Teaming vs. “Staying in Your Lane”: Understanding and Overcoming Interdisciplinary Team Conflicts

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Disclosure Information

- Presenter 1: Danielle Gainer, MD
  - No Disclosures
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  - No Disclosures
- Presenter 3: Isabelle Fox, BS
  - No Disclosures
- Non-Presenting Author: Sydney Silverstein, PhD
  - No Disclosures

Learning Objectives

- Discuss areas of tension/conflict identified in understanding of models of addiction, harm reduction, pharmacotherapy, and hierarchies within the medical system based upon qualitative research data.

- Understand the perspectives of those with lived experience who are working in treatment settings and how this impacts team dynamics and patient care, based upon qualitative data.

- Identify strategies to overcome conflicts and foster effective interdisciplinary teamwork, borrowed from other medical specialties to be applied to addiction medicine teams.

Background

- Ongoing debates about the etiology of addiction, with differing views taken by public health researchers, clinicians, neuroscientists, policymakers and those with lived experience
- Numerous models of addiction (i.e. Disease/Biological, Learning, Biopsychosocial, Moral/Spiritual, Psychodynamic)
- We aren't here to debate these models but would like to engage in a discussion about how backgrounds influence our current perspectives.

Barnett A, Savic M, Pickersgill M, O'Brien K, Lubman DI, Carter A. Addiction treatment providers' engagements with the Brain Disease Model of Addiction. In Evaluating the Brain Disease Model of Addiction 2022. Taylor & Francis.
Volkow ND, Koob G. Brain disease model of addiction: why is it so controversial? Lancet Psychiatry. 2015 Aug;2(8):677-679.

Use 3 words to describe conflict among Addiction Medicine interdisciplinary teams.

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Nobody has responded yet.

Hang tight! Responses are coming in.

Hierarchies in Medicine

Addiction medicine teams MAY contain:

- Physicians (MD/DO, Residents/Fellows)
- Nurses (RN, LPN)
- Pharmacists
- Licensed Addiction Therapists and/or Mental Health Therapists (LISW, LCSW, LPC, CAC, CAC)
- Technicians (CDCA in Ohio)
- Peer Supporters (PRS in Ohio)
- Support Staff
- Students of all disciplines

Interdisciplinary Team Dynamics

- Interprofessional teams collaborate to deliver high quality health care, yet there are barriers in place[1]
  - Miscommunication
  - Misunderstandings about roles/value of other professionals
  - Us vs. Them Mentality and stereotypes emerge

1. Thomson, K., Outram, S., Gilligan, C., & Levett-Jones, T. (2015). Interprofessional experiences of recent healthcare graduates: A social psychology perspective on the barriers to effective communication, teamwork, and patient-centred care [Article]. *Journal of Interprofessional Care*, *29*(6), 634-640. https://doi.org/10.3109/13561820.2015.1040873

Interdisciplinary Team Conflict Resolution

- There is a lack of data in the addiction medicine literature related to this topic
- Literature from other areas of medicine discuss this concept heavily.[2]
  - Understand the issue surrounding the conflict
  - Create alignment
  - Define a new path forward
- However, there are some unique aspects of working in addiction medicine teams.

2. Kennedy K, Cornelius T, Ansari A, Ring J, Kisuule F. Six steps to conflict resolution: Best practices for conflict management in health care. J Hosp Med. 2023 Apr;18(4):360-363.

Background

- History of collaboration between Dr. Silverstein, an anthropologist, & Dr. Gainer, a psychiatrist, doing qualitative research with PWUD.
- Research findings indicated PWUD often received contradictory information about treatment/management of their SUD.[3-4]
- Led to broader ethnographic project on SUD treatment ecosystem – “Contradictions of Care”

3. Silverstein, S. M., Daniulaityte, R., Miller, S. C., Martins, S. S., & Carlson, R. G. (2020). On my own terms: Motivations for self-treating opioid-use disorder with non-prescribed buprenorphine. *Drug and Alcohol Dependence*, *210*, 107958.

4. Silverstein, S. M., Rivera, J., Gainer, D., & Daniulaityte, R. (2023). ‘Things that you can’t really suppress’: Adverse childhood experiences in the narratives of people with opioid use disorder. *SSM-Mental Health*, *3*, 100185.

