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NAME	Tatiane Ferreira Mainart
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The use of dispute resolution tools and protocols in conflict situations regarding palliative care: An analysis of the attitudes of healthcare professionals in Ireland

The use of dispute resolution tools and protocols in conflict situations regarding palliative care: An analysis of the attitudes of healthcare professionals in Ireland

By

TATIANE FERREIRA MAINART

Student Registration No: 51694051

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> *I may not have been able to do the best, but I fought for the best to be done. I am not what I should be but thank God I am not what I was before.* (Martin Luther King)

Abstract

Conflict resolution strategies are an essential tool to resolve conflict when there are differences of opinion between individuals. Palliative care is an evolving modality of end-of-life care, based on a model of complete, active and holistic care provided to patients with advanced and terminal illnesses and their families, legitimised by the patient's right to die with dignity. The aim of this investigation is to explore how dispute resolution tools and protocols are used by healthcare professionals in conflict situations with patients and family members in relation to terminal illness.

To achieve this objective, a survey was carried out to analyse the attitudes of healthcare professionals in Ireland towards palliative care, and to identify possible barriers to such healthcare. A survey was devised using Google Forms with twenty-five questions, both closed and open, to gather all the relevant data for this research. This study has used a combination of methods, both qualitative and quantitative, as well as descriptive and transversal techniques and procedures. Through an analysis of all the data collected, it was observed there were misunderstandings about how to address a conflict situation due to the doubts, fears and lack of knowledge of the participants in their professional experiences.

As a result, it was identified that most participants believe that when conflict arises it can be caused by a lack of knowledge regarding conflict resolution leading to communication failure. A greater understanding on the part of individuals on how to improve communication and better express themselves would help to improve the results in a conflict resolution situation.

Keywords: conflict, palliative care, end-of-life care

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Acronyms

WHO   World Health Organization

PCCFSG   Palliative Care Competence Framework Steering Group

WHPCA   Worldwide Hospice Palliative Care Alliance

ICESCR   International Covenant on Economic Social and Cultural Rights

PCEG   Palliative Care Expert Group

RRDD   Reporter on the Right to Die with Dignity

PCS   Palliative Care Service

HSE   Health Service Executive

Introduction

The right to live or the right to die has been a controversial subject of broad polemic debate, causing us to challenge ethical, bioethical, religious and cultural views. However, all of this has created conflict around the treatment of patients regarding the terminal phase and palliative care. Negotiation and mediation processes are the basis for resolving disputes and differences of opinions in order to facilitate the achievement of goals by agreement where there are mutual interests, whether similar or opposed. According to Isenhart and Spangle (2000, p. 45), more than a state of mind, it means a choice of strategies to manage problems and situations.

In the literature reviewed, the form of intervention offered to patients with advanced and terminal diseases has become the subject of intense debate. This thesis will review the relevant literature and explore end-of-life treatment, with a focus on palliative care, a model that is spreading worldwide. It analyses some of the essential issues involved in this practice that tend to cause conflict. It accurately illustrates some complexities and problems in the area of pain management regarding the significance of autonomy, deemed one of the foundations of successful end-of-life medical care. Research suggests that patients who receive palliative care tend to survive better, rather than if the focus was primarily on preventing the disease. Although prolonging life is not a point of reference, taking care of the patient, and not just treating the disease, is a holistic view.

The current study is justified due to the necessity to investigate whether dispute resolution tools and protocols are used by healthcare professionals in conflicts involving patients and family members related to palliative care—a way of caring for people with potentially fatal diseases with a focus on the quality of life.

One of the most important steps in a study such as this is to identify and answer the research questions, as it is common to lose one's way during the process of research if this is not done. Defining the research questions at the beginning of the study is essential to guide the researcher throughout the

work, helping in the generation of goals and objectives, as well as highlighting the purpose of the study to the researcher and future readers (Saunders et al., 2006).

This study aims to investigate how conflict resolution tools and protocols are used by healthcare professionals in conflicts with patients and family members related to palliative care, in the case of terminal illness. How do healthcare professionals deal with a conflict situation, caused by the need for decision-making regarding the use and acceptance of palliative care. The questions are as follows:

1. What is the attitude of healthcare professionals in relation to this type of conflict?

2. How does the level of knowledge of professionals in conflict resolution help them to deal with this situation?

3. What are the causes of these conflicts?

4. What are the impacts and consequences of these conflicts and how are they managed?

5. What are the challenges to overcoming these conflicts?

6. What can be done to improve the management of these conflicts?

The objectives proposed for this study are as follows:

(i) Analyse conflicts generated in a healthcare setting, in relation to palliative care, through the point of view of a healthcare professional

(ii) Identify the factors that trigger these conflicts

(iii) Analyse the impacts and consequences of these conflicts

(iv) Identify the challenges faced by these professionals when dealing with such conflicts

(v) Identify ways of improving the management of these conflicts

In Chapter 1 a detailed literature review is discussed in order to assess what is conflict resolution, what are the tools and protocols used in its management, and what methods have been recommended to improve its efficacy. I shall also explore what exactly is palliative care and discuss its history and development throughout the ages. In Chapter 2 the research methodology is outlined. In Chapter 3

the data obtained from the investigation is presented. The purpose of this was to identify whether healthcare professionals are prepared to deal with these types of conflicts, and to ascertain their level of knowledge as regards the subject. Information about their professional experiences, which is presented in Chapter 4, was obtained from a questionnaire made on a Google research platform.

The World Health Organization includes much detail on the subject but, to summarise, palliative care improves the quality of life of patients, and their families, who are confronted by problems related to life-threatening illness (Palliative Care, 2018). This study will explore the situation regarding terminal illness through an analysis of the attitudes of healthcare professionals in Ireland, and will try to identify how strategies can be used to overcome possible challenges and existing barriers to care.

Conflict occurs because choices need to be made and decisions taken where personal interests are involved, the interests of one or more people with different thoughts and opinions. We can experience conflict on a daily basis, in many sectors of our lives, such as in the family, workplace, society, etc. and it should not be the cause of attack. Rather, conflict can be resolved by reaching a favourable agreement or decision that pleases all parties concerned, in the fairest way possible. Putting yourself in the other person's shoes would be a starting point for managing conflict situations and creating empathy. According to Whitford (2016), occasionally negotiation, in principle, fails to resolve the dispute or prevent conflict, even when one of the parties has the best intentions and excellent negotiation skills. In addition to this argument, concerning the strategies used, Fisher and Uri (1991) have created a middle ground, where win-win is the best way to resolve a conflict situation. This is through principled negotiation where "Focus on interests and not on positions" is one of the key points in dealing with a conflict. There is a difference between interests and positions where some issues tend to be exclusive to certain parties. Things become complicated when points of view strongly contradict the claims of other parties involved, creating a problematic situation where agreement between the parties is almost impossible.

Nowadays, the pros and cons of end-of-life care have been greatly debated, generating doubts and uncertainties about what to do and which decisions to make at this time. One of the central debates is based on the question of life and death, whether to prolong life or not, with respect to quality and dignity at the end of life. This controversial and delicate issue involves the use of palliative care and causes many implications, both directly and indirectly, for the patient, family and healthcare professionals involved. Thus, in recent years, the debate around what signifies a dignified death, appropriate for a human being, has been gaining much ground both in the legal sphere and in medicine. The topic deserves special attention because it is related to conflict about fundamental human rights, which makes the debate on the subject more controversial and complicated.

Palliative care is an emerging end-of-life modality, built on a model of the total, active and comprehensive care offered to patients with advanced and terminal disease, and their family, legitimised by the patient's right to die with dignity. Palliative medicine provides many ways of achieving reasonable control over the debilitating symptoms of terminal patients, as well as offering support to their families when reviewing the different causes of suffering, such as the process of medical decision-making in the care of the dying. It is necessary to search for ways to reduce suffering and to improve the quality of life that remains, instead of focusing on how to find a cure (Astudillo et al., 1993).

This is a discussion that has permeated human history because it is such a complex and delicate subject. This research paper is an opportunity to investigate whether conflict resolution tools and protocols have been used by healthcare professionals to encourage patients or family members to consider palliative care in terminal cases in Ireland. As a result, this paper will encourage the researcher and future readers to critically evaluate the use of palliative care and how to manage potential conflict situations.

"Although scientific advances in medicine have hijacked death in the hospital, almost as a forbidden event, it needs to be developed for humanity. We are entitled to a dignified death as much as we are entitled to a dignified life."- (Arantes, 2019, p. 190)

Chapter 1 – Review of the Literature

1.1 – Conflict

The entire process of human interaction is subject to conflict; this has been going on since the beginning of time, in different cultures and with different origins. Conflict is generated by disagreements that might include a multitude of factors and interests. Most of the time, it involves power struggles caused by differing opinions. Conflict could be described as a process incorporating claims and demands, involving at least two parties with different points of view, and arising when there is an incompatibility of wishes presented by these parties. Pope (2013) states that conflicts frequently occur in healthcare units. Moreover, how to use the dispute resolution mechanism in intractable medical conflicts is considered one of the most controversial issues in the healthcare environment.

According to Stewart (1998, p. 11), conflicts are initiated due to many factors, whether between individuals or groups of people, and usually arise from causes that can be analysed as structural, ideological, behavioural and emotional. Conflicts and disputes can occur between two or more parties in a relationship with opposing principles, ideas, etc.

A conflict can be generated for several reasons (Turkalj, 2008): *relationship conflict* is characterised by personal issues and can start due to a particular way of thinking, acting, etc.; *conflict of values* arises when people or groups have diverging points of view, with different ethics and morals; in a *conflict of interests* there is usually a strong desire for particular results, which diverges from the passions and interests of the other group or person.

Glasl (1999) says that conflicts are born out of differences but not all differences create conflicts. The dispute arises only when some essential elements appear: (i) we predict many things differently and our understanding, ideas and thoughts differ fundamentally; (ii) our emotions and feelings change; and (iii) our desires pull us in different directions.

"So, the existence of differences is not the problem, as differences in themselves do not constitute conflict between people. What is important is how people handle their differences and how they experience them." (Glasl, 1999, p. 17)

Moreover, conflict is natural in all types of relationships. The big challenge is how to manage it. Poorly managed or unresolved conflict can result in bitter relations if one party vehemently disagrees with the other, and takes it personally, as if the other party were deliberately attacking their beliefs and views on the matter rather than simply the situation. Health problems can occur when conflict arises and is not appropriately treated, with stress causing physical and mental damage (Cahn, 2007).

Below are some definitions of conflict, according to various authors:

"Conflict is complicated, especially when it involves deciding between two choices; conflict consists of the way decisions are made, the way we talk to each other" (Isenhart & Spangle, 2000, p. 3).

"There are many definitions of conflict, which would define as a real or apparent incompatibility of needs and interests between the parties" (Bush & Folger, 1994, p. 54, quoted in Isenhart & Spangle, 2000, p. 3).

"When two people cannot agree on the actions that one person takes or does not want the other to take" (Edelman & Crain, 1993, p. 18, quoted in Isenhart & Spangle, 2000, p. 3).

"Conflict means perceived divergence of interests or belief that the parties' current aspirations cannot be achieved simultaneously" (Rubin, Pruitt, & Kim, 1994, p. 5, quoted in Isenhart & Spangle, 2000, p. 3).

"The conflict involves a struggle for values and demands to frighten status, power and resources in which the opponent's goal is to neutralize, injure or eliminate rivals" (Corse, 1967, p. 8, quoted in Isenhart & Spangle, 2000, p. 3).

"Conflict is an intermediate stage in a spectrum of struggles that increases and becomes more destructive: differences, disagreement, dispute conflict, campaign, litigation and fight or war" (Keltner, 1987, pp. 1–2, quoted in Isenhart & Spangle, 2000, p. 3).

"Conflict is an express struggle between at least two interdependent parties who perceive incompatible goals, frightening" (Hocker & Wilmot, 1991, p. 23, quoted in Isenhart & Spangle, 2000, p. 3).

"Because of the complexity of their definitions, they tend to focus on a variety of many factors, such as the circumstances that lead to conflict or the disputing behaviours that produce perceptions of disagreement" (Cupach & Canary, 1997, quoted in Isenhart & Spangle, 2000, p. 2).

Conflict resolution, as a broad concept, can be any sharp reduction in social conflict and, more specifically, the result of a conscious solution to the issues in question. Due to its broad definition, it can arise through self-conscious efforts or other means, such as environmental changes, due to the influence of third parties involved. To be more specific, conflict resolution is the process of resolving issues consciously between opposing parties (Schellenberg, 1996, p. 9).

Most of the time, conflict arises due to a failure in the management of antagonistic relationships. The great challenge in managing conflict is, in part, to shed light on styles and methods of communication in order to overcome differences, along with an effort to minimise the damaging aspect of the struggle (Jeong, 2010).

A variety of conflict situations have traditionally been caused by competing for resources or other interests, fuelled by differences in values. Anger and hatred can be amplified, degrading verbal communication as well as nonverbal behaviour (Jeong, 2010). The psychological damage of the individual created by the conflict deepens as the struggle progresses. In general, conflict psychology directs individuals' attitudes and behaviour (Jeong, 2010).

According to Jeong (2010), not every contentious issue is subject to compromise, especially concerning fundamental rights related to an individual's freedom and autonomy, associated with control of one's own life. Regarding the conflict of values surrounding the abortion law and euthanasia, the hierarchy of the Catholic Church has always been attacked by the beliefs of the individual.

Conflict within the family, and between the patient's family members and healthcare professionals, very often occurs in a healthcare setting and palliative care can be particularly vulnerable to this. Back and Arnold (2005), in a conflict study carried out in intensive care units, found that episodes of conflict, which included disagreements within the core family or between the patient's family and the team of healthcare professionals, occurred in 78% of the 102 cases examined in a survey by the New York Department of Psychiatry and Behavioural Sciences, USA. Strawbridge and Wallhagen (1991) demonstrated that conflict within the family occurred in 24% of cases, mainly during decisions to suspend treatment. Lichtenthal and Kissane (2008) noted that the amount of time doctors spend managing conflict is significant and, in most cases, unreported.

In the 1999 study by Kissane et al. (quoted in Lichtental & Kissane, 2008), the presence of hostility was found where families were at greater risk of continuous conflict. High rates of hatred among the children of patients (26%) were found when compared to spouses (13%) and patients (9%). In a study on adult children carers, Strawbridge and Wallhagen (1991) observed that 40% of caregivers had a severe problem with another family member and that sibling conflict was incredibly common.

This kind of dispute over the futility of ongoing medical care is frequently encountered when the parties involved disagree on whether a current medical intervention is clinically ethically appropriate. Such disputes often occur about healthcare facilities, which are considered to be one of the most controversial healthcare issues. This thesis will describe and evaluate the mechanism that healthcare professionals can use to resolve this type of dispute when patients are often unable to make their own decisions (Pope, 2013).

Most patients prioritise their quality of life, not the quantity of life. Most patients do not want to continue life-support treatment when they are in critical health. If these patients documented their treatment preferences, most of this type of dispute could be avoided. Most patients still do not make known their desires before they lose the capacity to do so (Pope, 2013).

Through communication and mediation, it is possible to reach a consensus, achieved in more than 95% of litigation cases. Only about 5% of disputes remain unresolved (Pope, 2013).

