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The Emerging Culture of Health Care: From Horizontal Violence to True Collaboration

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The Emerging Culture of Health Care: Improving End-of-Life Care through Collaboration and Conflict Engagement Among Health Care Professionals

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I. FACTORS FOR IMPROVING END-OF-LIFE CARE: AN OVERVIEW

There are frequent calls for improving end-of-life care in the United States. In a recent Hastings Center special report, Murray and Jennings cite three areas that require rethinking of current assumptions regarding end-of-life care. These include greater attention to (1) the end-of-life care delivery system, (2) the approach to advance directives and surrogate decisionmaking, and (3) how we manage conflict and disagreement.[1]

Conflict is common during end-of-life decisionmaking. In a 2001 study, conflict was identified by at least one member of the clinical team in 78% of 102 cases of intensive care unit patients who were determined to have a likelihood of having treatment withheld or withdrawn.[2] Conflict surrounding end-of-life care typically takes three forms: conflict among the patient's family members, between the family and the health care providers, and conflict that arises among the team members themselves.[3] According to Breen and her co-authors, conflict among staff was identified in 48% of these cases, between staff and family members in 48% of the cases, and among family members in 24% of the cases.[4]

Conflict among family members who are tasked with decisionmaking on behalf of patients who are no longer able to decide for themselves is well documented and occasionally takes public focus, as in the unfortunate case of

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[1] *See* Thomas H. Murray & Bruce Jennings, *The Quest to Reform End of Life Care: Rethinking Assumptions and Setting New Directions*, HASTINGS CENT. REP., Nov.-Dec. 2005, S52.

[2] Catherine M. Breen et al., *Conflict Associated with Decisions to Limit Life-sustaining Treatment in Intensive Care* Units, 16 GEN. INTERNAL MED. 283 (2001).

[3] *Id.* at 285.

[4] *Id.*

Terry Schiavo.[5] Disagreements between family members and health care providers are also common given the complex nature of defining futility within the emotional climate of grief and uncertainty that accompanies severe illness.[6] Disputes arising from differences between clinicians and families have been the subject of legislative efforts and court cases for many years.[7] Conflict among health professionals plays a significant role in determining the quality of health services across the care continuum including during end-of-life. This area of conflict has received less attention until recently.

II. CONFLICT AMONG HEALTH PROFESSIONALS: A GROWING CONCERN WITHIN THE INDUSTRY

Intraorganizational conflict and its impact on patient safety and quality of the work environment is becoming a focus for the health care industry as demonstrated in the following recent activities. Recognizing the impact of the current health care culture on patient safety, the Joint Commission for the Accreditation of Health Care Organizations (JCAHO) is publishing a new set of leadership standards effective January 2009 for organizations seeking accreditation which includes two new standards which encompass expectations regarding management of disruptive behavior in those who work in the organization and that mandate conflict management among leadership groups, including physician leaders.[8] The American Association of Critical Care Nurses released their Standards for a Healthy Work Environment in 2005 emphasizing the need for good communication and true collaboration across professions.[9] The Center for American Nursing, an

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[5] *See* Lori A. Roscoe et al., *Implications of the Schiavo Case for Understanding Family Caregiving Issues at the End of Life*, 30 DEATH STUDIES 149 (2006); *See also* M. Gregg Bloche, *Managing Conflict at the End of Life*, 352 NEW ENG. J. MED. 2371 (2005).

[6] *See* Robert Fine et al., *Medical Futility in the Neonatal Intensive Care Unit: Hope for a Resolution*, 116 PEDIATRICS 1219 (2006), *available at* http://www.pediatrics.org/cgi/content/full/116/5/1219.

[7] *See* Texas Advanced Directives Act, Health & Safety, ch. 166 (2003); Cruzan v. Director, Missouri Department of Health, 497 U.S. 261 (1990).

[8] Joint Commission on Accreditation of Healthcare Organizations, *New Leadership Chapter*, http://www.jointcommission.org/JointCommission/Templates/GeneralInformation.asp (last visited Sept. 2007).

[9] *See* Am. Assoc. of Critical Care Nurses, *AACN Standards for Establishing and Sustaining Healthy Work Environments*, http://www.aacn.org/aacn/pubpolcy.nsf/Files/HWEStandards/$file/HWEStandards.pdf (last visited Sept. 2007).

affiliate of the American Nurses Association, has recently completed a national survey of their members regarding extent of conflict in the workplace[10] and the Arizona Academy of Family Physicians published a statement in 2007 supporting improved conflict management in health care organizations through training and process redesign.[11] These recent initiatives reflect the emergence of a new culture in health care. Although at a very early stage, significant changes are developing in a number of areas, each an indicator of a new direction in how health care professionals engage with each other, and taken together, these changes reflect a shift toward a more collaborative culture that will improve quality across the care continuum.

To improve end-of-life care, organizations have to improve how they manage conflict, particularly intra- and intergroup conflict among health professionals. Given the prevalence of such conflict,[12] the increased focus on improving how conflict is managed, and the concurrence of an aging population that will require end-of-life care,[13] there is a window of opportunity for dispute resolution professionals seeking to impact the ways in which health care organizations address conflict among health professionals. This paper will focus on the extent, sources, and impact of conflict among health care professionals in general as well as during end-of-life decisionmaking, followed by strategies dispute resolution professionals can take to expand capacity for engagement in and resolution of conflicts within the cultural confines of the health professions.

III. THE IMPACT OF TEAMWORK ON CLINICAL AND ORGANIZATIONAL EFFECTIVENESS

A. *The Emphasis on "Teamwork"*

There is a growing emphasis on teamwork in health care organizations. National efforts to incorporate team training in high risk areas based on

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[10] *See* Center for American Nursing, *Survey*, http://www.centerforamericannurses.org/advocacy/temp.htm.

[11] Arizona Academy of Family Physicians, *Conflict Management in Health Care*, http://www.azafp.org/online/az/home/meminfo/shouldknow/conflictres.html (last visited Sept. 2007).

[12] Breen et al., *supra* note 2.

[13] There is a growing demand for health services in the United States driven by an increasing proportion of elderly. Projections by the U.S. Census Bureau indicate that the older population (65+) will double from 36 million in 2003 to 72 million by 2030. U.S. CENSUS BUREAU, 65+ IN THE UNITED STATES: 2005, http://www.census.gov/prod/2006pubs/p23-209.pdf.

successful models developed by the aviation industry are increasing.[14] This shift is an outgrowth of the need for safer patient care.[15] The complexity of delivering health services requires integration of skills from multiple professions and disciplines. Inter-professional collaboration leads to better clinical outcomes in a variety of health care settings.[16] Recent studies looking at the impact of teams in critical care and primary care have linked teamwork to increased survival to discharge, decreased readmission to the intensive care unit (ICU), fewer adverse events, shorter lengths of stay and decreased mortality rates following surgical interventions.[17] There is also evidence that good team behaviors are linked to decreased turnover among nursing staff in the Operating Room and better outcomes during neonatal resuscitations.[18]

The construct of "team" has multiple definitions and in the clinical setting there is a morphing of team membership over time as the patient's needs shift.[19] In a recent literature review assessing the impact of teams on clinical and organizational effectiveness, team was defined as, "a collection of individuals who are interdependent in their tasks, who share responsibility for outcomes, who see themselves and who are seen by others as an intact social entity embedded in one or more larger social systems (for example, business unit or corporation), and who manage their relationships across organizational boundaries."[20] For purposes of this article, multidisciplinary team refers to teams composed of various specialties within a single profession (e.g. surgeons and intensivists are specialists within the medical profession), and inter-professional team refers to teams comprised of members representing multiple professions (e.g., an ICU team is comprised of nurses, social workers, physicians, therapists and other professionals).[21]

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[14] Agency for Health Care Research and Quality, *TeamSTEPPS: Strategies and Tools to Enhance Performance and Patient Safety*, http://www.ahrq.gov/qual/teamstepps/ (last visited Sept. 2007).

[15] *See generally* INSTITUTE OF MEDICINE, TO ERR IS HUMAN: BUILDING A SAFER HEALTH SYSTEM (2000).

[16] *See* Louise Lemieux-Charles & Wendy L. McGuire, *What Do We Know about Health Care Team Effectiveness? A Review of the Literature*, 63 MED. CARE RES. & REV. 263, 264 (2006), *available at* http://mcr.sagepub.com/cgi/content/abstract/63/3/263 ("The use of teams in health care delivery continues to grow as the added pressures of restructuring, reorganization, cost containment, and the increasing complexity of health care knowledge and work have reinforced the need for them.").

[17] *Id.* at 283.

[18] J. Bryan Sexton et al., *Teamwork in the Operating Room*, 105 ANESTHESIOLOGY 877 (2006).

[19] Laura A. Hawryluck et al., *Pulling Together and Pushing Apart: Tides of Tension in the ICU Team*, 77 ACADEMIC MEDICINE S73, S73–S76 (2002).

[20] Lemieux-Charles & McGuire, *supra* note 16, at 265.

[21] *Id.* at 265.

B. *Factors Contributing to Health Care Team Effectiveness*

To improve care, it is essential that a team function effectively. Team factors are divided into task, process, and relationship components. Processes include methods for communicating and sharing information, managing conflict, goal setting, and decisionmaking.[22] Relationship factors include trust, demonstration of respect, shared mental maps or frames, status differentials, and attitudes toward teamwork.[23] Given that breakdowns in teamwork associated with interpersonal communication are the leading causes of harm to patients, it is necessary to understand the factors that make for successful teams in order to improve care.[24] "High-functioning teams have been characterized as having positive communication patterns; low levels of conflict; and high levels of collaboration, coordination, cooperation, and participation."[25] Despite knowledge of the factors influencing team effectiveness, there is very little understanding of how to create and maintain effective teams. This is a ripe area for dispute resolution professionals given our expertise in methods for impacting process and relationship factors within and across groups.

IV. EXTENT AND TYPES OF CONFLICT WITHIN THE HEALTH CARE "TEAM"

A. *Extent of Conflict*

Health care professionals identify high levels of conflict in the workplace and much of that conflict is with each other. In a study by Anderson and

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Opie's (1997) conceptual review of the sociological and social work literature on the conceptualization of inter-professional care delivery teams found that the classification of teams as multidisciplinary, interdisciplinary, and transdisciplinary reflects the extent of team integration; that is, the extent to which members share a theoretical base and common language. However, this classificatory system has not been used consistently—most studies did not define these terms, did not report the number or types of disciplines represented on teams, and did not measure the levels of task interdependence or integration. *Id.*

[22] *Id.*

[23] *Id.* at 285–86.

