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An Intentional Conversation About Conflict Resolution in Health Care

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An Intentional Conversation About Conflict Resolution in Health Care

James R. Coben[1]

On November 8-10, 2007, the Dispute Resolution and Health Law Institutes at Hamline University School of Law hosted "An Intentional Conversation About Conflict Resolution in Health Care," the fifth biennial Hamline Symposium on Advanced Issues in Dispute Resolution. The symposium series brings together scholars and professionals to engage in purposeful conversation around critical issues in the field of conflict studies and dispute resolution. No papers are presented and, although certain individuals are given responsibility as theme leaders[2] to frame, open up, and promote the dialogue, the active participation of all attendees is encouraged by the use of intimate in-the-round seating. Participants are encouraged to submit post-symposium reflections -- the result is the compilation of 13 essays that follow this introduction.

The 2007 Symposium theme was chosen based on recognition that the American health care system affects every man, woman and child in our country. It encompasses over 16% of our Gross Domestic Product.[3] Costs of care continue to rise and insurance premiums routinely increase at alarming rates.[4] Regulators and health care managers impose policies that affect medical decisions and access to treatment. Advertising and internet research drive patient medical requests while the threat of malpractice claims impacts physician judgment and decision-making. Ultimately, fewer Americans can afford the high price of

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[1] James R. Coben is professor of law and director of the Dispute Resolution Institute at Hamline University School of Law.

[2] A list of symposium theme leaders is contained in Appendix One.

[3] Health Insurance Cost Fact Sheet, National Coalition on Healthcare, http://www.nchc.org/facts/cost.shtml (last visited Apr. 1, 2008).

[4] *Id.*

health services and many feel disengaged from crucial health and life decisions.

At the same time, we hold onto important myths about our system: that doctors and patients are still in charge of our medical decisions; that the American system promotes egalitarian principles of fairness and open access to the finest care in the world; that individual citizens have real choices about the management of their health; and that health care professionals work collaboratively. This intractable clash between myth and reality has consumed policy-makers and fueled conflict at many levels for years.

This clash between myth and reality is even more complex in light of our rapidly changing society. Health care decisions are influenced by different and competing value systems: an increasingly diverse and aging population of patients; a growing universe of traditional and non-traditional health care providers; the ever-expanding role of third-party payors; suppliers promoting rapidly changing technologies and marketing directly to patients; policy-makers who promote increasingly divided ideologies and regulators caught in the middle. The result is an overwhelmingly complex set of challenges that provoke conflict at all levels.

Recognizing that the system cannot be easily "fixed" or the problem "solved," the Symposium specifically focused on how health care professionals and conflict resolvers can work together to identify essential guiding principles for addressing conflicts across the health care field. Participants included 80 nationally recognized representatives of patients, health care providers, payors and regulators together with experienced conflict resolution professionals.[5] The two-day conversation was divided into four discrete sessions:

[5] A list of symposium participants is contained in Appendix Two.

Session One: Building a Context for Conversation – What Makes Health Care Conflicts Different?

Given the complexity of health care, the challenge of where to begin addressing its conflicts is daunting. Session one built a context for the conversation by framing key questions to help participants discern the scope and complexity of health care conflicts. Core questions addressed included:

- What role does increased patient access to information and the proliferation of direct advertising play in creating conflict?
- How do increased patient life-span and rapidly improving, yet costly, technologies increase conflict?
- How does the life-and-death nature of health decisions impact decision-making and conflict?
- What is the impact of the uninsured segment of the population on health care decision-making?
- What are the inherent tensions between patients, providers, payors and regulators?
- How do the economic peculiarities of the health care field complicate decision-making at all levels?
- How does the health care field's heavily regulated environment – including mandatory reporting -- impact disputes and disputing?
- Is the care of health an entitlement that changes how we understand/address conflicts?
- How does the culture of health care contribute to adverse outcomes that result in inter- and intra-organizational conflicts?
- How will a decreasing availability of experienced health care professionals impact conflict within care settings?

