MEDICAL ETHICS LECTURE SERIES

Lecture 7

Conflicts, Reporting Unsafe or Unethical Practice, Cooperation, and Conflict Resolution

Department of Psychiatry • Jordan University Hospital
Psychiatry Residency Training Program

Duration: 40 minutes

LECTURE OVERVIEW

Learning Objectives

- Identify the different types of conflict physicians encounter in practice
- Apply the concept of conscientious objection within its ethical limits
- Recognise obligations to report unsafe or unethical practice beyond individual colleagues
- Distinguish negotiation, mediation, ethics consultation, and formal grievance as tools
- Select the right conflict-resolution mechanism for a given situation

LET'S BEGIN WITH A SCENARIO

Case Study

CASE VIGNETTE

Hospital administration, citing bed occupancy targets, directs the psychiatry ward to discharge patients after five days regardless of clinical readiness. A resident's patient with severe depression and recent suicidal ideation is scheduled for discharge on day five, though the resident believes she is not yet safe to leave.

Discussion: Whose directive governs — the administration's policy or the resident's clinical judgement? What are the resident's options? Hold this question; we will return to it.

This is a conflict not between two people, but between clinical judgement and institutional policy.

NAMING WHAT YOU'RE DEALING WITH

A Taxonomy of Conflict in Medical Practice

With patients

Disagreement over treatment, refusal of recommended care, non-adherence — covered in Lecture 4

With colleagues

Clinical disagreement, hierarchy tension, impaired or unsafe practice — covered in Lecture 6

With institutions

Administrative directives, resource constraints, or policy that conflicts with clinical or ethical judgement

Within oneself

Conscience-based conflict, where a request or directive conflicts with the physician's own deeply held values

A QUICK RECAP

Conflicts with Patients & Colleagues

With patients (Lecture 4)

Respect informed refusal; offer second opinions; never let disagreement become coercion or abandonment.

With colleagues (Lecture 6)

Address disagreement professionally and privately; report impairment or incompetence through proper channels.

Today we go further: conflicts with the institution itself, and with your own conscience — territory those lectures didn't fully cover.

Conflicts with Institutions & Administration

Resource and productivity pressure	Targets for bed occupancy, visit length, or throughput can pressure decisions that should rest on clinical grounds alone.
Clinical judgement is not automatically subordinate	Institutional policy sets operational expectations; it does not override a physician's individual clinical and ethical responsibility to a specific patient.
Advocate through the right channel	Raise the conflict with clinical leadership — department head, medical director — rather than simply complying or simply refusing silently.
Document the clinical reasoning	A clearly documented clinical justification protects the patient and supports the physician if the decision is challenged.

Conflicts of Conscience

"Preserving opportunity for physicians to act in accordance with the dictates of conscience is important for the integrity of the profession… but physicians do not have unlimited freedom to act on conscience."[1]

The recognised limits on conscientious objection:

- Physicians must still provide emergency care, regardless of personal objection
- Informed refusals of life-sustaining treatment by a competent patient must still be honoured
- Civil liberties and non-discrimination obligations are not suspended by conscience claims
- A physician who declines to provide a legal service should generally refer the patient elsewhere promptly

[1] *AMA Code of Medical Ethics, Opinion 1.1.7, Physician Exercise of Conscience.*

CONFLICT IS NOT THE DEFAULT MODE

Cooperation as a Professional Value

Most disagreements in clinical practice are resolved through ordinary professional cooperation — conflict-resolution mechanisms exist for when cooperation alone is not enough, not as a replacement for it.

Habits that keep most disagreements small:

Assume good faith first	Most conflicts stem from differing information or pressures, not bad intentions — check before escalating.
Raise concerns early and directly	Address a small concern in conversation before it becomes a pattern requiring formal action.
Use structured communication	Tools like a clear “I am concerned / I am uncomfortable / this is a safety issue” framing help concerns land clearly under pressure.

BEYOND A SINGLE COLLEAGUE

Reporting Unsafe or Unethical Practice

Lecture 6 covered reporting an individual impaired or incompetent colleague. The same underlying duty extends further — to unsafe systems, policies, and institutional practices.

Unsafe systems

Staffing shortfalls, broken equipment, or workflow gaps that create risk, even with no individual at fault.

Unethical policy

An institutional directive that would require unsafe or unjustified clinical decisions, as in today's case.

Data or research misconduct

Falsified records, fraudulent billing, or research integrity violations discovered in institutional practice.

KNOWING WHERE TO GO

Systemic Reporting Pathways & Protections

Incident reporting systems

Most hospitals have a formal, often confidential system for reporting safety concerns — use it, and encourage colleagues to as well.

