Facing ICU Conflicts

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Research Group Pulmonary Involvement in Patients with Hematological Malignancies

FAMIREA Study Group
No conflict = no changes and little motivation. An optimal amount of conflicts will generate Creativity, strong team spirit, and motivation.

Abundant conflicts = loss of energy, decreasing productivity, increasing stress and, finally, disintegration.

No Creativity
No motivation

No productivity
No integration

...... LEADERSHIP ......
Conflicts and communication gaps in the intensive care unit

Thomas Fassier\textsuperscript{a} and Elie Azoulay\textsuperscript{b,c}

Typology of ICU conflicts

- Definition
- Epidemiology
- Parties involved
- Source categories
- Management

Consequences of ICU conflicts

- Patient’s level: safety and quality of care, preferences and values not respected
- Family level: mistrust dissatisfaction, inappropriate family-centered care
- Staff level: misunderstandings, burnout, turnover etc.
- Global level: increased healthcare expenditure from legal actions, increased length of stay, clinicians’ shortage

Targets for improvement

Higher conflict prevalence associated with: increased number of working hours, larger ICUs (i.e., >15 beds), end-of-life care

Lower conflict prevalence associated with: regular unit staff level meetings or when symptoms’ control at the end-of-life is performed jointly by nurses and doctors

Possible outcome measures of conflict prevention

- Prevalence of conflicts
- Patient’s safety
- ICU-acquired events (nosocomial infection, iatrogenic event)
- Quality of end-of-life care, use of non-beneficial care
- Family satisfaction
- Family burden: anxiety, depression, stress
- Staff turnover and burnout
Definitions of conflicts
from the ESICM Ethics committee

Dispute, disagreement, incompatibility, opposition, or difference of opinion involving more than one individual. This could be related to patient’s management (including admission, discharge, care, nursing, treatment decisions, respect of patient’s preferences and values), or to interpersonal conflict.

Conflicts can be measured
- By nurses, physicians, patients or family members
- During an interview or by a questionnaire survey
- During the ICU stay or after patient’s discharge
Withholding and withdrawal of life support from the critically ill

Two ICUs, One year (1987 to 1988)
- Withholding in 22/1719 patients (1%)
- Withdrawing from 93/1719 patients (5 %).
- All but 1 died = 45% of all deaths

Thirteen (11 percent) had earlier expressed the wish that their terminal care be limited, but this affected care in only four cases.

All but 5 of the 115 patients were incompetent.

100% of family participation
10 disagreements between clinicians and the relatives

Conflicts at the End of Life

Longitudinal study in 1996
- 102 patients with DFLSTs
- More than 400 caregivers interviewed

When a DFLST is implemented, conflicts occur in about 80% of the cases
- in 48% of cases between family and caregivers
- in 48% of cases within the caregiver team
- in 24% of cases within the family

Reasons for conflicts
- Appropriate level of care
- Communication
- Symptom control
- Social issues…

Breen J Gen Intern Med 2001
People involved in ICU conflicts

Hospital

Clinicians from the wards
- Consultants
- Referring team
- Rapid response team

ICU

Intrateam conflicts
- Nurses
- Physicians
- Physiotherapists
- Head nurse
- ICU directors
- Residents/interns
- Others

Intrafamily conflicts
- Family members
  - Spouse
  - Children
  - Siblings
  - Others
- Proxies
- Decision makers
- Friends
- Others

Team–family conflicts

Patient–team and Patient–family conflicts

Inter/Intra team conflicts
Parties Involved in Conflicts

Team-patient and team-family: distrust, inhibition of communication

Intra-team (nurse-physicians, physicians-physicians, nurse-nurse) or between ICU team and consultants: contradictory information to the family

Intra-family: create inertia over making decisions
Satisfaction is so subjective?

"Oh, sure! ... We find your luggage and you're still not happy!"
The Anne Karenine principle
Happy families are all alike;
every unhappy family is unhappy in its own way.
Conflict in the care of patients with prolonged stay in the ICU: types, sources, and predictors

