

# MEDIATING HEALTHCARE DISPUTES MORE, EARLIER . . . AND DIFFERENTLY: MEDIATING DIRECTLY IN THE CLINICAL SETTING

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## Introduction

For health lawyers, mediation is best known for addressing disputes that have become serious enough to litigate or initiate a hearing process. Even then it is often not used until discovery is essentially complete – almost literally on the courthouse steps.

Yet the conflicts themselves begin far earlier, a reality presenting productive opportunities. It has been said that these days, in-house counsel (and many other health lawyers) are often so busy putting out fires they can hardly focus on fire prevention. And yet, intuitively at least, it makes better sense to address problems early.

Healthcare conflicts can be particularly intense and frequent compared to other workplaces. If a barista at the coffee shop touches the wrong button on the computer, the customer might get the wrong beverage or the wrong price, usually correctable with little consequence. However, if a physician makes precisely the same kind of error when entering an online drug order, or if a nurse makes precisely the same kind of error when programming an I.V. pump, someone can die. So stress levels are high in healthcare, as teams with diverse skills and backgrounds must function seamlessly to achieve complex objectives, and sometimes to adjust those objectives in light of patients' and families' differing goals. Each day in the clinical setting can be a battleground, in small and large ways, compromising patient safety and exacerbating staff burnout and employee turnover.<sup>1</sup>

As described elsewhere,<sup>2</sup> well-functioning healthcare systems need to offer effective, user-friendly conflict resolution mechanisms at all levels.<sup>3</sup> One option is the organizational ombuds. A number of healthcare organizations have established ombuds offices to address conflicts among staff and employees via services ranging from one-on-one coaching to facilitated conversations, shuttle diplomacy, mediation and beyond.<sup>4</sup>

Another avenue for conflict resolution, particularly ethics-laden patient-provider issues, can come from hospitals' ethics committees.<sup>5</sup> According to the American Society for Bioethics and Humanities ("ASBH"), as the ethics consultant clarifies issues and advises parties regarding well-accepted norms and processes, an important part of the consult is to facilitate conversations in which everyone has the opportunity to be heard and to contribute to a resolution acceptable to all.<sup>6</sup>

Under whatever organizational umbrella – ombuds, ethics consultant, another structure or none at all – one powerful and arguably underused avenue for resolving conflict in healthcare is mediation. This article describes a diverse array of situations in which mediation has been used early and effectively to resolve conflict, promote improved teamwork, enhance patient safety and reduce the need for litigation.

One approach amply discussed elsewhere, hence not extensively in this article, concerns early resolution for harmful medical errors. Rather than the traditional deny-and-defend, many healthcare institutions now reach out to patients and families when they discover their own mistake has caused harm or inconvenience. Dubbed "communication and

resolution" programs, or CANDOR ("Communication AND Optimal Resolution"), these programs emphasize honest disclosure, quality improvement by learning from mishaps, and fair compensation. The result: dramatic decreases in filed claims, time to resolution, defense costs and overall payments, even as injured patients and families receive greater compensation than they might otherwise have received.<sup>7</sup> Indeed, the federal Agency for Healthcare Research and Quality ("AHRQ") has established a website with tools to help healthcare institutions create their own CANDOR programs.<sup>8</sup>

Here, the focus instead is on some of the most common conflicts in healthcare and how they can be addressed through mediation. Real cases discussed below include administration versus medical staff, treatment disagreements, discharge planning, intra-family disputes, bioethics issues, and peer review. With limited exceptions, these cases were mediated by the author – hence the use of first-person narrative for those cases. Facts are modified to protect confidentiality, but in each case the important "moving parts" remain accurate as events unfolded. Finally, as discussed below, mediation in the clinical setting differs markedly from the kind more familiar for resolving lawsuits. Clinical-setting mediation is fairly new, and it is hoped that this article will enable readers more clearly to understand how it proceeds in practice, and to envision what role it might have for their own clients and institutions.<sup>9</sup>

## Administration versus Medical Staff

Arrangements between physicians and healthcare organizations,

beyond medical staff membership, can be structured in a variety of forms, such as employment, co-management, professional services agreements, joint ventures, enterprise partnerships, and exclusivity contracts.<sup>10</sup> In recent years physicians have increasingly become health system employees rather than independent contractors, and some of those unions are showing signs of fracture.<sup>11</sup>

Familiar bones of contention between physician employees and management include the following:

- Common issues for employee-physicians concern salary and benefits, duty hours, call schedules, personal time off, productivity measures (whether by RVUs,<sup>12</sup> numbers of patients seen, procedures performed, or other method), governance, and peer review/disciplinary procedures. Administration must ensure 24/7 coverage, for instance, but if physicians are short-handed with too little time off, burnout and ultimately resignations can render a bad situation worse – and make recruitment of new doctors still more difficult.
- Ostensibly, administrative decisions about system-level issues are readily distinguishable from medical decisions about individual patients, but the two are inextricably linked. On one hand, every medical decision is also a spending decision. Testing, treatments, specialist referrals, and the like generate costs that, depending on patients' ability to pay, may be absorbed by the hospital. Medical decisions also implicate infrastructure, from ordinary supplies to high-cost items such as imaging equipment. On the other hand, although administration rightly controls how many and what sorts of ancillary staff to hire, those staffing levels, whether in- or outpatient nursing, pharmacy, or respiratory therapy, can significantly affect clinical realities: patient flow, speed of care, even testing and treatment options, especially in short-staffed

situations. Moreover, new staff invariably require a period of adjustment to learn the details of how work gets done locally. Staff turnover thus can greatly affect clinical efficiency and even patient safety. The bottom line: each side can affect the other's work in unanticipated ways, and failure to coordinate smoothly can generate ongoing conflict.

