

CURING CONFLICT: A PRESCRIPTION FOR ADR IN HEALTHCARE

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I. Healthcare: The Waiting Room Is Full

Healthcare in the United States is under significant pressure from a variety of sources. Costs are increasing -- including insurance markets in flux, the capital demands of technology needed to remain competitive and meet standards of care, and required spending for new threats and emergencies — at the same time that government and insurance reimbursement is declining (GHA, 2002). The ongoing, difficult dialogue concerning the ethics of using all available technology to create or prolong life, or safeguard other bioethical concerns, compounds this. A significant shift toward broader definitions (Banja, 2002) and disclosure of medical errors places physicians and administrators in a vulnerable position with heightened liability fears. The national shortage of nurses and increases in medical malpractice premiums jeopardize recruiting and retention of key professionals and threaten the ability to provide critical services.

These pressures must be taken into account as the healthcare industry works toward integrating the business of healthcare with the practice of healthcare, the two models impacting overall service delivery. Thus, the healthcare industry must balance what many see as a right or entitlement, *i.e.*, the delivery of quality healthcare, while simultaneously operating within a competitive business environment. The business of providing healthcare must address issues regarding employment and staffing, purchasing, inventory management, information technology, legal and regulatory compliance, corporate governance and structure, licensing, marketing, security, and risk management concerns – issues common to most businesses. It also must manage industry-specific business concerns, such as peer review, accreditation, and research. The industry must also simultaneously balance its more altruistic work in the areas of, for example, bioethical issues, social work, chaplaincy, and rehabilitation, with such complex operational and business concerns.

Healthcare is further distinguished by the number of stakeholders involved in the delivery of services, commonly considered to involve three key groups: patients, payers and providers. Each of these is further divided into sub-groups. Thus, patients may be viewed demographically based upon age, gender, education, location, beliefs about disease and treatment, and propensity toward specific diseases due to genetics, behavior or disease. Payers can be public or private, with public providers including local, state and federal programs for income- or age-based beneficiaries. Private payers include a mix of fee for service, HMOs, PPOs and others. Providers come in all sizes and distinguishing service lines from pharmaceutical giants to a self-employed nurse on contract to a home health agency. In between are large hospital groups, ambulatory surgery centers, community-based “any-test” laboratories and open MRIs, physician groups, and all of the suppliers and vendors that support an effort that together comprise a large portion of the U.S. economy.

A. The Diagnosis: “Pseudo pneumonic crisis”

The diagnosis is simple. The healthcare industry is plagued with potential for conflict. The unique combination of pressures in the healthcare industry have elevated conflict to a primary concern within both the business and practice models, and, as the societal, political and economic forces continue to press at the healthcare industry, there is a growing need to address such conflict with more systemic conflict management models that integrate system-oriented and participatory practices into the business of healthcare. (Constantino & Merchant, 1996).

B. The Prescription: Alternative Dispute Resolution

The prescription for the healthcare industry: Alternative Dispute Resolution (“ADR”). ADR and the techniques associated with it can, among other things:

- Produce better relations between patients and providers;
- Maintain important relationships;
- Restore a sense of control and empowerment to the myriad of stakeholders;
- Reduce the number of legal claims and the costs associated with such claims;
- Increase patient safety through the development of functional teams, agreed upon protocols and standards, effective communication, and coordinated treatment;

- Provide a “healing” experience for patients and providers;
- Enhance communication among all stakeholders;
- Promote thoughtful, evaluative discussions in the workplace that align an entity’s priorities with the organization’s actions;
- Re-focus providers on the business of healthcare as opposed to reacting to conflict; *and*
- Restore a sense of trust to the industry and to the providers in general.

In sum, because there is no shortage of conflict in healthcare, there is no shortage of opportunities for ADR practitioners within the industry. In order to explore the multitude of opportunities for ADR practitioners, it is first helpful to understand the unique types of conflict that occur within the industry, and the current resolution processes utilized.

II. Determining the Source of the Ailment:

A. Conflict Triage:

Conflict within the healthcare industry is not confined to singular disputes with external entities. Rather, it evolves from a variety of sources and differs significantly depending on whether the source(s) originates within an organizational framework or a clinical environment. While disputes may be categorized as an issue related to patient rights or professional negligence, for example, they often involve a blend of rights, interests, and values.

While the number and types of disputes within the healthcare industry are too numerous to be included in a singular listing, the following list provides examples of some of the most common types of disputes and their relationship to the current healthcare environment:

1. Emergent:

- a) **Professional Negligence:** Disputes arising out of medical errors and unanticipated outcomes comprise a majority of professional negligence rights-based claims. Typically, parties in a professional negligence matter rely on legislative and professional controls, which, when violated, create a cause of legal action. Here, parties are usually entrenched in their respective positions and seek traditional legal resources to resolve their claims. Professional interests in protecting reputation, maintaining control over practice, and seeking support by peers and the organization are blended with the legal response creating additional levels of conflict.
- b) **Employment:** Like any industry, the healthcare industry is not immune to disputes arising out of the employment relationship. Thus, typical employment-related disputes within the healthcare industry include issues pertaining to: discrimination and other EEO matters; compensation for the professional, clinical and non-clinical staff member; employee recruiting and retention; employee development (e.g. behavior, accountability, training, coaching, career planning); and issues pertaining to customer service and workplace violence and safety. In many organizations, there are multiple unions present to represent the diverse groups of employees adding various labor agreement requirements to the complex mix of dispute resolution processes.
- c) **Patient Issues:** Increasingly, patients are educated about their rights within a healthcare setting, and many states have required institutions to post rights provided to patients by law. Some states have also included mediation as a patient right when it comes to healthcare-related disputes. (*See, e.g., Illinois and Pennsylvania*). Sometimes healthcare stakeholders’ differing values about healthcare decisions lead to conflict within a treatment team or with a patient and family. Between payers and patients, typical conflicts involve coverage and/or claims, continuation of coverage, and physician selection. With respect to patient/provider relationships, typical conflicts include issues related to communication, coordination of care, clinical outcomes, end of life decisions, bioethical concerns, pain management, and error disclosure.

2. Urgent:

- a) **Case Management:** Disputes arising within the case management context can include issues regarding length of an institutional stay, the level of patient care to be delivered, determinations of medical necessity, placement for rehab or specialty care services, and durable medical equipment choices. Decreasing choices for placement in rehab facilities, ventilatory support units and assisted living facilities create conflict for families needing support and acute health care facilities that need to find placement to free up acute care beds.

- b) **Regulatory Compliance:** There are numerous local, state, and federal laws and regulations regarding the delivery of healthcare and the insurance market that services the industry. As the number of regulations continue to increase, so too, do the number of conflicts in this area.