<table>
<thead>
<tr>
<th>Conflict type</th>
<th>Frequency</th>
<th>Proportion of all conflicts (%)</th>
<th>Frequency among ICU patients with prolonged stay (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>All conflicts</td>
<td>248</td>
<td>100</td>
<td>32.1</td>
</tr>
<tr>
<td>Team-family</td>
<td>142</td>
<td>57.3</td>
<td>21.8</td>
</tr>
</tbody>
</table>
| Intrateam 
  ICU team vs. surgical specialists | 26        | 10.5                            | -                                                   |
| Nurse vs. physicians                 | 21        | 8.5                             | -                                                   |
| Multiple services                    | 13        | 5.5                             | -                                                   |
| ICU team vs. medical specialists     | 13        | 5.2                             | -                                                   |
| Attending vs. housestaff             | 5         | 2.0                             | -                                                   |
| Other                                | 6         | 2.4                             | -                                                   |
| Intrafamily                          | 30        | 12.1                            | 4.6                                                 |
Ten source categories

i. Poor communication

ii. LST preferences (Goals of therapy, level of care)

iii. The decision making process (Inability or unavailability of a family decision maker)

iv. Coping problems

v. Expected outcomes

vi. Symptoms control

vii. Staff behavior

viii. Lack of leadership and coordination

ix. Personal animosities

x. Mistrust
**Perceived conflict**

<table>
<thead>
<tr>
<th>Conflict Type</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Among family</td>
<td>22 (46)</td>
</tr>
<tr>
<td>Between staff and family</td>
<td>19 (40)</td>
</tr>
<tr>
<td>Among staff</td>
<td>2 (4)</td>
</tr>
<tr>
<td>Over treatment decision</td>
<td>7 (15)</td>
</tr>
<tr>
<td>Over communication</td>
<td>16 (33)</td>
</tr>
<tr>
<td>Over pain control</td>
<td>2 (4)</td>
</tr>
<tr>
<td>Over perception of care/experimentation</td>
<td>9 (19)</td>
</tr>
<tr>
<td>Over unprofessional staff behavior</td>
<td>15 (31)</td>
</tr>
</tbody>
</table>
Detecting Awareness in the Vegetative State

Adrian M. Owen, Martin R. Coleman, Melanie Boly, Matthew H. Davis, Steven Laureys, John D. Pickard

Fig. 1. We observed supplementary motor area (SMA) activity during tennis imagery in the patient and a group of 12 healthy volunteers (controls). We detected parahippocampal gyrus (PPA), posterior parietal-lobe (PPC), and lateral premotor cortex (PMC) activity while the patient and the same group of volunteers imagined moving around a house. All results are thresholded at $P < 0.05$ corrected for multiple comparisons. $X$ values refer to distance in mm from the midline in stereotaxic space (SOM text).

The power of doubt in medical Decision-making...
Television is an important source of information about CPR for patients. Analysis of 3 popular TV programs that depict CPR. 60 occurrences of CPR in the 97 television episodes: 31 on ER, 11 on Chic. Hope, and 18 on Rescue 911. Sixty-five percent of the cardiac arrests occurred in children, teenagers, or young adults. Seventy-five percent of the patients survived the immediate arrest, and 67 percent appeared to have survived to hospital discharge.

Television is providing the relatives with inaccurate expected outcomes and ... We fail to balance these information mostly by our lack of communication skills.
Man wants Pepsi after 19-year coma

Thrown into a stupor after an auto accident in 1984, he recently spoke his first words in 19 years: "Mom. Pepsi. Milk »

(quadriplegia)
Prevalence and Factors of Intensive Care Unit Conflicts
The Conflicus Study

Élie Azoulay¹, Jean-François Timsit², Charles L. Sprung³, Marcio Soares⁴, Kateřina Rusinová⁵, Ariane Lafabrie¹, Ricardo Abizanda⁶, Mia Svantesson⁷, Francesca Rubulotta⁸, Bara Ricou⁹, Dominique Benoît¹⁰, Daren Heyland¹¹, Gavin Joynt¹², Adrien Français², Paulo Azevedo-Maia¹³, Radoslaw Owczuk¹⁴, Julie Benbenishty³, Michael de Vita¹⁵, Andreas Valentin¹⁶, Akos Ksomos¹⁷, Simon Cohen¹⁸, Lidija Kompan¹⁹, Kwok Ho²⁰, Fekri Abroug²¹, Anne Kaarlola²², Herwig Gerlach²³, Theodoros Kyprianou²⁴, Andrej Michalsen²⁵, Sylvie Chevret²⁶, and Benoît Schlemmer¹, for the Conflicus Study Investigators and for the Ethics Section of the European Society of Intensive Care Medicine*


7358 questionnaires were evaluable

From 323 (81.4%) ICUs (24 countries)
Perceived conflicts are reported by 71.6% of ICU clinicians.
### Parties involved in conflicts among the 5268 respondents who reported at least one conflict

