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Potential sources of conflict in intensive care units – a questionnaire study

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Abstract

Background: Conflicts occur in intensive care units (ICUs), and an international multicentre study conducted in 2008, including 323 ICUs from 24 European countries, confirmed the occurrence of this phenomenon. There are no data in Poland. The aim of the study was to analyse the frequency of the occurrence of conflicts in ICUs in Polish hospitals, and their most frequent sources.

Methods: The study was based on an original questionnaire performed in 12 ICUs in the Pomeranian Voivodship. The respondents were asked questions regarding the frequency, type, and lines of conflicts between employees, as well as potential causes of conflicts.

Results: Completed surveys were received from 232 employees, including 79 doctors and 153 nurses. The phenomenon of occurrence of conflicts was confirmed by about 30% of the staff, providing answer that conflicts occur "often". About 43% of staff estimated that conflicts "sometimes" occur and 25% chose the answer "rarely". Analysis of the answers made it possible to identify the most common potential causes of conflict.

Conclusions: The main sources of conflicts in ICUs appear to be external factors such a financial issues and physical overload. The hospital policy and the health policy of the state are also important. The perceived conflicts require careful and constant monitoring. The frequency of hidden conflicts requires thorough assessment of their impact on the quality of work.

Key words: conflicts, teamwork in medicine, interpersonal relationships.

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Conflicts are common, inevitable and conflicts associated with social life. They concern interpersonal relationships and may result from differences in opinions, attitudes, values or conflicts of interest. Modern medicine is predominantly based on teamwork; in some hospital wards, e.g. intensive care units (ICUs), the teams of specialists representing various medical fields are particularly large, which is likely to increase the risk of conflict situations. An international multi-centre study involving 323 intensive care units from 24 European countries, including Poland, has confirmed that such phenomena occur [1]. About 70% of respondents reported ICU conflicts during the workweek preceding

the study. The most common causes of conflicts were found to be job overload and strain, inadequate communication and controversies regarding end-of-life care strategies. Except for one review [2], the Polish literature lacks any reports on ICU conflicts; therefore, we decided to determine the prevalence and the most common causes of such conflicts.

The findings of an anonymous questionnaire study carried out among the teams of physicians and nurses, essential for the interdisciplinary model of work followed in Polish ICUs, were presented.

METHODS

The study design was approved by the Bioethics Committee for Research of the Medical University of Gdańsk. An original questionnaire was used in the intensive care units of the Pomerania Province whose heads gave their consent for participation, taking all measures to ensure anonymity of the participants and confidentiality of their responses. The respondents were asked about the difficulties in ICU work, frequency, types and sides of conflicts, potential causes of conflicts, including work organisation and nature, financial and substiantive issues. Moreover, interpersonal communication, personal characteristics, values followed by participants, and external work-related determinants were considered.

Statistical analysis was based on IBM SPSS Statistics 25. Descriptive statistics and subgroup comparisons (the χ^2 test for comparing proportions) were used to analyse the data obtained. $P < 0.05$ was considered statistically significant.

RESULTS

The questionnaire study was carried out in 12 intensive care units of the Pomerania Province. The questionnaire was completed by 232 employees, including 79 male and female physicians and 153 female and male nurses. More than one-third of respondents had up to 10 years of ICU experience, including 19% with up to 3 years of ICU job seniority. The percentages of ICU staff members with experience between 11 and 20 years as well as above 20 years were comparable (in both cases about 30%). Almost all the participants assessed ICU work as relatively or very difficult.

The occurrence of conflicts was confirmed by about 30% of respondents who reported that conflicts among ICU employees were "common". About 43% of employees found conflicts to be occasional and 25% – "rare". The distribution of responses to the questions concerning the frequency, types and sides of conflicts was presented in Table 1. The respondents reported a higher frequency of hidden conflicts, which did not turn into public confrontations. In our questionnaire, conflicts were divided into overt and hidden. Some authors, however, have accepted the concept of six stages developing dynamically in each conflict. According to this concept, an overt conflict is a successive stage of a hidden conflict [3]. Physician-nurse, nurse-nurse, and nurse-head nurse conflicts were found to occur most commonly. Physician-physician and physician-head as well as physician-head nurse conflicts were identified as relatively rare; the rarest conflicts were those between head nurse-ICU head and between ICU team and physiotherapists.

Based on the analysis of the questionnaire answers, the most common causes of conflicts perceived by the ICU staff were identified; 28 possible answers concerning potential sources of conflicts were listed in Table 2. The results were ranked according "common" answers (in descending order). The first 10 table positions were chosen by > 50% of respondents.

TABLE 1. Frequency, types and sides of ICU conflicts

Type/side of conflict	Rare	Occasional	Common
Based on your observations and experience, assess the frequency of ICU conflicts	25.4%	43.1%	31.5%
How frequent are overt and hidden ICU conflicts?			
Overt conflicts	52.8%	30.7%	16.5%
Hidden conflicts	21.2%	33.8%	45.0%
Parties of conflicts in ICUs			
Physician ↔ physician	37.0%	48.1%	14.8%
Physician ↔ nurse	32.6%	38.8%	28.6%
Nurse ↔ nurse	25.7%	46.9%	27.4%
Physician ↔ head/consultant	52.3%	34.6%	13.1%
Nurse ↔ head nurse	41.1%	34.8%	24.1%
Physician ↔ head nurse	57.7%	30.9%	11.4%
Charge nurse ↔ head/consultant	66.2%	26.9%	6.8%
Intensive care team ↔ physiotherapists	80.8%	17.4%	1.8%

