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Ethics FAQ

**Addressing Conflict in Patient Care**

This **Ethics Frequently Asked Question (FAQ)** guide has been prepared in collaboratione between **Regional Ethics Network** and Hamilton Health Sciences’ **Office of Clinical & Organizational Ethics** for the purpose of educating staff, physicians and learners. *It does not constitute legal advice.* For more information about the Regional Ethics Network, and other FAQs please visit our [website](http://regionalethicsnetwork.com/wp/). If you have questions about this topic as it applies to a specific case, you may contact **Regional Ethicsit** for support (Monday-Friday, 8am-5pm) or email [regionalethics@HHSC.CA](https://hhssharepoint.hhsc.ca/teams/ocoe/Shared%20Documents/Ethics%20FAQ%20Project/regionalethics%40HHSC.CA).

**Example Scenario:**

Mr. Dhaliwal is 68 years old and suffered a massive stroke 3 months ago. He has a large extended family, including four devoted children and his wife who is at his beside from morning until night. Mr. Dhaliwal is conscious and aware, but responds to commands inconsistently. However, he clearly enjoys the presence of his family. Unfortunately, over the past few weeks the relationship between the family and the care team has become tense. Although Mr. Dhaliwal was provided with optimal stroke care, the team believes he will not recover the ability to walk or engage in activities of daily living without assistance. Now that his medical condition has stabilized, the team feels he should be discharged home with a wheelchair, permanent feeding tube and nursing support. However, the family is resistant to planning for his discharge; they continue to press for more treatment and rehabilitation in hospital. They have told the manager that the team has “just given up” on Mr. Dhaliwal, and they have begun to scrutinize every interaction between him and his care providers. The team has been heard to describe the family as “difficult.”

**What are the common causes of conflict in healthcare?**

Patients rarely come to hospitals voluntarily; usually a serious illness or injury has forced them to seek care. In hospital, they are out of their comfort zone…in a strange place, away from the comforts of home, surrounded by strangers who constantly invade their privacy, ask intrusive questions and do uncomfortable procedures. Family members may find their work and home lives disrupted as they try to support their loved one through a health crisis. In cases of serious illness, like Mr. Dhaliwal’s, patients and families are often trying to adjust to the loss of health, income, identity and control over their lives. *The experience of hospitalization can be frightening, even traumatic.* Patients and families have a variety of ways of coping with this stress and fear; expressions of anger, withdrawal, sadness, hyper-vigilance or other emotions are all normal responses to this acute stress.

In contrast, for healthcare professionals, the hospital is their workplace, a place of routines and familiar faces. Almost universally, *it is those patients/families who disrupt our routines, who get labeled as “difficult.”* Those who are compliant and agreeable never get this label. Conflicts often arise when our “usual way of doing business” is challenged by a patient’s or family’s *personal values or beliefs* (i.e. a belief in miracles), their *way of coping with stress* (i.e. avoidance or micromanagement), or their *patterns of communication* (i.e. the use of threats to resolve disagreements), or their long-standing unhealthy *family dynamics* that surface in time of crisis.

Conflict may erupt from misunderstandings stemming from a patients’/family’s medical literacy, or their inability to effectively communicate in either English or French or because their diseases/disabilities impede verbal communication (i.e. aphasia). Conversely, healthcare providers’ lack of understanding of patients’ and families’ cultural context or unconscious biases may impair communication. Conflict can also arise due to the *large and diverse teams* of professionals that deliver care 24/7 in an institutional setting. Professionals may inadvertently *give different messages* to patients/ families, causing them to mistrust the team and to second guess their treatment recommendations. It is important to remember that healthcare professionals often unintentionally contribute to patient/family behaviors that get labeled “difficult”; conversely, however, we can consciously engage in behaviors that ease conflict and build trust.

**What should I do if I think a conflict is brewing with a patient or family?**

Conflict with patients or families can consume a disproportionate amount of the team’s time and resources; they often take a real emotional toll on everyone involved, contributing to compassion fatigue and vicarious trauma. They can also lead to unwanted health outcomes for patients. Addressing conflicts proactively can help to avoid future problems.

The first step is to pause and reflect on the conflict, to determine the best strategies to address it. Contemplate the following questions/suggestions and select which ones are most fitting to the situation:

* *How am I feeling about this patient’s situation*? What are my gut responses, questions, worries, anxieties or frustrations? Identifying what you are bringing to the conflict will help you to see issues with more clarity and compassion. *Remember: how you speak and what you say can help to rebuild trust.*
* *Is the patient capable of directing his/her own care?* If so, perhaps talk with the patient privately about their concerns or questions, and explore how they want their family involved in their care.
* *If the patient’s isn’t capable, who is the appropriate substitute decision-maker?* Who else is important in the patient’s life? It is important to know the right people to engage in care planning for the patient.
* *Does the patient/family have suggestions or solutions?* Give the patient or family an opportunity to voice ideas and engage in shared decision-making, utilizing everyone’s expertise.
* Sometimes acknowledging the difficulty of the situation is the first step to finding common ground. Apologizing for past misunderstandings can also engender trust. Clearly describe what the issue is, and what steps have been taken to address it.
* Does the situation involve inappropriate behaviors? Setting boundaries is crucial; for example, make it clear that calling team members “incompetent” or swearing is unacceptable. Communicate behavioral expectations and uphold them consistently.

**What do I do if the conflict continues to escalate?**

In our organization, we have [insert local sources/policies/guidelines here]. You may start by talking with your manager and/or [professional practice lead], or consult with appropriate corporate resources:

* If the family wants confirmation of the diagnosis, prognosis or treatment options, the MRP can request a second medical opinion
* If you want legal or risk management advice, contact [insert contact for the appropriate service here] for support
* If the patient/family wants to lodge a complaint, refer them to the clinical manager or [insert contact for patient relations here]
* If you want coaching for managing the conflict with the patient/family or specific support in negotiating an appropriate treatment plan for the patient, contact Regional Ethicist or members of the local Ethics Committee [insert how to contact them]
* If you have concerns about staff/patient/public safety in the hospital, contact your Security Service [add contact here]
* For information about the organizational Code of Conduct contact the [appropriate service who owns the policy]
* Document all steps taken with the patient/family to resolve the conflict in the health record