Abstract

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Title: *Understanding intergroup conflict and facilitating integrative decision-making in the care of critically ill children.*

Summary: The complexity of medical care for critically ill children creates a unique psychological, social and technical crucible for all involved, one primed for conflict. (Frugé, et al 2020; Puri, 2019; Frugé & Adams, 2004) We conducted eight focus groups to identify the sources of conflict among multi-disciplinary/multi-specialty teams caring for pediatric cancer patients in critical care settings. (Brown-Hellsten, et al 2006) Based on these findings and our prior work on team-based medical education strategies (Howells, et al. 2015; Frugé, et al 2010; Frugé & Horowitz, 2005), we designed a structured method of intergroup discussion and decision-making with the aim of facilitating optimal coordination of care. Our paper will summarize results from the focus groups and pilot testing of the intervention. We offer hypotheses about how group-level unconscious processes (e.g. defenses against otherness) combine with other setting variables to impair collaboration and how the evolving case conference design may enhance integrative decision making. (Park & DeShon, 2018)

Background: Critical care settings are characterized by multiple factors associated with an increase probability of conflict across a variety of organizational settings. (Wall & Callister, 1995) These include the level of risk (e.g., death), the number and complexity of issues (e.g. unpredictable course of diseases), number of stakeholders involved (e.g. multiple sub-specialties), the nature of the goals/ commitment of stakeholders (e.g. "save the life of my child") and strong negative emotions. A cross-sectional survey of 323 intensive care units in 24 countries found that over 70% of the 7000+ respondents (multiple disciplines) had experienced conflict between professionals in the previous week. (Azoulay, et al 2009) These conflicts can be constructive when managed effectively. (Johnson, 2015) However, our findings indicate that unconscious intergroup dynamics can significantly impair collective work towards the best interests of patients in these fraught circumstances. The findings also provide clues for strategies to mitigate the impact of these dynamics.

Menzies's (1960) classic study of professionals in a non-psychiatric medical setting led to the concept of "social defense". Menzies interpreted the practical policies and procedures of the nursing service as group-level defenses that functioned to limit attachment of nurses to patients and thus manage the professionals' anxiety provoked by contact with suffering and death. Splitting in professional psychiatric teams is another concept that has received attention over the years. The first conceptualizations of "splitting" framed the dynamic as a one-way projective process whereby patients' differential treatment of staff generate conflicts among the professionals. (Green, 2018) However, even the earliest accounts of splitting noted the possibility of pre-existing fault lines within staff. (Main, 1957) Subsequent formulations offer a more interactional view were pre-existing splits in teams can have reciprocal but also independent, negative impacts on patients. These and other lines of inquiry open up several possibilities that we explore in our project. For example: What is the nature and impact of inter-group relations in the critical care setting? (Rice, 1969) Can carefully designed group-level procedures provide useful (non-defensive) containment functions in support of complex, high-stakes decision-making? (Bion, 1962)

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