3. **Routine:**

- a) **Intra-Institutional:** Organizationally, disputes can arise internally between physicians, support personnel, board members, and others on issues related to the proper standards of care, efficient and effective use of resources, the parameters for credentialing, and the priorities or mission of the provider. Medical staff and administration issues are enough of a concern that some professional organizations have adopted formal policies supporting the use of conflict management approaches in this area. (AMA, 1998). Additionally, payment contracts, billing regulations, and coverage issues with payers are an area that is too complex for individual physician practices to maintain expertise and individual negotiating ability. The contracts now routinely carry enforceable arbitration and mediation clauses (Charter v. Managed Health, 2002), and the number of disputes over slow or no payment is growing rapidly.
- b) **Bioethics:** As technology evolves, so too does the ability to keep patients alive longer. Accordingly, within the bioethics area, disputes may arise between providers and patients, or even patients and their families regarding advance directives, “Do not resuscitate” orders, de-escalation of care, and concepts of medical futility. Additionally, growing debate includes genetic testing and the use of such results, tissue banking, research subjects’ commercial interests in products, surrogate consent for research, allocation of scarce and expensive resources (*e.g.*, transplants), and cloning.
- c) **Professional and Accreditation Associations:** In addition, there are numerous professional associations that perform quasi-regulatory functions within the industry. For providers, these associations prove to be both a resource and a source of conflict. The latter arises as a result of the adoption of differing protocols and standards of care by the associations. The confusion created by the differing standards can provide fodder to perpetuate negligence actions against providers. Likewise, disputes arise over interpretation of standards and appropriate enforcement. Accreditation requirements drive much of the development of organizational policies which may conflict directly with established practice. Costs associated with accreditation requirements can create conflicts associated with diversion of finances to new requirements and away from strategic goals.
- d) **Other Public Policy Areas:** Finally, issues regarding non-prescription health-maintaining treatments and products are impacted by public policy concerns, as are issues related to medical futility, healthcare financing, health risks of dangerous lifestyle choices (*e.g.*, smoking), bioterrorism response planning, and the like. The debate often focuses on entitlement in tension with distribution of limited resources.

B. Managing the Illness, Not the Symptoms:

To date, much of conflict management in the healthcare industry has been reactive and focused on symptom management only. Like an individual, the industry cannot sustain its own health when it operates from a reactionary position. Just as individuals require lifestyle changes to ensure a healthier, more productive life, so too does the healthcare industry require a culture change toward earlier and more effective conflict management. The numerous examples of healthcare-related conflict provided above indicate that a variety of conflict management approaches are required to move the industry from reactive to proactive behavior. Moreover, when a conflict involves a patient or patient’s family, the healthcare community must also realize that healing the relationship is critical to patient recovery. For so long, the management of conflict in the healthcare community has been non-productive and alienating, embracing rights-based win/lose approaches that reward power and minimize progress. ADR processes provide a productive method for managing conflict and an opportunity for stakeholders to maintain or improve their relationships. In addition, productive methods for managing conflict may also lead to solutions that provide much more than anticipated. In such instances, productively managing conflict may result in expanding the proverbial pie rather than dividing it. Healthcare professionals already using ADR mechanisms are aware that in the healthcare context, productive conflict management translates into better and higher quality services. (Blanch, 2000).

However, despite these observations, a majority of healthcare stakeholders are currently entrenched in rights-based dispute resolution processes that serve more to position parties and entrench claims than to manage and resolve conflict. Current healthcare conflict resolution processes alienate stakeholders, are frequently protracted and involve a great deal of resource investment. A flexible, interest-based approach that integrates several response systems would contribute to developing cooperative resolution strategies with creative solutions and better resource allocation.

1. Patient Processes: Patients currently have access to a variety of dispute resolution mechanisms. However, many of these processes, as noted above, are derived from a rights-based perspective, attempt to utilize power only, and provide only the opportunity to complain rather than the opportunity to dialogue and work through a conflict. Most current mechanisms also fail to consider the interests and values that impact healthcare-related conflict. Often the processes are designed to placate “upset customers” with discounts on billing or offers of free parking or other amenities to be responsive to the customer rather than intentional dialogues designed to reach agreement.

Recognizing that patients require additional mechanisms by which to address their concerns, there has been an increased use of arbitration, especially in the area of denial of care issues and adverse outcomes. Some providers are using a binding arbitration clause in the admission document signed by a patient upon entering treatment to ensure arbitration is the mechanism by which conflict will be governed. While this may be a constructive step, the courts may limit the potential benefit of such agreements, thereby making resolution through ADR still elusive (*Pacheco v. Allen*, 2001; 2002 *on issue of whether the “Federal Arbitration Act preempts the restrictive provisions of §§13-64-403, 5 C.R.S. (2001), requiring enforcement of all arbitration provisions”*). Concerns about arbitrator bias and process manipulation must also be addressed for arbitration to be a fully viable option.

Bioethics consultations often operate from an interest-based perspective, though these processes are limited in applicability. Some organizations employ ombuds staff or patient liaisons, or contract with independent mediators, to address patient satisfaction concerns.

More typically, however, patients avoid the conflict or avail themselves of power-based processes. Patients may resolve some disagreements with a provider by seeking a second opinion, choosing another provider, or interacting with administrative staff and using an established chain of command, but these processes are ad hoc and typically require the patient to identify the next step rather than pro-actively providing alternatives for an integrated resolution to conflict.

In other instances, patients may seek to utilize consumer advocacy groups, legislators, or the media to publicize an issue of significant or widespread concern, seeking to force change and resolution through public pressure. Unfortunately, the ability to withstand public pressure typically outlasts a third party’s ability to sustain such pressure long enough to effectuate change, thus lessening the effectiveness of this process.

Patients may apply to regulatory bodies and accrediting organizations as these entities create opportunities for reporting conflicts. For example, an aggrieved patient may file an administrative claim with a state licensing agency that ultimately requires the licensing board to review the matter. Licensing boards typically have the ability to take temporary or permanent corrective action against a provider, but a very small percent of complaints warrant this action, and patients learn little of the actions taken. The boards provide few, if any, other remedies to patients. State or federal peer review processes – a chart-based investigation of care complaints designed as a faster alternative to reduce lawsuits – provide less than satisfying results to patients by vesting power in a single individual relying on limited information, and conveying limited information to the patient.

Patients may complain to state or federal agencies overseeing facilities’ licensure, or to accrediting organizations, each of which may initiate an investigation and require corrective action. These actions are aimed at generating practice changes, rather than helping an individual patient. Moreover, facility perceptions of fairness and applicability limit the effectiveness of corrective measures.

Whether the complaint is rights-based evolving from regulations, legislation, or professional standards, or interests, values, or communication-based conflicts, patients often end up within the traditional legal forum. The traditional legal setting has proved frustrating, time-

consuming, and costly to all stakeholders. Increased costs of insurance, frequency of claims and a focus on patient safety come at a time when the legal system is chasing doctors from our communities (Freedman, 2002). With the current debate over tort reform and medical malpractice in particular, you see numerous examples of statements such as: “In (a year between 1990 and 2002), the average medical malpractice award was \$ (large number), by (a more recent year) the average medical malpractice award was \$ (multiple of large number).”

With the financial terms of the resolution dominating actions in this forum, the benefits of creating accountability and better clinical approaches are sublimated. Thus, reliance on the litigation culture is perpetuated because valuable changes and approaches fail to become essential components of the resolution process.

The above-described practices uniformly fail to provide the remedy so many patients seek from them: an explanation, an apology, and some indication of commitment and practice change aimed at preventing recurrence.

