

Team Disputes at End-of-Life: Toward an Ethic of Collaboration

Team Disputes at End of Life

There are persistent calls for improving end-of-life care in the United States. Several recurrent issues make end-of-life care suboptimal, including disputes among members of the health care team. Difficulties in end-of-life care arise around issues such as: 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. Despite documented support for improved collaboration among health care providers, the struggle to work together continues, often to the detriment of patients and their families, and more profoundly to the caregivers.

The system for delivering end-of-life care is fragmented and current models for providing care are unsustainable. In a recent Hastings Center report,¹ Murray and Jennings cite three areas that require rethinking assumptions regarding end-of-life care. These include paying greater attention to the end-of-life care delivery system, the approach to advance directives and surrogate decision making, and managing conflict and disagreement. The disjointed and complex system for providing end-of-life care is costly, confusing, and invites legal intervention as the dominant response to anger, mistrust, and unmet needs. This serves no one well.

Given the likelihood of continuing to provide care within fragmented and complex structures, we

must look for and identify successful patterns. Often, we are able to come together, reach consensus, coordinate care, and resolve disputes, resulting in a respectful, authentic, and compassionate caress; a concerted action aligned with our common purpose to do no harm.

To provide better end-of-life care, we are compelled to create a normative ethic of collaboration, to transition toward more effective engagement, toward a higher level of professional consciousness. Our fragmented system has evolved to a level of complexity that demands a rebalancing, a swing toward integration that enables us to respond collectively to the overwhelming challenges in our clinical environments. We can transform our approach to end-of-life care by making conscious choices to work together, not just side by side. Creating an ethic of collaboration as a foundation for practice will allow us to better meet the needs of patients and to fulfill our own desire to do meaningful work.

Toward an Ethic of True Collaboration

True collaboration is a way of being and a way of working. It requires a personal commitment to self-awareness and development of skills for interacting at multiple levels. 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 organization and our

system for providing end-of-life care. Collaboration requires time and commitment; in return for that investment we gain understanding, build trust, discover common purpose, and expand possibility. An ethic of collaboration provides a foundation for addressing paradox and ambiguity, and for managing differences that, if left unaddressed, can lead to moral distress and service fatigue.

Starting From Where We Are

So how far do we need to travel to find an ethic of collaboration among health professions? Our dominant ethical principles of do no harm, distributive justice, patient autonomy, and integrity in practice do not expressly indicate an ethic of collaboration. On closer examination, however, it is clear that the threads of true collaboration are woven into our current ethos.

Collaboration requires reflection on our effectiveness in negotiating with colleagues on behalf of patients. Awareness of this and our ability to acknowledge others is the first step in patient advocacy.

To do no harm, the most fundamental of our ethical obligations, we must work together. Complexity dictates that no one person has enough information to care individually for the patient. Collaborative practice underlies nonmaleficence. Coming together is the only way to consistently prevent harm to patients.

Distributive justice by its nature involves a broad view of the needs of a community. Through discussion and consensus we are better able



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“Fragmentation consists of false division, making a division where there is a tight connection and seeing separateness where there is wholeness. Fragmentation is the hidden source of the social, political, and environmental crises facing the world.”

— David Bohm²

“Culture matters. It matters because decisions made without awareness of the operative cultural forces may have unanticipated and undesirable consequences. ... The argument for taking culture seriously, therefore, is that one should anticipate consequences and make a choice about their desirability.”
— Edgar Schein³

to determine just and equitable solutions in the face of competing interests and limited resources.

Patient autonomy, respect for an individual’s capacity for self-determination, reflects the personal responsibility patients carry and underscores the fiduciary duty of each practitioner to provide a framework built on trust from which patients can make decisions. Trust is the determining factor that enables collaboration.

True collaboration blends individual commitment with group action. Integrity in practice through truth-telling, reliability, equanimity and fidelity, has long been an expectation of practitioners and goes to the heart of our individual commitment as professionals. Without a commitment by each individual to contribute and participate with integrity, there is no collaboration.

The guidelines found in the ethics codes of various professional groups range across the collaboration continuum. The levels of ethical responsibility fall into five categories: professional conduct (citizenship), acknowledgment, cooperation, collaboration, and active conflict engagement. The categories reflect a progression in 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 lie at the heart of each professional culture.

Professional Cultures

Underlying our ability to engage with each other in resolving differ-

ences are professional cultures that reinforce fragmented approaches to end-of-life care and impact our ability to appreciate the contribution of others, to integrate ideas, to communicate effectively, to problem solve holistically, and to make sense of complexity. Structural and professional divisions create containers that make connection and collaboration difficult.

Professional cultures are composed of those things we see and what we do not see. Below the surface are unconscious assumptions that drive professional behavior. Within each profession are assumptions that can sabotage efforts to communicate clearly and collaborate effectively. Surfacing these assumptions and testing their validity is the key to building understanding and managing differences between professions.

Tools for Expanding Capacity to Collaborate

The field of alternative dispute resolution offers a number of processes and techniques to improve individual skills and enable groups to come together. Facilitation and mediation have traditionally been used to manage conflict and build agreement, particularly when there is a loss of trust or perceived differences that impede decision making or problem solving. Dialogue is a process that enables groups to establish common purpose, test assumptions, and collectively develop deeper meaning. Coaching and mentoring processes create clarity and promote self-awareness by providing structured feedback in a supportive environment. Appreciative inquiry helps groups to identify patterns of success. Through positive inquiry into stories of success, groups can move forward by envisioning solutions that build on what is already working. Integrating

these tools into clinical practice is a practical means for advancing collaboration.

Enhancing Our Delivery Systems

Most health care organizations have a need to redefine their processes for responding to conflict and for resolving disputes. System designs that enable productive engagement is a special application in the field of dispute resolution. Drawing on principles of emergence and self-organizing behavior, organizations can identify reliable methods for fostering collaborative problem solving and effective dispute resolution enhancing the ability of health care professionals to work together and truly live out their ethical obligations.

Conclusion

End-of-life care is fragmented and requires that we examine our commitment to work collaboratively as a means for improving end-of-life care and managing team disputes. Techniques used by conflict specialists can enhance the capacity of health care professionals to transition their practice toward a culture of collaboration. ❖

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