

Discussion paper in response to the

*Joint Statement on Resolving Ethical Conflicts
Between Providers of Health Care and Persons Receiving Care*
June 8, 1998 Draft

of the

The CHA, CMA, CNA & CHAC

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*The Provincial Health Ethics Network is a non-profit, non-partisan society
which aims to facilitate discussion and analysis of ethical issues in health
care in Alberta*

Introduction

The following discussion paper was generated in response to the Joint Statement on Resolving Ethical Conflicts June 8/98 draft. The Provincial Health Ethics Network (PHEN) facilitated informal discussion sessions in both Calgary and Edmonton on the topic of the document. A total of 60 individuals, primarily healthcare providers and ethics committee members affiliated with the Network, attended the sessions and provided input in small-group and plenary formats. In Edmonton, an instructor from Mediation Plus, a private mediation and arbitration firm, presented a brief introduction to the process of mediation prior to the beginning of discussion.. The purpose of the sessions was: 1) to facilitate analysis of the issues raised by the Joint Statement for the purpose of providing the following feedback to the authoring organizations; and 2) to stimulate dialogue around the ethics of conflict resolution within the healthcare setting, a common source of concern for healthcare providers and ethics committee members. Several invitees unable to attend the sessions provided written submissions which have also been considered.

The following is *not* intended to be a position paper or an exhaustive summary of the observations made, but an overview of some of the thoughts that emerged from the discussions and submissions. The views do not express the opinion of PHEN nor do they represent a consensus amongst participants, particularly as the Edmonton and Calgary groups did not have the benefit of reflecting on each other's comments.

General Comments

There was a clear sentiment that the document represented a step in the right direction and that the authoring organizations should be applauded for a difficult undertaking. A statement of this nature that provides guidance on means of addressing disagreement was generally welcomed in light of the increasing number of such conflicts arising in healthcare settings. Concern was expressed that the document made fairly general and basic statements, such as the need for respect and communication, at the expense of more specific suggestions on how to approach complex and sensitive situations of conflict. While it was recognized that this was not meant to be a document providing firm guidelines or premises for policy-making, a more thorough exploration of some of the more contentious statements in the document (e.g. principle #5 of the therapeutic relationship) would have been appreciated.

Major Themes

1. *Addressing systemic causes of conflict*

The Statement may benefit by explicitly and more thoroughly addressing the need for creating an organizational climate which fosters strong therapeutic relationships and thus the avoidance of conflict *before* it emerges. The root causes of weak therapeutic relationships can often be traced to systemic and complex institutional environments where open communication and caring are implicitly disvalued, sometimes for lack of sufficient resources that would enable care providers to spend more time on building relationships rather than only treating illness. The Joint Statement would do well to discuss some of the systemic causes of increasingly

conflictual care provider-recipient relationships in modern health care, particularly the impact of limited resources; the obligations of society and health institutions to recognize this as a factor contributing to conflict; and means to address these.

2. *Education of administration, care providers and the public*

Closely related to the above, a procedure for addressing conflict in healthcare situations is liable to be irrelevant if its existence is not adequately communicated to staff and particularly to clients and potential clients of healthcare organizations. This requires a strong commitment on the part of institutions to education. The importance of such communication/education could be more clearly articulated in the Statement.

3. *Targeting resources to conflict resolution*

Institutions that create policy around conflict resolution should be prepared to support these with adequate resources. Conflict resolution involves time and possibly additional costs associated with mediation/ethics committee support. While voluntary involvement of care professionals is laudable, most healthcare organizations can ill afford to further tax their employees by imposing additional duties in areas of conflict management for which there is insufficient compensation/relief from other duties.

4. *Involving care recipients in development of versus decisions regarding care plans*

In describing a need for involvement of care recipients in deciding courses of treatment, the document may unintentionally give the impression that care providers should be *informed* of the various possible goals of care and means of achieving them and then asked to *choose*

between these or to consent to/refuse them. An alternative description might emphasize the involvement of care recipients in the identification of these goals and formulation of courses of therapy through dialogue initiated early and maintained throughout. This may be a more accurate depiction of the process of informed consent within the context of a therapeutic *relationship*.

5. *Clarifying the goals of the document*

It was suggested that the goals of the document be more explicitly stated early in the Preamble.

