

CONFLICT MANAGEMENT IN HOSPITAL SYSTEMS: NOT JUST FOR LEADERSHIP

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I. Why?

Experience tells us that the majority of errors in healthcare come from communication problems.¹ Our view is that these problems stem in large part from conflicts, what one writer has called the “invisible” conflict that exists in healthcare.² Whether small or large, the important characteristic of conflicts for this discussion is that they exist, and they make it less likely that one healthcare person will communicate to another what may be important to the treatment outcome for the patient.

Taking this thought one step further, if communication before an event occurs is critical to an outcome, then so is the communication that occurs after an event. It is this post-occurrence communication that dictates whether the institution has the ability to learn and improve from the experience, and also whether they have the ability to deal fairly and openly with the providers, patient and family involved.

Because good communication before and after care is the essence of good healthcare, it will be important for healthcare enterprises to anticipate that communication skills and conflict skills will become primary predictors of the organization’s ability to progress in both quality improvement and patient safety, and will therefore equip its caregivers and administrators with these skills. For those who do adopt this approach, they can expect lower turn-over, less burnout, increased patient loyalty and lower rates of medical errors.³

¹Joint Commission Resources: *2011 Hospital Accreditation Standards*. Oakbrook Terrace, Ill.: Joint Commission on Accreditation of Healthcare Organizations, 2011.

²Matz, D.: The Inevitability and Perils of “Invisible” Health Care conflict. *Hamline J Pub L & Pol’y* 29(2):243-248. Summer 2005

³Angermeier, et al: The Impact of Participative Management Perceptions on Customer Service, Medical Errors, Burnout, and Turnover Intentions. *J HC Mgmt* 54(2) Mar/Apr 2009.

The Joint Commission has issued a Leadership Standard that requires conflict management process to be available to administration, medical staff leadership and the governing board.⁴ Similar requirements have been added for physician leaders. Our discussion will not be addressing the need for conflict management process or policy for just leadership, but instead will propose how to install a conflict management-based approach for patients who have questions about the outcome of care and for employees and managers who are dealing with conflict on the front lines in the environment of care.

II. When Events Occur – Existing Systems Create Conflict

Healthcare is unique in many ways. At the same time it is similar to other enterprises in the ways in which people behave when something happens that could give rise to liability or professional discipline. The event could be an unintended outcome, the filing of a peer review grievance, the filing of a lawsuit or receipt of an alert from a Patient Safety Organization. Many institutional processes and structures exist that describe the preferred communications pathways for dealing with these events. These structures each depend on people putting aside their personal fears and emotional filters and behaving professionally.

These processes also exist independently of each other for the most part. Because each process has a different purpose and “owner,” this independence is intentional in many respects. Whether it is due to the structure necessary for applicability of a legally-recognized privilege that protects information from discovery (such as peer review) or the historical separation between quality functions and direct administrative processes, when an event occurs, several independent systems engage which compete for -- and often limit access to -- critical information necessary to reduce conflict and to allow the organization to learn and improve.

When an event has occurred and the patient or family has questions about the outcome of care, the facility and each employee and provider should have the same moral and ethical

⁴ Joint Commission Resources: *2011 Hospital Accreditation Standards*. Oakbrook Terrace, Ill.: Joint Commission on Accreditation of Healthcare Organizations, 2011.

commitment to the patient as when the patient initially asked for care.⁵ All should continue to act in the best interest of the patient. The long-term interests of the institution are also best served by the same professional and disciplined behaviors. But it is very difficult to teach and learn how best to behave when something has gone wrong.

A. Event Response and Activities

For the sake of discussion, we will be using as an example the unintended outcome of care. Treatment has been rendered, and in spite of the intentions and actions of all involved to create the ideal outcome for the patient from the medical encounter, the patient has not responded well to the treatment. The outcome of treatment is unexpected. Not knowing what the cause of the outcome may be, the event is entered into the hospital's occurrence reporting system.

The Event Dynamics Chart [Fig. 1] illustrates the majority of processes that exist in healthcare relating to the occurrence of situations that call into question the appropriateness of the outcome of care. It is just a partial list, as many other department processes cascade from those listed.

Documentation

In the left-hand quadrant of Fig. 1 are those items that pre-exist any known occurrence. These are the things that may lead up to the event, or be relevant to understanding the underlying environment of the outcome, such as the medical record, policies, documents, processes and people who may be involved in care or members of the patient family. Documents would include any policies relating to the methods used to treat the patient, as well as processes relating to delivery of care, communication among care givers, ordering and delivering pharmaceuticals, and diagnostic testing. Documents would also include the ordinary business records created for billing and operations, and the elements of the patient medical record.

⁵ Scott, C.: Doctors as advocates, lawyers as healers. *Hamline J Pub L & Pol'y* 29(1):331-399, Spring 2008.

The items in this first quadrant all exist prior to the event. This quadrant also represents items which are typically discoverable should there be litigation relating to the event.⁶

Figure 1

Pre-event	Event Analysis	Event-related Response	Event Resolution
Policies Processes Medical Record Source Documents Witnesses	Quality Review RC Analysis Peer Review Occurrence Report Disciplinary Process Education	Process Improvement Administrative Public Relations Risk Management Licensing Board State Investigation Disclosure	Ethics Committee Insurance Legal Claim Investigation State Report JCAHO Report ADR

Risk Management

Each healthcare facility has its own system and practices in place to deal with these events. In many institutions, the first thing that follows recognition of an event is notice to risk management. The risk management office is connected to legal or quality, or sometimes other departments. In some jurisdictions the work of risk management may be privileged. In others it may not be, so this arrow is above the line. If the risk management department is part of a legal department, or acts at the instruction of legal services relating to events, it should be non-discoverable.

The notice to risk management of the occurrence of an event triggers the next several actions. If quality lives in the risk department, or if it is a separate department, quality is notified so its personnel can gather information that will assist the

⁶ Each jurisdiction will have differences in what may be discoverable. This is a placement of items based on a typical legal construction.

organization in determining systemic causes and preventing future occurrences.

The work being done by risk management may be turned over to attorneys who will represent the organization should a claim arise from the event. The investigation that is performed by risk and legal is shared with the insurance adjusters and defense attorneys, and is used to evaluate the potential liability. This investigation is legally privileged and not discoverable.