1.2 – Methods for Dealing with Conflict

1.2.1 Negotiation

The conflict resolution strategy can be used to help, support and actively encourage people to seek permanent solutions, if at all possible, to resolve their disputes (Stewart, 1998, p. 12). Negotiation, defined as the process by which a joint decision is made by two or more parties, is an important tool to resolve conflict situations between individuals (Pruitt, 1981, p. 1 in Borisoff, 1998).

Thus, in order to reach a solution to the conflict, favourable for all those involved, a negotiation process must be initiated. Negotiating ensures the achievement of goals by consensus when there are common interests, whether related or diverse, in a conflict situation. One of the failures attributed to negotiation, according to Jeong (2010), is the dispute of wills, which leads to a refusal to make necessary concessions required to reach an agreement.

For Isenhart and Spangle negotiation is more than a state of mind; it is the choice of strategies needed to manage problems and challenging situations (2000, p. 45). Negotiation aims at redressing the balance between the parties involved so that the organisational objectives and their success are guaranteed. Thus, the negotiation process also contributes to sustaining relationships, which facilitates results. Using negotiation skills is an essential competence for conflict resolution, as it seeks to minimise differences by providing for the proper management of these disputes.

In the past, the practice of negotiation was based on a different premise, where one party had to win and the other to lose. This theory fell apart when Fisher and Ury (1997) introduced the concept that both sides could win. The principal objective of negotiation is to find the best solution to the problem. Both parties involved have the same thought—victory. In other words, each side takes care of its own interests to the detriment of the other, without wishing to understand the needs and concerns of the

other party. It is like an arm-wrestling game (Fisher & Uri, 1997). Most people engage in positional bargaining, taking a position and then arguing for it, without analysing the consequences of such a position. The positional bargain, according to Fisher and Uri, involves a game using a 'hard' or 'soft' approach. Both fail to reach a wise agreement. "Any method of negotiation can be judged relatively by three criteria: it must produce a wise deal if a deal is possible; it must be efficient; it must improve or at least not damage the relationship between the parties." (Fisher & Uri, 1997, p. 7)

1.2.2 Positional bargaining: The hard or soft approach

For Fisher and Uri (1997), both approaches to negotiation, hard or soft, can bring about an unfair result. When you try to negotiate by digging in your heels, you will pay less attention to common interests. This becomes increasingly difficult when the parties try to discuss the situation, as they are not in a real relationship. On the other hand, in a soft approach, the behaviour is the opposite; you are willing to resolve the conflict as quickly as possible by making offers and not taking a firm position as regards negotiation.

The likely outcome in a negotiation when the parties adopt one of these approaches would be:

- Hard and soft: hard victory because the soft party gave in to pressure

- Hard and hard: no agreement is reached, nobody wins, the impasse remains

- Soft and soft: agreement is reached too quickly

In the above cases, people tend to develop individual styles of behaviour for conflict resolution. As Isenhart and Spangle (2000) and Kilmann (2008) have shown, various factors can influence the choice of using one of these approaches. The person's behaviour can be defined as a method of dealing with conflict to satisfy his or her concerns or that of the other person invloved.

In an agreement proposal, a positional negotiation arises with people making offers and counteroffers. In this initial stage, a pre-negotiation, people are in a dilemma. They see two ways to negotiate: challenging or easy. The soft negotiator wants to avoid personal conflict, preferring to see the other

party as a friend, to trust them, and give in if necessary to avoid confrontation. As a result of this, they make concessions promptly in order to reach an agreement (Fisher & Uri, 1997). They want an amicable resolution but in the process they often end up being exploited and feeling bitter. The soft approach can be defined as having too much focus on the integrative aspect and less emphasis on the distributive one.

The tough negotiator sees any situation in terms of a dispute of will in which the side that takes the most extreme position and resists does better. Their aim is to win; despite this, negotiation often ends up producing an equally hard response from the other party that drains the negotiator and his resources and ultimately damages the relationship with the opposing side.

1.2.3 The third element: negotiation based on principles

To negotiate in a way that is neither hard nor soft is a new concept. This new principle negotiation method is an approach developed by Fisher and Uri in the Harvard Negotiation Project to decide issues based on their merits, rather than through a negotiation process focused on what each party says they will do or not do.

They achieved acceptable solutions by determining which of the negotiator's needs were fixed and which were flexible. This approach suggests that mutual gains should be sought whenever possible and that results should be based on fair standards, regardless of the will of either party. This principle-based negotiation method does not employ tricks or posturing. It clearly points out those individuals who attempt to take advantage of another's sense of justice. Also described as a 'win–lose' trade, this tactic may not be suitable for all businesses, but it can be handy when used correctly.

The principles of the negotiation method developed by Fisher and Uri (1997) are: separate people from the problem; focus on interests, not positions; invent options for mutual gain; and insist on using objective criteria. Here, Fisher and Uri present a new concept of negotiation based on the middle ground between positional negotiation and the hard and soft approach. With an emphasis on conflict

management, it highlights the emotional aspects of the difficulty and thus directs the behaviour of others into putting themselves in the other person's shoes (Whitford, 2016). Occasionally, principle negotiations fail to resolve the dispute or prevent conflict, even when one of the parties has the best intentions and excellent negotiating skills.

1.3 – Mediation

Mediation is known to be one of the main critical dispute resolution approaches. Mediation is a more friendly way of ending conflict than simply resisting negotiation. When emotions contribute to misperceptions and stereotypes, based on inadequate communication or communication failure, mediation is the most suitable method. Since individuals see problems from a multitude of perspectives, they cannot draw the same conclusions from one point of view (Jeong, 2010).

Borisoff and Victor (1998) define mediation as a "form of alternative dispute resolution that is often sought when disputing parties are unable to resolve their differences on their own." This mediation process is characterised by some fundamental elements which are: impartiality, mutually acceptable, and a neutral third party. The mediator develops options and alternatives to try to reach a fair agreement that adapts to the needs of the parties involved. The mediator does not have the power to decide on a solution to the issue, and the parties themselves must reach a mutual agreement.

Mediation is a process focused on the voluntary involvement of the parties concerned, in which the mediator, without the power of adjudication, systematically encourages dialogue between both sides to enable them to assume responsibility for resolving the conflict at hand. The most important aspect of mediation is that both parties desire to resolve the problem. Another feature is that the intermediary, the mediator, has no authority to make a decision. The systematic promotion of communication by the mediator is the main link between the parties (Hopt & Seffek, 2013).

1.3.1 Communication in mediation

It is essential to establish an empathic relationship in mediation. Knowing how to position yourself in the role of the other and get in tune with them makes communication easier. This often allows one party to perceive, without judging or criticising, what the other person feels or thinks. It is essential to be able to put yourself in the other's shoes, to listen consciously, and to use verbal and non-verbal communication effectively to achieve a successful outcome in conflict mediation. In addition to all this, having concern for the suffering of others is vital. Effective communication can help in all these aspects.

Most theories and hypotheses raised about the communication process involve multivariate relationships in which the variable transmits an indirect effect through one or more intervening variables. Baron and Kenny (1986, quoted in Hayes et al., 2008) describe a set of conditions necessary for stabilising mediation that is widely used in the social sciences, including communication. Knowledge of how it works and what drives its effect, and its role as a mediator in behavioural, social and cognitive spheres, is of great importance (Hayes et al., 2008).

Berglund (1968, quoted in Borisoff & Victor, 1998) says that alienation, frustration and misunderstanding are the result when a person does not hear correctly what the other is trying to say. The first goal of communication is to try and persuade the other person to share their view about events. And with that, consciously or unconsciously, communication begins to change the way another thinks (Borisoff & Victor, 2008). The conflict management dimension deals with the defence of the case. Sometimes problems arise because events have ended or mistakes have been made. How these events are explained can have a significant impact on the situation in question. A lack of information about the problem can cause difficulties between the parties involved (Borisoff & Victor, 2008).

According to Borisoff and Victor (1998), some points on communication in a mediation process should be highlighted:

(i)   Descriptive speech: the strength of the word when used correctly;

(ii) The correct use of language in conflict management;

(iii) Problem oriented: focus on problems;

(iv) Spontaneity: promotes ideas and feelings in a friendly environment;

(v) Empathy: using strategies that can put you in the other's place;

(vi) Professionalism: an open space where communication can flow.

1.3.2 Non-verbal communication

Body language is considered non-verbal communication. Such communication can be realised through our posture, in gestures, in our closeness with another when talking to them, in facial expressions, and even in the movements that our eyes make. When a healthcare professional pays attention to the body language of the other person and knows how to interpret it correctly, he is more likely to have control over the situation.

It is increasingly essential that non-verbal communication be understood. Glasl (1999) says that such behaviour clearly demonstrates the intentions of an individual and that conflicts are always interpreted and perceived subjectively from another's point of view.

Verbal and non-verbal communication are both part of the entire negotiation process. The ability to analyse communication through body language is an important tool to assist the mediator in the development of their skills (Smith, 1998).

Non-verbal communication can show signs of insecurity, fear, desires, nervousness, frustration, etc. (Johnson, 1993). The more experienced a negotiator is in observing non-verbal communication, the greater the chance of them achieving their goals. There are specific meanings in differences in touch through body language; although everyone uses the same vocabulary, each has its own specificity.

Facial expressions are essential and each conveys a different message. The geometry of the use of the hands and the movement of the arms also transmit messages. The tendency to open your arms in a

negotiation can indicate that you are open to proposals and willing to negotiate, listening to what the other has to say.

According to a study made by Dr Albert Mehrabian in 1967, body language represents 55% of the message transmitted (n.d.). It is essential to learn how to use body language effectively. The message a person conveys is 55% body language, 38% tone of voice, and only 7% verbally, through words. Looking directly at a person when they are speaking, the handshake, the smile, all demonstrate that they are welcome in that place.

Through body language, we can transmit a huge amount of non-verbal information; however, most people ignore or do not know how to interpret the messages conveyed by gestures and expressions. These are a type of communication that words cannot convey (Weil & Tompakow, 2008). Communication is transmitted through any motion manifested voluntarily or involuntarily by the body, and is characterised as a universal language.

As mentioned above, many of our movements are unconscious—an important aspect in the observation and application of non-verbal communication. An agreement between the spoken word and body language is important as it makes a complete and coherent process of sending a message. This means that non-verbal communication alters the meaning of verbal interaction; the verbal message is contradictory to what is expressed by non-verbal communication between individuals. The spoken message and body language together contribute to a mutual strengthening.

Non-verbal communication increases the credibility of the message emitted, clearly and assertively. It also involves subjectivity, as it is affected by human relationships (Weil & Tompakow, 2008). These non-verbal signs complement, replace or contradict verbal communication and also demonstrate feelings. In the case of conflict between the verbal message and the non-verbal one, the non-verbal message prevails.

Another important means of non-verbal communication is touch, which expresses feelings or reactions. Contact as communication is vital and must not be relegated to technical-scientific

procedures. It can show affection, empathy, trust and closeness to another, which allows for intimacy, security and support. Touch might influence a person's physical and mental state, being able to generate protection and comfort, in addition to fear and anxiety.

1.3.3 Active listening

The relationship between healthcare professionals and patients must be a reliable one. This therapeutic relationship depends on the professional's ability to communicate effectively with the patient. Some research indicates that when healthcare professionals listen to patients, there is more compliance with medical regimes, patient satisfaction increases, and doctors are less vulnerable to lawsuits for negligence.

The Palliative Care Competence Framework Steering Group (2014) states that active listening means having your attention focused on the other person without being distracted. It also involves the ability to demonstrate that the person has been heard and understood, through restating or paraphrasing what has been said.

According to Klagsbrun (2001), active listening and non-verbal communication, called holistic communication, are two essential tools in a healthcare setting. Active listening is a technique for reflecting the essence of what the patient says and can help patients feel more deeply seen and understood. Non-verbal communication, a body-centred method for developing self-awareness, is a way of listening to feelings and becoming aware of bodily sensations that can carry meaning in relation to questions or concerns.

In recent decades, the doctor–patient relationship has been reconceptualised based along merely bureaucratic, dehumanised, paternalistic lines—a partnership between simply provider and patient (Davis et al., 2008).

"Communication is a fundamental clinical skill that, if performed competently and efficiently, facilitates the establishment of a relationship of trust between the medical staff and the patient-customer, a truly therapeutic alliance." (Chichirez & Purcărea, 2018, p. 119)

Listening must be total and absolute; in addition to receiving and understanding the verbal message, special attention must be given to non-verbal communication, such as hand signals. Thus, if the two parties in a dialogue are positioned on the same level, they will communicate better. In the discussion, the ideal is an open, patient and serene stance between the interlocutors.

Eye contact is critical and must be maintained. Facial expression must also be observed. The listener must be empathetic. This cognitive and affective process allows the healthcare professional to understand what the other party thinks and feels, encouraging them to express themselves in an open and unrestricted way. Empathy not only involves mere sympathy or the intuition of the patient's emotions, but also identification with their feelings, with their physical and psychological states.

This requires a change in the current way healthcare professionals communicate and listen to patients. Medical organisations are aware of this and have emphasised the importance of improving training and competency in communication skills. Effective communication and listening are also essential in the ethical treatment of patients and their families. Active listening is a factor associated with empathy, according to Haley et al. (2017).

1.4 – Emotional Intelligence

Psychologists have tended to focus on cognitive aspects, such as memory and problem-solving skills. However, some researchers realised that non-cognitive elements were also essential (Cherniss, 2000). David Wechsler defines intelligence as "the individual's aggregate or global capacity to act purposefully, to reason and to deal effectively with his environment" (1958, quoted in Cherniss, 2000, p. 2).

Goleman says: "The root of the word emotion is more, the Latin verb 'to move', plus the prefix 'e-' to connote 'move away', suggesting that tendency to act is implicit in every emotion." (1995, p. 6)

Salovey and Mayer define emotional intelligence as: "A social intelligence model that means the ability to monitor others' feelings and emotions, discriminate against them and use that information to guide someone's thinking and action." (1990, quoted in Cherniss, 2000, p. 4)

The ability to manage one's feelings and facial expressions is another essential aspect of emotional intelligence that is especially important for success. Another critical fact to note is that emotional intelligence has a lot to do with knowing when and how to express emotion and how to control it.

According to Salovey and Mayer (King, et al., 2012, p. 12), emotional intelligence is the ability to understand personal information and reason with emotions. It consists of four primary skills: (i) perceive emotions accurately, (ii) use emotions to facilitate thinking, (iii) understand emotional meanings, and (iv) manage emotions.

Thus, Mayer and Salovey (1993, quoted in King et al., 2012) have argued that many intellectual problems contain personal information that must also be interpreted and processed, and that in order to enter into and maintain satisfactory interpersonal relationships emotional intelligence, as well as standard intelligence, is necessary.

In their original emotional intelligence model, Salovey and Mayer (1990, quoted in King et al., 2012) show us the critical role that empathy brings to emotional intelligence, suggesting that empathy is an essential aspect in the assessment of emotions. King (2012) defines empathy as "the ability to understand the other's emotions and feelings, that is, to put oneself in the other's place, to be sensitive to the pain of the other".

Gardner (1983, quoted in King et al., 2012) says that healthcare professionals can demonstrate a high level of interpersonal intelligence. Empathy seems to be an established facet of emotional intelligence requiring the recognition and accurate identification of the emotional responses of others. At the same

time, emotional intelligence theory and research appear to confirm empathy as a critical component when dealing with patients and their families.

Our emotions are geared towards facing essential situations and tasks that the intellect cannot manage alone, such as dangerous and painful loss, persistence in goals despite frustration, creating bonds with a partner, and building a family (Goleman, 1995).

