Conversations for Kindness

Kindness in the face of conflict – How do clinicians manage to maintain compassion when their clinical, ethical and moral judgement is being contested at the highest level?

16 March 2023

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Contents

Context - Conversations for Kindness

About the movement

Conversations for Kindness is a monthly virtual meeting that was set up in the summer of 2020 by eight colleagues and friends working in healthcare across Sweden, the UK and the USA: Bob Klaber, Dominique Allwood, Maureen Bisognano, Goran Henriks, Suzie Bailey, Anette Nilsson, Gabby Matthews and James Mountford. The purpose of the meeting was to have some time together to continue some initial conversations around kindness, and its role at the 'business end' of healthcare, and to plan interactive workshops on this topic.

Conversations for Kindness

- Monthly Zoom call on the third Thursday of every month (6-7pm GMT)
- A focus on listening, learning, thinking differently and mobilising for action
- An open culture of sharing of resources, energy and ideas

If you would like to join the conversation for kindness, please complete this contact form

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An overview of this month's Conversation

Conversation overview: As clinicians working in a fast-moving, high-pressure and high-stakes environment, paediatric intensivists are no strangers to communicating with families under challenging circumstances. But when conflicts arise regarding what course of action is in a child's best interest, those challenges are intensified. In rare cases, the courts are requested to intervene, literally pitting the family against the clinical team. How do clinicians manage to maintain compassion when their clinical, ethical and moral judgement is being contested at the highest level? How can we maintain kindness in the face of conflict?

Our speakers: This month we were joined by three amazing paediatric intensivists – **Miriam Fine Goulden**, **Marilyn McDougall** and **Shelley Riphagen** who reflected on their professional and personal experiences.

To note: Unfortunately, the recording for this event is not available. This insights pack summarises the session.

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Joining from across the world...

We had more than **60** Kindness in Healthcare community members come together from all over the world for this Conversation for Kindness. A warm welcome to those who joined us for the first time!

A few of the hellos from around the world...

Hello! Also joining from Birmingham for the first time although have been meaning to join for well over a year!

Hi, I look forward to this amazing meeting so much!!

Hello everyone. A rainy day in the Peak District

Hi, I'm a first timer from Nottingham.

Good morning from Melbourne. Great to be here.

Hi all, joining from south west London

Hi - I am a first-timer from Monterey California.

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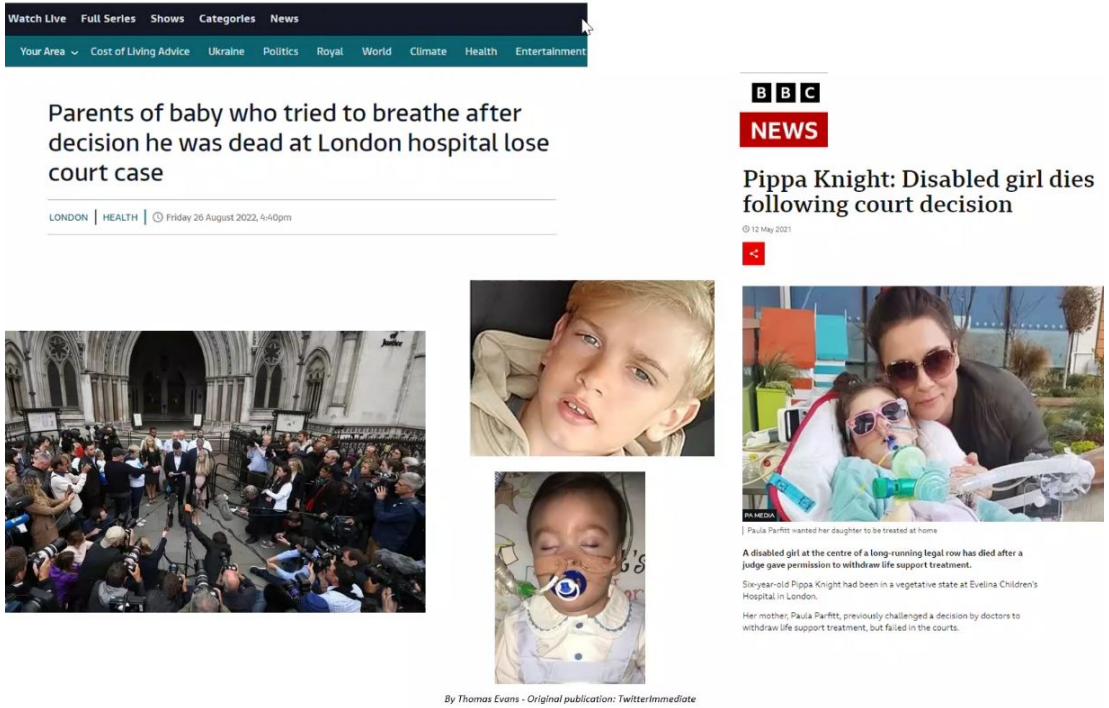
Opening perspectives from Miriam Fine-Goulden