- Administration often wants to control employee recruiting – for instance, to emphasize a particular line of service by hiring a nationally recognized cardiologist to chair that department. Yet if the process ignores existing physicians' perspective, or ends up hiring someone who does not get along well with current staff, poor morale and accelerated burnout can directly impact daily clinical operations.
- Healthcare now requires an array of technologies, such as advanced diagnostic equipment and electronic health record (“EHR”) systems that can accept patient data, track quality metrics and justify appropriate billing, at an acceptable price. Still, a system that is designed to do some things well can make life exceedingly difficult for others. For physicians, an EHR optimal for tracking billing and quality metrics can consume inordinate amounts of time checking boxes rather than writing important narrative descriptions, and can make important information difficult to find, such as consultants' reports or outside referral documents.<sup>13</sup>

In the instant case, several issues had been troubling both the administration and employed medical staff in a small, non-urban healthcare system consisting of an inpatient hospital and a number of clinics reaching neighboring communities. The primary care physicians were employed under annually renewed contracts. Physicians had taken umbrage at a number of administrative actions, including

staffing changes that affected daily clinical operations. Administration chafed at physicians' apparent failure to recognize the complexity of running a healthcare operation on a tight budget. The tensions were longstanding and, as such situations typically evolve, neither side had much trust for the other, nor spent much time listening to the other. Relationships had become frayed-to-fractured.

Additionally, an employee physician whose contract was up for renewal in a few days had inked a change onto a new clause in that contract, then turned it back unsigned – without requesting negotiation. Rather than offering negotiation, administration was ready to reject the proposed change and let that physician go. Neither side seemed willing to budge, and some other physicians under near-term renewal deadlines seemed ready to follow their colleague.

At this point the one thing on which both sides were more-or-less agreed was that it might make sense to try mediation. Mediation offers a fresh set of eyes and ears, and a “toolbox” of skills and strategies that can help people (re)evaluate what is important to them and create together a different path forward.

Although the fundamentals of mediation are the same no matter where it is practiced, mediation in the clinical setting differs markedly from the litigation-focused process with which readers of *The Health Lawyer* are likely most familiar. Here, there are no filed complaints, no pleadings, no formal discovery, no premediation statements, just a host of vaguely-described problems that needed problem-solving conversations. And although the parties in this conflict asked their outside counsel to help identify a suitable mediator<sup>14</sup> (this healthcare system was small, hence no full-time in-house counsel), the process did not primarily involve working with attorneys, or working with the parties in the presence of

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counsel. Nearly all of my conversations were directly with the parties.

Because of schedules, timing, and distance, many of those conversations needed to occur prior to my arrival on site. I needed to gather background information, identify and preliminarily prioritize issues so that I could “hit the ground running” and make optimal use of limited time once I got there. Advance phone communication would also provide a high degree of privacy for people who did not trust the “other side.”

I sent an email to my main administration contact and to the medical chief of staff, providing an invitation they could forward to their colleagues: anyone who wanted to share information, ideas or concerns in the privacy of a phone call could reach out by text message or email to set up a time to speak with me. The invitation also emphasized that, as mediator, I would not take sides or tell parties what they should do – that my role was only to facilitate their own collaborative problem-solving.

For those who were troubled by the ongoing tensions, or who did not want to be seen visiting me in person once I'd arrived, the offer was gratefully accepted. Moreover, those from both sides who would be directly involved in negotiations likewise had a chance to share their perspective and help me get up to speed on the issues.

These conversations continued after I arrived on site for the week, as I spent some of my time in a physicians' office area and some in an administrative office area, thereby shielding visitors from unwanted visibility. Privacy was additionally protected by a billing format in which, instead of “phone with [person's name]” or even “phone with [administrator] [physician],” I simply wrote “phone with member of [healthcare system].”<sup>15</sup>

The response was strong. Many hours of conversation revealed the depth and passion of concerns and hopes, together with information about which issues were most urgent, plus issues in which opposing parties' perspectives were closer than they realized and for which mediation strategies might be especially conducive to problem-solving.

During my week on site, two joint meetings were held between administrators and senior physicians. In both, an important mediation strategy was to connect my computer to the wall-mounted monitor in our conference room. I had pre-loaded various documents everyone had agreed were relevant, plus a few items of my own choosing.<sup>16</sup> As a classic mediation strategy this meant that, literally, the parties sat side by side, looking together at the problem(s) instead of at each other.<sup>17</sup> Each joint meeting also featured an evolving document that reflected the parties' emerging agreements – again, projected on the wall monitor for all to see and consider. Along the way my job as mediator was to help parties pause at critical junctures, ask pivotal questions, clarify what the real issues were, and identify common ground the parties had not yet realized they shared – the usual sorts of things mediators do.

The first joint meeting addressed the disputed contract clause, since the physician's contract would expire that evening. The issue was resolved remarkably fast. Perhaps the presence of an impartial outsider helped parties to step a bit outside their familiar fray and take a fresh look. Moreover, likely everyone at the table recognized the hazards of the direction they were moving – not just the loss of one physician and the ensuing clinical disruptions, but likely the loss of several of his colleagues, as well. The parties crafted an agreement that

they would then email to the hospital's attorney, with follow-up by phone later that day. Crisis averted.