Goleman applies the concept of emotional intelligence to the work environment. He argues that in the work environment, the emotionally intelligent person is skilled in two key areas that he presents in his emotional competence structure.

Each area consists of a series of specific skills, as described below:

Personal Competence	Social Competence
Self Awareness (of internal states, preferences, resources and intuitions)	Empathy (awareness of others feelings, needs and concerns)
Self Regulation (of internal states, impulses and resources)	Social Skills (adept at inducing desirable responses in others)
Motivation (tendencies that facilitate reaching goals)	

Figure 1 – Types of competency (Kierstead, 1999)

Goleman has devised twelve questions to ascertain emotional intelligence (Kierstead, 1999, p. 3). If you answer 'yes' to half or more (and if other people you know agree with your self-assessment), you are doing well.

Do you - can you - are you:

1- …understand both your strengths and weaknesses?

2- …be depended on to take care of every detail? Do you hate to let things slide?

3- …comfortable with change and open to novel ideas?

4- … motivated by the satisfaction of meeting your standards of excellence?

5- …stay optimistic when things go wrong?

6- …see things from another person's point of view and sense what matters most to that person?

7- …learn customers' needs to determine how you can serve them?

8- …enjoy helping co-workers develop their skills?

9- …read office politics accurately?

10- …able to find 'win-win' solutions in negotiations and conflicts?

11- … the kind of person other people want on a team? Do you enjoy collaborating with others?

12- …usually persuasive?

Responding 'yes' to six or more of the items means that you are functioning well and with maturity in the workplace. Did you answer 'no' to more than five questions? Do people who know you well agree with his high number of negative scores? If so, what can you do to change and improve your emotional intelligence score? (Goleman, quoted in Kierstead, 1999, p. 3). Emotional intelligence is about knowing when and how to express emotion with control.

1.5 – Empathy

Empathy is the ability to understand what another person is experiencing from within their frame of reference, that is, the ability to put oneself in someone else's shoes. The essence of empathic interaction is a precise understanding of another person's feelings. And it is hard (Bellet & Maloney, 1999).

The poor communication skills of doctors with patients or family members are one of the main causes of conflict within medical facilities. One of the qualities of effective communication is the use of empathy. Since some doctors have not learned to use empathy in their training as medical students, they can be ineffective in patient care (Bellet & Maloney, 1999).

In general, empathy can be recognised as including two essential components: (a) the therapist sees the patient's world the way the patient does and (b) the therapist's understands what the patient is going through, thinking, feeling and experiencing (Maher, et al., 1994).

According to Goleman (1995) empathy is anchored in self-awareness; if we look openly at our own emotions and feelings, we will be better able to interpret and understand the feelings of others. It is the ability to understand how another person feels, to see themselves in the other's situation in everyday life. The key to intuiting someone else's feelings is the ability to read *non-verbal* messages, such as tone of voice, appearance, facial expression and so on.

Furthermore, understanding what each person means by 'empathy' includes an understanding of their emotional experiences. There is a difference between empathy and sympathy but the former holds a degree of greater importance (Shlien, 1997, quoted in Elliott, et al., 2011). As for affective neuroscience, therapists often put more emphasis on the processes of obtaining a conscious perspective, rather than the more automatic and body-based emotional simulation processes.

Rogers (1980, quoted in Elliott, 2011, p. 2) defines empathy as: "the sensitive capacity and the willingness to understand the thoughts, feelings and struggles from the client's point of view. It is this ability to see completely through the eyes of the client, to adopt his frame of reference …" (p. 85). "It means entering the perceptive private world of the other … being sensitive, moment by moment, to the changes in meanings that flow in someone else … It means feeling meanings of which you are barely aware …" (p. 142).

According to what we've seen so far, empathy can be defined in different ways and by different subtypes, according to aspects, expressions and modes. There are various ways to experience empathy: emotionally, cognitively, from moment to moment, or to try and capture a general feeling of what it is like to be that person. Within these subtypes, different aspects of the customer experience can become the focus of empathy (Bohart & Greenberg, 1997, quoted in Elliott et al., 2011). Likewise, there are many ways to express sympathy, including empathic reflections, empathic questions,

interpretations of intimate experiences and empathic conjectures. Thus, in psychotherapy, empathy can be understood as a complex construction that consists of a variety of different acts used in different ways (Elliot et al., 2011).

1.6 – Palliative Care

1.6.1 History

The origins of the words hospice and hospital are the same and date from the fourth century AD. The original Greek word was 'xenodochium', which means hospitality. The first hospices date back to a Roman matron who opened her home to the poor, travellers, the hungry, thirsty and sick. At that time, the word hospice meant both host and guest, and the hospice was a place where hospitality was offered. Subsequently, many hospices were created along the routes of the Crusaders (Milicevic, 2002).

"Hospice care is end-of-life care provided by health professionals and volunteers. They give medical, psychological and spiritual support. The goal of the care is to help people who are dying have peace, comfort and dignity. The caregivers try to control pain and other symptoms so a person can remain as alert and comfortable as possible. Hospice programmes also provide services to support a patient's family." (Global Atlas of Palliative Care, 2020, p. 14)

Hospice care programmes often consist of a multidisciplinary group of professionals who offer treatment based on palliative care, including the services of a nurse, doctor, social worker and clergy. However, hospice treatment is not intended to cure terminally ill patients. Since the beginning, voluntary service care has always been part of the philosophy of hospices.

Hospices became places where pilgrims on their travels could receive food and medical care. Not only did the dying stay in such places, but also those who needed to remain on earth a little longer. In the mid-ninth century, Jeanne Garnier founded the first institution in Lyon, France, using the word 'hospice' to mean care for the dying. In England, the word 'hospice' was first used by the Irish Sisters

of Charity at St Joseph's in London in 1905. Its founder had already established a hospice for the dying in Dublin in 1879.

Interestingly, there was only one hospice founded by a doctor, Howard Barrett. Of all the houses, his São Lucas House for the Dying Poor, opened in 1893, was from the beginning the most similar to the hospices of today (Milicevic, 2002; Payne, 2016; Richmond, 2005).

The modern hospice movement is synonymous with the name Dame Cicely Saunders and was started in the UK in 1967 with St Christopher's Hospice. Cicely Saunders, born in 1918, trained as a nurse and later as a social worker. During her work in a hospital, she became aware of the psychological and spiritual needs of the dying, who often felt isolated and alone (Milicevic, 2002; Payne, 2016; Richmond, 2005).

Cicely Saunders was a pioneer in the creation of the first modern hospice and also established the discipline and culture of palliative care. She introduced effective pain control and insisted that people who were dying needed dignity, compassion and respect, as well as a rigorous scientific methodology for testing treatments (Richmond, 2005).

It was because of her ideas that social work became an essential factor in the holistic model of palliative care, initiated by her and developed by others, in different health environments in developed countries (Saunders, 2001, quoted in Payne, 2016). Her idea was to respond to pain by developing a multidisciplinary approach to practice.

Palliative care is a form of assistance at the end of life, within a model of total, active and integral respect for the patient and their family. In advanced and terminal illness, the patient has the right to die with dignity. This model is found within a conflicting field of interventions, which includes therapeutic obstinacy, euthanasia and assisted suicide, all having repercussions on the quality of life of patients and their families, with undeniable ethical implications.

At this stage in care, the chance of a cure is small and there is no longer any treatment that can be offered to prolong life. Care has become comforting rather than curative. Palliative care is a humane and rational approach for terminally ill patients.

The World Health Organization defines palliative care as the following:

"Palliative care is an approach that improves the quality of life of patients (adults and children) and their families who are facing problems associated with life-threatening illness. It prevents and relieves suffering through the early identification, and correct assessment and treatment of pain and other problems, whether physical, psychosocial or spiritual." (Palliative Care, 2018)

According to the WHO website, there are three fundamental components: meticulous prevention and symptom management, including pain; excellence in communication, in the discussion of care goals and in advance care planning; and an extra layer of support for practical needs, particularly concerning the care provided to the patient.

It goes on to further define palliative care as "the total and active care for the patient and his family by a multidisciplinary team when the patient's illness does not respond to curative treatment". The main aim is to provide a better quality of life for the patient and their family. Usually, palliative care affirms life but it accepts death as inevitable. The website also highlights the importance of palliative care in the treatment of advanced disease and chronic pain, seeing the expansion of the service as part of social development in countries where health is still precarious. Because of technological advances in medicine and the medicalisation of healthcare, there has been a recent increase in the development of palliative care (Payne, 2016).

In 1992, Margaret Somerville, a prominent medical law scholar, wrote a seminal article arguing that relieving suffering is a common goal of medicine and human rights and that reducing the pain and suffering of terminally ill patients is a human right (Brennan, 2007).

The *ABC of Palliative Care* describes it from various philosophical perspectives and assumptions (Fallon & Hanks, 2006):

* Nothing matters more than the bowels (Cecily Saunders)

* Humanise, personalise, de-institutionalise

* Clinical care grounded in qualitative and quantitative inquiry

* Experience of illness viewed as a narrative: relational, meaningful, filled with potential

* Assist progressive understanding of reality at a rate acceptable to the patient

* 'Reality' as an illusion; the subjectivity of experience; acknowledgement of the mystery

* Quiet efficiency, not the hustle and bustle

* Focus on quality of living in the present moment, not death

* Accompaniment: empathic presence to the other in the moment

* Team: led by the patient; egalitarian rather than hierarchical

* Environment: centred on the patient, welcoming, peaceful

* Uniqueness, limitations, defences of the patient/family

* Healing of psyche: an innate potential

* Potential for adaptation, integration, reconciliation, transcendence

* Importance of compassion, celebration, community, paradox, humour

* With unresolved symptoms, "Review! Review! Review!" (Robert Twycross)

According to Fallon and Hanks, palliative care has been recognised for being a holistic model of individualised care. It is characterised by careful, ethical and therapeutically sensitive consideration, through skills in patient care. However, palliative care is also the main ingredient in the quality of continuous care for the needs of the patient's family. The focus is on everything that can possibly be done during the disease process. The term 'palliative care' implies a form of personalised service, in addition to the biomedical model used today. The objective of palliative care is to support and optimise the quality of life.

The previously mentioned WHO report (2005) emphasised its relevance for patients who do not respond to curative therapy. This statement might be interpreted as relegating palliative care to the

last stages of care. Nowadays, there is widespread recognition that the principles of such care should be applied as soon as possible during the course of any fatal chronic disease.

This way of thinking came from a new understanding that problems at the end of life have their origins from an earlier time on the path of illness. Symptoms not treated at the beginning become challenging to manage during the last days of life. People do not understand the concept of 'being used to pain'; pain becomes chronic when it is not relieved and changes the status of neural transmission of the pain message within the nervous system, reinforcing pain transmission and activating previously silent neural routes (Sepúlveda et al., 2002).

Although some countries do not consider palliative care as relevant to public health issues and, therefore, do not include it in their public healthcare system, several initiatives have been developed to make it an essential tool in the care of patients. These initiatives, however, have not been well integrated into national health policies and, therefore, have not yet had a significant impact on the population of patients in need of palliative care. In some countries there are obstacles to the availability of opioids, an essential element of pain control. Morphine consumption is low in most developing countries (Sepúlveda et al., 2002).

1.6.2 Legal analysis: Palliative care as a human right

Death is impossible to avoid and often the time before dying is a painful one. Not everyone has the resources and capacity to guarantee they have access to palliative care at the end of their life. Many countries do not yet have policies and guidelines ensuring the provision of adequate palliative care services.

According to the Global Atlas of Palliative Care (2020), in international law there are two primary reasons for palliative care to be considered a human right: the right to health and the right to be free from cruel, inhuman and degrading treatment. The central affirmation of the right to health is contained in the International Covenant on Economic, Social and Cultural Rights (ICESCR, 1966).

Healthcare includes palliative care. Due to rapid demographic growth, worldwide changes have occurred which include the arising of complex needs at the end of life. Because of these changes, the World Health Organization has identified palliative care as an essential but neglected public health issue that requires an urgent political response (Palliative Care, 2018).

Across Europe, the provision of palliative care is growing and increasingly is being recognised as a mandatory part of healthcare. At the same time, there are continuous debates about what palliative care includes and where it starts and ends (stage and type of disease, prognosis, service environment). Regional, national and cultural differences exist in the approach and organisation of palliative care. These different points of view are also reflected by the professional staff in their daily duties (Materstvedt et al., 2003).

Each jurisdiction may have a constellation of legal rights on how to deal with pain and palliative care. Regarding this, health rights often come from national constitutions and based within the context of international human rights. Any discussion on the legal rights that underpin palliative care would need to include these developments.

Gwyther et al. (2009) state that a simple proposal has been put forward by the international palliative care community, highlighting that palliative care should become an international human right. The international human rights agreements in force within the arena of palliative care have as common themes the inherent dignity of the person and the principles of universality and non-discrimination. However, when analysing the evidence for the effectiveness of palliative care, the lack of provision of palliative care services for everyone who could benefit from them is seen as a huge problem.

The three most important topics under discussion—palliative care, public health and human rights—are now interacting with increasing resonance. The articulation of palliative care as a clinical speciality and academic discipline has culminated in the development of a public health approach to global and community health problems. Caring for the personnel responsible for maintaining life is a

public health problem. Bearing in mind that death is something we cannot avoid, caring for people with life-limiting illnesses is the same as all other public health issues (Gwyther et al., 2009).

Most countries do not have palliative care policies or integrated palliative care services. Research and data collection carried out by Clark and Wright of the International End of Life Care Observatory, demonstrates the distribution of palliative care worldwide (fig. 2), categorised into four levels: (i) no activity yet identified; (ii) capacity building activity; (iii) localised provision; and (iv) approaching integration (Gwyther et al., 2009).
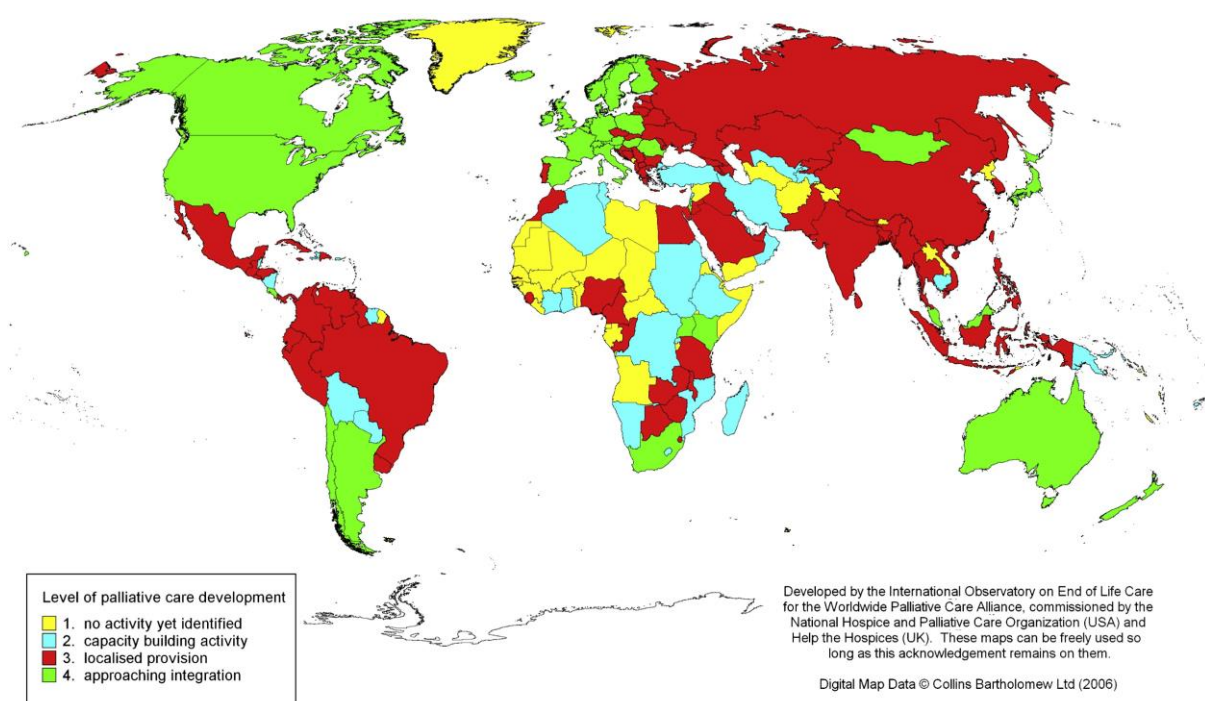
Figure 2 – Level of palliative care development (Gwyther et al., 2009, p. 769)

Regarding the legal right to palliative care around the world, and depending on the jurisdiction in which they live, patients with life-limiting illnesses have a constellation of such rights underlying pain management and palliative care. The health rights derived from national constitutions, the right to negligence, court declarations based on public interest, and federal legislation have all emerged over the past two decades (Brennan, 2007).

