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CONCEPT PAPER

The development of an educational workshop to reframe and manage professional conflict via a sex and gender lens

Ynhi T. Thomas MD, MPH, MSc[1] | Anita N. Chary MD, PhD[1] | Michelle I. Suh MD[1] | Mehrnoosh Samaei MD, MPH[2] | Valerie Dobiesz MD, MPH[3] | Annahieta Kalantari DO[4] | Greg Buehler MD, MBA[1] | Devjani Das MD[5] | Jeannette Wolfe MD[6]

[1]Henry J.N. Taub Department of Emergency Medicine, Baylor College of Medicine, Houston, Texas, USA

[2]Emory Department of Emergency Medicine, Emory University School of Medicine, Atlanta, Georgia, USA

[3]Department of Emergency Medicine, STRATUS Center for Medical Simulation, Brigham and Women's Hospital, Harvard Medical School, Harvard Humanitarian Initiative, Boston, Massachusetts, USA

[4]Department of Emergency Medicine, Penn State Health Milton S. Hershey Medical Center, Hershey, Pennsylvania, USA

[5]Department of Emergency Medicine, Columbia University Vagelos College of Physicians and Surgeons, New York, New York, USA

[6]Department of Emergency Medicine, University of Massachusetts Chan Medical School–Baystate, Springfield, Massachusetts, USA

Correspondence
Ynhi T. Thomas, Henry J.N. Taub Department of Emergency MedicineBaylor College of Medicine1504 Ben Taub LoopHouston, TX 77030, USA.
Email: ythomas@bcm.edu

Abstract

Background: Conflict is inevitable in the emergency department, and conflict resolution is an essential skill for emergency providers to master. Effective conflict management can optimize patient care and enhance professional satisfaction. To communicate effectively in high-stress, high-impact situations, sex- and gender-based differences need to be considered.

Methods: Nine resident, fellow, junior, and senior faculty members of the Academy for Women in Academic Emergency Medicine collaborated to design a 4-h workshop. The focus was on professional communication and conflict resolution in emergency medicine (EM), with special attention on how sex and gender can influence these processes.

Results: The final educational workshop utilized a variety of formats focused on communication and effective conflict resolution including: traditional didactics, facilitated small groups with case-based learning, expert panel discussion, and an experiential learning session. The consideration of how sex- and gender-associated factors might contribute additional complexity or challenges to conflictual interactions were interwoven into each session to highlight alternative vantage points.

Conclusions: Effective conflict resolution is an important skill for success in EM. We developed a workshop that went beyond typical communication-based programming to consider how sex- and gender-related factors influence communication and conflict resolution.

BACKGROUND

Effective communication and conflict resolution skills are essential to optimizing patient safety and provider career satisfaction in emergency medicine (EM). From a quality perspective, poor communication is a major factor associated with preventable medical errors that can lead to patient harm.[1–3] The Joint Commission lists poor communication as a leading cause for all five of the top sentinel event categories of the past 2 years, including falls and delays in treatment, which are known to occur in the emergency department (ED).[4] Ineffective communication is also costly to health care systems. A previous study showed that communication inefficiencies cost hospitals $12 billion dollars annually, averaging about $4 million annually in a 500-bed hospital.[5]

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There are numerous behavioral, cognitive, linguistic, environmental, and technological challenges that routinely create barriers to effective communication in EDs. Specific examples include multiple interruptions such as incessant alarms and shifting patient-related priorities (cognitive), electronic medical records requirements that may decrease time available for interpersonal interactions (technological), and a traditional hierarchical medical culture that has discouraged speaking up (behavioral).[6] In a busy, high-acuity ED, an emergency provider may face communication challenges from several fronts including patients and their families, staff, colleagues, consultants, and administrators.[7]

Communication styles are both learned and socialized behaviors. Sex- and gender-based differences in communication are influenced by personal characteristics as well as societal and cultural constructs.[8] Research demonstrates that men are stereotyped as agentic (active, decisive, self-assertive, independent) and women as communal (caring, concerned for others, with interpersonal sensitivity) and that agentic traits are perceived by both men and women as more important for success in science.[9,10] A growing body of literature on gender differences in communication during medical care demonstrates women focus more on rapport building, ask more psychosocial questions, and demonstrate more partnership building behaviors than their male counterparts, reflecting these communal stereotypes.[11–14]

This article is a description of an advanced workshop on communication skills regarding difficult conversations and reframing conflict from a sex and gender perspective presented at the 2022 Society for Academic Emergency Medicine Annual Meeting.