The second joint meeting addressed a variety of other ongoing issues. As before, a joint document was created, listing points of agreement and avenues for further exploration under each of several issue-headings. At a number of junctures, important points of misinformation and misunderstanding were clarified, from both sides. For instance, a recent complaint a patient had filed turned out to have a rather different character than initially believed, once additional background was supplied from around the table. In the end, although many of the issues were not completely resolved, most were narrowed with a clearer path forward. Another collectively constructed document was emailed to everyone, right there at the table for all to see on the monitor. Throughout, transparency promoted greater trust.

For both joint meetings, numerous private conversations with members of administration and staff helped enormously to discern which issues were most important to address and, perhaps above all, how to frame them without inflaming them.

This sort of mediation is not the familiar joint-session-followed-by-shuttling-between-caucuses. Shuttle mediation generally does not work here. Parties who must work together in the future need the positive experience of sitting together and solving problems collaboratively. They also need to see each other's facial expressions and tone – particularly as one party acknowledges aloud that someone on the other side has offered a worthwhile observation. And where tone instead exacerbates tension, the mediator can help reframe what has been communicated into a better opportunity for conversation.

Accordingly, this sort of mediation also indirectly serves to emphasize communication styles and skills. In addition to experiencing ways that comments can be offered respectfully and issues (re)framed productively, parties can appreciate the utility of forging a common document on a monitor visible to all and contemporaneously emailed to everyone. It reduces opportunities for post hoc “that’s not what I agreed to!” or “you changed what I said!”

## Treatment Disagreements

“Henry” was born “floppy”: little muscle tone and limited reflexes.<sup>18</sup> After ruling out spinal muscular atrophy, which would carry a particularly grim prognosis, physicians remained unsure of his diagnosis. Nevertheless, Henry did reasonably well. As he turned six months old, Henry’s parents asked his primary care pediatrician (“PCP”) if perhaps he could have speech therapy to improve his feeding, and physical therapy to improve his general physical ability. The PCP agreed, but wanted first to get a swallowing study. In a swallowing study the infant is fed several ways – thin feeds, thickened feeds, pudding, etc. – with imaging studies at various points to see exactly how the baby was swallowing, and whether the food went properly down the esophagus or into the trachea and lungs.

Henry “flunked” all phases. The PCP indicated that it was now time for Henry to have a G-tube inserted. A G-tube, or gastrostomy tube, is surgically inserted through the abdomen to permit liquid food to be delivered directly into the stomach, thereby bypassing the swallowing mechanism. The parents, taken aback, strenuously refused. The PCP responded that perhaps he would need to call the Department of Children’s Services (“DCS”), whereupon the parents dug in harder. Henry was then admitted to the hospital for further evaluation plus

naso-gastric feeding, and to ensure that he did not deteriorate while decisions were being made.

Three days later, with Henry still in the hospital, Henry’s parents, thinking that perhaps the physicians feared being held liable should Henry do poorly without a G-tube, declared that they would sign all of the papers to leave “AMA,” against medical advice. The hospital’s risk manager exclaimed that although the parents could leave, they could not take the child, and promptly posted two security guards outside Henry’s door. That night at 10:30pm the director of social work received a call instructing her to seek a court order mandating the G-tube. The next morning, the social worker on Henry’s unit got in touch with me, wondering if some sort of conflict resolution might be worth trying.

In contrast to the litigation context, clinical-setting mediation generally does not result in binding contracts. The only “enforcement” is the parties’ actual willingness to participate, and their genuine agreement with the outcome. Hence, the first step is an invitation to each person to explain what is being offered and to inquire whether that person might be interested in participating. Ordinarily it is appropriate to contact the physician first, since s/he has a prior relationship with the patient and family, and it would be unseemly as well as impolitic to appear to sneak into that relationship without first conversing with the physician. These mediations only go forward if everyone is willing; thus it works best to begin with the physician.

In this case the PCP was not merely willing, he was grateful for the opportunity to pull this mess out of the fire, expressing regret for threatening to call DCS so quickly. For physicians, conflicts like this tend to consume enormous amounts of time and energy, both intellectual and emotional. The prospect that

someone else is willing to spend time they simply do not have to resolve such matters is often welcome.

For patients and families, my invitation often observes that sometimes patients and families feel that their concerns have not been heard; I then inquire whether that is true in their own case. Henry’s parents emphatically agreed, so we talked for well over an hour. Not surprisingly, they had received numerous mixed messages from a variety of people in the physician’s clinic and the hospital. For instance, the swallowing study images did not show a “river of milk” flowing into Henry’s lungs; the surgery resident seemed quizzical that a G-tube would be inserted “so early.” The parents had reasonable questions and had not yet received answers that made sense to them. This is common in healthcare conflicts. When clashes erupt, opportunities for calm exchange are quickly lost.

As noted, clinical-setting mediations do not typically follow the classic formula of joint session-then-shuttle. The mediator must determine what design will work best for the specific case at hand, then be ready to adjust that design on the fly, as developments warrant. Here, it did make sense to bring everyone together – after making sure there would be available a quiet conference room with a computer and large monitor for bringing up whatever images or other data might be helpful to review together.