As an alternative to litigation, mediation is fast becoming the process of choice used to resolve malpractice claims outside of the court system. Insurance carriers typically will agree to mediate claims that have any merit, and will often suggest mediation as an option. Malpractice attorneys have mixed feelings about mediation, but those that “get it” and understand the dynamics of conflict and the patient’s need for answers in addition to monetary resolution are embracing mediation more and more. Used most often when claims are already filed and pending, private mediation has become an industry, and malpractice claims are a big part of the caseload. While you won’t find the mode of mediation practiced to be particularly transformative, it is becoming widely accepted, with some mediation offices claiming over 80% resolution rates.

2. Clinician Processes

When conflicts are handled within a facility or practice group, conflict resolution processes for clinicians also tend to be power-based. Clinicians may utilize their chain of command or use processes within patient relations, human resources, risk management, EEO offices, or Employee Assistance Programs. Some concerns about competence are handled through peer review. Because the power is shifted from the parties to these offices, and many processes are conducted punitively, many practitioners attempt to squelch conflict or differences of opinion, misdirect it into unproductive activities, or aim solely for minimum-level compliance instead of better practice and relationships.

With respect to external processes, clinicians are often involved in the patient-initiated processes described above, which are equally poorly suited to serving clinicians’ interests. In the most usual forum, the clinician is typically one of many parties named in a lawsuit. Litigation, by its very nature, diverts or destroys the possibility for closure and catharsis, not only for the patient, but for the provider as well (Marsh, 2000). In contrast, clinicians participating in alternative conflict management processes often find the experience healing and productive. (Blanch, 2000).

III. “Clinical Trials” – What can be done to help the healthcare industry?

ADR and the associated techniques provide tremendous opportunities to manage conflict within the institutionalized culture of the healthcare industry. ADR practitioners must identify small projects that demonstrate value in order to help healthcare leaders recognize those opportunities and build on them.

Additionally, advocates for broader application of systemic conflict management programs or approaches have identified that a significant change in the healthcare culture is required for optimum results (Marcus & Dorn, 2000). While shifts in organizational culture are typically slow and frustrating, a key question is what brings about culture change. Arguably, in addition to top-down or external pressure in favor of ADR, a positive ADR experience among discrete groups in the field or organization generates internal advocates for it, leading to a groundswell as they influence increasing circles of professionals and decisionmakers. ADR practitioners can also be comforted by the fact that the healthcare industry has already begun to initiate change and there are signs of a collective search for more effective responses to healthcare-related conflict. There are increasing opportunities for incorporating interest-based techniques into the clinical setting thus creating more opportunities for successes which can build into more widespread acceptance of ADR for resolving disputes and improving clinical care.

One component of influencing this change is that ADR practitioners entering this arena will have to recognize that a healthcare professional’s identity is extraordinarily intertwined with the profession as a whole. Thus, shifting perception in favor of meaningful participation in ADR -- including errors reporting, analysis, and disclosure -- in a culture where *reputation is everything* and vulnerability and fallibility may

be seen as lowered professional competence and personal inadequacy, will prove challenging, but not impossible.

ADR practitioners can also add value if they are willing to adapt their skills to the emerging healthcare culture. The term “emerging” is especially important. Successful ADR practitioners will have to recognize both the historical framework within which the healthcare industry evolved and the current pressures, and adapt ADR mechanisms to the industry rather than requiring the industry to adapt to the benefits of ADR mechanisms.

Accordingly, potential opportunities abound for ADR practitioners within a number of areas in healthcare. Examples of specific opportunities with respect to system design, training, patient safety initiatives and litigated claims are identified below:

A. System Design:

As the healthcare industry continues to evolve and social, financial and political pressures escalate, so too will the amount of conflict in the industry. Like other industries, the healthcare community is finding that the development of pro-active systems to manage conflict is essential to dealing with a myriad of issues. The use of a pro-active conflict management system or program provides a mechanism for resolution that is quick, is less adversarial, and gives parties much more control over the outcome than does traditional litigation. Carefully designed systems that integrate the healthcare culture with the interests of the payers, providers and patients can allow for a more rapid response to change while simultaneously maintaining the relationships that are so necessary for the industry’s survival. Finally, a conflict management system can assist with conflict that does not approach the likelihood of litigation; those day-to-day irritating conflicts and tensions that undermine effective functioning in the workplace. Because ADR has applicability in every segment of the healthcare industry, the opportunities for system design are endless.

Currently, several larger hospitals and university-based healthcare providers are considering or have included institutional mediation. By staffing an internal neutral, patients and providers can bring disputes for potential resolution without going to outside parties.. Having an in-house mediator involved in the day-to-day functioning of the organization means also that she can spot conflicts before they become disputes, and de-escalation techniques and preemptive problem-solving are used early. It provides the opportunity for accepting as part of a culture the idea of a dispute process as a natural complement to other systems in the facility (Houk, 2002).

As an individual cannot possibly manage all institutional demands, and different conflicts require different types of response, facilities may most benefit from an integrated conflict management system. In it, multiple mechanisms are available for disputes of different types and complexity, and a structured feedback loop maximizes institutional learning. Mechanisms generally include a combination of internal neutrals, grievance systems, contracting with outside mediators, and conscientiously developed conflict management skills in clinicians and administrators.

B. Training:

Conflict management techniques are becoming an important part of employee training programs in some institutions. In programs on coaching, improving interpersonal relationships, getting along with your co-worker, situational management, team-building, preventing employment discrimination issues, or workplace violence, all include aspects of conflict management. Professional health care associations are increasingly including mediation and conflict management in their leadership development programs for their members. Development of communication and conflict management skills combined with knowledge of collaborative processes serve as the basis for many of the sought after programs.

A few ADR practitioners provide training with a specific relevance to the healthcare environment, with courses tailored to clinicians and administrators learning negotiation, facilitation, conflict management, and mediation techniques (See attached: Curing Conflict™: Conflict Management Training for Health Care Professionals; Gerardi, 2003). Some specialized courses deal with topics such as patient customer service, patient safety techniques, error disclosure, unit-specific conflict management concerns, and bioethics committee operations. Healthcare professionals also require training in the development of facilitation skills to maximize time efficiency and improve operations and compliance. Likewise, communication and team-building will be critical as professionals shift to a paradigm of collaboration in patient care.

Among the benefits of this training are studies showing that a healthcare professional’s ability to communicate effectively with patients about both positive and negative outcomes may directly influence

the professional's chances of being involved in litigation over care issues (Levinson, Roter, et al, 1997). Physicians more often are sued if they fail to demonstrate understanding of the patient's perspective and deliver information poorly (Beckman, et al, 1994) or rush the patient and provide little explanation (Hickson, et al, 1994). Physicians can turn that around, however, by orienting patients, using facilitative comments and active listening, and asking patients their opinions (Levinson, et al, 1997).

The Harvard School of Public Health has created a yearly program for healthcare administrators that focuses on introducing ADR principles into healthcare negotiation and management (Lovern, 2001). Health Care Mediations, Inc., Mediate.calm, and The Consensus Group train clinicians in the U.S. and Canada to effectuate a non-punitive culture, develop a team approach to patient care, manage conflicts proactively, and negotiate many aspects of work life using IBN principles. Individual opportunities to do the same abound.