Background

- Research included Certified Peer Recovery Supporters (CPRS)[5] and other professionals working within local treatment ecosystems.
- Interview protocol developed from themes that emerged from past research with PWUD.
- Protocol questions centered around several themes, including beliefs and opinions regarding the origins of SUDs, beliefs and opinions regarding SUD treatment (esp. pharmacotherapy), and conflicts and tensions within the workplace.

5. Supporting and Building the Peer Recovery Workforce Lessons from the Foundation for Opioid Response Efforts 2023 Survey of Peer Recovery Coaches.; 2023.

Methods

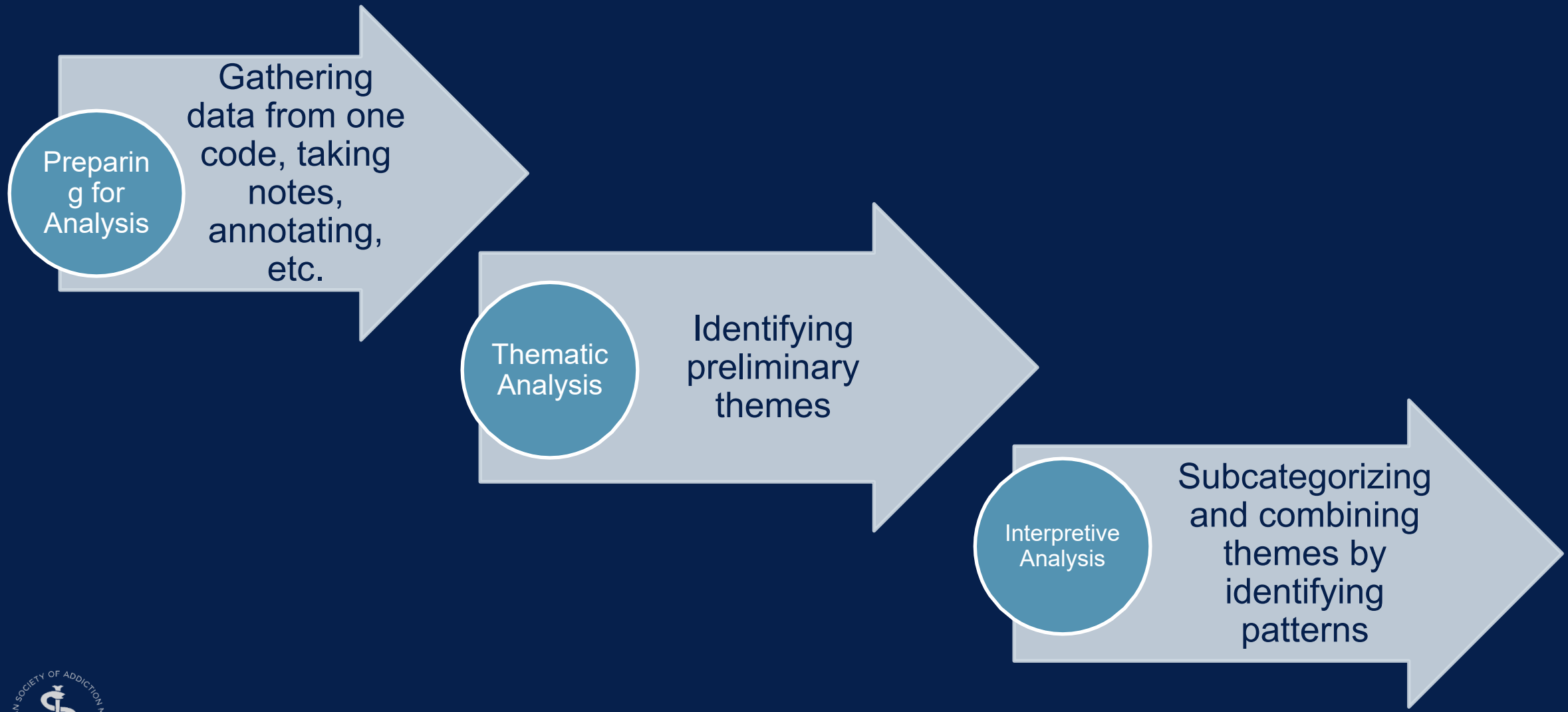
- 31 individuals interviewed
- Inclusion criteria: >18 years; work within local treatment ecosystem (Dayton, OH metro area)
- Dataset included individuals who have one or more of the following educational certifications: CPRS, CDCA, LCDC, CPC, LCSW, NP, MD .
- Interviews were conducted by member(s) of the research team; interviews were digitally recorded and transcribed verbatim.
- Study was approved by WSU IRB

