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Conflicts in the ICU: Management and Resolution Practices

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The complexities of decision-making and risk of conflict in ICUs will continue as demand for ICU care increases. Intractable conflict is resource intensive and emotionally and psychologically draining. Inconsistent responses to conflicts with patients and families often results in staff burnout (Poncet et al. 2007). Identifying and understanding causes of conflict and developing strategies to improve conflict resolution may decrease distress and improve patient care.

Causes of Conflicts

The most common conflicts in the ICU involve the goals of care and the role of life-sustaining interventions. These conflicts can occur between the ICU team and the patient's family, within the family itself and between or within healthcare teams (Studdert et al. 2003; Breen et al. 2001). Conflicts can occur when the designated substitute decision-maker makes judgements, influenced by cultural and religious expectations that do not reflect the patient's values or wishes. Intra-family conflicts challenge the relationship with caregivers, particularly when the law mandates that families make decisions by consensus. While mechanisms may exist to ensure that decisions be made in a timely manner, many healthcare providers are unaware of these options in their jurisdiction.

Conflicts within the ICU team may result when treatments do not seem to be in a patients' best interest, when risks outweigh the benefits or when it is clear that the goals of treatment will not be achieved, and yet families insist that treatments continue. Issues of limited resources are important, and often exacerbate such situations. Conflicts within and among healthcare teams regarding the

care plan also have the potential to escalate conflicts with families. Subspecialty teams may have overly optimistic views of prognosis, fail to consider the patient's overall well-being or set unrealistic expectations of what life-sustaining interventions can achieve.

Methods Used to Resolve Conflicts

Effective communication at various stages throughout the patient's stay in the ICU can help avoid conflict situations with family members. However, such communication is not always consistent, either in its frequency or content. Studies have reported an important shift in the language used as the ICU team reaches the conclusion that life-sustaining treatments should be withheld or withdrawn (Cook et al. 1999). The ethical concern with this approach is that personal and professional biases may unduly influence the language and timing of its use.

A physician may exercise caution by continuing life-sustaining interventions, even if treatment is believed to be against the patient's wishes. This type of conflict avoidance is often used in the hope that time may resolve the problem and families will realise the futility of continuing treatment. Compliance with families' wishes may result in continuing full treatment extending the patient's ICU stay until death ensues. A more paternalistic approach may involve providing fewer treatment choices for families. Such practices may be perceived as unethical (Asch, 1997), may not respect patients' preferences and values, and may result in family dissatisfaction (Azoulay et al. 2004).

When conflicts become intractable and a physician challenges a family's decision-making, support provided by their hospital is often variable, since it is viewed as an issue to be resolved by the individuals. Legal recourse can be seen as a difficult and unattractive option. Those who decide to challenge families by defending what they believe is best for the patient are often left with little if no legal support. Legal recourse is often avoided as it is a difficult, time-consuming and challenging process.

Recommendations for Conflict Situations

Focus on Prevention

Early, open and consistent communication with patients and families is essential. Clear and reasonable goals of care need to be established and documented when life-sustaining treatments are discussed. These goals should be reviewed at predetermined time intervals to evaluate response to treatment, or when/if complications arise. Early communication engages family members and helps empower their decision-making (Azoulay and Sprung, 2004).

Education and improvement in communication skills to facilitate shared decision-making and to address ethical and legal concepts are recommended. This is particularly important for referring clinicians, since decision-making prior to ICU admission often falls below ethical and legal standards of informed consent and is a source of false high expectations. Advance care planning is frequently uninformed as to what life-sustaining interventions entail, and patient wishes are often unclear. Public education campaigns and development of materials to facilitate the creation of informed advance directives/living wills is needed to fill this gap. Education of substitute decision makers about their obligations and responsibilities may avoid future stress and anxiety.

Multidisciplinary Approach

A multidisciplinary team approach can provide early and consistent psychological, emotional and spiritual support for the patient and family. Involvement of social workers, spiritual counselors or bioethicists may improve the level of comfort, rapport and trust with the family. The chaplain or religious leader can help address key spiritual and cultural values to ensure patients' wishes are

respected. Earlier ethics consultations can help elucidate and build understanding of values, beliefs and goals (Schneiderman, 2006). Conflict, by its very nature is polarising and the involvement of others may help delineate common ground and break impasses.

Resolving Inter- and Intra-Team Conflicts Before Engaging in Decision-Making with the Family

Conflicts among and between healthcare teams need to be discussed in a respectful, open way to achieve resolution. Few organisations have implemented processes to help resolve disputes among and between healthcare teams. In practice, such conflicts can be significant sources of stress affecting quality of care for patients and families. The development of such processes is urgently needed.

Development of Clear and Detailed Access and Utilisation Policies and Processes

Critical care is a limited resource, particularly in the face of globally limited healthcare resources. Clear and consistent recommendations are needed to guide all healthcare providers on appropriate use of life-sustaining treatments in order to ensure fair and reasonable access to such treatments in times of need. Otherwise, marginal gains to individuals may threaten the welfare of the majority.

Conclusion

Conflicts involving ethical, moral and religious beliefs are sources of anxiety, stress and burnout. Greater attention is needed at a system-wide level to support a culture aimed at preventing and resolving conflicts. Such efforts do not have to be complicated, they do however need to be initiated, revised and enforced, as the necessity of maintaining high quality decision-making is pivotal in improving patient-centred care and attending to the needs of all patients who may benefit from critical care services in the future.

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