INDICATORS OF SUCCESS: AN EXPLORATION OF SUCCESSFUL CONFLICT MANAGEMENT IN US HOSPITAL SETTINGS

A Thesis submitted to the Faculty of the Graduate School of Arts and Sciences of Georgetown University in partial fulfillment of the requirements for the degree of Master of Arts in Conflict Resolution

By

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Indicators of Success: An Exploration of Successful Conflict Management in US Hospital Settings

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ABSTRACT

This paper investigates how success is defined in managing healthcare conflicts. It introduces a framework for analyzing the different conflict management dynamics in healthcare, dividing conflict into four main categories based on the parties involved: provider-provider; patient-provider; provider-administration; patient-payer. Reviews of the literature and interviews with ten healthcare conflict management practitioners were used to analyze these four dynamics and identify key features of the conflicts and conflict management responses associated with each. The interviews further explored definitions of success, clarified training and research needs, and identified emerging trends in the field.

The findings suggest that dividing healthcare conflict into relationship-based categories of conflict is appropriate due to significant differences in the types of conflict experienced in these dynamics and the corresponding divergence in conflict management goals, focus, and interventions. Conflict management approaches in the four dynamics largely shared the aims of improving relationships, improving communication, and saving money, though each dynamic included additional aims. Specific definitions of success varied, at times widely. There were noteworthy difference in context and perspective between two of the largest categories of healthcare conflict, patient-provider conflict and provider-provider conflict. Patient-payer conflict interventions diverged from the others in being less relational and more transactional. Early intervention in conflict management was important in all dynamics.

How programs define success has implications for how hospitals design conflict management systems. The literature review suggests that the orientation of many existing healthcare conflict management programs may overlook certain conflict dynamics, unintentionally leaving certain types of conflicts unaddressed.
The conflict dynamic framework presented here can help design conflict management systems that capture the breadth of healthcare conflicts in more integrated ways.

Important trends in healthcare conflict management identified by the research include a shift away from interest-based negotiation models towards relationship-based approaches to conflict management; a reorientation towards prevention and early intervention, raising expectations that healthcare providers take the lead on conflict engagement and increasingly supplanting third-party intervention models; a push to include conflict management training in health professional schools; and utilization of a nested training-mentoring-communities of practice approach to developing healthcare providers’ conflict management skills.
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INTRODUCTION

The genesis for this thesis arose from what I noted as a tendency for authors or practitioners to focus on one particular conflict dynamic within healthcare, often to the relative exclusion of other dynamics. Similarly, many conflict management systems established in hospitals that I surveyed seemed to only deal with a certain type of complaint. While program focus is desirable in order to ensure quality outputs, the restricted horizon often seemed to arise unintentionally. As a result of this tendency to “silo” programs and activities, many conflict dynamics risk being left unrecognized and unaddressed.

Relatively little research has attempted to span or compare the different domains of healthcare conflict management to see how, and how widely, hospital ADR programs are focusing on these different dynamics. It is in this comparative examination that this thesis moves the existing research forward.

There is a strong case to be made that conflict dynamics in healthcare systems are interconnected and incapable of being separated into discrete parts. In such complex systems, it is often not possible to fully disaggregate the causal factors of any event. Conflict in healthcare is no different. Unresolved conflicts create ripple effects that impact outcomes far removed from the initial dispute. Different layers of individuals and systems in conflict create a complicated work environment, with interwoven causes and effects of many disputes.

The benefit of mapping and studying different healthcare conflict dynamics is to paint a fuller picture of the relationships and types of conflicts that need to be managed in healthcare. Artificially isolating categories of conflicts helps us examine if and how they are being addressed in a specific healthcare environment. Focused programs will likely still need to be designed to deal with distinct issues, but this conflict map helps decision makers ensure that other programs exist to address the additional disputes. Beyond this, a healthcare conflict map helps link programs together within a broader conflict management system for
increased synergy. Innovative healthcare dispute resolution programs will increasingly attempt to address the spectrum of conflicts in such an interrelated, comprehensive manner.

Part of understanding the context and implications of different conflict dynamics in healthcare is the issue of differing definitions of success. Clarity on how success is defined and measured is a necessary component for designing appropriate conflict management systems, conflict trainings for staff, and ADR interventions.

A second instigation for this thesis was my interest in conflict resolution training for health professionals. I am particularly interested in the potential for practicing clinicians who receive training and mentoring in conflict management to help mainstream conflict management skills and processes within the healthcare professions. Towards this end, my second goal for the thesis was to clarify where the field currently stands in relation to education and training opportunities for clinically-practicing healthcare professionals.

This research aims to serve five purposes:

1. Assist practitioners by mapping the conflicts and responses to conflict in healthcare.
2. Begin comparisons that may allow the industry to develop best-practice indicators of success.
3. Help hospitals as they establish new conflict management systems in response to the 2009 Joint Commission on Accreditation of Healthcare Organizations standards.
4. Help develop appropriate training for health care professionals on conflict management in healthcare.
5. Identify upcoming trends in the field.


RESEARCH DESIGN

The research was designed so that the bulk of the information used in the thesis was obtained through reviews of the published literature on the field and publicly-available documents describing the more innovative dispute resolution programs.

The research protocol was developed with the goal of conducting semi-structured interviews with 5-10 experts in the field of healthcare dispute resolution.

Ten subjects were formally interviewed as part of the research, identified through a combination of purposive sampling, snowball sampling, and convenience sampling. The interviews were largely conducted via telephone and in person, with one interview conducted via email.

Purposive sampling identified five of the final interviewees. In line with the initial research protocol for purposive sampling, a list of potential interviewees was compiled of established experts within the healthcare dispute resolution field who had published academic articles or books on this topic in the past. Requests for interviews were extended to ten individuals on this list, with five ultimately participating.

In a deviation from the original research design, three interviews were conducted with healthcare providers identified through convenience sampling (existing contacts of the author who were knowledgeable of healthcare conflict dynamics but had not published in the literature). They were selected to provide more balance to the interviewee pool, as relatively few practicing clinicians have been actively publishing in the literature and/or were available for interviews.

These three interviews with the non-publishing healthcare providers accessed valuable perspectives and resulted in additional interviews with non-publishing clinicians active in healthcare dispute resolution who
would not have been contacted through the purposive sampling. In future research, the purposive sampling design should be revised to include more diversity in the interviewee pool, specifically targeting clinically-practicing healthcare providers not identified through the literature.

The remaining interviews were conducted with individuals identified through snowball sampling arising from the initial round of interviews.

None of the interviews were digitally recorded. Notes were taken with summary take-away points repeated to the interviewee at the end of the conversation, if desired by the interviewee.

A semi-structured interview format was followed for all interviews. The preliminary core of questions centered on these two issues:

- "How do we know that dispute resolution practices are valuable and necessary in US hospital settings?"
- “What constitutes successful conflict management in US hospital settings?”

The questions evolved throughout the course of interviews, growing more specific at later stages with significant adaptation of the questions to match the specific aspect of healthcare dispute resolution applicable to the interviewee.

Interviewees were offered the option to request full anonymity, partial anonymity, or full disclosure about their participation in the interview. No interviewee requested full anonymity for the entire interview, although some requested that certain institutional names be omitted and some comments not be attributed. Some interviewees requested attribution for their comments.
This research methodology of a literature survey supplemented with semi-structured interviews was chosen as a compromise between the need to survey the field as it currently stands and the desire to identify general upcoming trends that have yet to emerge in the literature. The size of the interview pool and the scope of the research questions were dictated by the timeframe available to complete this master’s thesis.

Key assumptions underlying the research are that conflict exists in healthcare; that intentional management of this conflict is possible; and that there is value in attempting to manage this conflict. The survey of the literature is based on the premise that this literature is sufficiently broad to provide a fairly comprehensive map of the types of conflict in healthcare, and that the published work accurately reflects conflict as experienced by healthcare stakeholders in healthcare environments. Assumptions in utilizing semi-structured interviews are that published conflict management practitioners understand emerging trends in the field and that their perspectives are at least somewhat representative of the broader healthcare conflict management field.

This research is limited by its small survey size and its focus solely on US healthcare conflict management.
CONFLICT IN HEALTHCARE

What is meant by the term “conflict”?  

This paper defines conflict as a real or apparent incompatibility of parties’ needs or interests.¹ This positions conflict as a more expansive term than dispute, which traditionally is associated more closely with legal claims and more formal expressions of conflict.² This broad definition of conflict accommodates both latent and manifest forms of conflict. While this conceptualizes conflict as a relational phenomenon involving the interactions and relations between two or more parties, it accepts that conflict can exist when only one party perceives there to be conflict. Conflict can involve unresolved problems from past interactions, struggles for power, the ways parties talk with each other, and the ways decisions are made.³ Manifestations of conflict fall on a spectrum from disagreements to violence. Differentiation of conflicts is typically expressed according to severity of impact and intensity of conflict.

Does conflict exist in healthcare?  

Conflict is widespread in healthcare.⁴ While the conflict is rarely violent, it exists on a variety of levels with differing degrees of intensity. Healthcare conflict commonly occurs between patients and providers, patients and payers, providers with their colleagues, and providers with healthcare administrators.

Healthcare providers themselves identify high levels of conflict in the workplace. The American College of Physician Executives’ 2009 Doctor – Nurse Behavior Survey found that 98% of those surveyed had witnessed an incident of disruptive behavior between nurses and physicians in the last year, with 30% of participants reporting seeing incidents weekly and 10% daily.⁵

In a 2004 study by Anderson and D’Antonio, health professionals indicated their perception that 50% of a physician’s time is spent in conflict.⁶ 62% of the conflict experienced was with other health professionals.

An international survey of ICU care providers published in 2009 reported that 71% of the 7498 participants surveyed perceived conflict in the ICU within the previous week.⁷ 80% of the conflicts were seen as doing more harm than good, and over 50% of the conflicts were described as “severe.” Nurse–physician conflicts were the most common (32.6%), followed by conflicts among nurses (27.3%) and staff-relative conflicts (26.6%).

A study by Studdert, et al., of patients with a prolonged stay in the ICU found that over 30% of patients had conflict associated with their care.⁸ 57% of these conflicts were team-family disputes, 31% were intra-team disputes, and 12% occurred among family members.

**What fuels conflict in healthcare?**

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Many factors contribute to healthcare conflict. Chronic time pressures combine with resource and employee shortages to create communication challenges and place many providers in adversarial positions.\(^9\) Challenges balancing cost vs. quality pressures, budget cuts, provider shortages, and shifting expectations create conditions ripe for conflict.\(^10\) Market pressures, shifting financial risks, misaligned incentives, bioethical challenges, overburdened workloads and fatigue, and complex emerging technologies place additional stress on healthcare providers. The complexity and volume of regulations add frustration and pressures to many healthcare providers, leading to anger expressed in unprofessional behavior.

These pressures collide with the expanding demand for services, increasing regulation, and higher expectations for transparency, accountability and quality of care outcomes. Healthcare providers are caught in the middle.\(^11\) The changing landscape of healthcare is likely to increasingly alter systems and roles, setting the stage for further conflict.

Moreover, traditionally rigid professional hierarchies with strong power imbalances can perpetuate silence, unilateral decision-making and ineffective approaches to conflict. Research suggests that health care workers tend to either avoid managing conflict or be competitive, both of which can exacerbate conflicts.\(^12\) Decreased levels of trust between patients, clinicians, administration, payers, and organizations further strain all relationships and facilitate conflict.

**What are the costs of conflict?**


The data suggesting that 50% of physicians’ time is spent in conflict, with similar time burdens placed on nurses and executives, carries enormous financial and efficiency implications for healthcare organizations.\(^{13}\)

The Joint Commission July 2008 Sentinel Event Alert #40 cites evidence of correlations between unprofessional (disruptive and intimidating) behavior and the incidence of adverse events and medical errors, patient satisfaction, costs of care, and staff retention.

Gerardi provides the following table listing costs of unmanaged conflict:\(^{14}\)

**Table 1. Costs of Conflict**

<table>
<thead>
<tr>
<th>Direct Costs of Conflict</th>
<th>Indirect Costs of Conflict</th>
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<tbody>
<tr>
<td>Litigation costs: attorney’s fees, expert testimony, deposition, lost work time, transcripts, document production, etc.</td>
<td>Team morale, motivation for organizational change, workplace relationships damaged, unresolved tensions that lead to future conflicts</td>
</tr>
<tr>
<td>Management productivity: time spent working on resolving conflicts rather than other managerial duties</td>
<td>Lost opportunities for pursuing capital purchases, expanding services, enhancing customer satisfaction programs, developing staff/leaders</td>
</tr>
<tr>
<td>Turnover costs for training new staff, recruitment costs</td>
<td>Costs to patients due to delays in traditional litigation can lead to more costly outlays for healthcare than if conflicts are addressed early and directly</td>
</tr>
<tr>
<td>Disability/stress claims, workman’s compensation claims</td>
<td>Cost to reputation of organization and of care professional; negative publicity/media coverage</td>
</tr>
<tr>
<td>Regulatory fines for noncompliance or loss of contracts or provider status with insurers and Medicare/Medicaid</td>
<td>Loss of strategic market positioning due to public disclosure of information regarding the dispute/bad public relations</td>
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### Direct Costs of Conflict
- Costs associated with increased care expenditures for patients with preventable poor or adverse outcomes
- Sabotage, theft, damage to facilities

### Indirect Costs of Conflict
- Increased incidence of disruptive behavior by staff and medical professionals
- Emotional costs: pain, turmoil for those involved in the conflict

**Why is understanding conflict important in healthcare?**

Conflict is a fundamental aspect of healthcare and its presence affects all those associated with healthcare. The high prevalence and costs of conflict increasingly force stakeholders to confront conflicts that were ignored in the past. Increasingly, satisfactory performance of job duties requires successful engagement with conflict.

Rising expectations that providers and systems do more with less increase pressures on healthcare providers and force them to manage conflicting goals. The increasing complexity of healthcare environments necessitates more effective communication and joint problem solving within provider teams. Practitioners are called to collaborate better in multidisciplinary patient care teams, hospital committees, public health issues, teaching, and research.\(^\text{15}\) Advancing providers’ conflict engagement skills is required to successfully meet these expectations.

Additionally, healthcare consumers increasingly expect good communication, better information exchange, and less hierarchical interactions from their healthcare providers. This trend, along with increasing concerns over cost and the expectation that both health care providers and patients become increasingly conscious of the cost of their healthcare decisions, push the provider–patient relationship towards shared decision-making models that require new skills and frameworks for provider–patient interactions.

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\(^\text{15}\) Ellen Zweibel, et al., “What Sticks: How Medical Residents and Academic Health Care Faculty Transfer Conflict Resolution Training from the Workshop to the Workplace,” *Conflict Resolution Quarterly* 25, no. 3 (Spring 2008): 322.
There is an ethical push towards apology and full disclosure in many healthcare cultures, with accreditation standards and legislation also involved. Adverse event disclosure protocols are now standard within many healthcare organizations and insurance companies. Increasingly legislation is mandating disclosure.

In January 2009 the Joint Commission on Accreditation of Healthcare Organizations standards concerning conflict management went into effect, with direct implications for hospitals nationally. These accreditation standards require that: 1) “The governing body provides a system for resolving conflicts among individuals working in the hospital”; 2) “The [organization] manages conflicts between leadership groups to protect the quality and safety of care”; and 3) “Leaders create and maintain a culture of safety and quality throughout the organization,” including a process for managing disruptive and inappropriate behaviors. These standards push organizations to further develop conflict management policies and systems, bringing more healthcare stakeholders into contact with the field.

Categorization of Healthcare Conflict Dynamics

This paper organizes healthcare conflicts into four major dynamics based on the parties involved with the conflict: provider – provider; patient – provider; patient – payer; and provider – administration. An

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16 Quotations from: 1) Standard LD.01.03.01; 2) Standard LD.02.04.01; 3) Standard LD.03.01.01 and Elements of Performance for LD.03.01.01, respectively. Joint Commission Resources, *The Joint Commission Accreditation Standards for Hospitals* (Oakbrook Terrace, IL: Joint Commission on Accreditation of Healthcare Organization, 2009).


18 There are numerous additional, more specific categories of relationships that could be defined, yet when interpreted broadly these four dynamics capture most disputes. Provider is understood to include not only nurses and physicians but also physician’s assistants, nurse practitioners, social workers, laboratory staff, radiology staff, pharmacists, physical therapists, and others involved with patient care. In this typology, doctor-insurance and doctor-risk management conflicts fall under the dynamic of provider-administration conflicts. Doctor-family conflicts are similarly grouped under provider-patient conflicts. For alternative ways of categorizing these relationships, see Anderson and D’Antonio, “Empirical Insights,” 15-17.
alternative approach is to categorize conflicts based on type of dispute. This could be accomplished using the following five major types of conflicts and their causes suggested by Moore:¹⁹

- **Relationship conflicts**, caused by: strong emotions; misperceptions or stereotypes; poor communication or miscommunication; repetitive negative behavior. Relationship conflicts are present in most instances of healthcare conflict, in all four dynamics.

- **Value conflicts**, caused by: difference criteria for evaluating ideas or behavior; exclusive intrinsically valuable goals; different ways of life, ideology or religion. Value conflicts are notable in end-of-life decisions involving patients, their families, and provider, but also appear in some provider – administrator conflicts.

- **Structural conflicts**, caused by: destructive patterns of behavior or interaction; unequal control, ownership, or distribution of resources; unequal power and authority; geographical, physical, or environmental factors that hinder cooperation; time constraints. Structural conflicts are prominent in provider – provider disputes.

- **Interest conflicts**, caused by: perceived or actual competition over substantive (content) issues; procedural interests; psychological interests. Interest conflicts are found in each dynamic.

- **Data conflicts**, caused by: lack of information; misinformation; different views on what is relevant; different interpretations of data; different assessments procedures. Data conflicts are also found in each dynamic.

I categorize the conflicts by actors rather than type because the contexts, cultures, power dynamics, pressures, and approaches to conflict vary more across actors than they do across types of conflict. For healthcare conflict management systems, the actors involved with the conflict are more significant variables than the types of conflicts involved. Categorizing by actor better highlights the core relationships involved with each dynamic and is more useful for conflict analysis, training, and overall system design. If desired, having first distinguished the actors involved with the dynamic, further disaggregation of conflicts

by type can be used as a secondary tool to pinpoint problems, strengthen conflict management systems, and tailor interventions specific to a case.
CONFLICT MANAGEMENT IN HEALTHCARE

Definitions

The thesis utilizes the term *conflict management* in the broadest sense as the generic term to cover the entire range of positive conflict handling.²⁰

There remain no standardized definitions of conflict management, conflict resolution, conflict engagement, or dispute resolution. Despite efforts by individual authors to differentiate these into distinct concepts, the terms are still largely used interchangeably. Further, the definitions of and distinctions in these terms made by certain authors often only apply to a particular domain of conflict (workplace conflict, international conflict, environmental conflict, etc.) or a particular academic or professional field (law, sociology, international relations, management, etc.).

While the distinctions between these definitions can be important in certain domains, in the context of healthcare conflicts the different terms typically do not carry distinct theoretical orientations. The systems and interventions put in place to engage with healthcare conflicts are rarely determined by the term used to label that system or intervention. It is largely the system and its practitioners that define the theoretical orientation, not the label.

Thus, while acknowledging the potential that healthcare conflict terminology may increasingly correlate with distinct theoretical orientations in the future, this thesis uses these terms interchangeably. As conflict management is currently the term most widely used to describe systematic approaches to responding to healthcare conflict, that is the primary term adopted here.

²⁰ For further references to definitions, see Oliver Ramsbotham, Tom Woodhouse, and Hugh Miall, *Contemporary Conflict Resolution, 2nd ed.* (Malden, MA: Polity Press, 2005), 29.
One emerging trend in terminology worth noting is the possibility that *conflict engagement* will become the preferred meta-term in the healthcare field to refer to the “capacity to effectively enter into and address conflicts of various types, at various depths, and over differing time frames, ranging from short-lived interactions to more complex and protracted disputes.”