Methods

- Transcribed interviews were uploaded to Taguette for qualitative analysis.[6]
- Codebook collaboratively developed through close reading of interviews—saturation was reached after ~6 interviews.
- Interviews were coded in Taguette; select codes analyzed line-by-line using Iterative Categorization[7]

6. Rampin, R., & Rampin, V. (2021). Taguette: open-source qualitative data analysis. *Journal of Open Source Software*, *6*(68), 3522.
7. Neale, J. (2016). Iterative categorization (IC): a systematic technique for analysing qualitative data. *Addiction*, *111*(6), 1096-1106.

Iterative Categorization



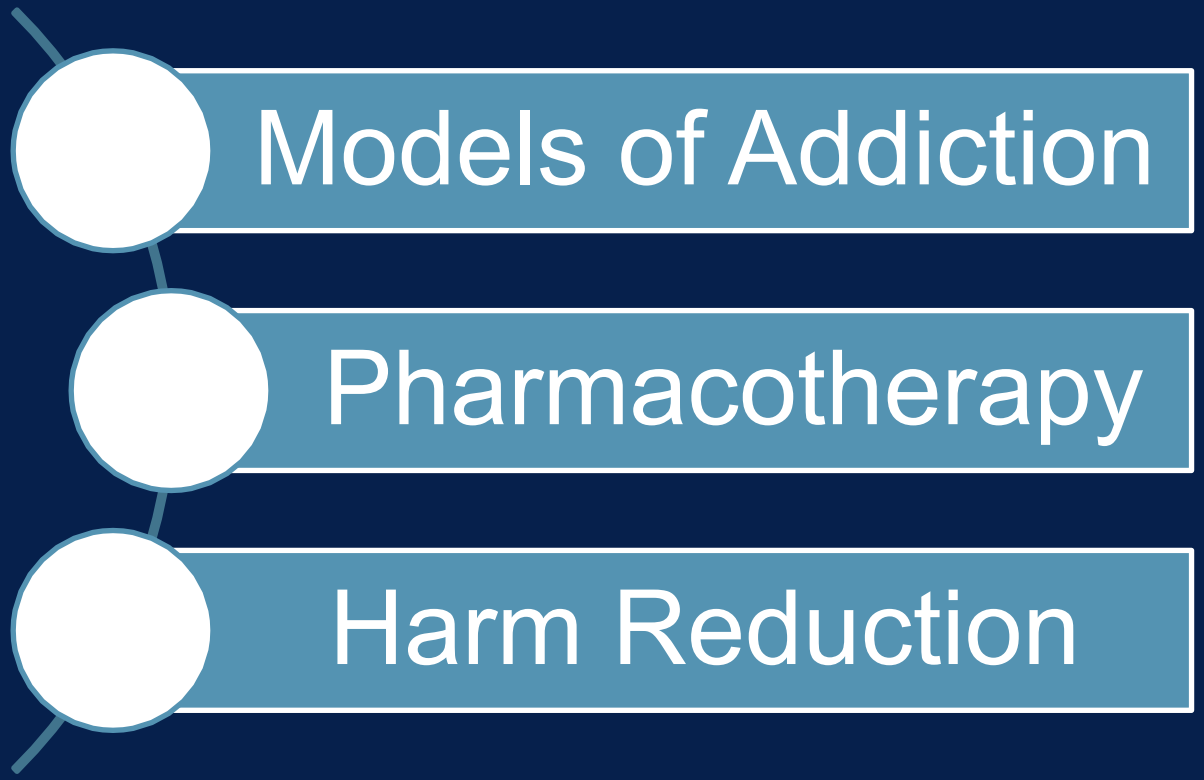
Results – Sample Characteristics

Sample Characteristics – Combined (n=31)		
Gender Identity	Female	21
	Male	10
Race/ethnicity	White	27
	Black	3
	Native American	1
Lived Experience with SUD[1]	Yes	23
	No	8
Education/Clinical Training	Certificate, no degree (CPRS, CDCA)	18
	Associate's level degree (LCDC or Mental Health Tech)	4
	Master's level clinical certification (CPC, LCSW)	5
	Nurse Practitioner	1
	Medical Doctor	3
Employer[2]	Public entity (county-run treatment, support, or diversion program)	5
	Non-profit organization or treatment provider	17
	Private treatment center	9
	Faith-based treatment center	2

1.One CPRS had lived experience with mental health but did not have lived experience with SUD.
