Received: 13 October 2023 | Accepted: 4 August 2024

DOI: 10.1002/jpn3.12365

JPGN

SOCIETAL PAPER

Gastroenterology

Conflict between parents, physicians, and healthcare professionals in medical decision-making: How to address it—A systematic review from the ESPGHAN Ethics Committee

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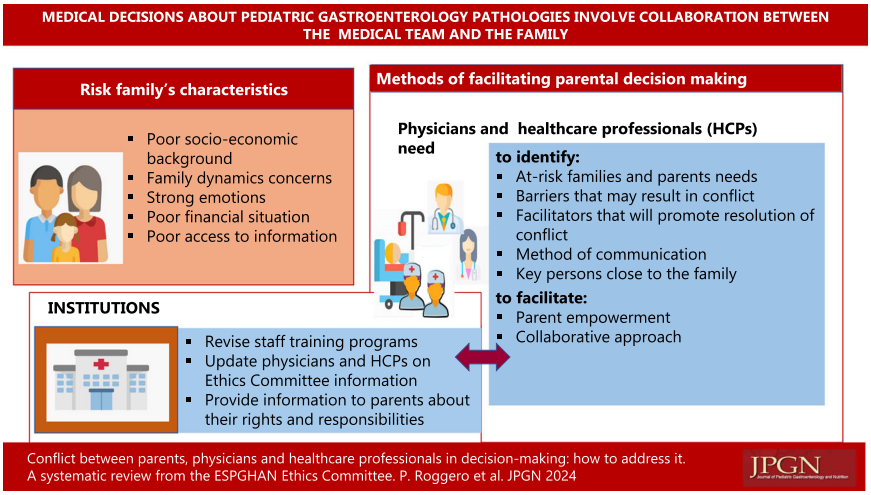
Funding information
None

Abstract

Medical decisions about pediatric gastroenterology pathologies often involve collaboration between the medical team and the family. On occasions, conflict may arise between the individuals involved in decision making (team–family conflict) causing delays in managing a child's health condition. Little is known on the strategies that can be implemented to address such conflicts. Using the systematic review model by McCullough et al., an electronic literature search was conducted using PUBMED databases and SCOPUS. Studies published between 2001 and 2022 were analyzed to identify high-risk families, the barriers and facilitators involved in the team–family conflict and the circumstances in which healthcare professionals can be ethically justified to override parents' medical decisions and to trigger the state intervention. The present review provides recommendations on the more suitable ways to manage team–family conflict and gives a practical approach using a case vignette.



KEYWORDS

best interest, harm principle, medical decisions, team–family conflict

1 | INTRODUCTION

Medical decision-making in pediatrics and neonatology is a complex process. The principles that govern decision making have changed over time. Historically, physicians used to decide for their patients based on the "best interest principle." A valid alternative to the concept of a patient's best interest was later described as the "harm principle" (or nonmaleficence).[1] Both principles aid physicians in acting on behalf of their patients, a practice described as paternalism. Over time the concepts of patient autonomy and patient dignity emerged and lead to a significant change in the decision-making process.[2–4] A shared decision-making approach (SDM) is now favored by most.[5,6] In this approach, physicians, healthcare professionals (HCPs), and families collaborate in the decision-making process. In SDM, physicians and HCPs share their medical expertise. They provide the best available evidence on the risks and benefits of available options. On the other hand, patients and parents contribute personal information such as their values and beliefs, social circumstances, and preferences regarding the options discussed. SDM presupposes that families are properly informed about the options, risks, and benefits of the proposed care pathway for their children.[7,8] The goal of this approach is to arrive at an informed choice for a course of action that is consistent with the parents and patients' values and priorities.

On occasions, team–family conflict might arise between the physicians, HCPs and parents about the best treatment option. Conflict may arise due to a difference in opinion between the members involved in decision making and can be difficult to manage if it reaches an impasse. This can lead to delays in making important medical decisions leading to deleterious effects on a child's health.

Recent bioethical studies have shown that SDM and team–family conflict can be influenced by factors relating to the decision itself but may also be influenced by the individuals involved in the SDM process and the environment they are in. These factors are described in the literature as barriers (factors that hinder medical decision making and contribute to team–family conflict) and facilitators (factors that aid medical decision making and help in resolving team–family conflict).[6–8]

The role of the physicians and HCPs is to manage the team–family conflict within the team involved in SDM. To do this, the physicians need to identify the cause of the conflict, address the contributing barriers and be aware of strategies to manage the conflict effectively. Tools that can help in resolving conflict include a sound knowledge of medical guidelines and best medical practice but also include knowledge of patients' rights-based principles.