<table>
<thead>
<tr>
<th>Party</th>
<th>Number (Percentage)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physicians and nurses</td>
<td>1719 (32.6)</td>
</tr>
<tr>
<td>ICU nurses</td>
<td>1437 (27.3)</td>
</tr>
<tr>
<td>ICU staff and family</td>
<td>1402 (26.6)</td>
</tr>
<tr>
<td>ICU physicians</td>
<td>1312 (24.9)</td>
</tr>
<tr>
<td>ICU staff and consultants</td>
<td>1075 (20.4)</td>
</tr>
<tr>
<td>ICU staff and patients</td>
<td>906 (17.2)</td>
</tr>
<tr>
<td>ICU staff and physiotherapeutists</td>
<td>882 (16.7)</td>
</tr>
</tbody>
</table>
Source of conflicts

- Personal animosity
- Mistrust
- Communication gaps
- Lack of regular staff meetings
- Family's misunderstandings
- Inadequacy of staff behaviours
- Lack of leadership
- Inadequacy of family behaviours
- Contradictory informations
- Inadequacy of visitation policies
- Patient's misunderstandings
- Inadequacy of patient's behaviours
Source of conflicts (EOL)

- Lack of psychological support
- Decision making process is not optimal
- Symptom's control is not optimal
- No respect of family's preferences
- Treatment provided is futile
- No respect of patient's preferences
- EOL decisions made too late
- EOL decisions made too early
Impact of conflicts on Job Strain

Presence of perceived conflict whose severity was ranked from 0 (not severe) to 5 (very severe)
No severity scores for conflicts

Subjectivity +++

Conflicts are mostly
- Severe: 53%
- Dangerous: 52%
- Harmful: 83%

Few conflicts lead to litigation
Possible side effects of conflicts

1. Patient’s preferences and values are not respected
2. Family dissatisfaction AND Conflicts with family members
3. The decision-making process is not ethically acceptable: ICU like a jungle
4. Non effectiveness of interventions aimed at improving end-of-life care
5. Burn Out Syndrome
Conflicts in the ICU: perspectives of administrators and clinicians

Table 5  Consequences of conflict

<table>
<thead>
<tr>
<th>Consequence</th>
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</thead>
<tbody>
<tr>
<td>• Refusal of potentially beneficial treatments</td>
</tr>
<tr>
<td>• Demands for treatments deemed inappropriate</td>
</tr>
<tr>
<td>• Re-establishing goals and conversations can be draining and time consuming</td>
</tr>
<tr>
<td>• Decreased quality of patient care</td>
</tr>
<tr>
<td>• Lack of resources to care for others who could benefit from ICU treatments</td>
</tr>
<tr>
<td>• Recourse to legal means to resolve conflict</td>
</tr>
<tr>
<td>• Remuneration for family conversations deemed inadequate</td>
</tr>
<tr>
<td>• Lack of patient/family understanding</td>
</tr>
<tr>
<td>• Staff burnout</td>
</tr>
</tbody>
</table>
Burnout Syndrome in Critical Care Nursing Staff

Marie Cécile Poncet¹, Philippe Toullie¹, Laurent Papazian², Nancy Kentish-Barnes³, Jean-François Timsit³, Frédéric Pochard⁴, Sylvie Chevret⁵, Benoît Schlemmer¹, and Élie Azoulay¹
1953 clinicians in 82 ICUs in 9 European countries and Israel.

PIC: situation in which the clinician acts in a manner contrary to his/her personal and professional beliefs.

PIC was independently associated with:
- Symptom control decisions
- Involvement of nurses in EOL decisionmaking
- Good collaboration (nurses & doctors)
- Freedom to perform one’s work-related tasks
- Higher intentional job leave
Six potential targets for improvement

Four factors were associated with conflict occurrence:
- working more than 40 hours per week,
- having more than 15 beds in the ICU,
- caring for one or more dying patients over the last week,
- and providing pre and postmortem care for at least one patient who died within the last week.

The other 2 factors were associated with fewer conflicts:
- symptom control performed jointly by physicians and nurses,
- routine unit-level meetings.
Dynamic process of conflicts

- Time from conflict initiation to conflict acknowledgment: minutes to months
- Six phases of conflicts
- Lessons from the Psychology literature

- Latent
- Aware
- Escalates
- Hurting or Stalemate
- De-escalation (negotiation)
- Post conflict peace building phase: Prevention
Managing ICU conflicts: a place for multimodal interventions

 Mostly ineffective

- Global interventions
- Non proactive interventions
- Interventions not designed at a patient level

 Effective (indirectly)

- Ethics consultation with multidisciplinary and easily available team. To broaden.
- Communication strategies