METHODS

Nine resident, fellow, junior, and senior faculty members of the Academy for Women in Academic Emergency Medicine (AWAEM) collaborated to design a workshop about navigating conflict in EM with a focus on how sex and gender impacts conflict communication and resolution. The organizers represented five institutions and different career phases that maximized the range of perspectives about the topic. Biweekly conference calls were held over 8 months to prep content, design activities, create discussion points, and summarize closing aspects of the workshop.

In general, there are four distinct types of workshops: skills, design, problem solving, and awareness raising.[15] The focus of the stated workshop was on problem solving. The workshop was intentionally designed to include multimodal educational formats involving traditional didactics, facilitated small-group case-based learning, expert panel discussion, and experiential learning. Careful planning went into ensuring that the workshop aims were clear and geared toward the appropriate audience of learners at different career stages. To optimize learner engagement and align with adult learning theory, Bloom's taxonomy was the standard framework used to design the workshop experience with the objectives focusing on the cognitive, psychomotor, and affective domains of learning.[16,17] The objectives are highlighted in Table 1. The group identified three major components for the workshop: (1) gendered communication and conflict, (2) panel discussion with senior leaders, and (3) experiential learning exercise to reframe conflict (refer to Table 2 for the complete program). The larger group divided into three subgroups to focus on content development for each section.

Session I: gendered communication and conflict

For the first session, the Thomas-Kilmann Conflict Mode Instrument,[18] one of several instruments used to determine personal conflict response styles, was the framework used to develop an effective conflict resolution strategy for ED health care providers. It focuses on the dimensions of assertiveness and empathy and consists of five conflict response styles: competitive, compromising, accommodating, avoiding, and collaborating. Several studies demonstrate that there are gender differences in conflict resolution styles, with women being more likely to use a collaborative approach prioritizing relationships over agenda than men who are more likely to use an assertive or avoidance approach.[19,20] In the context of specific situations in EM, each of these styles can be appropriate and useful. The conflict response style chosen should take into consideration the importance of the conflict substance and agenda versus the importance of the relationship in question. Mastery of all five response types is essential to effective conflict resolution.

Session II: panel discussion with senior leaders

Development of the second session was based on the educational principle of paradigmatic trajectories, in which the gap from identity to possibility can be more quickly bridged if learners are exposed to real-life role models who share vulnerable qualities.[21] Using this framework, the organizers intentionally selected panelists with a wide range of attributes (i.e., gender, race, and sexual orientation). Organizers were also mindful to include panelists that represented different geographical areas including northeast, southeast, southwest, and west coast. Questions for the panelists were developed by a resident and fellow on the organizing committee and then further honed after feedback from more senior

TABLE 1 Workshop learning objectives.

• Identify barriers to effective communication in EM
• Understand and describe the role of gender in conflict
• Practice an intentional growth mindset that normalizes conflict
• Illustrate how learning to manage a difficult conversation can accelerate personal and professional growth
• Describe concrete techniques to realign challenging professional conversations

TABLE 2 Workshop program.

Introduction—10 min
Session I: Gendered Communication and Conflict
• Didactics on managing conflict and Thomas-Kilmann tool—10 min
• Case-based learning exercises—30 min
• Large group discussion—20 min
Break and networking—15 min
Section II: panel discussion with senior leaders—50 min
Break and networking—10 min
Session III: Experiential Learning Exercise to Reframe Conflict
• Personal reflection on conflictual experience and introductory didactic—10 min
• Audio clips of insight from senior EM leaders in managing conflict—15 min
• Didactic of concrete tools and scripts to facilitate communication—15 min
• Didactic on the positive attributes of stress—20 min
• Opportunity to write personal story normalizing conflict—10 min
• Summary—5 min
Wrap-up and conclusions—10 min

members. The questions were designed to elicit the panelists to share their wisdom surrounding communication and conflict in an organic storytelling manner.