In the field of pediatric gastroenterology, hepatology, and nutrition (PGHN) little is known on how to manage team–family conflict scenarios. In this review, the authors strive to assess what literature is available on conflict management in scenarios faced by the pediatric gastroenterologist.

What is Known

- Lack of collaboration between parents and medical professionals in medical decisions has detrimental impact on the health of children.

What is New

- A practical approach for healthcare professionals on managing team–family conflict with a useful checklist that summarizes current literature.

The primary aim of this paper was to review the ethical literature about managing team–family conflict between physicians, HCPs, and parents in the field of medical decision-making for children, with a particular focus on identifying high-risk families, barriers, and facilitators involved in the team–family conflict. The secondary aim was to understand the circumstances in which physicians and HCPs are justified in overriding parents' medical decisions and trigger state intervention. The study also aimed to provide recommendations on how to manage team–family conflict through a hands-on approach by providing a case vignette and a checklist to aid physicians and HCPs reflect on their role in team–family conflict management.

To meet the study's aim, a systematic review of the literature was done. Several models of systematic review in bioethics have been proposed, each suited to different purposes, types of literature, and audiences. The model of systematic review proposed by McCullough et al. was deemed to be the most appropriate for this study.[9] According to the model proposed by McCullough et al. and to reduce potential bias, focused questions were first identified, and then a literature search was conducted using relevant keywords. The adequacy of the methods used in the papers were analyzed and finally, conclusions drawn in each paper were identified and assessed to see whether they applied to the focused questions.

This review addressed the following questions:

1. Definition of population: Who are the pediatric patients involved in a team–family conflict in terms of type of disease, prognosis, and the burden of treatment?
2. What are the causes and contributors (barriers) of HCPs team–family conflict?
3. What are the facilitators that help in managing team–family conflict and what interventions are used to manage the HCPs team–family conflict?

4. Under what circumstances are HCPs ethically justified to override parents' wishes?

2 | METHODS

2.1 | Stage 1: Literature review

An electronic literature search was carried out using key terms relevant to the focused questions on PUBMED databases and SCOPUS using combinations of the following keywords: (newborns OR pediatric patient OR child OR adolescent) AND (physician OR medical doctor OR pediatrician OR nurses OR healthcare professional) AND (parents) AND (disagree OR decision-making OR refuse treatment) AND (ethic OR morality OR role). The automated database search was supplemented by a manual search of the reference lists and footnotes of the included articles to identify additional pertinent publications.

To support the considerations of the inclusion criteria, two of the authors independently reviewed the titles and abstracts for all search records found by the database search. Following this, both authors reviewed the full text of publications deemed potentially relevant from their abstracts and they identified conclusions drawn in each paper and determined whether the conclusions applied to the focused questions. Disagreement about inclusion or exclusion of a study was settled through discussion between the two authors.

The inclusion criteria were:

1. Publication date between 2001 and 2022.
2. Articles written in English.
3. The authors describe the ethical context that specifies the circumstances revolving around the team–family conflict.
4. The authors discuss strategies on how to manage the team–family conflict involved in SDM.

The selected publications focused on the broad aspects of the decision-making process, on the several related issues that resulted in team–family conflict and on the active participants who played a decisive role in this complex process. This selection was conducted to define which pediatric patients were mostly affected, the pathologies involved, and the treatments prescribed which were refused by the parents. Furthermore, the authors looked at the characteristics of the parents that refused to follow medical advice, and the possible causes that led them to take a decision contrary to the medical advice given. Finally, the authors considered how to manage the team–family conflict and when HCPs were ethically justified to override parents' wishes.

Publications that focused on team–family conflicts about issues other than essential medical treatment (e.g., participation in research, vaccination, religious reasons, and cultural belief) were excluded. Publications about parental abuse were excluded as well as these situations are quite different.

A separate search related to gastrointestinal, hepatology, and nutrition scenarios that may result in a conflict was undertaken using the keywords (chronic AND gastrointestinal OR hepatology OR nutrition, (newborns OR pediatric patient OR child OR adolescent) AND (physician OR medical doctor OR pediatrician OR nurses OR healthcare professional) AND (parents) AND (disagree OR decision-making OR refuse treatment) AND (ethic OR morality OR role).