Session Two: Developing Guiding Principles for Addressing Patient Care Disputes.

Patient-provider conflicts arise from a range of situations, including adverse outcomes, treatment timing and location, decisions over appropriate treatment plans, whether and when to discontinue treatment, and many others. These tensions are exacerbated by existing conflicts among health professionals within patient-care settings. This session focused on representative examples of patient care challenges and provided a forum to identify principles for constructive resolution of such conflicts. Theme leaders modeled a conversation about how to identify conflict resolution principles, followed by small group break-out sessions where participants collaborated to develop helpful principles for addressing such conflicts.

Session Three: Developing Guiding Principles for Health Coverage Disputes.

An ever-increasing number of conflicts in the health care field arise in relation to coverage. A patient's request for a specific drug or treatment often results in a conflict seen through a variety of lenses: that of the employer who seeks to contain costs; the payor who carefully designs coverage limits; the regulator who weighs in on what constitutes mandatory benefits; the patient who expects treatment to be covered, and the provider who struggles with managed care guidelines, ethical responsibilities and stringent fraud and abuse laws. Additional complications arise in cases of poor quality care, where questions surface of who, if anyone, should pay and what information should be provided to patients about these disputes. The different perspectives of patients, providers and payors create profoundly different expectations and understandings of what can and should be done regarding health coverage. Following an opening conversation about the challenges

of coverage disputes, participants again met in small groups to identify principles for constructive conflict resolution.

Session Four: Developing Guiding Principles for Addressing Disputes in the Area of Provider Competency.

A third category of conflicts in the health care field arises in relation to provider competency. Here, the discussion focused on provider conflicts, including those over the granting of "privileges" and credentialing of practitioners by hospitals; the complaint and discipline process by health licensing boards; and the credentialing (and de-credentialing) of providers by managed care organizations. In small groups, we examined how conflict resolution is impacted by the peer review privilege, current credentialing mechanisms, mandatory reporting obligations and physicians' ethical obligations.

Synthesis and Key Principles

A concluding plenary offered opportunity for synthesis and sought to identify an over-arching set of principles for creating effective dispute resolution systems in health care. What emerged were eight key principles, summarized in draft form as follows by Hamline Professors Lucinda Jesson and Rob Routhieaux for inclusion in the soon-to-be published post-symposium booklet "Guiding Principles: Developing Effective Conflict Resolution Systems in Health Care"[6]:

An effective conflict resolution system in health care --

1) Centers on the Patient: Patients can fully participate in

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[6] GUIDING PRINCIPLES: DEVELOPING EFFECTIVE CONFLICT RESOLUTION SYSTEMS IN HEALTH CARE (Lucinda Jesson, Barbara Columbo, & Rob Routhieaux, eds, forthcoming Spring 2008) will be jointly published by the Dispute Resolution and Health Law Institutes at Hamline University School of Law and is intended for widespread dissemination in the health care industry. For information on how to obtain copies of the report, please visit http://law.hamline.edu/health/health-law-2007-symposium.html.

resolving disputes only where they can overcome the information imbalance and vulnerabilities that illness thrusts upon them. Enhanced communication and streamlined processes are central to achieving this goal. Patient advocates may be useful in many settings.

2) Recognizes and Addresses Disputes Within the Health Care Team. Patients are safer when teamwork is effectively practiced. Yet teamwork is not standard in health care. One tool of dispute resolution-- mediation --has been particularly effective in addressing workplace disputes where there is a shared interest in good outcomes. Even where formal mediation is not undertaken (and given the high stakes/tight time constraints of health care delivery that may be often), mediation skills such as active listening, expression of empathy, identification of mutual interests and concerns, reframing and a focus on verbal and non verbal messages will promote quicker informal resolution among team members. These skills will help team members more quickly recognize the existence of conflict and the opportunities to put in place effective mechanisms of dispute resolution.