Moreover, the International Covenant on Economic, Social, and Cultural Rights (ICESCR) states for Article 12:

1. The State Parties to the present … Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.

2. The steps to be taken. To achieve the full realization of this right shall include those necessary for the creation of conditions which would assure all medical service and medical attention in the event of sickness. (Brennan, 2007, p. 495)

1.7 Ethics in Palliative Care

Palliative care and human rights are mainly based on the principles of individual dignity, universality and non-discrimination. Doctors, members of the healthcare team, patients and their families are often involved in making decisions about the end of life. In this sense, palliative care has faced many moral and ethical challenges and, for several reasons, this moral obligation has become more critical today than ever before, as doctors still provide inadequate relief from pain.

According to the Palliative Care Expert Group (2010), some ethical issues that arise at the end of life can be problematic. Issues that can occur within a palliative care setting concern the method and time of conversations with family members about the impending death of a loved one, and deciding when to withdraw futile treatment options. Communicating such issues to the patient and their family requires advance care planning. The ethical principles that guide actions and responses to these situations are consistent with the principles applied in all areas of health. These principles include beneficence, respect, self-determination, telling the truth, confidentiality, informed consent, justice and an absence of maleficence.

According to Aulisio et al. (2004), consultations on ethics are available to an individual or group in order to help patients, family members, health professionals or other parties involved concerning medical treatment. Any uncertainties or conflict related to healthcare so far reviewed, showing the

impact of ethics or palliative care services on communicating with families, concern the objectives of care rather than addressing physical, psychological or spiritual issues. Any doctor who has struggled with the complexities of these cases knows that there is no purely medical solution to the issues raised.

1.8 – Palliative Care in Ireland

Additional human factors have also restricted the growth of palliative care. The end of life and death is now synonymous with palliative care. Most people, mentally, fear and avoid something related to death. In Ireland, patients with advanced diseases are becoming an increasingly important issue in healthcare services, policies and research, thus raising awareness of palliative care. In 2001, Ireland became one of the first nations to publish a national policy dedicated to palliative care (May et al., 2014).

Throughout the history of palliative care in Ireland, services have predominantly provided care for people with cancer. Previous estimates of the need for palliative care focused mainly on specialised care and included only a limited number of non-malignant diseases. A study in Ireland from 2011 found that one in ten (11%) of the population was aged 65 or older. It is estimated that number will double to 22% by 2041 as the proportion of people aged 65 and over is increasing in Ireland with the fastest rate in the European Union. It has been found that advanced chronic conditions increase with advancing age (Kane et al., 2015). The death rate of people over 65 years of age is expected to grow from 28,000 to 36,000 over the same period. This will be accompanied by a rise in fatalities from neurodegenerative diseases and cancer and will increase the demand for palliative care (Report on the Right to Die with Dignity, 2018).

In Ireland, the use of health services is related to many factors, including the health system and the characteristics of each patient. Over time, with ongoing social and economic transitions, characterised by increased life expectancy, population ageing, changing expectations and restructuring health

services, it will be essential to separate the intricate and motivating patterns of use of the health services. This will help us to understand what the future demand for health services will be like, as well as being able to better assess the potential impact of an ageing population (McNamara et al., 2013).

Palliative care is commonly associated with the care of terminally ill cancer patients; however, it cannot be limited to a single terminal condition or the end of life as it has a much broader role to play. The Irish Hospice Foundation states:

"Palliative care is appropriate at any stage for people with a life-limiting illness including advancing neurological illnesses, heart, circulatory and respiratory disease. Palliative Care can be provided with curative treatment. It is not designed to replace treatment; rather, it complements the treatment received." (Report on the Right to Die with Dignity, 2018, p. 21)

In November, 2017, a three-year development framework (2017–2019) for palliative care services in Ireland was launched. Its main objective was to direct and inform the development of palliative care services in Ireland, as well as improving care for people with disabilities and limited living conditions, and increasing collaboration in the provision of palliative care (Report on the Right to Die with Dignity, 2018).

The need to ensure assistance with and provision of palliative care services was raised on several occasions during a committee hearing on November 22, 2017. Dr Louise Campbell of the National University of Ireland, Galway, said that palliative care providers would become more accessible so that the demand for assistance at death could be reduced or eliminated (Report on the Right to Die with Dignity, 2018).

A study concluded that any future decisions on palliative care policies in Ireland should consider the rapid growth of the ageing Irish population and the development of 'plugs' caused by degenerative diseases, such as dementia and cancer. Due to this fast-growing area, there is a necessity to implement new models of palliative care to improve the quality of end of life care of these cases. Thus, according

to such data and an increase in demand, the need for quick future strategic planning has been identified (Palliative Care Service, 2017).
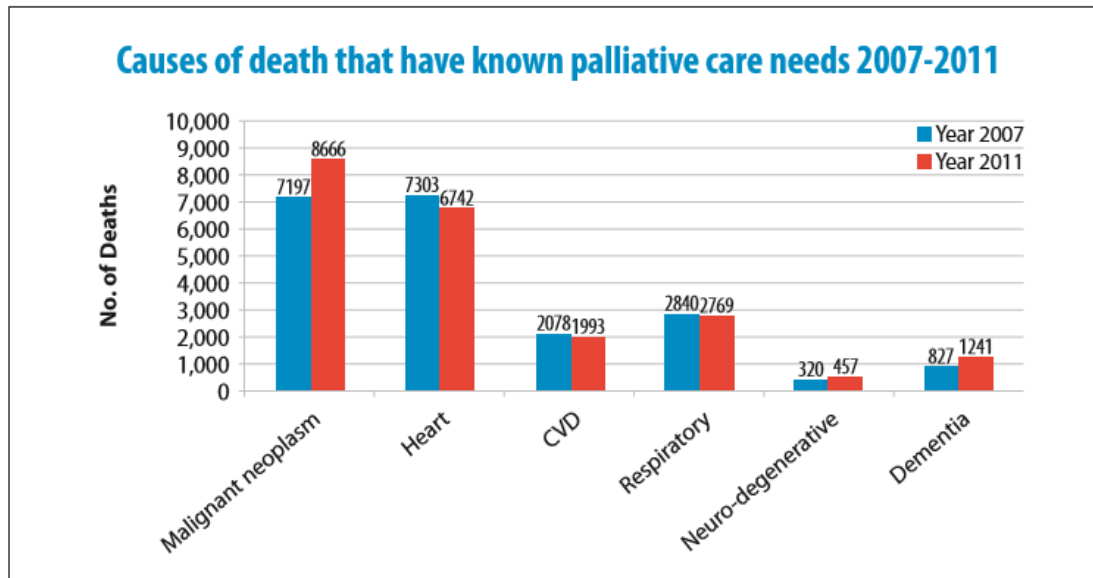
Source: Kane, et al., 2015

Figure 3 – Incidence of causes of death with known palliative care needs in 2007 and 2011 (Kane et al., 2015)

1.8.1 Provision of specialist palliative care in Ireland

A development plan drawn up by the Health Service Executive (Building a high quality health service, 2015) identified gaps in the provision of specialised palliative care services at the national level. It made some recommendations on how these needs should be addressed. Some advances have been made since 2009, mainly the opening of a new forty-four-bed unit in Marymount Cork (twenty additional beds); a new twenty-four-bed unit at St Francis Hospice in Blanchardstown, North West Dublin; six extra beds at Galway Hospice; and the opening of a new fifteen-bed unit in Kerry in 2017. However, there are still regional variations in access to specialised palliative care in inpatient units, day-care centres, emergency hospitals and community services, both in infrastructure and personnel. Some new development projects that correct infrastructure deficits are at an advanced stage and will shortly be delivered (Palliative Care Services: Three Year Development Framework, 2017–2019).

1.8.2 Levels of palliative care specialisation

A planned approach has been put in place among palliative healthcare teams to provide the necessary care appropriate to the individual needs of each patient and their family members. Within each health team there are three levels of palliative care with increasing specialisation from level 1 to level 3 (Adult Palliative Care Services, 2020):

    (i)   Level 1: Must be provided in any location or environment by all health professionals as part of their role and using a palliative care approach.

    (ii)   Level 2: Provided anywhere, using a palliative care approach by healthcare professionals who have additional knowledge of palliative care principles and use them as part of their role.

    (iii)   Level 3: Offered by health professionals who work exclusively in palliative care, and who have extensive knowledge and skill in the speciality.

In 2010, a National Clinical Program for Palliative Care was established in a joint initiative by the HSE Clinical Strategy and Programmes Division and the Royal College of Physicians. Its main objective was to ensure that people with limited finances and their families could easily access a level of palliative care service appropriate to their needs, regardless of the care environment or diagnosis (Adult Palliative Care Services, 2020).

Chapter 2 – Research Methodology and Methods

Epistemologically speaking, this study uses an inductive empirical approach based on a specific observation for a general conclusion. It is a mix of qualitative and quantitative research. The aim was to explain, evaluate and answer the research subject, using a questionnaire designed specifically for healthcare professionals currently working in Ireland. Based on this questionnaire their attitudes about the topic would be analysed and an attempt made to understand how they deal with the issue of using tools and protocols during conflict in their daily working lives.

Conflict frequently arises between healthcare professionals, patients and their families concerning encouraging the use of palliative care. The root of the issue is whether or not to use such care, which is based on a multidisciplinary approach, to improve the quality of life of terminally ill patients with incurable diseases. And for their close family members, facing the illness of a loved one whose continuity of life is threatened, it is of equal importance.

The prevention and relief of suffering are obtained through the identification, assessment and early treatment of pain and other physical, psychosocial and spiritual problems. From this case study and the conflicts involved, we can identify the results of palliative care and better understand the phenomenon. A brief explanation of how the research was designed and carried out, and how the methodology was used and the data collected, analysed and discussed will be presented in this chapter.

For a better understanding of the object of this research, a questionnaire was used to elicit information on such topics as the nature of the respondent's work, the length of experience held, and their knowledge about palliative care and conflict resolution, from different religious, cultural and ethical viewpoints. Problems that can occur in a healthcare setting and opinions about conflict management were also addressed. The results of the questionnaires were analysed along the lines of the literature discussed in the previous chapter. The aim of this research is to further investigation into the field of conflict resolution.

2.1 – Research Design

The research design reflects the strategy that was chosen to integrate the different components of the study in a cohesive, understandable and logical way and constitutes data collection, measurement and analysis (Saunders et al., 2007). The study was designed along the lines of the research onion model, which was developed by Saunders et al. in 2007. This model describes the various stages through which the researcher must pass when designing a practical methodology.

Throughout the work of analysis and reflection, the themes related to selection and collection were developed based on the below image. The following sections describe the philosophy, approach, strategy, time horizons and data collection methods that were chosen to carry out this research.
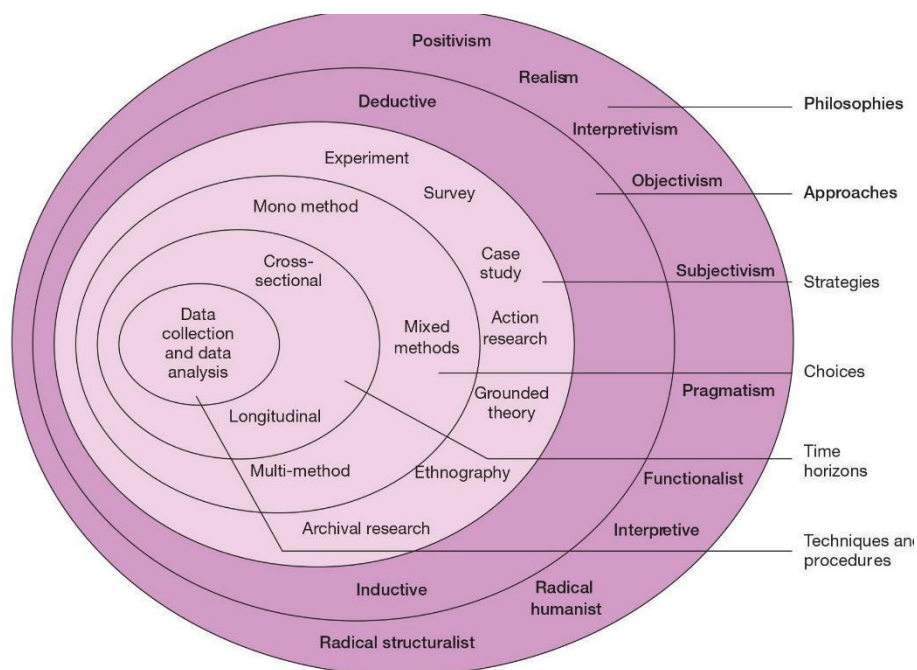

Figure 4 – Research onion model (Mark Saunders, Philip Lewis and Adrian Thornhill, 2007)

2.2 – Research Philosophy

Each step performed in this research process was based on assumptions made about the source of research material and the nature of the knowledge. The hypotheses considered significant by the

researcher were guided by the research philosophy, which supported the research strategy. In the case of studies on positivism, the primary function of the researcher is to collect and interpret the data objectively.

The positivism research philosophy includes essential deductions from the researcher's vision for the world. According to Walliman (2016, p. 12): "Positivism can be described as the application of the natural sciences to the study of social reality. An Objective approach that can test theories and establish scientific laws. It aims to establish causes and effects."

The philosophy adopted in this study is positivism, since the researcher analysed the attitudes of interviewees regarding the resolution of conflict in a healthcare setting. This conflict concerned decision-making that would determine the quality of life of the patient and, by extension, their family. The research was carried out through structured questions based on a similar search in secondary source material, collected through a literature review (books, articles, organisations, web sites). The results were analysed by the researcher at the end of the study. In these types of studies, the results are generally observable and eligible for use in the research.

2.3 – Research Approach

The type of approach used in a research paper can be either deductive or inductive. The deductive approach is where the researcher must develop a theory or hypothesis (or hypotheses) and launch a research strategy to prove the assumption. In the inductive method, data is collected and an approach is developed as a result of data analysis (Saunders et al., 2007; Walliman, 2016; Bell & Waters, 2018). According to Saunders et al. (2007, p. 120), the induction approach emphasises: gaining an understanding of the meanings humans attach to events; intimate knowledge of the research context; the collection of qualitative data; a more flexible structure to permit changes of direction as the research progresses; a realisation that the researcher is part of the research process; and less concern with generalisations.

