

IN-HOUSE CONFLICT RESOLUTION PROCESSES: HEALTH LAWYERS AS PROBLEM-SOLVERS

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Conflict is inevitable in healthcare. Disputes easily arise over adverse outcomes, medical necessity and payment determinations, peer review actions, quality evaluations and clinical care decisions, to name a few. Employment relationships between hospitals and physicians are another source of challenges. Although hospital-physician conflicts are not necessarily more frequent or more important, they can illustrate the ways in which health lawyers must understand the role of conflict in healthcare, and the need to build solid, user-friendly structures for conflict resolution into these relationships. Those structures are the focus of this article.

In the case discussed below, numerous issues arose after a hospital purchased a physician practice. The relationship ended in “divorce” – a dissolution of the employment arrangement. This article proposes that built-in conflict resolution processes, ranging from on-the-spot problem solving to formal mediation, might have instead permitted the parties to resolve these problems amicably. Finally, the discussion distills specific suggestions for health lawyers.

Background: The Rapid Rise of Physician Employment

Hospitals need broadly integrated networks to create Accountable Care Organizations, increase market share, collect facility fees for outpatient services, maximize revenues, minimize readmissions, and control healthcare processes to meet the enhanced quality and satisfaction expectations built into Value-Based Purchasing arrangements.²

Physicians, for their part, want better job security, improved work-life balance and reduced time spent on the business side of medicine. Many also hope to avoid paying for the high-cost electronic medical records (“EMRs”) now imperative in their practices.

In 2013 around 26 percent of physicians were employees rather than independent contractors, up from 20 percent the year before.³ In an even higher estimate, the Medical Group Management Association reports that more than 50 percent of physicians are employed by organizations affiliated with health systems, and in some specialties the figure may be as high as 75 percent.⁴

These relationships are not guaranteed to survive. As readers with a few gray hairs may recall, a tidal wave of such alliances in the 1990s was quickly followed by a tsunami of “divorces.”⁵ The same scenario could reappear if these new employment arrangements do not incorporate adequate mechanisms for resolving conflicts. Health lawyers need to play a major role not just in building these relationships, but also in preserving them. The following case illustrates how badly these relationships can go awry and how conflict management can prevent that.

Anatomy of a Divorce: A True Story⁶

Dr. Graham Keswick is a pediatric gastroenterologist who contracted to sell his practice to, and become an employee of, a large multi-hospital system. After years spending too much time on the business side of medicine, he just wanted to be a doctor. He also saw the trends towards consolidation in healthcare and felt he had little choice but to join a

hospital system. He sold his practice, including office equipment and furniture, in exchange for a fairly substantial sum of money and an employment contract. Unfortunately, the “honeymoon” was quickly over.

Staffing Issues

The hospital required all employed physicians to use hospital office and nursing staff. For a large system to work well across many service lines, the hospital needed staff who would implement consistent policies to ensure the best quality and efficiency of care while enabling employees to know what was expected of them. The hospital also needed to have a pool of well-trained staff so that, if any area in the system needed to add personnel, employees could step up at a moment’s notice. Additionally, the hospital’s nepotism policy precluded Keswick’s wife and daughter from continuing to work for him.

To Dr. Keswick, the hospital treated its staff like interchangeable cogs. Every few days he saw a different set of nursing and office staff. He was constantly trying to navigate his repeatedly rearranged exam rooms and patient schedules. His patients and families had come to expect certain amenities, like a personal reminder the day before each appointment – not the automated call they now received. Longer waiting times and disappointed expectations sent some of them elsewhere.

Hospital administrators saw these events as the adjustments familiar in every physician practice acquisition; such kinks tended to smooth themselves out quite rapidly. For Dr. Keswick these problems were new and upsetting. Of particular concern was that staff left each day right on time. Important work sometimes remained unfinished in ways Dr. Keswick could not detect until a problem cropped up.

If a nurse was entering information into a patient's chart and the day ended before she'd entered the latest lab values, those lab values might not be added until later. If a different set of staff came in the next day, unfinished tasks might not be passed along at all to the next person.

