PERSPECTIVES

A Tale of Two Rounds: Managing Conflict During the Worst of Times in Family-Centered Rounds

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> *It was the best of times, it was the worst of times, it was the age of wisdom, it was the age of foolishness, it was the epoch of belief, it was the epoch of incredulity.*
>
> Charles Dickens[1]

Family-centered rounds (FCRs) provide a framework for structuring rounds to optimize care of the pediatric patient and provide family-centered care.[2] However, the communication skills required to realize the benefits of FCRs are complex, and in practice, they can be easily derailed from their intended course.

For instance, during a recent faculty-development session that included direct observations of bedside teaching, 2 rounding experiences stood in sharp contrast. In 1 situation, the intern expertly led the communication with the family, incorporated all team members into the rounds, and integrated teaching points on her physical examination findings for the medical students, all of which were made easier by a cooperative patient. As the 10-minute encounter concluded, the team and family were in consensus with the management plan and were in consensus that all concerns were addressed.

The second experience was vastly different. The parents were already upset before rounds because a consulting service had visited earlier with recommendations that differed from those of the primary team, leading the family to question the primary team's clinical judgment and communication skills. This seed of mistrust seemed to grow as the parents directed questions to the attending physician throughout the intern's presentation. Perhaps sensing the anxiety within the room, the patient screamed and kicked throughout the physical examination, making it difficult to use the examination for teaching. Although this rounding encounter lasted twice as long, positive teaching moments were difficult to identify. Moreover, the misconceptions due to poor communication remained after the team left the room.

These scenarios, taken side by side, could have easily represented the 2 halves of a satirical video used to extol the virtues of FCRs as well as depict their shortcomings. Although the diagnosis and management were nearly identical, the experiences could not have been more divergent. Although both teams were led by experienced clinicians, 1 group left rounds with a confused and upset family, a disheartened team, and a dearth of teaching. How did 1 team's approach fall so far from the goals of improving communication and bedside teaching?

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Evidence reveals that FCRs improve communication with families and multidisciplinary teams, result in higher patient and family satisfaction, and increase time spent at the bedside.[3,4]

FCRs also afford unique educational opportunities at the bedside, including the ability to model and provide feedback on the physical examination and on communication skills. These studies have in part led to the American Academy of Pediatrics recommendation that FCRs be considered standard practice.[2]

However, the benefits of FCRs are not always clear in reality. Trainees perceive a decrease in the quantity of teaching during bedside rounds and are less comfortable with asking questions during bedside rounds,[3,5] which may be amplified when the trainee is inexperienced or has poor communication skills. Conflicts can arise from differences in perceptions or preferences among the participants in FCRs, which in turn may threaten its effectiveness. For example, it can be challenging to explain to patients a diagnosis with psychosomatic factors while not appearing dismissive of the symptoms. Advanced communication skills are required when families request unnecessary tests. A parent may insist on discharge despite the child not being medically ready, and escalating emotions can interfere with effective communication. Logistics of care (eg, the infant needing to be nil per os) can result in a stressful environment that can increase the risk of interpersonal conflict. There are also risks associated with placing bedside presentations in the hands of the most junior member of the team. The presence of multiple providers in the room may allow emotions to escalate in ways that would not have occurred in a smaller setting. Having the family present during the decision-making process may result in frustration or confusion when different alternatives are being considered. In short, both evidence and practice underscore the risk of interpersonal conflict that can surface in FCRs while providers are prioritizing both patient care and education.

Our residency program, like many others, emphasizes training our residents in FCRs. During intern orientation, they are taught a structure for FCRs that provides a systematic protocol for open-ended communication that is based on a family-centered communication model with intensive feedback both in simulated cases and on bedside rounds.[6] This approach is valuable for standardizing communication and setting expectations but may not adequately prepare participants when conflicts inevitably arise. Another group developed a de-escalation curriculum for pediatric residents for managing the angry caregiver,[7] but this was not specific to FCRs, which have unique hazards, as stated previously.

We propose a framework to specifically mitigate conflict during FCRs called TWIST (Fig 1). TWIST is meant to be used to prioritize addressing rising emotions rather than moving forward with the agenda of FCRs. TWIST differs from a conflict resolution model because it is meant to be used to address the emotional tone of the room at an earlier stage. Similar to the concept of "service recovery" in the customer service industry, in which companies employ intentional processes to turn an upset customer into an even more loyal and satisfied customer,[8] we aim to provide a tool in which the therapeutic alliance between the medical team and the patient and family is restored and, furthermore, strengthened.

TWIST first calls the trainee to "tune in" and be cognizant of impending conflict, which begins by checking in on one's own frame of mind before entering the room. Tuning in also entails checking in with the family, being vigilant for body language, and assessing the emotional tone of the room throughout the encounter. This step is crucial to the model because many trainees prioritize the agenda of FCRs over addressing the emotional tone. Once the trainee has tuned in to emotions in the room that need to be addressed, the trainee should ask himself or herself, "What?" by seeking to characterize the conflict and by identifying the emotions. The source of conflict may be quickly revealed by asking the family, "What is your understanding?" with genuine curiosity and openness to avoid an approach in which the family feels interrogated. Active listening is also essential in this step because misinterpreting the position of the patient and family is a common pitfall. This step is followed by "insight," in which the clinician offers his or her point of view and rationale. The family is then invited to provide feedback and their perspective to help build a "shared mental model" in managing conflict in which the medical team, family, and patient understand each other's point of view. The final step is to "take action," in which the trainee proposes a plan moving forward that incorporates all concerns and points of view.

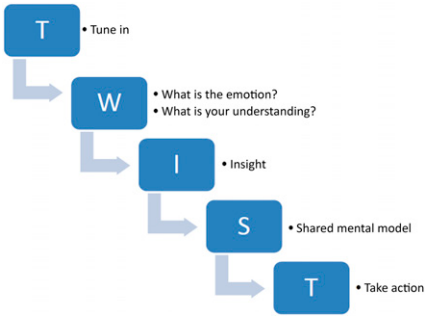

FIGURE 1 TWIST: a framework that can be employed as a modification to the typical structure.

Even when conducted with adequate preparation and a standardized communication structure, FCRs do not avert conflict that can lead to misunderstandings, patient and/or family dissatisfaction, and poor clinical outcomes. Many opportunities exist for teaching programs to ascend to the next level of communication training by having trainees (and their teams) practice managing common threats. This can be accomplished through active learning techniques, such as role play and simulation, coupled with direct observation and feedback. Just as communication frameworks help residents break bad news and discuss goals of care, an approach to developing a shared mental model during FCRs may help trainees address the manifold threats to FCRs and could transform a cautionary tale into an exemplar of shared decision-making.

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