"Getting to Yes" on Steroids: Clinical Mediation in Healthcare
By Haavi Morreim

Dispute resolution in healthcare is on the rise, addressing payor-provider disputes; frayed business relations, whether among members of a medical group, or a hospital's contracts with its suppliers; peer review mediation; medical malpractice; False Claims Act allegations; and a host of other issues. My own perspective on conflict in healthcare is somewhat distinctive. As professor in a medical school,[1] I teach health law, bioethics and conflict resolution to physicians and medical students on the wards, during the daily delivery of healthcare. I have watched conflict up close for over three decades in that clinical setting. This brief note will offer some perspective from the inside – a bit different from what attorneys and mediators usually encounter and, I hope, shed light on what happens before disputes reach the lawyers.

Conflict "In the Trenches" of Clinical Care

Healthcare is rife with conflict. The stakes are high, and with it the tensions. A simple error at the local coffee shop might lead to the wrong order or the wrong price. If noticed it can be corrected with a smile. Or not. Either way, no biggie. The exact same very human error, made while writing a medication order or programming an I.V. pump, can kill someone. Even if the mistake is caught before harm occurs, the fallout can be significant, as fingers of blame are pointed in all directions and stress levels rise. And with the changing structures of healthcare delivery, providers formerly accustomed to substantial professional independence must now collaborate in complex teams whose communication is not always as fluid as it needs to be.

These are healthcare conflicts at their earliest stages. Most never reach attorneys, and their amicable resolution is essential to high quality care. In pediatrics and internal medicine, the two departments in which most of my teaching is based, here are a few of the day-to-day conflicts I see:

*At 2:00am a nurse has asked the general medicine resident about what to do for a surgical patient in distress. She was afraid to talk to the surgery resident (the appropriate person to ask), because that particular resident is well-known to be nasty and argumentative. So she talks to the medicine resident instead. Such re-directed communication is medically inappropriate and potentially dangerous, yet a familiar work-around to avoid a dreaded conflict.

*An experienced cardiologist has sold his practice to a hospital system, only to find that most of his happy expectations have been dashed, and now he wants a "divorce."[2]

*A nurse in a children's hospital has insisted to a mother that her baby needs to go to the Pediatric Intensive Care Unit (PICU), pointing to his worsening respiratory distress. The second-year resident responds "I'm the doctor, and if I thought this child needed to be in the PICU I would transfer him there!" The mother is not reassured, because she believes these physicians-in-training too often overestimate their expertise.

*An intern is about to have a difficult conversation with a patient's family who demands that "everything" be done for their father, even though he is suffering, quite surely dying, and beyond any reasonable medical hope.

Conflict Management Strategies

Managing conflict productively in the clinical setting takes a variety of forms. In my own work, some of it is education-focused. The pediatrics department with which I work has now instituted two required trainings for all interns: a full-day "Communication Bootcamp" and a 2-hour training on how to disclose errors and adverse outcomes. Though both are new, the feedback has been very positive, as interns subsequently report episodes that might otherwise have been contentious, yet which turned instead toward collaborative problem-solving.[3]

Conflict coaching, one-on-one, is another tool I often use. As faculty I have the opportunity to sit down with faculty colleagues, residents and students, and help them plan ahead for a conversation they know will be difficult. We might discuss, for instance, a patient's condition, prognosis and social situation – or perhaps we may try to figure out why a colleague might be throwing so many roadblocks in one's way, or whatever else might be behind a troubling situation. We then explore various directions the conversation might take, with assorted options for responding. And we review some specific communication techniques, verbal and nonverbal, that might be helpful for moving the situation from animosity to rationality. After such coaching sessions the answer to my follow-up question "how'd it go?" usually seems to be "it went well; I'm so glad we had the chance to talk ahead of time."

Mediation and facilitated conversations can also work well for managing some of the most difficult clinical conflicts. The following are two recent cases in which mediation proved very helpful. The descriptions are modified just enough to protect confidentiality while preserving all the 'moving parts'. These are real mediations, although their form differs from the kind we commonly see in litigation.