Per hospital policies to promote "teamwork," after each mishap Dr. Keswick was expected to take the responsible person aside, explain the error, smile, and then let him or her return to work. The hospital knew that mutually supportive, respectful relationships were essential for patient safety and satisfaction, and for effective and efficient delivery of care, and that this mutual respect must include physicians. The problem for Dr. Keswick was that he spent enormous amounts of time educating staff to correct all those glitches in the office's workflow. Worse, as soon as one crew learned his in-house routines, it was replaced by newcomers. Finally Dr. Keswick lost all patience. He expressed his frustration vehemently, and was then written up for "disruptive behavior." Eventually the hospital did assign a single set of nursing and office staff to Dr. Keswick's office. The hospital would have done so earlier had it known how troubled Dr. Keswick was about the situation.

Computer Systems

Healthcare providers must now adopt EMR systems. Dr. Keswick's hospital committed to this transition earlier than most, and undertook a careful, systematic rollout in all of its facilities and practices. Problems arose at every stage, and the hospital addressed them as quickly and thoroughly as possible. Implementing such a system is incredibly complex, and it was simply not possible for the hospital's IT department to solve every problem immediately. It had to prioritize according to patient safety needs, the seriousness of the problem, and comparable factors.⁷

Dr. Keswick had used EMRs since the 1980s for both billing and patient

care. Understandably, the hospital required that he now use its system. Unfortunately, the two systems were completely incompatible, and no software could transfer Dr. Keswick's old records to the new system. Many of his patients have chronic illnesses, and he needed rapid access to past information. To read old records he had to log out of the new system, log into the old to view the information, then log out of it and back into the first. The exercise was endlessly frustrating and time-consuming.

The hospital could not afford to provide someone to transfer all of the old information, entry by entry, into its software, and neither could Dr. Keswick. The best solution he could devise was to print each page of the old records and scan it as a PDF that was captured in the new system. Unfortunately, these records could not be internally searched. If Dr. Keswick wanted to find out what happened during a patient's episode of pancreatitis several years ago, he had to guess at the probable date, then read every page until he found the needed information.

The software switch also created serious medical hazards. Dr. Keswick is a pediatric specialist and his former EMR system recorded patients' weights in kilograms. Pediatric drug doses are set according to the patient's (metric) weight, so the proper units are essential for pediatricians. The hospital's standard EMR system recorded patients' weight in pounds, not kilograms. The hospital willingly changed that feature for Dr. Keswick's office.

Unfortunately the change precipitated a new problem. On one recent occasion the hospital-supplied nurse, accustomed to recording weight in pounds, entered "30" into the space marked "weight" for a three-year-old child. The 30-pound child's weight was then deemed by the system to be 30 kilos, or 66 pounds. The resulting drug prescription would have overdosed the child twofold. The error

was a very human slip, but had Dr. Keswick not caught it in time it could have been fatal. Dr. Keswick anxiously wonders how many other such errors are out there, as yet undetected. Over the course of nearly a year, the ever-changing staff could have made this kind of mistake numerous times, with little chance of discovering it until a patient's return visit shows an incorrect dosage. The scenario is particularly frightening for patients with chronic illnesses requiring multiple medications.

In yet another software issue, the hospital's billing system requires that all information be complete and clear in the chart, and that the chart then be "locked" for a particular episode of care before billing can be submitted to the appropriate payor. Payors have come to insist on this because late-breaking changes in patients' medical records and accompanying invoices can cost considerable time and money to rectify. However, because EMR and staffing issues led to errors in Dr. Keswick's office, and because some of the errors were not spotted until clinical problems arose later, Dr. Keswick did not want to "lock" a chart (and potentially expose himself to liability) until considerable time had passed. Hospital administrators hesitated to contact Dr. Keswick about this; as the relationship had become strained, they did not want to add friction. Nevertheless, they grew increasingly annoyed with his seemingly chronic "tardiness" in completing/locking his charts. Indeed, the problem had gone on for nearly a year before Dr. Keswick learned that most of his billings were on hold.

