ANALYSIS OF HYPOTHETICAL CASE #1

You are the SURGERY CLERKSHIP DIRECTOR. The Surgery department recently recruited a transplant surgeon whose schedule is growing quickly, outpacing the surgeon's assigned block time when students are scheduled to be in the OR. When you contact several students who are absent from a didactic session, they explain that the transplant surgeon requires a third-year medical student to be present during every case. Students report that they typically hold retractors during these cases and teaching is focused on the fellow and residents. They do not feel comfortable asking to leave the OR to attend other scheduled clinical and educational sessions out of concern that it will compromise their clerkship grade.

1. What is the conflict? **Students are missing assigned didactic sessions because they are required to assist in surgical cases.**

2. Why is there a conflict? **Because these stakeholder perspectives appear incompatible:**
   - Clerkship director: *We require student attendance for didactics because they are linked to the medical school's learning objectives for our clerkship.*
   - Transplant surgeon: *Being present to assist with transplant surgery is educationally valuable for students and showcases team-based surgical care. Also, I need their help assisting.*
   - Students: *We are caught in the middle of a no-win situation. Either choice can put our clerkship evaluation at risk. If we had a real choice, some of us would rather be in the OR and some would rather be at didactics to push for a better score on their end-of-clerkship exam.*

3. As clerkship director, what is your strategy for understanding and managing this conflict?
   - **Self-awareness:** *I am ready to be very assertive in achieving my goal of the students attending their required didactics. I want to be as collaborative as possible in light of the important contributions made by the transplant surgeon, but how collaborative I am will depend on what the surgeon really wants. If I cannot create a win-win* (collaborating) *outcome I will push for a fair compromise (equitable concessions). This will be easy/hard for me because my preferred conflict style is* (complete using your results from the **Thomas-Kilmann Inventory)**.
   - **Skilled inner listening:** *What am I telling myself and what inferences am I making? Do I have preexisting ideas about surgeons in general, this particular surgeon, students in general or these particular students? Am I focusing on facts that support these beliefs and not using logic* (**the ladder of inference**)? *I need to hear different perspectives that create a truer understanding* (like **the cone in the box**).
   - **Skilled inquiry**: You arrange <u>separate conversations</u> with the surgeon and the students. In each meeting you ask inquiring questions that only they can answer, holding back your own interpretations. You schedule and conduct these conversations paying attention to their physiologic needs (tired, hungry, post-call?) and reassuring them about safety ("Am I in trouble? Is this confidential?"). During the meetings you use the **PEARLS** to address their potential social and self-esteem needs through statements of Partnership, Empathy, Acknowledgement, Respect, Legitimation and Support.

- **Skilled advocacy:** In each meeting you listen carefully, restate what you understand to be the other person's perspective and thought process. Before explaining your perspectives you ask their help in trying to understand the process by which you came to your interpretation. You continue using statements from the **PEARLS** as needed. You succeed in learning the transplant surgeon's perspectives described in #2 above.
- **Insights and outcomes:** Your management of this conflict has yielded insights that will prove very helpful in creating a win-win (collaboration) or equitable concessions (compromise) outcome. Here are two <u>potential</u> scenarios:
    A. The transplant surgeon has an urgent need for surgical assistants and is much less concerned about students missing out on educational value. You collaborate to create a **win-win outcome.** This could require engaging the department chair as an ally in advocating either for more residents and fellows (if feasible for the program director), with hospital administration for more surgical assistants (PA's), or with the OR committee for a different schedule that allows the students not to miss didactics.
    B. The transplant surgeon has other options for surgical assistants but worries that the students will miss out on important lessons about surgical anatomy and team care in the OR. The surgeon acknowledges the importance of didactics and you acknowledge the educational value of these cases. In exchange for the surgeon agreeing not to ask students to assist during didactics, you agree to create a transplant surgery elective so interested students can benefit from this experience. The outcome will be fewer students seeing these cases, which is concession on the surgeon's part. Because you paid attention to Maslow's hierarchy and took such care using the PEARLS, this feels like **an equitable compromise.**