**What does conflict management in healthcare mean?**

Conflict management in healthcare refers to systems, response frameworks, processes, skills, and interventions for engaging with healthcare conflict. The field draws from research and practice involving conflict resolution theory; workplace conflict management systems; conflict management skills, processes, and techniques; and conflict resolution training.

Gerardi suggests some of the core competencies for successful conflict engagement in healthcare:

- conflict analysis
- reflective practice
- negotiation
- communication skills (listening/acknowledging/reframing)
- giving and receiving feedback
- shared decision making
- debriefing and process evaluation
- group facilitation
- conflict dynamics
- mediation

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• conflict assessment
• conflict coaching
• agreement management

Additional principles and insights from the conflict resolution field merge with the specific healthcare context to shape programs and responses to healthcare conflicts.

**Unique Features of Healthcare**

Robson and Morrison highlight three distinguishing features of healthcare systems important in understanding healthcare conflict and its management.23 First, healthcare is a complex adaptive system characterized by constant change, fluid linkages, flexible rules dependent on specific actors and system history, large amounts of data, multiple feedback loops, and limited access to others’ information. This type of system generates more errors, though it also has the potential to be more responsive than other systems. Interrelated components of complex systems are difficult to differentiate, making it a challenge to fully identify linkages and sources of conflicts within the system.

Second, systematic inequalities and imbalances of power, knowledge, and control create strongly hierarchical healthcare environments. These imbalances affect the relationships between patients and providers; groups of providers (nurses, doctors, social workers, and others); types of providers (primary care vs. specialist care; curative versus preventative); management and providers; payers and management; and payers and patients, among other relationships.

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Third, due to differences in training and professional socialization, actors in the system often hold widely divergent cultures and value systems. This shapes how they define and respond to conflict. The range of actors and the extent of their cultural and value divergence create a unique environment for healthcare conflict management. Physicians, nurses, social workers, pharmacists, risk managers, hospital administrators, lawyers and patients may all be stakeholders in a single dispute. These stratifications can foster identities strongly linked to competent practice of one’s profession and actors with acute awareness of competing priorities between the parties. These factors can make conflicts particularly complex with multiple sources of resistance to conflict management, especially towards third-parties from outside the healthcare realm.

**Culture and Conflict in Healthcare**

Different cultures and cultural identities within healthcare can have significant impact on healthcare conflict management. Doctors, nurses, administrators, and healthcare lawyers, to name just a few, constitute distinct healthcare subcultures. Differences in training, values, philosophies, communication styles, professional expectations, and roles shape approaches to conflict and structure responses to it. Anderson and D’Antonio cite differences in the ways that ADR professionals (many of whom are attorneys) and healthcare providers make sense of information and the context around them. They note differences in legal and medical education towards inductive versus deductive reasoning approaches, highlighting the impact that can have on conflict management education and interventions. Value and identity conflicts amongst these professional cultures can pose significant challenges for healthcare conflict management.

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24 For further commentary on the role of culture in healthcare conflict, see Debra Gerardi, “The Culture of Healthcare: How Professional and Organizational Cultures Impact Conflict Management,” *Georgia State University Law Review* 21, no. 4 (Summer 2005), 857-890; also Dauer, “Postscript on Health Care Dispute Resolution.”


26 Anderson and D’Antonio, “A Participatory Approach.”
Relationships in Healthcare

Relationships are central to many healthcare cultures. Ethical and professional norms place a high premium on the trust, respect, and responsibility invested in health care providers’ relationships with both patients and with other health care providers. Interviewees suggested that healthcare provider identities are typically closely tied to the work that they do, possibly much more so than other professions.

By endangering relationships, healthcare conflicts threaten these professional identities and reputations, key aspects of who healthcare providers see themselves to be. Competent practice of one’s profession has been cited as particularly central to the identity of many healthcare providers. This professional identity is heavily determined by and reliant on relationships. Honoring and maintaining the trust of the patient in the healthcare provider and fulfilling the provider’s responsibility for the health and welfare of the patient requires not only intact relationships with the patient but also functioning relationships with other healthcare providers. Further broadening the relationship network to incorporate concerns with professional reputation and legacy, maintaining and repairing relationships in the face of conflicts that threaten those relationships is at the core of many healthcare conflicts.

This shift towards relationship may suggest increased utilization of transformative mediation approaches. These approaches place increased emphasis on empowerment and recognition, independent of any particular outcome to a mediation. Despite recognition of the importance of relationships, critiques that transformative mediation is paternalistic and impractical are unlikely to be diminished. Given the strict

time constraints on healthcare providers, conflict management interventions—whether mediation or otherwise—will likely need to retain their pragmatic, problem-solving capacity. The potential for expanding interest-based problem solving approaches to incorporate a greater focus on relationships and insights from transformative mediation is an important topic for further investigation.

**Challenges in Healthcare Conflict Management**

Structured healthcare conflict management remains a relatively new field. As such, it faces challenges and barriers to its spread. Some of these key challenges include:

1. Lack of systematized awareness of conflict management options. When a good conflict resolution program exists at a facility, must make others more aware of it so that they aren’t afraid to use it. Oftentimes the conflict engagement thinking / structures / activities are not systematized in a facility either. Organizing, clarifying, and publicizing this information is an important step in creating functioning systems.

2. Lack of support from superiors for conflict management systems / interventions. Within the hierarchical organization of health care delivery teams, lack of support from superiors and decision makers at the top can derail efforts for those below to productively respond to conflict. For example, in the context of shared decision making interventions, nurses may fear that doctors might be upset if they help with the decisions of the patients. As in many environments it is not the normal role for nurses to question physicians, this intervention may be seen as threatening. The same applies for medical residents and junior staff—they won’t be able to use their newfound skills (perhaps acquired in a training) if their superiors don’t support it. Good modeling and support from above is necessary for institutionalizing effective conflict engagement.

3. Lack of time and money for conflict resolution activities. From training to conflict interventions to coaching to using skills in an interaction, lack of time and money (including lack of financial reimbursement by employers and by insurance providers for time spent on these activities) are significant hurdles. It is challenging to be able to pay staff in a staff- and cash-strapped healthcare
environment to go to conflict management trainings and to find ways to cover their shifts so that they have that time off. With thousands of clinical staff working in many hospitals, it is tough to get everyone through even basic trainings. The need for regular mentorship and refresher trainings is an added difficulty.

4. Information gaps about what others in the healthcare conflict field are doing. Healthcare conflict resolution experts need to publish more to help overcome these gaps.

5. Lack of recognition by many health care providers that there are conflicts in healthcare, that people may need help dealing with these problems, and that seeking this help is okay.

6. Difficulties identifying and empowering change agents.

7. Hierarchical barriers in healthcare environments. These hierarchies are both horizontally across professions and vertically within professions. In academic teaching centers, the hierarchies between trainees and supervisors can leave trainees feeling vulnerable and reluctant to initiate difficult conversations or apply conflict resolution skills that they do not see modeled by superiors.30

**Conflict Management Training in Healthcare**

There is a growing literature on conflict management training for healthcare. The American Health Lawyers Association’s *Conflict Management Toolkit* outlines a standard approach to conflict management training for healthcare professionals. The trainings are designed as formal modules to be delivered by competent conflict management professionals, either internal staff or outside consultants. Suggested training objectives are to educate participants in (1) understanding the foundational principles of conflict

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30 Ellen Zweibel, Rose Goldstein, John Manwaring, and Meridith Marks, “What Sticks: How Medical Residents and Academic Health Care Faculty Transfer Conflict Resolution Training from the Workshop to the Workplace,” *Conflict Resolution Quarterly* 25, no. 3 (Spring 2008): 342.
management, (2) early recognition and intervention in response to conflict, (3) maintaining objectivity while limiting subjectivity and emotion, (4) neutral information and fact gathering, and (5) commitment to follow the conflict management process, policies, and procedures.

Research from Anderson and D’Antonio points to the importance of ADR professionals working more closely with healthcare providers on the design and implementation of conflict management training programs. They conducted a study of healthcare ADR professionals (largely attorneys) and healthcare providers who deal daily with conflict involving physicians. The study specifically focused on the two groups’ perspectives on the types and amounts of conflicts faced by and involving physicians. Regarding time spent on conflict, healthcare providers perceived that 50% of physician time was spent in conflict or imminent potential conflict situations, a rate twice that ADR experts expected. There were discrepancies between perceptions of which relationships were the greatest source of conflict for physicians. Selecting from a list of six relationships, ADR professionals perceived the greatest source of conflict as doctor-insurance (38%), doctor-patient (31%), and doctor-staff (13%). This was in significant contrast to the results from healthcare providers, who saw the greatest source of conflict as doctor-doctor (25%), doctor-administration (22%), and doctor-insurance (18%). The indication that the doctor-patient relationship is less problematic than ADR professionals perceived and the doctor-doctor relationship more problematic has important implications on the design and focus of conflict resolution trainings.

The toolkit lists the foundational principles necessary to support conflict management as: 1) a willingness to acknowledge the existence of conflict; 2) open communication; 3) dealing with conflict within an environment of mutual respect; 4) acceptance and tolerance of different perspectives through the process; 5) commitment to fundamental fairness; 6) educating all stakeholders about conflict management; 7) developing a conflict management process with policies and procedures with input from stakeholders; and 8) holding stakeholders accountable to use the conflict management process. See American Health Lawyers Association, Conflict Management Toolkit (2009), http://www.healthlawyers.org/Resources/ADR/Pages/ADRToolkit.aspx (accessed 29 May 2010), 4.


The six relationships were doctor-patient; doctor-family; doctor-staff; doctor-doctor; doctor-administration; doctor-insurance.
Additionally, they found that both ADR professionals and healthcare providers believe that the conflict management skills required by physicians are trainable.\(^{35}\) Both suggested that training physicians to deal with relational aspects of conflict could eliminate 50% of conflict in healthcare. They noted that perceptions of conflict engagement styles varied and training needs varied, both within and across groups, highlighting the importance of proper needs assessments prior to any training.

Lastly, there was divergence on when training should happen. Many ADR professionals suggested continuing education and professional development venues as sufficient training forums, while healthcare providers claimed that conflict management skills needed to be taught earlier, as part of a physician’s initial training. Residency was seen as the most critical phase, as this was cited as the period during which physicians’ conflict responses are shaped. There were concerns that even good conflict resolution skills taught during medical school would be “untaught” in residency if modeling from surrounding physicians was poor. The impact of modeling and mentoring from more senior residents and attending physicians during the residency years was seen as a primary factor shaping physicians’ future approaches to conflict. This suggested tapping into the unique apprenticeship model of healthcare education and refocusing conflict resolution training on mentoring, not lecturing. While conflict resolution courses for residents were still advised, increasing adoption of a train-the-trainers approach was recommended.

Recent research from Zweibel et al. demonstrated that even short professional development trainings on conflict resolution can positively impact the conflict management skills of healthcare professionals.\(^{36}\) An idea that emerged out of longitudinal research with medical residents was the benefit of setting aside time for weekly or monthly discussions of general “issues” arising in a medical unit. The existence of a distinct venue where residents were encouraged to discuss difficult issues was seen as helping to remove some of the inhibitions created by the hierarchy between residents and attending physicians, a hierarchy which

\(^{36}\) Zweibel, et al., “What Sticks.”
could otherwise dissuade residents from acknowledging challenges they are facing. Clinicians and faculty also report wanting regular, informal sessions to discuss their experiences applying conflict resolution skills. Creating these opportunities were seen as necessary to reinforce the learning that occurs in conflict management trainings.

Disruptive behavior presents an additional arena for conflict management training. Johnson suggests education on teamwork, collaboration, and productive problem solving as one important component of solutions to continuing problems with disruptive behavior by both physicians and nurses. Recommendations include starting this education early, specifically in medical and nursing schools, and creating opportunities for increased understanding of others’ needs, such as arranging for medical students to shadow nurses.

Gerardi has written extensively on healthcare conflict management training, including a 2010 white paper on conflict engagement training for health professionals. Key recommendations from this literature include the following:

1. **Recognize that training alone can’t solve existing conflicts.** Conflict training can be paired with an ADR intervention to handle an existing problem, but training does not suffice for an ADR intervention. Organizations facing conflict should not assume training will fix the problem.

2. **Expand Opportunities for Training.** For time and cost efficiency, and as well as to provide opportunities for application of newly-learned skills, conflict engagement trainings should be

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aligned with contemporary organizational goals and issues. Conflict training can be integrated with bioethics programs, grand rounds, M&M rounds, patient safety initiatives, leadership development, teambuilding and team training exercises, organizational change initiatives, and Joint Commission accreditation efforts.

3. Select the correct trainers. Trainer legitimacy is important in the face of healthcare providers skeptical of conflict management. Given healthcare provider cultures that often identify themselves as distinct from non-clinicians, trainers need an appreciation of clinical culture and a working understanding of the healthcare environment. They must understand the different dynamics in healthcare and tailor training for the specific audience and the conflicts they face. Partnered trainings are good—one clinician with some ADR skills alongside an ADR professional. The key is the ability to speak with authority and understanding of their issues and to answer questions participants bring up in the training.

4. Support Conflict Competency through Communities of Practice. For behavior change, training needs to be reinforced through regular follow-up activities. Supporting intentional communities of practice wherein healthcare professionals can meet to discuss conflicts they are facing, share ideas, and further explore conflict engagement can be an effective way to expand conflict competency within healthcare environments.

5. Be fast. The tremendous time and financial pressures on healthcare providers and healthcare systems constrain what is possible with trainings. Trainings must be concise, focused, and use experiential, hands-on methodologies. Expectations are high and trainers need to be prepared to navigate the challenges associated with healthcare identities and cultures.
LITERATURE REVIEW

The following literature review surveys the primary four dynamics in healthcare conflicts: provider-provider conflict; provider-patient conflict; patient-payer conflict; and provider-administration conflict.

I. Provider – Provider Conflict

The largest pool of conflicts with potentially the most serious and widespread impact is provider – provider conflicts. These conflicts occur among and between all types of clinical caregivers, often with high incidence rates. Disruptive behavior is one aspect of provider conflict, while demand for increased collaboration amongst providers is another.

Disruptive Behavior

The American College of Physician Executives’ 2009 Doctor – Nurse Behavior Survey found that 98% of those surveyed had witnessed an incident of disruptive behavior between nurses and physicians in the last year. 41 30% of participants reported witnessing bad behavior multiple times per year; 25% monthly; 30% weekly; and 10% daily. Physicians were most frequently cited as responsible for the disruptive behavior, though bad behavior was also noted in nurses. 42 Respondents cited poor communication and a fundamental lack of respect between physicians and nurses as the primary causes of conflict. 43

41 The survey was emailed to approximately 13,000 doctors and nurses; 2100 returned the completed survey. 67% of the participants were nurses, 33% physicians. The survey included the following activities as disruptive behavior: yelling; cursing; degrading comments and insults; refusing to work together; refusing to speak to each other; spreading malicious rumors; inappropriate joking; trying to get someone disciplined unjustly; trying to get someone fired unjustly; throwing objects; sexual harassment; physical assault; other. See Johnson, “Bad Blood,” 6-11.

42 While much of the literature focuses on physicians as the perpetrators of bad behavior, other studies have documented abusive behavior occurring with frequency among nurses, pharmacists, in radiology departments, and in the laboratory. See A.H. Rosenstein and M. O'Daniel, “Disruptive behavior and clinical outcomes: Perceptions of nurses and physicians,” American Journal of Nursing 105, no. 1 (2005): 54-64;
In Sentinel Event Alert #40 (issued July 09, 2008), the Joint Commission stated that organizations must address intimidating and disruptive behavior by healthcare providers in the interest of quality of care and a culture of safety. They cited research showing correlations between disruptive behavior and medical errors, poor patient satisfaction, preventable adverse outcomes, increased cost of care, and staff retention.

The 2005 Silence Kills study documented that healthcare providers are reluctant to engage in difficult conversations about many common concerns and problems involving their coworkers. While the majority of providers witnessed many of the types of problems surveyed, less than 10% spoke up. 20% of physicians reported seeing harm come to patients as a result of these concerns and 23% of nurses said they were considering leaving their position as a result of these concerns. In contrast, the 10% who felt confident enough in their ability to communicate their concerns were reported to observe better patient outcomes, work harder, be more satisfied, and be more committed to staying in their jobs. The study suggests that avoidance of conflict and failure to communicate concerns threatens patient safety, reduces staff satisfaction, and increases staff turnover.

Though these provider – provider conflicts impact relationships with patients, provider conflicts are frequently dealt with through channels separate from patient-provider conflicts. Many hospital conflict


45 The Joint Commission, “Sentinel Event Alert #40.”


management systems view staff conflict as an HR issue or a staff well-being concern; as a result, many
dispute resolution programs may not deal with it. As provider conflict is increasingly being
acknowledged as a major liability and disruption in healthcare, it is becoming a larger focus for conflict
management systems and trainings.

Efforts to improve relationships, communication, and recognition are at the heart of attempts to overcome
disruptive behavior. This presents opportunities for transforming relationships by refocusing on common
goals, acknowledging a common desire to be respected and listened to in the workplace, and exploring
healthier responses to conflict. In the context of the Silence Kills Study, efforts have been made to train
providers to speak up about the issues and concerns they previously ignored. The techniques needed for
these difficult conversations draw heavily from interest-based negotiation and mediation approaches. Data
from a critical-conversation training program at Maine General Health hospital showed significant (80-
160%) increases in providers’ willingness to speak up in situations that threatened patient safety, involved
disruptive behavior, or exhibited poor teamwork.

Similarly, the 2008 Joint Commission sentinel alert advocated inter-professional dialogues to proactively
address conflicts and improve communication and collaboration, among other suggestions. The Joint
Commission went on in 2009 to require as part of its accreditation standards that healthcare organizations
establish policies and procedures for conflict management, including a process for managing disruptive and
inappropriate behavior. Though the Joint Commission has yet to systematically enforce this requirement,
the existence of the standard serves as a significant force for improving conflict management in healthcare.

48 Adverse event disclosure programs increasingly aim to meet the needs of the provider involved with the
adverse event, in recognition that provider stress arising from these crises can have ripple effects on other
aspects of the workplace.
50 The Joint Commission, “Sentinel Event Alert #40.”
51 Standard LD.03.01.01 and Elements of Performance for LD.03.01.01. Joint Commission Resources, The
Joint Commission Accreditation Standards for Hospitals (Oakbrook Terrace, IL: Joint Commission on
Accreditation of Healthcare Organization, 2009).
Communication and Collaboration

Apart from disruptive behavior, provider conflict arises in the context of multidisciplinary care teams. Traditional models of autonomous decision making with strict professional hierarchies between providers clash with increasing expectations for collaboration on multidisciplinary teams, patient care, hospital committees, public health issues, teaching, and research. Barriers to such collaboration arise from structural challenges such as power imbalances (negotiating at an uneven table); different professional and educational cultures; time pressures; tendencies to disengage from conflict (silence); fear of retaliation; and a lack of training on how to build teams and function collaboratively. Successful collaboration among providers will require educating providers on different approaches to communication, facilitation, problem solving, decision making, and conflict engagement.

The Pennsylvania Hospital in Philadelphia introduced its Unit Based Clinical Leadership Program (UBCLP) in an effort to improve quality and patient safety. The program focused on improving relationships between nurses and physicians in healthcare delivery by creating channels for increased communication, collaboration, and shared ownership and responsibility for patient care. In the three years since it was instituted, the program has shown improvements in quality and safety of care as well as improved nurse-physician collaboration and job satisfaction.

