Curr Pediatr Res 2022; 26 (8): 1604-1608 *ISSN 0971-9032*
www.currentpediatrics.com

Negotiating unsettling situations in pediatric clinical encounters: A focus group study on guiding trainee education.

Khaliah Johnson*, Melissa Sacco, Tyler Crowe, Janet Serwint, Lewis Romer

Department of Pediatrics, Children's Hospital of Philadelphia, Stanford University School of Medicine, United States of America

Received: *04 August, 2022, Manuscript No. AAJCP-22-68267;* ***Editor assigned:*** *05 August, 2022, PreQC No. AAJCP-22-68267(PQ);* ***Reviewed:*** *08 August, 2022, QC No. AAJCP-22-68267;* ***Revised:*** *15 August, 2022, Manuscript No. AAJCP-22-68267(R);* ***Published:*** *22 August, 2022, DOI:10.35841/0971-9032.26.8.1604-1608.*

Abstract

The ways that one processes these tasks and subsequently cares for one-self can impact skills development and professional well-being. Conflict management and management of emotions in the setting of acute and critical illness is a daunting challenge for both novice and experienced health professionals. Conflict can arise between members of the medical team when handling complex clinical scenarios in which there may be multiple acceptable approaches to the plan of care. Conflict may also exist between the patient/family and healthcare professionals when a patient or family's goals are not in alignment with those of the medical team or if the family perceives communication difficulties. Transforming these challenges into navigable terrain with specific skills and milestones is an essential component of postgraduate medical education.

Keywords: Pediatric medicine, Pediatric critical care.

Accepted on 15th August, 2022

Introduction

Within pediatrics there is increasing awareness about the unique challenges of caring for critically ill and medically complex patients. As medicine advances and children with life-threatening illnesses live longer, clinicians face the responsibility to present honest information about care and treatment options in a way that is empathetic and supportive [1]. This responsibility may be highly poignant and even overwhelming for care providers and trainees. The ways that one processes these tasks and subsequently cares for one-self can impact skills development and professional well-being. Conflict management and management of emotions in the setting of acute and critical illness is a daunting challenge for both novice and experienced health professionals [2]. Conflict can arise between members of the medical team when handling complex clinical scenarios in which there may be multiple acceptable approaches to the plan of care. Conflict may also exist between the patient/family and healthcare professionals when a patient or family's goals are not in alignment with those of the medical team or if the family perceives communication difficulties. Transforming these challenges into navigable terrain with specific skills and milestones is an essential component of postgraduate medical education [3]. However, curricular content in this area remains underdeveloped [4]. Several studies have shown pediatric residents feel they have limited training and experience in caring for children and families facing critical illnesses where death may be imminent, and are uncertain about their role in serving these families [5-7]. Additionally, trainees have articulated the need for more support in unsettling situations that include managing parental anger regarding apparent conflicts in goals of care, in communicating with families about sudden clinical decompensating in patients, and in mediating disagreement within the PICU team.

National initiatives have been implemented to integrate wellness and self-care planning by the national academy of medicine for clinicians, and by the Accreditation Council on Graduate Medical Education (ACGME) for pediatric trainee education [8,9] but little is known about how self-care can practically help physicians manage unsettling clinical encounters for trainees or advanced level practitioners. Since faculty serve as important role models to resident trainees, the study of how faculty and master clinicians address these issues can have important ramifications for GME education [10].

The purpose of this study was threefold: 1) To identify common themes in the approaches of master clinicians to the target scenarios that trainees and experienced clinicians find unsettling; 2) To focus curriculum planning for crisis management; and 3) To gather consensus regarding the role and repertoire of physician self-care skills from expert practitioners.

Methods

Sample

Focus groups were conducted to discuss strategies faculty physicians have developed for the management of emotionally unsettling situations in patient encounters. Emotionally unsettling situations were defined for this study as communicating with families about acute patient decompensating, managing parental anger, and mediating

conflict within and among interdisciplinary care teams. A question guide was developed from review of the literature to address the goals of the study and to ensure that standardized questions were asked of each focus group. Each focus group was conducted and facilitated by the head of pastoral care (TC) and one of the co-investigators (KJ). The time duration of focus group discussions ranged from 60 to 90 minutes. All questions outlined in the question guide were asked, and the facilitators moved to the next question in the guide once thematic saturation was reached for the preceding question.