The next day, just prior to the joint mediation, I had a chance to converse further with the PCP and with the speech therapist who had undertaken the swallowing study. Then I met briefly with the family and offered an idea. Sometimes it can be helpful to bring forth one’s concerns via a different voice. By this point each side was hearing the other’s voice to be somewhat strident. To the parents I therefore offered to begin the conversation by articulating the various mixed messages they had

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heard. They would be free to correct anything and to take over in the description at any point. I was not offering to be their advocate, just to articulate their observations. They liked the idea.

The joint conversation lasted two hours. Each side learned things they had not hitherto realized. The PCP appreciated how the parents would be perturbed by so many mixed messages. At one point he brought up the swallowing study images on the computer and, by pointing out several less obvious concerns, showed the parents a longer-term medical concern they had not previously discussed: microcalcifications that, over time, were gradually and permanently reducing Henry's lung function. Here, as in the case just above, parties literally sat side-by-side, looking together at the problems on the radiographs.

Together they created three options from which the parents would choose by 4:00 that afternoon. By preference of all parties I wrote the three on my computer, passed the laptop around so that everyone could make sure it said what they wanted, and then with group affirmation emailed the document to everyone right then (using Bcc to ensure privacy of email addresses). This form of memorialization helped the family to think more clearly about each option as the day went on, and it also reduced the risk of "I never said that!" and "Yes you did!"

Although all three options concerned additional ways to evaluate Henry's condition and verify whether or not a G-tube might be premature, that afternoon the parents chose the G-tube. The next morning Henry's mother asked if perhaps she might join the group of parents who volunteer to help other parents whose child will have a G-tube.

## Discharge Planning

"Benny" was a happy, energetic seven-year old.<sup>19</sup> His parents, amicably divorced several years ago, shared custody equally and lived just two miles apart. On a Saturday afternoon as Benny and his father watched football, the father fell asleep in front of the TV. He awakened to find Benny gone – and his all-terrain vehicle ("ATV"). Half an hour later he and several neighbors found the ATV overturned, and Benny face down in a large puddle of rainwater.

Benny was resuscitated, but he had sustained severe anoxic brain damage.<sup>20</sup> At the one-week point he was in a "minimally conscious state" – not vegetative or permanently unconscious, but only marginally responsive.<sup>21</sup> Prospects for significant recovery were dim. Around that time, Benny's father had "words" with Benny's mother's fiancé and the latter was expelled from the hospital. At four weeks, the mother quietly went down to court and filed for full custody. Hence a legal battle was now in the offing.

By the end of week six Benny was nearly ready for discharge. He was not on a ventilator, but would need 24/7 care. Copious respiratory secretions required frequent suctioning, lest he suffocate. He was fed through a G-tube and, although he made some physical movements, he still needed to be turned regularly. Neither parent's insurance would cover home nursing care. The immediate question was: to which parent's home should he be discharged.

Benny's hospitalist physician, aware of the parents' favorable experience in mediating their divorce, suggested that "it will take a village" to care for Benny and offered the idea of mediation for their discharge planning. They accepted, and the hospitalist phoned.<sup>22</sup>

I met initially with Dad, Mom, and Mom's fiancé, who had recently been permitted to return to the hospital. I indicated that I had some familiarity with the situation but asked what issue(s) they would most like to address that evening. Mom did not hesitate. Pointing to both Dad and fiancé, she exclaimed that she needed for them to be more civil to each other; the tension between them had become intolerable. Responding to mediator questions the two men described their perspectives and found their way to a better understanding.

As the conversation shifted toward Benny, key questions focused not on who was the better parent (a losing battle and a poor mediation strategy), but to the factual details of what, exactly, Benny would need no matter where he lived. By prior arrangement Benny's outpatient pediatrician was available by phone. We learned that Benny would not need a special bed and would be considerably more mobile than anyone had expected. That information opened the door to the parents' taking turns caring for him in their own homes. The parents created a sharing arrangement – one that almost certainly could not quite work, because it envisioned that Dad would sometimes care for Benny alone for several days at a time – not sustainable by anyone, given Benny's need for 24/7 care. Nevertheless, in another difference with litigation-mediation, it was equally clear that further conversations would be held. Benny would not depart the hospital immediately, and there would be time enough for the plan to evolve.

Dad asked to meet the following day. Dad's mother had moved into his home after the recent death of her spouse. However, she was too distraught initially to come to the hospital amid all of the sadness and acrimony, so we brainstormed about who might help him take care of

Benny. We also discussed his fears about the impending custody litigation.

Several other meetings ensued, with varying combinations of people, over the course of 10 days. During that time Dad's mother became fully ready to step up and help care for her grandson. Mom realized that her custody lawsuit would take months, if not years, and considerable sums of money better spent on Benny. She also understood that whatever may happen in court, appropriate and cooperative discharge planning was essential right then. It would indeed take a village. To this day I am unsure with which parent Benny initially left the hospital. However, several months later a chance encounter with Benny's PCP revealed that, in the end, both parents had been able to work together – not seamlessly, but well enough – and that Benny was doing reasonably well.

### **Intra-family Disputes: Resources**

Sometimes a terrible illness or injury – cancer, traumatic brain injury, severe burns – requires a patient to receive care far from home. Specialty facilities, particularly those serving children, sometimes provide resources such as air travel, lodging, and meals. However, to conserve limited resources, often only one plane ticket, lodging room and meal card are provided for a member of the patient's family.

