Using Case Conflict to Improve Consulting Relationships

Bridgeport Hospital—Yale New Haven Health System
Bridgeport, CT
Kristin.Edwards@bpthosp.org

Clinical Case Background

- 60 yo Spanish speaking male with stage IV colon cancer with liver metastases diagnosed two years prior.
- Well known to the Palliative Care team from prior hospitalizations during which he had demonstrated significant depression and difficulty clarifying his goals of care because of his primary coping skill of denial. His sister was his surrogate decision maker and had been previously very focused on a cure as well.
- This hospitalization, he was admitted for failure to thrive. During his stay, he developed acute dyspnea and hypotension, and was transferred to the ICU for treatment of a new cardiomyopathy. He was requiring bipap intermittently and remained unable to discuss goals of care secondary to either delirium or severe depression. His sister changed his code status to limited code status (DNR/DNI) and acknowledged that he was suffering, but could not yet remove any therapies, including bipap, secondary to caregiver guilt over the decision making responsibility.
- On the day that the team conflict developed, the patient was declining; somnolent, but tolerating bipap and hemodynamically stable, but requiring vasopressors.

Development of the Conflict

9:00 am — Patient discussed during morning ICU rounds (RN and ICU Attending present). Plan established to call sister to transition patient to comfort measures.

11:00am — Pt seen by Palliative Care MD. No decision making capacity. Sister not at bedside. Pt remained a limited code status (DNR/DNI), on bipap and pressors. Although lethargic, hemodynamically stable with those interventions.

12:00pm — Bladder scan done by RN Trainee showed pt bladder volume greater than 700ml.

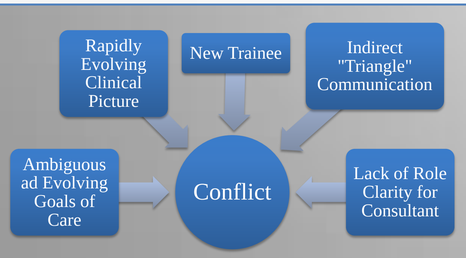
1:00pm — RN Trainee communicated problem of urinary retention with ICU MD. ICU MD did not agree with urologist evaluation. Rationale given to RN: Pt's goals of care would be soon changed to comfort measures, so urologic intervention would not be necessary.

2:00pm — RN Trainee felt that patient showed signs of abdominal pain. RN Trainee expressed to RN Educator discomfort not doing anything about bladder retention because the goals of care were not yet comfort measures.

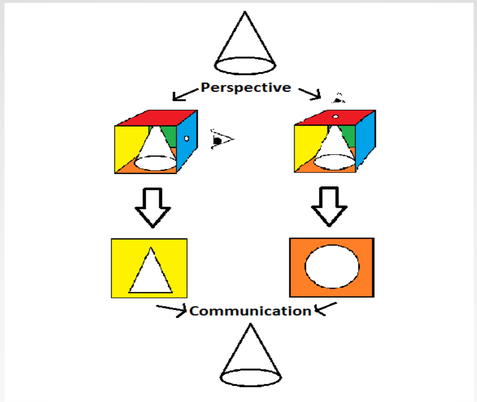
2:45pm — RN Trainee paged Palliative Care MD: "Update, unable to get a hold of family, not yet comfort care, new issue of bladder retention." Palliative Care MD returned page and discussed with RN Trainee. Palliative Care MD recommended urologist evaluation. Rationale given: Treatment of acute bladder distention with decompression would be both medically and palliatively indicated for most rapid and effective relief of discomfort.

3:00pm — RN communicated with ICU MD that Palliative Care MD was updated and recommended urologist evaluation. ICU MD expressed frustration that RN Trainee paged Palliative Care MD despite his recommendations earlier.

4:45pm — RN Educator paged Palliative Care MD. Palliative Care MD returned page and was updated by RN Educator that ICU MD seemed upset that they reached out to Palliative Care MD and continued to disagree with urologist evaluation.



Cone in the Cube: a Metaphor for Perspective



Barry Dorn and Leonard Marcus of the "National Preparedness Leadership Initiative" at Harvard School of Public Health

Initial Reactions

- "My initial reaction was anger and defensiveness regarding my recommendations to the nursing staff. I felt wrongly judged for simply answering a clinical question with my recommendations.
- "I was worried that the referring physician would stop using our services if he was genuinely upset with me. I had worked very hard to build strong relationships with our referring physicians."
- "I also wanted to support the nurses right to call me when they felt uncomfortable with a clinical situation." - Palliative Care MD

- "I wanted to role model to the nurse trainee that it was okay to seek another opinion when uncomfortable about a situation. Therefore, I encouraged her to call the Palliative Care MD to weigh in." - ICU RN Educator

- "I just didn't feel right about not doing anything. I felt that since the patient was not comfort measures only yet, we needed to continue treating the patient, which would warrant a urology consultation. On the other hand, if the patient was comfort measures only, I felt that urinary retention was painful, and a urologist consultation may provide strategies to decrease this pain. Either way, I did not see the harm to having urology come see the patient." - RN Trainee

- "I felt frustrated and undermined that the nurses had gone around me. I thought that the reasons behind our decision to avoid invasive interventions were explained clearly on rounds. The patient's clinical status had deteriorated very quickly during the day to obtundation and death was likely imminent once bilevel support was removed."
- "I knew that the team had contacted the patient's sister who had agreed in principal to comfort measures only, but she wanted to be present before bipap was removed. My approach was to use IV opioids for analgesia until the sister arrived, when we could transition the patient rapidly to our comfort measures protocol." - ICU Attending MD

Collaborative Conflict Resolution

Problem Solving/Problem Confronting:
An attempt to work together to find a solution which satisfies the concerns of all involved parties

Process:
- Identifies underlying concerns of the opponents
- Find an option which meets each party's concerns.

Useful strategy when:
- Consensus and commitment of other parties is important
- When a high level of trust is present
- When a long-term relationship is important
- When responsibility is shared

Advantages:
- Leads to true problem solving
- Reinforces mutual trust and respect
- Builds a foundation for effective collaboration in the future
- Decreased stress related to the outcome for those involved.

Disadvantages:
- Requires a commitment from all parties to look for a mutually acceptable solution
- May require more effort and more time than some other methods
- Not practical when conflict resolution is urgent
- If one or more parties lose their trust in an opponent, the relationship falls back to other methods of conflict resolution

Stepwise Approach to Conflict Resolution

1) Become aware of own emotional reaction, recognize triggers
2) Determine if conflict is related to underlying values versus perspective
3) Identify known facts
4) Approach with an attitude of "curiosity" regarding perspective
5) Problem solve for solution to put the pieces together.
6) Establish a plan for future.

Outcome for Working Relationships

In a high trust relationship, the discussion of the conflicting opinions lead to an even better trusting relationship. The Palliative Care clinical team received several additional consults from the referring physician because of this increased trust. Working relationships were also strengthened with the RN Educator generating additional opportunities for collaboration on other projects.

Team Members

Kristin Edwards, MD, Chief of Palliative Care, BH-YNHHS
Jennifer Healy, RN, ICU Nurse Educator, BH-YNHHS
John-Paul Ayala, MD
Laura Ritter, RN, ICU Staff Nurse