Ian Anderson Continuing Education Program in End-of-Life Care

Module 9

CONFLICT RESOLUTION

A Joint Project of Continuing Education and the Joint Centre for Bioethics, University of Toronto
and The Temmy Latner Centre For Palliative Care, Mount Sinai Hospital

Author:

Kerry Bowman, MSW, PHD
University of Toronto Joint Centre for Bioethics
Clinical Bioethicist, Mount Sinai Hospital
Assistant Professor, Family and Community Medicine, University of Toronto

Case Scenario

Mrs. S. was a 75-year-old widow with breast cancer metastatic to bone. She was admitted to intensive care after a spinal fusion to relieve pain and prevent paraplegia. Post-operatively, she developed respiratory distress and pulmonary edema, and was intubated.

Through written communication, Mrs. S. repeatedly indicated that she wished to "get off the machines" and return home as quickly as possible. She was consistently silent when asked what her wishes would be if this were not possible. All attempts to wean her from the ventilator were unsuccessful. In her second month in ICU, Mrs. S. became increasingly confused and agitated. At times, she would panic when medical staff entered the room. She was frightened that someone would try to kill her while she slept.

Oncology assessment indicated that the cancer had now spread to the lungs and metastases to the brain were suspected. Mrs. S.'s level of consciousness receded. Physicians approached Sandra, Mrs. S.'s daughter and only living family member, to question the amount of aggressive treatment her mother should receive. Sandra stated that her mother would want full and aggressive treatment, describing her mother as a "fighter" and a "survivor."

Several members of the health care team became increasingly upset with what was being referred to as Mrs. S's "pathetic quality of life." Each conversation between Sandra and the physicians became more adversarial. Sandra's position was, "You can't just give up on a person." The physicians' position was, "We are now only prolonging her dying, not her life." Mrs. S.'s skin began to break down and she started having small seizures. Many members of the health care team felt that discontinuation of treatment without family consent should be enacted. The situation had now been labeled as "a major ethical problem."

Introduction

When dealing with end-of-life decisions, health care professionals can face a variety of complex factors: family dynamics, varying beliefs about end-of-life decisions, ever changing health care teams, inconsistent opinions about prognosis, and cultural differences between physicians and patients and their families. When these factors converge, conflict may erupt.

While rare, situations of conflict command an inordinate amount of the health care worker's time. Prolonged disputes are extremely stressful for both health care teams and families, and they may leave patients in pain or receiving unwanted treatment. Ultimately, resolving these conflicts is the responsibility of the health care professional; and understanding the importance of balanced communication, negotiation and mediation will make this job much easier.

Medical technology, despite its enormous advances, can often complicate the process of end-of-life decision-making. Patients who are no longer cognizant may be sustained on life support. In this situation, negotiation often involves families, rather than patients themselves. While advance directives or **living wills** may help guide families with difficult decisions, few people create these documents. Despite positive attitudes towards them, efforts to increase the rate of completed documents are only modestly successful.

When faced with end-of-life decisions the stakes are high. These decisions involve several factors: life-or-death choices, views about the quality and meaning of life, high costs, moral principles, and legal rights. Not surprisingly, such decisions can generate intense emotions and increase the potential for conflict. Furthermore, all of these factors occur within the climate of endless change that defines the contemporary health care system.

Given these various factors, it is not surprising that conflict in end-of-life decisions arises. And disagreements over end-of-life care will only become more common as the number of people receiving such treatment increases. It is therefore best to anticipate conflict and develop mechanisms and policies to address it before it erupts. The most important task for health care workers is to focus on consistent and balanced communication and negotiation; and if necessary, to turn to mediation, defined as the **principled resolution of disagreements by a knowledgeable and neutral third party**.

Mediation promotes good end-of-life care by creating a forum that fosters respect for family perspectives, while allowing for a comprehensive examination of the medical, ethical and legal elements of a situation. Mediation can also create an environment in which multi-disciplinary teams can learn to integrate the psychosocial, cultural, ethical, legal and medical concerns in a case. It is important that clinicians involved in end-of-life work be trained in third party mediation. These skills may be highly

useful when asked for a second opinion in end-of-life care. Furthermore, many of these skills are transferable to establishing patterns of balanced communication, consensus building and well-functioning teams.

