

Résumé

**Les perceptions qu'a le personnel infirmier
en soins intensifs de son rôle dans les conflits
entre la famille et l'équipe de soins
relativement aux plans de traitement**

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Les conflits concernant les plans de traitement sont une source de préoccupation pour les personnes qui travaillent dans le domaine des soins intensifs. Cette étude a pour but d'explorer et de décrire les perceptions qu'ont les infirmières et les infirmiers en soins intensifs de leur rôle dans les situations de conflit entre les membres de la famille et les fournisseurs de soins dans les services de soins intensifs. Suivant un plan d'analyse descriptive et qualitative, l'étude a comporté des entretiens individuels avec douze membres du personnel infirmier en soins intensifs et des entretiens de groupe avec quatre membres d'expérience. Ces personnes ont décrit leur rôle comme suit : fournir des soins sûrs, satisfaisants et de qualité aux malades; bâtir ou rétablir des relations de confiance avec les familles; et soutenir les autres membres du personnel infirmier. Elles ont attiré l'attention sur le niveau de stress dans les situations de conflit, le besoin de faire preuve de prudence dans la prestation des soins et dans les communications avec les membres de la famille, et le besoin de soutien du personnel infirmier. Les auteures concluent qu'il faudra faire d'autres recherches sur le travail dans les situations de conflit ainsi qu'améliorer la formation dans ce domaine pour le personnel infirmier en soins intensifs.

Mots clés : conflit, personnel infirmier en soins intensifs, famille, communications, confiance

Critical Care Nurses' Perceptions of Their Roles in Family-Team Conflicts Related to Treatment Plans

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Conflict over treatment plans is a cause of concern for those working in critical care environments. The purpose of this study was to explore and describe critical care nurses' perceptions of their roles in situations of conflict between family members and health-care providers in intensive care units. Using a qualitative descriptive design, 12 critical care nurses were interviewed individually and 4 experienced critical care nurses participated in focus group interviews. The roles described by the nurses were as follows: providing safe, competent, quality care to patients; building or restoring relationships of trust with families; and supporting other nurses. The nurses highlighted the level of stress when conflict arises, the need to be cautious in providing care and communicating with family members, and the need for support for nurses. More research related to working in situations of conflict is required, as is enhanced education for critical care nurses.

Keywords: conflict, critical care nurses, family, communication, trust

Introduction

A hallmark of critical care nursing is the proximity of nurses to patients and their family members (Malone, 2003). This provides nurses with the opportunity to come to know a patient's pattern of responses to treatment and the patient as a person and as a family member (Benner, Hooper-Kyriakidis, & Stannard, 1999; Benner, Tanner, & Chesla, 1996; Edwards & Donner, 2007; Malone, 2003; Tanner, Benner, Chesla, & Gordon, 1993). This proximity also means that when conflict arises over treatment plans, nurses are likely to be the members of the health-care team with the most contact with the patients and family members involved (Halcomb, Daly, Jackson, & Davidson, 2004; Peter & Liaschenko, 2004). Although conflict is known to be an issue of concern in the intensive care unit (ICU), we have limited knowledge about the role of critical care nurses in situations of conflict.

Conflict in the ICU

Conflict is not uncommon for those working in critical care settings. In a survey of 7,358 ICU staff members in 24 countries, 72% of respondents

had experienced at least one situation of conflict in the week the questionnaire was completed, with 27% of conflict occurring between patients' families and health-care providers (Azoulay et al., 2009). The most common sources of conflict were behaviour issues (e.g., mistrust, communication gaps) and concerns related to end-of-life care (e.g., patient preferences were ignored). In other studies, conflict was identified in 32.1% of 656 adult patients with prolonged stays in ICU (Studdert et al., 2003) and in 78% ($n = 102$) of adult patients when discussions had taken place regarding withholding or withdrawing life-sustaining treatment (Breen, Abernathy, Abbott, & Tulsky, 2001). In those studies, disagreement between family and staff accounted for approximately half of all conflict. Families of adult ICU patients have also reported family-staff conflict related to treatment decisions, communication, and unprofessional behaviour (Abbott, Sago, Breen, Abernathy, & Tulsky, 2001; Norton, Tilden, Tolle, Nelson, & Eggman, 2003).

