Do not go off the record, get too complex, or be negative. Stick to the points you prepared. Do not feel intimidated to refute a statement made by a reporter which is presented as fact.

Conclusion

Whether as clinicians or managers, CRNAs are placed in stressful situations. Being prepared to deal with difficult clinical encounters is an expected part of the profession. Dealing with the psychosocial aspects of these encounters, while expected, does not come with the same guidebook and practicum. Handling these situations well, whether with other providers, patients, or patients’ families, is critical to reducing stress for the CRNA and will hopefully lead to more successful outcomes in all respects.

REFERENCES


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