The Conflict Pathway: a model to address conflict in paediatric practice:

BJ Teuten, E Forbat, SF Barclay

Plenary Presentation delivered at the RCPCH Annual Conference in Glasgow on 24.05.12 by Sarah Barclay, Medical Mediation Foundation - www.medicalmediationfoundation.org.uk.

“Some of you may have had personal experience of conflict with a parent or family over the treatment of their child – conflict which involves a breakdown in communication, a loss of trust, a fundamental disagreement about what is in that child’s best interests, or perhaps all three.

If you have, the chances are you will probably remember it. Conflict in paediatrics can be frightening, it is damaging to all those involved - especially the child - and it can have long-lasting impact.

Some of the clinicians we interviewed for this study described conflicts which had occurred a decade before but they said the hairs on the back of their neck stood up when they started to remember what had happened.

At the extreme end of the spectrum, such conflicts can end up in court, with judges asked to rule on apparently intractable disputes between clinicians and parents, for example, the case of Charlotte Wyatt – which many of you no doubt remember.

But where do these conflicts begin – and why?

The Conflict Pathway identifies the early warning signs for conflict in paediatrics and offers appropriate interventions at each stage of escalation

Slide 2: (Research Questions)

This was qualitative research and we began by asking two questions: One - does conflict involving treatment decisions in paediatrics follow an identifiable pathway and Two - if it does, what action might be taken and when to prevent such conflicts escalating?

I’d like to set the scene with two quotes from our research – the first is from a consultant paediatrician, talking about how clinicians approach discussions with parents when difficult decisions need to be made.

Slide 3

“Our whole approach is to steer people towards the direction we want, without even realising we’re doing it.”

The second quote is from a mother who had concerns about her newborn son and was trying to communicate these concerns to the health professionals involved.
Slide 4

“Every time I wanted someone to listen to me I felt as if I had to go into battle, gird up my loins, put my armour on, get my spear out and say, ‘listen to me, I think I've got something to say here’.”

And she was a GP!

In their different ways, both the consultant and the mother are talking about communication – the thing you hardly think about when it’s effective but which is one of the key triggers for conflict in paediatrics when, for whatever reason, it goes wrong. And then it seems to take centre stage.

Slide 5 (methodology)

The Conflict Pathway is adapted from a conflict escalation model published by a German researcher, Friederich Glasl in the 1990s. It offered a series of interventions for resolving conflict and we wanted to investigate its potential relevance to conflict resolution in paediatrics.

We were given NHS Research Ethics approval for a pilot study which was supported by the Department of Health £30 million fund. Using qualitative research methods, we conducted a series of multi-disciplinary interviews with clinicians, parents, lawyers, clinical ethicists, hospital chaplains and representatives from other faiths. All had personal experience of conflict over treatment decisions – from the apparently minor to those at the extreme end of the scale involving verbal and physical violence.

We also ran a series of Conflict Management workshops in hospitals and hospices in which we asked participants to identify triggers for conflict between parents and health professionals.

Interviews were transcribed, anonymised and analysed together with the information gathered from workshop participants.

Slide 6:

This analysis revealed a clear pattern of escalation. We have used traffic lights to illustrate this - with each stage containing clearly identifiable warning signs.

Slide 7: Green Zone:

In the green zone, the warning signs are subtle:

1. Insensitive use of language: Our analysis suggests that the wrong word at the wrong time; for example, a clinician describing a child as “moribund” may never be forgotten – or forgiven - by families.

One senior consultant told us that something as apparently simple as: “getting a child’s name wrong, or getting a parent’s first name wrong” could be enough to trigger conflict at this level.
2. Conflicting messages: different members of a clinical team may give a family mixed messages about their child’s prognosis or treatment. This may be for good clinical reasons or because there is a difference of view among team members but from a parent’s perspective, apparently conflicting messages can affect confidence in those looking after their child.

3. Poor management of care:
Perceived or genuine errors in the treatment or management of a child - currently or in the past can also lead to increased parental anxiety and mistrust.

4. History of unresolved conflict:
And in this Green Zone – the first step of the conflict pathway, so to speak, what our interviews also revealed was that if a family OR members of the clinical team have previous experience of conflict over treatment decisions, their “tolerance” levels for disagreement were lowered and the likelihood of conflict escalating, increased.

