Conflicts in the intensive care unit

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Abstract
Conflicts in intensive care units (ICUs) are common and concern all professional groups, patients and their families. Both intra- and inter-team conflicts occur. The most common conflicts occur between nurses and physicians, followed by those within nursing teams and between ICU personnel and family members. The main causes of conflicts are considered to be unsatisfactory quality of the information provided, inappropriate ways of communication and improper approach towards treatment of patients. ICU conflicts can have serious consequences not only for families but also for patients, physicians, nurses and wider society. Lack of communication among ICU teams is likely to impair cooperation and ICU team-family contacts. From the point of view of patients and their families, communication skills, as one of the factors affecting the satisfaction of families with treatment, are essential to ensure high quality of ICU treatment. While conflicts are generally unfavourable, they can also have positive implications for the parties involved, depending on their prevalence and management, as well as the community they concern.

Key words: conflicts, ICU, communication, teamwork, family satisfaction
According to Hartog and Benbenishty [9], the factors underlying nurse-doctor conflicts can be grouped into four categories. One of them includes personality traits, e.g., personal aversions and a lack of trust. The second category involves procedural aspects regarding teamwork, e.g., lack of guidelines, poorly transparent decisions, communication gaps or lack of a team leader, whose leadership abilities, mainly cooperation and communication skills, should ensure high quality of teamwork [10, 11]. The third category encompasses organizational factors that can contribute to unit- or hospital-level conflicts whereas the fourth category includes political, legal, social and cultural conditions affecting perception and expectations.

The time between the onset of conflict and its identification can take up even many months. Conflicts are characterized by their own dynamics, thus it is not always possible to distinguish their six typical stages. The first stage is a “hidden conflict”, which the parties involved are not aware of, but which grows until finally recognized. However, those involved still do not change their mind (conflict escalation). Left unresolved at this stage, the conflict leads to stagnation and everybody feels offended. Once the parties involved realize that the conflict costs are too high, negotiation is possible (de-escalation). The final stage is a laborious process of building up new interpersonal relations [11].

A lack of communication between ICU teams is likely to impair cooperation and contacts between the team and the family, some members of which have limited knowledge about ICU processes and cannot understand the basic information regarding patients, treatment or prognosis [12]. As the information provided by conflict-ridden team members may not reflect the present patient’s health condition, families become disoriented, anxious, depressed and stress-affected [13, 14].

From the point of view of patients and their families, proper communication is essential for ensuring the high quality of ICU treatment [15] and is one of the factors affecting satisfaction with treatment of their relatives [16]. Families stress the importance of proper timing and comprehensible way of provision of information, as well as the display of empathy [17].

Conflicts can be differently perceived by physicians and individuals authorised to make health care decisions for the patient. Schuster et al. [18] have demonstrated that doctors notice conflicts less frequently than family members or decision-makers.

ICU conflicts can have serious consequences not only for families but also for patients, physicians, nurses and the wider society [19]. For patients, this can regard delayed potentially beneficial therapeutic decisions, the maintenance of aggressive therapy and the resultant lower quality of treatment. Almoosa et al. [20] have shown that lack of clear decisions concerning the continuation or withdrawal of treatment, as well as waiting for admission, prolonged unjustified ICU stays and the prevented hospitalisation of other patients. The negative impact of conflicts on the ICU team manifests as lack of coherence, lower efficiency and quality of work, and irrational behaviour. In some cases, a realisation of the inappropriateness of treatment was a reason for resigning from the profession, both among nurses and physicians [21] and the main cause of moral distress that arouses increasing interest [22, 23]. Moreover, the financial consequences of conflicts are important, including costs of legal proceedings, team changes or treatment of complications [24].

Studies on ICU conflicts reveal that they are considered an epidemic [25]. According to the majority of researchers, the major causes of conflicts are poor quality of information provision, inadequate communication [6, 26–28] and inappropriate approaches towards the treatment of patients [6, 8, 21, 29].

By nature, while conflicts are undesirable, they may have positive implications for the parties involved, depending on their incidence, management and the community affected [30]. Their positive role is that on-going problems are revealed, the sense of identity and the involvement of team members increase, group contacts and the transfer of information improve, while a readiness to introduce various innovations grows, resulting in greater family satisfaction.

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