2.Total comes to more of sample size as some participants worked multiple jobs.

Results – Key Themes

- Conflicts and tensions within interdisciplinary team amongst 3 key topics



Models of Addiction

- “I'm a firm believer that you're either an addict genetically or by trauma. It's one or the other. Mine is definitely trauma-based” (CPRS, male, private Tx center).

- “I think it's a product of the environment, lack of finances, lack of proper housing, definitely lack of peer support, family structure. All those things play a part in your ***choice*** to use drugs” (CPC, female, non-profit treatment center).

Pharmacotherapy

- "We probably have the most evidence for the medications that we have for opioid use disorder, specific naltrexone and buprenorphine. I don't think for most people, it's a complete fix. Certainly, that's not all it takes to resolve the issue, but again, to not have to be activated by opioid withdrawal constantly and just be in the misery of that can put people so far ahead in their recovery" (Physician, male, non-profit treatment center).

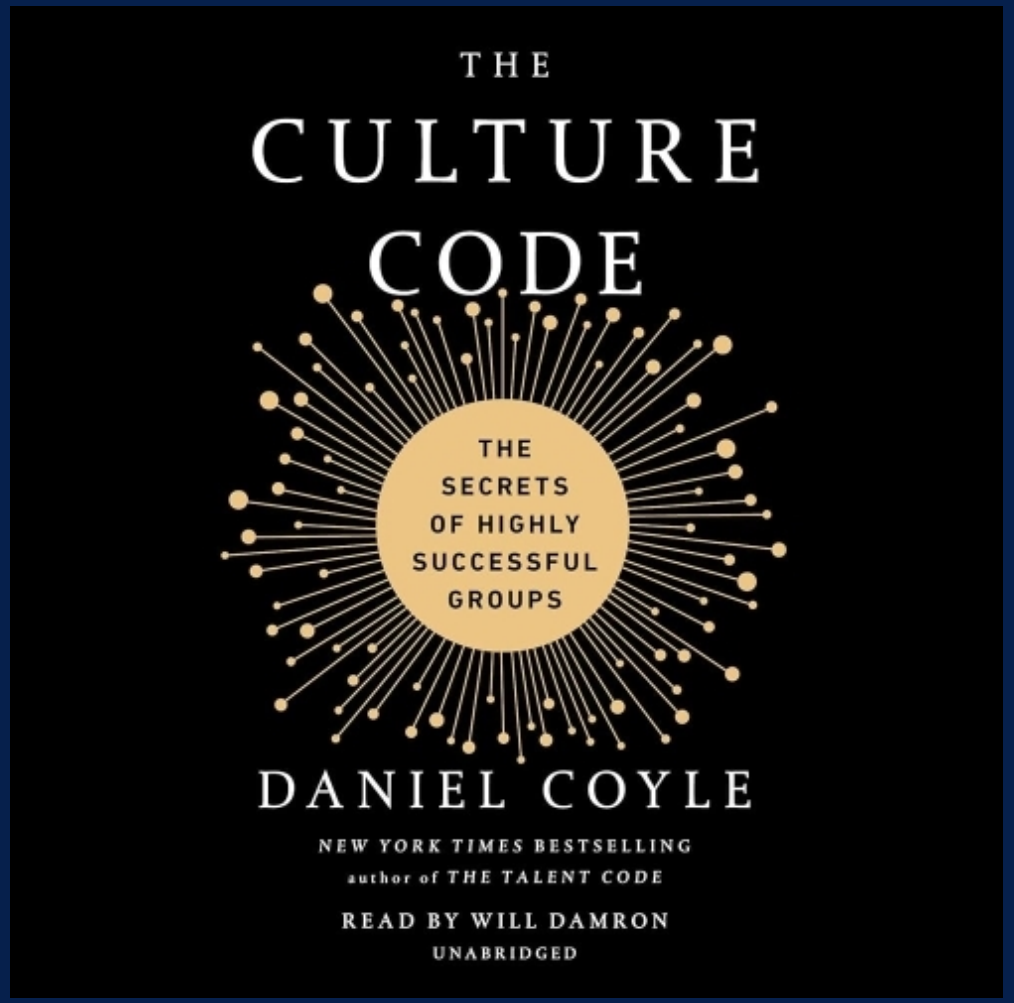
- "I think my personal opinions on it is that it should be used as it was designed and as a taper. Quit stringing us out" (LCSW/CPRS, male, public treatment and outreach program).