Miriam Fine-Goulden started by outlining the work of the paediatric intensive care unit at Evelina Children's Hospital, which provides specialist children's care in London. Although it is relatively rare for the courts to intervene to determine the best interests of a critically ill child, in recent times there have been several high-profile cases in the media, which Miriam, Marilyn, Shelley and their teams at Evelina Children's Hospital have become involved in.



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Reflections from Marilyn McDougall

Marilyn McDougall shared her reflections about a child who had a series of viral infections that led to devastating disabilities over the course of two years before her eventual death. The treatment in response to these infections was increasingly difficult and complex – and increasingly unsuccessful, with the child's ability to fully recover eroded after each episode. The child remained unstable, the prognosis grew increasingly poor and the child became terminally ill.

There were complicating factors in the child's care during her time at the hospital – the child's mum was a single mum who had a very strong ability to cope with the challenges but refused to allow anything negative to be said about the child's prognosis or treatment prospects. It led to difficulties with communication, and lines of communication broke down when advice on prognosis and treatment were not accepted or able to be discussed openly. Eventually, the courts became involved to intervene to allow the child to be treated in accordance with what was deemed to be in her best interest.

Reflections from Marilyn McDougall, continued

Of the court process, Marilyn described how the child's best interest was discussed within a holistic framework. In email communication following this meeting, she wrote: "*I was struck by how carefully the judge took into account the parent's wishes and tried to understand what the child would have wanted, not just what the medical professionals put forward. In the court judgement he wrote about 'love that she could receive and give balanced with suffering that she would experience'.*"

Marilyn talked of some of the difficulties of communication - but also of the ability for kindness to continue to be present in communication despite the conflicts between parties. All involved in the child's care wanted the best for the child, but were coming to the discussion from very different expectations, world views, and knowledge bases – there were many different relationships to manage within the care approach. Marilyn identified that the multi disciplinary team was of great support to each other, with regular meetings with each other, away from the bedside. This led to a united front when dealing directly with the family members. Of the family, she talked of "holding their wishes in her hand and heart" in all her communications and interactions within the team of people caring for this child.

Reflections from Shelley Riphagen

Shelley Riphagen then shared her reflections about caring for another child, a baby boy who had a cardiac respiratory arrest at home and required prolonged CPR before he could be transported to hospital. He was admitted to ICU where numerous specialised tests were done. When these tests indicated serious brain damage sustained from the cardiac arrest with no obvious response to any interaction or intervention, the next step in the baby's care was to conduct brainstem testing. Shelley recalled sitting down with the parents prior to the testing, in an effort to help them understand that if there were no brainstem reflexes, then there would be no further treatment available and the baby would not be able to recover from his injuries.

The father made it very clear that no matter what the testing showed, that they believed that God would make their baby boy well and they would not accept the outcome of the tests. Shelley knew at this stage that this would end up in court and the team was very careful to complete all required tests and cover all bases. The brain stem tests were repeated by external colleagues and the findings confirmed the baby was brain dead.