Mediation in the Clinical Setting

In the first case,[4] the parents of 7-year old Benny had been amicably divorced for four years, sharing custody equally as they lived only a short distance apart. Dad's mother had recently moved in with him after the death of her spouse, while Mom lived with her fiancé. Benny was at Dad's home on the day of the accident. Dad had fallen asleep in front of the TV and when he awoke, Benny was gone and so was Dad's all-terrain vehicle (ATV). Benny was found shortly later, face down in a pool of rainwater near the overturned ATV. His heartbeat was restored but, by the end of a week in the PICU, he had clearly suffered massive anoxic brain damage. He would quite likely be permanently in a condition called "minimal consciousness," only a little better than a persistent vegetative state. It was doubtful he would ever regain significant physical movement.

During that first week Benny was in PICU, Dad had exchanged heated words with Mom's fiancé, and the hospital had banned the fiancé from returning to visit. Sometime during week four Mom had gone to juvenile court and filed to gain full custody of Benny. At the end of week six Benny was nearly ready for discharge. He was not on a ventilator, but copious mucous secretions in his trachea would suffocate him if not frequently suctioned out. He also was fed directly into his stomach via a gastrostomy tube.

With all this afoot the question arose, to which parent's home should Benny be discharged. Benny would need 24/7 care, but insurance would not cover home nursing. Each parent insisted that s/he, not the other parent, was the right person to care for him, and neither trusted the other at this point. Because the parents had had a good experience mediating their divorce, they accepted the hospitalist physician's suggestion to try an informal, in-house

mediation. I provided that mediation, which involved five meetings (with various combinations of people including Mom's fiancé and Dad's mother), totaling seven hours, over the course of 10 days.

In the end the parents came to their own agreement, recognizing that any court proceeding would play out over many months, whereas a workable arrangement had to be reached promptly. They also concluded that their limited resources would be far better spent on Benny than on a court fight. Follow-up with Benny's outpatient pediatrician, several months later, indicated that the parents' agreement seemed to be holding up fairly well and that Benny was now capable of social smiling – encouraging and helpful to both parents.

In the second case, a five-month old baby had significant overall muscle weakness and difficulty swallowing since birth. When testing showed he was unable to eat without at least partly aspirating (sending food down the trachea into the lungs), the pediatrician insisted on surgical placement of a gastrostomy tube to send feeds directly into the stomach, bypassing the throat and the usual swallowing process. The parents objected vigorously, insisting among other things that the test did not adequately reflect their son's real ability to feed. The physician responded equally vigorously, threatening to call the Department of Children's Services if parents refused the surgery. While the baby was in the hospital the conflict escalated for several days, with the parents threatening to leave against medical advice and then "firing" the physician. Hospital risk management responded by placing security guards outside the family's hospital door to prevent them from taking the baby home.

The social worker in that unit requested conflict resolution assistance and I agreed to provide it. The mediation process began with a number of separate pre-mediation conversations to explore the two physicians' concerns and goals, plus a lengthy listening-session with the parents. All were glad for the opportunity to have a problem-solving conversation. The social worker reserved a conference room in which the baby's x-rays and other relevant medical information could be displayed on a screen for all to see and discuss. The next day the parents, physician, speech therapist, social worker and I met for two hours. Emotional tension on all sides had been considerably reduced following the previous day's conversations, and so the discussion permitted each side to ask questions and provide information that the other side had not heard, or perhaps not fully appreciated, before. Collectively they agreed on three medically reasonable options. Later that day, the parents chose one of those options.

Clinical Mediation: Different from Litigation-Mediation

Mediation in this setting differs markedly from the kind familiar in litigation.[5] The latter transpires in the shadow of a future court adjudication. Someone completely outside the conflict will decide what happens, if the parties themselves fail to settle, and ordinarily they abide by that ruling, like it or not. If the parties do settle they have little choice but to honor their agreement, unless their contract is somehow unenforceable. As a result, it is fairly common for mediators to use evaluative techniques to move parties, even if reluctantly, to agreement.