Faculty were selected and approached for participation by the investigators based on identification by residents and faculty members that they were skilled in providing effective communication, humanistic care and expertise in handling emotionally unsettling situations. Invitations to participate were sent through interdepartmental email. A total of four focus groups were conducted and included 4-6 participants per group. A total of twenty physicians participated (one group of 6, one group of 4, and two groups of 5). Inclusion in a particular focus group was decided by availability of the faculty members in addition to consideration of diversity of gender and discipline within the focus groups. Focus group participants included faculty from a large children's center in the Mid-Atlantic region of the United States. All participants had been faculty members for 3 or more years.

Data Analysis

The focus group dialogues were audio recorded and transcribed verbatim by an outsourced transcription company. The transcripts were then analyzed in an iterative process guided by grounded theory. Data were primarily analyzed using the *nvivo* 9.0 (QSR International, 2010) qualitative software. Concepts were viewed as grounded in the data, leading successive phases of analysis to identify themes as they emerged through a process of coding. Emergent themes were related by the research team to those found in the literature concerning the handling of emotionally unsettling clinical scenarios.

Through open coding, four coders independently coded one focus group interview transcript to develop a codebook, identify main themes, and to also help determine whether there was adequate inter-rater reliability among the coders. The research team then examined these provisional codebooks, agreed on and reordered their codes, and created a final codebook for use in the entire analysis. We found inter-rater reliability to be >80% upon using the codebook to guide the analysis of the data. Subsequently, the main categories were developed into subcategories, tentative themes and subthemes through axial and selective coding. Relevant quotes from the transcripts were then selected to demonstrate the themes and subthemes.

The participants' identities were not included in the transcripts in order to protect confidentiality. Techniques to increase the validity of findings include the development of a codebook by a team of four coders to help guide the coding of all the data, triangulation (members of the research team were from three professional disciplines-pediatric medicine, pediatric critical care, and social work), member checking (transcripts and tentative findings were shared amongst focus group participants who could verify authenticity), and peer debriefing through presentations at a national conference. Institutional Review Board approval was obtained and consent was obtained from all participants.

Results

Multiple themes emerged from the focus groups. Faculty physicians spoke about their own experiences of learning to handle emotionally unsettling situations in the practice of pediatrics, and noted that lessons learned in training helped to shape their current approaches to such situations. Focus group participants identified approaches to (i) managing acute patient decompensating, (ii) parental anger, and (iii) conflict within the medical team, with significant overlap in the approaches noted. These three concepts serve as the organizational strategy and the themes identified are outlined below (and summarized in. Relevant quotations from focus group participants are included.

Strategies for acute patient decompensation

Key themes that emerged in discussion of the management of acute patient decompensation included 1) The importance of offering parents the option of being present for medical interventions if their child is acutely decompensating, 2) Providing honest information in real time about what changes are taking place in their child's condition, 3) Sharing this information in a sensitive, yet concise manner, 4) Clarifying the family's wishes for their child's care and 5) Acknowledging patients' cultural values and practices.

Focus group participants also spoke to the importance of clarifying the family's goals and wishes for their child's care, so as to avoid interventions that might not be in alignment with their values. This relates intimately to another theme that emerged acknowledgement of cultural values or practices that may be of importance in the setting of critical illness and/or end of life.

Strategies for parental anger

Data analysis revealed that identifying strategies for managing parental anger was the most frequently referenced theme throughout all four focus groups. The three most commonly identified approaches to parental anger included 1) Communicating effectively, 2) Partnering with families around uncertainty, and 3) Anticipating and planning for possible parental reactions, including the possibility of an unsafe situation.

In regards to communicating effectively, the acknowledgement of parental emotions and demonstration of empathy on the part of healthcare providers were important skills identified by focus group participants. Being direct, clear, and open in one's language were also elements of effective communication that were identified as important. In partnering with families around uncertainty, focus group members emphasized the idea

of forming an alliance, viewing the circumstance as an opportunity to work together, rather than to be divided. The techniques of pre-emptively planning how to have a discussion with parents who are angry about their child's condition or aspects of their child's care were also noted to be important steps.

An element of anticipation includes protecting oneself against the potential harms in dealing with an angry parent. There is a balance between accepting anger from a patient or family which can result in the parent or family developing trust in the provider and understanding when escalation of that anger can lead to an unsafe interaction. Setting up for safety in the event of a parent reacting with verbal or physical violence was raised as particularly important strategy in the management of parental anger. Less commonly noted approaches to parental anger included remaining calm and professional, engendering trust, and offering parents options for their child's care.