2.2 | Stage 2: Data extraction and development of recommendations

The data was collated into four separate sections according to the review questions described above and circulated to the ESPGHAN ethics committee members for comments and feedback. Recommendations based on the data found were discussed and agreed upon unanimously by all committee members.

3 | RESULTS

From the database (PUBMED and Scopus), 64 publications fulfilled the inclusion criteria. The manual search of the reference lists of these articles identified 22 additional publications. After analyzing and screening the 86 manuscripts against the study by McCullough et al., 37 publications were selected for the systematic review.

Out of these studies, there were one position statement, two case studies, eight review articles, 10 interview analyses, two surveys, four intervention studies, one fieldwork study, and nine ethical consideration studies. No publications on specific gastrointestinal, hepatology, and nutrition scenarios fulfilled the inclusion criteria. A summary of the literature search process is shown in Figure 1.

3.1 | Definition of the population: Patient group characteristics

The most common instances of team–family conflict include (i) when patients had an acute, life-limiting condition, (ii) when treatment was uncertain or had major risks, and (iii) chronic illness conditions that led to multiple team–family encounters and a long-term relationship between the family, physicians, and HCPs. Other scenarios reported in the literature included managing extremely premature neonates,[10] managing children with congenital abnormalities or

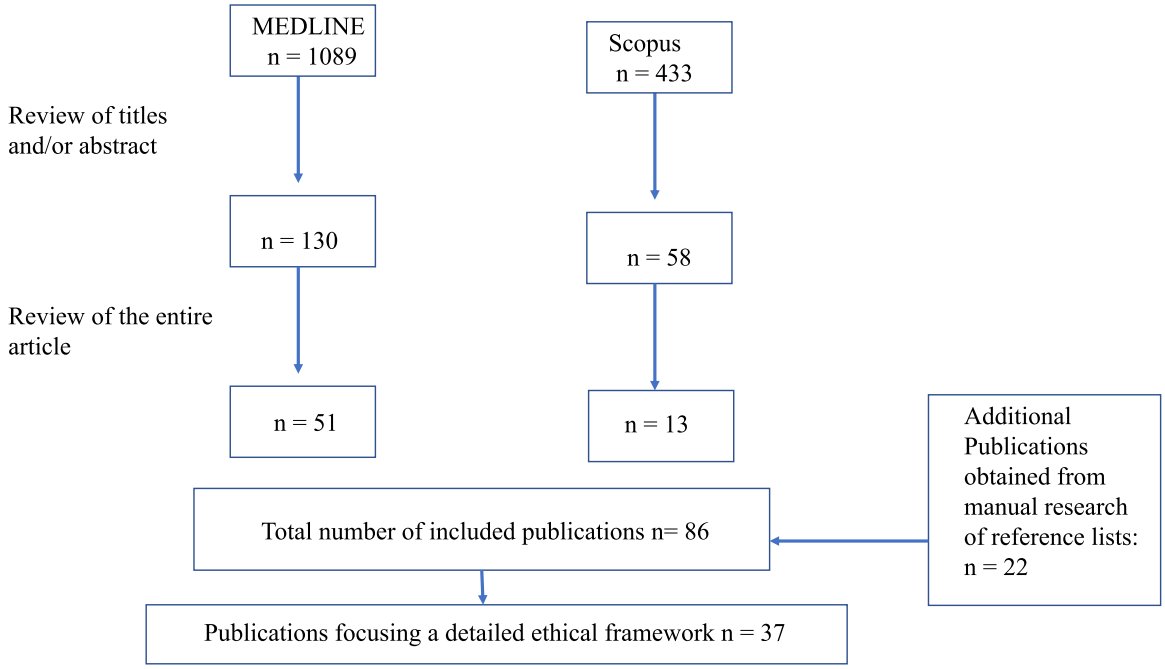


FIGURE 1 Literature research process.

life-limiting syndromes,[11] managing children who need life-sustaining treatment,[12] managing children with trauma requiring pediatric emergency department (PED) admission,[13,14] managing oncology patients,[15] managing transplant patients,[16] and managing patients with chronic illness.[17]

3.2 | Causes of HCPs team–family conflict

Team–family conflicts may involve more than one issue at a time and can arise secondary to common themes that include four complicating contexts and/or family-related factors.[18] The factors noted by Forde et al. included diagnostic and prognostic uncertainty, families' strong negative emotions, limited health literacy, and the burden of responsibility.[19] These factors are further described in the following subsections about barriers in SDM.