ANALYSIS OF HYPOTHETICAL CASE #2

You are the INTERNAL MEDICINE RESIDENCY PROGRAM DIRECTOR. Third-year residents in your program do several rotations at a smaller affiliated hospital where all of the internal medicine staff physicians attend on the inpatient service in 1-week assignments. Although the relationship between the main hospital and affiliated hospital has improved in recent years, many of the senior physicians feel like they are second-class citizens in the eyes of the residency program. One of the senior physicians is on service and asks the residents how to manage patient problems that would typically result in a subspecialty consultation. When the third-year resident suggests that a consultation be obtained, the attending becomes upset and contacts the program director, asking that the resident be disciplined for insubordination.

1. What is the conflict? **The resident perceives that a subspecialty consult is needed to provide optimal care to the patient, whereas the attending physician disagrees.**

2. Why is there a conflict? **Because these stakeholder perspectives appear incompatible:**
   - Resident: *Instead of getting a consult the attending is asking me what I would do. I don't understand why. At the main hospital where we spend most of our time, the standard of care is to request subspecialty consults in this situation. I have never seen that not done.*
   - Senior attending: *I've been practicing for 30 years and have expertise managing patients like this, and I have always used a Socratic method to teach the residents. Are they teaching residents to get consults on everyone before thinking through what they would do? Do they not respect the expertise we have here in the community? This is unacceptable.*

3. As program director, what is your strategy for understanding and managing this conflict?
   - **Self-awareness:** *Resolving this successfully requires that I learn more about what happened during their interaction. I am ready to be very assertive in obtaining an equitable outcome for the resident and I am ready to be very cooperative in light of the important contributions made by the community hospital faculty. If I cannot create a win-win* (collaborating) *outcome I will push for a fair compromise* (equitable concessions). *This will be easy/hard for me because my preferred conflict style is* (complete using your results from the **Thomas-Kilmann Inventory)**.
   - **Skilled inner listening:** *Suggesting a consult does not seem like insubordination. What am I missing? The senior attending has practiced at this hospital for many years, and has lived through some of the hardest times when the relationship with us was strained. I wonder if that's influencing the attending's reaction to the consult suggestion, i.e., that the attending does not feel respected* **(Maslow's hierarchy of needs**). *On the other hand, this resident is one of our best in terms of clinical judgment and professionalism, so I wonder if the attending is up-to-date on management of this problem. I need to be careful, as this belief could bias my willingness to accept that the resident said something inappropriate* (a misstep on **the ladder of inference**). *I need to gather different perspectives to get to a more detailed and comprehensive understanding* (like **the cone in the box**).

- **Skilled inquiry**: You arrange separate conversations with the resident and with the attending physician. In each meeting you ask inquiring questions that only they can answer, holding back your own interpretations. You schedule and conduct these conversations paying attention to their physiologic needs (tired, hungry, post-call?) and reassuring them about safety ("Am I in trouble? Is this confidential?"). During the meetings you use the **PEARLS** to address the participants' potential social and self-esteem needs through statements of Partnership, Empathy, Acknowledgement, **Respect,** Legitimation and Support. You succeed in learning the perspectives of the resident and attending physician described in #2 above.
- **Skilled advocacy:** In each meeting you listen carefully, restate what you understand to be the other person's perspective and thought process. Before explaining your perspectives, you ask their help in trying to understand the process by which you came to your interpretation. You continue using statements from the **PEARLS** as needed.
    - You work to provide additional perspective for the resident, e.g., how the consult request may have been perceived, and how this particular attending is known to be a fan of the Socratic method in which "why" questions are used to spur critical thinking and for which ordering a consult would be the wrong answer.
    - You work to provide additional perspective for the attending, e.g., how common it is to obtain consults at the main hospital where residents train, how some residents may not have experienced the Socratic method, and how evaluations of the community hospital rotation show it to be a highly valued experience for the residents.
- **Insights and outcomes:** Your management of this conflict has yielded insights that will prove very helpful in creating a win-win (collaboration) or equitable concessions (compromise) outcome. Here are two potential scenarios (both may be in play):
    A. The attending physician accepts that the resident did not mean to question their judgment and was inexperienced with the Socratic method. The resident understands how jumping to the consult was perceived by the attending, and that the attending's intention as to develop their critical thinking skills. You facilitate a meeting in which they each feel respected for their shared intentions to provide excellent patient care and their shared interest in teaching and learning. Both are happy with this as a **win-win outcome.**
    B. The resident reminds you that the main hospital has created evidence-based care pathways that make a consult the best choice for this particular patient, and asks whether the attendings at the community hospital are aware of this pathways. You realize that the community hospital attendings were not involved in the preparation or implementation of the care pathways, and that this will be perceived as a lack of respect for their expertise and teaching roles.