Productivity Targets

Dr. Keswick and the hospital also clashed over productivity demands. He was reconciled to the Relative Value Unit ("RVU") targets that had become the norm in many medical practices. The 1990s taught hospitals that physicians' salaries must be accompanied by incentives to ensure

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that physicians remain productive and attend also to quality of care, patient satisfaction and other important dimensions of care.

Although the hospital said that Dr. Keswick's RVU target was based on national standards for his field, he found it impossible to meet. National standards presumed a context he lacked: allied providers such as nurse practitioners, a smooth-functioning office staff, and a smooth-functioning EMR system. Dr. Keswick could not meet his RVU target no matter how hard he worked, and he watched his salary shrink.

The "divorce" lawyers are busy getting Dr. Keswick and the hospital out of this mess. Dr. Keswick and his attorney did anticipate some of these issues. They knew, for example, that hospital-provided staff would replace his wife and daughter. But neither envisioned the seemingly endless parade of staff-du-jour. Similarly, they accepted the idea of RVU productivity requirements, based on national standards. But Dr. Keswick had never analyzed his practice in terms of such units. He had no idea how many RVUs he typically worked, and thus could not discern what a reasonable target would be. Neither did he anticipate how much time he would spend re-educating staff, or commuting to and from the distant satellite clinics the hospital expected him to serve.

Finally, Dr. Keswick and his lawyer knew he must switch to the hospital's EMR system, that theirs and his were not compatible, and that a transposition of every entry from every chart into the new system would not be feasible. The hospital quickly made the necessary modifications to capture patients' weight in metric units and their ages in days, weeks and months as well as years. Quite unexpected was the hospital's apparent resistance to make further efforts to ease the transition. During

negotiations they had promised to make reasonable efforts to accommodate his needs. But given that neither Dr. Keswick nor his lawyer understood much about the new system, neither could predict just what the needs would be, in order to negotiate the definition of "reasonable efforts."

Conflict Resolution Processes: A Range of Options

Conflict resolution in healthcare is gathering considerable momentum. Joint Commission⁸ standards issued in 2009 require that hospitals' governing bodies "provide[] a system for resolving conflicts among individuals working in the hospital" (LD.01.03.01 EP-7) and that, particularly for senior management, "[t]he hospital manages conflict between leadership groups to protect the quality and safety of care" (LD.02.04.01).⁹ Hospitals should identify an individual, inside or outside the hospital, "with conflict-management skills who can help the hospital implement its conflict-management process. . . . This individual can also help the hospital to more easily manage, or even avoid, future conflicts."¹⁰

In hospital-physician alliances, both sides have strong reasons to maintain the relationship. Here, the hospital needs a pediatric gastroenterologist and, nationwide, pediatric subspecialists tend to be in short supply. The hospital's up-front investment will be lost when the separation is final. Hospitals "lose \$150,000 to \$250,000 per year over the first 3 years of employing a physician – owing in part to a slow ramp-up period as physicians establish themselves or transition their practices and adapt to management changes. The losses decrease by approximately 50% after 3 years but do persist thereafter."¹¹ Reciprocally, physicians who have sold their practices can face difficulty finding financing to establish a new practice.¹²

Surely it would be better to solve problems like Dr. Keswick's before they destroy a relationship – to build conflict resolution into the original agreement – rather than simply sign the contract and hope that people will be able to resolve on their own the ensuing disputes that are virtually inevitable no matter how carefully the contract is crafted.

For health lawyers, mediation is probably the most familiar form of dispute resolution. A suit has been filed, discovery has taken place, and either the parties voluntarily mediate or a judge requires them to. On mediation day the mediator might meet with everyone together initially, but then will likely separate the parties and shuttle back and forth with monetary offers. Rarely will the mediation focus on repairing a broken relationship.¹³

Whether or not this model is optimal for litigation, it is rarely suitable for ongoing clinical problems as seen in Dr. Keswick's situation.¹⁴ A more nuanced array of conflict resolution processes, at various levels, needs to be available, with those structures built into the relationship from the outset.