Session III: experiential learning exercise to reframe conflict

The framework for the third session on experiential learning was based on several psychological theories including: growth mindset,[22,23] social belonging,[24] and stress appraisal and optimization.[25,26] Specifically, the workshop creators considered Dweck's work on growth mindset in which intelligence is considered malleable, emphasizing that communication skills are not innately determined and can be improved with intentional focus and practice.[23] The work by McGonigal[25] and Jamieson et al.[26] on stress reappraisal was also included to highlight and leverage the potential "upside" of stress such as physiological focus, approach-oriented action, and stimulation of personal growth. Their work suggests that situational framing can enhance agency and the sense of self-efficacy in navigating challenging encounters.

Finally, the work by Walton and Brady[24] work on social belonging intervention was considered. This intervention was developed from research that helped students from underrepresented backgrounds successfully transition into college.[27] The theory considers the sense of "belonging uncertainty" that occurs when any individual moves into a new social space. Walton et al postulate that this uncertainty is likely amplified in students who do not fit the stereotype of individuals who typically occupy this space. Consequently, commonplace challenges (i.e., a bad grade on a paper or feeling lonely) can be interpreted as evidence of not belonging.[27]The intervention involved having new students read stories written by older students—both with and without specific attributes—to normalize transition challenges and to reinforce that they can be overcome with time and effort. Finally, students completed a "saying-is-believing" exercise geared toward enhancing learning through an internal shift in perspective. They were asked to write reflections about their own transition along with their anticipated future, with an understanding that their stories might later be shared with new students. The social belonging intervention has now been successfully applied to other areas, such as the integration of women into engineering programs.[28] The workshop creators included it to foster specialty belonging in participants who might not fit the traditional stereotype of a physician and who find navigating conflict challenging. Using the above theories, the framework of the experiential session was further crafted to spotlight the following take home points: conflict in the ED is inevitable, effective communication is a learned skill, and situational appraisal can enhance self-efficacy in challenging situations.

RESULTS

Following the frameworks highlighted, the overall workshop program was created as shown in Table 2.

Session I: gendered communication and conflict

The content of the first session on gendered communication and conflict consisted of three main components: (1) didactics on managing conflict, (2) case-based learning exercise, and (3) large-group discussion. The didactics summarized the relevancy of communication and conflict resolution to EM, highlighting the impact of sex and gender. Emphasis was placed on the context of a situation, with consideration of the importance of assertive action versus consensus building in response to conflict, utilizing an adaptation of the Thomas-Kilmann Conflict Mode Instrument.[29] To give learners the opportunity to apply the concepts directly, participants were split into small groups and asked to role-play through different case-based conflict-oriented scenarios.

Cases focused on addressing conflicts involving different groups including: (1) allied health professionals and emergency physicians, (2) consulting specialists and emergency physicians, (3) resident and attending physicians, and (4) resident physicians and nurses. Based on the medical context, the urgency of the situation, and the dyad involved, participants were asked to weigh the use of different conflict response styles considering the importance of immediate medical outcome against the importance of individual relationships. Subgroup members of the planning committee developed scenarios for simulation based around these types of interprofessional conflicts, and they mapped out how participants might balance the outcome and relationship in each scenario. Cases were intentionally created to include characters who possessed varying sociocultural

TABLE 3 Case-based learning example.