Objectives

- To identify the nature of conflict
- To identify the cost of conflict
- To identify the causes of conflict in end-of-life care
- To teach techniques for subverting conflict in the early stages
- To teach techniques for third party mediation in end-of-life care

The Causes Of Conflict In End-Of-Life Care

Conflict is a given in end-of-life care. Debates about the standard, nature and delivery of end-of-life care are potentially explosive, raising profound questions about the meaning and treatment of human life, about the kind of care that should be received and about who has the right to make such decisions. For example, there is no widely accepted ethical and legal framework underlying a situation where patients or families request treatment that health care workers believe is inappropriate. Moreover, substantial differences in age, culture, social class and education often exist between health care workers and families. When differences exist, so too will perspectives on choices, creating a greater opportunity for conflict. What is known or valued by health care workers may be illusive or irrelevant to families. Conflicting perspectives become increasingly obvious when major decisions must be made. Large health care teams with shifting and inconsistent members – each trained in separate professions with separate working cultures – often fracture communication and make for an environment that is not conducive to balanced discussion and negotiation.

The Nature of Conflict

By its very nature, conflict is a process of polarization and receding opportunity. When two people or parties are in conflict, they characteristically move to opposite sides of an issue. They fortify their position by overstating their case, creating further distance between themselves. As the conflict escalates, they become more resolute in defending their position and destroying that of their opponent's. Conflict is a

process of simplification. We ignore the reasons, justifications, viewpoints and concerns of the other side. We dismiss the texture and meaning of their statements, and we are blind to the shortcomings of our own. They are wrong and we are right.

The Price of Conflict

Situations of conflict, whether they are between health care workers or health care workers and families, command large amounts of time. If conflict exists within a health care team, everyone is affected, regardless of the source. Both sides in a dispute tend to interpret the other side's intentions through the lens of their own anger, hurt and fear. By evading such problems, there is the risk that the matter will escalate or fester. Health care teams can begin to experience frustration, tension, caregiver burnout, and intra-team conflict due to muted tension or the polarization of opinion. Even if one side perceives itself to have "won," both sides suffer unrecoverable losses of time, emotional depletion, stress, and often professional or personal regard. Patients and families begin to feel intense anxiety, decreased confidence in the health care system and, in the event of the death of a family member, complications in the bereavement process. The resolution of conflict in end-of-life care can create a higher quality of health care, more cohesive, happy and efficient health care teams and a substantial increase in patient and family satisfaction.

Anticipate conflict, it is inevitable.

- Conflict is a given in end-of-life care.
- Interdisciplinary teams, with distinct working cultures and endlessly shifting membership, must make complex end-of-life decisions that involve high stakes and moral complexity.
- End-of-life decisions evoke strong feelings in people.
- The pace of some end-of-life care, such as ICU, is brisk and opportunities for reflection are often limited. Conflict in such situations can easily emerge.

Conflict resolution as a quality improvement strategy in end-of-life care

By acknowledging the inevitability of conflict we can both develop strategies to deal with it and use it as an opportunity for quality improvement. The following questions can help to improve end-of-life care:

1. How can we manage conflict when it does occur?
2. How can we alter our working procedures to reduce the likelihood of conflict?
3. How can we integrate lessons learned from disputes into end-of-life decisions quality improvement initiatives?

Subverting conflict

- The intensity and recalcitrance of conflict is greatly influenced by the early stages of a disagreement or altercation.
- No matter how difficult or irrational the other side appears to be we must ask, “In what way might we have contributed to this conflict?” This need not be done in the presence of the other party.
- We must honestly and openly consider what elements of our health care system or procedures might have contributed to this conflict. Failure to do so will, at the very least, create a significant impediment or escalate conflict.
- A change in our own behaviour, or conciliatory gesture, no matter how slight, is the best way to trigger a change in others.
- Avoid labels such as "dysfunctional" or “crazy” families that may lead toward gossip. This usually begins the process of polarization and reduces common ground for resolution.
- Avoid matching other parties’ anger and arguments.
- Focus on **affective** rather than **cognitive** aspects of the conflict.
- Try to understand the emotional meaning of the conflict.

Requisite Skills for Conflict Resolution and Mediation

Creating a climate of understanding and change

- Understand that focused, unbroken listening is essential.
- Communicate a constant atmosphere of non-bias.
- Constantly stress that the goal is to resolve the conflict and express disinterest in the outcome.
- Remember a huge element of communication is non-verbal and not in the conscious mind.

Self-Awareness

- Realize that self-awareness is critical in both mediation and conflict resolution but that people are at remarkably different levels in this area.
- Establish a climate in which self-examination of any kind is encouraged and is not seen as giving in.

Listening

- Listening is an acquired skill. It takes conscious, focused effort and refinement.
- The purpose of listening goes far beyond gathering information.
- When listening to patients and families tell their stories, allow and encourage them to explain what this illness or experience has been like for them.
- There is mounting evidence that there is a strong therapeutic value in truly listening to people to tell their story.