The Pennsylvania Hospital UBCLP is only one of many efforts underway to transform relationships between healthcare providers through restructuring healthcare delivery systems. Healthcare conflicts and

efficient responses to them are central aspects of these innovative approaches to healthcare delivery. Conflict resolution theory and processes are imbedded within many of the emerging systems. Healthcare delivery science and its relationship to healthcare conflict is emerging as a key area of conflict management practice and research.

II. Patient – Provider Conflict

Patient – provider disputes constitute the core of what many have traditionally considered healthcare ADR. Family members of the patients are key participants in these disputes, with risk management, legal, patient safety, and quality of care departments other common stakeholders. While a necessarily incomplete effort, I have chosen to categorize the literature on this dynamic into four groupings: Communication, Patient Safety, and Quality of Care; Adverse Outcomes and Disclosure; Shared Decision Making; and Ethics Conflicts.

A. Communication, Patient Safety and Quality of Care

Communication plays a central role in an extensive range of conflicts between providers and patients. Common examples include concerns about perceived errors, coordination between levels of care and providers, patient comprehension of procedures and treatment plans, medication compliance, concerns over continuity of care (and continuity of care providers), pain management, length of stay, level of care, services and equipment, cost of treatment, informed consent, privacy and confidentiality.\(^\text{55}\) Relationship, value, structural, interest, and data conflicts all arise between providers and patients.

The most significant instances of communication-based conflict involve patient safety and quality of care. Concern with avoidable medical errors has increased the need for greater collaboration between providers and patients, with effective communication at the heart of this collaboration. The failure to share information—whether due to time constraints, a reluctance to “bother” the provider, or feelings that it is not appropriate for a patient to offer information unsolicited—contributes to medical errors, misdiagnoses, and unnecessary treatment. Poor communication can lead to a lack of patient trust in healthcare providers, with detrimental impacts on both patient satisfaction and quality of care provided. Language and cultural barriers can also lead to breakdowns in communication and subsequent loss of trust.

Dissatisfaction with the communication skills of healthcare providers or the quality of care received often leads to officially registered patient complaints. Many of these complaints are handled through mechanisms associated with Quality Assurance, Patient Relations, or Risk Management departments. The Kaiser Permanente Health Care Ombuds/Mediator program is an example of a particularly well-integrated approach that expands the focus on communication to the institutional complaint-handling and patient support level.

Mediation has been used to handle physician misconduct complaints that do not involve malpractice claims. In the 1990s, the Massachusetts Board of Registration in Medicine with support from the Program for Health Care Negotiation and Conflict Resolution at Harvard University piloted a mediation program for complaints against physicians that appeared to arise from poor communication, not malpractice concerns. Despite reaching a mutually-satisfactory agreement in 90% of the cases mediated, the program was discontinued for lack of funding. The Canadian College of Physicians and Surgeons operated a similar mediation program for physician misconduct complaints. Over the first five years (1992-1997), the

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program achieved a successful settlement rate of 84%. However, in 1999 the program was discontinued due to a drop in settlement rates and the amount of time it took to convene mediation.\textsuperscript{57}

Mediation has also been used in long-term care facilities to resolve quality-of-life disputes between staff, residents, and their families.\textsuperscript{58} Some nursing homes have trained staff on conflict management techniques; others use mediation for disputes between residents of the long-term care facility.\textsuperscript{59}

Most training on communication that is offered as part of medical school, nursing school, or residencies focuses on communication skills to improve this provider–patient dynamic. While there are commonalities between this communication context and the communication required for engaging with provider–provider conflict, these often involve very different types of conversations, focus on different issues, and situate the participants in different roles. This difference in focus has implications for conflict management trainings that use communication courses centered on patient–provider interactions as the venue and point of access for conflict management.

B. Adverse Outcomes and Disclosure

Disclosure and transparent responses to adverse outcomes are prominent examples of conflict engagement principles and systems implemented in healthcare. Movements advocating proactive responses to adverse outcome events initially arose from outside of the health professions. Adverse outcome disclosure became closely connected with the emergence of the modern patient safety movement in the US, spurred by a 1999

\textsuperscript{58} Liebman and Hyman, \textit{Medical Error Disclosure, Mediation Skills, and Malpractice Litigation}, 107.
\textsuperscript{59} Liebman and Hyman, \textit{Medical Error Disclosure, Mediation Skills, and Malpractice Litigation}, 107.
Institute of Medicine Report on the prevalence of adverse medical events. Today, disclosure of errors and unanticipated outcomes is a central component of the patient safety movement but remains closely linked with healthcare dispute resolution more broadly.

While it is widely recognized that mistakes occur in the complex system of contemporary health care, the scale of incidents is staggering. The Institute for Healthcare Improvement estimates there are 15 million incidents of medical harm in the US each year, or approximately 40,000 per day, including up to 100,000 preventable deaths annually in US hospitals. The push for transparency and disclosure with this volume of incidents has huge implications for the dispute resolution field.

A traditional response to adverse outcomes has often been characterized as “deny and defend.” Communications with patients and families are strategic and defensive, a posture emerging from the belief that the best protection against litigation in the context of an adverse events is to say as little as possible to the patient and family members. This model seeks to avoid disclosure if possible, recognizing that most patients never discover cases of medical error. In this framework, proactively disclosing medical errors to patients and acknowledging a role in them was seen as a high-risk endeavor that would open the floodgate to increased litigation claims. Many more patients would sue for events that otherwise never would have been recognized as medical error by the patient. Further, by acknowledging a role in the adverse event

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(even if not admitting fault) would increase the likelihood that settlements would favor the plaintiff.\textsuperscript{65} As a result of these beliefs, providers were advised not to disclose information to the patient and typically all findings from investigations were kept secret. Conversations between provider and patient about the incident were discouraged if not prohibited.

Many were dissatisfied with this approach, which frequently lead to a destructive and unsatisfying pattern of secrecy, distrust, and poor communication. Early disclosure programs were attempts to break the following common cycle\textsuperscript{66}: an unanticipated adverse medical outcome fails to meet the expectations of a patient; the physician, either on instruction from legal counsel or due to their own denial about the unanticipated outcome, communicates minimally if at all with the patient; the patient/provider relationship disintegrates; the patient grows increasingly frustrated by continued unsuccessful attempts to get information; the frustration and lack of information evolves into anger; the anger and mistrust, if unaddressed, leads to a medical malpractice claim. The resulting emotional and financial damage is significant, affecting both provider and patient.

Using research that suggested litigation is more likely when patients and families feel they have not received answers to their questions,\textsuperscript{67} providers, hospitals, and insurers began promoting more open, honest communication with patients and their families following adverse outcomes. Early research highlighted that emotional trauma from a serious adverse event often arises from both the event and the way that it is


handled by the provider, insurer, and hospital. Insensitive management of the situation can lead to greater emotional damage, while sensitivity, transparency, good communication, and effective responses to the patient’s needs can reduce emotional trauma. Though concerns with litigation remained, this approach was seen to better meet the needs of patients and align more closely with what the providers felt was right.

The support for a shift in strategy came from a variety of sources. There was a strong moral argument that transparency and open communication was a requirement of the professional ethics of healthcare providers. From a risk management perspective, initial support for disclosure came from data suggesting that litigation often results from the way that an unanticipated outcome is handled rather than the incident itself. Early enthusiasm for this idea, coupled with the ethical argument behind the principle of transparency and opportunities for improving patient safety through a robust feedback loop, helped mainstream disclosure practices.

As the orientation towards transparency and disclosure has garnered advocates within the healthcare field, it has established a distinct terminology. Two definitions introduced by the American Society for Healthcare Risk Management in 2003 remain widely in use:

**Adverse Event**: An injury that was caused by medical management rather than the patient’s

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70 Vincent, Young, and Phillips. “Why do people sue doctors?”

underlying disease; also referred to as an incident, adverse outcome or unanticipated outcome. An adverse event may or may not result from an error. Medical management refers to all aspects of health care, not just the actions or decisions of physicians or nurses.

**Disclosure:** Providing information to a patient and/or family about an incident. The American Society for Healthcare Risk Management and others suggest “communication” as the preferred term moving forward, stating, “Using the word “disclosure” can often give the impression that the consequences of not having such a policy would indicate “non-disclosure.” Instead, using proactive terms such as “communication” may avoid this impression and convey a positive cultural statement.”\(^{72}\) However, at present disclosure remains the most widely utilized term.

There is variation in what institutions categorize as an adverse event.\(^ {73}\) While some institutions use restrictive definitions such as that listed above, others, such as Kaiser Permanente, adopt an expansive definition that triggers their Health Care Ombuds/Mediator system any time the patient is not satisfied.\(^ {74}\) This broadened definition is in line with the orientation towards continuity in services and improved communication between providers and patients throughout all interactions.

The culture of the healthcare industry continues to shift towards adopting proactive disclosure, transparent communication, and empathetic, patient-centered responses to adverse outcomes as the professional and ethical duty of healthcare providers. Disclosure policies are being advocated and increasingly implemented by providers and risk managers, insurers and hospitals, and regulation and accreditation bodies.

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\(^ {72}\) For additional comments on the trend towards using the term communication instead of disclosure, see Harvard Hospitals, *When Things Go Wrong*, 7.
\(^ {73}\) Harvard Hospitals, *When Things Go Wrong*, 4.
Though the increasing consensus on the need for disclosure, there remain differences in perspective on the ultimate justifications for adopting full-disclosure policies.

Children’s Hospitals and Clinics in Minneapolis\textsuperscript{75} institutionalized a policy of full-disclosure to:

- Improve patient and staff safety by decreasing system vulnerability to future accidents
- Improve care provided
- Restore patient, family, employee, provider, and community confidence that systems are in place to assure future accidents are not likely to recur
- Emotionally, professionally, and legally support staff who have been involved in events
- Ensure disclosure of the accident, near miss, or sentinel event to the family, as well as ongoing communication of system improvements to family and caregivers involved in the accident

The Sorry Works! Campaign orients full disclosure towards the following outcomes:\textsuperscript{76}

- Provide swifter justice for victims
- Reduce medical errors
- Restore the doctor-patient relationship
- Improve communication and trust between all parties
- Repair the reputation of doctors and hospitals by turning them into “straight shooters” who can be believed when they say a death or injury wasn’t their fault
- Reduce the filing of non-meritorious claims through the “honesty dividend”
- Address the root causes of medical malpractice claims

\begin{footnotesize}
\begin{itemize}
\item[\textsuperscript{76}] Doug Wojcieszak, John Banja, and Carole Houk, “The Sorry Works! Coalition: Making the Case for Full Disclosure,” \textit{Joint Commission Journal on Quality and Patient Safety} 32, no. 6 (June 2006); 344-346.
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While these widely-cited benefits of disclosure and transparency have helped to spread the movements, the ultimate justification for full-disclosure continues to rest in ethical arguments. Kaiser Permanente as an institution states that it promotes disclosure because “it is the right thing to do.”77 The Consensus Statement of the Harvard Hospitals echoes this, with justification for the shift resting on a moral argument, rather than a business case, although the benefits of increased trust and promotion of patient safety were also noted.78 The Dartmouth Medical School Handbook on Rural Medicine references the ethical principles underlying the medical profession for a more explicit explanation of why we feel disclosure is the “right thing to do.”79 In the end, it is the ethical force of disclosure that is the backbone of this movement.

There are similar disagreements about how to define and measure successful disclosure. In 2001, the JCAHO Standards on Accreditation began requiring institutions to have a disclosure policy to qualify for accreditation. This significantly bolstered the disclosure movement. The Standards, however, have never defined successful disclosure. As a result, definitions of a successful disclosure conversation vary and include:80

- The patient and family do not sue
- The patient and family understand that mistakes happen and do not get angry
- The patient and family don’t go to the press

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78 Harvard Hospitals, When Things Go Wrong, 3.
• The press praises the caregivers’ action and honesty

For the bottom line, skeptics (as well as many adherents) often look to the financial costs and benefits of implementing a proactive disclosure program relative to other programs that do not promote full-disclosure.

The American Society for Healthcare Risk Management, in an influential 2003 monologue, directly contested measurements of success based upon self-serving outcomes. They argued that such frameworks miss the point:  

It fails to recognize the true purpose of disclosure: the open communication about all aspects of care with patients and families. A successful disclosure process could best be described as one that enables the patient and family to understand what happened and the ramifications of the event as well as have sufficient information to make future decisions….The true success of disclosure can only be measured in the efficacy of communicating facts and sharing regret for the patient’s/family’s trauma.

Importantly, the monologue continues with a vision for an improved patient – provider relationship in the future:

In the spirit of improving patient safety and creating a “learning organization,” it would help to think of all disclosure communications as opportunities for improving communication with patients at all points of the healthcare continuum. If healthcare providers can get to the place where they begin their relationships with patients talking about the potential for error and the need for interactive communication and partnership, the stage can be set for more effective interaction should the need for the disclosure of an unanticipated event arise.

This focus on respect, access to information, and partnership was a precursor to current calls for shared decision making, increased communication, and revamped patient-provider relationships.

*Critiques of Disclosure*

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While the healthcare culture and its accompanying policies and regulations increasingly adopt full disclosure of adverse outcomes as the normative standard of practice for healthcare providers, insurance companies, and hospitals, questions remain. A 2007 study by Studdert, et al. using mathematical modeling suggested that full disclosure of medical error would likely greatly increase the number of claims and cost of reimbursement. While the article advocated for disclosure as best practice due to ethical reasons, it predicted that disclosure would create significant financial burdens if adopted widely. Critics of the research denied this and called for further research on the actual claim increases and cost burden experienced by hospitals and insurance companies who have instituted disclosure policies. Recent data continues to suggest that the predicted (feared) cost burden has not materialized for institutions implementing disclosure policies, but more research on the subject is desired.

While the ethical argument in support of disclosure is rarely contested, resistance to implementing full-disclosure programs remains. ADR practitioners continue to cite barriers to using disclosure and other patient-centered responses to adverse outcome events as conventional ways of thinking, unjustified fear, and institutional and professional cultures. Physicians remain concerned with being reported to licensing  

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84 Kelly Saran, “The University of Michigan Claims Experience: Disclosure, Communication, and Patient Safety,” powerpoint presentation at CAPSAC Annual Convening, April 30, 2010, http://www.capsac.org/documents/Saran_K.pdf (accessed 14 May 2010) [showing feared cost burden has not materialized]; Richert Quinn, “Copic’s 3Rs Program: Recognize, Respond to, and Resolve Patient Injury,” powerpoint presentation, http://www.sorryworks.net/copic.phtml (accessed 14 May 2010) [see slide 30, showing actual reimbursements for claims handled through disclosure protocols were only 41% of the reimbursement values predicted by claims adjusters; indicates lower reimbursement per claim but does not show how many more claims they receive]; Gallagher and Quinn, “What to do with the Unanticipated Outcome,” 142 [2003 COPIC results showed that loss ratios for physicians participating in the program were 25% less than for those not participating in the program, despite slightly higher than average historic loss ratios for the participating physicians prior to enrollment].
86 Liebman and Hyman “Mediating Medical Malpractice Lawsuits,” 6.
boards and damaging professional reputation. Many stakeholders remain on the fence about disclosure, awaiting further data. For practitioners, the potential for disclosure to restore public trust in the honesty and integrity of the medical profession are seen as strong selling points.\textsuperscript{87} For risk managers, patient satisfaction rates and the rates and cost of litigation are important.\textsuperscript{88} Data, case studies, and impact indicators measuring these factors are especially valuable as disclosure programs seek to expand and be sustainable.

\textit{Potential Exploitation of Disclosure}

Disclosure processes have the potential to be abused by bad or under-skilled doctors. The private nature of disclosure conversations has the potential to become problematic if the lack of transparency and public accountability allows physicians or hospitals to chronically commit medical errors. If the traditional accountability mechanisms—a lawsuit or a claim filed with the NCDM or MCE against a physician—are not activated, then it is only internal actors (an insurance company or the involved healthcare institution) in the position to monitor problem physicians and ensure that physician or hospital practices change in response to adverse events. If programs indicate problem physicians and institutions are exploiting disclosure conversations, it may become necessary to balance the benefits of confidentiality with the need for physician monitoring and oversight.

\textit{The Role of Apology}

Expressions of apology by healthcare providers are closely linked with disclosure conversations. Apologies usually take one of two forms. Full apologies accept responsibility for what has transpired: “I’m sorry, I did this to you,” is an example. Partial apologies refer to apologies of sympathy without admission of responsibility or fault: “I’m sorry this happened to you,” is an example. While it was traditionally assumed


\textsuperscript{88} Gallagher, Studdert, and Levinson, “Disclosing Harmful Medical Errors to Patients,” 2713.
that a partial apology was better than no apology, recent empirical evidence suggests that is false.\textsuperscript{89} Other studies suggest that full disclosure has significant positive impact on patient trust and their perceptions of the physician and can play an important role in restoring the patient-physician relationship.\textsuperscript{90}

While full disclosure policies typically encourage full apologies, many institutions, insurers, and providers still operate disclosure conversations under protocols that do not permit or encourage care providers to admit fault for an adverse outcome. The primary barrier to apologizing is liability concerns. Traditionally, apologies were admissible in court as evidence of wrongdoing in most jurisdictions. Increasingly this is changing: as of 2008, 36 states had enacted apology laws protecting voluntary disclosures.\textsuperscript{91} However, 28 of these laws protect only partial apologies, preventing the admission of expressions of sympathy, regret, and condolence in future litigation proceedings against a physician. Only the remaining 8 laws protect admissions of fault as well.\textsuperscript{92} While laws governing the admissibility of apologies in trials are changing to address this concern, the reluctance to admit fault for fear of litigation remains a significant hurdle.

The relationship between disclosure and full apology admitting fault has not yet been standardized across the models mentioned below. Much of the literature reviewed describing the different disclosure models and programs does not specify what kind of apology with what degree of admission of fault is delivered as part of the program, who has final authority to decide this, and the degree of apology variation across specific disclosure conversations. Understanding the effect of different types of apology on the outcome of disclosure conversations and medical malpractice disputes remains a topic for further study.


\textsuperscript{92} The situation is complicated by the fact that some states (such as Vermont) protect oral and written statements differently. Other states have moved beyond voluntary disclosure to mandate that hospitals and physicians inform patients when a medical error has led to an adverse outcome, though these states protect this mandatory disclosure from being used as an admission of fault in litigation proceedings. See McDonnell and Guenther, “Narrative Review: Do State Laws Make It Easier to Say “I’m Sorry”,” 812.
Effects on Health Care Providers

Medical errors and adverse outcomes can have significant negative impacts on the healthcare providers responsible for these events. Medical errors and adverse outcomes can be traumatic events that place enormous emotional, psychological, and professional stress on providers, many of whom feel tremendous responsibility for their patients’ wellbeing. Adverse events can cause clinicians to doubt their practice, fear legal actions, fear losing their license or job, and dread losing the respect of their peers. The stress from such trauma can create a toxic work environment. Stress and burnout, common amongst healthcare providers, have increasingly been associated with suboptimal attitudes and practices that lead to conflict and can compromise patient care and patient safety. To address this, programs that support clinicians are seen as important aspects of comprehensive responses to adverse outcomes and medical errors.

Examples of Disclosure Programs

Recommendations for how to conduct disclosure conversations are often structured around the conflict management and mediation concepts of information gathering, identifying stakeholders, communicating the goal, active listening, seeking agreement, finding solutions, exploring mutual gain, and participatory decision making. Disclosure programs utilize these approaches in various arrangements. The following descriptions of the Sorry Works! Coalition, the VA Health System, the COPIC 3Rs, and the Kaiser Permanente programs help examine the details of how disclosure programs are designed and function.

