

MODULE: CONFLICT RESOLUTION

Detailed Case Scenario

Having reviewed the variety of factors that may intersect to create conflict in end-of-life decisions, let us revisit the case of Mrs. S to understand what got lost in the communication process. A series of one-to-one interviews with Sandra, Mrs. S's only family member, revealed the following information.

Family History

Mrs. S. was a Dutch Roman Catholic who married shortly after the German invasion of The Netherlands. Her husband was Jewish, yet living under the pretence of being Roman Catholic due to the new laws imposed by the Third Reich. Mr. and Mrs. S. planned to leave Holland for Switzerland as soon as they could save enough money for their passage. The Nazis, however, discovered their true identity and arrested Mrs. S. in her workplace. Mr. S. escaped minutes before his attempted arrest. Mrs. S. was sent out to a concentration camp, where she struggled to survive until the war ended and she was liberated. Mr. S. went into hiding and eventually made safe passage to England. They were reunited after the war and immigrated to Canada. This history helps to illuminate Sandra's view of her mother as a "fighter" and a "survivor" who would struggle for life against all odds.

Sandra reported that her parents had a "close but crazy marriage". She stated that, as a child, she often felt frightened by the emotional intensity between them. Sandra described her mother as a vibrant woman with a strong zest for life, yet she suffered from severe bouts of clinical depression. The war was never spoken of in their home, yet it had shaped the lives of this family. Mrs. S. reportedly feared illness, took many measures to safeguard her health, and avoided doctors. Both of Sandra's parents were highly observant of the Jewish faith and had a strong regard for the "sanctity of life." Sandra described her father as a passive, "worrying man." Sandra herself was married with two children under five. She was now facing marital problems and beginning to question why she had married such an emotionally erratic man. She was in therapy and exploring just how much her parents past had influenced her life.

Physicians' Perception of the Situation

Mrs. S.'s admission to the ICU was questioned from outset. Three out of five ICU staff physicians felt that, in light of Mrs. S.'s seriously impaired lung capacity and metastatic CA, ICU admission was not realistic. At the first family conference, the physician on duty felt it was very important that Sandra – as the only family member – be made aware of the severity of Mrs. S.'s situation and of the strong likelihood that treatment would be unsuccessful. He felt it would be unfair to give her unrealistic hope. This physician's communication to Sandra was specific to

interventions, and he strongly and repeatedly highlighted the probable futility of each intervention. Sandra had prepared a list of questions that generally fell within two categories: the first category related to her mother's comfort and care, and the second related to the possibility of more accurate diagnostic procedures. Communication between the two parties broke down quickly and ended in disagreement and silence. Following the conference, the physician described Sandra to the team as "difficult" and "unrealistic." Subsequent meetings were strained and increasingly brief, with physicians repeatedly stressing the growing futility of treatment. Physicians spoke of the frustration of dealing with a person "who just doesn't understand" and "wasn't listening." Sandra repeated her alarm at the thought of "just giving up."

Sandra's Perception of the Situation

Sandra felt that the physicians had been begrudging of her mother's ICU admission from the outset. She stated that her mother had commented on this attitude several times following her admission. Sandra also stated that, although she was told that the first conference would be an opportunity for her to ask questions, her questions were twice interrupted. She felt the real agenda "was for the staff doctor to stress that treatment should not be given." Sandra left the meeting with a mounting fear that her mother would be covertly "under-treated."

Sandra described the physician at the first conference as "cold." She found his approach "depressing." She was also very upset that he had twice referred to her mother as "him." Sandra saw this as a sign of extreme disinterest in the "human side of all this." Yet, the physician – who was Chinese – later stated that he regrettably made the mistake because gender distinction is not used in the third person in Chinese, and he was "a little nervous" because the meeting wasn't going well.

This case highlights the interface of fractured communication, conflicting family and physician perspectives, and the profound effect of family history, functioning and cultural/religious values on end-of-life decisions. Mrs. S.'s religious beliefs in the sanctity of life in combination with the trauma of the war greatly affected both her and her daughter's perspectives on end-of-life decisions. These decisions opened up painful and unresolved issues for Sandra, which had a greater influence on her decision-making than did the notions of medical outcomes or futility definitions. Although this case was framed as an ethical dilemma requiring an "either/or" decision, the locus of the conflict was rooted in inconsistency, miscommunication and profound events that transpired over 55 years ago. It highlights the depth and complexity of end-of-life decisions.

Teaching Tips

1. Distribute the case and allow time for participants to read it.
2. Identify topics for discussion/learning objectives and write these on a flip chart. Topics should include:
 - ❑ Influence of patient's and family's understanding and perception of illness and its treatments on end-of-life decision-making
 - ❑ Role of the substitute decision-maker
 - ❑ Role and influence of health care providers' perceptions of illness and quality of life in end-of-life decision-making
 - ❑ Nature of conflict
 - ❑ Price of conflict
 - ❑ Predisposing factors to conflict
 - ❑ How to avoid conflict
 - ❑ Required skills for resolving conflicts
 - ❑ Steps to resolve conflicts
 - ❑ Role of conflict resolution in providing quality end-of-life care
3. Ask participants how they would approach this situation if they were asked to provide a second opinion AND help resolve the conflict.

TIP: Participants should be encouraged to ask for more detail regarding Mrs. S.'s past, her values and beliefs and Sandra's relationship with her mother, her perceptions of her mother's illness and her own values and beliefs. How do/should Sandra's beliefs affect her decision-making? This information is found in the detailed case scenario

4. Ask participants to reflect on how the knowledge they have gained regarding Mrs. S. and Sandra changes their perception of the conflict. Does this knowledge help them in their efforts to resolve conflict?
5. Ask participants to discuss how the health care providers' values and beliefs, AND the way information is communicated to Sandra, may be contributing to escalation of conflict.

TIP: Ask participants to role-play their discussions with Sandra. The opinion leader or another participant can assume the role of Sandra. Ask participants to reflect on what language/way of communicating escalates conflict and why or what they did to avoid conflict.

6. Ask participants to reflect on what skills are needed for conflict resolution

TIP: Good listening skills, empathy and self-awareness are best modeled by opinion leaders. Share some of your past experiences with conflict: how did you respond? What was the effect of your response on the conflict? What would you do differently next time?

7. What steps would participants take to resolve this conflict?

TIP: Ask participants to reflect on conflicts they have had in the past. How were these resolved? Could anything have been done better?

8. What would participants do if this conflict could not be resolved?
9. Discuss any remaining learning objectives and assign tasks.