Empathy

- Pay attention to your non-verbal cues. The quality of a person's presence and empathy is non-verbally communicated.
- Put yourself in their shoes – imagine the force of emotion they are feeling.
- Imagine facing the other's situation from the perspective of a family member, or another professional perspective or cultural background.

What if disputants don't want to settle?

- Meet individually with each party.
- Assess and highlight the cost of the conflict.
- Ask them if they can afford not to settle.
- Appeal to higher order.

Are there cultural differences?

The following are questions designed to assess cultural differences:

- How are disputes such as this resolved in your community?
- Do you believe both sides should talk openly about these problems?
- What is most important to you about settling this problem?

Pre-Mediation Steps
Step1: Normalize the conflict.
Step 2: Acknowledge the voluntary nature of a settlement.
Step 3: Consider the differences in power and hierarchy.
Step 4: Assess if cultural differences are a part of the conflict.

Pre-Mediation Steps

Step1: Normalize the conflict.

It is best that we regularly acknowledge that we have a difficult, ever changing task in caring for people at the end of life. We have developed large interdisciplinary teams to deal with complexities. Our processes and teams are ever changing to keep pace with the changing technologies and demographics around us. We are not always going to agree. Furthermore, we work for the public and, in so doing, we will deal with a broad range of people, problems and situations. Conflict is inevitable; it happens to everyone sooner or later.

Step 2: Acknowledge the voluntary nature of a settlement

Anticipate that disputants will feel angry and vengeful, sometimes untrusting and humiliated. As much as there is a desire to end the conflict there is usually a desire to see the other side publicly defeated. These feelings are best acknowledged and "normalized" by the mediator as feelings common to conflict. Although disputants may be well aware of the cost of the conflict and recognize that what they perceive to be a **total win** is unlikely, they often do not want to be seen as backing down or accepting defeat.

Recognition and reinforcement of this concept is critical for successful mediation. Mediators must clearly, and often repeatedly, distinguish the desire to settle from the acceptance of defeat. The mediator must be highly aware of what each party would consider to be a defeat. This distinction is best made through stressing that the settlement is **voluntary**. Parties do not have to accept anything they do not wish to. Throughout the process, they remain in control of the negotiation. When all of this has been made clear, the desire to settle must be openly expressed and acknowledged by both sides in the dispute.

Step 3: Consider the differences in power and hierarchy

Hierarchies exist in all human societies and cultures; they can be obvious or implied. Power balances enormously affect the occurrence, nature and outcome of conflict. We must look deeply into this area, considering our own positions within hierarchies. This is a challenge in end-of-life care that often promotes a belief of balanced equality on health care teams that often goes unexplored. Many factors including status, rank, race, gender and socioeconomic status must be considered in relation to how they interact with our health care system. Furthermore, consider the power and hierarchical structures within a family.

Step 4: Assess if cultural differences are a part of the conflict.

The vast majority of mediation models are grounded in the western concepts of the individual and the negotiation of boundaries. These concepts may be foreign to people of non-western origin. Left unacknowledged, these differences will lead to a complete breakdown in the mediation process. If there are cultural differences, alternative approaches may need to be attempted. See the following section on **cross-cultural mediation models**.

Mediation Steps
Step 1: Negotiate ground rules.
Step 2: Identify the cost of conflict
Step 3: Appeal to a higher responsibility.
Step 4: Clarify what is really being said.
Step 5: Identify the meaning of the conflict.
***Step 6*:** Look for the affect.
Step 7: Act as a messenger.
Step 8: Find a shared purpose.
Step 9: Test the choices for outcome.
Step 10: Assess the larger picture and make changes to the system.

Mediation Steps

Step 1: Negotiate ground rules.

Ground rules are of the utmost importance in mediation. First, it is important to stress that only one party speaks at a time. The other party must agree to listen to the other as carefully as they can. Mediators are best to establish an agreement before meeting with both parties that raised voices, intimidation or threats are unacceptable. Mediators must also establish an agreement that they can call a caucus (a meeting with each party alone) when they see fit. Caucuses are used in angry, escalating disputes in which communication and common ground are receding. They may also be used to test a strategy, gain further information or to inform parties of the potential collapse of the process.

Step 2: Identify the cost of conflict.

This step involves the recognition of the costs of ignoring a shared problem. If there is conflict within a health care team everyone has a problem regardless of the source of the conflict. However, disagreement within a team is not a problem in and of itself. Whether or not the disagreement becomes a problem depends on how it is handled. If the problem is ignored, dismissed or demeaned, then conflict will surface further down the road.