Administration

Administration is notified of the event. This notice is part of ordinary business operations. This communication and all of the administrative communication and actions that follow are part of the evidence that can be used by either side in a trial. It is important to note that all of the e-mails that administration generates talking about events that have occurred are generally discoverable.

The actual occurrence report that is filed by either a person on the floor or risk management can be protected in some jurisdictions, depending on the way the reporting system is administered, and the extent of the peer review privilege in that jurisdiction. It often becomes the data set that is used to track and trend this event within the quality and safety database of the organization. The specific report is usually maintained in a manner that preserves its confidentiality and privilege.

Administration will typically include public relations in its list of offices that are notified of an event that is significant. This is an important business consideration, and remember that all of the information and documents that go to a public relations office will be discoverable in litigation.

By this time, risk management will have opened a potential compensable event or "PCE" file if the event is significant, and will put insurance carriers on notice if that is the method it has for financing potential hospital liability. The efforts of risk management to gather information in anticipation of litigation, *if properly performed*, and if the risk management office is within legal services, should be protected from discovery in most jurisdictions under the attorney-client privilege.

While risk is investigating for liability purposes, quality is performing an "RCA", or root cause analysis. This process is

separate, and the information that is generated should be protected under the peer review privilege in most jurisdictions. This organizational peer review is a self-critical analysis of the various contributing factors that led to the event. Identifying fault is not the objective of an RCA; rather, it looks at the systems, methods and behaviors that contribute to an event.

Disclosure

At some point very close to the time of the event, it is appropriate for the treating physician to disclose to the patient and/or family the outcome of treatment.⁷ It should be a disclosure of what has occurred and how that is different from what was intended. It should not include any speculation regarding cause or fault. What the event means for the course of treatment should be discussed. In order for the disclosure to be considered effective, it is our recommendation that the disclosure be documented in the patient record.

The documentation of disclosure in the medical record is something for which there is no generally accepted standard, so we suggest that the documentation of the patient disclosure include the identity of the disclosing physician, the date and time of the disclosure, the basic facts of the event, who was present at the disclosure and the impact the event may have on future treatment. Note that no discussion of causation or fault is to be made in the disclosure or in the documentation at this time. It is premature to draw conclusions regarding causation. The patient should also be given the name of the person with whom they can communicate in the future should they have questions. In our experience this is someone such as a nurse in the role of the clinical risk coordinator.

Some states require certain events to be reported to the state licensing board. The report to the state is usually confidential and not discoverable. The report may be made from quality, and often there is a short timeline for reporting to the state.

Ethics

If there are issues regarding the ethical implications of the treatment decisions, or if there is now a decision to be made, there

⁷ Joint Commission Resources: *2011 Hospital Accreditation Standards*. Oakbrook Terrace, Ill.: Joint Commission on Accreditation of Healthcare Organizations, 2011.

may be a need for an ethics consult. The ethics committee will not make a determination regarding what is clinically appropriate, but may offer an opinion on whether a course of action or treatment would be ethically appropriate in a particular situation.

Process improvement

As a result of their work, quality produces a work product that is in the form of a recommendation. This recommendation, when it arises from a peer review privileged process, is itself protected from discovery. The recommendation is given to administration, and if it is implemented, the changes that are made to system policies and procedures may become discoverable to the extent relevant to the litigation, and as allowed by rules of evidence.

The work of quality is parallel to another peer review protected process that includes physician peer review. Physician peer review will look at the role of the physicians involved if there is any question that their behavior or clinical skills contributed to the outcome of the event. This process and the resulting action against the physician is privileged and not discoverable.

Human Resources

At the same time, there may be involvement of employees of the hospital. Whether an investigation and action taken against an employee as the result of involvement in an event is discoverable will be case specific, and may depend on both jurisdiction and whether an attorney has done the investigation. This issue is the subject of a significant amount of litigation and could be the topic of an entire discussion in and of itself.

Reporting

In addition to the mandatory state report of some events, the Joint Commission has a voluntary reporting system that accepts information on occurrences that are deemed to be sentinel events. These events will be reported if the institution determines it would be helpful to do so. The Joint Commission may also hear of an event and request information to be filed relating to the event. When the credentialing body does its review of the facility in the

future, it may request to see the files relating to the event, the RCA and the resulting actions taken in response.

The state report, while not public, may generate a state investigation, which could result in public disclosure of their findings and penalties imposed, if any.

Litigation

By the time a claim is filed, much information may be out there for a plaintiff to accumulate. Litigation may ensue, and when it does, all of these processes and the underlying policies, processes and documentation may be requested. If mediation, or any form of ADR is pursued, it may limit the expense and time involved in finding resolution. It may also be appropriate in mediation to offer to show the plaintiff some or all of the non-privileged documentation that shows how the organization responded to this event and the changes to policies, if any, that have been made as a result.

Should a physician or nurse have been named in a written demand or in the complaint, they should be involved in the resolution of a claim. If a payment is made, the payment may have to be reported to the national practitioner data bank. These reports are not publically available, but they are available to other facilities where the practitioners apply for privileges, and to insurance companies.

When a case is resolved that involves a physician, there is also typically a report to the state licensing board of any payment made. This report may cause the board to investigate and to take some action against the physician relating to the occurrence.

B. Poor Communication Breeds Conflict

With all of this activity in all of these departments, along with the informal communication that attends any significant occurrence, it is no wonder that conflict arises both formally and informally. At each step in any event response process, information sharing and communication skills and the existence of conflict can make a significant difference in the ability to improve the system of care and treatment outcomes. The primary cause of

sentinel events, some of the most serious of unintended outcomes, is communication failure.⁸

The implications for patient care are significant. If you are not getting along with the nurse to whom you are handing over the care of a patient, you may not be as inclined for that conversation to last as long as need be in order to properly transfer care. If your peer review processes are not properly set up, you may not be able to protect the information that is generated for self-improvement. If that privileged information gets disclosed because an administrator demands to know what is going on in peer review, thereby sacrificing the ability to protect it, how many spontaneous reports will be made in the future?