[24] JOINT COMMISSION ON ACCREDITATION OF HEALTHCARE ORGANIZATIONS, SENTINEL EVENT STATISTICS: ROOT CAUSES OF SENTINEL EVENTS (ALL CATEGORIES, 1995–2004), http://www.jointcommission.org/NR/rdonlyres/FA465646-5F5F-4543-AC8F-E8AF6571E372/0/root_cause_se.jpg (last accessed: Sept. 2007). Breakdowns in interpersonal communication cause 60% of all sentinel events. *Id.*

[25] Lemieux-Charles & McGuire, *supra* note 16, at 288 (citations omitted).

D'Antonio, health professionals indicated that 62% of the conflict they experienced was with other health professionals and that 50% of each physician's day was spent dealing with conflict.[26] In an informal poll of physician executives, those polled estimated they spent 20% of their time dealing with conflict.[27] In a 2004 survey of 1627 physician executives, 18.1% indicated there was disruptive physician behavior in their organization monthly with 14.1% indicating it occurred weekly and 56.5% of the time the problem behavior resulted in conflict between the physician and a nurse or other staff.[28] Among those surveyed, over 71% indicated that there was a code of conduct already in place.[29]

"Conflict in medical settings has been defined as 'a dispute, disagreement, or difference of opinion related to the management of a patient involving more than one individual and requiring some decision or action."[30] However, variability in categorizing a particular situation as a "conflict" is probable and it is likely that conflict is underreported due to power differentials and the need to maintain one's reputation.[31]

B. *Impact of Task and Relationship Types of Conflict*

Conflict among health professionals has been categorized as both task and relationship based.[32] There is ongoing research to determine the significance of each on team performance and professional satisfaction.[33] Inherent in both are the processes used by team members to communicate with one another. One of the primary tasks of the team is decisionmaking. Integration of divergent viewpoints within the team is traditionally held to be a positive with regard to robust decisionmaking, particularly in the context of complex decisions: "...research on team decision making by Hollenbeck et al. (1995, 1998) indicated that, all else equal, team members whose recommendations are uncorrelated or negatively correlated (i.e., conflict)

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[26] Coby J. Anderson & Linda L. D'Antonio, *A Participatory Approach to Understanding Conflict in Healthcare*, 21 GA. ST. U. L. REV. 817 (2005).

[27] Anthony L. Back and Robert M. Arnold, *Dealing With Conflict in Caring for the Seriously Ill, "It Was Just Out of the Question,"* 293 JAMA 1374, 1375 (2005).

[28] David O. Weber, *Poll Results: Doctors' Disruptive Behavior Disturbs Physician Leaders*, THE PHYSICIAN EXECUTIVE, Sept.–Oct. 2004, 6–8.

[29] *Id.* at 10.

[30] Back & Arnold, *supra* note 27, at 1375.

[31] *Id.*

[32] Lemieux-Charles & McGuire, *supra* note 16.

[33] *See* Carsten K. W. De Dreu & Laurie R. Weingart, *Task Versus Relationship Conflict, Team Performance, and Team Member Satisfaction*, 88 J. OF APPLIED PSYCHOLOGY 741, 741 (2003).

provide more value as a unit than do team members whose recommendations are correlated high and positive (and hence redundant)."[34] Integration of the diverse perspectives offered by members of inter-professional teams can lead to decisions that reflect a rich array of viewpoints, experience, and information.[35] Negotiating through the differences to reach a common goal is essential for collaborative practice across professions and within disciplines.

Decisionmaking is clearly dependent upon relationship factors. Teams that adopt competitive, rather than collaborative approaches are not only less effective, they also create environments in which there are lower levels of satisfaction.[36] When negotiations are cooperative, team members are better able to remain flexible and open to the ideas of others leading to more creative problemsolving[37]. When conflict levels are high and negotiations are competitive, cognitive flexibility decreases and defensive postures prevent effective collaboration.[38]

V. EXPRESSION OF TEAM CONFLICT — A VIEW FROM THE INSIDE

The expression of conflict in the clinical environment takes multiple forms, some overt and others quite subtle. The health care literature paints a picture of what conflict looks like among health professionals and its impact on patient care and quality of the work environment.[39] What emerges is a

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[34] *Id.*

[35] *Id.*

[36] *Id.* at 746. "Our results show that relationship conflict is more disruptive than task conflict when it comes to team member satisfaction." *Id.* "It should be noted, however, that even when correlations between task and relationship conflict were weak, task conflict still had a significant negative correlation with team performance. This suggests that only at relatively high levels of within-team trust, openness, and psychological safety can task conflict have any positive effects on team performance." *Id.*

[37] De Dreu & Weingart, *supra* note 33, at 746.

[38] *Id.* at 741–42.

> Carnevale and Probst (1998) showed that, compared with a control condition in which no conflict was induced, participants were more flexible in their thinking and more creative in their problem solutions when they anticipated a cooperative negotiation (low conflict) with another individual. When participants anticipated a competitive, hostile negotiation (high conflict), however, cognitive flexibility and creative thinking decreased substantially. Carnevale and Probst explained these effects in terms of cognitive load—as conflict intensifies and arousal increases, cognitive load increases, which interferes with cognitive flexibility and creative thinking. *Id.*

[39] *See* INSTITUTE OF MEDICINE, KEEPING PATIENTS SAFE: TRANSFORMING THE WORK ENVIRONMENT OF NURSES 215–16 (2004), *available at* http://www.nap.edu/openbook/0309090679/html/.

montage of silence, avoidance, and unprofessional conduct which become the backdrop to the main event, delivery of patient care[40]. Health care organizations are filled with episodes of miscommunication,[41] intimidation,[42] disruptive behavior,[43] ineffective hierarchy,[44] horizontal (lateral) violence,[45] avoidance,[46] and defensive posturing to protect professional status.[47] In a

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[40] Kieran Walshe & Stephen M. Shortell, When Things Go Wrong: How Health Care Organizations Deal With Major Failures, 23 HEALTH AFF. 103, 105 (2004).

[41] JOINT COMMISSION ON ACCREDITATION OF HEATHCARE ORGANIZATIONS, *supra* note 24.

[42] *See generally* ISMP, *Intimidation: Practitioners Speak Up About This Unresolved Problem (Part I)*, ISMP MEDICAL SAFETY ALERT, Mar. 11, 2004 [hereinafter *Practitioners Speak Up*], *available at* http://www.ismp.org/Newsletters/acutecare/articles/20040311_2.asp?ptr=y. Regardless of the source of intimidation (physicians or others), respondents reported that subtle yet effective forms of intimidation occurred with greater frequency than more explicit forms. For example, during the past year, 88% of respondents encountered condescending language or voice intonation (21% often); 87% encountered impatience with questions (19% often); and 79% encountered a reluctance or refusal to answer questions or phone calls (14% often). Almost half of the respondents reported more explicit forms of intimidation during the past year, such as being subjected to strong verbal abuse (48%) or threatening body language (43%). Incredibly, 4% of respondents even reported physical abuse.

[43] Alan H. Rosenstein & Michelle O'Daniel, *Impact and Implications of Disruptive Behavior in the Perioperative Arena*, 203 J. OF THE AMERICAN COLLEGE OF SURGEONS 96–105 (2006).

[44] Editor's Note, *Preventing Infant Death and Injury During Delivery*, JCAHO SENTINEL EVENT ALERT, July 21, 2004, *available at* http://www.jointcommission.org/SentinelEvents/SentinelEventAlert/sea_30.htm (last visited Sept. 2007).

[45] B.G. McKenna, N.A. Smith, S.J. Poole, & J.H. Coverdale, *Horizontal Violence: Experiences of Registered Nurses in the First Year of Practice*, 42 J. ADVANCED NURSING 90–96 (2003); J. Longo and R.O. Sherman, *Leveling Horizontal Violence*, 38 NURSING MANAGEMENT 34–51 (March 2007).

[46] Patricia E.B. Valentine, *A Gender Perspective on Conflict Management Strategies of Nurses*, 33 J. NURSING SCHOLARSHIP 69, 69–74 (2001). *See also* David Maxfield et al., *Silence Kills: The Seven Crucial Conversations for Healthcare* (2005) [hereinafter *Silence Kills*], *available at* http://www.aacn.org/aacn/pubpolcy.nsf/Files/SilenceKills/$file/SilenceKills.pdf (last visited Sept. 2007).

[47] Adrian Jones, *Multidisciplinary Team Working: Collaboration and Conflict*, 15 INT'L J. MENTAL HEALTH & NURSING 19, 25 (2006). "Respondents defended their professional training and practice, and this is usually articulated through language and rituals. In this research study, much dialogue took place around the need for discipline groups to carry out their own assessments. This appeared to be a professional signature, which was defended rigorously in most exchanges. By the end of the research project, the care pathway contained nursing, OT, psychology and community worker assessments.

2006 study of disruptive behavior in the perioperative areas, "disruptive behavior by attending surgeons was witnessed by others on a daily basis 15% of the time, and on a weekly basis 22% of the time. Disruptive behavior by anesthesiologists was witnessed on a daily basis 7% of the time and on a weekly basis 12% of the time. Disruptive behavior by nurses was witnessed on a daily basis 7% of the time and on a weekly basis 21% of the time."[48] Additionally, "...participants believed that disruptive behavior was linked to the occurrence of adverse events (67%), medical errors (67%), compromises in patient safety (58%), impaired quality (68%) and patient mortality (28%) a significant percentage of the time."[49] Occurring across professions and with perceived impact on patient outcomes, disruptive behavior has become a key focus for improving safety, and effective January 2009, the Joint Commission for the Accreditation of Health Care Organizations (JCAHO) will require that organizations implement codes of conduct and processes for effectively managing disruptive behavior.[50]

In the seminal 2005 study, *Silence Kills*, researchers discovered that the majority of critical care staff and physicians surveyed had concerns about competence of colleagues, had witnessed shortcuts and mistakes and experienced disrespect and insufficient team support, often occurring for over a year with very few speaking up to address these concerns.[51] The reasons given by those surveyed for not speaking up include fear of retaliation, lack of skills, deference to authority and the belief that nothing will come from speaking up. Avoidance of difficult conversations expanded into elaborate workarounds that compromised patient care. There is evidence that habitual avoidance also has an emotional impact on clinicians and that open communication improves inter-professional relationships.[52]

Not limited to the nursing profession but well documented by the nursing literature, is the prevalence of bullying and horizontal violence.[53] Overt

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There was little enthusiasm for endorsing a single assessment process, as this would be seen to work against professional roles." *Id.*

[48] Rosenstein & O'Daniel, *supra* note 43, at 98.

[49] Rosenstein & O'Daniel, *supra* note 43, at 99.

[50] JOINT COMMISSION ON ACCREDITATION OF HEATHCARE ORGANIZATIONS, *supra* note 8.

[51] *Silence Kills*, *supra* note 46.