Is the purpose of the Statement to underscore the importance of conflict resolution processes to an audience of care providers and healthcare organizations; to encourage organizations to develop resolution mechanisms; to provide guidance on what such policies might look like; or all of these?

6. *Input from non-provider groups*

Some concern was expressed that the document reflected the viewpoints of care providers and administrators, but did not resonate with a tone that suggested substantial input from care recipient groups, particularly those easily marginalized or disempowered such as the cognitively incapacitated, mental health consumers and the disability community. If this is indeed the case, the authoring institutions of the Statement may wish to solicit the opinions of non-provider groups prior to releasing their final draft. Additions/modifications to the document that might more accurately reflect the perspectives of these groups include: 1) identifying the need for healthcare providers to be particularly vigilant in promoting the autonomy of the most disadvantaged and those who often do not enjoy the same privileges/basic rights extended and assumed by other care recipients; 2) identifying the

danger of care providers unjustifiably allowing their own implicit quality of life valuations to influence courses of care; and 3) recognizing the need for healthcare providers to advocate “together with” rather than “on behalf of” competent care recipients.

Specific Comments: Possible Additions/Modifications

Preamble

1. Conflict *per se* should be recognized as healthy and as providing the opportunity for the proper airing of different perspectives. Many well-managed situations of conflict with a positive outcome can be gratifying educational experiences for those involved. It was suggested that the focus of the document be changed from ‘resolving’ conflict to ‘facilitation of discussion through’ or ‘managing’ conflict.
2. In identifying what the authors hope to achieve through the Joint Statement, it may also be useful to clarify what such a document *cannot* do – i.e. to express *the limits* of what can be accomplished through such a document alone.

I. Principles of the Therapeutic Relationship

1. Respect for difference and cultural diversity could be cited as a principle. A strong therapeutic relationship will involve respect for value and cultural differences. Cultural variance can have many origins, including but not limited to gender, race, religion,

nationality, family upbringing, socioeconomic background, profession and geographical (rural vs. urban) background.

2. 'Privacy and Confidentiality' may be cited as an additional principle of therapeutic relationships, particularly in situations of conflict when gossip, innocent lunch-room conversation or inadvertent comments between healthcare providers may inopportune impact the outcome of conflict resolution processes or exacerbate difficult situations. In particular, the involvement of family members in the dispute resolution process should be at the request of the patient/resident wherever possible and should not be assumed. The term 'family members' may be expanded to the more inclusive 'loved ones'.
3. The term 'care' may substituted for 'treatment' throughout to reflect a more holistic approach to the role of healthcare providers.
4. The section's subheadings should be altered to be (grammatically) consistent. While *Reciprocity and Communication* is a principle of therapeutic relationships, *The Person Receiving Care* and *Substitute Decision-Makers* are not themselves principles.
5. In the first sentence of the section, the phrase "mutual giving and receiving" is vague. A more precise definition may be more useful.
6. The distinction between competent and non-competent patients/residents is rarely absolute or clear. This should be recognized and reflected in the discussion of decision-making for 'incompetent persons'.
7. Clause #5 requires clarification. Given its complexity, it may be wise to eliminate the clause entirely for eventual replacement by a more comprehensive document addressing the issue of denying requested care on the basis of limited resources. As is, the statement is unclear about whether it is attempting to emphasize that in those situations where care recipients' requests

cannot be met because of resource limitations, they should be so informed *as opposed to not being informed at all*, or whether it is a claim about the appropriateness of making such decisions unilaterally and of being informed *as opposed to being consulted*. In either case, the claim is tenuous and requires substantial elaboration if it is not to be subject to misinterpretation by healthcare providers singularly making resource allocation decisions without recognition of the vast ethical implications of doing so.