C. Patient Safety:

The patient safety movement is monumental, and there is much synergy between its principles and those of ADR. Its advocates recognize that most errors are the result of system breakdowns rather than competency issues, so prevention is best served by open discussion to identify and remedy those breakdowns. This relies on a major culture change to create a non-punitive atmosphere in which errors and near misses can be reported with reduced fear and shame, and facilitated analysis serves those aims. Additionally, improving collaboration among care providers can decrease the risk of adverse outcomes leading to a safer clinical environment.

The non-punitive approach has gone from academic contemplation to a focus of mainstream media to a generally accepted ethic. The principles have been implemented by early adopters and are on the verge of being taken up by the early majority. This evolution points to the number of stakeholders impacted by the movement, including educators, patients and communities, providers, and payers. While many now espouse the rationale, most need support in translating it into action. It is there that ADR professionals can be of great benefit. ADR providers are well suited to assist health care professionals in blending competing cultures and integrating processes for managing conflicts associated with unanticipated outcomes and near misses.

An overview of key features of patient safety practices provides a better understanding of how ADR practitioners can add value:

1. **Culture Change:** As indicated above, the patient safety movement requires a culture change from a punitive to a learning atmosphere. All levels of management must use interactive listening and reframing, express non-judgmental interest in others' perspectives, and create safety for people to express very exposing or humbling information. A culture of safety requires that stakeholders remain open to practice changes, process analyses, and open reporting of errors and adverse events. Administrators will be required to reward and incentivize reporting to develop adequate data for analyzing trends and triggers that can lead to system improvements and enhanced safety for patients. The current culture of nondisclosure and closely held information adds to conflict and prevents systems improvements.
2. **Analysis:** The patient safety movement has focused on a thorough analysis of system breakdowns to understand what steps might be taken to improve patient safety. Through root cause analysis, failure mode and effects analysis, and corrective action plan design and implementation, clinicians identify system breakdowns and build in means to minimize recurrence, such as standardizing protocols and using decision support systems. Here, facilitation skills are crucial, including the ability to focus teams on systems and fact-based agendas, and fostering effective brain-storming sessions and reality-testing for remedies.

3.

Error Disclosure / Unanticipated Outcomes: The main accrediting organization, JCAHO, and the state of Pennsylvania are among the first bodies to require conversations with patients and families about potential errors (each has specific definitions) (JCAHO, 2001). A growing number of professional societies and organizational management encourage such conversations (O'Connell, et al, 2003). Done thoughtfully, this involves a very complicated balance of legal requirements, ethical concerns, and patients' and professionals' needs.

Studies and experience show there are three things patients seek: an explanation of what happened, an apology or acknowledgement of what they have been through, and a sense of confidence that the providers are acting to prevent this happening to someone else. These

conversations are best conducted through the utilization of ADR principles. Naturally, these conversations are difficult for clinicians, as well. The clinician is accustomed to a one-way delivery of information, and rarely has had any type of communication training. Moreover, the clinician typically has an emotional investment in the subject, often a combination of guilt, shame, fear of exposure and liability, self-doubt, and an experience of feeling unsupported by colleagues. Thus, ADR practitioners can offer a real service in preparing clinicians with skill development and coaching in listening, mutuality, non-judgmental approaches, surfacing interests, validating emotions and expressing empathy. In different contexts, then, an attending physician, alone, may conduct the conversation, s/he may do it in conjunction with an in-house ADR professional, or a response team may be designated. In some cases, a professionally mediated conversation may be called for.

Additionally, as facilities are called on to generate policies governing these conversations, facilitation may help healthcare decisionmakers generate thoughtful discussions of important policy considerations, such as timing of the conversation, the number and type of team members and/or administration to be involved, the scope of the conversation, documentation, and follow-up coordination.

D. Litigated Claims:

Too often, once a conflict or dispute reaches the level of a lawsuit, the dispute is shifted into “auto-pilot” where the focus is on the litigation process and not on parties or the dispute issues. As noted above, when the traditional legal forum and litigation process are used to resolve healthcare related conflict, the benefit of creating accountability and better clinical approaches to procedures is often secondary to the financial terms of the resolution. The opportunity to maintain relationships is often lost. Thus, reliance on the litigation culture is often perpetuated because valuable changes and approaches fail to become essential components of the resolution process.

Many healthcare organizations are exploring the utilization of ADR techniques and mechanisms within the litigation environment in non-healthcare related industries in an attempt to adapt such ADR processes to the healthcare environment. One such approach is the adoption of early case assessment and resolution programs and strategies that work cooperatively and concurrently with the litigation track, but nevertheless focus entirely on resolution of the dispute rather than the merits of the case or the litigation strategies employed by the parties. Early case assessment and resolution programs reduce costs by establishing procedures for evaluation and assessment of disputes and by shifting the focus from the traditional “processing” of a lawsuit to resolution of the business problem. In the context of healthcare litigation, the focus shifts from the “processing” of a lawsuit to the resolution of the business and relationship concerns. It allows for the provider / payer to present the mission of the organization and to understand the basis for the dispute. If compared to litigation, an early case assessment program essentially provides for an early focus on those functions generally relegated to the end of the processing of a lawsuit, e.g. thorough exploration of the issues in dispute, resolution options, strengths and weaknesses of the case, interaction with opposing counsel, etc.

While early case assessment programs focus on the early resolution of disputes, successful programs do not require a payer or provider to resolve the matter at any cost. Rather, a successful early case assessment program should assist the healthcare payer or provider to consistently and thoroughly approach matters. The process should assist the parties in defining what constitutes a favorable case resolution, as well as assist in the development of the overall case management strategy that takes into consideration the interests of the stakeholders.

In addition to providing an opportunity for early intervention, early case assessment and resolution programs may be used as a tool to reduce the escalating costs associated with healthcare related disputes and / or litigation. A reduction in costs may be achieved through the streamlining of work processes focused on obtaining information in specifically defined areas so that a realistic assessment of the matter and a long term litigation plan, if necessary, may be developed. A successful program will also allow for frequent opportunities to re-examine resolution options.

If resolution is not viable or possible at any given time during the evolution of the dispute, the overall assessment may serve as the basis for a litigation plan and include a general a summary of the basic strategies to be considered in order to meet the company’s objectives. The assessment may also, depending on the criteria selected for review, provide a timetable and budget for completing each major task. Such a program, when interfaced with the appropriate technology, serves as an invaluable planning and evaluation

tool. Additionally, as new or different information becomes available over the life of the matter, the assessment may be updated and refined. The ultimate goal is to create a program where there is an evolving framework for evaluating a case's status, risk, and value individually and as it compares to the company's overall goals.

ADR practitioners can serve as Early Case Assessment Counsel, Resolution Counsel, or provide guidance and consultation on the development and design of an early case assessment program.