[52] Back & Arnold, *supra* note 27, at 1375. "Yet habitual conflict avoidance can increase stress over time rather than decrease it and a study of physicians responding to complaints indicates that conflict carries strong emotional repercussions. Another study of non-physicians indicates that replacing avoidance behaviors with open communication is better for relationships and for health, a finding that likely generalizes to physicians." *Id.*

[53] Center for American Nursing, *Bullying in the Workplace: Reversing a Culture* (2006); *see also* Keith Stevenson, Jacqueline Randle, & Ian Grayling, *Inter-Group*

behaviors such as verbal abuse, eye rolling, slamming of objects, yelling, public shaming, and occasionally physical abuse have been documented along with more covert behaviors such as withholding information, undermining, inappropriate assignments, failure to assist when help is needed, damage to reputation, gossiping, and exclusion from social interactions.[54] The persistence of these phenomena is of increasing concern given the growing shortage of nurses[55] and the link between disrespect in the workplace and intent to leave the job.[56]

Horizontal violence takes its toll on clinicians and depletes organizational resources. Energy spent on dealing with a difficult work environment is energy that is not available for patients and their families. For those professionals working in a toxic environment, there are fewer emotional resources available for engaging in highly emotional disputes such as those that may occur at end-of-life.[57] All-in-all, the realities of working in

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Conflict in Health Care: UK Students' Experiences of Bullying and the Need for Organizational Solutions, 11 ONLINE J. OF ISSUES IN NURSING, *available at* http://nursingworld.org/MainMenuCategories/ANAMarketplace/ANAPeriodicals/OJIN/TableofContents/Volume112006/Number2May31/tpc30_516077.aspx (last visited Sept. 2007).

[54] J.J. Baltimore, *Nurse Collegiality: Fact or Fiction*, 37 NURSING MANAGEMENT 28, 30 (May 2006).

[55] United States Department of Human Services, Health Resources and Services Administration, *What is Behind HRSA's Projected Supply, Demand and Shortage of Registered Nurses?* (2004), http://nursing.about.com/gi/dynamic/offsite.htm/bhpr.hrsa.gov/healthworkforce/reports/nursing/rnbehindprojections/index.htm (last visited Sept. 2007).

> Comparing the baseline supply and demand projections suggests that the U.S. had a shortage of approximately 168,000 FTE RNs in 2003, implying that the current supply would have to increase by 9 percent to meet estimated demand. By 2020 the national shortage is projected to increase to more than 1 million FTE RNs (Exhibit 23), if current trends continue, suggesting that only 64 percent of projected demand will be met (Exhibit 24). *Id.*

[56] Janice K. Cook et al., *Exploring the Impact of Physician Verbal Abuse on Preoperative Nurses*, 74 ASSOC. OPERATING ROOM NURSES J. 317 (2001).

[57] Debra Gerardi & Mary Kunes Connell, *The Emerging Culture of Health Care: From Horizontal Violence to True Collaboration*, THE NEBRASKA NURSE (Sept. 2007).

> Physical and mental health costs to individual victims of horizontal violence have been well-documented. Anxiety, decreased concentration, depression, post-traumatic stress syndrome, and suicide are commonly cited consequences of horizontal violence. Experts identify the costs associated with horizontal violence may range from $30,000 to $100,000 per year for each individual experiencing the hazards of horizontal violence. Different studies identify absenteeism ranging from 26–50%. Impaired performance, increased turnover, increased errors at work, task

the clinical setting are beset with challenges that are incompatible with the healing mission of the health professions and the organizations where they serve.

VI. SOURCES AND DRIVERS OF TEAM CONFLICT

Analyzing the difficulties that arise routinely among health care professionals provides a foundation for understanding emergent issues associated with end-of-life disputes.

Conflicts in the health care work environment include the usual difficulties underlying conflict in other organizations such as miscommunication, role confusion, fragmented structures, and basic desires for fairness, respect and contribution. However, there are unique contributors in the clinical environment that add to the complexity of conflict among health professionals particularly during end-of-life disputes. The following provides an overview of some of these drivers of team conflict.

A. *The Culture of Health Care: Ethical and Educational Underpinnings of the Health Professions*

All conflict is contextual and the culture of health care and its various subcultures impact the type and extent of conflict as well as organizational receptiveness to alternatives for addressing conflict productively.[58] Underlying conflict among the various professional groups are issues of identity, reputation, embedded hierarchies, and the foundational ethos of "do no harm." The depth of these underpinnings gives insight into the difficulty of managing inter-professional conflict and the need for redesign of structures and processes to facilitate emergence of new paradigms. When combined with the value-laden issues surrounding end-of-life decisionmaking, these cultural factors serve to amplify the complexity of improving end-of-life care.

1. *Professional Identity as Source of Conflict*

Acculturation to any profession is a long process that involves education, adoption of group assumptions and mental models, and reinforcement of group beliefs through tacit rules of professional practice and membership in

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avoidance, increased grievances, and lower morale have been commonly identified consequences for organizations. *Id.*

[58] Debra Gerardi, *The Culture of Health Care: How Professional and Organizational Cultures Impact Conflict Management*, 21 GA. ST. U. L. REV. 857 (2005).

professional associations. Health care professionals typically have strong identity ties to their chosen field. As specialization and education have developed across the professions, there has been further identification with more specifically defined classifications of professionals, for example, "interventional radiologists," "critical care clinical nurse specialists," and "pediatric intensivists." Additionally, an inherent dividing line exists between clinical professionals and non-clinical managers and administrators.[59] The fragmentation that is created from separate training, licensure, and scope of practice has developed some deep rifts among various categories of professionals and sets the stage for deeply embedded "us" vs. "them" disputes in the clinical arena.[60] Supported by identification with associations which set professional standards and work politically to maintain scope of practice, professional identity becomes a stable force that can lead to intractable conflict.[61]

Clinical care providers often have a stronger allegiance to their professional values than to those of the organization they work in.[62] This can make it difficult for organizations looking for strategies to standardize practice through development of inter-professional practice protocols.[63]

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[59] Marie Carney, *Positive and Negative Outcomes from Values and Beliefs by Healthcare Clinician and non-Clinician Managers*, 54 J. OF ADVANCED NURSING, 111, 111 (2006). "The most widely perceived values held by both groups were similar, although clinicians perceived that non-clinicians did not hold the same ethical values and beliefs as they did, and vice-versa, demonstrating a lack of trust in each other's moral and ethical value system." *Id.*

[60] Hawryluck et al., *supra* note 19 at S75. "Notions of 'us' and 'them,' and recognition of responsibilities as independent professionals and collaborative team members play an important role in trainee socialization. While such notions can pull the team together, they also risk pushing members apart, increasing tensions, competition, and conflict and decreasing the quality of patient care." *Id.*

[61] Jessica Katz Jameson, *Transcending Intractable Conflict in Health Care: An Exploratory Study of Communication and Conflict Management among Anesthesia Providers*, 8 J. OF HEALTH COMMUNICATION 563, 565 (2003). "Northrup's theory of intractable conflict suggests that threats to identity are central to conflict escalation. Northrup identifies four stages of intractable conflict: threat, distortion, rigidification, and collusion. As conflict progresses through each stage, de-escalation becomes less likely." *Id.*

[62] Carney, *supra* note 59, at 113.

> A modern form of ethical conflict is that of clinical vs. organizational conflict. Cooper et al. argue that healthcare organizations have become more accountable to the expectations of stakeholders such as Trust Managers. Consequently, this accountability raises ethical issues for health professionals and as a result clinical ethics and organizational ethics often collide. *Id.*

[63] Jones, *supra* note 47, at 25.

Fidelity to the role of the professional group can create impasse in negotiations when individuals perceive that their role is threatened in some way.[64] With each group grounding their perspectives in the values of their profession and filtering information through the frames of reference created by their professional training, it is clear that differences of opinion related to patient care decisions can become more strident than would otherwise be expected. This is particularly true when the decisions go to the heart of the clinical ethos of "do no harm," a concept that becomes more difficult to define in increasingly complex care environments where differing values emerge related to aggressiveness of treatment vs. quality of life.

2. *Professional Code of Ethics as Precursor to Conflict*

Each of the health professions is rooted in a code of ethics specific to that profession. A review of the various codes reveals a number of contributors to inter-professional conflict that relate to perceptions of collaboration, clinical status, and conflict management. Although the vast majority of health professionals have likely not read the fine print of their codes of ethics, the codes do reflect the thinking of the professional associations who develop and update the statements. Given the importance of the professional associations in reinforcing the culture of each profession, it is worth exploring the impact the codes of ethics have on inter-professional collaboration.

A review of the various codes of ethics for the professions of nursing, pharmacy, medicine, occupational therapy, social work, physical therapy, respiratory care, and chaplaincy indicate that the levels of ethical responsibility associated with inter-professional practice fall into five categories: professional conduct (citizenship),[65] acknowledgement of

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[64] *Id.*

> Clinicians felt threatened by exposing their role to other clinicians, and this appears to be mediated by the amount of contact with the patient, particular theoretical view of care and treatment and time spent in practice. To protect their role, clinicians attempted to protect role boundaries and function. This has also been described by Davies who found both medical and nursing staff intransigent in working towards collaborative ways of working. Others have suggested that when role conflict and ineffective social support from colleagues combine, it may lead to a decreased sense of work satisfaction. *Id.*

[65] "A physician shall uphold the standards of professionalism, be honest in all professional interactions." American Medical Association CEJA Principles of Medical Ethics, E-1.001,
http://www.ama-assn.org/apps/pf_new/pf_online?f_n=resultLink&doc=policyfiles/ (last visited Sept. 2007).

others,[66] cooperation,[67] collaboration, and conflict engagement. The categories reflect a progression in depth of professional engagement and provide a glimpse into the attitudes each profession holds toward collaborative practice. A look at the words used within these codes reveals the stories each profession has crafted to define their role, including respect for hierarchy, expectations of cooperativeness, acknowledgment of alternative points of view, and collaboration for the sake of the patient's well-being. Each code is distinct and provides insight into the assumptions that form the core of each professional subculture.

Common to many of the codes is the underlying ethos of "do no harm" and there are frequent references in the codes to "what is best for the patient." The medical student code of ethics explicitly reinforces established hierarchy between physician and trainee juxtaposed with the trainee's responsibility for speaking up, both for the purpose of preventing harm. "A medical student shall respect the directives of one's superiors and recognize a responsibility to seek changes in those requests that seem contrary to the wishes or best interests of the patient."[68] This concern for patient welfare provides a common goal for team members to rally behind; however, there is not as much agreement among the ethics codes for how to achieve this end.

3. *Medicine and Nursing: Perspectives on Inter-Professional Collaboration and Conflict Management*

> Overall, surgeons and anesthesiologists seemed more satisfied with physician-nurse collaboration than nurses did. OR nurses and certified registered nurse anesthetists did not reciprocate the high ratings of teamwork climate given by physicians. Our data suggest that this global difference in frontline caregiver assessments may be due to several specific issues. Relative to physicians, nurses were less positive about speaking up, feeling supported by others, physician–nurse collaboration, conflict

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[66] "VI. A pharmacist respects the values and abilities of colleagues and other health professionals." Code of Ethics for Pharmacists, http://www.aphanet.org/pharmcare/ethics.html (last visited Sept. 2007).