3) Places Individual Conflicts in the Broader Health Care Picture. Moral hazard, in its many manifestations, should be eliminated. Patients who spend more than optimal on care because they are not directly paying the bills and physicians who order marginal tests or prescriptions need a dispute system that compels them to look beyond their individual circumstances to consider the collective burden their decisions place upon the health care system. Payors facing coverage disputes may need to look beyond the contractual language governing an individual procedure (the immediate bottom line) to determine whether the procedure serves health and efficiency in the long term. In short, parties to a dispute need to recognize the cumulative impact of their behavior as part of the resolution process.

4) Promotes Communication Skills and Professionalism. Most regulatory systems focus on measuring technical competence rather than the ability to work within a complex system. Creation of a relationship centered dispute resolution

system depends upon improved listening and communication skills. This requires individual providers to acquire a set of interpersonal competencies that extend well beyond medical expertise. While this training begins in the education setting, it must continue within the workplace (i.e. hospital health plans) and be assessed in both the employment and licensure settings.

5) Exudes Transparency. A culture where communication flows freely needs to be created. Even where privacy concerns limit transparency as to facts (i.e. sharing the personnel record of an employee), transparency as to the conflict resolution process is possible. Transparency will not occur unless providers and plans succeed in their attempt to communicate in the clearest possible manner. Documents and discussion should be as free of acronyms, industry-speak and bureaucratic language as possible so that the information is truly available to all.

6) Encourages Timely Truth Telling and Acceptance of Responsibility. Patients have a right to understand as quickly as possible what happened when an unanticipated outcome occurs. Often, in the immediate aftermath, health care providers may not understand the answer themselves. But rather than accede to a "culture of silence", immediate steps should be taken to share what is known to describe what will be done to investigate what occurred (including the role the patient may play in the review), and to provide a timeline so that the patient will know when to expect a more complete report. Factual information should be shared when the review is complete. If mistakes were made, apologies and explanations for what steps will be taken to prevent the mistake from happening again should be forthcoming.

7) Focuses on "How Did This Happen" Rather Than "Who Did It". Only with a restorative, rather than punitive, approach can real change happen. A conflict should be reviewed from the assumption that mistakes at the heart of the dispute most likely are system mistakes, rarely placed at the foot of any one individual. Where an individual is at fault, remediation rather than a disciplinary approach should be the focus whenever possible. A "root cause" analysis including cultural,

communication and broader competency problems should be applied to a conflict, and not just the investigation of medical errors.

8) Recognizes the Centrality of Emotion. Empathize with the patient and, where appropriate, the provider. Apologize if mistakes were made. Sympathize in difficult situations regardless of cause. Create a process that provides for this interaction and which applies in patient care, payor and provider competency disputes. To honor this principle, more than a "paper review" may be required in grievance and appeal settings, as well as in other health care disputes.

Post-Symposium Reflections

In the collection of post-symposium essays to follow, you will find these principles referenced directly and indirectly, as well as a number of additional themes explored. In the opening essay, Diane Hoffman hypothesizes that while healthcare conflicts do have unique features, the conflict is not necessarily more difficult, complex, or challenging than other types of disputes.[7] She specifically compares physician-patient and lawyer-client conflicts, finding them more alike than different.

As a counterpoint, David Matz's short essay makes a convincing argument that "invisible" conflict is ubiquitous in health care, poses special challenges for identification and resolution, and merits investigation because it can result in professional error and harm to patients.[8]

Four different authors then explore specific barriers to conflict management innovation. Dr. Jay Hoecker posits that the design and implementation of conflict resolution systems must

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[7] Diane E. Hoffman, *Are Health Care Conflicts Really All That Different? A Contrarian View*, 29 HAMLINE J. PUB. L. & POL'Y 235 (2008).

