The Final ADR Frontier: Conflict Resolution in Health Care

by Rob Robson and Ginny Morrison

You are probably saying to yourself "What a strange title." This seems especially true when you consider that conflict resolution practitioners are a fairly flexible, adaptable and imaginative group. Surely there will be lots of new "frontiers" left for us to conquer in the future? But when you stop and think about it, there is little doubt that health care is one of the last major fields to consistently show interest in using conflict resolution techniques and experience. Why is this so, and what can we do about it?

The health care system has a number of characteristics that make it less amenable to using alternative dispute resolution than other environments. To begin with, health care has been described as a complex adaptive system—that is, one characterized by fluid linkages, flexible rules that are heavily reliant on system history, constant change, a huge volume of data, and multiple feedback loops but limited access to others' information. Typically this type of system generates more errors but is more innovative than other social structures. The complex nature of the system makes it harder for both system participants and conflict resolvers to fully understand its various components, how these components interrelate, and sources of conflict within the system.

Another dimension of health care is the presence of widespread inequalities and imbalances of power, knowledge and control. Few other social systems are characterized by so many imbalances. Some are obvious, such as the inequalities between health care providers and patients, but other imbalances are present between groups of providers (doctors, nurses, and others); types of providers (primary care versus specialist care or curative versus preventive orientation); payers and management; and management and providers, to name only a few.

Accompanying these imbalances are the widely divergent "cultures" and value-systems held by professional and non-professional players in the system. Patients and their families will look at a clinical problem through very different eyes than their health care providers. Physicians, nurses, social workers, pharmacists, risk managers, hospital administrators, lawyers, and patients will all examine a particular health care error from distinct perspectives. While parties to a dispute usually bring differing values and perspectives to the table, it is unusual to find such a variety of people affected by such widely divergent views, many of which are based in their training and institutionalized by cultural support. Often, just identifying the parties who should sit at the table can be a major challenge.

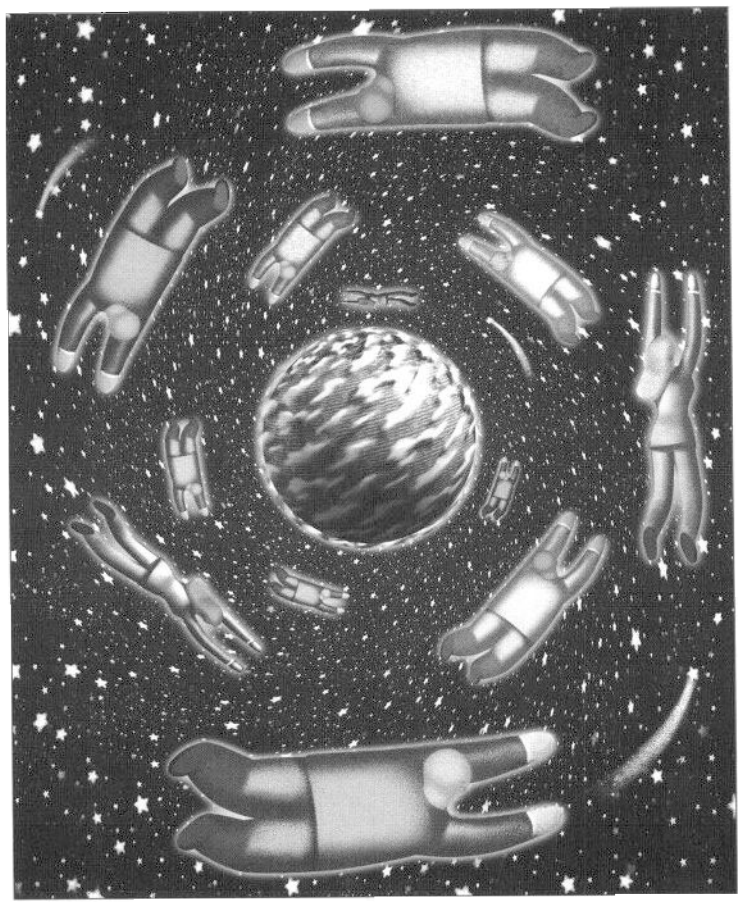
Despite the imbalances between different types of players, most health care professionals tend to strongly link their identities to competent practice of their profession, to hold a sense of community that does not include those outside the health care arena, and to be acutely aware of competing priorities. Taken together, these features and others generate a special situation where it is most unusual to find a simple straightforward two-party conflict, and sources of resistance are many.