Management skills? For which outcomes?
Review

Bench-to-bedside review: Leadership and conflict management in the intensive care unit

Rob JM Strack van Schijndel¹ and Hilmar Burchardi²
Conclusion

- Conflicts are reported variably across studies.
- There is evidence of poor communication.
- Many discrepancies between perceptions by nurses and physicians of end-of-life issues.
- Conflicts and communication gap may result in nonoptimal end-of-life care. Preventive strategies rest on improving communication skills and on restoring leadership within ICUs.
- General and interventional studies are needed.
Thank you for your Attention
Thank you for your attention

Élie Azoulay, MD, PhD
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Paris 7 Denis Diderot University
Paris, France
Each additional patient per nurse was associated with:
- a 7% increase in the likelihood of dying
- a 23% increase in the odds of burnout
- a 15% increase in the odds of job dissatisfaction

Table 4. Patient-to-Nurse Ratios With High Emotional Exhaustion and Job Dissatisfaction Among Staff Nurses and With Patient Mortality and Failure-to-Rescue*

<table>
<thead>
<tr>
<th></th>
<th>Unadjusted</th>
<th></th>
<th>Adjusted for Nurse or Patient Characteristics</th>
<th></th>
<th>Adjusted for Nurse or Patient and Hospital Characteristics</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Nurse outcomes</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>High emotional</td>
<td>1.17 (1.10-1.26)</td>
<td>&lt;.001</td>
<td>1.17 (1.10-1.26)</td>
<td>&lt;.001</td>
<td>1.23 (1.13-1.34)</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>exhaustion</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Job dissatisfaction</td>
<td>1.11 (1.03-1.19)</td>
<td>.004</td>
<td>1.12 (1.04-1.19)</td>
<td>.001</td>
<td>1.15 (1.07-1.25)</td>
<td>&lt;.001</td>
</tr>
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<td></td>
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<td></td>
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<tr>
<td><strong>Patient outcomes</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mortality</td>
<td>1.14 (1.08-1.19)</td>
<td>&lt;.001</td>
<td>1.09 (1.04-1.13)</td>
<td>&lt;.001</td>
<td>1.07 (1.03-1.12)</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Failure-to-rescue</td>
<td>1.11 (1.06-1.17)</td>
<td>.004</td>
<td>1.09 (1.04-1.13)</td>
<td>.001</td>
<td>1.07 (1.02-1.11)</td>
<td>&lt;.001</td>
</tr>
</tbody>
</table>

*Odds ratios, indicating the risk associated with an increase of 1 patient per nurse, and confidence intervals were derived from robust logistic regression models that accounted for the clustering (and lack of independence) of observations within hospitals. Nurse characteristics were adjusted for sex, experience (years worked as a nurse), type of degree, and type of unit. Patient characteristics were adjusted for the patient’s Diagnosis Related Groups, comorbidities, and significant interactions between them. Hospital characteristics were adjusted for high technology, teaching status, and size (number of beds).
une analyse à plusieurs niveaux

**National/cultural context**

<table>
<thead>
<tr>
<th>Local community/institutional context</th>
<th>Ex: Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual analysis</td>
<td>Conflict sources</td>
</tr>
<tr>
<td>Examples: 1 Nurse, 1 Physician, 1 Spouse</td>
<td>Dogmatism, Power motivation, Job characteristics, Cognitive and affective state</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Group analysis</th>
<th>Conflict sources</th>
<th>Conflict consequences</th>
</tr>
</thead>
<tbody>
<tr>
<td>Examples: Nurses/Physicians, physiotherapists, ICU/wards, families</td>
<td>Power differentials, Leadership style, Group heterogeneity, Group communication, Interaction patterns</td>
<td>Aggression, Escalation, Team motivation, Team performance, Team membership</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Organizational analysis</th>
<th>Conflict sources</th>
<th>Conflict consequences</th>
</tr>
</thead>
<tbody>
<tr>
<td>Examples: ICU/hospital management</td>
<td>Mergers and acquisition, Systems of conflict management</td>
<td>Organizational change, Innovation</td>
</tr>
</tbody>
</table>
Abraham's Sacrifice of Isaac

(insidious process...)