IV. Non-random, Not blinded, Uncontrolled “Clinical Trial” Results:

As all of the above information indicates, healthcare-related disputes can be complex and divisive. In order to bring such conflicts to an effective and efficient resolution, ADR practitioners must recognize and appreciate the many factors that contribute to a dispute's escalation while simultaneously identifying and building opportunities for its resolution (Marcus & Dorn, 2000). Currently, a number of progressive and pragmatic programs have been developed within the healthcare community.

A. Program Characteristics

Successful healthcare-related ADR programs share some common characteristics. For example, ADR systems and process can:

- 1. Promote fairness, equality and empowerment** by giving a wider range of stakeholders the opportunity to be heard and to be a part of the resolution process. In this way, the playing field is leveled and the parties can participate more equally than in their routine dealings. As the parties are provided the training and opportunity to effectively manage conflict, they are typically more empowered and trusting of the process, and may be better able to apply those concepts to daily practice.
- 2. Facilitate effective communication to improve clinical outcomes, deescalate high-stakes conversations, support early resolution of conflicts, and** add the benefit of time-efficiency.
- 3. Foster collaboration** by creating safe environments for discussion and brainstorming, as opposed to the type of confrontational atmosphere that exists within the traditional litigation framework.
- 4. Enhance or maintain relationships** through ADR processes that are collaborative in nature, thereby decreasing the chance for relationships to be broken down altogether; in most instances, relationships can be salvaged or even enhanced.
- 5. Ensure flexibility** by adapting ADR processes to the healthcare industry and to respective disputes, as opposed to requiring the industry to conform to a pre-determined approach for conflict management.

B. Program Examples:

There are a number of interesting and progressive ADR processes utilized within various aspects of the healthcare industry. The examples that follow illustrate ADR approaches effective in both the public and private healthcare sectors.

1. National Naval Medical Center – Bethesda, Maryland

The National Naval Medical Center (NNMC) in Bethesda, Maryland appears to be the first acute healthcare institution in the nation to offer a full-time internal neutral for the resolution of healthcare issues. (Houk, 2002). Through the use of a well-trained and experienced organizational ombudsman/mediator, who is also an experienced clinician, NNMC has improved patient safety, reduced medical malpractice costs, enhanced both staff and patient satisfaction, and created an informal feedback loop that identifies and fosters systemic improvements within the hospital (Houk, 2002).

The program's director is a civilian employee who reports directly to the Admiral and the Deputy Commander of the Medical Center. The program director's role fluctuates depending on the conflict at issue. The program director may work as an ombuds, providing patients with a direct response upon request, or as a mediator between patients and providers.

The program does not diminish any of the legal rights to which a patient otherwise has access. It should be noted that NNMC is a military hospital without some of the pressures of a private provider (e.g. , no dependence on outside insurers, limits on liability risk). While these reduced pressures may have better positioned NNMC to take the first risk in implementing such a program, the dramatic claims history demonstrates that the principles are transferable to other sectors, and any experience variation would likely be a matter of degree.

The program's success is attributed to early intervention. Before positions get hardened, NNMC attempts to reach out and pro-actively address issues. The program is not intended to be an investigative process. Rather, it is an information-sharing process. It precludes participation by a patient's legal counsel.

In less than eighteen months, the program has processed approximately 134 cases. Of the 134 matters processed, 133 resolutions have been achieved. While the resolutions reached are typically not reduced to a signed agreement between the parties, the program does utilize a formal response system to document the understanding reached among the stakeholders. It is remarkable to note that all of the 133 resolutions have involved non-financial solutions and to date, no suits have been filed subsequent to the resolutions.

The program has been extremely effective for patients of the medical center, and is deemed just as important for the providers who also work through the ADR processes. Providers typically buy-in to resolutions in which they have participated. Additionally, providers have indicated that the ADR processes employed by the program are therapeutic. Provider participation has also resulted in the implementation or enhancement of specific medical center protocols and procedures. Simultaneously, patients feel like they have made a difference when they are able to see change take place as a result of their involvement.

Organizers have received requests from physicians and nurses to be trained to resolve conflict within the program. While additional staffing for the program is desired, there is a concern that the program's independence might be impacted by this endeavor. Providers within the medical center do receive disclosure training to better help them communicate to patients errors or issues related to patient care. This approach is deemed vital to preclude the need to employ attorneys to get explanations.

In the future, the program will seek a more active involvement with providers in the area of patient safety. Additionally, the program will seek a more active involvement in the resolution of claims where litigation has already ensued.

2. Stanford Hospital and Clinics –

Stanford Hospital and Clinics is actively adopting ADR principles into its patient safety program to enhance collaborative practice, create a culture of safety, and improve communication between interdisciplinary and interdepartmental groups. The program makes use of facilitation and mediation techniques in creating patient safety workgroups, responding to sentinel events, conducting process analyses, and in creation of an organizational structure that encourages participation and collaboration. Several patient safety workgroups have been established in high-risk areas to address patient safety concerns and create process improvements. The focus for each team is equally allocated between relationship-building within the team in addition to solution generation. A thirty-member patient safety advisory group with representatives from throughout the organization serves as the steering committee for patient safety initiatives within the organization. The group is actively focusing on culture change as a primary goal to encourage open reporting of clinical events and create a supportive environment for clinicians and patients. In addition, Stanford offers a series of training courses through its continuing education center to provide health care professionals with an opportunity to learn basic conflict management skills, negotiation, mediation, facilitation and team management. To date, over 200 clinicians, managers, and physicians have completed the training courses. SHC is also beginning to involve patients and families into their patient safety efforts and training for staff will be available to encourage collaboration with patients and their families and avoid adversarial communications.

3. Kaiser Permanente –

Encouraged by the success of the Ombuds program at the National Naval Medical Center (NNMC), Kaiser Permanente has committed to adopting a comparable program for its patients and providers. While the program is still in its planning stages, Kaiser has devoted significant resources and support for the

program. Like the program at NNMC, Kaiser has deemed the placement and authority vested within the organizational Ombuds to be crucial to the program's success. Within Kaiser's paradigm, the Ombuds is scheduled to report to the Physician in Chief and have authority over providers within the network.

Kaiser's program has been developed within the Office of Patient Safety which clearly recognizes that they will experience issues distinct from a public provider. Despite the anticipated distinctions, the programs share a common goal: they both seek to ensure earlier, more personal intervention in patient / provider conflicts.

Kaiser identified a need for such a program after assessing the efficacy of its current arbitration system. Kaiser currently utilizes an arbitration provision within the contract for its members that provides for mandatory arbitration of claims. In Kaiser's experience, the arbitration process has taken on characteristics of traditional litigation, requiring the exchange of discovery, depositions, and the ultimate presentation to the arbitrator. Kaiser sought to introduce an approach to conflict management that impacted conflict earlier and enabled information to be shared more easily. Kaiser also sought a way to ensure that conflict was addressed face to face, as opposed to electronic or written correspondence which so often is repetitive of information that was initially shared.

As Kaiser's system is vastly larger than the population served by NNMC, Kaiser anticipates utilizing multiple conflict managers with clinical experience to serve as Ombuds. It is anticipated that the Ombuds program will decrease the number of issues typically dealt with through the customer care/member services department.