The scope of all of these committees, functions, responsibilities must be properly drawn and followed in order for the environment of care to function properly. Each person has to know the limit of his/her “need to know” and the risk that is created when being curious beyond the scope of their responsibility. If properly educated, instead of being suspicious, or feeling excluded, each involved party will recognize the importance of following the process established to support patient safety.

C. Medical Liability - Unintended Outcome, Disclosure and Malpractice

Talk about an existing system that creates conflict! Can you imagine the response when the first risk manager told a hospital administrator or physician that he or she was going to sit down and tell the patient what happened?

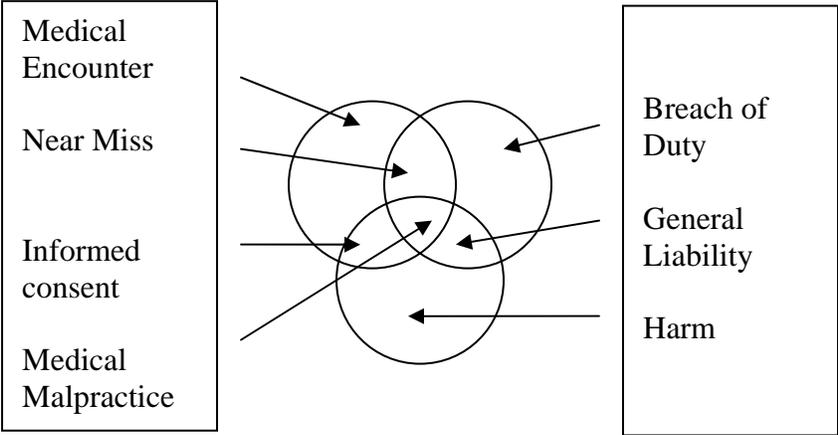
Much discussion about unintended outcomes has focused on the wide range of outcomes that occur and are not desired. Some providers have become reticent to acknowledge and address those harms for which a systematic review of underlying causes may be beneficial. In line with the traditional view of apology as admission against interest, providers are saying that they feel a

⁸ The Joint Commission. Most Frequently Identified Root Causes of Sentinel Events Reviewed by The Joint Commission by Year. http://www.jointcommission.org/assets/1/18/se_root_cause_event_type_2004_2Q2011.pdf. Accessed August 29, 2011.

sense of risk associated with establishing processes that look into cause when the cause is not error.

While this reluctance understandable, and is a natural product of the over-zealous pursuit by some for accountability of individuals instead of systems, the actual range of cases for which liability would exist is rather narrow. Industry data shows that relatively few cases are brought on the basis of medical negligence, and that the majority of harm is not caused by a breach of professional duty.⁹ The illustration below [Figure 2] shows the relationship between a medical encounter, harm and breach of duty. In a perfect world, all cases would be based on the intersection of all three circles. In reality, the cases represent an area broader than the larger intersection of the medical encounter, harm and breach of duty portions of the chart.

Figure 2



III. Enterprise Conflict Management (ECM)

⁹ Studdert, D. et al. Claims, Errors, and Compensation Payments in Medical Malpractice Litigation
N Engl J Med 2006; 354:2024-2033. May 11, 2006. Accessed on line August 29, 2011.

What would a comprehensive conflict management approach look like in a multi-campus hospital system? ECM will be whatever the organization is willing and able to do to give the administration, employees, board of trustees and medical staff the tools they need to address communication and conflict in a manner that resolves disputes and encourages the sharing of lessons learned.

Most hospitals that have seen improvement in conflict management ability have picked one area and focused on that area for initial improvement. Successful examples include medical¹⁰ or hospital liability defense¹¹ and medical staff behavior issues.¹² The hospitals involved have usually taken this step because an individual champion of an interest-based approach to resolving conflict was responsible for an area of operation where conflict management had the potential for high impact. These individuals plot out a course to change some well-established systems, either overtly sanctioned by the board and leadership, or covertly hidden within their budget in a manner that draws little attention. In some organizations this initial transformation is accomplished either completely or to a large extent by stealth. In the later case, the individuals who introduce the initial steps are critically dependent upon early success so as not to be caught in the trap of having gone down the road of “career limiting behavior” before they could demonstrate significant return on their investment. In both cases the individuals realize very early that they have the potential to introduce a new concept that could impact both patient outcomes and expense. The trick is to get progress and show results in a way that draws positive attention and support for the program before resistance can take hold.

A. Beginning in Risk Management

¹⁰ Hickson, G., et al: Patient Complaints and Malpractice Risk in a Regional Healthcare Center. *S Md J.* 2007; 100:791-6

¹¹ Kachalia, A. et al: Liability Claims and Costs Before and After Implementation of a Medical Error Disclosure Program. *Ann Intern Med.* 153 (4) 213-221. Aug 2010

¹² Hickson G., et al: A complimentary Approach to Promoting Professionalism: Identifying, Measuring and Addressing Unprofessional Behaviors. *Acad Med.* Vol. 82, No. 11.

At our hospital, the first point of entry was the hospital liability program. The role of risk manager has been transformed into one of resolution manager. The following chart [Figure 3] shows the differences between a focus on resolution and the traditional focus on defense.

Figure 3

<u>Traditional Approach</u>	<u>New Resolution Focus</u>
Avoid disclosure	Disclose outcome
Retain outside counsel, notify carrier	Notify Carrier
Investigate/interview internally	Invite patient/family/attorney to meet
Wait for suit or demand letter	Listen to patient experience/narrative
Deny liability; Send BS ¹³ letter	Agree to investigate, meet again
Engage in discovery, litigation	Provide discoverable documents
Adopt litigation management plan	Ask what resolution may look like
Litigate for 2 years +	Apologize, examine root cause
Make minimal offer	Claims committee assess value
Mediation	Meet again, make offer, explain value
Settle or go to trial	Settle or agree to mediate
Win or lose	Mediate, settle or agree to litigate
Pay outside counsel	Significant cost reduction

When first looking at the traditional approach used in most hospitals, it is important to recognize that few risk managers and outside attorneys see any need for change. To the contrary, for many years the measure of success of a risk management program was determined by the premium paid and success in litigation. The

¹³ BS stands for Bart Simpson, a member of the cartoon Simpson family who famously says “I didn’t do it, nobody saw me, you can’t prove anything.” Trademark and Copyright owned by FOX and its related entities.

fact that it took three years and \$100,000 to resolve a case that was “won” through the established process, was not part of the equation. In addition, most hospitals will tell you that they are using alternative dispute resolution process “when the timing is right.” This usually means that they go through the entire litigation defense process, full discovery and then after three years and much expense, they send their defense attorney to shuttle-style mediation. Folks, this is a lot of things, but aggressive resolution of claims it is not.