[67] "Members shall establish and maintain inter-professional relationships to foster partnerships and interdisciplinary cooperation." Professional Chaplain's code of ethics, 130.54, http://www.professionalchaplains.org/uploadedFiles/pdf/code_of_ethics_2003.pdf (last visited Sept. 2007); *see also* National Association of Social Work Code of Ethics, http://www.socialworkers.org/pubs/code/code.asp (last visited Sept.2007) ("Social workers should cooperate with social work colleagues and with colleagues of other professions when such cooperation serves the well-being of clients.").

[68] American Medical Student Association, Code of Medical Ethics, http://www.amsa.org/bio/medethics.cfm (last visited Sept. 2007).

resolution, and heeding nurse input. The origins of these discrepant attitudes are not fully understood.[69]

The codes of ethics for the professions of medicine and nursing indicate diverse views on inter-professional collaboration and approaches to conflict management.[70] The following statements taken from the American Medical Association's (AMA) Committee on Ethics and Judicial Affairs (CEJA), Principles of Medical Ethics outlines the AMA's stance on inter-professional collaboration:

E-3.00 Opinions on Inter-professional Relations: Nurses:

The primary bond between the practices of medicine and nursing is mutual ethical concern for patients. One of the duties in providing reasonable care is fulfilled by a nurse who carries out the orders of the attending physician.

Where orders appear to the nurse to be in error or contrary to customary medical and nursing practice, the physician has an ethical obligation to hear the nurse's concern and explain those orders to the nurse involved.[71]

Although acknowledging that both the physician and nurse have a common bond in their ethical concern for the patient, the statement clearly underscores the assumption of dominant status of physicians as related to nurses and joint decisionmaking does not seem to be valued, in fact the assumption is that questioning a component of the treatment plan is assumed to be due to lack of understanding rather than legitimate difference of opinion. In comparison, the American Nurses' Association Code of Ethics states:

ANA Nursing Code of Ethics Interpretive Statement 2.3: Collaboration

Collaboration is not just cooperation, but it is the concerted effort of individuals and groups to attain a shared goal. By its very nature, collaboration requires mutual trust, recognition, and respect among the health care team, shared decision-making about patient care, and open dialogue among all parties who have an interest in and a concern for health outcomes.

Nurses should work to assure that the relevant parties are involved and have a voice in decision-making about patient care issues. Nurses should

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[69] Sexton et al., *supra* note 18, at 881.

[70] Back & Arnold, *supra* note 27, at 1378. "Studies indicate that physicians do not always recognize nurses' perspectives on conflict. In a study of conflict in intensive care units, nurses identified nearly twice as many conflicts as were identified by both the physician and the nurse." *Id.*

[71] American Medical Association, *supra* note 65.

> see that the questions that need to be addressed are asked and that the information needed for informed decision-making is available and provided.
>
> Nurses should actively promote the collaborative multi-disciplinary planning required to ensure the availability and accessibility of quality health services to all persons who have needs for health care.[72]

The ethical framework for nurses indicates that collaboration is more than cooperation and that the nurse has an affirmative duty to promote and enable collaboration, including joint decisionmaking by relevant parties which include the patients.

These divergent viewpoints are reflected in the practice arena in multiple studies examining the perspectives of nurses and physicians regarding inter-professional collaboration. In a survey of intensive care nurses and physicians, 73% of physicians believed that collaboration with nurses was high or very high, while only 33% of nurses in the same units believed that to be true.[73] This discrepancy suggests that the differing definitions found in the codes of ethics may impact the way in which each profession is defining and perceiving collaboration. This idea proves accurate based on a 2006 survey of staff and physicians measuring teamwork in the OR setting. Discussions with survey respondents indicated that, "nurses often described good collaboration as 'having their input respected,' whereas physicians often described good collaboration as having nurses, 'who anticipate their needs and follow instructions.'"[74] Expectations of joint decisionmaking by nurses and social workers[75] are based in their codes of ethics. The inability to carry out these expectations due to hierarchies rooted in the medical paradigm creates conflict among team members.[76] The impact of this dilemma during end-of-life decisionmaking is significant as discussed in section VII infra.

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[72] American Nurses Association Code of Ethics, http://nursingworld.org/ethics/code/protected_nwcoe303.htm (last visited Sept. 2007).

[73] Eric J. Thomas, J. Bryan Sexton, & Robert L. Helmreich, *Discrepant Attitudes About Teamwork Among Critical Care Nurses and Physicians*, 31 CRIT. CARE MED. 956–959 (2003).

[74] Back & Arnold, *supra* note 27, at 881.

[75] National Assoc. of Social Workers, Code of Ethics 2.03 *Interdisciplinary Collaboration*, http://www.socialworkers.org/pubs/code/code.asp (last visited Sept. 2007). "Social workers who are members of an interdisciplinary team should participate in and contribute to decisions that affect the well-being of clients by drawing on the perspectives, values, and experiences of the social work profession. Professional and ethical obligations of the interdisciplinary team as a whole and of its individual members should be clearly established." *Id.*

[76] Joint Commission on Accreditation of Healthcare Organizations, *Preventing Infant Death and Injury During Delivery*, SENTINEL EVENT ALERT, July 21, 2004, *available at*

Similarly, there are differences between the professional codes with respect to conflict management. The nursing code of ethics is the only code to create an affirmative duty for assessing and managing team conflict. The ANA code of ethics states:

> Nurses are frequently put in situations of conflict arising from competing loyalties in the workplace, including situations of conflicting expectations from patients, families, physicians, colleagues, and in many cases healthcare organizations and health plans.
>
> Nurses must examine the conflicts arising between their own personal and professional values, the values and interests of others who are also responsible for patient care and healthcare decisions, as well as those of patients.
>
> Nurses strive to resolve such conflicts in ways that ensure patient safety, guard the patient's best interests and preserve the professional integrity of the nurse.[77]

The medical code of ethics mandates nonspecific processes for addressing abuse of power and unsafe care situations involving trainee physicians and staff.[78] The social work code indicates that social workers are obligated to refrain from conflicts of interest, should raise concerns about unethical team decisions, and should not involve clients in conflicts with colleagues.[79] The role of the nurse, as defined by their code, is clearly that of an intermediary in creating collaborative work environments and in managing team conflict related to patient care.[80] This professional obligation suggests the nurse is a logical candidate for mediating disputes among the members of the team and fostering improved understanding in the midst of bioethical dilemmas. This positioning within the team and the concomitant

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http://www.jointcommission.org/SentinelEvents/SentinelEventAlert/sea_30.htm (last visited Oct. 17, 2007).

[77] AMERICAN NURSE'S ASS'N CODE OF ETHICS, § 2.2 (2001).

[78] American Medical Ass'n, *supra* note 65, at E-9.055 Disputes Between Medical Supervisors and Trainees.

> Clear policies for handling complaints from medical students, resident physicians, and other staff should be established. Medical students, resident physicians, and other staff should refuse to participate in patient care ordered by their supervisors in those rare cases in which they believe the orders reflect serious errors in clinical or ethical judgment, or physician impairment, that could result in a threat of imminent harm to the patient or to others. *Id.*

[79] Nat. Assoc. of Social Workers, *supra* note 75 (Dec. 1993) (based on the report "Disputes Between Medical Supervisors and Trainees")

[80] AMERICAN NURSE'S ASS'N, *supra* note 77.

ethical duty imply that nurses should be trained in mediativetechniques to accomplish this expected role.

Given the disparities among ethical approaches to inter-professional collaboration and the resulting impact on clinical practice, it seems that professional identity is a contributing factor in team conflicts. The status differentials implied in the ethics codes are routinely reflected in difficulties encountered in clinical practice. Embedded hierarchy and its impact on communication fundamentally contribute to team conflict and impact quality of care.[81]

4. *Medicine and Nursing: Status Differentials and Communication*

Physicians and nurses speak different languages, approach patient care from different frames of reference, and carry out their work very differently from each other. A look at communication patterns during patient care rounds demonstrates both the status differential between physicians and nurses and the differing perceptions of information sharing. In a nine month study in which researchers observed 2391 intensive care interactions, it was noted that nurses made only 12% of comments during rounds and only 10% of the team discussion was directed toward the nurses.[82] The observed nurses were asked their opinion by the medical staff only four times in the nine month period, and when interviewed the nurses portrayed themselves as assertive during rounds.[83] Lack of assertiveness by nurses and an inability to defend a position taken during clinical team rounds was a recurring theme.[84]

Physicians rely on the surveillance function of nurses who are present with the patient a larger portion of the time and whose assessment

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[81] Joint Commission on Accreditation of Healthcare Organization, *supra* note 76.

> In the 47 cases studied, communication issues topped the list of identified root causes (72 percent), with more than one-half of the organizations (55 percent) citing organization culture as a barrier to effective communication and teamwork, i.e., hierarchy and intimidation, failure to function as a team, and failure to follow the chain-of-communication. *Id.*

[82] Maureen Coombs & Steven J. Ersser, *Medical Hegemony in Decision-Making: A Barrier to Interdisciplinary Working in Intensive Care?*, 46 J. OF ADVANCED NURSING 245, 252 (2004).

[83] *Id.* at 246.

[84] *Id.* at 250.

> A medical consultant commented: Nurses play a key role in the ward round, in assessing the patient, and yet nurses find it difficult to chip in. The registrars don't always present the patient well. Nurses are getting better, but they are frightened—but why? They say—but I'm only a nurse. Yes, but you are there for 24 hours, and I'm only here for 5 minutes and your observational skills are better than mine. *Id.*

information is relied upon by the physician to make clinical decisions. When the nurse is not assertive in sharing information or when that information is dismissed as unimportant, patient care suffers.[85] Schmitt identifies the key inter-professional communication patterns that contribute to errors in diagnosis and treatment as: (1) counterproductive hierarchical communication; (2) disjunctions in distribution of authority, responsibility, and accountability across disciplines; and (3) issues of lack of respect and lack of clarity with regard to legal and ethical obligations across disciplines.[86] The classic negotiation tension between assertiveness and cooperativeness plays itself out as a key component of effective clinical decisionmaking.[87]

The choice of language used by nurses is seen by some physicians as frustrating.[88] Given the holistic model of nursing practice and its emphasis on the caring perspective and sensitivity to patients' needs, as compared with the scientific and objective model of medicine and its emphasis on disease process and diagnosis, communication difficulties are predictable.[89] Additionally, the nursing focus on patient comfort is at times in tension with physiologic management of the patient and disputes arise regarding appropriate use of pain medication.[90] During end-of-life care, the nurses' discomfort with continued treatment may not be expressed directly to the physician even when the concern is aligned with the desires of the family.[91] Often nurses express this concern more indirectly at first, perhaps to seek validation from colleagues, and then to the physician as described in the following vignette:

> "The position adopted by all nurse participants was that the quality of life for the patient was paramount and that ethical issues should remain an

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[85] Coombs and Ersser, *supra* note 82.