Harm Reduction

- “I think it [harm reduction] is, one, celebrating any victories in your life, period, celebrating it. I think on the other side, it's literally reducing harm. It's like, "What am I gonna’ do today to not harm myself? Or to take care of myself”? (CPRS, female, private treatment center)

- “My passion now is how can we combine harm reduction, medication, and personal responsibility, because If you aren't someone that has this disease, it's easy to say, harm reduction and medicine, that should do it, but it's not working” (Physician, female, non-profit treatment center).

Transition to Cases



- We intend to utilize the data from this qualitative research to go beyond strategies employed in other areas of medicine.
- We also will present tips from The Culture Code: The Secrets of Highly Successful Groups,[8] a book by Daniel Coyle.

8. Coyle, D. (2018). The culture code: the secrets of highly successful groups. First edition. New York, Bantam Books.

Case #1 – Models of Addiction

A (male) CPRS with no other training who works at a non-profit Tx center:

"Doctors, I think what they—'cause they've been through all their school and they've done their thing, they've done career, I feel that doctors are set in their ways where they don't wanna listen to someone who talks to somebody every day and knows what they're going through. "

A (black) (female) therapist (CPC) who works at a non-profit Tx center:

"I see that with the medical professionals. I understand why. I haven't quite figured out how to communicate with them 'cause they're headstrong, and they think they know everything. Even though I'm very passionate and very understanding and sympathetic, they just refuse to hear it our way 'cause they're medical, which makes sense. They're doctors, so I'm not going to argue with them because they are medical professionals, and I was trained not to do that. You don't argue with the doctor".

Case 1

- Mr. B is a 24 yo woman on Day 7 of his stay in a residential treatment facility. This is his sixth admission to this facility and he has left AMA in the past. He has been admitted for treatment of both stimulant and opioid use disorders. He has a history of co-occurring ADHD, but this has not been treated since he was 16 years old. He is unable to sit still in groups or participate in discussions, often interrupts others, and has a difficult time regulating his emotions.

- The interdisciplinary team meets for their daily meeting. The interdisciplinary team consists of a physician, a mental health counselor, a SUD counselor, a nurse manager, a peer supporter and a medical student.

Case 1 continued

- The physician is concerned about ADHD symptoms interfering with treatment progression and would like to start stimulants.
- The counselor is concerned that the patient is manipulating and is “seeking stimulants” as they are "his drug of choice" and worries he is “not ready for real recovery”.
- The counselor is recommending a behavior plan and is openly against stimulant treatment. The counselor has lived experience and has been in recovery for the past twenty years. She has interacted with this person previously in outside NA meetings.

You are the physician in this conversation with the counselor and the rest of the interdisciplinary team. What emotion(s) are you feeling during this interaction?

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Nobody has responded yet.

Hang tight! Responses are coming in.

Case 1

Discussion in your groups: Talk through how each of you would optimally manage this situation

What role does conflict play in the team dynamics?