In many hospitals there has been an evolution toward self-insurance, increased retention or the creation of captive insurance companies to help manage the cost of insuring professional and hospital liability. These approaches increase the attention being paid to the overhead and defense costs of managing risk defense, but still do not often recognize the potential for taking a completely different view of how best to reduce both cost of resolution and improvement in patient care, thereby increasing the opportunity to reduce frequency of claims. When the company has a self-insurance trust, the measure of success is how much you have to contribute to the program each year, and is based on the actuarially-determined exposure over a number of years. If you have additional insurance over the trust funding, when, for example, the trust funds the retention only, you have to be able to work with and convince the insurance carrier of the soundness of the program that you are using to limit claims and costs. There are some insurers who have been very willing to work with hospitals in this approach, and others who have not yet come to an understanding of the underlying approach and the benefits it offers.

In some measure, resistance may be based on jurisdictional variation regarding the protections available for the disclosure and apology conversations.¹⁴ Some states protect these conversations should the case ultimately go to litigation, while others do not. Even those states that have adopted some protections may not yet

¹⁴ Segal, J. & Sacopulos, M: Apology Laws: A Variety of Approaches to Discussing Adverse Medical Outcomes with Patients and Others, *AHLA Connections*, 26-29, Nov 2009; O’Reilly, K., “I’m Sorry”: *Why Is That So Hard for Doctors to Say?* AMEDNEWS, Feb. 1, 2010, <http://www.ama-assn.org/amednews/2010/02/01/prsa0201.htm> retrieved January 9, 2011.

have defined the scope and extent of protection in case law. An additional reason for resistance may be that the insurance companies rely heavily on local counsel to advise them on how best to manage litigation and resolution. Even when a hospital adopts an approach to engage in early evaluation and attempt early resolution, often it is met with an opinion from outside insurance counsel that formal discovery and case evaluation by the firm is necessary before any case can be considered for resolution.

What is different when the traditional defense approach is replaced with a focus on resolution? Examining the events and outcome through the words of the patient and family, the hospital's focus moves from "winning" at litigation to resolving questions about the outcome of care through a series of conversations. Instead of denying liability from the start, the in-house risk management staff meets with families and provides information that helps give perspective and context to the outcome. It also allows for identification of a richer series of behavioral markers and communication failures which give the provider the opportunity to improve without regard to fault.

As the new approach is learned by both risk staff and outside attorneys, there is some agony and debate that goes on. Certainly there will be those who resist the change, and will take every opportunity to characterize the approach as soft, weak, or "opening the flood gates" to more claims.¹⁵

The outside attorneys that have been defending the hospital will be reluctant, and may even behave adverse to your client's interests by using the language of resolution in your claims management meetings, but when talking with opposing counsel or your board members, criticizing the approach as a "losing" proposition. Indeed, we have seen dramatic reductions in the cost per case, as few as one fifth the number of lawsuits, and the length of time to resolution reduced to a year or less. The savings to the hospital in outside attorney fees is significant. The reduction in

¹⁵ Golden, J., *et al*: *The Negotiation Counsel Model: An Empathetic Model for Settling Catastrophic Personal Injury Cases*, 13 Harv. Neg. Law Rev. 211, 241 (2008); ; O'Reilly, K., "I'm Sorry": *Why Is That So Hard for Doctors to Say?* AMEDNEWS, Feb. 1, 2010, <http://www.ama-assn.org/amednews/2010/02/01/prsa0201.htm> retrieved January 9, 2011.

income to the outside firms is not a popular outcome of the new process.

The key to success is to have formal training as a requirement for being part of the new approach. Every member of the risk management department, every member of your claims committee,¹⁶ and every outside attorney handling general or hospital liability cases should be sent for what we call collaborative mediation training. Not to be confused with collaborative law, collaborative mediation is a form of mediation where instead of holding an exercise in shuttle diplomacy, the parties and their representatives remain together for the majority of the time. The agenda is one of collaboration in identifying what issues and questions are to be discussed, and truly the parties are provided an opportunity to develop their resolution.

With collaborative mediation as the resolution tool of choice, you remain true to the primary goal of resolving questions about the outcome of care in a way that rebuilds trust and does not use litigation to further drive an adversarial wedge between the hospital and its patient community.

B. Implementing the Resolution Management Approach

The implementation of this approach has to be looked at as a system of resolution that is focused on patients and their perceptions as they experience outcomes that are not as they had expected. Once training has been provided to all involved in risk management, the process depends on strict adherence. You must perform the process as you have described it in your department process manual.

Notify Carrier

Having the carrier on board is critical. With the resources available, it is a great conversation to have during renewal time. The size of your retention or the presence of a captive insurer would make the conversion easier, but in any event, the approach

¹⁶ For example, a claims committee may include the chief nursing officer, chief medical officer, chief financial officer, chief legal officer, risk management representatives and outside counsel, all of whom should be trained in collaborative mediation.

has the benefit of being in compliance with the Joint Commission standards, the values of the organization and with the positive results that have been published. We have been very fortunate to have worked with several insurers and brokers who were willing to embrace this approach. They were a bit wide-eyed at first, and could not believe the extent to which we would go to share information and apologize when appropriate, but eventually all of the representatives that have taken part in our collaborative mediations have said they felt that this was truly a refreshing change, and one for which they were proud to be a part.

Each carrier will have a different view based upon their perception of the overall exposure and impact on their ability to manage their cases. When there is a “consent to settle” provision in the policy you have more leverage to consent to a process that is otherwise consistent with cooperating with the carrier.

