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**Interspeciality Othering: A Qualitative Analysis of Physician Interpersonal Conflict at the Time of Admission From the Emergency Department**

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**Purpose:** Communication, teamwork, and conflict navigation among physician colleagues are core competencies for graduate medical trainees. Yet, how these core elements of professional behavior are enacted in practice remains poorly characterized, and interpersonal interactions continue to be a central source of workplace conflict. While this threat to an effective learning environment has been described in the nursing literature, physicians’ experience of conflict with other physician colleagues remains poorly characterized. The goal of this study was to gain a more nuanced understanding of interphysician conflict to provide foundational guidance for how training communities can support best practices and curricular innovation regarding communication.

**Methods:** Using a constructivist grounded theory approach, the authors explored the perceptions of interpersonal interactions of emergency medicine (EM) and internal medicine (IM) clinicians, using conversations regarding hospital admissions as a critical interface between members of these 2 disciplines. The authors used a purposive sampling approach to recruit participants and included EM residents and attending physicians and IM attending physicians who serve in the triage hospitalist role. Two authors conducted hour-long, semistructured interviews over Zoom. The 2 primary investigators then coded the transcripts according to Charmaz’s 3 stages of coding: initial, focused, and theoretical. Investigators used a constant comparative and integrative analysis to refine the interview guide, and interviews continued until thematic sufficiency was reached.

**Results:** The authors interviewed 18 participants for this study, including 9 IM faculty and 9 EM providers (4 faculty, 5 residents). Participants identified primers, modifiers, consequences, and solutions to interphysician conflict. They described how preconceived perceptions of their colleagues’ specialty and misalignments in expectations around clinical care primed the learning environment for conflict. EM and IM providers also emphasized the role of word choices in creating mutual feelings of being undervalued, disempowered, and having their clinical judgment questioned. They described important personal and professional consequences that occurred secondary to this conflict, such as stress, burnout, job dissatisfaction, self-doubt, questioning their choice of medical specialty, and concerningly they expressed these encounters reinforced bias and stereotyping among specialties. Finally, providers suggested strategies to repair conflictual interactions and improve communication. They noted that focusing on honesty, empathy, teaching, and active team formation could be used to resolve or avoid conflict.

**Discussion:** Our data suggest that interpersonal conflict between physicians is a pervasive issue. Participants describe that these encounters impact both their professional and personal wellness, which aligns with the broader workplace conflict literature. Interspecialty “othering” and preexisting biases and stereotypes prime the workplace for these conflictual interactions. They also serve as a lens to interpret misaligned expectations and difference of opinion as error, clinical incompetence, and work avoidance, which further propagate conflict. Trainees are exposed to interspeciality othering and expressions of other specialties’ relative inferiority early in training. These attitudes are often modeled by supervisors and play a role in specialty identity formation. Finally, propagation of bias and stereotyping is a concerning consequence of interphysician conflict and may serve to further the divide between EM and IM providers. Empathy, honesty, and mutual teaching are important strategies to combat stereotyping and othering and may help mitigate the deleterious consequences of interphysician conflict.

**Significance:** Educators should specifically target interventions to foster improved inter specialty communication to promote conflict navigation and teamwork competencies. Learners need to not only understand how to give a structured handoff but also have strategies for both preventing conflict and navigating it once it does occur. Additionally, it is critical for educators to be mindful of the role that our words, actions, and attitudes play in influencing trainees’ perspectives of other specialties.

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**References**


**Perceived Barriers to Using De-Escalation Techniques to Approach the Agitated Patient: Insights From Fourth-Year Medical Students**

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Purpose: Health care workplace violence is an underreported, ubiquitous, and persistent problem. Despite its pervasiveness, medical students receive little training in how to respond to workplace violence, although they are frequently exposed to patients in high-risk settings such as the emergency department and psychiatric wards. De-escalation training has been shown to improve provider confidence in managing these scenarios and provider attitude and temperament when faced with aggressive patients. For any training to be executed and used in real-world conditions, it is important to assess barriers to implementation. The purpose of this study was to identify medical students’ perceived barriers to using verbal de-escalation techniques when faced with an aggressive or agitated patient and to characterize gender-related differences in these perceived obstacles. We hypothesized that female students would be more likely to identify internal barriers to de-escalation.

Methods: This study analyzed qualitative data collected as part of a required workplace violence online training module completed asynchronously by fourth-year medical students at the Michigan State University (MSU) College of Human Medicine in the fall of 2019. The module addressed the appropriate management of agitated patients in the health care setting, including verbal de-escalation. Students were required to answer multiple open-ended questions including this prompt about verbal de-escalation: “What barriers do you anticipate might make it challenging for you to use this technique with agitated patients in the future?” The authors then performed a qualitative analysis of de-identified student responses to this prompt. Using constant comparison, the barriers were sorted into internal or external loci of control. Disputes were resolved by iterative conversation among the researchers until consensus was achieved. The MSU institutional review board reviewed and approved this study.

Results: The module was completed by 161 students who identified 337 barriers. This included 91 female students identifying 191 barriers and 70 male students identifying 146 barriers, for an average of 2.1 barriers per student, irrespective of gender. Two barriers were uncategorizable. The most common barrier cited overall was emotional, namely fear or anxiety felt by the student (40.7% of total). Female students cited emotional barriers most commonly (50% of female responses). Male students cited patient-based barriers most commonly, for example, the patient was too agitated or did not speak English (45% of male responses). We classified 155 total internal barriers (46%) and 180 external barriers (53.4%). 68.3% of the internal barriers were identified by female students, while only 46.1% of the external barriers were identified by female students, which is statistically significant ($P < .02$).

Discussion: Workplace violence is unavoidable for health care workers. It is imperative that medical students are trained early to safely interact with agitated patients, and specifically, how to de-escalate them appropriately, including verbal de-escalation when possible and appropriate. Our data demonstrate that students anticipate multiple barriers to using verbal de-escalation techniques appropriately; ranging from “my attending will prefer using restraints” (male, external) to “more concerned for my own safety” (female, internal). The preponderance of female-identified internal barriers fits with literature that suggests that females are more likely to attribute failures to their own actions, as opposed to males, who will attribute them to external events.

Significance: Our data suggest that not only are students wary of putting these important skills into practice, but it may be beneficial to offer targeted reassurances to male and female medical students based on their perceived barriers. Even without a gender-based component to the training, the anticipated barriers themselves can help guide future instruction to keep our students feeling safe in their environments and confident in their abilities.

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References

Residency Program Director Perceptions of Resident Performance Between Graduates of Medical Schools With Pass/Fail Versus Tiered Grading System for Clinical Clerkships: A Meta-Analysis

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Purpose: The variability and imprecision of clerkship grading raise concerns for program directors (PDs) during applicant selection. Although the majority of medical schools have adopted pass/fail (P/F) preclinical grading, only 12 schools formally use P/F grading for clerkships. Additionally, per Liaison Committee on Medical Education recommendations, events such as Hurricane Katrina and the COVID-19 pandemic have led additional schools to adopt P/F clerkship grading temporarily. Moreover, the rise in studies describing student- and institutional-level disparities in clerkship grading has tasked medical education personnel with weighing the fairness and risk of disparities as well as the potential benefits of tiered grading. With the continued paucity of literature examining P/F