[Image of the Sacrifice of Isaac]
## Step-Wise Approach to Address Conflicts

<table>
<thead>
<tr>
<th>Step</th>
<th>Self-assessment Questions</th>
<th>What to Say to a Family</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Notice the conflict</td>
<td>Am I feeling angry, or irritated, or bored, or having my usual response to conflict?</td>
<td>This is an internal reflective step</td>
</tr>
<tr>
<td>2. Prepare yourself</td>
<td>Am I too angry to listen fully? Am I still rehearsing why I’m right? Am I feeling punitive?</td>
<td>This is an internal reflective step</td>
</tr>
<tr>
<td>Examine the 3 stories</td>
<td>What happened? What are my feelings? How does this involve my identity?</td>
<td>This is an internal reflective step</td>
</tr>
<tr>
<td>Decide on the purpose of working through the conflict</td>
<td>What are the consequences of not addressing this conflict? What are my needs that should be addressed in dealing with this?</td>
<td>This is an internal reflective step</td>
</tr>
<tr>
<td>3. Find a nonjudgmental starting point for the conversation</td>
<td>What would an impartial third person say that this conflict is about?</td>
<td>“Let’s start with the big picture about what we are hoping for in Mrs X’s situation.”</td>
</tr>
<tr>
<td>4. Reframe emotionally charged issues</td>
<td>How can I describe the issue so that it is something that we both need to work together on? Am I moving back into the me against you stance?</td>
<td>“For a lot of people, providing food is a way of showing love. If that’s part of the issue, let’s talk about other ways you can do that.” “I don’t think of withholding intravenous fluid as starvation. It’s a medical treatment that isn’t always good for someone who is in the last phase of life.”</td>
</tr>
<tr>
<td>5. Respond empathetically</td>
<td>Have I given explicit feedback that shows that I understand how the other person is feeling?</td>
<td>“I know that you would never want to feel that you were starving your mother. These decisions definitely require a lot of thought.”</td>
</tr>
<tr>
<td>6. Look for options that meet the needs of both parties</td>
<td>Does this option address the other person’s concerns? Does this option address my concerns?</td>
<td>“How about if I describe a treatment trial and you can tell me your reactions, both positive and negative?”</td>
</tr>
<tr>
<td>7. If no satisfactory agreement can be reached, get help</td>
<td>What resources exist to help us negotiate?</td>
<td>“I think it would be helpful to have another impartial person help us discuss what is best.”</td>
</tr>
</tbody>
</table>
Conflicts regarding decisions to limit treatment: a differential diagnosis.

Ask yourself:
What do I think are this patient’s chances of surviving to discharge/recovering function? What have I told the patient/family are his/her chances of surviving to discharge/recovering function? How sure am I about his/her prognosis? On what is it based? What do I know about what this patient wants (or would have wanted)? How do I know? How sure am I?
Is this patient competent to make his/her own decisions? How do I know? How sure am I?
Could it be fluctuating or reversible incompetence?
Did I/we contribute to a bad outcome in any way (eg, missed diagnosis, delayed treatment)? How do I feel about discussing this patient’s death with him/her (his/her family)?
Who is this patient’s “family doctor”? Clergy of choice? Primary nurse? Social worker? Do I feel I have enough time to talk to the patient/family about prognosis, options, and goals?
What words or phrases have I (or others) used that might be contributing to the conflict (eg, “stopping treatment,” “comfort measures only,” “hopeless,” “certain”)?
What aspect(s) of this patient’s life do I feel justify withholding or withdrawing life-sustaining treatment?
Does the family trust us? If not, why not?

# Dealing With Conflict in Caring for the Seriously Ill

“IT WAS JUST OUT OF THE QUESTION”

Anthony L. Back, MD  
Robert M. Arnold, MD

| Empathizing: Provide listener with evidence that you understand his emotional state | “I can see that you care a great deal about what happens to your mother.”  
“This just feels like a sad situation.”  
“I think anyone would feel as worried as you given the circumstances.” |
<table>
<thead>
<tr>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>Reframing: Describe situation as a mutual problem to be solved collaboratively</td>
<td>“Now I think we should look at the issue of intravenous fluid as not just ‘Do we do it?’ but as part of the bigger picture of her care.”</td>
</tr>
<tr>
<td>Brainstorming: Propose potential solutions without critiquing them as a first step in problem solving</td>
<td>“Let’s try to come up with a few ideas about how to prepare for her death and then pick a few to work on.”</td>
</tr>
</tbody>
</table>
The End of Life WHO DECIDES?

- Lessons of the Schiavo Battle
- Plus: Living Will Resource Guide

TIME April 4, 2005
Do you agree with the decision to remove Terri Schiavo’s tube? 59% say YES.
not consciously suffering. I also believe that both her husband and her family, while seeing the situation in radically different ways, were trying to do what was right for her. Her family and the public another." Schiavo’s legacy has turned out to be worse than he feared. After her death, her parents and husband continued to battle — over access to her remains.