For this reason it is important to sit down with the carrier before implementing the change to a resolution focused process, and actually walk through the steps with them to see what if anything they may question. As you train your employees in the process, include the carrier and broker representatives with which you commonly work, and also include them in the membership of your claims committee. This integral connection to the process and the other participants will be critical to their ability to understand and report on the cases that are handled in this manner.

Remember, your progress reports sent to the carrier and broker by their agents will look different from those generated relating to cases where outside law firms are providing case management. The litigation milestones and markers of progress are far different from the resolution milestones and markers of progress.

The benchmarks and measures of success of the program will also look very different. You will certainly keep track of the cost per case per month, time to resolution, and overall cost of resolution. In addition you will also have data on how quickly you meet with patients/families/attorneys, how many meetings you hold over what period of time, how quickly you determine a value, and how quickly after you know a value you are able to resolve the case within that range.

These benchmarks are unfamiliar to the insurance industry, and will not be seen as a true value until you are able to show a

correlation between the time it takes to speak with a family and the overall life and cost of resolving a case.

Invite Patient/Family/Attorney to Meet

The single most important aspect of this process is providing the early opportunity for the patient, family and their attorney to meet with you to tell you what has occurred through their eyes. It is so important, we make a point to talk to the patient or attorney immediately when we learn that they have questions about the outcome of care, and begin describing what we would like to accomplish with their help. Inviting them to meet, and truly welcoming the opportunity to hear their story is something that distinguishes this approach from other forms of alternative approaches. Some hospitals will hire an outside firm to do an early case evaluation. This may involve the outside attorney interviewing the patient or their attorney. That is very different from inviting the patient and their attorney into our offices, or meeting at their offices, and thanking them for taking the time to share their experience with you.

By making contact immediately and offering the chance to meet and hear from the patient or family directly, you set the stage for a collaborative approach to solving the problem presented. If you are sincere in your desire to learn from what the patient tells you, and if your reaction is not one of defense but one of a need for sharing information, you will have a unique opportunity to see just how well this process can work.

When an attorney is involved on the other side, and we find the whole process actually works very well when the patient is represented by competent counsel, it is our habit to invite the attorney to lunch. So when we get a demand or notice letter, it is not uncommon to pick up the phone and call the attorney and ask if they would join us for a bite and to discuss our approach to resolving questions about the outcome of care such as those posed on behalf of their client. It is very important to think of the process as beginning in that first phone call. If you are not walking the talk immediately, you are not being consistent and genuine and can send confusing signals.

This is why we recommend immediately disclosing that what we would hope to discuss at lunch is the process we would like to use to share information about the occurrence. It is not

intended to be a negotiation or opportunity to make an offer or demand. The last thing we want is a stake in the ground or expectation made before any information is known.

What our goal should be is to agree to a process by which information that is not otherwise privileged will be shared and discussed in order for all to have a complete set of documents and facts on which to evaluate and discuss the case. We also invite the attorney to consider allowing us to meet with the client to hear their story first hand.

Some attorneys are reluctant to agree to this with the thought that we are trying to judge the strength of their client as a witness. Through discussion of the patient safety and process improvement goals of the hospital, we try to explain that until we hear exactly how the patient perceived what was happening, and how we communicated with them before and after the occurrence, we are not in a position to address their complaint as well as we would like. We also cannot improve as well without hearing their story.

It is also our recommended practice to take our outside attorney to this lunch meeting. It not only shows your own counsel how to approach resolving questions about care, but it also gives you the opportunity to tell the opposing counsel and your counsel in one breath the same thing. You expect them to work together to share information that will help you reach resolution in a timely way. It is more powerful to have that discussion together, and it allows the opposing counsel to feel that if they are not getting the type of collaboration that you describe they can pick up the phone and call you.

Listen to Patient's Narrative

A lot of work has been done in the field of mediation studying the importance of a party's narrative. The patient's story as it is expressed first person is typically so rich and vital to understanding what has occurred from the patient's perspective. When you listen to the narrative, you do not interrupt. To the contrary, you do nothing to interrupt his or her speaking. No clarifying questions, no dramatic note taking, no glancing about the room or conferring with others at the table. When the patient is finished, you even ask, "Is there anything else you would like to

say?" Not until he or she is completely finished do you then move to the next step.

Agree to Investigate, Meet Again

You immediately thank the patient for sharing his or her story with you, and remind him or her that you cannot improve as an organization unless you hear from patients. We then acknowledge that although we are 4500 employees showing up every day to try to help people, the outcome is not always what we or anyone would have hoped for. We then ask if we can take some time to look into his or her concerns and questions, and then meet again. We identify 3 or 4 items at the most that seem to be key to the matter, and ask the patient if information on those items would be helpful. We agree that we will talk with our employees involved, and will look in the records. We give the patient the name of a person to call if he or she thinks of anything else he or she would like us to look into, and we ask if a meeting in about 30 days would be acceptable.

Provide All Non-Privileged Information

We then talk with all involved, and a nurse from risk management goes through the medical record. By the time we meet again, we have all of the non-privileged information with us and available to share. When we meet again, we first thank the patient for taking the time to meet, and for sharing his or her story at the first meeting. The first information shared is all of the people with whom we have met, and their titles or involvement in the matter. We will offer a summary of what those employees have shared, and will also highlight and provide copies of portions of the medical record that are relevant. We will decipher the writing in the record, and tell the patient who signed each part of the medical record.

As the information is shared, there is often an explanation for some of the treatment choices, or a reason that a certain test or treatment was performed or not performed at particular time. All of this is discussed, and the patient is encouraged to ask questions throughout.

Once all of the information is shared, we ask if there are any additional questions that have come up during this discussion.

Sometimes it will have to do with equipment, or dosing of medications. If we can, we get answers right away, if not we may schedule another time to demonstrate equipment or provide additional information.

Ask What Resolution Might Look Like

Once all information has been shared, we ask if there is anything else we can do. Sometimes the answer is that we have provided the information, and the patient understands that the outcome was not one that we could have avoided. Other times the patient believes that the information has not provided good support for how the outcome has occurred, and would like to have some form of redress.