[86] Susan Yeager, *Interdisciplinary Collaboration: The Heart and Soul of Health Care*, 17 CRIT. CARE NURSING CLINICS N. AM. 143, 144–148 (2005).

[87] Valentine, *supra* note 46.

[88] Coombs & Ersser, *supra* note 82, at 248. "Strong comments were made by medical staff in all the sites about the professional language used by nurses. They were also frustrated with what they believed was the inability of nurses to defend their arguments on clinical ward rounds." *Id.*

[89] *Id.*

[90] *Id.* at 249.

> The difference in priority for doctors and nurses is reflected in the following excerpt from a medical consultant: Nurses want to focus on sedation—they think I don't see it as a problem—it is, but it's much more . . . I'm looking at the plan for the next two days, and if we give the patient more sedation, we won't get them off the ventilator. *Id.*

[91] Betty R. Ferrell, *Understanding the Moral Distress of Nurses Witnessing Medically Futile Care*, 33 ONCOLOGY NURSING F. 922, 927 (2006).

> important dimension of the knowledge used in formulating clinical decisions. This was often observed in ward rounds across the sites. One nurse commented on the inappropriate management of a 72-year-old man, who was kept alive needing increasing amounts of drugs. She felt that he should be allowed to die with dignity. This issue was also closely aligned to the quality of life for relatives. With patients who had been very sick over a prolonged period of time, nurses would start voicing treatment concerns, often in the coffee room, and first to colleagues, and then more formally to medical staff."[92]

It is clear that both the physicians and the nurses are attempting to do "what is best for the patient" from their own professional frames of reference and within the embedded structures that have traditionally guided their negotiations.[93]

In part, the status of the physician is linked to the general valuing by society of the scientific model, which emphasizes collection of quantifiable data and objective analysis.[94] This is the underpinning of medical practice and has become a highly valued aspect of health care generally. There is an assumption that medical treatment has a solid base in scientific evidence.[95] Although there is some truth to this, much of medical practice does not have a solid evidence base.[96] The ease with which the physician's work can be measured quantitatively through data collection (lab work, scans, and diagnostics) and treatment (surgery, procedures, and prescribing of medications) reinforces the valuing of medicine. The work of other health professionals, including nurses, is less quantifiable and therefore more easily minimized.[97] This dichotomy sets up two situations that impact end-of-life

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[92] Coombs and Ersser, *supra* note 82, at 249.

[93] *Id.*

[94] *Id.* at 250.

[95] *See* INSTITUTE OF MEDICINE, CROSSING THE QUALITY CHASM: A NEW HEALTH SYSTEM FOR THE 21ST CENTURY 78–80 (2001) [hereinafter CROSSING THE QUALITY CHASM], *available at* http://www.nap.edu/books/0309072808/html/R1.html (last visited Oct. 18, 2007).

[96] Jones, *supra* note 47, at 25.

> It has been argued that doctors are not fully aware of why they use interventions in a certain way, and medical respondents in this study were open about the lack of evidence-supporting practice. However, non-medical staff perceived medical treatment to be guided by a clear scientific judgment, and this somehow led them to feel inferior when discussing their own practice. *Id.*

[97] Coombs & Ersser, *supra* note 82, at 248.

> Measurable variables and the use of quantitative data were seen to be more robust by medical staff than the qualitative language more commonly used by nurses. Doctors espoused a fundamental belief that their practice was demonstrably

care. The first is the exclusion of nurse knowledge from decisionmaking.[98] The second is the ambiguity associated with defining futility in the absence of hard science.[99] Both of these situations make negotiations regarding treatment in the last days of life difficult.

5. *Minimization of Emotion as a Driver of Conflict*

In her article on the cognitive aspects of emotion in clinical care, Allison Robichaud sheds light on another aspect of the culture of health care: the separation of emotion from clinical practice.[100] She writes:

> By shunting emotion aside, health care providers fail to recognize and address the many ways in which emotion influences clinical care, both positively and negatively. In the clinical setting, emotion is at best met with compassionate understanding, at worst ignored or discounted. While treating emotional suffering compassionately by providing company and moral support is decent and humane, it is not enough. Values, beliefs, desires, human motivations—all are made available by the recognition that emotion is cognitive, not merely physiological.[101]

Clinical practice, and end-of-life care specifically, are enmeshed in emotional responses. Grief, fear, guilt, sadness, and anger are all a natural part of the human condition, yet clinical training with its emphasis on the objective and scientific distances emotion as unimportant.[102] Acknowledging

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rigorous and evidenced-based. However, when questioned they would query how achievable this was in an intensive care environment: It is difficult in ICU because there is little hard evidence. It is impossible to do a random controlled group test with a heterogeneous group. *Id.*

[98] Arino Yaguchi et al., *International Differences in End-of-Life Attitudes In the Intensive Care Unit,* 165 ARCH INTERNAL MED. 1970, 1972 (2005).

> The first question dealt with the decision-making process. The United States was the country with the largest proportion (45%) of respondents saying that they would ask for an ethical consultant in the hospital or make a court referral. Of respondents from Southern Europe, only 32% replied that they would involve nurses; percentages for Turkey (41%), Brazil (38%), Japan (39%), and the United States (29%) were similarly low. *Id.*

[99] *See* Robert L. Fine, Jonathan M. Whitfield, Barbara L. Carr, & Thomas W. Mayo, *Medical Futility in the Neonatal Intensive Care Unit: Hope for a Resolution,* 116 PEDIATRICS 1219–1222 (2005).

[100] Allyson L. Robichaud, *Healing and Feeling: The Clinical Ontology of Emotion,* 17 BIOETHICS 59, 59 (2003).

[101] *Id.* at 60.

[102] *Id.*

emotion is at the heart of conflict resolution and failure to do so not only limits assessment of the situation; it can escalate conflict by sending messages of lack of concern and abandonment.[103]

Most people are uncomfortable with strong emotions and feel at a loss for how to engage without making things worse. When someone is expressing strong emotions, they can be perceived as unpredictable and if the skills are not there for assessing and acknowledging what lies behind the emotions; it is unlikely that clinicians will engage given their desire to appear in control and protect reputation.[104] For health care professionals, emotions also serve as a reminder that caring for others involves experiencing human suffering.[105] As a protective measure to enable clinicians to do their work, some distancing is needed. However, when that distancing extends to difficult situations that require acknowledgement of the issues represented by the emotions being expressed, then the opportunity for escalation of conflict arises.[106] In one study, researchers "found that physicians are less likely to initiate important discussions when they feel uncomfortable and, therefore, in an effort to avoid burdensome discussions, have continued treatment until death or withdrawn treatment without the family's knowledge."[107] This behavior has implications for patients and families and also for its impact on the clinical team itself.[108]

Integrating emotional assessment into the professional skill set enables clinicians to acquire good information about the needs of patients and families and transferring that skill to interact with colleagues during conflict

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[103] Levinson, Roter, Mullooly, Dull, & Frankel, *Physician-Patient Communication: The Relationship with Malpractice Claims Among Primary Care Physicians and Surgeons*, 277 JAMA 553 (1997).

[104] Robichaud, *supra* note 100, at 61.

[105] *Id.* at 62.

[106] *Id.* at 65. "Monitoring people's (and one's own) actions and decisions by paying attention to the role emotion is playing, can be of great value in trying to manage or pre-empt conflict. The search for a source of the conflict may end with the recognition that emotion is playing a pivotal role." *Id.*

[107] *See* Diane K. Boyle et al., *Communication and End-of-Life Care in the Intensive Care Unit Patient, Family, and Clinician Outcomes*, 28 CRIT. CARE NURSING Q. 302 (2005).

[108] Lilia Susana Meltzer, *Critical Care Nurses' Perceptions of Futile Care and Its Effect on Burnout*, AM. J. CRIT. CARE 202, 206 (2004).

> The frequency with which critical care nurses encountered moral distress situations involving futile care was directly and significantly related (accounting for 10% of the variance) to the experience of emotional exhaustion, 1 of the 3 components of the burnout syndrome as postulated by Maslach and Jackson and by Pearlman and Hartman. *Id.*

situations is equally beneficial.[109] Overcoming the avoidance tendency of health care professionals through conflict engagement training and improved inter-professional decisionmaking is key for those interested in improving patient care.[110]

B. *Environmental Contributors to Team Conflict*

The work environment of health care professionals also contributes to conflict among inter-professional teams.[111] Production pressures, competition for finite resources, emphasis on cost containment, increasing demand for services, changes in the workforce and blurring of roles all impact opportunities for productive conflict engagement.[112]

1. *Production Pressures and Competition for Resources*

Conflict during end-of-life care can occur in many venues and one of the most frequent locations is in the intensive care unit. Tensions in the ICU among team members are frequently related to resource issues including time pressures.[113] Combining production pressures with competition for resources creates fertile ground for disputes and when merged with the embedded difficulties associated with negotiation among the various professions, there exists the perfect recipe for protracted conflict.[114]

2. *Evolving Team Membership Roles and Workforce Issues*

Contributing to team dynamics and effectiveness of collaboration is the continuous morphing of team membership. The idea of team in a traditional

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[109] Robichaud, *supra* note 100, at 60–61.

> Values, beliefs, desires, human motivations, all are made available by the recognition that emotion is cognitive, not merely physiological. Misapprehensions can be corrected, lost opportunities properly mourned, and choices respected, if more rather than less attention is paid to emotion: emotion is a valuable source of information. It also means that much more has to be done in medical centers and medical training to equip people to deal effectively and productively with emotion. both their own and patients and families. *Id.*

[110] *See Silence Kills*, *supra* note 46.

[111] *See generally* Am. Ass'n of Critical Care Nurses, *supra* note 9.

[112] *See generally* Gerardi, *supra* note 58.

[113] Hawryluck et al., *supra* note 19, at S75. "Time governs many variables in the ICU, including the nature of team collaboration. For instance: Fellow: 'Okay, we have seven patients left to see in 40 minutes.'" *Id.*

[114] *Id.*

work setting is much different in the clinical setting where shift changes, floating, locum tenens, trainee rotations, cross-covering, consultation, procedural specialists, and interdepartmental support staff all impact team configuration at any point in time.[115] This forming and re-forming requires establishment of relationships on an ongoing quick-time basis.[116] This dynamic creates challenges for communication and development of trust among team members.

