



Conflict Resolution in Health Care

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Litigation may be the most familiar paradigm of conflict for health lawyers, with lawsuits concerning adverse medical outcomes, payment issues, peer review decisions, employee discharge problems, and other similar issues. Yet health care conflicts far outpace litigation. Covert tensions and overt clashes arise daily on the wards and in examination rooms, C-suites, physician groups, and insurance transactions. Examples abound:

- » A veteran nurse believes the patient is deteriorating but says nothing because the last time she spoke up, a physician's remarks "put her in her place."
- » The family of a permanently unconscious elderly patient demands endless heroic care, while most—but not all—of his physicians recommend "let nature take its course."
- » The day-shift nurse is fed up with the night nurse's unfinished tasks so she leaves them unfinished, hoping the supervisor will notice and finally address this ongoing feud.
- » A clinic patient demands useless antibiotics for a viral infection as his physician faces pressure to reduce antibiotic overuse.
- » A multispecialty physician group is deeply divided about selling their practice to a hospital.
- » The parents of a critically ill child feel desperately confused because every time a different specialist appears, she contradicts the last specialist.
- » A community physician directs the third-year resident to provide care the resident knows is out of date and potentially harmful.

Failure to address these pervasive conflicts can fuel medical errors, staff burnout, and lawsuits. As health care increasingly relies on integrated networks of providers, those networks require enduring relationships. As any reader with a few gray hairs will recall, a tidal wave of hospital-physician alliances in the 1990s quickly led to a tsunami of "divorces."¹ The same fate could easily befall today's Accountable Care Organizations and other integrated systems if they fail to include readily available, user-friendly processes for resolving day-to-day conflicts.² Health care now requires teamwork and intense interdependence, as providers are judged on quality, efficiency, and patient satisfaction. Simmering conflicts are toxic to every one of these goals.

The Joint Commission (TJC) recognized the need for in-house conflict resolution processes in 2009, requiring that hospitals "provide[] a system for resolving conflicts among individuals working in the hospital" (LD.01.03.01 EP-7), and

that "[t]he hospital manage[] conflict between leadership groups to protect the quality and safety of care" (LD02.04.01).³ Hospitals should identify an individual, from within or outside the organization, "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."⁴

This article discusses such in-house conflict resolution processes. These processes differ markedly from the pre-trial mediation familiar to health lawyers and, because they are now essential, health lawyers need to be conversant with them. First, as attorneys create new relationships for clients, they need to foster durability of those relationships. They need to build conflict resolution structures directly into the relationships. Second, since health lawyers may be directly involved in some conflict negotiations, they need to understand how to serve in a collaborative rather than adversarial mode, to preserve and improve rather than sever relationships.

In-House Conflict Resolution Processes

These in-house processes have been dubbed "conflict resolution," "conflict management," and "collaborative problem-solving"—perhaps preferable over "mediation" because, particularly for physicians, "mediation" often conjures up nightmare images of being sued, and of the typically evaluative mediation style that follows: the mediator separates the parties and seemingly pummels them with reasons they should make concessions to the other side.

In-house conflict resolution systems are not merely a TJC requirement. They provide user-friendly avenues for addressing disputes that erode the complex relationships on which health systems now depend. As described by other authorities,⁵ a multi-faceted approach is needed. A physician newly employed by a hospital system may need a liaison whose job is to answer questions, help the physician navigate the system and, in some instances, to coach him on how best to approach the department or person in question.⁶ Beyond that, provider organizations need in-house "conflict specialists" with skills to facilitate problem-solving conversations. More difficult disputes may require an outside third-party facilitator.

Optimal conflict resolution, then, requires options and flexibility. In addition, the actual processes of in-house conflict resolution differ markedly from the litigation-focused mediation with which *Connections* readers may be best acquainted. Health lawyers wishing to help their clients create an effective conflict resolution service need to be keenly aware of these differences.