What we do if the patient feels that redress is appropriate is ask what resolution would look like for him or her. This phrasing is done so as to not suggest any resolution on our part, but to hear what that might mean to the patient. Sometimes it is a request to talk with the nurse involved. Sometimes it is an apology from us. Sometimes it is a request for compensation or for the bill for services to be forgiven. Whatever the request, we take it very seriously, and we do not react in a negative way. We thank the patient for telling us what he or she sees as a resolution, and if it involves compensation, we describe our claims committee, and tell the patient on what date it will next meet. On occasion, we have actually invited the patient and his or her family to come to the claims committee meetings to tell their story.

Apologize, Change Policies

When the request for resolution includes an apology, or a request to change a policy or procedure, we listen very carefully to the elements of this request. The specifics are often important, because the patient generally does not want to hear that you are sorry this happened, he or she wants to hear that you understand that when coming to us for help, he or she did not expect to be meeting with lawyers and suffering an additional injury. We offer an apology in the context of understanding that the patient trusted us with his or her well-being and that we have failed the patient's expectation of being cared for. It is sincere, and it is offered in the hope that the patient will trust us in the future.

When a policy is in question, we offer to send the patient a copy of any changes we make when the policy is changed. The offer includes some information on how our policies are developed, and not a promise that we can change as the patient wants, but that we will look at the opportunity to be sure we have the industry standard, and that we will address all of the concerns the patient has identified in the process.

Have Claims Committee Assess Value

At the conclusion of the second meeting, if the patient's resolution idea includes compensation, we agree that we, or he/she, will present his/her request for compensation to our claims committee. After the committee meets, we will meet again to tell him or her the result. The claims committee is a very thoughtful group, all trained in mediation and familiar with our approach. It includes the Chief Nursing Officer, the Chief Medical Officer, an outside attorney, risk management, the Chief Legal Officer, the SVP of Human Resources and a finance representative.

This committee listens to the history of the claim, the circumstances, what the questions were that we identified, what documents and interviews were gathered, and what the patient has requested. Through deliberation they agree on a resolution amount.

Meet Again, Discuss Value, Explain

With the claims committee value in hand, we meet again with the patient. You may be wondering at this point why we meet three times, and have the process take 60 days or more. We believe that when we meet and agree to provide something at a subsequent meeting, we provide also the opportunity for us to follow through and do as we have promised. If we can deliver as promised and on time the follow-up information and discuss with the patient the progress we are making toward resolution of his or her questions, we have shown the patient what we believe is a trustworthy process.

When we meet with a value, we again begin by thanking the patient for his or her participation and time. We summarize the presentation to the committee, and tell the patient that the value

reached has no relationship to the value we place on the patient or the experience, but is based on the standards of liability.

We then tell the patient the value that the committee has provided, and leave the patient, his or her family, and/or his or her attorney to discuss among themselves. When we are asked to return, we do not entertain counters or negotiations, but tell them that if there is additional information of which we are not aware, it could influence the value. If all is as it is known as of that date, then the value will not change.

Settle Or Agree To Mediate

If the amount is accepted, then a release is prepared and signed. If not accepted, we encourage the patient, his or her family and/or his or her attorney to pursue any available avenue for resolution, and tell them that we will continue to collaborate with them in whatever process they choose. If they would like to mediate the matter, we are willing to do so. We use a mediator who is collaborative in process so that much of the time is spent together as a group exploring resolution in an open and widely varied range. By this I mean that it is not about just money. The discussion includes all of the issues that have arisen, and when we discuss compensation, it is about what those dollars represent.

Settle Or Agree To Litigate

Some attorneys or patients are more comfortable in the legal framework, and we are fine with that. If they would like to file a lawsuit, we try to expedite discovery to try to resolve the matter quickly. If they will not agree to mediate until a lawsuit is filed, we work with them to schedule the mediation as soon as they are comfortable. If mediation does not resolve the matter, we will prepare for trial. Throughout, we do not attack or punish the patient for asking questions about the outcome of care. We maintain the same obligation of respect we had the first day they came in our door.

C. Leadership Training – A Continuous Process

Early success in the highly visible, traditionally costly area of risk management was used literally to fund and support a

training program to teach collaborative problem solving in the healthcare environment to leadership. The organization has approx. 18 executives, 11 board members, 120 manager level or higher positions and 4500 employees. The classes are taught by the same training team that teaches the risk staff and outside counsel in collaborative mediation.

After two years, a range of leaders, managers and front line employees have attended training. It is not a required class in the sense that employees are directed to a specific session. The invitees of the first class, and each subsequent class, have been identified through those who had received the training and nominated others, the executives, and the original conflict policy-writing committee. It is important that the mediation training office is familiar with the healthcare setting, understands the Joint Commission requirement and can tailor the training specifically to your needs.

With the relative success of both the hospital liability program and the training program being known, the Board received its own two-hour session on conflict and collaborative problem solving in healthcare, presented by the same mediation trainer. The chair of the Board, having heard about the impact this approach could make, and being a champion of patient satisfaction and service excellence, took the three-day training class, and soon followed up with full 40 hour mediation training. Acceptance of this initial leadership training has been better than expected. Half of the executives, the board chair, and another 70 employees have attended.

The key to success is consistency, and introducing a program incrementally through evolution, rather than introducing it through revolution, takes some thoughtful involvement of leadership sooner rather than later. Even with incremental success, it may be a long time before all of the key personnel are willing or able to attend training and embrace the behavioral changes that it will demand.

The current schedule for training is an average of 10 attendees at each quarterly class. It will take several years to be able to capture all willing. And there will be those who do not wish to share the common language and experience of learning conflict management skills.

Because so many projects depend on the same skills and abilities to communicate and resolve conflict, the CEO of the

organization has to be on board to support the training. If you look at any organization, the ongoing projects will typically lend themselves to the observation that they all rely upon the organization having a common language and process for resolving disputes. Studies show when leaders “walk the talk” it improves morale and patient safety¹⁷ so a connection between this training and success in future projects is easy to make.

Resistance

The Joint Commission recently implemented a standard on conflict which requires these skills to be present in an organization and available to the administration, medical staff and board. What becomes of the managers, supervisors and vice presidents who never find it within themselves to set aside the three days it takes to get an introductory immersion in conflict? Is it appropriate to require the unwilling to train in conflict management? Unless required to attend, will they ever be supportive of a process without the understanding of how it works? If required to attend, will resistance outweigh opportunity?