Strategies for team conflict

In suggesting approaches to addressing conflict within the primary care team (including nursing and allied health professional staff), or between the primary care team and consulting providers, study participants consistently emphasized the importance of 1) honestly disclosing conflict to patients and families as a means of ensuring for integrity in care and 2) medical providers taking focused time to communicate with one another in efforts of resolving conflict. Helpful strategies include reaching a consensus when possible or better understanding the basis for the differing opinions so that unbiased information could be presented to the patient and/or family. Focus group members discussed the importance of having an organized "preemptive" approach to inter-team conflict, addressing it early on or in advance, before it escalates to the point of compromising care.

Strategies common to all themes

Of all three emotionally unsettling situations that participants were asked about (acute decompensation, parental anger, and medical team conflict), certain skills were identified as being helpful regardless of the scenario. Experienced pediatricians identified empathy, honesty, and timely communication as skills important in negotiating emotionally unsettling clinical scenarios.

Focus group participants were not directly asked about the emotional responses they have to unsettling situations in their work. However, several participants volunteered comments about the impact of such experiences on their own emotions and the personal toll of emotional encounters.

Generally, participants noted the value in acknowledging one's emotional response to unsettling clinical encounters, learning from those responses, and in turn, using those lessons to shape how you handle and approach future unsettling encounters.

Strategies for provider self-care

Focus group participants identified an organized approach to self-care as being crucial to maintaining balance in the practice of medicine and more poignantly, in the negotiation of emotionally unsettling situations in pediatrics. Strategies included (i) Taking time to debrief with colleagues, (ii) Valuing the relationships of caring loved ones (iii) Acknowledging personal emotions, and (iv) Viewing outcomes not as a personal failure but as an opportunity to support families. Taking time to debrief with colleagues was a commonly recognized self-care strategy. Relationships or the caring support of loved ones were also identified as being important to self-care. Acknowledging one's sadness about the loss of a patient, or a patient's suffering was also seen as an important part of self-care. Allowing oneself the time and space to cry was mentioned by several focus group participants. In a variety of ways, participants noted that accepting loss and viewing it as an opportunity to support families, rather than as a failure, was important in how they care for themselves emotionally.

The general sentiment of participants regarding self-care is that it is crucial for young pediatricians to adapt a means of self-care early on in their careers, as a means of maintaining boundaries in one's work and personal life, processing emotionally unsettling situations, and maintaining a sense of satisfaction with work.

Summary of action items from focus group responses

Effective communication that is honest, respectful and sensitive was identified as being of core importance in the management of emotionally unsettling situations in the pediatric ICU setting by focus group participants. These experienced pediatricians felt that pediatricians-in-training could most readily learn these skills through role-modeling and mentorship, directed self-reflection, partnered with opportunities to put these skills into practice. Self-care was felt to be a core necessity in maintaining one's practice of medicine and overall well-being that should be included in the education of young pediatricians.

Discussion

The results of these focus groups identified the importance of effective communication strategies and mechanisms for self-care when working with patients in unsettling circumstances. Strengths of this study include the perspectives of 20 skilled and diverse clinicians, which inform a growing body of literature on the importance of communication and empathy in medical encounters, as well as the importance of physician well-being and self-care.

Many of the concepts that the identified by the master clinicians mentioned have been corroborated in studies describing communication strategies in bad news. These concepts include the importance of validating feelings while communicating at emotional and intellectual levels, partnering with families, and identifying emotions and possible areas of conflict. While participating in sessions and simulations in

communication are helpful witnessing what role models have done and direct training in these experiences are critically important [10].

Comments from the focus groups also reinforce the emotional impact that these experiences have on physicians and other medical providers. Distress can be exhibited by burnout and distancing from patients, and may lead to depression, anxiety, and disillusionment. This faculty related the importance of self-reflection taking time to grieve for losses, and talking about the experiences in a debriefing with colleagues. Other strategies included reaching out to one's family, exercise, and meditation. West et al. conducted 19 biweekly physician discussion groups that allowed participants to engage in reflection and mindfulness, and to share their experiences and small group learning. They found an increase in engagement and empowerment at work. Shanafelt and Noseworthy suggested organizational strategies to promote engagement and cultivating community, providing support and resources for self-care. In addition, providing protected time to meet and discuss experiences in healthcare was found to be helpful. In the most recent systematic review and meta-analysis available authors identified both individually-focused and organizational strategies that may prevent and reduce physician burnout. Both the ACGME and the national academy of medicine are now emphasizing the importance of organizational strategies to address these issues.