Distinctive Conflicts

In health care the questions on the table are fairly distinctive. In litigation-mediation the focus is usually on money (even where non-monetary issues may be much more important to the parties⁷). Numbers are concrete and lend themselves to reasonably tidy contracts. In-house clinical conflicts, in contrast, rarely focus on money. The question whether a highly experimental treatment is worth trying in a desperate situation cannot be reduced to numbers. The question is whose values should prevail and for how long. Emergency Department (ED) physicians who are under pressure to reduce ED wait-times may want to move newly admitted patients up to their hospital rooms quickly, whereas nurses up on the floor may strongly resist accepting new patients during shift-change. The question concerns patient safety and staff workload at both ends, not money.

At the staff level, conflicts both resemble and differ from ordinary workplace disputes. Sometimes one's job requires challenging superiors, as nurses must question dubious medical orders. The stakes can be exceptionally high. The simplest error—tapping the wrong computer button or failing to record an allergy—can threaten a life. TJC has found that communication failures are “a root cause in nearly 70% of reported sentinel events, surpassing other commonly identified issues such as staff orientation and training, patient assessment, and staffing.”⁸

Some conflicts are ethical challenges at the boundaries of life and death. Although a hospital “ethics consult” would seem like a request for help to discern the right thing to do, the real issue is usually conflict. Rather than “we don't know what to do,” ethicists are more apt to hear “I know very well what's right . . . but those other people don't understand, so please tell them they're wrong!” Consequently, one specialized form of health care conflict resolution is called “Bioethics Mediation.”⁹

Additionally, parties in health care conflicts often wield enormous power over one other, as each side feels hostage to the other. Physicians essentially exercise monopoly control over tests and treatments requiring a prescription. Reciprocally, patients and families can threaten a lawsuit any time they are unhappy—a looming specter inducing many physicians to succumb to demands they deem inappropriate.¹⁰

Moreover, payment for health care services is now increasingly based not just on services provided, but on patient satisfaction, insurers' utilization criteria, and on how often inpatients are readmitted within 30 days after discharge. All these matters require communication and cooperation. Conflict must be addressed promptly and productively.

Distinctive Outcomes

In litigation-related mediation, the mediator's job is to help parties craft an agreement that is then memorialized in a contract signed by all, whereupon the lawsuit is dismissed. The End. The contract is enforceable in court.

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Health care conflict resolution rarely has any such formal End. Sometimes the outcome is a smile or a handshake. Other negotiations may produce an informal agreement, e.g. that the information technology department will make a specified change in the hospital's electronic medical record software, or that a physician-employee's work assignment will change.

These outcomes are almost never a contract, and agreements are often unenforceable. A family may agree that their mother should be made “DNR” (do not resuscitate), but they can change their minds before the day is over—before the hour is over—and anyone who wants to enforce the earlier concurrence has no leverage. An agreement lasts only as long as the facts (medical and otherwise) continue to support it, and only as long as the parties remain genuinely committed.

Conflict resolution in health care is at least as much about relationships as it is about specific facts, issues, and decisions. The longevity of an agreement will often depend more on parties' mutual trust than on the merits of their chosen course of action. In some cases the entire focus of a facilitated negotiation may be on how people will relate to each other in the future—e.g., on how a resident will frame his questions for the attending physician henceforth, or how nurses will allocate their shared tasks—and an outcome may simply be an agreement to speak to each other differently in the future. In a highly fluctuating medical situation the agreement may be nothing more than “here's what we'll try next,” leaving wide open the question of what happens after that.

Distinctive Processes

The classic hallmarks of traditional mediation—particularly facilitative-style mediation—are very appropriate in health care: separate the people from the problem, focus more on parties' underlying needs and interests than on their stated demands, and brainstorm new alternatives that might solve the problem better than obvious options.¹¹ At the same time, major differences demarcate in-house conflict resolution from



litigation-mediation. A health lawyer wishing to help her client set up effective conflict resolution processes must be aware of these features, because a defective configuration of the system can render the whole effort useless. Additionally, a health lawyer who is either coaching or directly assisting a client in such negotiations needs to understand how they work, so that she can serve in a collaborative, problem-solving rather than adversarial fashion.

