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Teamwork and conflicts in paediatric end-of-life care

Paediatric end-of-life care relies on teamwork, and physicians, nurses and other healthcare professionals are required to work together as a team to achieve common goals and provide optimal end-of-life care at the bedside. Young patients, and the parents of critically ill children, often want to be involved in choices about the type of care that is provided. In this context, differences in individual opinions, interests, backgrounds and beliefs may give rise to conflicts, which are disputes or disagreements that require some action or decisions.

In end-of-life care, conflicts are usually related to withholding or withdrawing treatment. Most studies about end-of-life conflicts have focused on adult medicine, but it is clear from the limited number of studies about paediatric end-of-life care that conflicts about treatment decisions are common between healthcare providers and parents and families (1–4). Similar conflicts occur between members of the healthcare team and between healthcare staff and parents and family members. Conflicts during end-of-life care are an inevitable consequence of working with people with different opinions, interests, goals, values, cultures and needs.

But are conflicts good or bad? One approach might be that conflicts are good because they enable the healthcare professionals to function at a higher level. They may be able to refine their ways of thinking and their approaches to end-of-life care, by sharing different views and opinions about tasks, commitments and their interactions with each other and with patients and families. If we follow this line of thinking, then parents also profit from conflicts in a similar way.

Alternatively, we could argue that conflicts impair the way teams function and harm professionals, patients and families. When conflicts occur, the team and, or, the parents may become emotional and distracted, and they are forced to spend energy on conflict resolution that might have been better used for caring or for comforting and loving the sick child. In addition, the team’s negative experience of problematic teamwork may decrease their work satisfaction, commitment and well-being, which will, in turn, influence the level of care they provide other patients.

Several studies have examined how conflicts in health care are managed and how different types of conflicts have an impact on team functioning. The overall picture that has emerged from the studies about conflicts is that the effects are generally negative for healthcare professionals and parents (5). The practical consequence is that healthcare professionals try to avoid conflicts, which may exacerbate the situation.

We want our medical teams to provide a high-quality, effective, empathic end-of-life care and manage conflicts positively. The ability to accomplish that depends on how well the team members understand the origins of conflict and try to develop strategies to resolve them. The paper by Archambault-Grenier et al. (6) in this issue of *Acta Paediatrica* is a great example of a team systematically examining the origins and nature of conflict in their own workplace. They report the results of a questionnaire survey of professionals involved in end-of-life care for children in a large tertiary university hospital in Canada. The professionals were physicians, nurses, psychologists, physiotherapists and inhalotherapists. The aim of the study was to investigate their experiences with end-of-life conflicts and to explore other details of these conflicts, such as frequency, perceived importance, contributing factors and strategies for conflict resolution and coping.

The authors report several important results. First, they state that a very high proportion of healthcare professionals (71%) had experienced at least one conflict in the preceding five years and these were more frequent between professionals (58%) than between professionals and parents (33%). This finding is remarkable and differs from most of the earlier paediatric studies, which reported conflicts between healthcare teams and families as the most common type of conflict (1–3). One interesting, and potentially worrisome, finding was the observation that most of the nurses did not express their opinions. The authors’ suggestion was that this phenomenon could be a barrier to truly interdisciplinary decision-making and that theory seems realistic. It may also be that these nurses suffered in silence, because they were involved in conflicts but their voices were not heard or taken into account. Those of us who work in paediatric end-of-life care should recognise and address those risks.

A second result that deserves our attention is the detailed list of factors that frequently contributed to conflicts, as this provides a first step towards targeting them with specific interventions to improve end-of-life care. The top five major contributing factors were as follows: physicians’ rotations, parents’ lack of preparation, parent’s unrealistic expectations, emotional load and differences in values and beliefs. Physicians’ rotations may not be easy to change, but the other reported factors may be good candidates for interventions. For example, these could include the early introduction, and integration, of palliative care and ethics...
consultations to address parents’ fears and expectations more effectively and increasing measures to overcome differences in culture, norms and values. These may appear to be simple suggestions that could be easily brought into practice tomorrow. However, experts in paediatric palliative care have strongly recommend the early introduction of palliative care for more than a decade (7) and this does not occur in most cases.

One of the most prominently suggested interventions and strategies was to designate a lead physician and nurse for each patient to ensure continuity of care. This could also improve communication between the parents and the team and also within the team. Intuitively, the next step would be to implement and test the efficacy of this suggestion, as there is already some evidence that the parents of children receiving palliative care find single contact points very useful for continuity of care (8). But we need to know more about the parents’ perceptions of conflicts and resolution strategies. Studies about the implementation of specific interventions, and the development of best practice, are the next steps towards reducing conflicts, increasing the chances of conflict resolution in end-of-life care and improving teamwork.

CONFLICT OF INTEREST
The author declares no conflict of interest.

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References