How does your individual perspective impact the team conflict?

What tools might you use to facilitate working through this conflict?

Case 1: Areas for Consideration

Conflict Resolution Training in Academic Health

Qualitative study on transfer of knowledge from 2-day team based conflict workshop

Provides "top 5" lessons retained with participants 12 months later

9. Zweibel, E. B., Goldstein, R., Manwaring, J. A., & Marks, M. B. (2008). What sticks: How medical residents and academic health care faculty transfer conflict resolution training from the workshop to the workplace. Conflict Resolution Quarterly, 25(3), 321–350.

What Sticks...

1. A new spin on conflict: Constructive Potential of Conflict
2. Permission to take a breath and analyze (instead of reacting emotionally and defensively)
3. Eye Opener: Use Interest Analysis to understand others point of view
4. Self – awareness: Knowing your own hot buttons/ triggers and conflict style
5. Communication Skills: words to avoid, it's better to listen than be smart.

9. Zweibel E, Goldstein R, Manwaring J, and Marks M. "What Sticks: How Medical Residents and Academic Health Care Faculty Transfer Conflict Resolution Training from the Workshop to the Workplace". *Conflict Resolution Quarterly. 2008: 25 (3).*

Resources

1. A new spin on conflict: Constructive Potential of Conflict

   Guttman H (2008) *When Goliaths Clash.* Mt Arlington Business Press LLC.[10]

2. Permission to take a breath and analyze

   Crowley K et al (2006) *Working with You is Killing Me.* Warner Books.[11]

3. Eye Opener: Use Interest Analysis

   Stone D et al (2010) *Difficult Conversations: How to discuss what matters most*. Penguin Books.[12]

4. Self – awareness: Your triggers and conflict style

   Patterson K (2002) *Crucial Conversations: Tools for Talking when the stakes are high.* McGraw-Hill.[13]

5. Communication Skills

   Patterson K (2002) *Crucial Conversations: Tools for Talking when the stakes are high.* McGraw-Hill.[13]

Key Takeaways

- Recognize the different backgrounds and perspectives of different team members. Respect their roles and their responsibilities.
- Remember that conflict can potentially move us forward as a team, embrace it as a creative tension instead of a destructive force.
- Check in with yourself emotionally.
- Communication includes actively listening.

Case #2 - Pharmacotherapy

- A (white, female) NP, non – profit treatment center:

"I know if I reduce the patient's Suboxone, and they're stable on that, that [reducing or stopping] could lead them to relapse on fentanyl. It could lead to death…but also I just want the patient to be as safe as possible. That's the approach I have during a case, when we're talking about cases in our provider meetings…They will discharge patients if their urines are not clean. Even if these patients have marijuana in their system, they will talk to the patient and give warnings out, or basically that patient is shifted into this potential discharge lane if their urines aren't clean. I completely disagree with that too."

Case 2

Miss K is a 23 year old female is seeing you for on- going management of OUD. She has been on Buprenorphine-Naloxone 8/2 mg film, two films daily, for 18 months. She has not had a return to use of illicit opioids in more than 12 months.

She has recently had a return to use of cocaine. She uses a few times per week. She relates this to increased stress with managing her new job and the separation from her partner. She is glad that she has been able to decrease use from daily to a few days per week.

Her goal is to stop completely again and feels she will be able to. She is unable to increase her level of care or her frequency due to work. If she loses her job, she will lose her insurance, and therefore any connection to services/medication coverage.