At the most basic level, a hospital-physician liaison should be established¹⁵ – a specific person the physician can contact whenever a problem arises and whose job is to help physicians navigate the hospital system. One of Dr. Keswick's greatest frustrations was that the simple question, "whom do I call?" was invariably followed by a series of hand-offs, often with no one actually able to address his issue.

A liaison can also serve as a kind of negotiation coach, helping the physician explain his problems once he reaches the right person/department and, when they cannot be solved, perhaps negotiate a mutually acceptable alternative. Dr. Keswick raised a number of problems regarding the EMR, for instance, and even where IT staff agreed that a modification would be

desirable, they were not always able to provide it. With a bit of coaching, physicians might be better able to establish a priority list. In Dr. Keswick's case, listing pediatric patients' weight in grams/kilograms, and their ages in days/weeks/months instead of years was a serious issue of patient safety, not just convenience. It required, and received, a prompt software change. However, not all EMR problems can be quickly fixed, and Dr. Keswick needed to focus on the most important ones and explain, in appropriate detail, the importance of each.

Not all issues can be resolved at the liaison level or by direct negotiation, so other kinds of conflict resolution will be needed. While this article does not propose specific internal dispute resolution systems – that has been done elsewhere¹⁶ – a few points can illustrate.

When direct negotiation is unsuccessful or too daunting to try, third-party facilitation by trained, neutral conflict specialists can help disputing parties maintain their focus on problem-solving and prevent further conflict. Some of them will be internal to the organization, providing informal conflict management by meeting with parties, gathering information, helping parties identify issues and priorities, and facilitating problem-solving conversations.¹⁷ The advantage of in-house facilitators is that usually they are readily available, familiar with the institution, and sometimes may be best suited to maintaining a collaborative mood.¹⁸

In areas where disputes are fairly predictable, a conflict prevention strategy might involve systematic communication opportunities. Medical staff conflicts, for instance, might be reduced by instituting regular staff meetings and workshops to air and address workplace concerns, and by identifying a trusted medical staff member to serve as ombudsman, among other measures.¹⁹

The most contentious cases, as when the issues threaten dissolution of the relationship, may require more formal processes, ranging from an outside mediator to neutral case evaluation and perhaps even arbitration.²⁰

Finally, some situations may benefit from a process akin to collaborative law.²¹ In collaborative law each side is represented by an attorney, but here each attorney's goal is not to fight against the other, or to gain for one's client at the other side's expense. Instead the aim is to work towards a mutually acceptable resolution. Although collaborative law is most common in the family law/divorce arena, in health law the goal would be to keep the parties together rather than split them up – to sort out problems so the relationship can succeed.

How Clinical Conflict Resolution Processes Differ From Familiar Forms of Mediation, and How They Might Have Averted the Keswick-Hospital Divorce

Conflict resolution in the health law setting has distinctive features. Readers may be most familiar with the sort of mediation a judge or statute might order prior to trial. A shuttling, "give me a number" mediation may work well enough for litigation. But the kinds of conflict resolution discussed here are markedly different.²²

First, there is no litigation afoot. Parties generally want to preserve, not sever, their relationship. The goal is not to determine who wins and who loses, but rather to identify each party's most important goals and interests, engage in creative problem-solving, and forge solutions that make sense for everyone.

Second, for routine clinical conflict resolution processes, attorneys will generally not be present. Instead, the participants might be the physician,

someone from (for instance) the IT department and, if the parties need or want it, a neutral third-party facilitator. The facilitator might be a trained in-house individual or, where neutrality is particularly important, an outside facilitator or mediator.

Third, those who serve as third-party facilitators or mediators will need to adjust their techniques considerably for these disputes. Shuttling between separated parties usually will be unproductive. The goal, after all, is not just to address the particular problem at hand, but also to help the parties communicate with each other. Except for particularly contentious situations, parties should be encouraged to speak face-to-face so they can have more productive conversations in the future.

Third-party facilitators thus need to bring a highly collaborative emphasis to these conversations. Rarely if ever will the outcome be a legally enforceable contract of the sort that usually caps a mediation during litigation. As a result, mediations in a clinical setting are only successful if the parties reach a genuine agreement. Allusions to litigation may frighten or un-nerve participants to the point of abandoning the process. For physicians in particular, words like "lawsuit," "litigation" or even "mediation"²³ evoke scenarios that could inhibit a full commitment to the problem-solving process.