It would seem logical that a system that is prone to generating errors would welcome conflict resolution practitioners with open arms, but this is not the case, mainly because our work is not well understood. Mediators and arbitrators are all too often viewed as the people who step in at the eleventh hour to settle a nasty labor dispute. There's an urgent need to perform basic educational work to explain our field and its concrete benefits.

Offering ADR workshops for health care providers is a good way to educate people about how ADR works. Presenting workshops is also a good way to begin to develop your own professional credibility in the field. You may want to volunteer to speak at clinical roundtables, present a guest lecture to students in a medical or nursing school, offer your services through hospital human services departments, or publish an article in the hospital newsletter. Speak to professional societies, and approach them to consider offering mediation as a member benefit. You may not get paid in these endeavors, but you will make contacts. Once you have generated interest, discuss prevention and early intervention strategies with decision-makers.

If health care professionals need to become educated about our work, conflict resolution practitioners, for their part, must be willing to learn more about the specific characteristics of the health care system. There are many listservs, professional societies, and journals geared toward health care sectors and disciplines that can provide you with the proper technical information and contexts.

Similarly, by participating in trainings alongside health care practitioners, ADR practitioners can gain insight into the field and a better understanding of the issues that face health care providers. Different programs are geared toward different disciplines (clinicians, administrators, etc.), and require varying time and financial commitments.



Finally, we need to work together to make the ACR Health Care Section a vibrant place to learn and exchange ideas and to strengthen our abilities to provide high quality conflict resolution services in the health care field. Active participation in the Health Care Section will develop momentum that will be helpful to each of us in our individual initiatives to introduce alternative dispute resolution to health care.

In order for ADR to gain acceptance and recognition in the health care field, conflict resolution practitioners must take proactive steps to encourage its use. First and foremost, we must become adept at building alliances. Collaborative partnerships among ADR practitioners or firms allow a flexible response to projects that require more manpower or specialized expertise. Consumer and advocacy groups, for example, can encourage various sectors (insurers, hospitals, doctors' offices, government offices, accrediting agencies, national organizations) to fund and offer ADR. Interestingly, risk managers also show an increasing interest in facilitated discussion.

The growing patient safety movement is another natural ally. Its advocates share many of the same concerns, but are often not very knowledgeable about conflict resolution. ADR professionals can teach medical staff better ways of talking with patients and families about medical errors, and are uniquely qualified to facilitate those discussions. Patient safety demands a culture open to discussion of difficult topics, in the hope that discussion can lead to prevention. Here, too, conflict resolvers can assist administrators to create that environment. Find out if your local hospital has a patient safety coordinator, and which administrators have a particular commitment to the effort. Attend meetings organized by the National Patient Safety Foundation and visit its Web site (www.npsf.org/) for more information.

To convince health care leaders that conflict resolvers can make important contributions, we must also develop a persuasive economic argument for using ADR in health care. One of the authors of this article was recently involved in a mediation concerning the hospital privileges of a physician. Prior to the mediation, the direct legal costs to all parties exceeded $100,000 and the associated administrative costs amounted to an additional $75,000. By bringing in a mediator, the case was settled at a cost of just over $10,000. Find examples such as this in your own community and share this information with others.

Finally, conflict resolution practitioners often feel too busy helping people solve their problems to write about their experiences, yet many are doing interesting and challenging things in the health care field. We need to share our victories and our defeats with each other, both in case studies and in methods of overcoming resistance.

With the current emphasis on implementing major patient safety initiatives, the nationwide nursing shortage, rapidly increasing medical malpractice premiums leading to walkouts and practice or service closures, and financial pressures from many directions, this is an opportune time to make the case for investing in alternative dispute resolution mechanisms. We will need to continue to take on the role of conflict resolution "missionaries" for some time to come.

Rob Robson is an emergency physician and health care mediator based in Ottawa, Canada. He is a founding director of mediate.calm™, which provides a full range of mediation services to the health care sector in Canada, and is presently Co-Chair of the ACR Health Care Section.

Ginny Morrison mediates clinical health care disputes, designs conflict resolution systems to advance patient safety, and educates health care professionals about conflict resolution. She is an active member of the ACR Health Care Section Advisory Committee.