Curing Conflict

A prescription for ADR in health care

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Increasing pressures, the complex nature of health care structures and an explosion of diverse interests lead to chronic conflict from the waiting room to the board room, and current resolution methods are inadequate to address it. The need for ADR—creatively adapted to this field—is acute, and extends well beyond settling malpractice lawsuits and mediating labor negotiations.

Sources of conflict

The national focus on health services cost containment includes declining government and insurance reimbursements that are not structured to pay for improving quality of care or safety.[1] This competes with expensive demands—in some cases, unfunded regulatory mandates—for safer care, high-tech services, updated facilities and extraordinary insurance and labor costs. Safety and quality concerns are driving culture change at the intersection of law and medicine, with expectations of disclosing medical "errors," placing professionals in vulnerable positions with heightened liability fears.[2] The national nursing shortage and physician discontent, along with fewer carriers writing malpractice policies, jeopardize recruiting and retaining personnel and affect the quality of services provided. Meanwhile, accrediting bodies and multiple state and federal agencies require compliance with such a volume of regulations—some of them conflicting—that paperwork consumes patient care time and threatens to obscure the regulations' purposes.

Health care's structure and organizations also fuel conflict.[3] The individuals involved are accustomed to autonomous problem-solving, but this is in tension with necessary interdependence with other professionals—and is often complicated by poor information-sharing structures.

Additionally, the health care arena is distinguished by the variety of stakeholders within it, each with diverse interests and priorities. Patients have different interests based on demographics, beliefs about disease and treatment and disease propensity due to genetics or behavior. Administrators, physicians, nurses and other professionals—and within each profession, the specialists—bring different perspectives to delivering care.

Types of conflict

Health care conflict is rarely a matter of simple two-party disputes; it stems from a variety of sources across clinical and business environments. But here we focus on the conflicts that resonate most with consumers: conflicts between doctors and patients that run the gamut of concerns from perceived medical errors and disclosure, coordination between levels of care and providers, end-of-life decisions, pain management, medical necessity, length of stay, level of care, services and equipment, informed consent, appropriate notices and privacy.

One of the greatest areas of conflict involves concern about the quality and safety of treatments. The heightened focus on medical error in the media and through professional patient safety organizations has increased the need for improving collaboration between providers and patients. A typical scenario: A patient is admitted to an outpatient facility for routine cardiac testing. The patient does not bring her list of medications and is uncertain what she has taken that day. The clinic does not have access to an electronic record of her current medications and her written record is in her primary physician's office at another location. The patient waits more than 30 minutes to be seen by the physician who has been called to help with an emergency elsewhere. Upon arrival, the physician is hurried; the patient does not want to interrupt the busy physician with questions and the physician does not take time to ask. During the patient's test, she has a respiratory arrest and has to be resuscitated. There is some question as to what dose of sedative the patient received, since vials with a different concentration than usually used were found on the procedure cart. Additionally, it is later determined that the patient had earlier taken an anti-anxiety drug that might have interacted

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with the medications received for the procedure. Although the patient recovers without further harm, she and her family want to know what happened. There are many breakdowns in delivering care and communication—and the fear of liability and lack of a complete explanation for what occurred create barriers to a full discussion.

ADR to the rescue

As health care evolves and incorporates alternative models for treating patients, its organizations must also evolve to provide complementary conflict management processes.

A prime benefit would be to restore patients' trust. Many legal claims filed because of inadequate conflict management options are preventable, as are the resulting legal and insurance costs and specialty practice closings or relocations.[4] For clinicians, interest-based processes often can be healing, helping them to reclaim trust in one another and create true treatment teams.[5] There is also mounting evidence that conflict management translates into higher quality services.[6] The hospital accreditation body, the Joint Commission on Accreditation of Health care Organizations (JCAHO), notes that team communication failure is a top contributor to severe injuries, and one study shows that 70 to 80 percent of errors are associated with interpersonal interaction breakdowns.[7]

Support for these ideals is growing in diverse quarters. The American Medical Association has policies supporting intra-institutional conflict management.[8] Hospitals are beginning to encourage mediation in admission forms. The Institute for Safe Medication Practices (ISMP) recommends a conflict resolution process and moderated dialogues to reduce intimidating behaviors and the dangers they pose.[9] And the Institute of Medicine (IOM) calls for ongoing collaboration training and adopting interdisciplinary practice.[10] Medical school and health administration programs' accrediting bodies now emphasize managing conflict and change and communication.[11]

Where and How ADR Is Working

Several progressive uses of ADR in health care are outlined below. You can obtain specific information on any of these programs by contacting Health Care Mediations, Inc. at (866) 286-1813.

Medicare beneficiary mediation. The state-based organizations responsible for Medicare's day-to-day operations are mandated to offer mediation as an option for communication-based patient complaints. They contract with mediators and hope to foster co-mediation with a clinician, as well as offering "mediation advisors" for support and information.