Conflict between resident and nurse	
A nurse calls the resident to bedside to request emergent chemical sedation for a patient with known psychiatric history with pressured speech but staying in his bed and not threatening violence. The resident does not think he meets criteria for emergent medication. Through discussion with the patient, the resident decides to give oral Ativan. The nurse says loudly to the nurse next to her, "Oral? Are you serious?" When the resident asks if she has concerns, the nurse immediately says, "There's no problem. It's fine; I'll grab the oral Ativan."	
Notes for facilitator. Scripting and context	
• You, the nurse, have been practicing in the ED for about 25 years. A decade ago, no one would have hesitated to give this patient intramuscular injections.	
• As a nurse, you have been physically assaulted at work by patients with behavioral health complaints. Most of your colleagues have as well.	
• A part of you understands that residents are learning and figuring out their practice style, but the other part is annoyed that the resident seems tentative with the plan.	
• You have other patients you are taking care of and wanted the situation resolved quickly.	
Prompt	Discussion takeaways
Using the framework of importance of case versus importance of relationship, where would this scenario fall?	Case less important, relationship more important
What are aspects of this scenario that makes it difficult?	Resident feeling "junior" in relationship to nurse Nurse not engaging in good-faith discussion Navigating the nurse–nurse relationship as a resident
What are anticipated challenges of addressing the situation?	Ignoring it versus pushing the nurse to engage as she already has declined the first attempt Future working relationship between the nurse and resident may be negatively affected Nurse may feel like the resident is not respectful of concerns for staff safety
What are some actions participants could take to address the situation?	Ask for a team debrief Alert the attending (which has its own pitfalls) Try to elicit the nurse's thoughts later when everyone had a chance to cool down
What role does gender play in this interaction?	Resident approach may change if this nurse is of the same gender or a different gender

attributes beyond gender (i.e., age, level of training, professional role) to highlight the role of intersectionality in communication and conflict resolution (refer to Table 3 for a case-based learning example). Facilitators were prepped with additional information involving the characters in the cases and were encouraged to prompt learners to consider alternative vantage points in their assessment of the scenarios. The organizers allowed adequate timing for active engagement and participation along with discussion and summarization of key goals and objectives in the large-group discussion.

Session II: panel discussion with senior leaders

The content of the second session centered on a panel discussion in which academic leaders in EM shared their experiences and reflections surrounding communication and conflict resolution. The panel discussion sought to provide real-world, personal examples from senior leaders in EM on how to handle, normalize, and approach conflict through a sex- and gender-based lens. Highlights from the discussion include encouragement for participants to embrace conflict, as it is inevitable given the pace and sheer number of personal interactions in the ED. Panelists prompted learners to be an active participant and lean into disagreement, rather than be a bystander. Though initially uncomfortable, the process of voicing individual differences in agreement can create a point of vulnerability on both sides and forge a new path. Similarly, panelists encouraged learners to intervene and call out observed sex- and gender-based biases to help facilitate awareness, prevent normalizing behaviors, and shift the conversation.

In terms of the specific approach to managing conflict, panelists mentioned that the success of different techniques will depend on multiple factors. These include urgency of the situation, level of clinical experience, and gender dyads of the involved individuals (i.e., women on women, men on women, women on men). There was agreement that the well-being of patients must always be the priority. Panelists shared that having more clinical experience may allow one to have increased awareness of the personalities, interactions, and overall situation in the room. This situational awareness can assist with managing conflict. As for specific gender dyads, panelists shared that learners should be aware of the gender-based differences in communication, which were discussed previously, and how those impact perception and interpretation. Participants were encouraged to ask the individuals involved in the conflict to repeat back their understanding of the discussion before any agreement on resolution.

Finally, panelists brought up the importance of both receiving and providing mentorship. Panelists encouraged learners to seek advice from or even comanage a conflict with a senior leader to receive real-time insight. The senior leaders also emphasized the importance of the participants becoming mentors as they reflect on their own experiences, assisting junior colleagues in navigating conflict. It was noted, however, that participants should be careful in making

assumptions, and a discussion with the individual should occur beforehand to ensure guidance is both wanted and needed.