In addition to the dynamics of team composition, there is also the phenomenon of role shifting and blending occurring in many organizations.[117] With the expansion of technology for diagnosing, treating, and sharing of clinical information, what was once an easily defined area of practice linked to a particular type of professional is no longer so cut and dry.[118] The overlapping of capacity for various types of medical specialists to perform interventions on patients creates difficulty for many organizations as they negotiate credentialing for particular interventions.[119] In addition, morphing of functions between professions is blurring the lines between physicians, nurses, and therapists, further complicating the identity issues and creating positional stances couched in quality of care language that protect traditional perceptions of the professional's role.[120] Many of these conflicts have gone on for years and are only elevated by the advances in technology and increasing demand for care.[121]

Workforce challenges contributing to inter-professional tensions include: aging of the workforce,[122] multigenerational blending,[123] and shortages of

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[115] *Id.*

[116] *Id.* "The finding that ICU teams are not rigidly defined but are continually shifting entities provoked by recurrent and interrelated catalysts is crucial for trainees to grasp. They need to decode the implicit membership of the team: who is 'us' and who is 'them' (membership negotiated for finite periods of time or individuals viewed as opponents)." *Id.*

[117] Jackie Bridges, Julienne Meyer, Michael Glynn, Jane Bentley, & Scott Reeves, *Inter-Professional Care Co-Ordinators: The Benefits and Tensions Associated with a New Role in UK Acute Health Care*, 40 INTN. J. OF NSG. STUDIES 599–607 (2003).

[118] *Id.*

[119] David C. Levin et al., *The Controversy Over Advanced Cardiovascular Imaging: Relative Roles of Radiologists, Cardiologists, and Other Physicians in CT and MRI of the Cardiovascular System*, 3 J. AM C. RADIOLOGY 16, 17–18 (2006).

[120] *See* Jessica Katz Jameson, *Transcending Intractable Conflict in Health Care: An Exploratory Study of Communication and Conflict Management Among Anesthesia Providers*, 8 J. HEALTH COMM. 563 (2003).

[121] *Id.*

[122] Karen A. Hart, *The Aging Workforce: Implications for Health Care Organizations*, 25 NURSING ECON. 101, 102 (2007), http://www.medscape.com/viewarticle/556420 (last visited Sept. 2007).

key workers,[124] Accommodations for progression in the average age of clinical staff and shifts in work ethics among the four generations delivering health services create challenges in negotiation of staffing, call schedules, and assignments.[125] Tendencies toward "us" vs. "them" arise around generational perspectives of clinical practices including disputes related to availability for overtime, weekend call, and other work-life balance issues. Daily tensions arise when demand exceeds the supply of clinical staff and schedules are double and triple booked, resulting in compromised time for seeing each patient. Fatigue, hunger, and other practical consequences of an overcommitted work schedule leave health care professionals stressed and emotions raw, making it more difficult for them to engage in emotionally charged conversations like those that occur in end-of-life decisionmaking.

VII. END-OF-LIFE CARE AND INTER-PROFESSIONAL COLLABORATION

The foregoing analysis of conflicts that arise routinely among health care professionals provides a foundation for understanding issues associated with end-of-life disputes. The difficulties discussed thus far encompass various collaborative practice deficiencies in health care organizations. Collaboration occurs across a continuum with conflict being just a small part of that continuum.[126] Collaborative engagement requires skills of increasing depth and nuance.[127] These skills include the capacity for self-reflection, the ability to communicate effectively across professional groups, ability to give and receive feedback, ability to engage in shared decisionmaking and consensus building, and the ability to engage in and resolve conflicts.[128] Difficulties for clinicians in providing end-of-life care include: variability in practice, poor communication among providers, lack of consensus regarding plan of care, incomplete documentation, and differences of opinion regarding the definition of futility.[129] Clearly, improved capacity for collaborative work among the professions is in line with addressing these challenges.

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[123] Marla J. Weston, *Integrating Generational Perspectives in Nursing*, 11 ONLINE J. ISSUES NURSING (2006), http://www.medscape.com/viewarticle/536479 (last visited Sept. 2007).

[124] *See generally* U.S. Dept. of Human Services, *supra* note 55.

[125] Weston, *supra* note 123.

[126] Gerardi, *supra* note 57.

[127] *Id.*

[128] *Id.*

[129] Int'l Consensus Conf., *Challenges in end-of-life care in the ICU—Statement of the 5th International Consensus Conference in Critical Care: Brussels, Belgium, April 2003.*

End-of-life care occurs in many settings, all of which require a team approach for effective outcomes.[130] Two settings which encompass end-of-life care most frequently are the intensive care unit and hospice. Both settings present particular challenges that highlight the need for inter-professional coordination of services. Applications of inter-professional collaboration to both settings are provided below.

A. *A Model for Inter-Professional Collaboration*

A model for interdisciplinary collaboration developed by Bronstein includes five aspects of successful teamwork. These are: interdependence, newly created professional activities (collaborative acts and structures), flexibility in traditional roles, collective ownership of goals, and reflection on process.[131] Interdependence is a difficult concept for clinicians as it requires sophisticated negotiation skills necessary for balancing autonomy and group effort.[132] Flexible and adaptive responses to shifting roles, new information, and changing situations that stress deeply held values or identity frames are needed to maintain connection.[133] Collective accountability for patient care goals requires joint decisionmaking and individual as well as group reflection on how well the team has performed together.[134] Reflective practice enables members of the team to learn what works and to stay engaged in the midst of conflicting interests.[135]

1. *Interdependence, Collaborative Structures, and Collective Ownership of Goals*

Interdependence and collective ownership of goals require joint decisionmaking and communication across the team. According to a statement released from the 5th International Consensus Conference in Critical Care, "The principles of shared end-of-life decision making between

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[130] Murray and Jennings, *supra* note 1.

[131] Debra Parker Oliver & Marlys Peck, *Inside the Interdisciplinary Team Experiences of Hospice Social Workers*, J. SOC WORK END-OF-LIFE & PALLIATIVE CARE, 2006 Issue 2, at 9.

[132] Jameson, *supra* note 120, at 578. "One of the most illuminating themes of this study was the tension between CRNAs' and anesthesiologists' dependence on each other and their simultaneous need for autonomy." *Id.*

[133] Oliver and Peck, *supra* note 131.

[134] Kelly Fryer-Edwards, Robert M. Arnold, Walter Baile, James A. Tulsky, Frances Petracca, & Anthony Back, *Reflective Teaching Practices: An Approach to Teaching Communication Skills in a Small-Group Setting*, 81 ACADEMIC MEDICINE 638–44 (2006).

[135] *Id.*

patients, family members, and clinicians can be achieved only through full participation of all ICU healthcare professionals in the communication and decisionmaking process.[136] Among hospice social workers, the following were identified as keys to successful collaboration: speaking with other disciplines informally, reestablishing trust when communication breakdowns occur, joint home visits especially at admission, and supportive managers who attend interdisciplinary team meetings and help refocus conversations back to an interdisciplinary approach.[137] Although 70% of the social workers surveyed mentioned team conflict, they also indicated that communication in a group setting helped to resolve the issues and felt that working through the conflict helped improve team strength and led to deeper assessment of patient and family needs.

How decisions are made may be contingent upon the values held by the physician who has primary responsibility for the ICU.[138] If responsibility for the ICU is shared among physicians or decisionmaking emerges from the intersection of joint patient responsibility among primary care and specialty care physicians then conflict can occur due to values differences held by each professional.[139] Each team member may have a different focus such as targeting the disease, not abandoning the patient, holding out hope for a cure, palliative care, quality of life, maintaining personal reputation, giving hope to the family, or judicious use of finite resources.[140] Conflicts can center on lack of consensus regarding the basis for treatment and each individual's definition of what is best for the patient.[141] Communication problems that lead to conflict also result in distancing behaviors, fatigue, depersonalization, and avoidance of patient's families, further impacting the quality of care.[142]

Collective ownership of goals is more likely when the team works together to develop the plan of care and effectively communicates that plan

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[136] Boyle et al., *supra* note 107, at 313.

[137] *See* Oliver & Peck, *supra* note 131.

[138] Joan Cassell et al., *Surgeons, Intensivists, and the Covenant of Care: Administrative Models and Values Affecting Care at the end of Life*, 31 CRIT. CARE MED. 1551 (2003). "When surgeons had primary responsibility for the ICU, the surgical 'covenantal' ethic was paramount. When intensivists controlled the ICU, an 'ethic of scarce resources' determined care, with attention given to quality-of-life concerns. When responsibility was shared between the two specialties, conflict regarding end-of-life decisions was often observed." *Id.*

[139] *Id.*

[140] *Id.*

[141] *See* Mary Fran Tracy & Charles Ceronsky, *Creating a Collaborative Environment to Care for Complex Patients and Families*, 12 AACN CLINICAL ISSUES 383 (2001).

[142] *See* Boyle et al., *supra* note 107.

across the various areas responsible for carrying out the plan.[143] An effective means of coordinating joint care plan development is through inter-professional rounds and case conferencing.[144] There is evidence that joint rounds and intentional processes for consensus building and goal setting reduce length of stay in ICU, improve communication within the team, and improve satisfaction among clinicians.[145] "Daily multidisciplinary (i.e., nurses, physicians, and allied health professionals) rounds in ICUs should be used to establish consensus on goals of care for each patient, including plans for communication with family members, long-term goals, and, when appropriate, limitation of treatments and goals for palliative care. In addition, standardized order forms should be used to improve communication among clinicians once goals of foregoing life-sustaining treatments have been established; examples include DNR orders and protocols for withdrawal of life sustaining treatments."[146] Development of collaborative processes helps teams manage the impact of their differing beliefs and values and fosters interdependence and collective ownership of patient care goals.

2. *Flexibility in Roles and Reflection on Process*

Role distinctions are not as clear as they once were, and there is even interest in some areas for creating generic health care workers guided by national regulatory standards rather than profession-led standards.[147] Although this concept seems farfetched, practically there is already extensive overlap in clinical competencies and duties. Effective collaboration requires flexibility among team members with regard to role. When actions are guided by group consensus regarding goals and structures are in place for ongoing communication in achieving those goals, there is less need for assignment of tasks according to predetermined job descriptions. Particular tasks will remain with certain professionals, but for those areas where tasks can be done by various individuals, team effectiveness is improved when

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[143] INSTITUTE OF MEDICINE, *supra* note 39.

[144] Tracy & Ceronsky, *supra* note 141.

[145] *Id.* at 395.

[146] Boyle et al., *supra* note 107, at 310.