Patient safety programs. Children's Health care of Atlanta's program for talking about patient harm includes collaborative policy design; training in web, video and skill development formats for nurses, leaders, physicians and the community; providing clinician support; and coordination with its legal and risk management departments. The Veterans' Administration policy encourages full and early disclosure of suspected errors by a multi-disciplinary committee after its Lexington Medical Center demonstrated a dramatic drop in payouts. When Stanford Hospital initiated its patient safety program, it used ADR techniques to create a multidisciplinary patient safety advisory group and workgroups and to analyze patient harms.

Collaborative claims management. Children's Health care of Atlanta's dispute resolution program approaches patient claims through a frame of common interests and institutional values. Attorneys provide access to documents and personnel and frequently participate in mediation.

Internal neutral/ombuds programs. The National Naval Medical Center and Kaiser Permanente use an in-house position to address patient care concerns within hours of learning about them. This clinician employs multiple techniques, including an ombuds/investigatory role, interest-based negotiation and mediation and emphasizes truthful discussion with families, apology and joint problem-solving.

Internal/external resource continuum. Kindred Health Care includes a mediation clause in its consent documents; it also trains staff in conflict management skills, particularly key risk managers. Tahoe Forest Hospital District mandates mediation skills training for all employees; encourages their use in operations, human resources complaints and contract bargaining; and contracts with an outside facilitator.

Mediation for mental health clients. Arizona State Hospital and the District of Columbia Department of Mental Health offer mediation for patient complaints. Features include employee time dedicated to this effort and explicit attempts to address power imbalance.

Bioethics operations. Baystate Health Care System uses transformative mediation in its bioethics committee consultations, mandating both a 40-hour and ongoing training for all committee members.

Facilitated early settlement programs. Rush Presbyterian Hospital and health facilities at Johns Hopkins and Drexel Universities use a plaintiff's and defense attorney team to facilitate early settlement of selected malpractice lawsuits, using interest-based techniques.

Long-term care ombudsmen. Created by legislation, each state employs ombudsmen who advocate for long-term care residents and coordinate volunteer ombudsmen to handle complaint resolution and train nursing home staff in these skills. Find out more at http://www.ltombudsman.org.

Some creative approaches

To move the industry from reactive to proactive behavior, a variety of conflict management approaches is needed. Small successes in using interest-based techniques will build into more widespread acceptance and opportunities.

System design. There is a growing need for conflict management systems integrating internal and external resources. The best of these models incorporate system-oriented and participatory practices into the business of health care and address conflicts involving patients and professionals.[12] They help form a cultural expectation that a dispute process is a natural complement to other facility systems.[13]

Training. Conflict management techniques are included in some of the employee training, leadership development and courses on health care applications such as patient safety and bioethics. Studies show training benefits, in that physicians more often are sued if they fail to demonstrate understanding of the patient's perspective and deliver information poorly or incompletely,[14] but are sued less if they orient patients, use facilitative comments and active listening and ask patients their opinions.[15]

Patient safety. There is much synergy between patient safety and ADR principles. Most errors result from system breakdowns rather than incompetence, so prevention is best served by open discussion to identify and remedy them. This relies on a culture change to a non-punitive atmosphere in which errors and near misses are reported with reduced fear and shame; conflict management techniques are key in creating this atmosphere. Likewise, facilitated formal analysis of these harms can ensure a learning environment.

Conversations after patients have been harmed during treatment are a central focus in the patient safety field. JCAHO and three states—Nevada, Florida and Pennsylvania—require this conversation, and a growing number of professional societies and health care organizations encourage it.[16] The legal system and the usual conversation approaches fail to provide the remedies many patients seek: an explanation, an apology and change to prevent a recurrence. Clinicians must become skilled in addressing these elements and, in some cases, mediation may be appropriate.

Litigated claims. Even when a conflict becomes a lawsuit, conflict management techniques can reduce costs, help satisfy interests and encourage valuable changes to prevent future claims. In early case assessment programs, evaluation procedures shift the focus from "processing" a lawsuit to resolving a business problem;[17] ADR practitioners can serve as early case assessment counsel or resolution counsel or consultants in designing a program. Mediation is also fast becoming the process of choice to settle malpractice claims. Insurance carriers typically will agree—and will often suggest—mediating claims that have merit. Arbitration is also common for denial of care and adverse outcome concerns, and some hospital admission documents include a binding arbitration clause. On the other hand, organizations find that cost and time savings are diminishing and courts may limit this method, making the potential benefit elusive.[18] Public outcries against predispute arbitration clauses are causing organizations and states to reconsider the application to health care.

With this range of conflict resolution options, and others developing daily, there are myriad opportunities for helping affect health care conflict earlier and more effectively.

Endnotes

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