Sorry Works! Coalition


The Sorry Works! Coalition, an organization of health care providers, insurers, lawyers, and patient advocates, promotes policies of full disclosure and apologies for medical error, accompanied with upfront compensation. The standard Sorry Works! protocol, based on the disclosure program developed at the Department of Veterans Affairs Hospital in Lexington, Kentucky, states:

If a standard of care was not met (as shown by a root cause analysis) in a bad outcome or adverse event, the providers (and their insurer) should apologize to the patient/family, admit fault, provide an explanation of what happened and how the hospital will ensure that the error is not repeated, and offer compensation.95

In this model, plaintiffs are encouraged to contact a legal representative, who can also be present for the disclosure conversations. Patients are not asked to sign any waivers of their right to pursue litigation as a precondition to participation in disclosure. This is justified on the belief that by not asking for a waiver of their right to sue, patients are more likely to trust that the process is fair and nothing is being covered-up. Further, some hospitals suggest that it is beneficial to know that legal counsel has been consulted, as it helps ensure the patient/family is aware of their rights, any decisions reached are with full knowledge of the alternatives, and patients/families have a realistic understanding of claims processes.96 This can be seen as a voluntary step to minimize power imbalances that can occur in the wake of an adverse outcome, when patients are often quite vulnerable. It is also believed to create more robust agreements, leading to more complete resolution.

The Coalition advocates a three-step disclosure process.\textsuperscript{97} Step One, initial disclosure in the immediate aftermath of an adverse event, involves apology, recognition of the patient’s situation, and expressing empathy, aiming to re-establish trust and communication with patients and families. Step Two, investigation, looks at the details of the incident to determine if a standard of care was breached. Frequently this is accomplished by outside experts to avoid perceptions of a cover-up. Step Three, resolution, involves sharing the results with the patient/family and their legal counsel. If there was a mistake, the provider/hospital/insurer continues through the protocol outlined above. If there was no mistake, they share the results of the investigation and continue to empathize with the patient, but seek to prove their innocence. No settlement is offered and any litigation is contested. The Coalition describes its approach as “compassion with a backbone.”\textsuperscript{98}

\textit{VA Health System Experience}

The VA Health System full-disclosure model was one of the first in the country. It is largely the early success of this program that led to the birth of the disclosure movement in the US.\textsuperscript{99} The general VA approach, described above in the section entitled “Sorry Works! Model,” forms the core of many disclosure policies. More than some models, the VA explicitly encourages patients to contact a legal representative, in order to foster patient trust in the system and to ensure that the hospital is dealing with someone familiar with claims issues.\textsuperscript{100}

\textsuperscript{98} Sorry Works! website, \textit{Three Step Disclosure Process}.
The VA approach to disclosure distinguishes two types of disclosure, explained here in their VA Disclosure Policy:101

(2) Disclosure of Adverse Events. For the purpose of this Directive, the phrase “disclosure of adverse events” refers to the forthright and empathetic discussion of clinically significant facts between providers and/or other VHA personnel and patients or their representatives about the occurrence of an adverse event that resulted in patient harm, or could result in harm in the foreseeable future. VA recognizes two types of disclosure of adverse events:

(a) Clinical Disclosure of Adverse Events. An informal process for informing patients or their representatives of harmful adverse events related to the patient’s care. In a clinical disclosure, one or more members of the clinical team provides factual information to the extent it is known, expresses concern for the patient’s welfare, and reassures the patient or representative that steps are being taken to investigate the situation, remedy any injury, and prevent further harm. The clinical disclosure of adverse events needs to be considered a routine part of clinical care, and needs to be made by the attending or senior practitioner, or designee.

(b) Institutional Disclosure of Adverse Events. In cases resulting in serious injury or death, or those involving potential legal liability, a more formal process is needed. This process is called institutional disclosure of adverse events. In an institutional disclosure the patient or representative and any family members designated by the patient or representative are invited to meet with institutional leaders and others, as appropriate. An apology is made, and information about compensation and procedures available to request compensation is provided, when appropriate.…

The VA disclosure system is well-integrated with established channels for reporting, response, documentation, and follow-up. Although the legal context of the government-run VA health system differs from that of the private health systems, this has relatively little effect on the efficacy of the disclosure program and is not a barrier to spreading the VA system success to non-government health settings.102 Numerous academic centers and private hospitals have used the VA Disclosure Model with similarly strong results.103

The COPIC 3Rs Program

102 For differences in the legal environment surrounding the VA health system versus private health systems, see Kraman, “Victim Compensation without Litigation” powerpoint, slide 18.
103 The University of Michigan system in particular is frequently cited as an example of how effectively the VA Disclosure model can function outside of the government system.
COPIC Insurance of Colorado, a physician malpractice insurer based in Denver, was one of the early insurers to advocate for physician disclosure in adverse outcome cases.\(^\text{104}\) While their approach utilizes many features found in the Sorry Works! Model, COPIC only uses disclosure on cases below $30,000 in value and excludes plaintiff’s attorneys from participation.\(^\text{105}\) Further, cases are ineligible if any of the following have occurred: patient death; formal written demand for compensation filed; summons and complaint lodges; attorney involvement; request for action from state licensing board; or incidents involving certain nationally recognized unacceptable outcomes.\(^\text{106}\) Usually the responsible physician leads a private disclosure discussion directly with the patient/family, though COPIC may also arrange a mediation session with an external neutral.\(^\text{107}\)

Participating physicians are expected to attend a COPIC educational seminar addressing physician/patient communication. Additionally, as appropriate, they are expected to investigate and implement practice alterations to avoid injury in the future. The physicians themselves conduct the actual disclosure conversations. The physicians do not handle compensation matters but inform the patient of the COPIC claims process—COPIC will reimburse patients for out-of-pocket medical expenses related to the adverse event, up to the value of $25,000 (plus up to $5,000 for recognized loss of time). The patient must submit


\[^{105}\text{Gallagher, Studdert, and Levinson, “Disclosing Harmful Medical Errors to Patients,” 2716.}\]


receipts to an administrator to process these payments. Participation in the 3Rs program does not preclude patients/families from filing future litigation if they so desire.

Practitioner participation in the program is incentivized by the fact that under Colorado law, payments made to patients/families through the COPIC 3Rs program are not reportable to either the National Practitioner Data Bank or the Colorado Board of Medical Examiners. Justification for the exclusion rests on the grounds that the program is not a response to a demand from the patient and the program does not ask patients for a waiver or release. There is some disagreement about the impact of not publicly reporting incidents, for while it may help protect reputations it could also reduce institutional learning from errors and fail to oust bad doctors providing unacceptable levels of care. To somewhat mitigate this concern, cases registered against a physician are flagged internally by COPIC and steps are taken to address the issue if COPIC deems it necessary.

COPIC 3Rs’ program goals match those of many hospital-based disclosure programs: maintain the Physician/Patient relationship; encourage open/honest communication including disclosure of unanticipated event; encourage expressions of concern including an apology when appropriate; meet patients’ needs at crucial time, including need for information; promotes patient safety and improved quality of care; and reduce litigation expenses.

Post-incident questionnaires delivered by COPIC to patients and providers who participated in their 3Rs program show that patients’ evaluations of the process are largely favorable. Rates of litigation following participation in the 3Rs program are low, the patient-provider relationship is almost always described as

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108 Gallagher and Quinn, “What to do with the Unanticipated Outcome,” 141.
109 Gallagher and Quinn, “What to do with the Unanticipated Outcome,” 141.
intact, and the financial data on the program shows that it is financially cost effective.\textsuperscript{111} One notable arena for improvement concerns physicians’ communication skills during the disclosure conversation. Questionnaire results showed that the “patient’s perception of most physician’s [sic] communication [is] not favorable… [pointing to] physician’s [sic] false perceptions of their own communication skills.”\textsuperscript{112} This points to the importance of increasing physician’s skills in this arena.

The significance of the COPIC 3Rs program is that an insurance company, not a healthcare delivery institution, administers the disclosure program. This is a key step in expanding the stakeholders who utilize the approach, showing that sustainable business models incorporate disclosure are possible, and mainstreaming the ethic of disclosure.

\textit{Kaiser Permanente: Integrated Patient Response}

In many disclosure programs, it is the responsible licensed independent practitioner (typically a physician) involved with the incident who is expected to lead the conversation with the patient/family. To support the care provider in preparing for and carrying out the disclosure conversation, some facilities have established a “disclosure team” including representatives from patient safety, risk management, and legal departments. The Kaiser Permanente system shows how disclosure programs can be integrated within a larger system for patient response.

Kaiser Permanente is the largest non-profit managed health provider in the United States. As an integrated system, they have piloted and adopted numerous innovation approaches to health care delivery. The Health Care Ombuds/Mediator system (HCOM) is an example of a progressive, comprehensive response to patient-provider healthcare conflict, including adverse outcomes.

\textsuperscript{111} Quinn, “Copic’s 3Rs Program,” slide 20.  
\textsuperscript{112} Quinn, “Copic’s 3Rs Program,” slide 20.
In the Kaiser Permanente system, the responsible care providers (often physicians) are expected to lead disclosure and apology conversations with a patient/family. However, these conversations are imbedded within a comprehensive response system in place to address unanticipated outcomes and provide necessary support to providers and patients/families throughout the process.

The first component of the system is the four-hour Communicating Unanticipated Adverse Outcomes training for care providers.\textsuperscript{113} The training content focuses on the importance of good communication before, during, and after an adverse event.\textsuperscript{114} The introductory trainings, as well as refresher trainings on the same topic, utilize role plays and feedback sessions to reinforce the principles. In the early years, this training was delivered only to physicians but currently the aim is for all members of the health care team to receive this training. Kaiser Permanente regularly offers additional staff trainings focused on communication in the healthcare environment that complement this course focused specifically on adverse outcome responses.

Kaiser Permanente also formed Situation Management Teams (SMT) to take the lead in the early response to a report of an adverse outcome.\textsuperscript{115} This core team enters the situation at a very early stage (typically within 72 hours of a report) to assess the context, investigate what has happened, and stabilize the situation. Professionals from different disciplines comprise the team (such as risk management physicians, medical-legal physicians, administrators, and clinical experts, as required by the case) so as to allow it to address all aspects of the situation. Special training is provided to the staff who serve on the SMT, but it is not a full-

\begin{footnotes}
\item[113] There is now a 2.5 hour version of this training as well. Author telephone interview with Kathleen Nelson, National Leader, Patient & Family Centered Care & HealthCare Ombudsman/Mediator, Patient Safety & Risk Management, Kaiser Permanente, 14 May 2010.
\item[115] Clark, “Advocacy in Health Care,” 11; also author interview with Kathleen Nelson.
\end{footnotes}
time position. Generally, providers and staff rotate through service on the SMT as part of their professional responsibilities.

After the investigation is complete and the situation has been stabilized, the Health Care Ombuds/Mediator is called in. The HCOM is an internal neutral dedicated to dispute resolution. The HCOM may be mobilized through numerous channels to respond to any unanticipated outcome, including times when the patient or family is simply surprised or disappointed with the outcome of their treatment, whatever the cause.\(^\text{116}\) The HCOM operates under the four principles of impartiality, independence, confidentiality, and neutrality.\(^\text{117}\) They do advocate for the patient, provider, or organization but instead advocate for a fair process to resolve healthcare issues, disputes, and conflicts.\(^\text{118}\) They are available at any time as a resource for patients and families and they dedicate whatever time required to the participants and process. They remain in frequent contact with patients/families as they follow the patient/family through to the end of the unanticipated outcome case.

The aim is of the HCOM is to resolve issues as early as possible and at the lowest possible level.\(^\text{119}\) They utilize a range of conflict resolution skills and processes in their work while building trust, identifying interests, promoting mutual understanding of needs and concerns, and facilitating communication. They assist both providers and patients/families in these activities. In the context of adverse outcomes, they counsel providers on effective disclosure conversations and may play a direct role in facilitating them. There is flexibility in the procedures and activities of the HCOM, as all HCOMs are expected to enter the position as skilled dispute resolution professionals.

\(^{116}\) This also includes disappointment due to “uncorrected ‘unreasonable’ expectations.” See Tracey Walker, “Advocacy with compassion: Dorothy Tarrant’s role as healthcare ombudsman/mediator places her at the nexus of patient-provider interaction,” Managed Healthcare Executive (June 1, 2006), http://managedhealthcareexecutive.modernmedicine.com/mhe/Visionaries/Advocacy-with-compassion-Dorothy-Tarrants-role-as-/ArticleStandard/Article/detail/329925 (accessed 15 May 2010).

\(^{117}\) Clark, “Advocacy in Health Care,” 11.

\(^{118}\) Walker, “Advocacy with compassion.”

\(^{119}\) Clark, “Advocacy in Health Care,” 11.
The HCOM role is a full time position dedicated to responding to unanticipated outcomes. This allows the HCOM to take whatever time is necessary to assist patients/families and providers with as they work through their issues. All HCOMs are trained as mediators and ombudsmen. While some HCOMs may enter the position through a healthcare background, no HCOMs have clinical duties. Kaiser Permanente currently employs 28 HCOMs nationally.  

Improving patient safety, enhancing provider and patient satisfaction, and addressing patients’ quality of care concerns “in a timely, empathetic, and honest manner” are the goals of this program. While there may be a business case to support this model, Kaiser Permanente explicitly does not invoke that as a justification. The culture that Kaiser Permanente attempts to build around its dispute resolution programs is one based on “doing the right thing.”

The HCOM does not handle compensation affairs, as cases are referred to the Early Resolution Program (largely comprised of legal staff) for financial reimbursement or settlements related to the unanticipated outcome. Patients/families are free to bring further legal action regarding the incident. HCOMs do not participate in this more formal process.

Alongside this, Kaiser Permanente’s Employee Assistance Program (EAP) provides support for clinicians and staff following adverse events. While the EAP was originally intended to provide staff support for

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120 Clark, “Advocacy in Health Care,” 11.
121 Walker, “Advocacy with compassion.”
other issues (such as workplace disputes), the emotional trauma of adverse events was recognized as a source of workplace conflict and provider vulnerability. Providing support for providers’ emotional needs can help providers restore their professional confidence following an adverse event; reveal and address past grievances, anger, and frustration; and lead to better performance and communication.\textsuperscript{126} When an adverse outcome occurs, the EAP under the direction of the Situation Management Team actively reaches out to providers involved with the case to head off any potential problems and ensure that they receive the support they need. Types of support provided include a targeted assistance program for physicians; a nursing peer-support program offering guidance, consultation and direction; debriefing; one-on-one counseling; referral; and coordination with the institution’s chaplaincy and social services.\textsuperscript{127}

**ADR approaches to Adverse Outcomes and Medical Malpractice Litigation**

Conflict management responses to adverse outcomes are largely distinguished by the phase of conflict at which the response is targeted: preventative; early intervention (pre-lawsuit); and late intervention (response to litigation).

**Category One: Preventative Interventions**

**Provider Early Intervention Model**

Though provider early intervention typically does not constitute a stand-alone system, it is a goal and a component of many systems.\textsuperscript{128} This model attempts to prepare providers to recognize and address unfolding problems with their patients in real time, so as to redirect/correct an encounter that is trending

\textsuperscript{126} Carr, “Disclosure and Apology.”
\textsuperscript{127} Carr, “Disclosure and Apology.”

towards a negative (unsatisfactory) outcome. This approach relies on the practitioner, not a third party, for intervention. In comparison to all other responses, this intervention occurs at the earliest stage (as potential adverse outcome is unfolding). Such intervention is not possible in all types of adverse outcomes, as not all adverse outcome dynamics unfold at a pace that allows for correction or early recognition.

Design features: third party role is to provide training and skill-building support.

**Category Two: Early Interventions (pre-litigation)**

*Internal Neutral Health Care Ombuds/Mediator (HCOM) Model*

The Internal Neutral Health Care Ombuds/Mediator model is displayed prominently in the Kaiser Permanente and the Bethesda Naval Medical Center systems. The internal ombuds/mediator deals with the needs of both providers and patients. Often they counsel providers on how to have a disclosure conversation and may participate directly in the disclosure conversation, although in many systems the health care provider is expected to lead the conversation. In addition, they assist with reality checking for patients; help patient navigate the system; and facilitate conversations and information collection/exchange.

Ombuds/mediators are expected to have completed courses in Mediation and Ombuds training, supplemented by extensive conflict management experience. The prior work background is varied, with some entering the position through clinical routes while others come through counseling or dispute resolution backgrounds. This is typically a full-time position; ombuds/mediators with medical backgrounds

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129 The Medical Ombudsman/Mediators Program developed by Carol Houk of Carol Houk International is another example of this model. Houk was instrumental in designing and spreading this model. See [http://www.chi-resolutions.com/](http://www.chi-resolutions.com/) for more details. For reference to the Bethesda Naval Medical Center experience, see Gary Balcerzak and Kathryn Leonhardt, “Alternative Dispute Resolution in Healthcare: A Prescription for Increasing Disclosure and Improving Patient Safety,” *Patient Safety and Quality Healthcare*, July/August 2008.

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typically perform no clinical duties. Involvement with patient and provider on these cases may extend to a year or beyond.

Design features: Internal, neutral; interest-based, facilitative mediation approach; creates opportunities for all sides to be heard; increased focus on relationships and quality of care/experience.

*Liaison Physician Model*

Various forms of a Liaison Physician model are found in physician practice groups and hospital facilities. There are numerous dynamics to which Liaison Physicians may be assigned: relations with specialists; relations with nursing staff, patient billing complaints, and patient-provider disputes are some of the common ones.

This model typically utilizes a designated practicing clinician with training and skills in conflict management as a third-party responder to a patient complaint. The Liaison Physician does not mediate between patient and provider but rather enters into a negotiation with the patient as a clinician representative of the practice group or institution. The goal of the intervention is to fully resolve the patient’s complaint in a fair and efficient manner that leaves the patient satisfied. To achieve this, Liaison Physicians use the conflict resolution skills and techniques of conflict analysis, identification of interests, active listening, and joint problem solving.

Unlike the Health Care Ombuds/Mediator models, the Liaison Physician is not neutral. Some Liaison Physicians are involved with financial aspects of a resolution, and may be empowered to adapt patient charges on their bill or directly offer compensation, activities in which internal neutrals do not directly participate. Furthermore, unlike most internal neutrals, some liaison physicians perform evolving roles as
they may participate in a case throughout all of its stages, from the initial investigation through mediation to arbitration, litigation, and compensation.

The training for the Liaison Physician role is similar to that for an HCOM, although it may not be as in-depth. Often the Liaison Physician role is not a full-time position; in some contexts, it may be a rotating, non-reimbursed duty for clinicians that they are expected to fill as part of their professional obligations to the hospital or practice group.

Liaison Physicians are likely candidates for advanced conflict resolution trainings.

Design features: Internal, non-neutral; interest-based, facilitative mediation approach; creates opportunities for all sides to be heard; increased focus on relationships and quality of care/experience.

*Disclosure Support Team Model*

This model, in use by the Advocate Lutheran General Hospital in Illinois, serves as an advisory resource to providers involved with unanticipated outcomes. The Disclosure Support Team, often initially contacted by a provider who has identified an unanticipated outcome, provides advice on how to conduct disclosure conversations and support to the provider on self-care. Members of the Disclosure Support Team may or may not participate in the disclosure conversation.

This model is most analogous to a conflict coaching dynamic, rather than a mediation dynamic. The Disclosure Support Team is not neutral.

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The model is also used by physician malpractice insurance companies such as The Doctors Company. In their case, the Disclosure Support Team is the Patient Safety / Risk Management department. Advocacy for disclosure meetings by insurance companies is an important development as it shows how disclosure has moved beyond hospitals and academic care centers towards the mainstream culture of healthcare.  

Design features: Internal, not neutral, not party to conversation; focused on communication, encourages opportunities for listening and sharing experiences;

“Pinch hitter” Model

In this model, a rapid response team may be brought in to research and conduct the disclosure conversation, with the provider deliberately situated on the periphery of the process. The rapid response team does not play the role of a neutral mediator but instead is a direct party to the disclosure conversation. Questions arise regarding the impact of this approach on the dynamic of the disclosure conversation, patient perceptions of the interaction, and the benefits of using experienced disclosure teams versus the potential damage to the clinician-patient relationship due to non-participation or non-communication by the clinician in the conversation. This approach may deprive the patient of the opportunity to hear directly from the provider responsible for the adverse outcome event, potentially diminishing the positive impact of the disclosure conversation altogether.