Very little of this applies to clinical mediation. If participants fail to agree, there is no designated party who will assign a decision. The physician may simply shrug and acquiesce to a patient's or family's demands[6]; or the patient's condition might change dramatically and with it the entire question at issue; or in extreme cases hospital administration may call out security staff or otherwise impose its will (sometimes unexpectedly and arbitrarily). Even if participants do reach agreement, there is no enforceability akin to a contract. Their agreement will hold up only so long as all parties genuinely embrace it. Many physicians have expressed surprise and

disappointment when, after they thought a patient or family seemingly accepted a recommendation, they suddenly changed their minds shortly later. An "agreement" borne of misunderstanding or bullied acquiescence will often fall apart before the day is over. Thus the clinical mediator cannot "notch his gunbelt" and claim success, simply by getting signatures on paper.[7]

As a result, the clinical mediator's approach must be highly facilitative. The goal must be to explore each person's most important information, unmet needs and goals and to assist all to find, for themselves, a resolution that works. A typical evaluative-style mediator will quickly become just one more pair of fists in the fight. And then the fight then becomes even more deadlocked.

Moreover, the framework for these mediations differs significantly from that for litigation. Logistically, gathering everyone into one or two rooms for eight or ten hours is simply not an option. An hour or two is the most one can hope for, if that. On the other hand, clinical mediations often afford enviable flexibility. The most contentious inpatient disputes often involve complex medical situations for which the patient remains hospitalized for more than just a day or two. Hence a brief, on-the-fly conversation can often be followed up by more in-depth communication; further information or expertise can be sought as needed; and one can speak directly with each party, rather than through the filter of a representative.

That flexibility also can extend to the outcome of mediation. Often is it not even possible to craft a single, comprehensive, this-is-the-final-answer for clinical conflicts. More commonly the question simply concerns what to try next. Even a bona fide agreement on that question can be upended if the patient's condition unexpectedly changes, or if a new person (the nephew from California) enters the conversation. Thus, mediations in clinical care may become more of an ongoing conversation – conflict management – than the single event we usually see for litigation.

Finally, in clinical care the parties often need to continue their relationship, at least for a while. Switching to a different hospital may be impossible physically or fiscally; there may not be another doctor available (or not available within one's health plan), particularly for subspecialist care; and even if the patient can "fire" the doctor or vice versa, others such as nurses are still involved in caring for that person. The same applies in healthcare's broader setting, beyond provider-patient relationships. Workplace conflicts, e.g. between nurses in a unit or housekeeping staff, are not always resolvable by sending someone elsewhere. Hence, one of the greatest services a conflict neutral can provide is to help parties learn how to communicate with each other more effectively. And this requires that, at least for some parts of the process, people in conflict meet face-to-face. The "separate-and-shuttle" technique is rarely effective in this setting.

In this sense it might be said, in a way, that clinical mediation is "Getting to Yes"[8] on steroids. The conflict neutral must help parties to focus on the problem, not on each other, and must create a setting in which everyone at the table focuses more on creative problem-solving than on winning or losing. Because safe, high-quality healthcare relies so heavily on creating and preserving successful relationships, those of us in dispute resolution can anticipate new and ever more interesting opportunities in the years ahead.

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[1] College of Medicine, University of Tennessee Health Science Center.
[2] Haavi Morreim, In-House Conflict Resolution Processes: Health Lawyers as Problem-Solvers. 25(3) The Health Lawyer 10 (2014).
[3] Other departments with which I work are now increasing their communications training as well, and upper-level medical students can take an elective course focusing on negotiation and mediation.
[4] For a more detailed description of this case see Haavi Morreim, Conflict Resolution in the Clinical Setting: A Story Beyond Bioethics Mediation. Journal of Law, Medicine & Ethics; forthcoming 2016
[5] For more detailed discussion see Haavi Morreim, Conflict Resolution in Health Care. 18(1) Connections 28 (2014).
[6] Such acquiescence can happen, e.g., when physicians urge abating aggressive life-support for a patient who is quite clearly dying, yet family demand relentless care, whereupon physicians continue the heroics because the family, not the patient, will be alive to sue.
[7] Indeed, ink on paper is rarely an outcome, except to the extent that a collective patient care decision is entered into the medical record.
[8] Roger Fisher & William Ury, Getting to Yes, 2nd edition, 1991.