4. Children's Healthcare of Atlanta – Atlanta, Georgia

Children's Healthcare of Atlanta's Office of General Counsel contains both risk management and legal services functions. The risk management department provides preventive and initial claims processes that have direct connectivity with patient safety, quality and occurrence reporting areas. When potential events are received, in addition to making required insurance notifications, the risk managers focus immediately on patient care, and help identify areas to be referred for process improvement.

When a claim arrives in legal services, the litigation manager, a trained pediatric nurse, reviews all available information and makes contact with the claiming party or attorney. The purpose of this contact is to establish a connection between the party and the person at Children's that will be able to answer questions and provide information so that factual data can be exchanged on an accelerated basis. At the same time, for reasons discussed below, an attempt is made to arrange an in-person meeting. If the case progresses to litigation, the same manager is the liaison between outside counsel and Children's for all documents, witnesses, scheduling and other matters.

Children's has taken the view that there are several measures to gauge the success of a dispute resolution program as it relates to third-party claims. The system has adopted as its underlying principle, that the values of the organization must be upheld consistently even when faced with legal challenges and litigation. Success is assessed with integrity, respect, nurturing, excellence, and teamwork in mind. Children's shares a concern with those that may be pursuing litigation, and that shared concern is for the health of patients, the one that may be the subject of the case, and in addition all future patients.

The specific measures set for the program include the average number of days to initial meeting with the attorney or claimant representative, percent of cases mediated (with the goal being 100%), and percent of cases resolved within 18 months (with a goal of 75%). Other measures include the total costs and any settlement associated with a case, when compared to comparable cases.

When the program was established, the concept was to prioritize the institutional values. This led to a hierarchy of institutional reputation, relationships with patients and the community, and finally the value of the individual case. It does not mean that any case has settlement value. To the contrary, it reinforces the approach of bringing an objective analysis to mediation, including stating reasons to decline to recognize value. This requires a transformative approach to mediation. For the relationship to be the focus, Children's representatives strive to spend as much time with the opposing party as possible, particularly when delivering or receiving key information and valuations.

The program has exceeded its measurable goals and has created a recognizable shift for third parties involved in the litigation process. Third parties involved with the process recognize the program's focus on fairness and empowerment, and the spirit of cooperation with which the program was created. Over time, relationships have become less adversarial.

5. The Veterans' Administration Patient Safety Initiative Case Example: Lexington VA Medical Center:

In 1995, the Department of Veterans Affairs updated its policy manual with respect to the risk management policies to be employed by its medical facilities in a section called "Patient Safety." The new wording stated that, with respect to patient injury caused by accidents or negligence, "the medical center will inform the patient and / or the family, as appropriate, of the event, assure them that medical measures have been implemented, and that additional steps are being taken to minimize disability, death, inconvenience, or financial loss to the patient or family." The policy also provides that the institution must inform the patient or his family about the right to file an application for compensation or to file a federal tort claim (Kraman & Hamm, 1999).

In 1998, the Lexington VAMC addressed this issue by implementing a trust-based patient safety policy hospital-wide. Key features of the policy include routine, full disclosure of errors; proactive compensation for patients injured by negligence or errors; and systematic improvements in clinical processes to avoid future errors (Kraman & Hamm, 1999). The Lexington VAMC model employs a multi-disciplinary committee that is vested with the responsibility to investigate incidents potentially caused by medical errors. When the committee's review reveals that a patient has been injured, the medical center does not wait for the possibility of a claim or lawsuit before taking action. Instead, the medical center intervenes early and the patient is promptly contacted, notified of the findings, advised about options, and assisted in applying for compensation. Since the program's inception, the medical center has witnessed a steady increase in provider self-reporting - suggesting that a trust-based patient safety program can work (Kraman & Hamm, 1999). Over a seven-year period studied, the number of claims increased, but the

payouts were lowered dramatically. This has been attributed to satisfying patients' actual needs – medical care, an explanation, an apology/acknowledgement, and an action plan for preventing recurrence – and generating a reasonable response in return.

The success of this program indicates that, at least within the public setting, the utilization of a humanistic risk management policy that includes early intervention, maintenance of the provider/patient relationship, pro-active full disclosure to patients, and fair compensation for injuries may not be financially catastrophic or even significant to the organization.

While these results merit examination for application elsewhere, because the VA features some special conditions, there should be careful consideration of how to adapt such a program to private sector realities. The public setting provides for remedies not available in the private sector. For example, VA patients may receive remedial treatment or monthly disability payments as a result of a medical error. These remedies are less likely to be available in the private sector. In the VA model, providers are not personally named in cases of negligence that occur during the normal course of their activities. However, when there is a payout as a result of such a physician's actions, the physician is still reported to the National Practitioner Data Bank and state licensure boards must acknowledge this information on future employment applications.

In sum, the early intervention of the provider tends to be relationship-sustaining, thus allowing the provider and patient to work through claims that may have arisen. The program has proven to be a solution that is both ethically correct and cost-effective.

6. Long Term Care Ombudsman Program

The Long Term Care Ombudsman Program (LTC) began as a part of federal nursing home reform legislation in the 1970s and became a national program authorized by the Older Americans' Act (OAA) amendments in 1978. The purpose of the program is to designate an ombudsman in each state who will advocate on behalf of long-term care residents in nursing homes, board and care, assisted living facilities, and other settings, with a focus on complaint resolution.

The LTC state ombudsman office must be independent of a respective state's nursing home regulatory agency (ARA, 2001). The separation, however, is not intended to preclude cooperation with respect to abuse cases. The role of the LTC ombudsman has broadened significantly over the years to include such tasks as recruitment and training of ombudsman volunteers, training of nursing home staff, participating in surveys, working with family / resident councils, providing community and media education, complaint investigation and media advocacy. Id. As of 2000, the Office of LTC Ombudsman had approximately 970 compensated ombuds and over 8,300 volunteers. Id.

The LTC ombudsman program is deemed critical to nursing home resident protection, the source of more than 80% of the offices' complaints. Id. For example, of the over 186,000 complaints processed in 2000, more than 78% were resolved to the full or partial satisfaction of the complainant. Id. The LTC ombudsman has the opportunity to file a complaint on behalf of a resident or family member of a long term care facility. It is expected that the pressure on the LTC ombudsman program will increase substantially as funding remains level and there is a corresponding increase in complaints and an aging population. Id.

4. Arizona State Hospital – Phoenix, Arizona

Arizona State Hospital employs a Human Rights Coordinator within the hospital, who also serves as the director of mediation for mental health services at the center. The program levels the playing field for patients through a number of methods, including, but not limited to, establishing a limit on the number of clinicians that can participate in a mediation session with a patient. The program also typically provides for the patient to provide an overview of his or her position first to allow the clinicians involved to not only listen, but to *hear* the patient's perspective. The program's director has indicated that mediation helps participants feel that they have some control over what happens to them and fosters a less confrontational atmosphere.

This was particularly true in one instance, where a mental health patient actively involved in his own treatment had been in the hospital for some time when he first had occasion to interact with the Human Rights Coordinator. In that instance, the patient had been laughing with his fiancé in the day room, a little too loudly according to staff members, who asked the patient's fiancé to leave and restricted further visitation. A short mediation session resulted in a contract that met all parties' needs. Further, the patient

indicated that the process taught him a different way of approaching problems, by providing him tools that helped him focus on fixing the problem.

