Conflict Management Case Study: The Patient Care Dilemma

Background

Green Valley Hospital is a regional healthcare facility with a reputation for collaborative, patient-centered care. Recently, the hospital admitted Elnora Hayes, a 74-year-old woman diagnosed with Stage IV colon cancer. Ms. Hayes has been undergoing palliative chemotherapy and targeted radiation therapy. Despite this aggressive, Ms. Hayes' condition has deteriorated significantly. She is now experiencing side effects from the treatment, including chemotherapy-induced peripheral neuropathy, nausea, and cancer-related fatigue, leading her to express a desire to discontinue further aggressive interventions and transition to home care.

Key Stakeholders

Horace Clarke, oncology clinical pharmacist, plays a critical role in managing the pharmacological aspects of Ms. Hayes' treatment. His advocacy for continuing FOLFIRI (folinic acid, fluorouracil, and irinotecan) plus bevacizumab reflects his clinical judgment that Ms. Hayes may continue to benefit from additional treatment. Clarke is, however, aware of the regimen's toxicity profile, including neutropenia, diarrhea, mucositis, and fatigue, as well as bevacizumab-related risks such as hypertension and headaches.

Helen Hayes, the patient's daughter, is emotionally distressed and insists that all possible life-sustaining treatments be pursued. She is exploring clinical trials, compassionate use protocols, and immunotherapy options, without fully understanding whether her mother meets eligibility criteria. Helen has initiated discussions about obtaining medical power of attorney, but Ms. Hayes has not legally designated her as a surrogate decision-maker. Helen has shared with friends her own guilt about not previously being involved with her mother's medical care.

RN, BSN, OCN Rachel Kim, has developed a strong therapeutic alliance with Ms. Hayes. Drawing on her experience in chemotherapy infusion and symptom management from her work at the state teaching hospital, Kim supports Ms. Hayes' wish to prioritize quality of life over life-prolonging interventions. Kim advocates for a palliative care consult to explore comfort-focused options for Ms. Hayes. Her past suggestions with attending physicians at the hospital about non-pharmacologic interventions such as relaxation techniques and nutritional support have generally been ignored.

Kim is looking for a new job due to past discussions with several physicians (including Ms. Hayes' attending physician, Dr. Sarah Lee) and administrators at the hospital in which (Kim believes) patient preferences are overruled by family directives or hospital

administration concerns about time delays and liability issues arising from patient care decision-making.

Dr. Sarah Lee, the attending oncologist, believes that continuing chemotherapy may offer a marginal survival benefit (estimated 2–3 months) and is concerned about setting a precedent for discontinuing treatment prematurely. Lee has been with Green Valley Hospital for 10 years and is known for her evidence-based approach to patient care. Due to a shortage of oncology specialists, Lee manages a high patient load, which (on occasion) has impacted her ability to engage in extended shared decision-making discussions with nursing staff, the hospital's pharmacy, and hospital administration.

Conflict Situation Description

During a team meeting, Lee recommends continuing chemotherapy, citing limited but potential benefits. Kim expresses concern, relaying that Ms. Hayes has clearly articulated her desire to discontinue treatment and focus on end-of-life care. Helen becomes visibly upset, accusing the team of "giving up" and threatens to escalate the matter to hospital administration and legal counsel. She demands that chemotherapy continue and that the team explore experimental therapies and expanded access programs. The meeting ends without consensus.

Discussion Questions

1. What are the different sources and types of conflict present in this situation?

2. How might cognitive bias (psychological filters), emotional fatigue or systemic constraints (e.g., staffing shortages, time pressures, etc.) influence the conflict situation?

3. How would you describe the interests of the people involved – Ms. Hayes, Helen Hayes, Sarah Lee, and Rachel Kim? What interests do they share?

4. What strategies can the team use to ensure Ms. Hayes' voice remains central in decisions about her care?

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Conflict Management Case Study: Voices Unheard – A Safety Culture in Crisis

Background

Northside Medical Center is a large urban-based hospital with a well-regarded oncology unit. Despite its clinical reputation, the hospital has faced persistent challenges with staff retention, particularly among its oncology nurses. Over the past three years, turnover has exceeded 35%, with exit interviews frequently citing burnout, lack of support, and fear of retaliation for speaking up as reasons for the nurses to leave Northside. There also seems to be a pattern developing in that Northside is having difficulty recruiting and retaining recent nursing graduates, particularly those in the Gen Z generation (people born between 1997 and 2012).

Conflict Situation Description

Hospital leadership, prompted by a recent Joint Commission review, launched a new initiative to improve Northside's safety culture. The initiative included posters promoting "Speak Up for Safety," monthly town halls, and an anonymous digital suggestion box/hotline. However, the effort was met with skepticism by nursing staff, especially in oncology, who felt the initiative was mere "window dressing," and who did not believe hospital leadership was committed to taking safety concerns seriously.

Historically, nurses who raised concerns—such as unsafe staffing ratios, delayed chemotherapy administration due to pharmacy bottlenecks, or the personal emotional impact attributed to patient loss—were either ignored or subtly reprimanded. One nurse, who anonymously reported a near-miss incident involving a chemotherapy dosage error, was later excluded from key team meetings and had her work schedule changed without explanation. Recent nursing graduates hired by Northside report that their concerns are being dismissed by older colleagues and supervisors who complain about the newer nurses' "lack of resilience" and failure to understand "that's how things are done around here."

There have also been episodes of miscommunication between the oncology unit and the Northside pharmacy, resulting in delayed chemotherapy treatments for patients. Oncology nurses report when they raise these concerns to hospital administration they are told "the problem is being addressed," and to prioritize other job tasks.

Escalation

Tensions peaked when a respected nurse manager, submitted a formal complaint about chronic understaffing and its impact on patient care. Her complaint was met with a

generic acknowledgment email, and no follow-up occurred. Within weeks, the nurse manager resigned, citing a toxic work culture and fear of professional retaliation.

The nurse manager's departure triggered a wave of resignations and internal conflict. Northside staff began refusing to participate in the safety initiative, and informal peer support groups formed to vent frustrations. Leadership interpreted this as resistance to change, further widening the gap.

Intervention

A newly appointed chief nurse executive, with a background in trauma-informed leadership, initiated a listening tour. She met with oncology nurses in small, confidential groups and acknowledged past failures. She implemented: (1) anonymous reporting with guaranteed follow-up, (2) peer-led safety rounds, and (3) psychological safety workshops

Outcomes

Six months later, early signs of improvement emerged: (1) Reporting of safety concerns increased by 40%, (2) nurse turnover in oncology dropped to 18%, and (3) staff surveys showed a 60% increase in perceived psychological safety. Despite these improved outcomes, however, challenges remained. Some staff still feared retaliation for reporting safety incidents, and, antidotally, nursing staff reporting they did not feel that their input about improving the Northside safety culture and work environment was being heard or meaningful considered by hospital administration. Additionally, nurses participating in peer-led safety rounds feel uncomfortable critiquing their co-workers, while others (again) feel the safety problems identified and discussed during the peer-lead safety rounds are being ignored by hospital administration.

Discussion Questions

1. What are the different types and sources of conflict in this conflict situation?
2. How would you describe the interests of the nursing staff in working at Northside and being part of restoring an effective safety culture?
3. How can Northside administration build trust and meaningful rapport with its nursing staff?

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