Quality & patient safety committees

Structured bodies exist specifically to review systemic issues — the appropriate venue for policy-level concerns.

Regulatory & licensing bodies

For serious, unaddressed risks, national medical councils or health ministries are the appropriate final channel.

THE FIRST, MOST COMMON TOOL

Resolving Conflict: Direct Discussion & Negotiation

The great majority of conflicts — including many institutional ones — resolve through a direct, well-prepared conversation with the right person.

Making a direct conversation effective:

- State the specific clinical concern, with facts, rather than a general objection to the policy
- Propose an alternative that addresses the underlying pressure (e.g., a step-down or outpatient plan)
- Ask questions to understand the constraint on the other side — it clarifies whether compromise is possible
- Follow up in writing when the outcome affects patient care, to create a clear record

WHEN A THIRD PARTY HELPS

Resolving Conflict: Mediation & Ethics Consultation

Mediation

A neutral facilitator helps two parties in genuine disagreement — e.g., a physician and a department — find a workable resolution. Useful when the conflict is more about competing legitimate interests than a clear ethical violation.

Ethics consultation

Hospital ethics committees provide expert, structured analysis of a genuinely difficult ethical question — useful when the issue is which value should prevail, not merely a disagreement between people.[2]

THE LAST, NECESSARY RESORT

Resolving Conflict: Formal Grievance & Escalation

Formal written complaint

Used when direct discussion has failed and the issue is significant enough to require a documented process.

Chain-of-command escalation

Raising the issue through progressively senior levels of clinical leadership when lower levels cannot resolve it.

External/regulatory escalation

Reserved for serious, unresolved risks to patients — licensing bodies, ministries, or legal channels.

Protection while escalating

Good-faith formal escalation should be protected from retaliation — know your institution's whistleblower policy.

A DECISION FRAMEWORK

Choosing the Right Mechanism

The goal is not to avoid conflict, but to resolve it at the lowest effective level — quickly, fairly, and with the patient protected.

1

Clarify the type of conflict

nterpersonal, institutional, ethical, or conscience-based — the type shapes which tool fits.

2

Try direct discussion first

Unless there is immediate danger, start with the most direct, least escalated conversation.

3

Add a third party if stuck

Bring in mediation for interest conflicts, or ethics consultation for genuine value conflicts.

4

Escalate formally if needed

Use written grievance or chain-of-command escalation when informal steps have been tried and failed.

5

Protect the patient throughou

Whatever mechanism is used, immediate patient safety should neve wait on the process.

RESOLUTION

Back to the Case Study

Clinical judgement governs here — an administrative occupancy target cannot require discharging a patient the treating team assesses as unsafe to leave. The resident should not comply silently, nor refuse without escalation.

Applying the framework:

- Document the specific safety concern — recent suicidal ideation — clearly in the chart
- Raise the conflict directly with the attending and, if needed, the medical director — not just comply
- Propose an alternative that addresses both concerns: partial hospitalisation or intensive outpatient follow-up
- If overridden without adequate justification, this becomes a matter for formal escalation, not silent compliance

KEY TAKEAWAYS

Conflicts, Reporting, Cooperation & Resolution

- Conflict in medicine takes several forms — with patients, colleagues, institutions, and one's own conscience
- Institutional policy sets operational expectations; it does not override individual clinical and ethical responsibility
- Conscientious objection is protected but bounded — emergencies and informed refusals still must be honoured
- The duty to report extends beyond individual colleagues to unsafe systems and unethical institutional practices
- Resolve conflict at the lowest effective level — direct discussion, then mediation or ethics consultation, then formal escalation

References

1. American Medical Association. AMA Code of Medical Ethics, Opinion 1.1.7 — Physician Exercise of Conscience.

2. American Medical Association. AMA Code of Medical Ethics, Opinion 10.7 — Ethics Committees in Health Care Institutions.

3. American Medical Association. AMA Code of Medical Ethics, Opinion 9.4.2 — Reporting Incompetent or Unethical Behaviors by Colleagues.

4. American Medical Association. AMA Code of Medical Ethics, Opinion 11.1.2 — Physician Stewardship of Health Care Resources.

5. World Medical Association. Medical Ethics Manual. 3rd ed., Chapter Four — Physicians and Colleagues. Ferney-Voltaire: WMA; 2015.

6. World Medical Association. WMA International Code of Medical Ethics. Adopted 1949; revised 2022.

7. Agency for Healthcare Research and Quality. TeamSTEPPS — Team Strategies and Tools to Enhance Performance and Patient Safety.