The dangers of a disavowed conflict are especially acute in end-of-life care. Buried tensions lead to impairment of the functioning of the health care team and invariably undermine patient care. Patients at the end-of-life are highly dependent on the team, and staff need healthy emotional working environments to meet the complex needs of patients. Tension produced by submerged conflict also compromises the ability of health care teams and institutions at all levels to adapt to the ever changing, ever challenging demands of end-of-life care. Unresolved conflict is a formidable obstacle. If health care teams are unable to adapt to conflict, then they must accept decreased effectiveness, patient satisfaction and a limited ability to change and recognize new opportunity. Conflict can also lead to damage to the public reputation of the hospital or program.

Step 3: Appeal to a higher responsibility.

The price of conflict in end-of-life care is high and far reaching. It affects many people who are peripheral to the conflict, such as other patients, their families and the morale of the unit staff. Raising the question "Can we ethically afford to not deal with this conflict?" and asking disputants to consider the many people it is affecting, who already are facing major problems, can be a means of moving forward. This question will often create a desire to settle beyond personal interests. It is often good to frame this as a shared and challenging task.

The sense of broader responsibility and challenge can greatly motivate disputants toward resolution.

Step 4: Clarify what is really being said.

Conflict, particularly at the end of life, is laden with raw emotion and accusation. Under the surface are often hurt, fear and feelings of loss. Each side hears the other through their own filter of defensiveness, anger and painful feelings. True listening goes out the window.

The task here is to create an environment where each party actually hears what the other is saying. Each point of view almost always contains some measure of truth. Under the anger and accusations there are genuine feelings, concerns and beliefs that lie at the heart of the dispute and that must be illuminated. Ask “Why?” Think deeply and put yourself in the disputant’s place. Most people in conflict share things in common with the other side. Identifying points of commonality and difference is critical to effective mediation.

Step 5: Identify the meaning of the conflict.

This step assesses the broader context of the present conflict. A certain context that may include social, emotional, managerial, cultural, personal or political factors, could be feeding this conflict. Is there a subtext that underlies the words? Are the other people reacting to experiences separate from the immediate problem? Are they reacting to unrelated tensions within their work environment or family? It is important to consider if disputants are in fact reacting to what the other party is actually saying, or if they are reacting to what it represents, or the timing of what is being said. The task here is to step back from the details of the conflict as described by the disputants. At this juncture you want a view of the forest, not the trees. Through the successful management of this stage there is great potential for quality improvement.

Step 6: Look for the affect.

Under the surface of conflict and anger in end-of-life care there are often rarely acknowledged and poorly understood emotions that run deep. Fear or rejection will often manifest as anger. The goal here is not psychotherapy; rather it is to allow the identification, expression and acknowledgment of painful emotions as a means of moving forward in resolution. Remember, the emotional response of one party may trigger emotions in the other party. Similarly, the identification and amelioration of one party's emotions will trigger an emotional change in the other. There is tremendous therapeutic value to expressing on an emotional level what this dispute and illness have been like for a patient, their family or staff member. In many cases this initial expression will take place between the mediator and one party; in some cases, it will then be brought before each party.

Step 7: Act as a messenger.

Conflict distorts communication. Even when parties are speaking, what is being said is often different than what is being heard. Things are heard through a filter of anger and distrust. As a mediator, repeat succinctly, clearly and positively what is being said, first to the disputant who has just communicated it to you, then to the other party. This step may first be done in caucus then together. However, you must use your judgment, as each situation is different.

Step 8: Find a shared purpose.

In tense, conflicted situations most people instinctively want to narrow the gap, not broaden the options, so creativity is stifled. Searching for single answers often curtails the capacity for wiser, deeper solutions. Support disputants, while at the same time creating an atmosphere of problem solving. This is a perspective that

implicitly acknowledges the interdependence between patients/families and health care workers by identifying common goals. Shared responsibility makes for shared solutions. Patients and families are an integral part of this system and their conflicts become ours.

Step 9: Test the choices for outcome.

People immersed in conflict often reduce the outcome of conflict to two results: win or lose. To make matters more difficult, many disputants want not only to win but to also have their adversary publicly humiliated as well as to be compensated for the damage and expenses they have suffered.