It is not only the frequency of conflict over treatment plans that is worrying, but also the fact that conflict can be difficult to address. A group of clinical bioethicists in Toronto, using a modified Delphi survey technique, identified the top ethical challenge in health care as disagreement between patients/family members and health-care providers regarding treatment decisions (Breslin, MacRae, Bell, Singer, & University of Toronto Joint Centre for Bioethics Clinical Ethics Group, 2005). This disagreement was described as involving either patients or family members requesting treatment options that were deemed inappropriate by the team, or team members proposing treatment options that patients or family members would not accept, with the most charged and intractable examples occurring at end of life in critical care settings. In the past few years, at least three cases of conflict over treatment decisions in ICU have been heard in Canadian courts (*Golubchuk v. Salvation Army Grace General Hospital et al.*, 2008; *Jin (next friend of) v. Calgary Health Region*, 2007; *Rasouli v. Sunnybrook Health Sciences Centre*, 2011). Work has been done to develop strategies to prevent or mitigate conflict in ICUs, including the use of structured family meetings within 72 hours of admission (Lilly et al., 2000), a screening tool to identify families at risk for conflict followed by interventions aimed at improving family-team communication (Burns et al., 2003), and interactive workshops to improve communication within teams and with families (Hales & Hawryluck, 2008).

Nurses and Conflict in the ICU

While nurses have participated in studies exploring the prevalence and characteristics of conflict in ICU settings (Azoulay et al., 2009; Breen et

al., 2001; Danjoux Meth, Lawless, & Hawryluck, 2009; Studdert et al., 2003), we found only two studies that explicitly explored the roles or responses of critical care nurses in situations where disagreement over treatment plans was present. Jezewski (1994) used interviews to explore, with 22 critical care nurses, the experience of interacting with patients or family members as a decision was made regarding resuscitation status. Conflict was identified as a core category in this grounded theory study, with two subcategories evident: interpersonal and intrapersonal. Interpersonal conflict could occur among family members, between family members and health-care providers, or between health-care providers. The nurses described roles in both preventing and resolving conflict through “brokering care,” which included “advocating, negotiating, mediating, and most importantly being sensitive to the needs of patients and families” (p. 464). There was more discussion of the roles in preventing conflict than those in dealing with conflict when it arises.

Robichaux and Clark (2006) examined the actions of critical care nurses in situations where aggressive treatment continued when the nurse believed the patient would not regain “an acceptable quality of life despite the provision of all therapies and interventions” (p. 481). Nurses ($N = 21$) described their responses to these situations in terms of (a) protecting or speaking for the patient, particularly in relation to preserving patient autonomy; (b) presenting a realistic picture to family members with regard to recovery; and (c) experiencing resignation and frustration due to feelings of moral responsibility and an inability to change how events would unfold. The nurses’ stories involved a particular type of disagreement: situations where patient treatment wishes conflicted with family or physician desire for more aggressive interventions. Other types of disagreement were not considered. In addition, the researchers examined only the perspectives of nurses recognized as “experts” by colleagues.

Clearly, there is a gap in our understanding of critical care nurses’ experiences with conflict. The purpose of this study was to explore and describe critical care nurses’ perceptions of their roles in situations of conflict between family members and health-care providers in the ICU. The definition of conflict used in this study was “a dispute, disagreement, or difference of opinion related to the management of a patient in the ICU involving more than one individual and requiring some decision or action” (Studdert et al., 2003, p. 1490). The research question was as follows: *What roles do critical care nurses assume in situations where patients are unable to express their wishes due to illness/injury, family members act as surrogate decision-makers, and family members and health-care providers disagree about treatment decisions?*

Methods

A qualitative descriptive design was used to explore the research question. In this type of study, researchers “offer a comprehensive summary of an event in the everyday terms of those events” (Sandelowski, 2000, p. 336). Approval was obtained from the University of Manitoba research ethics board. Two recruitment strategies were used: an invitation to participate in the study was e-mailed to all Manitoba members of the Canadian Association of Critical Care Nurses, with the assistance of the Association; and a recruitment notice was placed in the newsletter of the Manitoba chapter of the Association. To participate, individuals were required to have worked as a registered nurse in an ICU for a minimum of 1 year. As only three nurses volunteered to participate, permission was obtained from the research ethics board to have the College of Registered Nurses of Manitoba send invitations by regular mail to all nurses who self-reported as working in an ICU in one of two tertiary care teaching hospitals. Interested individuals contacted the principal investigator (MPE) by phone or e-mail and a meeting was arranged. All nurses gave written informed consent prior to being interviewed.