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132 Gallagher, Studdert, and Levinson, “Disclosing Harmful Medical Errors to Patients,” 2713.

133 Liebman and Hyman, “Mediating Medical Malpractice Lawsuits,” 8; COPIC, Copic Tip: Lessons Learned from the 3Rs program, 1 May 2010, [http://www.callcopic.com/resources/custom/PDF/copic-tips/Lessons%20Learned%20from%20the%203Rs%20Program.pdf](http://www.callcopic.com/resources/custom/PDF/copic-tips/Lessons%20Learned%20from%20the%203Rs%20Program.pdf) (accessed 15 May 2010).
Design features: Internal, not neutral; party to conversation; usually focused on facilitative, interest-based approach to resolving problems; focus on communication.

University of Illinois Program: Faster Response

A more recent program (launched in 2006) that is proving successful in one of the more challenging medical malpractice litigation environments is the disclosure program at the University of Illinois Medical Center in Chicago. While this program utilizes most protocols of the Sorry Works! Model, unique features of this program include: 134

• Speed of processing: their goal is to investigate, apologize, settle or mediate, and learn from mistakes within 60 days of an adverse event. They try to complete investigations within 72 hours of a report.
• Rapid investigation team and an error disclosure team trained in communicating with patients and families after an adverse event
• Patient liaison assigned to work with the patient/family constantly throughout the process
• Staff support services focused on addressing the emotional impact of adverse events on the providers involved
• Anonymous hotline to report adverse events to the risk team (seen as especially helpful for enabling lower-level employees to feel comfortable reporting incidents)
• Institution of a robust, non-punitive review system to systematically learn from mistakes
• Ability to immediately stop all billing to a patient in the event of an adverse event claim (as errant bills or collection notices were seen as having the ability to disrupt the whole process)

After their first year of implementation (2006/07), they had one claim in 40 disclosures, which was cited as an exceptional rate for the Cook County litigation environment. In addition to physician candor and apology, good customer service with excellent communication skills and effective problem solving were seen as key elements to this success.

Design features: Internal, not-neutral; direct participation in conversations; various actors coaching/facilitating at different points; interest-based, facilitative approach to problem solving.

*External Neutral: Mediating Disclosure prior to litigation*

The COPIC 3Rs program utilizes external neutrals to mediate difficult disclosure conversations. In the published literature, it was not clear who makes the decision in the COPIC system for the physicians to hold the disclosure conversation on their own or as part of mediation.

*Category Three: Responses to Litigation*

A variety of ADR processes—including arbitration, mediation, early neutral evaluation, and conciliation—are frequently utilized processes to help settle medical malpractice lawsuits outside of the courtroom. Legal counsel typically plays a central role in these ADR responses to lawsuits that have already been filed.

The impact of medical malpractice claims on physician reputation is an important factor in this category of responses. In most circumstances, once a plaintiff’s attorney presents a written demand for compensation to a physician defendant, subsequent settlements resulting in payouts on behalf of physicians must be reported to the National Practitioner Data Bank (NPDB) and, in some states, to the Board of Medical Examiners.
This applies equally to settlements negotiated through mediation. As being publicly reported to the NPDB or BME can have long-term impacts on a physician’s reputation and practice, this can significantly dampen physicians’ enthusiasm for making late-stage settlements through any channel. ADR interventions that can interrupt the litigation process before reporting to the NPDB is required are seen by many physicians to offer significant benefits.

**Pew Disclosure Mediation Model: Facilitative mediation by an external neutral**

In this approach to medical malpractice litigation arising from an adverse event, an external neutral organizes and conducts a facilitative mediation that includes all parties and their legal counsel. This process aims to improve communication between patient and physician; learn from those events; and arrive at fair and cost-effective settlement of claims.

Their model recommends:

- physicians and other healthcare professionals learn communication skills for disclosure conversations;
- process experts help plan, conduct, and debrief disclosure conversations;
- hospitals allow physicians and hospital staff the time necessary for disclosure conversations;
- all involved parties, including physicians and hospital leaders, offer an apology;
- debriefing and support of healthcare professionals after the error or adverse event;
- use of mediation to settle potential claims.

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137 Guadagnino, “Malpractice Mediation Poised to Expand.”
This model employs many of the same features, processes, and goals as the internal neutral Health Care ombuds/mediator system, although these neutrals are generally called on to engage with the dispute at a much later stage. It focuses on identifying interests; advises direct participation by the responsible health care provider involved with the litigation; provides opportunities for all participants (rather than their legal counsel) to tell their story and be heard; encourages full-disclosure and apology; encourages all parties to talk with one another throughout all sessions; supports the expression emotion; provides reality-checking rather than evaluation; seeks to help identify information useful for changing hospital policies and systems (for institutional learning and improved patient safety); and helps parties explore alternative settlement options.139

The Pew Demonstration and Mediation Project was a two-year demonstration program piloted in four hospitals in Pennsylvania. While only a small number of cases were mediated under this system, it is an example of how systems may use external neutrals for mediations involving disclosure conversations at later stages, after the litigation process has been activated. Programs adopting similar approaches continue to be introduced and assessed.140

Design features: External neutral; leads process of interest-based, facilitative mediation; participation in the process is voluntary (by both plaintiff and physician).

Rush Medical Center Model: Evaluative Mediation

In contrast to a facilitative, interest-based mediation approach taken by many of the models mentioned above, evaluative, settlement-conference mediation is also used in medical malpractice cases. This style of

139 Liebman and Hyman, Medical Error Disclosure, 78.
140 Chris Stern Hyman and Carol Liebman, “Mediating Medical Malpractice Lawsuits: The Need for Plaintiff and Physician Participation,” Dispute Resolution Magazine 16, no. 3 (Spring 2010), 8.
mediation is largely conducted between the mediator and legal counsel for the plaintiff and defendant. Evaluative mediators typically spend relatively little time in joint session, do not encourage the participation of the plaintiff and defendant, and focus largely on the economic issues of the case. These mediations rarely deal with emotions or underlying interests and tend to seek solutions based on the parties’ adversarial monetary positions.

A prominent example of this approach is a model for co-mediating medical malpractice litigation that emerged from the Rush-Presbyterian-St. Luke’s Medical Center in Chicago in the mid-1990s. The Rush model aims for early settlement of filed medical malpractice lawsuits prior to the court hearing the case in court. It largely utilizes an evaluative style of mediation, in which external neutral mediators assess the strengths and weaknesses of the parties’ positions and suggest a value range for settlement, with little time spent in dialogue or joint session.

This voluntary process begins with a joint meeting introducing the mediation approach to both the plaintiff and the defense, including their legal counsel. This meeting provides an overview of the terms and conditions of the mediation, describing confidentiality, defining finality, outlining caucus procedures, and explaining that both sides share equally the mediation expenses.

The plaintiff and his or her attorney then select a mediator from a list of practicing medical malpractice trial lawyers trained in mediation. Having the plaintiff select the mediator is designed as an inducement for the plaintiff to participate. A second lawyer is then assigned as a co-mediator, intentionally pairing a

143 Hyman and Liebman, Medical Error Disclosure, 74.
144 Guadagnino, “Malpractice Mediation Poised to Expand.”
lawyer who would typically handle a plaintiff’s medical malpractice case with a lawyer who traditionally defends these cases.¹⁴⁵

Generally these mediations occur at a fairly late stage in the litigation process with most discovery of case details having already occurred.¹⁴⁶ A typical mediation begins with each side (usually the attorneys) making a brief opening presentation; the parties are also offered the opportunity to speak, if they choose. The mediators then shuttle between separate caucuses with each side until the parties agree on a settlement figure. The parties then reconvene in a joint session, affirm the terms of settlement, and exchange comments.¹⁴⁷ The hospital representative may offer an apology of sympathy during the mediation, though this generally will not include an acknowledgement of liability.¹⁴⁸

Rush instituted this system to lower legal defense costs and provide a more reliable procedure for settling medical malpractice disputes.¹⁴⁹ In line with this, Rush established definitions of success for this program:¹⁵⁰

- Would the settlement value of cases resolved through mediation be increased or reduced?
- Would defense costs be increased or reduced?
- Would initiating the program cause plaintiffs’ attorneys to sue Rush with greater frequency?

Data evaluating the early performance of this model of co-mediation indicates that they were successful on all three criteria. Overall, approximately one-third of medical malpractice cases involving Rush enter voluntary mediation. 90% of mediated cases are successfully settled, with 80% of the cases resolved within

¹⁴⁵ Balcerzak and Leonhardt, “Alternative Dispute Resolution in Healthcare.”
¹⁴⁶ Hyman and Liebman, Medical Error Disclosure, 74.
¹⁴⁷ Hyman and Liebman, Medical Error Disclosure, 75.
¹⁴⁸ Hyman and Liebman, Medical Error Disclosure, 74.
¹⁴⁹ Guadagnino, “Malpractice Mediation Poised to Expand”; Hyman and Liebman, Medical Error Disclosure, 74.
one year of the filing of the lawsuit. Upon reaching mediation, the vast majority of settlements are reached within three to four hours of mediation. From the hospital’s perspective, this brought significant financial benefits as well. Compared to similar non-mediated cases, the mediated cases are resolved more quickly (in one-half to two-thirds the time in which similar non-mediated cases came before a jury or were settled), with lower pay-outs (a 40-60% savings in payments, though patients reported being satisfied with the lower amounts because of the faster speed of resolution), and with a 50-70% reduction in legal defense fees.

Concerns that the success of a relatively quick and cost-effective mediation program might attract an increase in the number of lawsuits have so far proved unfounded, as results indicated a reduction in lawsuits filed during the early years of study.

Rush continues to use this model, citing its success in meeting the interests, concerns, and emotional needs of patients and providers; reducing the costs and time involving with traditional responses to litigation; achieving win-win solutions through alternative approaches to settlement; and gaining support from both plaintiff and defense attorneys.

However, this model has been criticized for its overarching evaluative approach to mediation. Liebman and Hyman argue that the Rush model fails to realize the full benefits of mediation, claiming it focuses almost exclusively reaching a monetary settlement. They claim that the evaluative approach misses opportunities for repairing relationships, exploring non-monetary remedies, and discovering information that would promote patient safety.

155 Liebman and Hyman, Medical Error Disclosure, 73.
156 Liebman and Hyman, Medical Error Disclosure, 74.
The Drexel University College of Medicine established a mediation program that adopts the basic framework of the Rush model but integrates features of disclosure conversations and facilitative mediation. Like the Rush Model, it utilizes co-mediators selected from a pool of practicing trial lawyers to conduct the mediation. Unlike the Rush model, the focus of the mediation is on repairing the patient-physician relationship. Both patient and physician attend and speak.

Design features: External neutral; co-mediation by practicing trial lawyers; evaluative mediation style; patient / provider participation often minimal; no full apology.

C. Shared Decision Making

Shared decision making (SDM) is a burgeoning example of conflict management in healthcare. Movements promoting patient engagement for patient safety are one aspect of shared decision making. In attempts to improve patient safety and quality of care, hospitals are increasingly promoting a partners-in-care model between patients, their families, and providers. Pediatric hospitals have been especially active in attempting to involve patients and family in care decisions and care delivery as a productive source of differing opinion and perspective. The key assumption is that when patients and families are encouraged to ask questions and participate in care of their children, they are more likely to trust in the caregivers and the institution as a whole. This is similar to the focus on improved communication between patients and

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161 Morath and Hart, “Partnering with families.”
162 Morath and Hart, “Partnering with families,” 3.
providers discussed above, with increased focus on the patient - provider relationship, informed consent, patient preferences, and structures for sharing information and making decisions.163

Concerns with the cost of healthcare in the US are raising expectations that both patients and providers be conscious of the cost implications of various procedures and treatment options. This shift in the field may increase provider conflicts with both patients and payers over resource allocation, cost reimbursement, and decision-making authority. Addressing these conflicts will entail new approaches to problem solving, impacting the traditional hierarchies of knowledge and decision-making power in patient – provider relationships. Healthcare providers who previously viewed healthcare decisions as too complex for patients to understand will increasingly be expected to share more information with their patients so that the patients can make more informed, autonomous decisions about treatment options. Cost concerns will increasingly make shared decision making an important new model for how healthcare is delivered.

Alongside this, there is a second vein of shared decision making that centers on assisting patients with decisional conflict. Decisional conflict refers to patients struggling to select from among the available treatment options. This version of shared decision making draws from the background of bioethics disputes and difficult end-of-life decisions (see below). Decisional conflict is frequently associated with preference-sensitive care but can also arise when patients are asked to place value on the potential costs and benefits of many treatment options that had previously been decided unilaterally by physicians.164 Increasing concerns with cost, resource allocation, and patient satisfaction rates may shift more of the responsibility for decision making on to patients, making decisional conflicts potentially even more common in the future.

163 Karen Sephucha, Floyd Fowler Jr., and Albert Mulley Jr., “Policy Support for Patient-Centered Care: The Need for Measurable Improvements in Decision Quality,” Health Affairs (Web Exclusive, October 7, 2004), http://content.healthaffairs.org/cgi/content/abstract/hlthaff.var.54v1 (accessed 26 May 2010).
Decisional conflict can burden healthcare providers and absorb considerable amounts of time. Patients with decisional conflict are more likely to schedule repeat appointments and contact providers outside of appointments via telephone and email for additional information. Patients may be less satisfied with the care they receive, have less ownership of the decision, feel disempowered, and experience unnecessary emotional or psychological stress. In some cases, patients may not receive the treatment they prefer or they may be pressured into unnecessary procedures.

The goals of interventions for decisional conflict are to advocate for patients and to help them make decisions that they can act on. To achieve this, SDM utilizes techniques from conflict coaching and mediation: conflict analysis, particularly identifying key issues, stakeholders and underlying interests; ensuring process fairness; raising awareness of power imbalances; reality testing; and generating options. Shared decision making can be facilitated by a provider directly involved with the patient’s care team or by a third party advocate who is not part of clinical care team. The neutrality towards the ultimate decision is a distinct departure from the normal healthcare provider role of recommending options; this focus on process and ensuring that patients have the information and knowledge they need to make an informed decision are additional correlations with conflict management.

Decision aids are frequently utilized to assist patients with their decisional conflicts. In some systems, such as that of the Dartmouth-Hitchcock Medical Center, patients diagnosed with certain cancers are automatically sent decision aids upon being informed of their diagnosis. Prior to their next scheduled appointment, patients are encouraged to work through these aids, which provide background information on the disease and outline a variety of factors, including potential costs and benefits, involved with the

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165 Kate Clay, Program Director, Center for Shared Decision Making, Dartmouth-Hitchcock Medical Center, Hanover, NH, 4 May 2010.
166 Author interview with Kate Clay; additional information on the Dartmouth-Hitchcock Medical Center programs is available at www.informedmedicaldecisions.org.
treatment options. Ideally patients then arrive at their appointment better prepared to engage more quickly with the most contentious issues at the heart of their decision on treatment options.

Shared decision making approaches can achieve a better use of clinical time, as appointment time is spent on more substantial issues and patient needs. Often the use of decision aids prior to an appointment allows patients to make a difficult treatment decision at that appointment, something that rarely happens otherwise in these contexts. While SDM does occasionally save time because it avoids the lingering time sinks associated with decisional conflict (follow up emails & phone calls from patients with unanswered questions, repeat visits), typically the time justification for shared decision making is that it allows for provider and patient to engage at a more meaningful level and use their time together to achieve better outcomes.

Beyond time benefits, shared decision making can help avoid unnecessary treatment, especially surgeries; improve patient knowledge scores about their condition, options for treatment, and likely results; help patients gain realistic outcomes for operations, a key aspect of informed consent; reduce liability by increasing patient ownership of the decision; increase patient satisfaction scores; and help providers feel more fulfilled because they are better able to empower patients. 167

The shared decision making model complements the internal neutral ombuds model as they address conflict at different stages of manifestation. Decisional conflict often does not register as something that a patient recognizes as an unmet need for information, communication, or support. For this reason, a patient with decisional conflict is not likely to activate HCOM system. Because patients’ expectations for the provider encounter are often low, they typically do not perceive unresolved decisional conflict to be an unanticipated

167 Timothy Whelan, et al., “Effect of a decision aid on knowledge and treatment decision making for breast cancer surgery: a randomized trial,” Journal of the American Medical Association 292, no. 4 (July 2004): 435-41; also, author interview with Kate Clay, Program Director, Center for Shared Decision Making, Dartmouth-Hitchcock Medical Center, Hanover, NH, 4 May 2010.
outcome to complain about. In this way, SDM is a form of awareness-raising about expectations and what patients deserve. This can be an example of a deeper form of relationship transformation, as it looks more closely at the goal of the encounter than do many patient-provider interactions. It is not activated in response to a particular adverse event but looks to deepen what the patient receives out of their medical encounter.

D. Ethics Conflicts

Ethics conflicts in healthcare are a third domain of dispute resolution in the patient-provider dynamic. While disagreements surrounding end of life decisions are a high-profile example these types of conflict, additional disagreements routinely arise around the issues of confidentiality, resource allocation, transparency, competing interests, locus-of-authority, and reproductive care, among others. These ethics conflicts can carry high costs that affect multiple dimensions of the healthcare environment. As Wilson points out, the impacts of ethics conflicts in healthcare practices can include:

- **Staff**: caregiver stress; deflated morale; weakened professionalism
- **Patients**: Poor patient satisfaction; loss of self-referrals
- **Organization’s Culture**: Diminished quality of care
- **Relationship with Community**: Diminished organizational image; decreased trust; poor public relations; lower levels of philanthropic giving
- **Legal**: Increased litigation and settlements
- **Regulations**: Negatively influences adherence to Joint Commission Standards and other regulatory organizations

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Because ethics issues in healthcare arise with frequency and have widespread impact, it is seen as important for institutions to develop systems for preventive, proactive responses to ethical uncertainty and likely disagreements, rather than relying on a reactive approach. One component of this approach is to help providers increase their knowledge and skills for recognizing and managing ethics conflicts at all stages. A second component is to provide training on conflict resolution skills and processes to bioethics committees. A third component is the development of bioethics mediation resources.

*Care Providers: Early Interventions*

Care providers play important roles in early patient conversations surrounding ethics conflicts. To prepare providers for these encounters, bioethics decision-making tools are widely available.\(^\text{170}\) Many of these tools attempt to provide practical frameworks for evaluating and reaching decisions. While these frameworks provide substantive ethical guidance, they often do not equip providers with the communication and conflict resolution frameworks necessary for effective management of the ethics conflict. Among other conflict management process skills, providers may require training and professional support on communication in difficult conversations, conflict analysis, identifying underlying issues, active listening, group facilitation, and agreement management.\(^\text{171}\) Familiarity with an interest-based negotiation model can be particularly helpful for identifying underlying needs that may otherwise be overlooked by many bioethics frameworks. There are additional opportunities for moving beyond interest-based models in order to raise providers’ awareness of the importance of trust, respect, participatory decision making, and communication in these situations.

\(^{170}\) For examples, see Purtilo, “The Ethical Life of Healthcare Professionals”; and Jonsen, Siegler, and Winslade, *Clinical Ethics*.

Bioethics Committees

Requests for bioethics consultations are more advanced manifestations of the conflicts that arise when clinicians, patients, or family members perceive other actors as impeding their goals for care or outcomes. Training bioethics consultants on communication skills and conflict management process skills can improve their handling of these issues and also help them serve as models for the hospital on collaborative conflict engagement. This may include increasing consultants’ familiarity with facilitated dialogue, mediation, consensus building, and participatory decision making processes.