An even greater impact, and one that we had not anticipated, was the reluctance of the executives who had not attended to allow their managers to attend. We offer the basic three day course, and we also offer a second three day course that allows the participant to be listed as a Rule 31 mediator with the Supreme Court of Tennessee. We find that unless executives are familiar with these classes, they do not support full participation by their staff.

It is understandable that executives who have not had the opportunity to experience this unique type of training would question its value. It is new, it is unfamiliar, and by very description, it threatens the existing hierarchy of decision-making in the hospital system. It is our hope that with the support of the CEO and the Board chair, all leaders in the organization will be able to see the value of the approach to conflict resolution being offered, will participate in the training, will encourage their

¹⁷ Angermeier, et al, the Impact of participative management Perceptions on Customer Service, Medical Errors, Burnout, and Turnover Intentions. J. of HC Mgmt. 54:2 Mar/Ap 2009.

managers to do the same, and will begin to use these skills in their day-to-day interactions.

Time will tell the individual response; but in healthcare we know that once the train leaves the station it picks up steam rapidly. It is becoming established that when patients look at a hospital, they see nursing care and staff care as the primary drivers of their view of quality, willingness to recommend and willingness to return.¹⁸ Will the organization that controls conflict deliver better care? If the conflict management train has left the station, how long can it be before this management/organizational attribute becomes an integral part of the language of healing?

IV. Proposed Comprehensive ECM System Design: A View to the Future

The process the hospital uses to address its internal conflicts will be reflected by its image in the public eye. Regardless of the type or source of a conflict, the longer it remains unresolved, the more it escalates -- increasing the awareness of those from within and outside the organization, building negative sentiment along the way. A positive work environment has been shown to have a direct influence on patient satisfaction and outcomes, while decreases in staff morale produce decreases in patient satisfaction and poorer patient outcomes.¹⁹ Providing a collaborative process of solving problems and addressing conflict that is also appropriate for the situation will create a more harmonious, productive work environment that provides a consistent, higher quality service of care.

This proposed system design addresses disputes between and among employees, volunteers and other hospital personnel. Addressing patient grievances is a parallel process that is underway and will work in conjunction with this proposed system design.

¹⁸ Otani, K. et al: How Patient Reactions to Hospital Care Attributes Affect the Evaluation of Overall Quality of Care, Willingness to Recommend, and Willingness to Return. *JHC Mgmt*55(1) Jan/Feb 2010.

¹⁹ Duddle, M. & Boughton, M.: Interpersonal relations in nursing *JAN* 59(1) 29-37, March 2007.

Identifying Stakeholders

The stakeholders in a system design involve every position within the organization, as well as every partner organization. Internal stakeholders typically include: Board of Trustees, Legal Department, Compliance Office, President's Office and staff, Clinical Services Department, Information Systems Department, Medical Officer and staff, Nursing Officer and staff, Human Resources Department, Planning Office, Payer Relations and Performance Improvement Office, Development Officer and staff, as well as all providers, nurses, clinicians, equipment technicians, in-take clerks, billing clerks, facilities personnel and volunteers.

Externally, stakeholders are any organizations working with the hospital such as suppliers/vendors; outsourced service providers, lab services; outside physicians providing or receiving referrals for patients and anyone utilizing services/care provided by the hospital, i.e. patients, and their families.

Assessment Methodology

The culture of most hospitals traditionally is one of addressing conflict with a rights-based approach. In a rights-based approach, a manager for example will cite a policy as a reason to discipline an employee, and the employee will in turn cite another policy or regulation as a reason to justify his or her behavior or to call out the manager for discipline. This creates a competitive scenario that generally disallows opportunity for an amenable resolution or prevention of a similar occurrence in the future. To assess the most frequent types of conflicts, and the severity of each, a matrix survey can be utilized. The results would indicate the parties involved in conflict, be it peers, managers and subordinates, providers and staff, administrators and managers, and so on.

This can be done anonymously and easily with Internet-based survey tools. Each person participating in the assessment survey would indicate disputes he or she is having and with whom. The information gathered from this assessment can reveal the nature of most disputes within the hospital and the number (as it relates to the sample size) of disputes as well. From here, the effect of the disputes on the organization can begin to be evaluated as to the severity, frequency and involved parties.

Additionally, a review of claims filed with Human Resources and the legal department could be done as part of the assessment. Evaluating the grievances and disputes formally processed will provide historical documentation of employee-related problems. Further, it will provide a comparison of what the employees determine as problems in relation to the problems that are officially filed with the hospital, indicating types of issues that are going unreported or avoided altogether.

Without a current conflict management system in place, it is difficult to know how various disputes are being handled before reaching a formal phase of the process, which may lead to litigation.

In addition to the internal surveys noted above, patient surveys to assess satisfaction are routinely conducted by hospitals both through retained third parties and through Centers for Medicaid and Medicare.²⁰ These surveys can be used to provide valuable insight to employee relations in addition to direct patient feedback. Evidence suggests that reduced job satisfaction leads to lowered motivation and decreased job performance and productivity.²¹

Environmental Awareness

Healthcare workers face many challenges that likely increase conflict, including under-staffing, cost containment, limited resources, and downsizing. Although conflict has been identified as a fundamental problem of the organizational life, conflict among healthcare professionals is detrimental to patients and team performance.²² True to any environment where small mistakes and human error can lead to severe outcomes, including death of patients, providing health care can be stressful. This type

²⁰ HCAHPS: Patients Perspectives of Care Survey, Centers for Medicare and Medicaid Services
http://www.cms.gov/HospitalQualityInits/30_HospitalHCAHPS.asp#TopOfPage Retrieved January 10, 2011.

²¹ Duddle, M. & Boughton, M.: Interpersonal relations in nursing *JAN* 59(1) 29-37, March 2007.

²² Baltimore, J.J: Fact or Fiction? *Nursing Management*, 28-36, May 2006.

of stress combined with long hours, working in close proximity to others and the physical drain of being on your feet constantly is the perfect storm for strife.