Data were collected through interviews using a semi-structured guide developed by the researchers. Open-ended questions explored participants’ experiences with situations of conflict, sense of the role of the nurse in these situations, and thoughts on addressing conflict. The nurses were asked to tell a story from their practice about a situation involving a dispute or disagreement between family members and health-care providers over the plan of care; then questions were asked about the nurse’s role in those situations. Field notes were kept, and these informed the revision or addition of questions on the interview guide. Two nurses were interviewed twice in order to clarify comments from the first interview and ten were interviewed once. Interviews ranged in length from 45 to 90 minutes, were held in a private office or at the nurse’s home, were carried out in English by the principal investigator, and were audiorecorded and transcribed. To ensure privacy, members of the research team signed a confidentiality pledge, data were stored securely, and identifying information was removed from transcripts.

Following the individual interviews, letters were sent to eight experienced critical care nurses, known to the principal investigator because of their leadership roles, inviting them to take part in a focus group to discuss insights and patterns evident in the individual interviews. It was felt that a focus group of four to six persons would yield a rich discussion (McLafferty, 2004). It proved challenging to schedule one focus group meeting, so two separate meetings were held, in private offices, with two experienced nurses present at each; these individuals also gave written

informed consent. Each group interview was carried out by the principal investigator, lasted approximately 90 minutes, and was audiorecorded and transcribed.

Data analysis and collection took place concurrently and the process fit the description of conventional content analysis provided by Hsieh and Shannon (2005). All team members were involved in this process. Team members read each transcript carefully to get a sense of the whole, and descriptive words or phrases (Benner et al., 1996) were written in the margins of the transcript to capture meaning. Meetings of research team members were held to discuss the nurses' responses to interview questions, compare phrases written in the margins of transcripts, reach agreement on categories, refine categories, and identify themes based on patterns.

Morse, Barrett, Mayan, Olson, and Spiers (2002) define "verification" as "the mechanisms used during the process of research to incrementally contribute to ensuring reliability and validity, and, thus, the rigor of a study" (p. 17). To ensure the descriptive validity or "factual accuracy" (Maxwell, 1992, p. 285) of the account presented, interviews were audiorecorded and transcribed, transcriptions were checked for accuracy, and data were managed using Ethnograph software. Data collection and analysis moved forward concurrently and interview questions evolved based on early patterns evident in nurses' responses (Morse et al., 2002). To promote interpretive validity in the analysis process, attention was paid to the "the language of the people studied" (Maxwell, 1992, p. 289). In addition, there was constant movement back and forth within transcripts and between transcripts as the team met to identify categories, patterns, and themes. The focus group interviews with experienced critical care nurses to discuss patterns and themes in the data were used as a strategy to ensure the credibility of the findings (Sandelowski, 1986).

Sample

A convenience sample of 12 critical care nurses volunteered to take part in the individual interviews. They worked in medical, surgical, or mixed ICUs. Eleven nurses worked in tertiary care, university-affiliated teaching hospitals and one worked in an ICU in a community hospital where medical residents were not present; six worked full-time and six part-time. Their mean age was 40.6 years ($n = 11$) and the mean experience was 17.2 years in nursing and 12.3 years in ICU ($n = 12$). Seven of the nurses were degree-prepared and five diploma-prepared and all but one had completed an ICU course.

Following the individual interviews, four experienced critical care nurses met with the principal investigator for a focus group interview. Their mean experience was 24.5 years in nursing and 21.75 years in crit-

ical care, with the majority of that experience in tertiary care, university-affiliated teaching hospitals. All had completed a university degree program and an ICU course.