While interest-based negotiation models are useful for bioethics consultations, transformative mediation models open additional opportunities for reaching deeper levels of acknowledgement and understanding of the needs of the parties to a dispute. The Baystate Health Care System uses transformative mediation in their bioethics committee consults and requires all committee members to undergo a 40-hour transformative mediation course and ongoing trainings. Further acknowledgement of the importance of trust, autonomy, and recognition in bioethics conflicts may increase the use of transformative mediation techniques.

Bioethics Mediations

While informal mediation is an aspect of many bioethics consultations, more formal bioethics mediations are likely only after the two earlier levels of interventions (care providers and bioethics committees) have failed to resolve a dispute. Cooley argues that successful bioethics mediation is dependent upon selecting

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the right mediator and utilizing the correct model of mediation.\(^{175}\) He suggests that members of hospital bioethics committees are often not the most appropriate choice for mediator as they are subject to bias and unresolved power disputes within the institution.\(^{176}\) Instead, nurses and patient advocates may be able to serve as mediators more effectively, if trained in mediation by bioethics consultants. External mediators can also be an appropriate option, if the mediator is familiar with bioethics mediation and the legal and ethical norms applying to the case; has sufficient knowledge of the administrative and political dimensions of the particular healthcare institution; and has sufficient background in healthcare to understand the issue at hand.\(^{177}\)

Cooley argues that bioethics mediation differs from other models of mediation because it is constrained by relevant legal and ethical principles.\(^{178}\) Because there are recognized legal and ethical frameworks that stipulate who has the final authority to decide on the ultimate course of action, part of the mediator’s job is to help patients, families, and caregivers properly identify this person.\(^{179}\) As a result, Cooley argues that bioethics mediations generally must adopt a rights-based mediation model rather than an interest-based mediation model.\(^{180}\) This has significant implications for the role of the mediator in the process, who cannot function as a full neutral. Instead, they must advocate for the laws and ethical principles that are accepted as applying to the case, in addition to seeking to meet the interests of the parties involved to the extent possible. The mediator can remain neutral as to the outcome only so long as the resolution complies with ethical and legal norms affecting the case.\(^{181}\)

\(^{175}\) Cooley, *A dose of ADR*, 17.
\(^{176}\) Cooley, *A dose of ADR*, 17.
\(^{177}\) Cooley, *A dose of ADR*, 17.
\(^{181}\) Liebman and Hyman, *Medical Error Disclosure,*” 107.
III. Patient – Payer Conflicts

This dynamic, often referred to as health coverage disputes, typically involve disputes over coverage or reimbursement of claims.\textsuperscript{182} Patient-payer conflict interventions differ from the other dynamics in being less relational and more transactional in nature. Conflict management interventions tend to be largely focused on interest-based negotiation, mediation, and advocacy (for patients in the face of power imbalances with payers).

Besides disputes with insurance companies, patient disputes with managed care providers also fall under this dynamic. Patient disputes involving payment affect managed care organizations, as in managed care organizations payer and provider are often part of the same system. Additionally, patients may charge that the managed care plan misapplied protocols or neglected acceptable medical standards.\textsuperscript{184} Because there is increased overlap between patient-provider disputes and patient-payer disputes in managed care plan contexts, many such disputes are often dealt with by an internal neutral (such as an HCOM) in large managed care organizations.

*Medicare beneficiary mediation.* The Centers for Medicare and Medicaid Services (CMS) contract with Quality Improvement Organizations in each state to implement the daily operations of Medicare and determine whether the services rendered as medically necessary and appropriate.\textsuperscript{185} These state-based organizations are required to offer the option of mediation for communication-based patient complaints.\textsuperscript{186} Contracted mediators assist with these cases, which may involve co-mediation with a physician.\textsuperscript{187}

\textsuperscript{182} There is also a related arena of conflicts between physicians and payers. Many of these conflicts involve physicians on behalf of a patient, hence I categorize them under this dynamic. Other physician – payer disputes are grouped under the physician – administration category of conflict.
\textsuperscript{183} Cooley, *A dose of ADR*, 17.
\textsuperscript{184} Cooley, *A dose of ADR*, 17.
\textsuperscript{185} Liebman and Hyman, *Medical Error Disclosure*, 107.
\textsuperscript{186} Hetzler, et al., “Curing Conflict,” 5-7.
\textsuperscript{187} Hetzler, et al., “Curing Conflict,” 5-7.
Collaborative claims management. This is an approach to patient claims utilizing ADR frameworks for reconciling disagreements. Reconciliation attempts may involve mediations and the culture of interest-based negotiation encourages open access to documents and personnel. These mediations can be conducted by internal neutrals or by regular billing and customer service staff.

Mediation for Mental Health Clients. Some organizations, such as the District of Columbia Department of Mental Health and Arizona State Hospital, offer mediation for patient complaints. Significantly, this includes explicit efforts to address power imbalance and dedicated staff time to helping patients in this process.

Long-term care ombudsmen. As per legislation, states employ ombudsmen to advocate for long-term care residents. Additionally, they may oversee the coordination of volunteer ombudsmen to handle patient complaints.

Consumer Advocacy. Connecticut created the Office of Healthcare Advocate (OHA), an independent government agency, to play a consumer advocacy role protecting the interests of people covered under managed care organization health plans. It educates consumers about their rights and responsibilities, analyzes trends, and makes public policy recommendations. Moreover, the OHA acts as a direct advocate for policyholders and will intervene to hold insurers accountable. OHA staff members provide information to consumers, assist with filing complaints and internal and external appeals, help communicate with insurers on behalf of the patients, and may appear at administrative hearings, though they do not represent policyholders in court.

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This intervention on behalf of patients is noteworthy as an attempt to address power imbalances in the interaction between patient and payer. The OHA handles 2-3,000 cases per year, with 85% of the cases involving policy rescission for undisclosed information. According to the state healthcare advocate, less than 10% Connecticut policyholders appeal the denial of a claim, so increasing awareness about the available advocate resources is a key focus. Additionally, physicians can turn to the OHA when working on behalf of a patient to get a denial overturned.

While the changing landscape of US health care will continue to shift the details, advocacy interventions aimed at addressing power imbalances in the patient–payer dynamic are an important application of conflict resolution in healthcare.

IV. Provider–Administration Conflicts

Provider–administration conflicts range from traditional workplace and labor–management disputes to serious power struggles and destructive relations that can pollute entire workplaces. A growing literature documents competition and adversarial relations between physicians and administrators that can fuel bitter and entrenched conflict in healthcare environments. These conflicts can arise from different professional

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192 Clark describes a common context of policy rescission: “An individual purchases a health insurance policy, pays premiums, gets sick, and submits a claim, to which a carrier responds with rescission. The policyholder is informed that the decision to rescind is based on the insurer’s determination that, had particular information been disclosed, the policy would not have been written.” Clark, “Advocacy in Health Care,” 10.
194 This includes clinician employment contracts and terms, discrimination, working conditions, inter-professional relations, and intra-organizational issues. Cooley, A dose of ADR, 18.
cultures, educational backgrounds, power hierarchies, incomplete access to information, communication breakdowns, competing responsibilities, and perceptions that the professions hold divergent values.

To deescalate adversarial relations between physicians and administrators, Cohn and Peetz suggest increased focus on communication skills, dealing with emotion, team building, collaborative problem solving, participatory leadership, and consensus building. They suggest that successfully managed conflict “clears up misunderstanding, decreases anger and resentment, heightens understanding, and fosters the development of innovative services for patients and improved surgeons’ and hospitals’ standing in the community.”

Cohn, Friedman, and Allyn advocate three additional techniques for overcoming the conflicts that result from defensive reasoning and entrenched positions. Structured dialogue creates a forum for practicing physicians to articulate clinical priorities to healthcare administrators in a structured process based on consensus building and participatory problem solving. Appreciative inquiry reframes relationships and reorients towards the future to build on successes rather than remain fixated on root-cause analyses of problems. Positive deviance as a method for overcoming problems seeks to promote ownership of change by finding solutions that already exist in the community instead of importing practices from outside. Cohn and others report these strategies can be utilized in an overarching conflict resolution framework with considerable success.

Many interventions in the provider – administration dynamic involve traditional labor – management disputes. Mediation is frequently used to resolve disagreements regarding employee operations, human

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198 Cohn, Friedman, and Allyn, “The Tectonic Plates are Shifting,” 11-26.
resources complaints, union negotiations, and contract bargaining.\footnote{Hetzler, et al., “Curing Conflict,” 6.} Organizations often employ a variety of internal (ombuds, Management Review Committee, and executive designated as arbiter) and external (mediation and arbitration) dispute resolution interventions to deal with these disputes.\footnote{Cooley, \textit{A dose of ADR}, 18.}

As the relationships between health care institutions, payers, and providers continue to evolve, changes resulting from mergers, shifting alliances, and new organizational systems can lead to a category of disagreements called “disaffiliation disputes.” Examples of disaffiliation disputes include incidents when a provider is released from a practice group due to physician-competency concerns, is excluded from a newly-formed provider group or managed care organization, or is not designated as an eligible provider for a certain insurance plan.\footnote{Cooley, \textit{A dose of ADR}, 17.} These disputes often carry significant financial consequences for health care providers, threaten professional reputations, and involve high emotions.\footnote{Cooley, \textit{A dose of ADR}, 17.}

Some of these cases can be effectively settled through mediation, as mediation can often handle the emotional and reputational elements of disputes better than litigation. Mediation as a quicker, quieter, and cheaper option is also appealing to many parties. However, significant power imbalances (such as a lone physician versus a large corporate provider) and different perceptions of conflict ripeness can affect the appropriateness of mediation in such cases.

Finally, provider – administration conflicts often arise over resource allocation decisions. These disputes can involve conflicts between competing values: personal, professional, organizational, and community.\footnote{Paul B. Gardent and Susan A. Reeves, “Ethics Conflicts in Rural Communities: Allocation of Scarce Resources,” in \textit{Handbook for Rural Healthcare Ethics}, ed. William A. Nelson (Hanover, NH: Trustees of Dartmouth College): 169. \url{http://dms.dartmouth.edu/cfm/resources/ethics/full-book.pdf} (accessed 14 May 2010).} Difficult resource allocation decisions pose significant communication challenges and are prime grounds
for conflicts. Effectively addressing disagreements in this context often requires skill in identifying and facilitating a process that is fair, inclusive, and transparent. The capacity to navigate contentious issues and feelings is important.204

204 Gardent and Reeves, “Ethics Conflicts,” 174.
INTERVIEW RESULTS

Nine separate interviews were conducted with ten interviewees. Two interviewees were together for business purposes at the time of the scheduled interview, and they elected to provide their interview responses together in a single email.

The interviews did identify definitions of success, but there was less variation on this topic than expected. A common core of five underlying metrics kept recurring: financial impact; time savings; patient safety/clinical outcomes; patient satisfaction; and staff morale/retention. Reductions in lawsuits and protection of professional reputation (fewer complaints filed against clinician) also were repeated by multiple interviewees. There were differences in emphasis that roughly correlated with the professional responsibilities of the interviewee, with some definitions of success focusing more on money, others on patient outcomes. Many interviewees felt the ultimate definitions of success will rest in maintaining and repairing relationships and therefore involve qualitative measurements of success (feelings, perceptions, happiness, morale, legacy, fear/comfort, communication, atmosphere)

Research Challenges: Challenges faced in this research included lack of access to healthcare organizations’ internal documentation describing underlying conflict management system design principles, performance indicators, data collected, and measurements of success. Access to such documentation would be necessary for systematically comparing definitions of success across conflict management systems in various healthcare organizations.

While response rates to invitations to participate in the research interviews were overall high, no response was received from numerous academics and private practitioners invited to participate. Additionally, I was unable to contact representatives from government or accrediting bodies associated with healthcare conflict.
Limitations: The size of the interview pool was very small so extrapolating from interview comments is not appropriate. The selection of three initial interviewees based on convenience sampling (rather than identified based on published literature) did not follow the research design protocols, although it did add significant value in bringing noticeably different perspectives into the interviews. In future research, the sampling methodology should be adapted to reflect the importance of gathering perspectives from diverse sources: conflict management experts and lay people; adherents and skeptics; and publishing and non-publishing practitioners.

Interview Findings

The following table lists the interviewees’ comments broken down by topic:
Table 2. Interview Findings

<table>
<thead>
<tr>
<th>Interviewee Description</th>
<th>Dispute Dynamic Discussed</th>
<th>Goals for Conflict Management</th>
<th>Success Indicators</th>
<th>Conflict Costs / Challenges</th>
<th>Training Comments</th>
<th>Other</th>
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<tr>
<td>Physician, Hospital</td>
<td>Nurse-physician (usu. over diagnosis of patient and treatment plan) Physician-Physician (usu. miscommunication over phone about urgency of a case when seeking consult from specialist) Physician-oversight standards/government regulations boards (impractical standards; miscommunication on ultimate goals; no feedback mechanism)</td>
<td>Head off disagreements in real time, before any difference of opinion gets to be a problem Use difference in perspective to everyone’s advantage (source of new information, imp. for patient safety &amp; quality of care) Avoid activating complaint mechanism</td>
<td>Improved quality of patient care Improved staff morale Increased efficiency Reduced liability Higher patient satisfaction scores</td>
<td>Modeling good communication skills is key (if see throughout medical school and residency = later comes naturally)</td>
<td>“Good communication” was key term Early intervention most important</td>
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<td>Critical Care Nurse, Academic Medical Center</td>
<td>Disputes within medical team (nurse-doctor; doctor-doctor) Medical team – families of sick patients Medical team - patient</td>
<td>Disputes within Medical Team: • Resolve problem early and internally by stepping outside of the room Medical team – Pt. • Honor patient’s wishes while helping them be informed about recommended treatment options • Quality of care / medical outcome (includes compliance with medication regimen) • Honor patient’s wishes by being a proper advocate • Family comfortable with course of treatment</td>
<td>Increased efficiency Improved quality of care More pleasant work environment Honored patients’ wishes Family satisfied with decision</td>
<td>Unmanaged disputes slow down patient flow and cause tasks to back up</td>
<td>Recent nursing “unit education training” in dept. had 40-minute training on conflict resolution; received CE hours for this</td>
<td>People want to feel listened to and respected in their workplace Patient care disputes go up through Quality Control infrastructure Staff disputes go up through nurse manager channel to HR Complaint feedback mechanisms improve quality of care bc prompt changes in protocols</td>
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<td>Physician, Hospital; Patient Complaint Liaison Physician for practice group</td>
<td>Patient – Provider disputes (usu. complaint over interaction with physician or nurse; outcome of visit; or bill) As Patient Complaint Liaison Physician for practice group, usually interacts via telephone with angry patients ~ one week after complaint is filed</td>
<td>Listen to patient; let them tell their story; don’t rush them Acknowledge story/feelings Reality Check patient expectations Information sharing (provide fuller picture of what physician was doing and why) Problem-solve to meet patient’s needs</td>
<td>Patient satisfied with outcome of problem-solving conversation Increased pt satisfaction rates Reduced number of malpractice cases “Doing the right thing” Improved quality of care Improved communication</td>
<td>“Poor communication, miscommunicati on, and no communication” are the main problems leading to disputes</td>
<td>“Good Communication” was key term used throughout conversation Patient complaints collected via hospital business office, quality management office, or direct call to practice group Role of liaison physician very similar to mediator’s role though not neutral and terminology is very different</td>
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<tr>
<td>Nurse, Manager of hospital shared decision making program</td>
<td>Ethics Disputes (end-of-life decisions) Patient – Family - Provider</td>
<td>Better use of time (provider time with patient spent on more substantive issues and patient needs) Help patients make decisions in line with their values and preferences Help patient have ownership of decision Empower patients Avoid unnecessary treatment Improve patient knowledge about treatment options</td>
<td>Patient able to make a decision they are comfortable with (ownership of decision) and act on it Unnecessary treatment avoided Patient has realistic expectations for treatment outcomes of options Providers feel more fulfilled</td>
<td>Decisional conflict adds time / tasks to nurses &amp; physicians Most patient decisional conflict not addressed Pts. don’t receive the treatment they prefer Pts. pressured into unnecessary treatments (cost)</td>
<td>Need change agents at all levels Barriers: Hierarchical problems may prevent implementation if no support from superiors; lack of time; lack of reimbursement for time spent on this; lack of recognition of preference sensitive decisions; insufficient collaboration of healthcare team)</td>
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<td>Physician, Healthcare Management Consultant</td>
<td>Physician – Admin Physician - Physician</td>
<td>Help physicians deal with conflict and confrontation Help people recognize that differences are a positive force that creates innovation and improvement Embrace complexity bc it improves our understanding Better communication (lead to less frustration; time savings) Improved collaboration of health care providers across sectors Reduce medical litigation</td>
<td>Time savings (increase efficiency) Lower expenses Higher incomes Better clinical outcomes Improved patient satisfaction scores Improved relations between hospital administrators and physicians</td>
<td>Many physicians struggle to admit they need help dealing with conflicts Accountable care organizations demand more collaborate work across sectors, which requires better and more communication</td>
<td>Introducing communication-focused trainings into medical schools may not be a high priority for many schools Start of medical internship year is opportunity to introduce process skills training Need to collect stories and cases for use in trainings Must show that long-term benefits outweigh short-term costs of attending training Physicians motivated to attend trainings due to money, legacy, job at stake, etc.</td>
<td>“Good communication” and “process skills” were key recurring terms Need more research on causal links &amp; long-term benefits of good communication &amp; process skills Modeling of good communication by senior physicians in teaching settings is important Look for senior physician champions who can serve as role models (for residents, junior physicians) on communication &amp; process skills by tapping into aging physicians’ desire to leave a positive legacy</td>
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<td>Social Worker (Psychologist), Pediatric Hospital</td>
<td>Provider - Provider Patient – Provider Family of patient - Provider</td>
<td>Handle provider – provider disputes early &amp; within the team before HR gets involved Less disruption in work environment Improved efficiency Avoid mobilizing ethics committee unnecessarily Collaborate with parents of sick children on care / treatment options</td>
<td>Dispute addressed and effectively managed at early stage Dispute resolved internally (within healthcare team) HR is not involved Respected patient wishes (for disputes between patient – provider re. medicating psychiatric patients)</td>
<td>Staff disputes are disruptive Getting HR involved makes things messy</td>
<td>Conflict coaching skills important Train supervisors to mentor / advise on good conflict management Early phase interventions are important</td>
<td>Systematize awareness of conflict resolution structures / options Hold weekly meetings with supervisor; use this forum to discuss cases, problems, etc., including early intervention options Supervisors and supervisees must know they can use these meetings to discuss advice for conflicts Morbidity and Mortality rounds option for analyzing case with patient dispute</td>
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</table>
| Healthcare ADR Professional, Consultant | Provider – Provider | Improve / restore relationships  
Reduce negative impacts of conflict (time, money, emotional stress, damaged relationships)  
Design minimally-disruptive conflict management interventions | Definitions of success vary significantly: Staff satisfaction, happier work environment, lower turnover, people feel more comfortable participating and speaking out, etc.  
Must ask parties at beginning of every intervention, “What is your definition of success for this interaction / program?”  
Many definitions of success are hard to quantify:  
“We are happy”  
“We feel good about the process”  
“We restore the relationship”  
Be conscious of need to track improvements in relationships that may be hard to measure | Disruptive behavior impacts on patient safety and retention | Trainings don’t solve conflicts  
Embed conflict training in medical culture of see one, do one, teach one  
Use trainings to cross silos  
Important that communication skills training now required for M.D. board exams and residency programs  
Training barriers: time, funding, need for repeat trainings, logistics of getting entire staff to trainings  
Selection of trainer important | Shift away from interest-based negotiation towards relationship models  
Need both qualitative and quantitative data  
Must develop conflict competence for leadership  
Match healthcare culture of Do No Harm  
Link conflict management field with complex systems research  
Measure actual costs of conflict (in time/ money)  
Intentional Mentorship/ modeling relationships important part of conflict engagement training |
<table>
<thead>
<tr>
<th>Interviewee Description</th>
<th>Dispute Dynamic Discussed</th>
<th>Goals for Conflict Management</th>
<th>Success Indicators</th>
<th>Conflict Costs / Challenges</th>
<th>Training Comments</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Lawyer / ADR Professional, Consultant</td>
<td>Patient – Provider (especially legal) Provider - Provider</td>
<td>“Quieter, quicker, cheaper” Preserve relationships Address conflicts (rather than ignore and let them radiate) Address conflict “within your own culture” (control of outcome) Achieve win-win solution, not capitulation</td>
<td>Fewer lawsuits Fewer med staff credentialing disputes Fewer patient complaints to Risk Management Fewer employee complaints / grievances to HR Less turn-over, more stable nursing staff</td>
<td>Next steps in training: • training for both medical and legal professionals, perhaps collaboratively • Education in graduate training: law schools, med schools, nursing schools, MHA programs</td>
<td>Promotion of conflict management: • Won’t appeal to all; begin with medical staff moderates • Educate hospital administrators • Educate risk managers • Educate health law providers Use anecdotes to illustrate value of conflict management (with skeptics)</td>
<td></td>
</tr>
<tr>
<td>Interviewee Description</td>
<td>Dispute Dynamic Discussed</td>
<td>Goals for Conflict Management</td>
<td>Success Indicators</td>
<td>Conflict Costs / Challenges</td>
<td>Training Comments</td>
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</tr>
</tbody>
</table>
| Healthcare ADR professional employed by health organization | Patient – Provider (specifically unanticipated outcomes) | Handle errors with compassionate treatment of all involved  
Ethically do the right thing for patients  
Support patients, their families, and providers following adverse outcome  
Avoid reputational problems for providers/facility  
Avoid visits from DHHS or Joint Commission  
Avoid losing patients  
Institutional learning and improved system for patient care as result of root cause analysis  
Repair / retain relationships  
Patients satisfied with response | 100% transparency in response to adverse outcome (full access by patients / providers)  
Provider / staff satisfaction scores [internal perception of how response was handled]  
They do not track patient satisfaction scores to avoid triggering emotional pain / survey fatigue  
Cost and litigation rates are not used to measure success; overarching theme is “to do the right thing”  
Claim many benefits cannot be measured | Training on adverse outcome disclosure should teach providers how to be honest, transparent, and compassionate in these conversations; how to prep for the conversations; need multiple trainings  
Need different types of trainings for people in different roles of the response | Increasingly encourage patient and family participation in root cause analysis process  
“Staff disputes” handled by different mechanism from patient – provider disputes  
Employee issues typically related to emotional problems (stress, burnout, etc)  
Utilize different conflict management programs together in integrated system capable of responding to disputes at different levels |
DISCUSSION