Returning to the divorce story, a user-friendly conflict resolution process could have solved many of Dr. Keswick's problems if implemented early enough. For instance, as Dr. Keswick's staffing problems emerged, no one he phoned could actually give him answers. With a liaison to connect him to the right people, he might have resolved the problem much earlier. Eventually the hospital did provide a single set of continuous staff, but by that time the animosity was entrenched.

Dr. Keswick's EMR problems were never satisfactorily addressed.

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Although the hospital genuinely did not have the manpower or money to transcribe every old record into the new software, a compromise might have been to create timelines for his most complex patients' records. If Dr. Keswick still has to search PDFs to find older records, a timeline identifying the major events in a patient's medical history could have saved a great deal of time. Similarly, a conversation about RVU demands could have produced a more realistic productivity target.

Both parties had good reasons for entering into an employment arrangement, and those reasons did not disappear when problems arose. Had there been reliable, welcoming opportunities to discuss problems, this divorce might have been avoided.

Take-Away Insights for Health Lawyers

As providers become more and more integrated, health lawyers will need to negotiate new features into contracts and play some new roles. In the physician-hospital alliances discussed here, lawyers traditionally help create relationships. Now they must help sustain them by addressing the need for conflict resolution from the outset.

For their own ongoing education and to improve the quality of their service to clients, health lawyers should also welcome detailed information about their clients' experiences as these relationships are begun, as problems arise and, where separation ensues, the specifics of why things fell apart. Attorneys need to know what happens after the ink dries. It may be wise to invite clients to provide periodic updates – and not necessarily bill them for the conversation – to ensure that legal services are sufficiently attuned to what clients really need.

Additionally, health lawyers need to familiarize themselves with conflict resolution processes – coaching, negotiation, collaborative law, third-party facilitation, and formal mediation.²⁴ If a relationship has deteriorated to the point where separation appears possible, the best way to advocate for one's client may be a process in which both sides seek not just to solve problems, but to rediscover their common interests. Zealous advocacy here is marked by creativity and by a recognition of the other side's needs, even as one pursues the client's most important priorities.

Health lawyers can also serve as background coaches when their clients are involved in informal negotiations. An attorney with a solid understanding of dispute resolution tools and techniques will be far better able to advise his or her client on how to achieve important objectives without inducing needless alienation. When warranted, the attorney can also coach the client on how to create a user-friendly memorandum to summarize the conclusions of these informal negotiations.

Although the specific conflict featured in this article was a hospital-physician "divorce," the same observations about conflict resolution apply to other tensions arising in the complex world of healthcare. Health law attorneys need to be familiar with conflict resolution tools, to build them into the structure wherever possible, and to help their clients draw on them early and often.



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Professor in the College of Medicine, University of Tennessee, she specializes in health law and bioethics. Her teaching is not the traditional courses-in-classrooms. Rather, Dr. Morreim's work is clinically focused, taking place in the regular rounds and conferences during which faculty and physicians-in-training discuss patients, make medical decisions, and explore broader issues. That vantage-point permits a first-hand view of the conflicts that arise day-to-day for patients, families, physicians, nurses, administrators and others in healthcare. Conflict can arise not just between patients and providers, but in any area of healthcare delivery that now requires intense interdependence among professionals previously accustomed to substantial independence.

Dr. Morreim is vice-chair of the ABA's Task Force on alternative dispute resolution ("ADR") and Conflict Management in Health Care. She is also vice-chair of American Health Lawyers Association's ADR Affinity Group. Dr. Morreim is a principal in the ADR Institute, which provides traditional mediation training, as well as specific training for conflict resolution in healthcare. She can be reached at hmmorreim@adrinst.com.