> Holzapfei et al. used an observational design to examine a 4-step protocol for end-of-life decision making. Each morning during rounds the care team—which included attending physicians, residents, and nurses determined each patient's level of care regarding probability of death, survival quality, and family viewpoint. Initially, to assign a patient to steps 2, 3, or 4 or to change the step, all care team members had to come to consensus. *Id.*

[147] Hazel M. Colyer, *The Construction and Development of Health Professions: Where Will it End?*, 48 J. OF ADVANCED NURSING 406–412.

there is flexibility and emphasis is placed on achieving the goals rather than defending the turf. As mentioned earlier, when team conflict levels are manageable, there is a greater capacity for flexibility and openness. When conflicts erupt due to overlap of responsibilities, developing processes for clarifying assumptions and developing collaborative practice agreements is essential. These agreements provide the foundation for individual and team accountability.

Reflective practice enables clinicians to evaluate their own responses to situations and to identify areas that need attention. Reflective practice techniques have increasingly been integrated into the teaching of communication skills in medical schools to improve clinician-patient interactions.[148] Use of observation and reflection techniques creates a space for clinicians to focus on the bigger picture in the clinical environment and to integrate knowledge from observations of interpersonal interactions with the diagnostic and therapeutic responsibilities that typically take central focus.[149] Developing team practices that allow for self-reflection, observation, and evaluation of group process, and incorporation of what is learned into process improvement greatly enhances team effectiveness and develops improved trust as the team discovers what qualities and activities enable them to function effectively. Despite use of reflective practice in training programs, it is less commonly integrated into clinical practice environments, particularly at a team level.[150] Enhancing capacity for team process review can reduce conflict, improve team communication and improve inter-professional relationships, all of which ideally alleviate some of the stressors associated with end-of-life care decisions.

B. *Moral Distress and Burnout Syndrome*

Consensus about the treatment plan enables nurses to make clear determinations about care of the patient.[151] When it is unclear whether aggressive treatment is to continue or whether the goals have moved toward comfort care and support of dying, there is often confusion and conflict associated with proper treatment decisions and patient's families get mixed

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[148] Fryer-Edwards et al., *supra* note 134.

[149] Joseph J. Fins, Bethany J. Gentilesco, Alan Carver, Philip Lister, Cathleen A. Acres, Richard Payne, and Carol Storey-Johnson, *Reflective Practice and Palliative Care Education: A Clerkship Responds to the Informal and Hidden Curricula*, 78 *Academic Medicine* 307–312 (2003).

[150] Agency for Health Care Research and Quality, *supra* note 14.

[151] James Badger, *Factors that enable or complicate end of life care*, 14 AM. J. OF CRIT. CARE 513–22 (2005). The most important factor enabling nurses to move from cure- to comfort-oriented care was developing a consensus about the treatment.

messages from the clinical team. Critical care nurses have consistently described the greatest stressors in their work to be related to decisionmaking regarding futile treatment.[152] A survey of 864 critical care nurses revealed barriers to good end-of-life care to be disagreement about the direction of the dying patient's care, actions that prolong a patient's suffering, and physicians who were evasive and avoided talking with patient's families.[153] Disconnects between nurses' perceptions of what is best for the patient (i.e. quality of life, alleviate suffering), and an aggressive treatment plan create emotionally charged situations that contribute to burnout.[154] When nurses believe that they are powerless to impact decisions related to course of treatment that is perceived to be unethical, it leads to moral distress.[155]

Moral distress and burnout are not exclusive to nurses.[156] All health care professionals experience the impact of their work environment and the profound nature of their work. Moral distress has been shown to result from team conflict and interdisciplinary disputes.[157] The nursing literature provides insight into the link between moral distress and burnout which underscores the impact of team conflict on clinicians.[158] Moral distress has been described as "a psychological disequilibrium that occurs when the ethically right course of action is known but cannot be acted upon."[159] Physiologic reactions to

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[152] *Id.*

[153] Ferrell, *supra* note 91, at 924.

[154] Wendy Austin, Marlene Rankel, Leon Kagan, Vangie Bergum, & Gillian Lemermeyer, *To Stay or To Go, To Speak or Stay Silent, To Act or Not To Act: Moral Distress as Experienced by Psychologists*, 15 ETHICS & BEHAVIOR 197, 199 (2005). "Unresolved moral distress can have lasting effects on a person in the form of physical, emotional, and spiritual consequences. Professionals with moral distress may feel "burnt out" and withdraw from their place of practice or from their profession entirely." *Id.*

[155] Lilia Susana Meltzer, *Critical Care Nurses' Perceptions of Futile Care and Its Effect on Burnout*, 13 AM. J. CRIT. CARE 202–08 (2004).

[156] Austin et al., *supra* note 154, at 197.

> Psychologists described specific incidents in which they felt their integrity had been compromised by such factors as institutional and interinstitutional demands, team conflicts, and interdisciplinary disputes. They described dealing with the resulting moral distress by such means as silence, taking a stance, acting secretively, sustaining themselves through work with clients, seeking support from colleagues, and exiting. *Id.*

[157] *Id.* at 199.

[158] Meltzer, *supra* note 108.

[159] American Association of Critical-Care Nurses, *AACN Public Policy Position Statement: Moral Distress* (July 2004). *See also* Am. Ass'n of Critical Care Nurses, *supra* note 9, at 200.

> Moral distress is the pain or anguish affecting the mind, body or relationships in response to a situation in which the person is aware of a moral problem,

moral distress are not uncommon and include sweating, headaches, nausea, crying, and feelings of sadness, depression, anger, shame, embarrassment, and grief.[160] The sentiments expressed in the narrative below reflect the difficulty experienced by one particular nurse:

> I've been a nurse for 30 years, 25 of which have been focused on quality end-of-life care. I see more "suffering" today than I did 25 years ago. Our technology has surpassed our humanity, and our current focus on "technological brinksmanship" has increased costs while decreasing quality of life. As a nurse who has seen numerous "deaths" that occurred peacefully and gently, I am always saddened when I see one that isn't. I think it's extremely hard on nurses when all of our life experiences and lessons learned from those dying can't make an impact.[161]

Burnout syndrome is described as the inability to cope with the emotional stress of work or as excessive use of energy leading to feelings of failure and exhaustion.[162] The physiologic symptoms of burnout syndrome are similar to those of moral distress and also include rigidity in relationships, which is clearly contrary to the need for flexibility and openness necessary for team effectiveness. Burnout syndrome has an impact on quality of care, absenteeism, staff turnover, and communication. Perceived conflicts with colleagues contribute to burnout syndrome and result in depersonalization, withdrawal, and exhaustion.[163] In a 2006 study involving 2,392 ICU nursing staff, 32.8% were revealed to have severe

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acknowledges moral responsibility, and makes a moral judgment about the correct action; yet, as a result of real or perceived constraints, participates in perceived moral wrongdoing. *Id.*

[160] Austin et al., *supra* note 154, at 200.

> The embodied component to the anguish of moral distress may be very evident with physical reactions such as sweating, headaches, nausea and diarrhea, and crying. Participants described feeling angry, frustrated, depressed, ashamed, embarrassed, heartsick, grief, miserable, in pain, sad, and ineffective. Their descriptive comments included I can't stand it. I just can't stand it; it's intolerable. I can't tolerate it; and I still feel horrible. *Id.*

[161] Ferrell, *supra* note 91, at 927.

[162] Marie Cecile Poncet et al., *Burnout Syndrome in Critical Care Nursing Staff*, 175 AM. J. RESPIR. CRIT. CARE MED. 698–704 (2007).

[163] *Id.* at 701.

> Perceived conflicts with patients, families, or other staff members increased the risk of BOS in our study. Emotional exhaustion is a direct consequence of conflict that leads to depersonalization and to loss of a sense of personal accomplishment. In our study, both perceived conflicts and perceived poor relationships with other staff members were strong independent risk factors for severe BOS. *Id.*

burnout syndrome according to assessment using the Maslach Burnout Inventory.[164] Burnout syndrome is serious and given the growing shortage of clinical staff and the deteriorating work environments in health care, significant attention must be paid in recognizing, preventing, and responding to all health care professionals who find themselves unable to cope with the cumulative effects of clinical practice.

Two questions arise related to moral distress and burnout syndrome. The first is the question of how to develop consensus regarding futility within the context of the team; and the second is how to address the real or perceived constraints on one's ability to influence or take part in decisions related to the patient's plan of care. Although there is continued movement toward inter-professional rounds and joint treatment planning generally, additional skills and processes must be in place for the value-laden discussions related to futility and end-of-life decisionmaking: this more than any other area implicates professional identity issues, frustrations with hierarchical barriers to ethical mandates for joint decisionmaking, and deficits in negotiation skills including assertive contribution, openness to diverse viewpoints, and consensus building. Given the combined impact of embedded structures, cultural practices among the professions, strong social constructions surrounding death and dying, skill deficits, and the levels of emotional distress and fatigue among clinicians, intentional design of processes to enable consensus, inter-professional information sharing, conflict management, and peer support is essential for improving quality of patient care and alleviating distress among health professionals.

VIII. NURTURING AN EMERGING CULTURE: STRATEGIES FOR DISPUTE RESOLUTION PROFESSIONALS SEEKING TO IMPROVE COLLABORATION WITHIN HEALTH CARE ORGANIZATIONS

True collaboration is both a way of being and a way of working. Collaboration occurs at the intersection between self-reflection and active engagement; it is simultaneously a conscious act by individuals and the product of group wisdom. It is the antidote to the epidemic of fragmentation that runs throughout our organizations and our system for providing health services. Collaboration takes time and attention, and in return for that investment we gain understanding, build trust, discover common purpose, and expand possibility. Achieving true collaboration is the next evolution in healthcare.

Despite the challenges outlined above, there is much that is possible for improving end-of-life care by nurturing the growth of an emerging culture, a

[164] *Id.* at 699.

culture that is already pushing up tender shoots in a variety of areas. Efforts to take patient safety seriously are continuing which reinforce the need for collaborative practice; increased consumer involvement is placing emphasis on the value of health services leading to conversations related to the balance between quality of life and sanctity of life. Inter-professional education is popping up in multiple venues. Health care organizations are requesting training for senior leaders, staff and physicians in conflict and negotiation skills; hospitals are making increasing use of ombudsmen and mediators, and regulators are seeking better ways for protecting the public through collaborative mechanisms rather than adversarial approaches. There is a great need for a broad range of services, and for dispute resolution professionals the task is to become familiar with successful strategies that are culturally congruent with the health care environment. The first step, of course, is to take a look at ourselves.

A. *Adapting Dispute Resolution Practice: Reflection on Our Own Capacity*

Expanding the role of dispute resolution professionals from "firemen" to "gardeners," may be a way to become more effective and thereby more accessible to the health care industry as a whole. Whether we are focusing on disputes related to end-of-life care or disputes among physician practice groups, the systems we are entering are complex and interconnected. The relationships among health professionals are crucial to safe patient care and as such, we must become facile at doing more than stopping the fighting or negotiating settlement agreements. We must expand our vision and develop approaches that enable us to foster working relationships that can withstand the rigors of the clinical practice environment. To do this, we must be clear about our own intent and our own capacity for working at a deeper level in complex living systems.