Conflict resolution in the clinical setting requires an array of tools as diverse as the situations addressed. Sometimes, as in Bioethics Mediation of an end-of-life dispute, a third-party neutral helps parties to define the issues more clearly and together (try to) arrive at a mutually agreeable resolution—or at least, to identify the next step in what is often a rapidly evolving situation. Other times a conflict specialist may focus more on coaching, helping someone to negotiate more effectively in one-on-one disputes.¹²

Although conflicts in health care do not always require a third-party neutral, an independent facilitator can nevertheless be useful in many instances. For example, the “care conferences” that periodically occur for patients with complex problems present an opportunity to bring together the family, patient (if he is able), attending physician, various consultants, nursing staff, and others with key information about the patient. Although these may often be led by the attending physician, sometimes the most acrimonious, challenging care conferences could be greatly enhanced by a neutral facilitator.

What follows thus applies particularly to situations featuring a third-party neutral, ranging from informal in-house facilitator to an outside professional conflict specialist. For convenience in this discussion, all these neutral-assisted conversations will be dubbed “mediation.”¹³

Logistics

The mediations that happen in litigation typically take a full day, sometimes more. In contrast, a clinical mediation usually must be compressed into an hour or two. Providers have other patients, and it can be exceedingly difficult to assemble a complex patient’s many consulting specialists, whose input may be as necessary as the attending physician’s. Family members likewise may only be available for limited periods. In conflicts between employees, e.g. two nurses, those nurses still have patients to care for, hence limited time.

Pre-Mediation Communication and Mediator’s Orientation

These time constraints, plus the fact that mediators speak directly with parties rather than through any attorney-intermediaries, lend great importance to pre-mediation communication. The mediator/facilitator usually needs to meet personally

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with parties in advance, for as long as it takes, to explain the process, build trust, and develop a reasonably clear picture of the overall situation and of each person’s greatest priorities.

In health care disputes the focus is usually on immediate and fast-changing problems. Parties’ emotions may be especially high, and the stakes likewise can be very high—life and death. Accordingly, the mediator’s opening remarks during the meeting are particularly important. This may be the mediator’s best opportunity, not just to (re)explain a process that may be unfamiliar to participants but, based on the neuroscience of mediation, to induce calm in the parties by modeling, with her own voice and gestures, the calm and respectful conversation that will occur.¹⁴

Impartiality/Neutrality

In litigation, typically the mediator is unaffiliated with any party or attorney. Neutrality is usually not an issue. In health care, however, the mediator is often employed by the hospital or an associated institution. Depending on the extent to which conflict has damaged trust, that person may be regarded as simply another Hospital Authority seeking one side’s acquiescence to the other. Establishing the mediator’s role as an impartial facilitator, and particularly establishing the mediation’s purpose as an opportunity for everyone to be heard in a respectful, problem-solving manner, is essential but sometimes difficult. Several strategies can help.

For any of these disputes the mediator can best create trust and credibility via careful pre-mediation conversations. Where a controversy has arisen among the staff—whether medical, nursing, or other—an in-house mediator should come from a department unrelated to any party’s, to minimize opportunities for bias and to allay fears of recrimination. The site of such a mediation should likewise be neutral territory—another wing or floor of the hospital, away from prying eyes and ears.

In the most contentious situations it may be preferable to use an outside mediator who has no connection with the hospital. While that option may be costlier in the short term, effective resolution of intense conflicts can be considerably less costly in the long run.

Style of Mediation

Mediations in litigation often feature shuttling: the mediator separates the parties, carries offers back and forth, and weighs in on offers' credibility. The goal, after all, is an enforceable agreement, and mediators may nudge parties toward sometimes-grudging concessions.