3.3 | Barriers in the shared decision-making process

Several barriers were identified that can affect decision making. These barriers can be subdivided into barriers to the decision, interpersonal barriers, and environmental barriers.[5]

a). *Barriers to the decision* include uncertainty about the diagnosis and prognosis, treatment uncertainty and/or long-term outcomes, limited health literacy, poor quality of information, or misinterpretation of the information given. In most studies, parents had expressed specific concerns about their need for information. Complete information helped them to trust HCPs and provided them with a sense of control.[20]

b). *Interpersonal barriers* include the parental burden of responsibility, conflict between the parents themselves and emotional incongruency. When both parents did not have the same viewpoint of a medical decision, a situation was created where the physician and HCPs had to mediate between family members. The physicians and HCPs may be seen to take a particular side leading to distrust from the offended party. Studies show that parents' emotions may impact on their ability to concentrate, to communicate their feelings and fears and to make decisions.[21,22] Strong negative emotions such as fear, guilt, anger, distrust, and hostility toward medical professionals were described as common barriers to communication and resolution of conflict.[18] In most studies, parents voiced their decision-making approach as being based on the feeling of being a good parent.[21,23] Parents may have had unrealistically optimistic expectations, which could have led to a discrepancy between the information given by HCPs and the parents' understanding. This misinterpretation of information could have led to anger and frustration.[18] Marron et al. noted that some parents could not recall the information given to them during the discussions of

informed consent because of their emotional state during the discussion.[24]

c). *Environmental barriers* included insufficient time to make a decision.[18,25] Specific medical areas had a higher incidence of conflict which was partly related to the clinical condition of the child but may have been attributed to factors within the specific environment. The environment of the neonatal intensive care (NICU) provided HCPs and parents a distinct challenge with regard to communication and information.[26] In PEDs, parenting was a challenging process as well, and having a child in the PED could have been an emotionally difficult situation for a parent.[13] In pediatric oncology, the parents faced important ethical challenges because of the difficulty in distinguishing between established care and research as these were often interconnected.

3.4 | Interventions used to manage the team–family conflict

The current literature described strategies on how to intervene once the team–family conflict was present. These strategies can potentially help doctors and HCPs to improve the situation and try to solve it. Conflict management practices mainly focused on communication skills for doctors and HCPs, exploring the role of parents in childcare, parental empowerment practices, and team training.[18,27,28]

Four communication strategies were described to manage team–family conflict. These were (i) content-focused, (ii) process-oriented, (iii) moral, and (iv) empathic communication strategies. Each of these approaches gave a different result in the management of conflicts between team and family.[18]

It was shown that doctors tended to use content-oriented strategies to try to resolve conflicts. Content-focused strategy focused on providing or requesting information. The physicians' perspective were discussed, the parents' personal information were acknowledged, and previously received information was explained. On the contrary, process-oriented strategies focused on negotiation between the team member and the family. Some examples included postponing a decision, requesting cooperation or giving in to parental wishes or avoiding discussion altogether. Moral strategies were based on the principle of good medical practice. In this approach, the physicians communicated their beliefs based on medical guidelines and ethics of conduct and did not take into consideration parental viewpoints. Emphatic strategies prioritized emotions over knowledge.

These approaches have been shown to give different outcomes in conflict resolution. A common conclusion in these studies showed that the most effective strategy was the emphatic approach followed by content- and process-oriented approach. Studies showed that doctors used more than one strategy when communicating with parents and patients.[18,26] If the physician or HCPs did not recognize the families' signs that indicated the presence of one or more risk factors as defined in the preceding section, conflict was likely to persist during the discussion.[18] The moral approach, surprisingly, was liable to have a detrimental effect and lead to more conflict.

In addition to these four strategies, an approach that potential led to better communication and a decrease in conflict was to inquire about the role parents wished to take in the decision-making process. Some parents chose to have a passive role, others chose to collaborate while other parents chose to have a more active role in the decision-making process.[29] Enquiring about the parental role early in a discussion helped the physicians and HCPs to communicate effectively and avoid conflict altogether.