Findings

In the individual interviews, each nurse told a story about a situation of conflict from practice. All but one of those situations was characterized by the nurse as end-of-life or involving decisions about withdrawal of treatment, with the majority involving family desiring more aggressive treatment than was recommended by the team. Most situations were characterized by differences between the family and the team, with the nurses and physicians having a strong sense of an expected downward trajectory of the illness and the family holding out hope for recovery. In three of the end-of-life situations, culture was mentioned as a factor in family decision-making. Conflict was expressed in a number of ways but could involve family behaviours perceived as demonstrating surprise at the proposed plan, suspicion of team members, confusion, and/or anger.

From these stories and from the nurses' responses to interview questions, four themes were identified. The first, *heightened stress in an already stressful place*, is a broad contextual theme, placing conflict situations in the context of the ICU. The other three relate to nurses' roles in situations of conflict. The themes are: *the patient comes first*; *building relationships, building trust*; and *supporting each other*.

Contextual Theme: Heightened Stress in an Already Stressful Place

The nurses described their work environments as stressful due to the acuity of patients' conditions, the unpredictable nature of patients' illnesses, the fear and anxiety exhibited by families, the complexity of the technology used, and the rapid pace of change. All of the nurses indicated that conflict could heighten stress in the already stressful environment of the ICU. One nurse stated, "Family conflict is one of the greatest stresses that I face when I go to work." Given nurses' proximity to the patient, the nurses identified how conflict could cause more stress for nurses than for other team members, as nurses worked with the patient and family "every hour, minute-to-minute, dealing with the conflict," whereas other team members "speak to the family, and they leave."

The responses to heightened stress in situations of conflict were varied. Some nurses indicated that it affected how they thought about their work and their patient assignment. One participant stated, "You didn't want to come to work, you did not want to be in that room, you didn't want to be the nurse there." Others noted that they or their colleagues, when assigned to the care of a patient where conflict was known

to be present, responded by “backing away” from the family. This was described as a strategy to protect the nurse from the emotional costs of the conflict. One of the ways they did this was by controlling visitation, as described in this excerpt:

[Some nurses] do back away. They try and avoid confrontations. They're not comfortable with that. They . . . minimize their contact with the family. They'll sometimes — I don't know if they mean to, but they may have the family come in and then go for break and redirect all of their questions to the [charge nurse] or even to the physicians that are on.

While “backing away” was evident in some of the situations described by nurses, and was associated with a prolonged stay and nurse-family interactions over time, the more common response in the stories told was to engage the family while proceeding with caution in terms of how they communicated with the family and what they said and did. One person described this as being “on guard” so as not to “escalate the conflict.”

The other themes relate to the roles of the critical care nurse in situations of conflict. Even in the presence of heightened stress and an environment that caused nurses to be cautious in their interactions with patients and families, it was evident in nurses' stories and comments that a great deal of work went into caring for the patient and building or restoring relationships of trust with family members in the ICU. The three themes below illustrate the roles that nurses assumed as they cared for patients, worked with families, and supported each other in situations of conflict.

The Patient Comes First

All of the nurses highlighted the role of the nurse in conflict situations of focusing first on providing safe, competent, quality care to the patient and in bringing forward knowledge about patients to other team members. Some nurses described their perspective as seeing the “big picture” or the “whole picture”:

It seems like my role as a nurse a lot of the time is to think of the big picture, because so often it feels like the attending physicians are so focused on certain medical problems — like the lungs or a certain body system — they are not seeing what I think is the whole picture.

Nurses would describe for the attending physician, many of whom spent 1 week at a time in the unit, “the whole span of events,” as “they aren't seeing . . . the months of care that have gone into taking care of a patient.” This “whole picture” perspective could also involve coming to know the patient and his/her wishes regarding treatment through advance directives or through the family, if the patient no longer could

express his/her wishes, and bringing those wishes forward to other team members. Knowledge or information about the patient and the illness trajectory could put the conflict over the treatment plan into a temporal context, shed light on its sources, or point to the need for a family meeting.

Building Relationships, Building Trust

All of the nurses stated that an essential aspect of their work in the ICU was establishing and building relationships of trust. This was particularly true in situations of conflict. Nurses saw themselves as well situated for this relationship-building role:

We have the gift, really, of time with the families and establishing a rapport . . . so we really are, I think, very key in laying the foundation for what's going to come. . . . Trust takes time, and we have the ability to give the patient and the family that.