Design Recommendation

In order for a hospital to not just meet the requirements of the Joint Commission but to go a step further and fulfill its vision, it should continue its efforts to lessen the frequency and severity of employee disputes and address processes for resolving patient and leadership disputes. This system design not only meets the requirements of the Joint Commission, it is expected to also lower litigation costs, reduce turnover of staff (saving money on recruiting and training of new staff) and increase the quality of care provided.

Collaborative Approach Training

Employees at every level should receive basic collaborative-approach training. A short (30-45 minute) training video would be produced by mediation services professionals. This training would be integrated into the standard enrollment for new hires; additional training videos will be provided for all employees and be required annually.

As part of changing an undesirable process, alternatives to the current rights-based processes for resolution of grievances must be provided. The collaborative approach is counterintuitive for many. The mindset is different, the words are different, the conversations follow a different path and, with a sincere effort, the outcomes can be different. Changes in practice emerge when the language that we use to perform these actions also changes. New meanings, new concepts and new metaphors give rise to new ways of talking about our practices. A shared language and the adoption of common terms to describe and address conflict are key. The potential of peer collaboration as a context for promoting learning in the workplace is because it offers substantial opportunities for language change.²³ During the training process, an internal

²³ Phelan, A.M. et al: Occasioning Learning in the workplace: The case of interprofessional peer collaborations *JIC* 20(4) 415-424, Aug 2006.

promotional campaign should be presented by the hospital. Employees will hear about the ‘Collaborate – Facilitate – Mediate’ Resolution Plan the hospital is incorporating into its processes, including the process for addressing disputes among employees. The training will include information regarding what types of disputes could be mediated and what alternative routes of resolution are available should the complaint not be resolved in mediation.

Mediation Training

The training of hospital administrators and high level managers is critical so leadership understands and embraces the process offered. Advanced skills training should also be provided for those interested. The managers trained in mediation will have opportunities to lead by example in addressing disputes with a collaborative approach and can be called on when the need arises. And it doesn’t take a formal mediation for employees to see these skills at work. We find that once trained in the collaborative approach, managers often model these behaviors in staff meetings. The advantage of internally training the natural troubleshooters, or the organizational leaders, as mediators is that they can help resolve conflicts long before they escalate to formal grievances. This type of training can improve the employee relations skills of operations personnel and supervisors.²⁴

Collaborate – Facilitate – Mediate Resolution Plan

Collaborate:

The first step of the new process empowers employees with a complaint to address the other disputant within a structured process that is intended to be collaborative in nature and as comfortable as possible for both parties. Addressing issues directly with the individuals involved causes much less damage to work relationships than avoiding the person and/or engaging in

²⁴ DeSouza, J.R: Alternative Dispute Resolutions: Methods to Address Workplace Conflict in Health Services Organizations *JHC Mgmt* 453-466, Sept/Oct 1998

negative conversation with peers.²⁵ The collaborative approach training will provide the steps needed to encourage a positive result. If the process is successful in resolving the dispute, the parties go back to work while implementing their agreement as necessary. Parties are required to contact their supervisor(s) if 1) the discussion reveals a policy or procedure can be improved with a more senior staff's involvement or 2) a resolution was not agreed to by either party.

Once a complainant initiates the Collaborate Phase of the process, the respondent is required to meet with the complainant within one (1) week, or reply with a formal request to initiate the Facilitate Phase of the process. The Facilitate Phase is available to all employees at anytime; however, employees are strongly encouraged to begin with the Collaborate Phase and are required to give an explanation should he or she choose to skip the initial phase of the process.

Facilitate:

When a supervisor receives notification that disputants need assistance in facilitating collaborative efforts, he or she acknowledges receipt of the notification and determines a time to meet with both parties. Much like mediation, during the facilitation process the supervisor provides an opportunity for all parties to be heard. The facilitator will have an opportunity to hear party recommendations and reality test possible solutions to the problem at hand based on his or her experience. Managers who actively intervene in [workplace] problems can increase productivity and trust while improving relationship and reducing tension.²⁶ Similar to mediation, the parties are under no obligation to agree to any suggestions discussed during facilitation, only to have an integrative approach to the discussion.

If a resolution is reached, the process concludes with the option to bring the dispute to the supervisor for facilitation in the future should it be necessary. If no resolution is reached, the

²⁵ Baltimore, J.J: Fact or Fiction? *Nursing Management*, 28-36, May 2006.

²⁶ Baltimore, J.J: Fact or Fiction? *Nursing Management*, 28-36, May 2006.

facilitator will refer the matter to the process coordinator to assign an internal mediator.²⁷ Neither party should have a personal relationship with the chosen mediator. The program coordinator will schedule a mediation as determined by schedules of the parties and requested mediator.

Mediate:

The chosen mediator will conduct the mediation as a neutral party, according to the formal training of a mediator in that jurisdiction. Mediators will be encouraged to follow the process of collaborative mediation and refrain from going into caucus unless absolutely necessary as deemed by the mediator or requested by a party. If a resolution is reached, the parties will record the agreement. Each party will have an opportunity to provide policy and procedural change suggestions that may be beneficial in reducing potential conflict for other staff members.

If mediation does not achieve a resolution, the complainant has the option to contact Human Resources and proceed as he or she deems necessary. This may or may not involve escalating the conflict to legal remedies.

Resistance

As with any change within a large organization, there will be many who are hesitant to believe anything will really be different regardless of the leadership's message. There will be many who won't give up their rights-based positioning "without a fight". With a consistent message that is not only delivered often, but also completely woven into the function of the hospital, the culture can change. The commitment of those requesting advanced mediation skills training will lead the way, and an internal awareness campaign will keep the new ideas in the forefront of employees' minds.

As all become more familiar with the process and understand the commitment by hospital leadership the benefits of the approach will begin to surface. The managers will likely see

²⁷ Mediators will be predetermined based on the mediator's roll in the hospital and the lack of personal or professional potential or apparent conflict.

less hostility among the staff, increased quality of patient care and thereby the value in their efforts.

Conclusion

Hospitals are committed not only to meeting the standards of the Joint Commission, but also to changing the culture of the hospital to support improved outcomes. A culture of collaboration can be a key asset in addressing the future environment of care. By creating a more conflict enlightened work environment, the quality of care provided to patients may increase, and the cost of doing so may in fact decrease.