The clinical setting largely precludes this approach. As noted, there is no formal contract at the conclusion, and there is no leverage analogous to judicial enforceability. Moreover, relationships play a major role. In most cases the people around the table must continue to interact with each other. Indeed, one of the most important outcomes may be that these parties learn how to communicate more effectively. For that, they must ordinarily speak to each other face to face during mediation, albeit with coaching from the mediator.

Additionally, these mediations can elicit new information that completely transforms participants' picture of the issues. Although providers may have provided frequent updates to patients and families, they may never have heard how that information was received, or how other providers' conflicting information may have created confusion, or how prior health care experiences have shaped patients' and families' current perceptions.

All of this requires that the mediator be comfortable with intense emotion, with silence in the room, and with the reality that the most important outcome may not be some kind of "deal" that everyone signs onto. This does not mean, however, that the mediator should refrain from appropriate reality-testing. The realities will be clinical and practical, and the mediator must help each side understand as clearly as possible the potential consequences of each option, and to absorb the messages presented by other participants.

Confidentiality

Traditional mediation emphasizes confidentiality, also important in health care. If feuding members of the housekeeping crew fear that what they say in mediation will get back to The Boss, they are unlikely to speak freely. At the same time, an agreement the employees reach may need approval from higher-ups, hence confidentiality here may apply more to the conversation than to its outcome. If someone says "I really do know how you feel—the same terrible things happened to me when I was 8 years old," such revelations must receive the strongest protection.

Patient-care mediations add confidentiality wrinkles. Per the Health Insurance Portability and Accountability Act, the mediator must either be already entitled to the patient's health information, or must secure patient/surrogate consent to learn about the situation. As above, the conclusion of patient-focused mediations may not have the full privacy of, say, a contract reached by parties in a lawsuit. Some decisions may need administrative approval, such as those involving costly resources. And patient care plans must be recorded in the chart.

Implications for Health Lawyers

As health care increasingly relies on complex teamwork, and as providers become integrated across a broader spectrum of care, maintaining relationships becomes a pivotal necessity. Given the inevitability of conflict, and conflict's detrimental effects on relationships, user-friendly, effective conflict resolution processes are imperative.

Health lawyers must help clients to create and implement these processes. Sometimes attorneys will be at the forefront, drafting appropriate clauses in the contracts that create relationships. Other times they will coach clients from the shadows. And sometimes they will directly participate, perhaps in processes akin to collaborative law. In collaborative law each side has an attorney, yet the attorneys' goal is not to fight, but to seek mutually acceptable resolutions. Although collaborative law is usually seen in family law/divorce, in health law the goal is to keep parties together rather than split them up—to solve problems so the relationship can succeed.

The logistics, skills, and styles of conflict resolution in health care are markedly different from those used for litigation-mediation. Health lawyers would be wise to enhance their familiarity with processes that aim to preserve and enhance relationships. Properly provided, the tools and skills of conflict resolution can enhance quality of care and quality of life for everyone. **■**

About the Author



Haavi Morreim, JD, PhD (hmorreim@adrinst.com) is an academician, attorney, and an active mediator for both civil and family matters. Dr. Morreim brings a distinctive perspective to health care conflict resolution. As a 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, but rather 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 locus permits an



ongoing, first-hand view of day-to-day conflicts arising for patients, families, physicians, nurses, administrators and others in health care. Dr. Morreim is a vice chair of AHLA's Alternative Dispute Resolution Affinity Group. Additionally she is vice chair of the ABA's Task Force on ADR and Conflict Management. Dr. Morreim is a principal in the ADR Institute, which provides traditional mediation training, as well as specific training for conflict resolution in health care.

Endnotes

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- 12 For an excellent discussion of the spectrum of ways in which conflict can effectively be addressed, see Scott & Gerardi, *supra* note 3.
- 13 As noted just above, "mediation" may not be the best term to use around physicians because to them, the term often carries negative connotations.
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