This section discusses the findings of both the literature review and of the interviews. It is divided into the following sub-sections:

1. Main Dynamics in Healthcare Conflict
2. Definitions of Success
3. Theoretical Shift Towards Relational Model
4. Early Intervention: Health Care Workers as the Front Line
5. Education and Training: Opportunities to Create Positive Change
6. Merging the Cultures of Health Care and Dispute Resolution
7. Suggested Future Research

1. **Main Dynamics in Healthcare Conflict**

The two dynamics found most prominently in both the literature and the interview data were patient-provider disputes and provider-provider disputes. Healthcare providers tended to associate conflict more closely with provider-provider conflicts and communication-based patient-provider conflict. This was in contrast to many full-time conflict management professionals, especially though not exclusively those with legal backgrounds, who focused much more on adverse outcome interventions, disclosure conversations, and malpractice claims. Some interviewees mentioned conflicts with patients’ families, especially in the context of end-of-life decisions and bioethics committees, although this dynamic was not prominent in either the literature or the interviews. A much smaller number of physician executives and conflict management specialists highlighted provider-administration conflict and disruptive behavior.

Interviews with healthcare providers focused on communication; indeed, this was the “go-to” word in the interviews with most healthcare providers. In many interviews, providers used the term “poor
communication” synonymously with conflict, indicating the extent to which the need for good communication has become ingrained in healthcare cultures. Numerous providers noted being trained in school and residency on the importance of good communication in relations with patients, though the primary context in which they reported most needing those skills was with other providers. The need for collaborative working relationships with other providers was the single most referenced conflict context by healthcare providers in the literature and the interviews. This supports the suggestion that communication trainings may be an effective access point for introducing conflict management to healthcare professionals.

With some exceptions, the literature and interviews from ADR professionals as a whole were more likely to focus on patient-provider disputes, specifically those related to unanticipated outcomes and litigation. While some of this may be attributable to the legal backgrounds of many full-time ADR professionals, a second factor may be that there has traditionally been more money at stake in this dynamic. The higher financial risk of these conflicts seems to have played a role in giving these conflicts more attention, in turn increasing the likelihood that ADR and conflict management interventions to deal with them will be requested, funded, and written about. Many of the conflict management systems discussed in the literature were developed in response to patient-provider disputes, although this focus may shift with the new Joint Commission standards on managing workplace conflict.

Numerous interviewees largely referred to one conflict dynamic alone, at times indicating an explicit lack of awareness of other dynamics. While tunnel vision was less present in the literature, much of the literature and interview data suggested that certain types of conflicts (often provider-provider) are dealt with by alternative systems (often HR) that are not well coordinated with conflict management programs in the organization working on other dynamics.

While much of the literature referred to more formal, later stage interventions, healthcare providers were more likely to discuss informal, early interventions responsive to relationships, trust, and time constraints.
The literature survey also noted significant differences in the orientation of typical conflict management responses to provider-provider, provider–administrator, and patient-provider disputes, as the following table shows:

Table 3. Conflict Management Foci

<table>
<thead>
<tr>
<th>Dynamic</th>
<th>Skill-building Focus</th>
<th>Intervention Model</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider-Provider</td>
<td>Collaboration, team building, conflict analysis, interest-based negotiation, communication</td>
<td>Coaching</td>
</tr>
<tr>
<td>Provider-Administration</td>
<td>Participatory decision making, consensus building, interest-based negotiation</td>
<td>Facilitation</td>
</tr>
<tr>
<td>Patient-Payer</td>
<td>Negotiation</td>
<td>Advocacy, mediation</td>
</tr>
<tr>
<td>Patient-Provider:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>General</td>
<td>Communication</td>
<td>Training</td>
</tr>
<tr>
<td>Adverse event disclosure</td>
<td>Difficult conversations, interest-based mediation, transformative mediation (trend)</td>
<td>Mediation, coaching</td>
</tr>
<tr>
<td>Shared decision making</td>
<td>Participatory decision making, communication, conflict analysis, mediation process skills</td>
<td>Training, coaching (for patient)</td>
</tr>
<tr>
<td>Ethics conflict</td>
<td>Conflict analysis, communication, mediation process, interest-based negotiation</td>
<td>Training, mediation</td>
</tr>
</tbody>
</table>

Understanding the different conflict dynamics and the conflict management interventions associated with each can improve the conflict management systems and trainings being designed for hospitals in the wake of the Joint Commission standards. Since a major challenge for productive conflict engagement is recognizing that the conflict even exists, ignoring (or failing to highlight) some of the dynamics involved with healthcare disputes is unhelpful and makes mainstreaming comprehensive, productive engagement with conflict more difficult. Acknowledging what conflict dynamics are included and excluded from existing conflict management systems can help healthcare providers and programs adapt as necessary.

2. **Definitions of Success**
This research was unsuccessful in accessing the internal documents of actual healthcare conflict management programs, thus it was not possible to compare the performance indicators and matrices that particular conflict management programs use to measure the effectiveness of their activities. While accessing such data was attempted in the early phases of the research process, it proved unsuccessful and largely unrealistic given the context of the research.

Instead, the literature and interviews served as the sole source for exploring definitions of success. Relatively little literature was found that systematically discussed definitions of success or performance indicators pertaining to the different dynamics of healthcare. Similar challenges were noted with the interviews.

Despite this lack of clarity on how most conflict management programs actually define and measure success, the literature review and interview data did suggest that definitions of successful conflict management vary significantly across healthcare conflict dynamics. Within dynamics, there is general consistency in overarching goals and broad definitions of success, although differences emerge even here in response to variation in local context.

The interviews and literature reviews produced these responses regarding indicators of success for conflict management:
Table 4. Indicators of Success for Conflict Management

<table>
<thead>
<tr>
<th>Provider - Provider</th>
<th>Pt. – Provider: General</th>
<th>Pt. – Provider: SDM</th>
<th>Pt. – Provider: Adverse Outcomes</th>
<th>Pt. – Provider: Ethics Disputes</th>
<th>Provider – Admin</th>
<th>Patient – Payer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Achieved early phase, low-disruption, internal resolution (avoid involving HR / management)</td>
<td>Improved patient satisfaction</td>
<td>Patients receive treatment they prefer</td>
<td>Ethical duty fulfilled</td>
<td>Honored patient’s wishes</td>
<td>Improved relations with physicians</td>
<td>Transaction settled</td>
</tr>
<tr>
<td>Improved staff morale, less frustration</td>
<td>Improved communication</td>
<td>Patients have realistic expectations for outcomes</td>
<td>Improved patient trust</td>
<td>Resolution of issue achieved</td>
<td>Improved decision making process</td>
<td>Patient satisfaction with resolution</td>
</tr>
<tr>
<td>Improved collaboration amongst healthcare providers</td>
<td>Improved patient trust</td>
<td>Patient is empowered in relationship</td>
<td>Improved patient safety outcomes</td>
<td>Family comfortable with outcome</td>
<td>Productive use of conflict</td>
<td>Clients retained</td>
</tr>
<tr>
<td>Increased efficiency in workplace</td>
<td>Maintain / restore relationships</td>
<td>Increased efficiency</td>
<td>Fewer lawsuits</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Increased buy in to the decision making process, treatment regimen, overall care goals</td>
<td>Protect professional reputation / positive public perception of industry</td>
<td>Avoided unnecessary treatments</td>
<td>Faster resolution</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fewer employee grievances to HR</td>
<td>Fewer formal complaints filed</td>
<td>Lower overall legal expenses</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Greater staff retention</td>
<td>Fewer lawsuits</td>
<td>Less provider stress</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fewer reports of disruptive behavior</td>
<td>Improved patient safety outcomes</td>
<td>Maintain relationship</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fewer medical error root cause analyses point to provider communication breakdown as cause</td>
<td></td>
<td>Learn from errors</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Staff feel more comfortable participating and speaking out at work</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

One of the problems highlighted by interviewees is the difficulty in quantitatively capturing some of the most important impacts of conflict management. They suggested that many of the most important definitions of successful conflict management are hard to measure, especially in the context of provider-provider conflicts. Suggested examples of the types of changes that indicate deeper levels of success include: the workplace is less stressful; relationships have been improved; staff are more engaged in work.
and willing to participate in decision making; and greater awareness and acknowledgement of others’ needs.

The lesson drawn from this diversity of definitions of success in healthcare is that it may never be possible to standardize conflict management goals and definitions of success across different conflict dynamics and contexts. The implication for trainings, interventions, and conflict management systems is that it is crucially important to conduct a robust conflict analysis and needs assessment as part of the design phase so as to identify the most appropriate indicators of success for that particular context.

Indicators tracking patient satisfaction, patient safety, quality of care, cost effectiveness, efficiency, staff satisfaction, and staff retention will increasingly become the common benchmarks against which conflict management systems are evaluated. However, expanding and maintaining support for healthcare conflict management systems, trainings, and interventions requires a persuasive economic argument. Regardless of the ethical or cultural arguments supporting it, without a sustainable business justification at its core, conflict management will forever remain vulnerable in resource-constrained healthcare environments. For this reason, definitions of success and performance metrics, whether made explicit or not, will be indelibly linked with financial impacts.

3. **Theoretical Shift Towards Relational Model**

The interviews highlighted the recent theoretical shift away from the traditional interest-based negotiation model towards relational models of conflict resolution. Interviewees suggested that the emerging relational models move away from negotiated solutions for a bounded conflict event and shift the focus towards ongoing, relationship-based concepts such as trust, respect, recognition, and reputation.
The central role of relationships suggests that genuinely engaging with conflicts in healthcare requires enabling deeper conversations on power, decision making, respect, authority, identity, and perception, themes largely outside the scope of interest-based negotiation models. Approaches emerging from the transformative mediation models may herald forthcoming trends in the field.

One interviewee suggested that definitions of success pointing to recognition (acknowledgement of what health care providers do and of their human limitations), to respect (the desire be respected in their workplace and for their work), and to honorably serving patients (clinical outcome and patient satisfaction) herald the change of focus that may emerge with relationship-based models of conflict resolution. The extent to which such definitions of success will supplant or simply expand upon current expectations for conflict management remains to be seen.

Research and theoretical reflection is required on what it means to step beyond an interest-based negotiation model towards relational models of conflict engagement. What are the implications of this? How does this difference in framework manifest in practice? Does this completely re-conceptualize the goal for a conflict intervention? How can the need for deeper conversations be integrated into healthcare settings with severe time constraints? Theoretical and evaluative research is required to further conceptualize this emerging trend.

4. **Early Intervention: Health Care Workers as the Front Line**

Medical staff will increasingly play a leading role in healthcare conflict resolution as more of the focus shifts to prevention, early recognition and early intervention in conflicts. Clinicians, not ADR professionals, are the vanguard for the earliest interventions. Direct management of conflict will increasingly rest with the growing cadres of healthcare workers trained and empowered to productively engage with the conflicts they witness daily.
Much of what is written about ADR in healthcare involves later stage interventions. Disclosure can be an exception to this, in that it can be launched immediately after discovering an error. Many interventions are only activated once a formal complaint has been made. Further, much of the literature, especially that emerging from the health law field, continues to frame early intervention as more quickly mobilizing external ADR professionals to respond to disputes at earlier stages. These are considerably different conceptions of who is ultimately responsible for engaging with the conflict.

The cutting edge in early intervention conflict management lies not in activating an outside neutral quickly but in increasing the capacity and willingness of parties directly involved with the conflict to redirect the disagreement in a positive way as it is emerging. This refocuses the intervention away from an ADR professional towards better equipping clinicians and health care staff to deal with disputes. Acknowledging this represents a shift in control of the healthcare ADR field.

Furthering this shift in influence, the third party called on to mediate or provide conflict coaching will increasingly be a supervisor or coworker rather than an internal or external neutral. The need for ADR professionals will not disappear, but their roles may gravitate towards mentor and master trainer, enabling others to engage directly. Especially during the transition years, outside ADR professionals will still be required to perform important roles in integrated conflict engagement systems, working as mediators, ombuds, facilitators, conflict coaches, and trainers. Comprehensive systems that utilize tiered responses to conflicts, selectively activate conflict engagement specialists, and intentionally develop advanced skills in conflict-competent leaders form a strong backstop for healthcare providers engaging with conflict on the front-lines.

Finally, the Liaison Physician Model was one of the more interesting approaches that could be adapted for a variety of contexts to improve communication and collaboration in all healthcare relationships. With
relatively little investment of capital or time, this model opens channels for constant, ongoing dialogue that is non-confrontational. Resistance to change is minimized as the approach utilizes structures and systems that many providers are already familiar with. To make participation in a liaison physician model attractive to busy practitioners, the program either needs to be funded or celebrated. Clinician leaders who want to advance in their conflict management skills need to be identified, groomed, and supported. In return, the liaison physician model provides regular opportunities to practice and model conflict management skills, helping leverage change in how that workplace culture engages with conflict.

5. **Education and Training: Opportunities to Create Positive Change**

Education and training were identified throughout the literature and interviews as crucial for creating conflict-competent healthcare cultures. This section outlines ten key findings related to conflict management training and education.

*Opportunities for Training:* The interviews and literature combined to produce a broad picture of opportunities for training. The following table lists a summary of possible training venues:
Table 5: Venues for Conflict Management Trainings in Healthcare

<table>
<thead>
<tr>
<th>Training Opportunity:</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing School</td>
<td>• Basic conflict management trainings as part of communication courses</td>
</tr>
</tbody>
</table>
| Advanced Practice nursing/ nursing management graduate school programs | • Trainings exist in programs for Advanced Practice nurses and nurse administrator courses  
• Some programs (Creighton University Doctorate in Nursing Degree) require nursing students to take 2-3 graduate courses from conflict resolution department  
• Receptive audience as nurse managers expected to negotiate and deal with significant conflict on daily basis |
| Medical School                                | • Medical schools usually fit conflict management-related training in with the communication skills section, so they don’t necessarily label it as conflict resolution  
• 1.5 hour modules on shared decision making piloted at Dartmouth Medical School in communications section  
• University of Michigan has established CR modules for medical school  
• Helps that communication training is now mandated by boards and medical education curriculum—use this as access point  
• Communication courses may still not have as much weight as hard-science courses, so challenges remain to getting more time for teaching communication in med school curriculum |
| Physician Residency                           | • Helps that communication training is now mandated by boards and medical education curriculum—use this as access point  
• 10-day window before start of residency, with captive audience who is receptive to all advice but still before time pressures start  
• Residents in some programs are exposed to shared decision making as part of residency |
| Continuing Education                          | • Need CME and CE credit for courses to make it viable  
• Edelstein—expand to weekends, multiple day courses, etc.  
• In-house staff trainings (for specific unit of hospital, etc) one option  
• Offer different modules of different lengths and levels of advancement |
| Law School                                    | • Can offer joint training with health care providers and executives on health care ADR, esp. disclosure and malpractice |
| Health Administration graduate education      | • Training modules on facilitation, participatory decision making, consensus building  
• Utilize case studies on effective physician-administration engagement  
• Can do joint trainings with health professionals |
| Mentorship / Modeling                         | • Teach older trainers (such as physicians working in teaching settings) who are receptive to the importance of communication and process skills; they will then teach newer medical residents; the selling point is that passing on these important process skills is “part of their legacy”  
• Work through people who have been socialized to value human relationships and communication; this means acculturating people to value quality of care (not just clinical outcomes) and the interpersonal dynamic  
• Establish / support communities of practice  
• Consider adopting the term “co-mentoring” to reduce sensitivities to hierarchy. |
| Bioethics Committees                          | • Opportunity to create conflict management leaders who will model good behavior  
• Conducive to tiered training  
• Reliable forum for training, reflection on conflict, and sharing  
• Limitation: typically low volume of cases per year |
| HR New Employee Orientation Trainings          | • Familiarize all new employees with conflict management systems as part of orientation training  
• Could offer basic CM communication training as part of orientation  
• Use HR trainings to increase awareness about CM systems, opportunities for mentoring/advice, coaching opportunities, etc. |
<table>
<thead>
<tr>
<th>Training Opportunity:</th>
<th>Comments</th>
</tr>
</thead>
</table>
| Institutional Change Initiatives | • Change processes tend to create conflict  
• Typically funding exists for training as part of initiatives  
• Provides context to apply skills learned in training  
• Trainings can be tailored to specific context |
| Management / Leadership Training for health care providers | • For people elevated to positions of increasing authority and management, many feel like they are asked to do things for which they have no training  
• Groom for leadership positions (Mazur said something similar about this in interview) |
| Executive Coaching (conflict competency for executives and senior leadership) | • Leadership often purchase trainings for staff but don’t know or practice the skills themselves  
• Leadership level is important because if they don’t change, then those lower can’t implement their skills |
| Grand Rounds | • Training parameters (time, topic) may be more constrained  
• Existing forum with legitimacy |
| Patient Safety Initiatives | • Important opportunity to use conflict management skills when managing processes of change  
• Can link with training  
• Potential justification of time/money for introducing training |
| Joint Commission Accreditation efforts | • Overarching impact on organization  
• Mandatory so cannot be ignored indefinitely |
| Team building and team training exercises | • Supports mainstreaming conflict management and integrating with broader organizational values; can more closely relate training to existing conflicts in team  
• Training audience can focus on units (i.e. multidisciplinary work teams in ICU) for more targeted impact with potential for longer-term engagement and reinforcement of learning  
• Effective way to overcome silos and build collaboration  
• May help form communities of practice |
Many of these supplements and alternatives to formal workshops on conflict management provide cost- and time-efficient training forums with existing legitimacy. Rotating through various forums for training at shorter intervals can help reinforce the learning from earlier trainings, create important opportunities for mentoring and modeling, and form the basis for communities of practice.