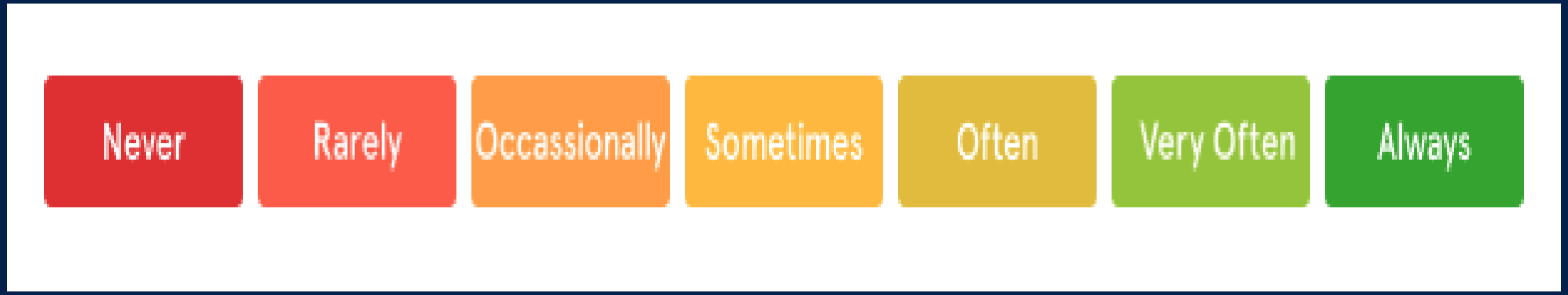
Case 2

You receive an email from her counselor. The counselor is concerned that Miss K has missed 2 appointments in the last 3 months, most recently last week. She feels with this and her most recent urine drug screen showing cocaine that the patient should be either enter into residential treatment or discharged from the program.

The email has an overtly negative tone and includes many members of the outpatient treatment team, including the office manager and director.

Case 2 : Audience Question

How often do your teams discuss care of individuals electronically versus in person (via electronic medical record, email, etc.)?



Case 2 : Group Questions

How does electronic communication change team dynamics and how does your team address those differences? What is your preferred style of interacting with the team?

How are decisions made within your local interdisciplinary treatment team?

- Decisions surrounding pharmacotherapy (whether to start/stop medication)
- What do you think is the optimal way?

How often do your teams discuss care of individuals electronically vs. in person (via electronic medical record, email, etc.)?

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Case 2: Discussion

"The Culture Code: The Secrets of Highly Successful Groups"

Based on 4 years of qualitative research of successful teams

Consistent Themes of Success

I. **Build Safety**
II. **Share Vulnerability**
III. Establish Purpose

8. Coyle D (2019). *The Culture Code: The Secrets of Highly Successful Groups*. Bantam Books.

Build Safety

Eg. Intentional individual to cause trouble in staff meetings

- Effectiveness of most teams dropped 30-40%
- 1 team diffused the troublemaker time and time again

<u>Successful Leaders' skills:</u>

- Builds in intentional "collisions"
- Makes "collisions" safe and part of the process
- We're all in this together

Creating Psychological Safety

- Creating an environment of psychological safety is something that any member of the team can do, not just the "identified leader"
- Tips for Addiction Medicine Teams:
  - Frame the work as a learning problem: Remind the team and call attention to the fact that we are all working toward the same goal of treating the patient. Let's learn about this patient together.
  - Acknowledge your own fallibility: this creates safety for speaking up.
  - Ask Thoughtful Questions: Be curious about why and give all members an opportunity to voice their perspectives.

14. Edmondson, A. C. (2018). The fearless organization: Creating psychological safety in the workplace for learning, innovation, and growth. John Wiley & Sons.
15. O'Donovan, R., McAuliffe, E. Exploring psychological safety in healthcare teams to inform the development of interventions: combining observational, survey and interview data. BMC Health Serv Res 20, 810 (2020).

Share Vulnerability

- Not sharing your deepest darkest secret!
- Relentlessly being an imperfect part of the group process : the leader is vulnerable first and often
- Sharing ideas in ways that allow for debate
  - Airplane with blown engine and hydraulic failure
  - "Tell me what you want and I'll help you".
  - "We're gonna have trouble stopping also", "Oh yea, we don't have brakes"
  - Quick ideas, open to feedback, able to save lives
- "Surfacing"
  - Team lead using time together to uncover and address both project barriers and team dynamic conflicts in a safe way

Key Takeaways

- Create a safe environment for conflict:
  - Leaders should make "collisions" safe and part of the process
  - Ask questions and learn together
- Sharing vulnerability
  - Leaders share first and often

Case #3 – Harm Reduction/Stigma

A patient (white) female, age 37

"One time I went in there with pneumonia and I had this really bad pain, it was right here and they did all these tests, they was trying to find out what it was, they couldn't find anything wrong with me. Eventually they did find out there was a spot on my lung and I guess that is what was hurting me so much. I mean it was bad, bad pain....I went to the hospital, and they pretty much blew it off as if I was drug seeking and I told them I can get better drugs for a lot less hassle on the streets you know, I am not here for that, I want to know what is wrong with me. But at the beginning they were like you just want drugs, there's nothing wrong with you, we can't find anything wrong with you...I won't go [back] there unless I am bad off because they don't do anything for me. They just write me off as drug seeking."