For this research paper, an inductive approach (where a theory was developed as a result of data analysis) was chosen, evaluated using primary and secondary source material.

2.4 – Research Strategies

Applied research strategies can be classified as quantitative, qualitative, case studies or action-oriented research. According to Saunders et al. (2007), no research strategy is better or worse than any other; the most important thing is whether your chosen strategy will allow you to answer your research questions and reach your goals. Any of these methods might be applied simultaneously to assist in different aspects of the research project, such as an experiment, a case study, action research, grounded theory, ethnography or archival research. The study presented here was structured in a mixed way to collect both quantitative and qualitative data to be measured using descriptive and inferential statistics.

According to Saunders et al. (2007), Walliman (2016) and Bell and Waters (2018), the objective of qualitative research is to understand a phenomenon through the collection of narrative data, studying particularities and individual experiences. The qualitative research method gathers data that is presented as a narrative, such as in open questionnaires, interviews and observations not coded in a numerical system—it is used to understand underlying reasons, opinions and motivations.

This type of research provides information about a problem or helps to develop ideas or hypotheses. Qualitative research is also used to discover trends in thought processes and opinions—subjective, process-oriented. The quantitative method, on the other hand, aims to understand a phenomenon through the collection of numerical data, pointing out preferences, behaviours and other actions of individuals who belong to a specific group or society. Various methods can be used in a data collection technique and analysis procedures to answer research questions.

Therefore, mixed-method research can be used, such as quantitative and qualitative data collection techniques and analysis procedures, at the same time or in sequence. Mixed methods is the general

term used when both quantitative and qualitative data collection techniques and analysis procedures are utilised together in a research project (Saunders et al., 2007).
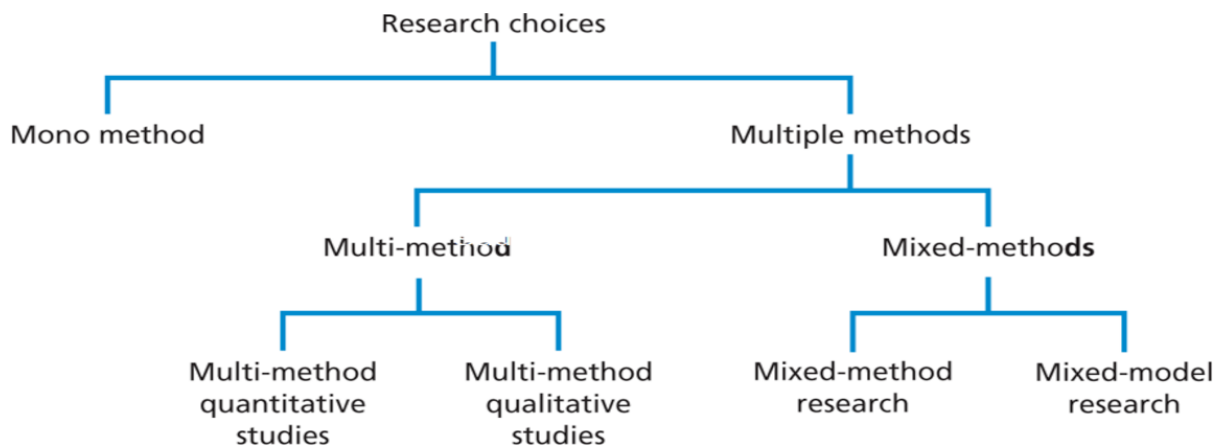

Figure 5 – Research choices (Saunders et al., 2007)

Regarding this research paper, both quantitative and qualitative methods were used. The qualitative approach was utilised to discover the degree of knowledge health professionals possessed concerning conflict resolution tools and palliative care. Qualitative data was obtained through books and articles (literature review) on conflict management. The quantitative approach was used on the data collected from an analysis of the survey and its results.

2.5 – Time Horizon

The horizon time refers to the determined time of your search when data is collected. Whether it concerns a specific time interval (only once), or several time intervals (repeatedly), the answer may vary according to its purpose. It is called transversal, during a specific period, or longitudinal, when the research is carried out over various periods of times (Saunders et al., 2017).

The time horizon defined for this paper is a cross-sectional, transversal analysis since the research was based on a sample determined by the researcher, and carried out over a certain period of time.

This timeframe was established for the collection of data and information regarding the research question.

2.6 – Ethical Research

The credibility and value of a study depends on the information obtained being ethical, as well as ethical and moral research techniques used during its compilation. The research must be guided by ethics, regarding both access to information and the research object itself. Ethical research is related to such issues as how the researcher formulates and clarifies the research topic and design, obtains access, collects data, processes, stores and analyses the data and, in the end, writes the conclusions according to current ethics and morals (Saunders et al., 2007; Walliman, 2016; Bell & Waters, 2018).
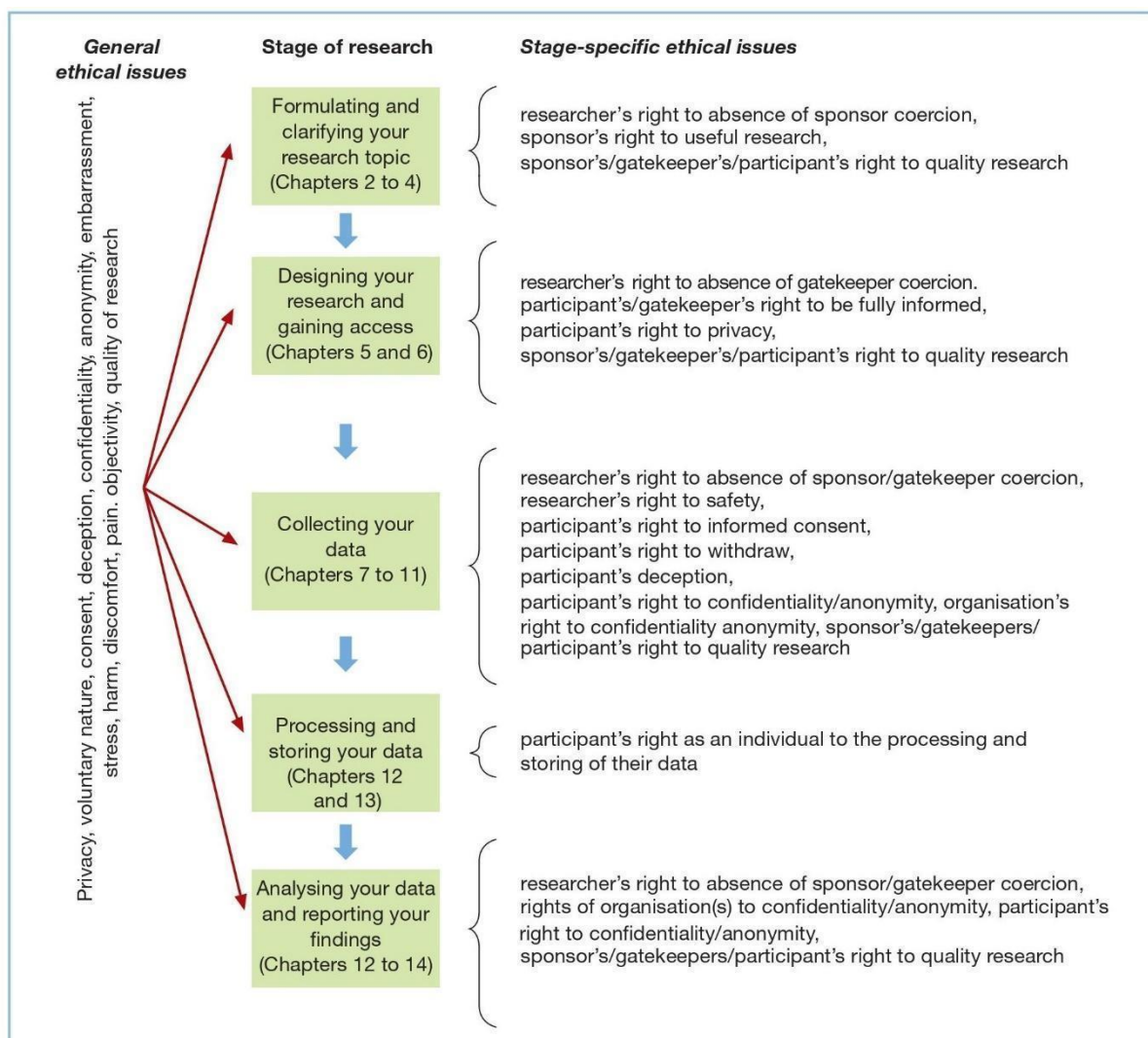

Figure 6 – Ethical issues at different research stages (Saunders et al., 2007)

The study carried out was guided honestly and followed ethical and moral parameters. Moreover, it was faithful to objective and specific aspects without prejudice to the nature of respondents and sources, including data design, analysis and interpretation. Specific guidelines were followed during this study, including protecting the privacy of personal data collected. Information was obtained in the most reliable way about the respondents through their answers.

The researcher obtained informed consent from the participants and the survey carried out did not contain any personal or confidential information. The research policies were defined and those involved were previously informed about the consent form. Moreover, the questionnaire was sent to the supervisor for analysis and approval before its public launch.

To assist the researcher in obtaining better results, the secondary data presented in Chapter 1 was based on a detailed review of the literature according to the research theme and objective. All the information collected was analysed to obtain a better understanding of how health professionals deal with conflict generated by the use of palliative care in terminally ill patients. The answers contained in this study will be kept confidential, used only in this dissertation, and will not be published on any other platform.

2.7 – Sample

When conducting any research for the purpose of collecting information, or using a specific case study, the following questions will arise: In what way, or through what method, does the collected information represent the chosen subject of research? How does one choose the sample of participants in the study? (Walliman, 2016).

The sample in this study was chosen from the category of healthcare professionals. Sampling techniques produce a variety of methods that allow you to reduce the amount of data you need to collect, by considering only a sub-group of data rather than all possible elements (Saunders et al., 2007).

When using the word 'population' in a survey, it does not necessarily mean a specific number of people. Population is the collective term used to describe the total number of people being studied (Walliman, 2016). Therefore, the number of responses (or size of the sample) to your investigation will necessarily depend on the amount of time dedicated to data collection.
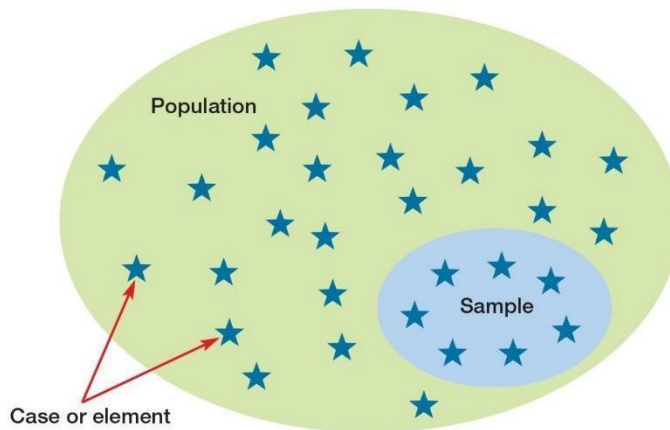

Figure 7 – Population, sample and individual cases (Saunders et al., 2007)

The sample was randomly chosen from healthcare professionals from different areas of expertise, such as doctors, nurses, caregivers, amongst others, all of them being the target research audience. The objective of the study was to explore the attitudes of healthcare professionals working in Ireland on the efficacy of conflict resolution tools used with patients and their families due to the use of palliative care, and how these conflicts are managed and the barriers that exist based on such a choice of care. An initial sample of thirty-nine healthcare professionals agreed to respond to the survey, which was based on open and closed questions allowing for broad and varied answers.

2.8 – Data Collection Methods

Data collection for the study in question occurred through consistent and grounded information gathering, acquired from both primary and secondary source material. The data pool and analysis were organised as explained below.

Once a researcher has decided on a refined topic and specified objectives, the method of how to collect the evidence required is then considered. So, the main question is not what kind of methodology should be used, but *what* do I need to know and *why*? Then the researcher must decide *how* best to obtain this information and, once obtained, *what* should be done with it? (Bell & Waters, 2018).

The questionnaire used in the study might be considered as a mixed *quanti-quali* research method, as the questions were designed exclusively to elicit information about the research question. The research objective can be classified as *exploratory explanatory*. It is exploratory because it aims to simply explore the problem, in this case concerning existing conflict, in order to provide the basis for a more thorough investigation. It is explanatory in terms of connecting identified ideas and factors in order to understand the causes and effects of a given phenomenon. This is the part where researchers try to explain what is actually going on (Saunders et al., 2007; Bell & Waters, 2018).

Participants were selected at random but all worked exclusively within the arena of professional healthcare due to the research topic, which required the study of interaction between these professionals with patients and their family members in a health environment.

When the healthcare professionals were asked to participate in the survey, they were all informed about the purpose and objectives of the research, as well as about confidentiality and data protection issues. The questionnaire consisted of twenty-five questions.

The questions were structured in such a way as to help the researcher analyse the possible conflicts existing in a healthcare setting, as well as the dispute resolution tools and protocols used to resolve these conflicts generated between professionals, patients and family members regarding the conduct, treatment and decisions concerning the authorisation and use of palliative care in terminally ill patients. A link containing the questionnaire, created specifically for the research project on a platform called Google Forms, was sent by email and through social media networks (Facebook,

WhatsApp). The following information was included at the beginning of the questionnaire to explain the reason for the research and its objectives:

This survey is directed to healthcare professionals and aims to answer the research question: 'How have dispute resolution tools and protocols been used to help healthcare professionals encourage patients or family members to consider palliative care in terminal illness cases? An analysis of the attitudes of health professionals in Ireland.'

The data collection does not contain any personal information. This research aims to collect data that will be analysed and interpreted as a part of the investigation in the field of conflict resolution. The study is an evaluation that is part of the requirements for the researcher to graduate from the Independent Colleges Dublin Masters in Dispute Resolution program.

The treatment of the data collected here will be respected for the adequate confidentiality of the commercial or professional information provided to the researcher.

Thank you for agreeing to participate in this research study. Your participation helps the researcher to understand the behaviour in the face of conflicts in the health environment regarding the use of palliative care in patients with life-sustaining diseases, which will allow them to provide sufficient data for the construction of the Master's Dissertation in Dispute Resolution, as well as for the construction of strategies that disseminate practices of peaceful conflict resolution in health conflicts.

NOTE: This survey complies with the general data protection regulations and applicable laws in Ireland and Europe. This has been done to protect the rights and freedoms of the individuals who are participating in this research.