Session III: experiential learning exercise to reframe conflict

The third and final session was led by two senior faculty. It started with one of the moderators asking participants to identify a stressful situation and then break it down into four specific components: (1) context of the situation, (2) emotions involved, (3) time spent on reflection, and (4) self-perceived efficacy in its management. Participants were then given a brief didactic, emphasizing that the "context" of conflict in the ED is often predictable and unavoidable and hence *that conflict is to be expected*. By stating this, learners could intentionally begin to demystify and normalize conflict. In turn, they could redirect their energy to focus on new ways to ease the potential consequences of the other components in the initial exercise (i.e., emotions involved, time spent on rumination).

Participants then listened to three prerecorded audio clips featuring the personal stories of some of the panelists who participated in the second session. Each story highlighted a challenging professional encounter, how the panelist managed it, and what they learned from the experience. Table 4 provides key take-home points from the prerecorded audio clips.

After the audio clips, learners were provided with several concrete tips and prescripted phrases to help them develop greater self-efficacy in the real-time management of professional conflict[30] (refer to Table 5 for examples). As shown in Table 2, the session ended with a didactic on the positive attributes of stress. Learners were encouraged to reconsider their approach to conflict and stress to allow for a positive-growth mindset. Participants had the opportunity to reevaluate their approach to the conflict they wrote down at the beginning of the session. They concluded with writing a reflection piece, addressed to colleagues struggling with conflict, on how to master and reframe it.

TABLE 4 Summary of audio clips and take-home points from senior leaders.

Panelist 1
Story: The panelist shared his experiences regarding renegotiation of salary as a young physician after realizing colleagues were making different amounts.
• Separate and acknowledge both a situations objective and subjective components • Know the audience and understand their priorities • Collect and present data • Recognize your value • Know the pros and cons of big picture options • Frame outcomes, even if not ideal, to highlight personal growth
Panelist 2
Story: While the panelist was engaged in a conversation, an unfamiliar consultant abruptly interrupted her and demanded information about a patient. The panelist asked the consultant gently how he would perceive a stranger barging into his home without proper introduction. This helped shift the discussion onto a more collegial path.
• Allow for silence to reflect before responding to avoid negatively escalating the situation • Ask the other person to consider your viewpoint and perception • Stay focused on patient outcomes • Invest consciously in creating professional and collegial work environments
Panelist 3
Story: While working as a brand-new attending, the panelist suggested to a female triage nurse that they should trial a process that directed pediatric patients to a specific area of the department. The nurse questioned the panelist's authority and sought the opinion of another male attending, who was in her residency class, prior to implementation.
• Engage key stakeholders in the development and implementation of a new project • Provide opportunity for productive feedback • Allow shared ownership of project integration

TABLE 5 Tips for self-efficacy in managing conflict.

Example of prescripted phrase to redirect a challenging conversation
"I hear our voices getting louder, and I sense this is becoming challenging for both of us. I know that we both want to be *professional* and *deliver excellent patient care*. Do you think that we could restart this conversation?"
Example of "BRAVE" mnemonic
B—**B**reathe **R**—**R**ealign, identify shared goals **A**—**A**ctive listening **V**—**V**erbalize concerns **E**—**E**stablish a plan moving forward

DISCUSSION

Effective communication is essential for EM providers to optimize patient care, team morale, and career satisfaction.[31] *Conversely*, ineffective communication can contribute to medical errors, dysfunctional teams, staff turnover, and burnout.[6] For example, a study showed how a disparaging comment delivered to neonatal intensive care teams prior to a skills update workshop led to lower test scores and impaired team performance.[32] Specific to EM, nonideal conditions commonly experienced such as overcrowding, understaffing, high acuity, and incongruent interprofessional roles can exacerbate the likelihood of suboptimal communication.[31]

As communication is linked to critical outcomes, it is imperative to offer EM providers access to resources to help them master effective communication and conflict resolution skills. This is particularly important for early career physicians who are more likely to be the recipient of inappropriate comments and microaggressions from senior physicians and staff. Early career physicians and students from underrepresented minorities or the LGBTQ community may be especially vulnerable.[33,34] As professional conflict has been identified as a challenging area to navigate successfully, residency programs

are increasingly integrating communication related topics into their curriculum.[35,36] There is limited evidence, however, that these discussions in EM have considered the variables of biological sex and sociocultural gender in conflict management.

