UAMS Journal Club Summary
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Dr. Paige Dailey, MD and Dr. Ariel Noble, MD
Faculty Advisor: Dr. Carly Eastin, MD

Critical Bottom Line:
Both articles addressed the difficulty and personal/professional impact of experiencing conflict in medicine, specifically between EM and IM physicians. In the first study, researchers looked at the outcome of the conflict and how this impacted physician well-being and job satisfaction. In the second study, researchers examined what factors actually led to conflict between physicians and which of these factors could be addressed. The overall finding was that conflict between EM and IM physicians led to higher levels of job dissatisfaction and a continuous cycle of conflict in the workplace.

PICO
P - Physicians working in emergency medicine and internal medicine specialties
I - Inter-physician conflict
C - Compared to interactions without conflict
O - Impact of conflict on emotional, physical, and moral personal and professional well-being

How does inter-physician conflict between EM and IM physicians impact personal and professional well-being of the physicians themselves?

Background:
It is well-known that communication in healthcare is an important part of patient care, but conflict at the most common transitions of care remains to be a critical issue. Conflicts among colleagues on the healthcare team can dangerously affect patient care. Most literature focuses on interprofessional conflict as a whole, but conflict between physicians warrants further attention. Conflict among physicians while trying to perform clinical duties has not been widely studied, but can be a source of potential burnout among physicians of various specialties. While there have been efforts to provide educational content, structure, and professional development, the interface between emergency medicine and internal medicine physicians at the time of hospital admission continues to be a well-recognized source of conflict. There are many studies on the dynamics that contribute to conflict between the internal medicine and emergency medicine groups; however, there is little known about how this conflict impacts the physicians themselves.

Trial 1
Amick A, Schrepel C, Bann M, et al. From Battles to Burnout: Investigating the role of interphysician conflict in physician burnout. Journal of AAMC. 2023; Apr. doi: 10.1097/ACM.0000000000005226.

Link:
https://journals.lww.com/academicmedicine/abstract/9900/from_battles_to_burnout__investigating_the_role_of.409.aspx

The Basics:
This study was a retrospective qualitative study completed at 2 urban academic centers located in Washington between June 2020 and October 2020. This study enrolled 18 physicians (EM residents, EM attendings, and IM triage hospitalist) and conducted interviews where participants were asked about their experiences with conflict during transitions of care. The goal of this study was to explore the social processes and interpersonal interactions surrounding inter-physician conflict and their impact on physician burnout. This study used interviews where participants were asked to recall conversations regarding admission between internal medicine and emergency medicine physicians as a lens to explore this topic in clinical practice. Analysis was done using constructivist grounded theory and interviews were coded in 3 phases and constant comparative analysis was used to refine emerging codes.

Inclusion Criteria:
18 participants from 2 urban academic hospitals were recruited and participated in research from June 2020 to October 2020. EM residents (physicians in post-graduate training), attending physicians (board-certified emergency medicine physicians), and internal medicine triage hospitalist physicians met the inclusion criteria for this study.

Exclusion Criteria:
Participants who did not have experience with conversations regarding admissions at their institution were excluded from the study.

Results:
In this relatively small study, 18 physicians were interviewed about how engaging in inter-physician conflict led to both personal and professional harm. Specifically, physicians described how conflict in the workplace resulted in more emotional distress, demoralization, job dissatisfaction, and a diminished sense of professional attributes. Participants also described how emotional residue attached to previous interactions primed the workplace for future conflict.This study concluded that inter-physician conflict may represent a serious yet underrecognized source of harm to physician well-being as well as patient outcomes. Participants described both personal and professional consequences of inter-physician conflict which align with the core attributes of burnout. The study outlines that while some aspects of burnout are inevitable, conflict between physicians can be modified and improved with education that equips physicians with the skills to navigate conflict more effectively and professionally.

Limitations/Bias:
As this study was an analytical study with qualitative data, the reproducibility of this study is limited and results may vary. The results of this study were recruited from a single institution

and may impact the transferability of the findings as communication styles between physicians may vary regionally or even nationally. This study focuses on relationships between internal medicine and emergency medicine physicians, and future studies with interactions between various specialties in other clinical environments may demonstrate different results. I think that this study limits bias as much as possible with multiple stages of coding and blind recordings, but it would be interesting to see the breakdown of the participant variables such as age, gender, ethnicity, etc to check for bias. This was also a relatively small study with only 18 participants within 2 specialties and larger studies may be beneficial in drawing further conclusions.

Trial 2

Title: “Friction by Definition”: Conflict at Patient Handover Between Emergency and Internal Medicine Physicians at an Academic Medical Center

Citation: Kanjee Z, Beltran CP, Smith CC, Lewis J, Hall MM, Tibbles CD, Sullivan AM. "Friction by Definition": Conflict at Patient Handover Between Emergency and Internal Medicine Physicians at an Academic Medical Center. West J Emerg Med. 2021 Nov 5;22(6):1227-1239. doi: 10.5811/westjem.2021.7.52762. PMID: 34787545; PMCID: PMC8597691.