Weiss et al.[30] demonstrated that medical decisions were influenced by parental preferences. The study showed that in situations where children had emergent pathologies and/or pathologies requiring high level of medical expertise, the parents were more inclined to delegate decisions to the medical team.[27] Preferentially maintaining parental control was noted in situations with high perceived risk, high personal experience with the decision, involvement of foreign biological fluids, and decisions that parents perceived as part of the normal parental role.[27]

A study on parental empowerment showed that parents gave value to a positive relationship with health professionals.[25] Positively perceived HCPs behaviors were shown to stabilize the partnership between parents and HCPs. Being knowledgeable, transparent, approachable, accessible, dependable, and supportive were examples of these behaviors.[25] Parental empowerment was based on parents' ability to use their physical and psychological resources to meet their child's growing healthcare needs, which was influenced by the good-parent belief.[25] The theme of being a good parent was commonly discussed in many studies on parental empowerment and decision-making. The belief of good parents was influential in family decision making and family relationships. HCPs who were knowledgeable about this concept, were more able to employ techniques to empower parents by complementing their involvement in a child's care.[21] This was achieved through a path aimed at creating an atmosphere of trust, open communication, shared decision-making, support, and helping parents accept their role in the care of their children. Strategies for parental empowerment included educating parents about their child's condition, teaching them new skills, and providing support services. Finally, a structured communication intervention was applied in a study by

Hendricks et al. using a team-based training approach in the context of palliative care communication. In this study, a faculty composed of specialists in medical ethics, communication, palliative care, and parent advisors led a 1- or 2-day program for doctors and HCPs who were split into groups of two (a doctor paired with an HCP). The modules discussed in this training program included family assessment, goal-directed treatment planning, anticipatory guidance, and staff communication and follow-up. Training physicians and HCPs in a collaborative approach had a positive impact, as evidenced by this study, and participants expressed interest in this type of training opportunity.[31,32] Medical centers are nowadays offering more resources to their medical staff on conflict resolution such as mediation services.[28]

4 | UNDER WHICH CIRCUMSTANCES WOULD A HEALTH CARE PROFESSIONAL BE ETHICALLY JUSTIFIED TO OVERRIDE PARENTS' MEDICAL DECISIONS AND TRIGGER THE STATE INTERVENTION?

Children are considered as not competent to give legally binding consent for their healthcare and thus parents are empowered to make those decisions on their behalf. The law respects these decisions unless it places the child's health, well-being, or life at risk.[1,33] To guide HCPs in dealing with team–family conflict scenarios that can be harmful to a child, it is important to understand the principles that are used in law and in medical practice. To answer this question, the best interest and harm principles should be discussed. There is no consensus among bioethicists about the definition of the best interest principle. A possible definition is that the decision-makers should take any decision with the aim of promoting the maximum well-being of patients.

The harm principle refers to when a decision-making process poses some harm to the child, and it represents a reason for restricting parental decision-making power. The state should intervene when parental decisions place children at risk of harm, as children should be protected. Ross et al. describe the term "constrained parental autonomy" which means parental autonomy within limits. Parents may trade their child's best interest for their familial interests. When this leads to deprivation of a child's basic needs or deprivation of needs required to become autonomous adults, the state may be justified to intervene.[34] The definition of serious harm thus include loss of life, loss of health, and the deprivation of basic needs as well as deprivation of needs required by children to become autonomous adults.[34]

Ethicists argued that state intervention is justified when parental refusals are life-threatening or increase the morbidity and risk of death of the child, and/or when the therapeutic option is proven efficacious with a high rate of success.[31] Diekema proposed that the following eight conditions must be met before considering that the state should overturn parental objections.[1]

These eight conditions were:

1. "Are the parents placing their child at significant risk of serious harm?"
2. "Is the harm imminent, requiring immediate action to prevent it?"
3. "Is the intervention that has been refused necessary to prevent the serious harm?"
4. "Is the intervention that has been refused of proven efficacy, and therefore, likely to prevent the harm?"
5. "Does the intervention that has been refused by the parents places the child at significant risk of serious harm? Do its projected benefits outweigh its projected burdens significantly more favorably than the option chosen by the parents?"
6. "Would any other option prevent serious harm to the child in a way that is less intrusive to parental autonomy and more acceptable to the parents?"
7. "Can the state intervention be generalized to all other similar situations?"
8. "Would most parents agree that the state intervention was reasonable?"[1,33]

Given the complexity of the decision-making process, the best interest and harm principles represented a means of allowing parents and medical staff to be guided in this kind of process. Doctors and HCPs need to be aware of parental autonomy and their rights as parents and have the medicolegal knowledge to be able to address team–family conflict that may lead to a child being at risk of harm.