TABLE 2. Potential causes of conflicts

Cause	Rare	Occasional	Common
Inadequate salaries	6.9%	16.4%	76.7%
Excessive bureaucracy	10.8%	16.4%	72.8%
Job overload (physical)	8.7%	19.9%	71.4%
Frustration connected with low salary	11.6%	19.0%	69.4%
Hospital and financial policy	11.6%	24.6%	63.8%
Differences in salaries of various employees	12.5%	24.1%	63.4%
Shortage of employees (difficulties in assigning tasks)	15.2%	23.4%	61.5%
Government health policy	17.7%	22.0%	60.3%
Work-related stress (mental strain)	16.8%	23.7%	59.5%
Work under time pressure	17.7%	28.9%	53.4%
Insufficient flow of information	33.2%	28.4%	38.4%
Inappropriate flow of information (tone of voice, language)	33.6%	30.2%	36.2%
"Difficult" personalities of some staff members	28.0%	38.4%	33.6%
Necessity to make decisions in critical situations	32.9%	34.2%	32.9%
Lack of engagement in work of some staff members	38.7%	33.5%	27.8%
Rotation of workers	46.1%	26.8%	27.2%
Insufficient qualifications of some workers	39.7%	37.1%	23.3%
Lack of respect for co-workers	51.9%	26.0%	22.1%
Personal animosities	38.8%	39.2%	22.0%
Differences regarding therapeutic management strategies	47.0%	31.7%	21.3%
Shift work	55.2%	25.9%	19.0%
Bad manners of some employees	42.9%	38.5%	18.6%
Inadequate training in the unit	56.9%	25.9%	17.2%
Lack of mutual confidence	60.8%	23.7%	15.5%
Necessary skills to manage teamwork	58.9%	28.1%	13.0%
No respect for patients and their families	65.9%	25.9%	8.2%
Inobservance of ethical norms	73.6%	19.5%	6.9%
World-view differences	77.1%	18.6%	4.3%

According to the responses regarding potential sources of conflicts, the financial issues were found to be the most conflictogenic factor. Moreover, 76.7% of respondents reported inadequate salaries as the common source of conflicts – 80.4% of nurses and 69.6% of physicians.

Excessive bureaucracy was ranked second of the most relevant sources of conflicts (72.8%) – 75.9% of physicians and 71.2% of nurses (in the group of physicians this source was most commonly chosen).

The next factors identified as the common sources of conflicts were associated with the nature of ICU work, including work overload (physical), shortage of workers, work under time pressure, and mental strain related to work. Furthermore, the other two relevant conflictogenic factors included frustration related to low salaries (this factor was statistically significantly more frequently reported by nurses, as compared to physicians, $P < 0.05$) and external determinants – hospital and financial policy as well as government health policy.

DISCUSSION

An intensive care unit is a special hospital facility abounding in specific everyday challenges faced by ICU personnel. Despite novel therapeutic strategies and technologies, the challenges seem similar to those faced in the 50ties when the first intensive care units were organised [4, 5]. The intensive care units employ many professionals, which translates into more common differences in opinions (informally defined as conflicts). The literature contains many reviews regarding conflicts [6, 7] yet only few research studies [1, 8]. The study regarding American ICUs carried out in 2006 emphasised a slightly different perception of conflicts by the ICU personnel and patients' families [8] – the latter reported a significantly higher incidence of conflicts (42.3%) compared to clinicians (27.8%). In our study, both physicians and nurses stated that conflicts with patients' families were occasional (about 40% of physicians and nurses). The limitation of our study was that the questionnaire was carried out only among

ICU staff; therefore, the comparison with the incidences of conflicts perceived by patients' families is impossible.

Detailed analyses of our findings confirmed that both nurses and physicians of ICUs perceived the phenomenon of conflicts and their extent was comparable to literature data (about 30%). In one of the studies among nurses, the nurse-physician conflicts were considered a significant stressogenic factor in everyday work [9]. Our study results did not confirm the frequency of conflicts between the other professional groups employed in intensive care units or between ICU staff and patients' families (i.e. conflicts which have been considered relevant by many authors) [7, 8].

According to the multi-centre study, job strain was found to be one of the common causes of conflicts [1]. The above factor was also identified by nurses as a significant cause of stress related to everyday work [9–11]. In 2020, the guidelines of the Ministry of Health on standards of management in anaesthesiology and intensive therapy for therapeutic centres were launched [12], which should considerably reduce job overload and strain among ICU workers.

The analysis of the questionnaire responses did not demonstrate a significant frequency of conflicts with patients' families concerning discontinuation or abandonment of new intensive care strategies. The above issues are one of the essential problems described in literature reviews [13–15]. Our findings are consistent with the specificity of Polish ICUs, i.e. patients' families are informed about the discontinuation of futile therapy without discussing the wishes of patients [16].

Almost 40% of positive answers were related to inadequate flow of information as a common source of conflicts. This source of conflicts was also identified as a relevant factor in reviews [6, 17, 18] and in the multi-centre study [1].

Half of respondents reported that the common factors of interpersonal conflicts are related to mental strain and work under time pressure. The above factors, frequently discussed in literature [19, 20], are associated with the specificity of ICU work and any changes in this respect are rather difficult to be expected.

CONCLUSIONS

The major sources of ICU conflicts, such as inadequate salaries or shortages of staff, require further in-depth analyses and studies to determine possible measures to mitigate or counteract them at the systemic as well as ICU level.

The conflicts perceived by respondents should be carefully and continuously monitored in order to limit them by improving work organisation, communication between staff members and skills to cope with stress situations.

The prevalence of hidden conflicts, which do not escalate to the level of public confrontations, require comprehensive assessment of their effects on the quality of performance of ICU personnel.

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