[8] David Matz, *The Inevitability and Perils of "Invisible" Health Care Conflict*, 29 HAMLINE J. PUB. L. & POL'Y 243 (2008).

involve physicians in order to succeed.[9] He also systematically catalogues the many barriers -- cultural, organizational, and personal -- that inhibit physician participation in conflict system design.

John Conbere and Alla Heorhiadi focus on the individual and organizational reasons why physicians might have tendencies that make it harder for them to utilize interest-based conflict resolution processes, such as principled negotiation, mediation, and collaborative decision-making.[10] Conbere and Heorhiadi go on to describe in detail a physicians leadership curriculum designed to encourage a shift from authoritarian to adaptive leadership in health care organization management.

Dr. Armand H. Matheny Antommaria brings a practitioner's perspective to bear in speculating on how interest-based approaches to dispute resolution hold promise for success in overcoming a range of patient-provider conflicts.[11] According to Antommaria, the contemporary approach to assessing medical residency program effectiveness through core competency emphasis on skills and attitudes provides a natural bridge to introducing negotiation training to complement the interpersonal and communication skills education traditionally focused on such topics as breaking bad news or discussing advanced directives.

Four essays next examine various aspects of doctor-lawyer collaboration. First, Bobbi McAdoo suggests that the ADR movement's modest success in changing the standard philosophical map of lawyers may provide a path for similar improvement in

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[9] Jay L. Hoecker, MD, *Guess Who's Not Coming to Dinner: Where are the Physicians at the Healthcare Mediation Table?*, 29 HAMLINE J. PUB. L. & POL'Y 249 (2008).

[10] John Conbere & Alla Heorhiadi, *Preparing Physicians to Manage Conflict, or, How the Physician Leadership College Teaches Physicians to Use Interest-based Processes*, 29 HAMLINE J. PUB. L. & POL'Y 261 (2008).

[11] Armand H. Matheny Antommaria, *How Can I Give Her IV Antibiotics at Home When I Have Three Other Children to Care For? Using Dispute System Design to Address Patient Provider Conflicts in Health Care*, 29 HAMLINE J. PUB. L. & POL'Y 273 (2008).

physician communication, listening skills, and conflict resolution participation.[12] According to McAdoo, two specific components of mediation skills training -- 1) the distinction between "positions" and "interests"; and 2) the emphasis on communication skills, specifically "active listening." -- were instrumental in freeing lawyers to re-conceptualize their role in conflict. The same principles, she argues, should be at the center of conflict education for physicians.

Second, Charles Wiggins makes a convincing case that disruptive behavior by both doctors and lawyers is more than just unpleasant, but inherently "counterproductive, injurious to others, and corrosive of the aspirations at the core of both disciplines."[13] He argues that clinical legal education provides a model for professional training that best addresses the tension between preparing for a successful career in law or medicine and simultaneously "keeping alive the interpersonal dynamic so critical to the altruistic and empathic aspects of the work."[14]

Third, Linda Morton, Howard Taras, and Vivian Reznik explicitly advocate for cross-disciplinary cooperation and education.[15] They critically examine medical and law school standards of accreditation, noting that both stress the teaching of communication skills, albeit only with clients and patients, or members of their own profession. According to Morton, Taras, and Reznik, the path forward to close the professional gap between doctors and lawyers is for the leaders of each profession "to create standards specifically encouraging, if not mandating, inter-

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[12] Bobbi McAdoo, *Physicians: Listen Up and Take Your Communication Skills Training Seriously*, 29 HAMLINE J. PUB. L. & POL'Y 287 (2008).

[13] Charles B. Wiggins, *"He's Such a Jerk": Education as a Response to Professionally Inappropriate* Behavior, 29 HAMLINE J. PUB. L. & POL'Y 299, 315 (2008).