2.9 – Data Analysis Procedures

This study used a combination of two types of data collection techniques, quantitative and qualitative. The analysis first considered *qualitative* data in order to understand the research subject through the

collection of narrative data, studying the particularities of the answers to the questionnaire, as well as a literature review based on books, articles, and the websites of organisations. *Quantitative* data was then collected after analysing the results of the questionnaires in order to understand the phenomenon through numerical data, which can point out preferences, behaviours and other actions of individuals belonging to a specific group or society (Saunders et al., 2007; Walliman, 2016; Bell & Waters, 2018).
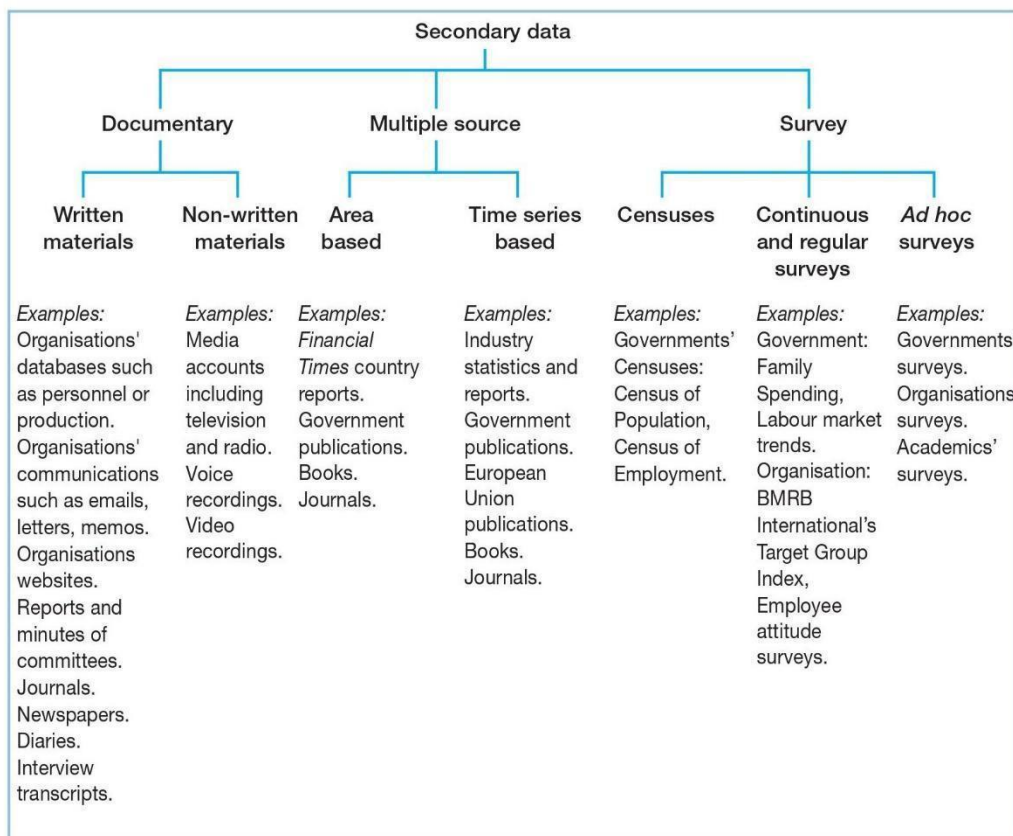

Figure 8 – Types of secondary data (Saunders et al. 2007)

The statistical analysis included data collection, analysis, interpretation, presentation and modelling. A descriptive analysis of responses enabled relevant data to be found on conflict resolution and palliative care. Finally, after analysing the content of the answers, the results were explored from the perspective of the sample.

2.10 – Limitations of Methodology

As the topic addressed in this research is quite an extensive and sensitive one, relating to life and death issues, it is possible that some relevant information was left out or missed. Also, participants responded according to their own professional experiences, whether these were positive or negative, thus influencing the results of the survey. All the participants involved had genuinely relevant professional experience; however, they may not be the most representative sample of the population studied. As one of the main objectives of the research was to analyse people from different social backgrounds with different work experiences, leading to different perspectives on the subject, it is possible that the sample number of health professionals was not large enough to be meaningful. Finally, some of the questions in the survey might be considered as insufficient, despite being specific and related to the research subject.

Chapter 3 – Presentation of the Data

The cross-sectional study was defined by observational, behavioural and performance research, which analysed the data collected over a period of time in a sample population of a subset. The information collected in the cross-sectional study is from people from different sectors in the healthcare arena but in the same area of activity. The study variables did not change throughout the investigation. The cross-sectional study was concrete, using a qualitative and quantitative approach, descriptive and transversal. It was descriptive due to the fact it was assessing the frequency and distribution of a topic studied. The link containing a survey (composed on Google Form) with twenty-five questions, exclusively based on the research subject and addressed only to healthcare professionals, was sent by email and through social media.

All questions were concise and checked by the supervisor before forwarding them to the research participants. Due to the variety of data obtained and the fact that the healthcare professionals involved were from different sectors, the quality of the research results and conclusions are in line with the central research theme. Each participant was provided with a brief introduction to the research aim and given essential information, such as the ethical and moral issues relating to data protection. All questions were answered and remain on the platform Google Form. The open-ended items had unlimited space for writing and an indefinite time limit so that all participants would feel comfortable expressing their feelings, thoughts and personal experiences while responding.

In the first part of the survey there are some general questions, such as age, gender, nationality, profession and more. The remainder of the questions were open-ended in order to obtain information about who, among the participants, may have been influenced by their professional experience, or affected by culture, personal beliefs, religion, etc.

Chapter 4 – Data Analysis/Findings

The purpose of this chapter is to present the data analysis derived from the participants' responses. The main objectives were to identify and measure the participants' knowledge concerning the conflicts they may face in the work environment, and how they manage them using conflict resolution tools and protocols, as well as their understanding of when to use palliative care in terminally ill patients. Understanding the impacts and consequences of these conflicts, how they are managed and which challenges professionals may face in their management, as well how this situation can be improved through the negotiation process, are all subjects discussed.

As already mentioned, professionals from different cultures and nationalities, who worked in different healthcare sectors, answered the questionnaire; this resulted in procuring relevant information according to the objectives of this research. From the varied responses, it was possible to analyse how they coped and dealt with issues in certain conflict situations.

The twenty-five questions were as follows:

Gender of participants

The first question in the survey was to identify the participant's gender. All thirty-nine participants were women, as shown below in figure 9. According to a survey conducted by the World Health Organization in March 2019, women represent 70% of social and healthcare workers (Boniol et al., 2019). This could explain why 100% of the participants in this current study were female. The health and social sector, with its 234 million workers, is one of the largest and fastest-growing employers of women. The feminisation of the healthcare professions can be easily observed. Women comprise seven out of ten social and health workers and contribute $3 trillion annually to global health, half in the form of unpaid care work (Boniol et al., 2019).
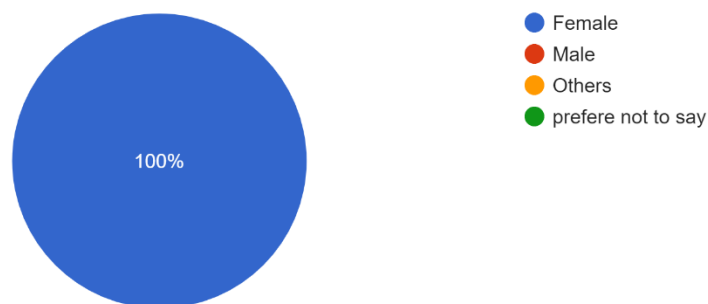
Graph 1 – Gender of participants

Age of participants

The results show that most participating professionals had an average age of between 31 and 40 years, representing 35.9% (14 participants) of the sample. Moreover, 28.2% (11 participants) belonged to the youngest group of professionals, aged between 20 and 30 years. In contrast, 17.9% (7 participants) were between 51 and 60 years' old, 12.8% (5 participants) between 41 and 50 years' old, and only 5.1% (2 participants) were aged over 60.

2) Age
39 respostas
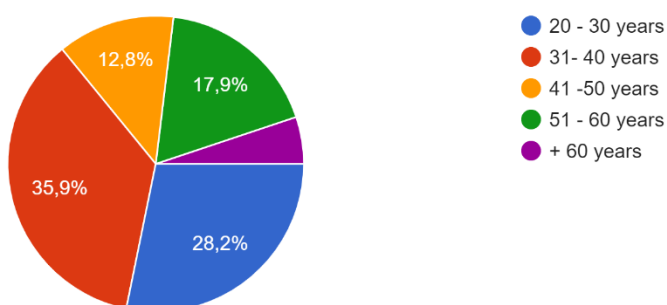
Graph 2 – Average age of participants

Regarding the age variable, about a third of the sample was middle-aged. These results agree with those from many other studies in healthcare, in which middle-aged professionals also predominated.
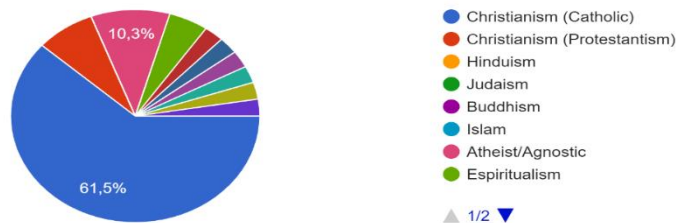
Nationality

Regarding the nationality of the participants, 38.5% (15 participants) were *Irish*; 38.5% (15 participants) were *Brazilian*; 4.8% (2 participants) were *Mexican*; 2.6% (1 participant) was *Filipino*; 2.6% (1 participant) was *Portuguese*; 2.6% (1 participant) was *Kenyan*; 2.6% (1 participant) was *Nigerian*; 2.6% (1 participant) was *Lithuanian*; 2.6% (1 participant) was *Estonian*; and 2.6% (1 participant) was *Mauritian*.
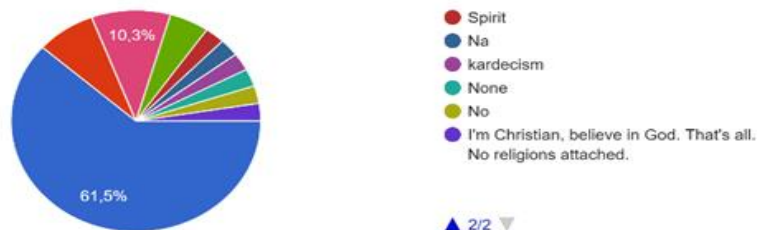
Religion/philosophy

The survey showed that 61.5% (24 participants) considered themselves Catholics, while 10.3% (4 participants) claimed to be atheists or agnostics. Another 7.7% (3 participants) defined themselves as Protestants, 5.1% (2 participants) as Spiritualists, 2.6% (1 participant) as a Spirit, and 2.6% (1 participant) as a Kardecis. Of the remaining three participants, one responded with "no", one with "n/a" and the final participant considered herself as follows: "I am a Christian, I believe in God. No religion connected." Philosophy and religion are an integral part of many cultures and cultural identities. Attitudes based on religious and philosophical viewpoints are involved in everyday decision-making in the area of healthcare, and this can be very striking.

4) Do you have any religion or philosophy?
39 respostas

- Christianism (Catholic)
- Christianism (Protestantism)
- Hinduism
- Judaism
- Buddhism
- Islam
- Atheist/Agnostic
- Espiritualism

△ 1/2 ▼

10,3%

61,5%

4) Do you have any religion or philosophy?
39 respostas

- Spirit
- Na
- kardecism
- None
- No
- I'm Christian, believe in God. That's all. No religions attached.

△ 2/2 ▽

10,3%

61,5%

Graph 3 – Religion/philosophy

Being religious can have some health and wellbeing benefits, including social support, existential meaning, a sense of purpose, a coherent belief system and an exacting moral code. But these benefits can also come from other sources. On the other hand, religion is shaped by the social context within which it exists, in ways that affect its social role. Religion is not a panacea when it comes to improving health. The role of religion in health needs to be examined in a broader context, mainly concerning how culture can influence the religious expression of the spiritual.

Profession and performance in the area of health

The data collected regarding the profession of the participants shows that 79.5% (31 participants) were caregivers, followed by nurses with 7.7% (3 participants). The other 5.1% (2 participants) of responses came from domestic assistants. Three participants (7.7%) were from other professions.

5) Profession / performance in the health area

39 respostas
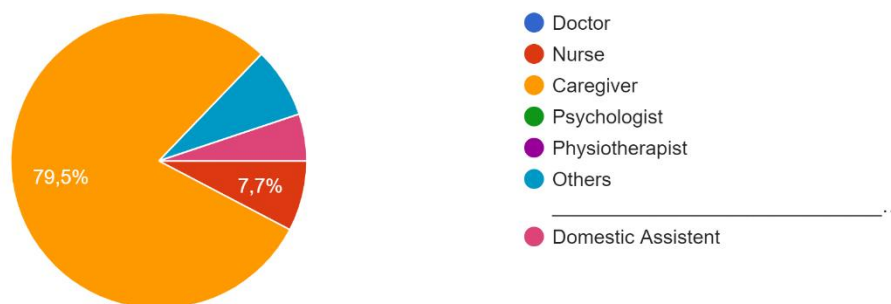
Graph 4 – Professional practice area

Length of professional experience

Most participants had between one and five years of experience in the healthcare arena, representing about 71.8% (28 participants) of the sample. Seven participants (17.9%) had between 11 and 20 years of experience and two participants (5.1%) had between 6 and 10 years of experience. Only 2.6% (1 participant) had between 21 and 31 years of experience in the field, and the final participant had 40 years or more of professional experience.

6) How long have you worked in the area / training (years)

39 respostas
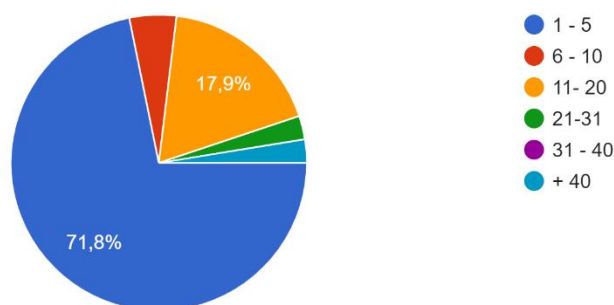
Graph 5 – Length of time in the professional area

Knowledge of palliative care acquired during undergraduate or professional life

This question was intended to uncover whether the participant had any initiation, learning or training in palliative care during their academic training, or even afterwards, while working as a professional. As we can see, 53.8% (21 participants) experienced some training before graduation or afterwards, during their professional activities. The other 46.2% (18 participants) had no previous training in palliative care, either during their academic life or later during their professional activities.

7) During your graduation / professional life, did you have any discipline/training to learn about palliative care and how to approach it?
39 respostas
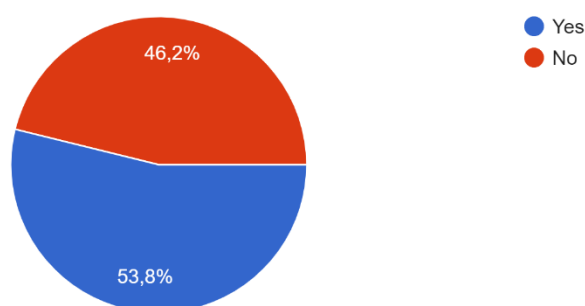
Graph 6 – Knowledge of palliative care as a student or professional

Definition of palliative care from the perspective of health professionals

This question was geared towards measuring the degree of knowledge participants held about palliative care, and how they would define the concept of such care. Based on the answers, it can be concluded that most of the participants understood the meaning of the term palliative care, what it represents, its function and its purpose. Many of them managed to define its real meaning—a multidisciplinary, holistic approach to end-of-life care, imbued with the values of empathy, respect and dignity, and offering emotional comfort. The focus of care is no longer on the treatment of the disease, but on the wellbeing of the human being.

Professional experience in palliative care

Based on the survey, approximately 66.6% (26 participants) affirmed that they had already had contact and experience directly linked to palliative care. The remaining 33.3% (13 participants) answered that they had never encountered palliative care in the workplace.