8. Clause #12 seems to confuse the standards of ‘substituted judgment’ and ‘best interests’. If any information is available about an incompetent person’s preferences, it is unlikely that the ‘best interests’ standard would be used. The clause may thus more appropriately read: “If an incompetent person’s wishes for treatment/care have not been made explicit either through an advance directive, proxy decision maker (where recognized) or by reliable verbal communication, every effort should be made to ascertain what that individual would choose if they were able to communicate such a preference, based on their known values and preferences. If no information is available regarding an incompetent person’s values and preferences, decisions regarding care should be based on the person’s best interests, taking into account the person’s diagnosis, prognosis and treatment options.”
9. Clause #13 was thought to be problematic for at least three reasons: 1) If healthcare providers have an obligation to advocate on behalf of clients, what are the limitations of such advocacy? If they are to advocate in order that clients have access to “the most beneficial treatment” without stipulated limits, this could potentially conflict with the sentiment expressed in clause #5 (depending upon its interpretation). 2) Given that their particular knowledge of the health care system is unlikely to be available to others, do healthcare providers have an obligation to advocate on behalf of society’s interests? If so, how are these

competing interests to be reconciled, if at all? 3) Do care providers ever have a moral responsibility to advocate for an improved health system (as opposed to health services)?

Some elucidation of these issues may be warranted here.

10. To clause 16, “Providers of care should not be subject to discrimination or reprisal for acting on their beliefs” may be added “*as long as it does not harm the recipient of care*”.

II. Procedure for Ethical Conflict Resolution

1. The physical location of a conflict resolution process is important. Discussions that take place away from the unit/location of original dispute may inspire a helpful air of detachment or removal from the immediacy of a situation and may provide needed space for calm reflection.
2. In step 4, it may be useful to establish the areas *of agreement* as well as *of disagreement* before commencing a wide-ranging discussion of the contentious issues. The second sentence may begin with “*With respect for the confidentiality of the patient/care recipient, share with all those involved...*”
3. Step 5 may be premature, or inconsistent with an attempt to reach agreement amongst all the stakeholders in the situation. Deciding who has the ‘authority and responsibility’ may undermine the legitimacy of a conflict resolution process which attempts to bring all stakeholders together in an attempt to achieve consensus. Only if such an endeavour is unsuccessful (i.e. closer to the end of the conflict resolution procedure) would such a step become potentially appropriate.

4. Step 9 may beg the question. That is, in many such cases, the individual with the right or responsibility for making the decision is unclear, which gives rise to the conflict. It may be more helpful then to state “If, after reasonable effort, agreement or compromise cannot be reached through dialogue, seek further mediation, arbitration or adjudication”.
5. An additional step may be added to the procedure in the relevant place – namely, “*Arrive at a decision and act on it*”.
6. Step 12 may be modified with “Following the resolution of the dispute, review, evaluate *and document* the process...”

III. Policy Development

1. With increasing regionalization of health services, moves from institutional to community settings of service provision and the potential for care recipients to be served simultaneously by several agencies with differing policies, institutions may wish to coordinate their policy efforts with nearby others to ensure as much consistency and equal accessibility as possible within a fragmented service delivery system.
2. (Last sentence) Committee membership should also include representatives of *administration*.
3. Variations in conflict resolution processes will inevitably exist between urban healthcare organizations and their rural counterparts who may not have similar access to readily identifiable ethics committee or mediation services. This could be acknowledged as a source of difficulty that may be partially mitigated by inter-agency collaboration across regions to share resources wherever feasible.

4. The idea of two different mechanisms – one for conflicts among providers/administrators and another for conflicts between providers and beneficiaries, was thought to be an excellent suggestion.
5. As indicated in the *Major Themes* section above, focusing on conflict resolution policies alone in addressing tensions that arise largely when strong relationships have not been formed may not be enough. Rather, some attention must be paid to the development of policies that educate staff and providers about both the importance of developing good relationships (if for no other reason than to avoid conflict), and to providing guidance on what such relationships consist in and how they can practically be cultivated.

Summary

While the comments above offer thematic and specific suggestions for improvement, it was generally recognized that the thrust of the Statement (as interpreted by the participants) was an important advancement in the area of conflict and ethical issues resolution. Discussions ensued about the availability of ethics committees, the role and distinction between mediators and ethicists, and the practical implications of involvement of such external consultants or facilitators. Most agreed that such a process would be valuable, but noted that many ethics committees already exist without sufficient institutional support or in relative obscurity, unknown to most staff. The stimulus to establish clear conflict resolution policies may provide the opportunity to clarify the role of such committees and of other departments, such as Pastoral Care, in the resolution process.

PHEN thanks the authoring organizations for soliciting its members' input and for the their efforts in drafting the Joint Statement.