In the case at hand, divorced parents from a distant state brought their child to the hospital for cancer care. Their marital dissolution agreement and parenting plan allocated custody and decisionmaking equally. In this scenario early questions include which parent will receive the flight ticket, lodging, and meal card. Where treatment requires multiple returns home followed by additional treatment visits, the same allocation questions arise again. And where the non-supported parent wishes to be present,

the additional money for flights, lodging and meals must come from somewhere. If both parents work outside the home, further fodder for conflict concerns who will use how much sick leave, or forfeit how much income in taking time off to be with the child during treatment (with potential implications for previously established child support).

Parents may therefore also (re) consider how parenting time will be allocated, both at the treatment facility and while back at home. If additional family members or parties' significant others are also present at the treatment site, further negotiations may concern who can visit when, and who will be present during treatments and clinic visits. Divorced couples are not always pleased to share important time with the other party's new girl/boyfriend or fiancé, or even ex-in-laws.

If the prior custody arrangement had been 50/50, it may seem obvious that would apply here, too. Yet serious illness in a loved one can upend even the most comfortable arrangements. In the instant case hospital staff had initially proposed a 50/50 arrangement, but it quickly fell apart. Treatment facilities need to maintain the trust and respect of everyone involved in the patient's care, and therefore may need to shy away from becoming too involved in family disputes. An outside, neutral mediator becomes a reasonable option.

In this case each parent and I had various phone conversations, and the three of us met twice in person, the first time to address immediate issues, such as resource allocation and time allotments for each parent during this initial treatment visit. In the second meeting we addressed longer-term issues such as parenting time when they returned to their home state and resource allocation for future visits.

Once again, clinical-setting mediation requires a distinctive approach. Simply finding a private, comfortable

space in a busy healthcare facility can be daunting. Likewise, memorializing agreements requires flexibility. In this case both parents preferred that I write down their short-term agreements on my laptop, then text the content to both cell phones simultaneously, directly from the laptop. They wanted to be able to bring forth their mutual agreements from a common source any time it might be needed. Longer-term arrangements did not reach sufficient agreement during our second meeting to require memorialization.

### **Intra-family Disputes: Treatment Decisions**

"Jennie," 10 years old, was a generally happy child. Recently, however, her school work had deteriorated, and she began "acting out." Three years earlier her father died of Huntington's Disease, an invariably fatal neuromuscular disease. A year afterward Jennie's mother remarried, to a man who was fully aware of the situation and who adored and adopted Jennie.

Because Huntington's is genetically transmitted in an autosomally dominant pattern, Jennie stood a 50 percent chance of inheriting the disease. According to the pediatric neurologist, Jennie's recent behavioral changes could be a sign of early onset Huntington's. Ordinarily the disease appears in adulthood, and early-onset Huntington's tends to be particularly rapid and virulent.

In this case Jennie's father wanted very much to find out whether Jennie had the Huntington's gene. He needed to know what he was up against, and he worried about some dark possibilities as Jennie approached adolescence, should she somehow become pregnant and unknowingly pass along this sad legacy. Her mother wanted with equal urgency to be spared this information, to avoid "ringing a bell" that could not be unringed. Moreover, she had additional life-worries and was unsure she had the emotional resilience to

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withstand a tragic finding. Both were uncertain just how to involve Jennie in the question, if at all. The issue appeared to create a strain on their marriage.

Given that the parents were unable to agree on what should be done, the neurologist contacted me, requesting an ethics consult, although mediation is what ensued.

Prior to meeting with them I explored how geneticists approach this situation. The profession distinguishes between *diagnostic* versus *predictive* testing. Diagnostic genetic testing is used when signs and symptoms indicate the presence of a disease, and the genetic workup serves mainly to confirm what is strongly suspected. Predictive genetic testing, in contrast, is undertaken when the patient has no symptoms of illness, just a significant statistical possibility of carrying the gene(s) for a particular condition. Thus, a woman with breast cancer might test for the BRCA1 and BRCA2 genes to explore what particular kind of cancer she has and what risk she might have for additional problems, such as ovarian cancer or recurrent breast cancer: a case of diagnostic testing, because immediate treatment decisions can be affected. In contrast, if a woman has no such cancer but is aware of close relatives who have had it, she might test for the genes predictively to assess her likelihood of having the disease sometime in the future. Major genetics organizations strongly discourage predictive genetic testing in children, particularly where nothing can be done to forestall or attenuate the disease, as is the case with Huntington's.<sup>23</sup>

That information, however, did not dictate that I abdicate the role of mediator neutrality and simply tell the parents which view was (in)correct and what they should do. Instead, we explored each parent's concerns. They

had a chance to hear each other, including a few concerns that had not been articulated previously.

At a certain point in the conversation I posed a question to the father, who wanted Jennie to be tested. After I described the difference between diagnostic and predictive testing, the neurologist indicated that for Jennie at this time, a test for Huntington's would be predictive. I asked the father: "Suppose you were to take Jennie to the geneticists, and they told you they were not okay with predictive testing for children? How might you respond to that?" His answer was somewhat surprising: "I would feel relieved," he said. As mediator, I felt relieved just then.

The neurologist, present but mainly silent because he believed the parents should be free to consider and decide this difficult issue, then offered important factual information. Because early-onset Huntington's progresses quite rapidly compared to adult-onset, Jennie's situation will likely be much clearer in six months or so. If this were Huntington's, by then any symptoms would be considerably more pronounced.

Jennie's parents mutually agreed to wait six months. This decision needed no written memorialization. If one partner subsequently changed his/her mind additional conversation, not waving a signed document, would be the appropriate course.