Slide 8: Amber Zone
In the amber zone, conflict starts to escalate more significantly.

1. Repetitive arguments lead to entrenchment:
Conversations between clinicians and parents feel as if they are going round in circles - with both family and clinicians repeating themselves because they believe that what they are trying to say is not being heard or acknowledged. As each family member or clinician defends their position, communication becomes entrenched.

2. Avoidance
At this point both parents and health professionals often start adopting “avoidance” tactics – either physically avoiding each other or – if they DO meet - avoiding discussing the issues underpinning their disagreement.

3. Micro-managing:
As trust breaks down, families start to monitor and question every aspect of their child’s care and treatment, taking up increasing amounts of staff time. Clinicians sometimes call this “micro-managing” but from a parent’s perspective you’re doing what any parent would do - making sure your child is getting the best possible care.
4. **Faction Building:**

If parents and staff feel alienated and misunderstood they turn to others to try and ‘drum up’ support for their position – with the result that growing numbers of people are drawn into a conflict which by this stage, is escalating rapidly.

**Slide 9: Red Zone**

1. **Child no longer the focus:**

In the Red Zone, interviewees used terms such as “win” and “lose” to describe what they wanted to happen in order to resolve conflict at this extreme end of the scale.

There was also a recognition, that the interests of the child could become marginalised as conflict escalated.

2. **Conflict takes on life of its own**

At this point, a number of clinicians described what they called a snowball moment – and what they meant by that was that it was a moment at which they were losing control - as if the conflict had taken on a life of its own.

3. **Verbal and physical threats**

There may be verbal and even physical threats at this stage of conflict escalation. A parent may threaten to go to the media or report a doctor to the GMC. A clinician may tell a parent that if they don’t agree with them, they will have no option but to seek resolution through the courts. Or a family may warn a doctor to be careful when they leave the hospital because they’re being watched.

4. **Attack:**

At the extreme end of the conflict pathway, threats turn into physical or verbal attack. A family may report a doctor to the press or GMC. And some of our interviewees also described being physically assaulted by family members. Doctors may bring in lawyers, the police or make a referral to social services.

Our analysis suggests that if the *significance* of early warning signs in the Green Zone is missed or ignored, then conflict will escalate, moving from green, to amber, to red.

So what can be done – and when - to try and prevent this happening?

We showed Glasl’s conflict escalation model to a selected group of interviewees who had been involved in conflicts at the extreme end of the spectrum and asked them to tell us which of his suggested interventions they considered would be most appropriate to resolving conflicts in paediatrics. Based on these discussions, we suggest a series of actions for each stage of the Conflict Pathway.
**Slide 10:** Green Zone:

**Actions:**

In the green zone, a team-based approach to recognising the warning signs, is critical. A pro-active strategy which involves spending time listening to the family and understanding the underlying cause of their concerns, may be enough to de-escalate and resolve conflict without having to seek help elsewhere.

**Slide 11:** Amber zone:

**Actions**

If the conflict has progressed into the amber zone, it is likely to need help from others outside the team to resolve it, for example a matron, head of nursing or by seeking advice from PALS, or the clinical governance team. Parents should be given the option of seeking an independent second opinion at this stage. And all interviewees shown the GLASL model suggested that independent, external mediation would help at this level.

**Slide 12:** Red Zone:

**Actions**

By the time the conflict has entered the red zone, with threats of or actual verbal and physical violence, a hospital’s own Conflict management and security policies should be invoked. Legal advice should also be sought and there may be police involvement if physical assaults have taken place. External mediation may continue to be used but alongside some or all of these other interventions.

No health professional wants to find themselves moving towards an apparently intractable conflict with a family. But some of you may have found yourselves in just this position - wondering how it happened - and why.

**Slide 13 (Conclusions)**

Our pilot study has shown:

- that there is an identifiable pattern of escalation to conflicts in paediatrics and
- that recognition and Action in the Green Zone is critical to preventing conflict escalating.

Further work will now be undertaken to pilot and evaluate the interventions within each zone with the aim of developing a toolkit for health professionals to use to help identify, manage and above all, to avoid, future conflicts.

I would like to thank all those who agreed to be interviewed for this project. We can’t tell you their names but we hope that for some, it has given them a voice which may not previously have been heard. Thank you.

*Copyright BJ Teuten & SF Barclay/Medical Mediation Foundation 2012*