5 | DISCUSSION

Medical decisions about pediatric pathologies involve collaboration between the medical team and the family. In this process a good communication between parents and HCPs, based on the respect for the dignity of the child as an individual person and on its best interest, represents a central aspect.[1,7,27,29,35,36]

According to Aarthun et al.,[37] the participation of parents in healthcare decision-making for hospitalized children was made easier by the sensitivity of physicians and HCPs to their needs and demands, as well as the methods of communication and relationships with them. Particularly, it seemed that empathic communication and confidence played an essential role in the team–family relationship. Moreover, a greater involvement of parents in decision-making appears to improve the ability to cope with the difficulties during

children's hospitalization. This facilitated the parents' empowerment, and the ability of parents to channel their physical and psychological resources to meet the growing healthcare needs of their child.[38] A systematic review by Boland et al.[5] reported that the most frequent causes of conflict between HCPs and parents included lack of information on the therapeutic options available, poor quality of given information, the parents/child emotional state, family dynamics, and the burden of responsibility, and insufficient time to make a conscious decision. Low-risk decisions, good quality and complete information, decision-sharing, mutual trust, respect within the team, and tools/resources for shared decision making were the most frequent facilitators.

6 | PRACTICAL APPROACH: "CASE VIGNETTE" AND CHECKLIST

A limitation of this study is that no publications on specific gastrointestinal, hepatology, and nutrition scenarios fulfilled the inclusion criteria for this study. In view of this limitation, the authors prepared a case study to illustrate further how this paper can be used in practice. A checklist is being provided to help reflect on the case and highlight the principles discussed in this paper.

Tony is a 6-year-old boy with short gut syndrome secondary to surgical resection due to necrotizing enterocolitis in the neonatal period. Since the intervention, he has been receiving parenteral nutrition at home. He has 15 cm of small bowel left and has lost his ileocecal valve. He is currently on five nights of parenteral nutrition and has been growing well on the 15th centile for weight and height. The central venous catheter is accidentally removed. The dietician notices that the child is eating very high quantities of carbohydrates. The child has already been diagnosed with severe D-lactic acidosis due to bacterial overgrowth and distended loops in their digestive tract. The medical team have proposed intestinal lengthening surgery to increase the absorptive surface area of the bowel and reduce the caliber of the bowel and to insert a new central venous catheter. After discussing with the parents, the parents declined the intervention and decided to cease providing parenteral nutrition for their child.

The proposed treatment option is known to be effective by physicians or HCPs, but there may be some risks to consider. The parents' decision to stop parenteral nutrition without discussing it with the medical team can be construed as harmful to the child. What barriers are contributing to the conflict between this team and family in this scenario? Is it the team's responsibility to request state intervention for the child?

The checklist provided in Table 1 can help us determine which factors are contributing to this team–family conflict and which strategies may help in resolving it.

1. **Does the medical condition of the child put him/her in the at-risk group?**

   In this case study, a 6-year-old boy with a chronic debilitating condition is involved in a team–family

TABLE 1 A checklist for healthcare professionals. A guide to resolve team–family conflict.

Reflect on the following and highlight where appropriate:

Does the medical condition of the child put him/her in the at-risk group?

a. Chronic illness
b. Acute life-threatening condition
c. Trauma
d. Oncology patient
e. Neonatology patient
f. Life sustaining treatment

Are there family characteristics that can put the child in the at-risk group?

a. Poor socioeconomic background
b. Concerns regarding current family dynamics
c. Strong emotions
d. Poor financial situation
e. Poor access to information
f. Others (e.g., spiritual convictions)

Can you identify any barriers to resolving conflict?

a. Does the environment pose a barrier?
b. Misinterpretation of information
c. Limited health literacy
d. Language barrier
e. Diagnosis is uncertain
f. Treatment suggested is not well known
g. Prognosis is uncertain
h. Concerns about morality

Can you identify any facilitators to resolve conflict?

a. Do you have a member of the team who can act as a mediator?
b. Do you need a medical translator to confirm the information received is correct?
c. Can you assess what role the parents want to take in their child's care?

What strategies can you use to resolve conflict?

a. Consider moving to a quiet environment
b. Empower the parents with knowledge
c. Be vigilant of the parents/patients' needs as these can change in time
d. Use a collaborative approach between healthcare professionals and families
e. Use an emphatic approach when discussing with patients, parents and caregivers
f. Avoid using morality to back up your arguments

If these fail, seek help from the Ethics Committee in your institution.

conflict that can have serious effects on his health and life.

