Promoting Workplace Safety: Teaching Conflict Management and De-Escalation Skills in Graduate Medical Education

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A patient with chronic pain presents to clinic requesting a refill of an opiate prescription. The internal medicine resident recommends anti-inflammatories. The patient becomes agitated and paces the room.

The mother of an infant, admitted for bronchiolitis, is frustrated because "no one is doing anything." The pediatrics resident is paged to meet with her. The mother becomes increasingly upset, yells, and threatens to sue.

A patient presents to the emergency department, intoxicated and with multiple rib fractures, after a motor vehicle collision. The consulting surgery resident tries to examine him. The patient lashes out and strikes the resident.

These incidents are all examples of workplace violence, defined as any act or threat of physical violence, harassment, intimidation, or other disruptive behavior that occurs in a work context and may cause physical or emotional harm.[1] Workplace violence is divided into 4 types (TABLE 1).[2] This perspective focuses on Type II violence, which includes the actions of patients, as well as the actions of their family members and friends.

Workplace violence impacts physician well-being. Research has demonstrated negative consequences, including physical injury and mental health issues, which can impair work performance and strain personal relationships.[3] Victims frequently report symptoms of depression, anxiety, fear, and altered mood. These symptoms result in higher rates of emotional fatigue and depersonalization, which may undermine career satisfaction and contribute to burnout.[4,5]

According to 2015 data from the US Department of Labor, the rate of injury secondary to workplace violence was higher in health care than in any other industry.[6] High rates of violence have been reported in the nursing literature,[7] and within specific health care specialties (eg, emergency medicine, psychiatry, geriatric medicine).[8–10] In a survey study of emergency medicine physicians, more than 75% of respondents reported being verbally or physically threatened by a patient at least once in a 12-month period.[11] There are very little data for many other specialties. Workplace violence, in general, is thought to be underreported in health care, making its true incidence unknown.[12] In non–health care fields, younger and less experienced employees are more frequently victimized.[13] We believe Type II workplace violence is an underrecognized problem in graduate medical education that impacts trainees from all specialties.

Conflict Management and De-Escalation Training

Education and training have been identified as "key elements of any workplace violence prevention program."[6] *Conflict management* refers to techniques and strategies designed to reduce the negative effects and enhance the positive effects of conflict for all parties involved.[14] Within health care, *conflict de-escalation* builds on conflict management principles, and is specifically aimed at preventing the escalation of agitation and aggression to physical violence.[15] This is different from conflict de-escalation in some other fields, which focuses on mitigating violence that is already occurring. We refer to these skills collectively as conflict management and de-escalation (CMD). Workplace violence is a multifaceted problem, influenced by environmental factors (eg, noise, lack of privacy), system-based factors (eg, delays of care), patient factors (eg, intoxication, cognitive impairment), and care team factors (eg, prior disagreements).[13] Many of these factors are beyond the physician's control at the time of the conflict.

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TABLE 1
The 4 Types of Workplace Violence[2]

Type	Definition	Example
I	Criminal intent: The perpetrator has no relationship to the workplace other than to commit a crime.	A robbery leading to an assault against a clinic employee.
II	Violence directed against a person providing services to the perpetrator.	A patient assaults a nurse attempting to take vital signs.
III	Worker-on-worker violence.	An employee uses racial slurs against another employee.
IV	Intrapersonal violence that occurs in the workplace. The perpetrator does not have a relationship with the workplace but rather a personal relationship with the victim.	While at work an employee is assaulted by his or her domestic partner.

Competency in CMD, however, can help individuals attain an optimal outcome for a given situation. Training has been shown to improve trainee confidence levels and performance in CMD, and may improve the safety and emotional well-being of the health professional.[16,17]

To our knowledge, there are no CMD training guidelines for resident physicians. There are general recommendations for remediating residents in patient-centered communication skills (eg, discuss patient interactions with faculty mentor), but the only recommendation specific to CMD requires outsourcing the training (eg, attending conflict resolution and communication courses).[18] Simulation-based training is recommended, but specific curricula and training principles have not been reported. Furthermore, existing curricula in the health literature frequently target nursing and ancillary staff.[19] In a study of workplace violence prevention programs in 167 hospitals, physicians were the employee group least likely to attend training.[20] Survey data from emergency medicine and pediatrics suggest that resident physicians are not being reached in appreciable numbers when institutions use an "all staff" approach to training.[11,21] We recommend that all resident physicians who engage in direct patient care receive CMD training.

A Conceptual Model to Guide Training

A robust body of literature related to CMD can help inform educators interested in developing curricula for residents. This includes several models for conflict analysis and mapping, all of which use a curve to represent escalating behavior.[22–26] The literature suggests that aggression in health care settings follows a pattern that is affected by various factors, including the physician's response to aggression.[27] A situation may escalate rapidly, in part due to previous interactions (eg, prior hospitalization).