Finding common ground is a delicate process in which a structured, supportive atmosphere of relative calm, listening and unbiased facilitation must take place. This step is a means of exploring the range of potentially acceptable settlements. This could mean a compromise, exchange, acknowledgment or apology. In truly successful mediation, this more often means finding a creative solution not before considered. This step allows both parties to learn more about the other's opinions and beliefs, something that may not have happened before or for some time. Disputants can also learn something about themselves, their limits and how their positions sound as information is measured and weighed. By "demonizing the enemy," disputants may have overlooked important information, such as their role in the conflict.

Step 10: The larger picture.

This stage refers to developing solutions in the larger context of shared interests and goals. For example, following the death of a loved one, a family may find that using the circumstances of this death as a means of exploring shortcomings in the system is a highly satisfactory outcome. Many hospitals as well are very concerned about improving the care of the dying, so the different parties can find a commonality in this situation.

When we are only looking after our own family unit, floor or program the opportunity of making the system work smoothly and as an integrated whole will be greatly diminished. Building solutions based on shared goals will create outcomes that work better in the long run for all elements of our working systems, including patients and families

One must think broadly and contextually at this point as finding potential solutions is challenging in a complex health care system. Support in conflict resolution from as high up as possible is important as conflicting parties in the conflict may not have the authority to effect changes that will bring solutions. There is a strong element of healing and closure that can accompany such a step.

Culture and Mediation
Background:
Mediation is frequently a search for meaning.
Meaning is deeply embedded in culture.
Mediation cannot be effective without accommodating culture.
Rights Based Mediation
A western concept.
Struggle to define where one person's rights end and another's begin.
Stands in contrast to non-western communal forms of negotiations.

Potential areas of difficulty in cross-cultural mediation.
Assertiveness in expressing demands.
Direct disclosure of needs.
Verbal openness.
Confrontational interpretations.
Pre-mediation cross-cultural assessment
Clarify mediation expectations.
Clarify expectations for the process.
Define expectations of an enduring agreement.
Necessary attitude
Anthropological inquiry – how does this culture work?
Willingness to suspend usual theoretical framework.
Critical self-reflection.
Possible cross-cultural approaches to mediation
Tacit understanding
Paradox
Proverbs
Stories
Humour
Metaphor
Shuttle mediation *(meeting with conflicted parties separately)*
Face saving.
Maintains respect.
Protects honour.

Conclusions

The best mediators are those who are able to understand fundamental differences between parties, understand the context and meaning, find common purpose, view the larger picture and bring imagination and creativity to the process.

References

1. Singer, PA, Et al. Appropriate Use of Life Sustaining Treatment. University of Toronto Joint Centre for Bioethics. In press.

2. Gamble ER, McDonald PJ, Lichstein PR: Knowledge, attitudes and behavior of elderly persons regarding living wills. Arch Intern Med 151:277-280, 1991.

3. Kelner MJ, Bourgeault IL, Patient control over dying: responses of health care professionals. Soc Sci Med 36:757-765, 1993.

4. Dubber Marcus LJ, Mediating Bioethical Disputes: a practical guide. New York: United Hospital Fund of New York, 1994.

5. Woolley N, Crisis theory: a paradigm of effective intervention with families of critically ill people. Journal of Advanced Nursing 15:1402-1408, 1990.

6. Miller RB, Invited Editorial: mediation for challenging patients – a promising approach. Advances in Renal Replacement Therapy 4:372-376, 1997.

7. Aguilera DC, Messick JM, Crisis intervention: theory and methodology. 5 1h ed. Toronto: The C.V. Mosby Company, 1986.

8. Rando TA, Loss and Anticipatory Grief Toronto: Lexington Books, 1986.

9. Rosen EJ, Families Facing Death: family dynamics of terminal illness. Toronto:Lexington Books, 1990.

10. Reiss D.,The Family's Construction of Reality. Cambridge: Harvard University Press, 1981.

11. Kelly SE et al, Understanding the Practice of Ethics Consultation; Results of an Ethnographic Multi-Site Study,. The Journal of Clinical Ethics vol.8 no.2 Summer 1997. 136-149.

12. Levine C, Zuckerman C, The Trouble with Families: toward an ethic of accommodation. Ann Intem Med 130:148-152, 1999.

13. Schneiderman LJ, Jecker NS, Jonsen AR, Medical futility: Its meaning and ethical implications. Ann Intern Med 1990; 122: 949-54.

14. Schneiderman LJ, Jecker NS, Jonsen AR, Medical futility: Response to critics. Ann Intern Med 1996; 125: 669-74.

15. Bowman KW, Bioethics and Cultural Pluralism, Humane Health Care International, vol. 13, no.2, Summer 1997

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 instructions for opinion leaders

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.