It was acknowledged that there was much about the dynamic and uncertain ICU environment that made it challenging to nurture relationships of trust. One nurse noted that “the stakes are high” because they were frequently talking about “life and death” situations and the credibility of the nurse or the team “can slip away pretty quick.” Not only could patients’ conditions change rapidly, but shift workers came and went, new resident physicians circulated through units, and different attending physicians assumed responsibility for patient care each week. The challenges associated with the changing of attending physicians were discussed by all of the nurses and included the possibility of altered patient care plans, which could cause or increase conflict.

To build or restore relationships of trust in the presence of conflict, nurses emphasized the value of having consistent caregivers for patients, demonstrating competence and caring in working with the patient and family, communicating effectively with the family and with other team members, and collaborating with others (e.g., physicians, spiritual care providers, social workers) to support the family. The nurses stressed the importance of communication in building trust with families, while acknowledging the need for caution. This caution related to ensuring that the information provided was accurate, honest, and consistent with what had been communicated by others to promote trust in both the nurse and the team:

If there has been conflict, you become even more vigilant in making sure you don't . . . increase the conflict, potentially, or decrease the credibility of the team, thereby making the family feel less secure.

It was deemed essential to listen to family members and assess their understanding of the patient's condition. Nurses also played a role in reinforcing information provided by others.

Nurses described "planting the seeds" or "setting the stage" for families before conversations or meetings with physicians and acting as a "translator" or "interpreter" after these meetings:

A lot of times I feel like I need to help prepare the families for an in-depth discussion, or maybe a difficult discussion that I know is coming up, just to kind of plant the seeds in some families' minds. A lot of the doctors will come in and they'll have . . . what seems like a very brief discussion about a certain medical decision or medical issue. And I can see that the family is — maybe the doctor has explained it in terms that are too detailed, or maybe the family is processing too much at one time. And so I'll try to revisit that later on, explain it in maybe more lay terms for the family.

Nurses saw themselves as a bridge or link between families and physicians, highlighting their role in passing along knowledge about the family at rounds. In the presence of conflict, it became particularly important to seek clarity in the goals of care, alert physicians to family concerns, and advocate for family meetings. Another aspect of communication was interacting with other team members, including social workers, spiritual care providers, and psychiatric liaison nurses, to refer families for support and to exchange knowledge about the conflict situation.

Supporting Each Other

All of the nurses spoke of the importance of being supported in situations of conflict. The ends of the continuum in terms of support are exemplified by two comments:

You had the physicians, who were basically wanting to stay away, and they were distancing. And the nurses were left to deal with this whole scenario. There wasn't much support given to the bedside nurses by management, either. . . . It was so that people were saying, "Maybe I should phone in sick" [or] "No, I don't want to be involved with that family."

The reason why I think it was handled well was because as a nurse I felt supported. I felt supported by my colleagues, I felt supported by my unit manager, I felt supported by the physicians. And then you can manage anything, right? When you feel that you are in a team, and you are working at this together, and your goal is to take care of the patient, you all have the same goal.

When nurses did not feel supported, as in the first of the above two excerpts, it could have an effect on staff morale. Nurses stated that while

it was important for managers to be supportive and that formal debriefing sessions could prove helpful in the midst of or after a situation of conflict, it was their nursing colleagues who were the most supportive of them on a moment-to-moment basis. This support could involve listening to the nurse's concerns, offering ideas or suggestions for working with families, offering assistance with patient care, or relieving the nurse for breaks. This ongoing support was viewed as an important nursing role in situations of conflict.

Discussion

The purpose of this study was to explore and describe critical care nurses' perceptions of their roles in treatment plan conflict between family members and health-care providers in the ICU. The nurses in this study did not see their roles in the presence of family-team disagreement as being much different from the roles they assumed in other patient-care situations. What was different in situations of conflict was threefold: the perceived level of stress when conflict arose; the need to be "on guard" when providing care and communicating with family members, so as not to escalate the conflict; and an increased need for support of nurses.