Both an individual's biological sex and their learned sociocultural expectations influence how they perceive and react to conflict. Evolutionary biology theory suggests that males are more comfortable with assertive communication and hierarchy, while females tend to be more egalitarian and conflict averse, as the risk of physical injury threatens an ability to conceive, carry, and parent offspring.[37] Practically speaking, direct or assertive language from a male may unintendedly be perceived as critical or intimidating to a female. Unchecked, this could lead to unnecessary rumination and a wariness of the female to approach that male with future concerns. In the context of medicine, this could lead to harmful consequences if, for instance, a female nurse becomes hesitant to clarify a medication order with a male physician after she perceived an earlier interaction as challenging. Along these lines, a study that asked listeners to rate a surgeon's tone of voice on a dominance scale found a possible correlation between malpractice claims of a surgeon and their perceived level of dominance.[38]

Sociocultural norms surrounding "expected" gender-related roles also come into play in professional communication. Explicit and implicit biases that portray men as dominant and agentic and women as collaborative and agreeable can trigger different perceptions in a recipient, even when men and women exhibit similar behavior. For example, one study showed that professional women who advocated for the hiring of diverse candidates were looked upon as less competent than men (particularly white men) who did.[39] Similarly, a qualitative study of women surgeons revealed that female surgeons believed they were held to a different standard and suffered different consequences when they exhibited the same behavior as a male colleague.[40] Another study suggests that professional agentic women are also more vulnerable to workplace incivility from female coworkers, which contributed to their lower job satisfaction and increased professional withdrawal.[41]

As more women join the EM workforce,[42] the impact of sex and gender on communication will become increasingly relevant to the specialty. Specifically, to optimize patient care, it is imperative that all emergency physicians are comfortable and effective in managing diverse teams and leading critical resuscitations with direct and concise language. Currently, there are several studies that suggest women face different obstacles than men in stepping into traditional leadership roles and that women face more pressure to manage the logistics of the resuscitation *and* to preserve their relationships with other team members.[43,44] Issues surrounding leadership skill development are further complicated by evidence suggesting that female EM residents are more likely to receive incongruent feedback compared to their male peers regarding autonomy and leadership.[45] For example, the same female resident may be told by two different attendings that she is being too assertive or not assertive enough when she steps into a resuscitative leadership role.

Men and women (along with trans and nonbinary individuals) often face different communication challenges in the workforce and these challenges can be further confounded by other personal attributes including seniority, personality, race, ethnicity, sexual orientation, religion, and other features. This workshop was developed to acknowledge and legitimize these differences and to provide participants with a framework along with concrete tools to better navigate them.

CONCLUSIONS

Effective communication is a critical skill for emergency physicians to optimize patient safety, team morale, and career satisfaction. Enhancing professional communication skills can be approached as a procedure, and just like other procedures, communication skills can be learned, practiced, and further mastered. This paper describes the development of a communications workshop using a multimodal education format that incorporated didactics, small-group learning, panel discussion, and an experiential learning session. Learners were provided a framework in which conflict was normalized and anticipated and given several tools to increase their self-efficacy during challenging conversations including growth mindset training, stress reappraisal, scripting, and values affirmation. The workshop's distinguishing characteristic, however, was that communication and conflict were framed through a sex and gender lens. This lens acknowledges that men and women often face different challenges when it comes to professional communication and conflict. As the demographics of the emergency medicine workforce have rapidly evolved, understanding these differences and helping physicians successfully navigate them is critical for our specialty to optimize the opportunities and performance of its members and the care provided to patients.[46]

CONFLICT OF INTEREST STATEMENT

The authors declare no conflicts of interest.

ORCID

Ynhi T. Thomas https://orcid.org/0000-0003-3120-6397
Devjani Das https://orcid.org/0000-0002-2373-9890

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