The program's director has observed that learning about conflict management can help mental health professionals and recipients understand such concepts as "consumer-directed" services in new ways. "Some people think that consumer-directed means that clients always get their own way—even if what they want is to be taken to the grocery store at 3:00 a.m.," she notes. "Training in conflict management helps people to see that you don't have to fight about one specific choice—there are always other options. What really matters is how people go about sorting things out." (Blanch, 2000).

The program's greatest success, however, is with disputes about medication and treatment issues. The program has found that such disputes almost always boil down to a communication issue—the doctor or the treatment team either hasn't listened to what the patient is saying or hasn't explained things well. Within the hospital's program, mental health patients are given a real chance to be heard. Moreover, the program director has observed that once doctors realize that people are not trying to usurp their power, that they just want their histories and experiences to be recognized, a solution always seems to emerge.

The biggest lesson to the program and the hospital in general is that conflict resolution is extremely compatible with the mental health recovery movement. Consumers learn to speak for themselves and have control over their lives and providers learn that their patients just want to be heard.

5. The American Health Lawyers Association Mediation and Arbitration Program:

This program provides industry-experienced neutrals the opportunity to assist in resolving disputes among industry members (AHLA, 2001). The program has been used by hospitals, physicians, and vendors to provide a forum that is attuned to their area of healthcare specialty. Several hundred dispute resolvers are registered, and when a party pays an administrative fee and requests a list, the qualifications and experience of each of ten neutrals is provided. AHLA also provides a series of training programs at different levels focused on providing ADR skills and resources to healthcare practitioners.

II. CONCLUSION

ADR practitioners can provide tremendous value to their healthcare clients. There is opportunity to advance the movements identified above (e.g., patient safety training, communication, error disclosure, etc.), as well as introduce ADR concepts that would otherwise be new to this particular industry (e.g. early case assessment and resolution). ADR processes also seem a perfect addition to the management of healthcare-related conflict. The interdependent nature of the healthcare industry supports the need to maintain relationships, seek quick and effective resolution to conflict, and respond to change.

Finally, the unique combination of pressures in the healthcare industry have elevated conflict to a primary concern within both the business and medical model, and, as the societal, political and economic forces continue to press at the healthcare industry, there will continue to be a growing need to address such conflict with more systemic conflict management models that integrate system-oriented and participatory practices into the business of healthcare. Because there is no shortage of conflict in healthcare, there is no shortage of opportunities for ADR practitioners within the healthcare community.

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Curing Conflict™ Conflict Management Training for Health Care Professionals

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*“You can not teach anyone anything, you can only help them find it within themselves.”
Galileoi*

The health care professional’s typical day involves a frenetic race to coordinate resources, provide care, perform procedures, gather data, integrate information, respond to emergencies, solve problems and interact with diverse groups of people. Regardless of the role of the professional; physician, nurse, administrator, manager, social worker or technician, as a group, health care professionals face more conflict and greater complexity than any other profession. Despite the challenges of balancing competing interests, philosophies, training backgrounds, the endless quest for adequate resources, and the emotional quality of the work that they do, very few health care professionals have had the opportunity to learn the skills and

processes necessary for negotiating their environments. There is little formal training available to them in this area and role models for collaboration and good negotiation are far and few between. As a result, the clinical environment is one of competition, quick fixes, hot tempers, avoidance tactics and at times, hopelessness.

The field of dispute resolution has a unique opportunity to inject hope into our hospitals and clinics. By providing education, professional development, and strategies for conflict management and dispute resolution, the ADR field can create synergy by merging solid conflict resolution processes with an environment rife with complex problems and motivated problem solvers. By creating shared meaning between ADR and health care, clinicians can begin to integrate interest-based processes into their existing activities. Through development of conflict management skills of experienced clinicians and administrators, health care organizations can begin to raise the level of dialogue from that of survival-of-the-fittest to that of collaboration and synergy.

Where to Provide Training/ Professional Development

Providing training and education for health care professionals can take various forms. For licensed providers, creating continuing education courses can provide an educational forum that takes advantage of their licensure requirements and creates an opportunity for more intense learning outside of the clinical environment. Continuing education can take place at conferences and workshops, or through CE centers. Additionally, education can take place within the clinical setting through grand rounds, staff meetings, retreats, HR development programs, brown bag discussions, leadership development courses, and internal newsletters, websites and journals. From within the health care organization, education in conflict management can occur through integration of facilitation and mediation techniques into patient safety processes such as root cause analysis, process reviews, failure modes and effects analysis, disclosure conversations with patients, and team care conferences. Finding multiple ways to integrate skill development and process understanding into currently existing health care activities is essential to the successful development of the field of health care alternative dispute resolution.

Using Analogies and Metaphors- Linking ADR and Health Care

To provide a framework for teaching conflict resolution to health care professionals, it helps to tie the principles of dispute resolution to their clinical experience. Simple analogies during a facilitated session can help them see how something they are doing to resolve the conflict is similar to something they do clinically. For example, a group of obstetrical physicians who are developing an important guidelines document and who are having difficulty understanding the importance of the process necessary for the creation of the document, by focusing on content alone, can be given insight with an analogy to the birth of a baby. As obstetricians, their focus for 42 weeks is on the process for development of a healthy baby. Analogizing how lack of attention to the process can affect the health of the baby (the document) helps them understand the collaboration and process issues and recognize the need to work together at a different level.

Health care professionals are excellent problem solvers. They are expert at analyzing a problem, developing a strategy, locating resources and implementing the plan. This is how they are trained to care for patients. Using the analogy to patient care enables clinicians to grasp quickly the concepts associated with conflict management. The skills used to take care of patients can be honed to resolve conflicts and negotiate effectively. A useful strategy for integrating skill development into a training session is to identify the steps in caring for a patient. The first step is assessment, then diagnosis of the disease or illness, then creation of a treatment plan, followed by evaluation of the treatment and modification of the plan if necessary. Given a clinical scenario, health care providers easily identify these steps in the process. They have difficulty applying the same process to conflict situations. If given a conflict scenario, for example a dispute regarding visiting hours on the unit, most of the clinicians will jump straight to diagnosis or treatment. They will describe the problem as, "inconsistency in the enforcement of visiting hours" and therefore there must be a stricter policy and re-education about the policy. Diagnosis- Inconsistent practice. Treatment- Tighter policy and re-education. Assessment of what is leading to the inconsistent practice is not done. Analogizing the situation to one of treating a patient without taking vital signs, listening to their

lungs or looking at their lab work helps clinicians grasp the importance of assessing the interests and needs at stake in a conflict situation. ADR professionals are expert at assessing needs and interests and can provide skill development for clinicians in this regard.