We have developed an arc of conflict, which applies this curve to model CMD in health care (FIGURE) and

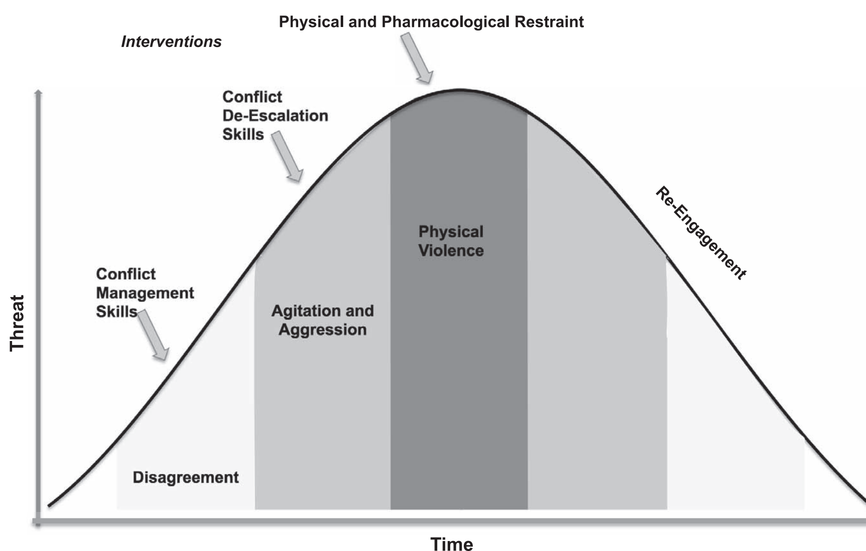

FIGURE
Arc of Conflict in Health Care

TABLE 2
Examples of Interests, Positions,[28] Intentions, and Impact[29]

Scenario	Underlying Construct	Manifestation
	Interest: The Need or Goal Underlying a Position	***Position: Expressed Statement or Action***
A patient is admitted for an asthma exacerbation. Her symptoms worsen and the rapid response team is activated for respiratory distress. Several people respond with multiple interventions occurring at once.	I am scared, and I want to feel in control of what is happening.	"I won't let you put oxygen on me!"
An elderly man is being discharged from the hospital. He lives alone and no one has talked to him about transportation options.	I need help getting home safely.	"You can't discharge me now! I'm going to file a complaint!"
A patient presents to the emergency department with abdominal pain. It is very busy, and he waits several hours for a computed tomography scan. While waiting he becomes progressively more agitated.	I am not being taken seriously.	"No one is doing anything for me! I'm going to call my lawyer!"
	Intention: The Aim of an Action or Statement	***Impact: The Other Party's Perception of the Action or Statement***
Emergency triage: A 5-year-old with diarrhea and normal vital signs has been waiting in the emergency department for 30 minutes to see a physician. From the doorway the patient's mother sees a middle-aged man brought to a room and the emergency medicine resident and a nurse rush to the bedside.	The emergency medicine team was informed that the new patient had chest pain and an abnormal electrocardiogram. The resident wants to ensure that all patients presenting with life-threatening conditions (such as possible myocardial infarction) are stabilized as quickly as possible.	The mother of the 5-year-old feels as though the emergency department team is ignoring her and her child.
Clinical interruptions: A surgery resident evaluates a postoperative patient with abdominal pain. She abruptly leaves the room when her pager goes off.	The resident knew there was an unstable patient in the intensive care unit, and she was concerned that the patient needed immediate intention.	The postoperative patient feels the physician was rushing and did not take her pain seriously.
Sensitive questions: An internal medicine resident asks an inpatient with fever and back pain about intravenous drug use.	The resident is trying to determine the risk of a spinal epidural abscess, and whether the patient needs additional imaging.	The patient feels she is being judged because she uses heroin.

maps the risk (instead of the severity) of violence over time. The model is intended for individual-level, rather than group-level, conflict. It consists of a curve broken into 3 zones (disagreement, agitation and aggression, and physical violence) corresponding to the level of threat. The model serves as a scaffold for organizing CMD skills, with conflict de-escalation skills that build on conflict management skills. Effectively managing conflicts using the least traumatic intervention benefits the patient, the physician, and the health care team.[30] This model can help educators create learning objectives related to specific CMD skills, that are appropriate for targeted workplace violence scenarios (ie, arc of conflict zones).

Conflict management is the foundation for approaching disagreement with any patient. Many physicians have a basic familiarity with pertinent interpersonal skills, including active listening,[31] addressing the emotional aspects of the situation,[32] building trust and empathy,[33] discussing options,[34] and establishing limits.[35] Other concepts from the conflict management literature may be less familiar to physicians (TABLE 2); for example, separating interests from positions.[28] The *interest* is the underlying goal or concern; the *position* is the statement or action. Recognizing this difference helps to establish common goals, identify unmet needs, and find creative solutions to problems. Another important skill is

self-reflection to recognize internal biases, understand one's contribution to the conflict, and identify potentially incorrect assumptions about the situation.[36] Differentiating between *intention* and *impact* can help physicians identify unanticipated negative impacts of their own actions on patients.[29] This differentiation is also important when interpreting the actions of an agitated patient, and it can help a physician reframe an interaction that would otherwise be regarded as negative.

Conflict de-escalation adapts many of the conflict management principles to situations of increased threat (ie, agitation and aggression). The American Association for Emergency Psychiatry Project BETA De-escalation Workgroup Consensus Statement on Verbal De-escalation of the Agitated Patient serves as a valuable resource for this type of intervention.[37] When the patient becomes more aggressive and less effective at communicating, the physician must be more verbally concise. Additional emphasis is placed on communicating nonverbally, assessing danger, and maintaining personal safety. The approach to physically violent patients, including physical and pharmacologic restraint, is addressed elsewhere.[38–40]

Conclusions

The incidence and impact of workplace violence in graduate medical education is not fully understood. We believe it is an underrecognized issue and that all resident physicians should receive CMD training. There is a robust body of literature pertaining to CMD, and our conceptual model will help to organize this information and inform training efforts.

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