



Skills for Conversations Involving Conflict at End of Life

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Disclosure

“No Conflict-of-Interest with Industry”

By way of this announcement, I disclose any involvement with industry that may be perceived as potentially influencing the presentation of the educational material.

Cases to Discuss



Case 1



- Pt , mid-70s, Dx pancreatic cancer 6 wks ago
- ICU x 4 wks post-op. Ventilated. Every few days another complication → another intervention.
- Pt extremely angry when woke up and learned truth about prognosis and recovery trajectory. Writes: "Being kept alive against my will." Wife admits she deceived pt, feels guilty.
- Physician and surgeon still optimistic. Pt sedated (pulls out lines). Wife begs to stop treatment, Drs encourage "wait and see".

Case 2



- 67 y/o man, cancer, no more curative Tx avail.
- Finished palliative radiotherapy
- Wife is surrogate
- She refuses transfer to palliative care. Demands full code (medical team believes inappropriate)
- Several conferences with wife and adult children. No resolution.



Most in-hospital deaths follow period of decision-making between family and team about:

- How much aggressive intervention, &
- When to shift the goals of care

The *quality* of that decision-making important
Conversation and communication skills required

Contributes most to satisfaction with decision-making

- Satisfaction with amount / level of healthcare received
- Completeness of information received
- Feeling supported through the decision-making process



(Heyland et al 2003
Surrogates in ICU decision-making)

Communication Models

- Better outcomes when:
 1. Engage (welcome, tell me about you, agenda, pt story, identify essential tools)
 2. Empathy (see, hear, and accept the other)
 3. Education (what do you think is going on, my impression)
 4. Enlistment (build trust, ask permission to tell more, close/summary)

(Bayer Inst. HC Communication E4 Model)

Build a Relationship: The Fundamental Communication Task

1. Open the Discussion
2. Gather Information
3. Understand the Patient's Perspective
4. Share Information
5. Reach Agreement on Problems and Plans
6. Provide Closure

(Kalamazoo Consensus Statement, 2001)

Match Response to Behavior

| Behavior Level | Response Attitude |
|-------------------|-----------------------------------------|
| Anxiety | Supportive |
| Defensive | Directive (set limits) |
| Acting-Out | Nonviolent physical crisis intervention |
| Tension Reduction | Therapeutic Rapport |

(www.crisisprevention.com)



When conflict over end-of-life decisions, often:

- Staff + family implicated
- Misunderstanding and miscommunication
- Staff not understanding family's rationale → disagree about goals of care
- Surrogates misunderstand Dx, prognosis or Tx

To Improve Decision-Making

- Early and effective communication ✓
- Consistency ✓
- Family conferences ✓
- One-on-one contact with designated providers ✓
- Meet unique information, interests, decision needs of each patient/family ✓

Role of Team

- Trigger decision process.
- Guide process
- Talk with patient/surrogate
- Inquire about preferences about care
- Provide information, advice, support
- Create safe, effective environment for decision-making
- Share info among team, try to reach consensus about recommendations

Role of HCPs on the Team

- Various Healthcare professionals (HCPs):
 - Know some pts very well
 - Follow from out-pt, units, ICU
 - See pt(s) respond/not in past
 - Pt tell others what they don't tell physicians
- Share info with team
- Support & educate pt, help pt discuss with family

Role of HCPs on the Team

- Help create safe environment
 - Pts trust relationship, knowledge
 - Act if see manipulation, coercion
- Help form team recommendations
- Trigger review of decision if necessary
- Use institutional resources to resolve uncertainty or conflict

Conflict is Not the Norm



- Consensus about decisions is usual
- Conflict when
 - Complex issues relate to resuscitation of decisions
 - Different understandings
 - Different values
 - Interpersonal dynamics
 - Other factors
- Conflict management strategy must suit particular circumstances of situation

Strategies to Manage Conflict

Four Categories:


1. Consensus Building
2. Obtaining Information & Advice
3. Reconciling Conflicts
4. Addressing Irreconcilable Conflicts



CONSENSUS BUILDING

Alliance and Consensus Building
between patient and healthcare team

- **Re-establish trust & relationship by:**
 - Listening, observing & responding
 - Compassionate communication
 - Sensitivity to and respect for different opinions and personal, cultural and spiritual issues



Alliance and Consensus Building
between patient and healthcare team


- Address source of conflict
- Spiritual, psychological & social supports
- What each “understands”, believes will happen
- Dx, prognosis, potential interventions
- Goals and values to guide decisions
- Re-establish goals of care, & how interventions will affect achievement of goals.
- Re-establish care plan.

