

I Have Something Interesting To Talk To You About: Speaking To Disagree, Agreeably



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ABSTRACT

Working in health care can sometimes be exhilarating. At other times it is exhausting, especially if there is interpersonal conflict amongst health-care providers about the best course of action. This can occur in relation to the care of frail older adults. Physicians and other health-care professionals often are not taught how to disagree. This short essay outlines a few steps that can be followed to allow disagreements to be identified in a respectful manner, focused on a solution that requires something from each side. Given the importance of interdisciplinary collaborative care in geriatric medicine, having a structured approach to disagreement is likely to be a useful tool in the geriatrician's kit.

Key words: disagreement, agreement, request, frailty, consultation, interprofessional collaborative practice

INTRODUCTION

That intelligent people of good will can often disagree is one of life's sometimes more painful lessons. The existence of the YouTube video "There is a fracture. I need to fix it"⁽¹⁾ and its many imitators (their combined number of online views being more than a million) suggests that the privilege of learning this lesson is not denied to physicians. My own experience working as a General Internal Medicine and geriatrician consultant to a busy emergency department underscores not just that disagreement is common, but that many physicians lack a systematic approach to speaking to disagree. This short essay offers a structured approach to that. The idea is to identify problems with a goal to their resolution — or the very least, to a clear statement of how resolution might come about.

In the late 1970s, then working as a fledgling health-care bureaucrat, I had the opportunity to attend a management services course where the guts of this approach were spelled out. I have adapted some aspects, but hasten to point out that this offering is not original to me. Still, I expect it will be novel — perhaps even useful — to many readers.

The heart of it is simple. First, the fact of disagreement must be acknowledged. Second, the nature of the problem needs to be communicated. Next, the speaker must make clear why this is a problem. Fourth, the speaker must outline what he or she is prepared to do to solve the problem. The penultimate step is to identify what is required from the other person for the problem to be solved. The final step is to hand back control of the conversation to the person with whom the problem was raised.

In this essay, I will spell out each of these, before considering finally why this seems like a reasonably useful approach, and why its uptake might allow for conflict resolution between health-care professionals who, in their ultimate duty to the patient, share common goals. This essay does not go into many widely employed negotiating tactics, usefully summarized in the short volume of the Harvard Negotiating Project called "Getting to Yes".⁽²⁾ Any interested reader can go into that or any number of similar volumes. The purpose here is simply to provide a framework. Given that frail older adults are defined by their multiple, interacting medical and social problems⁽³⁾ and that these attract a variety of medical, surgical, and other health-care professional perspectives,^(4,5-12) we can consider disagreement in the context of their care.

The First Step: Identifying the Problem Is To Be Raised

This I learned at my mother's knee. Growing up, few things had a more ominous ring to them than my mother looking me straight in the eyes, and saying, "I have something interesting I want you to talk about, Kenneth." (The absence of the diminutive was likewise significant.) "I have something interesting to talk to you about" now is the phrase that I use in the first step, which is to acknowledge that there is a problem. Any phrase will do, but something that is reasonably disarming, and that gets the attention of the individual, is what needs to be said. In preparing learners for the many stressful encounters that go with Emergency Department work, I encourage them to imagine what they would like to say, and hit on words that are useful to them — to think about "what sounds comfortable coming out of your own mouth". Having such a script reduces

stress on the part of the speaker, and if one person is calm, it is likely the other person will be calm too.

Second: What Is the Problem?

After having gained the speaker's attention, the next useful step is to identify the problem itself. This benefits from being succinct. In the Emergency Department, common reasons for concern are around consultations, either from an Emergency Department physician or from other consulting services. That these can reflect differences in outlook is unremarkable: health disciplines, like health professionals, have their own cultures. These cultures can be barriers⁽¹³⁾ — all the more so when two people use the same words to mean different things.⁽¹⁴⁾ From a general internist's or geriatrician's point of view, the tendency of other consulting services to hand over very ill patients with inadequate recognition of the severity of their illness is a common problem that requires interprofessional collaboration to address. Likewise, we get pushback from surgical and interventionist services about patients who have complications from these interventions that require medical management, which these specialists believe is out of their expertise. Further, their having to manage such problems then interferes with the flow of their services, which is key in their culture. Consider the example of an 86-year-old woman who was discharged postoperatively the day before and who presents now with wound infection and some shortness of breath. She is not septic, but there is suspicion of pulmonary embolus. Surgery was initially consulted, but on the advice of the clinical clerk who saw her in the Emergency Department, the internal medicine service was asked to admit her. In this case the problem can be formulated as, "You have asked us to see a surgical patient who has not been properly evaluated and who appears to have known complications of surgery."

Third: Why Is this Problem Important?