2. **Are there family characteristics that can put the child in the at-risk group?**

   A family assessment can help determine if there are socioeconomic factors leading to the decision the parents are taking.

3. **Can you identify any barriers to resolving conflict?**

   In this case study, the information that is being given to the parents and the perception of this information by the parents seems to be the main cause of conflict. Identifying any misinformation delivered and learning from the parents their reasons for stopping parenteral nutrition can help in establishing better communication in this situation. Having cared for this child for 6 years and probably having passed through multiple hospital admissions, the parents are hesitant of going through a surgical procedure with its complication risks and prognostic uncertainty. Using a content-oriented and empathic strategy to explore these questions might help identify the cause of the conflict.

4. **Can you identify any facilitators to resolve conflict?**

   A team member the family trusts or a mediator outside of the team may be used as a facilitator. The facilitator's role is to examine the perspective of both the parents and the team to try resolve conflict.

5. **What strategies can you use to resolve conflict?**

   Written information and visual aids can be helpful tools in empowering parents with the information needed to care for their child. Ensuring the family's needs are being met might also help in responding effectively to the team–family conflict. Using a collaborative approach between physicians, HCPs, and parents may help identify the cause of the conflict and help resolve it.

6. **If these fail, seek help from the Ethics Committee in your institution.**

This systematic review suggests that effective strategies such as empathic behavior, parental empowerment, and effective team training in communication and conflict management can help facilitate SDM and resolve this conflict in the best interests of this young boy. If this fails, the Institutional Ethics Committee can provide advice on the best way forward to resolve team–family conflict including medico-legal advice on state intervention.

7 | CONCLUSION

When there is a difference between the ideal (positive, collaborative, and active) and the actual decision maker role within the team–family block, there may be conflict between parents and HCPs. The role is influenced by multiple factors that pertain to the illness (prognosis, severity, uncertainty, availability of effective care), to the individual (culture, educational level, emotional distress, knowledge, experience), and to the relationship (the trust in healthcare providers, family support). To facilitate the SDM process and avoid team–family conflicts, it is advised to avoid barriers that are known to cause conflict and promote facilitators. Using strategies that are effective in managing team–family conflicts, encouraging parent empowerment, and fostering good communication techniques. By recognizing the strengths and weaknesses of families and facilitating decision making, parents can build confidence and be empowered to deal with difficult decisions.

Collaborative training programs for physicians and HCPs in team–family conflict management within institutions could be a helpful and useful initiative in staff training. This should prioritize collaboration between doctors, HCPs, and families to promote a truly therapeutic relationship between health professionals and parents.

In situations where the child's best interests are not being met or the child is being placed in harm and the team–family conflict cannot be resolved using the methods discussed in the manuscript, doctors and HCPs need to be aware of their legal obligations. Furthermore, they need to have access to their institution's ethics committee and consider the use of mediators to resolve the team–family conflict for the benefit of the child.

7.1 | Recommendations from the ESPGHAN ethics committee

Advice to physicians and Health Care Professionals

1. Be aware of at-risk families: parents of children suffering from chronic illness, oncology, prematurity, trauma, and acute life-threatening conditions.
2. Identify parent's needs: psychological, financial, and family dynamics.
3. Identify barriers and facilitators to try and avoid team–family conflict and manage it effectively
4. Choose your method of communication-empathic approach gives better results.
5. Collaborate as a team: identify key persons close to the family and ensure that the information given to families from different HCPs in the team is the same through communication within the team.
6. Seek advice from ethics committee if team–family conflict remains unresolved.
7. Allow time for decision making if agreement cannot be reached and the child's condition allows it.

Advice to Institutions

1. Revise staff training programs to include team-based training on effective communication and conflict management.
2. Update doctors and HCPs on ethics committee information in the institution with contact details.
3. Provide information to parents and caregivers about their rights and responsibilities

CONFLICT OF INTEREST STATEMENT

The authors declare no conflict of interest.

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How to cite this article: Roggero P, Grima A-M, Crespo-Escobar P, Tapsas D, Yahav J. Conflict between parents, physicians, and healthcare professionals in medical decision-making: How to address it—a systematic review from the ESPGHAN Ethics Committee. *J Pediatr Gastroenterol Nutr*. 2024;1-10. doi:10.1002/jpn3.12365