Case 3

Mr. Jones is a 32 year old male been admitted for endocarditis with MRSA bacteremia and has co-occurring intravenous fentanyl use. He is currently on hospital day 2. You are consulted to see him for his opioid use disorder.

On review of his chart, he has multiple emergency department visits for unintentional overdose in the last 4 years. You also note this is the third admission for this endocarditis in the last 2 weeks. The previous two he left AMA. You note that during those two admissions, treatment for his OUD was not addressed.

When you discuss with him treatment for his opioid use disorder, he states he was previously on buprenorphine – naloxone but had missed a few appointments and was discharged from his treatment center. He felt it was helpful for his cravings and he was able to be in complete abstinence from fentanyl for 6 months when he was on 24 mg daily. He last took buprenorphine- naloxone regularly 3 months ago.

Case 3 - continued

In your consultation, you recommend induction of buprenorphine/naloxone to treat OUD while he is getting medical care.

You note that, despite it being hospital day 2, and the infectious disease team was consulted at time of admission, that team has not seen him yet. When you run into the physician in the physician lounge, she says "He's just going to leave again, I will see him in another day or two if he stays".

How much responsibility do we have as individuals in the larger medical system to educate others about harm reduction/stigma?

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Group Discussion

How do we align the team's goals if everyone has a different individual goal?

How do conflicts with other specialties differ from those in our own addiction medicine teams?

What tools or methods are the same or different in the different team spaces?

Case 3: Discussion

"The Culture Code: The Secrets of Highly Successful Groups"

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Consistent Themes of Success

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Establish Purpose

- Purpose isn't tapping into mystical drive
- It's creating simple beacons to focus attention and engagement
- Here is where we are and here is where we want to go
- Successful cultures relentlessly tell and re-tell their story to drive purpose

Establishing Purpose

Robert Rosenthal 1969

California Public School : 1st and 2nd Grade

Harvard Test of Inflected Acquisition – test of kids for highest potential
20% of kids reported back to teachers of high potential

Kids in "high potential" group:
1st Grade: Gained 27 points on IQ (vs 12 of controls)
2nd Grade: Gained 17 points on IQ (vs 7 of controls

All "high potential" kids were chosen at random

The Beacon

The "high potential" kids (based on qualitative interviews) had 4 major differences compared to controls

1. **Warmth**: teachers were kinder, more attentive, more connected
2. **Input**: teachers provided more material for learning
3. **Response – Opportunity** : Called on more often, listened more carefully
4. **Feedback** : teachers provided more, particularly after mistakes

Establishing Purpose

- How do we align our team's goals and establish purpose if individual team members have differing goals?
  - Remember that one of harm reduction's core principles include meeting people where they are at.
  - Harm reduction psychotherapy emphasizes the patient's goals as paramount.[16]

16. Harm Reduction Psychotherapy: A New Treatment for Drug and Alcohol Problems. (2002). United Kingdom: Jason Aronson.

Final Takeaways/Summary

- We must strive to understand the perspectives of those on our teams

- Three main areas of conflicts arose from Qualitative data
  - Models of Addiction
  - Pharmacotherapy
  - Harm Reduction

- We can use tools from other team- based research to improve the care to patients
  - Team Based, Team Dynamic Training
  - Leading Teams with : Safety, Vulnerability, Purpose

References

1. Thomson, K., Outram, S., Gilligan, C., & Levett-Jones, T. (2015). Interprofessional experiences of recent healthcare graduates: A social psychology perspective on the barriers to effective communication, teamwork, and patient-centred care. Journal of Interprofessional Care, 29(6), 634-640.
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