## Bioethics Issues

These days, from historic case law<sup>24</sup> and from Joint Commission expectations,<sup>25</sup> hospitals typically have ethics committees or some sort of ethics consultation mechanism. As experienced bioethicists have seen, requests for ethics consults have diverse origins. Sometimes a difficult situation is marked by moral puzzlement in which everyone wonders

what is the right thing to do. The reflections of someone trained in the history and nuances of these questions can be of great value to help parties "think out loud" together and come to a reasonable decision. Or sometimes all involved are agreed on what they think should be done but, fearing they might be crossing some sort of line, may need reassurance from someone with relevant expertise.<sup>26</sup>

Other times, however, the situation features conflict. In a familiar scenario the patient may be dying, permanently unconscious or profoundly demented. The healthcare team has concluded that this person will not survive much longer and that the burdens of continued treatment outweigh whatever minimal benefit may be gained. Families in these cases, for a wide variety of reasons, sometimes insist that the team provide every possible life-prolonging intervention. Tensions and mistrust ensue; shouting matches are not uncommon.

In some cases, an ethics consultant might weigh in by gathering information and then opining – perhaps offering one recommendation (e.g. that it is time to abate aggressive support), or maybe identifying several ethically acceptable options (e.g. that it would be acceptable either to abate treatment or to try one last option for a limited time).<sup>27</sup>

In situations of conflict, mediation provides a rather different approach. Mediation is based on several important principles: privacy ("I won't share with the other side the things you say to me in private"); neutrality ("I'm not here to take sides"); and self-determination ("I'm not here to tell anyone what to do"). In practice, if an ethics consultant is forthright enough to tell parties s/he plans to gather information and then make a recommendation, parties in deep conflict will likely shape their information to be persuasive. Essentially it



will be a form of lobbying, to prompt the consultant to decide in one's own favor.

Mediation offers all of the parties the opportunity to confide their deeper concerns, consider aloud what is most important, and come to something of a resolution. Note that this is "something of a resolution" because in bioethics conflicts, unlike in litigation, outcomes of mediation can span a wide reach. The patient's condition might unexpectedly improve or worsen, markedly altering the medical questions and options. The parties might simply agree to try something new, perhaps just for a limited time. Or they may agree to let the situation ride for a few days, see if anything changes, then resume the conversation. Any short- or long-term decision that makes sense to the parties can be agreed on, and even then a new development, medical, social or otherwise, can upend an agreement and require additional conversation.

Note also that, although advisory-style ethics consultations might appear fairly definitive, they are generally only recommendations, so the parties can honor or ignore them. As a result, the conflict may continue unabated. When an ethics consultant issues a recommendation – perhaps perceived as taking sides for one party and against the other – s/he may well be regarded as just another pair of fists in the fight. Over several decades of providing bioethics education and consults in the clinical setting, and conferring with colleagues who do the same thing, not once have I heard a provider, patient, or family member say "Oh dear, the ethics person thinks I'm wrong, so I must be mistaken . . . surely I need to change my ethics!" Not once. That said, mediation likewise has its limits. Not every conflict about life and death can be resolved.

## Peer Review

Since 1952 the Joint Commission has required that physicians whose

practice involves caring for patients in hospitals be subject to peer review processes.<sup>28</sup> Hospitals must evaluate physicians at initial credentialing and every two years thereafter<sup>29</sup> to determine privileges for particular procedures and to discern whether or not that physician's practice falls within the standard of care when questions about quality have been raised. This last function features a series of progressive steps, sometimes leading to a Fair Hearing<sup>30</sup> and perhaps thereafter to discipline, suspension of privileges, even loss of credentials, followed by a lifelong report in the National Practitioner Data Bank.<sup>31</sup> The process can weigh heavily on physicians and on their colleagues.

Some peer review cases feature professional incompetence, e.g., lack of knowledge, poor judgment, or inadequate skills for surgeries or other invasive procedures. Many others, however, feature behavioral problems: the so-called "disruptive doctor." Throughout, mediation can be undertaken at any of several junctures:<sup>32</sup>

- early, when an apparent problem has been spotted but prior to invoking formal peer review processes;
- after peer review processes have been initiated but prior to a Fair Hearing; or
- amid or at the conclusion of a Fair Hearing, but prior to final adjudication.

At the earliest point possible, mediation offers the possibility of gaining a richer, more useful understanding of what is actually occurring. True, a surgery may have yielded an adverse outcome and the surgeon might have made better decisions at certain points. Yet adverse outcomes are often the product of highly complex system-level problems that, if not pinpointed and corrected, can continue to produce adverse events no matter who the surgeon is.<sup>33</sup> Similarly, disruptive doctors are often better described as distressed doctors,<sup>34</sup> often more in need of help than

punishment. Moreover, conversations in which physicians and allied staff have the opportunity to discuss their concerns openly and safely can sometimes lead to renewal of productive relationships, for the betterment of all. Aside from saving time and money for everyone, mediation in peer review can also protect privacy for both the institution and physician,<sup>35</sup> albeit with obvious exceptions, such as the need to stop a dangerous practitioner from causing further harm.