Skill Development

Despite an abundance of years in schools, most physicians and nurses are lacking in basic skills necessary for resolving conflicts. Some of the skills that must be developed for effective conflict management in the clinical setting include, being present in the moment, listening for understanding, mutuality, openness, and reflection. Due to the chaos and complexity that exists in most health care environments, a majority of health care professionals are busy thinking about the next patient, how to get the next resource, when to fit in a test or procedure, when to eat or sleep, and responding to multiple distractions and interruptions. It is difficult to truly be present in the environment and listen to what others are saying at a deeper level. Listening is typically restricted to information needed to move through the day and is rarely done at a level that enables understanding of a situation where there may be collaboration barriers resulting from fear, need for control, fatigue, a need to be right, or shame. Creating the ability to listen at a deeper level within a chaotic clinical environment is an essential skill for developing conflict resolution abilities in clinicians.

Despite the descriptor, “health care team”, there are relatively few times throughout the day when members of the interdisciplinary team function as a team. Most often, they are working as individual advocates for the patient through their role and only in rare instances, such as clinical emergencies, do they step out of the role and truly work together as a synergistic team. Turf battles, differences of knowledge level and experience, and rare opportunities for group conversation lead to a competitive atmosphere where everyone is struggling to do the right thing. Development of the skill of mutuality is essential for managing disputes and for preventing the shame/blame game that so frequently arises in the clinical setting. Fear of doing harm to the patient creates a great need for control of the patient and the environment and can cause harm to the development of true teams. Demonstrating ways for developing mutuality through exercises and role-playing is a great method for advancing the professional development of skilled clinicians.

Openness to alternative solutions is key to resolving complex problems. Developing this skill in clinicians enables them to consider creative alternatives to a conflict situation. It is what enables them to think beyond “a policy”, “a guideline”, or “re-education” as the solution to their current conflict. Openness is necessitated by a trusting and supportive environment. ADR professionals may be required to come into a toxic environment to recreate trust and establish support structures before openness can be fostered. In a competitive environment where mistakes can be lethal, it is difficult for health care professionals to be open to the fact that their idea or answer could be wrong. There is a need to be right so as not to hurt the patient. This trait carries over into conflict situations where everyone has the right answer to the problem and has difficulty hearing conflicting solutions. On a broader level, with varied levels of training, there is a built in tendency to believe that you know more than someone else because of specialty training, certification, more experience or position within the organization. Developing openness across professions and across hierarchical levels is difficult but necessary to foster just agreements and lasting solutions.

Training in methods of reflection is also key for health care professionals. As a result of the need to be right, there is a difficulty managing situations where it appears that the wrong choice was made or a system design flaw lead to a bad outcome for the patient. Many conflicts in health care flare up around adverse outcomes or near misses with a patient’s care. The quick jump to diagnosis usually results in a search for who to blame for the bad outcome. The blame environment exacerbates the conflict by creating secrecy and shame. Individual reflection is a necessary skill for resolving these types of conflicts by enabling clinicians to learn from the event and identify what they would do differently the next time. Organizationally, hospitals and health care organizations must also find a way to reflect on how to improve their processes rather than foster a punitive environment that adds fuel to conflicts or drives them underground until the next adverse event occurs.

Skill development in conflict management can enhance the role of the clinician in their current role and can assist managers and administrators in negotiating the complexity of their environments. In addition, skill

training programs can be designed specifically to develop health care professionals who are interested in becoming health care mediators or internal neutrals within health care organizations. Expanding the role of the mediator to include work within health care organizations will require training a core group of health care professionals who can integrate their clinical expertise with the practice of dispute resolution. Programs with this purpose are relatively new and are developing momentum as more health care professionals become interested in the field of dispute resolution.

Process Training

Clinical training does not prepare health care providers for working collaboratively, running care conferences, conducting a root cause analysis or working effectively on committees. There is no training in facilitation, mediation, dialogue, or negotiation. There may be a few hours of training within a psych rotation on group work or active listening but that is geared toward a therapeutic outcome and rarely does the knowledge transfer to non-therapeutic situations. Core training in how to facilitate, how to run a committee, how to create a team, how to intervene after a crisis, how to balance competing interests and how to manage culture change is key in integrating conflict resolution into the health care setting. Applying the processes that dispute resolution professionals use with clinical activities allows an immediate application of the principles of interest-based negotiation and mediation. It also enables clinicians to have a consistent method for doing non-clinical problem solving and for enhancing collaborative work relationships that carry back over into bedside care of the patient.

Process training can be done through formal courses in facilitation and mediation, through retreats for managers and administrators, through role-modeling by going in as a facilitator or mediator in a clinical situation, and through professional schools or associations in conjunction with conferences. All trainings should be interactive and allow opportunity to apply the process to a clinical conflict. Health care professionals are “doers” and learn well with applied exercises and the challenge of trying new skills. Applying the process to actual conflicts they are having in their workplace enables them to work through the conflict in a neutral setting and reinforces how to apply the process to their work environment. Processes that are beneficial in the clinical setting are facilitation, mediation, negotiation, appreciative inquiry, dialogue, and conciliation.

If You Build It, Will They Come?

Finding forums for providing the training and education programs takes some planning and networking. Contacting a local hospital or provider group to provide an in-service, workshop or training session is one method. Submitting a proposal to a professional health care association to present at upcoming conferences or events is a great method for disseminating introductory information and promoting the idea of conflict resolution training. Working with a continuing education center at a hospital, school of medicine, or school of nursing is another forum for providing training. Identifying where health care professionals look for education and professional development is essential to the success of a training program. Additionally, designing the program to fit their unique time dependencies and quick attention spans is key in creating good word-of-mouth with attendees. Obtaining continuing education credits for physicians, nurses and other licensed professionals adds to the likelihood they will attend. Designing the training to be challenging and interactive will increase their knowledge retention and also make the courses more popular.

Sample Programs

Integration of ADR and health care is relatively new. The impetus on improving systems and teamwork emanating from the patient safety movement is creating a new focus by health care organizations on the skills and processes provided by the ADR field. Additionally, the medical malpractice crisis and continued cuts in reimbursement necessitate better methods for resolving disputes to retain resources for caring for patients. There are many ADR providers who have provided ADR training within health care organizations but there are few specialized health care ADR programs in existence. Resolving Conflict in Health Care, Harvard Program for Negotiation in Health Care, and Curing Conflict™ are examples of

successful programs that have integrated the two disciplines and found methods for modifying ADR materials to fit the needs and interests of the health care industry.

A culture change is occurring in health care as the system grapples with ways to provide more care with fewer resources and improve safety through collaboration and better systems. For this change to be successful, health care organizations are going to need a critical mass of professionals with good conflict management skills and a means for integrating collaborative processes into their day-to-day operations. ADR professionals can fill that need by providing well designed, interactive training programs that enhance the ability of health care organizations to provide safe and effective care and that enable health care practitioners to regain hope that complex problems can have creative solutions.

To learn more about the programs mentioned:

Resolving Conflict in Health Care- Mediate.Calm
Contact: Rob Robson at robson@mediatecalm.ca

Program for Negotiation in Health Care, Harvard School of Public Health
Contact: Lenny Marcus at _____

Curing Conflict™: Conflict Management for Health Care Professionals-
Health Care Mediations, Inc.
Contact: Debra Gerardi or Ginny Morrison at info@healthcaremediations.com