Endnotes

- ¹ The author would like to express sincere gratitude for very helpful comments on earlier drafts of this article provided by Charity Scott, JD, MSCM, and Deborah Hiser, Esq.
- ² U.S. Dept. of Health and Human Servs., *Medicare Hospital Value-Based Purchasing Plan Development: Issues Paper*, (Jan. 17, 2007), available at https://www.cms.gov/AcuteInpatientPPS/downloads/hospital_VBP_plan_issues_paper.pdf. See also Jack Meyer, Lise Rybowski & Rena Eichler, *Theory and Reality of Value-Based Purchasing: Lessons from the Pioneers*, AHRQ/AGENCY FOR HEALTHCARE RESEARCH AND QUALITY, (1997), available at www.ahrq.gov/qual/meyerrpt.htm.
- ³ Anuja Vaidya, *Survey: Number of Hospital-Employed Physicians Up 6%*, BECKER'S HOSPITAL REVIEW, June 18, 2013; available at www.beckershospitalreview.com/hospital-physician-relationships/survey-number-of-hospital-employed-physicians-up-6.html.
- ⁴ Greg Mertz, *Hospital Employment vs. Private Practice: Pros and Cons*, June 02, 2013;

available at www.physicianspractice.com/blog/hospital-employment-vs-private-practice-pros-and-cons. See also Scott Gottlieb, *Hospitals Are Going On A Doctor Buying Binge, And It Is Likely To End Badly*, FORBES (March 15, 2013), available at www.forbes.com/sites/scottgottlieb/2013/03/15/hospitals-are-going-on-a-doctor-buying-binge-and-it-is-likely-to-end-badly/; Scott Gottlieb, *The Doctor Won't See You Now. He's Clocked Out*, WALL ST. J., March 14, 2013; available at http://online.wsj.com/article/SB10001424127887323628804578346614033833092.html?mod=Wsj_Opinion_LEADTo; Debra Beaulieu, *Physician Employment Could Hit 75%, Eclipsing Private Practice*, FIERCEPRACTICEMANAGEMENT.COM (July 18, 2012), available at www.fercepractice.com/story/survey-hospital-employment-eclipse-private-practice/2012-07-18.

- 5 Robert Kocher & Nikhil Sahni, *Hospitals' Race to Employ Physicians – the Logic behind a Money-Losing Proposition*, 364 NEW ENGL. J. MED. 1790 (2011).
- 6 A few details have been changed to protect confidentiality.
- 7 For example, physicians might be accustomed to seeing certain kinds of information, such as nurses' narrative notes or social work evaluations, in one part of the traditional paper chart. The EMR might place these in a completely different place, perhaps hard to locate or requiring multiple steps to reach the right information. Or physicians might be required to go through multiple pages, requiring myriad boxes to be checked and alerts to be acknowledged, just to gain access to the desired page. These processes often cost considerable time and tend to invite physicians to shorten the amount of time they spent gathering information from and entering information into the medical record. As discussed below, Dr. Keswick encountered significant problems because the new EMR system initially recorded patients' weights in pounds rather than in grams and kilograms.
- 8 The Joint Commission ("TJC"), formerly the Joint Commission on Accreditation of Healthcare Organizations, is the leading organization for accreditation of healthcare organizations such as hospitals. Many states, for instance, require Joint Commission accreditation as a condition for Medicaid reimbursement.
- 9 For an excellent discussion of Joint Commission standards and their respective elements of performance, see Charity Scott and Debra Gerardi, *A Strategic Approach for Managing Conflict in Hospitals: Responding to the Joint Commission Leadership Standard; Part 1*, 37 JOINT COMMISSION J QUAL & PATIENT SAFETY 59 (2011); *A Strategic Approach for Managing*

Conflict in Hospitals: Responding to the Joint Commission Leadership Standard; Part II, 37 JOINT COMMISSION J QUAL & PATIENT SAFETY 71 (2011). See also Jane Reister Conard and Jeanne F. Franklin, *Addressing the Art of Conflict Management in Healthcare Systems*, 16(3) DISPUTE RESOLUTION MAGAZINE 15 (2010).