[14] *Id.*

[15] Linda Morton, Howard Taras, & Vivian Reznik, *Encouraging Physician-Attorney Collaboration Through More Explicit Professional Standards*, 29 HAMLINE J. PUB. L. & POL'Y 317 (2008).

professional communication and collaboration in their professional training."[16]

Finally, Charity Scott takes the concept of doctor-lawyer collaboration even further with a provocative and exceedingly well-documented counterintuitive analysis of doctors as advocates and lawyers as healers.[17] "What would conflicts look like?" she asks, "if patients were cared for by doctors who viewed themselves as healing advocates...[and] if patients and their providers were represented by lawyers who viewed themselves as zealous healers?"[18] Her self-declared goal -- "to nudge both professions toward adopting and internalizing these alternative and perhaps counterintuitive self-images."[19]

The next pair of essays endorse specific initiatives for innovation in managing health care conflicts. Dale Hetzler and Carly Record offer a compelling argument that systematic improvement will only come if hospital boards of directors make conflict resolution a board priority.[20] Boards should, according to Hetzler and Record, promote processes and policies to address communication breakdowns and organizational conflict with the same care and deliberateness they routinely use to address clinical failures.

One possibility for boards to consider is the Medical Ombuds/Mediator (MedicOm) program described by Carole Houk and Lauren Edelstein.[21] The integrated conflict management system they detail promotes open communication and information transparency, encourages apologies and prompt remedial action

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[16] *Id.* at 319.

[17] Charity Scott, *Doctors as Advocates, Lawyers as Healers,* 29 HAMLINE J. PUB. L. & POL'Y 331 (2008).

[18] *Id.* at 397.

[19] *Id.*

[20] Dale Hetzler & Carly Record, *Healthcare Conflict Management: An Obligation of the Board,* 29 HAMLINE J. PUB. L. & POL'Y 399 (2008).

[21] Carole S. Houk & Lauren M. Edelstein, *Beyond Apology to Early Non-Judicial Resolution: The MedicOm Program as a Patient Safety-Focused Alternative to Malpractice Litigation,* 29 HAMLINE J. PUB. L. & POL'Y 409 (2008).

once system failures are identified, and holds promise to have deep impact on the way patients and their families respond when medical errors occur.

The two concluding essays address the broad and complex challenges posed by coverage disputes and health care payment models. David Reimer explains why the health care market is an anomaly, where the absence of real consumer choice and lack of monetary incentives and accountability combine to increase, rather than reduce provider error.[22] He challenges ADR professionals to bring their skills to bear in forging legislative compromise. Who better, he asks, than trained professionals to cross "the rubicon that divides individual disputes from societal disputes."[23]

James Jacobson looks at the problem from a provider's perspective, concluding the symposium collection with a prescription detailing health plans' responsibilities in making decisions and resolving disputes and the members' responsibilities when disputes do arise.[24]

On behalf of the symposium planning team, I would like to thank the theme leaders, symposium facilitator Ken Fox, and all of the symposium participants for their willingness to engage in the conversation that inspired these reflections. Special thanks to the authors and to the law journal staff for their tireless efforts to bring the reflections to print. And, a special debt of gratitude is owed by all to Kitty Atkins, Debra Berghoff, and Marcia Miller. Without their invaluable administrative support and good spirit, it would have been impossible to host the symposium.

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[22] David Reimer, *Follow the Money: The Impact of Consumer Choice and Economic Incentives on Conflict Resolution in Healthcare*, 29 HAMLINE J. PUB. L. & POL'Y 421 (2008).

[23] *Id.* at 41.

[24] James P. Jacobson, *To Pay or Not to Pay, That is the Question: Coverage Disputes Between Health Plans and Members*, 29 HAMLINE J. PUB. L. & POL'Y 443 (2008).

Appendix One: List of Symposium Theme Leaders

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Charity Scott, Professor of Law and Director for Center for Law, Health & Society, Georgia State University School of Law

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Dr. James N. Thompson, President and CEO, Federation of State Medical Boards

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