9) Have you ever worked in palliative care / Ever had to deal with patients in palliative care?
39 respostas
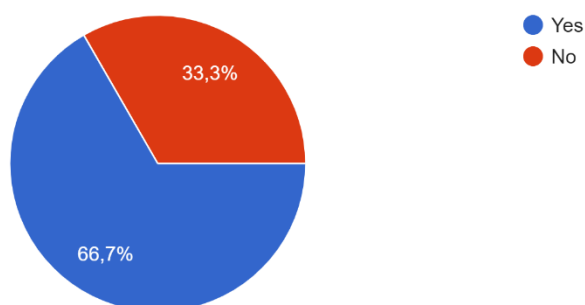
Graph 7 – Work experience in palliative care

Length of time in contact with palliative care

This question demonstrated that the length of time participants had spent working in palliative care was between 1 and 5 years, and was answered by approximately two-thirds of the sample—those who had experience of this area of care (26 participants).

10) If you answered yes to the question above, how long have you been in contact with the Palliative Care area?

26 respostas
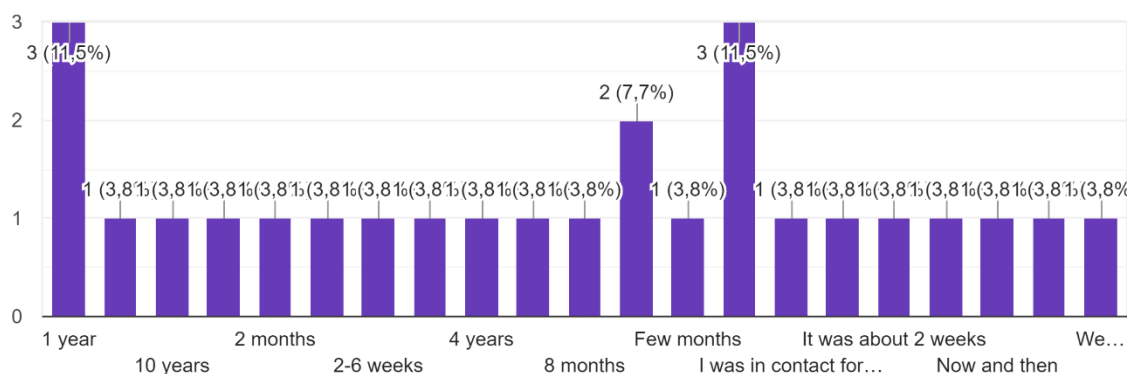
Graph 8 – Years of experience in palliative care in a health setting

Experience of conflict situations

The objective of this question was to identify whether participants had direct experience of conflictive situations in relation to palliative care during their professional duties. As the graph demonstrates, 71.8% (28 participants) had no previous experience of conflict, while only 28.2% (11 participants) answered in the affirmative.

11) Have you ever experienced a conflict situation about palliative care and end of life?

39 respostas
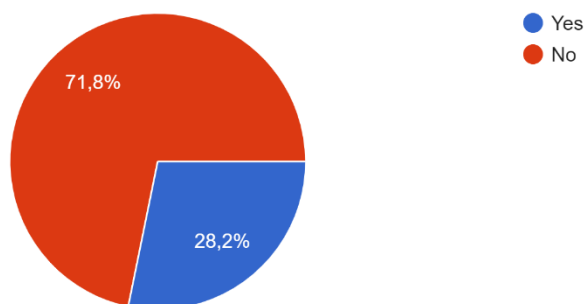
Graph 9 – Professional experience of conflict situations

Brief description of conflict situations

Most of the answers to this question were similar and concerned cases where family members refused to allow the patient to enter palliative treatment to relieve suffering in a situation considered irreversible, from a medical point of view. They "do not accept" that their loved one has no chance of recovery and they prevent the patient from availing of the palliative care being offered. In effect, they are turning their backs on a death with much less suffering and instead preferring to treat the disease rather than the patient at the end of life.

Barriers that have the most impact when deciding for or against palliative care

According to the participants' responses, ethical or moral factors represented only 2.9% (1 participant) of cases of conflict, religious issues accounted for 20.6% (7 participants), and cultural issues for a further 35.3% (12 participants). But the greatest percentage (41.2%; 14 participants) was made up of other conflictive factors (e.g., financial and emotional) not identified by the survey.

13) What kind of barrier do you think that has more impact when deciding end of life about use palliative care.

34 respostas
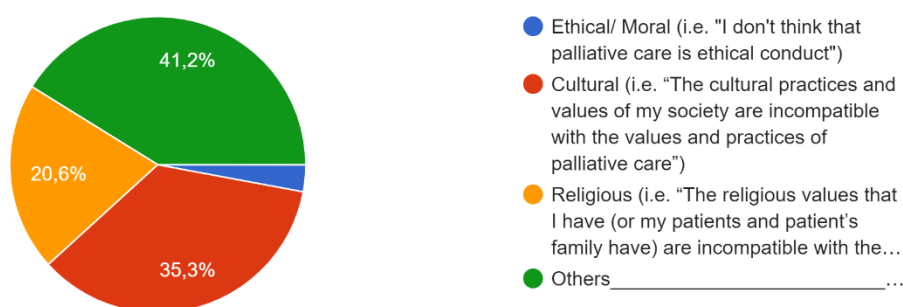
Graph 10 – Barriers regarding the use of palliative care

Any imperative (ethical, moral, religious, cultural, other) that could hinder the use of palliative care

In many cultures, families can act in a paternalistic way, denying information from their loved ones. It is essential to recognise and respect the different cultural, ethical and moral values of each patient and their family concerning information and decision-making. Health professionals should not ignore these factors. In answer to the question on this issue, most participants (97.4%; 38) replied in the negative, with only 2.6% (1 participant) affirming they had encountered an imperative that could impede the use of palliative care.

14) Do you have (or did you have) an imperative (ethical / moral / religious/cultural) that may hinder or have hindered palliative care for your patients?

39 respostas
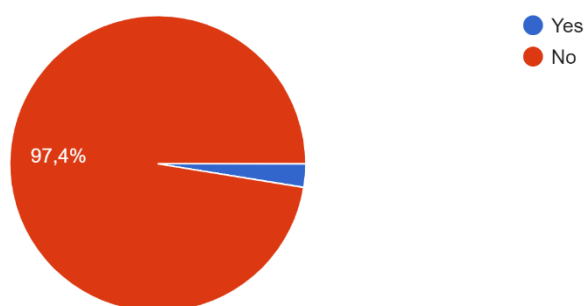
Graph 11 – Situations that hinder the use of palliative care

**The main obstacles identified in accepting palliative care**

Most of participants' responses were related to fear—fear of death, fear of leaving the family, refusing to accept the situation they are experiencing. Many questions are invariably asked as to why they are forced to go through this type of situation, having to witness the suffering of the process of mortality.

Classification of palliative care and end-of-life knowledge

According to the responses, 60.5% (23 participants) defined their level of knowledge on the subject as beginner, 18.4% (7 participants) declared themselves to have an intermediate level of knowledge, and a further 18.4% reported possessing no knowledge at all. Only one participant stated she had an advanced level of knowledge.

16) How do you classify your knowledge regarding palliative care and end of life?
38 respostas
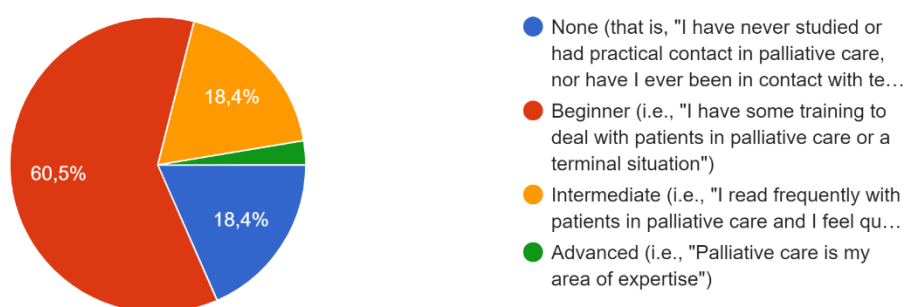
Graph 12 – Level of knowledge regarding palliative care

Knowledge relating to conflict resolution tools or protocols

Concerning knowledge of tools and protocols used in a conflict situation, the majority of participants (60.5%; 23) stated they knew nothing about them. Only nine participants (23.7%) confirmed they had such knowledge; six participants (15.8%) were unsure.
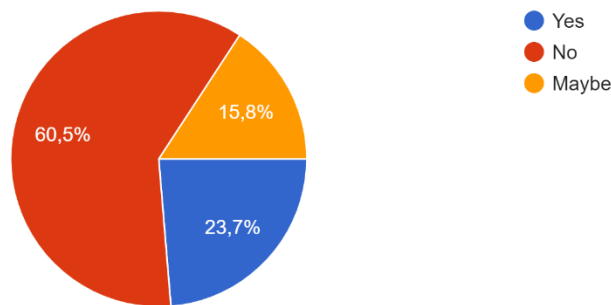
Graph 13 – Knowledge regarding tools and protocols used in conflict resolution

Brief description of conflict resolution tools or protocols

Of those who replied 'yes' to the previous question (9 participants), most of them had nothing meaningful to contribute regarding how to resolve a conflict situation. Below are the only two responses that came close to answering the question:

(i)   "Be a good listener, develop good open communication with your patient and their family."

(ii)   "Listen to both sides; try to get an agreement."

Definition of conflict-mediation tools and protocols

Following on from the previous question, the participants also demonstrated that they were not able to define a conflict situation. Below are some answers showing this:

(i)   "Ways to resolve conflicts/disagreements."

(ii)   "The mediator should be impartial, don't share any information related to the mediation except in the case of a notorious crime."

(iii)   "Better way to deal with conflicts."

(iv)   "Acknowledge the problem. Find common interests. Discuss the common interest and how to achieve it. Agree to implementation and responsibilities."

(v)   "Mediation skills call on you to use your counselling skills, your wisdom about life and to be practical and see outside the box."

(vi)   "A bunch of tools from several fields in the health care subject that together can create an integral therapy for those who suffer in this stage of life."

Participation in a situation of conflict mediation

According to the responses, 81.6% (31 participants) said they had never participated in any conflict situation related to care; 18.4% (7 participants) answered that they had intervened in a conflict situation related to palliative care.

20) Have you ever been in a situation where you had to mediate any conflict related to Palliative care?

38 respostas
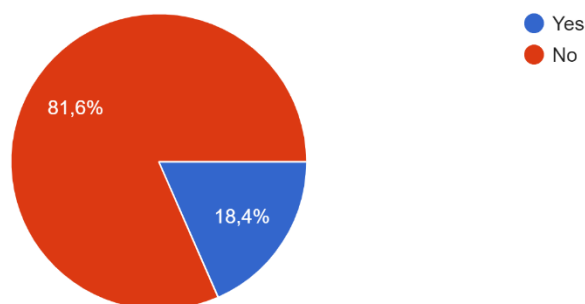
Graph 14 – Use of mediation in conflict resolution

Brief description about intervening in a conflict situation

Of the seven participants who answered this question, two of the more relevant answers were:

(i)   "A lady I was looking after was nearing the end, her son was living with her but didn't realise his mother was actively dying until I came to carry out my call. I went into her and could tell instantly she was coming to the end, and I had to tell him this and to maybe call the rest of their family. When his sister came she took over (oldest child and only girl) and he and another brother were getting very frustrated with the sister as she was all over the place (naturally, she

didn't know what steps to take next) and they started to fight and raise their voices at one another. I had to step in and gently remind them that it's a confusing time for them all and everyone wants to do the right thing for their mother. Still, that bickering isn't what they should be focusing on, that things will come together eventually and all they should be doing at that time was being with their mother."

(ii) "My mother had about a day to live. Her family gathered. It gave her comfort but she was in pain. My sister went to give her the Oramorph. My aunty got upset at her. I pretended that I had just got a call from the palliative care nurse, reminding me to give my mum her meds. The family accepted medical opinion. To stop that happening again, the palliative care nurse put in a pump for pain at that stage. In my professional life as an HCA [healthcare assistant], sometimes the person wants someone to acknowledge the stage they are at and be with them. Yesterday the man asked me to say a prayer for him. He was delighted when I said, would you like a prayer now. It was a special moment and a peaceful one."

Agreement with the sentence: "I believe that prolonging the patient's life using all possible means is the best action."

Concerning the above sentence, the majority of participants (44.7%; 17) expressed a neutral opinion. Those who disagreed represented 26.3% (10 participants) and those who agreed made up 13.2% (5 participants) of the sample. Three participants (7.9%) strongly disagreed with the statement, and another three strongly agreed.

22) Would you agree with the sentence: "I believe that, prolonging the patient's life using all possibles is the best action"

38 respostas
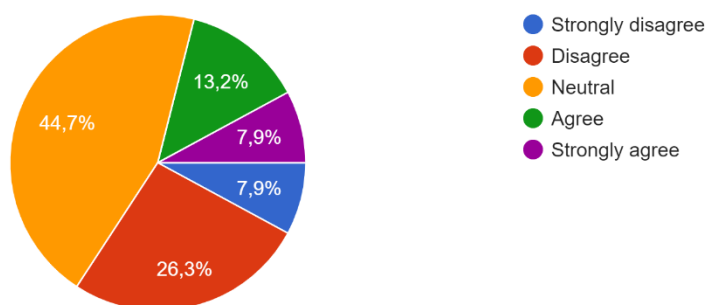
Graph 15 – Opinion regarding prolongment of the patient's life

Obstacles faced when applying palliative care

Regarding which circumstances could be an obstacle to accepting the use of palliative care, 29.7% (11 participants) answered that all of them could have an influence. For 27% (10 participants), a lack of knowledge about palliative care on the part of family members was considered to be the biggest obstacle. A lack of communication between professionals and family members was cited for about 21.6% (8 participants) of the sample. A lack of empathy about the situation was the reason given by 13.5% (5 participants) and, last but not least, a lack of information on palliative care by health professionals accounted for 8.1% (3 participants).

23) What is the biggest barrier/challenge you find or would face, when deciding on the application of palliative care?

37 respostas
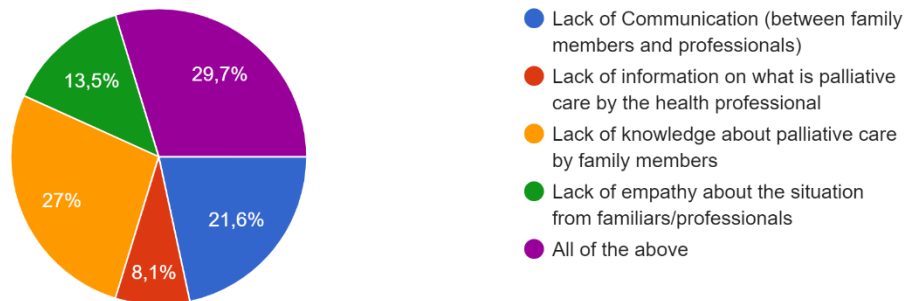
Graph 16 – Obstacles in the use of palliative care

Brief description of situations related above

Below are some of the most relevant answers concerning this question:

(i)   "In most of my patients in this stage of life, we all lack enough information and take a lot of things for granted and that doesn't let us ask ourselves the right questions."

(ii)   "When a family member or members or an individual don't understand what palliative care means. Treat the situation with great compassion and understanding from their perspective."