It is not uncommon for people to agree that there is a problem, but, reflecting their different cultures, disagree to a great extent on why this problem is important. In the Emergency Department, a source of agreement is that a patient cannot safely be discharged home. The common area of disagreement is who then becomes responsible for the patient. For example, when the patient who presented shortly after discharge following intervention is diagnosed with a pulmonary embolus requiring an inpatient admission (that need also driven by other active problems), the surgical service demurred, as is not rare. In their view, admitting a "non-surgical" patient to one of their beds will "block access" for other patients. A medical service might counter that "bailing out" patients who are discharged home with active problems only encourages the same low standard of post-operative care, and that the focus needs to be on the patient and not the procedure. Clearly there is merit to both sides; the point is that identifying why the problem is important does not lead to an automatic solution. Even so,

it does spell out what the different perspectives are, so that if there is to be a "win-win" solution, the grounds of what constitutes success are known by each side at the outset.

Disagreement often arises because of a difference in perspectives. In that case, spelling out what the differences are, while not resulting in a resolution of itself, does allow some of the emotions to be separated from the discussion. Each side can see that it is not that the other has some sort of personal flaw ("don't care" versus "lazy"), but that the strictures under which they operate make different solutions preferable to the individuals who differ.

Fourth Step: What the Person Who Has Identified the Problem Is Prepared To Do To Solve It

In some ways this is the most useful step for the person who has raised the problem. Often, in the heat of the moment, it is easy for an argument to become polarized. Each side holds that the solution lies in other person being obliged to do everything, and they very little. For the individual who has raised the problem, determining what a solution might be often is not easy to achieve. Again, consider the case of the patient who presented within 48 hours of discharge with dyspnea, found to have a pulmonary embolus and other active medical problems that were likely there at the time of discharge. The general medical service can, therefore, suggest to the intervention service that, although medicine is not prepared to admit the patient (surgical complications being the province of a surgery service), they are prepared for their inpatient consult service to see the patient in follow-up; that they have already put in place a medical care plan, and; that they have met with the family to identify goals of care and develop a care plan. In this way, the interventionist/surgical service does not have to engage alone in activities with which it does not feel entirely comfortable. The key source of the admission difficulty — a recently discharged patient remains the responsibility of the discharging service — has already been addressed. Note that recurring disputes between services often have resolution in hospital policy, but that still does not help if the policy does not exist or is routinely ignored without sanction. For the individuals involved, however, this is simply part of the environment in which they operate.

Step Five: What Is Required of the Other Side?

This option asks for a clear articulation of what the person who has identified the problem requires of the other side in order for the problem to be addressed adequately. Sometimes it works well to boil this down to two or three specific actions that need to be done straight away. It is not necessary to identify every step in a complex chain, but rather to focus on the key points. For example, a common sequence in medicine might be:

"I need you to do three things. First the patient needs to be admitted, which I can help you get

under way. Second, if this plan is meant to work it is going to require early involvement of a social worker, so I suggest that you talk to him/her as quickly as you can. Third, we will need to be clear who the attending physician is on your service, so that I can have the medicine consult team follow-up with him/her directly.”

Often in such cases, there are hospital or policy issues that give rise to differences. Sometimes it is useful to acknowledge these, and now is a good point to do it. Consensus is often catalyzed by a shared enemy. “We both know that the solution is well above our pay grades. Our lords and masters need to address this from a more policy point of view. We will have to leave that for another day.” This allows for some face-saving, which is key. Face-saving is more than a matter of letting a person off the hook. It is a clear sign you have considered the other person’s point of view, which is a sign of respect, and rightly so.

The Final Step — Getting Consensus

“Is that fair with you?” is a question I find useful. If the person appears to find this unfair, then you can offer “please tell me what is wrong with the analysis?”, or some such. This also makes the point that the long-term relationship needs to be considered, so that these are not conversational “one-off’s” but part of an ongoing interaction. Aiming to achieve solutions that are optimal for all concerned is an important strategy in problem-solving overall. Making a sincere effort to exercise that perspective can ultimately lead to happier outcomes. For this reason, speaking to disagree can be seen as an essential tool for physicians.

CONCLUSION

That communication at an early stage is key will surprise no one. Likewise, it is unsurprising that groups who communicate effectively with each other provide better and more effective care — that is to say, achieve better patient outcomes.⁽⁵⁾ Even so, many discussions about achieving good communication emphasize agreement and achieving consensus, rather than strategies for disagreement. In my experience, not having such strategies facilitates conditions of bullying and passive aggressive behaviour, both of which can erode morale, and are also likely to undermine effective care.

There is an old joke about why the Canadian chicken crosses the road: to get to the middle. Canadians have a cultural instinct for compromise. To achieve useful compromise however, we must have a strategy to address disagreement. To the extent that strategies like this are adopted, they can help to allow disagreements to be addressed without compromising the personal relationships that can make care better. Within health care, we can all appeal to better patient outcomes. This can also be a useful way for each of us to reflect on the

positions that we take and how those positions might best serve our common interest in making care better.

CONFLICT OF INTEREST DISCLOSURES

The author declares that no conflicts of interest exist.

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