Alliance and Consensus Building
within healthcare team

- Address in format that:
 - Hears serious objections
 - Encourages communication, and
 - Emphasizes respect for different HCPs

**Family Disputes
Competent Patient's Choice**


- HCPs as facilitators
- Refer to resources



**OBTAINING ADDITIONAL
INFORMATION AND ADVICE**

Second Medical Opinion

- Required by many professional codes and law
- If same as healthcare team,
 - Adds credibility to their assessment
- If differs from healthcare team,
 - assess difference,
 - reassess intervention options, and
 - discuss with physician (who gave 2nd opinion) and/or the patient.



Additional Professional Advice

- Specialists
- Patient's family physician
- Social Services
- Spiritual Care
- Patient Representative
- HCP credible to patient
- Institutional Leadership
- Legal Counsel
- Insurer
- Medical Defense Org.

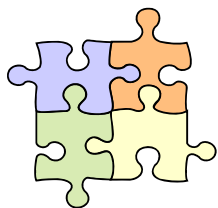
Clinical Ethics Consultation

- If conflict over ethical dimensions or there is an emerging ethical question
- If disagree with process/recommendation:
 - Reassess with consultant(s)
- If still unresolved, consider additional clinical ethics consultation options
 - E.g., NSHEN

Trial of Therapy

- To help determine whether intervention is effective, ineffective, beneficial, burdensome
- Agree on trial plan and goals with pt
- Plan to include what to do if pt status deteriorates during trial
- Document well
- Reassess at end of trial





RECONCILING CONFLICTS

Conflicts: Who Should be Surrogate



- Legal criteria
- Must be willing, available & capable
- Ideally knows pt's wishes, preferences, goals, & values best
- Explain different roles:
 - Surrogate has authority & responsibility
 - Others with important knowledge or care burden participate
 - Decision rules to follow
- Physician may petition court to appoint curator

Conflicts: Advance Directives

- First address any concerns with surrogate (may be misinformation or miscommunication)
- The pt's most recent competent wishes should guide care, even if differ from advance directive
- If no expressed wishes for situation, follow pt's best interests
- If concerns remain, consider advice from HCPs, ethics consult, legal counsel

Conflicts: Cultural /Religious requests

- Try to honour all relevant, important values (within limits of professional integrity, hospital commitments, policies & resources)
- Seek explanation for nature & rationale of cultural/religious request
- With pt's permission, possibly consult pt's spiritual/cultural leader or liaison
- Consult cultural interpretation service
– E.g., CHI-IS (Com Health Info & Interpret. Service)

Conflicts: Physician doubts effectiveness & benefit of intervention

- If previous strategies used, but conflict remains, and
- Physician believes pt's requested intervention may work, but uncertain whether the intervention is in pt's interests
→ pt's decision should prevail unless action contravenes hospital policy

Offer to Transfer Patient

- To physician or institution willing to provide care
- Required by many professional codes and law
- Document reasons & arrangements for transfer
- Assist pt to find another physician or institution
- If after reasonable effort , no other physician or institution will accept the patient, it is evident that no physician or institution is willing or available to provide disputed intervention



Facilitation or Mediation

Facilitator or mediator should:

- Have training, skills
- Be seen as objective
- Be acceptable to both pt & healthcare team

- When institutional resources are exhausted, consider external professional services



ADDRESSING IRRECONCILABLE CONFLICTS

Conflicts: Surrogate not acting in patient's best interest

- If used above strategies but conflict remains, the healthcare team has exhausted all reasonable professional & institutional processes to reconcile those in conflict.
- If healthcare team still judges that surrogate is not acting in the pt's best interest, consult legal counsel about petitioning the court to challenge surrogate's decision or establish a curatorship

Conflicts: Withhold / withdraw ineffective, non-standard of care interventions

- If used above strategies but conflict remains, team has exhausted all reasonable professional & institutional processes to reconcile those in conflict.
- If healthcare team still judges that requested intervention is clearly ineffective and outside professional standard of care, then may conclude that there is no duty to provide intervention
- May want advice from licensing association
- Inform pt of decision & rationale
- When possible, abide by pt's cultural/religious preferences when withhold/withdraw intervention
- If acrimony persists, consult legal counsel

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**Thoughts
&
Questions**



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- Jewish General Hospital (JGH) Clinical Ethics Committee
- JGH policy: "Levels of Intervention for Resuscitation and Other Critical Interventions"
- McGill University Health Centre policy: "Levels of Intervention"

Studies of Conflict & Decisions in ICU



- Abbott KH, Sago JG, Breen CM, et al. *Crit Care Med* 2001;29:197-201.
- Azoulay E, Chevret S, Leleu G, et al. *Crit Care Med* 2000;28:3044-3049.
- Breen CM, Abernethy AP, Abbott KH, et al. *J Gen Intern Med* 2001;16:283-289.
- Goold SD, Williams B, Arnold RM. *JAMA* 2000;283:909-914.
- Heyland DK, Cook DJ, Rocker GM, et al. *Intensive Care Med* 2003;29:75-82