As program director you take ownership of this oversight and the resulting conflict, and you explain this to the attending physician. You promise to share the care pathways that were implemented at the main hospital. If the attending can organize a meeting of the community hospital staff to determine which pathways they can endorse and which are too restrictive, you promise to share this with the residents before the rotation so misunderstandings like this happen less often. Because you paid attention to Maslow's hierarchy and took such care using the PEARLS, this feels like **an equitable compromise.** Concessions were made by the attending (the resident will not be disciplined; work is involved in evaluating the care pathways), the resident (it was not the resident's fault but they were made to look bad in the eyes of their program director and the community hospital attendings), and the program director (who took responsibility, apologized and has additional work ahead to make this right).

ANALYSIS OF HYPOTHETICAL CASE #3

You are a FACULTY MEMBER on the inpatient service. You observe your team of learners (residents and medical students) talking to a nurse about a hospitalized patient they just saw together. The nurse explains that the patient said they do not feel comfortable being seen by one of the team members because of their [pick one: race, gender, ethnicity, religion]. The senior resident decides that the team member should skip that patient on future rounds in order to support the patient's comfort and autonomy. The team member is visibly upset.

1. What is the conflict? **A learner is being denied a learning opportunity available to others because of their race, gender, ethnicity or religion.**

2. Why is there a conflict? **Because these stakeholder perspectives appear incompatible:**
   - Patient: *I can't believe how many people come to see me on rounds. They stand over me and talk to each other using words I don't understand. Some of them look like young doctors, but some don't look like doctors at all. Don't I have a say in this?*
   - Learner excluded from rounds: *That the patient doesn't want me present is very upsetting. That the senior resident is making me skip the patient on rounds is even more embarrassing and upsetting. I am angry that no one but me sees this as discriminatory and unacceptable.*
   - Senior resident: *It's awful that the patient does not accept the learner's [race, gender, ethnicity or religion]. I feel bad for the learner but we need to help the patient be as comfortable as possible. They have a right to decline having learners present, don't they?*
   - Nurse: *I know our patients come from all over and have a lot of different points of view. I feel bad for the learner. It's just not fair and I think it may go against our hospital policy, but I don't want to cross the senior resident's decision.*
   - Faculty on service: *This is awful and just wrong. Our medical school and hospital have policies pertaining to the clinical learning environment that do not permit discriminatory practices by faculty, staff, and learners. The Patient Rights document expects patients and families to be courteous and to consider the respect the rights of others.*
3. As the faculty member on service, what is your strategy for understanding and managing this conflict?
   - **Self-awareness:** *I am ready to be very assertive in achieving my goal of enabling our students to not be subjected to intolerance of their race, ethnicity, gender, religion and other characteristics. I want to support the patient's emotional well-being as much as possible, but I won't compromise the learner's rights just to satisfy the patient. If I cannot create an **equitable compromise** we'll have to see about transferring the patient* (competitive **win-lose** outcome). *This will be easy/hard for me because my preferred conflict style is* (complete using your results from the **Thomas-Kilmann Inventory)**.