When thinking about treatment plan conflict, it is important to acknowledge that nurses work the "in-betweens" in practice settings (Varcoe et al., 2004, p. 323). This is a place of opportunity and challenge for nurses (Bishop & Scudder, 1996), a place from which bridges can be built to enhance families' trust in nurses and the team, and a place of "conflict and tension" (Varcoe et al., 2004, p. 323). The nurses in this study described both building bridges and experiencing tension with conflict. It has been recognized that nurses play a significant role in the development of trusting relationships with patients and families (Liaschenko, O'Conner-Von, & Peden-McAlpine, 2009; Peter & Morgan, 2001; Rushton, Reina, & Reina, 2007; Sellman, 2006, 2007). In writing about relational ethics, Bergum (2012) indicates that relationships are "the space where health care professionals and patients make connection" (p. 127). The same can be said of relationships with families. Two themes identified by Bergum as "giving language" (p. 129) to relational ethics are mutual respect and engagement. Much of the work described by the nurses in the present study was focused on engagement, on gaining trust by being competent and caring, listening and communicating effectively, responding to and passing along family concerns, and mobilizing resources. But the nurses were cautious in their engagement and were concerned about escalating the conflict, and it is not clear how this affected their relationships.

The nurses acknowledged that some people “back away” or disengage from families in the presence of treatment plan conflict. This finding is similar to that of Badger (2005) in a study on coping strategies, where medical ICU nurses ($N = 24$) used “retreating, avoiding, and distancing behaviors” (p. 67) to cope in “complex patient care situations” (p. 66). Robichaux and Clark (2006) also describe the potential for “disengagement” from families with prolonged “suffering” (p. 487) related to conflict. Such behaviours are cause for concern, as it has been found that withdrawing from families can increase their distress (Wiegand, 2006). The notion of backing away from families draws attention to both the emotional costs of conflict for nurses and the distress nurses may experience when not connecting with families. Workman, McKeever, Harvey, and Singer (2003) report that physicians ($n = 6$) and nurses ($n = 6$) in the ICU found it “very upsetting” when there was a “severe breakdown” in relationships (p. 20). More research is needed to explore this notion of backing away from families when conflict arises, to understand its dimensions and the knowledge, skills, and support needed by nurses to engage families in challenging circumstances.

While it is not surprising that conflict situations were viewed as heightening stress in the already stressful ICU environment, the extent to which the nurses talked about it must be acknowledged. Being cautious in one’s actions and communications requires energy and attentiveness. In addition, nurses may experience moral discord in the face of disagreement over the plan of care (Badger & O’Connor, 2006). The nurses in our study expressed concern about the possible harm to patients of continued aggressive treatment, while acknowledging the angst of families in the face of the critical illness. The nurses were particularly concerned that they might contribute to patients’ suffering. Clearly, disagreement over the plan of care can have an impact on nurses’ perceptions of their work environments and their relationships. Poncet et al. (2007) found that the quality of working relationships, including the presence of conflict, was associated with severe burnout syndrome in critical care nurses ($n = 1,937$) in France. All of this underscores the importance of education regarding conflict and the importance of support from colleagues and managers in situations of conflict (Cronqvist, Lutzen, & Nystrom, 2006; Robichaux & Clark, 2006; Wall & Austin, 2008).

There are limitations to this study. A convenience sample of 12 nurses was used and the participants were experienced in nursing and in critical care. Less experienced nurses could have different perceptions of their roles in conflict. This question needs to be explored, and is especially important given the trend to hire new graduates into critical care settings (Halcomb, Salamonson, Raymond, & Knox, 2011). Only one of the participants worked in a community hospital, and that nurse’s experiences

were similar to those of the other nurses. It is acknowledged, however, that the realities of a non-teaching, community hospital may be different from those of a tertiary care teaching hospital, given that access to physicians, supports for families (e.g., psychiatric liaison nurses), and supports for nurses may be more limited and families may be interacting with fewer players, given the absence of residents. Finally, interviews were used to collect data, and the addition of observations, though difficult to arrange, could add rich data and deepen our understanding of nurses' roles in conflict.

As Fassier and Azoulay (2010) state, "because conflicts are inherent in all human activities, ICU conflicts are unavoidable" (p. 663). While it is essential that work on preventing conflict continue, it is also critical that we gain a greater understanding of the roles that critical care nurses play in working with families in the midst of conflict. The findings of this study add to our understanding of those roles, and extending this knowledge will help nurses to provide quality care to patients and families in the ICU.

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