(iii)   "The family sometimes are resistant because they don't completely understand the value of palliative care."

(iv)   "Family refuses to accept that their loved one is at the end stage of life and lack of knowledge about how to go forward with palliative care. Not enough."

(v)   "Communication from health care teams. Families hear palliative care and get very frightened thinking they have a brief time left, which in a lot of cases is untrue. Palliative care can enhance the quality of life, but families don't have this knowledge to help them move forward."

Resistance from family members or patients on the use of palliative care

The great majority of participants (63.2%; 24) said they encountered no resistance from family members when asked about the possibility of using palliative care. On the other hand, 36.8% (14 participants) stated they found resistance.

25) Have you ever found/faced resistance from family members or patients on the use of palliative care?
38 respostas
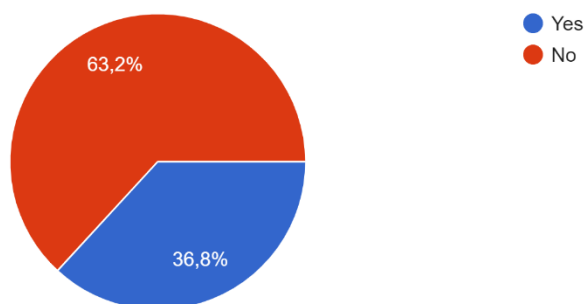
Graph 17 – Resistance by the patient's family regarding the use of palliative care

Chapter 5 – Discussion

The information gathered throughout the course of this study has been critically analysed and is presented here. Regarding the gender of the participants who engaged in the survey, all were women; this confirms previous research which reports that in the healthcare arena, most workers are predominantly female. It is estimated that the female labour force represents approximately 42% of the employed population worldwide. In the healthcare sector, this number increases considerably and in many countries the employment of female labour is over 75%, which makes women indispensable in the provision of health services (Sen et al., 2007; George, 2007; Messing and Östlin, 2006; Gupta et al., 2003; Standing, 2000).

The average age of healthcare workers who participated in this study survey was between 31 and 40 years. Based on the data, it is possible to infer that, within this cohort of participants, the average worker was about 36 years of age, had between one and five years of professional experience, had not acquired sufficient theoretical and experiential knowledge in the palliative care sector, and, consequently, was likewise lacking in experience in a conflict situation.

This is confirmed by the survey as a whole, which shows that regarding the level of knowledge on palliative care, the majority, about 60.5% of the participants, declared themselves as only having a beginner level of expertise. When asked about conflict resolution and tools and protocols, again, about 60.5% of the participants said they did not know how to deal with conflict. Thus, the majority of participants did not have adequate knowledge of what conflict entails or how to deal with a conflict situation. When referring to conflict resolution tools and protocols, most participants had no real understanding of what it means.

There were very few answers that were able to define how to manage a conflict situation, especially concerning such a sensitive subject as life and death. Two important factors considered fundamental in conflict-resolution situations are communication and empathy.

The lack of knowledge on the subject, in large part, is due to the limited experience of the participants, as well as their lack of a theoretical basis and academic background, as shown by their answers in the questionnaire. Much of the problem comes from the subject under consideration, palliative care, which despite dating from the nineteenth century and gaining strength over the following years, is still a relatively new area in mainstream healthcare.

Another question that has brought to light relevant results concerns "prolonging the patient's life". Almost half of the participants (44.7%) were neutral in their responses, that is, they had not yet formed an opinion on this issue due to a lack of in-depth knowledge on the subject.

Regarding which circumstances could be an obstacle to accepting the use of palliative care, for most participants there was no one predominant factor. Lack of information leads to a lack of knowledge, which in turn leads to a lack of communication, culminating in a lack of empathy. Altogether these factors can lead to misunderstandings on the use of palliative care between the patient, their family and healthcare professionals, thus generating conflict. Despite this, most participants, about 63.2%, reported that they did not encounter resistance on the part of family members when palliative care was suggested.

Conflict resolution among the different parties can be improved through the exchange of clear and objective information, thus creating a better understanding of the subject by family members and healthcare professionals (Spaho, 2013).

As the literature review revealed, traditionally in negotiation it has been considered essential that there should be a winner and, therefore, also a loser. Today, however, it is understood that two or more people with different opinions can still win in a negotiation. People will always try to achieve their desires but the main reason for success in a negotiation is finding the best solution to the problem (Fisher & Ury, 1991).

Different cultural values might influence decisions. Dealing with other people is always a challenge and conflict can arise for several reasons. According to Turkalj (2008), there are three essential factors

to be considered: (i) relationship conflict, when a person behaves in a negative manner; (ii) value conflict, when people or groups have different opinions about morals and ethics; and (iii) conflict of interest, when a person's desired outcome conflicts with the interests of another person or group. In certain situations, a better degree of clarity about the objective can help to communicate different opinions and reduce misunderstandings.

Human beings have the ability to be compassionate and express empathy. The purpose of the communication process is to connect with ourselves and with others, comprehensively and naturally. It is not just about trying to convince people to do what we want but about creating a connection with another person (Rosenberg, 1960).

The development of emotional intelligence can be considered a factor of importance in effective communication. Recognising emotions in both ourselves and others brings with it an ability to understand the reasons behind others' choices and can lead to better results in conflict situations in healthcare settings. Understanding another person, their emotions and behaviours, is an important skill in a conflict situation, as a range of positive and negative emotions is typically experienced during such a scenario.

Through this study, it has been possible to identify how essential verbal and non-verbal communication and active listening are in different sectors of life, both professional and personal. Chichirez and Purcărea define this critical aspect in the following way:

"Communication in the medical act is an active process of transmission and reception of information, and, at least one of the partners of communication must have active listening skills, understanding of the message, and answering some questions for interpretation of non-verbal language, motivating the speaker to support the conversation." (Chichirez & Purcărea, 2018, p. 121)

It is always important to observe non-verbal gestures, as some may have different meanings for people with diverse backgrounds. The practise of active listening can also help avoid misunderstandings and possible conflict. Communication failure and misinterpretation can lead to

confusion and misunderstandings. Avoiding hasty conclusions can also reduce misunderstandings and help in conflict-resolution situations. Moreover, there is little or no information about the principles and procedures of palliative care available to the vast majority of healthcare professionals worldwide despite the fact that, in recent years, the science of such care has accumulated a growing body of knowledge.

Conclusion

Palliative care is related to the theme of death and dying. This subject has been debated in many studies, as seen in the literature review in Chapter 1, with an emphasis on the death process and the act of dying. Based on this approach, however, the various reactions of each of the parties involved has been disregarded. While emotional reactions are inherently entwined with the theme of dying, little has been discussed about the attitudes of healthcare professionals to death. Coping with death and the end-of-life process produces a multitude of emotions, such as sympathy, remorse, guilt, indifference, denial, engagement and empathy. Health specialists are expected to save lives, which can lead to feelings of failure and helplessness when faced with a patient's death. Consequently, some authors emphasise the need to prepare them for this eventuality, as well as the necessity for research on this subject. Palliative care is included in the current debate on death and dying, stressing the historical aspect and the role of health practitioners. Therapeutic goals demonstrate a strong emphasis on the preparation and education of professionals. Palliative care is an example of a process that aims to transform the representation of death, making it a normal phenomenon, the result of life, and treatment is given to patients who have little chance of being cured. The results of this study reinforce the value of educating healthcare practitioners at the undergraduate level with appropriate training to cope with death and dying.

Understanding and recognising death as part of life makes it possible for the practitioner to view a patient's death as simply part of a process, rather than as a failure of treatment. Being exposed to the theme of dying and the use of palliative care during training can greatly assist those who work every day with death. To provide better treatment for both the patient and their family, during end-of-life situations, it is necessary to have training. A significant feature of this training is the integration of both technological and interpersonal factors in the development of skills and abilities. The theory of palliative care allows the patient and their family to pay attention to biopsychosocial and spiritual dimensions. An interdisciplinary professional team will ensure that all these criteria are covered.

Based on both patient and practitioner needs, this will encourage communication between the team and the system's users, thus preventing disagreement and conflict.

Some authors emphasise the working relationship of healthcare practitioners, especially within the context of witnessing human finitude, reflecting on the importance of teamwork on the success of care. Patient autonomy is beyond cure and is explored as a theme that is part of palliative philosophy. Scholars have examined how healthcare professionals deal with this problem since a theoretical understanding of the idea of self-reliance affects how the practitioner takes care of their patients. This topic is of the utmost significance to those who have no hope of cure, since it includes bioethical considerations and decisions about how to continue care at the end of life.

There have been some significant advances in understanding the benefits of an early integration of palliative care with disease management. Through this investigation, it has been possible to identify some of the reasons for failing to provide palliative care services, as well as some strategies to overcome these barriers. A better understanding of palliative care by healthcare professionals and patients' families is required; this would help to create a better experience for patients and their families and ensure better access to palliative care early on in the course of illness.

Palliative care research has focused on the way healthcare practitioners interact with patients and family members. Few articles have attempted to gain insight into the attitudes of health professionals, who face the imminence of death on a regular basis; gaining such an insight is essential to improving standards of treatment. The analysed data indicates there is a real need for training so that practitioners are qualified to offer both curative and palliative treatment, as both provide extensive assistance to the patient and their family. It is therefore recommended that future research on the difficulties facing multidisciplinary palliative care teams in their daily lives is essential, because death represents an ongoing challenging experience for healthcare professionals.

Some suggestions can be made in relation to overcoming the barriers identified in this study. The lack of understanding concerning the role of palliative care by healthcare professionals and the families

involved is an important obstacle in patients receiving adequate care. Both hands-on and academic preparation of professionals would help them understand the impact of palliative care in relation to conflict resolution. The results of this research have paved the way for a dialogue between the disciplines taught during professional training, which should include topics related to approaching and dealing with conflict situations in a health establishment. Ongoing professional training on the subject is urgent for those already working in the health field. The problem raised not only concerns the lack of provision of palliative care, but also the lack of knowledge about how to act when confronted with a conflict situation. It is essential to take into consideration the influences of culture, religion and ethics but, based on this study, they do not seem to have a large impact on the use of palliative care and are not determinants with regards to accepting or declining offers of such care. On the other hand, knowledge and effective communication, including active listening and empathy, are crucial in dealing with conflict situations. Moreover, some aspect of palliative care preparation is essential for all healthcare practitioners, whether they are physicians, nurses, specialists in mental health, volunteers or therapists. As well as this, it is vital that the community at large is educated so that there is an increasing awareness of palliative care, and all the benefits it can offer to patients and their families.

Reflection

Having trained as a social worker, as well as holding a Bachelor of Science in Interdisciplinary Health Services, my work on this thesis has only reinforced my view that I am on the right path. Currently working as a healthcare assistant in Dublin, I am surrounded by the mysteries of life and death on a daily basis. I am fascinated and, at the same time, grateful for all the knowledge I have acquired so far on the subject and further developed during this course. This master's degree in conflict resolution has added much to my professional training, as I have become familiar with special tools used in the field of social work. My work is directly linked to conflict generated within professional and personal relationships, mainly relating to the guarantee of human rights, both constitutional and fundamental. The understanding achieved from carrying out this study has clarified many of my doubts, and I have become increasingly able to deal with such a controversial subject as the end of life, a topic that will always be postponed if at all possible by the majority of people. Throughout all times and contexts, humans have built and continue to develop rituals and representations of life and death. Society, governed by the ideology of health and bodily perfection, places its hopes on biomedical knowledge, which is reflected in the medical environment. The health professional is responsible for controlling disease and, if possible, death. This has several consequences, for patients, family members and health professionals. I hope that future investigations and publications will explore in more depth the issues surrounding the end of life. I am incredibly grateful for the opportunity to carry out this research, through which I have been able to improve and expand my knowledge.

This research topic I believe to be an essential one for everyone, regardless of whether you are a frontline worker or a healthcare professional. The tools and protocols used in resolving a conflict situation, as well as having a small understanding of palliative care and its uses, are fundamental in a healthy society. I am proud of the research I have done and the conclusions I have drawn throughout this project—it has greatly improved my understanding of this area, which was not so clear at the beginning of the work.

Unless we change our way of thinking, we will not be able to solve the problems caused by the way we get used to seeing the world. (Albert Einstein)

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Appendix – Questionnaire

1 - Gender

a- Male

b- Female

c- Other

d- Prefer not to say

2 - Age

a- 20–30

b- 31–40

c- 41–50

d- 51–60

e- + 61

3 - Nationality

_____

4 - Do you have any religion or philosophy?

a- Christianity (Catholic)

b- Christianity (Protestantism)

c- Hinduism

d- Judaism

e- Buddhism

f- Islam

g- Atheist/Agnostic

h- Other_____

5 - Profession/performance in the health area

a- Doctor

b- Nurse

c- Caregiver

d- Psychologist

e- Physiotherapist

f- Other_____

6 - How long have you worked/trained in the area (years)?

a- 1–5

b- 6–10

c- 11–20

d- 21–30

e- 31–40

f- + 41

7 - During your education/professional life, did you have any training in learning about palliative care and how to approach it?

a- Yes

b- No

8 - How would you define palliative care? What would palliative care mean for you?

9 - Have you ever worked/ever had to deal with patients in palliative care?

a- Yes

b- No

10 - If you answered yes to the above question, how long have you been in contact with the palliative care arena?

11 - Have you ever experienced a conflict situation about palliative care or the end of life?

12 - If you answered yes to the above question, could you briefly describe the case?

13 - What kind of barrier do you think has the most impact when deciding end-of-life and palliative care?

a- Ethical (i.e., "I don't think that palliative care is ethical conduct")

b- Cultural (i.e., "The cultural practices and values of my society are incompatible with the values and practices of palliative care")

c- Religious (i.e., "The religious values that I have (or my patients and patient's family have) are incompatible with the values and practices of palliative care")

d- Other_____

14 - Do you have (or did you have) an imperative (ethical/moral/religious/cultural) that may hinder or have hindered palliative care for your patients in the past?")

a- Yes

b- No

15 - In your opinion, what is the main obstacle that terminal patients identify to accepting palliative care and the termination of life itself?

16 - How would you classify your knowledge regarding palliative care and the end of life?

a- None (i.e., "I have never studied or had any practical experience of palliative care, nor have I ever been in contact with a terminal situation")

b- Beginner (i.e., "I have had some training to deal with patients in palliative care or a terminal situation")

c- Intermediate (i.e., "I deal frequently with patients in palliative care and I feel qualified to work in this area, even if it is not my speciality")

d- Advanced (i.e., "Palliative care is my area of expertise")

17 - Do you know any tools or protocols used in conflict mediation?

a- Yes

b- No

18 - If you answered yes to the question above, could you briefly describe which?

19 - How would you define these conflict mediation tools and protocols?

20- Have you ever been in a situation where you had to mediate any conflict related to palliative care?

a- Yes

b- No

21 - If you answered yes to the question above, could you briefly describe the situation?

22 - Would you agree with the sentence: "I believe that prolonging the patient's life using all possible means is the best action."

a- Yes

b- No

23 - What is the biggest barrier or challenge you find or would face when deciding on the application of palliative care?

a- Lack of communication (between family members and professionals)

b- Lack of information on what is palliative care by health professionals

c- Lack of knowledge about palliative care of family members

d- Lack of empathy about the situation from familiars/professionals

e- All of the above

24 - Can you describe any real situations in which you have observed these barriers and challenges in real life?

25 - Have you ever found/face resistance from family members or patients on the use of palliative care?

a- Yes

b- No