- **Skilled inner listening:** *I wonder precisely what the nurse heard from the patient, and what the patient really meant*. *The patient didn't strike me as someone who was prejudiced, but I realize I may be biased because the patient looks just like me* (a misstep on **the ladder of inference**). *The nurse is experienced and knows about our hospital's expectations of patients and families so why did the nurse not speak up with the patient or the senior resident? I should talk with the patient and the nurse to get a clearer picture of what actually happened* (like **the cone in the box**).

- **Skilled inquiry**: You arrange separate conversations with the patient and the nurse. In each meeting you ask inquiring questions that only they can answer, holding back your own interpretations. You schedule and conduct these conversations paying attention to their physiologic needs (tired, hungry, post-call?) and reassuring them about safety ("Am I in trouble? Is this confidential?"). During the meetings you use the **PEARLS** to address their potential social and self-esteem needs through statements of Partnership, Empathy, Acknowledgement, Respect, Legitimation and Support.

- **Skilled advocacy:** In each meeting you listen carefully, restate what you understand to be the other person's perspective and thought process. Before explaining your perspectives, you ask their help in trying to understand the process by which you came to your interpretation. You continue using statements from the **PEARLS** as needed. You succeed in learning the patient's and nurse's perspectives described in #2 above.

- **Insights and outcomes:** Your management of this conflict has yielded insights that will prove very helpful. Here are two <u>potential</u> scenarios:
    A. In your discussion the patient admits feeling overwhelmed by the number of people on rounds and not being able to follow what they are saying to each other. They did not mean to offend anyone when saying "some don't even look like doctors". You agree to limit the number of team members present to only the people directly involved in that patient's care (the senior resident, intern, and student) and to be sure the team involves the patient in rounds by using language they understand. You give a brief biosketch of each of the 3 team-members who will be rounding, and leave the patient with a photo sheet including their names and roles. You explain that the mission of the hospital and medical school is to provide care for the diverse communities we serve, and that brings together patients, nurses, doctors and other health workers from many backgrounds and beliefs. The patient agrees to be seen by a smaller number of learners and accepts that some of them may not fit their preconceived ideas about "what a doctor looks like." The resident, intern and medical student may continue to be exposed to comments by the patient that are microaggressions (see below), and learners who are not on this team may miss some useful clinical education by not being involved with this patient at the bedside. This feels like **an equitable compromise.**

B. In your discussion the patient discloses feeling uncomfortable with the size of the rounding team, but even more upset that there are non-White students and residents present. The patient likes the idea of having a smaller team on rounds (as described in A.), but wants you to pick only White people. You escalate efforts to resolve this conflict to hospital administration. After exhausting opportunities for compromise, the patient is transferred to another facility that does not have any trainees present. This decision angers the patient and their family who feel judged for their beliefs and inconvenienced by the transfer (they perceive this as **a loss**). This decision garners approval by most of the health professionals and trainees involved with this patient's care, who consider this **a win**. Although they realize there will be polarized perspectives about this decision by the communities they serve (wins and losses), the hospital and medical school leadership consider this the **only appropriate outcome** as well as an opportunity to affirm their anti-discrimination policies and values.

EDUCATIONAL OPPORTUNITIES:
In either scenario, it will be important for all members of the team to review the hospital's policy delineating patient rights and responsibilities, and to discuss best practices for navigating tensions between the two. All should also receive training on how to identify and manage micro-aggressions. In this case the nurse witnessed the patient saying "some of them don't even look like doctors" in reference to the large number of people coming to round, so the nurse would have been the one to respond to the microaggression using the **ACTION or GRIT steps** (examples of skilled inner listening, inquiry and advocacy). It could have been anyone involved in the patient's care, which is why universal training is necessary.

These case-based resources from the AMA Journal of Ethics provide additional insights and strategies:

https://journalofethics.ama-assn.org/article/prejudiced-patient/2014-06
https://journalofethics.ama-assn.org/article/how-should-organizations-respond-racism-against-health-care-workers/2019-06