Note again that, just as physician issues can be mediated, so can employee conflicts throughout the healthcare arena. Organizational ombuds can ordinarily address employee concerns as an alternative to grievance processes or litigation.<sup>36</sup>

## Mediating in the Clinical Setting versus in Litigation

From the foregoing it should be evident that mediation offers fruitful possibilities for resolving healthcare's numerous and diverse conflicts far earlier, and often better, than is likely by the time litigation is considered. Those who serve healthcare organizations, whether as in-house or as outside counsel, would thus be well-advised to consider broadening the opportunities for high-quality, user-friendly conflict resolution, including mediation. It is worth highlighting several important differences between this sort of mediation and that more familiar for litigation.

### Enforceability

Perhaps the most basic difference was identified above: in clinical-setting mediation, agreements are rarely enforceable as binding contracts.<sup>37</sup> Situations are often too fluid, medically and otherwise, to be fixed by a static document; patients/surrogates have the right to change their minds about treatment decisions; some agreements might well be unenforceable as against public policy, e.g. where someone agrees to abate aggressive care for a moribund patient, then changes her

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mind; and some agreements, e.g. to speak to each other more respectfully, are too vague to be captured in meaningful contract language. Moreover, where parties must work together going forward, their mutual mistrust will more likely be exacerbated than alleviated by a legalistic effort to hammer out enforceable contract language. Wary word-smithing can quickly dominate the more important effort to uncover and address the parties' most crucial worries and goals.

From this reality other distinctions emerge. Absent judicial enforceability, clinical-setting agreements will succeed only if the parties actually embrace that agreement and are genuinely willing to implement it. That can happen only if the parties have had the opportunity to figure out what is most important to them and to see those priorities recognized in a mutually acceptable resolution. Thus, whereas litigation-mediations often feature a fairly strong evaluative dimension, a facilitative style suits clinical mediation far better. Although reality checks are still relevant, an arm-twisting mediator quickly becomes just another partisan in a fight among people who are already battle-weary.

## Privacy

Because these mediations are informal rather than court-annexed, protections for participants' privacy are limited. Although states' statutes and rules governing mediation vary, evidentiary privilege usually applies only in the context of an active lawsuit. Many states base their mediation privilege on Federal Rule of Evidence 408: "... [W]hether in the present litigation or related litigation, ... [e]vidence of conduct or statements made in compromise negotiations is [] not admissible."<sup>38</sup> A few states do protect mediation confidentiality beyond active lawsuits so that, e.g., parties can resolve potential medical malpractice events without resort to litigation. Those

protections typically carry limits, however. For instance, mediation privilege in Florida can be honored outside of litigation, but only if the mediator is certified by that state's supreme court.<sup>39</sup> The bare fact that people in a healthcare argument call their conversation a mediation and assert that it is confidential will not necessarily shield that conversation from discovery if a lawsuit is subsequently filed.<sup>40</sup>

Nevertheless, privacy of conversations is important. Helpfully, it is often the case that clinical matters most needing privacy are not the sort that would provoke litigation-type discovery. A patient may not wish his family to know about a past indiscretion; a physician may not want it known she's aware of some hospital gossip; a nurse may not want her supervisor to know she has just been diagnosed with cancer and is emotionally drained. These are the kinds of concern, more than the "material facts" targeted in discovery, that most often need privacy in clinical mediation.

Several protections for confidentiality are nevertheless available.<sup>41</sup> In a well-structured organizational ombuds office, the organization commits to honor visitors' privacy, and hence commits not to make administrative demands nor jeopardize the ombud's employment for honoring that privacy.<sup>42</sup> Standard exceptions apply for threats of imminent harm, child or elder abuse, and the like. Beyond that, protections for privacy reside in the simple facts that mediators standardly shred their notes, and that thereafter one's memory may predictably be unreliable, as cases often blend together over time.

## Logistical Differences

Logistical differences also distinguish the two kinds of mediation. As noted above, unlike litigation in

which mediators interact primarily with counsel, in the clinical setting virtually all conversations are directly with the parties. This is usually an advantage. In litigation-mediations, mediators sometimes find that attorneys' client communications are not altogether robust, and that the parties may have important concerns of which their lawyers are unaware – a situation requiring considerable diplomacy. In the clinical setting the mediator directly elicits the parties' concerns and priorities; as a result, the ambiguities of intermediary communication are generally avoidable.

At the same time, the parties in clinical healthcare are rarely familiar with mediation, and when they are it can carry negative connotations. For instance, for physicians mediation can invoke images of malpractice litigation and a shuttling mediator leaning on parties to settle even where the physician is convinced he did nothing wrong, and where his professional stature could be damaged by any concession. Invitations to consider mediation thus must include a description of what is being offered, perhaps with a friendlier label such as "collaborative problem-solving."

## Structural Differences

Lawsuits ordinarily describe issues clearly in detailed complaints on which a mediation then focuses. Not so in the clinical setting, where issues often first emerge as a vague complaint that may not begin to capture the most important concerns. The parties may not yet have discerned in their own minds what they think is amiss, let alone what they believe should be done about it. Only after careful explorations with various parties/groups does a clearer picture emerge regarding what needs to be discussed.

As a result, the sequence of activities has no pre-set or even typical

structure. There are no “premediation statements,” and almost never the familiar formula of a joint session followed by caucuses in which each set of parties sits in a room while the mediator is in another room talking to someone else. Essentially there is no “pre”mediation because, from the outset, all of the mediator’s conversations with various parties, in singles, groups and subgroups, are part of the mediation. In one case there may be no time during which everyone is in the same room, but in another case a major moment of the mediation may indeed be a conversation in which everyone is present, perhaps both preceded and followed by various private conversations. Clinical mediation can easily span multiple days, not hours-in-a-single-day because (1) clinical staff virtually never can free their time for such marathons and (2) it can be very useful to let time pass between conversations to provide the parties with time to reflect and, for patient-focused issues, as the patient’s health condition evolves. Broad flexibility, not formula, is imperative.