Link: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8597691/

The Basics: In this study conducted at Beth Israel Deaconess Medical Center, investigators identified in this large academic center that despite interventions implemented to mitigate conflict between Internal Medicine and Emergency Medicine, that “suboptimal interactions” may lead to circumstances influencing patient harm and subpar patient outcomes. The goal of this study was to identify factors which predominantly contribute to differences in perspectives regarding patient care during patient handoff and decisions related to patient care as well as disposition. This study used a qualitative approach focused on physician perspectives of interdepartmental conflicts and how this disrupts patient management, to include disturbing patient disposition, timely care, emergency department workflow, etc. This approach allowed several physicians from both teams to be interviewed in a focus group setting through cognitive interviews and provide open ended discussion regarding their experiences in conflict as it relates to unnecessary admissions, formulating diagnosis, disagreements about admission decisions, and ICU vs general medicine admission. From the cognitive interviews, information could then be analyzed and divided using a framework approach into two larger themes: contextual factors (i.e. limited knowledge of another’s field or that person’s workflow) contributing to conflicts between IM and EM physicians and disagreements regarding disposition.

Inclusion Criteria:

The sampling strategy was through purposive sampling, a form of non-probability sampling in which participants in which a group of individuals are selected from a subset of the population (in this case, a group of resident physicians and faculty physicians which were to be representative of the physician population.

Inclusion criteria included those who voluntarily agreed to participation after receiving focus group invitations to each department via email. These emails were sent to each group's department leadership and residency directors to disseminate. Focus groups were conducted until "data saturation" was reached.

In May to December 2019, 24 residents (11 IM and 13 EM) and 11 faculty members (6 IM and 5 EM) voluntarily agreed to participate in focus groups. All focus groups were confidential and recorded with respondent anonymity. This sampling strategy appeared appropriate for this approach as you would want individuals to know the purpose of this study, as they were offering their public opinions about interpersonal conflict, and the purposive sampling technique using only a subset of the population as it may not have been feasible to sample the entire population. The setting was appropriate as all members represented members of the internal medicine and emergency medicine community. Demographics represented in the population included the following: 2 PGY1 residents, 10 PGY-2 residents, 12 PGY-3 residents, 6 faculty members having served less than 5 years or equal to and 5 which had served greater than 5 and lastly there were 20 males and 15 females.

Exclusion Criteria: Though no specific exclusion criteria was outlined via the article, implied exclusion criteria would be members of departments who were not residency leadership/faculty or resident physicians (i.e. staff, students, etc.) In addition, excluded would be members who were not in the department of internal medicine or emergency medicine. Lastly, only those who voluntarily agreed to participate in focus groups could participate.

Results:
Results from the study as described showed that overall Emergency Medicine and Internal Medicine physicians described having effective and collaborative interdepartmental relationships. Issues identified related to the following themes: unnecessary admissions, attaching a diagnosis to patients, revisiting admission decisions, futility of IM arguing against admission, personal expertise and perspective regarding ICU admission, transfer delays due to requests for testing, discussion requests as priming for conflict, knowledge of other person and workflow and clinical workload/volume. Two key themes arose through this discussion: concerns about patient disposition and contextual factors (defensiveness, knowledge of other person's specialty/responsibilities and workflow, and systems issues). Regarding patient disposition, the greatest conflicts noted were in relation to whether a patient required admission, with many patients having short stay admissions which were deemed unhelpful to the patient or patient outcome, and the second was the question of a patient being appropriate for a general medicine floor versus having intensive critical care management. Internal medicine physicians noted that emergency medicine physicians may not have knowledge of

patient management and monitoring on the floor, and that some patients who seem floor appropriate may ultimately require transfers to the ICU due to requirements of close monitoring and likelihood of rapid response activations. Contextual issues discussed were that of discussion requests as priming for conflict, as both physician groups became defensive in this setting. Discussions were, as suggested by perspectives in the study, perceived as implied criticism of a physician's management or workup.

In response to these results, recommendations to improve conflicts included improvement to handoff communication and documentation by physicians, positive interdepartmental feedback, formal guidelines to direct patient disposition and shared social events between the two groups to promote familiarity of physicians.

Limitations/Bias:

Limitations noted by authors include the setting of the study, being in a single academic center, the perspectives and results may not be shared universally in other hospital groups or academic centers. The factors which contributed to conflicts at this academic center may not be similar to other settings, and cannot be generalized entirely though this study may be helpful in highlighting potential areas of conflict which can be studied in other settings. The authors note that attending participation was low (having only 6 IM and 5 EM physicians) and that low recruitment means that the study could have been more inclusive of a spectrum of perspectives on this topic. The limited sample may mean it is not as representative of the population as the study could have been. Lastly, sampling bias may be a limitation as all subjects voluntarily participated and this was a non-randomized approach of sampling.