**Partnered Training.** Mixed trainer teams consisting of a clinician with some ADR skills alongside a non-clinician ADR professional can be an effective way for outside trainers to build legitimacy with skeptical providers. This is an opportunity to build in-house capacity when these partnered trainings are nested within a broader training-of-trainers program for the organization. Trainers must be able to speak with authority and understanding of the issues, and be able to answer questions the participants bring up. Linking a clinician (who may lack depth in conflict management but understands the clinical context) and an ADR professional (who has advanced conflict management knowledge but lacks authority on the clinical context) can complement skills nicely.

*In healthcare, time is short!* Trainings must be quick and pass on techniques and skills that let people get to the deeper issues fast. For interest, retention, and legitimacy, trainings must be hands-on with feedback.

**Follow up.** Opportunities for follow-up training and support are necessary. One-off trainings are insufficient, as conflict management trainings won’t stick without longer-term reinforcement. Look to intentionally establish mentorship / modeling relationships (analogous to resident/attending dynamic) and communities of practice, linking these with trainings. Try to connect trainings to broader conflicts or issues the organization is facing, in order to link the training directly with practice opportunities.

**Mentoring and modeling.** Creating opportunities for regular mentoring and modeling of good conflict engagement behavior is crucial for long-term change. Trainings should be imbedded with more systematic opportunities for practice and reflection. Utilizing training of trainer models and identifying clinician
leaders for more advanced conflict management grooming can help infuse conflict management role models throughout the organization, with the potential to create widespread culture change in the organization. Tapping senior clinicians’ desire to leave a legacy can increase willingness to contribute the extra time and effort to become a role model.

*Use Existing Structures to Your Advantage.* Embedding conflict management training within the apprenticeship models of healthcare education can help integrate conflict engagement as a core professional competency. Adopting the term “co-mentoring,” as suggested by Cohn, can reduce sensitivity to hierarchy, increasing the likelihood that senior healthcare practitioners will want to participate.²⁰⁵

*Get People Early.* Introducing conflict management at early stages of medical careers increases the likelihood that positive conflict engagement will become natural for providers. Solidifying the learning requires regular follow-up training. Gaining greater access to the time-strapped medical and nursing school curricula may necessitate regulation from educational accrediting bodies.

*Use Communication Courses as the Access Point:* Communication courses in medical and nursing schools serve as a key entry-point for introducing basic conflict management skills to wide audiences. In order to facilitate this, instructors need to be given the resources to teach basic conflict management. Prepared conflict management modules for health professional schools can make it easier for supportive instructors to incorporate this. Scenarios and role plays similar to those produced (and sold) by educators for use in business school negotiation classes should be developed and made available to the health professional schools.

Continuing Education Credit. Conflict management trainings need to qualify for continuing education credit in order to increase the likelihood that providers will be able to attend conflict management workshops.

How to Promote Conflict Management Training?

The question posed to numerous interviewees, “What makes healthcare providers experiencing conflict want to change / want to attend a conflict management training / buy in to ADR?” produced varied responses. Many said data showing the value of conflict management is important, because healthcare providers are people who tend to think in evidence-based ways. Another interviewee implied that data was useful but stated that people don’t decide to attend trainings or seek help with conflict management based on data. Instead, the drivers are more likely to be fear or a visceral response to concerns with money, legacy, or a job at stake. To reach a larger audience, they suggested conflict management tap in to these drivers.

Another ADR professional noted that building trust in the individuals associated with the ADR activity and in the institution (trusting that it is okay to engage in the process and dialogue) is often a key enabler; providers may feel apprehensive and anxious about getting in trouble as a result of the conflict, so they must be reassured that participation in the conflict management activities does not expose them to extra risk. Creating opportunities for providers to talk with peers who have gone through the process in the past was noted as helpful.

Others noted that skeptical providers must perceive the long-term benefits of participating in a conflict management training or process as higher than the immediate costs, largely time and money. Suggested selling points for skeptics included: stories and case studies illustrating its value; the “quieter, quicker, cheaper” attributes of conflict management; the need to preserve essential professional relationships (as in a
practice group); the ability to control the resolution process, addressing the conflict “within your own culture, among your own kind”; and conflict management not as capitulation but as an opportunity for win-win solutions.

Additional recommendations for promoting conflict management included beginning with medical staff moderates; identifying and grooming clinician leaders who are interested; educating hospital administrators to garner support; engaging risk managers; and educating health law providers. These recommendations matched many of those suggested in the literature.

6. Merging the Cultures of Health Care and Dispute Resolution

Adapting ADR terminology, models, and packaging for the particular cultures of health care will aid in the process of mainstreaming health care dispute resolution.

Do No Harm

Healthcare ADR should increasingly utilize the clinical ethic of Do No Harm to shape the timing and form of ADR interventions. Formal ADR interventions activated through official channels can be disruptive, using staff time, attracting undesired attention, and potentially threatening relationships. This is particularly the case with disputes involving difficult co-workers or superiors. It is almost impossible in the mediation context to prevent the possibility of retaliation against the person who formally filed the complaint; even subtle forms of retaliation can destroy a workplace relationship.

Efforts to minimize such undesirable impacts of ADR interventions may increasingly lead the field away from formal mediation towards informal conflict coaching models and early interventions conducted
entirely by the health care providers involved with the case. This matches a broader trend in the ADR field overall away from mediation-based models towards conflict coaching.

The principle of Do No Harm, traditionally focused solely on patients and families, equally applies to relations with healthcare colleagues. Acknowledging coworkers’ needs has the potential to change systems that sustain disruptive behavior, abuse of power, and damaging hierarchies in healthcare organizations.

The ADR motto “quieter, quicker, cheaper” resonates with this Do No Harm ethic. While quieter and more confidential interventions pose less risk of retaliation, traditional conflict coaching models that ask for serious self-reflection on the part of the participant and a long-term time commitment (often up to a year) to the coaching process will face challenges in a time-constrained healthcare setting. To be relevant to healthcare, conflict coaching may need to explore alternative, less-formal avenues for conflict mentorship that utilize the co-workers and superiors with whom providers already interact regularly.

See One, Do One, Teach One: Familiar Models for Teaching Conflict Management

The learning model of See One, Do One, Teach One is a defining aspect of physician education. Providers are familiar with this learning style and ADR trainings can increasingly utilize this approach to integrate conflict resolution skills into providers’ repertoire. The medical student-intern-resident-attending physician progression in the training of physicians suggests a prototype for building various tiers of conflict resolution expertise within networks of clinical providers. This requires both structured learning opportunities and different types of conflict resolution trainings to address the needs of practitioners at different levels of expertise in the field. Modeling of effective conflict resolution skills, opportunities for practice, guided learning, and regular feedback are important for progressively building expertise.
Formal channels for grooming leaders in healthcare conflict resolution can help institutionalize this model. Those with the interest and aptitude to serve as mentors to others could be selected for conflict resolution trainings at the basic, advanced, and training-of-trainers levels. This approach has the potential to bring about widespread shifts in a workplace and its accompanying professional culture.

Establishing formal or informal communities of practice is another opportunity to facilitate mentorship and guided learning opportunities in healthcare conflict resolution. These communities of practice could take many forms and may revolve around numerous axes. If desired, outside ADR experts can also participate. The key is providing regular opportunities for consultation, sharing experiences, reflection, and reinforcement of learning. For sustainability, the ownership of such communities of practice must rest entirely with the members themselves, though institutions can encourage and support such communities as appropriate.

*Conflict Resolution Mainstreaming: Good Communication as the Entry Point*

To help mainstream conflict resolution in healthcare, conflict resolution practitioners should be willing to re-package their contributions to fit the terminology and cultures of health care. In particular, conflict resolution can actively use healthcare’s concern with “communication” as the entry point for introducing conflict resolution skills and techniques into educational curricula, certified continuing education training, hospital operating protocols, and the overall culture of healthcare.

Conflict resolution fields and healthcare fields often speak different languages. In the face of skepticism on the part of many health care providers towards the value of conflict resolution, terminology is important. Conflict resolution terms describing intangible concepts, relationships, and processes can seem overly “soft,” particularly to those healthcare practitioners trained to systematically analyze and process data. Additionally, in many healthcare contexts much of the dispute resolution field and its terminology has
overly legal connotations that do not match the breadth of skills and techniques that dispute resolution can bring to healthcare.

No health care providers interviewed for this thesis used the terms dialogue, negotiation, mediation, conflict resolution, (conflict) coaching, interests (vs. positions), or neutral during their interviews, even when describing processes that closely involved these activities and ideas. Moreover, many interviewees commented that they do not see or experience “conflict” in their work environment, before proceeding to describe “encounters,” “incidents,” and “experiences” that this author could only describe as conflict.

Instead, healthcare providers have problems with “communication.” “Good communication” was frequently heard as the key phrase in many of the interviews and much of the literature related to healthcare conflict resolution. The term “process skills” was often used when describing techniques of dialogue, negotiation, mediation, and other forms of conflict resolution. The concepts of communication and process skills already have traction within the healthcare field, making them access points for conflict resolution that should be capitalized on.

**Productive Conflict**

Conflict resolution practitioners should more explicitly raise awareness among healthcare stakeholders of the possibilities for harnessing conflicts and differences of opinion as productive and positive forces in healthcare. Given that conflict is a constant and inevitable presence in complex systems of interaction such as healthcare, the recognition that conflict can be embraced as a driver for innovation and improvement can revolutionize how many healthcare providers conceptualize their relationships with others in the healthcare environment. The comments of numerous interviewees and much of the literature suggest that healthcare providers can appreciate the idea of productive conflict, but greater outreach is needed.
Capturing the positive power of different perspectives (productive conflict) may require reconceptualizing the roles of providers vis a vis patients, other providers, and other stakeholders. Relationships based on fear, authority, and dramatic power imbalances involving large gaps in access to information and rigid professional hierarchies make consensus building, participatory decision making and institutional learning more difficult; settings characterized by such relationships will struggle to manage conflict productively. Supporting trends towards acknowledging the humanity of healthcare providers, recognizing their very human limitations on knowledge and mistakes, and understanding the constraints and responsibilities of other actors in the healthcare system will help open avenues for embracing complexity and capitalizing on the presence of different perspectives.

Conflict resolution professionals can help providers learn how to embrace certain types of conflict by highlighting how conflict already functions positively in their everyday activities. Disclosure of adverse outcomes has proven a powerful force for improving the systems and protocols that allowed those events to occur. Facilitating structured dialogue between administrators and different types of provider groups spurs creativity and deepens understanding of complex systems. And providers increasingly embrace the questions and observations of patients and fellow providers as a resource to alert the provider to key developments or information that they may have missed. Using these contexts to illustrate positive conflict can help health care providers reframe how they view disagreement and recognize how they can productively harness it.

*Dispute Resolution: Not Just for Lawyers*

Further integrating conflict resolution into the healthcare context is likely to expand the definition of what it means to be qualified as an ADR professional. As clinicians increasingly complement then supplant legally-trained ADR professionals as the front line in healthcare conflict management, the emphasis and approach of healthcare ADR may shift. Healthcare providers bring new perspective, training, and
professional culture to healthcare conflict management that may generate unique frameworks for interaction, different conceptual insights, and alternative educational and training avenues for establishing credibility as an ADR expert.

*Increased Collaboration between clinical staff and non-clinical ADR professionals*

Clinical staff can play important roles in designing, conducting, and interpreting future research in healthcare conflict resolution. Increasing the feedback, exchange of ideas, and collaboration between non-medical ADR professionals and clinical staff will help improve healthcare conflict resolution systems, interventions, and trainings. Accessing clinicians’ perspectives will advance the field as they help reality-check non-medical ADR professionals regarding the conflicts frontline medical responders regularly face, how they are actually using conflict resolution skills in these conflicts, their experiences with various techniques, barriers to implementation, unmet needs, and suggestions for improvements.

7. **Suggested Future Research**

Following are suggestions for future research. On all topics, it is recommended that the healthcare conflict resolution field explore how to better capture its qualitative data, while also looking to expand the quantitative data that is being collected.

*Relationships:* Qualitative research is needed to capture the long-term impacts of conflict resolution on the change in relationships in healthcare. Such research will be particularly valuable to help explore the implications of the conceptual shift away from interest-based models towards relationship-based models. Deconstructing the dynamic between conflict and relationships will be challenging but offers valuable insights that may produce new models, frameworks, and designs for conflict management systems. What does it mean to shift from interest-based models to relationship-based models? What does it change about
how we approach the paradigm of healthcare conflicts? What defines success with relationship-based conflict resolution? These and related conceptual questions will be at the front of forthcoming conflict resolution research.

*Training Impact:* Research is needed to measure the long-term impacts of conflict resolution training in the curricula of nursing schools, medical schools, residencies, and inter-professional trainings. Exploring the impact of modeling and the medical residency experience on the retention of conflict management skills learned during medical school could be part of research focused on when to best target conflict management training (during professional school, residency, or continuing education). Additional research questions include the impact of mandatory versus elective training; the long-term impacts of different training delivery mechanisms (online, structured mentoring, experiential workshop, etc.); and ways to combine training with coaching and intentional communities of practice.

*Costs of Conflict:* Measuring the actual costs of conflict call for mixed methodologies. Claims that providers spend 50% of their time in conflict carry enormous financial implications for the healthcare field. Disaggregating how this time is spent and documenting the time and money lost to conflict is an important research topic.

*Complex Systems Research:* Complexity and complex systems research have emerged as important topics of study in a variety of disciplines. Healthcare is a prime example of a complex adaptive system and certain aspects of healthcare have been examined through a complexity lens. However, there remain opportunities to more explicitly explore the link between healthcare conflict and system complexity. Such research may offer additional perspectives on the possible role of human relationships as the backbone linking many otherwise disparate processes and support structures in healthcare.

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Healthcare Delivery Science and Conflict Management: The restructuring of healthcare delivery systems is transforming relationships between healthcare providers. Healthcare conflicts and efficient responses to them are crucial components of these new systems. Healthcare delivery science and its relationship to healthcare conflict will continue to grow as a robust arena for future research.

Conflict Management Impacts: Further research is needed to strengthen the claim that effective conflict engagement causes:

1. Improved clinical outcomes
2. Increased patient safety
3. Increased patient satisfaction
4. Increased staff retention / improved staff morale
5. Financial benefit to a practice/facility/system (lower costs, higher revenues)
6. Time savings for providers

Such research will need to define what is meant by effective conflict engagement and what aspect of conflict engagement is being measured by the research.

Certain aspects of healthcare dispute resolution call for research that addresses questions in addition to those above.

Disclosure: Research specific to disclosure movements is needed to measure:

1. The difference in impact between full-apology disclosure and partial-apology disclosure.
2. The financial impact of proactive full disclosure programs, in the actual experience of institutions implementing such programs. Measuring how proactive disclosure alters the number of malpractice cases filed and affects settlement rates and compensation costs will be particularly valuable.
Shared Decision Making: Research on Shared Decision Making is needed to document the impact that the use of shared decision making aids has on:

1. Altering the amount and quality of time different types of providers spend with patients
2. Operation rates for specific preference-sensitive procedures

Disruptive Behavior: Further research is needed on the claims that:

1. Disruptive behavior negatively impacts patient safety
2. Disruptive behavior negatively impacts staff retention

Accompanying research can help quantitatively measure the costs associated with all of these changes arising from the conflict intervention.

Increased Publication of Stories and Findings

There is a continued need for healthcare conflict resolution professionals to share experiences, case studies, and success stories to a wider audience. Numerous interviewees cited their desire for case studies illustrating that process skills (in negotiation, mediation, dialogue, active listening) work in healthcare. Other professionals expressed their desired to learn more about innovative approaches to conflict emerging from different groups in healthcare (nurses, physicians, administrators, insurance providers, hospitals, managed care organizations, etc.), from different geographical regions, and from people working on different aspects of conflict in healthcare.

Numerous interviewees suggested collecting case studies and success stories into a book targeted for health care providers, especially cases illustrating how effective conflict engagement led to profound impacts or widespread culture change in a healthcare context.
A second recommendation is to assemble case studies and project them into conflict resolution teaching modules that could be utilized as part of a medical school or nursing school course on communication. Negotiation scenarios designed by various business schools for purchase/use by other instructors teaching courses on negotiation serve as an example of how such conflict resolution scenarios could be designed and used.
CONCLUSION

The findings suggest that dividing healthcare conflict into relationship-based categories of conflict is appropriate due to significant differences in the types of conflict experienced in these dynamics and the corresponding differences in conflict management goals and interventions. Conflict management interventions in all of the four dynamics largely shared the aims of improving relationships, improving communication, and saving money, though each dynamic included additional aims. Specific definitions of success varied, at times widely. There is a noteworthy difference in context and perspective between two of the largest categories of healthcare conflict, patient-provider adverse outcome conflict and provider-provider conflict. Patient-payer conflict interventions differed from the others in being less relational and more transactional. Early intervention in conflict management was important in all dynamics.

The literature review and interview data also identified important contextual features of healthcare conflict. The impact of healthcare culture and its professional subcultures on conflicts and conflict management is significant. The conflict management roles of healthcare providers vary significantly in different dynamics and at different stages of intervention, though they are increasingly expected to play leading roles in conflict management across all dynamics. While facilitation and conflict coaching interventions were prominent in all dynamics, only in adverse-event disclosure was mediation a prominent model for intervention. All other trends pointed towards early stage, healthcare provider-led interventions.

Important trends in healthcare conflict management identified by the research include an increased focus on relationships and relationship-based approaches to conflict management; a reorientation towards prevention and early intervention; increasing expectations that healthcare providers lead on conflict engagement, supplanting third-party intervention models; attempts to better align conflict management with healthcare identities, the principle of Do No Harm, and the See One, Teach One, Do One educational model; new forms of conflict management education involving mentorship/modeling and the formation of intentional
communities of practice; shifts towards less formal conflict coaching over more formal mediation; increased needs for conflict management skills for use in difficult conversations arising from mainstreaming of adverse event disclosure policies.

The research suggests that practitioners increase the amount of collaboration between ADR professionals and clinicians on conflict management research and training design; expand the scope of conflict management systems to include other types of conflict that may currently be ignored; integrate conflict management systems with HR and leadership structures; support communities of practice; ensure that conflict management systems are structures are visible and understood by all staff; look towards less disruptive models of intervention that are more aligned with healthcare culture; and accommodate the shift towards healthcare providers as the front line in healthcare conflict management.

The suggestions of this thesis carry the following policy implications: adapting the national-level and state-level legal frameworks affecting adverse outcome disclosure to promote apology and minimize structural disincentives to transparency; including skills for effective conflict management as professional competencies for healthcare providers; mandating modules on conflict management in professional schools and residency programs; enabling conflict management trainings to qualify for healthcare providers’ continuing education hours; enforcing the Joint Commission standards for conflict management systems in organizations; funding further research on healthcare conflict; and national-level funding for pilot conflict management programs with extensive data collection and publicly-available results.
BIBLIOGRAPHY


Cohn, Kenneth. “Medical Staff Relations.” *San Diego Physician.org* (June 2008): 24-32.

“Collaborative Co-Mentoring.” Online article (July 18, 2008) available at  
http://healthcarecollaboration.com/collaborative-co-mentoring/.


“Conflict Management Training for Health Care Professionals.” *ACResolution* (Spring 2003).


“Bad Modeling.” *Health Affairs* 26, no. 3 (May/June 2007): 903.