Intent drives outcome in many arenas, and it is particularly true for our field of practice. It has been suggested that to speed adoption of new practices, health care organizations should "build on the moral fabric of the health professions, stimulate the ethical knowledge that resides within them . . . developing from the values already existing within the professions."[165] Given the common moral value across the health professions

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[165] Carney, *supra* note 59, at 112.

Fasting argues that organizations should "build on the moral fabric of the health professions, stimulate the ethical knowledge that resides within them [and that] this is not value-based management from above, but management based on and developing from the values already existing within the professions." All healthcare

of "do no harm," it would seem that this is a good place for dispute resolution practitioners to start. Adopting the intent to "do no harm" as the value underlying the services we provide requires that we adapt traditional approaches for dispute resolution to fit within the unique culture that is health care; that we evaluate our effectiveness from the perspective of those who seek our services; and that we continuously reflect on how we can improve our interventions. Recognizing that fundamentally we cannot control or predict the impact we may have, we must remain conscious of the profound effect of our presence when we engage with those whose work is tied to caring for and healing others.

A significant first step is to recognize that most of health care conflict is among health professionals and not with patients or outside entities.[166] Despite the publicity surrounding high profile end-of-life disputes, there is a significant amount of work to do to address inter-professional conflict. Experience in or familiarity with clinical practice improves our credibility and enables us to recognize cultural patterns within the environment. Appreciating the impact of identity and embedded traditions is essential for us to be effective in crafting processes that are adapted specifically for busy clinical environments. Appreciating that one size does not fit all and working with emerging patterns within each group allows us to customize our approach in ways that are congruent with the needs of the professionals we are working with whether they be at a hospice, an ICU, or a community health clinic.

Reflecting on our own capacity also requires that we consider our personal comfort dealing with strong emotions. Given the high stakes environment surrounding end-of-life care combined with above normal levels of fatigue and well defined emotional distress among health professionals, it is clear that working with this population entails a roller coaster of emotions for clients as well as for ourselves. Grief, whether it is related to loss of a loved one, loss of reputation, or loss of identity is a powerful emotion. As such, engagement with health professionals requires compassion and adequate time for working through what in some cases is years of pent up frustration, anger, and fear.

An additional challenge in working within health professionals is the impact of the regulatory and legal environments. Traditional processes for addressing grievances create strong resistance among those for whom reputation is everything. This is particularly true in highly interdependent systems where professionals must rely on and trust each other to be

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team members have the same moral commitment to patients and therefore they promote co-operative moral decisions in healthcare delivery. *Id.*

[166] Anderson & D'Antonio, *supra* note 26.

successful. Recognizing the fears associated with legal actions, whether real or perceived, is key to appreciating resistance from some health care professionals. Expanding options for non-adversarial resolution of complex issues is greatly needed in all health care organizations and will be required in most of them by 2009.[167]

B. *Building Capacity for Engagement and Conflict Resolution*

In light of the data provided in this article, it is easy to think that health care professionals lack skills of any sort for communicating, negotiating, or collaborating. In fact, they have a broad range of competencies that enable them to negotiate high stakes environments marked by uncertainty. To improve collaborative practice, it is necessary to build on the foundations that exist, both at the individual skill level and also at the system level. Identifying what works well when teamwork is at its best enables us to start from where they are and build from an established foundation. Expanding individual and organizational capacity for engagement and not just resolution enables teams to function effectively across the collaboration continuum.

1. *Developing Collaborative Engagement Skills*

Recommendations for conflict management training are a part of the new 2009 JCAHO leadership standards.[168] There is recent evidence that scores on patient-physician communication skills exams are predictive of prevalence of patient complaints later during practice.[169] Although training alone does not effectively address the scope of conflict among health care professionals, it is a service that is consistent with the culture in that continuing professional development is required and competency-based learning is the standard. Additionally, until recently emphasis on conflict and negotiation has not been a part of professional education and new opportunities are developing in this area.

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[167] Joint Commission on Accreditation of Healthcare Organizations, *supra* note 8.

[168] *Id.*

[169] Robyn Tamblyn et al., *Physician Scores on a National Clinical Skills Examination as Predictors of Complaints to Medical Regulatory Authorities*, 298 JAMA 993, 997 (2007).

> Lower CSE communication scores were associated with a higher rate of retained complaints, particularly in the lowest quartile of these scores. The 853 physicians in the bottom communication score quartile and 236 retained complaints filed in their combined total of 5542 practice years. This yielded an overall rate of 4.26 complaints per 100 practice years compared with 2.51 per 100 practice-years for physicians in the top communication score quartile. *Id.*

There is a need for dispute resolution professionals to develop essential training guidelines regarding content, format, and evaluation of programs designed to instill competencies in communication, negotiation, and conflict engagement specific to health care environments. Designing training programs that provide for inter-professional learning promotes collaboration and understanding of roles, concentrates the group's efforts toward the needs of patients, and promotes professional satisfaction.[170] Team training programs are commonly available to health care organizations and have been designed to reflect current research on team effectiveness.[171] Integrating conflict and negotiation competencies into existing team training curriculum is one means of blending with established practices. Integrating conflict dynamics and mediation courses into health sciences schools is another means of improving competency.

Skills that have been shown to improve patient care include situational awareness, open communication, assertiveness, joint decisionmaking, giving and receiving feedback and team coordination.[172] A consensus document outlining competencies for social workers involved in end-of-life care has been developed and the competencies include: conflict resolution, including communication barriers; liaison skills; support of team members; promotion of discussion of ethical and legal issues; sensitivity and compassion in interacting with client-patients and their family members; willingness to work with other members of the community and interdisciplinary team; ability to handle conflict and crisis situations, among others.[173] Techniques that emerge as effective in developing competencies among health professionals include problem-based learning, reflective practice,[174] discussion, coaching and videotaped simulation.[175]

Although all health care professionals would benefit from training, targeting those groups who are already positioned organizationally to address conflict is a successful strategy. Providing training for social workers, bioethics consultants, charge nurses, house supervisors, department chairs, chaplains, and risk managers creates competency in those to whom conflicts

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[170] Pat Ashworth, *Nurse–Doctor Relationships: Conflict, Competition or Collaboration*, 16 INTENSIVE AND CRIT. CARE NURSING 127–128 (2000).

[171] Agency for Health Care Research and Quality, *supra* note 14. Developers of the Team Stepps curriculum have expressed interest in expanding it to include a conflict management module. Personal communication Oct. 2007.

[172] *Id.*

[173] Lisa P. Gwyther et al., *Social Work Competencies in Palliative and End-of-Life Care*, 1 J. OF SOCIAL WORK IN END-OF-LIFE & PALLIATIVE CARE 87–120 (2005).

[174] Fryer-Edwards et al., *supra* note 134.

[175] Amanda Zick, Michael Granieri, & Gregory Makou, *First-Year Medical Students' Assessment of Their Own Communication Skills: A Video-Based, Open-Ended Approach*, 68 PATIENT EDUCATION AND COUNSELING 161–166 (2007).

are already referred by clinical and administrative staff. Development of executive training programs designed specifically for board members, physician and nurse leaders, executives, and others with leadership roles will help organizations meet upcoming JCAHO requirements and will also impact the organizational culture through embedding of role models with collaborative mindsets.

2. *Facilitating Process Design Based on Best Practices*

Facilitating design of new processes and integrating current processes to enable collaborative engagement is a key function for dispute resolution professionals working within organizations. Health care organizations are naturally competitive and are interested in comparing themselves to similar facilities to assess the quality of care. Using benchmarking and best practices to build capacity for improving teamwork and inter-professional collaboration is another way to provide culturally appropriate service. Examples of potential best practices for end-of-life care in the neonatal ICU have been identified as: (1) clear, shared purpose, goals, and values; (2) effective communication among and between teams and team members; (3) leaders lead by example; (4) nurture a collaborative NICU environment with trust and respect; (5) live principled standards of conduct and standards of excellence; (6) nurture competent and committed teams and team members; and (7) commit to effective and positive conflict management.[176] Facilitating discussion across departments and specialties to enable self-organized processes for joint decisionmaking, information sharing and consensus building is an effective strategy for fostering inter-professional engagement. Identifying organizations that have created new positions to support inter-professional collaboration, such as the AGREE program at Akron General Medical Center and the bioethics mediation program at Montefiore Medical Center, provides baseline information to health care professionals seeking tested strategies for consideration.

Adapting facilitation techniques to include processes that fit within the constraints of the organization, such as accelerated decisionmaking and appreciative inquiry, are also effective strategies for enabling emergence of group goals and process designs that are most likely to be effective. Integration of ideas from the fields of business, organizational development, psychology, and the arts improves our capacity for creative approaches to complex environments. Combining best practices from within the industry

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[176] Judy Ohlinger et al., *Development of Potentially Better Practices for the Neonatal Intensive Care Unit as a Culture of Collaboration: Communication, Accountability, Respect, and Empowerment*, 111 PEDIATRICS 471, 474 (2003).

with effective process design will reinforce training and further embed collaborative practices with a higher likelihood of sustainability.

C. *Mediating Conflicts When Teams Are Stuck*

No matter how adept health care professionals become or how sophisticated the conflict management program design is, there will always be situations where teams get stuck and could use the assistance of a mediator. Integrating access to outside mediation services into the organization's plan for managing end-of-life disputes can help with conflicts that arise with patient's families and staff, and can also be useful when staff are unable to come to agreement or when a particular dispute surfaces old wounds that are impacting the team's ability to get back on track. Integrating such an option with internal processes such as bioethics consultations, peer review, and risk management creates a coordinated approach combining internal and external options for dispute resolution. An excellent document providing guiding principles for managing disputes at end-of-life is the Joint Statement on Preventing and Resolving Ethical Conflicts Involving Health Care Providers and Persons Receiving Care.[177] Use of consensus documents developed by health care professionals when designing systems approaches improves congruence with the health care culture.

IX. CONCLUSION

A key strategy for improving end-of-life care is through better management of conflicts and disagreements. Most conflict within health care organizations occurs among health professionals. Dispute resolution professionals seeking to work with health care professionals should appreciate the factors contributing to team conflict as well as the skills and processes needed to enable teams to succeed within the context of the health care culture. Reflecting on our own traditions and practices and adapting our approaches to be culturally congruent with the realities of clinical practice will lead to sustainable changes that together can nurture a collaborative culture in health care, a necessary component for improving patient care.

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[177] Canadian Healthcare Association, *Joint Statement on Preventing and Resolving Ethical Conflicts Involving Health Care Providers and Persons Receiving Care*, http://www.cnaaiic.ca/CNA/documents/pdf/publications/prevent_resolv_ethical_conflict_e.pdf (last visited Sept. 2007).