- 10 Governance Institute, *Leadership in Healthcare Organizations: A Guide to Joint Commission Leadership* (Governance Institute White Paper, Winter 2009) at p. 17; available at www.jointcommission.org/assets/1/18/WP_leadership_standards.pdf. The Governance Institute's White Paper provided the standards and underlying rationale that were adopted as Joint Commission standards on January 1, 2009.
- 11 Kocher & Sahni, *supra* note 5 at 1790.
- 12 Jerome W. Thompson, *One-Way Ticket for the Employed Physician*, 106(9) TENNESSEE MEDICINE 9 (2013).
- 13 Tamara Relis, *PERCEPTIONS IN LITIGATION AND MEDIATION*, Cambridge University Press, 2009.
- 14 For a more detailed description of the ways in which clinical conflict resolution processes need to diverge from familiar mediation, see Haavi Morreim, *Conflict Resolution in Healthcare*, 18 CONNECTIONS 28 (2014).
- 15 Some hospitals already have such a liaison, sometimes dubbed a "director of physician integration."
- 16 American Health Lawyers Association ("AHLA"), *Conflict Management Toolkit* (2011), Exhibit C, "Sample Guidelines, Checklists and Policy," available at www.healthlawyers.org/hlresources/ADR/Documents/ADRToolkit.pdf. See also Scott & Gerardi, *supra* n. 9.
- 17 AHLA, *supra* note 16 at 5-7.
- 18 The Joint Commission has described in-house conflict resolution in the Elements of Performance for Standard LD.02.04.01.

"4. The conflict management process includes the following:

 - Meeting with the involved parties as early as possible to identify the conflict
 - Gathering information regarding the conflict
 - Working with the parties to manage and, when possible, resolve the conflict."

Elements of Performance for LD.02.04.01, Element #4. Element #3, initially in the 5-item set but later removed said: "Individuals who help the hospital implement the process are skilled in conflict management. This accreditation stan-

dard became effective on January 1, 2009.

Note: These individuals may be from either inside or outside the hospital."

- 19 Marti G. O'Hare, *A Case Study for Effective Conflict Management in the Health Care Workplace: Lessons from Babb v. Centre Community Hospital*, AHLA LABOR & EMPLOYMENT NEWSLETTER (December 2013), pp. 5-7.
- 20 *Id.* at 7-8. Others have also proposed building in conflict resolution to preserve relationships in healthcare. See, e.g., Brian R. Browder and Douglas A. Hastings, *Increasingly Common Bedfellows – Collaborations between Academic Medical Centers and Investor-Owned Health Care Companies*, 17(9) AHLA CONNECTIONS 24, 26 (2013) (proposing that, for joint ventures between academic medical centers and investor-owned companies, informal mediation processes be built into the contract from the outset).
- 21 Kathleen Clark, *The Use of Collaborative Law in Medical Error Situations*, THE HEALTH LAWYER Vol. 19, No. 6, June, 2007.
- 22 For a more detailed discussion of these differences see Morreim, *supra* note 14.
- 23 For physicians the word "mediation" usually means s/he or a colleague has been sued and that the parties have been litigating for a prolonged period, at which point a judge or someone has then ordered parties to mediate. The actual mediation (to the physician) consists of some stranger putting everyone in separate rooms, then shuttling back and forth to tell the physician what a poor case s/he has and why s/he should grant concessions to the other side – even if the physician firmly believes no malpractice has been committed. Given that even a very small payment must be reported to the National Practitioner Data Bank, given also that many physicians' malpractice insurance features a consent-to-settle clause, and given finally that continuing the fight will usually result in a physician victory, mediation represents an annoying and hurtful waste of time in many physicians' eyes. See E. H. Morreim, *Malpractice, Mediation, and Moral Hazard: The Virtues of Dodging the Data Bank*, 27 OHIO ST. J. ON DISP. RES. 109 (2012).
- 24 Many lawyers are now completing state-authorized trainings to become mediators themselves. Even if these attorneys do not then become active mediators, their understanding of conflict resolution processes is greatly enhanced. Alternatively the attorney might take an intensive training in conflict resolution for healthcare. See, e.g., www.adrinst.com/educational_opportunities.htm.

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