Table 49: Tan 2013[427]

Study (ref id)	Tan 2013[427]	
Aim	To describe the conflict experience that family physicians have with substitute decision makers of dying people and to identify the factors that may facilitate or hinder the end of life decision making process.	
Population	Family physicians with experience of dealing with conflict with surrogate decision makers of dying people n=11	
Setting	Canada	
Study design and methodology	Semi-structured interviews using a guide created by the researchers. The initial questions asked was "could you please tell me in an anonymous manner about the time(s) when you experienced conflict during an end of life decision making discussion with a substitute decision maker of a dying person.	
Analysis methods	The transcripts were analysed individually by the researchers and discussed to come to a joint analysis. An outside researcher of the study coded the transcripts to confirm initial coding of themes.	
Themes with findings	**Facilitators**	**Barriers**
	Building mutual trust and rapport (using communication techniques) "*So I think you can enable the patients and families to digest things in smaller chunks so you can basically give them more information over time, and you see them over time, and they*	Families denial of the patients terminal illness: "The *wife wasn't really grasping it and probably in some denial… so she was sort of saying 'can we do this? Can we do this? Can we do more?"'* *"I think a lot of it has to do with unrealistic expectations for the patients and family though… they expect of medicine what medicine cannot do…".*

Study (ref id)	Tan 2013[427]	
	have a trust in you… to come to a better understanding of things."	
	Understanding one another as a facilitator *" and tell me a little bit about… what you're understanding is of what's going on here and what are your sorts of thoughts about what's going to happen now?... then I learn kind of where we're at".*	Lack of prior relationship between the physician and the dying patient and family: *" … Because I take on "orphan" palliative patients a lot of the time, you're meeting people for the first time at precisely the most emotionally stressful time of the patient and usually the family's life… the potential for me for conflict is greater when I'm coming in as a new physician".*
	Building common ground: Using time: *"It takes time. I think understanding the perspective of the substitute decision- maker or even the patient. And time. And that whole thing of finding common ground. I think it is important. And it takes time to find that common ground."* Using Other MDT such as nurses social workers and chaplains: *"Don't think that you're by yourself in these situations… If you ever feel that you're coming into conflict with someone, always just ask for help and get different perspectives on situations and different ways of dealing with things… don't ever get angry with it. You know just stop the conversation it you feel like you're not getting anywhere and leave and ask for help."*	No previous effective advance care planning by the patient and family: *"So I really think it is our responsibility, first and foremost, we are the people that know them the best. We are the people that can have this discussion and we've got the continuity and the longevity. We know how to bring this up, we know when to bring it up…"* *"It really has to be the family physician… in an ideal world, it would always be brought up by the family physician and we would have clear understandings about future wishes of patients".*
	Experience of the doctor: *"Conflict, dealing with conflicts, I think, makes you more grounded, makes you more experienced to deal with these kind of situations in the future. That's how I feel… I learn a lot. We all learn a lot from conflicts."*	Barriers to understanding one another (listed but not detailed in report0: • Language barriers • Cultural/religious barriers • Value difference • Legal concerns • Taking conflict personally • Being inflexible • Prior negative healthcare experiences

Study (ref id)	Tan 2013[427]	
		• Mistrust of system • Family discord/dysfunction • Unattainable goals and expectations • Denial of patients condition • Physician internal conflict.
Limitations	No limitations. Data saturation met during the study, and results triangulated through field notes to capture observations not taken in the audiotapes. Theoretical sampling also used.	
Applicability of evidence	Direct population, although the study only explores physicians who had experience of dealing with conflict, and did not speak to those who reported no conflict, this group may have had refined skills in preventing or handling conflict. Setting outside the UK.	