Progress within the field of palliative care lends the opportunity to utilize the expertise of clinicians with specialized training in communication and the mitigation of suffering to enrich the training experience of young faculty. As pediatric hospice and palliative medicine clinical programs and fellowship training programs grow nationally, there will be increasing opportunities to improve the training of pediatric residents in primary palliative care. Primary palliative care recognizes that all providers, regardless of their sub-specialty background, should have a basic skill set in communicating difficult news, addressing symptoms that cause distress and suffering, attending to psychosocial, cultural, and spiritual dynamics, and also coordination of care. Core domains of palliative care can be considered and applied to the training of pediatricians, even at institutions that do not have pediatric palliative care sub-specialists. This would ideally result in general pediatric trainees feeling better equipped to manage emotionally unsettling situations which is relevant to all future career trajectories involved with patient care.

Limitations to this study include the fact that focus group participants were individually selected based on their expertise and known ability to speak to the topics at hand. However, there were likely other clinicians at this pediatric academic center whose thoughts and contributions to the discussions would have been equally valuable, and perhaps would have offered additional diversity in perspectives. Although limited to those who were considered master clinicians, this limitation was thought to be important to better identify preferred practices. In general, the remarks in the transcripts were well-balanced in respect to the contributions of all participants, reducing the likelihood of biased contributions toward a select few participants. Many of the faculty had previously trained or worked at diverse institutions, but focus groups were comprised of faculty from one institution.

Conclusions

This focus group study revealed opinions and useful strategies used by a selected group of master clinicians in approaching emotionally unsettling situations across various clinical settings in pediatrics and emphasized the importance of communicating clearly, concisely, time-efficiently, and empathetically with families. Consensus supported the concept that caring for oneself as a person empowers a physician, helps one to better handle difficult and stressful scenarios, and allows for greater longevity and satisfaction in one's work.

Curricula for pediatric residents should consider incorporating skills training in communication, demonstrating empathy, conflict resolution and developing self-care strategies. Structured opportunities for role-modeling and mentorship during real time situations, as well as opportunities to engage in standardized-patient encounters and deliberate design of individualized self-care techniques) may make a significant difference in resident preparedness and well-being.

References

1. Pollack MM, Holubkov R, Funai T, et al. Pediatric intensive care outcomes: Development of new morbidities during pediatric critical care. Pediatr Crit Care Med 2014; 15: 821-827. [Crossref][Google Scholar][Indexed]
2. Fernandez R, Deutsch AL, Janairo MP, et al. Development of a content valid tool for assessing end-of-life communication in acute care settings. J Palliat Med 2012; 15: 381-387. [Crossref][Google Scholar][Indexed]
3. Villarreal D, Restrepo MI, Healy J, et al. A model for increasing palliative care in the intensive care unit: Enhancing interprofessional consultation rates and communication. J Pain Symptom Manage 2011; 42: 676-679. [Crossref][Google Scholar][Indexed]
4. Pekmezaris R, Walia R, Nouryan C, et al. The impact of an end-of-life communication skills intervention on physicians-in-training. Gerontol Geriatr Educ 2011; 32: 152-163. [Crossref][Google Scholar][Indexed]
5. Senthil K, Serwint JR, Dawood FS. Patient end-of-life experiences for pediatric trainees: Spanning the educational continuum. Clin Pediatr (Phila) 2016; 55: 811-818. [Crossref][Google Scholar][Indexed]
6. Yang CP, Leung J, Hunt EA, et al. Pediatric residents do not feel prepared for the most unsettling situations they face in the pediatric intensive care unit. J Palliat Med 2011; 14: 25-30. [Crossref][Google Scholar][Indexed]
7. http://www.acgme.org/What-We-Do/Initiatives/Physician-Well-Being Last Accessed Date 12/17/18.
8. https://nam.edu/national-academy-of-medicine-launches-action-collaborative-to-promote-clinician-well-being-and-combat-burnout-depression-and-suicide-among-health-care-workers/

9. Osterberg L, Swigris R, Weil A, et al. The highly influential teacher: Recognizing our unsung heroes. Med Educ 2015; 49: 1117-1123. [Crossref][Google Scholar]
10. Shanafelt TD, Noseworthy JH. Executive leadership and physician well-being: Nine organizational strategies to promote engagement and reduce burnout. Mayo Clin Proc 2017; 92: 129-146.

***Correspondence to:**

Khaliah Johnson

Department of Pediatrics

Childrens Hospital of Philadelphia

Stanford University School of Medicine

United States of America

E-mail: jserwint@jhmi.edu