Additionally, the scope of the mediation needs to be flexible. Sometimes parties want to focus entirely on one issue – perhaps a decision that must be made urgently, even if other important questions are on the table – while other times the conversation may move from one question to another and then revisit an earlier issue. Or the parties may simply need the positive experience of being in the same room together, discussing more productively the host of ongoing questions they face.

### **Outcome**

Successful mediation of a lawsuit typically resolves all of the identified issues – permanently. Parties sign a contract that, if well-devised, lets everyone get on with their lives. Done. Over. Occasionally parties regret their decisions and file an appeal, but generally the settlements are final.

Success is defined differently with mediation in the clinical setting. Ongoing tensions between administration and medical staff may never be “resolved” even if the parties find their way around an individual issue. If mutual mistrust is generating problems, new ones are sure to crop up even if older ones become history. Yet the situation can still be improved if everyone has the experience of negotiating more productively with each other with the help of a mediator. Similarly, a disruptive doctor may never become a “choir boy” even if he learns how to interact with colleagues more effectively. The patient may get better, or worse, regardless of anyone’s decisions. And intra-family conflict can erupt again even if the latest trigger-du-jour was settled.

Accordingly, the outcome of clinical mediation might simply be “here’s what we’ll try next.” Sometimes the agreement might be an interim step that, it is hoped, could build enough trust among warring factions that, at some later date, they might be able to address the larger issues more directly. Or the parties might come to agreement on one question and, by seeing that success’s impact on other issues, or perhaps on each other and on their relationship, may subsequently manage other issues a bit better – asking the mediator to return for further conversation, or perhaps not. The parties, not the mediator, define what they consider to be an acceptable outcome.

### **Memorialization**

Finally, as should by now be evident, the outcome of a clinical-setting mediation may or may not require any kind of memorialization. A set of hand-scratched notes, copied and distributed to all, may be sufficient to remind everyone what they discussed. A more detailed write-up can also be helpful, as in the G-tube case in which physicians needed to specify in fair detail what they would consider an adequate additional

evaluation of Henry’s condition. And as in the first scenario, a wall-mounted, computer-linked monitor helped administrators and staff physicians craft together the wording of their agreement.

Even with writings, signatures on documents are rarely needed and can often be intimidatingly (and counterproductively) “legalistic” – although in some cases, such as peer review or employee grievance mediations, signed writings may be essential. Where signatures are unnecessary or undesirable, sharing can take the form of xeroxing and distributing an agreed-on summary to everyone, or sending a single email or text message to everyone simultaneously. Memorialization is thus highly context- and party-dependent.

## **Conclusion**

Mediation is assuredly not the only vehicle for resolving conflict in the clinical setting. For most of healthcare’s daily tensions, people should and usually do learn to work problems out among themselves. Many medical centers host ombuds offices, which offer a broad array of options for addressing conflict, including coaching, informal facilitation and more.

Neither is mediation always the most suitable approach. For one thing, the process must be voluntary all around. If any individual does not wish to participate, there is little point in proceeding. As noted, the only “enforceability” in this setting is the parties’ genuine willingness to give this a try, and their authentic embrace of whatever agreement emerges. Thus there are times when mediation will not be one’s first tool. This can be a fairly involved process. It is also best undertaken by someone who has broad familiarity with the healthcare setting on a day-to-day basis.

Still, mediation can be extraordinarily effective. The foregoing cases illustrate the wide variation of conflict in healthcare’s clinical setting,

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and the ways in which mediation can be helpful, not just to reduce the frequency of situations requiring attorneys' attention, but to enhance patient safety and satisfaction, reduce provider burnout and employee turnover, and generally promote smoother operation throughout the organization. In recent decades healthcare has become increasingly complex – financially, structurally, and medically. With high stakes of life and death it is to be hoped that mediation for resolving its inevitable conflicts will be as wide-ranging and sophisticated as healthcare itself.

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## Endnotes

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- 14 The hospital system's outside counsel reached out to attorney colleagues, one of whom was familiar with my work in clinical-setting mediation.
- 15 In this system, since everyone involved was a hospital employee, the hospital paid for the mediation services and expenses. In other settings, by the time the parties have agreed that they would like to mediate, they have often already determined how it will be paid for; as noted, these non-litigation mediations are never court-ordered; they are just collections of problems needing productive conversation.
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- 24 See, e.g., *In re Quinlan* (70 N.J. 10, 355 A.2d 647 (NJ 1976)).
- 25 The Joint Commission on Accreditation of Healthcare Organizations (JCAHO, now known as The Joint Commission or TJC) in 1992 adopted a standard requiring a "mechanism" for considering ethical issues and noted that ethics committees are the most common way to provide that mechanism. Joint Commission, 2011 Comprehensive Accreditation Manual for Hospitals (CAMH): The Official Handbook § LD.04.02.03 ("1. The hospital has a process that allows staff, patients and families to address ethical issues or issues prone to conflict. 2. The hospital uses its process to address ethical issues or issues prone to conflict."). This provision was formerly in section RI.1.1.6.1 (in 1992) and in RI.1.10 (in 2007).
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