Reflections from Shelley Riphagen (continued)

The family did not consent to life support being withdrawn, and the medical team took the case to court to try to seek resolution and allow the removal of breathing support. In the 21 days between declaration of brain death and ensuing court proceedings, the baby recovered some breathing effort (though abnormal and not sustainable) with no other signs of any other recovery. The parents were ecstatic, and felt that God had answered their wishes, sending them a sign for their prayers. However, the specialist opinion remained consistent, that the baby would not recover the ability to breathe and from a medical standpoint the best course of action was to withdraw life support. Eventually, the medical team was given court approval to turn off ventilation support.

Shelley described that despite the difficult situation for all involved in the baby's care, the parents remained calm and dignified throughout, and relationships remained respectful and supportive on both sides, despite the outcome. Shelley identified key learning points – that although there were strong religious beliefs that clashed with medical evidence, everyone involved wanted what was right for the baby. She talked about the moral and ethical conflict the members of the multi-disciplinary team experienced as they continued to care for the baby while waiting for the court orders.

Breakout group discussion

We were asked to reflect on and discuss this question in breakout groups
What strategies have others developed to maintain kindness under conflict? Including in situations where the conflict includes personal attacks or slights towards one or both parties? How do we maintain our kindness towards our fellow humans in times of conflict?

We heard back from some of the groups about what they had discussed…

One group shared how they discussed the importance of kindness in conflict and how crucial it is to remain kind for the sake of the relationships needed to achieve the best outcomes for the child/patient

Another group discussed Len Berry's work on kindness in cancer care and how crucial these strategies are in times of conflict between parties (see next page).

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Breakout group discussion

Shelley Riphagen recounted how her group talked about how self-kindness is key as well – that we need to remember to be kind to ourselves in these situations so that we may be in a position to give outwards to others.

Miriam Fine-Goulden also reminded us that often ‘difficult behaviours come from difficult feelings’.

Jason Nichol highlighted how ‘clear is kind’, as well as the importance of ‘Listening to understand not listening to respond’.

Christina Rennie shared her thoughts on how ‘ listening is the starting point for everything’.

Maureen Bisognano shared with us “you can’t give what you don’t have”, a reminder to be kind to ourselves too.

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Reflections from the chat

Participants shared many insightful thoughts, learnings and reflections during the session. Just a few have been captured:

JM

MOUNTFORD, James (ROYAL FREE LONDON NHS FOUNDATION TRUST) 16/03 19:00

Great session. A takeaway insight for me : when the temperature and stakes rise, have a conscious thought to be kinder

Thank you to all

❤️ 6

RC

Rachel Crook (RRE) MPFT 16/03 18:54

Thanks Jason Nicol (NHS Grampian), my takeaway is also your 'Clear is kind' ❤️

❤️ 5

Listening to understand not listening to respond.

❤️ 1

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More reflections from the chat

HH

HUGHES, Henrietta (LIBERTY BRIDGE ROAD PRACTICE) 16/03 18:58

When I think about difficult patients, are they difficult, am I difficult, is the topic difficult to hear - remembering that the families at Mid Staffs were labelled as difficult

💔 6 👍 3

EA

Audet, Emily 16/03 18:56

We also discussed that behind strong emotion - including anger - there is deep caring, always important to acknowledge and recognize this even if you are in a position of disagreement

💔 3 👍 1

BK

KLABER, Bob (IMPERIAL COLLEGE HEALTHCARE NHS TRUST) 16/03 18:25

Thank you so so much Miriam, Marilyn & Shelley for your extraordinary thoughtfulness in sharing these extremely moving stories. I am looking forward to the discussions but you have so clearly demonstrated and role modelled how one can approach the most difficult of conflicts with such kindness.

💔 8

Further resources

Participants shared recommended reading, and resources in the chat box

- Malcolm Gladwell's **book** 'Talking to Strangers: What We Should Know about the People We Don't Know' was recommended, as an insight into how and why interactions with strangers can be misread.
- The **book** Difficult Conversations : How to Discuss What Matters Most was also recommended to help turn difficult conversations into positive, problem-solving experiences.
- On **Twitter**, you can check out #spacesforlistening for more about listening to understand not listening to respond.
- The 'Art of Communication' course was also highlighted as a tool to help make sense of the emotional/logic interface (especially in the highest stakes interactions).

Acknowledgements

This insights pack has been co-produced by
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For all enquiries please contact us via the Kindness in Healthcare website.

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